MEDICAL REVIEW – NORTHERN II SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE DENTAL AUDIT OF

Access Dental Plan

2021

Contract Number:	13-90115 12-89341
Audit Period:	January 1, 2020 Through June 30, 2021
Dates of Audit:	November 1, 2021 through November 12, 2021 and December 13, 2021 through December 21, 2021
Report Issued:	August 3, 2022

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I. INTRODUCTION

Access Dental Plan of California, Inc. (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 health plan with its own statewide network of contracted general and specialty dental providers. The Plan provides dental services to members under their Sacramento Geographic Managed Care (GMC) and Los Angeles Prepaid Health Plan (PHP) programs.

The Plan has approximately 190 general providers and 24 specialists for Sacramento County and has approximately 540 general providers and 281 specialists for Los Angeles County.

The Plan currently serves 280,003 Medi-Cal members in California. As of February 2022, the Plan’s membership was composed of 146,650 GMC and 133,353 PHP members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of DHCS dental audit for the review period of January 1, 2020 through June 30, 2021. A two-phase audit was conducted from November 1, 2021 through November 12, 2021 and December 13, 2021 through December 21, 2021. The audit consisted of document review, verification studies, and interviews with the Plan's personnel.

An Exit Conference with the Plan was held on June 23, 2021. 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 six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management (QM), and Administrative and Organization Capacity.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan is required by the contract to comply with the Medi-Cal Manual of Criteria (MOC), however the Plan requires prior authorization for services that should be automatically approved according to the Medi-Cal MOC.

The contract requires the Plan to state the relevant criteria and clinical guidelines, and explain the reason for upholding denials in its notice of action letters. During the audit, it was discovered that the Plan does not do this consistently.

Category 2 – Case Management and Coordination of Care

The Plan is required to track oral health assessments. The Plan did not have a mechanism to ensure new members received an Oral Health Information Form screening within 90 days of effective enrollment date.

The Plan's Provider Manual is required to include information about members' continuity of care protections, however the Plan's Provider Manual did not include this information.

The Plan is required to implement standardized procedures for dental care provider training for the identification of children with Special Health Care Needs (SHCN) at enrollment and on a periodic basis thereafter. The Plan did not ensure this training was implemented and completed.

The Plan is required to develop and implement written Policies and Procedures (P&P) for identifying and referring children with California Children's Services (CCS) eligible conditions to the local CCS program. During the audit period, the Plan did not ensure this referral occurred.

Category 3 – Access and Availability of Care

The Plan shall develop, implement, and maintain a procedure to monitor waiting times for telephone calls. The Plan did not issue Corrective Action Plans to provider offices that did not meet telephone wait time requirements.

Category 4 – Member's Rights

The Plan shall ensure that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal. The Plan has not implemented a process to ensure that the Dental Consultant reviewing a grievance did not participate in a prior related decision.

Category 5 – Quality Management

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. The Plan did not monitor, evaluate, and take action to address Potential Quality Issues (PQIs) and improve the quality of care delivered by all providers on its behalf.

The Plan is required to perform a comprehensive Quality Assurance and Performance Improvement program which must include mechanisms to assess the quality and appropriateness of care furnished to enrollees with SHCN. The Plan did not do this during the audit period.

Category 6 – Administrative and Organization Capacity

The Plan is required to report to DHCS all cases of suspected fraud and/or abuse. The Plan did not report fraud, waste, or abuse cases to DHCS.

The Plan is required to notify the Medi-Cal Dental Management Care Unit within ten business days of removing suspended, excluded, or terminated providers from its provider network and confirm that the provider is no longer receiving payment in connection with the Medicaid program. The Plan did not report suspended, excluded, or terminated providers to DHCS.

III. SCOPE/AUDIT PROCEDURES

SCOPE

DHCS, Medical Review Branch, conducted this audit to ascertain whether the dental services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's GMC/PHP contract.

PROCEDURE

A two-phase audit was conducted from November 1, 2021 through November 12, 2021 and December 13, 2021 through December 21, 2021. The audit included a review of the Plan's contract with DHCS, its 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

Prior Authorizations: 21 dental services prior authorization files were reviewed. The sample was selected to cover the different specialties of dentistry, different age range of members, and to reflect both counties (Sacramento and Los Angeles).

Appeals: Seven dental services appeals were reviewed and included the different specialties in dentistry, children and adults, and to reflect both Los Angeles and Sacramento counties. In addition, the sample comprised of resolutions that were upheld and overturned.

Category 2 – Case Management and Coordination of Care

Case Management: Five case management files were reviewed. This included members with SHCN.

Category 4 – Member's Rights

Grievance Procedures: 11 quality of care grievances and 22 quality of service were reviewed for timely resolution, compliance, and submission to the appropriate level of review.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
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CATEGORY 1 - UTILIZATION MANAGEMENT	
1.2	**PRIOR AUTHORIZATION REVIEW REQUIREMENTS**

1.2.1 Prior Authorization-Adherence to the Medi-Cal Manual of Criteria

Contractor shall ensure that its pre-authorization procedures are in accordance with the Medi-Cal Dental policy and procedures as described in the Medi-Cal MOC.
(GMC 12-89341 and PHP 13-90115 Contracts, Exhibit A, Attachment 7, Provision B)

The Plan's policy, *CL.003.02 Referrals for Specialty Dental Care-California Medi-Cal Programs,* states prior authorization is required for all non-emergency, basic, and major services.

Finding: The Plan requires prior authorization for services that should be automatically approved according to the Medi-Cal MOC.

The Plan's P&P *CL.003.02,* incorrectly requires prior authorization for all non-emergency, basic, and major services.

DHCS reviewed 21 prior authorizations verification study samples. In four of these samples, services were incorrectly denied.

For example, the MOC does not require periodontal charting to be submitted for a deep cleaning, however the Dental Consultant denied the service due to lack of charting submitted.

In another sample, for a pre-fabricated crown the Consultant used criteria for a custom-made crown. The criteria for a custom made crown requires more conditions to be met. This use of incorrect criteria resulted in the pre-fabricated crown to be denied.

DHCS also reviewed five verification study samples for members with SHCN. These samples required referrals to specialty dental care. In two of these samples, services were incorrectly denied.

In these two samples, the MOC does not require prior authorization or documentation for non-intravenous conscious sedation, however the Plan denied the sedation due to insufficient documentation.

The Plan stated during an interview that these denials occurred due to Dental Consultant errors.

If the Plan does not ensure that its adjudication process is consistent with the criteria in the MOC, dental services may be inappropriately denied.

Recommendation: Develop and implement a process to ensure the prior authorization process is consistent with the MOC.

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Notice of Appeal Resolutions (NAR)

The Plan's Notice of Appeal Resolutions (NAR) shall include in its written response the reasons for its determination and clearly state the criteria, clinical guidelines, or dental policies used in reaching the determination. The response shall either identify the document and page where the provision is found, direct the member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific dental service or benefit requested. *(Dental All Plan Letter (D-APL) 17-003E, D-APL 20-003)*

Finding: The Plan did not consistently state the relevant criteria and clinical guidelines, or explain the reason for upholding denials in its notice of action letters.

The Plans P&P *GA.001.01 Grievance and Appeals,* have not been updated to include language from *APL 20-003*, which states the Plan is required to include an explanation of denial and the criteria, clinical guidelines, or dental policies used in reaching the determination.

The verification study revealed that in three out of seven appeals, the NAR did not include the clinical reasons for denial decisions, nor references to the specific criteria or guidelines from the Provider Manual or MOC that were used.

The Plan does not have a process to ensure that its NAR meets the requirements of D-APL 20-003.

When NARs do not clearly state denial reasons and/or criteria references, members may not understand the reasons for why the denial of their appeal was upheld.

Recommendation: Establish a process to ensure NARs include all required clinical information and criteria to support reasons for denial.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE	
2.1	**CASE MANAGEMENT/ORAL HEALTH ASSESSMENT**

2.1.1: Tracking Member Oral Health Information Forms (OHIF)

The Plan shall comply with APLs issued by Medi-Cal Dental Services Division. (*GMC 12-89341 and PHP 13-90115 Contracts Exhibit E, Additional Provision, 5,d)*

The Plan is required to develop and implement an Oral Health Information Form (OHIF) to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new members. The Plan is also required to make and document at least two telephone calls to remind new members to return the OHIF, if it has not been returned. *(APL 18-007)*

The Plan's P&P, *AA.011.01, Initial Assessment and Members with Special Health Care Needs,* states all new members will have an initial screening within 90 days of the effective date of enrollment. In addition, the Plan is required to make at least two telephone calls to remind new members to return the OHIF to the Plan.

Finding: The Plan did not have a mechanism to ensure new members received an OHIF screening within 90 days of effective enrollment date.

The Plan documentation did not show that member OHIFs were received within the 90 day timeframe. In addition, the Plan did not document any phone calls made to remind members to return OHIFs within the 90 days post-enrollment.

Although the Plan's P&P *AA.011.01* includes the correct 90-day requirement for completion of new member OHIF, the Plan did not have a process in place to track, document, and ensure new members received and submitted the OHIF.

The Plan stated in an interview that at least two calls were made to each member that did not return an OHIF, however, the Plan's new member tracking spreadsheets did not identify which members did not submit an OHIF. In addition, there was no documentation that recorded the number of calls made to the members by the Plan.

If the Plan does not receive member OHIF forms, it could have difficulty determining necessary dental services for members.

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Recommendation: Implement a mechanism to document, track, and ensure new members receive and submit an OHIF within 90 days of the effective date of enrollment.

2.2	CONTINUITY OF CARE/TRANSITION OF CARE

2.2.1 Communicating Continuity of Care Protections to Providers

The Plan must abide by DHCS' issued APLs.
(*GMC 12-89341 and PHP 13-90115 Contracts Exhibit E, Additional Provision, 5, d)*

Plans must include information about members' continuity of care protections in the Provider Manuals. This information must include how the members and providers initiate a continuity of care request with the DMC plan. *(APL 17-011E)*

Finding: The Plan's Provider Manual did not inform providers of continuity of care protections for members.

The Plan's Provider Manual was last updated in October 2014, which does not reflect updates from *APL 17-011E.*

The Plan did not ensure its Provider Manual was revised to reflect updates in APLs and regulations.

If providers are not informed of the members' continuity of care protections, they may not initiate a continuity of care request with the Plan.

Recommendation: Develop and implement a process to ensure Plan documents are updated to reflect changes in the contract, regulations, and APLs.

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2.3	MEMBERS WITH SPECIAL HEALTH CARE NEEDS

2.3.1 Special Health Care Needs (SHCN) Dental Care Provider Training

Plan shall implement and maintain services for children with SHCN that include, but are not limited to, standardized procedures for dental care provider training for the identification of children with SHCN, at enrollment and on a periodic basis thereafter. *(GMC 12-89341 and PHP 13-90115 Contracts Exhibit A, Attachment 13, Provision C, 1)*

Plan policy *ED.002.01, Health Education Program* (Effective Date 1/1/2013), states that the Plan maintains a comprehensive Dental Health Education Program and provides continuous education to providers and members to ensure understanding of our process, Plan benefits, preventive dental care and managed care principles.

Plan policy *AA.011.01, Initial Assessment in Members with Special Health Care Needs* (Effective Date 7/1/2018), contains procedures for the identification of members with SHCN.

Finding: The Plan did not ensure the implementation of standardized procedures for dental care provider training for the identification of children with SHCN, at enrollment and on a periodic basis thereafter.

The Plan's policies and Provider Manual do not reflect the contract requirement to conduct provider training for the identification of children with SHCN at enrollment and on a periodic basis. While Policy AA.011.01, contains procedures for the identification of members with SHCN, there were no procedures regarding training providers to identify of children with SHCN.

If providers are not trained to recognize children with SHCN, members may not receive medically necessary services.

Recommendation: Develop and implement P&P to provide training to providers at the time they join the network, and on a periodic basis, for the identification of children with SHCN.

2.4	CALIFORNIA CHILDREN'S SERVICES

2.4.1 Identification and Referral of Children with CCS Eligible

The Plan is required to develop and implement written P&P for identifying and referring children with CCS eligible conditions to the local CCS program. The written P&P shall include the Plan's assurance to provide all medically necessary dental covered services for the member's CCS eligible condition until CCS eligibility is confirmed, and to provide all medically necessary dental covered services that are unrelated to the CCS eligible condition upon confirmation of the member's CCS program eligibility. Additionally, the Plan is required to monitor and ensure the coordination of services between its Primary Care Dentist (PCD), the CCS specialty providers, and the local CCS program. (*GMC 12-89341 and PHP 13-90115 Contracts Exhibit A, Attachment 13, Provision D)*

The Plan's policy *CL.005.01, California Children's Services Eligibility* (revised 1/1/2013), describes the procedures for identifying and referring children with CCS eligible conditions to the local CCS program. The PCD is required to perform a baseline assessment to identify children with suspected CCS conditions. The Plan will ensure the coordination of services between its PCD, the CCS specialty providers, and the local CCS program.

Finding: The Plan did not ensure the identification and referral of members with CCS-eligible conditions to the local CCS program.

The Plan's policy *CL.005.01* was last revised and reviewed in 2013. While the policy delineated the identification and referral of children with CCS eligible conditions to the local CCS program, the Plan's documentation did not show the Plan actually referred CCS members to the local program or coordinated efforts between PCDs and the local CCS program.

The Plan did not have a system in place to identify and refer children with CCS eligible conditions to the local CCS program. During a systems demonstration, there was no flag or indicator in the Plan's system to identify CCS eligible members. The Plan confirmed this in an interview.

Furthermore, the Plan did not communicate to its providers the responsibility to perform a baseline assessment to identify children with suspected CCS medical conditions in accordance with its policy. There was no evidence of communication nor written

procedures in the Plan's Provider Manual that PCDs are required to conduct screening and/or identification of suspected CCS medical conditions and to submit the CCS Orthodontic Screening Form to the Plan for referral, in accordance with the Plan's P&P *CL.005.01.*

When children in need of a referral to the CCS program are not identified they may be denied access to medically necessary services.

Recommendation: Implement the existing policy and ensure there is a process to identify and refer children with CCS eligible conditions to the local CCS program.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE	
3.1	**APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES**

3.1.1 Monitoring of Waiting Times

The Plan shall develop, implement, and maintain a procedure to monitor waiting times for telephone calls (to answer and return).
(*GMC 12-89341 and PHP 13-90115 Contracts Exhibit A, Attachment 11)*

The Plan's policy *AA.003.01, Access and Availability - Monitoring Compliance with Standards,* states the Plan's telephone access standards shall not exceed an average call wait time of 30 seconds. When an access to care problem is identified, corrective action shall be taken, which shall include, but not be limited to education and assistance to the provider, provider counseling, provider probation, suspension of new assignments, transfer of patient to another provider, contract termination for continuing non-compliance.

Finding: The Plan did not issue Corrective Action Plans to provider offices that did not meet telephone wait time requirements.

Internal Provider Relations documentation did not show evidence of follow-up or Corrective Action Plans issued to providers.

The Plan stated during an interview that it made calls to providers to test if telephone wait times exceeded 30 seconds, however Internal Provider Relations staff did not conduct follow-up procedures or Corrective Action Plans for providers that did not meet standards, contrary to the procedures stated in P&P *AA.003.01.*

Members are at risk of not receiving timely treatment if issues with provider telephone wait times are not addressed.

Recommendation: Establish a mechanism to ensure deficiencies with provider telephone wait times are addressed.

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CATEGORY 4 – MEMBER'S RIGHTS	
4.1	**GRIEVANCE SYSTEM**

4.1.1 Dental Consultant Review of Grievances

The DMC plan shall ensure that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal and is a health care professional with clinical expertise in treating a member's condition or disease.
(D-APL 20-003 and D-APL 17-003E)

Finding: The Plan has not implemented a process to ensure that the Dental Consultant reviewing a grievance did not participate in a prior related decision.

According to verification study documents, two out of 11 grievances included scenarios where the same Dental Consultant reviewing the grievance also participated in a prior decision related to the case.

During an interview the Plan stated that it did not have a mechanism to ensure the Dental Consultant reviewing a grievance was not the same who participated in a prior decision related to the case.

The grievance decision may be biased if the same clinician that reviewed and participated in a prior decision related to the case also reviews the subsequent grievance. This could lead to appropriate services not being provided to patients.

Recommendation: Implement a process to ensure the clinical reviewer of grievance cases did not participate in a prior decision related to the case.

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CATEGORY 5 – QUALITY MANAGEMENT	
5.1	**POTENTIAL QUALITY ISSUES**

5.1.1 Potential Quality Issues (PQI)

Contractor shall implement an effective Quality Improvement System in accordance with the standards in California Codes of Regulations, Title 28, section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. (*GMC 12-89341 and PHP 13-90115 Contracts Exhibit A, Attachment 5, Provision E)*

According to, Plan policy *5.1.A.2c. QM.017.01_Potential Quality Issues* (Effective date: 10/1/2016), the Plan must provide a systematic approach to identifying, reporting, tracking, trending and processing PQI to determine opportunities for improvement in the provision of dental care and services. All PQI's shall be reported to the Dental Director or designee and be reviewed for proposed action. Any confirmed or non-confirmed PQI shall be tracked, trended, and resolution documented for ease of case follow-up.

Finding: The Plan did not ensure the implementation of an effective process to monitor, evaluate, and take action to address PQIs and improve the quality of care delivered by all providers on its behalf.

In a verification study, the Plan documentation did not include the necessary dental charts to facilitate effective evaluation, monitoring, and resolution of providers with PQIs in 11 of 13 cases reviewed. Additionally, all 13 PQI cases showed that the Plan did not document how it addressed PQI issues through monitoring, follow-up, or corrective actions taken against providers by Plan staff or by the Peer Review Committee.

In an interview the Plan stated that due to the provider offices being closed and short staffed due to Covid-19, dental charts could not be collected. Furthermore, the Plan explained that its chart collection process needs to be improved and is currently reviewing its process to ensure the implementation of its monitoring, evaluation, reporting, and follow-up of providers with PQI.

If the Plan does not have an effective process to collect dental charts, or to monitor, evaluate, and take effective action to address any needed improvements in response to PQIs, the Plan may miss opportunities to improve the delivery of care to its members.

Recommendation: Develop and implement an effective process to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on the Plan's behalf.

5.1.2 Assessment of Quality of Care

Dental case management includes treatment, planning, coordination referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's dental care needs. (*GMC 12-89341 and PHP 13-90115 Contracts Exhibit E, Attachment 1, Definitions)*

The Plan is required to perform a comprehensive Quality Assurance and Performance Improvement program which must include mechanisms to assess the quality and appropriateness of care furnished to enrollees with SHCN, as defined by the State. (*APL 18-002*)

Plan policy *CL.008.01*, *Case Management and Care Coordination* (Revision Date 7/1/2018), states that case management activities are to be reported quarterly to the QM Committee and must be included in quarterly and annual reports of QM program activities to the Board of Directors. Quality issues identified through case management activities will be reported to the Dental Director and QM Committee.

Finding: The Plan did not have mechanisms to assess the quality of care furnished to enrollees with SHCN.

While the Plan has a policy to document and report case management activities to the QM Committee and Board of Directors, the Plan does not have a policy in place to monitor and assess the quality of care for members with SHCN.

The Plan's QM Committee minutes showed no reporting and discussion regarding the Plan's monitoring of quality regarding members receiving case management, including those with SHCN.

Upon DHCS' request, the Plan submitted four spreadsheets that listed the treatments rendered for members under case management. However, these spreadsheets lacked information on member assistance, case status, treatments, and claim codes, and showed no evidence of the assessment of quality of care.

During the interview, the Plan stated that it does not conduct record reviews to ensure that dental case management is monitored for quality of care.

Without the assessment of the quality of care furnished to enrollees, member harm can result. Additionally, this can also lead to missed opportunities for quality improvement in the Plan's provision of services for members with SCHN.

Recommendation: Ensure the performance of a comprehensive Quality Assurance and Performance Improvement program that includes mechanisms to assess the quality of care for members with SHCN.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY	
6.2	**FRAUD AND ABUSE**

6.2.1 Reporting of Suspected Fraud, Waste and/or Abuse Cases

The Plan is required to report to DHCS all cases of suspected fraud and/or abuse where there is a reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. The Plan is required to conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten business days of the date the Plan first becomes aware of, or is on notice of, such activity.
(*GMC 12-89341 and PHP 13-90115 Contracts Exhibit E, Additional Provision)*

The Plan's Policy *QM.038.01, Fraud, Waste and Abuse* (Revision: 07/01/2018), states the Plan maintains a compliance plan in order to detect and prevent fraud and abuse. The Fraud Officer shall be responsible for logging and conducting initial review of suspected fraudulent claim referral forms evaluating the need for additional investigation, forwarding suspected cases of fraud to the Contracted Investigator for investigation, and reporting fraudulent claims with the appropriate federal and/or state agencies.

Finding: The Plan does not have a mechanism or procedure to report fraud, waste, and abuse cases to DHCS.

The Plan did not report fraud, waste and abuse cases to DHCS during the audit period.

In addition, the Plan's P&P did not contain the required reporting timeframe for preliminary investigations of suspected fraud and/or abuse cases to DHCS.

With incorrect policies and no mechanism to ensure fraud, waste, and abuse cases are reported to DHCS, DHCS may not be able to mitigate the impact of fraud, waste, and abuse cases in a timely manner.

Recommendation: Develop and implement a procedure and mechanism to ensure reporting of suspected fraud cases to DHCS.

6.2.2 Suspended, Excluded and Terminated Providers

The Plan is required to have mechanism in place to track suspended providers in accordance with Code of Federal Regulations, Title 42, section 438.610.
(*GMC 12-89341 and PHP 13-90115 Contracts Exhibit E, Additional Provision)*

The Plan is required to notify the Medi-Cal Dental Management Care Unit within ten business days of removing suspended, excluded, or terminated providers from its provider network and confirm that the provider is no longer receiving payment in connection with the Medicaid program.
(*GMC 12-89341 and PHP 13-90115 Contracts Exhibit E, Additional Provision)*

Finding: The Plan did not report suspended, excluded, or terminated providers to DHCS.

The Plan has no P&P for reporting suspended, excluded, or terminated providers in the provider network.

During the interview, the Plan stated it reports suspended, excluded, terminated provider from its provider network to the Office of Inspector General within 30 days, however the Plan does not report these providers to DHCS.

Plan not reporting suspended, excluded and terminated providers to DHCS may result in diminished integrity of the Medi-Cal network.

Recommendation: Implement a process to ensure the reporting of suspended, excluded, or terminated providers to DHCS.