MEDICAL REVIEW – NORTHERN II SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE DENTAL AUDIT OF

Liberty Dental Plan Of California, Inc.

2022

Contract Number:	12-89343 13-90117
Audit Period:	July 1, 2021 Through June 30, 2022
Dates of Audit:	August 8, 2022 Through August 19, 2022
Report Issued:	January 17, 2023

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I. INTRODUCTION

Liberty Dental Plan of California, Inc. (Plan) has a contract with the California Department of Health Care Services (DHCS) to provide dental services to members in Sacramento and Los Angeles counties. The Plan has a license in accordance with the provisions of the Knox-Keene Health Care Service Plan Act of 1975.

The Plan is a specialty health plan with its own statewide network of contracted general and specialty dental providers. The Plan provides dental services to members under their Sacramento Geographic Managed Care (GMC) and Los Angeles Prepaid Health Plan (PHP) programs.

The Plan has approximately 191 general providers and 43 specialists for Sacramento County and has approximately 851 general providers and 216 specialists for Los Angeles County.

The Plan currently serves 575,500 Medi-Cal members in California. As of September 2022, the Plan's membership was composed of 330,892 GMC and 244,608 PHP members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS dental audit for the review period of July 1, 2021 through June 30, 2022. The audit was conducted from August 8, 2022 through August 19, 2022. The audit consisted of document review, verification studies, and interviews with the Plan's personnel.

An Exit Conference with the Plan was held on December 29, 2022 The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The findings in the report reflect the evaluation of all relevant information received prior and subsequent to the Exit Conference.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management (QM), and Administrative and Organization Capacity.

The summary of the findings by category follows:

Category 2 – Case Management and Coordination of Care

The Plan is required to ensure an initial screening is performed when a new member is enrolled. This assessment helps the Plan make informed decisions on what type of care patients need. The Plan is also required to submit to DHCS any changes to its initial screening policy within ten calendar days of any changes, and annually no later than 30 days after the first day of every calendar year. The Plan did not report changes to their initial screening policy within the required timeframe to DHCS.

The Plan is required to track and ensure the completion of its initial screening within 90 days of enrollment. The Plan did not ensure new members had an initial screening completed during the audit period. Attempts to contact members were not tracked nor documented.

The Plan shall implement mechanisms to comprehensively assess each member identified as having Special Health Care Needs (SHCN), to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The Plan did not ensure comprehensive assessments were completed during the audit period.

Category 4 – Member's Rights

The written record of grievances shall be submitted and reviewed at least quarterly by the Plan's Quality Assurance Committee and governing bodies for systematic aggregation and analysis for quality improvement; the review shall be thoroughly documented. During the

audit period, the Plan submitted the written record of grievances, however, did not thoroughly document the review by the Plan's governing bodies and committees.

Category 5 – Quality Management

The Plan is required to perform quality improvement on its systems and to track and report to DHCS all deferred Treatment Authorization Requests (TAR). The number of deferred TARs was not captured, reviewed, or validated. This information is necessary to perform effective quality improvement of the prior authorization system.

III. SCOPE/AUDIT PROCEDURES

SCOPE

DHCS, Medical Review Branch, conducted this audit to ascertain whether the dental services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's GMC/PHP contract.

PROCEDURE

An audit was conducted from August 8, 2022 through August 19, 2022. The audit included a review of the Plan's contract with DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorizations: 19 dental services prior authorization files were reviewed. The sample was selected to cover the different specialties of dentistry, different age range of members, and to reflect both counties (Sacramento and Los Angeles).

Appeals: 16 dental services appeals were reviewed and included the different specialties in dentistry, children and adults, and to reflect both Los Angeles and Sacramento counties. In addition, the sample comprised of resolutions that were upheld and overturned.

Category 2 – Case Management and Coordination of Care

Case Management: Four case management files, four SHCN files, and four Children with Special Health Care Needs (CSHCN) files were reviewed.

Oral Health Assessment: Nine oral health assessment files were selected for review.

Care Coordination: Five care coordination files were reviewed.

Category 4 – Member's Rights

Grievance Procedures: Nine quality of care and 15 quality of service grievances were reviewed for timely resolution, compliance, and submission to the appropriate level of review.

Category 5 – Quality Management

Potential Quality Issues: Seven potential quality issue files were selected for review.

Provider Training and Credentialing: Five credentialing, five re-credentialing, and ten provider training files were reviewed.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste and Abuse: Five overpayment, five recovery, and five fraud, waste and abuse cases were selected for review.

A description of the findings for each category is contained in the following report.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE	
2.1	**CASE MANAGEMENT/ORAL HEALTH ASSESSMENT**

2.1.1 Reporting of Changes to Initial Screening Policy

Consistent with the federal requirement, the contractor shall submit to DHCS any changes to their initial screening policy within ten calendar days of any changes, and annually no later than 30 days after the first day of every calendar year.
(GMC/PHP Contract, Exhibit A, Attachment 13)

DMC Plans are required to submit to DHCS any changes to their initial screening policy within ten calendar days of any changes, and annually no later than 30 calendar days after the beginning of every calendar year.
(D-APL 18-007, Requirements for Oral Health Assessments)

CM_2.1.3_QM PP – Oral Health Risk Assessments (OHRA): Liberty will attempt to collect an OHRA form for new members within 90 days of the effective date of enrollment and will make subsequent attempts to conduct an initial screening of a member's needs if the initial attempt is unsuccessful.

Finding: The Plan did not report changes to its initial screening policy within the required timeframes.

The Plan completes an OHRA form as its initial screening for members.

During the audit period, the Plan added four additional questions to their OHRA form. It also made changes to its OHRA screening policy and formed a work group as part of the quality improvement process to address the low rate of completion of OHRA forms in 2021. However, it did not report these changes to DHCS within ten calendar days, nor annually within the first 30 days of the calendar year. The Plan eventually contacted DHCS on April 20th, 2022, to report the changes.

During an interview, the Plan stated that there was no process and procedure in place to ensure changes were reported to DHCS on time.

Review of the Plan's P&P, *CM_2.1.3_QM PP Oral Health Risk Assessments_Initial Screening,* showed it did not have any stipulation in regards to informing the Department of changes to the Plan's initial screening policy.

Failure to communicate policy changes to DHCS makes the Plan out of compliance with program requirements.

Recommendation: Develop and implement a process to ensure timely reporting of any changes to initial screening policy to DHCS within ten calendar days and annually no later than 30 days after the first day of every calendar year.

2.1.2 Initial Screening

Contractor shall make a best effort to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. *(Contract 12-89343 A17 and 13-90117 A14 LDP Exhibit A, attachment 13*)

CM_2.1.3_QM PP – Oral Health Risk Assessments_Initial Screening: Liberty will attempt to collect an OHRA for new members within 90 days of the effective date of enrollment and will make subsequent attempts to conduct an initial screening of a member's needs if the initial attempt is unsuccessful. The methods of contact to complete an OHRA may include but are not limited to:

a. Smartphone access to the online OHRA forms from the Welcome Letters.
b. A tear-out version of the OHRA1 in the Member Handbook that can be mailed in.
c. A Welcome Call that provides members an option to complete the OHRA telephonically with a live agent in the member's preferred language.
d. A quick link via text message that directs members to the online OHRA form.

On a quarterly basis the completion rates and timeliness of OHRA attempts are reported to the Quality Management and Improvement Committee (QMIC) for oversight and ongoing monitoring. The QMIC will determine whether planned activities to collect initial screenings is effective or recommend modification to improve the completion rate and timeliness of OHRAs.

Finding: The Plan did not ensure new members had an initial screening completed within 90 days of enrollment. Attempts to contact members were not tracked nor documented.

The Plan's Initial Health Screening included the completion of the OHRA by each member, however the completion rate of OHRA of all new enrollees for the audit period was 0.78 percent. In addition, the Plan did not effectively track its attempts to contact members to complete the OHRA.

While reviewing the new member data received from the Plan, the data columns including “Outreach Effort”, and “Follow-Up Process” were left empty. The Plan did not document any outreach or follow up efforts to conduct or complete initial screenings for new members.

A verification study of nine OHRA files showed that six did not have OHRAs completed within 90 days, and all nine lacked outreach and follow up within 90 days of enrollment.

During an interview, the Plan stated that a new Population Health Team will oversee the completion of OHRAs for all enrollees. The team will be responsible for the aggregation of data, outreach attempts, documentation and evaluation of all interventions to assist members in the completion of OHRAs. The changes also include online forms for members to complete the OHRA as well as robo-calling for member outreach. A process for quarterly oversight reports was also created. However, all enhancements will not be fully implemented until Q3 of 2022.

When the Plan does not receive completed member initial health assessments such as the OHRA, the Plan may delay or fail to provide necessary services for members.

Recommendation: Develop and implement a process to ensure new members complete the OHRAs within 90 days of enrollment date, and to document and ensure subsequent attempts to contact the member if the initial attempt to complete OHRA is unsuccessful.

2.2	CONTINUITY OF CARE/TRANSITION OF CARE

2.2.1 Assessment of members with Special Health Care Needs and Children with Special Health Care Needs

Contractor shall implement mechanisms to comprehensively assess each member identified as having SHCN, to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.
(Contract 12-89343 A17 and 13-90117 A14 LDP Exhibit A, Attachment 13)

Contractor shall maintain methods for ensuring that each CSHCN receives a comprehensive oral assessment and development of a written dental treatment plan.
(Contract 12-89343 A17 and 13-90117 A14 LDP Exhibit A, Attachment 13)

CM_2.1B.2_SOP California Medicaid SNP Case Management Process: The Case Manager is to complete the OHRA, Comprehensive Review Assessment (CRA), Community Smiles, Dental Records, Medical Records, Transportation, and Nursing Care Plan Events at time of outreach. The Case Manager may direct the Coordinator Care Management to assist with requesting the dental and medical records and arranging transportation as needed. All events are to be completed on each case. The Case Manager is to outreach to the health plan to collaborate on member's care.

CM_2.1B.2_CM PP – Comprehensive Risk Assessment: CRA The Comprehensive Risk Assessment is a series of questions that gathers an in-depth dental and health risk profile. The Case Management Nurse uses the CRA to assign members a risk based on their individual care needs.
Care Management Outreach – Liberty's CM Nurse will conduct outreach to members that have been identified through the OHRA screening process or referred to CM with SHCN to complete a CRA.

Finding: During the audit period, the Plan did not ensure that initial screening and assessment were completed for SHCN and CSHCN members within 90 days of enrollment.

The Plan identifies potential SHCN and CSHCN members by using members' medical aid codes. However, although SHCN and CSHCN members were identified, many of these members were not assessed for medical and dental needs through the OHRA and through the Plan's own CRA, which is a series of questions that gathers an in-depth dental and health risk profile.

The Plan referred to the Oral Health Information Form as the "OHRA." During the audit period, the completion rate for the OHRA for all enrollees including SHCN and CSHCN members was 0.78 percent.

A verification study of four SHCN cases showed that two were late in collecting and following-up for the collection of OHRA forms. In the four files requested for CSHCN members, all four reviewed were late in collecting and following-up for the collection of OHRA forms.

The Plan confirmed during an interview that outreach to assist members in the completion of OHRAs was not done consistently, nor documented during the audit period. This is reflected in the OHRA completion rate for all members during the audit period being 0.78 percent.

When the Plan does not have a process for ensuring that SHCN and CSHCN members receive and complete an OHRA and CRA, it will not have the necessary information to conduct optimal case management and care coordination to address members' medical and dental needs.

Recommendation: Develop and implement a process to ensure the initial screening and assessment of members with SHCN and CSHCN.

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CATEGORY 4 – MEMBER'S RIGHTS	
4.1	**GRIEVANCE SYSTEM**

4.1.1 Governing Body Review of Grievance

The written record of grievances and appeals shall be reviewed periodically by the governing body of the DMC plan, the public policy body, and by an officer of the DMC plan or designee. The review shall be thoroughly documented.
(D-APL 20-003)

MR_4.1.1_GA PP – Grievance and Appeals Tracking and Reporting – California: The Grievance and Appeals Committee (GAC) will provide quarterly and annual reports to Liberty's Quality Management and Improvement Committee (QMIC) detailing the results of all analysis and actions taken for the indicated period.
The QMIC will provide quarterly reports to Liberty's Board of Directors.

Finding: The review of the written record of grievances was not thoroughly documented by the Plan's governing body of the DMC plan, the public policy body, and by an officer of the DMC plan or designee.

During the audit period, annual and quarterly reports and minutes from GAC, QMIC, and Board of Directors have only brief and non-specific documentation of metric data, grievance timeliness, and whether initiatives were implemented. However, there was no documentation of detailed analysis or of review of written grievance records, nor did, it include discussion of the details necessary to form conclusions, evaluation, and specific action to conduct quality improvement for the grievance systems.

Plan's P&Ps did not include language that required a process to thoroughly document the review of written records of grievances by Plan committees and governing bodies.

During an interview, the Plan stated the GAC and QMIC reviews data, trending reports, distribution of grievance types, and grievance and appeals reports. The Plan stated that committee members receive written reports and review them ahead of meetings. However, the Plan agreed that these activities and discussions were not documented in the minutes.

If the Plan doesn't document its review of the written record of grievances the department nor the Plan's oversight committees cannot properly oversee its grievance

quality review process.

RECOMMENDATION: Develop and implement a process to ensure the Plan's governing body, public policy and other Plan committees review and thoroughly document the periodic review of the written records of grievances.

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CATEGORY 5 – QUALITY MANAGEMENT	
5.1	**POTENTIAL QUALITY ISSUES**

5.1.1 Deferred Prior Authorizations

The Contractor shall integrate UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of grievances and appeals, denials, deferrals, and modifications to the appropriate QIS staff.
(Contract 12-89343 A17 and 13-90117 A14 LDP; Exhibit A, Attachment 7)

Contractor shall use the templates developed by DHCS in this attachment for submitting specific deliverables.
(Contract 12-89343 A17 and 13-90117 A14 LDP Exhibit A, Attachment 20

QI_5.1.A.QM PP –Department of Health Care Services Care Reporting –California:
LIBERTY will submit contractually required reports as indicated in Attachment 19 Deliverable Schedule, electronically to dmcdeliverables.dhcs.ca.gov as required by Contract.

Finding: The Plan did not have the necessary information to perform effective quality improvement on its UM activities, specifically its Treatment Authorization Requests (TAR system).

The number of deferred TAR was not captured, reviewed, or validated.

Treatment authorization documentation received from the Plan did not include data on prior authorization deferrals, nor dates of Notice of Delay (NOD) letter distribution.

The verification study reviewed seven files that exceeded the normal time requirement for Notice of Action distribution to members. All seven had NODs sent within zero to four days from date of receipt seeking additional information for radiographs and/or treatment plan. These verification study files showed evidence that the TARs were delayed, but the details of these delays (including whether they were delayed or not, and date of NOD distribution) were not tracked on the Plan's documentation nor in reports to Plan committees.

In addition, documentation reviewed by DHCS showed the Plan reported zero deferred

adult, child, and EPSDT member TARs to the DHCS during the audit period. During an interview, the Plan stated that the number of deferred TARs were not monitored by UM committee and were not reported up to QMIC and Board of Directors. In an email, the Plan stated that the team compiling UM data encountered an internal reporting error that caused the deferred TAR data to be left out of the monthly TAR reports that go to Plan committees and DHCS.

If the Plan does not have complete and accurate data of TARs, it will not be able to effectively evaluate, oversee, and perform quality improvement activity for its prior authorization process. This may cause delays in providing necessary services to members.

RECOMMENDATION: Implement a process to ensure the accuracy of TAR data including number and dates of approval, denials, deferrals, and modifications. This process should also include provisions to report data to Plan committees and to DHCS for review.