CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

May 10, 2024

Mr. Bary Bailey, Interim CFO
Access Dental Plan
8890 Cal Center Drive
Sacramento, CA 95826

2022 ACCESS DENTAL PLAN AUDIT – CORRECTIVE ACTION PLAN

Dear Mr. Bailey,

Access Dental Plan submitted a Corrective Action Plan (CAP) on April 12, 2024, in response to all findings identified in the report within 30 calendar days of the date of this letter. On the enclosed **CAP Response Form**, DHCS reviewed and responded to each of the findings. For any CAP that is not closed, please complete the CAP Response Form and submit supporting documentation organized in separate electronic folders that are clearly labeled by corresponding finding number (e.g., 1.1.1, 1.1.2, etc.).

The DMC plan is required to submit a Corrective Action Plan (CAP) in response to all findings identified in the report within 30 calendar days of the date of this letter.

DMC plans are required to complete CAPs within six (6) months of receiving notice of findings from DHCS. Plans are required to provide a monthly status update to DHCS utilizing the CAP Response Form and provide supporting CAP documentation until the CAP is completed. The DMC plan must demonstrate to MDSD ongoing active progress toward implementation of the CAP within the monthly status update, including key milestones, date(s) of milestone completion, and the expected date of when full compliance will be achieved. MDSD will monitor the plan's progress towards full CAP resolution through the monthly status update from the DMC plan until the CAP is closed.

The CAP Response Form must be signed by the DMC Plan's Project Representative. The CAP Response Form and corresponding supporting documentation should be submitted to dmcdeliverables@dhcs.ca.gov.

If you have any questions regarding this notice, please contact DHCS at dmcdeliverables@dhcs.ca.gov.

Sincerely,

Original signed by:

Adrianna Alcala-Beshara, JD, MBA
Chief, Medi-Cal Dental Services Division
Department of Health Care Services

Enclosure:
CAP Response Form

Access Dental Plan
2022 Audit Report Corrective Action Plan

Category 1 Utilization Management
Finding 1.1 Utilization Management Program
1.1.1 Over and Under-Utilization Monitoring

Finding: The Plan did not implement mechanisms to identify the over and under-utilization of dental services as detailed in the Plan's policies.
Verification Study Documents: During the audit period, the Plan underwent leadership, organizational, operational, and staff changes. With these changes taking place, the Plan's UM committees did not focus on over and under-utilization. The Plan stated in an interview that it did not conduct utilization review reporting as specified in its policies. In an email, the Plan acknowledged its limitations in oversight of utilization reporting, in particular for under- and over-utilization trends, and in using provider data to identify opportunities to conduct appropriate provider education and counseling. Without adequate mechanisms to detect under- and over-utilization of dental services, the Plan is unable to detect and address unusual patterns of care in its provider network.
A&I Recommendation: Develop and implement mechanisms to detect both under- and over-utilization of dental services.
Contractor Response: Access Dental Plan (ADP) will perform monthly routine utilization reviews of network providers and follow corrective action as per policy QM.006.01. We will reach out to providers identified as having unusual patterns of care and report to the Public Policy, Peer Review, UMC, QMC, and Board of Directors Committees. This process includes producing Utilization Reports by assessing patterns of clinical activity and evaluations of treatment outcomes based on quantitative data obtained from the encounter (claims) data and developing a list of providers with unusual patterns of services on a quarterly basis. ADP is implementing key performance measure reports to track **underutilization** at the provider level, identify low-performing providers, and work with them to improve

utilization. Member rosters are mailed to providers monthly and available on the provider portal.

ADP submits self-reported monthly utilization data by Primary Care Dentist service sites and identifies low-performing offices. Based on this data, we take proactive steps to engage with these offices, offering support and resources to help them improve their performance.

ADP will monitor trends of the top 7 utilized codes for **over-utilization**. This process involves a thorough analysis of the frequency and volume of these codes, allowing us to identify potential areas of over-utilization and take appropriate action. The following will be part of this process:

- Track offices that utilize costly and complex procedure codes to identify provider and member educational opportunities.
- Track and trend prior authorizations approved to claims received for service conversion rate.
- Compare denial conversion to appeal rate and no of appeals being overturned.
- Track if authorizations are being reviewed by appropriate dental specialists (E.g., Ortho cases reviewed by Orthodontist)
- Track dental consultants with a high overturn rate of their denials.

Supporting document(s):
QM006.01_Monitoring for Over and Under-Utilization_draft

DHCS Response:
Please submit the mechanisms that ADP uses to detect both under- and over-utilization of dental services. This includes examples of ADP's provider profiling based on under- or over-utilization findings, provider outreach regarding unusual patterns of care, and Utilization Reports produced by assessing patterns of clinical activity and/or evaluation or treatments. What thresholds are being set for detecting under- or over-utilization and how is ADP determining what the threshold limitations are?

Contractor's 60 Day Response (If CAP Is Not Cleared):

DHCS Response:

Category 1 – Utilization Management
Finding- 1.2 Prior Authorization Review

1.2.1 Notice of Action (NOA) Letter Templates

Finding:
The Plan did not utilize the revised NOA templates and "Your Rights" attachments included in Dental-All Plan Letter (D-APL) 20-003 and D-APL 22-006.

Verification Study Documents:
During the audit period, the Plan did not to use DHCS required templates for NOA letters. In a verification study, all 16 files selected in the prior authorization sample did not utilize DHCS NOA templates. The Plan stated that due to staff departures and shortages, the Plan was unaware of the requirements to use DHCS templates for NOAs included in D-APL 20-003 and 22-006.

When members receive notices that do not utilize DHCS NOA templates and "Your Rights" attachments, members may not receive accurate information about their rights

A&I Recommendation:
Develop and implement a policy and procedure to ensure the use of required DHCS NOA templates.

Contractor Response: The implementation of CA NOA's has commenced within our current processing system, beginning on January 17, 2024. Furthermore, the application of approved CA letters templates has been successfully integrated into our system, with mailings initiated as of January 18, 2024.

Supporting document(s):
UM.010.01_Prior Authorization Process 03.27.24

DHCS Response:
The Plan submitted Prior Authorization Process Standard Operating Procedure demonstrating that Access has developed and implemented a standard operating procedure to ensure the use of required DHCS NOA templates, approved on April 17, 2024.

DHCS closes this CAP effective April 12, 2024. The Plan does not need to provide further documentation for finding 1.2.1.

Contractor's 60 Day Response (If CAP Is Not Cleared):

DHCS Response:

Category 1 – Utilization Management
Finding- 1.2 Prior Authorization Review
1.2.2 Prior Authorization Timeframes

Finding: The Plan did not comply with contractual timeframes for prior authorization requests.
Verification Study Documents: A sample of 16 prior authorization verification files (four deferred, two modified, and ten denied) was reviewed during the audit. Two of four deferred prior authorization requests took 36 and 83 business days to complete from receipt date. One of two modified prior authorization requests took over five business days to complete from receipt date. Nine of ten denied prior authorization requests exceeded the required five business days from receipt date to complete.
A&I Recommendation: Develop and implement policies and procedures to ensure compliance with contractual timeframes for all prior authorization requests.
Contractor Response: During this Audit period, the plan experienced significant transformations across leadership, organizational structure, operations, and staffing. These changes adversely impacted the authorization turnaround times, resulting in delays. In June 2023, the Utilization Management team started to meet the turnaround times of the authorizations. The Utilization Management team continues to monitor the turnaround on a daily basis.
Supporting document(s): UM.010.01 Prior Authorization Process
DHCS Response: The Plan submitted a Prior Authorization Process Standard Operating Procedure demonstrating that Access has developed and implemented a standard operating procedure to ensure the Plan meets the contractual timeframes for prior authorization requests. The Plan has been contractually compliant for the Standard Turnaround Time (TAT) for 4 of the last 5 months, showing significant improvement in implementing the updated Standard Operating Procedure. DHCS closes this CAP effective April 12, 2024. Plan does not need to provide further documentation for finding 1.2.2.

Contractor's 60 Day Response (If CAP Is Not Cleared):

DHCS Response:

Category 1 – Utilization Management
Finding- 1.2 Prior Authorization Review
1.2.3 Prior Authorization Classification and Notifications

Finding:
The Plan did not send timely and appropriate notifications for denied, modified and deferred prior authorizations and did not classify the prior authorizations correctly.

Verification Study Documents:
During the prior authorization verification study, auditors observed inconsistency in the type of letter that was sent to providers:

- Three of ten denied prior authorizations – Delayed NOA letters and extension letters were sent out when they were not supposed to be sent.
- One of two modified prior authorizations - Delayed NOA letter was sent out when it was not supposed to be sent.
- Two of four deferred prior authorizations – Extension letters sent were not sent when they were supposed to be.

In addition, three denied and one modified prior authorization request were misclassified as deferred prior authorizations in the Plan's tracking logs submitted to DHCS.

A&I Recommendation:
Develop and implement a process to ensure timely and accurate processing of prior authorizations, NOA letters, and extension letters

Contractor Response:
With the current processing system, our Lead responsibilities consisting of additional monitoring of daily inventory. Inventory is pulled via reporting through our internal system in which is now required on 3 separate accounts to the Utilization Management Leadership team. The Utilization Management Leadership team has additional oversight now of daily inventory and this team responsibility to ensure daily turnaround times meet contractual requirements.

Supporting document(s):
N/A

DHCS Response:
The Plan submitted a Prior Authorization Process Standard Operating Procedure as part of finding 1.2.2, demonstrating that Access has developed and implemented a standard operating procedure to ensure the plan implemented a process to ensure timely and accurate processing of prior authorizations, NOA letters, and extension letters.

DHCS closes this CAP effective April 12, 2024. The Plan does not need to provide further documentation for finding 1.2.3.

Contractor's 60 Day Response (If CAP Is Not Cleared):

DHCS Response:

Category 3 – Access and Availability
Finding 3.1- Access and Availability
3.1. Call Center Timeliness

DHCS closed this CAP effective October 26, 2023. The Plan does not need to provide further documentation for finding 3.1.

Finding:
The Plan did not maintain the required weekly average "P" factor of seven percent or less.

Verification Study Documents:
The Plan stated in an interview that there were call center staffing challenges and unplanned absences during the audit period due to a re-organization within the Plan. This resulted in insufficient staff to respond to the increase in calls. As a result, the "P" factor rose to 11 percent in Q3 2022, and to 32 percent in Q4 2022. In October, the last month of the audit period, the "P" factor was 11.33 percent.
The Plan stated that another reason for the increase in the "P" factor was a change in the Plan's UM process in July 2022, which required providers to submit x-ray documentation in a new format. This change generated questions from the providers and resulted in a 34 percent increase in call volume. The increase in call volume had a significant impact on the Plan's ability to answer calls in a timely manner.

A&I Recommendation: Ensure the call center answers member calls in a timely manner.
DHCS Response: DHCS closed this CAP effective October 26, 2023. The Plan does not need to provide further documentation for finding 3.1.

Category 4 – Members' Rights
Finding 4.1- Grievance System
4.1.1 Review of Grievances by the Governing Body

Finding: The Plan did not ensure that periodic review of written grievance records was conducted by the Plan's Governing Body, public policy body, and Plan Officer.
Verification Study Documents: Grievance Procedures: Eight quality of care and 20 quality of service grievances were reviewed for timely resolution, compliance, and submission to the appropriate level of review.
A&I Recommendation: Develop and implement a process to ensure the Plan's Governing Body, public policy body, and Plan officials review the written records of grievances periodically and thoroughly document the review process.
Contractor Response: The Plan will share a minimum of 2 written records of grievances in the quarterly QMC, Public Policy and Board of Directors meetings for review. Complete redacted records will be included in the meetings and the review of said documents will be documented appropriately in the meeting minutes.
Supporting document(s): N/A
DHCS Response: Please develop and implement a process to ensure the Plan's Governing Body, public policy body, and Plan officials review the written records of grievances periodically and thoroughly document the review process. Please also submit the Standard Operating Procedure or other process implementation materials to DHCS for review.
Contractor's 60 Day Response (If CAP Is Not Cleared):

DHCS Response:

Category 5 – Quality Management
Finding 5.1- Quality Improvement Systems
5.1.1 Integration of UM activities into the Quality Improvement System

Finding: The Plan did not include data on the quantity of deferred prior authorizations in its reports to quality improvement staff.
Verification Study Documents: Potential Quality Issues: Six Potential Quality Issue (PQI) files were reviewed.
A&I Recommendation: Implement a process to integrate UM activities into the Quality Improvement System, including a process to integrate reports on the review of the number and types of deferrals and modifications to the appropriate QIS staff.
Contractor Response: Utilization Management began to report deferred related counts into QMC beginning Q3 2023 for data ranging from April – June 2023. This can be supported via QMC meeting minutes/supplementary decks for that meeting and moving forward. Additionally, UM has advised they continue to work through opportunities to report UM activity more granularly to support more efficient review and monitoring.
Supporting document(s): N/A
DHCS Response: Please submit the QMC meeting minutes/supplementary decks for the Q3 and Q4 2023 for review to support your representation that the finding has been remediated.
Contractor's 60 Day Response (If CAP Is Not Cleared): **DHCS Response:**

Category 5 – Quality Management
Finding 5.1- Quality Improvement Systems
5.1.2 Quality Improvement System Manual

Finding: The Plan did not maintain a QIS Manual.
Verification Study Documents: The Plan did not submit a QIS Manual to DHCS for review. In an interview, the Plan stated that due to new leadership, reorganization, and revision of all P&Ps, the Manual was in the process of being revised and updated during the audit period.
A&I Recommendation: Complete and implement the QIS Manual and submit to DHCS for approval.
Contractor Response: Access Dental drafted a 2023 Quality Program Description which was presented and approved in the QMC session for Q3 2023. It was sent to DHCS by Account Executive, Liz Bishop, originally back on 10/10/23 for feedback and approval.
Supporting document(s): ADP Medi-Cal QIS Quality Program Description_2023 DRAFT
DHCS Response: The Plan submitted the ADP Medi-Cal QIS Manual as part of finding 5.1.2, demonstrating that they have developed and implemented policies and procedures, staffing, and committees to support to drive quality by measuring performance, including over- and under-utilization, audit providers, credential and revalidate providers, and take disciplinary action when necessary. DHCS closes this CAP effective April 12, 2024. The Plan does not need to provide further documentation for finding 5.1.2.
Contractor's 60 Day Response (If CAP Is Not Cleared): **DHCS Response:**

Category 6 – Administrative and Organizational Capacity
Finding 6.2- Fraud Waste and Abuse

6.2.1 Compliance Officer Reporting Requirements

Finding: The Plan's Designated Compliance Officer (DCO) did not report directly to the Chief Executive Officer (CEO) and the Governing Body. During the audit period, the Plan's DCO reported to the Chief Legal Officer and Governing Body instead of the CEO.
Verification Study Documents: The Plan's DCO who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with requirements of the Contract, is required to report directly to the CEO and the Governing Body. According to the Plan's document Compliance Structure and Charter, "Oversight of the Compliance Program rests with the Compliance Officer who reports to the Chief Legal Officer and Governing Body." This document does not require the DCO report to the CEO. In an interview, the Plan confirmed that the DCO reported to the Chief Legal Officer instead of the CEO. Fraud, Waste, and Abuse: The Plan did not have any fraud, waste, and abuse cases during the audit period.
A&I Recommendation: Ensure the DCO reports directly to the CEO and Governing Body.
Contractor Response: Access Dental Plan reviewed the March 13, 2024, Notice of Deficiency from DHCS, section 6.2.1, related Compliance Officer Reporting Requirements for the audit period of July 1, 2021, through October 31, 2022. Upon receipt Access Dental Plan took steps to shift direct reporting obligation to the CEO. We should however note that during the audit period, and through today, Access Dental Plan has always and continues to operate a compliance program with dotted line reporting to the CEO and direct ongoing communication and accountability to the Board of Directors through regular ongoing reporting and communication, including that of FWA information.
Supporting document(s): ADP_Comp Org Chart 3.20.2024
DHCS Response: The Plan responded that it "continues to operate a compliance program with dotted line reporting to the CEO and direct ongoing communication and accountability to the Board of Directors through regular ongoing reporting and communication, including that of FWA information." The ADP Compliance Organizational Structure dated March 20, 2024 shows that the Chief Compliance Officer has a dotted line reporting to the Chief Legal Officer, but solid line reporting to the Chief Executive Officer and Governing Body. Can the Plan please confirm that the Chief Compliance Officer

reports directly to the Chief Executive Officer and Governing Body? Please submit a corrected organizational chart that shows that the DCO reports directly to the CEO and Governing Body without exception.
Contractor's 60 Day Response (If CAP Is Not Cleared): **DHCS Response:**