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

September 2023

Reporting Period: State Fiscal Year 2021-2022

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

CONTENTS

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) 2021-22 (July 1, 2021 through June 30, 2022). Dental FFS complaints and grievances data is 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 187 percent and DMC member complaints increased by 27 percent. The increase in complaints is largely due to the inclusion of Conlan cases and State Fair Hearings, which were not included in previous reports. In addition, the resumption of operations from the COVID-19 pandemic resulted in increased utilization of services, which in turn increased the number of potential members with complaints.

Key Findings

» Dental FFS

- Two categories were updated in this report. The "Provider Billed Member" category now 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.
- Of the total complaints received from FFS members, 40.55 percent were related to "Provider Billed Member" and 34.19 percent were related to "Quality of Care/Treatment" which included services rendered (e.g., ill-fitting dentures).
- The third and fourth highest complaints were for the "Scope of Coverage" at 16.24 percent and "Provider Office Conduct" at 8.03 percent. All other complaint categories constituted to 0.99 percent of the total complaints.

- Among the 4,232 TSC and general complaints, 99.9 percent were resolved within 30 days in all categories except for "Quality of Care/Treatment" where one case was resolved within 33 days.

» **Dental Managed Care**

- To align with FFS categories, "Provider Office Conduct", "Provider Billed Member", "Medical Necessity", and "Scope of Coverage" are newly added categories. Data captured for these categories were previously reported under "Quality of Care/Service" and "Other".
- Most of complaints were for "Accessibility", which was 31.9 percent of the total number of complaints received.
- The next highest complaint was for the "Other" category at 28.8 percent.
- The third and fourth highest complaints were for "Quality Care/Service at 22.8 percent and "Provider Office Conduct" at 16.6 percent.
- Among the 3,608 complaints, 99.7 percent were resolved within 30 days. Ten (10) cases across categories were resolved within 34 days.

Background on Medi-Cal Dental Delivery Systems

In SFY 2021-22, there were approximately 14.2 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

Figure 1, titled SFY 2020-21 and SFY 2021-22 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 2020-21[1], dental FFS member complaints increased by 187 percent and DMC member complaints increased by 27 percent. This report includes Conlan and State Fair Hearing counts not included in previous reports and the previous SFY was impacted by the COVID-19 Public Health Emergency (PHE).

Figure 1: SFY 2020-21 and SFY 2021-22 Medi-Cal Dental Complaints by Delivery System

Delivery System	Dental FFS			DMC		
Measurement Year	SFY 2020-21	SFY 2021-22	Percent Change	SFY 2020-21	SFY 2021-22	Percent Change
Number of Members*	12,214,861	13,169,543	+7.82%	916,278	975,873	+6.50%
Number of Complaints	3,399	9,756	+187.03%	4,041	5,144	+27.30%
Percentage of Complaints to Members	0.03%	0.07%	+133.33%	0.44%	0.53%	+20.45%
Percentage of Total Complaints	45.69%	65.5%	+43.29%	54.31%	34.5%	-36.44%

** Full scope Medi-Cal members who were enrolled in the same DMC plan or FFS for at least 90 continuous days during the SFY 2020-2021 and 2021-22. Enrollment data for SFY 2020-2021 and SFY 2021-22 as of November 2022 from the DHCS MIS/DSS Warehouse.*

[1] SFY 2020-2021 Medi-Cal Dental Complaints and Grievances Report

Dental FFS Complaints

Complaints from FFS members are categorized the same as the previous report 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.

Figure 2 titled SFY 2020-21 FFS Complaints by Filing Method shows a breakdown of the method members used to file a complaint for SFY 2020-21.

Figure 2: SFY 2020-21 FFS Complaints by Filing Method

Complaint Filing Method	Number of Complaints
By Mail (Mail/Email)	1,395
By Telephone	2,004
Total	3,399

Figure 3 titled SFY 2021-22 FFS Complaints by Filing Method shows a breakdown of the method members used to file a complaint for SFY 2021-22.

Figure 3: 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**

For SFY 2021-22, there were a total of 9,756 complaints; of those, 6,397 were received by mail and 3,359 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 187 percent due to the expansion of two categories. "Provider Billed Member" now includes Conlan cases (cases wherein the member files a claim as the provider erroneously billed for services and has not returned the funds paid to the Medi-Cal member) and the "Medical Necessity" category now includes state hearings (state hearing cases wherein the member has filed for a state hearing to dispute the DHCS decision the services were not medically necessary). In addition, offices are re-opening and dental service utilization is returning to pre COVID-19 PHE levels; thereby,

more members can receive services and open grievances for the care that they have received. 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.

Figure 4 titled SFY 2020-21 FFS Complaints per Quarter Submitted shows the quarterly breakdown by category for both mail and telephone complaints in order of least to greatest.

Figure 4: SFY 2020-21 FFS Complaints per Quarter Submitted

Category	July-September 2020	October-December 2020	January-March 2021	April-June 2021	Total
Accessibility	3	11	4	8	26
Quality of Care/Treatment	537	623	690	795	2,645
Provider Office Conduct	172	147	159	202	680
Medical Necessity	1	0	1	0	2
Provider Billed Member	5	12	1	0	18
Scope of Coverage	0	1	2	1	4
Clinical Screening Dentist	0	4	3	10	17
Provider Referral	3	2	0	2	7
Total	721	800	860	1,018	3,399

Figure 5 titled SFY 2021-22 FFS Complaints per Quarter Submitted shows the quarterly breakdown by category for both mail and telephone complaints in order of least to greatest.

Figure 5: SFY 2021-22 FFS Complaints per Quarter Submitted

Category	Source	July-September 2021	October-December 2021	January-March 2022	April-June 2022	Total
Accessibility	TSC	7	13	18	23	61
Quality of Care/Treatment	TSC	940	723	824	849	3,336
Provider Office Conduct	TSC	197	127	178	281	783
Medical Necessity	TSC	1	2	2	0	5
Provider Billed Member	TSC	1	2	0	0	3
	Conlans	1,775	1,564	280	334	3,953
Scope of Coverage	TSC	0	3	3	7	13
	State Hearings	392	398	388	393	1,571
Clinical Screening Dentist	TSC	7	2	4	3	16
Provider Referral	TSC	2	2	10	1	15
Total		3,322	2,836	1,707	1,891	9,756

During SFY 2021-22, a majority of FFS complaints were regarding "Provider Billed Member" and "Quality of Care/Treatment" with 40.55 percent and 34.19 percent respectively of the total complaints. Compared with the previous SFY, "Quality of Care/Treatment" complaints increased by 26.12 percent. The other complaints included the "Provider Office Conduct" category at 8.03 percent, the "Accessibility" category at 0.63 percent, the "Clinical Screening Dentist" category at 0.16 percent, the "Provider Referral" category at 0.15 percent, the "Scope of Coverage" category at 16.24 percent, and the "Medical Necessity" category at 0.05 percent.

SFY 2020-21 data cannot be compared to the SFY 2021-22 data due to the addition of State Fair Hearings and Conlans in SFY 2021-22

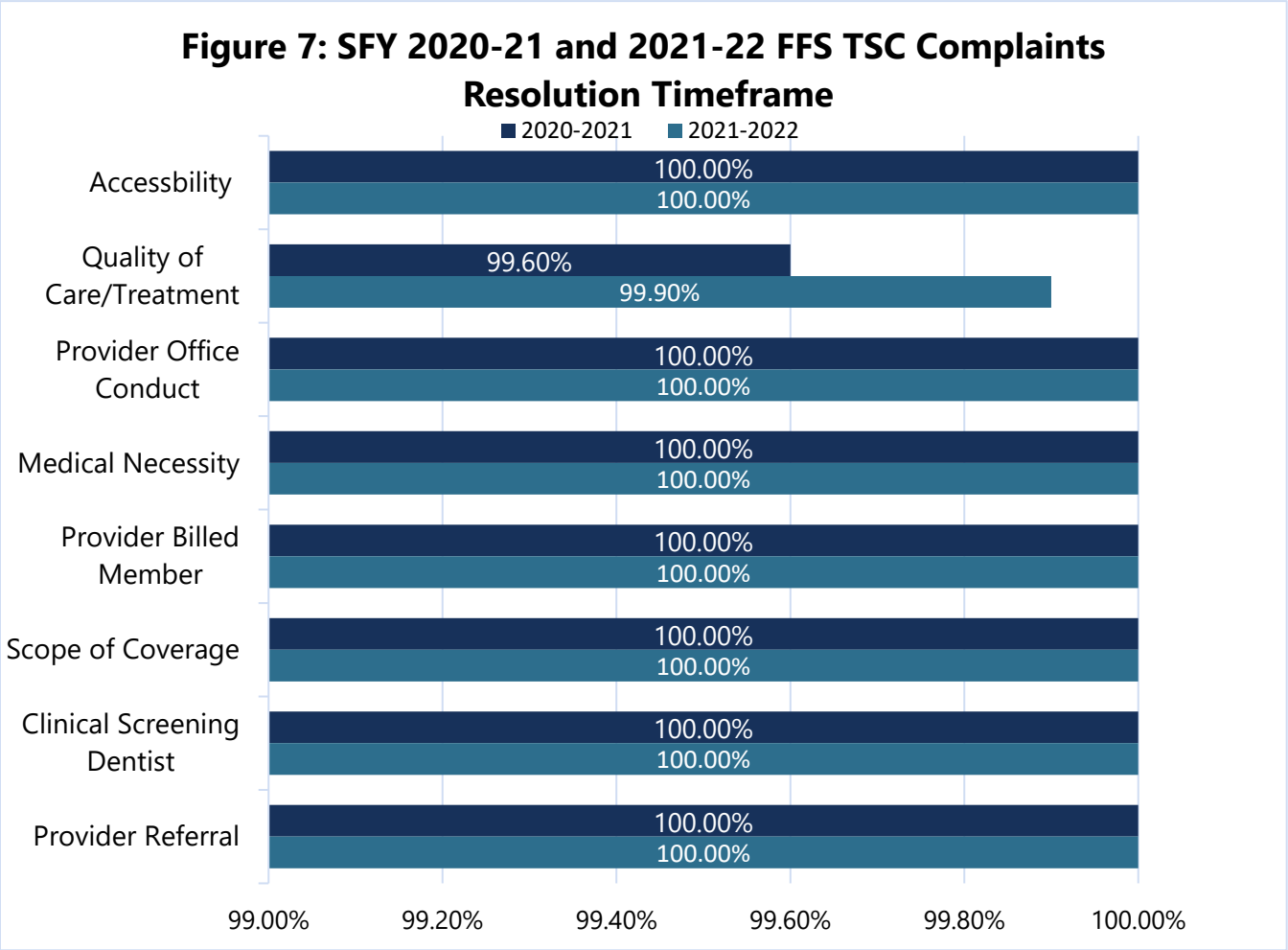
Dental FFS Complaints Resolved

Figure 6 titled Percentage of TSC Complaints Resolved within 30 days by Quarter for SFY 2020-21 and SFY 2021-22 indicates the percent of complaints resolved within 30 days at the end of each quarter for the measurement period.

Figure 6: Percentage of TSC Complaints Resolved within 30 days by Quarter for SFY 2020-21 and SFY 2021-22

Quarter	Resolution Percentage SFY 2020-21	Resolution Percentage SFY 2021-22	Percent Change
Quarter 1 (July-September 2021)	99.60%	99.90%	+0.30%
Quarter 2 (October-December 2021)	99.50%	100.00%	+0.50%
Quarter 3 (January-March 2022)	99.50%	100.00%	+0.50%
Quarter 4 (April-June 2022)	100.00%	100.00%	0.00%

Figure 7 titled SFY 2020-21 and 2021-22 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.



Data Source: FFS Complaint Deliverables from July 2020 to June 2021 and July 2021 to June 2022.

All TSC complaints are required to be resolved within 30 days from the day they were received, according to the ASO contract. 4,231 out of the 4,232 complaints received during SFY 2021-22 were resolved within 30 days, except for 1 case in the "Quality of Care/Treatment" category, which was resolved in 33 days due to the additional documentation/screening requirement. This data does not include rollover complaints from the previous quarter in order 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; 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 Office Conduct", "Medical Necessity", "Provider Billed Member", and "Scope of Coverage" are newly added DMC categories to align with the FFS categories. See Figure 8 below for crosswalk of subcategories that have been moved to the updated list of DMC categories:

Figure 8: FFS and DMC Category 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:** Conlan **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 2020-21 report[2], the DMC plans recorded a total of 2,661 complaints, which excluded Conlans, State Hearing Cases, and appeals. The 2020-2021 data has been updated in this report to include State Hearings, Conlans, and appeals to allow for better comparison to the SFY 2021-22 data. The updated complaints total for SFY 2020-2021 is 4,041. State Hearings and appeals were added to the "Scope of Coverage" category and Conlans were added to "Provider Billed Member".

Figure 9 titled Number of Complaints by DMC Plan for SFY 2020-2021 and SFY 2021-2022, shows the number of complaints recorded by each DMC plan. Based on the data,

[2] SFY 2020-2021 Medi-Cal Dental Complaints and Grievances Report

Access Dental Plan recorded the highest number of complaints in both GMC and PHP. DHCS will be conducting additional follow-up with Access Dental Plan to learn why the plan has the least amount of enrollment but double the amount of member complaints compared to other plans.

Figure 9: Number of Complaints by DMC Plan for SFY 2020-2021 and SFY 2021-2022

Delivery System	Access			Health Net			Liberty		
Measurement Year	SFY 20-21	SFY 20-22	Percent Change	SFY 20-21	SFY 20-22	Percent Change	SFY 20-21	SFY 20-22	Percent Change
GMC	745	1,391	+86.70%	610	659	+8.00%	653	809	+23.90%
PHP	540	947	+75.40%	1,037	949	-8.50%	456	389	-14.70%
Plan Total	1,285	2,338	+81.90%	1,647	1,608	-2.40%	1,109	1,198	+8.00%

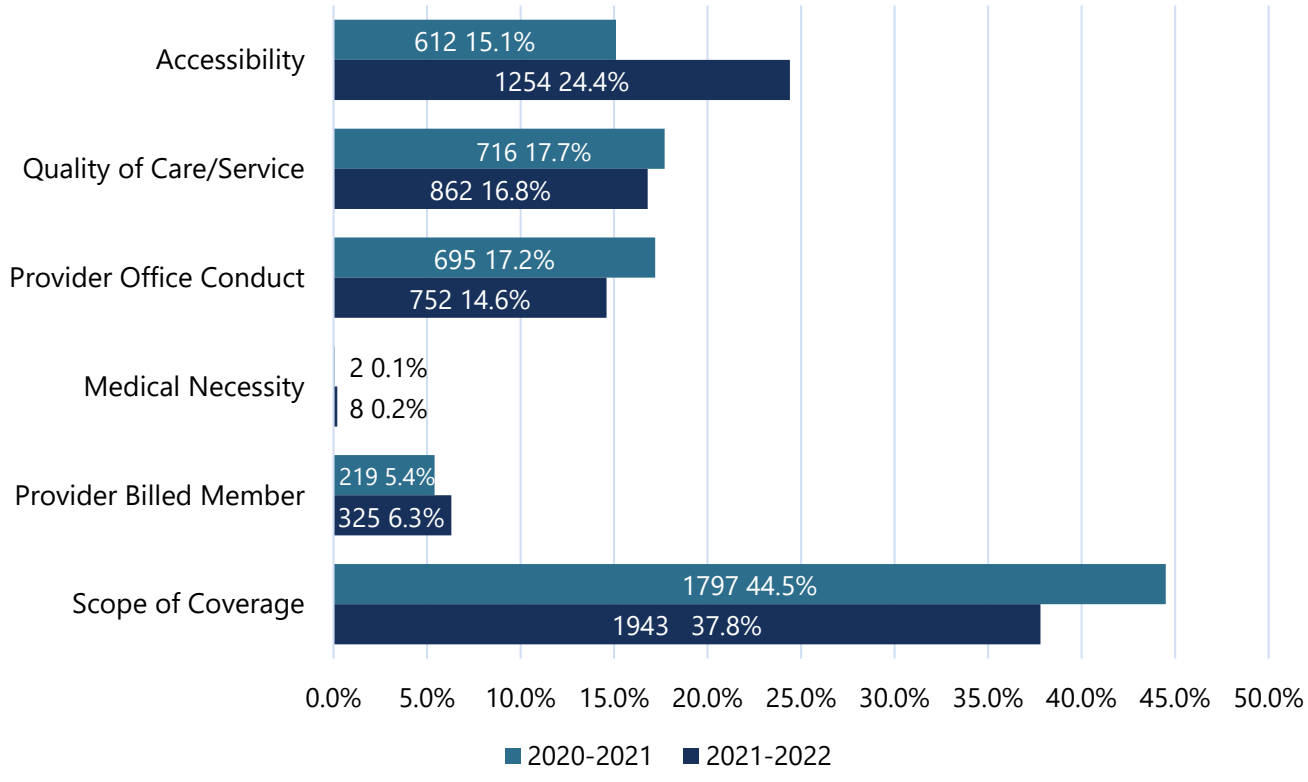
Figure 10 titled Number of Complaints by DMC Members for SFY 2020-2021 and 2021-2022 shows the percentage of complaints in GMC and PHP as a ratio to members. Note that "members" are those who were enrolled in the same plan for at least 90 continuous days during the indicated reporting period. Access Dental Plan has the highest member-to-complaint ratio in both GMC and PHP when compared to other plans during SFY 2021-2022.

Figure 10: Number of Unduplicated Complaints by DMC Members for SFY 2020-2021 and 2021-2022

Complaints	Access			Health Net			Liberty		
Measurement Year	SFY 20-21	SFY 21-22	Percent Change	SFY 20-21	SFY 21-22	Percent Change	SFY 20-21	SFY 21-22	Percent Change
GMC Complaints	745	1391	86.71%	610	659	8.03%	653	809	23.89%
GMC Members	146,023	154,827	6.03%	157,419	173,060	9.94%	188,875	203,395	7.69%
GMC Complaints to Member	0.51%	0.90%	76.47%	0.39%	0.38%	-2.56%	0.35%	0.40%	14.29%
PHP Complaints	540	947	75.37%	1037	949	-8.49%	456	389	-14.69%
PHP Members	143,832	141,592	-1.56%	206,771	222,109	7.42%	73,358	80,890	10.27%
PHP Complaints to Member	0.38%	0.67%	76.32%	0.50%	0.43%	-14.00%	0.62%	0.48%	-22.58%

Figure 11 titled SFY 2020-21 and 2021-22 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 2021-22, most DMC complaints were related to "Scope of Coverage" at 37.8 percent, followed by the "Accessibility" category at 24.4 percent, the "Quality of Care/Service" the "Provider Office Conduct" category at 14.6 percent, the "Provider Billed Member" at 6.3 percent, and the "Medical Necessity" category at 0.2 percent. The "Accessibility" category complaints increased by 104.9 percent as dental offices have seen a spike in members returning, and "Provider Billed Member" increased by 48.4%.

Figure 11: SFY 2020-21 and 2021-22 DMC Complaints by Category

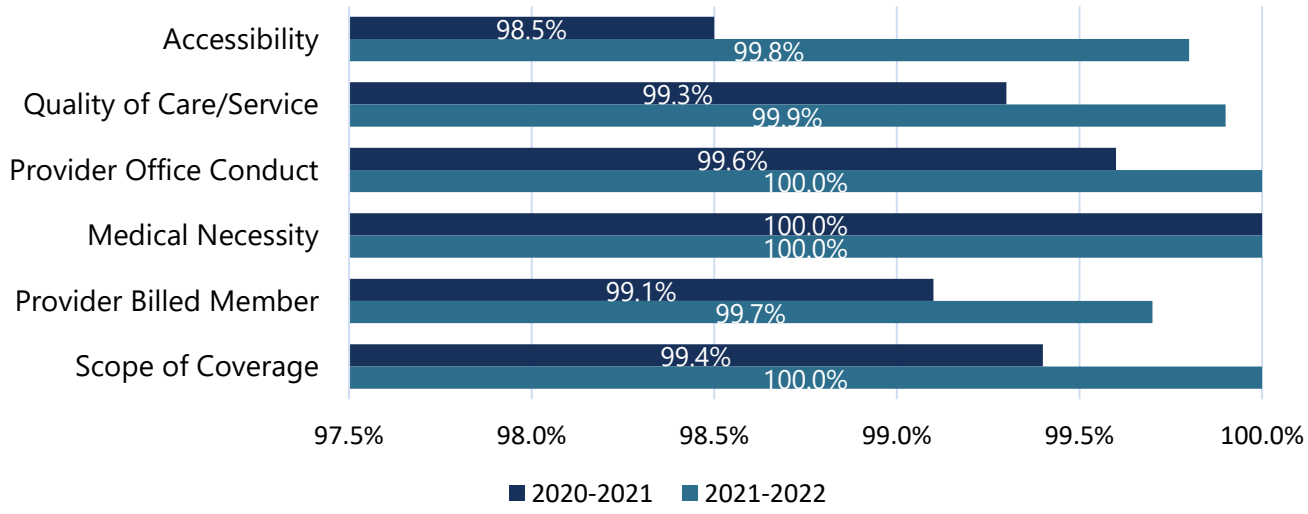


Data Source: DMC Complaint Deliverables from July 2020 to June 2021 and July 2021 to June 2022.

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 12 below does not include the 68 State Hearing cases received in SFY 2020-2021 and the 36 State Hearing Cases received in SFY 2021-2022, as State Hearings have their own separate resolution timelines. All the complaints were resolved by the end of the reporting period and 99.9 percent of the 5,108 complaints were resolved within 30 days. The turnaround time for the remaining 0.3 percent complaints varied between 31 to 34 days because of the additional time needed to gather and review documentation from members and/or providers. Resolution turnaround time for SFY 2020-21 ranged from 0 to 34 days with an average processing time of 9.6 days. Resolution and turnaround times have improved across all the dental plans when compared to the previous SFY.
Figure 12 titled Percent of DMC Complaints Resolved Within 30 Days for SFY 2020-21 and SFY 2021-2022 shows the percentage of complaints in each category that are resolved within 30 calendar days from date of receipt.

Figure 12: Percent of DMC Complaints Resolved Within 30 Days for SFY 2020-21 and SFY 2021-2022

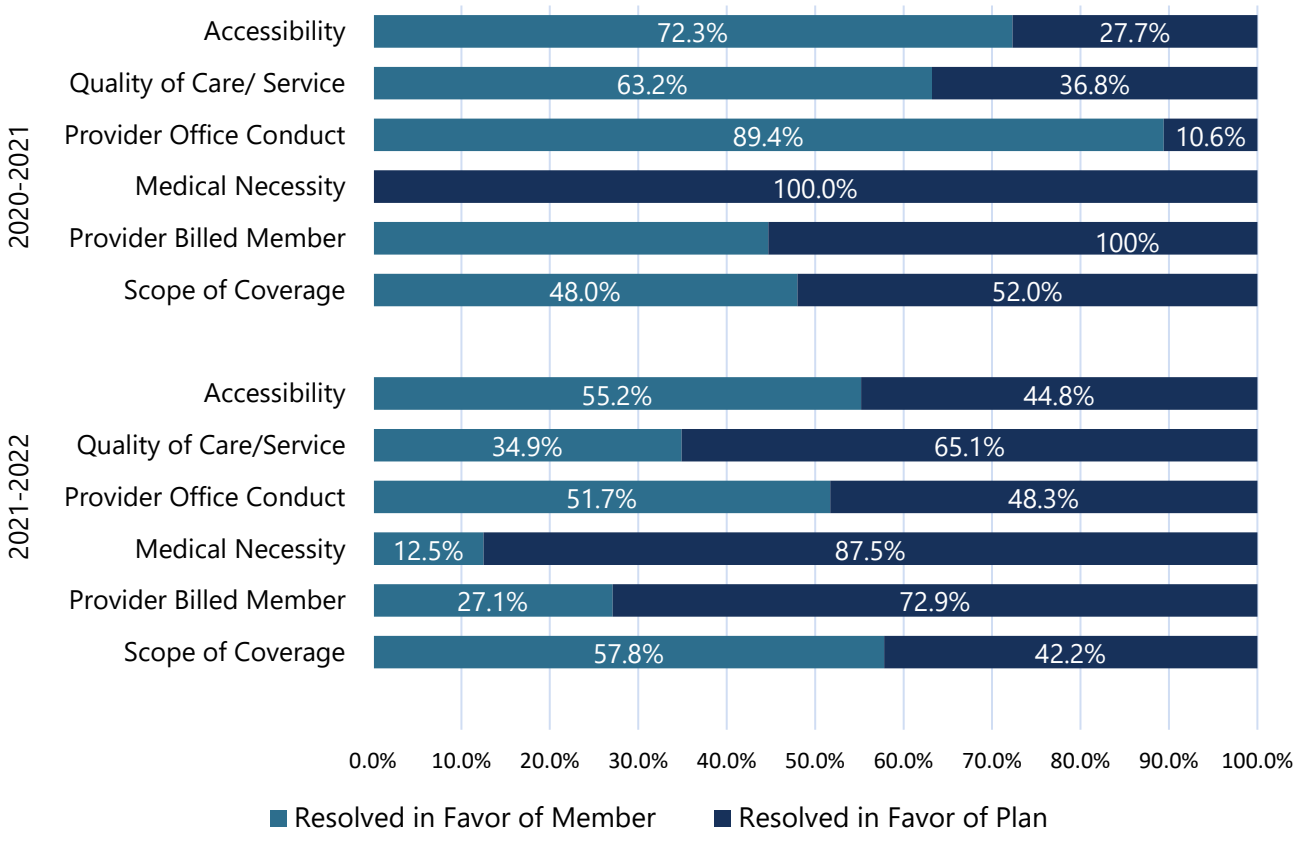


Data Source: DMC Complaint Deliverables from July 2020 to June 2021 and July 2021 to June 2022.

Figure 13 titled SFY 2020-2021 and 2021-2022 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

5,108 total resolved complaints across all categories, 50.4 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 2021-2022 57.8% of "Scope of Coverage", 55.2 percent of "Accessibility", and 51.7 percent of the "Provider Office Conduct" category were resolved in favor of members. During SFY 2021-22, 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 13: SFY 2020-2021 and 2021-2022 DMC Complaint Resolution by Outcome



Data Source: DMC Complaint Deliverables from July 2020 to June 2021 and July 2021 to June 2022.