CHP+
Child Health Plan *Plus*

Fiscal Year 2021–2022 Site Review Report

for

DentaQuest

March 2022

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

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

In order to evaluate the PAHP's compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2021–2022 was January 1, 2021, through December 31, 2021. This report documents results of the FY 2021–2022 site review activities for **DentaQuest**. For each of the standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2021–2022 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2020–2021 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for both the credentialing and recredentialing record reviews. Appendix C lists HSAG, PAHP, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan (CAP) process the dental plan will be required to complete for FY 2021–2022 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Sep 27, 2021.

Summary of Results

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

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

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
III. Coordination and Continuity of Care	10	10	4	6	0	0	40%
IV. Member Rights, Protections, and Confidentiality	5	5	5	0	0	0	100%
VIII. Credentialing and Recredentialing	32	5	5	0	0	27	100%
X. Quality Assessment and Performance Improvement	16	16	8	8	0	0	50%
Totals	**63**	**36**	**22**	**14**	**0**	**27**	**61%**

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

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	100	89	89	0	11	100%
Recredentialing	126	72	69	3	9	96%
Totals	**226**	**161**	**158**	**3**	**20**	**98%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

DentaQuest considered several factors when determining where to assign a member. **DentaQuest** took into consideration if a member had a history at an identified dental home, whether a sibling was currently assigned to a dental home, the distance from the member's home to a dental home, the member's age, and the available capacity of the dental home location. Additionally, **DentaQuest** mailed a welcome letter along with an identification (ID) card that included the member's dental home contact information to each new member.

Staff members described an overview of how the providers share the results of identification and assessment of the member's needs with other entities that service the member to prevent duplication of those activities.

DentaQuest conveyed privacy and Health Insurance Portability and Accountability Act of 1996 (HIPAA) expectations through the provider agreement and internally with staff members as evidenced through a training log. Policies and procedures addressed HIPAA regulations and adequate physical and electronic safeguards of member information.

DentaQuest does not require a referral for any member to see a specialist. The plan allows members direct access to a specialist, as appropriate for the member's condition and identified needs.

Summary of Findings Resulting in Opportunities for Improvement

HSAG did not identify opportunities for improvement other than those that resulted in required corrective actions for this standard.

Summary of Required Actions

The national quality improvement program indicated that **DentaQuest** coordinates the necessary dental services with the health plans. However, during the interview session, **DentaQuest** staff members stated they do not perform any coordination of care services for the Colorado CHP+ plan. **DentaQuest** provided a member outreach plan that mentioned that the dental plan would coordinate if/when asked by a member, family member/guardian, or provider. However, **DentaQuest** could not provide any evidence of proactive coordination efforts or procedures to describe this process. **DentaQuest** must develop and implement procedures to deliver care to and coordinate services for all members. The procedures must 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 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.

During the interview, staff members described several services the member could potentially receive from the community and from social support providers. However, **DentaQuest** did not submit procedures regarding how it coordinates services that the plan furnishes the member. **DentaQuest** must develop and implement procedures to coordinate services that the plan furnishes the member:

- Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. Examples may be: If dental care is required while a member resides at a long-term care facility; or non-emergent medical transportation; or a means for the transfer of information or activities between providers, per State contract 4.3.1.3.2.
- With the services the member receives from any other managed care plan.

Although **DentaQuest** stated that providers complete an assessment of each new member's needs, **DentaQuest** was unable to provide specific information regarding this process, and whether the assessment addressed members with special health care needs, high-risk health problems, and/or other complex health problems. **DentaQuest** must provide best efforts to conduct an initial screening of each new member's needs; for **DentaQuest**, this may be an assessment when the member presents for services.

The *Dental Participating Practice Agreement* has a section for professional standards that states, "participating practice, providers, and participating practices employees or agents rendering services to members shall provide dental care which meets or exceeds the standard of care for dentists in the region and shall comply with all standards for dentist as established by any state or federal law or regulation." During the interview, **DentaQuest** staff members were unable to describe a process or provide any evidence of how each provider is furnishing services to members, in accordance with professional standards. Dental record reviews were only completed in instances where a grievance or utilization concern needed to be investigated. **DentaQuest** must implement a method to ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards.

DentaQuest's national quality improvement program states, "all requests for care for complex health needs members and special needs members originate through the plan, where applicable. **DentaQuest** coordinates all aspects of care for the member as directed by the plan. This coordination of care includes, but is not limited to, identifying the appropriate provider, scheduling the appointment(s), claims processing and communicating the resolution of the request and final outcome of the care to the

plan." HSAG understands **DentaQuest**'s role in assessing members with special health care needs is narrow in the scope of dental services. However, when **DentaQuest** does become aware of a member who has special health care needs, there were no procedural details presented for how care is coordinated to ensure necessary dental services are provided. In addition, **DentaQuest** staff members mentioned during the interview that **DentaQuest** does not define members with special health care needs. **DentaQuest** must define special health care needs based on the CHP+ member population. Additionally, **DentaQuest** must implement a mechanism to comprehensively assess each CHP+ member with special health care needs for appropriate dental services and identify any ongoing special conditions that require accommodations. Regarding special health care needs, this could be an attempt to override auto-assignment to place the member with a specialist, as needed, or provide auxiliary aids.

During the interview, **DentaQuest** described the process that providers follow to produce a treatment plan for members that need a course of treatment or regular care monitoring. However, the process described did not include producing a treatment plan for members with special health care needs. **DentaQuest** must develop and implement a process to require providers to produce a "treatment plan" 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 policy must indicate whether **DentaQuest** requires the treatment plan to be approved by **DentaQuest**. The treatment plan must be in accordance with any applicable State quality assurance and utilization review standards (for example, if approval is required due to dental prior-authorization requests). The policy must require providers to review and revise the treatment plan when the member's circumstances or needs change significantly, or at the request of the member.

Standard IV—Member Rights, Protections, and Confidentiality

Summary of Strengths and Findings as Evidence of Compliance

The CHP+ member handbook and website provides members with information on their rights and responsibilities. Members are informed of the right to willingly participate in their healthcare and to communicate with their doctors about appropriate and effective care. The office reference manual (ORM) informed staff members and providers about member rights. **DentaQuest** provided the *Marketing Safeguard* policy, *Exhibit A-Member Rights and Responsibilities,* that outlined all the guaranteed rights and responsibilities of members as required by the federal regulation 42 CFR 438.100(b)(2) and (3). The policy discussed disciplinary actions that the organization may take in the instance a staff member or provider is found in violation of this policy, including any improper retaliation conduct and alleged discrimination complaints against workforce members.

The *Dental Participating Practice Agreement* requires providers to uphold all applicable laws that pertain to nondiscrimination and adhere to safeguarding of member information. **DentaQuest** staff members detailed how the organization supports candid and meaningful feedback from members, which can be submitted to the complaints and grievance department and, depending on the issue, will be researched and resolved through the complaints and grievance department; the fraud, waste, and abuse

department; or the dental board. The CHP+ member handbook discussed the responsibility of members to freely exercise their rights and that exercising those rights shall not adversely affect the way the Contractor, its network providers, or **DentaQuest** treats the member.

DentaQuest's *Nondiscrimination Compliance Program* document stated that, "**DentaQuest** will promptly investigate any discrimination complaints or allegation reported by a member related to race, color, national origin, age, disability, religion, sex, gender identity, sexual orientation, or any other classification protected by federal and state civil rights laws." The policy described its purpose, which is to enforce compliance with applicable federal and State laws related to discrimination in the provision and/or access to healthcare benefits and services. **DentaQuest**'s staff members described raising awareness of its policies on nondiscriminatory behaviors towards members by mandatory trainings and language within the provider agreement. **DentaQuest** submitted a *Training and Education* policy and provided additional evidence to show that the organization offers an annual cultural competency and nondiscriminatory training to staff members.

DentaQuest provided a robust privacy policy that detailed measures to secure all forms of protected health information (PHI), including electronic, paper, and verbal forms, and protect member privacy. The policy described **DentaQuest**'s commitment to only disclosing the minimum necessary information as permitted or required by federal or State law or client contract. **DentaQuest**'s staff members stated that annual compliance trainings are provided to employees, with additional trainings specific to individual departments. **DentaQuest** detailed in its policy the provision of notice of privacy practices to members upon enrollment, at least once every three years, and as requested or when there are material changes to notices. The policy also outlined the steps that the organization will take in responding to breaches in member PHI and described the role of the designated privacy officer in implementing privacy policies and procedures as well as trainings available to workforce members to ensure HIPAA compliance organization-wide.

Summary of Findings Resulting in Opportunities for Improvement

Staff members described the primary means of informing members about their rights was through the CHP+ member handbook. However, at the time of review, HSAG observed that **DentaQuest** did not have a link to the Spanish member handbook on the organization's website. HSAG recommends that **DentaQuest** update its website to include the Spanish member handbook.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

DentaQuest provided a variety of documents such as the credentialing plan description, Credentials Committee charter, *Provider Maintenance and Ongoing Monitoring* policy, and *Credentialing Guidelines* policy. The credentialing plan description and general procedures observed in the record review sample and described by staff members all followed National Committee for Quality Assurance (NCQA) standards and guidelines. The Credentials Committee charter described the roles and responsibilities of the Credentials Committee, which included reviewing practitioner applications with identified issues. **DentaQuest**'s staff members reported 19 total members attending the Credentials Committee, with only three non-voting members. The Credentials Committee charter outlined the criteria for which the Vice President of Clinical Management (or designee) reviews and authorizes a credentialing file as approved.

All record reviews were processed in a timely manner, with only one using the coronavirus disease 2019 (COVID-19) NCQA allowed extension of an additional two months. Current valid license to practice, education and training, and history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner were verified within 180 business days and work history was verified within 365 calendar days, with any gaps in work history explained in writing.

The *Provider Maintenance and Ongoing Monitoring* policy described that **DentaQuest** conducts a monthly review of providers against the National Practitioner Data Bank (NPDB), State licensing or certification agency, Drug Enforcement Administration (DEA), and federal and State exclusion list databases. The policy provided steps that the organization takes to maintain and update provider information in its credentialing system and ensure current and accurate information on the provider directory online, including quarterly outreach and regular auditing.

To prevent discriminatory practices when making credentialing/recredentialing decisions, **DentaQuest** detailed in its policies the process to redact all provider demographic information presented to the Credentials Committee. The *Credentialing Guidelines* policy also discussed that any complaints related to alleged discrimination would be sent for review and investigated by the credentialing management team.

The *Credentialing Guideline* policy discussed the processes that **DentaQuest** follows to maintain confidentiality. Credentialing files are only available for staff members with role-specific access, and granting/modifying rights are also only available for specifically authorized credentialing department staff. **DentaQuest**'s staff members described how the Intelex, Cactus, and Windward systems each integrate effectively and contained the necessary ad-hoc reporting capabilities to support the credentialing needs of the organization.

DentaQuest reported that it has no delegated credentialing organizations, and although **DentaQuest** refers members to dental schools if needed, **DentaQuest** still credentialed and recredentialed individual practitioners at those locations and does not delegate credentialing responsibilities to the dental schools.

Summary of Findings Resulting in Opportunities for Improvement

Staff members stated that **DentaQuest** operated a peer review process that the organization used to ensure that credentialing and recredentialing files are not denied based on any discriminatory reason. However, **DentaQuest** did not submit evidence that detailed this process. Policies and staff members described a process for redacting applications prior to committee review, but did not outline a monitoring process to ensure that this method was effective. Although very few CHP+ providers are declined each year (for example, only three were reportedly declined in calendar year 2021), HSAG recommends that **DentaQuest** develops a review mechanism that monitors to ensure providers are not denied based on discriminatory reasons. NCQA recommends that this review is completed on an annual basis.

DentaQuest reported that there was an issue with sorting its files into credentialing and recredentialing groupings. HSAG identified that due to this error, five initial files submitted for record review were submitted within the recredentialing sample. HSAG recommends that **DentaQuest** reviews its internal procedures for extracting and handling credentialing data to ensure accurate reporting internally and to external entities.

Lastly, in three recredentialing record review samples a Colorado DEA certificate was not included in documentation. When asked about one particular sample, **DentaQuest** reported the DEA certificate was verified for the Texas line of business, but was not verified for the Colorado CHP+ plan. HSAG recommends that **DentaQuest** enhances its documentation process to ensure that primary source verification for the Colorado DEA certificate occurs when a provider is credentialed across multiple states and implements a review mechanism as part of regular chart auditing. **DentaQuest** should begin with a full audit of Colorado CHP+ DEA certificate records.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

DentaQuest developed a national quality improvement program and evaluation. The Quality Oversight Committee met quarterly and included an interdisciplinary group of attendees. As evidence, HSAG reviewed committee meeting minutes from 2021. However, the program, evaluation, and committee minutes did not include discussion or oversight explicitly related to the Colorado CHP+ plan.

Clinical practice guidelines were adopted and based on valid and reliable clinical evidence. Policies and procedures described the process for reviewing, creating, and approving guidelines. Before the guidelines were approved, each guideline was reportedly passed through subject matter experts and a

committee for review. Minutes from the Peer Review Committee meeting, held on March 29, 2021, provided evidence of the most recent set of guidelines being approved. **DentaQuest** disseminated the guidelines to all providers through the ORM, and stated it would distribute upon request to members and potential members.

DentaQuest maintains health information systems that collect, analyze, integrate, and report data. During the interview, **DentaQuest** described the data flow for capturing and storing data, as well as for ensuring accurate reporting for quality management, provider network development, and organizational management decisions. **DentaQuest** furnished a process workflow to demonstrate the encounter data process and described the process for submitting to the Department on a monthly frequency. **DentaQuest** used the Windward claims administration system for claims and encounter data reporting.

Summary of Findings Resulting in Opportunities for Improvement

While staff members were able to describe how **DentaQuest**'s health information systems collect, analyze, integrate, and report data, no written policies, procedures, and/or protocols have been developed. HSAG recommends that **DentaQuest** develop policies, procedures, and/or a desk protocol for all claims processing activities, verifying the accuracy and timeliness of data, and a process for submitting encounter claims data to the Department.

Summary of Required Actions

DentaQuest submitted a national quality improvement program and Quality Oversight Committee meeting minutes for calendar year 2021. The minutes provided evidence that the committee is meeting on a quarterly schedule. During the interview, **DentaQuest** described the committee structure and the Quality Oversight Committee attendees that support the national quality improvement program. **DentaQuest** described a linear reporting structure that involved staff members who work on CHP+ projects. However, evidence that CHP+ activities were reviewed at the National Quality Improvement Committee was not provided during the interview or through submitted documents. **DentaQuest** reported that the National Quality Improvement Committee discussed only broad quality issues and recommendations, and does not discuss specific plans, such as CHP+. **DentaQuest** must have an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its CHP+ members.

DentaQuest's national quality improvement program included information about performance improvement projects (PIPs) and performance measures from a national perspective. The program description did not include information about conducting and submitting PIP(s) or performance measures to the Department on an annual basis. The goal of **DentaQuest**'s PIP and member outreach plan is to help increase preventive utilization for CHP+ members. The PIP enabled the team to identify and evaluate intervention processes that could be implemented and sustained over time, resulting in positive oral health outcomes. The PIP and performance measure information was submitted to the Department annually; however, evidence of PIP initiatives or performance measure reporting was not included in the 2021 Quality Oversight Committee meeting minutes. **DentaQuest** must incorporate PIP activities and any other performance measure reporting into the QAPI Program that are specific to the

CHP+ line of business. Committee discussions and updates must be reflected in the quality program meeting minutes.

The national quality improvement program and the utilization management program description both outlined mechanisms that **DentaQuest** uses to detect under- and over-utilization of services. **DentaQuest** reported that the fraud and prevention recovery unit runs monthly reports on under- and over-utilization by providers. However, **DentaQuest** indicated that these reports are proprietary and would not be shared with HSAG. Additionally, **DentaQuest** verbalized that they rarely have a finding, but if a concern was identified, the Provider Engagement and the Peer Review Committee would be contacted to address the finding. **DentaQuest** was unable to provide policies, procedures, and/or other protocols to describe this mechanism. HSAG reviewed the Quality Oversight Committee meeting minutes from 2021, and no evidence of under- and over-utilization monitoring was discussed. **DentaQuest** must include mechanisms to detect both under- and over-utilization of services that are specific to the CHP+ line of business. Committee discussions and updates must be reflected in the quality program meeting minutes.

DentaQuest conducts an annual member survey. Additionally, the national quality improvement program states that delivery of quality dental services is monitored through the complaint and grievance process, utilization data analysis, and random chart audits. During the interview, **DentaQuest** staff members stated that chart audits (dental record reviews) were only completed in instances where a grievance or utilization concern needed to be investigated. **DentaQuest** does not conduct chart audits proactively or on a regular basis. HSAG reviewed the Quality Oversight Committee meeting minutes from 2021, and no evidence of monitoring to assess the quality and appropriateness of care furnished to members with special health care needs was discussed. **DentaQuest** must include mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs that are specific to the CHP+ line of business. Committee discussions and updates must be reflected in the quality program meeting minutes.

DentaQuest's national quality improvement program included the process for evaluating the impact and effectiveness of the QAPI Program at least annually. As evidence, **DentaQuest** submitted a quality improvement program evaluation from 2020. However, the Colorado CHP+ line of business was not mentioned in the evaluation submitted. **DentaQuest** must include a process for evaluating the impact and effectiveness of the QAPI Program at least annually that is specific to the CHP+ line of business.

DentaQuest's *Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines* policy and procedure stated that the clinical practice guidelines must be consistent with other areas to which the guidelines apply. However, **DentaQuest** was unable to provide evidence or describe a process for how it ensures this process. For example, member educational materials are reviewed to ensure they are consistent with **DentaQuest**'s adopted clinical practice guidelines. **DentaQuest** did not submit details regarding how this occurs. **DentaQuest** must ensure that decisions for utilization management, member education, coverage of services, and other areas to which the clinical practice guidelines apply are consistent. In addition to the current policy statement, **DentaQuest** must have a method to actively monitor member and provider messaging and utilization management decision making for any inconsistencies.

DentaQuest provided the 2020 CHP+ member satisfaction survey results. During the interview, **DentaQuest** staff members were unaware of a process for monitoring and reporting improvement and/or results. HSAG reviewed the Quality Oversight Committee meeting minutes from 2021, which did not contain evidence of reviewing the CHP+ line of business' member satisfaction survey results or complaints, appeals, and grievance information. **DentaQuest** verbalized a process and provided evidence of scorecard (data) reports that were submitted to the Department quarterly. However, **DentaQuest** was unable to provide evidence that the scorecard findings and/or results were brought forward for leadership input, review, tracking, and trending. **DentaQuest** must monitor CHP+ members' satisfaction, which includes complaints, appeals, and grievance information.

2. Overview and Background

Overview of FY 2021–2022 Compliance Monitoring Activities

For the FY 2021–2022 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the dental plan's contract requirements and regulations specified by the federal Medicaid/CHP+ managed care regulations published May 6, 2016. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of records, documents, and materials requested during the site review; and interviews of key dental plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials.

HSAG also reviewed a sample of the dental plan's administrative records related to PAHP credentialing and recredentialing to evaluate implementation of federal healthcare regulations. Reviewers used standardized monitoring tools based on NCQA credentialing standards and guidelines to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of credentialing and recredentialing, and three records with an oversample of an additional three records for organizational providers. Using a random sampling technique, HSAG selected the sample from all PAHP credentialing and recredentialing records that occurred between January 1, 2021, and December 31, 2021. For the record review, the dental plan received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

The site review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2021–2022 site 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—Access and Availability, Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation.

Objective of the Site Review

The objective of the site review was to provide meaningful information to the Department and the dental plan regarding:

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

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

FY 2020–2021 Corrective Action Methodology

As a follow-up to the FY 2020–2021 site review, each health or dental plan 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 health or dental plan 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 health or dental plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **DentaQuest** until it completed each of the required actions from the FY 2020–2021 compliance monitoring site review.

Summary of FY 2020–2021 Required Actions

For FY 2020–2021, HSAG reviewed Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation.

Related to Standard V—Member Information Requirements, **DentaQuest** was required to complete the following actions:

- Update taglines and font sizes in the member handbook and welcome letter.
- Develop mechanisms to notify members that electronic information is available in paper form without charge upon request and is provided within five business days.
- Establish mechanisms to inform members of provider termination within 15 days of termination notice.
- Ensure all the required member rights are listed in the member handbook and that the member rights listed on the website are consistent with the member handbook.
- Update the member handbook to include information on continued benefits during an appeal.
- Revise the member handbook regarding continuous benefits, clarify information on appeals, and provide time frames for filing grievances and appeals.
- Clarify the member handbook language that the appeal process is not limited to denied claims.
- Revise the member handbook language to inform the member that prior-authorization is not required for emergency services and that the member has the right to seek services from any dental or emergency provider to obtain emergency care if needed.
- Update the member handbook to include other health services that are available under the State plan.

- Update the member handbook to include information on how to report suspected fraud or abuse and the number to reach medical management or other departments that provide services for members.

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

- Develop mechanisms to ensure that all grievance resolution letters are sent within the 15-working day resolution time frame.
- Create procedures to ensure that all appeals are acknowledged in writing within two working days of the receipt of the appeal.
- Revise its *Member Appeals* policy to include informing the member of the right to file a grievance if he or she disagrees with the decision to deny the expedited appeal.
- Develop mechanisms to ensure the 10-working day resolution time frame for appeals.
- Clarify time frames related to notice of adverse benefit determination (NABD) and appeals.
- Revise information regarding continuation of benefits in all relevant documents.
- Ensure that grievance and appeal records are accurately maintained.
- Inform providers about the member grievance and appeal systems and clarify information regarding the processes.
- Develop methods to verify whether services represented by providers are received by members.

Related to Standard VII—Provider Participation and Program Integrity, **DentaQuest** was required to create and implement a procedure that outlines how it provides disclosures of ownership as well as prohibited affiliation information to the Department.

DentaQuest did not have any required actions for Standard IX—Subcontractual Relationships and Delegation.

Summary of Corrective Action/Document Review

DentaQuest submitted a proposed CAP in April 2021. HSAG and the Department reviewed and approved the proposed plan and responded to **DentaQuest**. Initial documents as evidence of completion were submitted in July 2021 and additional documents in September 2021. **DentaQuest** met with HSAG and the Department for technical assistance calls as needed. **DentaQuest** resubmitted final CAP documents in November 2021.

Summary of Continued Required Actions

DentaQuest successfully completed the FY 2020–2021 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 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-2—4.3.1.3	DentaQuest believes that this does not pertain to dental. If you feel that this incorrect, please provide DentaQuest with examples of where coordination and continuity of care pertains to dental.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The national quality improvement program did indicate that DentaQuest coordinates the necessary dental services with the health plans. However, during the interview session, DentaQuest staff members conveyed they do not perform any coordination of care services for the Colorado CHP+ plan. DentaQuest provided a member outreach plan that mentioned that the dental plan would coordinate if/when asked by a member, family member/guardian, or provider. However, DentaQuest could not provide any evidence of proactive coordination efforts or procedures to describe this process.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DentaQuest must develop and implement procedures to deliver care to and coordinate services for all members. The procedures must 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 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.		
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-2—None	HCPF does not delegate the coordination of healthcare service to DentaQuest. HCPF delegates and pays the RAEs for this service. Members can choose their own primary dental provider via the find my dentists tool. - Can be found in the welcome letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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.	DentaQuest believes that this does not pertain to dental.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract: Exhibit B-2—4.4.4.9		
Findings: During the interview, staff members did describe several services the member could potentially receive from the community and from social support providers. However, DentaQuest did not submit procedures regarding how it coordinates services that the plan furnishes the member.		
Required Actions: DentaQuest must develop and implement procedures to coordinate services that the plan furnishes the member: • Between settings of care. Examples may be: If dental care is required while a member resides at a long-term care facility; or non-emergent medical transportation; or a means for the transfer of information or activities between providers, per State contract 4.3.1.3.2. • With the services the member receives from any other managed care plan.		
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-2—None	DentaQuest believes that this does not pertain to dental.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Although DentaQuest stated that providers complete an assessment of each new member's needs, DentaQuest was unable to provide specific information regarding this process, and whether the assessment addressed members with special health care needs, high-risk health problems, and/or other complex health problems.		
Required Actions: DentaQuest must provide best efforts to conduct an initial screening of each new member's needs; for DentaQuest, this may be an assessment when the member presents for services.		
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-2—4.3.1.3.4	DentaQuest believes that this does not pertain to dental. We are the only Dental administrator so there would be no duplication of those activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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-2—4.3.15.18.1	Please see section 3.f of 200101 CO CHP+.pdf, the provider agreement.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The *Dental Participating Practice Agreement* has a section for professional standards that states, "participating practice, providers, and participating practices employees or agents rendering services to members shall provide dental care which meets or exceeds the standard of care for dentists in the region and shall comply with all standards for dentist as established by any state or federal law or regulation." During the interview, DentaQuest staff members were unable to describe a process or provide any evidence of how each provider is furnishing services to members, in accordance with professional standards. Dental record reviews were only completed in instances where a grievance or utilization concern needed to be investigated.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DentaQuest must implement a method to ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards.		
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-2—None	HCPF does not delegate the coordination of healthcare service to DentaQuest. HCPF delegates and pays the RAEs for this service.	☒ 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-2—4.3.1.3.5	DentaQuest believes that this does not pertain to dental. Members with special conditions and qualify for a waiver are on the Medicaid program.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest's national quality improvement program states, "all requests for care for complex health needs members and special needs members originate through the plan, where applicable. DentaQuest coordinates all aspects of care for the member as directed by the plan. This coordination of care includes, but is not limited to, identifying the appropriate provider, scheduling the appointment(s), claims processing and communicating the resolution of the request and final outcome of the care to the plan." HSAG understands DentaQuest's role in assessing members with special health care needs is narrow in the scope of dental services. However, when DentaQuest does become aware of a member who has special health care needs, there were no procedural details presented for how care is coordinated to ensure necessary dental services are		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
provided. In addition, DentaQuest staff mentioned during the interview that DentaQuest does not define members with special health care needs.		
Required Actions: DentaQuest must define special health care needs based on the CHP+ member population. Additionally, DentaQuest must implement a mechanism to comprehensively assess each CHP+ member with special health care needs for appropriate dental services and identify any ongoing special conditions that require accommodations. Regarding special health care needs, this could be an attempt to override auto-assignment to place the member with a specialist, as needed, or provide auxiliary aids.		
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-2—4.3.1.3.6	DentaQuest believes that this does not pertain to dental. Members with special conditions and qualify for a waiver are on the Medicaid program.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest described the process that providers follow to produce a treatment plan for members that need a course of treatment or regular care monitoring. However, the process described did not include producing a treatment plan for members with special health care needs.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DentaQuest must develop and implement a process to require providers to produce a "treatment plan" 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 policy must indicate whether DentaQuest requires the treatment plan to be approved by DentaQuest. The treatment plan must be in accordance with any applicable State quality assurance and utilization review standards (for example, if approval is required due to dental prior-authorization requests). The policy must require providers to review and revise the treatment plan 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-2—4.3.1.7.1	DentaQuest believes that this does not pertain to dental. Members can see a specialist without a referral	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	6	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	4
				Total Score ÷ Total Applicable		=	40%

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-2—4.4.8.1-2	This is in the member handbook, ORM, and website. Website: https://dentaquest.com/getattachment/State-Plans/Regions/Colorado/Colorado-CHP/Colorado-CHP-Member-Page/Colorado-Medicaid-Dental-Program-Rights-and-Responsibilities.pdf/?lang=en-US	☒ 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-2—4.4.8.2	Providers are required to follow state and federal regulation as applicable to the program and services they provide. This includes non-discrimination and the ADA. Please see Provider contract template "200101 CO CHP+ MC.pdf" sections 2.d on page 2. ORM, Member handbook,	☒ 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.	COM15-ENT	☒ 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-2—4.4.8.2.1-6		
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-2—4.4.8.2.7	This is in the member handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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-2—None	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. *42 CFR 438.214(b)* NCQA CR1 Contract: Exhibit B-2—4.1.2.8	Note: These are NCQA health plan (HP) requirements available at the time of drafting this tool (07/2021). *For DentaQuest, please submit all relevant materials for the current credentialing process. HSAG will only score requirements that include a federal citation and will use all other information as general context for the report.* Credentialing Plan Description, Credentials Committee Charter, PEC01 and PEC04	☒ 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. *42 CFR 438.214(a–b1)* NCQA CR1—Element A1 Contract: Exhibit B-2—4.1.2.8	Credentialing Plan Description	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.B. The verification sources it uses. NCQA CR1—Element A2	*For items without federal citations, if DentaQuest policies and procedures address the elements, there will be no findings or recommendations.* *PEC01 and PEC04*	*For informational purposes only*

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	Credentials Committee Charter, PEC01 and PEC04	*For informational purposes only*
Findings: DentaQuest reported that there was an issue with sorting its files into credentialing and recredentialing groupings. HSAG identified that due to this error, five initial files submitted for record review were submitted within the recredentialing sample.		
Recommendations: HSAG recommends that DentaQuest reviews its internal procedures for extracting and handling credentialing data to ensure accurate reporting internally and to external entities.		
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	Credentialing Plan Description, Credentials Committee Charter, PEC01 and PEC04	*For informational purposes only*
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	Credentialing Plan Description, Credentials Committee Charter, PEC01 and PEC04	*For informational purposes only*
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include: non-discrimination of applicant, process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* *42 CFR 438.214(c)*	Credentials Committee Charter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR1—Element A6 Contract: Exhibit B-2—4.1.2.8		
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	PEC01 Procedure D	*For informational purposes only*
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	PEC01 Procedure D 5 a	*For informational purposes only*
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	Credentials Committee Charter	*For informational purposes only*
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	PEC01 Procedure G	*For informational purposes only*

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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	PEC04 A 3 and 4	*For informational purposes only*
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, and peer-review protected information available.* NCQA CR1—Element B1	PEC05 and PEC01 D and E	*For informational purposes only*
3.B. To correct erroneous information. NCQA CR1—Element B2	PEC01	*For informational purposes only*
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	PEC01 E 8	*For informational purposes only*

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2—Element A1	PEC01 E	*For informational purposes only*
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 A	Credentials Committee Charter and PEC01	*For informational purposes only*
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits.: • A current, valid license to practice (verification time limit = 180 calendar days). • A valid, current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit = 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 = prior to the credentialing decision; if board certification, time limit = 180 calendar days).	PEC01 and PEC04	*For informational purposes only*

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**

• Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or CV (verification time limit = 365 calendar days).
  – If a gap in employment exceeds six months, the 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 = 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		

Findings: In three recredentialing record review samples, a Colorado DEA certificate was not included in documentation. When asked about one particular sample, DentaQuest reported the DEA certificate was verified for the Texas line of business, but was not verified for the Colorado CHP+ plan.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Recommendations: HSAG recommends that DentaQuest enhances its documentation process to ensure that primary source verification for the Colorado DEA certificate occurs when a provider is credentialed across multiple states and implements a review mechanism as part of regular chart auditing. DentaQuest should begin with a full audit of Colorado CHP+ DEA certificate records.		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit = 180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions. *42 CFR 438.214(d)(1)* NCQA CR3—Element B Contract: Exhibit B-2—4.3.15.14.2.2	PEC01 and PEC04	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. Applications for credentialing include the following (attestation verification time limit = 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).	PEC01 and PEC04	*For informational purposes only*

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C		
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	PEC01 and PEC04	*For informational purposes only*
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-2—4.3.15.14.2.2	CGA04-INS-Monitoring complaints	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards: • 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.* NCQA CR6—Element A	PEC01 and PEC04	*For informational purposes only*
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—which may only include 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-2—4.3.15.14.2.2	N/A	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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—which may only include applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials (e.g., licensure, accreditation report, or letter) from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	PEC01 and PEC04	*For informational purposes only*
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; 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	PEC06	*For informational purposes only*

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's organizational provider assessment policies and process includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory • For physical health, at least the following providers: – Hospitals – Home health agencies – Skilled nursing facilities – Free-standing surgical centers NCQA HP CR7—Elements B&C	N/A	*For informational purposes only*
14. The Contractor has documentation that it assesses providers every 36 months. NCQA HP CR7—Elements D&E	PEC01 and PEC04	*For informational purposes only*
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.	PEC10	*For informational purposes only*

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Requires at least semiannual reporting by the delegated entity to the Contractor (includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • 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		
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *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	PEC10	*For informational purposes only*

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • 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. NCQA CR8—Element C	PEC10	*For informational purposes only*
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	PEC10	*For informational purposes only*

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	27	X	NA	=	27
Total Applicable		=	32	**Total Score**		=	32
				Total Score ÷ Total Applicable		=	100%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)(1)* Contract: Exhibit B-2—4.1.11.4	See National Quality Improvement Program 2021	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest submitted a national quality improvement program and Quality Oversight Committee meeting minutes for 2021. The minutes provided evidence that the committee is meeting on a quarterly schedule. During the interview, DentaQuest described the committee structure and the Quality Oversight Committee attendees that support the national quality improvement program. DentaQuest described a linear reporting structure that involved staff members who work on CHP+ projects. However, evidence that CHP+ activities were reviewed at the National Quality Improvement Committee was not provided during the interview or through submitted documents. DentaQuest reported that the National Quality Improvement Committee discussed only broad quality issues and recommendations, and does not discuss specific plans, such as CHP+.		
Required Actions: DentaQuest must have an ongoing comprehensive QAPI Program for services it furnishes to its CHP+ members.		
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department, one performance improvement project (PIP) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators.	See National Quality Improvement Program 2021	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Planning and initiation of activities for increasing or sustaining improvement. *42 CFR 438.330(b)(1) and (d)(2) and (3)* Contract: Exhibit B-2—4.1.11.5		
Findings: DentaQuest's national quality improvement program included information about PIPs from a national perspective. The program description did not include information about conducting and submitting PIP(s) to the Department on an annual basis. The goal of DentaQuest's PIP and member outreach plan is to help increase preventive utilization for CHP+ members. The PIP enabled the team to identify and evaluate intervention processes that could be implemented and sustained over time, resulting in positive oral health outcomes. Evidence of any PIP initiatives or reporting was not identified in the 2021 Quality Oversight Committee meeting minutes. The PIP was submitted to the Department annually.		
Required Actions: DentaQuest must include PIP activities and reporting into the QAPI Program that are specific to the CHP+ line of business. Committee discussions and updates must be reflected in the quality program meeting minutes.		
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* Contract: Exhibit B-2—4.1.11.6	See National Quality Improvement Program 2021	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DentaQuest's national quality improvement program included information about PIPs and performance measures from a national perspective. The program description did not include information about conducting and submitting PIP(s) or performance measures to the Department on an annual basis. The goal of DentaQuest's PIP and member outreach plan is to help increase preventive utilization for CHP+ members. The PIP enabled the team to identify and evaluate intervention processes that could be implemented and sustained over time, resulting in positive oral health outcomes. The PIP and performance measure information was submitted to the Department annually; however, evidence of PIP initiatives or performance measure reporting was not included in the 2021 Quality Oversight Committee meeting minutes.		
Required Actions: DentaQuest must incorporate PIP activities and any other performance measure reporting into the QAPI Program that are specific to the CHP+ line of business. Committee discussions and updates must be reflected in the quality program meeting minutes.		
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B-2—4.3.12.1.4.	See National Quality Improvement Program 2021	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The national quality improvement program and the utilization management program description both outlined mechanisms that DentaQuest uses to detect under- and over-utilization of services. DentaQuest reported that the fraud and prevention recovery unit runs monthly reports on under- and over-utilization by providers. However, DentaQuest indicated that these reports are proprietary and would not be shared with HSAG. Additionally, DentaQuest verbalized that they rarely have a finding, but if a concern was identified, the Provider Engagement and the Peer Review Committee would be contacted to address the finding. DentaQuest was unable to provide policies, procedures, and/or other protocols to describe this mechanism.		
Required Actions: DentaQuest must include mechanisms to detect both under- and over-utilization of services that are specific to the CHP+ line of business. Committee discussions and updates must be reflected in the quality program meeting minutes.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: (1) a significant limitation in areas of physical, cognitive, or emotional function; (2) dependency on medical or assistive devices to minimize limitation of function or activities; (3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions, or accommodations at home or at school.* *42 CFR 438.330(b)(4)* Contract: Exhibit B-2—4.1.11.7.2.	See National Quality Improvement Program 2021	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

DentaQuest conducts an annual member survey. Additionally, the national quality improvement program states that delivery of quality dental services is monitored through the complaint and grievance process, utilization data analysis, and random chart audits. During the interview, DentaQuest staff members stated that chart audits (dental record reviews) were only completed in instances where a grievance or utilization concern needed to be investigated. DentaQuest does not conduct chart audits proactively or on a regular basis. HSAG reviewed the Quality Oversight Committee meeting minutes from 2021, and no evidence of monitoring to assess the quality and appropriateness of care furnished to members with special health care needs was discussed.

Required Actions:

DentaQuest must include mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs that are specific to the CHP+ line of business. Committee discussions and updates must be reflected in the quality program meeting minutes.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract: Exhibit B-2—4.1.11.8.1-3.	See National Quality Improvement Program Evaluation 2020 Please also see the 2021 Utilization Management Program Description, Pages 12-13	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest's national quality improvement program included the process for evaluating the impact and effectiveness of the QAPI Program at least annually. As evidence, DentaQuest submitted a quality improvement program evaluation from 2020. However, the Colorado CHP+ line of business was not mentioned in the evaluation submitted.		
Required Actions: DentaQuest must include a process for evaluating the impact and effectiveness of the QAPI Program at least annually that is specific to the CHP+ line of business.		
7. The Contractor adopts or develops practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with participating providers. • Are reviewed and updated as appropriate. *42 CFR 438.236(b)* Contract: Exhibit B-2—4.3.12.1.8	See National Quality Improvement Program 2021 Please also see the 2021 Utilization Management Program Description, Pages 3-5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor disseminates the guidelines to all affected providers and, upon request, members and potential members. *42 CFR 438.236(c)* Contract: Exhibit B-2—4.4.7.4	See National Quality Improvement Program 2021 Please also see the 2021 Utilization Management Program Description	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* Contract: Exhibit B-2—4.3.12.1.8.2.	See National Quality Improvement Program 2021 Please also see the 2021 Utilization Management Program Description	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest's *Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines* policy and procedure stated that the clinical practice guidelines must be consistent with other areas to which the guidelines apply. However, DentaQuest was unable to provide evidence or describe a process for how it ensures this process. For example, member educational materials are reviewed to ensure they are consistent with DentaQuest's adopted clinical practice guidelines. DentaQuest did not submit details regarding how this occurs.		
Required Actions: DentaQuest must ensure that decisions for utilization management, member education, coverage of services, and other areas to which the clinical practice guidelines apply are consistent. In addition to the current policy statement, DentaQuest must have a method to actively monitor member and provider messaging and utilization management decision making for any inconsistencies.		
10. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* Contract: Exhibit B-2—None	See National Quality Improvement Program 2021 Please also see WW Claims Ops Overview-Workflow document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's health information system provides information about areas, including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of CHP+ eligibility. *42 CFR 438.242(a)* Contract: Exhibit B-2—4.1.7, 4.2.28.1.2	See National Quality Improvement Program 2021 Please also see the 2021 Utilization Management Program Description	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* Contract: Exhibit B-2—4.1.7.13	See National Quality Improvement Program 2021	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* Contract: Exhibit B-2—4.1.1.1.3	See National Quality Improvement Program 2021	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for CHP+ quality improvement and care coordination efforts. *42 CFR 438.242(b)(3) and (4)* Contract: Exhibit B-2—4.1.1.1.4	See National Quality Improvement Program 2021	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in Accredited Standards Committee (ASC) X12N 837, National Council for Prescription Drug Programs (NCPDP), and ASC X12N 835 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State. *42 CFR 438.242(c)* Contract: Exhibit B-2—4.1.1.1.5-6, 4.1.7.4.1	See National Quality Improvement Program 2021	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor monitors members' satisfaction, including complaints, appeals, and grievance log information. Contract: Exhibit B-2—5.1.1.6.1	See National Quality Improvement Program 2021	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest provided the 2020 CHP+ member satisfaction survey results. During the interview, DentaQuest staff members were unaware of a process for monitoring and reporting improvement and/or results. HSAG reviewed the Quality Oversight Committee meeting minutes from 2021, which did not contain evidence of reviewing the CHP+ line of business' member satisfaction survey results or complaints, appeals, and grievance information. DentaQuest verbalized a process and provided evidence of scorecard (data) reports that were submitted to the Department quarterly. However, DentaQuest was unable to provide evidence that the scorecard findings and/or results were brought forward for leadership input, review, tracking, and trending.		
Required Actions: DentaQuest must monitor CHP+ members' satisfaction, which includes complaints, appeals, and grievance information.		

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	8	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	8
				Total Score ÷ Total Applicable		=	50%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Credentialing Record Review Tool
for DentaQuest

Review Period:	January 1, 2021 – December 31, 2021
Date of Review:	December 20, 2021
Reviewer:	Sarah Lambie and Evarista Ogbon
Health Plan Participant:	Deseray Backman

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #1 Provider ID: **** Credentialing Date: 01/22/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #2 Provider ID: **** Credentialing Date: 02/25/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #3 Provider ID: **** Credentialing Date: 03/16/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #4 Provider ID: **** Credentialing Date: 05/07/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #5 Provider ID: **** Credentialing Date: 06/18/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Credentialing Record Review Tool
for DentaQuest

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #6 Provider ID: **** Credentialing Date: 07/15/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #7 Provider ID: **** Credentialing Date: 08/23/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #8 Provider ID: **** Credentialing Date: 10/12/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #9 Provider ID: **** Credentialing Date: 10/20/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #10 Provider ID: **** Credentialing Date: 11/11/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
Number of Applicable Elements	**10**	**8**	**10**	**1**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**8**	**10**	**1**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**89**
Total Number of Compliant Elements	**89**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

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 compliance tool for elements of complete application)
10. Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate • Education and training	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation • Work history

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Recredentialing Record Review Tool
for DentaQuest

Review Period:	January 1, 2021 – December 31, 2021
Date of Review:	December 20, 2021
Reviewer:	Sarah Lambie and Evarista Ogbon
Health Plan Participant:	Deseray Backman

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #1 Provider ID: **** Current Recredentialing Date: 01/29/21 Prior Credentialing or Recredentialing Date: 02/28/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #2 Provider ID: **** Current Recredentialing Date: 02/02/21 Prior Credentialing or Recredentialing Date: 12/28/17	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments: This file used the NCQA coronavirus disease 2019 (COVID-19) allowed extension of two months.									
File #3 Provider ID: **** Current Recredentialing Date: 03/18/21 Prior Credentialing or Recredentialing Date:	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Comments: DentaQuest staff members determined that this practitioner's file should have been included in the initial credentialing sample. HSAG replaced this file with an oversample.									
File #4 Provider ID: **** Current Recredentialing Date: 05/31/21 Prior Credentialing or Recredentialing Date: 04/30/20	Y ☒ N ☐	Y ☐ N ☒ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Recredentialing Record Review Tool
for DentaQuest

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
Comments: While DentaQuest verified this practitioner's Texas DEA certificate, DentaQuest did not verify a Colorado DEA certificate for this provider.									
File #5 Provider ID: **** Current Recredentialing Date: 06/28/21 Prior Credentialing or Recredentialing Date: 05/28/20	Y ☒ N ☐	Y ☐ N ☒ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments: While DentaQuest verified this practitioner's Texas DEA certificate, DentaQuest did not verify a Colorado DEA certificate for this provider.									
File #6 Provider ID: **** Current Recredentialing Date: 08/12/21 Prior Credentialing or Recredentialing Date:	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Comments: DentaQuest staff members determined that this practitioner's file should have been included in the initial credentialing sample. HSAG replaced this file with an oversample.									
File #7 Provider ID: **** Current Recredentialing Date: 09/21/21 Prior Credentialing or Recredentialing Date: 10/30/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #8 Provider ID: **** Current Recredentialing Date: 09/22/21 Prior Credentialing or Recredentialing Date: 10/15/18	Y ☒ N ☐	Y ☐ N ☒ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments: While DentaQuest verified this practitioner's Texas DEA certificate, DentaQuest did not verify a Colorado DEA certificate for this provider.									

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Recredentialing Record Review Tool
for DentaQuest

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #9 Provider ID: **** Current Recredentialing Date: 10/19/21 Prior Credentialing or Recredentialing Date: 01/25/19	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #10 Provider ID: **** Current Recredentialing Date: 10/31/21 Prior Credentialing or Recredentialing Date: 10/30/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #OS1 Provider ID: **** Current Recredentialing Date: 01/21/21 Prior Credentialing or Recredentialing Date:	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Comments: DentaQuest staff members determined that this practitioner's file should have been included in the initial credentialing sample.									
File #OS2 Provider ID: **** Current Recredentialing Date: 02/18/21 Prior Credentialing or Recredentialing Date:	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Comments: DentaQuest staff members determined that this practitioner's file should have been included in the initial credentialing sample.									

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Recredentialing Record Review Tool
for DentaQuest

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #OS3 Provider ID: ***** Current Recredentialing Date: 03/18/21 Prior Credentialing or Recredentialing Date:	Y ☐ N ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Comments: DentaQuest staff members determined that this practitioner's file should have been included in the initial credentialing sample.									
File #OS4 Provider ID: **** Current Recredentialing Date: 07/31/21 Prior Credentialing or Recredentialing Date: 07/06/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
Number of Applicable Elements	**9**	**9**	**0**	**9**	**9**	**9**	**9**	**9**	**9**
Number of Compliant Elements	**9**	**6**	**0**	**9**	**9**	**9**	**9**	**9**	**9**
Percentage Compliant	**100%**	**67%**	**NA**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**72**
Total Number of Compliant Elements	**69**
Overall Percentage Compliant	**96%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

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 compliance tool for elements of complete application)

8. Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation

9. Within 36 months of previous credentialing or recredentialing approval date

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2021–2022 site review of **DentaQuest**.

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

HSAG Review Team	Title
Sarah Lambie	Project Manager III
Amy Lewis	Director
Evarista Ogbon	Project Manager I
Crystal Brown	Project Coordinator III
DentaQuest Participants	**Title**
Candice Burdette	Contract Implementation & Compliance Specialist II
Chad Jacquart	Contract Implementation & Compliance Specialist II
Deseray Backman	Provider Enrollment and Credentialing Coordinator
Logan Horn	CHP+ Project Manager
Maureen Hartlaub	Contract Manager for Client Engagement
Quiana Thomas	Quality Specialist
Department Observers	**Title**
Russell Kennedy	Quality and Compliance Specialist
Yvonne Castillo	Medicaid Dental Specialist

Appendix D. Corrective Action Plan Template for FY 2021–2022

If applicable, the health plan 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 health plan should identify the planned interventions and 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 health plan must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
	If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The health plan 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 and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the health plan is unable to submit the CAP (plan only) 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: • Approve the planned interventions and instruct the health plan to proceed with implementation, or • Instruct the health plan to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the health plan has received Department approval of the CAP, the health plan will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The health plan will submit documents as evidence of completion one time only on or before the three-month deadline for all required actions in the CAP. (If necessary, the health plan will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the health plan within the intervening time frame.) If the health plan is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in writing from the Department to extend the deadline.

Step	Action
Step 5	**Technical Assistance**
	At the health plan's request, HSAG will schedule an interactive, verbal consultation and technical assistance session during the three-month time frame. The session may be scheduled at the health plan's discretion at any time the health plan 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 health plan 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 completion established by the Department. HSAG will continue to work with the health plan until all required actions are satisfactorily completed.

The CAP template follows.

Table D-2—FY 2021–2022 Corrective Action Plan for DentaQuest

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
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 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.	The national quality improvement program did indicate that DentaQuest coordinates the necessary dental services with the health plans. However, during the interview session, DentaQuest staff members conveyed they do not perform any coordination of care services for the Colorado CHP+ plan. DentaQuest provided a member outreach plan that mentioned that the dental plan would coordinate if/when asked by a member, family member/guardian, or provider. However, DentaQuest could not provide any evidence of proactive coordination efforts or procedures to describe this process.	DentaQuest must develop and implement procedures to deliver care to and coordinate services for all members. The procedures must 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 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	**Findings**	**Required Action**
42 CFR 438.208 Contract: Exhibit B-2—4.3.1.3		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
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-2—4.4.4.9	During the interview, staff members did describe several services the member could potentially receive from the community and from social support providers. However, DentaQuest did not submit procedures regarding how it coordinates services that the plan furnishes the member.	DentaQuest must develop and implement procedures to coordinate services that the plan furnishes the member: • Between settings of care. Examples may be: If dental care is required while a member resides at a long-term care facility; or non-emergent medical transportation; or a means for the transfer of information or activities between providers, per State contract 4.3.1.3.2. • With the services the member receives from any other managed care plan.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
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-2—None	Although DentaQuest stated that providers complete an assessment of each new member's needs, DentaQuest was unable to provide specific information regarding this process, and whether the assessment addressed members with special health care needs, high-risk health problems, and/or other complex health problems.	DentaQuest must provide best efforts to conduct an initial screening of each new member's needs; for DentaQuest, this may be an assessment when the member presents for services.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
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-2—4.3.15.18.1	The *Dental Participating Practice Agreement* has a section for professional standards that states, "participating practice, providers, and participating practices employees or agents rendering services to members shall provide dental care which meets or exceeds the standard of care for dentists in the region and shall comply with all standards for dentist as established by any state or federal law or regulation." During the interview, DentaQuest staff members were unable to describe a process or provide any evidence of how each provider is furnishing services to members, in accordance with professional standards. Dental record reviews were only completed in instances where a grievance or utilization concern needed to be investigated.	DentaQuest must implement a method to ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
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-2—4.3.1.3.5	DentaQuest's national quality improvement program states, "all requests for care for complex health needs members and special needs members originate through the plan, where applicable. DentaQuest coordinates all aspects of care for the member as directed by the plan. This coordination of care includes, but is not limited to, identifying the appropriate provider, scheduling the appointment(s), claims processing and communicating the resolution of the request and final outcome of the care to the plan." HSAG understands DentaQuest's role in assessing members with special health care needs is narrow in the scope of dental services. However, when DentaQuest does become aware of a member who has special health care needs, there were no procedural details presented for how care is coordinated to ensure necessary dental services are provided. In addition, DentaQuest staff mentioned during the interview that DentaQuest does not define members with special health care needs.	DentaQuest must define special health care needs based on the CHP+ member population. Additionally, DentaQuest must implement a mechanism to comprehensively assess each CHP+ member with special health care needs for appropriate dental services and identify any ongoing special conditions that require accommodations. Regarding special health care needs, this could be an attempt to override auto-assignment to place the member with a specialist, as needed, or provide auxiliary aids.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
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-2—4.3.1.3.6	DentaQuest described the process that providers follow to produce a treatment plan for members that need a course of treatment or regular care monitoring. However, the process described did not include producing a treatment plan for members with special health care needs.	DentaQuest must develop and implement a process to require providers to produce a "treatment plan" 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 policy must indicate whether DentaQuest requires the treatment plan to be approved by DentaQuest. The treatment plan must be in accordance with any applicable State quality assurance and utilization review standards (for example, if approval is required due to dental prior-authorization requests). The policy must require providers to review and revise the treatment plan when the member's circumstances or needs change significantly, or at the request of the member.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)(1)* Contract: Exhibit B-2—4.1.11.4	DentaQuest submitted a national quality improvement program and Quality Oversight Committee meeting minutes for 2021. The minutes provided evidence that the committee is meeting on a quarterly schedule. During the interview, DentaQuest described the committee structure and the Quality Oversight Committee attendees that support the national quality improvement program. DentaQuest described a linear reporting structure that involved staff members who work on CHP+ projects. However, evidence that CHP+ activities were reviewed at the National Quality Improvement Committee was not provided during the interview or through submitted documents. DentaQuest reported that the National Quality Improvement Committee discussed only broad quality issues and recommendations, and does not discuss specific plans, such as CHP+.	DentaQuest must have an ongoing comprehensive QAPI Program for services it furnishes to its CHP+ members.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department, one performance improvement project (PIP) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *42 CFR 438.330(b)(1) and (d)(2) and (3)* Contract: Exhibit B-2—4.1.11.5	DentaQuest's national quality improvement program included information about PIPs from a national perspective. The program description did not include information about conducting and submitting PIP(s) to the Department on an annual basis. The goal of DentaQuest's PIP and member outreach plan is to help increase preventive utilization for CHP+ members. The PIP enabled the team to identify and evaluate intervention processes that could be implemented and sustained over time, resulting in positive oral health outcomes. Evidence of any PIP initiatives or reporting was not identified in the 2021 Quality Oversight Committee meeting minutes. The PIP was submitted to the Department annually.	DentaQuest must include PIP activities and reporting into the QAPI Program that are specific to the CHP+ line of business. Committee discussions and updates must be reflected in the quality program meeting minutes.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* Contract: Exhibit B-2—4.1.11.6	DentaQuest's national quality improvement program included information about PIPs and performance measures from a national perspective. The program description did not include information about conducting and submitting PIP(s) or performance measures to the Department on an annual basis. The goal of DentaQuest's PIP and member outreach plan is to help increase preventive utilization for CHP+ members. The PIP enabled the team to identify and evaluate intervention processes that could be implemented and sustained over time, resulting in positive oral health outcomes. The PIP and performance measure information was submitted to the Department annually; however, evidence of PIP initiatives or performance measure reporting was not included in the 2021 Quality Oversight Committee meeting minutes.	DentaQuest must incorporate PIP activities and any other performance measure reporting into the QAPI Program that are specific to the CHP+ line of business. Committee discussions and updates must be reflected in the quality program meeting minutes.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B-2—4.3.12.1.4.	The national quality improvement program and the utilization management program description both outlined mechanisms that DentaQuest uses to detect under- and over-utilization of services. DentaQuest reported that the fraud and prevention recovery unit runs monthly reports on under- and over-utilization by providers. However, DentaQuest indicated that these reports are proprietary and would not be shared with HSAG. Additionally, DentaQuest verbalized that they rarely have a finding, but if a concern was identified, the Provider Engagement and the Peer Review Committee would be contacted to address the finding. DentaQuest was unable to provide policies, procedures, and/or other protocols to describe this mechanism.	DentaQuest must include mechanisms to detect both under- and over-utilization of services that are specific to the CHP+ line of business. Committee discussions and updates must be reflected in the quality program meeting minutes.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
5. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: (1) a significant limitation in areas of physical, cognitive, or emotional function; (2) dependency on medical or assistive devices to minimize limitation of function or activities; (3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions, or accommodations at home or at school.* *42 CFR 438.330(b)(4)* Contract: Exhibit B-2—4.1.11.7.2.	DentaQuest conducts an annual member survey. Additionally, the national quality improvement program states that delivery of quality dental services is monitored through the complaint and grievance process, utilization data analysis, and random chart audits. During the interview, DentaQuest staff members stated that chart audits (dental record reviews) were only completed in instances where a grievance or utilization concern needed to be investigated. DentaQuest does not conduct chart audits proactively or on a regular basis. HSAG reviewed the Quality Oversight Committee meeting minutes from 2021, and no evidence of monitoring to assess the quality and appropriateness of care furnished to members with special health care needs was discussed.	DentaQuest must include mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs that are specific to the CHP+ line of business. Committee discussions and updates must be reflected in the quality program meeting minutes.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
6. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract: Exhibit B-2—4.1.11.8.1-3.	DentaQuest's national quality improvement program included the process for evaluating the impact and effectiveness of the QAPI Program at least annually. As evidence, DentaQuest submitted a quality improvement program evaluation from 2020. However, the Colorado CHP+ line of business was not mentioned in the evaluation submitted.	DentaQuest must include a process for evaluating the impact and effectiveness of the QAPI Program at least annually that is specific to the CHP+ line of business.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
9. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* Contract: Exhibit B-2—4.3.12.1.8.2.	DentaQuest's *Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines* policy and procedure stated that the clinical practice guidelines must be consistent with other areas to which the guidelines apply. However, DentaQuest was unable to provide evidence or describe a process for how it ensures this process. For example, member educational materials are reviewed to ensure they are consistent with DentaQuest's adopted clinical practice guidelines. DentaQuest did not submit details regarding how this occurs.	DentaQuest must ensure that decisions for utilization management, member education, coverage of services, and other areas to which the clinical practice guidelines apply are consistent. In addition to the current policy statement, DentaQuest must have a method to actively monitor member and provider messaging and utilization management decision making for any inconsistencies.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		
HSAG Initial Review:		
Documents for Final Submission:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
Date of Final Evidence:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
16. The Contractor monitors members' satisfaction, including complaints, appeals, and grievance log information. Contract: Exhibit B-2—5.1.1.6.1	DentaQuest provided the 2020 CHP+ member satisfaction survey results. During the interview, DentaQuest staff members were unaware of a process for monitoring and reporting improvement and/or results. HSAG reviewed the Quality Oversight Committee meeting minutes from 2021, which did not contain evidence of reviewing the CHP+ line of business' member satisfaction survey results or complaints, appeals, and grievance information. DentaQuest verbalized a process and provided evidence of scorecard (data) reports that were submitted to the Department quarterly. However, DentaQuest was unable to provide evidence that the scorecard findings and/or results were brought forward for leadership input, review, tracking, and trending.	DentaQuest must monitor CHP+ members' satisfaction, which includes complaints, appeals, and grievance information.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
HSAG Initial Review:		
Documents for Final Submission:		
Date of Final Evidence:		

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided health plans with proposed review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary PAHP 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 PAHP in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the review activities. Thirty days prior to the review, the PAHP 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 PAHP's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The PAHP also submitted a list of all credentialing, recredentialing, and organizational provider records that occurred between January 1, 2021, and December 31, 2021 (to the extent available at the time of the review). The PAHP submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for the review. HSAG notified the PAHP five days following receipt of the lists of records regarding the sample records selected.

For this step,	HSAG completed the following activities:
	• The HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the PAHP's key staff members to obtain a complete picture of the PAHP's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the PAHP's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided PAHP staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2021–2022 Department-approved Site 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 Site Review Report to the PAHP and the Department for review and comment. • HSAG incorporated the PAHP 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 PAHP and the Department.