CONTRACT AND ENROLLMENT REVIEW –
SACRAMENTO SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE DENTAL AUDIT OF

Access Dental Plan of California

2022

Contract Number:	12-89341 13-90115
Audit Period:	July 1, 2021 through October 31, 2022
Dates of Audit:	February 6, 2023 through February 17, 2023
Report Issued:	July 5, 2023

TABLE OF CONTENTS

I. INTRODUCTION

Access Dental Plan of California (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 dental 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 243 general providers and 64 specialists for Sacramento County and has approximately 750 general providers and 580 specialists for Los Angeles County.

The Plan currently serves 307,582 Medi-Cal members in California. As of March 2023, the Plan's membership was composed of 170,238 GMC and 137,344 PHP members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS dental audit for the audit period of July 1, 2021 through October 31, 2022. The audit was conducted from February 6, 2023 through February 17, 2023. 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 9, 2023. 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 (UM), 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 to have mechanisms to detect over and under-utilization of services, however the Plan did not implement mechanisms to identify the over and under-utilization of dental services as detailed in the Plan's policies.

The Plan did not have a policy nor ensure a notification process that utilized the revised Notice of Action (NOA) templates and "Your Rights" attachments described in Dental- All Plan Letter (D-APL) 20-003.

The Plan is required to process standard prior authorizations within five business days and delayed prior authorizations within 28 days, however the Plan did not comply with contractual timeframes for prior authorization requests.

Category 3 – Access and Availability of Care

The Plan did not maintain the required weekly average "P" factor of seven percent or less. The "P" factor metric is a connection rate that indicates the Plan's ability to answer calls in a timely manner.

Category 4 – Members' Rights

The written record of grievances shall be reviewed at least quarterly by the Plan's Quality Assurance Committee and Governing Bodies for systematic aggregation and analysis for quality improvement; the review shall be thoroughly documented. 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.

Category 5 – Quality Management

The Plan shall integrate UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of deferrals and modifications to the appropriate QIS staff. The Plan did not include data on the quantity of deferred prior authorizations in its reports to quality improvement staff.

The Contract requires the Plan to maintain a (QIS) Manual, however, the Plan did not maintain a (QIS) Manual.

Category 6 – Administrative and Organizational Capacity

The Plan's Designated Compliance Officer (DCO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract, is required to 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.

III. SCOPE/AUDIT PROCEDURES

SCOPE

DHCS, Contract and Enrollment Review Division, 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

An audit was conducted from February 6, 2023 through February 17, 2023. 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: 16 dental services prior authorization files were reviewed. This included four deferred, two modified, and ten denied prior authorization. The sample was selected to cover the different specialties of dentistry, different age range of members, and to reflect both Sacramento and Los Angeles counties.

Appeals: Eight dental services appeals were reviewed and included the different specialties in dentistry, children and adults, and to reflect both Los Angeles and Sacramento counties.

Category 2 – Case Management and Coordination of Care

Case Management: Seven case management files, and ten special health care needs files were reviewed.

Oral Health Assessment: Ten Oral Health Assessment files were selected reviewed.

Category 4 – Members' Rights

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.

Category 5 – Quality Management

Potential Quality Issues: Six Potential Quality Issue (PQI) files were reviewed.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: The Plan did not have any fraud, waste, and abuse cases during the audit period.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Access Dental Plan of California
AUDIT PERIOD: July 1, 2021 through October 31, 2022 **DATES OF AUDIT: February 6, 2023 through February 17, 2023**

CATEGORY 1 – UTILIZATION MANAGEMENT	
1.1	**UTILIZATION MANAGEMENT PROGRAM**

1.1.1 Over and Underutilization Monitoring

The Plan is required to include within the UM program mechanisms to detect both under- and over-utilization of dental services. The Plan shall suspend all new enrollments for a provider who does not meet the thresholds of utilization. Reinstatement of enrollment may proceed once thresholds are met. The Plan's internal reporting mechanisms used to detect member utilization patterns shall be reported to DHCS no later than 30 calendar days after the beginning of each calendar year. The Plan shall submit self-reported monthly utilization data by Primary Care Dentist service site as determined by DHCS in an All Plan Letter. The report shall be submitted 30 calendar days after the end of each reporting month. (*Contract 12-89341 A15 and 13-90115 A15 ADP, Exhibit A, attachment 7)*

Plan policy *P&P 1.1.A.02_UM Monitoring UM.002.01 (effective 11/22/22) s*tates that the Plan is to perform routine utilization review of network providers, and is to outreach to providers that are identified as having unusual patterns of care by QM/UM Committees. This process includes producing Utilization Reports by assessing patterns of clinical activity and evaluations of treatment outcomes based on quantitative data obtained from encounter (claims) data, and developing a list of providers with unusual patterns of services on a quarterly basis.

Finding: The Plan did not implement mechanisms to identify the over and under-utilization of dental services as detailed in the Plan's policies.

The Plan did not complete Utilization Reports to assess patterns of clinical activity nor did it compile quarterly lists of providers that exhibit unusual patterns. A review of UM reports in Board of Directors and Quality Management Committee (QMC) minutes demonstrated a lack of discussion related to under and over utilization.

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 stated it 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.

Recommendation: Develop and Implement mechanisms to detect both under- and over-utilization of dental services.

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AUDIT PERIOD: July 1, 2021 through October 31, 2022 **DATES OF AUDIT: February 6, 2023 through February 17, 2023**

CATEGORY 1 – UTILIZATION MANAGEMENT	
1.2	**PRIOR AUTHORIZATION REVIEW**

1.2.1 Notice of Action Letter Templates

The Plan is required to utilize the revised NOA templates and corresponding "Your Rights" attachments included in this APL. Dental Managed Care plans shall not make any changes to the NOA templates or "Your Rights" attachments without prior review and approval from DHCS. *(D-APL 20-003 and 22-006 Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Effecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments)*

The Plan is required to render a decision on a provider's request for authorization of dental care services for a member, and notify the provider and the member using the appropriate NOA template. *(D-APL 20-003 and 22-006 Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Effecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments)*

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

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.

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

1.2.2 Prior Authorization Timeframes

The Plan is required to make decisions for routine authorizations within five working days from receipt of the information reasonably necessary to render a decision. *(GMC/PHP Contract Exhibit A, Attachment 7)*

The Plan is required to approve, delay, modify, or deny a provider's prospective or concurrent request for dental services in a timeframe which is appropriate for the nature of the member's condition, but no longer than five business days from the DMC plan's receipt of information reasonably necessary to make a determination. In instances where the Plan cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe because it is not in receipt of information reasonably necessary and requested, the Plan shall send out a delay NOA to the provider and member. A delayed NOA is warranted if the Plan extends the timeframe an additional 14 calendar days in addition to original five working days, because either the member or provider requests the extension, or upon DHCS satisfaction, the Plan justifies a need for additional information. Upon receipt of all information reasonably necessary and requested by the Plan, the Plan shall approve, modify, or deny the request for authorization within five business days or 72 hours for standard and expedited requests, respectively. *(D-APL 20-003 and 22-006 Centers for Medicare and Medicaid Services [CMS] Final Rule Revisions Effecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments)*

Finding: The Plan did not comply with contractual timeframes for prior authorization requests.

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.

The Plan stated during an interview that due to leadership changes and departmental re-alignment, prior authorizations were processed untimely during the audit period. The Plan also stated that during the audit period there was insufficient staff to assist with the volume of prior authorization requests it received.

When the Plan does not meet contractual timeframes for prior authorization requests, members may not receive medically needed dental services in a timely manner, which

might lead to patient harm.
Recommendation: Develop and implement policies and procedures to ensure compliance with contractual timeframes for all prior authorization requests.

1.2.3 Prior Authorization Classification and Notifications

The Plan is required to approve, delay, modify, or deny a provider's prospective or concurrent request for dental services in a timeframe which is appropriate for the nature of the member's condition, but no longer than five business days from the DMC plan's receipt of information reasonably necessary to make a determination. In instances where the Plan cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe because it is not in receipt of information reasonably necessary and requested, the Plan shall send out a delay NOA to the provider and member. A delayed NOA is warranted if the Plan extends the timeframe an additional 14 calendar days in addition to original five working days, because either the member or provider requests the extension, or upon DHCS satisfaction, the Plan justifies a need for additional information. Upon receipt of all information reasonably necessary and requested by the Plan, the Plan shall approve, modify, or deny the request for authorization within five business days or 72 hours for standard and expedited requests, respectively. *(D-APL 20-003 and 22-006 Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Effecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments)*

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.

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 authorizations were misclassified as deferred prior authorizations in the Plan's tracking logs submitted to DHCS.

The Plan stated during an interview that due to leadership changes and departmental

re-alignment, prior authorizations were processed untimely during the audit period. The Plan also stated that during the audit period there was insufficient staff to assist with the volume of prior authorization requests it received.

When the Plan does not properly notify members and providers of prior authorization status, delay in treatment can result.

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

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AUDIT PERIOD: July 1, 2021 through October 31, 2022 **DATES OF AUDIT: February 6, 2023 through February 17, 2023**

CATEGORY 3 – ACCESS AND AVAILABILITY	
3.1	**ACCESS AND AVAILABILITY**

3.1. Call Center Timeliness

The Plan must maintain a weekly average "P" factor of no more than seven (7) percent. The "P" factor metric is a connection rate that indicates the Plan's ability to answer calls in a timely manner. *(Contract Exhibit A, Attachment 14 C)*

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

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.

When the Plan's call center is unable to respond to member calls timely, the Plan may miss important opportunities to best serve its members.

Recommendation: Ensure the call center answers member calls in a timely manner.

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CATEGORY 4 – MEMBERS' RIGHTS	
4.1	**GRIEVANCE SYSTEM**

4.1.1 Review of Grievances by the Governing Body

The written record of grievances and appeals shall be reviewed periodically by the Governing Body of the Plan, the public policy body, and by an officer of the Plan or designee. The review shall be thoroughly documented. *(D-APL 20-003 and D-APL 22-006 Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Effecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments)*

Plan policy *P&P--4.1.08_GA.001.01 (effective 11/28/22)* states the Plan shall make a written record for each grievance received by the Plan, including the date received, the Plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the Governing Body of the Plan, the public policy body, and by an officer of the plan or his designee. This review shall be thoroughly documented.

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.

During the audit period, there was no documented discussion in the Governing Body and QMC minutes regarding the analysis of the written record of grievances.

During an interview, Plan staff acknowledged that no quarterly grievance analysis was conducted and review of grievance logs did not occur. The Plan also acknowledged that discussion of grievance logs was not documented.

The Plan stated it is undergoing a reorganization of its staff, system, and processes. Due to these organizational changes during the audit period, there were no regular or formal meetings of the Grievance Committee. In addition, review of grievance logs by Plan officials, QMC, and Governing Body did not occur.

When the Plan doesn't conduct and document the analysis of the review of the written record of grievances, it could miss opportunities to identify potential issues in the grievance system.

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.

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CATEGORY 5 – QUALITY MANAGEMENT	
5.1	**QUALITY IMPROVEMENT SYSTEMS**

5.1.1 Integration of UM activities into the Quality Improvement System

The Plan is required to integrate UM activities into the QIS, including a process to integrate reports on review of the number and types of deferrals and modifications to the appropriate QIS staff. *(Contract 12-89341 A15 and 13-90115 A15 ADP; Exhibit A, Attachment 7*)

Plan policy *P&P 5.1.A.02_QM.024.01_QI_Annual QMP (11/18/22)* states the Plan shall develop quarterly summary reports from minutes, to include a compilation of data obtained from QM Committee meetings, including statistical results, and utilization data.

Finding: The Plan did not include data on the quantity of deferred prior authorizations in its reports to quality improvement staff.

During the audit period, deferred prior authorizations were not captured nor reviewed in Plan reports to QIS staff.

Prior authorization reports that the Plan submits regularly to DHCS did not include data on deferred prior authorization until August 2022. In addition, Board of Director and QMC minutes demonstrated that deferred prior authorization were not discussed in committee meetings.

During an interview, the Plan stated that as a result of leadership, organizational, departmental, processing, and staff changes, there was no formal process during the audit period to regularly review deferred prior authorizations.

If the Plan does not report prior authorization data to its quality improvement staff, it will not be able to effectively evaluate, oversee, and perform quality improvement activity for its prior authorization process. This may cause delays in providing necessary services to members.

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.

5.1.2 Quality Improvement System Manual

The Plan is required to implement and maintain a QIS Manual. The QIS Manual shall be due to DHCS for approval prior to commencement of the contract and any revisions, updates and/or changes shall be submitted in writing to DHCS within fifteen (15) calendar days of the change. *(Contract 12-89341 A15 and 13-90115 A15 ADP Exhibit A, Attachment 5)*

Finding: The Plan did not maintain a QIS Manual.

The Plan did not submit a QIS Manual to DHCS for review. The Plan stated in an email that the Manual was undergoing revision, updates and approvals during the audit period.

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.

If the Plan does not maintain a QIS Manual it may not have a process to perform quality improvement activities on its systems.

Recommendation: Complete and implement the QIS Manual and submit to DHCS for approval.

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

6.2.1 Compliance Officer Reporting Requirements

The Plan is required to designate a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Contract, and who reports directly to the CEO and the Governing Body. *(42 Code of Federal Regulations (CFR) 438.608 (1)(ii))*

The Plan is required to meet the requirements set forth in 42 CFR § 438.608 as well as applicable state and federal law. The Plan is required to establish an Anti-Fraud and Abuse Compliance Program in which there will be written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards. The Plan or subcontractor will designate a Compliance Officer as a central point of contact for all fraud and/or abuse issues, who reports to the CEO and Board of Directors. This program will establish policies and procedures for identifying, investigating and taking appropriate action against fraud and/or abuse in the provision of health care services under the Medi-Cal Program. *(Contract Exhibit E, Additional Provision)*

Finding: The Plan's DCO did not report directly to the CEO and the Governing Body.

The Plan's administrative organization reporting structure for the DCO did not meet the contract requirement of reporting to both the CEO and 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 to report to the CEO.

The Plan confirmed in an interview that the DCO reported to the Chief Legal Officer instead of the CEO during the audit period.

When the Compliance Officer does not report directly to the CEO, compliance and fraud, waste and abuse information may not flow up to the appropriate personnel on a timely basis. This could affect the Plan's ability to solve compliance and fraud, waste, and abuse issues effectively and efficiently.

Recommendation: Ensure the DCO reports directly to the CEO and Governing Body.