

Beneficiary Letter

Description: Plans are expected to develop and distribute a beneficiary letter that provides information on the benefits available, a short narrative on the importance of dental care for children, and information on their assigned primary care dentist, including office location and telephone number. The letter should also include the plan's contact information as well as contact information for Medi-Cal Dental Managed Care. It is expected that the plans send two separate letters for the 0-5 year old members and the 6-21 year old members. The 0-5 year old letter should be developed and worked on in coordination with First 5.

Task	Target Start Date	Target Completion Date	Responsible	Status
Letter to families of 6 to 21 year olds	20120228	20120316	Premier Access Customer Service	Completed
Develop draft letter for comment targeted for families with children ages 0 to 5	20120315	20120319	Premier Access Plan Administration	Completed
Plans to develop one letter in collaboration with First 5	20120322	20120402	All Plans/ DHCS/ Sacramento First 5	Robin Muck - Plan lead
Finalize letter content for families with children ages 0 to 5	20120402	20120410	Premier Access Plan Administration	Target Completion Date to be developed/adjusted with the collaboration
Mail first batch - 0 to 5 letter	20120410	20120415	Premier Access Customer Service	Pending
Mail second batch - 0 to 5 letter	20120415	20120422	Premier Access Customer Service	Pending
Mail third batch - 0 to 5 letter	20120422	20120429	Premier Access Customer Service	Pending
Mail fourth batch - 0 to 5 letter	20120429	20120504	Premier Access Customer Service	Pending
Evaluation of metrics related to calls, appointments, and other follow up to beneficiary letter(s)	20120515	20120602	Premier Access Customer Service	Pending

Phone Call Campaign

Plans are expected to conduct a phone call campaign that will involve making a phone call to beneficiaries who have not been seen by their primary care dentist in the last year. The purpose of the call will be to set up an appointment for the beneficiary with their primary care dentist. In addition, the beneficiary should be educated on their right to timely access to care and what to do in situations where the beneficiary is having trouble accessing services. All call results should be tracked, i.e., successful calls, appointments set, appointments kept, etc. All results are to be submitted to Medi-Cal Dental Services Division (MDSD) based on the date designated in your implementation plan.

Task	Target Start Date	Target Completion Date	Responsible	Status
Identify initial list of members ages 0 to 20.99 years that have not been seen in last 12 months and phone numbers	20120314	20120315	Premier Access QI Manager	Completed
Identify phone call campaign resources and scripting	20120314	20120330	Premier Access Customer Service	In Process
Phase I - Initiate family phone calls to families with children ages 0 to 3.99	20120402	20120515	Premier Access Customer Service	
Phase II - Continue first contact family phone calls to families with children ages 0 to 3.99 years based on updated registries; Initiate family phone calls to families with children 4 to 6.99	20120521	20120615	Premier Access Customer Service	
Phase III - Continue first contact family phone calls to families with children ages 0 to 6.99 based on updated registries; Initiate phone calls to families with children 7 to 12.99 years	20120702	20120716	Premier Access Customer Service	
Phase IV - Continue first contact family phone calls to families with children ages 0 to 12.99 based on updated registries; Initiate phone calls to families with children 13 to 20.99	20120802	201201015	Premier Access Customer Service	
Continue first contact family phone calls based on updated registries	20121101	20121231	Premier Access Customer Service	
Ongoing metrics: Completed calls, appointments scheduled, and appointment follow up, including overall 2012 assessment, evaluation and identification of outcomes	20120402	20121231	Premier Access Customer Service and Quality Management	

Issue Resolution Reporting

Plans are expected to have an issue resolution process when their Member Services line receives Medi-Cal Dental Managed Care beneficiary phone calls. The resolution process is expected to help solve problems from a neutral standpoint to ensure that members receive all necessary covered services for which plans are contractually responsible. It is expected that all Member Services phone calls are investigated if related to complaints and are expeditiously resolved. The issue resolution process is expected to be able to identify systemic issues leading to poor service or breaches of the beneficiaries' rights. Plans are expected to submit to MDSO their issue resolution processes.

Task	Target Start Date	Target Completion Date	Responsible	Status
Submit descriptions of grievance resolution process , corrective action, and related policies and procedures to the DHCS	20120314	20120321	Premier Access Compliance/ Plan Administration	Completed

Informational Flyer

Plans are expected to work together to develop an informational flyer that can be distributed to plan members, advocates and community programs by the Department and DMC plans. The purpose of the flyer is to keep the flow of information continual and consistent to all avenues. It has come to MDSO's attention that many of the members and advocates are not given the information to properly redirect the beneficiaries back to the Department or plans for resolution. This flyer will be a constant stream of information to all beneficiaries, stakeholders, advocates and community programs.

This informational flyer shall be written from the standpoint of the beneficiary enrolled in a DMC Plan, and should include the following contact information: 1. Dental Plan (including grievance contact), 2. Plan and DHCS Ombudsman, and 3) HCO. Each contact should include: 1. Phone number and 2. A short description of the reasons you would call the number. This information shall be distributed via mail and/or email, to plan members, stakeholders, advocates, providers, throughout county community service programs, and any other entities that perform public services.

Task	Target Start Date	Target Completion Date	Responsible	Status
Identify Premier Access Ombudsman	20120301	20120314	Premier Access	Corina Lena
Identify Premier Access plan participant(s) for the Plan work group	20120314	20120314	Premier Access	Terri Abbaszadeh, Rene Canales
Identify Plan collaboration contact	20120314	20130315	Premier Access	Western Dental
Initiate collection of sample informational flyer material for Plans discussion	20120314	20120316	Premier Access Compliance/ Plan Administration	Propose initial discussion on CHIP collaboration informational flyer
Remaining work plan items are to be established based on the Plan collaboration	20120402	20120410	Premier Access Compliance/ Plan Administration	Target completion dates to be adjusted based on collaboration/ work group

Utilization Control with Enrollment

Plans are expected to review provider encounter data to identify beneficiaries that have not been seen in their dental office in a year. Plans are expected to halt all new enrollments for a provider who does not meet certain thresholds of utilization.

Task	Target Start Date	Target Completion Date	Responsible	Status
Initiate GMC provider/ facility utilization report cards	2011	201201	Premier Access Utilization Management/ Provider Relations	Launched utilization metrics and pay for performance initiative
Communicate baseline performance status to each facility and minimum standards for utilization metrics and corrective action points	2011	201201	Premier Access Utilization Management/ Provider Relations	Completed
Provide current registries by facility of members ages 0 to 20.99 that have not been seen in the last 12 months to each facility (quarterly)	20120415	Ongoing	Premier Access Utilization Management/ Provider Relations	
Identify and initiate corrective action with any providers below minimum monthly performance threshold of 4% target, including counseling and/or closure to new members pending demonstrated increased utilization (monthly)	20120415	Ongoing	Premier Access Utilization Management/ Provider Relations	

Education Seminars

Plans are expected to conduct educational seminars for both providers and providers' staff. Plans are expected to educate their provider community because it has come to the attention of the department that some providers are not in line with all Medi-Cal Dental policies. In addition, because of the low utilization DHCS wants to ensure providers are aware of the requirements to treat assigned members.

Seminars are expected to include at a minimum knowledge of what is covered in the beneficiary evidence of coverage, submitting encounter data, and what incentive programs that [are] available. Providers shall be aware of procedures that are covered under the Denti-Cal Manual of Criteria, as well as where to locate information about benefits, (i.e., Denti-Cal website). Plan should submit copies of materials and the schedule of seminars to DHCS.

Task	Target Start Date	Target Completion Date	Responsible	Status
One on one general dentist facility visits to address immediate concerns and program expectations	20120201	201203	Provider Relations	Completed
One on one specialist facility visits to address immediate concerns and program expectations	20120301	20120406	Provider Relations	In process
Develop Focused Training Agenda for refresh curriculum, including CDT transition/ program updates to be effective 4/2, risk assessment tool, periodicity, referral and pre-authorization processes, and reinforcement of 1st birthday initiative	20120314	20120330	Premier Access UM, QM, and Compliance/ Plan Administration, Provider Relations	In process
Prepare and Submit materials and seminar/ training schedule/ metrics to DHCS	20120328	20120330	Premier Access Compliance/ Plan Administration	In process
Initiate one on one facility training schedules for providers and provider staff regarding 4/2 Denti-Cal Provider Manual updates	20120402	20120416	Premier Access Provider Relations	
Schedule seminar event/ lunch and learn for providers' staff to be held in April to address Denti-Cal program updates	20120402	20120430	Premier Access Provider Relations, QM	
Roll out first three continuing education provider training modules for general dentists treating pediatric patients	20120601	20120629	Premier Access Provider Relations, QM	
Schedule seminar event/ continuing education for general dentists treating pediatric patients (UTHSC/ Dr. Donnelly)	20120701	20120815	Premier Access Provider Relations, QM	
Roll out remaining 5 provider training modules focused on general dentists treating pediatric patients as they are completed	20120801	20121001	Premier Access Provider Relations, QM	

Pay to Perform

Plans are expected to develop an incentive program for providers. Performance measures should be defined by the Plan, and based on the percentage of your assigned members that actually receive services. Plans should include in the incentive program a specific measure for preventative services. The program should apply to all enrolled Medi-Cal children (ages 0 to 21 years) assigned to the Plan.

Task	Target Start Date	Target Completion Date	Responsible	Status
Launch Pay for Performance (P4P) initiative in GMC program focused on Annual Dental Visit HEDIS performance metrics	2011	201201	Premier Access Utilization Management/ Quality Management	Completed
Update Pay for Performance (P4P) initiative to include preventive services metrics	20120321	20120601	Premier Access Utilization Management/ Quality Management	In process
Ongoing quarterly measurement, reporting, and corrective actions	20120620	Ongoing	Premier Access Utilization Management/ Quality Management, Provider Relations	

Withholds on Provider Payments

Plans are expected to implement withholds from providers in association with the minimum thresholds for utilization established by the plan. Plans are expected to take preventive services into consideration. The withhold mechanism placed on provider payments should be substantial enough to incentivize providers to submit timely and accurate encounter data in order to ensure complete utilization data.

Task	Target Start Date	Target Completion Date	Responsible	Status
Develop withhold program, including identification of thresholds, reconciliation process, policies and procedures, contract updates	20120314	20120715	Premier Access Utilization Management/ Quality Management, Compliance/ Plan Administration	In process
Launch updated withhold strategy with 2nd Quarter assessment facility level report card	20120314	20120731	Premier Access Utilization Management/ Quality Management, Provider Relations	In process

Federally Qualified Health Centers

Plans should conduct concentrated outreach to Federally Qualified Health Centers (FQHCs) and work to enroll them as providers in order to partner together to ensure access to services for plan members. Plans should also ensure that enrollment capacities of the FQHCs are capitalized. Number of FQHCs with enrollment and utilization data should be reported to MDSD separately for tracking.

Task	Target Start Date	Target Completion Date	Responsible	Status
Initiate recruitment outreach	20120401	20120531	Premier Access Provider Relations	
Establish reporting schedule, elements, and initiate reporting to DHCS of FQHCs assignment and utilization	20120401	Ongoing - TBD	Premier Access Plan Administration	

Timely Access Reports

Plans are expected to submit annual timely access reports. Please submit with your implementation plans the last annual timely access report completed by your plan. From then moving forward, please submit this report on an ongoing annual basis.

Task	Target Start Date	Target Completion Date	Responsible	Status
Submit November Annual review assessment	20120314	20120321	Premier Access Plan Administration	In process
Identify annual reporting deliverable date, update calendaring and report annually ongoing	20120314	Ongoing	Premier Access Plan Administration	In process

Increase Provider and Specialist Enrollment

Plans and the Department will work together to establish credentialing criteria that will be used by plans to enroll potential providers without enrolling into the fee for service program as well as work on the Encounter Data file edits that reject data with un-enrolled providers. In addition, plans should create an outreach campaign to increase provider and specialist enrollment into the DMC program.

Task	Target Start Date	Target Completion Date	Responsible	Status
Recruitment initiative, including orientation material development	20120201	20120402	Premier Access UM, QM, and Compliance/ Plan Administration, Provider Relations	In process
Submit credentialing/ recredentialing policies and procedures to DHCS	20120321	20120321	Premier Access Plan Administration	In process
Identify process improvement opportunities for Encounter Data file edits that reject data with un-enrolled providers	20120321	20120430	Premier Access CQI, IS	In process
Coordinate outreach with existing recruitment initiatives (cross reference other work plans) and educational seminar development	20120321	20120430 and ongoing	Premier Access Provider Relations, Plan Administration, and Compliance	In process

Specialty Referral Processes

Each plan is expected to work with the Department and other plans to develop a streamlined specialty referral process that will be uniform across all DMC plans. Plans are expected to submit their established specialty referral process to the Department with the implementation plan.

Task	Target Start Date	Target Completion Date	Responsible	Status
Submit existing specialty referral policies and procedures with implementation plan	20120314	20120321	Premier Access Plan Administration	In Process
Identify the plan contacts that will work in collaboration	20120314	20120321	Premier Access Plan Administration	Terri Abbaszadeh, Rene Canales, Dr. Baker
Identify the work group collaboration process and participate	20120314	20120321	Premier Access Plan Administration	
Remaining steps to be established based on collaboration process	20120314	20120402	Premier Access Plan Administration	

QUALITY MANAGEMENT PROGRAM ANNUAL EVALUATION

November 4, 2011

The Quality Management Program includes quality management activities related to government programs and managed care plans offered through Premier Access Insurance Company and Access Dental Plan. Premier Access Insurance Company and Access Dental Plan are collectively referred to as "Premier Access" within this document.

Overview

- QMC quarterly meetings were held, minutes were completed and reported to the Board of Directors, and to related programs/ clients, as required.
- Internal organizational improvements have resulted in changes to staff positions and responsibilities that need to be integrated into the QMP description and policies and procedures.
- Premier Access has completed significant development related to performance metrics processes and identification of key performance indicators for monitoring that need to be integrated into the related policies and procedures.
- Expansion of government programs and managed care plans into additional states have added dimensions to the policies and procedures, both applicability and scope, that need to be updated in the related documents.
- Through 3rd Quarter 2011, Premier Access membership in government programs and managed care plans has increased 2% over 2010 year end membership, for total membership of 425, 539. Combined with commercial PPO and self-funded membership, Premier Access currently has over 738,000 members.

Availability and Accessibility

- Monitoring of geo access standards and achieved goals is ongoing and evaluates geographic access to contracted general dentists and specialists within designated service areas and programs. Quarterly reviews are reported within the QMC and subcommittees.
 - Within the California Access Healthy Families program, the percentage of enrollees with access to a general dentist within 15 miles and a contracted specialist within 30 miles has consistently exceeded 98% of all enrollees. Rural access in some counties is monitored closely to ensure accessibility

within the community availability. Within 4th Quarter 2011, we have achieved access within Urban counties to 1 general dentist within 5 miles for 93.6% of the enrollees.

- Within the California Premier Healthy Families program, the percentage of enrollees with access to a general dentist within 15 miles is generally available to 95% of the enrollees. Within the 4th Quarter 2011, we have achieved access to 1 general dentist within 5 miles of 87.8% of the enrollees located in urban counties in this program. Access to contracted specialists within 30 miles is generally available to 80% of the enrollees, and has improved to 89.6% of the enrollees in the 4th Quarter. The service area for this program is within very rural counties of the state and access patterns are consistent with the geographic standards of the community. Access is monitored closely to ensure accessibility and arrange for non-contracted access as required. During 4th Quarter 2011, we have a decrease in access to general dentists within 15 miles across all regions of the program. Effective October 1, 2011, we implemented a provider fee schedule reduction resulting from corresponding premium reductions to the program that went into effect with the current plan year. Thirty-five (35) providers have terminated from the program with this implementation. We are monitoring closely to ensure that access is available.
- Within the California Healthy Kids – Santa Barbara program, the percentage of enrollees with access to a general dentist within 15 miles is generally available to over 98% of the enrollees. Specialist access within 30 miles is improved from 55% of the enrollees to 98.6% of the enrollees in the 4th Quarter 2011. Specialist access improvements are the direct result of the new recruitment of 2 pedodontists and 1 periodontist. Access is monitored closely to ensure accessibility and arrange for non-contracted access as required.
- Within the GMC and LAPH California Medicaid programs, the percentage of enrollees with access to a general dentist within 15 miles and a contracted specialist within 30 miles is consistently virtually 100%. Within 4th Quarter

2011, Premier Access has achieved access to 1 general dentist within 5 miles of 88.8% of the enrollees in the GMC program and 97.8% of the enrollees in the LAPHP program.

- Within the Utah CHIP program, the percentage of enrollees with access to a general dentist within 15 miles is approaching 98% of all enrollees. As of the 4th Quarter 2011, Premier Access has achieved access to 1 general dentist within 5 miles of 98% of the enrollees in urban counties. Within the rural counties, the percentage of enrollees with access to a general dentist within 40 miles is 100%. The percentage of enrollees with access to a contracted specialist within 40 miles (all counties) is 97%. The rural area (or Non-Wasatch region) of Utah includes some extremely rural areas and access patterns are consistent with the geographic standards of the community. Access is monitored closely to ensure accessibility and arrange for non-contracted providers as required.
- Within the California Commercial DHMO plans, the percentage of enrollees with access to a general dentist within 15 miles overall is at over 96% and access to contracted specialists within 30 miles is over 92%. Within the urban counties, access to general dentists within 15 miles is over 99% but within the rural counties it is at 76%. With the statewide service area, many of the counties are extremely rural and access is consistent with the workforce availability within the counties. Premier Access has an alternative access standard of 1 in 40 miles approved by the Department of Managed Health Care (DMHC) for many of the counties. Access is monitored closely to ensure accessibility and is an ongoing recruitment focus.
- During 2011, year to date the new recruitment efforts by Provider Relations have met or exceeded identified recruitment goals; however, retention is at 91% of the existing network and marketplace dynamics have introduced challenges in retaining providers without assigned membership volume.
- Premier Access continuously monitors Availability and Accessibility through:
 - Monthly transfer logs identifying members requesting office assignment changes based on appointment availability or service issues (TR2 and TR3

requests). Year to date there have been 98 requests for office reassignment due to appointment availability or office wait time. Generally, there has been no systemic issue identified within the offices; however, counseling has occurred in a few instances.

- Contracted Provider surveys related to appointment availability and wait time. Surveys are conducted through written surveys and phone surveys. Written survey responses (self-reported) indicate compliance rates year to date of over 98%. Phone surveys are focused on the full-risk facilities and indicate a compliance rate of just over 90%. Due to office capacity limitations, 7 of the full-risk offices have been closed to new members during 2011. Efforts are underway to implement an onsite appointment/wait time audit process that will be incorporated into the Provider Relations Representatives onsite visits to the facilities.
- The Customer Service issues log, which identifies daily issues that may provide early indication of developing trends or a problem with a specific contracted provider. This continues to be an effective proactive network management tool primarily allowing for individual provider counseling before misunderstandings can escalate into service issues.
- Member grievance monitoring. Premier Access believes that grievances play an important role in the overall continuous improvement efforts related to quality of care and service. As such individual attention is devoted to each grievance resolution. Year to date trends indicate an overall increase in the number of grievances and this has been an area of ongoing focus.

Facility Audit

- Scheduled 2011 Facility Audits for primary care providers and orthodontic specialists have been completed. In addition, targeted or focused audits have been completed as needed. Year to date, 36 facility audits have been completed. Quality of care issues detected in the audits have been addressed and included in the corrective action of the audit reports. Corrective actions have been acknowledged by providers and compliance is verified through follow-up audits.

- The Premier Access policy related to passing audit standards has historically been aligned with the minimum criteria established in the California Association of Dental Plans shared audit processes. During 2011, the Premier Access standards have been adjusted to establish 80% as the minimum compliance threshold to ensure that written policies are consistent with quality expectations. The change in standard is not expected to have a material impact on the outcome of facility audits or the number of passing/ compliant facilities.

Credentialing

- Credentialing of new providers and recredentialing of existing providers are ongoing monthly activities.
- During 2011, the transition to a 3 year cycle for recredentialing has been implemented for all contracted providers and the overall credentialing/ recredentialing policies and procedures have been aligned with the NCQA accreditation standards. A total of 629 providers have been initially credentialed (new providers) in the last two quarters. A total of 805 providers are identified as due for recredentialing during the last two quarters and recredentialing is in process. Recredentialing is initiated 90 days in advance of the actual recredentialing date.

Grievances and Appeals

- Within 2011, all grievances (100%) have been acknowledged within 5 days of receipt and resolved within 30 days.
- Premier Access has established a key performance indicator of .50 per 1,000 members (5 grievances per 10,000 members) as a monitoring threshold for number of grievances received. This threshold is consistent with the standards used by government enrollee advocacy groups in the United States and allows for identification of changes in the rate of grievances among enrolled members. The 2011 year to date grievance ratio is 0.81 per 1,000 members, which is an increase over the 2010 grievance ratio of 0.61 per 1,000.
- Premier Access has an incentive supplemental capitation payment offered to qualified providers within targeted Healthy Families counties for providers with less than 1 complaint per 1,000 assigned members within a designated calendar

quarter. The program criteria needs to be aligned with the adjusted benchmark thresholds.

- Primary categories of grievance between 2010 and 2011 are consistent: Access to Care, Coverage Disputes, Quality of Care and Quality of Service. During 2011, the most significant increase in grievances is related to Coverage Disputes. Review of the detailed grievances does not reveal any specific systemic issue, but falls into general areas of noncovered services and optional treatments. Year to date evaluation indicates that 54% of the grievances are found in favor of the provider and 46% of the grievances are found in favor of the member. Recalculation of the YTD grievance ratio based solely on those found in favor of the member reflects a grievance ratio of 0.41 per 1,000 (4.1 per 10,000). Based on the number of grievances that are ultimately found in favor of the provider, focused member education will be evaluated as a possible improvement initiative.
- Full-risk providers continue to have the highest percent of membership but the lowest ratio of grievances for assigned members. Within the full risk arrangements, the Access Dental Centers have the lowest rate of grievance and the West Coast Dental Centers have the highest rate of grievance. Specific corrective actions have been and continue to be in process for the West Coast Dental Centers.
- During 2011, 100% of the participating facilities with grievance ratios above 0.50% per 1,000 were reviewed for corrective action. The majority of the providers calculated ratios were the result of 1 isolated grievance but paired with low membership, translated to a high ratio. To prioritize improvement efforts, Premier Access is now evaluating the provider/ facility grievance ratios based on a per 100 assigned member basis and focusing on those providers with grievance resolutions in favor of the member. In the current quarter, there are 18 facilities targeted for corrective action but the trend continues to point to 1 isolated grievance in offices with small membership assignment. This continues to be an ongoing priority.

Language Assistance Program

- Language preferences identified by members enrolled in government programs and managed care plans continue to be predominantly in English and Spanish. Less than

one percent of enrollees have identified other languages, including Vietnamese, Cantonese, Mandarin, and Chinese.

- Language assistance services are available to all enrollees through bilingual staff, the external Language Assistance Line, and through arranged onsite translator services.

Member and Provider Education

- General processes informing contracted providers of our policies and procedures are ongoing, including provider relations onsite relationship management, new provider orientations, written provider notifications, website provider tools (including the provider manual(s)), provider newsletters, and individual provider training and counseling, as needed..
 - *The Premier Pipeline*, an updated provider newsletter format, was launched in May 2011. The newsletter is distributed to contracted providers via mail and on the website and includes updates, training and service information, and community/ volunteer or program updates. The next issue will be delivered in November.
 - The development of an 8-module training course focused on the treatment of young children by general dentists is underway. The curriculum is being developed by faculty of the University of Texas Health Science Center Dental School in San Antonio, Texas and is designed to increase the traditional general dentist's comfort level in treating the youngest children. The modules are being professionally produced for 1 hour filmed modules that will be available for continuing education credit via the website. Completion of the project is expected in 2012.
- Standard reminders continue to be sent within the California government programs:
 - Welcome packets provided to Healthy Families, GMC, and LAPHF new enrollees include reminders for beneficiaries/ families to initiate a new patient examination and establish the dental home.
 - 2011 Year to date – 57,964 Healthy Families letters
 - 2011 Year to date – 47,507 LAPHF letters

- 2011 Year to date – 11,751 GMC letters
- Reminder cards continue to be sent to government program enrollees that have no indication of a new patient encounter after ninety days of enrollment. Oral health education information is included within this communication.
 - 2011 Year to date – 67,389 Healthy Families letters
 - 2011 Year to date – 77,444 LAPHP letters
 - 2011 Year to date – 22,154 GMC letters

Provider Dispute Resolution

- Provider disputes are concentrated in claims payment disputes and include appeals of claims denied for insufficient information. During 2011, provider disputes are generally resolved within 30 business days.
- During 2011 year to date, Premier Access has received 113 California provider disputes within government programs and managed care plans.. There appears to be an increase in provider disputes from participating Healthy Families providers. Premier Access has received 121 Utah provider disputes. The majority of the provider disputes are received from non-government/ managed care program providers within the commercial PPO program.
- Year to date, disputes found in favor of the provider are as follows:

California AHF	California PHF	California GMC	California LAPHP	Commercial DHMO	Utah CHIP	Commercial PPO
41%	55%	0%	67%	12%	58%	50%

- Provider Satisfaction surveying indicates that 91% of the responding California providers are satisfied or highly satisfied overall with the Plan. Surveying within Utah is in development. During 2011, Premier Access implemented an e-survey tool. Refinements to the sampling methodology are in review.

Member Satisfaction Surveys

- Quarterly Member Satisfaction Surveys. During 2011, we have implemented new e-survey tools that have streamlined the survey process and increased the response rate and timing. Paper surveys continue to be mailed to members by program who

have accessed care to ensure broad response opportunity. Overall satisfaction with Premier Access Customer Service is at 96% for year to date 2011.

Internal Audits and Metrics

- Premier Access conducts monthly internal auditing related to claims and membership accounting. Year to date 2011, procedural and financial accuracy is at 98.72%. Additional internal auditing focused on data integrity within service related categories, e.g., provider activations and broker appointments, are in evaluation.
- Year to date the Customer Service Call Center has received almost 333,000 calls, averaging over 100,000 calls per quarter. Average speed to answer is 28% for the year and overall abandonment rate is at 5.3% year to date.
- Over 99% of clean claims are processed within 30 calendar day of receipt.

Utilization Management

- During 2011, Premier Access has focused on the development of Utilization Management activities related to over and under utilization within the programs. Monitoring is focused on overall aggregate monitoring for changes in treatment categories, ratios or costs, individual provider monitoring for over utilization and/or billing patterns, and individual provider performance outcomes.
- Individual outlier providers are identified through a provider profiling process for over-utilization. Corrective actions include administrative review and counseling.
- Premier Access has initiated provider contracting for minimum performance measurements, including HEDIS expectations for annual dental visit metrics with all full-risk providers. Implementation is targeted for January 2012. In addition, provider-level scorecards are in development for implementation to facilitate performance based incentive strategies for key utilization objectives (e.g., annual dental visit, preventive care services).
- Year to date HEDIS and other defined performance measurements are tracked quarterly for each program.
- Provider Relations continues to educate providers on the importance of encounter submission, and an additional incentive payment per encounter is included within the government and managed care programs.

Specialty Referral and Preauthorization

- Preauthorization of basic and major services is generally required within most of the government programs in both California and Utah. Within 2011 year to date, Premier Access has processed over 15,000 preauthorization requests within 2.32 working days from the date of the receipt. Over 85% of the preauthorization requests are approved. The majority of the preauthorization requests are processed for the Healthy Families program.
- Prior approval of specialty referral is required in California government and managed care programs. The Utah CHIP program does not have a prior approval requirement. Within 2011 year to date, Premier Access has processed over 8,000 specialist referrals within 2.41 working days from the date of receipt. Just over 77% of the specialist referral requests are approved.
- The highest level of specialty referrals year to date is for pedodontic referrals in the California government programs and for oral surgery referrals in the California Commercial DHMO programs. Specialty referral is not required in the Utah CHIP program.
- Premier Access modified the referral criteria within the California programs, effective October 1 2011, to require a minimum of two attempts by the Primary Care Dentist before routine referrals to pedodontists will be approved. Providers were notified via roster notices and through the website and provider manual updates.
- Year to date, generally less than 50% of the approved care has been received within 90 days of the approval date. Reminders are sent to members after 90 days.

Quality Improvement Studies and Initiatives

Provider Education

Initiative: Premier Access/Access Dental Plan will send periodic newsletters to the contracted provider community. The first 2011 newsletter is anticipated to be distributed in May.

- The first issue of the updated newsletter was issued May 2011. The second issue is slated for November 2011. Ongoing periodic newsletters will be issued in 2012/

Initiative: Premier Access/Access Dental Plan will evaluate options for offering enhanced continuing education/ training curriculums for contracted general dentists to increase the quality of care in pediatric patients.

- In collaboration with the MRMIB Healthy Smiles initiative, Premier Access evaluated the POHAP training curriculum as an option and determined that this training curriculum is not presently an option.
- Initial curriculum development is in process with the University of Texas Health Science Center Dental School – San Antonio.

Performance Measurement

Initiative: Premier Access/Access Dental Plan will review existing key performance indicators with emerging performance measurement and metrics strategies to ensure best practices.

- Baseline Key Performance Indicators and performance monitoring has been implemented across departments during 2011.

External Accreditations

Initiative: Premier Access/ Access Dental Plan will initiate review of the application processes for NCQA accreditation in credentialing and recredentialing processes as well as Utilization Management.

- Credentialing and recredentialing processes are in alignment with the requirements and standards of the NCQA guidelines.
- Utilization Management program requirements and guidelines have been reviewed. During 2012, we will implement updated policies and procedures that are aligned with the NCQA requirements.

2011 GMC/LAPHP Quality Improvement Initiative/ Study

Initiative: *The 2011 GMC/LAPHP Quality Improvement Initiative/ Study is a continuation of the efforts to increase fluoride varnish utilization in children ages 0 to 3 enrolled in the program.*

Year to date 2011 indicates that overall fluoride utilization for the children 0 to 3 is already at or above the annual 2010 utilization. Data indicates an increase in fluoride utilization for this age group. Overall annual dental visits for the age group are also increasing.

Premier Access has promoted best practices awareness within the network through the newsletter, additional provider mailings, and the continuation of the enhanced supplemental of \$5 for fluoride varnishes for traditional capitated providers received through encounter data. Monetary incentives for full-risk providers have not been implemented. Instead, education and movement towards overall performance minimums during the next calendar year is under evaluation.

Discussions at the California DHCS quality meetings have indicated a possibility of adoption of the CDT code D1206 during 2012 which will facilitate administration. We have not currently identified a process for coordination between medical pediatricians that may be administering fluoride varnish within the California Medicaid program.

Family letters reminding to access care and importance of first dental visit have been mailed to 1,500 GMC and 1,500 LAPHP members per quarter.

	Quality Improvement Initiatives and Studies 2011 GMC/ LAPHP Work Plan Target Population: Ages 0 to 3							
	2010	2011 Goal	1 st Q 2011	2 nd Q 2011	3 rd Q 2011	4 th Q 2011	2011 YTD	% of Goal
Program								
GMC -Fluoride Varnish	1.70%	3.00%	2.29%	5.80%	8.40%			
GMC – all Fluoride codes including varnish	13.45%		4.04%	9.43%	13.83%			
LAPHP-Fluoride Varnish	1.23%	3.00%	0.40%	0.84%	1.33%			
LAPHP – all Fluoride codes including varnish	7.31%		2.22%	4.82%	7.17%			



**Quality Improvement Initiatives and Studies
2011 GMC/ LAPHP Work Plan**

Target Population: Ages 0 to 3

Program – Performance Measurement – Annual Dental Visit	2010	2011 YTD – 3rd Q
GMC – Ages 0 to 1	3.44%	3.69%
GMC – Ages 2 to 3	19.85%	21.13%
LAPHP – Ages 0 to 1	4.42%	3.47%
LAPHP – Ages 2 to 3	19.02%	16.69%

2011 Healthy Families Quality Improvement Initiative/ Study

Initiative: Increase the percentage of Healthy Families enrollees receiving an annual dental visit and establish incentives to the contracted providers for age-appropriate preventive services: exam, prophylaxis, and fluoride. Emphasize improvements in the Healthy Smiles collaboration target age group of 0 to 6 in the designated pilot counties.

Year to date 2011, overall program improvements are present in the percentage of children ages 6 and under that have received an annual dental visit. Within the Healthy Smiles target counties (Los Angeles, San Diego, Santa Barbara and Ventura), the percentage of enrollees within each age range are below the state performance measurements year to date. Collaboration activities in 2011 have been primarily focused on the development of education and outreach tools and baseline information. Next steps include implementation of these new tools, including periodicity schedules and caries risk assessment tools, with our network providers.

For the Access Dental Plan Healthy Families providers, the enhanced supplementals were not implemented during 2011. Development has been focused on a performance measurement scorecard system that will support an overall incentive strategy based on the MRMIB defined performance expectations. Performance measurement and financial incentives are targeted for implementation in 2012. Premier Access Healthy Families is compensated on a discounted fee for service basis. No additional incentives have been identified for implementation at this time.

 	Quality Improvement Initiatives and Studies 2011 Healthy Families Work Plan Target Population: Ages 0 thru 6	
	2010	2011 YTD – 3rd Q
Program – Performance Measurement – Annual Dental Visit		
Access Healthy Families – Ages 0 to 1	4.13%	3.88%
Access Healthy Families – Ages 2 to 3	24.82%	23.17%
Access Healthy Families – Ages 4 to 6	53.75%	47.68%
Premier Healthy Families – Ages 0 to 1	16.47%	13.91%
Premier Healthy Families – Ages 2 to 3	44.87%	47.02%
Premier Healthy Families – Ages 4 to 6	75.27%	72.75%

County	Access Dental	Premier Access
Los Angeles	16,137	n/a
Santa Barbara	n/a	1,170
Ventura	883	n/a
San Diego	4,437	n/a



**Quality Improvement Initiatives and Studies
2011 California Healthy Families Quality Initiative
Healthy Smiles Collaboration Metrics**

County	Age Group	# Receiving Care (YTD)	# in age group (YTD)	Q1 2011 (YTD)	Q2 2011 (YTD)	Q3 2011 (YTD)	2011 YTD Comparison	Statewide YTD Comparison
Los Angeles	0 - 11.99	1	1041	0.001	0.001			
	12 - 23.99	43	1697	0.039	0.025		1.61%	3.88
	24 - 35.99	165	2291	0.066	0.072			
	36 - 47.99	385	2544	0.128	0.151		11.38%	23.17
	48 - 59.99	575	2516	0.166	0.229			
	60 - 71.99	496	2396	0.168	0.207			
	72 - 83.99	472	2730	0.17	0.173		20.19%	47.68
	0 - 83.99 (total)	2137	15215	0.122	0.14		14.05%	34.90
San Diego	0 - 11.99	4	473	0.008	0.008			
	12 - 23.99	38	547	0.056	0.069		4.12%	3.88
	24 - 35.99	76	615	0.122	0.124			
	36 - 47.99	88	636	0.178	0.138		13.11%	23.17
	48 - 59.99	149	602	0.29	0.248			
	60 - 71.99	123	546	0.253	0.225			
	72 - 83.99	155	624	0.256	0.248		24.10%	47.68
	0 - 83.99 (total)	633	4043	0.177	0.157		15.66%	34.90
Santa Barbara	0 - 11.99	0	48	0.023	0			
	12 - 23.99	2	59	0.087	0.034		1.87%	13.91
	24 - 35.99	19	101	0.1	0.188			
	36 - 47.99	33	155	0.251	0.213		20.31%	47.02
	48 - 59.99	51	128	0.42	0.398			
	60 - 71.99	81	175	0.373	0.463			
	72 - 83.99	70	177	0.382	0.395		42.08%	72.75
		0 - 83.99 (total)	256	843	0.301	0.304		30.37%
Ventura	0 - 11.99	1	71	0	0.014			
	12 - 23.99	4	93	0.054	0.043		3.05%	3.88
	24 - 35.99	12	138	0.103	0.087			
	36 - 47.99	16	154	0.161	0.104		9.59%	23.17
	48 - 59.99	34	127	0.315	0.268			
	60 - 71.99	31	126	0.194	0.246			
	72 - 83.99	25	129	0.276	0.194		23.56%	47.68
		0 - 83.99 (total)	123	838	0.178	0.147		14.68%

Premier Access contributed directory data to the MRMIB collaboration for the creation of a combined participating dental plans' directory of providers treating children under the age of 7. The Premier Access file includes all general dentists in the target counties with actual encounters during 2010 for children within the target age group and pediatric specialists. Next steps in the collaboration include a focused survey to network providers related to treatment challenges and/or successes with the target age group. The survey will be administered by the California Dental Association and will be concentrated on the combined directory participants identified for the shared directory. The survey is targeted for completion in 4th Quarter 2011 and will inform provider education initiatives.

A provider training program is in development with the University of Texas Health Science Center Pediatric Dental School – San Antonio, TX. The 8 module curriculum is focused on the treatment of children ages 0 to 6 by general dentists. It is targeted for completion in Q2 2012 and will be available to Premier Access contracted providers.

Provider level scorecards with performance measurement by age group (YTD) have been developed and will be utilized for quality initiatives within the network. Initiatives include incentive compensation to be rolled out in 2012 based on the MRMIB defined performance metrics. In addition, we will initiate discussions with providers with assigned membership within the designated age group with no indication of encounters and/or high rates of referrals. Corrective actions will include continuing education to enhance the facility comfort with the youngest children and/or reassignment of the age groups to providers that treat the age group.

In collaboration with the Healthy Smiles work group (including MRMIB, the Center for Health Care Strategies and the other Health Families contracting dental plans), we have developed and adopted a caries risk assessment tool that will be utilized within all government programs and managed care programs offered by Premier Access. Use of the risk assessment tool is encouraged and is one of the initial steps towards the establishment of a caries risk management program. We have initiated a pilot through selected Access

Dental Centers to utilize the risk assessment tool with Healthy Families patients and report results for tracking and evaluation. In addition, Premier Access Quality Management Committee has adopted periodicity policies developed based on the American Academy of Pediatric Dentistry guidelines, adopted patient safety and risk management policies and procedures, and adopted a dental home policy urging providers to support the establishment of dental home with eruption of the first tooth or by the first birthday.

Dental home and clinical guidelines related to fluoride varnish treatments have been ongoing topics of awareness and education campaigns during 2011, with particular focus in the 2011 newsletters. Next steps will include integration of the policies and procedures related to risk assessment and periodicity into the provider manual(s) and the development of training curriculum and strategy.

Premier Access has designated the Case Management Department as the liaison between health plans and dental plans to encourage integration of medical and dental services. Access Dental Plan and Premier Access presently have a case management function through the preauthorization/ specialty referral department that coordinates activities for complex cases between medical plan and dental plan (generally requires coverage coordination between medical and dental plan). Premier Access has indicated a willingness to pilot a data-sharing partnership with a Healthy Families medical plan. A proposal was offered to initiate such a pilot in Sonoma county; however, the Healthy Smiles collaboration did not extend to Sonoma county. Presently, we are participating in the medical collaboration workgroup and remain open to a pilot partnership.

We are pending the development and completion of a risk registry for enrolled children that are identified as at risk based on defined criteria. Discussions within the work group have emphasized that the highest indicator of caries risk continues to be the presence of caries, so some plans have indicated a movement towards identification of members with caries history (through claims/ encounter data) and/or siblings. Target families would then receive additional outreach and educational information to urge annual dental visits.

Premier Access is participating in the outreach/ public partnership collaboration work group. We have contributed to the development of outreach documents to community

partners that will aid in reinforcing access and messaging related to annual dental visits to member families. Premier Access continues to distribute notification to new enrollees on the importance of establishing a dental home and reminders to have necessary annual dental visits. Reminder letters are sent to Premier Healthy Families and Access Health Families members that have not received an annual dental visit within 2011.

2012 Annual Work Plan and Quality Studies/ Initiatives

PROPOSED 2012 MEETING CALENDAR				
QMC Quarterly Meetings	QMC Quarterly Meetings	Calendar Quarter	Months Reporting	Sub Committees Meeting
1 st Qtr Meeting 2012	February 17, 2012	4 th Qtr 2011	October November December	February 10, 2012
2 nd Qtr Meeting 2012	May 18, 2012	1 st Qtr 2012	January February March	May 11, 2012
3 rd Qtr Meeting 2012	August 17, 2012	2 nd Qtr 2012	April May June	August 10, 2012
4 th Qtr Meeting 2012	November 16, 2012	3 rd Qtr 2012	July August September	November 9, 2012
1 st Qtr Meeting 2013	February 15, 2013	4 th Qtr 20112	October November December	February 8, 2013

Facility Audit Schedule

Complete scheduled facility audits throughout the calendar year. Utilize the CADP shared audit results, as applicable.

Grievance ratio

***Initiative:** Premier Access will evaluate the grievances received during 2011 that are ultimately found in favor of the provider for member and provider education initiatives/strategies that will improve plan understanding and coverage expectations. Ongoing evaluation and corrective action will continue for grievances found in favor of the member, in accordance with policies and procedures.*

Year to date 2011 evaluation indicates that 50% of the grievances received during 2011 are found in favor of the provider. Initiate detailed evaluation of all of these grievances and launch member education strategies in 2012 to increase member understanding in key areas resulting in unjustified complaints.

***Initiative:** Update the enhanced capitation incentive for providers to align with the current target thresholds.*

Complete review and update of QMP/QMC Policies and Procedures.

Initiative: Scheduled review and update of policies to capture organizational changes and developments in performance metrics management. Based on prioritization, a group of policies will be addressed each quarter to completion, including reformatting to adopted standardized template and numbering system.

Code	Department/Function
AC	Accounting
CO	Corporate
CL	Claims, Referrals & NOAs
EB	Enrollment & Billing
GR	Grievances, Appeals & Disputes
IT	Information Technology
MA	Marketing & Sales
MS	Member Services
PR	Provider Relations & Services
QM	Quality Management
UW	Underwriting
UM	Utilization Management

Department/ Functional Area	Function/Process	Review Notes	Current Policy Number	NEW POLICY ID		
				Dept Code	Number (001,...)	Extension (Variable/ Exception) (01, 02, 03...)
CORPORATE OPS & PROGRAMS	QM-23_Policy & Procedure Dev		QM-23	CO	002	
QUALITY MANAGEMENT	QM-27_QM Committee (Description of the QMC)	<i>QMP Organization/ Governance</i>	QM-27	QM		
QUALITY MANAGEMENT	QM-05_Conflict of Interest (Employee and Committee members)	<i>QMP Organization/ Governance</i>	QM-05	QM		
QUALITY MANAGEMENT	QM-28_QM Subcommittees (Descriptions of QMC Subcommittees)	<i>QMP Organization/ Governance</i>	QM-28	QM		
QUALITY MANAGEMENT	QM-21_Peer Review Subcommittee	<i>QMP Organization/ Governance</i>	QM-21	QM		
QUALITY MANAGEMENT	QM-31_Staff Performance (QMC Staff)	<i>QMP Organization/ Governance</i>	QM-31	QM		
QUALITY MANAGEMENT	QM-32_Staff Qualifications (QMC Staff)	<i>QMP Organization/ Governance</i>	QM-32	QM		
QUALITY MANAGEMENT	QM-02_Annual QMP Evaluation	<i>QMP Organization/ Governance</i>	QM-02	QM		
QUALITY MANAGEMENT	QM-03_Annual Work Plan Dev	<i>QMP Organization/ Governance</i>	QM-03	QM		
QUALITY MANAGEMENT	QM-04_Confidentiality (QMC)	<i>QMP Organization/ Governance</i>	QM-04	QM		
QUALITY MANAGEMENT	QM-07_Coordination - QM_Other Dept	<i>QMP Organization/ Governance</i>	QM-07	QM		

Department/ Functional Area	Function/Process	Review Notes	Current Policy Number	NEW POLICY ID		
QUALITY MANAGEMENT	QM-19_Legal Counsel	<i>QMP Organization/ Governance</i>	QM-19	QM		
UTILIZATION MANAGEMENT	UM-15_Staff Roles and Resp	<i>UM Program</i>	UM-15	UM	006	
CLAIMS, REFERRALS AND NOAs	UM-02_Compliance Assessment	<i>UM Program</i>	UM-02	CL	002	
UTILIZATION MANAGEMENT	UM-05_Disclosure of UM Processes	<i>UM Program</i>	UM-05	UM	008	
QUALITY MANAGEMENT	QM-25_Provider Performance	<i>UM Profiling</i>	QM-25	QM		
CLAIMS, REFERRALS AND NOAs	UM-08_Review Criteria-Spec Ref	<i>UM Profiling</i>	UM-08	CL		
QUALITY MANAGEMENT	QM-37_CCS Eligibility (CCS Coordination and Referral Process)	<i>Preauth/ Referrals</i>	QM-37	QM		
CLAIMS, REFERRALS AND NOAs	UM-01_Case Management	<i>Preauth/ Referrals</i>	UM-01	CL	009	
CLAIMS, REFERRALS AND NOAs	UM-04_Denials	<i>Preauth/ Referrals</i>	UM-04	CL	003	
CLAIMS, REFERRALS AND NOAs	UM-06_Emergency Dental Care	<i>Preauth/ Referrals</i>	UM-06	CL	004	
CLAIMS, REFERRALS AND NOAs	UM-07_Referrals for Specialty Care	<i>Preauth/ Referrals</i>	UM-07	CL	005	
CLAIMS, REFERRALS AND NOAs	UM-09_Prior Authorization	<i>Preauth/ Referrals</i>	UM-09	CL	006	
UTILIZATION MANAGEMENT	UM-10_Review Criteria-Prior Auth	<i>Preauth/ Referrals</i>	UM-10	UM	001	
UTILIZATION MANAGEMENT	UM-13_Review Timeframes	<i>Preauth/ Referrals</i>	UM-13	UM	003	
UTILIZATION MANAGEMENT	UM-03_Delegation of UM Activities	<i>Preauth/ Referral</i>	UM-03	UM	007	
CLAIMS, REFERRALS AND NOAs	UM-14_Second Opinion	<i>Preauth/ Referrals</i>	UM-14	CL	009	01
GRIEVANCE, APPEALS & DISPUTES	GA-01_Grievance System	<i>Grievance System</i>	GA-01	GR		
QUALITY MANAGEMENT	QM-26_PQIs		QM-26	QM		
QUALITY MANAGEMENT	QM-33_805 Reporting (California)	<i>State Specific</i>	QM-33	QM		
QUALITY MANAGEMENT	QM-08_Corrective Actions	<i>Provider Corrective Action</i>	QM-08	QM		
GRIEVANCE, APPEALS & DISPUTES	Greivance Corrective Action	<i>Provider corrective action</i>	New	GR		
QUALITY MANAGEMENT	QM-34_Probation & Termination (Provider Corrective Actions)	<i>Provider Corrective Action</i>	QM-34	QM		
PROVIDER RELATIONS & SERVICES	QM-09_Credentialing	<i>Updated 1/2011</i>	QM-09	PR	004	
PROVIDER RELATIONS & SERVICES	QM-01_Block Transfers		QM-01	PR	005	
PROVIDER RELATIONS & SERVICES	QM-16_Education-Providers		QM-16	PR	006	
PROVIDER RELATIONS & SERVICES	New_Provider Satisfaction Surveys		New	PR	007	
GRIEVANCE, APPEALS & DISPUTES	GA-02_Provider Dispute Resolution		GA-02	GR	002	
MARKETING/SALES	Advertising		N/A	MA	001	

Department/ Functional Area	Function/Process	Review Notes	Current Policy Number	NEW POLICY ID		
MEMBER SERVICES	AA-05_ Language Assistance Program		AA-05	MS	001	
MEMBER SERVICES	AA-02_ Member Education		AA-02	MS	002	
MEMBER SERVICES	QM-15_ Member Education		QM-15			
MEMBER SERVICES	QM-20_ Member Satisfaction Survey		QM-20	MS	003	
QUALITY MANAGEMENT	QM-06_ Continuity & Coord of Care	<i>Cross reference Multiple</i>	QM-06	QM		
ENROLLMENT & BILLING	QM-14_ Disenroll-Enroll Tracking	<i>Metrics</i>	QM-14	EB	001	
GRIEVANCE, APPEALS & DISPUTES	Tracking and Reporting of Grievances	<i>Metrics</i>				
PROVIDER RELATIONS & SERVICES	AA-01_ Access & Availability	<i>Metrics</i>	AA-01	PR	001	
PROVIDER RELATIONS & SERVICES	AA-03_ Monitoring Compliance with AA	<i>Metrics</i>	AA-03	PR	002	
PROVIDER RELATIONS & SERVICES	AA-04_ Provider Dist Standards	<i>Metrics</i>	AA-04	PR	003	
QUALITY MANAGEMENT	QM-22_ Performance Measures	<i>Metrics</i>	QM-22	QM		
QUALITY MANAGEMENT	QM-29_ Quality of Care Studies	<i>Metrics</i>	QM-29	QM		
QUALITY MANAGEMENT	QM-30_ Rpts Data Collection	<i>Metrics</i>	QM-30	QM		
QUALITY MANAGEMENT	QM-10_ Data Collection	<i>Metrics</i>	QM-10	QM		
CLAIMS, REFERRALS AND NOAs	UM-11_ Claim Processing	<i>Metrics</i>	UM-11	CL	007	
UTILIZATION MANAGEMENT	UM-17_ Util Review Data-Reports	<i>Metrics</i>	UM-17	UM	005	
QUALITY MANAGEMENT	QM-13_ Chart Requests	<i>Facility Audit</i>	QM-13	QM		
QUALITY MANAGEMENT	QM-18_ Focused Reviews	<i>Facility Audit</i>	QM-18	QM		
QUALITY MANAGEMENT	QM-11_ Chart Audits	<i>Facility Audit</i>	QM-11	QM		
QUALITY MANAGEMENT	QM-17_ Facility Review	<i>Facility Audit</i>	QM-17	QM		
UTILIZATION MANAGEMENT	UM-16_ Standards & Methodology for Ortho	<i>Facility Audit</i>	UM-16	UM	004	
QUALITY MANAGEMENT	QM-12_ Chart Maintenance		QM-12	QM		
QUALITY MANAGEMENT	QM-36_ Infection Control	<i>Updated 11/2011</i>	QM-36	QM	036	01
QUALITY MANAGEMENT	QM-39_ Patient Safety	<i>Updated 11/2011</i>	QM-39	QM	039	01
QUALITY MANAGEMENT	QM-40_ Caries Risk Assessment	<i>Updated 11/2011</i>	QM-40	QM	040	01
QUALITY MANAGEMENT	QM-41_ Periodicity	<i>Updated 11/2011</i>	QM-41	QM	041	01
QUALITY MANAGEMENT	QM-24_ Preventive Dentistry Guidelines	<i>Cross Reference QM.041.01</i>	QM-24	QM		
QUALITY MANAGEMENT	QM-42_ Dental Home	<i>Updated 11/2011</i>	QM-42	QM	042	01
CLAIMS, REFERRALS AND NOAs	QM-38_ Optional Treatment	<i>Updated 11/2011</i>	QM-38	CL	007	01
CLAIMS, REFERRALS AND NOAs	Third Party Recovery	<i>Claims</i>				

Department/ Functional Area	Function/Process	Review Notes	Current Policy Number	NEW POLICY ID		
CLAIMS, REFERRALS AND NOAs	Coordination of Benefits	<i>Claims</i>				
CLAIMS, REFERRALS AND NOAs	Missed Appointment Policy	<i>Claims</i>		CL	010	
CLAIMS, REFERRALS AND NOAs	Encounter submission	<i>Claims</i>		CL	011	
UTILIZATION MANAGEMENT	UM-12_ Review Criteria-Claims Proc	<i>Claims</i>	UM-12	UM	002	
CORPORATE OPS & PROGRAMS	QM-35_ Fraud & Abuse (Waste, Abuse and Fraud Prevention)		QM-35	CO	007	
CORPORATE OPS & PROGRAMS	Data Retention and Records Management					
CORPORATE OPS & PROGRAMS	Business Continuity & Disaster Recovery Plan		N/A	CO	003	
CORPORATE OPS & PROGRAMS	HIPAA		N/A	CO	004	
CORPORATE OPS & PROGRAMS	Role Based Access Controls		N/A	CO	005	
CORPORATE OPS & PROGRAMS	Corporate Physical Access Policy		N/A	CO	006	
INFORMATION TECHNOLOGY	(User) Account Management	<i>Cross reference System Security</i>	N/A	IT	001	
INFORMATION TECHNOLOGY	Anti-Malware	<i>Cross reference System Security</i>	N/A	IT	002	
INFORMATION TECHNOLOGY	Data Backup	<i>Cross reference System Security</i>	N/A	IT	003	
INFORMATION TECHNOLOGY	Encryption	<i>Cross reference System Security</i>	N/A	IT	004	
INFORMATION TECHNOLOGY	Incidence Response	<i>Cross reference System Security</i>	N/A	IT	005	
INFORMATION TECHNOLOGY	Intrusion Detection	<i>Cross reference System Security</i>	N/A	IT	006	
INFORMATION TECHNOLOGY	IT Physical Access	<i>Cross reference System Security</i>	N/A	IT	007	
INFORMATION TECHNOLOGY	IT Business Continuity	<i>Cross reference System Security</i>	N/A	IT	008	
INFORMATION TECHNOLOGY	Mobile Device	<i>Cross reference System Security</i>	N/A	IT	009	
INFORMATION TECHNOLOGY	Network Security	<i>Cross reference System Security</i>	N/A	IT	010	
INFORMATION TECHNOLOGY	Password Usage	<i>Cross reference System Security</i>	N/A	IT	011	
INFORMATION TECHNOLOGY	Remote Access	<i>Cross reference System Security</i>	N/A	IT	012	
INFORMATION TECHNOLOGY	Security	<i>Cross reference System Security</i>	N/A	IT	013	
INFORMATION TECHNOLOGY	User Privilege	<i>Cross reference System Security</i>	N/A	IT	014	
INFORMATION TECHNOLOGY	VPN	<i>Cross reference System Security</i>	N/A	IT	015	
INFORMATION TECHNOLOGY	Wireless Access	<i>Cross reference System Security</i>	N/A	IT	016	
INFORMATION TECHNOLOGY	Workstation Security	<i>Cross reference System Security</i>	N/A	IT	017	
INFORMATION TECHNOLOGY	Application Implementation	<i>Cross reference System Security</i>	N/A	IT	018	

Initiate NCQA Accreditation Process

(Utilization Management Program and Credentialing/ Recredentialing)

Develop all written processes related to 2011 development

Evaluate clinical policies, as related, to profiling activities

Evaluate provider dispute processes related to government programs/ commercial DHMO

Proposed Quality Studies and Initiatives for 2012

1. Medicaid Programs- GMC, PHP:

- Expand the GMC/ LAPHP initiative to focus fully on the concept of dental home (including 1st birthday, fluoride varnish, and annual dental visit).
- Develop baseline provider report cards and evaluate next steps for performance measurement improvement
- Initiate full-risk provider performance measurement program

2. Healthy Families Healthy Smiles / MRMIB Quality Improvement Initiative:

- Continue all projects in 2012
- Implement provider score card/ performance measurement initiative in 1st Quarter
- Initiate full-risk provider performance measurement program

3. Risk Assessment:

- Pilot use of caries risk assessment process with targeted ADC centers for targeted membership

2012 Annual Work Plan - Quality Improvement Initiatives

Provider Education

Premier Access/Access Dental Plan will send periodic newsletters to the contracted provider community. First 2012 newsletter is targeted for May.

Date	Volume/ Issue	Distribution
May 15, 2012	Spring/ Summer, Volume II, Issue I	
November 2011	Fall/Winter, Volume II, Issue 2	

Premier Access/Access Dental Plan will evaluate options for offering enhanced continuing education/ training curriculums for contracted general dentists to increase the quality of care in pediatric patients.

Task	Target Completion	Status
UTHSC develop outline of 8 training modules (1 hour, CE certified, web-based delivery)	March 2011	1 st 3 modules Completed
UTHSC provides detailed PowerPoint curriculum presentation for 1 st 3 modules	June 2011	Completed
Onsite filming – 1 st 3 modules	August 2011	Completed
Carry Forward Remaining Tasks to 2012 Work Plan		
UTHSC develop detailed PowerPoint curriculum for next 3 modules	February 2012	Completed
Initiate CE Certification process	January 2012	In Process
Evaluate web-based CE software options	January 2012	In Process
Initiate develop of marketing/ roll-out strategy	January 2012	In Process
Onsite filming – 2 nd 3 modules	February 2012	Pending
UTHSC develop detailed PowerPoint curriculum for final 2 modules	March 2012	Pending
Onsite filming – final modules	March 2012	Pending
Final editing and completion of all modules	April 2012	Pending
Initial launch	May 2012	In Process

Review and Update QMP/QMC Policies and Procedures

Task	Target Completion	Status
Schedule a group of policies for each quarter based on priority. (establish chart/ prioritization)	January 2012	Identified
First group of policies	1 st Quarter QMC	In Process
Second group of policies	2 nd Quarter QMC	
Third group of policies	3 rd Quarter QMC	
Fourth group of policies/ Annual review	4 th Quarter QMC	

External Accreditations

Premier Access/ Access Dental Plan will initiate the application processes for NCQA accreditation in credentialing and recredentialing processes as well as Utilization Management.

Task	Target Completion	Status
Evaluate NCQA accreditation process for credentialing/ recredentialing. Develop Work Plan for application.	April 2011	
Evaluate NCQA accreditation process for utilization management program. Develop Work Plan for application.	April 2011	
Develop all written processes related to 2011 development	April 2011	In Process
Evaluate clinical policies, as related, to profiling activities	May 2011	
Evaluate provider dispute processes related to government programs/ commercial HMO	May 2011	

Risk Assessment Pilot Initiative

Premier Access/ Access Dental Plan will initiate an initiative to be implemented in partnership with the ADC/ BHD centers piloting the use of the adopted risk assessment standardized forms, periodicity and dental home policies. The initiative will focus on 100% of the assigned children between ages 0 and 6 (all government and managed care programs). First year initiative will be designed to establish baseline risk assessment status focused on registries of covered children assigned to the facilities and evaluating barriers/ solutions to network wide implementation.

Task	Target Completion	Status
Establish parameters of the initiative	January 2012	Completed
Establish communication and tracking strategy	February 2012	In Process
Initiate training, as needed	February 2012	In Process
Provide forms and registries of target children	February 2012	Completed
Launch initiative through target facilities	March 2012	Initiated

2012 GMC/ LAPHP Quality Improvement Initiative

Activities related to the 2011 initiative to increase Fluoride varnish utilization in children ages 0 to 3 will continue. The initiative will be expanded in 2012 to focus fully on the concept of the dental home (including 1st birthday, fluoride varnish best practices, periodicity and the annual dental visit).

Premier Access/ Access Dental Plan will initiate a provider performance measurement system, including baseline provider report cards and pay for performance incentives to emphasize performance measurement improvement within the individual provider facilities, including full risk (global) provides.

Task	Target Completion	Status
Continue the provider outreach campaign offering further clinical “best practices” information and specifically encouraging the use of therapeutic fluoride varnishes for effective risk management within the target age group.		
Implement program updates from DHCS for GMC/LAPHP transitioning to the current CDT versions (including D1206 and D1352)	April 2012	Pending finalization from DHCS
Continue the promotion of recommended pediatric risk assessment and appropriate intervention services at point of service, including therapeutic fluoride varnish. Identify additional communication strategies to ensure that pediatric early childhood clinical best practices are known within the contracted General Dentists for these programs		Cross reference Risk Assessment Pilot Initiative
Continue the family awareness campaign promoting the value of early childhood visits and the importance of the dental home.		
Q1 Family letter mailing for Fluoride varnish, ages 0-3	1500 GMC and 1500 LAPHP	March
Q2 Family letter mailing for Fluoride varnish, ages 0-3	1500 GMC and 1500 LAPHP	June
Q3 Family letter mailing for Fluoride varnish, ages 0-3	1500 GMC and 1500 LAPHP	September
Q4 Family letter mailing for Fluoride varnish, ages 0-3	1500 GMC and 1500 LAPHP	December

Task	Target Completion	Status
Continue to utilize individualized letters mailed to the families of the target age group at least once during the Plan Year 2011.		
<p>Continue the procedure-specific supplemental payment for contracted General Dentists.</p> <p>\$5 (in addition to regular capitation) for each therapeutic fluoride varnish performed for covered participants within the focus population (covered participants, ages 0 to 3). Limited to General Dentists under traditional capitation arrangements.</p>		
Initiate pay for performance report card	January 2012	Completed mailing
1st Quarter evaluation	April 2012	
2nd Quarter evaluation	July 2012	
3rd Quarter evaluation	October 2012	
4th Quarter evaluation	January 2013	

2012 AHF/PHF Quality Improvement Initiative

The 2012 initiative will be a continuation of the 2011 activities to increase the percentage of AHF/PHF Healthy Families covered children establishing a dental home and receiving age appropriate dental treatments.

Task	Target Completion	Status
Continue all projects in 2012		
Implement provider score card/ performance measurement initiative		
Initiate full-risk performance measurement program		

Strategy 1: Incentivize the contracted providers for age-appropriate preventive services: Exam, Prophylaxis, and Fluoride.

Action	Target	Status
Revised procedure based supplemental fee for service	March	Deferred
P4P supplemental payments for performance measurement thresholds related to annual dental visits	June	1 st Quarter 2012 Implementation
Carry Forward to 2012 Work Plan		

Strategy 2: Evaluate strategies to incentivize contracted providers to establish and reinforce the dental home.

- No monetary incentives in 2011.
 - Develop baseline database for development of P4P fee for service initiative related to achieved recall percentages.
- Sub-project Quality Initiative - Open Panel Dental Home evaluation; how to support a measureable P4P initiative focused on dental home in a FFS program without assignment (open panel fee-for-service programs):
- Establish baseline recall rates
 - First year tracking both programs; Utah CHIP and Premier HFP.
 - Identify possible P4P reward-based incentives

Action	PHF 2010 Calendar Year	UT CHIP 2010-2011 Plan Year	PHF 2011 Calendar Year	UT CHIP 2011-2012 Plan Year
Establish baseline recall rates (Achieved recall percentages - program average)	50.3%	48.2%		
First Year Tracking Both Programs			35.5%	7.1%
Identify possible P4P reward-based incentives			Pending completion of 1 st year tracking	Pending completion of 1 st year tracking
Carry Forward to 2012 Work Plan				

Strategy 3: Execute targeted Provider Education and Outreach.

Action	Target	Status
Establish/ adopt age-appropriate periodicity expectations and communicate to contracted providers (Access Dental Plan and Premier Access)	May	Completed
Continue outreach/education on clinical guidelines related to fluoride varnish. (Access Dental Plan and Premier Access)	Ongoing	Spring/Summer Provider newsletter focused on use of fluoride varnish.
Continue outreach/education on clinically appropriate sealant utilization (Access Dental Plan and Premier Access)	Ongoing	Fall Newsletter

Strategy 4: Execute Member Outreach and Education.

Access Dental Plan and Premier Access – continue letter campaigns to “at risk” families (i.e., initial enrollees, members enrolled for 6 months or more that have received no services, etc.). Continue age-appropriate wellness outreach focused on family education on the role of the dental home.

- For example: Parent Guardian education: periodic brochure mailing (members age 3 and under)
 - Educate the member guardian on the importance primary teeth and the first visit by age 1 year, and establishing the dental home.
 - Educated guardian on oral hygiene for their children and themselves; not sharing utensils or chewing the food of the baby.
 - Educate them on the Fluoride varnish function on primary teeth.
 - Sealant at age 6 and up
 - regular check-up
 - some self check up tips

Action	Target	Status
Evaluate and develop strategies for culturally appropriate outreach to “at risk” populations. (Access Dental Plan and Premier Access) Overlap with MRMIB Healthy Smiles Collaboration and GMC/ LAPHP Annual workplan	Year End 2011	Pending

MRMIB Healthy Smiles Collaboration Initiative

Strategy 1A: Incentivize the contracted providers for age-appropriate preventive services: Exam, Prophylaxis, and Fluoride with priority on the children ages 6 and under

Action 1A-1: Prioritize Children Ages 1 – 6.99; and located in Los Angeles, San Diego, Santa Barbara or Ventura Counties.

County	Access Dental		Premier Access	
	2011	2012	2011	2012
Los Angeles	16,137		n/a	
Santa Barbara	n/a		1,170	
Ventura	883		n/a	
San Diego	4,437		n/a	

Action	Target	Status	Metric/ Data	
			Total Eligible – 2010	Baseline % - 2010
AHF - Establish baseline on children aged 24 months who have seen a dentist in the last year	May	Completed	3,181	9.21%
PHF - Establish baseline on children aged 24 months who have seen a dentist in the last year	May	Completed	114	13.16%
AHF and PHF – Establish tracking registry of population and percentage receiving dental visit by age of 24 months	January 2012	Pending		
PHF – Evaluate incentive strategies that can be used effectively in fee for service open panel model for possible implementation in 2012.	December	Pending		

Action 1A-2: Prioritization of children ages 1 – 3.99 and Risk assessment for target children

Action	Target	Status	Metric/ Data	
			2011 – ADV	2011 – No ADV
Identification of current enrolled children ages 1 to 3.99 by assigned facility within the target counties	May	Completed		
Establish baseline data related to treatment, plan year status	May	Completed	531	8,946
Los Angeles County	May	Completed	290	6,490
Santa Barbara	May	Completed	50	323
Ventura	May	Completed	26	376
San Diego	May	Completed	165	1,757
Identification of race and ethnicity minority populations enrolled within the target counties and evaluate baseline treatment status data (Korean language, African American, etc.)	May	Completed		
Alaskan Native or American Indian			2	10
Amerasian				3
Asian or Pacific Islander			22	534
Black			7	88
Caucasian			27	459
Chinese			3	10
Filipino				1
Hawaiian				1
Hispanic			260	3,385
Japanese				1
Korean				3
No Valid Data Reported				10
Not Provided			207	4,421
Other			3	20
Identification of current enrolled children at risk based on defined criteria	January 2012	Pending		

Strategy 1B: Engage High-Opportunity providers in the target regions: Los Angeles, Ventura, Santa Barbara Counties (Access Dental Plan) Strategy 1B-1: Create a “preferred provider” status for general dentists who see young children

Action	Target	Status
Use encounter data to identify and engage general and pediatric dentists in target regions	June	Identification Completed
Identify all general dentists in the target regions with assigned patients in the priority age groups	June	Completed
Establish baseline performance measurement calculations for target population by facility utilizing/ based on MRMIB defined	June	Completed – HEDIS performance measures at facility level. (ages 2-3).

performance measures		Need target age range 0 to 24 months.
Identify general dentists with assigned patients that are treating the patients (versus referring or not treating utilizing defined parameters) "Treating" will include all dentists reporting any encounter for a child in the target age group (0 to 3 and 4 to 6) in 2010.	June	Completed Provided data file to partner plan in collaboration for common directory development
Identify general dentists with assigned patients in the target age groups with no reported encounters in 2010 for the target age group (0 to 3 and 4 to 6)	June	Completed – 53 facilities identified with assigned patients in the target age group with no reported encounter. Most facilities had less than 5 assigned patients at target age group
AHF – Establish ranking/ status of each contracted general dentist facility (Performance Measures Thresholds)	August	Q4 Scorecard completed
Evaluate reimbursement/ compensation methodologies for "preferred provider groups." For 2012 P4P initiative.	December	1 st Quarter Implementation
Identify corrective action strategy to include provider outreach, education (strategies below), and/or reassigning the patients to "treating" providers.	January 2012	In Process
PHF – Establish ranking/ status of each contracted general dentist. Evaluate quartile performance methodologies and identify benchmark performance based on 2010 data.	January 2012	In Process

Action 1B-1: MRMIB Collaboration Change Packet Element 13: Create a "preferred provider" status for general dentists who see young children across all HFP dental plans

Action	Target	Status
Provide "treating dentists" in format requested for shared directory (Plan Collaboration)	June	Completed
Update to include additional fields necessary to support provider surveying procedures	October	Completed

Strategy 1E: Institute provider profiling to encourage improvements at the provider level.

Action	Target	Status
Profile outlier providers and set benchmarks for improvement. Reward provider level improvements. Evaluate scorecard strategy for further consideration.	December	1 st Quarter Implementation

Strategy 3A: Establish process for providers to identify children at high risk and alert the dental plan.

Action 3A-1: MRMIB Change Packet Element 14: Promote standardized "risk assessment" protocols with network dental providers.

Strategy 3B: Provide standardized training to general dentists to enhance comfort level with treating young children.

Action	Target	Status
Implement standardized risk assessment tools (AAPD/ CABRA) – recommendations to MRMIB workgroup	June	Completed
Implement periodicity standards (AAPD)	June	Completed
Incorporate recommendations into dental provider handbook	January 2012	In Process
Initiate communication campaigns with network providers	January	Pending
Create process for providers to notify Premier Access of high risk patients/ Tracking process by Premier Access	January	Pilot activities in process with Blue Hills Dentals
Establish training curriculum/ provider handbook treatment expectations for children <age 6, including periodicity and risk assessment.	January	In Process -
Cross reference with provider education initiative (UTHSC)	April	In Process
Carry Forward to 2012 Work Plan		

Strategy 3C: Engage high opportunity dental providers to become involved with EHS/HS and other preschool programs.

Action	Target	Status
Include encouragement and public announcements of volunteer opportunities in provider newsletters	May	May newsletter included
Include encouragement and public announcements of volunteer opportunities in provider newsletters	November	Completed

Strategy 4A: Create a family “scan” for siblings at risk.

Action	Target	Status
Create a family scan for siblings at risk based on caries risk	July	Pending – base on sibling caries scan and integrate into quarterly family letters
Launch communication/ outreach campaign to families to encourage annual dental visits for siblings	July	Pending
Carry forward to 2012 Work Plan		

Strategy 4B: ID parents of newborns and provide educational materials.

Action	Target	Status
ID parents of newborns based on enrollment materials, establish new enrollee scan/ identification	June	Initial identification Completed – ongoing process
Launch communication/ outreach to families to encourage 1 st birthday visit	June	Pending
Initiate small hospital education campaign (UC Davis/ Sacramento) to pilot newborn mother campaign	TBD	Tabled
Carry forward to 2012 Work Plan		

Strategy 4C: Collaborate across dental plans on the development of culturally appropriate oral health educational materials.

Action	Target	Status
Collaborate across dental plans on development of culturally appropriate oral health education materials	TBD	In Process – Plan participating in work group
Post oral health educational resources on the HFP and Premier Access websites for providers and subscribers (based on collaborative materials)	July	In Process – Plan participating in work group
Participate in collaborative community outreach strategies	July	In Process – plan participating in work groups
Premier Access assigned the task of drafting collaboration introduction letter for inclusion with community outreach packet	July	Completed
Carry Forward to 2012 Work Plan		

Strategy 4D: Create incentives for families to see dentists within the limits of CMS policy.

Action	Target	Status
Participate in collaborative family education/ incentive initiatives (within resource limits)	TBD	Pending

Strategy 5: Designate Liaison staff between health plans and dental plans

Action	Target	Status
Designate “liaison staff” between health plans and dental plans to encourage integration of medical and dental services. Case Management Department is the designated liaison staff.	July	Completed

Strategy 6: MRMIB Collaboration Change Packet Element 4: Work with FQHCs in target area to integrate care for young children

Action	Target	Status
Identify targeted FQHCs in the pilot counties	June	Completed

MRMIB Collaboration Change Packet Element 5: Identify medical and dental plan collaboration opportunities.

Action	Target	Status
Work with collaboration work group on specific medical plan/ dental plan partnership opportunities	TBD	In Process – plan participating in work group

Strategy 7: Develop specific risk registries

Action	Target	Status
Develop plan specific oral health "risk registries"	May	In Process
Develop plan specific oral health "risk registries"	September	In Process
Develop plan specific oral health "risk registries"	December	Pending
Develop plan specific fluoride varnish registry	May	In Process
Develop plan specific fluoride varnish registry	September	In Process
Develop plan specific fluoride varnish registry	December	Pending
Develop plan specific dental home registry	May	In Process
Develop plan specific dental home registry	September	In Process
Develop plan specific dental home registry	December	Pending
Carry forward to 2012 Work Plan		

HEALTHY SMILES – MRMIB COLLABORATION PROJECT PERFORMANCE MEASUREMENTS

	<p>Healthy Smiles – MRMIB Collaboration Project Performance Measurements</p>							
<p><i>MRMIB Performance Measure</i></p>	<p><i>Target</i></p>	<p><i>2010 Baseline</i></p>	<p><i>2011 Calendar Year</i></p>	<p><i>1st Q 2012</i></p>	<p><i>2nd Q 2012</i></p>	<p><i>3rd Q 2012</i></p>	<p><i>4th Q 2012</i></p>	<p><i>2012 YTD</i></p>

Quality Management Policies and Procedures	Procedure #: UM-07
Procedure: Referrals for Specialty Dental Care	Effective Date: 3/21/2002
	Revised Date: 6/18/2004
Approval Signature:	Title: Dental Director

PURPOSE:

To ensure requests for referral for specialty dental care are consistently evaluated for appropriateness.

POLICY:

All non-emergency specialist referrals require prior authorization. All specialist referrals must meet criteria for dental necessity and be a covered benefit of the Medi-Cal program or Healthy Families program, as defined by Title 22 and Title 10, the Department of Health Services *Medi-Cal Manual of Criteria for Dental Services*, and the member's evidence of coverage.

Dental Necessity: Title 22, California Code of Regulations, Section 51307, states that the outpatient and inpatient dental services which are reasonable and necessary for the prevention, diagnosis, and treatment of dental disease, injury, or defect are covered to the extent specified in Section 51307 when fully documented to be medically necessary.

The underlying principle of whether a service is reasonable and necessary is whether or not the requested service or item, which is a program benefit, is fully documented to be immediately necessary, is in accord with generally accepted standards of dental practice and is indispensable to the oral health of the beneficiary.

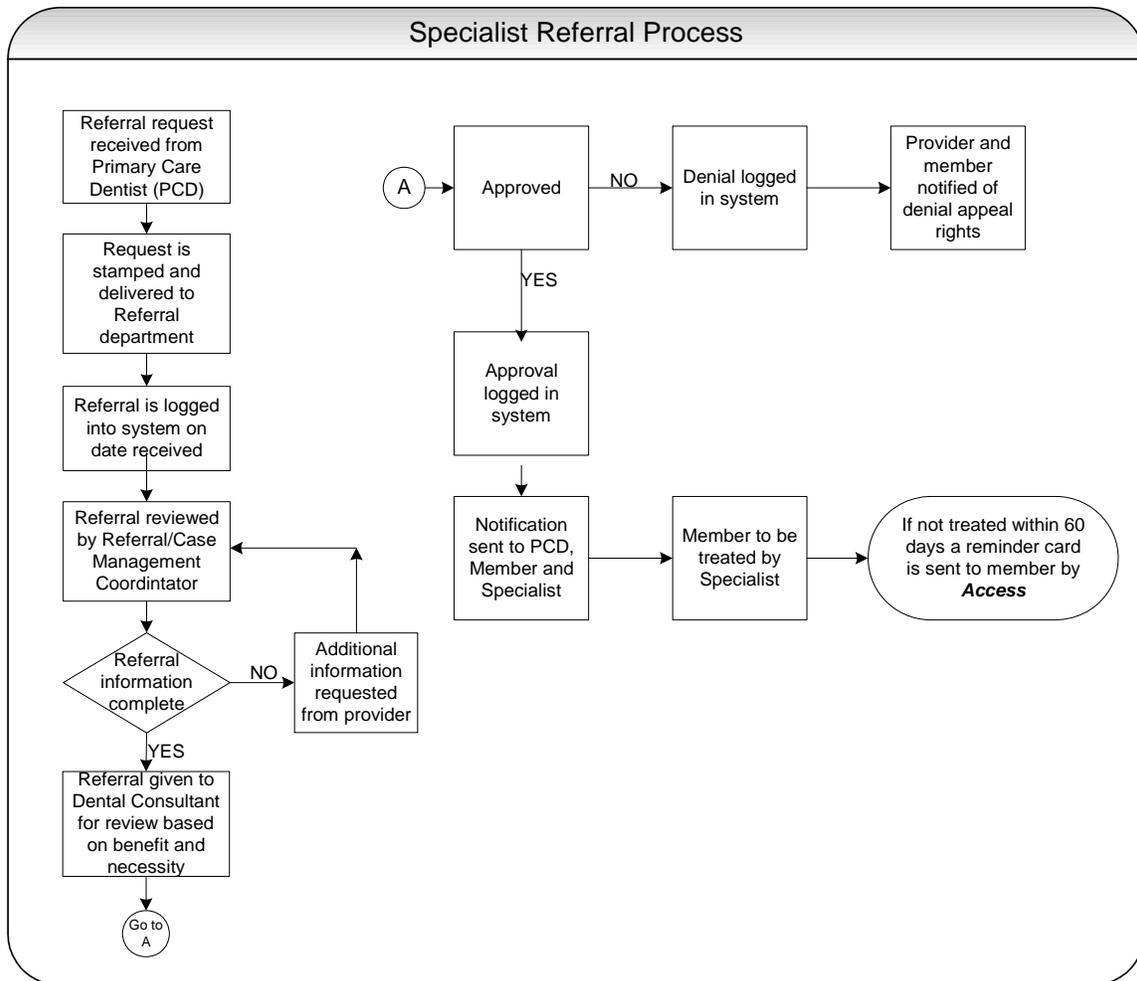
PROCEDURE:

1. The PCD submits a Request for Specialist Referral form.
2. The referral request is logged into the **Access** Dental MIS system and forwarded to the Referral/Case Management Coordinator for review.
3. The Referral/Case Management Coordinator reviews the referral and submitted documentation, and requests additional documentation as needed.
4. The Referral/Case Management Coordinator evaluates the request to determine dental necessity and covered benefits based on submitted documentation, established criteria, and benefits as outlined in the evidence of coverage and the *Medi-Cal Manual of Criteria for Dental Services*.

5. If the request does not meet criteria for dental necessity, the Referral/Case Management Coordinator refers the request to the Dental Director or a licensed dentist consultant for review. All specialty referrals are reviewed by the Dental Director or a licensed dentist.
6. The Dental Director, or a licensed dentist consultant, evaluates the request to determine dental necessity.
7. Following approval, a copy of the specialty referral form is sent to the specialist, the member, and the PCD. The PCD and member also receive a letter indicating the referral has been approved and advising them that, when appropriate, follow-up treatment needs to be performed by the PCD.
8. After completion of treatment, the specialist returns the referral form to **Access** Dental for payment of authorized services.
9. **Access** sends a reminder letter to the member within 60 days after specialist services have been approved if no claim has been received for the approved services.
10. If the referral is denied, the member and provider are notified as described in the *Denials* policy and procedure.
11. Referrals to non-contracted dentists are approved, if there is no similar or same contracted specialist within the network.

Attachment:

Specialist Referral Process Flow Chart



Policy and Procedure			
Policy Name:	Referrals for Specialty Dental Care	Policy ID:	CL.003.01
Effective Date:	02/17/2012	Application:	All programs
Revision Date:	N/A	States:	All States

This policy applies for operations under Premier Access Insurance Company and Access Dental Plan. For the purposes of this Policy, Premier Access Insurance Company and Access Dental Plan shall be collectively referred to as "Premier Access".

Purpose

To provide a standard process for consistent evaluation of referral requests for specialty dental care.

Policy

All non-emergency specialist referrals require prior authorization. All specialist referrals must meet criteria for dental necessity and be a covered benefit under the applicable program or plan..

Procedure

1. Specialist referral requirements vary by program.
2. The Primary Care Dentist ("PCD") submits a Specialist Referral Form request via mail, fax or email. The referral request must include the required supporting documentation demonstrating dental necessity.
3. All referral information shall be entered and tracked in Premier Access' benefits administration system.
4. The Referral Department reviews the referral and submitted documentation, and requests additional documentation as needed.
5. The Referral Department evaluates the request to verify that the necessary documentation is complete, the established criteria is met and the requested procedure is a covered benefit under the applicable program. (Specialty Referral criteria is defined under *Policy and Procedure "Review Criteria-Specialty Referrals"*.)
6. If the request meets the established criteria, the Referral/Case Management Coordinator refers the request to the Dental Director, or designee for review. All specialty referrals are reviewed by the Dental Director, or designee.
7. The Dental Director, or designee, evaluates the request to determine dental necessity.
8. If a determination cannot be made due to missing or insufficient information, the provider and member are notified according to the timeframes described in the *Policy and Procedure "Review Timeframes/Communication"*.
9. Following approval, a referral notification letter is sent to the specialist, the member, and the PCD. The referral notification indicates that the referral has been approved and advises that the PCD needs to be contacted for continuity of care and follow-up treatment.
10. The referral notification letter informs the Specialist that pre-authorization is required for all non emergency, basic and major services.
11. The referral notification letter shall include the valid period of the referral.
12. After completion of treatment, the specialist submits a claim form to Premier Access for payment of authorized services.

13. Premier Access sends a reminder letter to the member within 45 days after specialist services have been approved if no claim has been received for the approved services.
14. If the referral is denied, the member and provider are notified as described in the *Denials* Policy and Procedure.
15. Referrals to non-contracted dentists are approved, if there is no similar or same contracted specialist within the network.

References

This policy was previously tracked as *Quality Management Program Policy and Procedure UM-07 – Referrals for Specialty Dental Care*.

Exhibits

Exhibit A: Specialist Referral Process Flow Chart

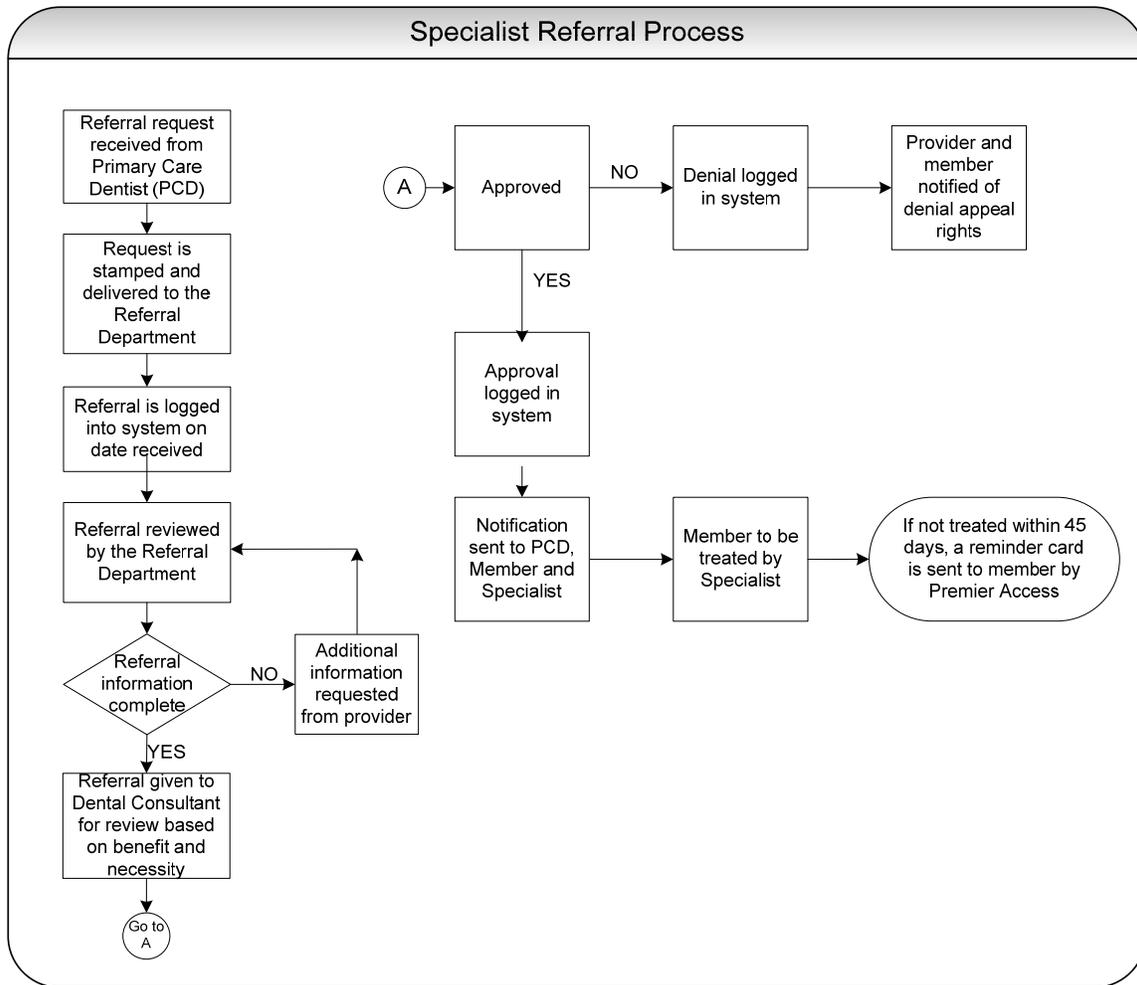
Approval

Approved By:		Date:	
Title:	Dental Director		

Revision History

Date:	Description
02/17/2012	Conversion to revised policy and procedure format and naming convention.

EXHIBIT A Referrals for Specialty Dental Care Specialist Referral Process Flow Chart



Quality Management Policies and Procedures	Procedure #: AA-01
Procedure: Access and Availability	Effective Date: 1/1/04
	Revised Date: n/a
Approval Signature:	Title: Dental Director

PURPOSE:

To ensure access to and availability of dental services for all members, including members in rural areas, members with special health care needs, members with special mental health needs, and members with special cultural needs and preferences.

References: AA-003 - 28 CCR 1300.67.2(b)

AA-005 - 28 CCR 1300.67.2(f)

UM-007 - 28 CCR 1300.67.2(c)

POLICY:

Participating dentists are required to provide covered services to members during normal working hours, and during such other hours as may be necessary to keep patient appointment schedules on a current basis. Emergency care shall be available to members 24 hours a day, seven days a week. An initial dental assessment shall be provided within 180 days of a member's enrollment date, unless the member has been treated within last the 12 months by his/her Primary Care Dentist (PCD).

APPOINTMENT SCHEDULING:

1. Appointments for routine and preventive care or hygiene shall not exceed three weeks from the date of the request for an appointment.
2. Appointments for initial specialist consultation shall be made as soon as all information needed to approve the request has been received, and shall not exceed six weeks from the request for an appointment.
3. Appointments for emergency care from a PCD or specialist shall not exceed one day from the date of the request for an appointment.
4. Members who are given an appointment for an emergency problem will not be kept waiting for more than thirty minutes from their scheduled appointment time.

5. Members who walk in with an emergency problem will be seen as soon as the provider's schedule permits.
6. Wait time in the provider's office shall not exceed 30 minutes.

PROCEDURE:

1. A welcome letter shall be sent to each member within 15 days of enrollment explaining the initial assessment, and instructing members to contact their PCD as soon as possible if they have not received treatment within last 12 months.
2. Once the member has contacted their PCD, the PCD shall schedule an appointment for an initial health assessment.
3. The after hours response system shall enable members to reach an on-call dentist 24 hours a day, seven days a week.
4. After regular business hours, members should first attempt to contact their Primary Care Dentist (PCD).
5. After-hours calls should be forwarded to an answering service or directly to PCD.
6. If the primary dentist is not on duty, an on-call provider should be available to act on his behalf.
7. If the PCD or on-call dentist does not respond, the member may contact **Access'** 24 hour answering service via a 1-800 toll-free line. The provider will be contacted and expected to call the member within one hour from the time member's call is received by the answering service.
8. If the member requires emergency care when outside the service area (greater than 50 miles from the PCD), the member may seek treatment from the nearest available dentist or emergency room as circumstances dictate.
9. Providers shall be notified of the standards in the provider manual and quarterly memorandums.
10. Provider compliance with accessibility parameters shall be routinely monitored by **Access** through member and provider surveys, facility site audits, review of complaints and PCD transfer tracking.
11. Deficiencies will be reported to Dental Director, Peer Review subcommittee, QM committee and VP Plan Administrator, responsible for provider contracting.
12. Corrective actions shall be implemented as needed, and monitored for effectiveness.
13. Accessibility findings shall be included in quarterly and annual QM summary reports developed by the Dental Director and QM committee, for submission to the Board of Directors for review.
14. The following telephone standards shall apply:
15. Average call wait time shall not exceed 2 minutes.

16. Average abandonment rate shall not exceed 10%
17. An automated call distribution (ACD) report shall be generated daily to monitor compliance with telephone standards.
18. Issues identified shall be reported to department management and the UM subcommittee.

Policy and Procedure			
Policy Name:	Appointment Availability and Wait Time Standards	Policy ID:	AA.001.01
Effective Date:	02/17/2012	Application:	All government programs and Commercial DHMO
Revision Date:	N/A	States:	All States

This policy applies for operations under Premier Access Insurance Company and Access Dental Plan. For the purposes of this Policy, Premier Access Insurance Company and Access Dental Plan shall be collectively referred to as "Premier Access".

Purpose

To ensure timely access to and availability of dental services for all members, including members in rural areas, members with special health care needs, members with special mental health needs, and members with special cultural needs and preferences.

Policy

Participating dentists are required to provide covered services to members during normal working hours, and during such other hours as may be necessary to keep patient appointment schedules on a current basis. Emergency care shall be available to members 24 hours a day, seven days a week. For California government programs, an initial dental assessment shall be provided within 180 days of a member's enrollment date, unless the member has been treated within last the 12 months by his/her Primary Care Dentist (PCD).

Appointment Scheduling Standards:

1. Appointments for routine and preventive care or hygiene shall not exceed three weeks from the date of the request for an appointment.
2. Appointments for initial specialist consultation shall not exceed six weeks from the request for an appointment.
3. Appointments for emergency care from a PCD or specialist shall not exceed one day (or 24 hours) from the date of the request for an appointment.
4. Wait time in the provider's office shall not exceed 30 minutes for scheduled routine or emergency appointments.
5. Urgent appointments shall be offered within 72 hours from the time of request for the appointment.
6. When it is necessary for a provider or a member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care.

Procedure

1. A welcome letter shall be sent to each member within 15 days of enrollment instructing members to contact their PCD as soon as possible.
2. Once the member has contacted their PCD, the PCD shall schedule an appointment for an initial health assessment.
3. After regular business hours, members should first attempt to contact their Primary Care Dentist (PCD).
4. Contracted providers shall employ an answering service or a telephone answering machine during non-business hours, which provides instructions regarding how members may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage by phone, or if needed, deliver urgent or emergency care.
5. If the PCD or on-call dentist does not respond, the member may contact Premier Access' 24 hour answering service via a toll-free line. The provider will be contacted and expected to call the member within one hour from the time member's call is received by the answering service.
6. If the member requires emergency care when outside the service area and cannot access a Premier Access provider, the member may seek treatment from the nearest available dentist or emergency room as circumstances dictate.

7. Providers shall be notified of the standards in the provider manual.
8. Corrective actions shall be implemented as needed, and monitored for effectiveness.
9. Accessibility findings shall be included in quarterly and annual summary reports to the QM Committee.
10. Premier Access' telephone standards shall apply as follows:
 - Average call wait time shall not exceed 30 seconds.
 - Average abandonment rate shall not exceed 5%
11. Interpreter services shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.
12. Monitoring of appointment and wait time standards is conducted according to the Policy and Procedure *Monitoring Compliance with Access and Availability Standards*.

References

This policy was previously tracked as *Quality Management Program Policy and Procedure AA-01, Access and Availability*.

Approval

Approved By:		Date:	
Title:	Dental Director		

Revision History

Date:	Description
02/17/2012	Conversion to revised policy and procedure format and naming convention.

Quality Management Policies and Procedures	Procedure #: AA-04
Procedure: Provider Distribution Standards	Effective Date: 1/1/04
	Revised Date: n/a
Approval Signature:	Title: Dental Director

PURPOSE:

To ensure appropriate and adequate access to routine and emergency primary and specialty care dental services for all members, including members in rural areas, members with special health care needs, members with special mental health needs, and members with special cultural needs and preferences.

References: AA-001 – 28 CCR 1300.51(d)H(i), 1300.67.2(a) and (d), 1300.67.2.1(a)
AA-002 – 28 CCR 1300.67.2(d) and (e), 1300.67.2.1(a)

POLICY:

Access provides for at least one full-time equivalent primary care dentist within 30 minutes or 15 miles of a member's business or personal residence. **Access** provides for one full-time equivalent specialty dentist within 60 minutes or 30 miles of a member's business or personal residence. This policy applies to all members, including those in rural areas and those with special health care needs, such as the mentally ill, children with special health care needs, and enrollees with special cultural needs and preferences. If this policy is unobtainable, i.e., rural areas, **Access** will allow services to be performed by non-provider dentists, as long as the services meet dental necessity and are a covered benefit.

Provider ratio standards, as approved by the State during its last dental survey, are one full-time equivalent dentist to 3,500 members. To maintain this ratio, **Access** strictly adheres to its appointment scheduling criteria of providing routine appointments within three weeks from the date of a request, and same-day care in cases involving urgent and emergency dental care. **Access** also monitors to ensure members are seen within 30 minutes of a scheduled appointment time. High volume specialists are defined as those specialists that see the highest volume of members, based on the **Access**' member population. For **Access**, the high volume specialists are pedodontists.

PROCEDURE:

1. Provider distribution and ratio standards shall be assessed and updated annually.
2. Evaluation of the adequacy of the primary care and specialty provider network shall be conducted quarterly, using industry standard software.
3. Results of network adequacy studies shall be reported to the QM committee and shall be used to identify and analyze any gaps in the network.
4. When gaps are identified, efforts shall be made to recruit and credential additional providers.

Policy and Procedure			
Policy Name:	Provider Accessibility Standards	Policy ID:	AA.002.01
Effective Date:	02/17/2012	Application:	Government programs and Commercial DHMO
Revision Date:	N/A	States:	All States

This policy applies for operations under Premier Access Insurance Company and Access Dental Plan. For the purposes of this Policy, Premier Access Insurance Company and Access Dental Plan shall be collectively referred to as "Premier Access".

Purpose

To ensure appropriate and adequate access to routine and emergency primary and specialty care dental services for all members, including members in rural areas, members with special health care needs, members with special mental health needs, and members with special cultural needs and preferences.

Policy

This policy applies to all members, including those in rural areas and those with special health care needs, such as the mentally ill, children with special health care needs, and enrollees with special cultural needs and preferences. If this policy is unobtainable, i.e., rural areas, Premier Access will allow services to be performed by non-provider dentists, as long as the services meet dental necessity and are a covered benefit. The provider accessibility standards are as follows:

State	Provider Type	Distance Standard	Ratio Standard
California	General Dentists	One full-time equivalent primary care dentist within 30 minutes or 15 miles of a member's personal residence or workplace. <i>Exception for Alpine, Mono, Sierra and Trinity counties:</i> One full-time equivalent primary care dentist within 40 miles of a member's personal residence or workplace.*	One full-time equivalent dentist to 3,500 members.*
	Specialists	One full-time equivalent specialty dentist within 60 minutes or 30 miles of a member's personal residence or workplace. <i>Exception for Alpine, Amador, Calaveras, Colusa, Del Norte, Glenn, Imperial, Lassen, Mariposa, Modoc, Plumas, San Benito, Sierra, Siskiyou, Tehama, Trinity and Tuolumne counties:</i> Members may access care from non-contracted specialists. If a member obtains services from a non-contracted specialist, the Plan will pay a non-contracting dental provider rendering Covered Services his / her billed charges, up to the usual and customary rates of the geographic region.*	One full-time equivalent dentist to 3,500 members.*
Utah	General Dentists	One (1) General Dentist within 40 miles; One (1) Specialist within 40 miles	Not applicable

* Alternative access standard for the applicable counties, as approved by the Department of Managed Health Care.

Procedure

1. Provider accessibility standards shall be assessed annually and updated when applicable.
2. Evaluation of the adequacy of the primary care and specialty provider network shall be conducted quarterly, using industry standard software.
3. Results of network adequacy studies shall be used to identify and analyze any gaps in the network. When gaps are identified, efforts shall be made to recruit and credential additional providers.
4. Results of network adequacy studies shall be included in quarterly and annual reports to the Quality Management Committee

References

This policy was previously tracked as *Quality Management Program Policy and Procedure AA-04 – Provider Distribution Standards*.

Approval

Approved By:		Date:	
Title:	Dental Director		

Revision History

Date:	Description
02/17/2012	Conversion to revised policy and procedure format and naming convention.

Quality Management Policies and Procedures	Procedure #: AA-03
Procedure: Monitoring Compliance with Access and Availability Standards	Effective Date: 1/1/04
	Revised Date: n/a
Approval Signature:	Title: Dental Director

PURPOSE:

To ensure thorough and continuous monitoring of compliance with access and availability standards.

References: AA-004 - 28 CCR 1300.67.2(f) and 28CCR 1300.70(b)(2)(G)(5)

POLICY:

Access' system for monitoring compliance with access and availability standards shall use only the most current data, collected on a monthly basis, to ensure that all information is relevant and conclusions are accurate. This monitoring system shall be used to identify individual provider and systemic availability/accessibility problems.

PROCEDURE:

Access monitors the following areas to identify both individual and systemic availability/accessibility problems and to evaluate whether standards are being met:

- ◆ Appointment wait times
- ◆ Reasons for PCD transfer
- ◆ Member/provider complaints/grievances
- ◆ Telephone: average speed of answer and abandonment rate
- ◆ Member satisfaction survey
- ◆ Facility self assessment tool
- ◆ On-site audit
- ◆ Provider survey

APPOINTMENT WAIT TIME VALIDATION

1. A provider access survey shall be sent to every PCD office in the network on a quarterly basis to obtain information on appointment availability.
2. Information provided via the quarterly provider access survey shall be validated through a review of appointment logs, which the Dental Director or designee performs during regularly scheduled facility site audits.

MEMBER SURVEYS

1. A survey of a randomly selected sample of members, assigned to PCD offices, shall be conducted quarterly on members receiving care.
2. The survey instrument shall include questions related to satisfaction with access to care, availability of care, cultural & linguistic needs, and overall satisfaction with **Access** and contracted PCDs/specialists.
3. Results of surveys shall be reviewed quarterly and shall be used to produce summary reports of member satisfaction.
4. Summary reports of member satisfaction shall be distributed to the Dental Director and QM committee.
5. Reports shall be used to analyze enrollment capacity and evaluate wait times in provider offices.

PCD TRANSFER REQUEST TRACKING

1. Access to care issues shall be monitored for compliance monthly through tracking of transfers when members request a Primary Care Dentist (PCD) change.
2. When a member requests a transfer to a different PCD, the **Access** Member Services Coordinator questions the member to determine the reason he/she is requesting the transfer.
3. Transfers are assigned one of the following reason codes, based on information given by the member, that allow tracking of potential access or appointment scheduling problems;
 - TR2 – Wait Time
 - TR3 – Appointment Time
4. Documentation of transfer activity is forwarded to the Dental Director, and reported to the member Grievances/Appeals and Member Services subcommittee of the QM committee.
5. When the review by these bodies substantiates an access or availability problem, further investigation is performed and appropriate corrective action is implemented.

MEMBER GRIEVANCE/COMPLAINT TRACKING

1. Access to care issues shall be monitored for compliance through tracking of member grievances/complaints.

2. **Access** staff monitors Member Grievance logs to determine whether there are any member complaints that may result from access/availability issues such as delayed availability of appointments, long office wait times, or other related access problems.
3. When access/availability issues are identified, they are referred to Member Grievances and Appeals Subcommittee of the QM committee for investigation and corrective action as needed.

TELEPHONE ANSWER TIME AND ABANDONMENT RATE

1. Monthly reports from the automated call distribution system shall be analyzed to identify issues with telephone wait times and abandonment rate.
2. When issues are identified, they shall be referred to Member Grievances and Appeals Subcommittee of the QM committee for investigation and corrective action as needed.

CORRECTIVE ACTIONS

1. Findings of non-compliance, resulting from the above activities, shall be further investigated by the Dental Director or his/her designee.
2. **Access** providers are expected to provide necessary dental services within acceptable time frames recommended by the State and **Access**.
3. When an access to care problem is identified, corrective action shall be taken, which shall include, but not be limited to the following:
 - ◆ Further education and assistance to the provider
 - ◆ Provider counseling
 - ◆ Provider probation
 - ◆ Suspension of new assignments
 - ◆ Transfer of patient to another provider
 - ◆ Contract termination for continuing noncompliance.
4. The Plan has an automated system, which generates monthly-customized letters to each provider's office with accessibility issues. The letter requires the provider to adhere to the Plan's corrective action plan regarding the indicated accessibility issues.
5. Depending upon severity of deficiency, the Dental Director shall re-assess effectiveness of corrective actions to ensure compliance.
6. Investigation results from subcommittees shall be reported to the QM committee.
7. Access to care issues shall be tracked by the QM committee along with all other quality-related issues reported by subcommittees.
8. Trends and other relevant information shall be included in quarterly and annual reports submitted to the Board of Directors.

Policy and Procedure			
Policy Name:	Monitoring Compliance with Access and Availability Standards	Policy ID:	AA.003.01
Effective Date:	02/17/2012	Application:	Government programs and Commercial DHMO
Revision Date:	N/A	States:	All States

This policy applies for operations under Premier Access Insurance Company and Access Dental Plan. For the purposes of this Policy, Premier Access Insurance Company and Access Dental Plan shall be collectively referred to as "Premier Access".

Purpose

To ensure thorough and continuous monitoring of compliance with access and availability standards.

Policy

Premier Access shall monitor compliance with access and availability standards to identify individual provider and systemic availability/accessibility problems. The monitoring system shall use only the most current data to ensure that all information is relevant and conclusions are accurate.

Procedure

Premier Access monitors the following areas to identify both individual and systemic availability/accessibility problems and to evaluate whether access and availability standards are being met. Results of monitoring activities shall be included in quarterly and annual reports to the Quality Management Committee.

1. Member satisfaction survey
2. Reasons for PCD transfer
3. Member/provider complaints/grievances
4. Telephone reports
5. Provider survey
6. Office visits and calls

Member Satisfaction Surveys

1. A survey of a randomly selected sample of members shall be conducted quarterly on members receiving care.
2. The survey instrument shall include questions related to appointment schedule, wait time and overall satisfaction with Premier Access and contracted Primary care dentist /specialists.
3. Reports shall be used to analyze enrollment capacity and evaluate appointment availability/accessibility in provider offices.

PCD Transfer Request Tracking

1. Appointment availability shall be monitored for compliance monthly through tracking of transfers when members request a Primary Care Dentist (PCD) change.
2. When a member requests a transfer to a different PCD, the Premier Access Member Services Representative questions the member to determine the reason he/she is requesting the transfer.

3. Transfers are assigned one of the following reason codes, based on information given by the member, that allow tracking of potential access or appointment scheduling problems;
 - TR2 – Wait Time
 - TR3 – Appointment Time

Member Grievance/Complaint Tracking

1. Appointment time shall be monitored for compliance through tracking of member grievances/complaints.
2. Premier Access staff monitors Member Grievance logs to determine whether there are any member complaints that may result from access/availability issues such as delayed availability of appointments, long office wait times, or other related access problems.
3. When access/availability issues are identified, they are referred to Member Grievances and Appeals Subcommittee of the QM committee for investigation and corrective action as needed.

Telephone Reports

Reports from the automated call distribution system shall be analyzed to identify issues with telephone wait times and abandonment rate.

Provider Satisfaction Surveys

1. On a quarterly basis, a provider survey shall be sent randomly to Network PCD offices to obtain information on appointment availability wait time, and Plan satisfaction
2. Result of provider survey findings shall be reviewed and included in quarterly and annual QM summary reports.

Office Visits and Calls

Provider Relations representatives perform random visits and calls to network offices. During these visits/calls, appointment availability and appointment wait time shall be assessed, including the review of appointment logs as needed.

Corrective Actions

1. Findings of non-compliance, resulting from the above activities, shall be further investigated by the Dental Director or his/her designee.
2. Premier Access providers are expected to provide necessary dental services within acceptable time frames recommended by the State and Access.
3. When an access to care problem is identified, corrective action shall be taken, which shall include, but not be limited to the following:
 - Further education and assistance to the provider
 - Provider counseling
 - Provider probation
 - Suspension of new assignments
 - Transfer of patient to another provider
 - Contract termination for continuing noncompliance.

4. Depending upon severity of deficiency, the Dental Director shall re-assess effectiveness of corrective actions to ensure compliance.
5. Access to care issues shall be tracked by the QM committee along with all other quality-related issues reported by subcommittees.

References

This policy was previously tracked as *Quality Management Program Policy & Procedure AA-03 – Monitoring Compliance with Access and Availability Standards.*

Approval

Approved By:		Date:	
Title:	Dental Director		

Revision History

Date:	Description
02/17/2012	Conversion to revised policy and procedure format and naming convention.

Quality Improvement Policies and Procedures	Procedure #: GA-01
Procedure: Grievance System	Effective Date: 01/01/04
	Revised Date: 10/27/10
Approval Signature:	Title: Dental Director

PURPOSE:

Under the direction of the Dental Director or designee, to provide a systematic process for members/providers to contact **Access** for general inquires and to report grievances/appeals; to provide an effective process for resolving grievances/appeals in a timely manner; and to provide a mechanism for identifying systemic or provider trends that may be deleterious to patient care.

References: GA-001-GA-005 - **CA Health & Safety Code** 1368(a) (1), 1368(a) (2),
1368(a) (5), 1368.01(a), 1368.01(b), 1368.02(b), 1374.30(m), 1374.30(i)

28 CCR 1300.68(a), 1300.68(b)(1), 1300.68(b)(2), 1300.68(b)(3),
1300.68(b)(4), 1300.68(b)(5), 1300.68(b)(6), 1300.68(b)(7), 1300.68(b)(8),
1300.68(b)(9), 1300.68(d)(1), 1300.68(d)(2), 1300.68(d)(3), 1300.68(d)(4),
1300.68(d)(5), 1300.68(d)(6), 1300.68(d)(7), 1300.68(d)(8), 1300.68(e),
1300.68(f)(1), 1300.68.01(a) and (b),

POLICY:

Members or their designee can file grievances for at least 180 calendar days following any incident or action that is the subject of the member's dissatisfaction. A grievance must be completed within 30 calendar days of **Access**' receipt of the grievance. If a grievance can't be resolved within 30 calendar days, **Access** shall notify the member and provider of the pended status of the grievance, track the grievance for completion, and report quarterly any grievances pended for 30 days or more to the State. Grievances referred to external review processes, such as the State Fair Hearing process, shall be reported to the State until the review and any required action by **Access**, resulting from the review, is completed. Members shall not be discriminated against (including disenrollment) solely on the grounds that the member filed a grievance. The member grievance process is not a delegated entity function.

DEFINITIONS:

- "Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by an **Access** member or the

member's representative. Where **Access** is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

- “Complaint” is the same as a “grievance.”
- “Complainant” is the same as “grievant,” and means the person who filed the grievance including the member, a representative designated by the member, or the individual with authority to act on behalf of the member.
- “Resolved” means that a final conclusion has been reached with respect to the member’s submitted grievance, and there are no member appeals that are pending within the **Access** grievance system.
- “Threshold language(s)” mean the language(s) identified by **Access** pursuant to Section 1367.04(b)(1)(A) of the Act. Generally, threshold languages are determined by the size of the dental plan.

PROCEDURE:

1. Members in all service areas report member grievances/ appeals to **Access** by telephone, online, mail, or in person between the hours of 8:00 a.m. to 6:00 p.m., Monday through Friday (holidays excepted), at the Plan’s headquarters located at:

Access Dental Plan
Complaints/Grievances Department
8890 Cal Center
Sacramento, CA 95826
1-800 – 70 SMILE (707-6453)

2. Members in all service areas also report grievances/appeals through their **Access** provider during regular business hours.
3. Members report a grievance by letter or by completing a Grievance Form.
4. A Grievance Form is included in the Evidence of Coverage booklet disseminated to all new members and in the provider manual. Grievance Forms are also available in provider offices and online at the **Access** website at: www.accessdental.com.
5. Grievance Forms are translated into **Access**’ threshold languages.

Members with Cultural and Linguistic Needs: The following are available to **Access** members with cultural and linguistic needs to assist them with reporting a grievance/appeal.

- Free interpreting services, which are available 24 hours per day, 7 days per week by qualified interpreters from **Access**’ interpreting service vendor.
- Standardized vital documents will be translated into **Access**’ threshold languages at no charge to enrollees.

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6. **Members with Disabilities:** Members who are hearing and speech impaired may use the California Relay Service's (CRS) toll-free telephone number (1-800-735-2929 [TTY]) to report their grievances/appeals, through a professionally trained Relay Operator.
- The CRS enables people, who use Text Telephones (TTYs) or personal computers (PC), to communicate with those who use voice telephones, and vice versa.
 - When a member uses the CRS, he/she dials one of the toll-free numbers below and asks the Relay Operator to dial the number of **Access**. The Relay Operator then stays on the line to "convey" the conversation between the member and **Access**.
 - 1-800-735-2929 TTY,
 - 1-800-735-2922 VOICE,
 - 1-800-855-3000 SPANISH (Voz y TTY),
 - 1-800-735-0091 COMPUTER
 - CRS toll-free numbers are included in the members' Evidence of Coverage booklet.
 - CRS is available for members' use 24-hours a day, 7 days per week. CRS is a benefit provided by the State of California and there is no charge for dialing the toll-free number.
7. **Exempt Grievances:** 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 response.
- Exempt grievances shall be logged into the automated system upon receipt.
 - The automated log 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 **Access** staff person who took the call and resolved the grievance.
 - The Member Services Coordinator shall enter the appropriate letter ("I" for inquiries, "C" for complaints (grievances/appeals), and "EG" for exempt grievances) into the members' record. This becomes a part of member's permanent on-line file.
 - The letter "I" shall be entered for inquiries that are calls requesting information about the Plan, requesting general information or requesting a change in a provider, and for similar reasons other than for the quality of care.
 - If the Member Services Coordinator determines the call is an inquiry or exempt grievance and not a grievance/appeal, appropriate action will be taken to respond to the caller's concern, and member's on-line record is updated to indicate the matter has been "resolved".
8. **Expedited Grievances:** Expedited grievances are processed as follows:
- **Access** shall conduct an expedited grievance review in cases involving an imminent and serious threat to the health of the enrollee, including severe pain or potential loss of life or major bodily function.

- Expedited grievances shall be forwarded to the Dental Director within 24 hours of receipt for review.
 - The member shall be immediately notified, via telephone, of his/her right to contact the State regarding the grievance.
 - A written statement of the disposition or pending status of the expedited grievance shall be provided to the State and the member within three calendar days of receipt of the expedited grievance.
 - The requirement that the member must participate in **Access**' grievance process prior to applying to the State for review of the expedited grievance shall be waived.
 - The State shall be able to contact **Access** regarding expedited grievances 24 hours a day, seven days a week.
 - When contacted by the State, **Access** shall respond within 30 minutes during normal business hours, and within one hour during non-work hours.
 - There shall be an **Access** representative with the authority to resolve expedited grievances and authorize the provision of dental services covered under the member's contract in a medically appropriate and timely manner, including making financial decisions for expenditure of funds without first having to obtain approval from superiors. *(See attached)*
 - When an **Access** member reports a grievance to the State that qualifies as an expedited grievance, the State may contact the **Access** corporate office directly during normal business hours.
 - After business hours, the State may contact the primary and/or back-up individuals listed in **Access**' Emergency Grievances Representatives Contact List. *(See attached)*
 - When the grievance system is revised, the State shall be notified at least 30 days in advance.
9. **Non-Exempt/Non-Expedited Grievances/Appeals:** Grievances/appeals are processed as follows:
- If the Member Services Coordinator determines the caller's concern qualifies as a grievance/appeal, the member's file is marked as "C" to be followed up by the Grievance /Appeals Coordinator.
 - If the Member Services Coordinator is unable to differentiate between an inquiry or exempt grievance and a grievance/appeal, it shall be considered a grievance/appeal and it is marked as "C" to be followed up by Grievance/Appeal Coordinator. forwarded to the Grievance/Appeals Coordinator for classification and follow-up.
 - All grievances/appeals are logged into an automated log with the date **received by the Plan**, the name of the complainant, the complainant's member identification number, the name of the individual recording the grievances/appeal, a description of the grievance/appeal, a description of the resolution/disposition of the grievance/appeal, and the date of the resolution.

- Grievances/appeals involving an Access department or staff shall be immediately referred to the management/supervisory staff who shall be responsible for implementing corrective actions as appropriate.
- Within five calendar days of receipt of a grievance/appeal, written acknowledgment shall be sent to the complainant.
 - The written acknowledgment shall explain to the complainant that the grievance/appeal has been received and the date of receipt.
 - The written acknowledgment shall also include the name, telephone number and address of the **Access** representative that the complainant can contact about the grievance/appeal.
- The Grievance/Appeals Coordinator shall review the grievance/appeal with the Dental Director and one of the following codes shall be assigned:
 - 0 - Non-Complaint
 - 1 - Access to care: emergency and time delays
 - 2 - Waiting time at office
 - 3 - Transportation or shuttle problems
 - 4 - Personality problems
 - a. Primary Care Dentist (PCD) staff
 - b. **Access** Staff
 - 5 - PCD office/facility problems
 - 6 - Communication problems
 - 7 - Disputes
 - a. Delay, modification, or denial of services based on non-dental necessity
 - b. Dispute involving dental necessity
 - c. Coverage dispute
 - d. Expedited grievances
 - 8 - Quality of care: Substandard care - faulty restorations, ill-fitting appliances, etc.
 - 9 - Quality of care: Inappropriate care - over- or under- treatment.
 - 10 - Grievance/Appeal of denial for referral to specialty care.
 - 11 - Grievance appeal
- The Grievance/Appeals Coordinator and/or Dental Director is responsible for obtaining necessary information to properly evaluate each grievance/appeal. This may include obtaining written statements from the member and/or dental records from the dental provider such as:
 - A copy of all of the member's relevant treatment records;

- A copy of the member's signed consent;
- A copy of all relevant x-rays
- A copy of the member's financial records pertaining to the service in question;
- Any additional comments the provider may have regarding the member's grievance.
- The Grievance/Appeals Coordinator, in conjunction with the Dental Director, shall review all submitted information and discuss the case with the member and/or provider as necessary.
- The Quality Management Manager shall present the grievance/appeal to the Member Grievances/Appeals and Member Services subcommittee.
- Licensed dentists determining grievances/appeals cannot have prior involvement in the initial denial decision and cannot have a vested interest in the case.
- Designated dentists determining grievances/appeals must be appropriately licensed dentists with pertinent clinical knowledge and expertise.
- The Dental Director or designated competent licensed dentist shall make a determination on appeals of specialty referral or claims denials.
- The Dental Director reviews the grievance and determines appropriate action to be taken.
- The Grievances/Appeals coordinator, in conjunction with the Dental Director ensures that actions are implemented, informs the member of the action taken, and closes the file.
- Grievances/Appeal resolutions shall be reviewed by the Member Grievances/Appeals and Member Services subcommittee, and any quality of care issues shall be referred to the QM committee for review and action.
- In the event that a provider does not show improvement or is uncooperative with **Access'** improvement efforts in resolving systemic interpersonal problems, the Dental Director shall consult with the QM committee to determine the next appropriate corrective action, up to and including termination of the provider's contract.
- If warranted, the provider shall be placed on probation pending the QM committee's decision or recommendations. Recommendations may include further investigation through focused review or studies, education to the provider or disciplinary action.
- When a resolution occurs, an entry shall be logged into the system indicating that the grievance/appeal has been resolved and the case is then closed.
- Within 30 days of receipt of the grievance/appeal by the Plan, the Grievance/Appeals coordinator shall mail a letter of resolution to the member and provider.
- The Dental Director shall review and approve the resolution letter to ensure accuracy and clarity of the letter.
- The letter of resolution contains clear and concise explanation of the reasons for Access' response.

- **Appeal of Denied Services**
 - For grievances/appeals involving the delay, denial, or modification of dental care services, based in whole or in part on dental necessity, the letter of resolution will describe the criteria used and the clinical reasons for its decisions.
 - For grievances/appeals involving the delay, denial, or modification of dental care services, based in whole or in part on a finding that the proposed services are not a covered benefit under the member's contract, the letter of resolution will clearly specify the provisions in the contract that exclude the coverage.
10. Any grievances alleging discrimination will be reported to QM committee and forwarded to the State for review and appropriate action.
 11. If **Access** cannot resolve the grievance within 30 calendar days of the Plan receipt of the grievance, then the plan shall send written notification to the complainant of the pending status of the complaint.
 12. All grievances/appeals pending for 30 days or more shall be tracked for completion.
 13. All grievances/appeals referred to external review shall be reported quarterly to the State until the review and any required actions to be taken by **Access** are completed.
 14. All grievances/appeals are reportable to the QM committee through the Member Grievances/Appeals and Member Services subcommittee.
 15. Reports shall be generated by the MIS department monthly from the automated grievance log.
 - The monthly report shall include grievances by category, type and line of business for each month in the current year, plus the aggregate data for the current year.
 - The monthly report shall include the percent of grievances resolved in favor of the Plan or provider, and the percent of grievances resolved in favor of the member.
 - For grievances pending over 30 days, the monthly report shall include the number of grievances pending at **Access**' internal grievance/appeal process; the State's consumer complaint process; an action filed or before a trial or appellate court; or other dispute resolution process.
 - For grievances referred to external review, the monthly report shall include the number of grievances submitted to the State fair hearing process, and the number undergoing arbitration.
 16. The QM committee reviews Grievances data to determine trends and initiate changes in policy or practice, as appropriate.
 17. Copies of the grievances and responses shall be maintained by the Plan for five years and shall include a copy of all dental records, documents, evidence of coverage, and other relevant information upon which the plan relied in reaching its decision.
 18. The process for initiating a grievance/appeal, including the location and telephone number where grievances may be submitted, shall be included in the member Evidence of Coverage (EOC) booklet and the provider manual.

19. Members shall be notified of the grievance process upon enrollment and annually thereafter.

20. **Grievance Appeal:** If **Access** is unable to come to a grievance/appeal resolution that is satisfactory to the member, the member may appeal the decision.

- The member may submit an appeal to the State after participating in **Access**' grievance system for 30 days.
- Appeals of grievance/appeal resolutions may be made in writing to the Dental Director, who shall present them to the Quality Management (QM) committee.
- Members are encouraged to submit appeals to **Access** within 45 days from the date of the notification letter to the member regarding initial grievance/appeal determination findings.
- Members will be informed in writing of the disposition of the appeal within 30 days of when the appeal request was received in writing.
- Medi-Cal Members may also appeal grievance/appeal decisions by requesting a Fair Hearing from the State. This information shall be included in the notification letter mailed to the member following a determination. The following information related to filing grievances/appeals is included in the Evidence of Coverage booklet received by every new member and also in the Provider Manual received by every new provider. The information is also included in all grievance/appeal letters.

“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-800-707-6453)** and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free **telephone number (1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department’s Internet **Web site <http://www.hmohelp.ca.gov>** has complaint forms, IMR application forms and instructions online.”

Attachments: Emergency Grievances Representatives Contact List

Grievance Process Flow Chart

Sample Grievance Forms

Emergency Grievances Representatives' Contact List

Primary Company Representative to Contact:

Dr. Laila Baker, D.D.S., Dental Director

Telephone: (916) 563-6011

Pager: (916) 499-0402

Cellular: (916) 804-9180

Email: DrBaker@premierlife.com

Back-up Representatives:

Dr. Reza Abbaszadeh, D.D.S, Chief Executive Officer

Telephone: (916) 563-6010

Pager: (916) 951-1444

Pager: (916) 951-1555

Email: reza@premierlife.com

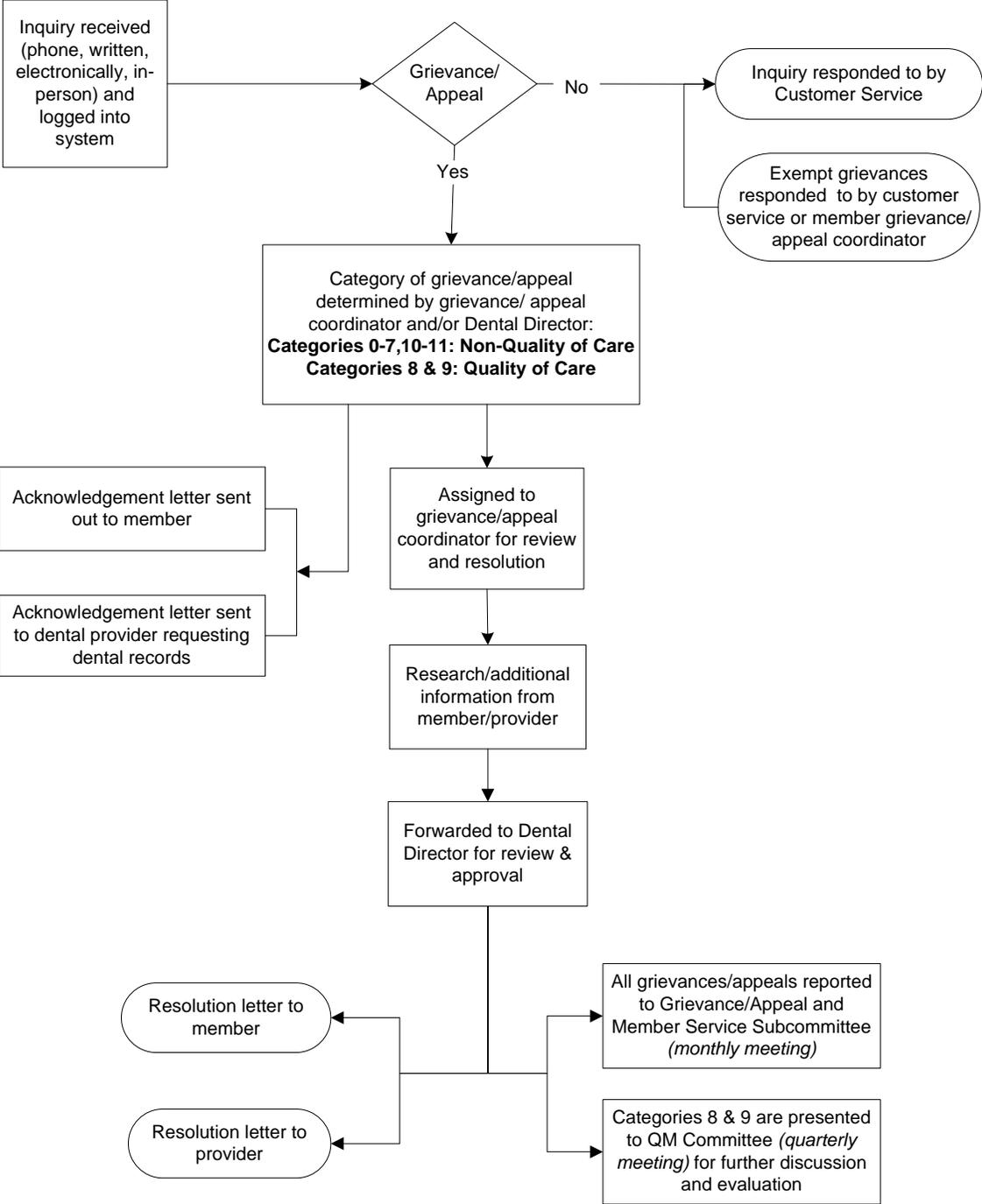
Terri Abbaszadeh, Vice President, Administration

Telephone: (916) 563-6020

Cellular: (916) 712-9100

Email: terri@premierlife.com

Grievance / Appeal Process



Quality Management Policies and Procedures	Procedure #: QM-08
Procedure: Corrective Actions	Effective Date: 09/01/99
	Revised Date: 12/14/07
Approval Signature:	Title: Dental Director

PURPOSE:

To provide a process for corrective action plans when quality of care and quality of service issues are identified.

POLICY:

Member and provider satisfaction is a priority at **Access** Dental Plan. In an effort to achieve ongoing satisfaction with the Plan, **Access** implements numerous monitoring activities to identify areas needing improvement. This involves routine data collection and report analysis to assess quality of care outcomes, administrative operations and services provided. If results of our monitoring and evaluation activities indicate improvement is needed, corrective actions are requested from the provider or in some instances formulated by **Access**.

PROCEDURE:

1. Opportunities for improving the quality of care or the quality of service may be identified through data/outcomes analyses, credentialing, facility and chart reviews or from direct referrals received from staff, providers, members, regulatory agencies or other interested parties.
2. The QM committee shall assess results of QM Studies, performance measure monitoring, Facility Reviews, Dental Chart Audits, Identification of PQIs, and other QM program activities to determine trends that suggest the need for revisions to:
 - ◆ policies and procedures,
 - ◆ increased provider/member/staff education, and/or
 - ◆ correction of staff/provider performance.
3. When quality of care or quality of service issues are identified, the Plan will request a corrective action plan from the provider. In some circumstances, **Access** will provide the corrective action plan.

4. Providers who do not comply with the corrective action plan may be subject to Plan sanctions including but not limited to probation or termination by the Dental Director.
5. Corrective actions plans implemented and results achieved from implementation shall be summarized in a quarterly report by the Dental Director, and shall be submitted to the QM committee for review and recommendations.
6. Corrective action plans implemented, and results achieved from implementation, shall be summarized in quarterly and annual reports to the Board of Directors, through the Dental Director and the QM committee.

Quality Management Policies and Procedures	Procedure #: QM-09
Procedure: Credentialing and Recredentialing	Effective Date: 12/18/06
	Revised Date: 01/24/11
Approval Signature:	Title: Dental Director

PURPOSE:

To provide a well defined credentialing and recredentialing process for evaluating and selecting individual licensed providers to provide care to Access Dental Plan (“Plan”) members.

References: QM-006- California Health and Safety Code 1367(b); 28 CCR 1300.67.2(e); Title 16 of the California Code of Regulations

POLICY:

The Plan will perform initial credential verification of all dental providers prior to contracting and perform recredentialing of contracted providers every three years. The Plan shall also conduct ongoing monitoring between recredentialing cycles to identify quality issues that may adversely affect member dental health.

The Dental Director shall have direct responsibility for implementing and monitoring the credentialing process. The Dental Director shall chair the Credentialing Committee, develop credentialing criteria and shall perform review during the initial credentialing and recredentialing processes.

The Credentialing Committee is made up of the Dental Director and a participating Dental Consultant. The Credentialing Committee will conduct peer review on all providers with credentials that do not meet the Plan’s established credentialing criteria.

[The Plan does not delegate credentialing activities.]

[The Plan may elect to have an outside source complete the credential verification process. In such case, The Plan will contract these services only with a vendor in the process of accreditation by the National Commission for Quality Assurance (“NCQA”) or fully accredited as a Credential Verification Organization (“CVO”) by the NCQA and is in compliance with applicable state statutes and regulations.]

PROCEDURE:

INITIAL CREDENTIALING

1. The Plan conducts initial credentialing to determine if educational, board certification and licensure requirements are met, and that nothing indicates a history of gross malpractice, disciplinary action or provider impairment that would jeopardize member safety and care.
2. Each prospective network provider completes an application which includes the following elements:
 - ◆ Education;
 - ◆ Work history;
 - ◆ Board Status;
 - ◆ DEA Certificate (if applicable);
 - ◆ Malpractice insurance coverage;
 - ◆ Malpractice history;
 - ◆ History of loss of license, limitation of privileges or disciplinary actions;
 - ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation
 - ◆ History of illegal drug use or chemical dependency or substance abuse problem; and
 - ◆ History of conviction of a crime.
3. Provider Services reviews the application and information from dental schools, state licensing agencies, specialty boards, certification agencies and the National Practitioners Data Bank (“NPDB”) to verify the Plan’s criteria is met in the following categories:
 - ◆ Current, valid Dental License in the state in which he or she is being contracted;
 - ◆ Current , valid DEA Certificate (if applicable);
 - ◆ Graduation from a Dental School and completion of other post graduate training, as applicable for Board Certification in a specialty field;
 - ◆ Five consecutive years of dental work history, with gaps of no more than 6 months;
 - ◆ Malpractice insurance coverage of at least \$500,000 per incident and \$1,000,000 aggregate;
 - ◆ No history of malpractice claims within the last five year period;
 - ◆ No history of loss of license, limitation of privileges or disciplinary actions;
 - ◆ No reason for inability to perform the essential functions of the position, with or without accommodation;
 - ◆ No history of illegal drug use, chemical dependency or substance abuse problem;

- ◆ No history of conviction of a crime;
 - ◆ No State sanctions, restrictions on licensure or limitations on scope of practice;
 - ◆ No Medicare or Medicaid sanction, restrictions or licensure limitations; and
 - ◆ Attestation as to correctness/completeness of the application is signed and dated by the provider.
4. If information obtained during the initial credentialing process varies substantially from the information on the provider application, the Plan notifies the provider by mail of the variance and the provider's right to correct erroneous information submitted by another source (refer to section "Provider Rights").
 5. After the verification process is complete, the Plan determines if the provider meets all credentialing criteria or if the provider requires review.
 6. The review and decision process is determined as follows:
 - ◆ Providers who meet all credentialing criteria are reviewed and approved by the Dental Director.
 - ◆ Providers who do not meet all credentialing criteria are reviewed by the Credentialing Committee for determination.
 - ◆ If the Credentialing Committee determines that additional review is required, the provider is reviewed by the Peer Review Subcommittee for recommendation. The Credentialing Committee shall then make a final determination. The Peer Review Subcommittee shall meet quarterly.
 7. Within 60 calendar days of the credentialing determination, notification of the decision is mailed to the provider.

RE-CREDENTIALING

1. Re-verification of provider credentials (re-credentialing) shall be done every three years for all contracted providers. Using the same verification sources as the initial credentialing process, the Plan re-verifies all credential criteria with the exception of provider education and work history.
2. If information obtained during the re-credentialing process varies substantially from the information on the provider application, the Plan notifies the provider by mail of the variance and the provider's right to correct erroneous information submitted by another source (refer to section "Provider Rights").
3. After the verification process is complete, the Plan determines if the provider meets all credentialing criteria or if the provider requires review.
4. The review and decision process is determined as follows:
 - ◆ Providers who meet all credentialing criteria are reviewed and approved by the Dental Director.

- ◆ Providers who do not meet all credentialing criteria are reviewed by the Credentialing Committee for determination.
 - ◆ If the Credentialing Committee determines that additional review is required, the provider is reviewed by the Peer Review Subcommittee for recommendation. The Credentialing Committee shall then make a final determination. The Peer Review Subcommittee shall meet quarterly.
5. If the provider is denied as result of the recredentialing review, a notification is mailed to the provider within 60 calendar days of the credentialing decision. Written notification shall indicate reasons for the action and a summary of the appeal right and process.
 6. If the provider is approved as result of the recredentialing review, notification will not be necessary.

ONGOING MONITORING

The Plan conducts ongoing monitoring between recredentialing cycles to identify quality issues that may adversely affect the member's dental health. Ongoing monitoring processes include review of complaints, adverse events, Medicare/Medicaid sanctions and license sanctions and limitations.

1. The Plan reviews the following:

Description	Frequency	Source
Sanctions or limitations on licensure	Monthly	State Dental Board
Medicare/Medicaid sanctions	Monthly	<i>List of Excluded Individuals and Entities</i> , maintained by Office of Inspector General (OIG)
Member grievances and appeals	Every 6 months	Plan report of member grievances by provider
Adverse events (An adverse event is an injury that occurs while a member is receiving health care services from a provider)	Every 6 months	Plan report of member grievances

2. When sanctions, grievances/appeals or adverse events are identified for a provider, the information shall be presented to Credentialing Committee to determine any evidence of poor quality that could affect the health and safety of Plan members.
3. If the Credentialing Committee is not able to make a determination on the required action for the findings, the information shall be presented to the Peer Review Subcommittee for review.
4. If a quality of care or quality of service issue is identified, the Credentialing Committee or Peer Review Subcommittee shall determine any corrective action plan implementation or

termination action required by the Plan. Written notification will be mailed. Written notification shall indicate reasons for the action and a summary of provider appeal rights and process.

CONFIDENTIALITY

1. Information obtained during the credentialing and recredentialing process is confidential and shall be protected by the Plan, except as otherwise provided by law.
2. Access to credentialing information is limited to Plan staff who are directly involved in the credentialing and recredentialing processes.
3. The Plan shall require all members of the Credentialing Committee and Peer Review Subcommittee to sign a Confidentiality and Conflict of Interest form, which states that the provider will keep all information confidential and not disclose, or make use of, confidential information to which he or she may have access.

NONDISCRIMINATORY CREDENTIALING AND RECREDENTIALING

1. The Plan does not make credentialing and recredentialing decisions based on a dental provider's race, ethnicity, nationality, gender, age, sexual orientation or the type of procedure or member (e.g., Medicaid) in which the provider may specialize.
2. The Plan shall perform audits of provider disputes every six month period to determine if there are complaints alleging discrimination.
3. The Plan shall require all members of the Credentialing Committee and Peer Review Subcommittee to sign a Confidentiality and Conflict of Interest form, which includes a statement affirming that the provider will not discriminate when making decisions related to credentialing review.

PROVIDER RIGHTS

Providers have the following rights related to the credentialing and recredentialing process:

1. Providers have the right to be informed of the status of their credentialing or recredentialing application. If a provider requests the status of his or her application, the Plan will provide a description of the status within 30 calendar days of the request. This status will specify if the application is in the verification process, review and decision process or if a credential decision has been made.
2. Providers have the right to review any information submitted in support of their credentialing decision, with the exception of references, recommendations or other peer-review review protected information. The provider must submit a written request to review the information. The Plan will respond to the request via mail within 30 calendar days.
3. Providers have the right to correct erroneous information obtained by the Plan during the credentialing and recredentialing process.
 - Corrections must be submitted within 30 calendar days from the date the provider is notified that information on the provider application varied significantly from verification information obtained by the Plan.

- Corrections must be submitted to the Plan's Provider Services Department in writing and must include the name and description of the element or criteria that requires correction, the correct information and explanation.
- The Plan documents receipt of corrections in the provider's file.

The Plan shall inform providers of these rights on the provider application and Plan's website.

PROVISIONAL CREDENTIALING

The Plan may need to make providers available prior to completion of the entire initial credentialing process. In this case, the Plan shall provisionally credential providers based on the verification of the following:

- Primary-source verification of a current, valid license to practice
- Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB)
- A current and signed application with attestation

Provisional credentialing shall only apply to providers applying to the Plan for the first time. A provider shall not remain in provisional status for more than 60 calendar days.

MEMBER MATERIALS

Member materials, including provider directories, reflect providers who have been verified, reviewed and approved through the Plan's initial credentialing process and providers approved through the recredentialing process at least every three year period thereafter. Information obtained during the credentialing process is entered in the Plan's system which is used for generating provider data for member materials.

Attachment:

Initial Credentialing and Recredentialing Process Workflow

Initial Credentialing and Recredentialing Process Workflow

