MEDICAL REVIEW – SOUTHERN SECTION V
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE DENTAL AUDIT OF

HEALTH NET OF CALIFORNIA, INC.

2021

Contract Numbers:	12-89342 13-90116
Audit Period:	March 1, 2020 Through February 28, 2021
Report Issued:	September 3, 2021

TABLE OF CONTENTS

I. INTRODUCTION 1

II. EXECUTIVE SUMMARY 2

III. SCOPE/AUDIT PROCEDURES 4

IV. COMPLIANCE AUDIT FINDINGS
Category 1 – Utilization Management 6
Category 4 – Members Rights 12
Category 5 – Quality Management 15

I. INTRODUCTION

Health Net 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 and has been providing dental services for Sacramento under the Geographic Managed Care (GMC) and Los Angeles under the Prepaid Health Plan (PHP) programs.

The Plan has a contract with an Administrator Services Organization (ASO) to administer the Medi-Cal Dental Programs in both Los Angeles and Sacramento counties. ASO areas of responsibilities and duties include utilization management, credentialing and provider training, claims processing, language assistance services, cultural competency, access and availability, exempt grievances, and member services. The Plan does not delegate grievances and appeals. The Plan retains the responsibility to provide oversight of the ASO's performance.

The Plan has a network of approximately 160 general providers and 60 specialists for Sacramento County and approximately 566 general providers and 183 specialists for Los Angeles County.

As of April 2021, the Plan served 345,311 Medi-Cal members in California. The membership was composed of 150,717 GMC and 194,594 PHP members.

EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS dental audit for the period of March 1, 2020 through February 28, 2021. The onsite review was conducted from April 26, 2021 through May 7, 2021.The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on August 11, 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. On August 26, 2021, the Plan submitted a response after the Exit Conference. The results of our evaluation of the Plan's response are reflected in this report.

The audit evaluated four categories of performance: Utilization Management, Access and Availability of Care, Members' Rights, and Quality Management.

The summary of the findings by category are as follows:

Category 1 – Utilization Management

Category 1 includes procedures and requirements for adherence to the Medi-Cal-Dental Manual of Criteria (MOC) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. These services are delegated to the ASO. Findings in this category concern the Plan's oversight of the ASO.

The Plan is required to verify that the ASO has developed a Utilization Management program that ensures appropriate processes are used to review and approve the provision of medically necessary dental covered services as identified in the Medi-Cal Dental MOC. The Plan did not ensure that all the provided covered services identified in the policies and procedures were consistent with the MOC.

The Plan is required to verify that the ASO has ensured the provision of EPSDT services for members under the age of 21. Based on staff training materials and the list of denials used for prior authorizations and claims, the Plan did not ensure the ASO considered EPSDT when program criteria were not met. The ASO only has denial reasons for EPSDT subject to age limitations, frequency limitations, and non-covered services. The denial sent to the member and the provider says that the service may be allowed if the EPSDT guidelines are met. This language is not used when the Medi-Cal Dental Program criteria were not met.

Category 3 – Access and Availability of Care

No findings noted for the audit period.

Category 4 – Member's Rights

Category 4 includes procedures and requirements for Grievance Resolutions and State Fair Hearings.

The Plan's written resolution is required to contain a clear and concise explanation of the MCP's decision. The Plan's member Quality of Care (QOC) resolution letters did not contain a clear and concise explanation of the Plan's decisions.

New federal regulations require members to exhaust the Plan's internal appeal process and receive notice that the adverse benefit determination has been upheld prior to proceeding to a State Fair Hearing. The Plan incorrectly included the State Fair Hearing as part of the grievance process in the resolution letters.

Category 5 – Quality Management

Category 5 includes procedures and requirements for Provider Training Time Frames and Provider Training Tracking.

The Plan is required to conduct training for all providers within ten business days after the Plan places a newly contracted provider on active status. The ASO's California Provider Reference Guide training requirements for newly contracted providers does not match contract requirements.

The Plan is required to conduct and track training for all providers within ten business days after the Plan places a newly contracted provider on active status. Provider means a primary care dentist, dentist, dental group, subcontractor, sub-subcontractor, or other individual or entity that renders covered services to a member. The Plan did not conduct and track new provider training to newly added subcontracted providers.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The 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

The audit review period was from April 26, 2021 through May 7, 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. DHCS reviewed the Plan's documents and interviewed the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Delegated Prior Authorization (PA) requests: 16 PA requests were reviewed for timeliness, consistent application of criteria, and appropriate review. The sample was selected to cover the different specialties of dentistry and the different age ranges of members in both Sacramento and Los Angeles counties.

Appeal procedures: 14 PA appeals were reviewed for appropriate and timely adjudication. The sample was selected to cover the different specialties of dentistry and the different age ranges of members in both Sacramento and Los Angeles counties.

Category 3 – Access and Availability of Care

None.

Category 4 – Member's Rights

Grievance procedures QOC: Ten QOC grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Grievance procedures (Quality of Service): 28 grievances, including 11 standard quality of service, ten exempt, seven expedited, were reviewed to verify the reporting time frames, investigation process, timely notifications, acknowledgements, resolution, appropriate processing, classification, and categorization.

Category 5 – Quality Management

New provider training: Ten new provider training records were reviewed for timely provision of Medi-Cal Dental Managed Care (DMC) Program training.

Potential Quality Issues: Five potential quality issues were reviewed for timeliness, consistent application of criteria, and appropriate review.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Net of California, Inc.
AUDIT PERIOD: March 1, 2020 through February 28, 2021 **DATE OF AUDIT: April 26, 2021 through May 7, 2021**

CATEGORY 1 – UTILIZATION MANAGMENT

1.1	Delegated Utilization Management Activities

1.1.1 Medi-Cal-Dental Manual of Criteria

The Plan is required to develop, implement and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary dental covered services as identified in the Medi-Cal Dental MOC.
(GMC/PHP Contract, Exhibit A, Attachment 7(A))

The Plan is required to ensure that its pre-authorization procedures are in accordance with the Medi-Cal Dental Policy and Procedures as described in the Medi-Cal Dental MOC.
(GMC/PHP Contract, Exhibit A, Attachment 7(B))

The DMC Plan is required to explicitly state how the member's condition does not meet the criteria or guidelines. *Dental All Plan Letter (APL) 20-003, Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Effecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments (12/10/2020),*

The ASO's policy and procedure *UM 2A Clinical Criteria for UM Decisions (12/18/2020)*, states that the ASO's Clinical Criteria Guidelines and Practice Parameters (CCG) should be applied only after consulting the applicable benefit Plan's Evidence of Coverage, Schedule of Benefits or other Plan materials, including State issued manuals, to determine plan-by-plan variations.

The ASO's policy and procedure *Denials for Treatment (12/18/2020)*, states that

- Reasons that dental services may be denied: procedure is not a covered benefit, lack of sufficient documentation to determine dental necessity, dental services do not meet dental necessity requirements.
- The denial notification is required to identify the enrollee, provide a description of the treatment and/or service submitted for review, and include a clear and concise explanation of the reason for denial, the criteria and guidelines used to make determination, and the clinical reason for the determination if the denial is based on dental necessity.

The ASO's policy and procedure *Coverage and Authorization of Services (12/18/2020)*, states that

- The ASO provides coverage for all dental benefits in accordance with specific plan/program benefits, frequency limitations and exclusions, including specialized benefits such as school-based dental, Skilled Nursing Facilities and programs tailored for pregnant women.
- The specific plan/program schedule of benefits must be consulted for applicable benefits, limitations and exclusions, including details on services that require PA.
- The ASO's Management Information System connects member eligibility, plan/program specific dental benefits, frequency limitations, exclusions, prior-authorization requirements, third-party liability, and member dental history data to allow for comprehensive and appropriate benefit determinations.
- The ASO's written and published CCG document that is the single source for CCG used to promote consistency in dental necessity determinations.
- Dental necessity determinations are made in a consistent manner based on sound clinical evidence that is no more restrictive in amount, duration, and scope than the definitions provided by governing state or federal statutes/regulations.

The ASO's policy and procedure *Appendix C, UM PP-Coverage of EPSDT Services (12/18/2020),* states that the frequency or periodicity of the Medi-Cal Dental program are:

- One periodic evaluation (D0120) – 1 service unit per 11 rolling months.
- Sealants (D1351), per tooth, once in a lifetime.
- Varnish (D1206) – 1 unit per 6 months.
- Fluoride application (D1208), excluding varnish, 2 times per rolling 12 months.
- One upper, lower, or complete set of full dentures (D5110, D5120, D5130, D5140).
- Reline (D5730-31, D5740-41, D5750-51, D5760-61) – 1 unit per 6 months, maximum of 6 units per 60 months.

Finding: The Plan did not ensure that all the provided covered services identified in the policies and procedures were consistent with the MOC.

There were nine services where policies were not consistent with the MOC: scaling and root planing, prefabricated stainless steel crown, extraction, sealant, endodontic procedures for members under the age of 21, periodic evaluations, fluoride, dentures, and relines. Reference documents given to providers and the Plan by the ASO were not adequately reviewed by the Plan and were different from the MOC. The ASO's EPSDT P&P Appendix C had frequency limitations that were more restrictive than those of the program.

For scaling and root planing, a review of five of five PAs showed that the Plan's ASO incorrectly informed members and providers that:

- "A4-1 Approved - The Plan only benefits up to two quadrants of scaling and root planing (D4341/D4342) on the same date of service. Exceptions may be submitted for consideration by a licensed Dental Consultant on a case-by-case basis."

The MOC does not include a limitation on the number of quadrants serviced per day.

For stainless steel crowns and extractions the Plan incorrectly included language that required a post-operative x-ray submitted for the payment of prefabricated stainless steel crowns and extractions services. In three of three files the Notice of Action requirement for the approved prefabricated stainless steel crowns and extractions services listed was:

- "AG-20 the service requested is approved. After the service is completed, the provider must submit dental notes, x-rays (pre-op and post-op) and/ or pictures to demonstrate that the service was medical necessary, completed successfully and if applicable meets the Plan guidelines for referable services. Payment is subject to receipt and review of documentation."

There is no requirement for post op x-rays for the payment of these services in the MOC.

In review of an appeal and QOC grievance, neither the Plan nor the ASO detected errors in the sealant benefit denial, nor member payment request. The ASO's claims system did not process a member's repair and replacement sealant benefit in accordance with the MOC. The MOC states "once per tooth every 36 months per provider regardless of surfaces sealed." In the QOC verification study, a member who originally received a sealant from a different provider, was charged for a new sealant when it was done within three years of its initial placement. Since it was a different provider, the member should have been provided the service and it should not have been billed to the member.

For root canals the MOC states, PA for endodontic procedures for members under the age of 21 is not required. The Plan's ASO includes endodontic procedures for members under the age of 21 in the document, "List of all services and procedures that require PA".

For UM PP-Coverage of EPSDT services the ASO's policy and procedure contains incorrect information:

- The ASO's policy stated "One periodic evaluation (D0120): one service unit per 11 rolling months."
  However the MOC CDT-19 Draft stated the services is once every six months up to the age of 21 not one unit per 11 rolling months.
- The ASO's policy stated "Sealants (D1351), per tooth, once in a lifetime".

However the MOC CDT-19 Draft stated the service is once per tooth every 36 months per provider not per tooth, once in a lifetime.

- The ASO's policy stated "Varnish (D1206), one unit per six months."
  However the MOC CDT-19 Draft stated the services is once every four months up to age six not one unit per six months.
- The ASO's policy stated "Fluoride application (D1208), excluding varnish, two times per rolling 12 months."
  However the MOC CDT-19 Draft stated the services is once every four months up to age six not two times per rolling 12 months.
- The ASO's policy stated "One upper, lower, or complete set of full dentures (D5110, D5120, D5130, D5140)."
  However the MOC CDT-19 Draft stated the services is once in a five year period.
- The ASO's policy stated "Reline (D5730-31, D5740-41, D5750-51, D5760-61) one unit per six months, maximum of six units per 60 months."
  However the MOC CDT-19 Draft-stated there is no maximum limitation.

The ASO reference document was not consistent with the MOC. In six of six PA appeals regarding members under the age of 21, the reference document that was sent from the ASO to the Plan contained incorrect information. The reference document incorrectly listed fluoride treatment as a benefit once every six months for patients up to the age of six. The benefit for fluoride treatment for patients up to the age of six is once every four months. The document did not take in to account that the Managed Care Dental Program considers a child to be under the age of 21 for Child Prophylaxis (D1120). The Plan's ASO considered a child to be under the age of 14 for Child Prophylaxis (D1120). Lastly, the document did not indicate that sealants were limited to once per tooth every 36 months per provider. It only had the three year time limitation.

The Plan's ASO administers multiple Medicaid programs from multiple states as well as commercial plans. The Plan did not ensure that all requirements in the California Medicaid Program take priority in the development of criteria, Clinical Dentistry Guidelines, the adjudication of GMC and PHP PAs, claims, and appeals. The Plan did not fully ensure that its ASO had included all services of the Medi-Cal Dental Program in its processes.

If the Plan does not ensure that all of the ASO provided covered services are consistent with the MOC members may not receive the services that they need.

Recommendation: Ensure the Plan's ASO revises and implements policies and procedures that meet all requirements of the MOC in PA, claims, and appeals processes. Revise the EPSDT Appendix C and the reference document.

1.1.2 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services

The Plan is required to ensure the provision of EPSDT services for members under the age of 21.
(GMC/PHP Contract, Exhibit A, Attachment 12(C))

The Plan is required to revise the Medi-Cal definition of “medical necessity” to incorporate existing federal standards related to EPSDT services. Specifically, Title 42, United States Code, section 1396d(r)(5)2 states: (r) The term “EPSDT” means the following items and services: (5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan [emphasis added].”

- Removal of Supplemental Services: DHCS is in the process of updating CCR, Title 22, sections 51184, 51242, 51242.1, 51340, 51340.1, 51532, 51532.1, 51532.2 and 51532.3 to remove the term "supplemental services” as a supplemental EPSDT benefit does not exist under the federal definition. DMC Plans must similarly remove all references to "supplemental services" from all impacted documents, including but not limited to, policies and procedures, Provider Manuals, Member Handbook, and provider trainings.
- Plans are required to retain responsibility for the review, authorization, and provision of EPSDT services.
- Plans must revise the review and authorization processes for dental services for members under the age of 21 to ensure consistent consideration of EPSDT criteria, including the federal definition of “medical necessity,” even when program criteria has not been met.

(Dental APL 19-001, Early and Periodic Screening Diagnostic and Treatment (EPSDT) Services (01/25/2019))

The ASO’s policy and procedure *Coverage of EPSDT Services (12/18/2020)*, stated that the ASO is required to cover all dental services for enrollees under the age of 21 listed in the applicable state appendix. In addition, the ASO is required to provide coverage of unlisted services if such services are medically necessary.

Finding: The Plan’s ASO did not inform the provider or the member that the denied services were consistently considered under EPSDT criteria when the standard program criteria were not met. The Plan’s ASO did not have a denial reason that references EPSDT services when program criteria has not been met.

The ASO only has denial reasons for EPSDT subject to age limitations, frequency limitations, and non-covered services. The Plan did not have policies and procedures and the ASO policies and procedures did not include APL requirements to include

services even when program criteria has not been met.

The Plan did not have a system in place to monitor the ASO and ensure consistent consideration of EPSDT medically necessary criteria. The Plan's ASO PA and claims processing focused on services that were not benefits and did not consider providing benefits that did not meet Medi-Cal Dental Program criteria.

Members, providers, and adjudication staff at the Plan's ASO are only reminded of the EPSDT benefit in some denial situations. Members may not have received treatment that could have corrected or ameliorated defects, physical and mental illnesses, and conditions.

Recommendation: Ensure the Plan develops and implement policies and procedures and the ASO revises policies and procedures to include the APL requirements. The Plan must also consider providing EPSDT services even when Medi-Cal Dental Program criteria are not met.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Net of California, Inc.
AUDIT PERIOD: March 1, 2020 through February 28, 2021 **DATE OF AUDIT: April 26, 2021 through May 7, 2021**

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1. Grievance Resolution

The Plan is required to implement and maintain a Member Grievance System in accordance with CCR, Title 28, section1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR 53858, Exhibit A, Attachment 14, Member Services, Provision D, Written Member Information, Sub-provision 4, Paragraph I).
(PHP/GMC Contract, Exhibit A, Attachment 15(A))

The Plan's resolution is required to contain a written response to the grievance and be sent to the complainant within 30 calendar days of receipt. The written response is required to contain a clear and concise explanation of the Plan's decision.
(CCR, Title 28, section 1300.68(d)(3),)

The Plan is required to provide subscribers and enrollees with written response to the grievance, with a clear and concise explanation of the reasons for the Plan's response. For grievances involving the delay, denial, or modification of health care services, the Plan response is required to describe the criterial used and the clinical reasons for its decision, including all criterial and clinical reasons related to medical necessity.
(Health and Safety Code, Section 1368(a)(5))

The DMC Plan's written resolution is required to contain a clear and concise explanation of the MCP's decision.
(Dental APL 20-003, Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Effecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments (12/10/2020))

The Plan's policy and procedure *GA-201ML: Medi-Cal Grievance Process (6/14/2021),* states that the Plan's written resolution is required to contain a clear and concise explanation of Plan's decision.

Finding: The Plan's member QOC resolution letters did not contain a clear and concise explanation of the Plan's decision.

In all ten QOC grievance files, the resolution letters did not say what steps the Plan had taken to address member's grievances or the outcome of the Plan's investigation. The Grievance Resolution letter did not tell the member whether or not the Plan's review was completed. In many of these letters it stated that the Plan will begin an investigation, when in most instances the analysis was completed.

The Plan acknowledged the use of a standard template to inform the members that a thorough review would be conducted. This was not tailored to the specific situation of each member's case. The Plan acknowledged the resolution letter did not match the timeline of the actual investigation.

The Plan is incorrectly applying the Knox Keene Act as a reason why explanations are not included in the resolution letters. The Knox Keene Act protects Peer Review Committee decisions. Decisions on QOC issues are not made by the Peer Review Committee.

Without receiving a written explanation of the Plan's findings and decisions, members are not aware if their issues have been investigated or resolved appropriately. Members are not able to get closure on their grievance.

Recommendation: Develop and implement policies and procedures that ensure the Plan's resolution letters contain a clear and concise explanation of the decision that addresses the specific situations of each member's case**.**

4.1.2 State Fair Hearing

The Plan's two contracts state "APL issued by Medi-Cal Dental Services Division (MDSD), DMC are hereby incorporated into this contract and are required to be complied with by contractor. APLs issued by MDSD subsequent to the effective date of this Contract are required to provide clarification of contractor's obligations pursuant to this Contract, and may include instructions to the contractor regarding implementation of mandated obligations pursuant to changes in state or federal statutes or regulations, or pursuant to judicial interpretation.
(PHP/GMC Contract, Exhibit E, Additional Provisions 5(d))

The Plan's contract states "subcontractor's agreement to comply with all applicable requirements specified in this Contract and subsequent amendments, federal and state laws and regulations, and Medi-Cal DMC APL." *(PHP/GMC Contract, Exhibit A, Attachment 8 (J)(2)(s))*

New federal regulations require members to exhaust the Plan's internal appeal process and receive notice that the adverse benefit determination has been upheld prior to proceeding to a State Fair Hearing.
(Dental APL 20-003, Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Effecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments (12/10/2020))

The Plan's policy and procedure *GA-201ML: Medi-Cal Grievance Process (6/14/2021)*, states that "If the member is not satisfied with the internal resolution of the grievance,

the member may elect a State Fair Hearing if the grievance is one for which the member may file for a State Fair Hearing."

Finding: The Plan incorrectly included reference to the State Fair Hearing in Grievance Resolution letters.

In all 11 quality of service grievances reviewed the Plan included a State Fair Hearing form in the Grievance Resolution letter. This may result in member confusion and a denial of service as members must exhaust the Plan's internal appeal process before using the State Fair Hearing.

APL 20-003 was issued in 12/14/2020, and changed the requirements for utilizing State Fair Hearing forms. The Plan did not update the required forms included with the Grievance Resolution letter.

Including the State Fair Hearing Form in the Grievance Resolution letter may confuse members and lead to a denial or delay in service as members must first exhaust the Plan's appeal process before utilizing the State Fair Hearing process.

Recommendation: Update grievance policy and procedures to ensure the Plan's grievance processes are consistent with the APL requirements.

CATEGORY 5 – QUALITY MANAGMENT

5.2	PROVIDER TRAINING

5.2.1 Provider Training Time Frame in the Provider Guide

The Plan is required to conduct training for all providers within ten business days after the Plan places a newly contracted provider on active status.
(PHP/GMC Contract, Exhibit A, Attachment 9(E))

The ASO's policy and procedure *Provider Orientation (08/04/2020)*, stated Provider Orientation must be completed prior to, but no more than ten days of activation.

Finding: The Plan delegates training to the ASO. The training requirements in the Plan's ASO California Provider Reference Guide for newly contracted providers did not match contract requirements.

In two of ten verification studies new providers did not receive training within ten business days after the Plan placed the newly contracted provider on active status.

The Plan is required to provide training within ten business days of provider's active status. The ASO's reference guide stated that "The ASO provides initial orientation and training to all new provider locations prior to or within ten days of activation and no later than 30 days of activation." The ASO's guide incorrectly stated training can be done no later than 30 days after activation.

The Plan did not monitor and provide oversight of the training information the ASO distributed to the newly contracted providers. The ASO did not have the correct information in the Provider Reference Guide.

When new providers receive inconsistent training through the Provider Reference Guide this may delay new provider training past the ten business day requirement.

Recommendation: Update the Plan's policy and procedures to ensure consistent oversight and monitoring of the ASO's policies and procedures.

5.2.2 Provider Training Tracking

The Plan is required to conduct training for all providers within ten business days after the Plan places a newly contracted provider on active status.
(PHP/GMC Contract, Exhibit A, Attachment 9(E)

Provider means a primary care dentist, dentist, dental group, subcontractor, sub-subcontractor, or other individual or entity that renders covered services to a member. *(PHP/GMC Contract, Exhibit E, Attachment 1)*

The Plan's policy and procedure *Provider Orientation (08/04/2020)*, states that the Provider Orientation must be completed prior to, but no more than ten days of activation.

Finding: The Plan did not conduct and track new provider training to newly added subcontracted providers.

The Plan did not conduct new provider training and had no oversight procedure to ensure training for the newly added subcontracted providers was provided and tracked. The Plan's new provider log tracked the new Provider Orientations by office, not the individual provider. Dates for some of the subcontracted providers were missing and noted as "existing office." The orientation network activity report also tracked the orientation by the office and not the individual. The Plan should fulfill the contract and provide new provider training to each newly contracted provider.

The Plan stated the subcontractor is delegated to train the new subcontracted providers. The Plan did not provide supporting documentation to prove its position that the subcontractor was fulfilling the Plan's contractual obligation to conduct new provider training for newly subcontracted providers.

Without oversight or a tracking system, the Plan cannot ensure newly added subcontractor providers receive new provider training.

Recommendation: Develop polices and tracking procedures to ensure new provider training is provided.