DEPARTMENT OF MANAGED HEALTH CARE HELP CENTER
DIVISION OF PLAN SURVEYS

AND THE

DEPARTMENT OF HEALTH CARE SERVICES MEDI-CAL DENTAL SERVICES DIVISION

FINAL REPORT
NON-ROUTINE SURVEY OF
LIBERTY DENTAL PLAN OF CALIFORNIA

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EXECUTIVE SUMMARY

In order to promote efficiency and avoid duplication of efforts, this Non-Routine Dental Survey of Liberty Dental Plan of California (“the Plan”) was conducted jointly by the Department of Managed Health Care (the “Department”) and the Department of Health Care Services (DHCS).

On March 9, 2012, the Department notified the Plan that a Non-Routine Dental Survey had commenced, and requested the Plan to submit information regarding its dental health delivery system. The survey team conducted the onsite portion of the survey from April 23, 2012, through April 25, 2012. The Department completed its investigatory phase and closed the survey on August 6, 2012.

ISSUE BACKGROUND

The California Department of Health Care Services contracts with four Geographic Managed Care (GMC) plans to provide dental services to Medi-Cal members in Sacramento County. The Department licenses the four GMC dental plans and is charged with enforcing the provisions of the Knox-Keene Health Care Service Plan Act of 1975 and the regulations issued under the authority of the Act. Liberty Dental Inc. Plan has a contract with the DHCS to provide dental services to Sacramento GMC members and is licensed by the Department.

In February of 2012, the Department was alerted to several media reports alleging that children in the Denti-Cal Program, receiving care in Sacramento County, were not obtaining services in a timely manner and were not receiving the appropriate level and quality of care for their dental needs. It was reported that in fiscal year 2010-2011, only 30.6 percent of Sacramento County children enrolled in a contracted managed care plan saw a dentist, compared with nearly half of the children receiving fee-for-service Medi-Cal statewide. Further, the articles alleged that children were experiencing long delays in receiving necessary dental care.

Title 28, California Code of Regulations section 1300.82.1(a)(2) allows the Department to conduct a Non-Routine Survey for good cause under Section 1382(b) when the Director has reason to believe the Plan has violated Section 1370. The nature of the allegations in the media reports if true, were likely violations of numerous provisions of the Act, including Section 1370, and contrary to provisions and requirements of the DHCS GMC Contract.

The Department, in coordination with the DHCS, determined that both departments would conduct an investigation of all four GMC dental plans contracting with DHCS and licensed by

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1 At the commencement of this Non-Routine Survey, the Department of Health Care Services contracted with five dental plans. However, as of June 1, 2011, Community Dental Services ceased operations and transferred enrollees to Liberty Dental Plan.

2 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.


the Department in order to assess the overall performance of the plans in providing dental care to members. The review concentrated on the Plan’s operational activities conducted for the time period of March 1, 2010, through February 29, 2012.

SCOPE OF SURVEY

The Department conducted a focused review of the issues presented in the media reports. The review included an examination of the Plan’s monitoring mechanisms for contracted providers, compiled encounter data, reports, policies, procedures, and standards in the following areas:

- Utilization Management
- Grievance and Appeals
- Timely Access to Care
- Quality of Care

The Department’s review also included an assessment of the Plan’s compliance with relevant provisions of the DHCS GMC Contract.

DEFICIENCIES

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

RECOMMENDATIONS

The Department’s review identified three recommendations during the Non-Routine Dental Survey.

QUALITY MANAGEMENT

Recommendation #1: Ensure that reports submitted for review to the Plan’s governing body are sufficiently detailed and accurately reflect the activities of the Plan’s various committees.

Statutory/Regulatory/Contract Reference(s): Section 1370; Rule 1300.70(a)(1); Rule 1300.70(b)(2)(C); DHCS GMC Contract 07-65805, Exhibit A, Attachment 4, Items 1 and 4

Assessment: A review of committee reports generated from the Plan’s committees showed that the reports lacked sufficient detail reflecting all of the activities conducted during meetings, and failed to provide a detailed description of how the committees arrived at conclusions. The Plan should ensure that committee minutes provide documentation of meaningful efforts undertaken by the Plan to improve quality of care provided to members and that the reports submitted for review to the Plan’s governing body are sufficiently detailed, as part of its Quality Assurance Program pursuant to Section 1370 and Rule 1300.70.

Section I of this Report contains a discussion of these deficiencies if any.
Health Care Impact: Committee minutes that reflect all of the quality assurance activities that are conducted by the Plan, and the governing body’s receipt of accurate and complete reports, are both essential for the Plan’s Quality Assurance Program to effectively assess the quality of care that is provided to members. Without detailed documentation of committee meeting minutes and reports, the Plan may not be able to ensure that potential quality issues are identified, addressed, and that appropriate follow-up is conducted in order to provide the best possible care to members.

UTILIZATION MANAGEMENT

Recommendation #2: Ensure that the Plan is receiving and reporting on accurate encounter data submitted from its provider network.

Statutory/Regulatory/Contract Reference(s): Section 1370; Rule 1300.70(a)(3); DHCS GMC Contract 07-65805, Exhibit A, Attachment 3, Management Information System, Items 1 and 2

Assessment: The Plan asserts that its utilization percentage for the reporting period is higher than the number reported by DHCS. Plan representatives described the various reasons why a discrepancy exists between the number reported by DHCS and the number reported by the Plan. The Act, Rules, and DHCS GMC Contract require that the Plan conduct continuous monitoring of the utilization of services at the provider level. The Plan should require providers to submit all monthly encounter data. The Plan should also ensure that it is submitting accurate and complete data to DHCS.

Health Care Impact: If the Plan receives incomplete encounter data from its provider network, the Plan may not accurately evaluate the utilization of services at each provider’s office, and may not be able to identify providers that are underperforming or withholding necessary care. This may lead to members’ under-utilizing care, and may detrimentally impact their overall dental health.

GRIEVANCE AND APPEALS

Recommendation #3: Revise the Provider Relations Provider Service Report template to include an assessment question regarding the availability of grievance forms in the provider office.

Statutory/Regulatory/Contract Reference(s): Rule 1300.68(b)(7); DHCS GMC Contract 07-65805, Exhibit A, Attachment 14, Item 1

Assessment: The Plan currently conducts provider office audits for its provider offices in Sacramento County. The Plan utilizes a review tool that contains assessment questions. A review of the assessment tool revealed that the tool does not contain a question regarding the availability of grievance forms in the provider office, nor does the tool assess the knowledge of the front office staff regarding the Plan’s grievance process.

The Plan should ensure that grievance forms are available to all members who want to file a complaint with the Plan as required by Rule 1300.68(b)(7) and the DHCS GMC Contract. Because the provider office can be the first point of contact for the member,
the Plan should ensure, through its auditing tool, that grievance forms are available for members at provider offices, and that the provider office staff possess the knowledge to assist members in filing grievances with the Plan.

**Health Care Impact:** GMC members may not know or understand that they have the ability to file a grievance with their assigned plan. Members may experience dissatisfaction at the provider level and may want to fill out a grievance form at the provider office. If the Plan does not ensure that its provider offices have the forms available, and that provider office staff are aware of the Plan’s grievance process, members may not be able to effectively access and utilize the Plan’s grievance process.

**CONTRACT FINDINGS**

The Department’s review identified **three** Contract Findings.

**Contract Finding #1:** The Plan does not have a formal documented process or methodology that evaluates the effectiveness of its Dental Health Program for GMC members.

**Contract Reference(s):** DHCS GMC Contract 07-65805, Exhibit A, Attachment 10, Items 7-A-5 and 7-A-6

**Assessment:** Although the Plan conducts numerous outreach efforts directed at its GMC members, the Plan does not evaluate the effectiveness of its programs or initiatives as required by the DHCS contract. The Plan should evaluate and assess the impact of its outreach efforts for increasing utilization in order to ensure that its efforts are effective in accomplishing the Plan’s stated goals. Specifically, the Plan should measure if its efforts to increase utilization through various methods are in fact increasing member use of dental services.

**Health Care Impact:** Without conducting appropriate analysis with measured results on the effectiveness of the Plan’s programs or initiatives, the Plan may not be able to identify ineffective programs or determine potential issues with its initiatives. This may lead to members being overlooked or ineffectively served by the Plan’s outreach efforts.

**Contract Finding #2:** The Plan does not have a formal policy that specifies all of the member education activities conducted by the Plan for GMC members.

**Contract Reference(s):** DHCS GMC Contract 07-65805, Exhibit A, Attachment 10, Item 7-A

**Assessment:** The Department’s review revealed that although the Plan does provide member education to its members through its contracted providers and through educational materials in the provider offices, the Plan lacks a formal education policy that specifically targets the GMC members as required by the DHCS GMC contract.

**Health Care Impact:** The Plan should ensure that its Member Education Program is formally documented and contains all of the elements required in the DHCS GMC
Contract. Formal documentation will assist the Plan in ensuring it is meeting its obligations in providing member educational services to GMC members.

**Contract Finding #3:** A review of the Plan’s utilization management template letters revealed that the letters are not written at a sixth-grade reading level.

**Contract Reference(s):** DHCS GMC Contract 07-65805, Exhibit A, Attachment 4, Quality Improvement System, Item 6-A and Exhibit A, Attachment 13 Member Services, Item 4-C

**Assessment:** The Department conducted a review of the Plan’s utilization management letter templates. The letters are not written at a sixth-grade reading level as required by the DHCS GMC Contract.

**Health Care Impact:** The Plan must ensure that written material is provided to members in a clear and understandable manner. Letters that contain technical language may hinder a member’s ability to make informed choices regarding their dental care.

**PLAN’S EFFORTS TO ADDRESS DHCS IMMEDIATE ACTION ITEMS**

On March 7, 2012, the Director of the DHCS, Toby Douglas, sent a letter to the dental plans participating in the Sacramento GMC Program asking that the plans commit to increasing utilization and ensuring timely access to services. Liberty Dental, Inc. responded by providing the following list of activities:

- **Beneficiary Letter:** In July of 2011, the Plan sent educational letters and informational flyers to members ages 0-21. The information met the requirements specified in the Immediate Action Items letter.

- **Phone Call Campaign:** The Plan completed outbound outreach campaigns to all members in the GMC Program ages 0-21 who did not have a dental appointment within the last six months. Liberty representatives attempted to make appointments for members through a three way transfer to a provider office or through a direct transfer.

- **Provider Education Seminars:** The Plan met with all of the Sacramento providers in person several times during 2012 to inform them of program changes, Medi-Cal dental policies and member benefits, and to stress the importance of treating members by their first birthday or by the time their first tooth erupts.

- **Pay for Performance and Provider Withhold:** The Plan has a pay for performance program that encourages providers to provide appropriate care to GMC members. The Plan is tracking provider encounter data monthly and has included utilization targets to their criteria when determining whether to halt enrollment to a particular provider office.

- **Issue Resolution:** The Plan has a specialized business unit within its Member Services Department in order to ensure that member and provider complaints receive immediate attention, and that follow-up of the complaint is monitored until a resolution is achieved.
• Increased Provider and Specialist Enrollment: The Plan enhanced its own independently contracted provider network by reaching out to and contracting with additional general providers, specialists and available FQHCs.

• Specialty Referral Process: The Plan is currently working closely with the other health plans and the DHCS to develop a streamlined referral process.

• Added a procedure code to increase utilization in children 0-3: The Plan added ‘Oral Evaluation for a Patient Three Years of Age and Counseling with Primary Caregiver’ to the Plan’s fee-for-service payment schedule with an enhanced reimbursement of $100.

• Hybrid Reimbursement Model: The Plan pays 100% of the GMC network providers at least a $4.00 per member per month capitation rate and a fee-for-service reimbursement for common procedures in order to increase utilization.

In addition to the activities above, the Plan has been collaborating with the DHCS and the stakeholder community group in order to better serve the Plan’s GMC membership.
The Department evaluates each health care service plan licensed pursuant to the Act. As authorized by Section 1380(c) of the Act, surveys performed pursuant to this section shall be conducted as often as deemed necessary by the Director to assure the protection of subscribers and enrollees.

This Non-Routine survey was limited to a review of the four managed dental care plans that have contracts with DHCS to provide dental services to Denti-Cal enrollees in Sacramento County. The Department’s review was limited to the issues presented in media reports. The Department evaluated the Plan’s monitoring mechanisms for contracted providers, compiled encounter data, reports, policies, procedures, and standards in the following areas:

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

**Grievance and Appeals** – The Plan is required to have compliant processes for resolving Member complaint/grievances in a professional, fair, and expeditious manner.

**Timely Access to Care** – The Plan is required to ensure that its services are accessible and available to GMC enrollees throughout its Sacramento service area and within reasonable timeframes. The Plan is required to monitor Primary Dentist assignment.

**Quality Management** – The Plan is required to assess and improve the quality of care it provides to enrollees.
The Department’s review also encompassed relevant DHCS GMC contract provisions including but not limited to: Quality Management, Member Rights, Access and Availability, Utilization Management and Member Education.

The Preliminary Report was issued to the Plan on October 25, 2012. 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. The Plan has an opportunity to review the Final Report and file a response with the Department prior to the Department issuing the Final Report and making the Final Report public.

This Final Report addresses the Non-Routine Survey of the Plan, which commenced on March 9, 2012, and closed on August 6, 2012.

**PLAN BACKGROUND**

Liberty Dental Plan of California, Inc. ("Liberty or “the Plan”) is a specialized health care service plan headquartered in Irvine, California. The Plan’s parent affiliate is Liberty Dental Plan Corporation (“the Parent”). The Parent obtained a Knox-Keene license when it acquired all the assets of Preferred Health Plans, Inc., on December 27, 2001. Preferred Health Plans, Inc. had previously received its Knox-Keene license August 3, 1978. The Plan is a for-profit dental benefit corporation. The Parent contracts with other health Plans, including GMC Dental Plan, Health Net Dental Plan, and other entities located outside of California. The Plan entered into the Sacramento Geographic Managed Care Dental (“GMC”) Program in May 2005.

The Plan contracts with 45 independent primary care dental locations and 79 specialty dentists located throughout Sacramento County. The primary care dentists (“PCD”) are paid a monthly capitation in addition to fee-for-service reimbursement for certain procedures. Non-contracted and specialty providers are paid on a fee-for-service basis or discounted Denti-Cal rates.

As of second quarter 2012, the Plan reported an enrollee population of 762,390, including 323,365 commercial enrollees. Enrollment also includes 163,159 Healthy Families, 115,390 Medicare Risk, and 160,476 Medi-Cal Risk members. The Department of Health Care Services reported the Plan was assigned 39,063 Sacramento Geographic Managed Care Dental members with 25,902 children under age 21.
SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

Within the scope of this Non-Routine Survey, the Department did not identify any Knox Keene deficiencies in the Plan’s operations.
In accordance with Section 1380(g), Department analysts offer advice and assistance to the Plan in the form of recommendations. Although a response to identified recommendations is not statutorily required, it is highly advised. These recommendations are not a statement of current Plan deficiencies. Recommendations are intended to alert the Plan to weaknesses in its operations or systems that have the potential to become deficiencies in the future. The Plan should review and evaluate recommendations, and take action as appropriate.

**QUALITY MANAGEMENT**

**Recommendation #1:** Ensure that reports submitted for review to the Plan’s governing body are sufficiently detailed and accurately reflect the activities of the various committees.

**Statutory/Regulatory/Contract Reference(s):** Section 1370; Rule 1300.70(a)(1); Rule 1300.70(b)(2)(C); DHCS GMC Contract 07-65805, Exhibit A, Attachment 4, Items 1 and 4

**Assessment:** The Department’s review included interviews with Plan representatives and a review of applicable policies and procedures. The Plan engages in thorough and consistent activities for overall quality improvement. However, a review of the Access and Availability Committee minutes showed that although grievance reports indicated there was a continuous upward trend in access grievances for the GMC population during the review period, the reports lacked discussion and indications of follow-up of the identified trend. Further, the Plan’s quality improvement reports did not include detailed descriptions of how the Plan arrived at specific conclusions.

Section 1370 and Rule 1300.70 require that plans continuously monitor the quality of care that is provided to enrollees and provide sufficient and detailed documentation of problems that are identified, action(s) taken to improve deficiencies, and that follow-up is planned where indicated, as part of its Quality Assurance Program. The DHCS GMC Contract requires that activities, findings, recommendations, and actions of the committees be reported to the governing body in writing. Without ensuring that all quality assurance activities are documented in committee minutes, and ensuring that reports to the Plan’s governing body are sufficiently detailed to include findings and actions taken as a result of the Quality Assurance Program, the Plan may not fully comply with the Act, the Rules, and the contract.

**Process or System Issues that Should Be Addressed:** The Plan should ensure that committee minutes are sufficiently detailed enough to show that the Plan does engage in significant quality improvement activities. The minutes should outline how the Plan identified issues, addressed the issues, and conducted follow-up. Detailed and specific minutes and reports ensure that the Plan is meeting all the requirements of the Act, the Rules, and the DHCS GMC Contract.

**Plan’s Response to Identified Recommendation:** The Plan stated that it has updated its minute taking to show more detail including distinct action items and detailed follow-up. Going forward, the Plan explained that it will be able to demonstrate that all quality activities fully comply with all contractual and regulatory requirements. The Plan’s response included copies of recently updated committee meeting minutes.


Recommendation #2: Ensure that the Plan is receiving and reporting accurate encounter data from its provider network.

Statutory/Regulatory/Contract Reference(s): Section 1370; Rule 1300.70(a)(3); DHCS GMC Contract 07-65805, Exhibit A, Attachment 3, Management Information System, Items 1 and 2

Assessment: Plan representatives indicated that utilization for the Sacramento GMC population was higher than reported by DHCS during the survey reporting period. DHCS reported the Plan’s utilization rate at 37.5%, while the Plan represents that member utilization rate for the reporting period was closer to 40%.

Plan representatives stated that various factors could lead to the discrepancy between the encounter data reported by DHCS for the reporting period and the Plan’s internal encounter data. Factors leading to differences in utilization numbers between the Plan and DHCS include but are not limited to: providers without electronic encounter reporting means may not report all encounters, providers may submit encounter data after the reporting due date, member ineligibility for the month of service, and provider rendering numbers missing from the submitted information.

Although the Plan discussed this issue with the Department and DHCS, the Plan could not provide the actual percentage of encounters that are either not processed or not reported to either the Plan or DHCS. In order to ensure that the Plan is adequately monitoring utilization occurring at its provider network level, it must be able to accurately account for all utilization. The Plan should develop a process and/or procedure that tracks all of the encounters that are not reported to DHCS.

Section 1370, Rule 1300.70(a)(3), and the DHCS contract all require that the Plan continuously review utilization of services. Here, the Plan could not provide documentation accounting for the discrepancy between the encounter data reported to DHCS and the Plan’s internal encounter data, even though Plan representatives are aware that possible causes for discrepancies exist.

Process or System Issues that Should Be Addressed: Plan Utilization Management Report Summaries for the reporting period indicate that the Plan is aware of providers who do not submit utilization data. The Reports also show that the Plan does continuously encourage and counsel providers when it becomes aware of providers who do not submit data. If the Plan has knowledge that providers are not submitting utilization data to the Plan or if the Plan is aware that not all monthly utilization is being reported to DHCS, then it should develop a system to ensure that: 1) it is receiving timely and accurate utilization data from its provider network, and 2) it is submitting accurate and complete data to DHCS. The Plan should also incorporate into its management information system a process that accounts for the encounter data that is not reported by the provider network and the various reasons why, so that the Plan is fully aware of the utilization of services by members.

Plan’s Response to Identified Recommendation: In its response, the Plan stated that it worked diligently with individuals at the Department of Health Care Services (DHCS), including the DHCS dental consultant, over the past two years, to reconcile the technical specifications and
formulas used to calculate utilization percentages and all other quality measures. As a result, the Plan stated that the collaborative effort has allowed the Plan and the DHCS to report utilization percentages that are close to identical. The Plan reported that it will continue to work with the DHCS to ensure the technical specifications and formulas used to calculate utilization percentages are identical and reported numbers are consistent.

GRIEVANCE AND APPEALS

Recommendation #3: Revise the Provider Relations Provider Service Report template to include an assessment question regarding the availability of grievance forms in the provider office.

Statutory/Regulatory/Contract Reference(s): Rule 1300.68(b)(7); DHCS GMC Contract 07-65805, Exhibit A, Attachment 14, Item 1

Assessment: Rule 1300.68(b)(7) requires Plans to ensure that grievance forms and a description of the grievance procedure are readily available at each contracting provider's office or facility and that grievance forms are provided promptly upon request.

The Plan conducts provider site visits and utilizes its audit tool, Provider Relations Provider Service Reports, to confirm facility compliance with several elements, such as appointment availability, reason for visit, office changes, and languages spoken. However, this audit tool, used by the Plan’s Provider Relations Representatives, does not evaluate if contracted dental office staff can direct members to the Plan’s grievance process or if the provider offices have grievance forms readily available. Without incorporation of elements in the audit tool to determine if grievance forms and descriptions of the grievance procedure are readily available at provider offices, or that provider office staff are knowledgeable of the Plan’s grievance process, the Plan may not ensure that the Plan and its providers are compliant with Rule 1300.68(b)(7).

Process or System Issues that Should Be Addressed: The Plan should incorporate into its provider audit tool questions that address whether or not facility staff are aware of the Plan’s grievance procedure and whether or not the provider office has grievance forms readily available.

Plan’s Response to Identified Recommendation: The Plan updated the Provider Service Report template to ensure that providers are more fully instructed on how to assist a member in filing a grievance if necessary. The Plan stated that it will also check and ensure that provider grievance forms are available in the provider offices. The Plan submitted its updated provider service report for the Department’s review.
SECTION III: DISCUSSION CONTRACT FINDINGS AND CURRENT STATUS

The Department’s review identified specific Contract Findings in particular survey areas. The Plan was required to review and evaluate the Department’s findings and provide corrective action within 45 days of the issuance of the Preliminary Report. The following discussion summarizes the Plan’s compliance effort and the Department’s finding concerning the Plan’s response.

The Department identified three Contract Findings.

MEMBER EDUCATION

Contract Finding #1: The Plan does not have a formal documented process or methodology that evaluates the effectiveness of its Dental Health Program for GMC members.


Assessment: For at least three years, the Plan has conducted a variety of outreach efforts. The Plan’s Provider Relations staff and Dental Director routinely visit contracted provider offices and send mass faxed newsletters and updates to promote the Plan’s dental health initiatives. The Plan also mails quarterly newsletters and conducts outbound call campaigns to its GMC members to encourage utilization of dental services. However, the Plan has no formal process in place to strategically evaluate the impact of these campaigns, specifically whether the Plan’s efforts meet its objectives to improve the GMC member access to and utilization of dental services as required by the GMC Contract.

Process or System Issues that Should Be Addressed: The policy should include methods for meeting all of the requirements articulated in the DHCS GMC Contract 07-65805, Exhibit A, Attachment 10, such as conducting “appropriate levels of evaluation, e.g. formative, process, impact and outcome evaluation, to ensure access, availability and effectiveness in achieving Dental Health Education Program goals and objectives.” The Plan should incorporate tracking measures into their Outreach Program such as maintaining a log of the members contacted, the number of calls resulting in an appointment, and the number of kept appointments. The knowledge gained from measuring program effectiveness allows the Plan to allocate its resources where they are most effective or most needed.

Plan’s Compliance Effort: The Plan acknowledged that while it conducts various Dental Health Programs, these Programs are not formally documented in appropriate detail in the Plan’s meeting minutes. As a result, the Plan stated that it will document its outreach efforts on a quarterly basis through its Quality Management Committee meetings. The Plan will document its methodology and the effectiveness of outreach activities which include the number of calls and contacts made, the result of such calls and contacts and will include the utilization results of such calls and contacts. The Plan explained that it would document analyses of the results to measure
the effectiveness of these Programs and also document appropriate program adjustments. The Plan provided a copy of its written Health Education Program.

**STATUS: NOT CORRECTED**

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

The Department reviewed the Plan’s submitted written 2012 Health Education Program Policy, which conforms to the requirements of the DHCS GMC contract. However, the Department will need to verify, through follow-up, that the Plan is documenting and evaluating its outreach and member education activities as proposed in the Plan’s corrective action. The Department will review the Plan’s compliance with this contract requirement after the first quarter of 2013

**Contract Finding #2:** The Plan does not have a formal policy that specifies all of the member education activities conducted by the Plan for GMC members.

**Contract Reference(s):** DHCS GMC Contract 07-65805, Exhibit A, Attachment 10, Item 7-A

**Assessment:** The Plan is currently conducting numerous activities to educate GMC members on dental health. During the onsite survey and review of the Plan’s submitted materials, the Department found that the Plan provides health education to members through the Plan’s contracted providers and through information distributed by the Plan’s Provider Relations representatives to provider facilities. The Plan communicates its initiatives to its network providers through mass faxes and quarterly newsletters. The Plan also reaches out to GMC members directly by conducting outreach call campaigns and member surveys. Upon request, the Plan also arranges for transportation at no cost to the member.

Although the Plan has a general policy, “Liberty Dental Health Education Program, 2012,” that discusses how the Plan educates its members, the Department found it unclear from the policy how often the Plan targets the GMC population in its member outreach/education. The DHCS GMC Contract 07-65805 requires that the Plan specify, in writing, how it provides an organized delivery of Dental Health Education Programs to GMC members, and how it evaluates those efforts. The Plan’s policy did not state how it provides resource information or educational materials to providers in order to enable providers to educate members at the time of visits. Further, the Plan’s policy did not state how it assists providers in developing and delivering culturally and linguistically appropriate services. The Plan is also required to assist providers in assuring members who are low-literate, illiterate, and visually and hearing impaired receive material and assistance in a suitable format; however, the Plan did not provide evidence to show how it does so.

**Process or System Issues that Should Be Addressed:** The Plan should revise its policy to describe the Plan’s current member outreach and education activities specific to the GMC population. The Plan should also implement a formal policy that discusses how it meets all of the requirements described in the GMC Contract 07-65805 Health Education for Members section.
Plan’s Compliance Effort: The Plan provided its updated Health Education Program that now includes all the outreach activities that the Plan conducts on a regular basis. In addition, the Health Education Program was updated to include information on how providers may educate members concerning the delivery of cultural and linguistic services as well as appropriate health education to assist members with illiteracy or other challenges.

STATUS: CORRECTED

Based upon the corrective actions undertaken, the Department has determined that this finding has been fully corrected.

The Department’s review of the Plan’s Health Education Policy confirmed that the Plan’s policy now contains the necessary elements provided for in the DHCS GMC Contract.

MEMBER WRITTEN MATERIALS

Contract Finding #3: A review of the Plan’s utilization management template letters revealed that the letters are not written at a sixth-grade reading level.

Contract Reference(s): DHCS GMC Contract 07-65805, Exhibit A, Attachment 4, Quality Improvement System, Item 6-A and Exhibit A, Attachment 13 Member Services, Item 4-C

Assessment: The DHCS GMC Contract 07-65805 requires that the Plan provide written material to GMC members that are written at a sixth-grade reading level. The purpose of the requirement is to ensure that members understand the services that are covered by the Plan and the processes that the Plan follows in making decisions, and to ensure members have clear information that enables them to make informed choices regarding their dental care.

A review of utilization management letter templates revealed that the letters were not written at the sixth-grade reading level as required by the DHCS GMC Contract.

Relevant Case Summaries: The Department utilized the Flesch-Kincaid Grade Level Readability Test function to evaluate the Plan’s delegate Utilization Management letter templates. The Department removed the required statutory language in the letter before conducting the analysis. The results indicated that the letter templates communicating the Plan’s decisions to modify or deny a member’s request for services, and its template indicating the need to delay decisions, are written above a sixth-grade level.

- The denial letter template is written at a 13.8th grade reading level.
- The modification letter template is written at a 12.4th grade level.
- The letter template communicating a delay in decision-making is written at a 11.4th grade level.

Process or System Issues that Should Be Addressed: The Plan should reevaluate and rewrite their utilization management template letters that are sent to members, and ensure that all written material provided to GMC members meets the sixth-grade reading level requirement.
Plan’s Compliance Effort: The Plan submitted four revised template letter forms. The Plan stated that it checked the letters for Flesch-Kincaid grade level readability and that the letters met the sixth grade reading level with the exception of language required by regulation, which cannot be changed.

Department’s Finding Concerning Plan’s Compliance Effort:

STATUS: CORRECTED

Based upon the corrective actions undertaken, the Department has determined that this finding has been fully corrected.

The Department reviewed three of the Plan’s revised letters using the Flesch-Kincaid Grade Level Readability tool and confirmed the following:

- The updated denial letter template is written at a 5.9th grade reading level.
- The modification letter template is written at a 6.1th grade level.
- The letter template communicating a delay in decision-making (NOA) is written at a 4.9th grade level.
SECTION III: SURVEY CONCLUSION

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, 2012 Routine Dental Survey - Document Request.
- Submit the response to the Final Report via the “DMHC Communication” tab.