DEPARTMENT OF HEALTH CARE SERVICES
MEDI-CAL DENTAL SERVICES
COMPLAINTS AND GRIEVANCES REPORT

February 2024

Reporting Period: State Fiscal Year 2022-2023

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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Executive Summary

Welfare & Institutions Code Section 14132.915(h) 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, as well as the corresponding outcome.

This report summarizes complaints and grievances received within the Dental Fee-For-Service (FFS) and Dental Managed Care (DMC) delivery systems, during the reporting period of State Fiscal Year (SFY) 2022-23 (July 1, 2022, through June 30, 2023). Dental FFS complaints and grievances data are collected from the Administrative Services Organization (ASO) contractor, Delta Dental of California, and DMC plans, Health Net of California, Inc. (Health Net), Access Dental Plan (Access), and Liberty Dental Plan of California, Inc. (Liberty), who operate in Sacramento and Los Angeles Counties only. The ASO and the DMC plans report their complaints and grievances from members to DHCS on a quarterly basis.

When compared to the previous SFY, dental FFS member complaints increased by 22 percent and DMC member complaints increased by 11 percent.

Key Findings

» **Dental FFS**

- As of the SFY 2021-2022 Complaints and Grievances Report, the "Provider Billed Member" category includes counts of requests from members for reimbursement of Medi-Cal covered services paid to providers, also known as Conlan claims, and the "Medical Necessity" category includes counts of State Fair Hearing case for services.
  - Percentage of total FFS member complaints by category is as follows from highest to lowest:
    - "Scope of Coverage" at 35.33 percent
    - "Quality of Care/Treatment" at 27.69 percent included services rendered (e.g., ill-fitting dentures)
    - "Provider Billed Member" at 20.37 percent and
    - "Provider Office Conduct" at 14.61 percent.
    - All other complaint categories constituted to 2.00 percent of the total complaints.
    - Among the 6,712 FFS member complaints, 99.9 percent were resolved within 30 days in all categories except "Provider Billed Member" and

the remaining percentage, which is one case for "Provider Billed Member", was resolved in 42 days.

- **Dental Managed Care**
  - To align with FFS categories, "Provider Office Conduct", "Provider Billed Member", "Medical Necessity", and "Scope of Coverage" were newly added categories in the SFY 2021-2022 Complaints and Grievances Report. Data captured for these categories were previously reported under "Quality of Care/Service" and "Other".
  - Percentage of total DMC member complaints by category is as follows from highest to lowest:
    - "Scope of Coverage" at 44.09 percent
    - "Accessibility" at 16.64 percent
    - "Quality of Care/Service" at 14.40 percent and
    - "Provider Office Conduct" at 13.51 percent.
    - All other complaints categories constituted to 11.36 percent of the total complaints.
  - Among the 5,719 complaints, 99.5 percent were resolved within 30 days and the remaining percentage, which were twenty-eight (28) cases across categories, were resolved within 34 days.

Background on Medi-Cal Dental Delivery Systems

In SFY 2022-23, there were approximately 14.9 million Californians enrolled in Medi-Cal for at least three continuous months. Most Medi-Cal members receive dental services through the dental FFS delivery system. The ASO contract has been in effect since January 29, 2018, for administrative services, including communications with Medi-Cal dental providers and members, operating the Telephone Service Center (TSC), processing of dental FFS member complaints statewide. DMC enrollment is mandatory for Medi-Cal members in Sacramento County and optional for members in Los Angeles County. DHCS contracts with three Geographic Managed Care (GMC) Plans in Sacramento County and three Prepaid Health Plans (PHP) in Los Angeles County licensed by the Department of Managed Health Care to provide Medi-Cal dental services to members. DMC plans' functions include monitoring and addressing member complaints.

Definition of Complaints and Grievances

For the 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 applied to both dental FFS and DMC for the purposes of this report:

- "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, and 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".

Data

Table 1, titled SFY 2021-22 and SFY 2022-23 Medi-Cal Dental Complaints by Delivery System shows the total number of complaints and members by delivery system for the indicated measurement period. When compared to the previous SFY 2021-22[1], dental FFS member complaints increased by 19.62 percent and DMC member complaints increased by 11.92 percent.

Table 1: SFY 2021-22 and SFY 2022-23 Medi-Cal Dental Complaints by Delivery System

Delivery System	FFS			DMC		
Measurement Year	SFY 2021-22	SFY 2022-23	Percent Change	SFY 2021-22	SFY 2022-23	Percent Change
Number of Members[2]	13,169,543	13,832,937	+5.04%	975,873	1,124,133	+15.19%
Number of Complaints	9,756	11,670	+19.62%	5,144	5,757	+11.92%
Percentage of Complaints to Members	0.07%	0.08%	+14.29%	0.53%	0.51%	-3.77%
Percentage of Total Complaints	65.50%	66.97%	+2.24%	34.50%	32.37%	-6.17

[1] Data source: SFY 2021-2022 Medi-Cal Dental Complaints and Grievances Report
[2] Full scope Medi-Cal members who were enrolled in the same DMC plan or FFS for at least 90 continuous days during the SFY 2021-2022 and 2022-23. Enrollment data for SFY 2020-2021 and SFY 2021-22 as of December 2023 from the DHCS MIS/DSS Warehouse.

Dental FFS Complaints

Complaints from FFS members are categorized as follows:

- **Accessibility:** Complaints regarding lack of facility physical access, language accessibility, primary care provider or specialist availability, lack of telephone accessibility or excessive long wait for scheduling appointments.
- **Quality of Care/Treatment:** Complaint about the quality of the dental services rendered by the dentist or other licensed professional such as a dental hygienist (e.g., ill-fitting dentures).
- **Provider Office Conduct:** Complaint regarding the behavior of non-clinical staff (not a dentist or hygienist) at a dental office.
- **Medical Necessity:** Complaint about a dental service Claim or Treatment Authorization Request that was denied because it did not meet Medi-Cal criteria for medical necessity for the provision dental services, as defined in the Provider Handbook.
- **Provider Billed Member:** Complaint because a member was billed for services that are considered a benefit, including Conlan cases filed by the member. In accordance court cases Conlan v. Bonta and Conlan v. Shewry, members who paid out-of-pocket for covered Medi-Cal services can request reimbursement either directly or be reimbursed through the state's reimbursement process which is now captured in this report.
- **Scope of Coverage:** Complaint regarding Medi-Cal dental benefits that the individual is eligible for, given their aid code including State hearing cases, in which the member requests coverage for denied services. Medi-Cal Dental provides members the right to a State Hearing if he/she contests with the adjudication of their Treatment Authorization Request (TAR) or reimbursement claim.
- **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.
- **Provider Referral:** Complaint related to the provider a member was referred to by ASO Customer Service.

Table 2 titled SFY 2022-23 FFS Complaints by Filing Method shows a breakdown of the method members used to file a complaint for SFY 2022-23.

Table 2: SFY 2021-22 FFS Complaints by Filing Method

Filing Method	Types of Complaints	Number of Complaints
By Writing (Mail/Email)	General complaints	2,106
	Medical Necessity (State Hearing)	338
	Provider Billed Member (Conlan)	3,953
By Telephone	TSC	2,126
	Medical Necessity (State Hearing)	1,233
Total		**9,756**

Table 3 titled SFY 2022-23 FFS Complaints by Filing Method shows a breakdown of the method members used to file a complaint for SFY 2022-23.

Table 3: SFY 2022-23 FFS Complaints by Filing Method

Filing Method	Types of Complaints	Number of Complaints
By Writing (Mail/Email)	General Complaints	4,077
	Medical Necessity (State Hearing)	429
	Provider Billed Member (Conlan)	1,629
By Telephone	TSC	1,888
	Medical Necessity (State Hearing)	3,647
Total		**11,670**

For SFY 2022-23, there were a total of 11,670 complaints received from FFS members. Of those, 6,135 were received by mail and 5,535 were by telephone. According to the ASO, complaints received by telephone are tracked by completing a TSC Service Form for each call. If the member has a complaint regarding more than one issue, a service form would be populated to capture each of the complaints. Conlan cases are all received through mail as signatures are required on the forms. State hearing cases can be filed by writing or phone calls.

When compared to the previous SFY, total dental FFS complaints received increased by approximately 20 percent, which could be partially due to the 5 percent increase in

population from the previous year. The ASO continued provider outreach and additional training to providers that appear to be repeatedly non-compliant with program requirements. The ASO has also taken efforts to minimize Quality of Care/Treatment complaints by involving the Care Coordination team to work with the providers and office staff to better serve the members.

Table 4 titled SFY 2022-23 FFS Complaints per Quarter Reports shows the quarterly breakdown by category for both mail and telephone complaints.

Table 4: SFY 2022-23 FFS Complaints per Quarter Reports

Category	July-September 2022	October-December 2022	January-March 2023	April-June 2023	Total
Accessibility	18	34	28	36	**116**
Clinical Screening Dentist	6	5	2	9	**22**
Provider Office Conduct	376	348	429	552	**1,705**
Provider Referral	17	21	6	21	**65**
Quality of Care/Treatment	792	876	716	848	**3,232**
Provider Billed Member	592	547	615	623	**2,377**
Medical Necessity	8	11	2	9	**30**
Scope of Coverage	817	904	1,029	1,373	**4,123**
Total	**2,626**	**2,746**	**2,827**	**3,471**	**11,670**

Table 5 titled SFY 2022-23 FFS Complaints per Quarter Reports by Source shows the quarterly breakdown by category for both mail and telephone complaints in order of highest to lowest counts.

Table 5: SFY 2022-23 FFS Complaints per Quarter Reports by Source

Category	Source	July-September 2022	October-December 2022	January-March 2023	April-June 2023	Total
Accessibility	TSC	18	34	28	36	**116**
Quality of Care/Treatment	TSC	280	249	224	383	**1,136**
	Mail	512	627	492	465	**2,096**
Provider Office Conduct	TSC	376	348	429	552	**1,705**
Medical Necessity	TSC	8	11	2	9	**30**
Provider Billed Member	TSC	191	180	174	203	**748**
	Conlans	401	367	441	420	**1,629**
Scope of Coverage	TSC	8	12	12	15	**47**
	State Hearings	809	892	1,017	1,358	**4,076**
Clinical Screening Dentist	TSC	6	5	2	9	**22**
Provider Referral	TSC	17	21	6	21	**65**
Total		**2,626**	**2,746**	**2,827**	**3,471**	**11,670**

During SFY 2022-23, a majority of FFS complaints were regarding "Scope of Coverage" and "Quality of Care/Treatment" with 35.33 percent and 27.69 percent respectively of the total complaints. The other complaints included the "Provider Billed Member" category at 20.37 percent, the "Provider Office Conduct" category at 14.61 percent, the "Accessibility" category at 0.99 percent, the "Medical Necessity" category at 0.26 percent, the "Provider Referral" category at 0.56 percent, and the "Clinical Screening Dentist" category at 0.19 percent.

Dental FFS Complaints Resolved

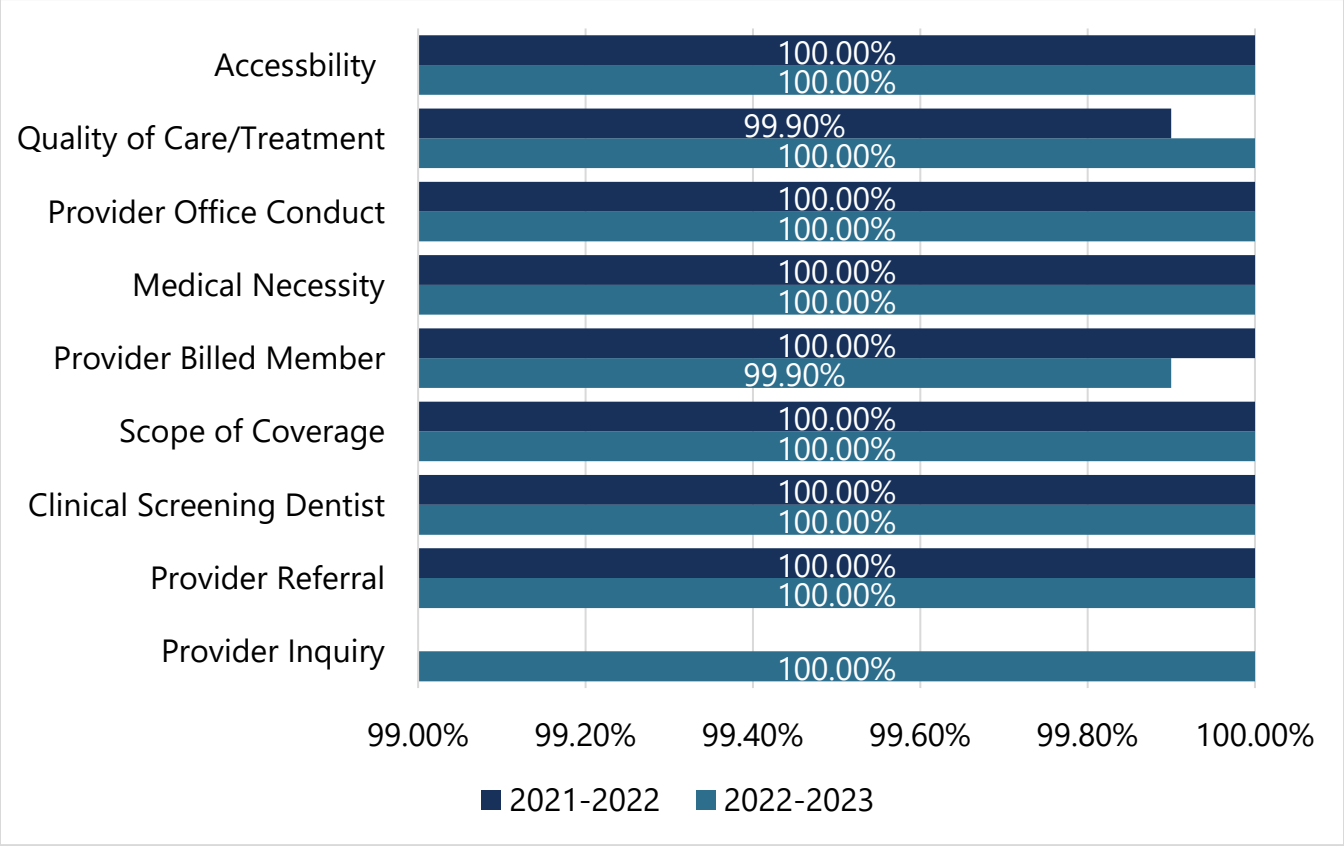
Table 6 titled Percentage of TSC Complaints Resolved within 30 days by quarter for SFY 2021-22 and SFY 2022-23 indicates the percent of complaints resolved within 30 days at the end of each quarter for the measurement period.

Table 6: Percentage of TSC Complaints Resolved within 30 days by quarter for SFY 2021-22 and SFY 2022-23

Quarter	Resolution Percentage SFY 2021-22	Resolution Percentage SFY 2022-23	Change
Quarter 1 (July-September 2022)	99.90%	100.00%	+0.10%
Quarter 2 (October-December 2022)	100.00%	100.00%	0.00%
Quarter 3 (January-March 2023)	100.00%	100.00%	0.00%
Quarter 4 (April-June 2023)	100.00%	99.90%	-0.10%

Figure 1 titled SFY 2021-22 and 2022-23 FFS TSC Complaints Resolution Timeframe indicates the percent of complaints (without Conlan and State Hearing data) resolved within 30 days at the end of the indicated SFY period. State Hearing and Conlan Reimbursement Claims are both complaint types that have different processing and timeframe requirements outside of the 30-day resolution.

Figure 1: 2021-22 and 2022-23 FFS TSC Complaints Resolution Timeframe[3]



All TSC complaints are required to be resolved within 30 days from the day they were received, according to the ASO contract. 6,172 out of the 6,173 complaints received during SFY 2022-23 were resolved within 30 days, except for 1 case in the "Provider Billed Member" category, which was resolved in 42 days. This data does not include rollover complaints from the previous quarter to capture an accurate snapshot of each quarter's data. In general, all complaints are resolved in favor of the member as these were the complaints initiated by the member.

DMC Complaints

Complaints from DMC members are categorized as follows:

- **Accessibility**: Complaints regarding excessively long wait time/appointment schedule time; lack of primary care provider availability; provider referral delays;

[3] Data Source: FFS Complaint Deliverables from July 2022 to June 2022 and July 2022 to June 2023.

lack of specialist availability; lack of telephone accessibility; lack of language accessibility; and lack of facility physical access.

- **Quality of Care/Service:** Complaints regarding inadequate facilities, non-access related; inappropriate provider care; plan denial of treatment; and provider denial of treatment.
- **Provider Office Conduct:** Complaint regarding poor provider staff or attitude for clinical or non-clinical staff.
- **Medical Necessity:** Complaint about a dental service Claim or Treatment Authorization Request that was denied because it did not meet Medi-Cal criteria for medical necessity for the provision dental services, as defined in the Provider Handbook.
- **Provider Billed Member:** Complaint regarding a member billed for services that are considered a benefit.
- **Scope of Coverage:** Complaint regarding Medi-Cal dental benefits that the individual is eligible for, given their aid code including State hearing cases, in which the member requests coverage for denied services, and appeals. Medi-Cal Dental provides members the right to a State Hearing if he/she contests with the adjudication of their Treatment Authorization Request (TAR) or reimbursement claim.
- **Provider Referral:** Complaint related to the provider a member was referred to

"Provider Office Conduct", "Medical Necessity", "Provider Billed Member", "Provider Referral", and "Scope of Coverage" are newly added DMC categories in SFY 2021-2022 to align with the FFS categories. See Table 7 for the crosswalk of FFS and DMC complaint categories.

Table 7: FFS and DMC Complaint Categories Crosswalk

FFS	DMC
Accessibility	**Existing category:** Accessibility **Other subcategory:** Facility Unsanitary
Quality of Care/Treatment	**Existing category:** Quality of Care/Treatment
Provider Office Conduct	**Other subcategory:** Discrimination **Other subcategory:** Entered in Error **Other subcategory:** Incorrect info (plan) **Other subcategory:** Administrative Issues **Quality of Care/Treatment subcategory:** Poor provider conduct/Staff attitude
Medical Necessity	**Other subcategory:** Limited Plan Benefits **Other subcategory:** Non-Covered Benefit
Provider Billed Member	**New category:** Conlans **Other subcategory:** Overcharging **Other subcategory:** Upselling **Other subcategory:** Billing Discrepancy
Scope of Coverage	**New category:** State Fair Hearing **New category:** Appeal **Other subcategory:** Eligibility Issues **Other subcategory:** Dispute over Covered Services **Other subcategory:** Referral Delay **Other subcategory:** Member Copay **Other subcategory:** Delay in Pre-Auth/Referral **Other subcategory:** Other (complaints related to scope of coverage)

In the previous SFY 2021-22 report the DMC plans recorded a total of 5,144 complaints. In SFY 2022-2023 the DMC plans recorded a total of 5,757 complaints, which is an 11.92 percent increase.

Table 8 titled Number of Complaints by DMC Plan for SFY 2021-2022 and SFY 2022-2023, shows the number of complaints recorded by each DMC plan. Based on the data,

Liberty Dental Plan recorded the highest count of complaints for GMC and Health Net recorded the highest counts of complaints for PHP. Liberty Dental Plan stated that the COVID-19 pandemic was still active during SFY 2021-2022, and many providers/offices remained closed during this time. COVID restrictions began to loosen in SFY 2022-2023 which resulted in an increase in utilization, and an increase in complaints as members returned to appointments. Health Net Dental Plan reported a membership increase of 12 percent from SFY 2021-2022 to 2022-2023 which could account for the increase in complaints. Liberty and Health Net Dental Plans continue to monitor trends with providers/offices and will take action as necessary.

Table 8: Number of Complaints by DMC Plan for SFY 2021-2022 and SFY 2022-2023

Delivery System	Access			Health Net			Liberty		
Measurement Year	SFY 21-22	SFY 22-23	Change	SFY 21-22	SFY 22-23	Change	SFY 21-22	SFY 22-23	Change
GMC	1,391	922	-33.72%	659	818	+24.13%	809	1,654	+104.45%
PHP	947	725	-23.44%	949	1,123	+18.34%	389	515	+32.39%
Total	**2,338**	**1,647**	**-29.56%**	**1,608**	**1,941**	**+20.71%**	**1,198**	**2,169**	**+81.05%**

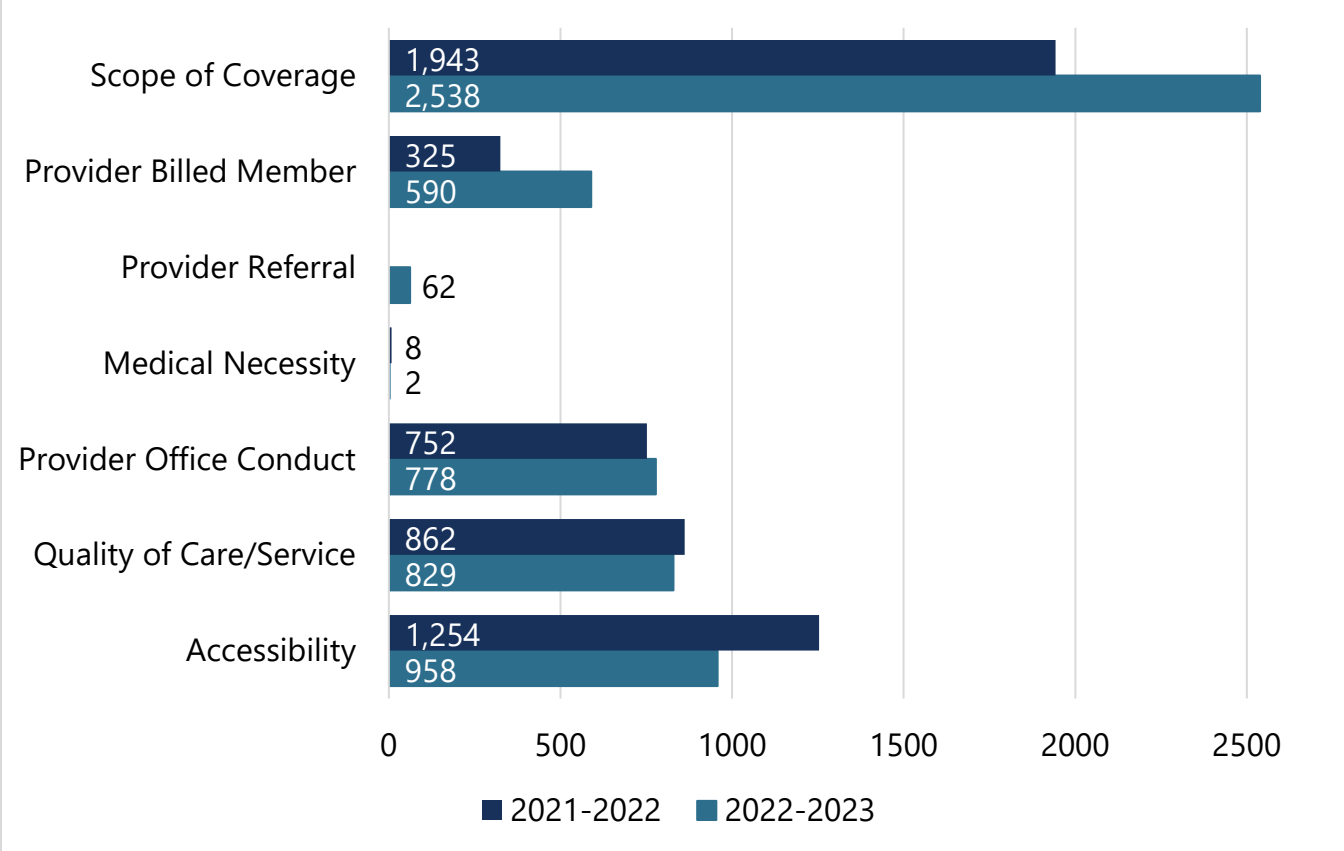
Table 9 titled Number of Complaints by DMC Members for SFY 2021-2022 and 2022-2023 shows the percentage of complaints in GMC and PHP as a ratio to members. Note that "members" are those who were enrolled in the same plan for at least 90 continuous days during the indicated reporting period. Liberty Dental Plan has the highest member-to-complaint ratio in both GMC and PHP when compared to other plans during SFY 2022-2023.

Table 9: Number of Unduplicated Complaints by DMC Members for SFY 2021-2022 and 2022-2023

Delivery System	Access			Health Net			Liberty		
Measurement Year	SFY 21-22	SFY 22-23	Change	SFY 21-22	SFY 22-23	Change	SFY 21-22	SFY 22-23	Change
GMC Complaints	1,391	922	-33.72%	659	818	+24.13%	809	1,654	+104.45%
GMC Members	154,827	184,448	+19.13%	173,060	208,260	+20.34%	203,395	242,086	+19.02%
GMC Complaints to Member	0.90%	0.50%	-44.44%	0.38%	0.39%	+2.63%	0.40%	0.68%	+70.00%
PHP Complaints	947	725	-23.44%	949	1,123	+18.34%	389	515	+32.39%
PHP Members	141,592	147,187	+3.95%	222,109	246,220	+10.86%	80,890	96,033	+18.72%
PHP Complaints to Member	0.67%	0.49%	-26.86%	0.43%	0.46%	+6.98%	0.48%	0.54%	+12.50%

Figure 2 titled SFY 2021-22 and 2022-23 DMC Complaints by Category shows the relative proportion of complaints by each category and represents number of complaints filed, not the number of members. If a member has two separate complaints, the complaints are counted twice in this table. If a complaint falls into multiple categories, each complaint was counted and placed into the applicable category to reflect the total percentage. During SFY 2022-23, most DMC complaints were related to "Scope of Coverage" at 44.09 percent, followed by the "Accessibility" category at 16.64 percent, the "Quality of Care/Service" category at 14.40 percent, the "Provider Office Conduct" category at 13.51 percent, the "Provider Billed Member" at 10.25 percent, the "Provider Referral" category at 1.08 percent, and the "Medical Necessity" category at 00.03%. The "Accessibility" category complaints decreased by 23.61 percent and "Scope of Coverage" increased by 30.62 percent.

Figure 2: SFY 2021-22 and 2022-23 DMC Complaints by Category[4]



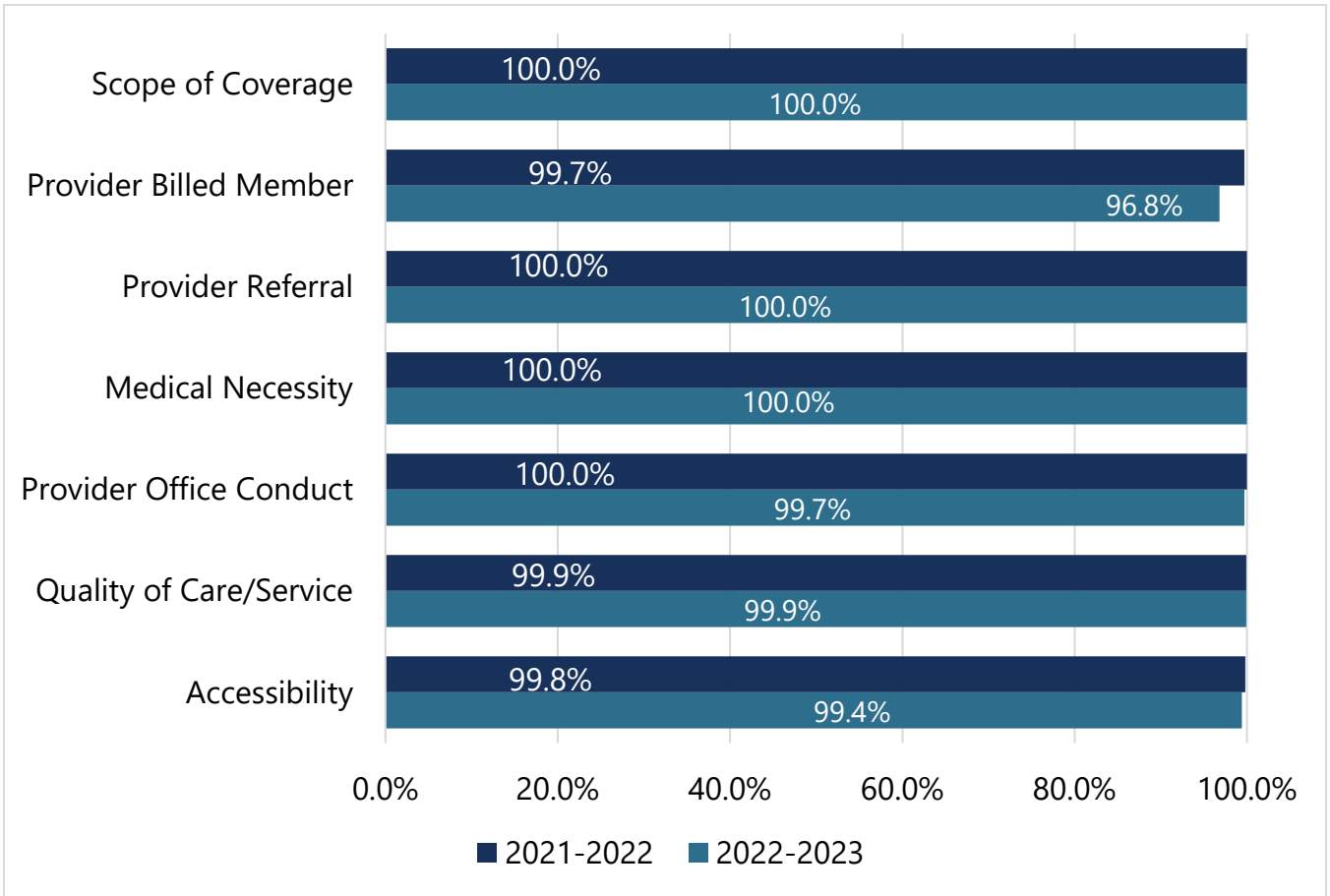
[4] *Data Source: DMC Complaint Deliverables from July 2021 to June 2022 and July 2022 to June 2023.*

DMC Complaints Resolved

DMC plans are required to provide a written acknowledgement to the member within five calendar days of receiving the complaint and resolve the complaint no later than 30 calendar days from the date of receipt. Figure 3 below does not include the 36 State Hearing Cases received in SFY 2021-2022 and the 38 State Hearing Cases received in SFY 2022-2023, as State Hearings have their own separate resolution timelines. All the complaints were resolved by the end of the reporting period and 99.5 percent of the 5,719 complaints were resolved within 30 days. The turnaround time for the remaining 0.5 percent complaints varied between 31 to 34 days because of the additional time needed to gather and review documentation from members and/or providers.

Figure 3 titled Percent of DMC Complaints Resolved Within 30 Days for SFY 2021-22 and SFY 2022-2023 shows the percentage of complaints in each category that are resolved within 30 calendar days from date of receipt.

Figure 3: Percent of DMC Complaints Resolved within 30 days for SFY 2021-22 and SFY 2022-23

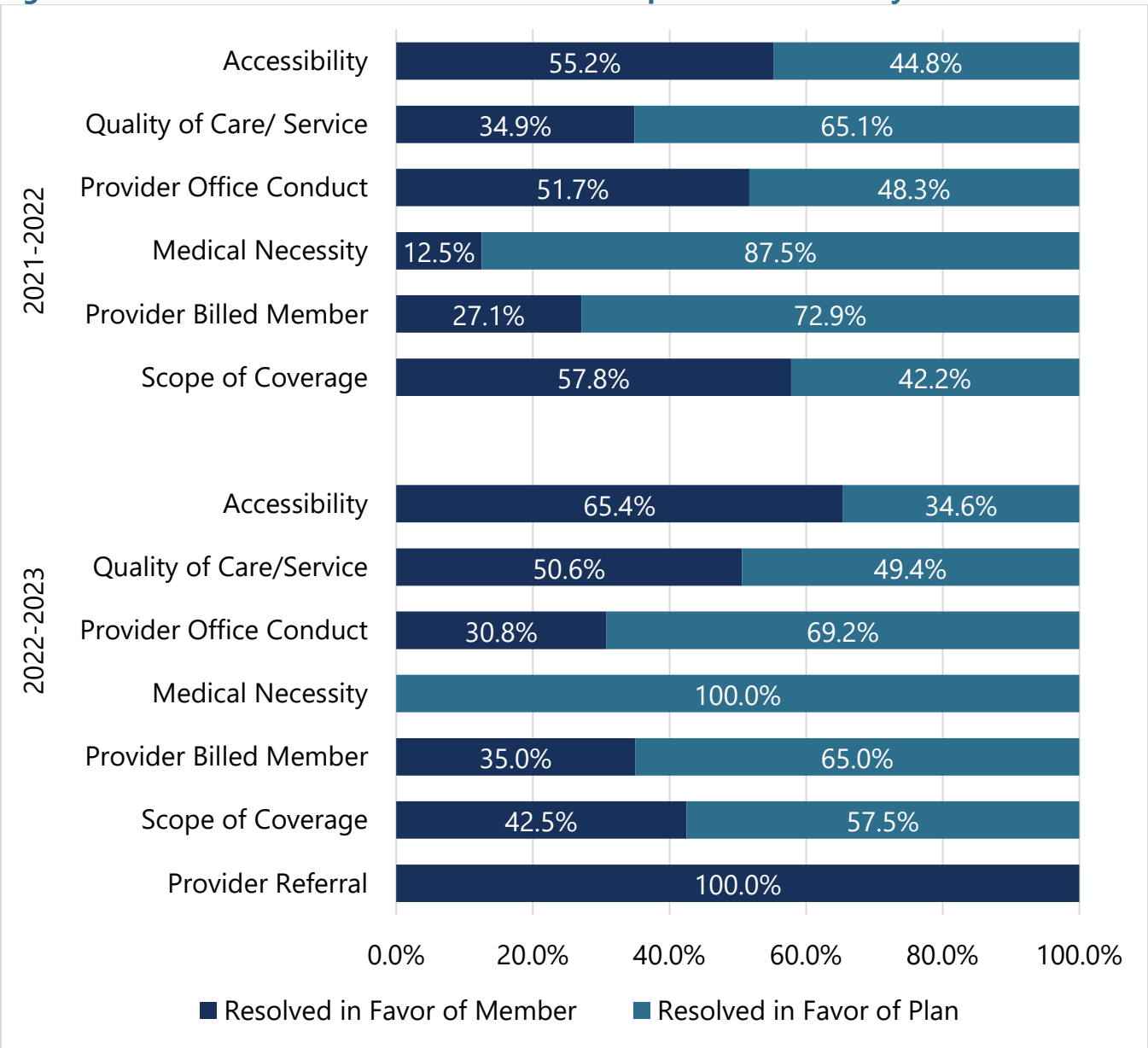


Data Source: DMC Complaint Deliverables from July 2021 to June 2022 and July 2022 to June 2023.

Figure 4 titled SFY 2021-2022 and 2022-2023 DMC Complaint Resolution by Outcome shows the percentage breakdown of resolutions for each complaint category. Duplication exists when a complaint falls under two or more categories. Among the 5,719 total resolved complaints across all categories, 45.7 percent of the complaints were resolved in favor of members over the DMC plans. When compared to the previous SFY, resolution in favor of members has decreased due to the enhanced record keeping system wherein the plans are able to retrieve documentation and objectively determine if the member's allegations are truly supported verses their perception of care especially in the "Quality of Care/Service" and "Provider Office Conduct" complaints. Also, most of the cases were resolved by providing benefit education to members to clarify miscommunications between the provider and the member.

For SFY 2022-2023, 100% of "Provider Referral", 65.4 percent of "Accessibility", 50.6% of "Quality of Care/Service", and 42.5 percent of the "Scope of Coverage" complaints were resolved in favor of members. During SFY 2022-23, the DMC plans continued to monitor grievances by conducting quarterly meetings to establish a forum for collaboration to improve both the provider and member experience, provided additional training to offices and hired new staff to identify opportunities to help reduce member abrasion.

Figure 4: SFY 2021-2022 and 2022-2023 DMC Complaint Resolution by Outcome[5]



[5] *Data Source: DMC Complaint Deliverables from July 2021 to June 2022 and July 2022 to June 2023.*