DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FOLLOW-UP REPORT

ROUTINE SURVEY

OF

LIBERTY DENTAL PLAN OF CALIFORNIA, INC.

DBA PERSONAL DENTAL SERVICES

A DENTAL HEALTH PLAN

OCTOBER 8, 2019

Routine Survey Follow-Up Report
Liberty Dental Plan of California, Inc.
DBA Personal Dental Services
A Dental Health Plan

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In the Final Report for the Routine Survey (Final Report) of Liberty Dental Plan of California, Inc. DBA Personal Dental Services (Plan), dated March 28, 2018, the California Department of Managed Health Care (Department) identified two corrected deficiencies and seven uncorrected deficiencies. The Plan was advised that the Department would conduct a follow-up review (Follow-Up Survey) to assess the status of the seven outstanding deficiencies and issue a report within 18 months of the date of the Final Report.[1]

The survey team conducted the Follow-Up Survey pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Act), codified at Health and Safety Code section 1340 *et seq*., and Title 28 of the California Code of Regulations section 1000 *et seq*.[2] On January 22, 2019, the Department notified the Plan of its scheduled Follow-Up Survey and requested the Plan submit information regarding its uncorrected deficiencies as cited in the Final Report.

The Follow-Up Survey addressed outstanding deficiencies in the following areas:

Quality Assurance
Access and Availability of Services
Utilization Management
Language Assistance

The Follow-Up Survey revealed of the previous **seven** outstanding deficiencies, two remain uncorrected.

	FOLLOW-UP SURVEY STATUS OF OUTSTANDING DEFICIENCIES FROM FINAL REPORT ISSUED ON MARCH 28, 2018	
#	**DEFICIENCY STATEMENT**	**FOLLOW-UP SURVEY STATUS**
	QUALITY ASSURANCE	
1	**The Plan inconsistently identifies quality of care problems, fails to take appropriate and effective action to improve care where it does identify quality of care problems, and fails to plan follow-up as needed.** Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A) and (B); Rule 1300.70(b)(2)(C).	**Corrected**

[1] Liberty Dental Final Report.
[2] All references to "Section" are to the Health and Safety Code unless otherwise indicated. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

	UTILIZATION MANAGEMENT	
2	**The Plan's written communications regarding denial, delay, or modification of provider authorization requests do not consistently:** **a) explain the reasons for the Plan's decision using clear and concise language;** **b) describe the criteria or guidelines the Plan used in making its determination;** **c) state the clinical reasons for the basis of the Plan's determination; and** **d) list the direct telephone number or extension of the dental professional responsible for the determination.** Section 1367.01(h)(4).	**Not Corrected**
3	**When the Plan cannot make a decision within the required timeframe for prior and concurrent requests for service authorization, it fails to notify the provider and the enrollee in writing of the anticipated date in which the Plan will render a decision.** Section 1367.01(h)(5).	**Not Corrected**
	ACCESS AND AVAILABILITY OF SERVICES	
6	**The Plan does not publish and maintain an accurate provider directory or directories with information on contracting providers who deliver dental care services to the plan's enrollees.** Section 1367.27(a), (c)(1), and (i).	**Corrected**
	LANGUAGE ASSISTANCE	
7	**The Plan did not properly assess its enrollee population to develop an accurate demographic profile or survey the linguistic needs of its individual enrollees.** Rule 1300.67.04(b)(1); Rule 1300.67.04(c)(1)(A) and (B).	**Corrected**
8	**With respect to the Plan's Language Assistance Program, the Plan operates in a manner contrary to the manner described within its application for licensure.** Section 1351(d) and (m); Section 1352(a); 1352.1(a); Section 1386(b)(1); Rule 1300.51.3(b)(1); Rule 1300.52(d) and (e); Rule 1300.67.04(c)(4).	**Corrected**

9	**The Plan's Language Assistance Program (LAP) fails to provide Limited English Proficiency (LEP) enrollees with meaningful access to services, by failing to ensure enrollees have access to competent and qualified bilingual providers and office staff.** Rule 1300.67.04(c)(2)(G)(iii) and (v); Rule 1300.67.04(c)(2)(H); Rule 1300.67.04(d)(9)(A) through (C).	**Corrected**

SECTION I: SUMMARY OF OUTSTANDING DEFICIENCIES FROM FINAL REPORT AND FOLLOW-UP SURVEY FINDINGS

The following details the Department's findings regarding the outstanding deficiencies. The Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health and Safety Code section 1380(i).

DEFICIENCIES

QUALITY ASSURANCE

Deficiency #1: **The Plan inconsistently identifies quality of care problems, fails to take appropriate and effective action to improve care where it does identify quality of care problems, and fails to plan follow-up as needed.**

Statutory/Regulatory Reference(s): Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A) and (B); Rule 1300.70(b)(2)(C).

The Plan's Follow-Up Compliance Effort: On February 27, 2019, the Plan submitted a narrative response to the notice to conduct the Follow-Up Survey (Narrative Response).

In its Narrative Response, the Plan stated that it:

- Surveyed enrollees who received services from providers for which the Plan audited.
- Issued updated audit finding letters to providers. These letters identified unacceptable elements and findings the Plan determined as potential quality issues (PQIs). Additionally, the audit finding letters detailed the Plan's corrective action requirements, and subsequent follow-up measures.
- Conducted peer-to-peer counselling with providers concerning all previously identified audit issues, emphasizing to the providers the requirement to comply with quality assurance activities.
- Completed subsequent reviews of contracted providers to evaluate their current performance.
- Developed a semi-automated, workflow-based system to manage the Plan's quality assurance review (QAR) process.

Additionally, the Plan stated it implemented the following corrective actions during the Follow-Up Survey review period.

- Its Compliance Committee, Quality Management Improvement Committee, and Board of Directors reviewed the Final Survey Report's findings.
- It hired a new California Dental Director and Vice President of Quality Management.

- It completed its full re-audit of the deficient providers identified through the Department's Routine Survey.
- It conducted a refresher training for its CADP[3] certified dental consultants, who perform provider audits.
- It enhanced the workflow it developed to track and monitor provider audit deficiencies, corrective actions, and follow-up activities.
- It continued to perform quality assurance review on all provider corrective action plans (CAPs) to ensure they properly address all deficiencies identified in the audit tool, before the Plan issues the CAP letter.
- It continued to place deficient providers on an accelerated audit schedule to ensure the corrective actions remain effective. (This includes unannounced provider office visits for quality assurance review involving structural deficiencies, and desktop audits for quality assurance reviews involving procedural deficiencies.)
- It implemented a Quality Improvement Project (QIP) to assess its performance in addressing the Department's deficiency findings and to plan future improvements. As a part of this QIP, the Plan regularly trained and coached its Quality Management personnel, on a formal and informal basis, to reinforce their understanding of the Plan's current PQI processes and controls.

Along with the Narrative Response, the Plan submitted its 2019 Quality Management and Improvement Program Description and its Policies and Procedures on its PQI process. These documents show the Plan's current process for identifying PQIs, correcting identified issues, and following-up to ensure compliance.

Supporting Documentation:

- 2018 Annual Quality Management And Improvement Program Evaluation (no date)
- 2019 Quality Management and Improvement (QMI) Program Description (12/18/2018)
- Policies and Procedures, Potential Quality Issue (PQI) Process (approved 12/6/2018)
- Policies and Procedures, Quality Assurance Review Processing (approved 12/6/2018)
- 14 PQI files (5/1/2018 through 12/31/2018)

Follow-Up Survey Assessment: The Department assessed the Plan's documents, including the universe of 14 PQI files for the survey review period, and determined the Plan has corrected this deficiency. The Plan's documents establish that the Plan initiated a QIP to assess its performance in addressing the Department's Final Report findings and to prepare for future improvements. It conducted appropriate root-cause analyses, issued corrective actions and continued follow-up through resolution of identified issues.

[3] CADP stands for the California Association of Dental Plans.

The Plan completed a full re-audit of impacted facilities to ensure it properly identifies quality of care issues. The Plan also continued to apply and enhance the workflow it developed to track and monitor deficiencies identified through its audits of providers, corrective actions and follow-up activities. The Plan conducted a provider audit refresher training for the CADP-certified Dental Consultants who perform provider audits. In addition, the Plan's Dental Director emphasized processes and controls and reinforced the importance of overall quality to the enrollees.

The Plan has corrected all three deficient elements identified in the Final Report.

a. The Plan's identification of quality of care issues requiring corrective action.

Of the 14 PQI files the Department reviewed, the Plan identified 13 through the provider audit process and 1 resulting from a claim submitted for services rendered. Out of the 14 files reviewed, only 1[4] file (7%) did not identify or assess all the quality issues.

b. The Plan's actions to improve care where it does identify quality of care problems.

The Plan performed provider audits on all providers subject to a CAP to ensure the provider properly addressed all deficiencies identified in the audit. In addition, it continued to place providers with deficiencies on an accelerated audit schedule to ensure that the corrective actions implemented remain effective.

c. The Plan's follow-up to ensure providers corrected quality of care problems.

The Plan now investigates:

- non-responsive providers;
- providers who have inadequately completed their CAPs;
- providers who have repeated or systemic issues, and
- providers who have otherwise failed to resolve quality issues.

The Department determined the Plan takes appropriate follow-up action as needed.

Follow-Up Report Deficiency Status: Corrected

The Department finds that the Plan has corrected this deficiency. The Plan has taken considerable steps to identify problems related to the quality of care provided, correct those problems, and follow-up as necessary.

Based upon the corrective actions undertaken, the Department has determined that the Plan has corrected this deficiency.

[4] File #14.

UTILIZATION MANAGEMENT

Deficiency #2: **The Plan's written communications regarding denial, delay, or modification of provider authorization requests do not consistently:**

a) explain the reasons for the Plan's decision using clear and concise language;
b) describe the criteria or guidelines the Plan used in making its determination;
c) state the clinical reasons for the basis of the Plan's determination; and
d) list the direct telephone number or extension of the dental professional responsible for the determination.

Statutory/Regulatory Reference(s): Section 1367.01(h)(4).

The Plan's Follow-Up Compliance Effort: In its Narrative Response, the Plan stated that it:

- Implemented new language in its denial letters, explaining the reason for the denial or modification, describing the criteria or the guidelines the Plan used to make its determination, and stating the clinical reason for the denial.
- Implemented new language, which lists the direct telephone number or extension of the dental professional responsible for the determination.
- Performed an informal, internal review of sample denial letters to validate whether they contained the name and direct telephone number of the professional responsible for the determination.
- Formalized a standing Denial Rationale Workgroup comprised of clinicians and Quality Management personnel responsible for regularly reviewing and developing denial rationales that employ clear and concise language; the criteria or guidelines used to make the decisions, and the clinical rationale underlying the determination.
- Issued and implemented revised denial rationales with lowered reading levels, aimed at further improving clarity, and conciseness.

In addition, the Plan stated it would train relevant personnel throughout the organization.

Supporting Documentation:

- 44 UM Denial Files (May 1, 2018 through December 31, 2018)

Follow-Up Survey Assessment: The Department acknowledges the Plan has taken steps to remedy this deficiency. However, the Department assessed 44[5] randomly selected files containing denial decisions and determined the Plan does not consistently

[5] From a universe of 14,557 files covering a 10 month review period.

comply with the requirements of Section 1367.01(h)(4). The Department found the following:

a. The utilization management (UM) denial letters do not clearly and concisely explain the reason for the denial.

The Plan's denial letters did not clearly and concisely explain the reason for the decisions in 20[6] of the 44 UM files (45%). The denial letters demonstrated that the Plan continued to used medical language such as "radiographic image(s)," "periapical pathology," and "endodontic prognosis." The Plan also included contradictory statements. The following case examples exemplify this problem:

- **File #1:** The Plan denied the provider's request. The Plan's denial letter states: "This letter is to inform you that the treatment has been approved/modified by [the Plan's] Dental Consultant." This language is not clear because the Plan did not approve or modify the request, but denied it. This language could confuse an enrollee who might believe that the Plan approved the request.

- **File #8:** The provider requested authorization for root canal therapy. The denial letter states: "'Root Canal, Retreatment' may be needed when a tooth with previous endodontic treatment is symptomatic or shows evidence of periapical pathology." This denial letter is not clear because it uses technical terms like "endodontic treatment," "symptomatic," and "Periapical pathology." Moreover, the denial letter says retreatment "may be needed," which is an ambiguous phrase that could confuse the enrollee.

b. The Plan's denial letters do not describe the criteria and guidelines the Plan used to base its rationale.

In 18[7] of the 44 files reviewed (41%), the Plan's denial letters did not describe the criteria or guidelines used to decide the authorization request. The following file exemplifies this problem:

- **File #38:** The provider requested authorization for general anesthesia during a tooth extraction. The Plan denied the request and stated the "dental records show no medical need to be put to sleep for dental work. The X-rays do not show a need to be put to sleep for dental work. Please ask your dentist for other ways you can have your dental work done." This letter did not describe the criteria or guideline the Plan used to make this denial.

c. The Plan's denial letters do not explain the clinical reasoning for the Plan's determination.

[6] DMHC File #1; File #2; File #3; File #4; File #5; File #8; File #12; File #13; File #16; File #18; File #21; File #22; File #24; File #28; File #31; File #32; File #33; File #36; File #41; and File #44.
[7] DMHC File #2; #3; #6; #7; #12; #13; #14; #18; #20; #22; #25; #26; #27; #30; #34; #38; #44; and #45.

The Department found 15[8] of 44 reviewed files (34%) failed to contain the clinical reason the Plan applied to decide the provider's authorization request, as required by Section 1367.01(h)(4). For example, in File #38 (above) the Plan failed to explain the clinical reason for the Plan's denial of the provider's authorization request.

d. The Plan's denial letters to providers contain the name and direct telephone number or extension of the dental professional who made the decision.

The Plan has corrected this portion of the deficiency. All 44 (100%) of the UM denial letters reviewed by the Department included the dental professional's name and direct telephone number.

TABLE 1
UM Denial Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
UM Denial Files	44	Denial letter contains a clear and concise explanation of the reason(s) for the decision	24 (55%)	20 (45%)
UM Denial Files	44	Denial letter contains a description of the criteria or guidelines.	26 (59%)	18 (41%)
UM Denial Files	44	Denial letter specifies the clinical reason for the decision.	29 (66%)	15 (34%)
UM Denial Files	44	Denial letter contains the name and direct telephone number or extension of the dental professional making the decision	44 (100%)	0 (0%)

Follow-Up Report Deficiency Status: Not Corrected

The Department finds that although the Plan's denial letters now include the dental professional's name and direct telephone number, the letters do not consistently meet all the required elements of Section 1367.01(h)(4). The Plan's denial letters do not explain the reason for the Plan's decision clearly and concisely, describe the criteria or

[8] DMHC File #1; #2; #4; #5; #6; #8; #13; #14; #18; #27; #32; #34; #38; #44 and #45.

guidelines the Plan used, or state the clinical reasoning for the Plan's decision regarding medical necessity.

Based upon the corrective actions undertaken by the Plan and review of the UM files, the Department has determined that the Plan has not corrected this deficiency.

Deficiency #3: **When the Plan cannot make a decision within the required timeframe for prior and concurrent requests for service authorization, it fails to notify the provider and the enrollee in writing of the anticipated date in which the Plan will render a decision.**

Statutory Reference: Section 1367.01(h)(5).

The Plan's Follow-Up Compliance Effort: In its Narrative Response, the Plan stated that it:

- Updated its processes to issue an initial and a final notice of delay letter to both the provider and enrollee. In October 2018, the Plan began sending letters when it cannot make a decision within the required timeframe. The new notification states, "If the additional information is not received within 14 days of the above Date Reviewed [the Plan] will make a decision based on the information available."
- Performed an internal audit of its UM process in the first quarter of 2019.

Supporting Documentation:

- 44 UM Denial Files (May 1, 2018 through December 31, 2018)
- *Final Notice of Delay* (UM Pend letter, provider, template)(No date)
- *Final Notice of Delay* (UM Pend letter, enrollee, template)(No date)
- *Initial Notice of Delay* (UM Pend letter, provider, template)(No date)
- *Initial Notice of Delay* (UM Pend letter, enrollee, template)(No date)

Follow-Up Survey Assessment: The Department assessed 44 UM Denial Files and the Plan's Final and Initial Notice of Delay letters to providers and enrollees. The Department found that in situations where the Plan does not have all the information reasonably necessary to make its determination it continues to fail to inform providers and enrollees of the anticipated date in which the Plan will make a decision.

Section 1367.01(h)(1) requires plans to make a decision on an authorization request within five business days of receiving all the information reasonably necessary to make the decision. The Department conducted a file review of 44 randomly selected UM denials in which the Plan resolved the case six or more calendar days after receipt. In 19[9] of the 44 UM files, the Plan did not decide the provider's request within the five business day period of Section 1367.01(h)(1). In these files, the Plan did not have all

[9] DMHC File #1; #2; #3; #5; #6; #7; #11; #18; #21; #22; #27; #29; #30; #31; #34; #36; #39; #41; and #42.

the information reasonably necessary to make a UM determination and requested additional information. However, in all 19 (100%) of the files, the Plan failed to notify the provider and enrollee, in writing, of the anticipated decision date as required under Section 1367.01(h)(5).

TABLE 2
Notification of Anticipated Date of Decision in Pending UM Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
UM Denial Files in which the Plan did not have all the information reasonably necessary to make the determination	19	Written notification to provider/enrollee includes the anticipated decision date	0 (0%)	19 (100%)

Follow-Up Report Deficiency Status: Not Corrected

The Department finds that when the Plan pends a prior authorization request for service because it needs additional information, it does not notify the provider and the enrollee of the anticipated decision date. Based upon review of the Plan's UM files where the Plan needed additional information to make its UM decision, the Department determined that the Plan has not corrected this deficiency.

ACCESS AND AVAILABILITY OF SERVICES

Deficiency #6: **The Plan does not publish and maintain an accurate provider directory or directories with information on contracting providers who deliver dental care services to the plan's enrollees.**

Statutory References: Section 1367.27(a), (c)(1), and (i).

The Plan's Follow-Up Compliance Effort: In its Narrative Response, the Plan stated that it:

- Performed a preliminary audit of its provider network data to review the total number of active dentists in each office and the total number of offices linked to each dentist.
- Conducted its "Provider Directory Information Validation Outreach Campaign" between June and August of 2018.

- Updated its public Provider Web Portal to list the network name to the plan name in the provider search feature.
- Contacted all dental offices within its networks and made appropriate updates to ensure it only lists primary care dentists at each listed location.
- Performed an additional audit of all dental offices within its networks to make appropriate updates to ensure each location only lists primary care dentists.
- Adhered to the set of controls outlined in its *Maintaining Provider Directory* policy and procedure.
- Implemented audit criteria for validating provider directory accuracy in quarterly provider surveys.
- Reminded providers of their obligation to notify the Plan of certain changes to the information they have on file.
- Performed an internal test to validate that the provider directory's search function works properly.

Supporting Documentation:

- *Provider List Monitoring* (December 6, 2019)
- *Maintaining Provider Directory* (December 6, 2018)
- Provider Lists for the CA80, CA90, CA1000, CA Select, Covered CA Choice, Covered CA Exchange, Covered CA Select, DHMO Choice, IHSS Santa Clara, and LDP Plans (February 25, 2019)

Follow-Up Survey Assessment: The Department assessed the Plan's online provider directory and reviewed its provider lists. The Plan's online provider directory includes the specific benefit plan available to enrollees. It allows enrollees to search dentists who participate in a specific California benefit plan.

The Department reviewed the information on the online provider directory, which appears accurate. While the Plan listed some providers at multiple locations due to the business model of certain provider groups, the Plan's provider list no longer contains the large discrepancies the Department identified in the Final Report. For example, the Plan no longer listed a dentist operating at 69 locations throughout California.

Follow-Up Report Deficiency Status: Corrected

The Department finds that the Plan has corrected this deficiency. The Plan has taken considerable steps to correct the inaccuracies within its provider directories. The Department's review during the Follow-Up Survey did not identify the significant discrepancies identified in the Final Survey Report.

Based upon the corrective actions undertaken, the Department has determined that the Plan has corrected this deficiency.

LANGUAGE ASSISTANCE

Deficiency #7: The Plan did not properly assess its enrollee population to develop an accurate demographic profile or survey the linguistic needs of its individual enrollees.

Statutory/Regulatory Reference(s): Rule 1300.67.04(b)(1); Rule 1300.67.04(c)(1)(A) and (B).

The Plan's Follow-Up Compliance Effort: In its Narrative Response, the Plan stated it:

- Updated its Evidence of Coverage (EOC) and NOLA to include a disclosure concerning how enrollees may obtain language assistance services at no cost by notifying the Plan or provider.
- Filed its updated EOC and NOLA in the third quarter of 2018.

Supporting Documentation:

- *California Group Plan Combined Evidence of Coverage (EOC) and Disclosure Form*; EOC-CC and Group (March 29, 2018)
- *California Group Plan Combined Evidence of Coverage (EOC) and Disclosure Form*; EOC-Individual Covered California EOC (March 29, 2018)
- *Notice of Language Assistance* (October 4, 2018)

Follow-Up Survey Assessment: In the Final Report, the Department found the Plan had corrected two of the three identified parts of this deficiency. In this Follow-Up Survey, the Department assessed whether the Plan corrected the third part: Whether the Plan surveys its enrollees in a manner designed to identify the linguistic needs of each of its enrollees pursuant to Rule 1300.67.04(c)(1)(B).

The Plan revised its *Notice of Language Assistance* (NOLA) to include the following language:

> **IMPORTANT**: You can get an interpreter at no cost to talk to your dentist or dental plan. To get an interpreter or to request written information (in your language or in a different format, such as Braille or larger font), first call your Dental plan's phone number at 1-888-703-6999 (TTY: 1-800-735-2929). Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at 1-888-466-2219. Make sure to notify your provider (Dentist) of your personal language needs upon your initial dental visit.

The Plan's NOLA now informs the enrollee of the availability of free language assistance services. The NOLA informs enrollees, in English and the Plan's threshold languages, how to notify the Plan and the provider of their language preferences.

The Plan's EOCs notify enrollees in English and Spanish by stating:

> Interpretation and translation services may be available for Members with limited English proficiency, including translation of documents into certain threshold languages at no cost to You. To ask for language services call [1-888-703-6999]. Make sure to notify your provider (Dentist) of Your personal language needs upon your initial dental visit.

However, the Plan's EOCs do not notify enrollees in its other threshold languages: Chinese, Tagalog, and Vietnamese.[10] Nevertheless, the Plan now issues the required statement in those languages through its NOLA, which it distributes to all enrollees.

Follow-Up Report Deficiency Status: Corrected

The Department finds that the Plan has updated its NOLA and EOC to inform enrollees that free language services are available. The Plan now sends a disclosure that informs enrollees to notify their providers of the need for such services through its NOLA. While the Plan's EOCs do not list the required disclosure in all threshold languages, the Plan sends a NOLA with each EOC that contains all the required elements.

Based upon the corrective actions undertaken, the Department has determined that the Plan has corrected this deficiency.

Deficiency #8: With respect to the Plan's Language Assistance Program, the Plan operates in a manner contrary to the manner described within its application for licensure.

Statutory/Regulatory Reference(s): Section 1351(d) and (m); Section 1352(a); 1352.1(a); Section 1386(b)(1); Rule 1300.51.3(b)(1); Rule 1300.52(d) and (e); Rule 1300.67.04(c)(4).

The Plan's Follow-Up Compliance Effort: On January 30, 2019, the Plan submitted its administrative service agreements and its language assistance program policies to the Department as an amendment to its licensure application. The Department reviewed the filing and, on June 11, 2019, closed the filing without further objection.

Supporting Documentation:

- E-filing 20190166 (closed by Department June 11, 2019)

Follow-Up Survey Assessment: In the Final Report, the Department identified three areas where the Plan operated in a manner contrary to that stated within its licensure applications:

[10] In the Plan's response to the Preliminary Report, it reassessed its enrollee population, using a statistically valid methodology for its demographic profile. This resulted in the Plan adding additional threshold languages. However, the Plan did not update its EOC to include the required language disclosure in these newly identified threshold languages.

a) The Plan used unqualified staff to provide interpretation services to enrollees:

b) The Plan used unapproved vendors to provide interpretation and translation services which it fails to monitor for accuracy, and

c) The Plan failed to file as an Amendment or Notice of Material Modification updates to its Language Assistance Program.

The Plan filed its administrative service contracts for the Plan's current interpretation and translation services vendors and its updated cultural and linguistic policies and procedures with the Department. The Plan no longer requires bilingual staff to provide translation and interpretation services. It filed the updates with the Department along with the contracts between its language translation and interpretation service vendors. Finally, the Department closed the filing without further objection.

Follow-Up Report Deficiency Status: Corrected

The Department finds that the Plan has corrected this deficiency by filing its administrative service agreements and updated language assistance program with the Department. The Department has closed the filing without further objection and the Plan no longer operates in a manner contrary to that stated within its licensure application in violation of Section 1386(b)(1)

Based upon the corrective actions undertaken, the Department has determined that the Plan has corrected this deficiency.

Deficiency #9: The Plan's Language Assistance Program (LAP) fails to provide Limited English Proficiency (LEP) enrollees with meaningful access to services, by failing to ensure enrollees have access to competent and qualified bilingual providers and office staff.

Statutory/Regulatory Reference(s): Rule 1300.67.04(c)(2)(G)(iii) and (v); Rule 1300.67.04(c)(2)(H); Rule 1300.67.04(d)(9)(A) through (C).

The Plan's Follow-Up Compliance Effort: In its Narrative Response, the Plan stated it updated its policies and procedures as a part of its CAP in response to the Preliminary Report. The policies and procedures no longer require the Plan's providers to interpret for LEP enrollees and instructs providers to contact the Plan for interpreting services.

The Plan filed these policies and procedures as a part of its LAP with the Department on January 30, 2019. The Department reviewed the LAP portion of that filing and asked the Plan how it complied with Rule 1300.67.04(c)(2)(G)(iii) and (v). The Plan stated that it met the requirements by ensuring it offered its enrollees interpretation services at no costs through contracts with an interpretation vendor that uses qualified interpreters, educating contracted network providers on the availability of free language assistance

services, and sending out the NOLA with all enrollee materials. The Department closed the filing without further objection on June 11, 2019.

Supporting Documentation:

- E-filing 20190166 (closed by the Department on June 11, 2019)

Follow-Up Survey Assessment: The Department assessed the Plan's Language Assistance Program documents. This included the Plan's amendment to its licensure application. The Plan has amended its LAP so it no longer requires providers to interpret for enrollees. Rather, the Plan now uses a vendor specifically for interpretation services.

Follow-Up Report Deficiency Status: Corrected

The Plan filed its Language Assistance Program with the Department and the Department reviewed the Language Assistance Program for compliance with Rule 1300.67.04(c)(2)(G)(iii) and (v) and (H). The Plan's LAP complies with these regulatory requirements and the Department approved the filing. Since the Plan no longer requires its providers to interpret for enrollees, the Plan need not meet the requirements or Rule 1300.67.04(d)(9).

Based upon the corrective actions undertaken, the Department has determined that the Plan has corrected this deficiency.

SECTION II: SURVEY CONCLUSION

Issuance of this Follow-Up Report concludes the Routine Survey of the Plan. The Department finds that the Plan has corrected four of the seven the deficiencies that remained uncorrected upon issuance of the Final Report on March 28, 2019.

In the event the Plan would like to append a brief statement to the Follow-Up Report as set forth in Section 1380(i)(3), please submit the response via the Department's Web Portal, eFiling application. Please click on the following link to login: **DMHC Web Portal**.

Once logged in, follow the steps shown below to submit the Plan's response to the Follow-Up Report:

- Click the eFiling link.
- Click the Online Forms link.
- Under Existing Online Forms, click the Details link for the **DPS Routine Survey Document Request** titled**, 2017 Routine Dental Survey - Document Request.**
- Submit the response to the Follow-Up Report via the Department Communication tab.

If the Plan's corrective actions result in revisions to documents and/or information previously submitted to the Department's Office of Plan Licensing, or new documents required to be filed as an Amendment or Notice of Material Modification, please submit those documents to the Department's eFiling Web Portal using the File Documents link. Please indicate in the Exhibit E-1 that the filing is in response to the survey. All applicable documents must be submitted as an Amendment or Notice of Material Modification, as applicable (see Section 1352 and Rule 1300.52.4).

Any uncorrected deficiencies identified in this Report will be referred to the Department's Office of Enforcement for potential further action.

Response to the Follow-Up Report