DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SACRAMENTO SECTION

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

Contract Numbers: 12-89342 and 13-90116

Audit Period: April 1, 2023 – March 31, 2024

Dates of Audit: July 22, 2024 – August 2, 2024

Report Issued: February 7, 2025

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INTRODUCTION

Health Net Dental Plan (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 the Los Angeles Prepaid Health Plan (PHP) programs.

The Plan has approximately 307 providers in Sacramento County and has approximately 956 providers in Los Angeles County.

As of May 2024, the Plan's California membership was composed of 169,527 GMC and 215,856 PHP members.

EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS dental audit for the period of April 1, 2023, through March 31, 2024. The audit was conducted from July 22, 2024, through August 2, 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 January 8, 2025. 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 23, 2025, 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 April 1, 2022, through March 31, 2023, was issued on October 17, 2023. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year 2023, Corrective Action Plan.

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

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

Category 2 – Case Management and Coordination of Care

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

Category 3 – Access and Availability of Care

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

Category 4 – Member's Rights

The Plan is required to provide clear and concise explanations of decisions for members' complaints in Quality of Care (QOC) grievance resolution letters. During the audit period the Plan did not provide clear and concise explanations of the decisions in QOC grievance resolution letters. This is a repeat finding.

Category 5 – Quality Management

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

Category 6 –Administrative and Organizational Capacity

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

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

The DHCS conducted an audit of the Plan from July 22, 2024, through August 2, 2024, for the audit period of April 1, 2023, through March 31, 2024. The audit included a review of the Plan's Contract with the 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, age range of members, and to reflect both Sacramento and Los Angeles Counties.

Appeals: 16 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: 28 files were reviewed. This included ten for case management, six for children with special health care needs, eight for adults with special health care needs, and four for fee-for-service to managed care transition.

Oral Health Assessment: Nine 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: 12 QOC and 20 quality of service grievance files were reviewed for timely resolution, compliance, and submission to the appropriate level of review. In addition, ten exempted grievances and ten call inquiry files were reviewed.

Category 5 – Quality Management

Prior Quality Issues: Ten prior quality issues files were reviewed.

Provider Training and Credentialing: 15 provider training files were reviewed.

Category 6 – Administrative and Organizational Capacity

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

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.1 Grievance System

4.1.1 Written Explanations in Grievance Resolution Letters

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

The Plan's policy, *CA.AG.50 Medi-Cal Dental P&P* (effective 12/18/23), states that grievance resolution letters are sent to members within 30 calendar days of receipt of the appeal or grievance and will contain a clear and concise explanation of the Plan's decision.

Finding: The Plan did not provide clear and concise explanations of the decisions for members' complaints regarding QOC grievance resolution letters.

In a verification study of the Plan's grievances, all 12 QOC resolution letters did not include concise explanations of why the Plan came to the grievance decision. Instead, the resolution letters contained a general statement that read, "the 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." The grievance letters also stated that, "Health Net is not allowed to reveal the specific results of our clinical review as it is considered confidential and protected by law."

The Plan acknowledged during an interview that the computer system incorrectly embedded the resolution letters with verbiage stating the clinical review or Medical Director review of grievances is confidential and protected by the Peer Review Committee pursuant to California Evidence Code section 1157.

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 protect Plan staff for decisions made on QOC grievances as the decisions are not made by the Peer Review Committee.

When grievance letters do not contain clear and concise explanations, the member is not informed on why the Plan came to the grievance decision, which could hinder the

member's ability to understand how to proceed if he/she received an unfavorable outcome.

This is a repeat of the 2021 and 2022 findings - 4.1.1 – Grievance Resolutions.

Recommendation: Revise Plan processes that ensure the correct application of California Evidence Code section 1157 and that the Plan's resolution letters contain clear and concise explanations of the decision that addresses the specific situation of each member's case.