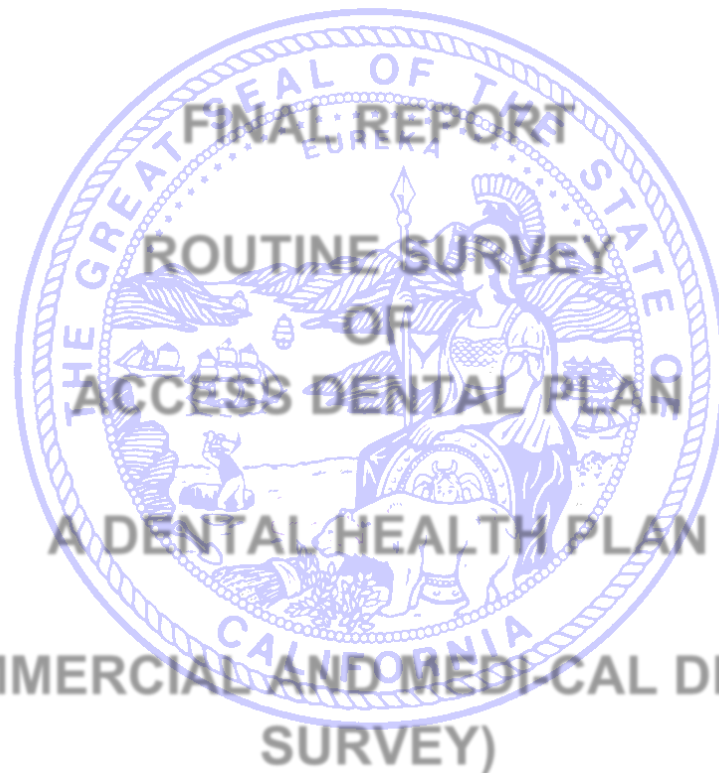




**DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS**



DATE OF FINAL REPORT: JANUARY 5, 2017

**Final Report of a Routine Survey
Access Dental Plan
A Dental Health Plan
January 5, 2017**

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EXECUTIVE SUMMARY

On January 8, 2016, the California Department of Managed Health Care (the “Department”) notified Access Dental Plan (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 March 29, 2016 through March 31, 2016.

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 identified **six** Knox-Keene deficiencies during the current Routine Survey:

2016 KNOX-KEENE SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	STATUS
QUALITY MANAGEMENT		
1	<p>The Plan’s Quality Management Program does not ensure a) that potential quality of care and service issues are appropriately assigned severity levels, corrective actions and follow-up, and b) that access issues are tracked and trended. Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A-B).</p>	<p>Not Corrected</p>
2	<p>The Plan did not consistently identify and elevate standard and exempt grievances with quality issues for PQI review. Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A-B).</p>	<p>Not Corrected</p>
GRIEVANCES AND APPEALS		
3	<p>The Plan did not ensure adequate consideration and rectification of enrollee grievances. Section 1368(a)(1); Sections 1368(a)(4)(A) and (B); Rule 1300.70(a)(1).</p>	<p>Not Corrected</p>

#	DEFICIENCY STATEMENT	STATUS
UTILIZATION MANAGEMENT		
4	For retrospective denials, the Plan did not consistently send written communication to the requesting provider that included the name and number of the dentist responsible for the denial, delay, or modification, nor was it documented that a dentist conducted clinical reviews. Section 1367.01(h)(4); Section 1367.01(e).	Not Corrected
5	For retrospective reviews, the Plan does not issue denial letters to the beneficiary that include how the beneficiary may file a grievance with the Plan and Independent Medical Review information. Section 1367.01(h)(4); Section 1374.30(i).	Not Corrected
LANGUAGE ASSISTANCE		
6	The Plan does not adequately monitor and make modifications, as needed, to its language assistance program. Rule 1300.67.04(c)(4)(A).	Not Corrected

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 the Report outlines the areas of the Contract assessed.

The Department identified **four** findings related to the Plan’s adherence to the Contract:

**2016 MEDI-CAL DENTAL MANAGED CARE CONTRACT
 CONTRACTUAL FINDINGS TABLE**

GRIEVANCES AND APPEALS		
1	The Plan does not send information to each member describing the procedures for submission, processing, and resolution of member grievances and complaints within 7 days of the date of enrollment in the Plan nor does it provide the state’s Medi-Cal Managed Care Ombudsman program’s TDD telephone numbers. Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision A; 22 CCR 53858(a)(2)(F).	Not Corrected
2	The Plan’s grievance log does not include the time the grievance is filed with the Plan or provider. Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision A; 22 CCR Section 53858(e)(1)(A).	Corrected

ACCESS AND AVAILABILITY OF SERVICES		
3	<p>The Plan does not have a current and complete Disaster Recovery Program. Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision I.</p>	Not Corrected
4	<p>The Plan does not have written procedures regarding care under emergency circumstances provided by non-plan providers, including verification of enrollment and the transfer of medical management to a plan provider. Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision D. Emergency Care; 22 CCR 53216.</p>	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 five 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 care, and the overall performance of the Plan in providing dental care benefits and meeting the dental 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 Department issued the Preliminary Report to the Plan on September 7, 2016. The Plan had 45 days to file a written statement with the Director identifying the deficiency and describing the action taken to correct the deficiency and the results of such action.

This Final Report addresses the most recent Routine Survey of the Plan, which commenced on January 8, 2016.

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.

PLAN BACKGROUND

Access Dental Plan (“the Plan”) was incorporated on January 14, 1993 and was licensed on December 22, 1993, to offer dental products and services as a specialized health care service plan under the Knox-Keene Health Care Service Plan Act of 1975.

The Plan’s service delivery model features an extensive network of contracted primary and specialists dentists.

The Plan serves the State’s Medi-Cal population through California's Geographic Managed Care Program (GMC) and the Los Angeles Prepaid Health Plan (LAPHP). The GMC and the LAPHP are administered by the California Department of Health Care Services.

As of July 11, 2016, the Plan had 52,787 commercial enrollees and 369,492 Medi-Cal enrollees.

DISCUSSION OF KNOX-KEENE DEFICIENCIES

On September 7, 2016, the Plan received a Preliminary Report regarding these deficiencies. In that report, the Plan was instructed to:

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

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

DEFICIENCIES

QUALITY MANAGEMENT

Deficiency #1: **The Plan's Quality Management Program does not ensure a) that potential quality of care and service issues are appropriately assigned severity levels, corrective actions and follow-up, and b) that access issues are tracked and trended.**

Statutory/Regulatory Reference(s): Rule 1300.70(a)(1); Rule 1300.70(b)(1)(A-B); Section 1386(b)(1); Section 1351(m).

Rule 1300.70(a)(1)

(a) Intent and Regulatory Purpose.

(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

Rule 1300.70(b)(1)(A-B)

(b) Quality Assurance Program Structure and Requirements.

(1) Program Structure.

To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:

- (A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees;
- (B) quality of care problems are identified and corrected for all provider entities;

Assessment: Rule 1300.70(a)(1) requires Plan's to ensure that the quality of care provided is being reviewed, that problems are being identified, that effective action is

taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

a. Identifying and Applying Corrective Actions to Potential Quality Issues (PQI)

The Department reviewed the Plan's Policy and Procedure QM.017.01 – Quality Indicators – PQI's. The Policy describes the Plan's procedures for identifying and processing Potential Quality Issues. The procedures include clinical and non-clinical identification. They also include differentiation of quality of care and quality of service, and acknowledging both as quality issues. The policy further addresses prioritization, categorization, and considerations, and includes a clear definition of severity levels and assignment of severity levels.

During the onsite survey, the Department reviewed a total of 45 PQI files. None of the 45 PQI files (100%) were assigned severity levels. Per the Plan's Policy and Procedure QM.017.01 – Quality Indicators – PQI, all 45 files should have had a severity level assigned.

Based on the Department's clinical review of these 45 PQI files, it was determined that 17 (38%) out of the 45 PQI files reviewed did not include an appropriate Corrective Action Plan (CAP) or follow-up conducted by the Plan.

During onsite interviews with the Plan's Dental Director and Quality Management staff, the Department asked the Plan to explain how these 45 cases were identified for elevation for PQI review. Plan staff were unable to provide a clear process or explanation as to how or why these files were identified. The Plan has policies and procedures in place to identify, categorize, and implement corrective actions for PQI; however, onsite PQI file review indicated that the Plan was not following those policies operationally.

Relevant Case Summaries:

Inappropriate Categorization and Corrective Actions – PQI

In the Preliminary Report, the Plan was provided case summaries for PQI file #XXX9901 and #XXX2200.

b. Access/Specialty Referral PQI and Monitoring

Of the 45 PQI files reviewed for quality of care issues, 32 files (71%) involved access issues. Out of these 32 access related issues, 7 issues were related to specialty referrals that were not being timely approved. While the Plan assisted each beneficiary in the 7 cases related to specialty referral, the Plan failed to address the additional quality issues in 2 of the 7 cases.

Examples - Access & Specialty Referral Issues - PQI:

In the Preliminary Report, the Plan was provided with case summaries for PQI file #XXX6800 and #XXX560F.

Example of a Transfer Request Not Tracked and Trended by the Plan:

In the Preliminary Report, the Plan was provided with a case summary for PQI file #XXX540F.

The Department finds the Plan out of compliance with Rule 1300.70(a)(1) and Rule 1300.70(b)(1)(A-B) for not ensuring the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

TABLE 1

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
PQI	45	Severity Level Assigned	0 (0%)	45 (100%)
PQI	45	Appropriate CAP and Follow-Up Conducted by the Plan	28 (62%)	17 (38%)
PQI	7	Access/Specialty Referrals: Other Issues Not Addressed	5 (71%)	2 (29%)
PQI	32	Access Issues Not Tracked and Trended	0 (0%)	32 (100%)

Corrective Action: Within 45 days following notice to a Plan of a deficiency, the Plan was required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan has updated the Policy and Procedure (P&P) QM.017.01 to provide a systemic approach to identifying, reporting, tracking, trending, and processing Potential Quality Issues. All potential quality of care and service issues are now appropriately assigned severity levels by the Dental Director or designee. Opportunities for improvements impacting quality of care and services are identified, tracked and trended.

The Plan has implemented a new process which requires all PQI's to be categorized with severity when filed in the log, regardless of confirmation. In addition the new process ensures that each case includes: an investigation/follow-up, an interim action (prior to Peer Review Committee decisions), confirmation of the quality issue, referral to Peer Review as appropriate and close out. Regardless of confirmation, all PQI's will be

tracked and trended. Providers with repeat potential quality issues will be counseled regardless of the confirmation, as such a trend in and of itself may be evidence of a separate quality issue (i.e. member communication).

P&P GA.001.01 has been updated to require all grievance and appeals to be added to the PQI for review. A new PQI Log has been implemented which will be reviewed by the Dental Director for completeness, appropriateness of the actions taken and identification of quality issues. This will ensure that all grievances, including exempt, shall be reviewed by the Dental Director and used for tracking and trending to identify quality issues. Categories demonstrating the severity of the PQI have been re-defined to clearly delineate for tracking. Category 1 will be used for clinical issues, ensuring a dental professional review. Categories 2 and 3 will be non-clinical and administrative.

Final Report Deficiency Status: Not Corrected

The Department recognizes the Plan's efforts to ensure that all potential quality of care are assigned severity scores, tracked, trended and monitored according to the updated Policies and Procedures, QM.017.01 for Quality Management and GA.001.01 for Grievance and Appeals. Since the Board of Directors only recently (on November 3, 2016) approved the new policies, additional time is necessary to allow for full implementation and to assess the effectiveness of the Plan's corrective actions.

Based on the above, the Department has determined that this deficiency has not been corrected.

The Department will verify implementation of the Plan's corrective action and conduct file review during a Follow-Up Survey to assess the effectiveness of the Plan's corrective action.

Deficiency #2: The Plan did not consistently identify and elevate standard and exempt grievances with quality issues for PQI review.

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

Rule 1300.70(a)(1)

(a) Intent and Regulatory Purpose.

(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

Rule 1300.70(b)(1)(A-B)

(b) Quality Assurance Program Structure and Requirements.

(1) Program Structure.

To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:

- (A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees;
- (B) quality of care problems are identified and corrected for all provider entities...

Assessment:

During the Department’s review of standard and exempt grievances, it was noted that 15 standard and 12 exempt grievances involving quality issues were not identified and elevated for PQI review.

The Plan’s Quality Management Performance Measures QM.009.01 indicates that the Plan would monitor its providers on an ongoing basis via grievance monitoring and corrective actions via grievance reports. Additionally, the Plan’s AA.003.01- Monitoring compliance with Access and Availability Standards policy states the Plan will conduct monitoring activities related to grievances on access issues.

During onsite interviews, the Department asked the Plan about the lack of identification and elevation of grievances to PQI review. Plan staff were unable to answer why these grievances were not identified as quality issues and not elevated for PQI review. It was also revealed that the Dental Director did not review exempt grievances. There was no evidence provided by the Plan that access issues were being tracked and trended and reported by the Plan.

Relevant Case Summaries:

Example - Standard Grievances with Quality Issues - Not elevated to PQI

In the Preliminary Report, the Plan was provided a case summary for File #XXX500F.

A. Examples – Exempt Grievances with Quality Issues – Not elevated to PQI

In the Preliminary Report, the Plan was provided with case summaries of File #XXX9500 and #XXX3300.

The Plan does not consistently identify and elevate grievances with quality issues for PQI review. The Department finds the Plan out of compliance with Rule 1300.70(a)(1) and Rule 1300.70(b)(1)(A-B) which require the Plan ensure that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

TABLE 2

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
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Standard Grievances	15	Quality Issue Elevated to PQI Review	0 (0%)	15 (100%)
Exempt Grievances	12	Quality Issue Elevated to PQI Review	0 (0%)	12 (100%)

Corrective Action: Within 45 days following notice to a Plan of a deficiency, the Plan was required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan’s Compliance Effort: The Plan updated the Grievance and Appeals policy, GA.001.01 to include language that requires all grievances to be reported to the QM PQI committee to ensure that quality of care provided is being reviewed. Each issue identified in the grievance with a PQI component is logged as its own separate PQI for tracking, trending, and follow-up. The Dental Director reviews issues for completeness, appropriateness of actions taken and proper identification of quality issues including access issues.

The Plan has trained the grievance staff to ensure that all grievance and complaints are addressed and entered into the log for tracking and trending. The grievance staff has also been trained on the new policy on Quality Management, QM.017.01 and Grievance and Appeals policies, GA.001.0. Both policies were implemented on October 1, 2016.

Final Report Deficiency Status: Not Corrected

The Department recognizes the Plan’s effort to ensure that standard and exempt grievances with quality issues are elevated for PQI review pursuant to the updated policies and procedures. Since the Board of Directors only recently, on November 3, 2016, approved the new policies, sufficient implementation has not been established yet. Additional time is necessary to allow for full implementation and to assess the effectiveness of the Plan’s corrective actions.

Therefore, the Department has determined that this deficiency has not been corrected. The Department will verify implementation of the Plan’s corrective action and conduct file review during a Follow-Up Survey to assess the effectiveness of the Plan’s corrective action.

GRIEVANCES AND APPEALS

Deficiency #3: The Plan did not ensure adequate consideration and rectification of enrollee grievances.

Statutory/Regulatory Reference(s): Section 1368 (a)(1); Section 1368(a)(4)(A) and (B); Rule 1300.70(a)(1).

Section 1368(a)(1)

(a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Section 1368(a)(4)(A) and (B)

(a) Every plan shall do all of the following:

(4)(A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:

- (i) That the grievance has been received.
- (ii) The date of receipt.
- (iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.

(B) Grievances received by telephone, by facsimile, by e-mail, or online through the plan's Internet Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:

- (i) The date of the call.
- (ii) The name of the complainant.
- (iii) The complainant's member identification number.
- (iv) The nature of the grievance.
- (v) The nature of the resolution.
- (vi) The name of the plan representative who took the call and resolved the grievance.

Rule 1300.70(a)(1)

(a) Intent and Regulatory Purpose.

(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

Assessment: The Plan's Grievance and Appeals Policy and Procedure states:

A. Exempt Grievances (applicable for California only)

Grievances received over the telephone that are not coverage disputes, disputed dental care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgement and resolution letter.

1. Exempt grievances shall be logged into the automated system upon

- receipt in the same manner as non-exempt grievances.
2. If a Member Services Representative receives a call that meets the criteria for an exempt grievance/appeal and the appropriate action is taken to respond to the caller's concern by the close of the next business day, the Member's record is updated in the automated system to indicate the matter has been "resolved" and a Category Code of "EG" for exempt grievances is assigned.
 3. During review of Category Code "C" records assigned by the Member Services Department, the Grievance/Appeal Coordinator may take the appropriate action to resolve an issue within the allowed exemption timeframe. In this case, the Member's record is updated in the automated system to indicate the matter has been "resolved" and the Category Code is updated to "EG" for exempt grievances.
 4. The automated log for tracking exempt grievances/appeals shall include the date of the call, the name of the complainant, the complainant's Member identification number, the nature of the grievance, nature of the resolution, and the name of the ADP staff person who took the call and resolved the grievance.

During the onsite survey, the Department reviewed 43 exempt grievances. In 24 (56%) of those 43 exempt grievances, the grievance involved multiple issues, but the Plan only addressed one issue and only categorized that issue for tracking and trending, not the other issues.

Since not all of the issues were properly categorized and addressed, the exempt grievances were not fully resolved, nor were they tracked and trended to monitor access and quality issues.

The Department finds the Plan out of compliance with Sections 1368 (a)(10) and 1368(a)(4)(A) and (B) for not ensuring adequate consideration of enrollee grievances and rectification when appropriate. Additionally, the Department finds the Plan out of compliance with Rule 1300.70(a)(1), for not ensuring the quality of care provided was being reviewed, that problems were being identified, that effective action was taken to improve care where deficiencies were identified, and that follow-up was planned where indicated.

Relevant Case Summaries:

In the Preliminary Report, the Plan was provided with case summaries for File #XXXD/5555/1, #XXXA/5555/1, and File #XXXF/5555/1.

TABLE 3

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
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Exempt Grievances	43	All issues in grievance addressed and categorized for tracking and trending.	19 (44%)	24 (56%)
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Corrective Action: Within 45 days following notice to a Plan of a deficiency, the Plan was required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan’s Compliance Effort: The Plan has updated the Grievance and Appeals Policy and Procedure (P&P) GA.001.01 to include understanding of grievances with multiple issues identified. Grievances with multiple issues will be categorized based on severity. All issues will be resolved prior to closing the grievance. The new policy provides an upgraded process to contact the Plan for general inquiries, report a grievance/appeal, and provide an effective process for resolving grievances in a timely manner. Each issue identified in the grievance with a quality component shall be logged as its own separate PQI to ensure tracking, trending, and follow-up.

Final Report Deficiency Status: Not Corrected

The Plan has updated the Grievance and Appeals Policy to provide for adequate consideration and rectification of all issues in enrollee grievances. However, additional time is necessary to allow for full implementation and to assess the effectiveness of the Plan’s corrective actions.

Therefore, the Department has determined that this deficiency has not been corrected. The Department will verify implementation of the Plan’s corrective action and conduct file review during a Follow-Up Survey to assess the effectiveness of the Plan’s corrective action.

UTILIZATION MANAGEMENT

Deficiency #4: For retrospective denials, the Plan did not consistently send written communication to the requesting provider that included the name and number of the dentist responsible for the denial, delay, or modification, nor was it documented that a dentist conducted clinical reviews.

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

Section 1367.01(h)(4)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

Section 1367.01(e)

No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

Assessment: The Plan's internal Policy CL.012.01 – Denials states:

“Written communication to the dentist requesting the service includes the name and direct phone telephone number/extension of the dental professional responsible for the denial, delay, or modification.” It further states, “[o]nly a qualified, licensed dentist, competent to evaluate the specific clinical issues involved, may deny, delay, or modify requests for authorization of dental services of dental necessity or inappropriate treatment.”

The Department's review of the retrospective UM denial files revealed that they did not consistently include any documentation that a dentist actually conducted the clinical review. Additionally, written communication of the denial (i.e. denial letters, Notice of Actions, etc...) did not consistently include the name and direct number of the physician or health care provider responsible for the decision.

The Department reviewed 57 retrospective UM denial files. In 28 (49%) of the 57 files, the Plan issued written communication of the denial that did not include the name and

telephone number of the health care professional responsible for the denial, delay, or modification.

During onsite interviews with the Plan, the Plan disclosed it does not send the requesting provider a denial letter for retrospective reviews in addition to the NOA, just the NOA.

The Department finds the Plan out of compliance with Section 1367.01(h)(4) for not consistently sending written communication to requesting providers with the name and telephone number of the health care professional responsible for the denial, delay, or modification, for retrospective review. The Department finds the Plan out of compliance with Section 1367.01(e) for failing to demonstrate that a licensed physician or professional who is competent to evaluate the clinical issues involved conducted the clinical review.

TABLE 4

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Retrospective UM Denials	57	Written communication to the requesting provider that includes the name and direct phone # of reviewing physician or health care professional	29 (51%)	28 (49%)
Retrospective UM Denials	57	Documentation that a dentist conducted the clinical review.	29 (51%)	28 (49%)

Corrective Action: Within 45 days following notice to a Plan of a deficiency, the Plan was required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan currently sends providers an Explanation of Payment (EOP) as well as a Notice of Authorization (NOA) when applicable, for retrospective denials. The Plan updated the EOP, NOA and Referral Notice for full and partial denials to include the name and telephone number of the Dental Director responsible for the denial, delay or modification of retrospective review.

The updated EOP, NOA and Referral Notice changes will be implemented on January 31, 2017. The changes require system edits to include system generated notices.

During the survey preparation, the Plan recognized its process error with not capturing the documentation of the dentist actually conducting the clinical review. According to

the Plan, the documentation was being shredded once the decision had been captured in the system; however, the claims adjudicator should have scanned and electronically filed the paper documentation. This misunderstanding in the process by the claims staff was corrected the week prior to the onsite on March 25, 2016, and the Director of Claims reviewed the files from April through July to ensure documentation is maintained per the process. The Plan represented that it released a Claims Training Memo to inform the staff of the updated process.

Final Report Deficiency Status: Not Corrected

The Department finds that the deficiency has not been fully corrected. The new process regarding documentation of the clinical reviewer was implemented a week prior to the onsite survey on March 25, 2016. The name and number of the dentist who actually made the clinical review will be added on January 31, 2017. The Plan indicated that the updates to the Explanation of Payment, Notice of Authorization and Referral Notice would be submitted to the Department. Once the updates are submitted to the Department and reviewed, additional time is necessary to allow for full implementation and to assess the effectiveness of the Plan's corrective actions.

Therefore, the Department has determined that this deficiency has not been corrected. The Department requests the Plan submit a supplemental response within 60 days of the date of this report providing status on the implementation of the clinical reviewer documentation process. Please also provide a print-out of an updated EOP, NOA and Referral Notice with the supplemental response. The Department will verify implementation of the Plan's corrective action and conduct file review during a Follow-Up Survey to assess the effectiveness of the Plan's corrective action.

Deficiency #5: **For retrospective reviews, the Plan does not issue denial letters to the beneficiary that include how the beneficiary may file a grievance with the Plan and Independent Medical Review information.**

Statutory/Regulatory Reference(s): Section 1367.01(h)(4); Section 1374.30(i).

Section 1367.01(h)(4)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:...

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing,

and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

Section 1374.30(i)

No later than January 1, 2001, every health care service plan shall prominently display in every plan member handbook or relevant informational brochure, in every plan contract, on enrollee evidence of coverage forms, on copies of plan procedures for resolving grievances, on letters of denials issued by either the plan or its contracting organization, on the grievance forms required under Section 1368, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the plan, or by one of its contracting providers.

Assessment: The Plan does not issue retrospective denial letters to the beneficiary that include how the beneficiary may file a grievance with the Plan and Independent Medical Review information. During the onsite survey, the Department reviewed 57 retrospective denial files. The Plan did not issue a beneficiary denial letter to communicate denial decisions in any (100%) of the 57 files.

As a result, beneficiaries were not provided information on how to file a grievance with the Plan or how to file for an Independent Medical Review (IMR).

The Plan's internal policy CL.012.01 – Denials states:

“#7. Written communication includes instructions on how to file a grievance so that members who believe that dental services have been improperly denied, modified, or delayed by Premier Access or a contracting provider have an opportunity to file a grievance.”

The Plan did not provide a policy on providing beneficiaries information on how to request an IMR. During onsite interviews with Plan staff, the Director of Claims, Membership Accounting and Provider Services and Director of Government Programs were asked if the beneficiary receives information on how to file a grievance or how to request an IMR when denied on a retrospective denial. They stated that they were not, but if the beneficiary called in they would be given the information.

Corrective Action: Within 45 days following notice to a Plan of a deficiency, the Plan was required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan recognized the oversight in sending denial information to members that did not include how the beneficiary may file a grievance with the Plan and Independent Medical Review information. The Plan will send all members an Explanation of Benefits (EOB) including information on denied services in compliance with Plan policy as well as the Grievance, Appeal and IMR insert.

The Plan stated that the EOB changes will be implemented by January 31, 2017. These changes require system edits to include system generated notices.

Final Report Deficiency Status: Not Corrected

The Plan will implement the EOB changes by January 31, 2017. Once the updates are submitted to the Department and reviewed, additional time is necessary to allow for full implementation and to assess the effectiveness of the Plan's corrective actions.

Therefore, the Department has determined that this deficiency has not been corrected. The Department requests the Plan submit a supplemental response within 60 days of the date of this report providing the status of EOB updates. Please also provide a print-out of an EOB illustrating the correction. The Department will verify implementation of the Plan's corrective action and conduct file review during a Follow-Up Survey to assess the effectiveness of the Plan's corrective action.

LANGUAGE ASSISTANCE

Deficiency #6: The Plan does not adequately monitor and make modifications, as needed, to its language assistance program.

Statutory/Regulatory Reference(s): Rule 1300.67.04(c)(4)(A).

Rule 1300.67.04(c)(4)(A)

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring...

(4) Compliance Monitoring.

Every plan shall monitor its language assistance program, including delegated programs, and make modifications as necessary to ensure compliance with Section of the Act and this section.

Assessment:

The Department reviewed the Plan's Language Assistance Program Policy ID: AA.004.01: Language Assistance Program. The policy states that the language assistance needs of the enrollee population is under the direction of the Dental Director or designee. The policy includes a section for Compliance Monitoring, which states:

COMPLIANCE MONITORING

7. Language Assistance Program policies and procedure will be evaluated on an annual basis, during which time its effectiveness will be assessed as part of the overall Quality Management Annual Review. The policies and procedures will be modified as necessary based on this annual evaluation.

Onsite interviews with Plan staff revealed that the Plan does not have a person responsible for Language Assistance Program monitoring. According to the Director of Government Programs, the responsibility was with the Vice President of Administration, but since she left the company, each department had been responsible for their part of the language assistance program. However, this change was not reflected in the Plan's policy. Since 2014, there has been no one person or department identified as having responsibility for the Language Assistance Program.

Additionally, the plan had recently moved the member services department to Spokane, Washington. Plan staff stated that all of the new member services staff have been trained with regards to the language assistance program. The Quality Management Committee Meeting Minutes indicated that the Committee does monitor aspects of the language assistance program such as language line usage, face-to-face interpretation usage, and the compilation of language preferences. However, the Minutes do not demonstrate monitoring of required language assistance training.

The Department finds the Plan out of compliance with Rule 1300.67.04(c)(4)(A) for not adequately monitoring its language assistance program and making modifications, as necessary, for its language assistance program.

Corrective Action: Within 45 days following notice to a Plan of a deficiency, the Plan was required to file a written statement with the Department signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan has implemented an annual LAP review schedule in line with the Plan's policy and procedure, to occur every October to be reviewed by the Dental Director, presented and approved by the Quality Management Committee and approved in the next Board Meeting. This policy was reviewed by the Dental Director in October 2016, presented to the Quality Management Committee on November 11, 2016, and thereafter sent to the Board for approval.

The Plan will implement the annual reviews of the LAP and will ensure that the Quality

Management Committee reviews and approves the LAP processes and monitors staff compliance. The Dental Director, or designee will be responsible for the annual LAP review and monitoring. Any modifications will be presented to the Quality Management Committee for review and to the Board of Director's for approval.

Additionally, the Plan's Member Services division, located in another state, was provided training on compliance with LAP regulations. The Plan will conduct monitoring, review of training materials and staff compliance. Information will be presented during Quality Management Committee meetings.

Final Report Deficiency Status: Not Corrected

Additional time is necessary to allow for full implementation and to assess the effectiveness of the Plan's corrective actions. The Department will verify implementation of the Plan's corrective action during a Follow-Up Survey to assess the effectiveness of the Plan's corrective action. The Department will need to see evidence of implementation and reports to the QM committee to make sure that the staff are in compliance with the new policy.

Therefore, the Department has determined that this deficiency has not been corrected.

KNOX-KEENE SURVEY CONCLUSION

The Department has completed its Routine Survey. The Department will conduct a Follow-Up Review of the Plan and issue a report within 14-16 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. 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 "eFiling" link.
- Click the "Online Forms" link.
- Under Existing Online Forms, click the "Details" link for the **DPS Routine Survey Document Request** titled, **2016 Routine Dental Survey - Document Request**.

Submit the response to the Final Report via the "DMHC Communication" tab.



**DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS**



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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 plans to provide dental services to Medi-Cal Beneficiaries in Sacramento and Los Angeles counties through the Geographic Managed Care (GMC) Plan and the Prepaid Health Plan (PHP). 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 SURVEY OVERVIEW

The Medi-Cal Dental Managed Care Program Contracts (“Contract”) requires that the Plan continuously monitor its associated contracted providers to ensure adherence with access and availability, grievance and appeals policy and procedures, quality management and proper 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 7, 2016. The Plan had 30 days to file a written statement with the Department identifying each contractual deficiency and describing the action taken to correct the finding 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 to the Plan and to the public.

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

DISCUSSION OF CONTRACTUAL FINDINGS

All contractual findings cited in this Final Report require corrective actions.

The contractual findings cited in this Final Report will be addressed by the Department of Health Care Services. Any responses to contractual findings that are also identified as Knox-Keene deficiencies will be reviewed and approved by the Department as set forth in Section 1380(h)(2). However, responses to contractual findings must be provided within 30 days.³

Within 30 days following notice to the Plan of a contractual finding the Plan is required to file a corrective action report that:

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

CONTRACTUAL FINDINGS

GRIEVANCES AND APPEALS

Finding #1: **The Plan does not send information to each member describing the procedures for submission, processing, and resolution of member grievances and complaints within 7 days of the date of enrollment in the Plan nor does it provide the state's Medi-Cal Managed Care Ombudsman program's TDD telephone numbers.**

Contractual/Statutory/Regulatory Reference(s): Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision A; 22 CCR 53858(a)(2)(F).

Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision A

A. Member Grievance System

Contractor shall implement and maintain a Member Grievance system in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR 53858, Exhibit A, Attachment 14, Member Services, Provision D, Written Member Information, Subprovision 4, Paragraph I). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's dental condition requires, or no later than thirty (30) calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written Member notice.

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

22 CCR 53858(a)(2)(F)

(a) Each plan in a designated region shall establish and maintain written procedures for the submittal, processing, and resolution of all member grievances and complaints. The grievance system shall include the handling of complaints and shall:...

(2) Be described in information sent to each member within 7 days of the date of enrollment in the plan and annually thereafter, pursuant to sections 53893 and 53894. The description shall include:...

(F) An explanation of the state's Medi-Cal Managed Care Ombudsman program and the program's voice and TDD telephone numbers.

Supporting Documentation:

- GA-001_GA.001.01_Grievance System.doc Grievance and Appeals Policy and Procedure (06/21//2013)

Assessment:

The Plan does not send information to each member describing the procedures for submission, processing, and resolution of member grievances and complaints within 7 days of the date of enrollment in the Plan. In addition, the information provided does not include the state's Medi-Cal Managed Care Ombudsman program's TDD telephone numbers. The Plan's Grievance and Appeals policy and procedure states: "Members shall be notified of the grievance process upon enrollment and annually thereafter." The policy does not state that the notification should be made within 7 days of the date of enrollment in the Plan. During interviews, the Plan's Director of Government Programs stated that each new member is sent a copy of the GMC Combined Evidence of Coverage and Disclosure Form (EOC) within 30 days of enrollment.

Additionally, the EOC states:

The DHCS is responsible for monitoring contractual compliance of all managed care plans who serve Medi-Cal beneficiaries. DHCS has established an Ombudsman Unit to receive complaints regarding Medi-Cal managed care plans. To contact the DHCS Ombudsman Unit, call (866) 452-8609.

The EOC does not contain the state's Medi-Cal Managed Care Ombudsman TDD telephone number. During onsite interviews with the Plan, the Department asked Plan staff about the TDD number. The Plan's Director of Government Programs confirmed that the TDD number was missing and would be corrected in the next issuance of the EOC.

The Department finds the Plan out of compliance with Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision A and 22 CCR 53858(a)(2)(F) for not ensuring its enrollees are notified of the grievance process within 7 days of enrollment in the Plan and for not including the state's Medi-Cal Managed Care Ombudsman TDD telephone number in the EOC.

Plan's Compliance Effort: The Plan shall send all members within 7 days of enrollment into the Plan a Welcome Letter/ID card. The information captured on the

Welcome Letter/ID card was updated to include all required information, including the grievance process. The new Welcome Letter/ID card shall be implemented 01/31/2017. This implementation requires system changes.

The Plan recognizes the requirement to include the Medi-Cal Managed Care Ombudsman TDD telephone number in the EOC, however there is not one posted. Until MDSO updates the Plan on the appropriate number the Plan cannot update the EOC. <http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOOfficeoftheOmbudsman.aspx>.

Final Report Finding Status: Not Corrected

Finding #2: The Plan's grievance log does not include the time the grievance is filed with the Plan or provider.

Contractual/Statutory/Regulatory Reference(s): Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision A; 22 CCR Section 53858(e)(1)(A).

Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision A

A. Member Grievance System

Contractor shall implement and maintain a Member Grievance system in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR 53858, Exhibit A, Attachment 14, Member Services, Provision D, Written Member Information, Subprovision 4, Paragraph I). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's dental condition requires, or no later than thirty (30) calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written Member notice.

22 CCR Section 53858(e)(1)(A)

(e) The member grievance procedures shall at a minimum provide for:

(1) The recording in a grievance log of each grievance received by the plan, either verbally or in writing. The grievance log shall include the following information:

(A) The date and time the grievance is filed with the plan or provider.

Supporting Documentation:

- GA-001_GA.001.01_Grievance System.doc Grievance and Appeals Policy and Procedure (Rev 06/21//2013)

Assessment:

The Plan's grievance log fails to note the time the grievance is filed with the Plan. The Plan's Grievance and Appeals Policy and Procedure includes maintaining a grievance log that includes the date a grievance is filed with the Plan; however, it does not include the time that the grievance is filed.

During onsite interviews with Plan staff, the Department asked the Plan whether it records the time of the grievance. The Plan's Team Leader of Quality Management confirmed that the automated log records the date but not the time grievance is logged into the system.

The Department finds the Plan out of compliance with Medi-Cal Dental GMC Program Exhibit A, Attachment 15, Provision A and 22 CCR Section 53858(e)(1)(A) for not maintaining a log which includes the time a grievance is filed with the plan.

Plan's Compliance Effort: The Plan has corrected this issue by adding a field for time to the grievance tracking log. It will capture the time from the customer service notes, voicemail or email timestamp. The P&P GA.001.01 has been updated to include "time" as a requirement of tracking, and the revised policy was implemented on 9/23/2016. Updated P&P GA.001.01 has been provided to the Board and will be reviewed at the next Board meeting on November 3, 2016. The Plan will submit evidence of Board approval with an amended response. All relevant staff have been trained on this change to the policy and procedure. The Team Leader, Quality Management will review the Grievance Log monthly for 4 months to ensure compliance with the policy.

Final Report Finding Status: Corrected

ACCESS AND AVAILABILITY

Finding #3: The Plan does not have a current and complete Disaster Recovery Program.

Contractual/Statutory/Regulatory Reference(s): Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision I

Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision I
Healthcare Surge Events

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

Supporting Documentation:

- Policy ID: AA.006.01 Access & Availability – General, 1/1/2013
- Premier Access Insurance Company, Business Continuity Disaster Recovery Plan, September 8, 2010
- Policy IT.008.01, IT, Business Continuity (not provided by Plan, see below)

Assessment:

The Plan does not have a current and complete Disaster Recovery Program. The Plan provided policy AA.006.01 Access & Availability – General which includes a section regarding Healthcare Surge Events that states that “Premier Access has established a disaster recovery and business continuity plan in accordance with Policy IT.008.01, IT, Business Continuity” which contains the required processes for disaster recovery. However, despite specific request, policy number IT.008.01 was not provided by the Plan.

Policy AA.006.01 Access & Availability – General, section regarding “Healthcare Surge Events” states, “The disaster recovery and business continuity plan is designed to proactively cope with healthcare surge events resulting from such disasters or states of emergency...” It includes that the plan will protect enrollees, keep revenue streams flowing, provide for transferring members from provider to provider, and provide for prompt notification to the Department.

During staff interviews, the Department was informed that Policy IT.008.01 had been superseded by the business continuity plan developed by the new parent company, Guardian. However, this document did not include any reference to Access Dental Plan. The Department was then provided the Premier Access Insurance Company, Business Continuity Disaster Recovery Plan, dated September 8, 2010, prior to the acquisition by Guardian in August of 2014. Plan staff stated that this was the document initially developed as the Plan’s disaster recovery program, but that it had never been updated. The Business Continuity Disaster Recovery Plan document does not comply with the GMC contract requirements. The overview in the introduction of the document states that “[t]he plan is a comprehensive document containing the necessary instruction, policies, organization, and information required to be prepared for an emergency or disaster that would affect Premiere’s information systems.” It does not include information relative to a transfer of members from provider to provider or regarding notification to the DHCS of the status of the availability and locations of covered services. The document lists key Action Teams and the management staff responsible for each of the teams; however, due to the sale of the company to Guardian Life of America, there had been a significant turnover of management staff and none of the management staff listed in the document still worked for the company. As a result, the Business Continuity Disaster Recovery Plan was incomplete and did not accurately identify the current Plan staff. A disaster recovery plan had not been created or filed with the DHCS since the acquisition of Access Dental by Guardian.

The Department finds the Plan out of compliance with the Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision I for not having a current disaster recovery program.

Plan's Compliance Effort: The Plan is working with the parent company Guardian Life Insurance of America to execute an updated Business Continuity Plan and a Disaster Recovery Plan to ensure physical and technical infrastructure is maintained. Our plan is to have an approved Business Continuity and a Disaster Recovery Plan to DMHC and DHCS no later than 11/4/2016. Alisha Hightower, Director of Government Programs will confirm the submission date on 10/17/2016 to ensure completion.

On 11/04/2016, the Plan submitted a draft Disaster Recovery and Business Continuity Plan, which is pending approval in February 2017 at the next Board of Directors meeting.

Final Report Finding Status: Not Corrected

Finding #4: **The Plan does not have written procedures regarding care under emergency circumstances provided by non-plan providers, including verification of enrollment and the transfer of medical management to a plan provider.**

Contractual/Statutory/Regulatory Reference(s): Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision D. Emergency Care; 22 CCR 53216.

Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision D. Emergency Care

Emergency Care

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

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

22 CCR 53216

Care Under Emergency Circumstances.

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

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

- (1) Verification of membership.
- (2) Transfer of the medical management of the member to a plan provider.

(3) Payment within 60 days of receipt of properly documented bills for the services rendered to the member. Bills for services rendered to the member shall be submitted not later than the second month following the month of service, except for good cause.

(4) Written notice of action within 60 days of receipt of bills which are denied or reduced for any reason by the plan. The notice shall include a statement, subject to prior approval by the Department, of the provider's right to:

(A) Dispute the plan's rejection or reduction of the bill.

(B) Submit the dispute to the Department pursuant to Article 7.

(5) Reimbursement to nonplan emergency care providers shall be in accordance with Section 53623.

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

(c) Each provider who agrees with a plan to provide emergency medical services shall furnish, when the course of treatment of a plan member under emergency circumstances requires the use of drugs, a sufficient quantity of such drugs to last until the member can reasonably be expected to have a prescription filled.

Supporting Documentation:

- Policy ID: AA.001.01 Appointment Availability and Wait Times Standards, 01/01/2013 (from the provider manual)
- Policy ID: QM.026.01, Continuity & Coordination of Care, 1/1/2013 (onsite from the provider manual)
- Policy ID: CL.011.01, Emergency Dental Care, 1/1/2013 (onsite from the provider manual)

Assessment: The Plan does not have a process that ensures compliance with Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision D. Emergency Care of the GMC Contract, which requires that the Contractor cover emergency dental services without prior authorization, pursuant to 22 CCR 53216. 22 CCR 53216 specifies that written procedures must be developed and applied by the plan regarding care under emergency circumstances provided by non-plan providers in and outside the service area and that the procedures must include but not be limited to (1) Verification of membership and (2) Transfer of the medical management of the member to a plan provider.

The Plan provided policy documents related to this subject to the Department for review. Policy AA.001.01, Appointment Availability and Wait Times Standards, states that emergency care should be available to members 24 hours a day. Additionally, the CL.011.01, Emergency Dental Care policy, defines availability for emergency care.

The Department conducted onsite interviews with Plan staff to determine if there was a policy which was compliant with the contract requirement. It was confirmed onsite that none of these three documents include provisions that address non-plan provider verification of membership or transfer of medical management after the emergency.

The Department finds the Plan out of compliance with Medi-Cal Dental GMC Program, Exhibit A, Attachment 11, Provision D, pursuant to 22 CCR 53216, for not having written procedures regarding care under emergency circumstances provided by non-plan providers, including verification of enrollment and the transfer of medical management to a plan provider.

Plan's Compliance Effort: The Plan has developed and filed Policy and Procedure (P&P) CL.003.06 for Out-of-Network General and Specialty Care Referrals. It was filed with DMHC in filing #20151544 on 3/26/16. This P&P was implemented on 3/15/16.

Final Report Finding Status: Corrected

MEDI-CAL DENTAL MANAGED CARE SURVEY CONCLUSION

The Department has completed its review of the Plan and has identified **4** Findings related to the DHCS Contract during the current Routine Survey.

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 contractual findings in 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, **2016 Routine Survey - Document Request**.
- Submit the response to the **contractual findings** identified in the Final Report via the 'DMHC Communication' tab and select **General Message** from the 'Subject' dropdown menu.

The Department will forward the Plan's response to contractual findings to DHCS.