



**Department of Health Care Services
Medi-Cal Dental Services
Complaints and Grievances Report**

Prepared May 2018

Reporting Period: State Fiscal Year 2016-2017

Submitted by the
California Department of Health Care Services

Table of Contents

Executive Summary	2
Medi-Cal Dental Delivery System Background	3
Definition of Complaint and Grievance	4
Dental Managed Care Complaints	5
Dental Fee-for-Service Complaints	8
Resolution of Fee-for-Service Complaints	11

Executive Summary

Assembly Bill 2207 (Wood, Chapter 613, Statutes of 2016) requires the Department of Health Care Services (DHCS) to prepare and post online an annual summary report describing the nature and types of complaints and grievances regarding access to, and quality of, Medi-Cal dental services, including the outcome.

This report summarizes complaints and grievances regarding both Dental Managed Care (DMC) and Medi-Cal Dental Fee-For-Service (FFS) delivery systems, reported during State Fiscal Year (SFY) 2016-17. SFY 2016-17 occurred from July 1, 2016 through June 30, 2017. This report does not include cases opened in previous fiscal years. This report also does not include data regarding State Fair Hearings, as those are reported separately by the state's Office of the Patient Advocate in their *Annual Health Care Complaint Data Report*.

Figure 1, titled *2016-17 Medi-Cal Dental Complaints and Grievances by Delivery System*, shows the total number of complaints and grievances and number of beneficiaries by delivery system for State Fiscal Year (SFY) 2016-17.

Figure 1: 2016-17 Medi-Cal Dental Complaints and Grievances by Delivery System		
Delivery System	Number of Complaints	Number of Beneficiaries*
Medi-Cal DMC	2,521	1,044,979
Medi-Cal Dental FFS	3,872	12,567,409
Total	6,393	13,612,388

*Beneficiaries who were enrolled in the same plan for at least 90 continuous days during the measure year with full scope and no share of cost.

Key Findings

DMC

- The majority of complaints recorded for DMC were related to Quality of Care/Service, at 44 percent of the total. The other main categories were related to Accessibility and Benefits/Coverage at 28 percent and 16 percent respectively.
- Most of the complaints from each category were resolved in favor of Medi-Cal beneficiaries (known as members in DMC). The other complaints were resolved in favor of the DMC plan with the exception of six.

Dental FFS

- Complaints regarding Quality of Care, which included complaints regarding the services rendered (i.e., ill-fitting dentures), were the highest recorded category.
 - 73 percent of *telephone* complaints were related to Quality of Care.

- 61 percent of *written* complaints were related to Quality of Care.
- All complaints were resolved for the following categories:
 - Provider Referral
 - Office Conduct
 - Scope of Coverage
- Complaints regarding Quality of Services, Miscellaneous, Clinical Screening Dentist, Quality of Care and Providers Billing Beneficiaries had unresolved complaints at the end of 2016-17.

Note: In preparing this report, DHCS determined that the Medi-Cal Dental Fiscal Intermediary (FI) was out of compliance with the contractually required complaint response process during the SFY 2016-17 report period. Specifically, the FI was inconsistent in its disposition, complaint categorization, and record-keeping of complaints, and did not consistently include certain telephone complaints in its total count of complaints. In January 2018, the complaint processing responsibilities transitioned to the new Administrative Services Organization (ASO) contract. DHCS determined the ASO's complaint response process maintained the same deficiencies as the prior FI contract and in March 2018, DHCS initiated a Corrective Action Plan process with the ASO contractor to correct the deficiencies in its complaint response process.

Medi-Cal Dental Delivery System Background

California's 13.6 million Medi-Cal beneficiaries access dental services through two delivery systems: DMC and FFS. Most beneficiaries receive dental services through the dental FFS delivery system. In Sacramento County, DMC enrollment is mandatory, and in Los Angeles County, DMC enrollment is optional.

DMC is carried out through contracts with DMC plans licensed by the Department of Managed Health Care (DMHC). DMC plans operate member services phone lines to process beneficiary complaints and grievances, and provide quarterly reports to DHCS on the status of complaints and grievances.

In 2016-17, the dental FFS delivery system was administered by the Dental FI contractor. The FI operated a Telephone Service Center (TSC) which received and processed beneficiary complaints and grievances, and provided summary reports to DHCS. Starting in January 2018, the FI contract was divided into two parts – the ASO and FI. The ASO contractor is now responsible for administrative services, including communications with providers and beneficiaries, operating the TSC, and processing beneficiary complaints and grievances. The FI contractor is responsible for the California Dental Medicaid Management Information System, which processes claims and issues payments to dental FFS providers.

Definition of Complaint and Grievance

For purposes of this report, all complaints and grievances are referred to as complaints. Title 28, California Code of Regulations, Section 1300.68 provides the following definitions, which are relevant to both DMC and Dental FFS:

- “Grievance” means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.
- “Complaint” is the same as “grievance.”

Dental Managed Care Complaints

For DMC plans, complaints are categorized as follows:

- **Accessibility:** Complaints regarding excessively long wait time/appointment schedule time; lack of primary care provider availability; lack of specialist availability; lack of telephone accessibility; lack of language accessibility; lack of facility physical access.
- **Quality of Care/Quality of Service:** Complaints regarding inadequate facilities, non-access related; inappropriate provider care; plan denial of treatment; provider denial of treatment; poor provider/staff attitude.
- **Benefits/Coverage:** Complaints regarding disputes over covered services.
- **Referral:** Complaints regarding a plan's refusal to refer, a provider's refusal to refer, and delays in referral.
- **Other:** All other categories outside the ones described above are included in this category, including complaints related to second level complaints, appeals, expedited complaints, eligibility, and administrative issues.

In 2016-17, the DMC plans recorded a total of 2,521 unduplicated complaints. Figure 2, titled *Number of Unduplicated Complaints by DMC Plan*, shows the unduplicated number of complaints recorded by each DMC plan. DHCS contracts with three Geographic Managed Care (GMC) Plans in Sacramento County and three Prepaid Health Plans (PHP) in Los Angeles County to provide dental managed care services to Medi-Cal beneficiaries.

Figure 2: Number of Unduplicated Complaints by DMC Plan		
DMC Plan / County	Unduplicated Complaints	DMC Plan Totals
Access / Los Angeles County	151	232
Access / Sacramento County	81	
Health Net / Los Angeles County	810	1,293
Health Net / Sacramento County	483	
LIBERTY/ Los Angeles County	258	996
LIBERTY / Sacramento County	738	
	Total Complaints	2,521

Figure 3, titled *DMC Complaints by Category*, provides the relative proportion of complaints by category. In the event that a complaint falls into multiple categories, each complaint was counted multiple times and placed into the applicable category to reflect the total data percentages. During this reporting period, the majority of DMC complaints were related to Quality of Care/Service with a total of 1,183 complaints. Subsequently, the other types of complaints were related to Accessibility with 749 complaints and Benefits/Coverage with 416 complaints. The Referral category had 217 complaints while the Other category had 111 complaints.

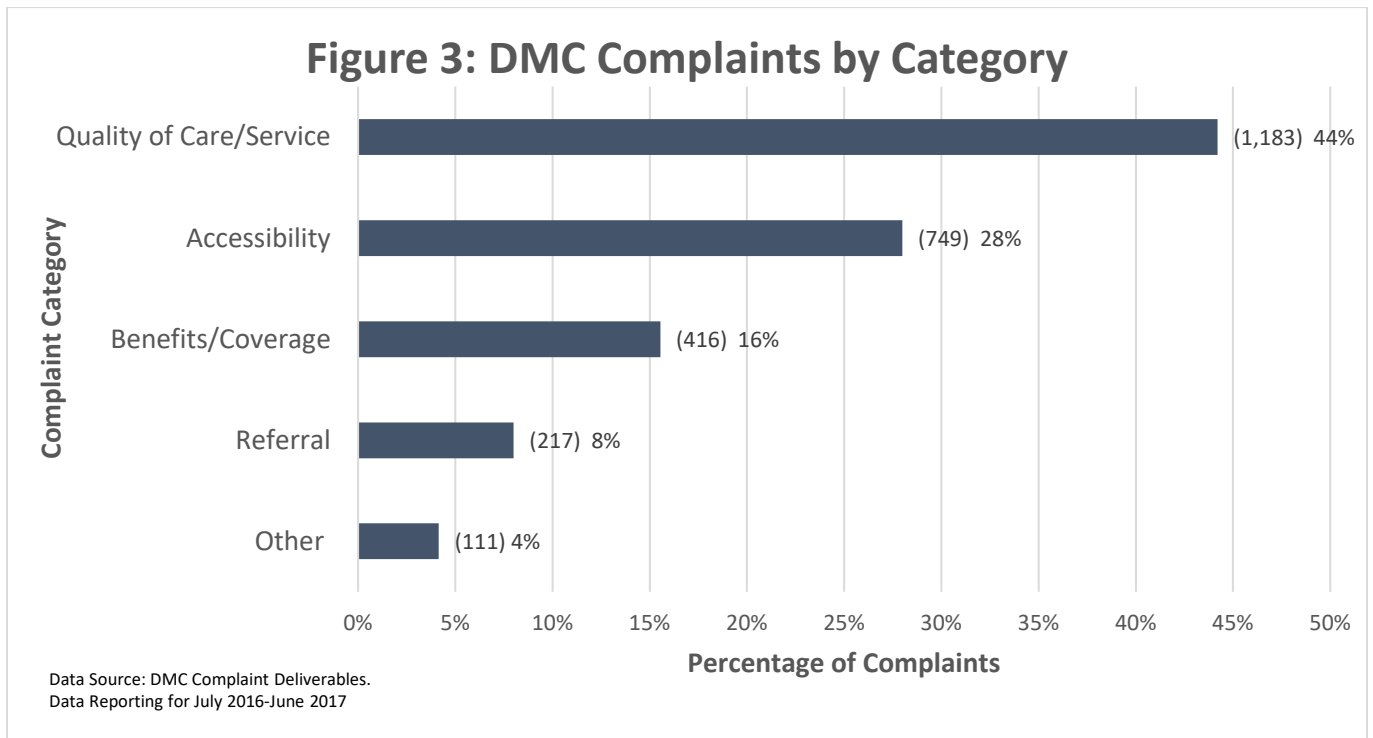
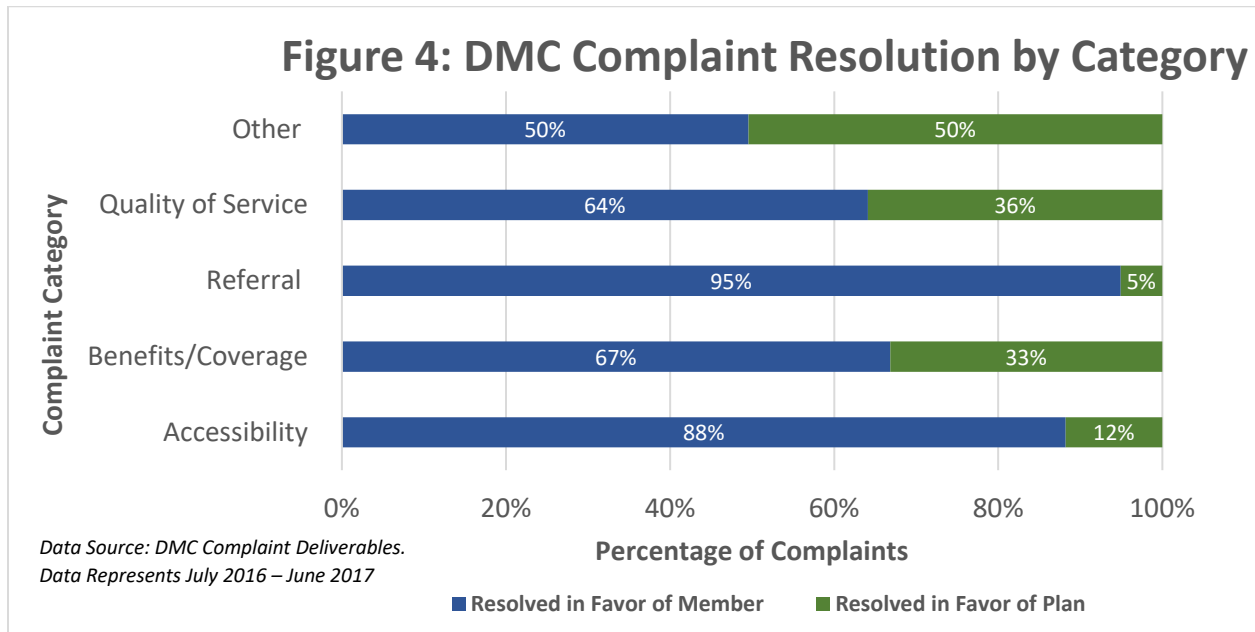


Figure 4, titled *DMC Complaint Resolution by Category*, provides the percentage breakdown of resolutions for each complaint type. Most of the complaints from each category were resolved in favor of Medi-Cal members. The other complaints were resolved in favor of the DMC plan except for six unresolved. Figure 4 displays the outcome of resolved cases.



Dental Fee-for-Service Complaints

The Dental FI categorized complaints as follows:

- **Provider Referral:** Complaint related to the provider a beneficiary was referred to by FI Customer Service.
- **Clinical Screening Dentist:** Complaint regarding a Clinical Screening Dentist appointment. This includes actions of the dentist, the result of the screening, and/or the appointment time and place.
- **Quality of Care:** Complaint about the quality of the dental services rendered by the dentist or other licensed professional such as a dental hygienist s (i.e. ill-fitting dentures).
- **Office Conduct:** Complaint regarding the behavior of non-clinical staff (not a dentist or hygienist) at a dental office.
- **Scope of Coverage:** Complaint regarding Medi-Cal Dental Program benefits that the individual is eligible for, given their Aid Code.
- **Provider Billed Beneficiary:** Complaint because a beneficiary was billed for services that are considered a benefit.
- **Medical Necessity:** Complaint about a dental service Claim or Treatment Authorization Request that was denied because it did not meet Medi-Cal Dental Program criteria for medical necessity, as defined in the Provider Handbook.
- **Quality of Service:** Complaint regarding the quality of service at a dental office, which includes office cleanliness, usage of appropriate safety measures such as wearing gloves, and procedural and technical aspects of care.
- **Miscellaneous:** This category is used to designate a record received or in process and is not a punitive complaint issue.

Figure 5, titled *FFS Complaints by Category and Filing Method*, provides a breakdown of the method beneficiaries used to file a complaint, by category for 2016-17.

Figure 5: FFS Complaints by Category and Filing Method		
Category	Written	Phone
Provider Referral	0	1
Clinical Screening Dentist	0	52
Quality of Care	1,411	2840
Office Conduct	1	168
Scope of Coverage	0	2
Provider Billed Beneficiary	0	305
Medical Necessity	0	0
Quality of Service	0	100
Miscellaneous	890	404
Total	2,302	3872

In 2016-17, the Dental FI received complaints via telephone and in writing. According to the current FI process, complaints received in writing were frequently preceded by a telephone complaint, except for complaints categorized as miscellaneous. Due to the manner in which the written complaints were subsequently handled, the total number of unduplicated complaints in 2016-17 for FFS is the sum of the telephone complaints in Figure 5.

A majority of FFS complaints were regarding Quality of Care. Note that the FI's process was to only categorize written complaints as those inquiries regarding services with a greater than 12-month service limitation, which had already been provided to the beneficiary. Concerns about quality of care for prophylaxis service, lack of service, access that is not timely, or issues that are addressed in a state fair hearing were not consistently recorded as complaints.

The second most frequent complaint category is Miscellaneous. Although this category is included in the complaint summary figures provided by the FI, it includes questions about a complaint or inquiry on the status of a complaint, so it does not reflect additional complaints beyond the figures captured in other categories.

Figure 6, titled *FFS Complaints per Quarter Submitted in 2016-17*, presents the quarterly breakdown by category for both written and telephone complaints in order of greatest to least.

Figure 6: FFS Complaints per Quarter Submitted in 2016-17				
Category	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Quality of Care	1145	967	1150	989
Miscellaneous	342	335	306	311
Provider Billed Beneficiary	80	69	88	68
Office Conduct	45	45	42	36
Quality of Service	15	22	24	39
Clinical Screening Dentist	10	6	9	27
Scope of Coverage	0	2	0	0
Provider Referral	0	0	0	1
Medical Necessity	0	0	0	0
Total	1637	1446	1619	1471

Please note, for Quality of Care and Miscellaneous, the number of complaints is duplicated, as these categories contain both written and phone complaints.

Resolution of FFS Complaints

Figure 7, titled *FFS Complaints Resolution Outcome by Category*, indicates the percent of complaints resolved by the end of 2016-17.

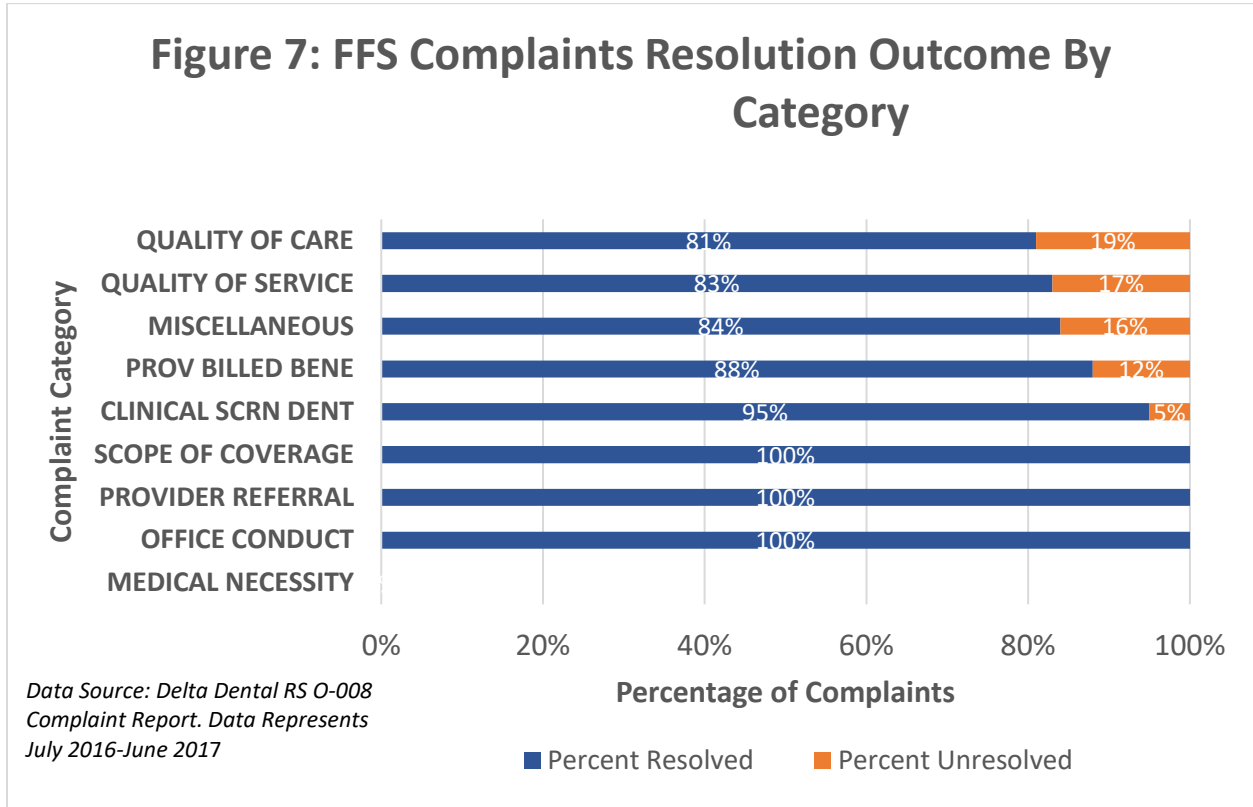


Figure 8, titled *FFS Resolution of Complaints by Category per Quarter*, shows the percent of complaints resolved per category for each quarter. To capture an accurate snapshot of each quarter’s data, this data does not include rollover complaints from a previous quarter. If there were more complaints resolved than received for a particular subcategory, this indicated that some of the previously unresolved complaints from prior quarters were resolved in the current quarter. In those cases, the category was marked as 100 percent resolved, as all complaints from the current quarter had been resolved.

Figure 8: FFS Resolution of Complaints by Category per Quarter					
Quarter 1			Quarter 2		
Complaint Category	Resolved	Unresolved	Complaint Category	Resolved	Unresolved
Quality Of Care	81%	19%	Quality Of Care	81%	19%
Miscellaneous	84%	16%	Miscellaneous	87%	13%
Provider Billed Beneficiaries	88%	12%	Provider Billed Beneficiaries	90%	10%
Office Conduct	100%	N/A	Office Conduct	100%	N/A
Quality Of Service	73%	27%	Quality Of Service	68%	32%
Clinical Screening Dentist	100%	N/A	Clinical Screening Dentist	83%	17%
Medical Necessity	N/A	N/A	Medical Necessity	N/A	N/A
Provider Referral	N/A	N/A	Provider Referral	N/A	N/A
Scope Of Coverage	N/A	N/A	Scope Of Coverage	100%	N/A
Quarter 3			Quarter 4		
Complaint Category	Resolved	Unresolved	Complaint Category	Resolved	Unresolved
Quality Of Care	82%	18%	Quality Of Care	79%	21%
Miscellaneous	84%	16%	Miscellaneous	80%	20%
Provider Billed Beneficiaries	90%	10%	Provider Billed Beneficiaries	92%	8%
Office Conduct	100%	N/A	Office Conduct	100%	N/A
Quality Of Service	92%	8%	Quality Of Service	90%	10%
Clinical Screening Dentist	80%	20%	Clinical Screening Dentist	100%	N/A
Medical Necessity	N/A	N/A	Medical Necessity	N/A	N/A
Provider Referral	N/A	N/A	Provider Referral	100%	N/A
Scope Of Coverage	N/A	N/A	Scope Of Coverage	N/A	N/A