DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SACRAMENTO SECTION

REPORT ON THE DENTAL AUDIT OF HEALTH NET DENTAL PLAN FISCAL YEAR 2024-25

Contract Numbers: 12-89342 and 13-90116

Audit Period: April 1, 2024 — December 31, 2024

Dates of Audit: September 2, 2025 — September 12, 2025

Report Issued: February 12, 2026

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I. INTRODUCTION

Health Net Dental Plan (Plan) has contracts with the California Department of Health Care Services (DHCS) to provide dental services to members in Sacramento and Los Angeles Counties. The Plan is licensed 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 a statewide network of contracted general and specialty dental providers. The Plan provides dental services to members under the Sacramento Geographic Managed Care and Los Angeles Prepaid Health Plan programs.

The Plan has approximately 956 providers for Sacramento County and has approximately 1,888 providers for Los Angeles County.

As of October 2025, the Plan's Medi-Cal membership was composed of 212,906 Geographic Managed Care and 212,405 Prepaid Health Plan members.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS dental audit for the audit period of April 1, 2024, through December 31, 2024. The audit was conducted from September 2, 2025, through September 12, 2025. The audit consisted of document review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on January 15, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On January 30, 2026, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated four categories of performance: Utilization Management, Access and Availability of Care, Member's Rights, and Administrative and Organizational Capacity.

The prior DHCS dental audit covering the period of April 1, 2023, through March 31, 2024, was issued on February 7, 2025. This audit examined the Plan's compliance with its DHCS Contracts. This audit examined the Plan's compliance with the DHCS Contracts and assessed the implementation of the prior year 2024, Corrective Action Plan (CAP).

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Utilization Management

Dental All Plan Letter (D-APL) 22-006, *Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Affecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments,* requires that decision makers for appeals possess the required clinical experience related to the subject of the appeal. Finding 1.3.1: The decision makers for the Plan's orthodontic appeals did not possess orthodontic experience.

Category 3 – Access and Availability of Care

There were no findings noted for this category during the audit period.

Category 4 – Member's Rights

D-APL 22-006 requires the Plan to provide clear and concise explanations of its decisions for members' complaints regarding Quality of Care (QOC) Grievance Resolution letters. Finding 4.1.1: The Plan's resolution letters did not include clear and concise explanations.

D-APL 21-001, *Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*, requires the Plan to submit required information to the DHCS discrimination grievance email inbox after mailing Discrimination Grievance Resolution letters to the member. Finding 4.1.2: The Plan did not submit required information to the DHCS Office of Civil Rights' (OCR) discrimination grievance email inbox after mailing Discrimination Grievance Resolution letters to the member.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that dental services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and State Contracts.

PROCEDURE

DHCS conducted an audit of the Plan from September 2, 2025, through September 12, 2025, for the audit period of April 1, 2024, through December 31, 2024. The audit included a review of the Plan's Contracts with DHCS, policies and procedures for providing services, 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 Authorization (PA): Fifteen dental services PA files were reviewed. This included deferred, modified, denied, and approved PA. 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: Eleven dental services appeals were reviewed and included the different specialties in dentistry, including children and adults, and to reflect both Los Angeles and Sacramento Counties.

Category 3 – Access and Availability of Care

There were no verification studies conducted for the audit review.

Category 4 – Member's Rights

Grievance Procedures: Twelve QOC and 17 quality of service grievance files were reviewed for timely resolution, compliance, and submission to the appropriate level of review. In addition, five exempt grievances and five call inquiry files were reviewed.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: Ten fraud, waste, and abuse files were reviewed for timely accuracy and timely submission to DHCS.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.3 Appeals Procedures

1.3.1 Prior Authorization Appeals

The Dental Managed Care (DMC) plan must ensure that the person making the final decision for the proposed resolution of a grievance or appeal must be a dental professional with clinical expertise in treating a member's condition or disease if any of the following apply:

1. An appeal of an adverse benefit determination that is based on lack of medical necessity
2. A grievance regarding denial of an expedited resolution of an appeal
3. Any grievance or appeal involving clinical issues

(D-APL 22-006, Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Affecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments)

A "qualified orthodontist" is a dentist who "confines his/her practice to the specialty of orthodontics, and, who either has successfully completed a course of advanced study in orthodontics of two years or more in programs recognized by the Council on Dental Education of the American Dental Association" or "who has completed advanced training in orthodontics prior to July 1, 1969, and is a member of, or eligible for membership in the American Association of Orthodontists." *(California Code of Regulations, Title 22, section 51223(c))*

Plan Policy, *Health Net P&P: MR-4.1.1-CA.AG.50 Medi-Cal Dental PP* (revised03/11/2025), stated the Plan will ensure that decision makers on appeals and grievances have clinical expertise in treating the member's condition when deciding the following:

- Appeal of a denial based on lack of medical necessity
- Grievance regarding denial of an expedited resolution of an appeal
- Appeal or grievance involving clinical issues or contested claims to evaluate the clinical issues of the claim

Finding: The Plan did not ensure that it utilized dental professionals with clinical expertise in orthodontics while adjudicating orthodontic appeals as required by D-APL 22-006.

The Medi-Cal Dental Manual of Criteria requires the Handicapping Labio-Lingual Deviation index to be evaluated by an orthodontist consultant and only enrolled "qualified orthodontists" may provide orthodontic services for members in the Medical-Dental program.

In a verification study of member appeals files, 5 of 11 files reviewed were for orthodontic services. All five were reviewed by one of the two Plan Dental Directors, who are both general dentists and not qualified orthodontists. Two files were denied because the patient was assigned low Handicapping Labio-Lingual Deviation index given by the Plan's Dental Directors.

The Plan's Dental Directors do not possess any additional training in orthodontics, nor have they had clinical experience in treating members' conditions requiring orthodontic services. Neither Dental Director met the criteria as "qualified orthodontists" as defined in the Medi-Cal Dental Manual of Criteria. The Plan does not delegate PA appeals to another entity with qualified orthodontists.

During an interview, the Dental Directors confirmed they have not had any additional training in orthodontics, nor did they practice orthodontics.

The Plan did not implement its policy and procedure to ensure qualified decision makers for appeals possessed the required orthodontic experience.

When appeals are resolved by dental consultants who lack clinical expertise in the member's condition, the Plan may incorrectly adjudicate medically necessary services.

Recommendation: Implement the policy and procedure to ensure decision makers for appeals related to orthodontic services are dental professionals with clinical expertise in treating a member's condition or disease.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.1 Grievance System

4.1.1 Quality of Care Grievances Resolution Letters

The DMC Plan's written resolution shall contain a clear and concise explanation of the DMC Plan's decision. *(D-APL 22-006, Centers for Medicare and Medicaid Services (CMS) Final Rule Revisions Affecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments)*

Confidentiality of Peer Review Proceedings: Any records, reports, or proceedings of medical Peer Review Committees—such as those evaluating the QOC provided by health professionals—are not subject to discovery in civil litigation. This includes grievance investigations conducted by health plans when they involve clinical evaluations. *(California Evidence Code section 1157)*

Plan policy, *Health Net P&P MR-4.1.1 CA.AG.50 Medi-Cal Dental PP* (revised 03/11/2025), stated the Plan will give the member written notice of the resolution with a clear and concise explanation of the reasons for the decision within 30 calendar days of receipt of the appeal or grievance. Grievance Resolution letters do not include the Notice of Appeals Resolution Your Rights document.

A Notice of Appeal Resolution or a Grievance Resolution letter is sent to the member with a clear and concise explanation of the reasons for the decision on any administrative or service outcome information. Additionally, the letter describes the members' options if a member is not satisfied with the grievance outcome.

Finding: The Plan's Grievance Resolutions letters did not provide a clear and concise explanation of the decisions.

In a verification study, 12 of 12 QOC Grievance Resolution letters did not include clear and concise explanations that explain to the members why the Plan came to its grievance decision. Instead, each explanation displays templated language that the complaint has been resolved with no detail or explanation. For example, in one file the member reported that a provider had placed two temporary crowns on the teeth, which subsequently cracked and caused discomfort to nearby teeth. The member expressed

concern about potential further complications and requested to transfer to a different dental office. The Plan's explanation in the resolution letter stated:

> "We received your dental records, and provider's response related to your case. Health Net's Clinical Appeals and Grievances Department has finished a clinical review of your dental information and concerns. Your complaint has been investigated and resolved. Our Dental Director has requested that the provider be monitored for future complaints. Thank you for sharing your experience with us, as it helps us meet our members' needs. Health Net is not allowed to reveal the specific results of our clinical review as it is considered confidential and protected by law."

According to the Plan's grievance documentation, the section titled *"Medical Director Review - QOC Grievance"* was labeled as "CONFIDENTIAL: Protected by Peer Review and California Evidence Code section 1157." This section contained detailed information regarding the reason for grievance decisions.

The Plan is misinterpreting California Evidence Code section 1157 which protects records of Peer Review or Quality Committee meetings from discovery only. This law does not prevent the Plan from detailing the reasons for grievance decisions since grievance decisions are not made in the Peer Review or Quality Committee meetings and does not require discovery. The Plan stated during an interview that it agrees its system needs to change and that it has submitted the changes to Medi-Cal Dental Services Division .

This is confirmed by Medi-Cal Dental Services Division in the CAP which states, "the Plan submitted its desktop procedure for letter writing guidelines, demonstrating the use of clear and concise language in resolution letters. DHCS closes this CAP effective July 2, 2025."

When grievance letters do not contain clear and concise explanations, the member is not informed on why the Plan came to its grievance decisions which could hinder the member's ability to understand how to proceed if they received an unfavorable outcome.

This is a repeat of the 2022, 2023, and 2024 Findings - 4.1.1 – Grievance Resolutions.

Recommendation: Implement a policy and procedure to ensure the Plan's resolution letters contain clear and concise explanations of the decision that addresses the specific situations of each member's case.

4.1.2 Submission of Discrimination Grievances to DHCS Office of Civil Rights Email Inbox

Within ten calendar days of mailing a Discrimination Grievance Resolution letter to a member, Plans must submit detailed information (Grievance Resolution letter, Discrimination Grievance Reporting form, supporting documentation) regarding the grievance to the DHCS OCR designated discrimination grievance email inbox. *(D-APL 21-001, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Finding: The Plan did not submit required information to the DHCS OCR discrimination grievance email inbox after mailing Discrimination Grievance Resolution letters to the member.

A verification study of discrimination grievance files found that the Plan did not submit required information to the DHCS OCR email inbox in two of three samples as required in D-APL 21-001. Below are the reasons they were not submitted:

- In one sample, the Plan failed to send out the required supporting documentation due to human error
- In the second sample, the Plan misclassified the initial complaint
- Later, the Plan reclassified the second sample after an internal audit found that it should have been classified as a discrimination grievance. However, after the reclassification, the documentation was not sent to the DHCS OCR email inbox.

The Plan's Compliance Department is responsible for the submission of the supporting documentation to the DHCS OCR email inbox regarding discrimination grievances. However, there was no process in place to ensure the required information was sent.

If the Plan does not submit the required information, DHCS OCR will miss information that allows it to ensure the member's complaint was appropriately addressed and resolved.

Recommendation: Develop and implement a process to ensure the submission of required grievance information to the DHCS OCR email inbox within ten calendar days.