DEPARTMENT OF
Managed
Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE SURVEY

OF

LIBERTY DENTAL PLAN OF CALIFORNIA, INC.

A DENTAL HEALTH PLAN

(COMMERCIAL AND MEDI-CAL DENTAL SURVEY)

DATE ISSUED TO PLAN: DECEMBER 17, 2014
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Routine Survey Final Report
LIBERTY Dental Health Plan of CA, Inc.
A Dental Health Plan
December 17, 2014

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EXECUTIVE SUMMARY

On September 4, 2013, the California Department of Managed Health Care (the "Department") notified LIBERTY Dental Plan of California, Inc. (the "Plan") that its Routine Survey had commenced, and requested the Plan to submit information regarding its health care delivery system. The survey team conducted the onsite portion of the survey from January 14, 2014 through January 17, 2014. The Department completed its investigatory phase and closed the survey on April 11, 2014.

The Department assessed the following areas for Knox-Keene compliance:

Quality Management
Grievances and Appeals
Access and Availability of Services
Utilization Management
Language Assistance

The Department, through the Interagency Agreement 13-90172 with the Department of Health Care Services ("DHCS"), also assessed the Plan's compliance with the Medi-Cal Dental Managed Care Program Contract ("Contract"). Part II of this Report outlines the areas of the Contract assessed.

There were no Knox-Keene Act deficiencies identified during the Routine Survey.

The Department identified two deficiencies related to the Plan's adherence to the DHCS Contract during the Survey:

2014 MEDI-CAL DENTAL MANAGED CARE CONTRACT
CONTRACTUAL DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	STATUS
	QUALITY MANAGEMENT	
1	**The Plan's provider manual, with instructions and updates, sent to the providers of Medi-Cal dental services, does not contain all information required in the DHCS Medi-Cal Dental Geographic Managed Care contract.** DHCS GMC Boilerplate Contract Exhibit A, Attachment 9, Provision D(1-5); Exhibit A, Attachment 14, Provisions A(1)(a)(1-16) and (D)(4)(i)	**Corrected**

	GENERAL CONTRACTUAL REQUIREMENT	
2	**The Plan does not have a written policy addressing the requirement to provide written notifications to enrollees at least thirty days prior to the effective date of any changes in the grievances, appeals, and State Fair Hearings processes and procedures. The Plan did not notify enrollees at least thirty days prior to the effective date of any changes in the grievances, appeals, and State Fair Hearings processes and procedures.** DHCS GMC Boilerplate Contract Exhibit A, Attachment 14, Provision H (1-2)(a-c)	**Corrected**

SECTION I: KNOX-KEENE SURVEY

KNOX-KEENE SURVEY OVERVIEW

The Department evaluates each health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975.[1] At least once every three years, the Department conducts a Routine Survey of a Plan that covers major areas of the Plan's dental care delivery system. The survey includes a review of the procedures for obtaining health care services, the procedures for providing authorizations for requested services (utilization management), peer review mechanisms, internal procedures for assuring quality of health care, and the overall performance of the Plan in providing dental care benefits and meeting the dental care needs of the subscribers and enrollees in the following areas:

Quality Management – Each plan is required to assess and improve the quality of care it provides to its enrollees.

Grievances and Appeals – Each plan is required to resolve all grievances and appeals in a professional, fair, and expeditious manner.

Access and Availability of Services – Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes.

Utilization Management – Each plan manages the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.

Language Assistance – Each plan is required to implement a Language Assistance Program to ensure interpretation and translation services are accessible and available to enrollees.

The Preliminary Report was issued to the Plan on September 10, 2014. No Knox-Keene Act deficiencies were identified. The Plan has an opportunity to review the Final Report and file a response with the Department prior to the Department issuing the Final Report and making the Final Report public.

This Final Report addresses the most recent Routine Survey of the Plan, which commenced on September 4, 2013 and closed on April 11, 2014.

PLAN BACKGROUND

LIBERTY Dental Plan of California, Inc. was incorporated on December 27, 2001 as a for profit dental benefit corporation, headquartered in Irvine, California, and the parent affiliate is Liberty Dental Plan Corporation. The Plan is licensed as a specialty dental

[1] The Knox-Keene Act is codified at Health and Safety Code section 1340 et seq. All references to "Section" are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

care plan that provides dental benefits statewide to individuals and employer groups. The parent plan contracts with other dental health plans, including GMC Dental Plan, Health Net Dental Plan, and other entities outside of California. The plan entered into the Sacramento Geographic Managed Care ("GMC") Dental Program in May 2005 to serve Medi-Cal Beneficiaries. The Plan's approximate enrollment includes 148,084 commercial, 174,166 Medi-Cal Risk, 23,544 IHSS, and 157,421 contracted from other plans.

The Plan contracts with specialty and primary care dentists through a network model HMO. The Plan's provider network consists of 8,131 primary care dentists ("PCD") reimbursed through Co-payments and/or Capitation. There are 3,895 specialty care dentists ("SCD") reimbursed through Negotiated Fee for Service arrangements. The Plan shares financial risk with its PCD and assumes full risk for the costs related to services rendered by its contracted SCD.

MEDI-CAL DENTAL MANAGED CARE BACKGROUND

The Department of Health Care Services contracts with three GMC and three PHP plans that provide dental services to Medi-Cal Beneficiaries in Sacramento and Los Angeles counties. In Sacramento county, Dental GMC is the mandatory Medi-Cal dental program that requires eligible recipients to select one of the available GMC plans for their dental care services. Dental PHP is a voluntary Medi-Cal dental care program established in Los Angeles County to allow Medi-Cal recipients the option to enroll in HMO as an alternative to the Medi-Cal Dental FFS Program. All Medi-Cal dental managed care plans are licensed by the State of California, Department of Managed Health Care, pursuant to the Knox-Keene Health Care Service Plan Act of 1975.

DISCUSSION OF DISCUSSION OF KNOX-KEENE ACT DEFICIENCIES

Within the scope of this Routine Survey, the Department did not identify any Knox-Keene Act deficiencies in the Plan's operations.

SECTION II: MEDI-CAL DENTAL MANAGED CARE SURVEY

MEDI-CAL DENTAL MANAGED CARE BACKGROUND

The Department of Health Care Services ("DHCS") contracted with three dental care plans in California to provide dental care services to Medi-Cal Beneficiaries in Sacramento and Los Angeles counties through the Geographic Managed Care (GMC) Plan and the Prepaid Health Plan (PHP) contract. All Medi-Cal dental managed care plans are licensed by the State of California, Department of Managed Health Care, pursuant to the Knox-Keene Health Care Service Plan Act of 1975.

MEDI-CAL DENTAL MANAGED CARE CONTRACT SURVEY OVERVIEW

The Medi-Cal Dental Managed Care Program Contract ("Contract") requires each Plan to monitor its associated contracted providers continuously to ensure adherence with access and availability, grievance and appeals policies and procedures, quality management, and utilization management. This survey includes a review of the contract elements in the following areas:

- Provider and Enrollee Ratios;
- Geographic and Timely Access to Care;
- Assignment of Primary Care Dentist Methodology;
- Grievance and Appeals;
- Pay for Performance Initiatives;
- Utilization Management;
- Utilization Management in relation to the Quality Management Program;
- Specialty Network and Referrals;
- Delegation Oversight;
- Preventative Care Outreach; and
- Marketing Practices and Training.

The Preliminary Report was issued to the Plan on September 10, 2014. The Plan had 30 days to file a written statement with the Department and DHCS identifying each contractual deficiency and describing the action taken to correct the findings and the results of such action.[2] The Plan has an opportunity to review the Final Report and file a response with the Department prior to the Department issuing the Final Report and making the Final Report public.

[2] Pursuant to Exhibit A, Attachment 5, Provision N of the Contract and APL 13-004.

DISCUSSION OF CONTRACTUAL DEFICIENCIES and CURRENT STATUS

The Department of Health Care Services addressed the contractual deficiencies cited in this Final Report.

Within 30 days[3] following notice to the Plan of a contractual deficiency the Plan is required to file a corrective action report that:

- Identifies the contractual deficiency; and
- Describes the actions taken to correct the contractual deficiency and the results
- Bears the signature of a principal officer of the Plan.

The Department received the Plan's timely responses and released them to DHCS for review and approval. The results of that review are reported below.

CONTRACTUAL DEFICIENCIES

QUALITY MANAGEMENT

Finding #1: The Plan's provider manual, with instructions and updates, sent to the providers of Medi-Cal dental services, does not contain all information required in DHCS Medi-Cal Dental Geographic Managed Care contract.

Contract Reference(s): DHCS GMC Boilerplate Contract Exhibit A, Attachment 9, Provision D (1-5); Exhibit A, Attachment 14, Provisions A (1)(a)(1-16) and (D)(4)(i)

Assessment: Document review and onsite interviews with LIBERTY's Dental Director and staff revealed the Plan's provider manual, *Provider Reference Guide – California*, did not adequately inform contracted dentists of Members' Rights regarding available options to file grievances and appeals. The Contract requires, among other provisions, that the following information and instructions are included in the provider manual:

1. Members' rights to file written grievances and appeals, and the toll-free number available to file oral grievances and appeals. While the provider manual includes timeframes for filing appeals, it did not include timeframes for filing grievances, nor the toll-free number to file an oral grievance.

2. Processes and procedures members must follow to obtain State Fair Hearings and the State Fair Hearing representation rules. The Plan provided this State Fair Hearing information in a separate internal policy and procedure entitled, *Grievance Process Medi-Cal*, however, providers did not receive this document, nor was this policy incorporated by reference into the provider manual.

3. Instructions for members to request benefit continuation during an appeal or State Fair Hearing. This information is included in members' Evidence of

[3] Pursuant to Exhibit A, Attachment 5, Provision N of the Contract and APL 13-004.

Coverage (EOC) documents, but the provider manual did not reference the EOC to make providers aware of this information source.

The Contract stipulates, "...a contracted health plan shall issue a provider manual that includes procedures and processes regarding members' rights for filing grievances, and applying for and obtaining representation at State Fair Hearings." The Plan's staff confirmed that providers did not receive any additional policies and procedures with this required information, nor did the provider manual identify any other reference sources for this information.

Because the Plan has not included pertinent Contract information in its provider manuals the Department finds the Plan does not comply with Exhibit A, Attachment 9, Provision D(1-5); Exhibit A, Attachment 14, Provision A(1)(a)(1-16) and (D)(4)(i).

Plan's Compliance Effort to Correct the Deficiency: The Department's Preliminary Report cited three specific issues listed above that the Provider Reference Guide did not address. The following describes the Plan's corrective actions and compliance efforts.

1. While the provider manual includes timeframes for filing appeals, it did not include timeframes for filing grievances, nor the toll-free number to file an oral grievance.

   a. LIBERTY has updated the Provider Reference Guide to include the following information: *"Members may file a grievance for at least 180 calendar days following any incident or action that is the subject of their dissatisfaction. Members can submit a grievance via telephone by calling LIBERTY's Member Services Department toll-free at (888) 703-6999, or by fax, email, letter, or grievance form."*

LIBERTY submitted the *"Provider Reference Guide-CA"*, as an excerpt from the revised Provider Reference Guide demonstrating the revision regarding filing grievances and the toll-free number to file an oral grievance.

2. Processes and procedures members must follow to obtain State Fair Hearings and the State Fair Hearing Representation rules. The Plan provided this State Fair Hearing information in a separate internal policy and procedure entitled, *"Grievance Process Medi-Cal",* however, providers did not receive this information, nor was it incorporated by reference into the provider manual.

   a. LIBERTY has added State Fair Hearing information from the policy *Grievance Process Medi-Cal* to the provider manual.

LIBERTY submitted the "*Provider Reference Guide-CA"*, as an excerpt from the revised Provider Reference Guide demonstrating the revision on State Fair Hearings.

3. Instructions for members to request benefit continuation during an appeal or State Fair Hearing. This information is included in members' Evidence of Coverage (EOC) documents, but the provider manual did not reference the EOC to make providers aware of this information source.

a. LIBERTY has added language to the Provider Reference Guide from the EOC that instructs members that *"Requesting a Fair Hearing will not affect a member's eligibility for coverage, and members will not be penalized for seeking a hearing. Members may request benefit continuation during an appeal or State Fair Hearing by contacting LIBERTY 's Member Services Department toll-free at (888) 703- 6999".*

LIBERTY submitted the *"Provider Reference Guide-CA"*, as an excerpt from the revised Provider Reference Guide demonstrating the revision on State Fair Hearings.

Final Report Deficiency Status: Corrected

The DHCS finds that Deficiency #1 is now corrected. The Plan revised its policies and procedures on the Provision of Member Information to include all the required information regarding members' rights for filing grievances, appeals and for requesting State Fair Hearings.

Based upon the corrective actions undertaken, the DHCS has determined that this deficiency has been fully corrected.

GENERAL CONTRACTUAL REQUIREMENT

Finding #2: The Plan does not have a written policy addressing the requirement to provide written notifications to enrollees at least thirty days prior to the effective date of any changes in the grievances, appeals, and State Fair Hearings processes and procedures. The Plan did not notify enrollees at least thirty days prior to the effective date of any changes in the grievances, appeals, and State Fair Hearings processes and procedures.

Contract Reference(s): DHCS GMC Boilerplate Contract Exhibit A, Attachment 14, Provision H(1-2)(a-c)

Assessment: The Plan did not notify enrollees of changes in grievances, appeals, or State Fair Hearings procedures and timelines, and did not have a written policy with instructions to notify enrollees at least thirty days prior to any of these changes. As specified in the contract, the written notifications are to include information regarding:

- Grievances, appeals and fair hearing procedures and timeframes
- Right to a state fair hearing
- Methods for obtaining a hearing
- Rules that governing hearing representation
- Right to file grievances and appeals
- Requirements and timeframes for filing grievances and appeals
- Availability of assistance in the filing process
- Toll-free numbers for enrollees to file grievances or appeals by phone
- Any appeal rights the State makes available to providers to challenge the failure of the organization to cover a service.

The Plan acknowledged that its current policies did not address these conditions and submitted a revised policy for review and final approval by its Board of Directors.

Because the Plan did not have written policies addressing member notifications, nor did the Plan notify members, of changes in grievances, appeals, and the State Fair Hearings procedures and processes the Department finds the Plan does not comply with Exhibit A, Attachment 14, Provision H.1-2a-c.

Plan's Compliance Effort to Correct the Deficiency: The Department indicated in the Preliminary Report that LIBERTY did not have written policies addressing member notifications, nor did the Plan notify members of changes in grievances, appeals, and the State Fair Hearing procedures and processes, as required in the Contract. The Department indicated that LIBERTY acknowledged that its current policy did not address these conditions and submitted a revised policy for its Board of Directors' review and final approval.

LIBERTY updated its policy on the Provision of Written Member Information to address the deficiencies noted by the Department. The Board of Directors approved this revised policy on April 1, 2014.

With the provision of the above-referenced materials, LIBERTY will make the sequential improvements and revisions to its policies and procedures to properly and completely meet the DHCS Geographic Managed Care and Los Angeles Prepaid Health Plan Program requirements.

Final Report Deficiency Status: Corrected

The DHCS finds that the Plan corrected this deficiency by updating its policy on the Provision of Written Member Information to notify members of changes in grievances, appeals and the State Fair Hearing procedure and processes.

Based upon the corrective actions undertaken, the DHCS has determined that this deficiency has been fully corrected.

MEDI-CAL DENTAL MANAGED CARE SURVEY CONCLUSION SURVEY

The Department has completed its survey of the Plan and identified two Medi-Cal Dental Managed Care Survey deficiencies related to the DHCS Contract during the current Survey. These two deficiencies are now deemed corrected based on the updated and revised policies and procedures submitted by the Plan.

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web portal, eFiling application. Click on the Department's Web Portal, **DMHC Web Portal**

Once logged in, follow the steps shown below to submit the Plan's Response to the Final Report:

- Click the 'e-filing' link.
- Click the 'Online Forms' link.
- Under Existing Online Forms, click the 'Details' link for the online form titled
- **DPS Routine Survey Document Request** titled, **2014 Routine** Survey **- Document Request.**
- Select **Response to the Final Report** from the 'Subject' dropdown menu.