DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

# REPORT ON THE DENTAL AUDIT OF ACCESS DENTAL PLAN FISCAL YEAR 2023-24

Contract Numbers: 12-89341 and 13-90115

Audit Period: November 1, 2022 through October 31, 2023

Dates of Audit: March 18, 2024 through March 29, 2024

Report Issued: October 10, 2024

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# I. INTRODUCTION

**Background**

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 a statewide network of contracted general and specialty dental providers. The Plan provides dental services to members under the Sacramento Geographic Managed Care (GMC) and Los Angeles Prepaid Health Plan (PHP) programs.

The Plan has approximately 287 providers in Sacramento County and has approximately 1,272 providers for Los Angeles County.

The Plan currently serves 275,969 Medi-Cal members in California. As of May 2024, the Plan's membership was composed of 159,733 GMC and 116,236 PHP members.

# II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS dental audit for the period of November 1, 2022, through October 31, 2023. The audit was conducted from March 18, 2024, through March 29, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on September 24, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On October 9, 2024, 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 six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS dental audit for the period of July 1, 2021, through October 31, 2022, was issued on July 5, 2023.

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:

## Performance Area:

### Category 1 – Utilization Management

The Plan is required to utilize Notice of Action (NOA) letter templates detailed in Dental-All Plan Letter (D-APL) 20-003 and D-APL 22-006. The Plan did not review and update NOA letter templates and "Your Rights" attachments according to D-APL 22-006. This is a repeat finding.

The Plan is required to process standard prior authorizations within 5 business days and delayed prior authorizations within 28 days; however, the Plan did not always comply with contractual timeframes for prior authorization requests. This is a repeat finding.

The Plan did not consistently apply its Utilization Review guidelines when adjudicating dental prior authorizations.

## 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. This is a repeat finding.

## Category 4 – Member's Rights

The Contract requires the Plan to adjudicate grievances to final conclusions before considering them resolved. During the audit period, the Plan did not ensure member grievances were completely resolved prior to closing them.

The Plan is required to resolve grievances within 30 calendar days of receipt. The Plan did not comply with the 30 calendar day requirement for grievance resolution because complaints were closed and re-opened later when records were received.

The Contract requires the Plan to provide written grievance acknowledgment letters to members within five calendar days of receipt. During the audit period, the Plan did not provide written grievance acknowledgement letters to members within the five calendar day requirement.

## Category 5 – Quality Management

The Plan is required to involve providers in the review of Potential Quality Issue (PQI) cases. The Plan did not involve contracting and community providers' records or opinions in the review of Potential Quality Issue (PQI) cases.

The Plan is required to ensure newly contracted providers completed the mandatory training within ten business days of their activated status. During the audit period, the Plan did not document whether providers completed training within the required timeframe.

## Category 6 –Administrative and Organization Capacity

The Plan's Chief Compliance Officer (CCO) is required to report directly to the Chief Executive Officer (CEO) and the Governing Body. During the audit period, the Plan's CCO reported to the Governing Body as well as the Chief Legal Officer and the CEO. This is a repeat finding.

# 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 the State Contract.

**PROCEDURE**

DHCS conducted an audit of the Plan from March 8, 2024, through March 29, 2024, for the audit period of November 1, 2022, through October 31, 2023. The audit included a review of the Plan's Contract 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 Plan 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 authorizations. 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: Seven 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 2 – Case Management and Coordination of Care

Case Management: 19 files total were reviewed, including 7 for case management, 5 for children with special health care needs, and 7 for adults with special health care needs.

Oral Health Assessment: Seven Oral Health Assessment files were reviewed.

## Category 3 – Access and Availability of Care

There were no verification studies conducted for the audit review.

## Category 4 – Member's Rights

Grievance Procedures: 7 quality of care and 20 quality of service grievance files were reviewed for timely resolution, compliance, and submission to the appropriate level of review. In addition, five exempted grievances and five call inquiry files were reviewed.

## Category 5 – Quality Management

PQI: Ten PQI files were reviewed.

Provider Training and Credentialing: 12 provider credentialing files, 12 re-credentialing files, and 20 provider training files were reviewed.

## Category 6 – Administrative and Organization Capacity

Fraud, Waste, and Abuse (FWA): Two FWA files were reviewed. These were the only FWA cases opened by the Plan during the audit period.

# IV. COMPLIANCE AUDIT FINDINGS

## Performance Area

### Category 1 – Utilization Management

#### 1.2 Prior Authorization Review

##### 1.2.1 Use of Notice of Action Letter Templates

Dental Managed Care (DMC) plans must provide members with written notice of an adverse benefit determination using the DHCS-developed, standardized NOA template and the NOA "Your Rights" template. (DAPL 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 review and update NOA letter templates and "Your Rights" attachments according to D-APL 22-006.

A verification study showed that in 16 of 16 prior authorization files provided members with a written notice of action (NOA) of an adverse benefit determination; however, these NOAs did not utilize the revised DHCS NOA template language.

During the audit period, the Plan's Policy and Procedure (P&P), 1.1.A.01_UM Program Description_Finaled stated members and providers are notified in written form of the adverse determination. However, the policy did not require that written letters notifying members and providers of prior authorization decisions use the approved letter templates from DAPL 22-006.

In an interview, the Plan stated the UM committee staff are responsible for reviewing D-APLs annually in order to update Plan documents, such as NOAs. The Plan stated that the failure to update its NOA letters was due to a leadership change and merging of staff in the UM section as well as the turnover and shortage of key staff related to the review of regulations.

When the Plan does not utilize the required NOA templates, members may not be informed of important details about the status and/or decision of their prior authorizations for dental services.

**This is a repeat of the prior year finding - 1.2.1 - Notice of Action Letter Templates**.

**Recommendation:** Develop and implement a P&P to ensure the utilization of required NOA templates.

### 1.2.2 Prior Authorization Decision and Notification 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. (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. 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)

Decisions to approve, modify, or deny requests, must be communicated by the plan to the provider within 24 hours of the decision and to the member within two business days using the appropriate NOA template. (DAPL 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 (PA) treatment request decisions and notifications.

In a verification study of the Plan's prior authorization system, 16 standard PA and three expedited PA files were reviewed:

•For 8 of 16 standard PAs, the Plan made PA decisions past five business days from receipt to determination of the PAs. These decisions ranged from 2 to business days to eight months past the five business day timeframe.

•For two of three expedited PAs, the Plan made PA decisions past 72 hours from receipt to determination of the PAs. past the 72-hour timeframe.

•For 10 out of 16 samples, the Plan exceeded the timeframe for written communication to providers within 24 hours and to members within two business days. These timeframes were exceeded by a range of 15 to 58 business days.

The Plan did not have a P&P in place for timeline requirements for written notification to providers and members regarding prior authorizations. During the audit period, the Plan stated it had several challenges that hindered its ability to comply with contractual timeframes for prior authorizations, including leadership changes, system backlogs, and staff shortages.

When the Plan does not meet contractual timeframes for prior authorizations decisions and notifications, members may not receive medically necessary dental services in a timely manner, which could lead to patient harm.

**This is a repeat of the prior year finding - 1.2.2 Prior Authorization Timeframes.**

**Recommendation:** Revise and implement policies and procedures to ensure compliance with all contractual timeframes for prior authorization requests.

### 1.2.3 Prior Authorization Decisions

The Plan must use a set of written criteria or guidelines for utilization review that is based on the dental standard of care, is consistently applied, regularly reviewed, and updated. (Contract, Exhibit A, Attachment 7)

1.1.C.04_UM.004.01 Clinical Review Staff Roles and Responsibilities (effective 7/27/23) stated that Plan staff must maintain consistency with dental clinical principles and processes when making decisions. A monthly calibration of utilization management (UM) decisions shall be conducted to ensure UM decision are consistent among reviews. Results shall be reported to the Peer Review Subcommittee.

**Finding:** The Plan did not consistently apply its Utilization Review guidelines when adjudicating dental prior authorizations.

In a verification study, the Plan did not consistently apply its utilization review guidelines when adjudicating dental prior authorizations for three of its members. For one member, two PA requests for the same tooth were submitted to the Plan. These two separate PAs were for the same procedure type; however, the Plan denied one PA and approved the other. This same pattern of inconsistent PA decisions was evident for a second and third member from the verification study sample.

The Plan's policy, 1.1.C.04_UM.004.01 Clinical Review Staff Roles and Responsibilities (effective 7/27/23) stated that Plan staff must maintain consistency with dental clinical principles and processes when making decisions. However, the verification study shows that the Plan failed to adhere to its policy to maintain consistency with prior authorization decisions.

In an interview, the Plan stated that PA adjudication inconsistencies were due to the Plan's application of two utilization review systems, which resulted in inconsistent decisions. The Plan explained that, as a result of leadership changes and staff shortages, there was a backlog of PAs during the period between August 3, 2022, and March 14, 2023. To expedite the processing of the backlog, the Plan applied an "auto-approval system" where PA requests for the highest utilized procedures were approved by the Dental Director without the requirement of a documentation review. The "auto-approval" process led to approvals for services that otherwise should have been denied based on the Plan's utilization review criteria used by its dental consultants.

During this "auto-approval" period, a select number of prior authorizations were still reviewed outside of the "auto-approval system" by dental consultants. In these cases, during which documentation was reviewed, the prior authorizations were denied appropriately.

When the Plan does not consistently apply its utilization review guidelines, it can lead to inconsistent adjudication of dental prior authorizations that may result in the Plan approving services that are not medically necessary.

**Recommendation:** Ensure prior authorization decisions are made consistently.

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**Recommendation:** Ensure prior authorization decisions are made consistently.

## Category 3 – Access and Availability of Care

### 3.1 Access and Availability

#### 3.1.1 Call Center "P" Factor

The Plan must maintain a weekly average "P" factor of no more than seven 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.

A review of the Plan's P Factor Call Center Results document showed that the Plan did not maintain a weekly average "P" factor of seven percent or less. The Plan's connection rate that indicates the Plan's ability to answer calls in a timely manner ranged from 32-59% during the audit period.

In an interview, the Plan acknowledged its "P" factor was above seven percent during the audit period. The Plan stated that the rise in the "P" factor began at the end of 2022 due to a backlog in authorization processing, as well as a change in the Plan's utilization management (UM) process in July 2022. This UM change required providers to submit x-ray documentation in a new format which led to an increase in questions from providers and increased call volume. The Plan stated that staff shortages contributed to a high number of unanswered calls and adjudication backlogs.

When the Plan does not meet the "P" factor requirements, there is potential that the Plan may miss important opportunities to better serve their members' and providers' needs.

**This is a repeat of the prior year finding - 3.1 Call Center "P" Factor.**

**Recommendation:** Revise and implement procedures and adequate staffing to ensure that the "P" factor is maintained at a seven percent or lower rate.

## Category 4 – Member's Rights

### 4.1 Grievance System

#### 4.1.1 Grievance Resolutions

"Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance as delineated in existing state regulations. (D-APL 22-006 Centers for Medicare and Medicaid Services [CMS] Final Rule Revisions Effecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments)

In the Plan's policy, 4.1.01_GA.001.01 Grievance & Appeals (effective 10/26/23) stated a resolved grievance means that the grievance has reached a final conclusion with respect to the member's submitted grievance, and there are no pending member appeals within the plan's grievance system, including entities with delegated authority.

Resolution means the written conclusion is reached with respect to the Member's submitted grievance or appeal, and there are no pending member issues within the Plan's grievance system.

**Finding:** The Plan did not ensure member grievances were completely resolved prior to closing them.

In a verification study of the Plan's grievances, three out of seven quality of care samples and 3 of the 20 quality of service verification samples were closed by the Plan without final resolution due to lack of documentation or response from the provider. In each of the six samples, the Plan sent a resolution letter to the provider requesting records that contained the following language: "Once we receive your records, we will reopen your complaint for further review...at this time, we consider the grievance resolved and the case closed."

The Plan's policy, 4.1.01, GA.001.01 Grievance & Appeals (effective 10/26/23), describes a resolved grievance; however, this policy did not include internal control procedures to ensure complete collection or timely follow-up of grievance records.

In an interview, the Plan explained that it lacked a process for timely follow-up with provider offices when requested records were not received by the initial due date. Furthermore, the Plan acknowledged that its practice of closing and re-opening cases does not meet the definition of resolution according to the Contract.

Incomplete resolutions of member grievances may result in missed opportunities for improved health care delivery and could cause adverse health outcomes for members.

**Recommendation:** Revise and implement policies and procedures to ensure all grievances are thoroughly investigated and appropriately resolved prior to sending a resolution letter to members.

### 4.1.2 Grievance Resolution Timeframe

Contractor shall resolve the Grievance and provide notice to the affected Member no later than 30 calendar days from the day Contractor receives the Grievance. (Contract, Exhibit A, Attachment 15(A))

The state's established timeframe is 30 calendar days. DMC plans must comply with the state's established timeframe of 30 calendar days for grievance resolution.

a. "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance as delineated in existing state regulations.

The DMC plan must establish and maintain a system of aging grievances and appeals that are pending and unresolved for 30 calendar days or more and include a brief explanation of the reasons for each pending and unresolved grievance and each appeal. (D-APL 22-006 Centers for Medicare and Medicaid Services [CMS] Final Rule Revisions Effecting Grievance and Appeal Requirements; Revised "Your Rights" Attachments)

The Plan's policy, 4.1.01_GA.001.01 Grievance & Appeals (effective 10.26.23) stated the Plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in subsection (8). The written response shall contain a clear and concise explanation of the plan's decision.

**Finding**: The Plan did not resolve these grievances within the 30 days from the time of receipt.

During the audit period the Plan closed grievance cases before fully resolving them, then re-opened them after receiving additional records from providers. As a result, these grievances exceeded the 30-calendar day resolution timeframe. In a verification study, 2 of the 7 Quality of Care samples and 2 of the 20 Quality of Services samples were closed, then re-opened after the 30 calendar day timeline had already passed. The final resolution time for these cases range from 2 months to 11 months.

The Plan stated in an interview that during the audit period, the Plan's grievance P&Ps did not include a policy that established and maintained a system to ensure that grievances have reached their final conclusion by 30 calendar days or less from the time of the initial receipt of the grievance, and did not have a system for aging grievances that are pending and unresolved for 30 calendar days or more. In addition, the P&Ps did

not include a procedure that monitors and notifies Plan staff when grievances are approaching or past this deadline.

When the Plan does not track, monitor, and ensure complete and timely resolution of grievances, members may experience delays in obtaining medically necessary dental care.

**Recommendation**: Revise and implement policies and procedures to fully resolve grievances within 30 calendar days from receipt of the grievance. In addition, establish and maintain a system of aging grievances that are pending and unresolved for 30 calendar days or more.

### 4.1.3 Grievance Acknowledgement Letters

Contractor shall provide written acknowledgement to the affected Member within five (5) calendar days of receipt of the Grievance. (Contract, Exhibit A, Attachment 15)

The Plan's policy, 4.1.01_GA001.01 Grievance and Appeals (effective 10.26.23) stated a member may file a Grievance either orally or in writing with the Plan at any time. The Plan shall provide written acknowledgement to the affected Member within five (5) calendar days of receipt of the Grievance.

**Finding**: The Plan did not send grievance acknowledgement letters to members within five-calendar days of receipt of the grievance.

In a verification study for Quality of Service Grievances, 3 of 20 samples revealed that the Plan did not send grievance acknowledgement letters to members within five-calendar days of receipt of the grievance.

The Plan stated in an interview that these delays were a result of unexpected departures of key employees responsible for the creation and distribution of acknowledgement letters.

When the Plan does not send acknowledgement letters in a timely manner, members will not know the process the Plan follows when it receives a complaint, the possible outcomes of the investigation, and grievance resolution timeframes. Without this information, members can miss important timeframes, resulting in delays and missed services.

**Recommendation**: Ensure there is adequate staffing or cross-training to facilitate the creation and distribution of acknowledgement letters within five calendar days of receipt of grievances.

## Category 5 – Quality Management

### 5.1 Quality Improvement Systems

#### 5.1.1 Provider Participation in Potential Quality Issues

Contractor shall ensure that contracting dentists and other providers from the community shall be involved as an integral part of the Quality Improvement System (QIS).

The Plan's QIS system must include a description of the system for provider review of QIS findings, which at a minimum, demonstrates provider and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QIS study outcomes. (Contract, Exhibit A, Attachment 5)

**Finding**: The Plan did not involve contracting and community providers records or opinions in the review of Potential Quality Issue (PQI) cases.

In a verification study of the PQI system, three out of ten samples did not include documentation of provider involvement during the review process, nor did they include provider records, which are an integral part of the PQI process. In these cases, records were requested but were not received, and cases were closed before the investigations were completed.

Attendance records of Peer Review Committee Minutes did not show that providers from the community were present to review PQIs presented during the meeting.

The Plan did not have a formal written P&P for its PQI review process. In addition, the Plan did not have a written process for requesting provider records pertaining to PQIs.

During an interview, the Plan confirmed it did not have a P&P for provider involvement in the PQI process, nor had it invited contracting dentists and other providers from the community to participate in Peer Review Committee where PQI cases were presented and discussed.

When the Plan does not involve provider documents and input in PQI investigations, cases may remain unresolved and may adversely affect member care. If contracting dentists or other community providers do not participate or have provider records necessary for PQI reviews, important input and feedback may be lacking from the Plan's quality improvement system.

**Recommendation**: Develop and implement policies and procedures that ensure contracted and community providers' records and participation in the Plan's PQI processes.

### 5.2.1 New Provider Training

Contractor shall conduct training for all providers within ten business days after the contractor places a newly contracted provider on active status. Contractor shall ensure that provider training includes, but is not limited to, information on all member rights specified in Exhibit A, Attachment 14, Member Services, including the right to full disclosure of dental care information and the right to actively participate in dental care decisions. (Contract, Exhibit A, Attachment 9, E)

The Plan's policy, ED.003.01 Education Providers (effective 08.31.23) stated orientation related to access and availability responsibilities, reporting requirements, and monitoring completed by the Plan is conducted for all newly contracted dental facilities within ten business days of the effective date for new contracts.

**Finding**: The Plan did not document whether newly contracted providers completed the mandatory training within ten-business days of activated status.

The Plan's provider training log did not document the training completion dates for new providers. Additionally, the Plan did not collect provider attestations documenting the completion of new provider training, nor did it verify whether providers completed the training in another way that was documented.

The Plan stated in a written response that providers had the ability to email a training completion attestation to the Plan; however, most providers were not doing so.

In addition, the Plan's provider training P&P regarding the ten-business day training timeframe only applies to newly contracted facilities, but not individual providers. The contract requires individual providers to complete new provider training within ten-business days as well.

Providers who do not complete the initial training may lack the necessary knowledge to provide all covered services to Medi-Cal members.

**Recommendation**: Revise and implement the P&P to ensure new provider training is documented and that provider training policies align with contractual requirements.

## Category 6 – Administrative and Organization 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. (Code of Federal Regulations, Title 42, Section 438.608 (1)(ii))

Contractor 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. (Contract, Exhibit E, Additional Provision)

**Finding**: The Plan's Chief Compliance Officer (CCO) did not report directly to the CEO and the Board of Directors. This is a repeat finding.

The Plan's Compliance Structure Chart and ADP Compliance Organizational Chart submitted by the Plan indicated that the Plan's CCO reported directly to the Chief Legal Officer and not directly to the CEO. In addition, the Plan's P&P did not contain guidelines for CCO reporting structure.

During an interview, the Plan confirmed that the CCO reported to the Chief Legal Officer during the audit period.

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

**This is a repeat of the prior year finding - 6.2.1 Compliance Officer Reporting Requirements.**

**Recommendation:** Revise and implement policies and procedures to ensure the CCO reports directly to the CEO and the Board of Directors.