DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE SURVEY

OF

HEALTH NET OF CALIFORNIA, INC. (DENTAL)

A DENTAL HEALTH PLAN

FEBRUARY 6, 2020

Routine Survey Final Report
Health Net of California, Inc. (Dental)
A Dental Health Plan

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EXECUTIVE SUMMARY

On October 3, 2018, the California Department of Managed Health Care (Department) notified Health Net of California, Inc. (Plan) that it would conduct its scheduled Routine Survey pursuant to Health and Safety Code section 1380. The Department requested the Plan submit information regarding its health care delivery system in connection with the Routine Survey. The survey team conducted the onsite survey from February 5, 2019 through February 7, 2019.

The Department assessed the following areas:

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

The Department identified **four** deficiencies during the Routine Survey. The 2019 Survey Deficiencies Table below notes the status of each deficiency.

2019 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	
	QUALITY ASSURANCE	
1	**The Plan failed to ensure that all potential quality issues (PQI) were identified and processed in accordance with its Quality Assurance (QA) Program.** Section 1370; Rule 1300.70(b)(1)(B).	**Not Corrected**
	GRIEVANCES AND APPEALS	
2	**The Plan's website does not provide an easily accessible online grievance submission procedure accessible through a hyperlink on the homepage or member services portal clearly identified as "GRIEVANCE FORM."** Section 1368.015(b).	**Not Corrected**
	ACCESS AND AVAILABILITY OF SERVICES	
3	**The Plan does not ensure after-hours availability of its providers to receive/respond to phone calls and messages left by enrollees.** Rule 1300.67.2(b); Rule 1300.67.2.2(c)(9) and (d)(1).	**Not Corrected**

	UTILIZATION MANAGEMENT	
4	**The Plan does not conduct adequate oversight of its delegate to ensure compliance with required utilization program standards.** Section 1367.01(a), (h)(1) and (4), and (j).	**Not Corrected**

SURVEY OVERVIEW

At least once every three years the Department evaluates each licensed health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975[1] through a routine survey that covers major areas of the plan's health care delivery system. Surveys are conducted pursuant to Section 1380 and include a review of the overall performance of the plan in providing health care benefits and meeting the health care needs of enrollees in the following areas:

Quality Assurance – Each plan is required to have a quality assurance program directed by providers and designed to monitor and assess the quality of care provided to enrollees, and to take effective action to improve the quality of care when necessary. The quality assurance program must address service elements, including accessibility, availability and continuity of care and must monitor whether the provision and utilization of services meets professionally recognized standards of practice.

Grievances and Appeals – Each plan is required to have a grievance system that ensures a written record and adequate consideration of grievances, appropriate and timely processing and resolution, continuous review to identify any emergent patterns of grievances, and reporting procedures to improve plan policies and procedures.

Access and Availability of Services – Each plan is required to provide or arrange for the provision of access to health care services in a timely manner, appropriate for the enrollees condition and consistent with good professional practice.

Utilization Management – Plan and delegate utilization management functions must ensure that decisions based on medical necessity are consistent with clinical criteria/guidelines, that utilization review and oversight operations are performed by appropriate personnel and that enrollees and requesting providers receive timely and appropriate information concerning approvals, denials and modifications of requested services. Plans must also ensure that utilization functions satisfy access and quality requirements.

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 Department issued the Preliminary Report to the Plan on September 23, 2019. The Plan had 45 days to file a written statement with the Director identifying each deficiency and describing the action taken to correct each deficiency and the results of such action.

[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.

This Final Report describes the deficiencies identified during the survey, the Plan's compliance efforts, the status of each deficiency at the time of the Department's receipt of the Plan's 45 day response and actions for outstanding deficiencies requiring more than 45 days which will be reassessed at a Follow-Up Survey.

PLAN BACKGROUND

The Plan is a wholly owned subsidiary of Centene Corporation. Centene Corporation is a diversified, multi-national healthcare enterprise that provides programs and services to government sponsored healthcare programs, focusing on under-insured and uninsured individuals. The Plan received its Knox-Keene License on March 7, 1991.

The Plan currently contracts with the State of California's Department of Health Care Services (DHCS) to provide Medi-Cal dental benefits in Los Angeles and Sacramento Counties. The Plan started providing fee-for-service (prepaid health plans or PHP) benefits in 1998 after a merger with Foundation Health. In 2008, they were awarded a contract under the Sacramento Geographic Managed Care (GMC) dental program. The Plan's contract for Los Angeles County is for a PHP model of care, where members can opt in, and the contract for Sacramento County is for a GMC model, enrollment in which is mandatory for Medi-Cal beneficiaries in Sacramento County. The Plan provides dental services to 181,223 Medi-Cal beneficiaries in Los Angeles County and 124,971 Medi-Cal beneficiaries in Sacramento County as of October 1, 2018.

The Plan has a contract with Liberty Dental Plan of California, Inc. (Liberty Dental). Liberty Dental administers the Medi-Cal Dental Programs in both Los Angeles and Sacramento counties. Liberty Dental's functions include utilization management (UM), access, provider credentialing and contracting, and language assistance services. The Plan does not delegate grievance and appeals (G&A) to Liberty Dental. The Plan retains the responsibility to provide oversight of Liberty Dental's performance.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On September 23, 2019, the Department issued the Plan a Preliminary Report that described each deficiency, as well as the legal and factual basis for each deficient finding. In that report, the Department instructed the Plan to within 45 days of issuance of the Preliminary Report:

(a) Develop and implement a corrective action plan (CAP) for each deficiency, and
(b) Provide the Department with evidence of the Plan's completion of, or progress toward, implementing those corrective actions.

The following describes the Department's preliminary findings, the Plan's corrective actions, and the status of the deficiency following the Department's review of the Plan's compliance efforts.

DEFICIENCIES

QUALITY ASSURANCE

Deficiency #1: The Plan failed to ensure that all potential quality issues (PQI) were identified and processed in accordance with its Quality Assurance (QA) Program.

Statutory/Regulatory References: Section 1370; Rule 1300.70(b)(1)(B).

Assessment: Through document and file review, the Department determined that the Plan does not consistently identify access issues in grievances as potential quality issues (PQIs) and process these PQIs in accordance with the Plan's *Quality Improvement Plan System Manual* (QI Program). Section 1370 requires that the Plan establish procedures in accordance with department regulations for continuously reviewing the quality of care and Rule 1300.70(b)(1)(B) requires that the Plan's QA Program continuously reviews the quality of care provided, and ensure that quality of care problems are identified and corrected for all provider entities.

Document Review

The Department reviewed the Plan's Policy: *DN-L059 Access and Availability Guidelines* (November 17, 2018) (Access Policy). The Access Policy states that when the Plan becomes aware of access issues, the Plan's Dental Director, and/or the Plan's Grievance and Quality of Care teams will conduct additional investigation to assess the access problems and propose corrective actions. The Access Policy states:

> **Member Complaints/Grievances**. Under the Plan's grievance procedures, the Plan tracks complaints regarding access. The Dental Director will receive monthly reports describing the number of complaints /grievances received for each dental office by category (e.g., appointment wait/ quality of care). The Dental Director will review those reports to identify specific and systemic problems for trending purposes. The Dental Director will determine the necessary corrective actions.

> **Accessibility Standards**. The Grievance team conducts ongoing investigation of complaint/grievance cases for which members have expressed dissatisfaction with access and availability. Dissatisfaction with access and availability may include but are not limited to, lack of appointment availability or the inability to schedule appointments due to cultural and language barriers. Corrective actions are required for offices found non-compliant during individual case reviews as not meeting the emergent, urgent, non-urgent, and/or preventive appointment standards or in office wait times for scheduled appointments.
>
> The Quality of Care Team conducts periodic reviews of contracted provider offices that include verification of ongoing compliance with timely access standards. Verification of ongoing compliance include but are not limited to the following activities; onsite quality reviews, and/or "secret shopper call" campaigns. Corrective actions are required for deficiencies identified during these activities.

The Plan submitted for the Department's review its QI Program. The QI Program also describes how the Plan provides oversight of access issues by stating:

> **Access and Availability**: Health Net has established standards for geographic access and for timeliness of preventive care appointments, routine appointments, urgent appointments, emergency care, access to afterhours care, wait time in the provider office, and elements of telephone service. On an annual basis, data is collected and analyzed to measure performance against the standards. Information is compared to Member Service reports on access complaints and the most recent member survey data. Opportunities for improvement are identified and decisions are made, and specific interventions are implemented to improve performance where needed. The effectiveness of the interventions is re-measured annually or sooner if necessary. Annual analysis of Member Service complaint data is performed to identify opportunities for improvement in member satisfaction. Grievance and Appeal data is included in this analysis in order to analyze trends in overturned appeals related to benefit interpretations.

The QI Program also explains the Plan's delegated relationship for access issues with Liberty Dental as follows:

> **Delegation**: Liberty Dental is delegated administration of Health Net's Network Providers. Liberty Dental will monitor compliance with access and availability as described. Liberty Dental will develop and act upon a Corrective Action Plan if deficiencies occur. Actions by Liberty Dental will be reported quarterly or more frequently if indicated to the Health Net UM/QI Committee, which maintains responsibility for monitoring Liberty's actions and compliance and assuring compliance with standards. Appropriate staff and departments within Health Net monitor and oversee Liberty's Quality Management of the items listed.

Finally, the QI Program clarifies how the Plan handles access issues as a PQI by stating:

> **Enforcing Provider Compliance with Accessibility**
>
> Our dental directors review all member grievances, including grievances related to member appointments and after-hours access to network dentists. Depending on the severity, the chief dental director may escalate the case to the Dental Peer Review Committee, where the grievance process interacts with the processes described below.

To assess compliance regarding oversight of access issues, the Department reviewed the Plan's *UM/QI Committee minutes* for 2017 through 2018. These minutes established that the utilization management/Quality Improvement (UM/QI) Committee receives two reports that discuss exempt grievances involving access issues: *Exempt Grievance Access & Availability Issues Report* and *Resolved Exempt Grievances Report*.

a. Exempt Grievance Access & Availability Issues Report

The Department's review found that the UM/QI Committee reviewed the *Exempt Grievances Access & Availability Report*. The August 24, 2017 *UM/QI Committee meeting minutes* reference the data in this report under category N – *Exempt Grievance Access & Availability Q2 2017*. Category N states that the Plan resolved 274 exempt grievances regarding Access and Availability in the second quarter of 2017 and noted: "grievances associated with Access and Availability issues increased 121% (124 to 274) from the previous quarter. Most of these concerns were resolved with office transfers or with 'other' methods." Similarly, the November 30, 2017 *UM/QI Committee meeting minutes* reference this report under category M – *Exempt Grievance Access & Availability Q3 2017*. Category M states that the Plan resolved 289 exempt grievances regarding Access and Availability in the third quarter of 2017 while noting that grievances associated with access and availability issues increased 5% (274 to 289) from the previous quarter. The Plan's minutes state most of these concerns were resolved with office transfers or with "other" methods.

b. Resolved Exempt Grievances Report

The Department's review of the *UM/QI Committee meeting minutes* established the committee also reviewed the *Resolved Exempt Grievances Report*. The August 24, 2017 *UM/QI Committee meeting minutes* reference the data in this report under category L – *Resolved Exempt Grievance Report Q2 2017*. Category L states that the Plan resolved 358 exempt grievances regarding access in the second quarter of 2017 and noted this constituted a 108% increase (172 to 358) from the previous quarter and that "the majority of these grievances ... were resolved with office transfers or 'other' methods." Similarly, the November 30, 2017 *UM/QI Committee meeting minutes* reference this report under category K – *Resolved Exempt Grievance Report Q3 2017*. Category K states that the Plan resolved 405 exempt grievances in the third quarter of 2017 while noting this constituted a 13% increase (358 to 405) from the previous

quarter. Again, the Plan's notes state most of these concerns were resolved with office transfers.

Although the second and third Quarter *UM/QI Committee meeting minutes* indicate a significant increase in access issues, the Department's review of these minutes established the Plan did not take any specific action. Both the August 24, 2017 and November 30, 2017 meeting minutes contain a column labelled "Recommendation / Decision / Action / Date" that describes the committee's proposed corrective actions. For both quarters, in response to the increased access issues described by both the *Exempt Grievance Access & Availability Issues Report* and *Resolved Exempt Grievances Report*, the committee's proposed corrective action only states that it will wait until the next meeting for further reporting. The Department reviewed the next two UM/QI meeting minutes dated February 22, 2018 and May 24, 2018 and found the committee's proposed actions state that it will again wait for updated information in these reports. In addition, the Department's review of these minutes and reports established no evidence these access issues were investigated or that corrective actions were proposed by the Dental Director, Grievance Team and/or the Quality of Care Team as stated in the Plan's Access Policy and QI Program. Thus, the Department's review of the Plan's meeting minutes found no evidence that the committee addressed these access issues.

Interviews

During onsite interviews, Plan staff stated the Plan recognizes access issues are included as issues for quality review. However, Plan staff also acknowledged the Plan failed to record access issues on the Plan's PQI log, which accounts for the Plan's inability to produce PQI files with access issues (discussed in the File Review section below). With regard to the *UM/QI Committee minutes*, the Plan could not clarify whether resolution of an exempt grievance access issue by "other methods" included review and resolution through the Plan's PQI review process. Thus, the Plan could not establish that the numerous access issues being reported to the UM/QI Committee were reviewed and resolved through the Plan's PQI review process.

The Department also asked why the Plan was only able to produce 33 PQI files. This number of PQI files appeared disproportionately low in comparison to the numerous access issues identified to the UM/QI Committee. The number of PQI files produced also appears low given that the Plan allows PQIs to be identified through numerous areas of the Plan including: member services, G&A, claims utilization patterns, provider quality assessment patterns, referrals and preauthorization reviews. The Dental Director and the Plan's Quality staff could not provide an explanation accounting for the comparatively small number of PQI files produced by the Plan.

In addition, interviews also established the Plan was unable to clarify its responsibilities from those of Liberty Dental for delegated activities including access and availability. For example, the Plan was not able to explain whether Liberty Dental's reports for access issues including afterhours care, wait times in the provider's office, and telephone services were reviewed by the Plan's UM/QI Committee. During interviews the Plan's Dental Director expressed that such reports were not reviewed by the Plan. However, the Plan's other staff stated that such reports were prepared by Liberty Dental

and reviewed by the Plan. Liberty Dental staff, also present during interviews, indicated that Liberty Dental produced such reports for the Plan's review. The Department found uncertainty exists between the Plan and Liberty Dental with respect to oversight of delegated responsibilities including access.

File Review

For the review period, the Plan only produced a total of 36[2] PQI files. The Department reviewed 33 PQI files. Of the 33 files, the Department found that none of the PQI files contained any access issues. This finding does not comport with the numerous access and availability issues discussed in the Plan's *UM/QI Committee minutes* for 2017 to 2018 and that the Plan's policies and procedures include access issues as PQI. The Department also determined the Plan's production of only 33 PQI files without access issues was not consistent with the access information contained in the Plan's *Exempt Grievance File Log*, which listed "access" in 405 (60%) out of 680 enrollee's complaints. The Plan's *Exempt Grievance File Log* listed a resolution of "office transfer" for 194 entries and "other resolution" for 124 entries. However, as discussed above, during interviews the Plan could not define what it meant to resolve an access issue by "other resolution." Therefore, the Department found that the Plan could not specify whether it had resolved 124 potential access issues through its PQI review process.

The Department found access issues in two grievances files, which were produced by the Plan as part of its production of standard grievance files. Neither file appeared on the Plan's PQI log. In both files, the Plan informed the enrollee that the access issue would be referred to the Plan's PQI Committee. During interviews, the Dental Director confirmed the Plan had no PQI Committee, and that the correct name should have been listed as the Plan's Peer Review Committee. The Department reviewed the Peer Review Committee minutes and found no evidence that either case was discussed by that Committee. There was no evidence the Plan addressed the access issue in either grievance files. The Department determined that both files should have appeared on the PQI log for further review and appropriate resolution.

Plan's Compliance Effort: The Plan provided a written response to the Department that provided a CAP to address the deficiency. The Plan explained that enrollees receive dental care from Liberty Dental's provider network, and tracking and trending of access issues are included in their PQI log. Maintaining and monitoring PQIs are included in the delegation agreement between the Plan and Liberty Dental and the Plan's Dental Director has oversight of the process. The Plan provided Liberty Dental's *Standard Operating Procedure* for Office Quality Profiling (October 25, 2019) which describes Liberty Dental's process to evaluate PQIs related to access and availability. The Plan also provided Liberty Dental's *Office Quality Profiling Log* which tracks PQIs at provider offices specifically noting which provider offices have five or more quality issues per quarter.

[2] File #5 and File #20 were discarded from review as duplicate files. File #24 was discarded as it was not from Health Net's line of business.

The Plan also explained that it has worked with Liberty Dental to enhance its tracking of exempt grievances related to access issues as follows:

1. Liberty Dental's Grievance and Appeals (G&A) Dental Director conducts a weekly review of the Exempt Grievance Log to identify and ensure identified PQIs are sent to the PQI Unit for investigation and tracking and trending of outcomes.

2. The Plan's Dental Director has been added to the distribution of the weekly Exempt Grievance Log to review and ensure that any Plan PQIs are included for Liberty Dental's investigation and that tracking and trending of outcomes are reported to the Liberty Dental G&A Committee quarterly.

3. Liberty Dental has revised its Provider Profile Log with a new column for Access/Availability. The column will allow tracking by Provider and category type for increased tracking and trending. If a specific provider has an access or availability issue, the provider will be added to the PQI Log.

The Plan's Dental Director has been working with the Plan's G&A Team, Liberty Dental's QM Team and Liberty Dental's G&A Dental Director to ensure access and availability grievances are added to the PQI log. The specific actions include:

1. The Plan's G&A Team has updated the member resolution letter to state that the access issue is being forwarded to the appropriate team for tracking and trending and that appropriate actions will be taken.

2. When the Plan sends resolution letters to Liberty Dental, the Plan's G&A Team includes the Plan's Dental Director to determine that PQIs are being added appropriately to the PQI log.

3. Liberty Dental's G&A Dental Director reviews the PQI Log and determines whether the actions taken, if any, are appropriate. Those items are sent to Liberty Dental's QM Department for investigation and resolution. All PQIs require approval from the Liberty Dental G&A Dental Director prior to closure.

4. Beginning in the fourth quarter of 2019, the Plan's Peer Review Committee receives details of the confirmed PQIs and the actions taken when it involves either a Plan Dental enrollee or a provider in the Plan's Dental network.

The Plan provided Liberty Dental's QM Policy and Procedure *Potential Quality Issue (PQI) Process* (December 6, 2018), which discusses the Liberty Dental's process to identify and address PQIs. The Plan also provided a sample report from Liberty Dental to the Plan that discusses the actions taken to address PQIs during the second quarter of 2019.

Finally, the Plan's Dental Director has been added to Liberty Dental's Peer Review and Utilization Committees. These sub committees oversee the quality of the provider network and report up to the Liberty Dental QM and Improvement Committee. The results and summaries of these sub committees will report at the Plan's UM/QI and/or

Peer Review Committees on a quarterly basis to improve the Plan's oversight and input into the overall quality of care and service provided to Plan enrollees.

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions that the Plan has proposed and undertaken, the Department has determined that this deficiency has not been corrected. Although the Plan has delegated to Liberty Dental the maintenance and monitoring of all PQIs, Rule 1300.70(b)(1)(B) requires that the Plan's QA Program Structure continuously reviews the quality of care provided and ensures that quality of care problems are identified and corrected for all provider entities

The Department finds that the Plan has taken steps towards correcting this deficiency. The Plan explained that it has worked with Liberty Dental to improve the tracking of exempt grievances related to access issues by having the Plan's G&A Team, Liberty Dental's QM Team and Liberty Dental's G&A Dental Director work together to ensure access and availability grievances are added to the PQI log. However, the Department finds that the Plan will need additional time to fully implement the proposed corrective actions.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency through review of the Plan's documents and reports. These documents may include: the *Potential Quality Issue Process Policy and Procedure*, *UM/QI Committee minutes,* the *Exempt Grievance Access & Availability Issues Report*, *Resolved Exempt Grievances Report* and any additional reports from Liberty Dental to the Plan that discuss the actions taken to address PQIs. The Department may also review PQI files. Finally, the Department may also conduct interviews, review any additional relevant Plan policies and procedures, audit tools and results and/or any other information deemed relevant to this deficiency.

GRIEVANCES AND APPEALS

Deficiency #2: **The Plan's website does not provide an easily accessible online grievance submission procedure accessible through a hyperlink on the homepage or member services portal clearly identified as "GRIEVANCE FORM."**

Statutory/Regulatory Reference: Section 1368.015(b).

Assessment: The Department found that the Plan's online grievance process is not easily accessible through a hyperlink clearly identified as "GRIEVANCE FORM" on the Internet website's homepage or member services portal. Section 1368.015(b) requires the Plan's website to have an easily accessible online grievance submission procedure. Specifically, there must be a hyperlink titled "GRIEVANCE FORM" on either the homepage or the member services portal.

The Department's review found that from the homepage, enrollees must click on either *"Los Angeles"* or *"Sacramento,"* which takes enrollees to a screen that offers the following hyperlink options:

- *Health Net's Medi-Cal Dental Plan (pdf)*
- *2019 Geographic Area's Evidence of Coverage (EOC) – "Language" (pdf)*
- *Grievance Form – "Language" (pdf) – a printable grievance form*
- You can also *"File an Appeal or Grievance ONLINE here."*

The enrollee must then click *"File an Appeal or Grievance ONLINE here,"* which goes to another screen that then offers the following hyperlink options:

- *APPEAL FORM*
- *GRIEVANCE FORM*
- *MEMBER SERVICES FORM*

The enrollee must then click *"GRIEVANCE FORM,"* which goes to a login screen. Once the enrollee logs in, an account overview screen is presented with the hyperlink option available to *"File an Appeal or Grievance."* Clicking on this option takes the enrollee to another screen, which presents the enrollee with additional options for contacting Member Services, submitting a grievance via U.S. Mail, and submitting online. The enrollee must then click on the hyperlink titled *"Submit a Grievance"* to be taken to the online grievance submission form.

The Department found that the online grievance process is not easily accessible through a hyperlink clearly identified as "GRIEVANCE FORM" on the Plan's Internet website's homepage or member services portal. As set forth above, the Plan's process requires the enrollee to navigate through at least five different screens in addition to being required to log into the system. The improper listing of "Submit a Grievance" is the hyperlink that takes the enrollee to the online grievance submission form. Therefore, the Department finds the Plan in violation of this statutory requirement.

Plan's Compliance Effort: The Plan's response stated its online grievance process was updated to improve the navigation steps from the homepage to file a grievance online and/or obtain the grievance form. The Plan provided a document demonstrating that the homepage was updated to include a clearly defined hyperlink "GRIEVANCE FORM."

Final Report Deficiency Status: Not Corrected

The Department has determined that this deficiency has not been corrected. The Department's review of the Plan's website established the Plan's online grievance submission procedure includes a hyperlink on the homepage clearly identified as "GRIEVANCE FORM." However, the Department's review found that the link titled "GRIEVANCE FORM" takes the user to a page that contains links to "APPEALS FORM," "GRIEVANCE FORM," and "MEMBER SERVICES FORM." When the Department selected "GRIEVANCE FORM," it requires the user to sign in to access the form and it took two clicks to get to the sign-in page. The Department determined that the Plan's corrective action was insufficient to correct the deficiency.

ACCESS AND AVAILABILTY OF SERVICES

Deficiency #3: The Plan does not ensure after-hours availability of its providers to receive/respond to phone calls and messages left by enrollees.

Statutory/Regulatory References: Rule 1300.67.2(b); Rule 1300.67.2.2(c)(9) and (d)(1).

Assessment: The Department's review established that the Plan's policies and procedures do not define the Plan's responsibilities for providing monitoring and oversight of after-hours access and that the Plan does not monitor enrollee access to after-hours access.

Document Review

The Department reviewed the Plan's policies and procedures: *DN-L059 Access and Availability Guidelines* (November 17, 2018) (Access Policy) and *DN-L077 Member Services Department Standards for After Hours Access* (November 17, 2018) (After Hours Access Policy). The Plan's Access Policy acknowledges that the Plan's contracted providers must provide after-hours access by stating:

> **Availability of After Hours and Emergency Services**. The Plan will require contracting dentists to make dental services available to members after hours and to make dental services available to members after hours and to make dental services available to a member in an emergency availability 24 hours a day, seven days a week. Health Net 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. Health net's 24 hour Dentist on Call is expected to respond to the member within 30 minutes.

In addition, the Plan's After Hours Access Policy states, "Health Net provides access to the Member Services Department after business hours to ensure assistance is available for emergent or palliative treatment." However, the Department's review of both policies and procedures established that they do not specifically describe the Plan's responsibilities to provide monitoring and oversight of after-hours access.

The Department also reviewed the Plan's *UM/QI Committee Meeting Minutes* to assess the Plan's oversight of after-hours access issues. The Plan's *Availability Reports* are provided to the UM/QI Committee for review and discussion of access issues. Although the Plan's *Availability Reports* specifically states that its purpose is to monitor the established standards for "afterhours care," the Department's review of these quarterly reports for the survey period established that none of the reports contained data regarding after-hours access. Accordingly, the Department's review of the Plan's *UM/QI Committee Meeting Minutes* established that the committee did not specifically address any issues regarding after-hours access. In addition, the Department reviewed the

Plan's *Enrollee Satisfaction Surveys* for the survey review period and found that these reports did not include any results for after-hours care.

Interviews

During onsite interviews, with respect to oversight of after-hours access issues, the Plan was unable to distinguish its delegated responsibilities from those of Liberty Dental. Plan staff were not certain whether reports from Liberty Dental included results with respect to after-hours access issues. Finally, Plan staff stated that the detailed delegation responsibilities for Liberty Dental, including those related to oversight of after-hours access, were not clarified in writing, reviewed by the Plan's UM/QI Quality Committee, or voted on by the Plan's Board of Directors.

Plan's Compliance Effort: The Plan states it ensures each provider office maintains a proactive 24 hour contact system either by answering service or telephone that provides instructions on how enrollees may obtain urgent/emergency care during non-business hours.

Liberty Dental also collects and verifies after-hours availability of network providers routinely as follows:

1. Initial office demographics are collected upon initial contracting (including office hours, appointment availability and 24 hour emergency/after-hours contact system).

2. Liberty Dental Network Managers contact offices for routine service calls at least twice a year (call or face-to-face visit), which includes validation of after-hours availability.

3. Provider Directory Information Verification (DIV) forms are sent to provider's offices quarterly and request each office to validate hours of operations, appointment availability, and the maintenance of a 24 hour emergency / after-hours contact system. The quarterly DIV form was modified to ensure emergency / after-hours contact system identifies the type of after-hours contact system available to enrollees.

4. If providers indicate that the 24 hour emergency / after-hours are not available, the Liberty Dental Network Managers contact the office to clarify and to communicate this requirement.

To demonstrate how the Plan monitors provider after-hours access, the Plan provided the following Liberty Dental documents:

- Policy and Procedure *Maintaining Provider Directories in California* (December 6, 2018), which describes how the Plan maintains accurate provider directories.
- *Provider Service Report* for California, which is an audit tool used to capture provider access information including emergency / after-hours care.
- *Provider Directory Information Verification*, which requires providers to include information regarding emergency / after-hours care.

The Plan further explained that it hired a new Dental Director in September 2019. The new Dental Director will be responsible for the joint Plan and Liberty Dental quarterly UM/QI Quality Committee meeting. During these meetings, the Committee will review data presented for access and availability, identify deficiencies and opportunities to improve enrollee access to care and assign corrective actions.

The Plan's CAP also includes additional oversight and monitoring of 24 hour after-hours access as follows:

1. The Plan and Liberty Dental have created an *Access & Availability Roles & Responsibilities Matrix* which defines the respective responsibilities for monitoring and oversight for access and availability. Also, Liberty Dental's *Access and Availability Guidelines* describe how the Network Management Committee monitors access and availability.

2. The Plan restructured the UM/QI Committee meeting. Access and availability reports will be a separate section to ensure proper review, documentation and follow-up action is captured in the UM/QI Committee meeting minutes.

3. The *Committee Report Summary* has been modified to report outcomes of the monitoring activities of provider offices for 24 hour emergency / after-hours contact system including recommended actions.

4. The *Enrollee Satisfaction Survey* will be updated by November 30, 2019 with two questions regarding after-hours access. Enrollee responses will be tracked and trended to determine whether there are irregular patterns regarding after-hours access. The Plan will take appropriate action.

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions proposed actions, the Department has determined that this deficiency has not been corrected because the Plan has not yet demonstrated that it has implemented its CAP. The Plan has taken steps to address after-hours issues by clarifying the Plan and Liberty Dental's respective responsibilities regarding monitoring and oversight and hiring a new Dental Director who will chair the joint Plan and Liberty Dental quarterly UM/QI Quality Committee meeting. The UM/QI Quality Committee reviews data presented for access and availability and identifies deficiencies and opportunities to improve enrollee access and assigns corrective actions. Finally, the *Committee Report Summary* will report outcomes of the monitoring activities at provider offices for emergency / after-hours contacts and the *Enrollee Satisfaction Survey* will contain two questions regarding after-hours access.

To determine whether the Plan corrected this deficiency, the Department will conduct a Follow-Up Survey to assess whether the Plan's policies and procedures define the Plan's responsibilities for providing monitoring and oversight of after-hours access and whether the Plan monitors enrollee access to after-hours access. The Department will review relevant Policy and Procedure documents including: *Maintaining Provider Directories in California*, *UM/QI Committee Meeting Minutes*, *Committee Report*

Summaries, Enrollee Satisfaction Surveys, *Provider Information Verification* forms and *Provider Service Reports.*

UTILIZATION MANAGEMENT

Deficiency #4: The Plan does not conduct adequate oversight of its delegate to ensure compliance with required utilization program standards.

Statutory/Regulatory References: Section 1367.01(a), (h)(1) and (4), and (j).

Assessment: The Department's review of UM denial files established that the Plan's written notifications to enrollees denying requests for services were not in compliance with the requirements of the Plan's written policies and procedures and the requirements of the Act. The Plan delegates all UM functions to Liberty Dental. Section 1367.01(a) requires that the Plan and "any entity with which it contracts for services that include utilization review or UM functions ... or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section." Section 1367.01(h)(1) provides that decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent, to rendering services, shall be made in a timely fashion appropriate for the enrollee's condition not to exceed five days. Section 1367.01(h)(4) requires a clear and concise explanation of the reasons for the Plan's decision to deny, delay or modify requests based on medical necessity, a description of the clinical criteria or guidelines and the clinical reasons. Section 1367.01(j) requires the Plan to review compliance with these requirements as part of the Plan's QA program.

Plan Document Review

The Department reviewed the Plan's *Dental Administrative Services Agreement* (March 12, 2007) (Services Agreement) with Liberty Dental. The Services Agreement provides that Liberty Dental assumed responsibility from the Plan for all aspects of UM. However, the Services Agreement also specifies that Liberty Dental will comply with the Plan's oversight of Liberty Dental's UM activities. The Services Agreement states in relevant part:

> **UTILIZATION MANAGEMENT**
>
> (a) LIBERTY shall assume responsibility for administration of all aspects of Utilization Management.
>
> (i) LIBERTY shall comply with HEALTH NET oversight policies and procedures that detail oversight of the Utilization Management process.
> (ii) LIBERTY shall maintain policies and procedures that detail the Utilization Management process. These policies shall meet all contractual, legal and regulatory requirements including but not limited to the Department of Managed Health Care and the California Health and Safety Code.

(iii) LIBERTY shall provide quarterly Utilization Management reports to HEALTH NET ... within thirty (30) days following the end of each reporting period....

(b) LIBERTY shall allow HEALTH NET or its designated agent, or any accreditation organization designed by HEALTH NET, to perform an annual, or as needed, on-site audit. LIBERTY shall allow access to files, and records and committee meeting minutes for the purpose of conducting oversight of LIBERTY'S Utilization Management.

Liberty Dental's policy and procedure: *Clinical Criteria for UM Decisions* (July 31, 2018) (UM Policy) provides that UM denial letters must be sent in five days and must contain clinical criteria and reasoning. The UM Policy states:

PURPOSE/SCOPE:

LIBERTY Dental Plan will ensure that Utilization Management decisions are based on written, objective clinical criteria that are consistent with current clinical principles.

LIBERTY's Dental Director and its Dental Consultants use clearly written criteria based on sound clinical principles, processes, and evidence in order to consistently evaluate the appropriateness of dental services requiring review. LIBERTY implements written procedures for applying stated written criteria in a consistent manner. A licensed Dental Director or Dental Consultant reviews and makes all UM determinations based on dental necessity. LIBERTY's Dental Director and Dental Consultants consider specific needs of the individual patient and characteristics of the local delivery system when making determinations consistent with written criteria.

LIBERTY Dental shall notify Member/Enrollees of delays in the review process no later than the fifth (5th) day after the delay has been identified due to a lack of supportive documentation or other significant reason....

All Lines of Business: The length of time for the delay shall not exceed 5 business days from receipt of necessary information.

To assess the Plan's oversight of Liberty Dental's UM practices, the Department reviewed the Plan's audit tools.[3] The Department's review of these audit tools found they only reviewed whether the Plan had written UM policies and procedures rather than investigating whether the Plan's actual UM practices followed the policies and procedures. This was evident in one of the audit elements, 6B1: Written Policies and Procedures for Requested Service Reviews, which investigates whether, "The organization has written policies and procedures establishing the process by which the organization reviews requests for the following services." The response checkboxes list: "Prospective, Retrospective and Concurrent" review.

[3] HHNCA Dental_2017 UM PDAT and HNCA Dental_2017 UM PDAT Annual Audit P&P.

The Department also reviewed the results of the Plan's 2018 fourth quarter audit of Liberty Dental.[4] For this audit, the Plan reviewed UM denial letters and found they did not contain clear and concise language, criteria or guidelines, lacked clinical reasoning and did not cite specific facts regarding the enrollee's condition. The Plan also found that initial notification of the Plan's decisions to providers was not made within the timeframe designated in the *UM Timeliness Standards of UM Decisions* policy. For these findings, the Plan required corrective action from Liberty Dental to update and implement all processes within 120 days from issuance of a Corrective Action Report (CAR). Liberty Dental's CAR due date was December 25, 2018. However, the Department did not find evidence that Liberty Dental ever submitted a CAR to the Plan or that specific action was taken to address these findings. Moreover, the Department found no evidence the Plan conducted or intended to conduct a follow-up audit to investigate whether these specific findings were corrected. Finally, the Department reviewed the Plan's *UM/QI Committee meeting minutes* and found no evidence the Plan addressed either deficiency or planned follow-up with Liberty Dental.

File Review

The Department reviewed 71 delegate UM denial files randomly selected from the universe of 52,528. The Department's file review established the following:

a. The UM decision was not made within five business days of receipt of necessary information.

Section 1367.01(h)(1) provides that decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent, to rendering services, shall be made in a timely fashion appropriate for the enrollee's condition not to exceed five days. In 14[5] (20%) of the 71 files reviewed, the Department determined the UM written denial did not meet the required five-business day timeframe for notification decision.

b. The UM decision contained insufficient citation to clinical criteria.

Section 1367.01(h)(4) requires a clear and concise explanation of the reasons for the Plan's decision to deny, delay or modify requests based on medical necessity, a description of the clinical criteria or guidelines and the clinical reasons. In 26[6] (37%) of the 71 files, the Department determined that the UM written denial did not include a sufficient description of the criteria or guidelines used for the Plan's decision to deny, delay, modify health care services. The Department determined that general references in the letters to "LIBERTY Dental Plan rules," "LDP Guidelines," and/or "all information relied upon to make this decision" does not constitute a reference to clinical criteria.

[4] The Audit results provided by the Plan was a document identified as D101 2018 UM CAP.
[5] File #3; File #12; File #20; File #22; File #24; File #30; File #33; File #34; File #43; File #44; File #58; File #65; File #71; File #77.
[6] File #12; File #23; File #24; File #27; File #28; File #30; File #31; File #32; File #33; File #34; File #35; File #38; File #39; File #40; File #44; File #46; File #47; File #52 ID; File #54; File #58; File #62; File #63; File #65; File #70; File #71; File #80.

These citations are too general and do not account for the enrollee's specific condition. The following cases provide examples to illustrate this aspect of the deficiency:

- **File #12:** The Plan denied the provider's request for a root canal. The Plan's letter states as the reason for the denial:

  The root canal treatment is denied. Your dentist's records do not show a need for root canal treatment for this tooth. Please check with your dentist for other options. This decision was made on LIBERTY Dental Plan rules. For more details see your Member Handbook.

  You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on.

- **File #47:** The Plan denied the provider's request for tooth removal. The Plan's letter states as the reason for the denial:

  Dr. [ ] has asked Health Net Dental to approve:

  We cannot approve this treatment the way it is. This is because:

  We will instead approve:

  D7140 Extraction, erupted tooth or exposed root - #18, 18, 18, 18, 18, 18, 18, 18, 18, 24, 24, 24, 24, 24, 24, 24, 24, 24, 25, 25, 25, 25, 25, 25, 25, 25, 25

  You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on.

c. The UM decision contained insufficient citation to Clinical Reasons.

Section 1367.01(h)(4) requires a clear and concise explanation of the reasons for the Plan's decision to deny, delay or modify requests based on medical necessity, a description of the clinical criteria or guidelines and the clinical reasons. In 62[7] (87%) of the 71 files, the Department determined that the UM written denial did not include the specific medical or clinical reason or reasons specific to the enrollee's clinical condition. The Department's review found that the UM denial letters did not provide a specific clinical reason or reasons based on the enrollee's specific condition. As a result, the Plan's medical necessity determination is unclear. In addition to File #12 and #47

[7] File #5; File #8; File #9; File #10; File #11; File #12; File #14; File #16; File #17; File #18; File #20; File #21; File #22; File #23; File #24; File #25; File #27; File #28; File #29; File #30; File #31; File #32; File #33; File #34; File #35; File #37; File #38; File #39; File #40; File #41; File #42; File #43; File #44; File #45; File #46; File #47; File #48; File #49; File #50; File #52; File #53; File #54; File #55; File #56; File #57; File #58; File #59; File #61; File #62; File #63; File #64; File #65; File #67; File #68; File #69; File #70; File #71; File #72; File #78; File #79; File #80; File #81.

discussed above, the following case provides an example to illustrate this aspect of the deficiency:

- **File #58:** The Plan denied the provider's request for a composite tooth. The Plan's letter states as the reason for the denial:

  Your dentist's records do not include one or more of the following to demonstrate medical necessity: A radiographic image(s), intra- or extra-oral photographs. The procedure is denied because the documentation submitted does not specifically demonstrate medical necessity. Please check with your dentist for other options. This decision was based on LDP Guidelines for "Code Submission" (page 27). For more information see your Member Handbook.

TABLE 1
Delegate UM Dental Denial Files

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Delegate Denial Files	71	Denial decision made within five business days of receipt of necessary information	57 (80%)	14 (20%)
Delegate Denial Files	71	Denial letters included a description of the clinical criteria or guidelines used	45 (63%)	26 (37%)
Delegate Denial Files	71	Denial letter included a clinical reason / rationale for the decision	9 (13%)	62 (87%)

Plan's Compliance Effort: The Plan states that its Delegation Oversight department annually audits Liberty Dental's UM program. The Plan uses an audit tool (PDAT) to review policies and procedures and conduct file review.

On October 29, 2018 the Plan conducted an annual audit of Liberty Dental which noted deficiencies in the denial letters for written confirmation turnaround time and content. The Plan scored Liberty Dental at 90%, which was noted in the Plan's document *Liberty Annual Audit Overall File Review Summary.* Pursuant to the Plan's *Delegation Oversight* Policy and Procedure (October 1, 2019), the Plan provided Liberty Dental with its findings and requested corrective action on December 20, 2018, and Liberty Dental was required to correct the deficiencies by February 28, 2019.

On November 27, 2019 the Plan conducted its 2019 Liberty Dental annual audit. The Plan reviewed 30 denial and 12 approval files. On December 5, 2019 the results were presented at the Delegation Oversight Workgroup and presented again on December

12, 2019 at the Plan's fourth quarter 2019 UM/QI meeting. The Plan will require Liberty Dental to provide written documentation of actions taken and the Plan will document its follow-up actions.

Finally, the Plan has newly implemented more frequent monitoring with quarterly reporting of authorization turnaround times including written/oral notifications. Training occurred for this new process on November 7, 2019.

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions that the Plan has undertaken, the Department has determined that this deficiency has not been corrected.

The Department finds that the Plan has taken steps towards correcting this deficiency by implementing increased monitoring with quarterly reporting of authorization turnaround times while continuing its annual audit of Liberty Dental. However, the Department is unable to consider this deficiency corrected because the Plan has not yet implemented its corrective actions. Also, the Department has not reviewed UM denial files to determine whether the Plan's written notifications to enrollees denying requests for services are made within five business days of receipt of necessary information, include a description of the clinical criteria or guidelines used, and include a clinical reason / rationale for the decision.

At the Follow-Up Survey, the Department will assess the Plan's progress in correcting this deficiency by reviewing UM denial files to determine whether the files demonstrate that the Plan's written notifications denying requests for services comply with the requirements of the Plan's written policies and procedures and the requirements of the Act. The Department will also review any relevant results from auditing/monitoring tools including the Plan's PDAT audit tool, corrective actions provided to Liberty Dental and the Plan's follow-up regarding those corrective actions. Finally, the Department may also conduct interviews, review any relevant Plan policies and procedures, and any other information deemed relevant to correct this deficiency.

SECTION II: SURVEY CONCLUSION

The Department has completed its Routine Survey.

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).

The Department will conduct a Follow-Up Review of the Plan and issue a Report within 18 months of the date of this Final Report.

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. Please click on the following link to login: **DMHC Web Portal**.

Once logged in, follow the steps below to submit the Plan's response to the Final 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, **2019 Routine Dental Survey – Document Request**.
- Submit the response to the Final Report via the Department Communication tab.