CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Department of Health Care Services

Medi-Cal Dental Services

Complaints and Grievances Report

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Reporting Period: State Fiscal Year 2020-2021

Submitted by the
California Department of Health Care Services

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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, 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 State Fiscal Year (SFY) 2020-21, which covers the period from July 1, 2020 through June 30, 2021. This report does not include cases opened in the previous SFYs or 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*. Dental FFS complaints and grievances are collected by the Administrative Services Organization (ASO) contractor and DMC complaints and grievances are collected by six DMC plans (three plans in Sacramento County and three plans in Los Angeles County). The ASO and the contracted plans report their complaints and grievances data to DHCS on a quarterly basis.

Figure 1, titled *SFY 2020-21 Medi-Cal Dental Complaints by Delivery System* shows the total number of complaints and total number of members by delivery system for SFY 2020-21. During SFY 2020-21, the ASO used updated action codes in all complaint categories to differentiate counts of complaints and inquiries. Therefore, complaints in Dental FFS decreased from the last SFY. Complaints for DMC increased, particularly in one plan as a result of improvements made to their reporting to align with DHCS' standards.

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

Delivery System	Number of Members*	Number of Complaints	Percentage of Complaints to Members	Percentage of Total Complaints
Dental FFS	12,214,861	3,399	0.03%	56.1%
DMC	916,278	2,661	0.29%	43.9%
Total	**13,131,139**	**6,060**	**0.05%**	**100.0%**

** Full scope Medi-Cal members who were enrolled in the same plan for at least 90 continuous days during the SFY 2020-21. Enrollment data as of November 2021 from the DHCS MIS/DSS Warehouse.*

Key Findings

Dental FFS

- Of the total complaints received, 77.8 percent of complaints recorded for Dental FFS were related to “Quality of Care/Treatment”, which included services rendered (i.e., ill-fitting dentures).
- The second and third highest complaints, were for the “Provider Office Conduct” at 20 percent and “Accessibility” at 0.8 percent. All eight other complaint categories constituted to 1.4 percent of the total complaints.
- Among the 3,399 complaints, 99.7 percent were resolved within 30 days in all categories with the exception of Quality of Care/Treatment where 11 cases were resolved within 33 days.

DMC

- The majority of complaints recorded for DMC were related to “Quality of Care/Service”, which was 48 percent of the total number of complaints received.
- The next highest complaint was for the “Other” category at 29.9 percent, followed by the third highest “Accessibility” category at 22.1 percent of the total complaints received.
- Among the 2,661 unduplicated complaints, 99.1 percent were resolved within 30 days. 23 cases across categories took longer than 30 days but were resolved within 67 days. Among the 2,667 total resolved complaints for all categories (duplication may exist if complaint falls in two different categories), 75.3 percent were resolved in favor of Medi-Cal members.

Medi-Cal Dental Delivery System Background

In SFY 2020-21, there were approximately 13.0 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), and processing FFS member complaints statewide. In Sacramento County, DMC enrollment is mandatory, and in Los Angeles County, DMC enrollment is optional. DHCS contracts with three Geographic Managed Care (GMC) Plans in Sacramento County and three Prepaid Health Plans (PHP) in Los Angeles County to provide DMC services to Medi-Cal members. DMC is administered through contracts with Access, Health Net, and LIBERTY, who are licensed by the Department of Managed Health Care. DMC plans’ functions include operating member services phone lines to process member complaints.

Definition of Complaints and Grievances

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, 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”.

Dental FFS Complaints

For SFY 2020-21, the ASO completed all proposed changes to the categories and reporting requirements to accurately capture and label complaints data. These changes included differentiating counts of complaints versus inquiries using appropriate action codes and additional training to the TSC agents to accurately label complaints as opposed to inquiries. The following are the complaint categories captured during SFY 2020-21:

- **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.

- **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.

- **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.

- **Provider Office Conduct:** Complaint regarding the behavior of non-clinical staff (not a dentist or hygienist) at a dental office.

- **Provider Referral:** Complaint related to the provider a member was referred to by ASO Customer Service.

- **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 (i.e., ill-fitting dentures).

- **Scope of Coverage:** Complaint regarding Medi-Cal dental benefits that the individual is eligible for, given their aid code.

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	1,395
By Telephone	2,004
Total	**3,399**

In SFY 2020-21, the ASO received complaints by telephone and mail. According to the ASO, complaints received were frequently handled by telephone using a TSC Service Form. The TSC procedure is to create a unique service form for each call. If the member has a complaint regarding more than one issue, the service form would be populated to capture each of the complaints. For SFY 2020-21, there were a total of 3,399 complaints; of those, 1,395 were received by mail and 2,004 were by telephone.

In addition, when a “Quality of Care/Treatment” complaint was not resolved by telephone, TSC agents referred it to the correspondence unit for further research and closed out the complaint. When the correspondence unit receives the referral, a new complaint is opened and member is contacted to resolve the compliant. This method was only applied to “Quality of Care/Treatment” complaints. All other telephone complaints were handled by TSC agents. At this time, the ASO does not have the capability of using the same tracking number for complaints that were referred from TSC to the correspondence unit. As a result, some of the total number of complaints in SFY 2020-21 could be duplicates. However, DHCS has initiated the work to request

changes in the ASO's reporting requirements to eliminate duplication in these escalated complaints for the next SFY report.

Figure 3 titled *SFY 2020-21 FFS Complaints per Quarter Submitted* shows the quarterly breakdown by category for both mail and telephone complaints in order of greatest to least.

Figure 3: SFY 2020-21 FFS Complaints per Quarter Submitted

Category	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Quality of Care/Treatment	537	623	690	795	**2,645**
Provider Office Conduct	172	147	159	202	**680**
Accessibility	3	11	4	8	**26**
Provider Billed Member	5	12	1	0	**18**
Clinical Screening Dentist	0	4	3	10	**17**
Provider Referral	3	2	0	2	**7**
Scope of Coverage	0	1	2	1	**4**
Medical Necessity	1	0	1	0	**2**
Total	**721**	**800**	**860**	**1,018**	**3,399**

In the previous SFY, complaints in the "Scope of Coverage", "Provider Billed Member", and "Medical Necessity" categories included both inquiries and complaints, which were remediated during SFY 2020-21 contributing to the overall decrease in complaints when compared with the previous SFY. During SFY 2020-21, a majority of FFS complaints were regarding "Quality of Care/Treatment" with 77.8 percent of the total complaints. Compared with the previous SFY, "Quality of Care/Treatment" complaints decreased by approximately 35.6 percent likely due to the lower number of overall complaints recorded and the outreach efforts by the ASO in reaching out to providers on these issues.

The second most frequent complaint category is "Provider Office Conduct" at 20.0 percent, followed by the "Accessibility" category at 0.8 percent of the total complaints received. The other complaints included "Provider Billed Member" 0.5 percent, "Clinical Screening Dentist" 0.5 percent, "Provider Referral" 0.2 percent, "Scope of Coverage" 0.1 percent and "Medical Necessity" 0.1 percent.

Resolution of Dental FFS Complaints

Figure 4 titled *Percentage of Complaints Resolved within 30 days* indicates the percent of complaints resolved within 30 days at the end of each quarter for SFY 2020-21.

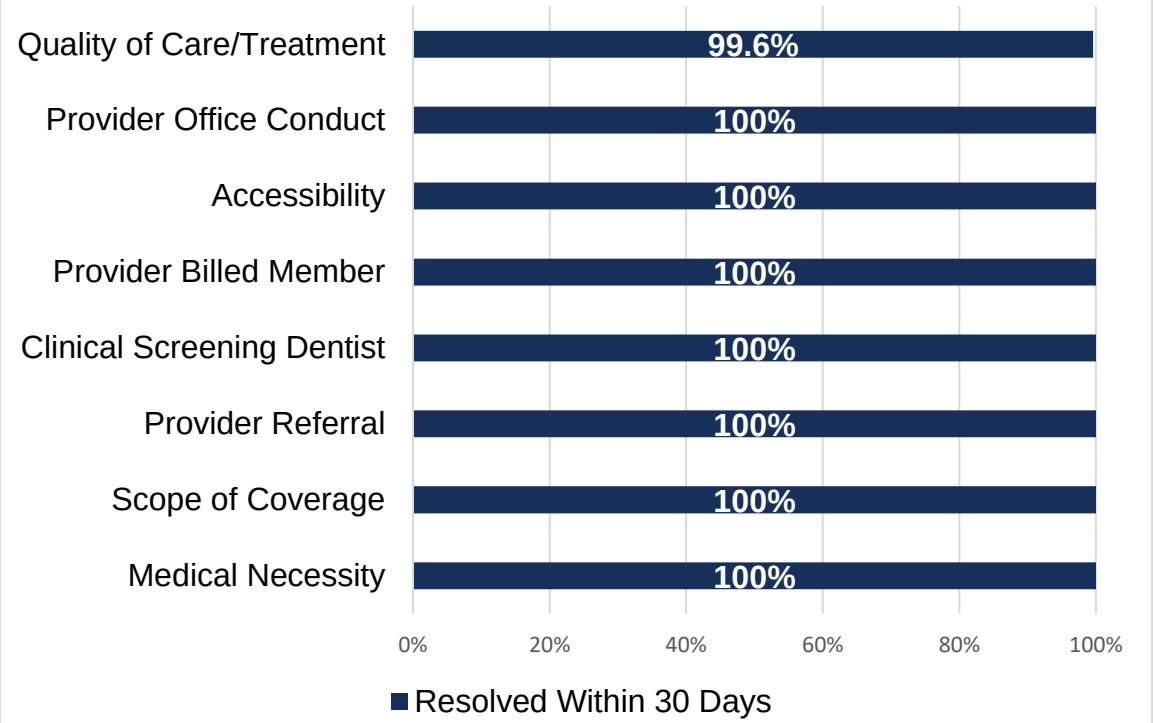
Figure 4: Percentage of Complaints Resolved within 30 days

Quarter	Resolution Percentage
Quarter 1	99.6%
Quarter 2	99.5%
Quarter 3	99.5%
Quarter 4	100.0%

All complaints are required to be resolved within 30 days from the day they were received according to the ASO contract. For SFY 2020-21, on average 99.7 percent of the complaints were resolved within 30 days. 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 complaints initiated by the member. Cases that went over 30 days were due to additional documentation/screening required.

Figure 5 titled *SFY 2020-21 FFS Complaints Resolution Timeframe* indicates the percent of complaints resolved within 30 days at the end of SFY 2020-21.

Figure 5: SFY 2020-21 FFS Complaints Resolution Timeframe



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

Complaints in all categories were resolved by the end of the reporting period. One hundred percent of the complaints in all categories were resolved within 30 days with the exception of “Quality of Care/Treatment” category. Complaints in the “Quality of Care/Treatment” category required more time to gather and review information from members and/or providers compared to other categories; therefore, 11 cases in this category took longer than 30 days but were resolved within 33 days. Resolution turnaround time for SFY 2020-21 ranged from 0 to 33 days with an average processing time of 6.90 days. Overall, 99.7 percent were resolved within the required timeframe in all categories.

DMC Complaints

DMC plans categorized complaints 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; and lack of facility physical access.

- **Quality of Care/Service:** Complaints regarding inadequate facilities, non-access related; inappropriate provider care; plan denial of treatment; provider denial of treatment; and poor provider/staff attitude.

- **Other:** All other categories outside the ones described above are included in this category, including complaints related to second level complaints, expedited complaints, provider referral delays, eligibility, and administrative issues.

In SFY 2020-21, the DMC plans recorded a total of 2,661 unduplicated complaints. Figure 6 titled *Number of Unduplicated Complaints by DMC Plan* shows the unduplicated number of complaints recorded by each DMC plan.

Figure 6: Number of Unduplicated Complaints by DMC Plan

DMC Plans	GMC	PHP	Plan Total	Percentage of Total DMC Complaints
Access	614	486	1,100	41.3%
Health Net	364	659	1,023	38.4%
LIBERTY	358	180	538	20.2%
Total	**1,336**	**1,325**	**2,661**	**100.0%**

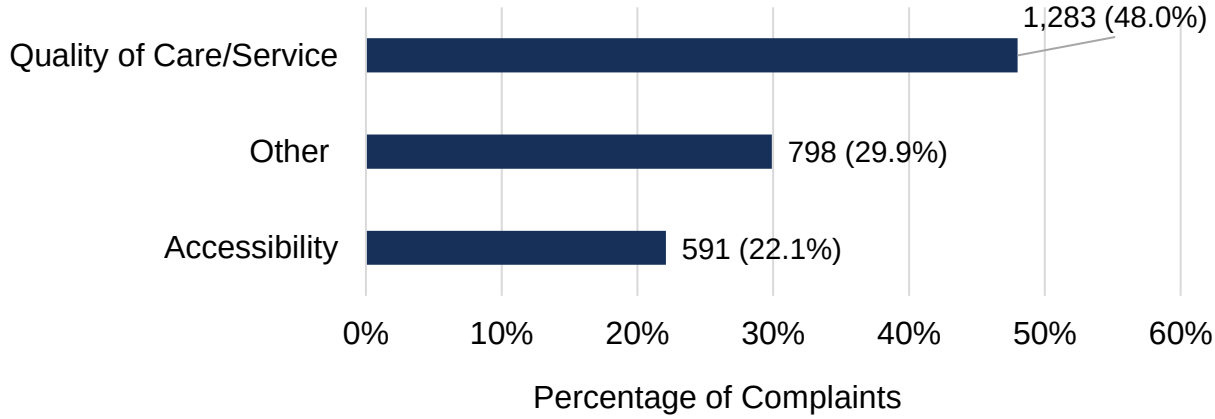
Figure 7 titled *Number of Unduplicated Complaints by DMC Members* shows the percentage of complaints in GMC and PHP as a ratio to members. Note that members are those who were enrolled in the same plan for at least 90 continuous days during the SFY 2020-21. Based on the data, member to complaint ratio in PHP is slightly higher than GMC.

Figure 7: Number of Unduplicated Complaints by DMC Members

Category	Access	Health Net	LIBERTY	Total
GMC Complaints	614	364	358	1,336
GMC Members	146,023	157,419	188,875	492,317
GMC Complaints to Member	**0.42%**	**0.23%**	**0.19%**	**0.27%**
PHP Complaints	486	659	180	1,325
PHP Members	143,832	206,771	73,358	423,961
PHP Complaints to Member	**0.34%**	**0.32%**	**0.25%**	**0.31%**

Figure 8 titled *SFY 2020-21 DMC Complaints by Category* shows the relative proportion of complaints by each category. The unduplicated complaints only capture number of complaints filed, not the number of members. If a member has two separate complaints, the complaints are counted twice in this table. In the event that a complaint falls into multiple categories, each complaint was counted and placed into the applicable category to reflect the total percentage, which may result in duplication. During SFY 2020-21, the majority of DMC complaints were related to “Quality of Care/Service” with a total of 1,283 complaints. Subsequently, the other types of DMC complaints were related to the “Other” category with 798 complaints, while the “Accessibility” category had 591 complaints. Compared with SFY 2019-20, complaints in “Quality of Care/Service” category increased by approximately 20.6 percent, “Other” category complaints increased by 4.6 percent, and “Accessibility” complaints increased by 38.1 percent. This increase was largely driven by Access Dental Plan reporting improvements made to accurately track and report grievances per DHCS’ standards.

Figure 8: SFY 2020-21 DMC Complaints by Category



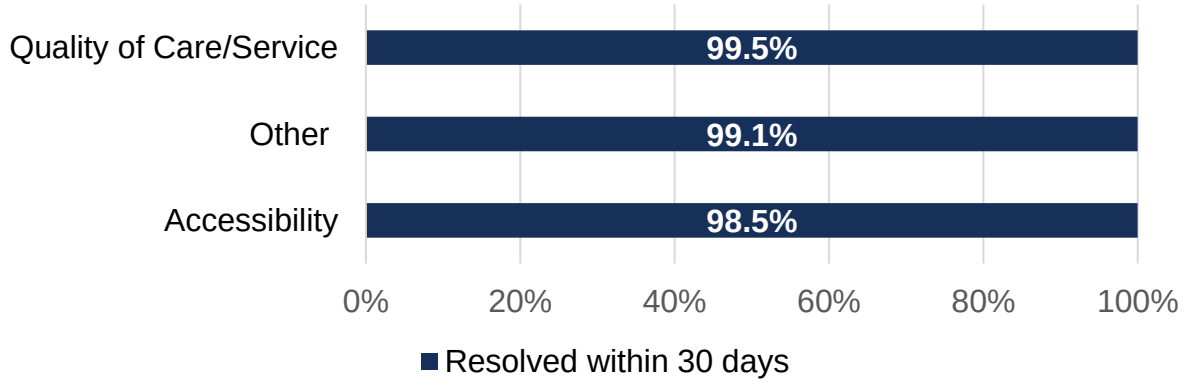
Data Source: DMC Complaint Deliverables from July 2020 to June 2021.

Resolution of DMC Complaints

DMC plans are required to provide a written acknowledgement to the member within 5 calendar days, and resolve the complaint no later than 30 calendar days from the date of receipt. During SFY 2020-21, 99.1 percent of the 2,661 complaints were resolved within 30 days. The turnaround time for the remaining 0.9 percent complaints varied between 31 to 67 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 67 days with an average processing time of 16.72 days.

Figure 9 titled *SFY 2020-21 DMC Complaint Resolution Timeframe* shows the percentage of complaints in each category that are resolved within 30 calendar days from date of receipt. Most complaints that were not resolved within 30 days are from Access Dental Plan.

Figure 9: SFY 2020-21 DMC Complaint Resolution Timeframe

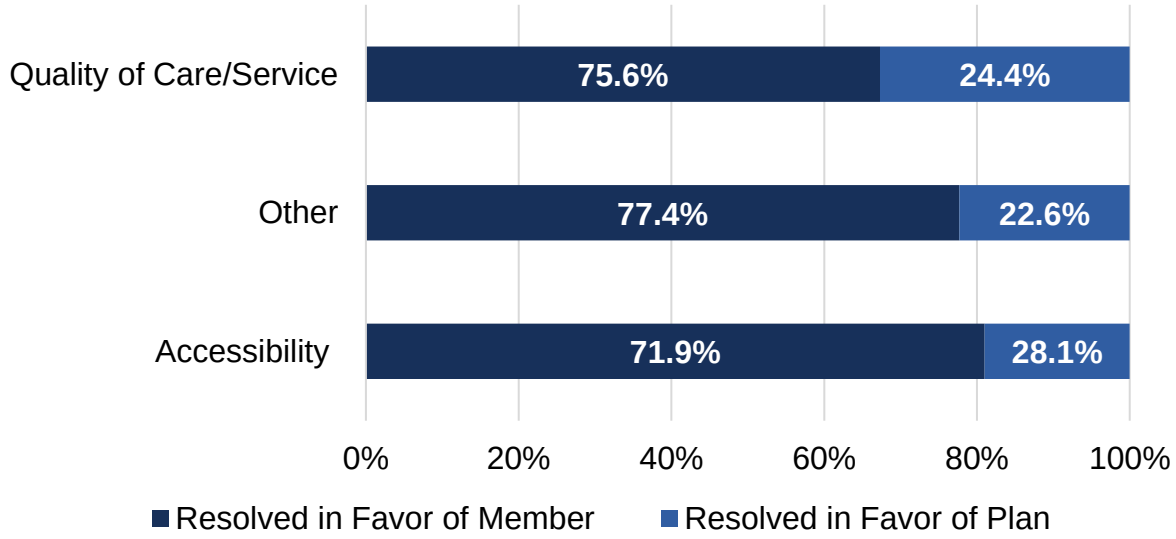


Data Source: DMC Complaint Deliverables from July 2020 to June 2021.

Figure 10 titled *SFY 2020-21 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 2,667 total resolved complaints across all categories, 75.3 percent of the complaints were resolved in favor of members over the DMC plans. “Quality of Care/Service” category percentage was split between 75.6 percent in favor of members and 24.4 percent in favor of plans. Similarly, 77.4 percent of “Other” and 71.9 percent of cases in “Accessibility” category were resolved in favor of members. Five complaints were unresolved by the end of the reporting period. Tracking the outcome in favor of the member helps DHCS to further evaluate DMC performance and address quality of care as well as service-related

issues. Furthermore, DMC plans are required to track the outcome of complaints in accordance with federal law. During SFY 2020-21, DMC plans have initiated several efforts to address high grievances, such as providing additional resources/education to providers to reduce quality of care complaints pertaining to dentures and crowns.

Figure 10: SFY 2020-21 DMC Complaint Resolution by Outcome



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