CAP Response Form

DMC Plan: Access Dental Plan

CAP Type: Department of Health Care Services Dental Audit

The Medi-Cal Dental Managed Care (DMC) plan is required to submit a corrective action plan (CAP) within 30 calendar days. The CAP response must include completion of the prescribed columns below to include a description of the corrective action, a list of all supporting documentation submitted, and the CAP implementation date. For systemic deficiencies that may be reasonably determined to required long-term corrective action for a period longer than 30 days to fully remediate or operationalize, the DMC plan must demonstrate that sufficient progress has been made toward implementation of the CAP. In those instances, the DMC plan is required to include the dates for key milestones as well as when full compliance will be achieved.

The Medi-Cal Dental Services Division of the Department of Health Care Services will maintain close communication with the DMC plan throughout the CAP review process and provide technical assistance as needed.

Finding	Description of Corrective Action	Supporting Documentation (include list of file names)	Implementation Date	DHCS Comments
1.1.1 The Plan did not inform DHCS of the change of Dental Director within ten calendar days.	The Plan acknowledges that DHCS was not informed of the change in Dental Director within ten calendar days as required. This requirement was reiterated to the Access Dental Plan Strategic Client Partner. Should any future changes occur communication will be sent to The Department of Health Care Services by the SCP within the required timeframe.			**9/8/20:** The plan submitted the following documentation: • The new Dental Director's contact information **9/9/20:** The plan submitted the following additional documentation: • *"Policy and Procedure: Key Staff Roles and Responsibilities"* (draft) as evidence that plan has updated its policy

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				to detail the Strategic Client Partner's responsibility in informing DHCS of any changes in the Dental Director within the required 10 calendar days. **This finding is closed.**
1.1.2 The Plan did not have a process in place to ensure consistency and compliance with the Medi-Cal Manual of Criteria when making clinical dental decisions.	The Plan acknowledges that dental staff's decision-making and adherence to the Medi-Cal Manual of Criteria must be improved in accordance with The State's expectations. To address this concern a new policy detailing the Inter-rater reliability (IRR) process was drafted and reviewed with the Chief Compliance Officer to ensure adherence to DHCS requirements. A final draft will be completed no later than August 31, 2020 and the first IRR session with the newly established process will be completed in the 4th quarter of 2020.	IRR_2020.08.14_ DRAFT	4th Quarter 2020	**8/14/20:** The plan submitted the following documentation: • *"Policy and Procedure: Inter-Rater Reliability"* (8/13/20) as evidence that the plan has developed a quarterly IRR process to ensure consistent application of the Medi-Cal Manual of Criteria. The plan will utilize an 8/30 sampling methodology and individuals who score less than 90% will be monitored for an additional 30 days until 90% is achieved. The Dental Director will lead group meetings to discuss each case and

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				the group will identify the Medi-Cal criteria used to make the ultimate decision. **12/11/20:** The plan submitted the following documentation: • *"Q3 Inter-Rater Reliability Report" and "Three (3) Inter-Rater Reliability Dental Consultant Reviews Q3"* as evidence that the plan implemented a quarterly IRR process to ensure decision-makers consistently apply the Medi-Cal criteria when making clinical decisions. **This finding is closed.**
1.2.1 The Plan's prior authorization denial reasons are written using dental terminology that may be difficult for	The Plan acknowledges that written communication with members may be improved to provide more clearly understandable explanations framed in language reasonably accessible to laypersons. As a result of this finding the Plan has begun a review of all existing approval and denial codes to ensure the		September 11, 2020	**9/29/20:** The plan submitted the following documentation: • Email response indicating that the original 9/11/20 implementation was

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members to understand.	verbiage used on member noifications are clear and concise, and writt a sixth-grade level based on the Fel -Kinkaid Grade Level Test. All revisi to approval/denial code reasoni will be finalized by August 21, 2020 aill be incorporated into letters genered after September 11, 2020.			delayed. The codes will be released for testing on 10/8/20, but there is no implementation date as of yet. • *"2020 Clinical Administration Code"* list as evidence that the majority of denial codes have been extensively revised to be clear and concise, and written at a sixth-grade level. The plan included revised denial language for both provider and member notices. (Columns H, I, P) **10/12/20:** The plan provided an email response indicating that implementation is set for 10/30/20. **10/27/20:** During a conference call with the plan, the plan provided an update indicating that they recently performed re-measurement activities

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				but the results were still not what they would like to see. Therefore, the plan will continue to make revisions to the template and will provide an updated response on status, including further re-measurement activities on **11/19/20:** The plan submitted the following documentation as evidence of implementation: • Five (5) sample provider NOA letters dated after implementation • *"Notification Audit Workflow*" does not demonstrate monitoring of clear and concise denial reasons. **11/25/20:** The plan submitted the following documentation as evidence of implementation:

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				• *"Notification Audit Workflow*" an updated version which does demonstrate monitoring of clear and concise denial reasons **12/04/20:** The plan submitted the following documentation as evidence of implementation: • Two (2) sample member NOAs dated after implementation that demonstrate usage of the new denial codes **This finding is closed.**
1.2.2 The Plan did not communicate with members' providers nor consider all information available to them about the enrollee's condition when making decisions to approve, modify, or	The Plan acknowledges this deficiency and understands that all information must be considered about the enrollee's condition when rendering a decision on a prior authorization. To address this finding the Dental Director completed a review of all procedure codes and identified all codes that are clinically appropriate to be modified by the dental consultants. These codes and guidance on modification were reviewed with Plan dental		August 5, 2020	**9/30/20:** The plan submitted the following documentation: • *"Policy and Procedure: Inter-Rater Reliability"* (8/13/20) as evidence that the plan has developed a quarterly process to ensure all clinical information available is reviewed

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deny prior authorizations.	consultants during a training held on August 5, 2020. In future cases such as verification study sample #13, the consultant will review the member's history to modify the procedure code when sufficient information is available within the member's record to make the modification. For verification study sample #8, the Plan respectfully disagrees that the modification of a filling material by the Plan was appropriate. To address these types of cases in the future, cases where a provider submits multiple prior authorization requests for non-covered services will be escalated by the Prior Authorization team to the Provider Relations Team that will outreach to the provider to conduct reeducation on the services that are covered by the Plan in an effort to reduce the recurrence of subsequent duplicative resubmissions.			and contact with a provider occurs when necessary before making prior authorization decisions. **This finding is closed.**
1.2.3 The Plan did not meet prior authorization decision and Notice of Action letter timeframes.	Access Dental Plan has implemented several reporting enhancements to improve the oversight of the prior authorization process and enhancements to the NOA and delayed NOA process to ensure timely notification of written correspondence occurs. Effective June 10, 2020 a daily tracking report was implemented to monitor and track extensions and ensure delayed cases are reviewed timely and closed appropriately if additional information has not been received. In addition, enhancements were requested to the		June 10, 2020 September 1, 2020 September 15, 2020	**10/01/20:** The Plan submitted the following documentation: • *"NOA Batch Inventory Monitoring"* process (effective 7/14/20) as evidence that the plan has created a new monitoring process to track the inventory of prior authorization requests received

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	existing report to include information on the aging of pending requests. All enhancements will be completed by September 15, 2020. Furthermore, effective September 1, 2020 all written notice of action letters will be automated to ensure notifications are distributed to members and providers as appropriate. Claims Management will continue ongoing monitoring of these processes after implementation to ensure timely adjudication of all prior authorizations as required by DHCS.			against the number of authorizations processed. • *"MC Claim_NOA Control Log"* (September 2020) as evidence that the plan has fully implemented its monitoring process and is tracking turnaround times for all prior authorization requests received (column R). **10/7/20**: DHCS provided technical assistance to the plan's and noted its internal 12-day EPSDT prior authorization timeframe. DHCS reminded the plan that the timeframe requirements for all prior authorizations is the same regardless of population (within 5 business days of receipt of necessary information but no more than 14 calendar days) as outlined in APL 17-003E (page 4). **This finding is closed.**

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1.3.1 Clinical appeals were not routed to appropriate clinical staff.	Access Dental Plan acknowledges this deficiency and has identified opportunities to improve the clinical appeals process. A staff meeting was held on March 11, 2020 to reiterate the established procedures for routing cases to the appropriate consultant for review and determination. Once a decision has been rendered, the Consultant will document their determination via email and a copy of the communication will be included within the case file.		March 11, 2020	**11/17/20:** The plan submitted the following documentation: • *"Appeal Review by Dental Director"* cover sheet (11/16/20) as evidence that final review of the appeal case includes a cover sheet that contains fields to clearly delineate the initial and appeal reviewer to ensure they are not the same. • Email response clarifying that the Dental Director can be either the initial or appeal reviewer since he occasionally assists with consultant review of initial prior authorizations but that he is never both on the same case. **This finding is closed.**

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3.1 The Plan did not document its monitoring of telephone wait times in the Provider offices, nor did it ensure member phone calls were returned in a timely manner.	Access Dental Plan has identified opportunities to improve the oversight of telephone wait times in Provider offices. Effective August 20, 2020 calls will be made to all in network provider offices at least annually to query member average hold time and the time an office takes to return a member call. Responses will be captured and tracked by the Provider Services Team and communicated to the Manager, Provider Relations. If an office does not meet the compliance thresholds a member of the Provider Relations Team will complete provider re-education. If continued non-compliance is noted Provider Relations will coordinate additional corrective measures, up to and including the issuance of a corrective action plan. Documentation of this process will be added to the AA.001.01 Appointment Availability and Wait Time Standards policy and presented at the Policy and Procedure meeting scheduled on August 20, 2020 for approval.	AA.001.01_Appt Avail and Wait Time_2020.08.14 DRAFT	August 20, 2020	**9/18/20:** The plan submitted the following documentation: • *"Accessibility and Validation Spreadsheet"* as evidence the plan has developed a monitoring tool to capture telephone wait times (columns H and I).The plan indicated that the survey process began 9/21/20. **9/23/20:** The plan submitted the following documentation: • *"Policy AA.001.01: Appointment Availability and Wait Time Standards" (draft)* as evidence that the policy was updated to incorporate monthly monitoring of average telephone wait times (Telephone Access Section – 2 and 3; Compliance Monitoring Section –5.g). Plans will be surveyed on a

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				rolling basis no less than annually. • Email response confirming that the survey process began on 9/21/20. **This finding is closed.**
4.1.1 The Plan's grievance resolution letters were not clear and concise. The letters consisted of extensive explanations written using several paragraphs and uncommon dental terminology.	Access Dental Plan has identified opportunities to improve the grievance resolution process. Grievance and Appeals staff were retrained on appropriate letter resolution procedures on May 29, 2020 and June 9, 2020 by the department Supervisor to reinforce the requirement that letters must be clear and concise and pass all readability requirements. Furthermore, the Supervisor implemented a process that requires a screenshot of the readability statics score for each letter must be documented within the case file so the information is available during future reviews. To ensure readability requirements are met and captured within the case file a monthly audit of Grievance and Appeals files will be conducted by the Compliance Team through the end of the calendar year. Letters that are inconsistent with Access Dental Plan standards will be shared with Grievance and Appeal Management. Compliance will monitor to ensure corrective actions,		May 29, 2020	**9/24/20:** The plan submitted a sample email (8/24/20) as evidence that G&A staff receive monthly reminders to include readability statistics of response letters for each case file. **9/30/20:** The plan submitted the following documentation: • "*Grievance and Appeals Review Process*" (effective 9/1/2020) as evidence that the plan has implemented a new monthly auditing process to review of resolution letters to ensure they are clear, concise, and at a sixth-

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	including retraining of staff, is completed as necessary.			grade level readability The process includes a 10% monthly sampling of letters using the Microsoft Word readability function (Flesch-Kincaid). • 5 sample grievance resolution letters (post 6/9/20 training) as evidence of the effectiveness of staff retraining and monthly oversight. The resolution letters submitted included member responses that were that were clear and concise. Technical assistance was provided to the plan to continue to working on ensuring 6th grade readability. **This finding is closed.**
4.1.2 The Plan did not address all grievance complaints when there were multiple	Access Dental Plan has identified opportunities to improve the grievance resolution process. Grievance and Appeals staff were retrained on appropriate letter resolution procedures on May 29, 2020 and June 9, 2020 by the Supervisor, Appeals		May 29, 2020	**9/24/20:** The plan submitted a sample email (8/24/20) as evidence that G&A staff receive monthly reminders to address all

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complaints within one grievance.	and Grievances. During these trainings the Supervisor reiterated the need to remain vigilant and respond to all concerns listed in the member's complaint. To ensure all noted issues were addressed a monthly audit of letters issued by the Grievance and Appeals team will be conducted by the Compliance Team through the end of the calendar year. Letters that are inconsistent with Access Dental Plan standards will be shared with Grievance and Appeal Management. Compliance will monitor to ensure corrective actions, including retraining of staff, is completed as necessary.			member concerns in each grievance response letter. **9/30/20:** The plan submitted the following documentation: • 5 sample grievance resolution letters (post 6/9/20 training) as evidence of the effectiveness of staff retraining and monthly oversight. The resolution letters submitted adequately addressed multiple issues raised by the member. **This finding is closed.**

Submitted by: Jessica de Lyon **Date: August 12, 2020**
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