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Health and Human Services Agency

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February 7, 2012

via USPS and eFile

Reza Abbaszadeh, DDS
Access Dental Plan
8890 Cal Center Drive
Sacramento, CA 95826

FINAL REPORT OF ROUTINE EXAMINATION OF ACCESS DENTAL PLAN.

Dear Dr. Abbaszadeh:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Access Dental Plan (the "Plan"), conducted by the Department of Managed Health Care (the "Department"), pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.¹ The Department issued a Preliminary Report to the Plan on October 21, 2011. The Department accepted the Plan's electronically filed response on December 2, 2011.

This Final Report includes a description of the compliance efforts included in the Plan's December 2, 2011 response, 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 ten (10) days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and electronically file copies of those portions of the Plan's response excluding information held confidential pursuant to Section 1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its December 2, 2011 response,

¹ References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal. Please file this addendum electronically via the Department's eFiling web portal at <https://wpsso.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select “eFiling”.
- From the eFiling (Home) menu, select “File Documents”.
- From the File Documents Menu for:
 - 1) File Type; select “Amendment to prior filing”;
 - 2) Original Filing, select the “Filing No. 20111088 assigned by the Department; and
 - 3) Click “create filing”.
- From the Original Filing Details Menu, click “Upload Amendments”; select # of documents; select document type: “Plan addendum response to Final Report (FE5)”; then “Select File” and click “Upload”.
- Upload all documents, and then upload a cover letter as Exhibit E-1 that references to your response.
- After upload is complete, select “Complete Amendment”, complete “Execution” and then click “complete filing”.

As noted in the attached Final Report, the Plan's response of December 2, 2011 did not fully respond to the deficiencies raised in the Preliminary Report issued by the Department on October 21, 2011. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained within the attached Final Report, within 30 days after receipt of the 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 Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

Questions or problems related to the electronic transmission of the above responses should be directed to Rita Ultreras at (916) 322-5393 or email at rultreras@dmhc.ca.gov. You may also email inquiries to wpsso@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter through the eFiling system. The report will be located at the Department's web site at www.dmhc.ca.gov.

If there are any questions regarding this report, please contact me.

**REZA ABBASZADEH, DDS
FINAL REPORT OF ROUTINE EXAMINATION OF
ACCESS DENTAL PLAN**

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Sincerely,

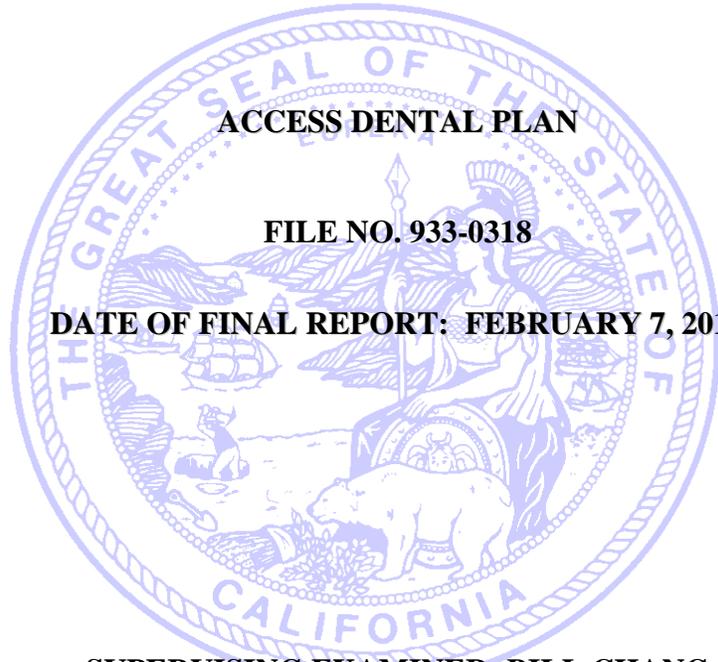
Original Signed By

Bill Chang
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

cc: Suzanne Goodwin-Stenberg, Chief, Division of Financial Oversight
Steven Alseth, Oversight Examiner, Division of Financial Oversight
Anna Belmont, Examiner in Charge, Division of Financial Oversight
Ashika Vinod, Monitoring Examiner, Division of Financial Oversight
Christina Hooke, Licensing Counsel, Division of Licensing
Marcy Gallagher, Chief, Division of Plan Surveys

**STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE**

DIVISION OF FINANCIAL OVERSIGHT



ACCESS DENTAL PLAN

FILE NO. 933-0318

DATE OF FINAL REPORT: FEBRUARY 7, 2012

SUPERVISING EXAMINER: BILL CHANG

OVERSIGHT EXAMINER: STEVEN ALSETH

EXAMINER-IN-CHARGE: ANNA BELMONT

FINANCIAL EXAMINERS: JESSICA TRAN, DAYANA JOSEPH, LORI AMBROSINI

BACKGROUND INFORMATION FOR ACCESS DENTAL PLAN

Date Plan Licensed:	December 22, 1993
Organizational Structure:	The Plan was incorporated in California in 1993 to provide dental services to eligible subscribers for the Medi-Cal and Healthy Families programs. The Company is wholly owned by Abbaszadeh Dental Group, Inc.
Type of Plan:	The Plan is a specialized dental plan.
Provider Network:	The Plan contracts with affiliated and non-affiliated dental clinics throughout California.
Plan Enrollment:	As of March 31, 2011, the Plan had total enrollment of 356,722. Total enrollment was comprised as follows: 5,010 group (commercial), 198,275 Medi-Cal Risk, and 153,487 Healthy Families enrollees.
Service Area:	All California counties.
Date of last Routine Financial Examination Final Report	March 11, 2009

FINAL REPORT OF A ROUTINE EXAMINATION OF ACCESS DENTAL PLAN

This is the Final Report of a routine examination of the fiscal and administrative affairs of Access Dental Plan (the “Plan”), conducted by the Department of Managed Health Care (the “Department”) pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.¹ The Department issued a Preliminary Report to the Plan on October 21, 2011. The Department accepted the Plan’s electronically filed response on December 2, 2011.

This Final Report includes a description of the compliance efforts included in the Plan’s September 28, 2011 response to the Preliminary Report, in accordance with Section 1382(c). The Plan’s response is noted in *italics*.

We examined the financial report filed with the Department for the quarter ended March 31, 2011, as well as other selected accounting records and controls related to the Plan’s various fiscal and administrative transactions. Our findings are presented in this report as follows:

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

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained within this report, within 30 days after receipt of this report.

¹ References throughout this report to “Section” are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code Section 1340, et seq. References to “Rule” are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

SECTION I. FINANCIAL REPORT

Our examination resulted in no adjustments or reclassifications to the Plan's March 31, 2011 financial statements filed with the Department. A copy of the Plan's financial statements can be viewed at the Department's website by typing the link <http://wpsso.dmhc.ca.gov/fe/search.asp> and selecting Access Dental Plan on the first drop down menu.

No response required to this Section.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

	DATE	Dollar Amount
Net Worth as Reported by the Plan as of Quarter ended	03/31/2011	\$13,423,910
Less:		
Unsecured Affiliate Receivables-Past Due		53,500
Tangible Net Equity		\$13,370,410
Less: Required TNE as of	03/31/2011	<u>564,117</u>
TNE in Excess per Examination at	03/31/2011	<u>\$12,806,293</u>
The Plan is in compliance with the TNE requirement of Section 1376 and Rule 1300.76 As of March 31, 2011.		

No response required to this Section.

SECTION III. COMPLIANCE ISSUES

AFFILIATE TRANSACTIONS

Deficiency # : 1.

Rule 1300.51(d) N-1 requires all plans to file a copy of each contract that the plan has entered into for administrative or management services, or consulting contracts.

Rule 1300.51(d) N-2 requires all plans to file with the Department the Plan's administrative arrangements to monitor the proper performance of its contracts and the provisions, which are included in them to protect the Plan, its business, enrollees and providers in the event there is a failure of performance, or in the event the contract is terminated.

Deficiency:

The Department's examination disclosed that the Plan failed to comply with the filing requirements of the above Sections and Rules because the administrative service agreement filed with the Department does not support the current arrangements as follows:

- a. The Plan does not have an administrative service agreement with its Dental Clinics.
- b. There is no written right of offset agreement authorizing the offset of receivables and payables transactions between the Plan and Dental Clinics.
- c. The administrative service agreement with Premier Access Insurance Company (Premier) does not provide for Premier to provide the services relating to solicitor agreements.

Plan's response:

In the response to the preliminary report the Plan stated that the following:

Response to deficiency 1(a):

In fact, on or about January 2005 the Plan filed an Administrative Services Agreement between the Plan and Abbaszadeh Dental Group, Inc., the entity that owns and operates the "dental clinics."² If requested, the Plan will re-file the service agreement.

Response to deficiency 1(b)

Plan personnel have reviewed the service agreement noted above and recognizes that it does not include a "right of offset" provision. The agreement does, however, describe the "cost segregation study," that is prepared by the Plan's CFO to analyze the costs associated with the services provided among the Plan, Premier Access Insurance Company, Abbaszadeh Dental Group, Inc., and all other affiliated entities within the family of companies owned and operated by Dr. Reza Abbaszadeh. The "cost segregation study" ensures that costs are allocated equitably among the affiliated group and that they are apportioned in accordance with generally accepted accounting

² See Notice of Material Modification numbers 20035738, 20036606 and 20037472.

principles. As a result of the cost segregation study, the Plan does not believe a “right of offset” provision was required.

In any event, the Plan will revise the service agreement by adding the following provision under “Section III CHARGES:”

Right of Offset

3.2 *This Agreement establishes a legally enforceable rights between the parties so that a debtor, having a valid right of offset, may offset the related assets and liability and report the net amount. Upon reconciliation of the obligations for each, Parent and Access agree that each may and shall offset against the obligations owed to it by the other party the amount of the obligations it owes to the other party. To the extent that Parent’s obligations exceed Access’ obligations for each designated period, Parent agrees to pay such excess to Access within twenty (20) business days following the end of each designated period. To the extent Access’ obligations exceed Parent’s obligations, for each period, Access agrees to pay such excess to Parent within twenty (20) business days following the end of each designated period.*

Response to deficiency 1(c):

In fact, section 2.6 of the Premier Access Insurance Company and Access Dental Plan “Administrative Services With Right of Setoff Agreement” specifically addresses “marketing related services” provided by Premier on behalf of the Plan. While section 2.6 does not provide inordinate amount of detail, the parties understand and have agreed since January 1, 2005, to jointly provide marketing services on behalf of each party.

In any event, Premier and the Plan will enter into the Premier Access Broker Agreement, whereby the parties agree to market jointly and operated in accordance with the Knox-Keene Act while Premier markets on behalf of the Plan.

The Department finds that the Plan’s compliance effort is not responsive to the corrective action required as follows:

Item 1(a) The Department’s records do not reflect that the above referenced administrative service agreement was filed in 2005. The Administrative service agreement should be filed through the Department’s e-filing system.

Item 1(b) Section 3.2 needs to be included in the administrative service agreement before it is filed with the Department as requested in Item 1(a).

Item 1(c) The administrative service agreement needs to provide a description of the services that are being provided. A general description of how costs will be

reimbursed is not sufficient. The administrative services agreement should be updated to provide a description of the actual services being provided, and the amended agreement should be filed with the Department through the e-filing system.

The Plan is required to file the requested documents within 30 days of this report through the Department's e-filing system.

CLAIMS PAYMENTS

Deficiency # : 2.

Statutory/Regulatory Reference:

Rule 1300.71.38(g) Past Due Payments. If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan or the plan's capitated provider shall pay any outstanding monies determined to be due, and all interest and penalties required under sections 1371 and 1371.35 of the Health and Safety Code and Rule 1300.71 of title 28, within five (5) working days of the issuance of the Written Determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" as forth in Rule 1300.71(g).

Deficiency:

The Plan provided staff with provider dispute resolution claims data for the period of January 1, 2011 through March 31, 2011. A total of 7 claims were reviewed. Our examination disclosed that the Plan did not pay the provider the outstanding monies determined to be due within five (5) working days of the issuance of the Written Determination on four (4) of the seven (7) PDRs (or 57 percent). Additionally, the plan did not pay interest or penalties due on two (2) of the seven (7) PDRs (or 29 percent).

Plan's response:

In the response to the preliminary report the Plan stated the following:

The Plan has reviewed all provider disputes received from July 1, 2009 to November 30, 2011. During the review period a total of ninety-two (92) provider disputes were received by the Plan. The total percentage of disputes received by the Plan is insignificant in relationship to the total number of transactions between the Plan and its contracted providers. Furthermore, none of the processed disputes were found in favor of the provider. The Plan, however, often reimburses a provider even though it was not required to under the terms of the provider's contract. The Plan reimburses providers even when it is not contractually obligated to in order to foster "goodwill" among its

network of dentists. The Plan values its provider network and makes every effort to compensate them adequately and fairly. In all instances when the Plan reimbursed its contracted providers as a result of a dispute, the disputed claim was determined to be correctly non-covered and/or processed on initial submission in accordance with the applicable plan and contract provisions.

Year (Date of Original Claim Submission)	Total Provider Disputes	Found in Favor of the Plan (including one-time exceptions)		Found in Favor of the Provider
		Total	One-time Exceptions Resulting in Additional Payment	
2009	26	26	20	0
2010	31	31	19	0
2011	35	35	14	0
Total	92	92	53	0

*The attached **Exhibit 1**, an electronic data file in Excel, identifies all the disputed claims during the review period. Note in Column [Q] of the data file, Exception to Policy, those claims that were paid by the Plan on a one-time exception basis. Interest was not included in these payments since the payments were made solely as a “goodwill” gesture and are not subject to the provisions of the statutes and regulations for timely payment of claims.*

Calculated interest and penalties for the additional payments that were processed as exceptions that were paid in excess of 45 days from the date of the receipt of the dispute would total \$435.88. However, it is our firm belief that interest and penalties would not apply to these payments. Title 28, California Code of Regulations, Rule 1300.71.38(g) requires that “interest and penalties” be included in a claim when the Plan determines that it finds (in whole or in part) in favor of the provider in a disputed action. The Plan carefully reviews claim disputes by its providers and, for the period under review, determined that all were in favor of the Plan. The Plan paid its providers the amount under dispute simply as goodwill gesture and not in order to comply with Rule 1300.71.38(g).

	2009	2010	2011	Total
# of Disputes	26	31	35	92
Total Claim Payments	\$7,279.05	\$8,395.50	\$3,043.24	
Number of Disputes paid beyond applicable statutory/regulatory date	9	8	1	18
Interest	\$ 96.22	\$ 58.48	\$ 1.18	\$ 155.88

Penalties	\$ 190.00	\$ 80.00	\$ 10.00	\$ 280.00
	\$ 286.22	\$ 138.48	\$ 11.18	\$ 435.88

The Plan has revised the Provider Dispute Resolution Mechanism policies and procedures to ensure that payments of any late adjusted claims resulting from provider disputes in favor of the provider include interest and penalty, if applicable, in compliance with the above applicable regulations.

*Please see **Exhibit 2**, revised Provider Dispute Resolution Mechanism Policy and Procedure. The Policy and Procedure will be submitted to the Department of Managed Health Care on December 2, 2011 with an effective date of November 1, 2011. Additional training for Provider Dispute Resolution personnel and claims staff has been completed addressing the new procedures and the methodologies for calculating any applicable interest to be paid with additional payments resulting from disputes.*

With respect to the requirement for payments within five days of the written determination, the existing policies and procedures are designed to ensure that additional payments resulting from a dispute are paid within five (5) working days of the issuance of the written determination; however, we have identified isolated instances of payments that were not issued within the five working day time period due to scheduled check generation cycles.

When reviewing the timeliness of claims payment for these provider disputes, the Plan did identify that claims processing was completed as soon as the issuance of the written determination was made; however, actual checks were issued on the next standard claims payment cycle. This resulted in some claims being paid after the identified five (5) working days requirement that would be applicable to additional payment timeliness for disputes found in whole or in part to be in favor of the provider. As a result, the Plan has implemented additional procedures between the Provider Dispute Department and the Claims Department to ensure that standard check cycles will not delay processing of additional payments.

*The Plan has implemented this change and training has taken place with the Claims Department and the Quality Management Department to administer correctly when interest and penalties are applicable and to issue payment on provider disputes that are in favor of the provider in a timely manner. See attached **Exhibit 3**, a document that describes the timeframes for processing provider disputes received, for use in the training of the Plan's staff.*

Revisions to this policy were implemented on November 1, 2011 and the Manager, Quality Management Department has been designated as the principal officer responsible for the maintenance of the Plan's provider dispute resolution mechanism. Oversight includes the maintenance of this policy, reviewing its operation and noting any patterns of provider disputes in an effort to improve the Plan's administration, plan-provider relations and patient care. Quarterly review of all provider disputes, categorized by date of receipt, identification of the provider, type of dispute, disposition

and working days to get these disputes resolved will be ongoing. This information is an ongoing review element of the Quality Management Program.

The Department finds the Plan's compliance effort is not responsive to the corrective action required. The Plan was sending determination letters indicating that the original claim finding was being overturned and payment was being made on a one time only basis. When the Plan makes payment as a gesture of goodwill the determination letter should clearly indicate the Plan is not overturning its decision, and payment is only being made as a gesture of goodwill.

After reviewing the Plan's response to the preliminary report it was necessary to review additional PDRs to confirm that payment was due to the Plan making payment as a goodwill gesture to the provider, and not the claim decision being overturned.

The Plan in its response should describe the corrective action it has taken to correct its determination letter for PDRs that are paid as a gesture of goodwill.

STATUTORY COMPLIANCE

Deficiency # : 3.

Statutory/Regulatory Reference:

Section 1351(q) and Rule 1300.76.3 requires each plan to at all times maintain a fidelity bond covering each officer, director, trustee, partner and employee of the plan, whether or not they are compensated. The fidelity bond shall provide for 30 days notice to the Director prior to cancellation. The fidelity bond shall provide at least the minimum coverage for the plan, as required by the schedule in this Rule.

Deficiency:

Our examination disclosed the following deficiencies in the fidelity bond:

The fidelity bond did not contain a provision that required a 30 day notice of cancellation be provided to the Department.

The Plan's policy with Westchester Surplus Lines Insurance does not provide exclusive coverage to the Plan in the required minimum amount of \$1,000,000. Consequently, any losses incurred by Abbaszadeh Dental Group Inc., or any of its subsidiaries covered under this policy, can dilute the available coverage for the Plan below the required minimum.

Plan's response:

In the response to the preliminary report the Plan stated the following:

The Plan had in place, since 2001, a fidelity policy, underwritten by Travelers Casualty and Surety Company of America. In 2010, the policy was moved to Westchester Surplus Lines Insurance Co. When the coverage was moved to the new carrier, additional coverages for Directors & Officers (D&O) and Excess Liability (EPL) were added to the policy and the policyholder name was changed to Abbaszadeh Dental Group, the holding company for the Plan. Consolidation of the corporate coverages under the holding company for all companies was done to include D&O and EPL insurance coverage for all of the entities that fall under the holding company umbrella.

The Plan was covered at the time of the examination under the fidelity bond for \$1,000,000 issued to Abbaszadeh Dental Group, Inc, the holding company of the Plan. The fidelity bond included the proper endorsement with the 30 day notice of cancellation to be provided to the Department of Managed Health Care. A copy of the fidelity bond was provided to the Department of Managed Care on October 13, 2011 during the Routine Examination of Access Dental Plan.

*Based on the findings from the examiner, the Plan was notified during the Routine Examination that the existing Fidelity bond did not meet the minimum requirements of providing exclusive coverage to the Plan. Although we believe that the \$1 million fidelity bond provided adequate coverage to address the specific dollar amounts for the Plan, we obtained a separate Fidelity bond in the amount of \$1,000,000 issued exclusively to the Plan, effective November 10, 2011. The separate fidelity bond includes all required notification and cancellation provisions. A copy of the endorsement is included in **Exhibit 4**.*

Under existing policies and procedures, the Chief Financial Officer and the Compliance Officer for the Plan are responsible for the implementation and ongoing monitoring of all necessary and required insurance and liability coverages, including the required fidelity bond. Per regulatory requirements, we will ensure that the fidelity bond we have in place is in an amount based on the annual gross income, general liability insurance and, if applicable, recommend a reinsurance policy through annual reviews paralleling the renewal of these policies. The fidelity bond will provide at least the minimum coverage for the Plan, as determined in the schedule indicated in applicable rules and regulations. The Chief Financial Officer and the Compliance Officer will ensure that the fidelity bond is written by an insurer licensed by the California Insurance Director prior to cancellation. Furthermore, in the event the fidelity bond contains a provision for a deductible amount from any loss, we will ensure that such deductible provision shall not be in excess of 10 percent of the required minimum bond coverage and in no event shall the deductible amount be in excess of \$100,000.

At the time of the examination the fidelity bond did not include the proper endorsement with the 30 day notice of cancellation to be provided to the Department of Managed Health Care. The corrected Fidelity Bond endorsement was submitted September 14, 2011, a couple months after the deficiency was noted.

The Department finds that the Plan's compliance effort is responsive to the corrective action required.

SECTION IV. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

No response required to this Section.