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October 27, 2014

**via USPS Delivery and eFile**

Dr. Amir Neshat, Chairman of the Board of Directors  
Liberty Dental Plan of California, Inc.  
340 Commerce Way  
Irvine, CA 92602

**FINAL REPORT OF ROUTINE EXAMINATION OF LIBERTY DENTAL PLAN OF CALIFORNIA, INC.**

Dear Dr. Neshat:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Liberty Dental Plan of California, Inc. (Plan), conducted by the Department of Managed Health Care (Department), pursuant to Section 1382(a) of the Knox-Keene Health Care Plan Act of 1975.<sup>1</sup> The Department issued a Preliminary Report to the Plan on July 18, 2014. The Department accepted the Plan's electronically filed response on August 18, 2014.

This Final Report includes a description of the compliance efforts included in the Plan's August 18, 2014 response, in accordance with Section 1382(c).

Section 1382(d) states "If requested in writing by the plan, the director shall append the plan's response to the Final Report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the Department that the Final Report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and electronically file copies of those portions of the Plan's response exclusive of information held confidential pursuant to Section 1382(c), no later than ten (10) days from the date of the Plan's receipt of this letter.

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<sup>1</sup> References throughout this letter to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code, Section 1340, *et seq.* References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Chapter 2 of Division 1, Title 28, of the California Code of Regulations, beginning with Section 1300.43.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the Report or wishes to modify any information provided to the Department in its August 18, 2014 response, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal. Please file this addendum electronically via the Corrective Action Plan system (CAP system) within the Online Forms Section of the Department's eFiling web portal <https://wpsso.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "Online Forms".
- From the Existing Online Forms menu click on the "Details" for the DFO Corrective Action Plan S14-R-052.
- Go to the "Messages" tab
  - Select "Addendum to Final Report" (note this option will only be available for 10 days after the Final Report has been issued)
  - Select the deficiency(ies) that are applicable
  - Create a message for the Department
  - Attach and Upload all documents with the name "Addendum to Final Report"
  - Click "Send Message"

The Department finds the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.

Questions or problems related to the electronic transmission of the response should be directed to Susan Levitt at (916) 255-2443 or email at [SLevitt@dmhc.ca.gov](mailto:SLevitt@dmhc.ca.gov). You may also email inquiries to [wpsso@dmhc.ca.gov](mailto:wpsso@dmhc.ca.gov).

**The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter through the eFiling system. The Report will be located at the Department's web site at [View Department Issued Final Examination Reports](#).**

If there are any questions regarding this Report, please contact me.

Sincerely,

**ORIGINAL SIGNED BY**

**BILL CHANG**

Supervising Examiner

Office of Financial Review

Division of Financial Oversight

cc: Maja Kopic, CFO, Liberty Dental Plan of California, Inc.  
Gil Riojas, Deputy Director, Office of Financial Review.  
Sang Le, Examiner IV (Supervisor), Division of Financial Oversight  
Ashika Chiu, Examiner, Division of Financial Oversight  
Micki Gibbs Counsel, Office of Plan Licensing  
Laura Dooley-Beile, Chief, Division of Plan Surveys

**STATE OF CALIFORNIA  
DEPARTMENT OF MANAGED HEALTH CARE**

**DIVISION OF FINANCIAL OVERSIGHT**

**FINAL REPORT OF ROUTINE EXAMINATION**

**OF**

**LIBERTY DENTAL PLAN OF CALIFORNIA, INC.**

**FILE NO. 933-0052**

**D4**



**014**

**BACKGROUND INFORMATION FOR LIBERTY DENTAL PLAN OF CALIFORNIA, INC.**

Date Plan Licensed:	August 3, 1978.
Organizational Structure:	Liberty Dental Plan of California Inc. (Plan) is a for-profit dental benefit corporation. The Plan has an affiliate known as Liberty Plan Corporation (CORP). CORP has contracts with other health plans and entities located outside of California. The Plan has an Administrative Service Agreement with CORP to provide administrative services to these out-of-State entities.
Type of Plan:	The Plan is a specialized health care service plan which arranges for dental services for Plan enrollees.
Provider Network:	The Plan contracts with independent dentists and various specialists. The general dentists are paid on a capitated basis. Non-contracted providers are paid on a fee-for-service basis or discounted rates. The Plan also provides a commercial referral product.
Plan Enrollment:	The Plan reported 1,778,969 enrollees as of June 30, 2014, with 148,084 in commercial, 174,166 in Medi-Cal Risk, 23,544 in IHSS, and 157,421 in Contracted from Other Plans, and 1,275,754 in Administrative Services Only (ASO).
Service Area:	All major counties in California.
Date of last Final Routine Examination Report:	November 15, 2010.

## **FINAL REPORT OF A ROUTINE EXAMINATION OF LIBERTY DENTAL PLAN OF CALIFORNIA, INC.**

This is the Final Report of a routine examination of the fiscal and administrative affairs of Liberty Dental Plan of California, Inc. (Plan), conducted by the Department of Managed Health Care (Department) pursuant to Section 1382(a) of the Knox-Keene Health Care Plan Act of 1975.<sup>1</sup> The Department issued a Preliminary Report to the Plan on July 18, 2014. The Department accepted the Plan's electronically filed response on August 18, 2014.

This Final Report includes a description of the compliance efforts included in the Plan's August 18, 2014 response to the Preliminary Report, in accordance with Section 1382(c). The Plan's response is noted in *italics*.

The Department examined the Plan's financial report filed with the Department for the quarter ended December 31, 2013 as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. The Department's findings are presented in this Report as follows:

Section I.	Financial Statements
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues
Section IV.	Internal Control

***The Department finds the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.***

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<sup>1</sup> References throughout this letter to "Section" are to section of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code, Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Chapter 2 of Division 1, Title 28, of the California code of Regulations, beginning with Section 1300.43.

## **SECTION I. FINANCIAL REPORT**

The Department's examination did not result in any adjustments or reclassifications to the Plan's December 31, 2013 financial statements filed with the Department. A copy of the Plan's financial statements can be viewed at the Department's website by typing the link <http://wpsso.dmhc.ca.gov/fe/search.asp> and selecting Liberty Dental Plan of California, Inc. from the first drop-down menu.

**No response was required to this Section.**

## **SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)**

Net Worth as reported by the Plan as of the quarter ended December 31, 2013	\$ 5,464,011
Less:	
Intangibles and Goodwill	(2,995,985)
Unsecured Receivables from Officers	(25,106)
Unsecured Affiliate Receivables	<u>(808,345)</u>
Tangible Net Equity as of December 31, 2013	\$1,634,575
Required TNE as of December 31, 2013	<u>915,588</u>
TNE Excess per Examination quarter ended December 31, 2013	<u><u>\$718,987</u></u>

The Plan is in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of December 31, 2013.

**No response was required for this Section.**

## **SECTION III. COMPLIANCE ISSUES**

### **A. PROVIDER DISPUTE VIOLATIONS**

Rule 1300.71.38 requires all health care service plans and their capitated providers that pay claims to establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes.

The Department's examination found that the Plan failed to comply with the requirements of a fast, fair and cost-effective resolution mechanism for the three month period ended December 31, 2013, as summarized below:

### **LATE CLAIM PAYMENT ON PROVIDER DISPUTES – Repeat Deficiency**

Rule 1300.71.38 (g) states that if the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan shall pay any outstanding monies determined to be due, and all interest and penalties required under Section 1371 and Rule 1300.71, within five (5) working days of the issuance of the Written Determination.

The Department's examination disclosed that the Plan failed to pay additional amounts due to providers, resulting from provider disputes, within five (5) working days from the date of the determination letter in five (5) out of the entire population of 31 provider disputes reviewed for the three month-period ended December 31, 2013. These included samples PDR-103, PDR-108, PDR-115, PDR-120, and PDR-127.

The Plan's failure to pay additional amounts due to providers within five (5) working days from the determination letter date is a *repeat deficiency*, as this issue was previously reported in the Department's Final Report of Examination dated November 15, 2010 (for the quarter ended September 30, 2009). This examination disclosed that the Plan's compliance efforts in response to the prior examination report have not achieved the necessary levels of compliance with the Act and Regulations cited.

#### **This repeat violation may be referred to the Office of Enforcement for appropriate administrative action.**

The Plan was required to explain why the previous corrective action taken was not effective in preventing this repeat deficiency and to state the measures taken to prevent further recurrence of non-compliance in this area.

The Plan was required to submit its revised policy and procedures for ensuring that additional payments resulting from a dispute are issued within five (5) working days of the determination letter date, in compliance with the above Rule. The Plan was also required to demonstrate that it provided training to its staff and established internal auditing procedures to ensure that policies and procedures are followed. In addition, the Plan was required to provide the date of implementation and the management position(s) responsible for ensuring continued compliance with this Rule.

*The Plan responded that it regrets this repeat deficiency and respectfully acknowledges that the six deficient files in question represent only 16% of the files examined during this review, as compared to the 56% that were found to be deficient during the previous survey. The Plan attributes the breakdown that resulted in this repeat deficiency to a number of factors, including staff turnaround (including at the management level), failure to implement and consistently utilize resolution letter templates, lack of formal documentation and definition around the process, and irregular oversight to ensure staff compliance.*

*The Plan has updated existing template letters to include payments to be issued within five (5) working days of the issuance of this written determination letter. Use of the revised templates was implemented on July 14, 2014, and all staff responsible for responding to provider disputes was trained on their use on July 25, 2014.*

*The Plan responded that it has issued a revised policy and procedure for ensuring that additional payments resulting from a dispute are issued within five (5) working days of the determination letter date. The policy for Claims Settlement Practice and Provider Dispute Resolution Mechanism was submitted along with Plan's response to the Preliminary Report. Additional language has been added to document the process that is to be followed to ensure prompt payment to providers.*

*With respect to internal auditing procedures to ensure that policies and procedures are followed, the Plan again points to the fact that additional supervisory staff has been added to the Quality Management Department. With the addition of a new Supervisor of Grievance and Appeals, the Plan has increased oversight and review of provider dispute resolutions. Furthermore, in accordance with the Claims Settlement Practice and Provider Dispute Resolution Mechanism, quarterly timeliness of payment reports shall be generated and reviewed by the Manager of Grievance, Appeals and Quality Management, as well as the National Dental Director.*

*As of July 25, 2014, the Plan finalized formal documentation of the Provider Payment Process, and training of all staff involved in the process was completed on July 25, 2014.*

*The Plan's Manager of Grievance, Appeals and Quality Management and the National Dental Director shall review quarterly timeliness of payment reports to ensure continued compliance with the prompt payment rule.*

**The Department finds that the Plan's compliance effort is responsive to the corrective action required.**

## **B. FINANCIAL STATEMENT PRESENTATION**

Rule 1300.84.2 sets forth the requirements for the filing of quarterly financial statements with the Department. The rule states that the quarterly financial statements (which need not be certified) are to be prepared in accordance with generally accepted accounting principles and on a basis consistent with the certified financial report furnished by the plan pursuant to Section 1384(c). This rule also refers to Rule 1300.84.06(b) that sets forth the requirements for the supplemental information that is to accompany the DMHC Reporting Format.

The Department's examination noted the following concerns with the DMHC Reporting Format filed for the quarter ended December 31, 2013:

1. Security held for trading was reported on Aggregate Write-Ins (AGWI) for Current Assets of Report #1-Part A: Assets. In accordance with the DMHC Report Form instructions, this item should be reported on Line 2, Short-Term Investments.
2. Other Short Term Receivable for \$2,002,270 was reported on AGWI for Current Assets of Report #1-Part A: Assets. These are all health care type receivables that meet the DMHC Report Form instructions for Line 6, Other Health Care Receivables.
3. Restricted cash of \$192,404 was reported on AGWI for Current Assets of Report #1-Part A: Assets. This deposit meets the DMHC Report Form instructions for Line 12, Restricted Deposit.

The Plan was required to state the corrective action taken to ensure that the DMHC Reporting Format is properly completed on all future financial statements and that the quarterly report for June 30, 2014 due to be filed on August 15, 2014 would demonstrate compliance. The Department recommended that the Plan refer to the "General Information, Definition and Instruction" guide that provides instructions by line item for proper completion of the DMHC Report Forms and supplemental information.

In addition, the Plan was required to provide the date of implementation and the management position(s) responsible for ensuring continued compliance.

*The Plan responded that as of August 18, 2014, all deficiencies listed above have been addressed in the Plan's quarterly financial statements for the period ending June 30, 2014 filed with the Department. The corrective action involved auditing the current financial statement's preparation procedure and making sure everything is properly recorded in the DMHC Reporting Format and that the "General Information, Definitions and Instruction" guide is followed.*

*The Plan's Chief Financial Officer is responsible for ensuring continued compliance with the Rule 1300.84.2 and 1300.84.06(b).*

**The Department finds that the Plan's compliance effort is responsive to the corrective action required.**

#### **SECTION IV. INTERNAL CONTROL**

Rule 1300.67.3(a)(3) requires a licensed health care service plan to have written procedures for the conduct of the business of the plan so as to provide effective controls.

Section 1384, 1345(s), and Rule 1300.45(q) include requirements for filing financial statements in accordance with generally accepted accounting principles (GAAP) and other authoritative pronouncements of the accounting profession.

Statement on Auditing Standards (SAS) No. 78 states "Internal control is a process---effected by an entity's board of directors, management, and other personnel---designed to provide reasonable assurance regarding the achievement of objectives in the following categories: (a) reliability of financial reporting, (b) effectiveness and efficiency of operations, and (c) compliance with applicable laws and regulations."

SAS No. 60 requires an auditor to communicate reportable conditions noted during the examination to appropriate personnel. Reportable conditions involve matters coming to the auditor's attention relating to significant deficiencies in the design or operation of the internal control structure, which could adversely affect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

The Department's examination disclosed the following weakness in internal control:

#### **A. INVESTMENT**

The Department's examination disclosed that the Plan did not have investment policies and procedures in place to ensure that the Plan's assets are invested in accordance with Section 1346(a)(11).

The Plan was required to submit investment policies and procedures (P&P) with evidence that they were approved by the Plan's Board of Directors. Additionally, all investment transactions are to be approved by the Board and disclosed in the Board meeting minutes. The Plan was required to state the date of implementation of the P&P, as well as when the reporting to the Board began. In addition, the Plan was required to state the management position(s) responsible for ensuring continued compliance with the P&P.

*The Plan responded that it implemented a new investment policy as of July 31, 2014. A copy of the new investment policy along with the approval from the Board of Directors is included in the Plan's response to the Preliminary Report. All investments transactions in prior periods have been approved by the Board and disclosed in Board meeting minutes. The new policy will require official reporting to the Board on no less than a quarterly basis and more often if deemed appropriate by the Board. The Plan's Chief Financial Officer will be responsible to ensure continued compliance with the investment policy.*

**The Department finds that the Plan's compliance effort is responsive to the corrective action required.**