DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SACRAMENTO SECTION

REPORT ON THE DENTAL AUDIT OF LIBERTY DENTAL PLAN OF CALIFORNIA YEAR 2025

Contract Numbers: 12-89343 and 13-90117

Audit Period: July 1, 2024 — June 30, 2025

Dates of Audit: February 17, 2026 — February 27, 2026

Report Issued: August 4, 2026

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I. INTRODUCTION

Liberty Dental Plan of California (Plan) has a contract with the California Department of Health Care Services (DHCS) to provide dental services to Medi-Cal 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 Medi-Cal Dental Managed Care program.

The Plan has approximately 459 providers for Sacramento County and has approximately 1,507 providers for Los Angeles County.

As of March 2026, the Plan's Medi-Cal membership was composed of approximately 306,917 Geographic Managed Care members and 90,988 Prepaid Health Plan members.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS dental audit for the audit period of July 1, 2024, through June 30, 2025. The audit was conducted from February 17, 2026, through February 27, 2026. The audit consisted of document review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on June 4, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On June 18, 20260, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability to Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS dental audit for the period of July 1, 2023, through June 30, 2024, was issued on March 25, 2025. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year 2024, Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management

For Notice of Action (NOA) letters to the provider, the Plan must include the name and direct telephone number or extension of the decision maker. Finding 1.2.1: The Plan did not ensure that the name of the decision maker listed on Prior Authorization (PA) NOA letters to providers matched the name of the decision maker in the Plan's adjudication system.

Category 2 – Case Management and Coordination of Care

There were no findings noted for this category during the audit period.

Category 3 – Access and Availability to Care

There were no findings noted for this category during the audit period.

Category 4 – Member's Rights

Within ten calendar days of mailing a Discrimination Grievance Resolution letter to a member, Plans must submit detailed information regarding the grievance to the DHCS Office of Civil Rights' (OCR) designated discrimination grievance email inbox. Finding 4.1.1: The Plan did not submit the required information to the DHCS discrimination grievance email inbox within ten calendar days after mailing a Discrimination Grievance Resolution letter to the member.

Category 5 – Quality Management

There were no findings noted for this category during the audit period.

Category 6 – Administrative and Organizational Capacity

There were no findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

DHCS conducted an audit of the Plan from February 17, 2026, through February 27, 2026. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, 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 the Plan's service areas.

Appeals: Twelve dental services appeals were reviewed and included the different specialties in dentistry, including children and adults, and to reflect the Plan's service areas.

Category 2 – Case Management and Coordination of Care

Initial Health Appointment/Oral Health Information Form: Ten initial health appointment/Oral Health Information Form files were reviewed for compliance with timeliness and completion requirements.

Category 3 – Access and Availability

There were no verification studies conducted for the audit review.

Category 4 – Member's Rights

Grievance Procedures: Twelve quality of care grievance files and 15 standard quality of service grievance files were reviewed for timely resolution, compliance, and submission to the appropriate level of review. In addition, five exempt grievance files and five call inquiry files were reviewed.

Category 5 – Quality Management

New Provider Training: Ten new provider training files were reviewed for compliance with training requirements.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: Eight fraud, waste, and abuse case files were reviewed for compliance with investigation, reporting, and referral requirements.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.2 Prior Authorization Review

1.2.1 Prior Authorization Decision Maker Identification

For written NOA letters to the provider, the Plan must include the name and direct telephone number or extension of the decision maker. *(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)*

Plan policy, *Liberty Dental UM 1.2.1.05 Timeliness Standards of UM Decisions* (approved 11/26/25), states that provider written determination notices to deny, delay, or modify a request for services will include the name, telephone number, of the Plan's professional who made the determination to allow for a peer-to-peer discussion.

Finding: The Plan did not ensure that the name of the decision maker listed on the NOA letter matched the name of the decision maker listed in the Plan's adjudication system.

A verification study revealed that in 3 of 15 prior authorization files, the name of the decision maker identified in the Plan's adjudication system did not match the name of the decision maker listed on the NOA letters sent to providers.

In one sample:

- The Plan's adjudication system identified a dentist as the decision maker. However, the corresponding NOA letter dated October 1, 2024, listed a different dentist name as the decision maker.

In a similar sample:

- The same discrepancy occurred on the NOA letter dated March 28, 2025.
- During the interview, the Plan stated that the two names point to same individual. However, the Plan's computer system used the dentist's middle name instead of first name on the NOA letter. The Plan could not explain why two different name variations were used across its systems and written notifications.

In another sample:

- The Plan's adjudication system identified Dentist X as the decision maker on March 4, 2025. However, the NOA letter to the provider dated March 11, 2025, listed Dentist Y as the decision maker.
- In addition, it was determined that Dentist X was not employed with the Plan on March 4, 2025. According to Plan documents, Dentist X was employed May 13, 2025, through January 2, 2026, yet he was listed as the clinical reviewer by the Plan's adjudication system.

During an interview, the Plan stated that its system pulls the names of decision makers from a different list than the list used to generate written PA NOA letters to providers. One list is maintained by the Adjudication Unit and the other is maintained by the NOA Letter Unit. The Plan indicated that both lists are updated regularly but could not explain why the names on the NOA letter did not correspond with the decision makers names in the adjudication system.

These two lists are not reviewed for synchronization, which allows for mismatches to occur. Printing incorrect names on NOA letters can lead to delays when routing a provider that calls for a peer-to-peer reason for the denial to the correct consultant.

When the name of the decision maker on the written notification does not match the decision maker in the Plan's system, providers may experience confusion when attempting to identify and contact the appropriate dental professional for a peer-to-peer discussion. Any delay or confusion in the peer-to-peer discussion process may result in delays for members to receive medically necessary dental services.

Recommendation: Develop and implement procedures to ensure that the decision maker's name on PA written notifications to providers matches the decision maker's name in the Plan's adjudication system, in accordance with D-APL 22-006 and Plan policy UM 1.2.1.05.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.1 Grievance System

4.1.1 Discrimination Grievance Reporting

Within ten calendar days of mailing a Discrimination Grievance Resolution letter to a member, Plans must submit detailed information regarding the grievance to the DHCS OCRs' designated discrimination grievance email inbox. *(D-APL 21-001, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Finding: The Plan did not submit the required information to the DHCS OCR' discrimination grievance email inbox within the required ten calendar days after mailing a Discrimination Grievance Resolution letter to the member.

The Plan lacked a policy requiring the reporting of discrimination grievances to DHCS within ten calendar days until June 20, 2026, ten days before the end of the audit period.

A verification study revealed that in six of nine discrimination grievance files, the Plan did not submit the required information to the DHCS OCR' designated discrimination grievance email inbox in a timely manner until between 14 and 311 days.

The untimely submissions were attributable to two issues. First, in certain cases, the Grievance and Appeals (G&A) analyst failed to send the required email to the OCR' email inbox when closing the discrimination-related grievance. The Plan stated that the G&A analyst was not aware of the requirement to send the email upon closure of a discrimination grievance. Second, in other cases, the G&A analyst initially misclassified discrimination-related grievances as non-discrimination grievances. Because the grievances were classified as non-discrimination in nature, sending the email to the OCR' email inbox was not identified as a necessary step when closing the grievance.

Through a retrospective review of grievances completed in July 2025, the Plan identified the affected grievances where the G&A analyst failed to send the required email and where grievances were initially misclassified. The Plan stated that these grievances were subsequently reinvestigated and reclassified. New Grievance Resolution Letters addressing the members' discrimination allegations were issued, and the required emails with supporting documents were sent to the OCR' email inbox.

When the Plan does not submit the required supporting documentation to DHCS within the required timeframe, DHCS may not be able to obtain a detailed understanding of the grievance which may affect the DHCS' ability to ensure that the affected member's discrimination complaint was appropriately addressed and resolved.

Recommendation: Develop and implement policies and procedures to ensure that G&A staff send the required supporting documents to the DHCS OCR' discrimination grievance email inbox within ten calendar days of mailing a Discrimination Grievance Resolution letter to the member.