

DHCS AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
SACRAMENTO SECTION

**REPORT ON THE DENTAL AUDIT OF ACCESS
DENTAL PLAN OF CALIFORNIA
FISCAL YEAR 2024-25**

Contract Numbers: 12-89341 and 13-90115

Audit Period: November 1, 2023 — March 31, 2025

Dates of Audit: April 21, 2025 — April 25, 2025

Report Issued: September 26, 2025

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I. INTRODUCTION

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

The Plan is a specialty dental health plan with a statewide network of contracted general and specialty dental providers. The Plan provides dental services to members under the Sacramento Geographic Managed Care and Los Angeles Prepaid Health Plan programs.

The Plan has approximately 224 providers for Sacramento County and has approximately 843 providers for Los Angeles County.

As of May 2025, the Plan's Medi-Cal membership was composed of 125,830 Geographic Managed Care and 109,866 Prepaid Health Plan members.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS dental audit for the audit period of November 1, 2023, through March 31, 2025. The audit was conducted from April 21, 2025, through April 25, 2025. The audit consisted of document review, verification studies, and interviews with the Plan's personnel.

An Exit Conference with the Plan was held on September 5, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The findings in the report reflect the evaluation of all relevant information received prior and subsequent to the Exit Conference.

The audit evaluated three categories of performance: Utilization Management, Access and Availability of Care, and Member's Rights.

The prior DHCS dental audit covering the period of November 1, 2022, through October 31, 2023, was issued on October 10, 2024. This audit examined the Plan's compliance with its DHCS Contracts. The Corrective Action Plan was only partially closed at the time of the audit. Category 1 findings were not yet closed.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Utilization Management

Dental All Plan Letter (D-APL) 22-006, *Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Affecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments*, introduced changes to Notice of Action (NOA) letter templates. Finding 1.2.1: The Plan did not utilize the required NOA letter templates and attachments in accordance with D-APL 22-006. This is a repeat finding from the prior year's audit.

When the Plan receives information that is reasonably necessary to make a determination, it must approve, delay, modify, or deny a provider's request for dental services. Finding 1.2.2: The Plan did not consider all available information received about members' conditions when making decisions to deny or modify Prior Authorizations (PA).

Category 3 – Network and Access to Care

The Plan is required to maintain a call center response abandonment rate of seven percent or less. Finding 3.1.1: During the audit period, the Plan did not maintain a call abandonment rate (weekly average “P” factor) of seven percent or less.

Category 4 – Member’s Rights

The Plan is required to resolve member grievances within 30 calendar days of receipt of a grievance. A grievance is resolved when it has reached a final conclusion with respect to the member’s complaint. Finding 4.1.1: The Plan did not fully resolve member Quality of Care (QOC) grievances within 30 days of receipt.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and State Contracts.

PROCEDURE

An audit was conducted from April 21, 2025, through April 25, 2025. The audit included a review of the Plan's Contract with DHCS, the policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

PA: Fifteen dental services PA files were reviewed. This included deferred, modified, denied, and approved PA. The sample was selected to cover the different specialties of dentistry, different age range of members, and to reflect both Sacramento and Los Angeles Counties.

Appeals: Seven dental services appeals were reviewed and included the different specialties in dentistry, including children and adults, and to reflect both Los Angeles and Sacramento Counties.

Category 3 – Network and Access to Care

There were no verification studies conducted for the audit review.

Category 4 – Member's Rights

Grievance Procedures: Seven QOC and ten quality of service grievance files were reviewed for timely resolution, compliance, and submission to the appropriate level of review. In addition, three exempt grievances and five call inquiry files were reviewed.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.2 Prior Authorization Review

1.2.1 Notice of Action Letters

Dental Managed Care (DMC) plans must provide members with written notice of an adverse benefit determination using the DHCS-developed, standardized NOA template and the NOA “Your Rights” template. The following distinct NOA templates accommodate actions that DMC plans may commonly take:

1. Denial of a treatment or service
2. Delay of a treatment or service
3. Modification of a treatment or service
4. Suspension or reduction of the level of treatment or service currently underway

DMC plans are not permitted to make any changes to the NOA templates or NOA “Your Rights” templates without prior review and approval from DHCS, except to insert information specific to the member as required. (*D-APL 22-006, Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Affecting Grievance and Appeal Requirements; Revised “Your Rights” Attachments*)

UM.017.01 Written Notification 12/23/24, states that as contractually required, all written notifications issued to member/representative and provider are completed via template(s) approved and supplied by Managed Care Oversight (MCO). Templates provided by plans will be utilized unless otherwise specified.

Written notices of denial, deferral, or modification of PA requests, including requests for referral for Specialist Dental Care, shall be provided on a standardized form, approved by the DHCS.

Finding: The Plan did not utilize the required NOA letter templates and attachments according to D-APL 22-006.

A verification study showed that in 15 of 15 PA files, the Plan provided members with a written NOA without using the revised DHCS NOA template.

According to the February 2024 Corrective Action Plan, prior submissions of the NOA letter template were not formatted properly and were not approved by Medi-Cal Dental Services Division.

If the Plan does not utilize the required NOA templates, members may not be fully informed of important details about the status of or decision related to their PA for dental services.

This is a repeat of the prior year's finding - 1.2.1 - Notice of Action Letter Templates.

Recommendation: Ensure the use of required NOA templates.

1.2.2 Prior Authorization Decisions

When the Plan receives information that is reasonably necessary to make a determination, it must approve, delay, modify, or deny a provider's request for dental services. (*D-APL 22-006, Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Affecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments*)

UM.004.01 Clinical Review Staff Roles and Responsibilities, states that determinations to approve, deny, delay, or modify requests by providers are based in whole or in part on dental necessity.

Finding: The Plan did not consider all available information received about members' conditions when making decisions to deny or modify PA.

In PA verification file 11, the provider submitted PA requests for procedure codes D1557 (removal of a fixed bilateral space maintainer) and D2931 (prefabricated stainless-steel crown). The Plan found two issues with the provider's PA documentation and subsequently denied both services:

1. Code D1557: This is the procedure code for removal of a fixed bilateral space maintainer. The provider's documentation uses oral area code 00, which normally refers to the "entire oral cavity," instead of code 01, which is more appropriate for the patient's maxillary arch area.
2. Code D2931: The PA documentation includes the appropriate tooth number for the stainless-steel crown (number 19), but the provider handwrote the word "deep" next to the tooth number on the documentation. The handwriting caused the Plan's computer system to not read the tooth number to input into the system.

The Plan's reason for denial reads: "This has been denied because the tooth number/quadrant/arch/surface for the requested service was missing and we did not receive it within 14 days. This is not medically necessary."

The documentation, however, includes radiograph images which show the location of the maxillary space maintainer requiring removal. The Plan could have used the information to modify the oral area code from 00 to 01. A separate radiograph image shows the tooth that requires a stainless-steel crown. The Plan could have used the information to override its computer system error to tooth number 19 instead of denying the service.

The Plan confirmed during an interview that it relies on its computer system to read and input PA claim information without human verification. In addition, the Plan stated that while Dental Consultants review documentation such as the radiographs, verification file 11 was not modified because the Plan's does not modify or correct provider PA submission errors, even if the Plan is in possession of documentation to substantiate a modification.

When the Plan does not consider all available information to modify PA, medically necessary services may be delayed.

Recommendation: Implement policies and procedures to ensure the Plan modifies PA decisions based on all information received that is reasonably necessary to make the determination.

COMPLIANCE AUDIT FINDINGS

Category 3 – Access and Availability

3.1 Access and Availability

3.1.1 Call Center Availability

The contractor must maintain a weekly average call abandonment rate ("P" factor) of no more than seven percent. This is defined as the percentage of connected calls versus non-connected calls and/or busy signals. (*Contract, Exhibit A, Attachment 14(C)*)

Finding: The Plan did not maintain a weekly average call abandonment rate of seven percent or less.

According to the Plan's 2024-2025 P Factor Quarterly Report, the Plan did not meet the call abandonment rate requirement for quarter four (Q4) of 2024 and quarter one (Q1) of 2025. The abandonment rate in Q4 of 2024 was 9.78 percent (Sacramento) and 9.70 percent (Los Angeles) respectively. The abandonment rate in Q1 of 2025 was 18.46 percent (Sacramento) and 17.71 percent (Los Angeles) respectively.

During an interview, the Plan stated that it had migrated to a new computer system in Q4 of 2024 and that the change required the Plan to conduct new training and staffing efforts to support the changes. Confusion surrounding the new system caused an increase in call center volume from members and providers, exacerbating the wait times. This impacted the Plan's average speed of answering calls and its ability to meet abandonment rate requirements.

When the abandonment rate is high, the Plan may not be able to adequately respond to member inquiries and may miss important opportunities to serve their members.

Recommendation: Ensure staff are adequately prepared for changes in the call center system to maintain the required call abandonment rate.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member’s Rights

4.1 Grievance System

4.1.1 Grievance Resolution

The Plan is required to resolve member grievances within 30 calendar days of receipt of a grievance. A grievance is resolved when it has reached a final conclusion with respect to the member’s complaint. (*D-APL 22-006, Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Affecting Grievance and Appeal Requirements; Revised “Your Rights” Attachments*)

GA.001.01 Grievance and Appeals 5/29/24, states the Plan's resolution containing a written response to the grievance shall be sent to the complainant within 30 calendar days of receipt. “Resolved” means that the grievance has reached a final conclusion with respect to the member's submitted grievance, and there are no pending member appeals within the Plan's grievance system, including entities with delegated authority.

Finding: The Plan did not fully resolve member QOC grievances within 30 days of receipt.

In four of seven QOC grievance verification study files, the Plan did not take action to rectify the member’s complaint within the 30-day grievance resolution deadline. Instead, the Plan referred the grievances to Potential Quality Issue (PQI) review and did not take action to rectify members’ complaints until the completion of the PQI reviews, which occurred after the 30-day grievance resolution deadline.

Regardless of whether a grievance is referred to PQI review, the action to address the member’s concern must be completed within 30 calendar days.

According to the Plan’s grievance documentation from the four verification study files, PQI reviews were not completed until after the 30-day grievance resolution time limit transpired. For example, in QOC grievance verification file three, the Plan completed its PQI investigation and took action to reinstate the member’s eligibility for deep cleaning. However, the resolution did not come until 41 days after the Plan initially received the grievance.

The Plan did not follow its policy and procedure *GA.001.01* to fully resolve grievances to their final conclusions within 30 calendar days. During an interview, the Plan

acknowledged the gap in timeliness from when the grievances were first received and when actions were subsequently taken after PQI investigation.

Delays in taking action for member grievances may lead to the perpetuation of member mistreatment.

Recommendation: Ensure the implementation of the Plan's existing policy to fully resolve grievances within 30 calendar days.