

**DEPARTMENT OF MANAGED HEALTH CARE  
HELP CENTER  
DIVISION OF PLAN SURVEYS**

**TECHNICAL ASSISTANCE GUIDE**

**ACCESS AND AVAILABILITY OF SERVICES**

**ROUTINE DENTAL SURVEY**

**OF**

**PLAN NAME**

**(A Medi-Cal Dental Managed Care Plan)**

**DATE OF SURVEY:**

**PLAN COPY**

*Issuance of this January 15, 2016 Technical Assistance Guide renders all other versions obsolete.*

# DENTAL TAG

## ACCESS AND AVAILABILITY OF SERVICES REQUIREMENTS

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### Requirement AA-001: Number and Distribution of Primary Dental Care Providers

#### STATUTORY/REGULATORY CITATIONS

##### **CA Health and Safety Code section 1367(d)**

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

##### **CA Health and Safety Code section 1367(e)(1)**

(e)(1) All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.

**(Section 1367.03 refers to the Department's timely access to care regulations.)**

##### **CA Health and Safety Code section 1367(e)(3)**

(3) The plan shall make all services accessible and appropriate consistent with Section 1367.04.

**(Section 1367.04 refers to Language assistance regulations.)**

##### **28 CCR 1300.67.2(a) and (d)**

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

(a) The location of facilities providing the primary health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility.

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably ensure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees.

##### **28 CCR 1300.67.2.2(c)(1)**

(c) Standards for Timely Access to Care.

(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

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### **28 CCR 1300.67.2.2(c)(3)**

(c) Standards for Timely Access to Care.

(3) When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of Section 1367.03 of the Act and the requirements of this section.

### **28 CCR 1300.67.2.2(c)(4)**

(c) Standards for Timely Access to Care.

(4) Interpreter services required by Section 1367.04 of the Act and Section 1300.67.04 of Title 28 shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. This subsection does not modify the requirements established in Section 1300.67.04, or approved by the Department pursuant to Section 1300.67.04 for a plan's language assistance program.

### **28 CCR 1300.67.2.2(c)(7)**

(c) Standards for Timely Access to Care.

(7) Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.

(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

### **28 CCR 1300.70(a)(3)**

(a) Intent and Regulatory Purpose.

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

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**INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED**

**Staff responsible for the activities described above, for example:**

- Dental Director
- Director of Contracting/Provider Relations
- QM Director

**DOCUMENTS TO BE REVIEWED**

- Policies and procedures that define the standards for the number and distribution of dentists within the service area
- Documents describing how the Plan monitors and ensures compliance with network standards.
  - Distribution service area maps indicating location and numbers of enrollees in comparison with dentists
  - Plan primary health care access reports that provide information on provider distributions, closed practices and the like.
- Policies and procedures to periodically update/review the standards for the number and distribution of dentists within the service area
  - Record of periodic review of the standards for the number and distribution of dentists within the service area, including minutes of relevant committee meetings (QM Committee, Public Policy Committee, etc.)
- Corrective action plans for areas where access does not meet the standards

**AA-001 - Key Element 1:**

**1. The Plan has established a standard for geographic distribution of specialty/dental care providers.**

**CA Health and Safety Code section 1367(e)(1); 28 CCR 1300.67.2(a) and (d); 28 CCR 1300.67.2.2(c)(1); 28 CCR 1300.67.2.2(c)(7)(A); 28 CCR 1300.70(a)(3)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard on geographic distribution of specialty/dental care providers? (GMC Requirement AA-008, KE1, AQ 1.1)			

**AA-001 - Key Element 2:**

**2. Can the Plan demonstrate that, throughout the geographic regions designated as the Plan's Service Area, a comprehensive range of specialty/dental services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.**

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**CA Health and Safety Code section 1367(e)(1); 28 CCR 1300.67.2(a) and (d); 28 CCR 1300.67.2.2(c)(1); 28 CCR 1300.67.2.2(c)(7); 28 CCR 1300.70(a)(3)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have an established standard for the numbers of dental providers which is proportionate to the enrollee population?			
2.2 Can the Plan show reasonable accessibility of dental services within all regions of the Plan's service area?			
2.3 Can the Plan show sufficient numbers of staff, professionals, administrative and support staff that reasonably ensures that all services offered by the Plan will be accessible to enrollees on an appropriate basis without delays?			

**AA-001 - Key Element 3:**

**3. The Plan has established a mechanism that ensures that its health care services are readily available at reasonable times to each enrollee consistent with good professional practice.**

**CA Health and Safety Code section 1367(e)(1); 28 CCR 1300.67.2.2(c)(1); 28 CCR 1300.67.2.2(c)(3); 28 CCR 1300.67.2.2(c)(7); 28 CCR 1300.70(a)(3)**

Assessment Questions	Yes	No	N/A
3.1 Does the Plan have mechanisms to ensure that its health care services are readily available at reasonable times to each enrollee consistent with good professional practice?			
3.2 If the Plan operates in a service area that has a shortage of Primary care dentists, does the Plan refer enrollees to or assist the enrollee to locate available and accessible contracted providers in neighboring service areas?			
3.3 Do the Plan appointment processes include prompt rescheduling of appointments in a manner appropriate for the enrollee health care needs?			

**End of Requirement AA-001: Number and Distribution of Primary Care Providers**

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### Requirement AA-002: Number and Distribution of Specialists

#### STATUTORY/REGULATORY CITATIONS

##### **CA Health and Safety Code section 1345(i)**

(i) "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

##### **CA Health and Safety Code section 1367(d)**

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

##### **CA Health and Safety Code section 1367(e)(1)**

(e)(1) All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.3.

**(Section 1367.3 refers to the Department's Timely Regulations.)**

##### **28 CCR 1300.67.2(d) and (e)**

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;

(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral;

##### **28 CCR 1300.67.2.2(c)(1)**

(c) Standards for Timely Access to Care.

(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

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### 28 CCR 1300.67.2.2(c)(7)

(c) Standards for Timely Access to Care.

(7) Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.

(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsing standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

#### Staff responsible for the activities described above, for example:

- Dental Director
- Director of Contracting/Provider Relations
- QM Director

### DOCUMENTS TO BE REVIEWED

- Policies and procedures that define the standards for the number and distribution of specialists
- Policies and procedures to periodically review and update the standards for the number and distribution of specialists
  - Record of periodic review of the standards for the number and distribution of specialists, including minutes of relevant Committee Meetings (QM Committee, Public Policy Committee, etc.)
- Documents that demonstrate how the Plan ensures that appropriate specialty services are available without delays detrimental to the health of the enrollees, including out of network referrals, if service is unavailable within network, and medically necessary for the enrollee's medical condition.
- Documents that demonstrate how the Plan defines high-volume specialists
- Documents that define the availability of specialty services (including the number or percentage of open practices)

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- Summary referral data indicating number of referrals for each specialty within a given timeframe
- Plan specialist access reports and analysis
- Electronic version of the Plan’s Provider Directory(s) and the link to the Plan’s online directory(s).
- Review licensing filing of the Plan’s access standards and confirm submission of appropriate policies and procedures.

**AA-002 - Key Element 1:**

- 1. The Plan has established a standard for the number of dentists within the service area. The standard provides for at least one full-time equivalent dentist to each 1,200 enrollees or the Plan may provide an alternative mechanism (i.e., via the filing of a material modification) to demonstrate an adequate ratio of dentist to enrollees. 28 CCR 1300.67.2(d) and (e); 28 CCR 1300.67.2.2(c)(1); 28 CCR 1300.67.2.2(c)(7)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard on the ratio of dentists to enrollees? <b>(GMC Requirement AA-008, KE1, AQ 1.3)</b>			
1.2 Does the Plan’s standard provide for at least one dentist for each 1,200 enrollees? <b>(GMC Requirement AA-008, KE1, AQ 1.3)</b>			
1.3 If “no,” has the Plan established an alternative standard? <b>(GMC Requirement AA-008, KE1, AQ 1.7)</b>			
1.4 If the Plan has established an alternative standard, has this standard been submitted to the Department via the filing of a material modification? <b>(GMC Requirement AA-008, KE1, AQ 1.8)</b>			

**AA-002 - Key Element 2:**

- 2. The Plan has established a standard for the distribution of and accessibility to medically required specialists. CA Health and Safety Code section 1367(d); CA Health and Safety Code section 1367(e)(1); 28 CCR 1300.67.2(d) and (e); 28 CCR 1300.67.2.2(c)(1); 28 CCR 1300.67.2.2(c)(7)**

Assessment Question	Yes	No	N/A
2.1 Does the Plan have an established standard on the distribution of and accessibility to specialists in its network? <b>(GMC Requirement AA-008, KE1, AQ 1.9)</b>			

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### **End of Requirement AA-002: Number and Distribution of Specialists**

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### Requirement AA-003: Hours of Operation and After Hours Service

#### STATUTORY/REGULATORY CITATIONS

##### **CA Health and Safety Code section 1367(d)**

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

##### **CA Health and Safety Code section 1367(e)(1)**

All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.3.

**(Section 1367.3 refers to the Department's Timely Access Regulations.)**

##### **28 CCR 1300.67.2(b) and (d)**

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

(b) Hours of operation and provision for after-hour services shall be reasonable;

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;

##### **28 CCR 1300.67.2(d)**

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;

##### **28 CCR 1300.67.2(f)**

(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments;

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### **28 CCR 1300.67.2.2(c)(1), (7) and (10)**

(c) Standards for Timely Access to Care.

(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

(7) Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.

(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition.

Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

(10) Plans shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes.

### **28 CCR 1300.67.2.2(c)(7)**

(c) Standards for Timely Access to Care.

(7) Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.

(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition.

Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a

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plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

### **28 CCR 1300.67.2.2(c)(9)**

(c) Standards for Timely Access to Care.

(9) Dental, vision, chiropractic, and acupuncture plans shall ensure that contracted providers employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency Dental, vision, chiropractic, and acupuncture plans shall ensure that contracted providers employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

### **28 CCR 1300.67.2.2(d)(1)**

(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability, and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:

(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.

### **28 CCR 1300.70(a)(3)**

(a) Intent and Regulatory Purpose.

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

### **28 CCR 1300.80(b)(5)(D)**

(b) The onsite medical survey of a plan shall include, but not be limited to, the following procedures to the extent considered necessary based upon prior experience with the plan and in accordance with the procedures and standards developed by the Department.

(5) Review of the overall performance of the plan in providing health care benefits, by consideration of the following:

(D) The practice of health professionals and allied personnel in a functionally integrated manner, including the extent of shared responsibility for patient care and coordinated use of equipment, medical records and other facilities and services;

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**INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED**

Staff responsible for the activities described above, for example:

- Dental Director
- QM Director
- Provider Relations Manager

**DOCUMENTS TO BE REVIEWED**

- Policies and procedures defining standards for hours of operation
- Policies and procedures for monitoring of the standards for hours of operation
- Policies and procedures defining standards for after-hours coverage requirements
- Policies and procedures for monitoring of the standards for after-hours care
- Plan after-hours coverage and access monitoring reports, after-hours or other types of telephone access studies from the Plan’s telephone system or other methodologies (such as random calling at various times and dates)
- Committee Meeting minutes (of any/all appropriate committees)
- Provider Manual or other methods to communicate standards to providers
- Corrective Action Plans
- Review licensing filing of the Plan’s Access standards and confirm submission of appropriate policies and procedures.

**AA-003 - Key Element 1:**

- 1. The Plan has established a standard defining reasonable hours of operation for provider health care facilities that are sufficient to prevent delays detrimental to the health of enrollees.  
CA Health and Safety Code section 1367(d); 28 CCR 1300.67.2(b) and (d); 28 CCR 1300.67.2.2(c)(1), (7) and (10)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard that defines reasonable hours of operation for provider facilities?			
1.2 Does the standard ensure that availability is sufficient to prevent delays detrimental to the health of enrollees?			
1.3 Does the Plan assist enrollees to contracted neighboring service areas when there is a shortage of primary dentists in a particular area?			
1.4 Does the Plan arrange for specialty care outside the network if medically necessary for the enrollee? <b>(GMC Requirement AA-008, KE7, AQ 7.1)</b>			

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### AA-003 - Key Element 2:

- 2. The Plan has established standards that ensure that the availability of and access to after-hours services both at the Plan and provider-level are sufficient to prevent delays detrimental to the health of enrollees.**

**28 CCR 1300.67.2(b) and (d); 28 CCR 1300.67.2.2(c)(7); 28 CCR 1300.67.2.2(c)(9)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have established standards on availability of and access to after-hours services which address provider message/answering service requirements? <b>(GMC Requirement AA-008, KE5, AQ 5.2 and 5.4)</b>			
2.2 Does the Plan have established standards on availability of and access to after-hours services which address availability of providers? <b>(GMC Requirement AA-008, KE5, AQ 5.2 and 5.4)</b>			
2.3 Does the Plan have established standards on availability of and access to after-hours services which address provider response to messages left after hours? <b>(GMC Requirement AA-008, KE5, AQ 5.2.4)</b>			
2.4 Does the Plan have established standards on availability of and access to after-hours services which address Plan services (e.g., customer service)? <b>(GMC Requirement AA-008, KE5, AQ 5.2 and 5.4)</b>			
2.5 Do the standards ensure that availability of and access to after-hours services is sufficient to prevent delays detrimental to the health of enrollees? <b>(GMC Requirement AA-008, KE5, AQ 5.2 through 5.4)</b>			
2.6 Does the Plan ensure that contracted providers employ an answering service or telephone answering machine during non-business hours? <b>(GMC Requirement AA-008, KE5, AQ 5.2 and 5.4)</b>			
2.7 Does the answering service, or answering machine used during non-business hours provide instructions regarding: (a) How enrollees may obtain urgent or emergency care? (b) How to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care? <b>(GMC Requirement AA-008, KE5, AQ 5.2 and 5.4)</b>			

### AA-003 - Key Element 3:

- 3. The Plan has established and implemented a documented system for monitoring and evaluating providers' adherence to the standards regarding hours of operation and after-hours services.**

**28 CCR 1300.70(a)(3); 28 CCR 1300.67.2(b);-28 CCR 1300.67.2.2(d)(1); 28 CCR 1300.80(b)(5)(D)**

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<b>Assessment Questions</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
3.1 Has the Plan established standards for hours of operations and after-hours services?			
3.2 Does the Plan disseminate its standards to providers (e.g., via provider contracts, provider manual, etc.)?			
3.3 Does the Plan have a system of audits and/or monitoring tools used to evaluate provider compliance to standards?			
3.4 Does the Plan regularly monitor providers' performance against its standards and evaluate results?			
3.5 Does the Plan implement corrective action and follow-up review to address any deficiencies?			
3.6 Does the Plan periodically review the appropriateness of its standards and update it when indicated?			

### **End of Requirement AA-003: Hours of Operation and After Hours Service**

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### Requirement AA-004: Appointment Availability

#### STATUTORY/REGULATORY CITATIONS

##### **CA Health and Safety Code section 1367(d)**

The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

##### **CA Health and Safety Code section 1367(e)(1)**

All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.3.

(Section 1367.3 refers to the Department's timely access to care regulations.)

##### **28 CCR 1300.67.1(a), (d), and (e)**

Within each service area of a plan, basic health care services shall be provided in a manner, which provides continuity of care, including but not limited to:

- (a) The availability of primary care physicians, who will be responsible for coordinating the provision of health care services to each enrollee;
- (d) The maintenance of staff, including health professionals, administrative and other supporting staff, directly or through an adequate referral system, sufficient to assure that health care services will be provided on a timely and appropriate basis to enrollees;
- (e) An adequate system of documentation of referrals to physicians or other health professionals. The monitoring of the follow up of enrollees' health care documentation shall be the responsibility of the health care service plan and associated health professionals.

##### **28 CCR 1300.67.2(e) and (f)**

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

- (e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral;
- (f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

##### **28 CCR 1300.67.2.2(c)(3), (4), and (6)**

(c) Standards for Timely Access to Care.

- (3) When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's

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health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of Section 1367.03 of the Act and the requirements of this section.

(4) Interpreter services required by Section 1367.04 of the Act and Section 1300.67.04 of Title 28 shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. This subsection does not modify the requirements established in Section 1300.67.04, or approved by the Department pursuant to Section 1300.67.04 for a plan's language assistance program.

(6) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each dental plan, and each full service plan offering coverage for dental services, shall ensure that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:

A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;

(B) Non-urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subsection (c)(6)(C); and

(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

### **28 CCR 1300.67.2.2(c)(6)**

(c) Standards for Timely Access to Care.

(6) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each dental plan, and each full service plan offering coverage for dental services, shall ensure that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:

A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;

(B) Non-urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subsection (c)(6)(C); and

(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

### **28 CCR 1300.67.2.2(d)(1)**

(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability, and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:

(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.

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### 28 CCR 1300.70(a)(3)

(a) Intent and Regulatory Purpose.

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

### 28 CCR 1300.70(b)(2)(G)(5)

(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements.

(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.

If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

**Staff responsible for the activities described above, for example:**

- QM Director
- Director of Provider Relations
- Director of Network Management or its equivalent

### DOCUMENTS TO BE REVIEWED

- Policies and procedures that define appointment availability and the Plan's standards for the provision of covered services in a timely manner
- Policies and procedures that address re-scheduling of appointments
- Appointment availability studies
- Enrollee and provider satisfaction surveys
- Reports on complaint and grievances
- Telephone access studies from the Plan's telephone system or other methodologies (such as anonymous "mystery shopper" or random calling at various times and dates)
- Committee or applicable subcommittee minutes, prior two years
- Corrective action plans and re-measurement of appointment availability to assure improvements are sustained

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- Review licensing filing of the Plan’s Access standards and confirm submission of appropriate policies and procedures

### AA-004 - Key Element 1:

- 1. The Plan ensures that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental service in accordance with requirements.  
28 CCR 1300.67.2.2(c)(6)**

Assessment Questions	Yes	No	N/A
1.1 Are urgent appointments within the dental plan network offered within 72 hours of the time of request?			
1.2 Are non-urgent appointments offered within 36 business days of the request for appointment?			
1.3 Are preventive dental care appointments offered within 40 business days of the request for appointment?			

### AA-004 - Key Element 2:

- 2. Each health care service Plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.  
28 CCR 1300.67.1(a), (d) and (e); 28 CCR 1300.67.2(e) and (f); 28 CCR 1300.67.2.2(c)(3), (4), and (6); 28 CCR 1300.67.2.2(d)(1)**

Assessment Questions	Yes	No	N/A
2.1 Does the health Plan have a documented system of monitoring and evaluating access to care, including waiting time and appointments consistent with time elapsed standards noted in Key Element 1? <b>(GMC Requirement AA-009, KE1, AQ 1.9)</b>			
2.2 Does the documented system for monitoring and evaluating access to care include <b>urgent</b> appointments?			
2.3 Does the documented system for monitoring and evaluating access to care include <b>non-urgent</b> appointments?			
2.4 Does the documented system for monitoring and evaluating access to care include <b>preventive</b> dental care appointments?			
2.5 Does the documented system for monitoring and evaluating <b>include rescheduling</b> of appointments to ensure rescheduling is prompt and consistent with health care needs, continuity of care?			
2.6 Does the Plan monitor coordination of language interpreters with scheduled appointments?			

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<b>Assessment Questions</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
2.7 Does the Plan monitor to ensure providers use an answering service or telephone answering machine during non-business hours?			
2.8 Does the Plan monitor to ensure the answering service provides instructions regarding how enrollees may <b><u>obtain urgent or emergency</u></b> care?			
2.9 Does the Plan monitor to ensure the answering service provides information, when applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care?			
2.10 Does the Plan monitor performance against the standards?			
2.11 Does the Plan monitor telephone service accessibility?			
2.12 Does the Plan evaluate network capacity to ensure that its contracted provider network has the adequate capacity and availability of licensed provider to offer enrollees appointments that meet time elapsed standards? <b>(GMC Requirement AA-012, KE2, AQ 2.4)</b>			
2.13 When the Plan identifies problems, does it take action to ensure appointment availability?			
2.14 When the Plan identifies problems, does it monitor to assure improvements are maintained?			

### End of Requirement AA-004: Appointment Availability

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### Requirement AA-005: Enrollee Health Education

#### STATUTORY/REGULATORY CITATIONS

##### **28 CCR 1300.6(f)(8)**

The basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director may approve:

- (f) Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a physician's supervision,
- (8) effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

##### **28 CCR 1300.67.2(g)**

A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that Plan or area.

##### **28 CCR 1300.70(b)(2)(G)**

- (b) Quality Assurance Program Structure and Requirements.
- (2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

- (G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.

#### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

##### **Staff responsible for the activities described above, for example:**

- Supervisor or Manager of Health Education or equivalent
- QM Director
- Director or Manager of Customer Relations or Member Services

#### DOCUMENTS TO BE REVIEWED

- Policies and procedures of the Health Education Program
- Health Education Program description
- Plan and delegate Web sites
- Patient education materials regarding the accessibility of service (e.g., certificate of coverage member handbook);

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- Plan review of delegated entities' Health Education Programs and notification to enrollees of how to access services

### AA-005 - Key Element 1:

1. The Plan has an effective Health Education Program designed to educate enrollees regarding personal health behavior and health care, including recommendations regarding the optimal use of health care services provided by the Plan or health care organizations affiliated with the Plan.

**28 CCR 1300.67(f)(8)**

Assessment Question	Yes	No	N/A
1.1 Does the Plan have effective health education services that include information regarding personal health behavior and optimal use of preventive services provided under the Plan? <b>(GMC Requirement AA-010, KE1, AQ 1.2)</b>			

### AA-005 - Key Element 2:

2. The Plan regularly distributes materials to each enrollee that explain how to access Plan services.

**28 CCR 1300.67.2(g)**

Assessment Questions	Yes	No	N/A
2.1 Has the Plan developed materials that explain how to access <b><u>primary</u></b> dental care services?			
2.2 Has the Plan developed materials that explain how to access <b><u>specialty</u></b> dental care services?			
2.3 Has the Plan developed materials that explain how to access <b><u>after-hours</u></b> care?			
2.4 Has the Plan developed materials that explain how to access <b><u>urgent</u></b> care?			
2.5 Has the Plan developed materials that explain how to access <b><u>emergency</u></b> care?			
2.6 Does the Plan regularly distribute the materials to enrollees?			

### AA-005 - Key Element 3:

3. The Plan ensures that Health Education Programs conducted by delegated entities inform enrollees how to access services.

**28 CCR 1300.67.2(g); 28 CCR 1300.70(b)(2)(G)**

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Assessment Questions	Yes	No	N/A
3.1 Does the Plan rely or delegate responsibility for health education to its providers?			
3.2 If the Plan relies on delegation of health education to its contracted providers, does the delegated program inform in enrollee on how to access services?			
3.3 If yes, to 3.1 and 3.2, does the Plan have a system of oversight to monitor enrollee information and health education services by its contracted providers?			
3.4 Does the Plan ensure that delegated entities inform enrollees how to access (as applicable to the delegate’s responsibilities) <b><u>primary</u></b> dental care services?			
3.5 Does the Plan ensure that delegated entities inform enrollees how to access (as applicable to the delegate’s responsibilities) <b><u>specialty</u></b> care services?			
3.6 Does the Plan ensure that delegated entities inform enrollees how to access (as applicable to the delegate’s responsibilities) <b><u>after-hours</u></b> care?			
3.7 Does the Plan ensure that delegated entities inform enrollees how to access (as applicable to the delegate’s responsibilities) <b><u>urgent</u></b> care?			
3.8 Does the Plan ensure that delegated entities inform enrollees how to access (as applicable to the delegate’s responsibilities) <b><u>emergency</u></b> care?			

### End of Requirement AA-005: Enrollee Health Education

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### Requirement AA-006: Preventive Health Care

#### STATUTORY/REGULATORY CITATIONS

##### **28 CCR 1300.67(f)(1)**

The basic health care services required to be provided by a health care service plan to its enrollees shall include,

(f) Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a Web site's supervision,

(1) Reasonable health appraisal examinations on a periodic basis;

##### **28 CCR 1300.70(b)(2)(A)**

(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(A) There must be a written QA plan describing the goals and objectives of the program and organization arrangements, including staffing, the methodology for on-going monitoring and evaluation of health services, the scope of the program, and required levels of activity.

##### **28 CCR 1300.70(b)(2)(G)(5) and (6)** *(Applicable to delegated groups only)*

(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.

If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

(6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

#### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

##### **Staff responsible for the activities described above, for example:**

- Dental Director
- QA Director

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- QA Coordinator

### DOCUMENTS TO BE REVIEWED

- Policies and procedures ensuring provision of preventive care services
- Preventive care guidelines
- Minutes of QA Committee or subcommittee meetings
- Provider Manual
- Health education literature
- Provider education and informational materials
- Results of measurement of other preventive health guidelines
- List of preventive care objectives with associated tracking reports

### AA-006 - Key Element 1:

**1. The Plan has established preventive care standards. The Plan has disseminated its standards to its providers, regularly monitors performance against the standards and addresses any deficiencies.**

**28 CCR 1300.67(f)(1); 28 CCR 1300.70(b)(2)(A); 28 CCR 1300.70(b)(2)(G)(5) and (6)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have established preventive standards?			
1.2 Does the Plan use appropriate methods in developing or adopting preventive health standards?			
1.3 Does the Plan have an effective mechanism for distributing its standards to participating providers?			
1.4 Does the Plan monitor the provision of preventive services on an individual and Plan-wide basis?			
1.5 Does the Plan regularly measure the level of preventive care provided to enrollees against its established standards?			
1.6 Does the Plan critically evaluate the results of preventive care monitoring?			
1.7 Does the Plan <b>develop and implement</b> corrective actions or QM Programs with measurable goals to increase levels of preventive care for enrollees?			
1.8 Does the Plan <b>re-measure and critically evaluate</b> the results of corrective actions or QM Programs to increase levels of preventive care for enrollees?			
1.9 Does the Plan develop and implement additional corrective actions or QM Programs based on the critical evaluation of its past corrective actions or QM Programs?			

### End of Requirement AA-006: Preventive Health Care

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### Requirement AA-007: List of Contracting Providers Available Upon Request

#### STATUTORY/REGULATORY CITATIONS

##### **CA Health and Safety Code sections 1367.26(a)(1) through (3), and (b) through (g)**

(a) A health care service plan shall provide, upon request, a list of the following contracting providers, within the enrollee's or prospective enrollee's general geographic area:

- (1) Primary care (dental) providers.
- (2) Medical/(dental) groups.
- (3) Independent practice associations.

(b) This list shall indicate which providers have notified the plan that they have closed practices or are otherwise not accepting new patients at that time.

(c) The list shall indicate that it is subject to change without notice and shall provide a telephone number that enrollees can contact to obtain information regarding a particular provider. This information shall include whether or not that provider has indicated that he or she is accepting new patients.

(d) A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee, satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan's provider listings on its website. Plans shall ensure that the information provided is updated at least quarterly. A plan may satisfy this update requirement by providing an insert or addendum to any existing provider listing. This requirement shall not mandate a complete republishing of a plan's provider directory.

(e) Each plan shall make information available, upon request, concerning a contracting provider's professional degree, board certifications, and any recognized subspecialty qualifications a specialist may have.

(f) Nothing in this section shall prohibit a plan from requiring its contracting providers, contracting provider groups, or contracting specialized health care plans to satisfy these requirements. If a plan delegates the responsibility of complying with this section to its contracting providers, contracting provider groups, or contracting specialized health care plans, the plan shall ensure that the requirements of this section are met.

(g) Every health care service plan shall allow enrollees to request the information required by this section through their toll-free telephone number or in writing.

##### **CA Health and Safety Code section 1367.26(d)**

(d) A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee, satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan's provider listings on its website. Plans shall ensure that the information provided is updated at least quarterly. A plan may satisfy this update requirement by providing an insert or addendum to any existing provider listing. This requirement shall not mandate a complete republishing of a plan's provider directory.

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### CA Health and Safety Code section 1367.26(e) and (g)

(e) Each plan shall make information available, upon request, concerning a contracting provider's professional degree, board certifications, and any recognized subspecialty qualifications a specialist may have.

(g) Every health care service plan shall allow enrollees to request the information required by this section through their toll-free telephone number or in writing.

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

#### Staff responsible for the activities described above, for example:

- Dental Director
- Director of Contracting / Provider Relations
- Director of QM

### DOCUMENTS TO BE REVIEWED

- Plan Provider Directory
- Electronic version of the Plan's Provider Directory and the Plan's online Provider Directory
- Any available updates to the Plan Provider Directory.
- Policies and procedures relevant to the update of contact information for contracted providers.
- Previous versions of the Plan Provider Directory that show that modifications have been made, where needed.
- Documents and correspondence between the Plan and contracted providers that indicate any changes to the provider's contact information.

### AA-007 - Key Element 1:

#### 1. The Plan has a complete list of contracted providers that includes all required information.

CA Health and Safety Code sections 1367.26(a)(1) through (3), and (b) through (g)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a list of all of its contracted providers?			
1.2 Does the Plan maintain records of each provider's professional degree, board certifications, and any recognized subspecialty qualifications that a specialist may have?			
1.3 Does the Plan's list of contracted providers indicate which providers have notified the Plan that they have closed practices?			
1.4 Does the Plan's list of contracted providers indicate which providers are not accepting new patients at this time?			

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Assessment Questions	Yes	No	N/A
1.5 Does the Plan's list of contracted providers indicate that the list is subject to change without notice?			
1.6 Does the Plan's list of contracted providers include a telephone number that enrollees can contact to obtain information regarding a particular provider, including whether or not that provider is accepting new patients?			

### AA-007 - Key Element 2:

- 2. The Plan properly updates its list of contracted providers.  
CA Health and Safety Code section 1367.26(d)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan either: a) provide the provider list in written form to its enrollees and prospective enrollees upon request or, b) with the permission of the enrollee or prospective enrollee, refer the inquiry to the Plan's Web site?			
2.2 Does the Plan have policies and procedures that ensure that all of the information contained in its provider directory is updated quarterly?			

### Key Element 3:

- 3. The Plan provides provider information to its enrollees upon telephone or written request.  
CA Health and Safety Code section 1367.26(e) and (g)**

Assessment Questions	Yes	No	N/A
3.1 Does the Plan provide enrollees and prospective enrollees with provider information through their toll-free telephone number or in writing?			
3.2 Does the Plan provide information to enrollees and prospective enrollees about each provider's professional degree, board certifications, and any recognized sub-specialty qualifications that a sub-specialist may have?			

### End of Requirement AA-007: List of Contracting Providers Available Upon Request

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### DHCS REQUIREMENTS FOR GMC PROGRAMS

**Introduction:**

Any negative finding in Requirements AA-001 through AA-007 could potentially be a GMC finding. The GMC surveyor is instructed to confer with the Surveyor responsible for Requirements AA-001 through AA-007, especially regarding any shaded element below, to ensure uniform findings. The shaded elements indicate elements that are also included in Requirements AA-001 through AA-007.

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### Requirement AA-008: Provider Network

#### CONTRACT CITATIONS

##### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 8, Provision B**

###### B. Provider to Member Ratios

1. Contractor shall be in accordance with 28 CCR 1300.67.2 Accessibility of Services, and submit the methodology used to monitor Member ratio to DHCS for approval prior to the commencement of the Operations Period.
2. Contractor shall assess each Primary Care Dentist's enrollment capacity. Enrollment capacity shall be assessed by Contractor using factors including, but not limited to:
  - a. Appointment availability.
  - b. Use of professional and ancillary dental personnel including, but not limited to, Registered Dental Assistants and Registered Dental Hygienists.
  - c. Specific "office efficiencies" including, but not limited to, the number of available operators and extended office hours;
  - d. Existing number of Members;
  - e. Existing number of active (non-Member) patients; and
  - f. Full time equivalent dentists, hygienists, and dental assistants devoted to clinical activities.

##### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 8, Provision D**

###### D. Specialists

Contractor shall provide accessibility to required specialists who are certified or eligible for certification by the appropriate specialty board, through contracting or referral. Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care. Contractor shall provide a record/tracking mechanism for each authorized, denied, or modified referral. In addition, Contractor shall offer second opinions by specialists to any Member upon request.

Contractor shall actively conduct outreach activities to subcontract with Pediatric Dentists in the service area, including specific attempts to recruit them as Primary Care Dentists and include them as part of the Contractor's provider network. The Contractor must submit a quarterly detailed written report to DHCS highlighting the activities associated with active recruitment. This report shall be submitted to DHCS within fifteen (15) days following the end of the quarter.

##### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 8, Provision E**

###### E. Time and Distance Standard

Contractor shall maintain a network of Primary Care Dentists that are located within thirty (30) minutes or ten (10) miles of a Member's residence unless the Contractor has a DHCS approved alternative time and distance standard.

##### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 8, Provision H**

###### H. Plan Provider Network

Contractor shall submit to in a format specified in Exhibit A, Attachment 19, Deliverable Template a report containing the names of all subcontracting providers, specialists and provider

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groups including FQHCs and RHCs. The report must be sorted by subcontractor type, indicating the county or counties in which Members are served. In addition, the report should also indicate where relationships or affiliations exist between direct and indirect subcontractors. The report shall be submitted monthly, no later than fifteen (15) calendar days following the end of the reporting month or within ten (10) calendar days of DHCS' written request.

### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 8, Provision L**

L. Subcontracts with Federally Qualified Health Centers, Rural Health Clinics and Indian Health Service Facilities (FQHC/RHC)

Contractor shall actively conduct outreach to subcontract with Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Service Facilities in the service area and include them as part of the Contractor's provider network.

Subcontracts with FQHCs shall also meet subcontract requirements of Provision J above and reimbursement requirements in Exhibit A, Attachment 10, Provider Compensation Arrangements, Provision G. In subcontracts with FQHCs and RHCs where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the subcontract.

Contractor shall assign Members to FQHCs, RHCs and Indian Health Service Facilities.

### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision A**

A. General Requirement

Contractor shall ensure that each Member has a Primary Care Dentist who is available and physically present at the service site for sufficient time to ensure access for the assigned Member to the Primary Care Dentist. This requirement does not preclude an appropriately licensed professional from being a substitute for the Primary Care Dentist in the event of vacation, illness, or other unforeseen circumstances.

Contractor shall ensure Members access to specialists for medically necessary dental covered services. Contractor shall ensure adequate staff within the service area, including dentists, administrative and other support staff directly and/or through subcontracts, sufficient to assure that dental care services will be provided in accordance with this contract and applicable law.

### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision B**

B. Access Requirements

Contractor shall establish acceptable accessibility standards in accordance with 28 CCR 1300.67.2 and as specified below. Contractor shall submit any revisions, updates and/or changes in writing to DHCS within fifteen (15) calendar days of the change. DHCS will review and approve standards for reasonableness. Contractor shall ensure that contracting providers offer hours of operation similar to commercial Members or comparable to Medi-Cal Dental Fee-for-Service (FFS), if the provider serves only Medi-Cal Dental Members. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

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### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision B(4) and (5)**

#### B. Access Requirements

##### 4. Telephone Procedures

Contractor shall provide 24-hour a day telephone access for Members to Primary Care Dentists, emergency services, and specialists, including access to telephone interpreters.

##### 5. Specialty Services

Contractor shall arrange for the provision of specialty services from specialists outside the network if unavailable within Contractor's network, when it is determined to be medically necessary dental covered services.

Contractor shall submit a Specialty Referral Report in a format specified by DHCS (see Exhibit A, Attachment 20, Deliverable Templates) on a biannual basis, no later than January 31st and July 31st of each calendar year that shows how many referrals were made per month to specialists with the detail for each referral, timeliness of receipt and review, and the result of each referral.

### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision C**

#### C. Access to Services to Which Contractor or Subcontractor Has a Moral Objection

Unless prohibited by law, Contractor shall arrange for the timely referral and coordination of covered services to which the Contractor or subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals at no additional expense to DHCS.

### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision D**

#### D. Emergency Care

Contractor shall ensure that a Member with an emergency dental condition will be seen on an emergency basis and that emergency services will be available and accessible within the service area 24 hours a day, 7 days a week.

Contractor shall cover emergency dental services without prior authorization pursuant to 22 CCR 53216 and 28 CCR 1300.67(g).

### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 14, Provision B(5) and (6)**

#### B. Member Services Staff

5. Contractor shall conduct phone calls to Members who have not seen their Primary Care Dentist in the last 12 months. Contractor shall ensure that Members are set up with an appointment, if requested, and Members understand their rights to access to care and services. Contractor shall report the results to DHCS no later than thirty (30) calendar days following the end of the reporting month.

6. Contractor shall ensure that the average wait time during business hours for a Member to speak by telephone with Member services staff does not exceed ten minutes, in accordance with 28 CCR 1300.67.2.2(c)(10).

### **22 CCR 53216 KE5**

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(a) Each plan shall provide, directly or by subcontract, at least one physician and a nurse on duty 24 hours a day, 7 days a week, at each location designated as a location where members can obtain medical services in the event of emergency circumstances, as defined in Section 51056.

(b) Written procedures shall be developed and applied by the plan regarding care under emergency circumstances provided by nonplan providers in and outside the service area. These procedures shall include but not be limited to the following:

(1) Verification of membership.

(2) Transfer of the medical management of the member to a plan provider.

(c) The plan shall provide or pay for medical transportation, as defined in Sections 51151 and 51323, to members needing care when such transportation is necessary due to the medical condition of the member.

### **28 CCR 1300.67(g)**

#### 1300.67(g)

(1) Emergency health care services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health care service plan area. Emergency health care services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan.

### **28 CCR 1300.67.2(a), (d) and (e)**

#### Accessibility of Services

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

(a) The location of facilities providing the primary health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility.

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;

(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral;

Subject to subsections (a) and (b) of this section, a plan may rely on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.

## DENTAL SERVICE TAG

### 28 CCR 1300.67.2(b) and (c)

#### Accessibility of Services

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

(b) Hours of operation and provision for after-hour services shall be reasonable;

(c) Emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week;

Subject to subsections (a) and (b) of this section, a plan may rely on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.

### 28 CCR 1300.67.2.2(c)(10)

#### (c) Standards for Timely Access to Care.

(10) Plans shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes.

## INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

### Staff responsible for the activities described above, for example:

- Dental Director
- Director of Contracting / Provider Relations
- Director of QM

## DOCUMENTS TO BE REVIEWED

- Plan Provider Directory
- Electronic version of the Plan's Provider Directory and the Plan's online Provider Directory
- Policies and procedures relevant to the update of contact information for contracted providers
- Previous versions of the Plan Provider Directory that show that modifications have been made, where needed
- Documents and correspondence between the Plan and contracted providers that indicate any changes to the provider's contact information
- Policies and procedures that address the reporting requirements to DHCS
- Committee/Board meeting minutes that indicate submission/approval of reports

## DENTAL SERVICE TAG

**AA-008 - Key Element 1:**

- 1. Access Requirements: The Plan establishes acceptable accessibility standards approved by DHCS.  
Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision B; 28 CCR 1300.67.2(a), and (d) through (e)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have established accessibility standards on geographic distribution of specialty/dental care providers approved by DHCS? <b>(KKA Requirement AA-001, KE1, AQ 1.1)</b>			
1.2 Does the Plan have a process to ensure the location of facilities providing the primary health care services of the plan are within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility?			
1.3 Does the Plan have an established standard on the ratio of dentists to enrollees? <b>(KKA Requirement AA-002, KE1, AQ 1.1)</b>			
1.4 Does the Plan have a standard for the ratio of enrollees to staff, which includes health professionals, to ensure that all services offered by the Plan are accessible to enrollees without delays detrimental to the health of the enrollees?			
1.5 Does the Plan’s standard provide for at least one dentist for each 1,200 enrollees? <b>(KKA Requirement AA-002, KE1, AQ 1.2)</b>			
1.6 Does the Plan’s standard provide for at least one primary care dentist for each 2,000 enrollees? <b>(KKA Requirement AA-002, KE1, AQ 1.1)</b>			
1.7 If “no,” has the Plan established an alternative standard? <b>(KKA Requirement AA-002, KE1, AQ 1.3)</b>			
1.8 If the Plan has established an alternative standard, has this standard been submitted to the Department via the filing of a material modification? <b>(KKA Requirement AA-002, KE1, AQ 1.4)</b>			
1.9 Does the Plan have an established standard on the distribution of and accessibility to specialists in its network? <b>(KKA Requirement AA-002, KE2, AQ 2.1)</b>			
1.10 Does the Plan provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral?			
1.11 Did the Plan submit any revisions, updates, and/ or changes in writing to DHCS within 15 calendar days of the change?			
1.12 Does the Plan ensure that providers offer hours of operation			

## DENTAL SERVICE TAG

Assessment Questions	Yes	No	N/A
comparable to commercial members or Medi-Cal Fee for Service, if the provider serves only Medi-Cal Dental Members?			

### AA-008 - Key Element 2:

- 2. Time and Distance Standard: The Plan maintains a network of Primary Care Dentists that are located within 30 minutes or 10 miles of a Member’s residence, unless the Plan has a DHCS approved alternative standard.  
Medi-Cal Dental GMC Program, Exhibit A, Attachment 8, Provision E**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan maintain a network of Primary Care Dentists located within 30 minutes or 10 miles of their Members’ residences?			
2.2 Does the Plan have a DHCS approved alternative time and distance standard?			
2.3 Is the Plan in compliance with any approved alternative standard?			
2.4 Does the Plan have a process for periodic evaluation of its network to ensure accessibility standards are met?			

### AA-008 - Key Element 3:

- 3. Plan Provider Network: The Plan submits to DHCS or upon request, a report containing the names of all subcontracting providers, specialists and provider groups including FQHCs and RHCs in the format outlined in the DHCS contract.  
Medi-Cal Dental GMC Program, Exhibit A, Attachment 8, Provision H**

Assessment Questions	Yes	No	N/A
3.1 Does the Plan submit a report to DHCS containing the names of all subcontracting providers, specialists, and provider groups sorted by subcontractor type, indicating the county or counties in which Members are served? And does the report indicate where relationships or affiliations exist between direct and indirect subcontractors?			
3.2 Does the Plan submit this report on a monthly basis, no later than 15 calendar days following the end of the reporting month? Or within 10 calendar days of DHCS’ written request?			

### AA-008 - Key Element 4:

- 4. Religious or Ethical Objections: The Plan arranges for the timely referral and coordination of covered services to which the Plan or provider has religious or ethical objections to perform or otherwise support.  
Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision C**

## DENTAL SERVICE TAG

Assessment Questions	Yes	No	N/A
4.1 Does the Plan have procedures in place to arrange for the timely referral and coordination of covered services to which the Plan or provider has religious or ethical objections to perform or otherwise support?			
4.2 Does the Plan have procedures <b>to arrange, coordinate and ensure</b> the provision of these services at no additional expense to DHCS?			

**AA-008 - Key Element 5:**

- 5. Availability of Services: The Plan ensures the availability of services in accordance with the DHCS Contract.**  
**Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provisions B (4) and (5); Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision D; Medi-Cal Dental GMC Program, Exhibit A, Attachment 14, Provisions B (6); 22 CCR 53216; 28 CCR 1300.67(g); 28 CCR 1300.67.2(b) through (c)**

Assessment Questions	Yes	No	N/A
5.1 Does the Plan have policies and procedures that define reasonable hours of operation for provider facilities?			
5.2 Does the Plan ensure 24-hour a day telephone access for Members to primary care dentists?			
5.3 Does the Plan ensure 24-hour a day telephone access for Members to specialists?			
5.4 Does the Plan ensure 24-hour a day telephone access for Members to emergency care?			
5.5 Does the Plan ensure 24-hour a day telephone access for Members to telephone interpreters?			
5.6 Does the Plan ensure the availability and accessibility of emergency health care services within the service area 24 hours a day, 7 days a week?			
A. Does the Plan maintain written procedures regarding care under emergency circumstances provided by non-plan providers in and outside the service area?			
B. Does the Plan maintain written procedures that address non-plan providers' verification of enrollee's membership in the Plan?			
C. Do the written procedures address transfer of the medical management of the Member to a Plan provider?			
5.7 Does the Plan provide or pay for medical transportation for Members needing care when such transportation is necessary due to the medical condition of the member?			

## DENTAL SERVICE TAG

### AA-008 - Key Element 6:

- 6. Availability of Primary Care Dentists: The Plan ensures that each Member has a Primary Care Dentist who is available and physically present at the service site for sufficient time to ensure access for the assigned Member. Medi-Cal Dental GMC Program, Exhibit A, Attachment 8, Provision B; Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision A; Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision B(4); Medi-Cal Dental GMC Program, Exhibit A, Attachment 14, Provision B(5) and (6); 28 CCR 1300.67.2.2(c)(10)**

Assessment Questions	Yes	No	N/A
6.1 Does the Plan have policies and procedures that define the ratio of Primary Care Dentists to the enrollee population?			
6.2 Does the Plan ensure that each Member has a Primary Care Dentist who is available and physically present at the service site for sufficient time to ensure access for the assigned Member to the Primary Care Dentist or substitute appropriately licensed professional?			
6.3 Are there policies and procedures that define the hours the Primary Care Dentist must be available and physically present?			
6.4 Does the Plan communicate these standards to providers?			
6.5 Does the Plan monitor provider compliance with these standards?			
6.6 Does the Plan have policies and procedures for time-to-answer and time-to-return telephone access in provider offices?			
6.7 Does the Plan conduct phone calls to Members who have not seen their Primary Care Dentist in the last 12 months?			

### AA-008 - Key Element 7:

- 7. Availability of Specialty Services: The Plan arranges for the provision of specialty services from specialists outside the network if unavailable within Plan's network. Medi-Cal Dental GMC Program, Exhibit A, Attachment 8, Provision D; Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision A; Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision B (5)**

Assessment Question	Yes	No	N/A
7.1 Does the Plan have a process in place to ensure the provision of specialty services from specialists outside the network if unavailable within the Plan's network? <b>(KKA Requirement AA-003, KE1, AQ 1.4)</b>			
7.2 Does the Plan ensure Members have access to specialists for medically necessary dental services?			

## DENTAL SERVICE TAG

Assessment Question	Yes	No	N/A
7.3 Does the Plan provide access by contracting or by referrals to specialists who are board certified or eligible for board certification by the appropriate specialty board?			
7.4 Does the Plan have a mechanism to track each authorized, denied, or modified referral?			
7.5 Does the Plan offer second opinions by specialist to any Member upon request?			

### AA-008 - Key Element 8:

**8. Availability of Pediatric Dentists: The Plan conducts outreach activities to subcontract with Pediatric Dentists including specific attempts to recruit them as Primary Care Dentists and include them as part of the Contractor’s provider network. Medi-Cal Dental GMC Program, Exhibit A, Attachment 8, Provision D**

Assessment Question	Yes	No	N/A
8.1 Does the Plan have a process in place to subcontract with Pediatric Dentists?			
8.2 Does the Plan have mechanisms in place to recruit the Pediatric Dentists as Primary Care Dentists?			
8.3 Has the Plan provided evidence of any specific attempts to recruit Pediatric Dentists?			

### AA-008 - Key Element 9:

**9. Availability of Additional Facilities: The Plan conducts outreach to subcontract with Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Service Facilities in the service area and includes them as part of the Plan’s provider network. Medi-Cal Dental GMC Program, Exhibit A, Attachment 8, Provision L**

Assessment Question	Yes	No	N/A
9.1 Does the Plan have a process in place to conduct outreach to Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Service Facilities in the service area to attempt to include them as part of the Plan’s provider network?			
9.2 Does the Plan subcontract with FQHCs and RHCs?			
9.3 Does the Plan assign members to FQHCs, RHCs and Indian Health Service Facilities?			

### End of Requirement AA-008: Provider Network

## DENTAL SERVICE TAG

### Requirement AA-009: Availability of Appointments

#### CONTRACT CITATIONS

#### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision B (1) through (3) B. Access Requirements**

Contractor shall establish acceptable accessibility standards in accordance with 28 CCR 1300.67.2 and as specified below. Contractor shall submit any revisions, updates and/or changes in writing to DHCS within fifteen (15) calendar days of the change. DHCS will review and approve standards for reasonableness. Contractor shall ensure that contracting providers offer hours of operation similar to commercial Members or comparable to Medi-Cal Dental Fee-for-Service (FFS), if the provider serves only Medi-Cal Dental Members. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

##### 1. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine dental care, emergency services, and specialty referral appointments. Contractor shall also include procedures for follow-up on missed appointments.

##### 2. Waiting Times

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the provider's offices for scheduled appointments, telephone calls (to answer and return), and time to obtain various types of appointments indicated in Sub provision 1, Appointments, above. The following standards shall apply:

- a. Initial Appointment – within 4 weeks
- b. Routine Appointment (non-emergency) – within 4 weeks
- c. Preventive Dental Care Appointment – within 4 weeks
- d. Specialist Appointment – within 30 business days from authorized request
- e. Emergency Appointment – within 24 hours from the request for appointment

Patient sign-in forms shall be maintained in order to document any time beyond the scheduled appointment time spent by the Member in provider office waiting area.

##### 3. Timely Access

Contractor shall survey, within a year's time, all Primary Care Dentists on the average amount of time it takes for Members to obtain initial appointments, routine appointments, specialist appointments, and emergency appointments. Contractor shall also survey for the number of no show appointments, rescheduled appointments, the availability of interpreter services and an answering service, and the ratio of Members to Primary Care Dentist. Contractor shall submit a Timely Access Report for those Primary Care Dentists surveyed in the reporting quarter in a format specified by DHCS (see Exhibit A, Attachment 20, Deliverable Templates) on a quarterly basis, no later than 30 days after the end of the reporting quarter.

## DENTAL SERVICE TAG

### 28 CCR 1300.67.2(f)

#### Accessibility of Services

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees.

(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments;

#### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

##### Staff responsible for the activities described above, for example:

- Dental Director
- Director of Contracting / Provider Relations
- Director of QM

#### DOCUMENTS TO BE REVIEWED

- Plan Provider Manual
- Provider Contract
- Policies and procedures that address availability of appointments.
- Quality Assurance Plan/Program
- Grievance and Appeals that indicate possible issues related to appointment availability.

#### AA-009 - Key Element 1:

1. **Availability of Appointments:** The Plan ensures that providers schedule appointments in a timely manner. Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision B (1) through (3);  
28 CCR 1300.67.2(f)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan ensure that providers schedule <b><u>initial</u></b> appointments within 4 weeks?			
1.2 Does the Plan ensure that providers schedule <b><u>routine</u></b> appointments within 4 weeks?			
1.3 Does the Plan ensure that providers schedule <b><u>preventive</u></b> dental care appointments within 4 weeks?			
1.4 Does the Plan ensure that providers schedule <b><u>specialist</u></b> appointments within 30 business days from the authorized request?			

## DENTAL SERVICE TAG

Assessment Questions	Yes	No	N/A
1.5 Does the Plan ensure that providers schedule <b>emergency</b> appointments within 24 hours from the request for appointment?			
1.6 Does the Plan survey all Primary Care Dentists on the average amount of time it takes for Members to obtain initial appointments, routine appointments, specialist appointments, and emergency appointments? Does the Plan submit on a quarterly basis, no later than 30 days after the end of the quarter a Timely Access Report in the format specified?			
1.7 Does the Plan maintain procedures to monitor waiting times for scheduled appointments, telephone calls, and time to obtain various types of appointments?			
1.8 Does the Plan maintain procedures for follow-up on missed appointments?			
1.9 Does the Plan have a system of monitoring and evaluating access to care, including waiting time and appointments? <b>(KKA Requirement AA-004, KE2, AQ 2.1)</b>			
1.10 Does the Plan have procedures for Members to obtain appointment for routine dental care, emergency services, and specialty referral appointments?			
1.11 Does the Plan require that sign-in forms be maintained to document any time beyond the scheduled appointment time spent by the Member in the provider office waiting area?			

### End of Requirement AA-009: Availability of Appointments

## DENTAL SERVICE TAG

### Requirement AA-010: Health Education

#### CONTRACT CITATIONS

##### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision B**

###### B. Access Requirements

Contractor shall establish acceptable accessibility standards in accordance with 28 CCR 1300.67.2 and as specified below. Contractor shall submit any revisions, updates and/or changes in writing to DHCS within fifteen (15) calendar days of the change. DHCS will review and approve standards for reasonableness. Contractor shall ensure that contracting providers offer hours of operation similar to commercial Members or comparable to Medi-Cal Dental Fee-for-Service (FFS), if the provider serves only Medi-Cal Dental Members. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

##### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 12, Provision D (1)**

###### 1. Health Education

- a. Contractor shall implement and maintain a dental health education system that provides the organized programs, services, functions, and resources necessary to deliver dental health education to assist Members to improve their dental health and manage dental disease.
- b. Contractor shall ensure the organized delivery of dental health education programs and services, at no charge for Members, using a variety of educational strategies, methods and materials that are appropriate for the Member population and effective in achieving behavioral change for improved dental health. Contractor shall ensure that all dental health education information and materials are provided to Members at no higher than a 6th grade reading level, unless otherwise approved by DHCS, and are provided in a manner and form that are easily understood and culturally and linguistically appropriate for the intended audience.
- c. Contractor shall provide dental health education programs and services directly and/or through subcontractors that have expertise in delivery of dental health education programs and services.
- d. Contractor shall ensure that Members receive dental health education services as part of preventive services and primary dental health care visits. Contractor shall provide resource information, educational materials and other program resources to assist providers to provide effective dental health education services for Members. Contractor is responsible to assist Primary Care Dentists in the development and delivery of culturally and linguistically appropriate health education interventions and assure provisions for low-literate, illiterate and visually and hearing impaired Members.
- e. Contractor shall adopt and maintain appropriate dental health education program standards/guidelines and policies/procedures. Contractor shall maintain documentation that demonstrates effective implementation of all DHCS health education requirements under this contract.
- f. Contractor shall monitor the performance of subcontractors that deliver dental health education programs and services to Members, and implement strategies to improve performance and effectiveness.

## DENTAL SERVICE TAG

g. No later than thirty (30) calendar days after the beginning of each calendar year, Contractor shall submit to DHCS documentation on the Contractor’s health education programs and services and all materials related to health education for review and approval.

### **28 CCR 1300.67.2(g)**

#### Accessibility of Services

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

(g) A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that plan or area.

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

#### **Staff responsible for the activities described above, for example:**

- Dental Director
- QA Director
- QA Coordinator

### DOCUMENTS TO BE REVIEWED

- Policies and procedures ensuring provision of preventive care services
- Preventive care guidelines
- Minutes of QA Committee or subcommittee meetings
- Provider Manual
- Health education literature
- Provider education and informational materials
- Results of measurement of other preventive health guidelines
- List of preventive care objectives with associated tracking reports

### AA-010 - Key Element 1:

**1. Educational Outreach: The Plan provides outreach to educate and encourage members to improve dental health, manage dental disease and obtain preventive care. Medi-Cal Dental GMC Program, Exhibit A, Attachment 12, Provision D (1); 28 CCR 1300.67.2(g)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan provide services, DHCS approved educational materials and other program resources to assist providers with delivering effective dental health education services for Members?			
1.2 Does the Plan have effective health education services that include			

## DENTAL SERVICE TAG

Assessment Questions	Yes	No	N/A
information regarding personal health behavior and optimal use of preventive services provided under the Plan? <b>(KKA Requirement AA-005, KE1, AQ 1.1)</b>			
1.3 Does the Plan assist Primary Care Dentists in the development and delivery of culturally and linguistically appropriate health education interventions and assure provisions for low-literate, illiterate, and visually and hearing impaired Members?			
1.4 Does the Plan maintain documentation that demonstrates effective implementation of all DHCS health education requirements as required in the DHCS-GMC contract?			
1.5 Does the Plan monitor the performance of the providers and subcontractors that deliver dental health education programs and services to Members, and implement strategies to improve performance and effectiveness?			
1.6 Does the Plan have a section of the health education program designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that Plan or area?			
1.7 Does the Plan monitor subcontractors' dental education programs? If a subcontractor's performance in dental education is deficient, does the Plan implement strategies to improve performance and effectiveness?			
1.8 Does the Plan have standards, guidelines, policies or procedures to maintain appropriate dental health education programs? Is there appropriate documentation of this program to demonstrate effectiveness?			

### End of Requirement AA-010: Health Education

## DENTAL SERVICE TAG

### Requirement AA-011: Changes in Availability or Location of Services

#### CONTRACT CITATIONS

##### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision E**

##### **E. Changes in Availability or Location of Covered Services**

Contractor shall obtain written DHCS approval prior to making any substantial change in the availability or location of services to be provided under this contract, except in the case of natural disaster or emergency circumstance, in which case notice will be given to DHCS as soon as possible. Contractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to DHCS at least sixty (60) calendar days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes. The Contractor's proposal shall allow for timely notice to Members to allow them to change providers if desired.

#### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

##### **Staff responsible for the activities described above, for example:**

- Dental Director
- Director of Contracting / Provider Relations
- Director of QM

#### DOCUMENTS TO BE REVIEWED

- Plan Provider Directory
- Electronic version of the Plan's Provider Directory and the Plan's online Provider Directory
- Any available updates to the Plan Provider Directory.
- Policies and procedures relevant to the update of contact information for contracted providers.
- Previous versions of the Plan Provider Directory that show that modifications have been made, where needed.
- Documents and correspondence between the Plan and contracted providers that indicate any changes to the provider's contact information.
- Credentialing/recredentialing policies, procedures and processes

#### **AA-011 - Key Element 1:**

- 1. Changes in Availability or Location of Covered Services: The Plan follows the submission procedures and obtains written DHCS approval prior to making any substantial change in the availability or location of services to be provided under this contract.**

**Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision E**

## DENTAL SERVICE TAG

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a process in place to ensure timely notification to DHCS of any changes in network availability or location of covered services?			
1.2 Does the Plan have procedures in place to ensure 60 day notice to DHCS prior to the effective date of any change in availability or location?			
1.3 Does the Plan have policies and procedures in place to ensure that proposed changes are not implemented until approved by DHCS?			
1.4 Does the Plan have a process in place for timely notification to Members to allow for a change in provider if desired?			

### End of Requirement AA-011: Changes in Availability or Location of Covered Service

## DENTAL SERVICE TAG

### Requirement AA-012: Case Management and Coordination of Care

#### CONTRACT CITATION(S)

##### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 13, Provision A**

###### A. Case Management Services

Contractor shall provide dental case management to each member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all medically necessary dental covered services delivered both within and outside the Contractor's provider network.

##### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 13, Provision B**

###### B. Out-of-Plan Case Management and Coordination of Care

Contractor shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan providers and/or programs to ensure coordinated service delivery and efficient and effective joint case management for services presented in Provisions C and D below.

##### **Medi-Cal Dental GMC Program, Exhibit A, Attachment 13, Provision C**

###### C. Services for Children who are under 21 years of age with Special Health Care Needs

Contractor shall implement and maintain services for Children with Special Health Care Needs (CSHCN) that include but are not limited to, the following:

1. Standardized procedures that include dental care provider training for the identification of CSHCN, at enrollment and on a periodic basis thereafter. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of 42 CFR 438.208(b)(3) and (b)(4) and 438.208(c)(2), (c)(3), and (c)(4).
2. Methods for ensuring and monitoring timely access to pediatric specialists, sub-specialists, ancillary therapists, community resources, and specialized equipment and supplies; these may include assignment to a specialist as Primary Care Dentist, standing referrals, or other methods as defined by Contractor.
3. Methods for ensuring that each CSHCN receives a comprehensive oral assessment and development of a written dental treatment plan.
4. Case management or care coordination for CSHCN, including coordination with the child's medical managed care plan for surgicenter or hospital operating room support services for dental services, and with other agencies which provide services for children with special health care needs (e.g. mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency).
5. Methods for monitoring and improving the quality and appropriateness of care for CSHCN

## DENTAL SERVICE TAG

### Medi-Cal Dental GMC Program, Exhibit A, Attachment 13, Provision D

#### D. California Children's Services (CCS)

Services provided by the CCS program are not covered under this Contract. Upon diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS eligible condition, Contractor shall refer the Member to the local CCS office for determination of eligibility.

1. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to those which:

- a. Assure that contracting providers are informed about CCS-paneled providers within Contractor's network, and procedures that provide for continuity of care between the contracting providers and CCS providers for CCS-covered conditions.
- b. Ensure that Contractor continues to provide all medically necessary dental covered services for the Member's CCS eligible condition until CCS eligibility is confirmed.
- c. Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all medically necessary dental covered services that are unrelated to the CCS eligible condition and shall monitor and ensure the coordination of services between its Primary Care Dentist, the CCS specialty providers, and the local CCS program.

#### **42 CFR 438.208(b)(3), (b)(4), and (c)(2) through (c)(4) [Back to Question](#)**

(b) Primary care and coordination of health care services for all MCO, PIHP, and PAHP enrollees.

Each MCO, PIHP, and PAHP must implement procedures to deliver primary care to and coordinate health service for all MCO, PIHP, and PAHP enrollees. These procedures must meet State requirements and must do the following:

(3) Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.

(4) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

(c) Additional services for enrollees with special health care needs.

(2) Assessment.

Each MCO, PIHP, and PAHP must implement mechanisms to assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph (c)(1) of this section) and identified to the MCO, PIHP, and PAHP by the State as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

(3) Treatment plans.

If the State requires MCOs, PIHPs, and PAHPs to produce a treatment plan for enrollees 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 —

## DENTAL SERVICE TAG

- (i) Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;
  - (ii) Approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO, PIHP, or PAHP; and
  - (iii) In accord with any applicable State quality assurance and utilization review standards.
- (4) Direct access to specialists.

For enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with §438.208(c)(2)) to need a course of treatment or regular care monitoring, each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

**Staff responsible for the activities described above, for example:**

- Dental Director
- UM or QM Director
- Director of Governmental Compliance

### DOCUMENT(S) TO BE REVIEWED

- UM Program
- Policies and procedures that address case management, continuity of care, and coordination of care
- Policies and procedures that outline how the Plan conducts outreach and community and agency resource coordination
- Policies and procedures for monitoring and improving the quality and appropriateness of care
- Policies and procedures that address requirements for the CSHCN Members (Children under 21 with special health care needs.)
- Evaluate the Plan's process and methods for monitoring and evaluating care and services

### AA-012 - Key Element 1:

1. **Case Management Services:** The Plan provides dental case management to each Member. The Plan maintains procedures for monitoring the coordination of care provided to Members, including, but not limited to, all medically necessary dental covered services delivered both within and outside the Plan's provider network. Medi-Cal Dental GMC Program, Exhibit A, Attachment 13, Provision A

## DENTAL SERVICE TAG

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a system in place to provide case management to each Member as appropriate?			
1.2 Does the Plan maintain procedures for monitoring the coordination of care provided to members, including, but not limited to, all medically necessary dental covered services delivered both within and outside of the Plan’s provider network?			

**AA-012 - Key Element 2:**

- 2. Services for Children under 21 years of age with Special Health Care Needs: The Plan implements and maintains services for Children with Special Health Care needs (CSHCN).**  
**Medi-Cal Dental GMC Program, Exhibit A, Attachment 13, Provision C; Medi-Cal Dental GMC Program, Exhibit A, Attachment 13, Provision D; 42 CFR 438.208(b)(3) and (b)(4), and (c)(2) through (c)(4)**

Assessment Questions	Yes	No	N/A
2.1 Do the Plan’s policies state that the Plan will implement and maintain services for Children with Special Health Care Needs (CSHCN)?			
2.2 Does the Plan have standardized procedures that include dental care provider training for the identification of CSHCN, at enrollment and on a periodic basis thereafter?			
2.3 Does the Plan’s identification, assessment, treatment, and coordination of care of CSHCN comply with the requirements of <a href="#">42 CFR 438.208(b)(3) and (4), and (c)(2), (3) and (4)?</a>			
A. Has the Plan implemented procedures to coordinate health services for all Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), and (Prepaid Ambulatory Health Plan) PAHP enrollees?			
B. Do the Plan’s procedures include the sharing with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment of that enrollee’s needs to prevent duplication of those activities?			
C. Do the Plan’s procedures ensure that, in the process of coordinating care, each CSHCN enrollee’s privacy is protected?			
D. Does the Plan have mechanisms in place to assess each Medi-Cal enrollee identified by the State to have special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring? And does the assessment mechanism use appropriate health care professionals?			
E. Does the Plan provide treatment plans for CSHCN that are			

## DENTAL SERVICE TAG

Assessment Questions	Yes	No	N/A
developed by the enrollee’s primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee?			
F. Does the Plan provide treatment plans for CSHCN that are approved in a timely manner when approval is required?			
G. Does the Plan have a mechanism in place to allow CSHCN enrollees direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee’s condition and identified needs?			
2.4 Does the Plan have methods for ensuring and monitoring timely access to pediatric specialists, sub-specialists, ancillary providers, community resources, and specialized equipment and supplies? Such methods may include assignment to a specialist as a Primary Care Dentist, standing referrals, or other methods as defined by Plan. <b>(KKA AA-004, KE2, AQ, 2.12)</b>			
2.5 Does the Plan have methods for ensuring that each CSHCN receives a comprehensive oral assessment and development of a written dental treatment plan?			
2.6 Does the Plan maintain procedures to identify individuals who may need or who are receiving services from out-of-plan providers and/or programs to ensure coordinated service delivery and efficient and effective joint case management for services for services provided to CSHCN?			
A. Does the Plan coordinate with the child’s medical managed care plan for surgicenter or hospital operating room support services for dental services as needed?			
B. Does the Plan coordinate with other agencies which provide services for children with special health care needs? (e.g. mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency)			
2.7 Has the Plan developed and implemented methods for monitoring and improving the quality and appropriateness of care for children with special health care needs?			

**AA-012 - Key Element 3:**

**3. California Children’s Services (CCS): The Plan identifies and refers CCS to the local CCS program and ensures coordination of services between the CCS eligible condition and all other medically necessary dental covered services.  
Medi-Cal Dental GMC Program, Exhibit A, Attachment 13, Provision D**

Assessment Questions	Yes	No	N/A
3.1 Does the Plan maintain written procedures to identify and refer			

## DENTAL SERVICE TAG

<b>Assessment Questions</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
children with eligible CCS conditions to the local CCS Program?			
3.2 Does the Plan ensure that contracting providers are informed about CCS-paneled providers within Contractor’s network, and procedures that provide for continuity of care between the contracting providers and CCS providers for CCS-covered conditions?			
3.3 Does the Plan ensure that all medically necessary dental covered services for the Member’s CCS eligible condition continues until CCS eligibility is confirmed?			
3.4 Does the Plan ensure CCS Members receive all medically necessary dental covered services that are unrelated to the CCS eligible condition and monitor and ensure the coordination of services between its Primary Care Dentist, the CCS specialty providers, and the local CCS Program?			

### End of Requirement AA-012: Case Management and Coordination of Care

## DENTAL SERVICE TAG

### Requirement AA-013: Healthcare Surge Events

#### CONTRACT CITATIONS

##### Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision I

###### I. Healthcare Surge Events

Contractor shall develop and implement policies and procedures to mitigate the effects of natural, manmade, or war-caused disasters involving broad healthcare surge events greatly impacting Contractor's health care delivery system. Contractor's policies and procedures shall ensure that Contractor will pro-actively cope with healthcare surge events resulting from such disasters or states of emergency, and shall include but are not limited to protecting enrollees, if necessary, by keeping covered services available to Members; keeping the revenue stream flowing to providers in order to keep covered services available; transferring Members from provider-to-provider in the event of diminished plan capacity to keep covered services available; and promptly notifying DHCS of the status of the availability and locations of covered services, and/or providers. Contractor shall submit disaster recovery policies and procedures to DHCS no later than thirty (30) calendar days after contract execution for review and approval. Contractor shall submit any revisions, updates and/or changes in writing to DHCS for approval fifteen (15) calendar days prior to implementing the proposed revision, update and/or change.

#### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

##### Staff responsible for the activities described above, for example:

- Dental Director
- Director of Contracting / Provider Relations
- Director of QM
- Compliance Officer
- MIS Director

#### DOCUMENTS TO BE REVIEWED

- Plan's Disaster Plan
- Policies and procedures that relate to access and availability during a disaster situation, including those related to the provision of covered services to members, network management, information exchange and provider payment.
- Provider Manual
- Policies and procedures relevant to information processes during disaster situation, including communication with and from providers.

## DENTAL SERVICE TAG

**AA-013 - Key Element 1:**

- 1. Healthcare Surge Events: The Plan has developed and implemented DHCS approved policies and procedures to mitigate the effects of natural, man-made, or war-caused disasters involving broad healthcare surge events greatly impacting Plan’s health care delivery system.**  
**Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision I**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a disaster plan that describes the processes by which the Plan will continue to operate during a disaster?			
1.2 Do the Plan’s policies and procedures ensure the availability of covered services Members during a healthcare surge event?			
1.3 Do the Plan’s policies and procedures ensure the continued flow of the revenue stream to provider during a healthcare surge event in order to keep covered services available?			
1.4 Do the Plan’s policies and procedures provide for the transfer of Members from provider-to-provider in the event of diminished Plan capacity to keep covered services available?			
1.5 Does the Plan have a process in place to promptly notify DHCS of the status of the availability and locations of covered services, and/or providers?			
1.6 Has the Plan submitted disaster recovery policies and procedures to DHCS for review and approval? Within 30 calendar days of contract execution?			
1.7 Does the Plan have a process in place to submit revisions, updates and/or changes in writing to DHCS for approval? Within 15 calendar days prior to implementing the proposed revision, update and/or change?			

**End of Requirement AA-013: Healthcare Surge Events**