Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
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December 10, 2024 **Via eFile**

Mr. Kirk Rothrock
Chairman of the Board of Directors
Access Dental Plan
8890 Cal Center Drive
Sacramento, CA 95826

FINAL REPORT OF A ROUTINE EXAMINATION OF ACCESS DENTAL PLAN

Dear Mr. Rothrock:

Enclosed is the final report (Final Report) of a routine examination for the quarter ended March 31, 2024, of the fiscal and administrative affairs of Access Dental Plan (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a preliminary report (Preliminary Report) to the Plan on September 20, 2024. The Department accepted the Plan's electronically filed responses (Responses) on November 4, 2024 and December 5, 2024.

The Final Report includes a description of the compliance efforts included in the Plan's Responses, in accordance with Section 1382(c).

Section 1382(d) states, "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within 10 days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its Responses. If so, please indicate which portions of the Plan's Responses should be appended, and electronically file copies of those portions excluding information held confidential pursuant to Section 1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's

[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in California Health and Safety Code section 1340 et seq.

Responses or wishes to modify any information provided to the Department in its Responses, please provide an addendum no later than 10 days from the date of the Plan's receipt of this letter. Please file this addendum electronically via the corrective action plan (CAP) system within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, select "Details" for "CAP #L24-R-318."
- Go to the "Messages" tab, then:
    - Select "Addendum to Final Report" (note this option will only be available for 10 days after the issuance of the Final Report).
    - Select the deficiency(ies) that are applicable.
    - Create a message for the Department.
    - Attach and upload all documents with the name "Addendum to Final Report."
    - Select "Send Message."

As noted in the attached Final Report, the Plan's Responses did not adequately respond to the deficiencies raised in the Preliminary Report issued by the Department on September 20, 2024. The Plan is required to respond to any request for corrective actions contained within the attached Final Report within 30 days of receipt of the Final Report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Department's Office of Enforcement for appropriate administrative action.

Please file the Plan's response electronically via the CAP system within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, click on the "Details" for "CAP #L24-R-318."
- Go to the "Data Requests" tab, then:
    - Click on the "Details" for each data request that does not have a status of "Complete."
    - Follow the instructions and/or use the form shown to add the requested data (depending on the type of data requested: New Filing, Document Request, Claims Data, or Financial Statement Refile).

The Department will also e-mail the Plan requesting all items that are still outstanding. The e-mail(s) will contain a link to the CAP system for the Plan to file the response electronically.

Questions or problems related to the electronic transmission of any addendum should be directed to the Office of Financial Review administrative support team at 916-255-2345 or by e-mail at ofr_admin@dmhc.ca.gov.

The Department will make the Final Report available to the public in 10 days from the Plan's receipt of this letter. The Final Report will be located at the Department's web site at http://www.dmhc.ca.gov/LicensingReporting/ViewFinancialExaminationReports.aspx.

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative actions upon the completion of the required remediation.

If there are any questions regarding the Final Report, please contact me at 213-620-2057 or by e-mail at Suhag.Patel@dmhc.ca.gov.

Sincerely,

SIGNED BY

Suhag Patel
Corporation Examiner IV, Supervisor
Office of Financial Review
Division of Financial Oversight

cc: Kristyl Thompson, Chief Compliance Officer, Access Dental Plan
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Ned Gennaoui, Supervising Examiner, Division of Financial Oversight
Sebas Alex, Corporation Examiner IV, Specialist, Division of Financial Oversight
Ashika Chiu, Examiner, Division of Financial Oversight
Helen Louie, Attorney III, Office of Plan Licensing
Chris Wordlaw, Staff Services Manager III, Office of Plan Monitoring
Chad Bartlett, Staff Services Manager II, Help Center

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

OFFICE OF FINANCIAL REVIEW
DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF A ROUTINE EXAMINATION

OF

ACCESS DENTAL PLAN

FILE NO. 933 0318

DATE OF FINAL REPORT: DECEMBER 10, 2024

SUPERVISING EXAMINER: NED GENNAOUI

OVERSIGHT EXAMINER: SUHAG PATEL

EXAMINER-IN-CHARGE: SEBAS ALEX

FINANCIAL EXAMINER: NAVDEEP SANDHAR

BACKGROUND INFORMATION FOR ACCESS DENTAL PLAN

Date Plan Licensed:	December 22, 1993
Organizational Structure:	Access Dental Plan (Plan) is a for-profit, wholly owned subsidiary of Avatar Holdings, LLC, which is a wholly owned subsidiary of First Commonwealth, Inc., and which is ultimately owned by the Guardian Life Insurance Company of America. The Plan receives from and provides services to various affiliates pursuant to administrative services agreements.
Type of Plan:	The Plan is a specialized health care service plan offering dental coverage. The Plan operates as a dental plan under the California Geographic Managed Care Program (GMC) in Sacramento County and under the Los Angeles Prepaid Health Plan (LAPHP) in Los Angeles County. Both GMC and LAPHP are administered by the California Department of Health Care Services. The Plan also offers dental coverage to commercial groups.
Provider Network:	The Plan contracts with independent dentists and various specialists. The general dentists are compensated on a capitation basis, and specialists are reimbursed on a fee-for-service basis.
Plan Enrollment:	As of March 31, 2024, the Plan reported total enrollment of 289,996 enrollees, consisting of 277,963 Medi-Cal, 11,360 commercial large group, and 673 commercial small group members.
Service Area:	The Plan operates in all counties in California.
Date of Prior Final Routine Examination Report:	September 17, 2020

FINAL REPORT OF A ROUTINE EXAMINATION OF ACCESS DENTAL PLAN

This is the final report (Final Report) for the quarter ended March 31, 2024, of a routine examination of the fiscal and administrative affairs of Access Dental Plan (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a preliminary report (Preliminary Report) to the Plan on September 20, 2024. The Department accepted the Plan's electronically filed responses (Responses) on November 4, 2024 and December 5, 2024.

This Final Report includes a description of the compliance efforts included in the Plan's Responses to the Preliminary Report, in accordance with Section 1382(c). The Plan's Responses are noted in italics within this Final Report.

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative actions upon the completion of the required remediation.

The Department's findings are presented in this Final Report as follows:

Part I.	Financial Statements
Part II.	Calculation of Tangible Net Equity
Part III	Compliance Issues

The Plan is required to respond to any request for corrective actions contained herein within 30 days of receipt of the Final Report.

[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in California Health and Safety Code section 1340 et seq. References to "Rule" are to regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act of 1975 contained within title 28 of the California Code of Regulations.

PART I. FINANCIAL STATEMENTS

The Department's examination did not result in any adjustments or reclassifications to the Plan's financial statements for the quarter ended March 31, 2024, as filed with the Department. A copy of the Plan's financial statements can be viewed by selecting "Access Dental Plan" on the second drop-down menu of the Department's financial statement database available at http://wpso.dmhc.ca.gov/fe/search/#top.

No response is required to this Part.

PART II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth and TNE as reported by the Plan as of quarter ended March 31, 2024	$6,580,449
Required TNE	1,338,208
TNE Excess per Examination	$5,242,241

The Plan was in compliance with the TNE requirements of Rule 1300.76 as of March 31, 2024.

No response is required to this Part.

PART III. COMPLIANCE ISSUES

A. CLAIM SETTLEMENT PRACTICES – "UNFAIR PAYMENT PATTERNS"

Section 1371.37 prohibits a health care service plan from engaging in an unfair payment pattern and defines certain claim settlement practices as "unfair payment patterns."

Rule 1300.71(a)(8) defines an "unfair payment pattern" or "demonstrable and unjust payment pattern" as any practice, policy, or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

The Department's examination found that the Plan engaged in demonstrable and unjust payment patterns and unfair payment patterns for the three-month period ended March 31, 2024, as follows:

1. PAYMENT ACCURACY OF INTEREST ON LATE CLAIMS – REPEAT DEFICIENCY

Section 1371 and Rule 1300.71(i)(2) require that if an uncontested claim is not reimbursed within 30 working days after receipt, interest shall accrue at the rate of 15 percent per annum, beginning with the first calendar day after the 30-working day period.

Rule 1300.71(j) states that the penalty for failure to comply with the requirements of Rule 1300.71(i)(2) shall be a fee of $10 paid to the claimant for each late claim.

Rule 1300.71(a)(8)(K) describes a demonstrable and unjust payment pattern as the failure to reimburse at least 95 percent of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

The Department's examination disclosed that the Plan underpaid the amount of interest on late claim payments. The underpayment of interest was due to a coding error in the Plan's claim payment processing system to pay interest on late payments at the rate of 10 percent instead of the required 15 percent. As a result, a penalty of $10 was also required for each late adjusted claim where interest was underpaid. This deficiency was noted in the following claims:

- 84 out of 126 late paid claims reviewed. Based on the sample, the Department inferred with 90 percent confidence that the true compliance rate was between 26.45 percent and 40.21 percent, with the upper bound being less than the required 95 percent compliance rate. Examples of this deficiency included late paid claim sample numbers: 1, 3, 4, 6 and 8.

- 24 out of 122 paid claims reviewed. Based on the sample, the Department inferred with 90 percent confidence that the true compliance rate was between 73.78 percent and 85.56 percent, with the upper bound being less than the required 95 percent compliance rate. Examples of this deficiency was noted in paid claim sample numbers: 11, 13, 14, 17 and 22.

The Plan's failure to reimburse claims accurately, including the automatic payment of interest and penalty, was a repeat deficiency, as this issue was previously noted in the Department's prior final report dated September 17, 2020, of a routine examination for quarter ended September 30, 2019. The reasons for this deficiency in the current examination were different from the reasons for the previous examination.

Prior to issuance of the Preliminary Report, the Plan stated that during the timeframe of January 13, 2024 through February 20, 2024, the Plan's claim payment processing system was configured incorrectly to pay 10 percent interest using 41 calendar days. Due to a national security incident, the Plan was unable to send the payment files to a print source from February 21, 2024 through March 26, 2024. Claims processed during this period had interest manually calculated and adjusted. On April 26, 2024, the Plan's claim payment processing system was updated to calculate interest at 15 percent with the inclusion of weekends based on 38 calendar days. With this setting, the Plan would slightly overpay the interest each time. The Plan would review all claims paid from January 13, 2024 through February 20, 2024 and from March 26, 2024 through April 26, 2024 to ensure interest was paid correctly.

The Preliminary Report required the Plan to submit a detailed corrective action plan (CAP) to address the deficiency cited above, and to include the following:

a. Audit procedures implemented, and date of implementation, to ensure that the Plan was monitoring the accurate payment of interest and penalties on all late claim payments.

b. Identification of all late paid claims for which interest and penalties were not correctly paid from January 13, 2024 (the date of the programming error) through April 26, 2024 (the date of the programming correction).

c. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraph “b” of the required action. This evidence was to include an electronic data file (Excel or Access) or schedule that identified the following:

    - Claim number
    - Date of service
    - Date original claim received
    - Date of receipt of new information
    - Date of receipt for complete claim
    - Total billed
    - Amount of original payment
    - Paid date (mail date)
    - Amount of original interest paid
    - Date interest paid
    - Number of late days used to calculate interest (with formula)
    - Total interest owed per claim (with formula)
    - Amount of additional interest paid in remediation (total interest owed minus previous interest paid)
    - Penalty amount paid
    - Date additional interest and penalty paid, if applicable
    - Check number for interest and penalty
    - Provider name

    The data file was to provide the details of all claims remediated, including the total number of claims and the total additional interest and penalties paid as a result of remediation.

d. Management positions responsible for ensuring continued compliance.

The Plan responded that the claim payment processing system programming was corrected as of April 26, 2024, and, therefore, now the system applies the appropriate interest and penalties for late claim payments.

For any changes in the system set-up, the Plan would go through validation to ensure the system update was appropriate and interest calculation was occurring as per the update. After the last update on April 26, 2024, validation occurred to ensure interest and penalties were paying appropriately and has been since that time.

Furthermore, the Plan indicated that it was in the process of identifying all late paid claims for which interest and penalties were underpaid from January 13, 2024, through April 26, 2024. The Plan would issue all interest and penalty payments and provide the Department with the requested electronic data file no later than December 19, 2024.

The Plan's Senior Operations Director is the management position responsible for ensuring continued compliance.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required since the Plan did not complete the required remediation. The Department acknowledges the Plan's representation that the required CAP will be completed by December 19, 2024.

The Plan is required to submit evidence of remediation for all late claims where interest was underpaid, including all the information required by paragraph "c" of the required CAP above.

2. ACKNOWLEDGEMENT OF CLAIMS

Rule 1300.71(c) states that the plan shall identify and acknowledge the receipt of each claim. In the case of an electronic claim, identification and acknowledgement shall be provided within two working days of the date of receipt of the claim by the office designated to receive the claim, or in the case of a paper claim, identification and acknowledgement shall be provided within 15 working days of the date of receipt of the claim by the office designated to receive the claim.

Rule 1300.71(a)(8)(E) describes a demonstrable and unjust payment pattern as the failure to acknowledge the receipt of at least 95 percent of claims consistent with Rule 1300.71(c) over the course of any three-month period.

The Department's examination disclosed that the Plan failed to enter claims timely and consequently failed to timely acknowledge the receipt of these claims. This deficiency was the result of the Plan's pausing the processing of claims in late December 2023 through mid-January 2024, to facilitate the conversion to a new claim payment processing system. This deficiency was noted in the following claims:

- 122 out of 126 late paid claims reviewed. Based on the sample, the Department inferred with 90 percent confidence that the true compliance rate was between 1.43 percent and 6.88 percent, with the upper bound being less than the required 95 percent compliance rate. Examples of this deficiency included late paid claim sample numbers: 1, 3, 4, 6 and 8.

- 42 out of 122 paid claims reviewed. Based on the sample, the Department inferred with 90 percent confidence that the true compliance rate was between 58.51 percent and 72.64 percent, with the upper bound being less than the required 95 percent compliance rate. Examples of this deficiency was noted in paid claim sample numbers: 10, 11, 13, 14, and 17.

- 69 out of 138 denied claims reviewed. Based on the sample, the Department inferred with 90 percent confidence that the true compliance rate was between 43.11 percent and 56.89 percent, with the upper bound being less than the required 95 percent compliance rate. Examples of this deficiency was noted in paid claim sample numbers: 2, 6, 11, 13, and 15.

Prior to issuance of the Preliminary report, the Plan indicated that it underwent a system conversion to a new claim payment processing system on January 16, 2024. In late December of 2023, the Plan initiated a blackout period during which no claims were processed. The blackout period was necessary to close out the previous system and load the existing data into the new system. All claims received during the holding period were loaded into the new system and, as a result of holding of claim processing and post system stabilization efforts, the Plan experienced a delay in processing. All held claims were loaded into the new system and were accounted for.

The Preliminary Report required the Plan to submit a detailed CAP to address the deficiency cited above, and to include the following:

a. Policies and procedures implemented, and the date of implementation, to ensure that claims are acknowledged in compliance with Rule 1300.71(c).

b. Management positions responsible for ensuring continued compliance.

The Plan responded by submitting an updated policy, titled "Claim Processing," which specifies the turnaround times, processing requirements, interest rates, audit procedures, and timeframes required for notifications of denied claims.

The Plan's Vice President of Claims Administration is the management position responsible for ensuring continued compliance.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required since the Plan did not complete the remediation required by the Department.

The Plan is required to submit the date of implementation of the updated policy.

B. FIDELITY BOND – REPEAT DEFICIENCY

Rule 1300.76.3 requires each plan to maintain at all times a fidelity bond covering each officer, director, trustee, partner, and employee of the plan, whether or not they are compensated. In addition, the fidelity bond shall provide for 30 days' notice to

the director of the Department (Director) prior to cancellation, and it shall provide at least the minimum coverage for the plan as required by the schedule set forth in Rule 1300.76.3.

The Department's examination of the Plan's fidelity bond disclosed the following deficiencies:

- The fidelity bond did not provide the required coverage amount for the Plan. The fidelity bond named the Plan's parent as the insured party and did not indicate the "exclusive right" of coverage for the Plan.

- The fidelity bond did not provide the required 30 days' notice to the Director prior to cancellation. The policy included an endorsement that stated, "The Underwriter…will use its best efforts to…notify such entity(ies)…" This endorsement language did not comply with the requirements of Rule 1300.76.3.

The Plan's failure to maintain the required 30 days' notice to the Director prior to cancellation for the fidelity bond was a repeat deficiency, as this deficiency was previously noted in the Department's final report of routine examination dated September 17, 2020, for the quarter ended September 30, 2019. The Plan's corrective actions in response to the prior final report did not achieve the necessary levels of compliance with the Rule cited.

The Preliminary Report required the Plan to explain why the corrective actions implemented by the Plan to resolve this deficiency, found in the Department's previous examination, were not effective in ensuring ongoing compliance.

In addition, the Plan was required to submit a detailed CAP to address the deficiency cited above, and to include the following:

a. Endorsements to the fidelity bond, or a new fidelity bond, correcting the above noted deficiencies.

b. Policies and procedures implemented, and date of implementation, to ensure compliance with Rule 1300.76.3 at all times.

c. Management positions responsible for ensuring continued compliance.

The Plan responded that the corrective actions implemented by the Plan to resolve this deficiency, found in the Department's previous examination, were not effective in ensuring ongoing compliance due to the extenuating circumstance of acquisition and restructuring activity in 2021. Upon review of the old Plan-exclusive bond with its insurance broker, it was determined that the fidelity bond was not renewed upon expiration in October 2021. Furthermore, it was instead replaced with the master fidelity bond for all entities of Avatar Holdings, LLC, Plan's parent, and the master fidelity bond did not include the necessary exclusivity coverage for the Plan, nor the required cancellation language.

The Plan's exclusive fidelity bond for the required coverage amount was established on October 1, 2024, reflecting the cancellation language required by Rule 1300.76.3. The Plan submitted a copy of a new fidelity bond demonstrating compliance with the requirements of Rule 1300.76.3.

In addition, an internal policy was established that mandates the annual renewal of the fidelity bond, containing the required coverage amount and cancellation language at all times, and specifically prohibiting any changes to the terms of the bond except for changes mandated by the Department. The Plan submitted a new policy, titled "Fidelity Bond and Restricted Deposit Policy," which was approved and implemented on November 27, 2024.

The Plan's Treasury Manager is the management position responsible for ensuring continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. Therefore, no further response is required.

C. RESTRICTED DEPOSIT

Rule 1300.76.1(a) requires each specialized health care service plan to deposit with the Director or at the discretion of the Director with any bank authorized to do business in this state and insured by the Federal Deposit Insurance Corporation an amount which at all times shall have a value of not less than $150,000. The deposit must be assigned to the Director, until released.

The Department's examination disclosed that the Plan failed to file an updated assignment form with the Department when the information on the assignment form changed. The account number on the bank statement for the restricted deposit did not agree with the account number on the restricted deposit assignment form on file with the Department.

The Preliminary Report required the Plan to submit a detailed CAP to address the deficiency cited above, and to include the following:

a. Policies and procedures implemented, and date of implementation, to ensure changes to the information on the assignment form are filed timely with the Department in compliance with Rule 1300.76.1.

b. Management positions responsible for ensuring ongoing compliance.

The Plan responded that this deficiency resulted from a clerical error concerning the account number on the assignment form not matching the bank account in which the restricted deposit was kept. On September 16, 2024, the Plan filed with the Department (eFiling number 20244260) a revised assignment form reflecting the correct account number and amount. The filing is currently under review by the Department.

In addition, the Plan submitted a new restricted deposit policy, titled "Fidelity Bond and Restricted Deposit Policy," which was approved and implemented on November 27, 2024.

The Plan's Treasury Manager is the management position responsible for ensuring continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. Therefore, no further response is required.

D. PAYMENTS TO NONCONTRACTING PROVIDERS OR SUBSCRIBERS AND ENROLLEES

Rule 1300.84.2 requires each plan to submit the "Quarterly DMHC Financial Reporting Form" (Financial Reporting Form) within 45 days after the close of each quarter of its fiscal year. The Financial Reporting Form requires the reporting of supplemental information, including the amount of health care expenses incurred during the six-month period immediately preceding the date of the Financial Reporting Form which were or will be paid to noncontracting providers or directly reimbursed to subscribers and enrollees.

The Department's examination disclosed that the Plan failed to disclose on the Financial Reporting Form for the quarter ended March 31, 2024 the amount of health care expenses incurred during the six-month period immediately preceding the date of the Financial Reporting Form which were or will be paid to noncontracting providers or directly reimbursed to subscribers and enrollees.

The Preliminary Report required the Plan to submit a detailed CAP to address the deficiency cited above, and to include the following:

a. Written assurance that the Plan will report the amount of health care expenses incurred during the six-month period immediately preceding the date of the Financial Reporting Form which were or will be paid to noncontracting providers or directly reimbursed to subscribers and enrollees on all future Financial Reporting Form filings, starting with the Financial Reporting Form for the quarter ended September 30, 2024.

b. Management positions responsible for ensuring ongoing compliance.

The *Plan responded by attesting and confirming that the required information was included in the Financial Reporting Form for the quarter ended September 30, 2024 and would be included in all future Financial Reporting Form filings.*

The Plan's Controller is the management position responsible for ensuring continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. Therefore, no further response is required.