



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

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Reporting Period: State Fiscal Year 2019-2020

**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 Managed Care (DMC) and dental Fee-For-Service (FFS) delivery systems, during State Fiscal Year (SFY) 2019-20, which covers the period from July 1, 2019 through June 30, 2020. This report does not include cases opened in the previous SFYs. 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*. 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, three plans in Los Angeles County). All contracted plans and the ASO report their complaints and grievances data to DHCS on a quarterly basis. In SFY 2019-20, the ASO contractor configured their call center software to align with DHCS' requirement on reporting and added Accessibility as a new complaint category.

Figure 1, titled *SFY 2019-20 Medi-Cal Dental Complaints by Delivery System*, shows the total number of complaints and total number of members by delivery system for SFY 2019-20.

**Figure 1: SFY 2019-20 Medi-Cal Dental Complaints by Delivery System**

<b>Delivery System</b>	<b>Number of Members*</b>	<b>Number of Complaints</b>	<b>Percentage of Complaints</b>
DMC	901,996	2,245	25.8%
Dental FFS	11,946,744	6,446	74.2%
<b>Total</b>	<b>12,848,740</b>	<b>8,691</b>	<b>100%</b>

*\*Represents members who were enrolled in the same plan for at least 90 continuous days during the SFY 2019-20 who have full scope no cost Medi-Cal. Enrollment data is current as of December 2020 from the DHCS MIS/DSS Warehouse.*

## Key Findings

### DMC

- The majority of complaints recorded for DMC were related to Quality of Care/Service at 47.2 percent of the total number of complaints received.
- The Other category, which included second level complaints, appeals, expedited complaints, eligibility, and administrative issues was at 33.8 percent and the Accessibility category was at 19.0 percent of the total complaints received.
- Among the 2,249 resolved complaints by each category, 73.4 percent of the complaints were resolved in favor of Medi-Cal members over the DMC plans.
- The Quality of Care/Service category percentage was split between 67.3 percent in favor of members and 32.7 percent in favor of plans; and 81.0 percent of Accessibility and 77.7 percent of cases in the Other category were resolved in favor of members. Six complaints were unresolved.

### Dental FFS

- The majority of complaints recorded for Dental FFS were related to Quality of Care/Treatment, which included services rendered (i.e., ill-fitting dentures), at 63.7 percent.
- The other categories of complaints were related to Scope of Coverage at 21.4 percent, Provider Office Conduct at 8.6 percent, Provider Billed Member at 4.7 percent, Clinical Screening Dentist at 0.9 percent, Accessibility at 0.5 percent, Provider Referral at 0.1 percent and Medical Necessity at 0.1 percent.
- Among the 6,446 complaints, 98.4 percent were resolved within 30 days. All complaints were resolved within 30 days in the Clinical Screening Dentist, Accessibility, Provider Referral, and Medical Necessity categories. Two complaints were unresolved.

### Medi-Cal Dental Delivery System Background

In SFY 2019-20, there were 12.8 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. 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 DMC plans; Access, Health Net and LIBERTY, licensed by the Department of Managed Health Care. DMC plans operate member services phone lines to process member complaints.

Since January 29, 2018, when the ASO contract became operational, the ASO contractor has been responsible for administrative services, including communications with Medi-Cal dental providers and members, operating the Telephone Service Center (TSC), and processing member complaints in dental FFS.

## **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”.

## **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.

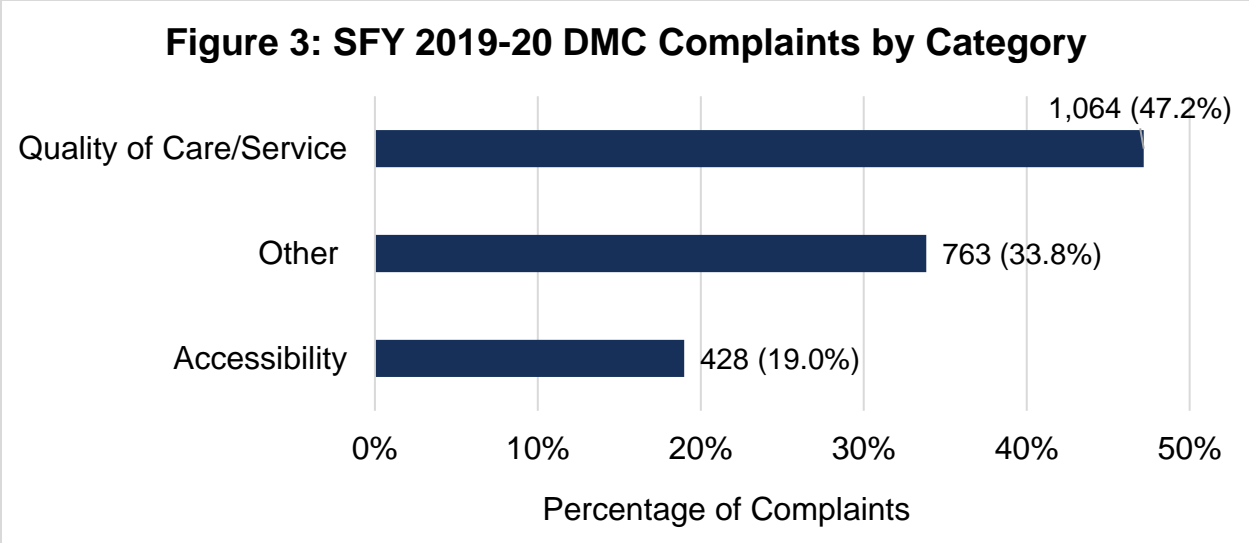
In SFY 2019-20, the DMC plans recorded a total of 2,245 unduplicated complaints.

Figure 2, titled *Number of Unduplicated Complaints by DMC Plan*, shows the unduplicated number of complaints recorded by each DMC plan.

**Figure 2: Number of Unduplicated Complaints by DMC Plan**

<b>DMC Plans</b>	<b>GMC (Sacramento County)</b>	<b>PHP (Los Angeles County)</b>	<b>Plan Total</b>	<b>Percentage of Total DMC Complaints by Plan</b>
Access	156	134	290	12.9%
Health Net	547	696	1,243	55.4%
LIBERTY	521	191	712	31.7%
<b>Total Complaints</b>	<b>1,224</b>	<b>1,021</b>	<b>2,245</b>	<b>100%</b>

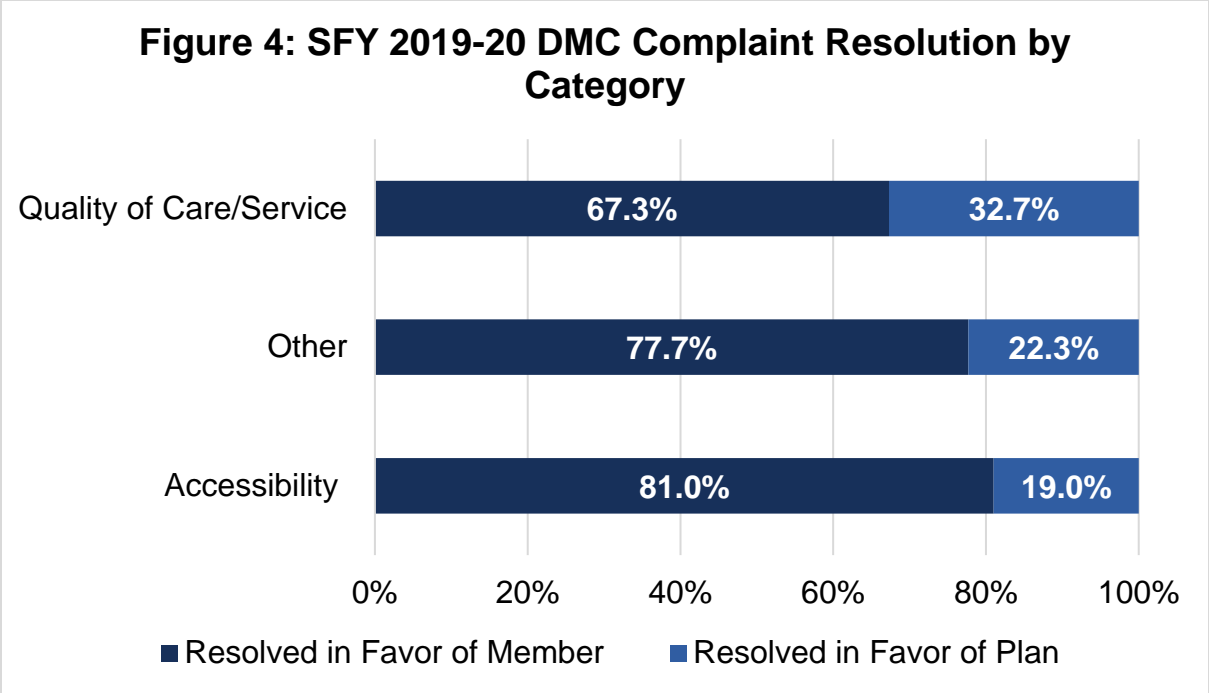
Figure 3, titled *SFY 2019-20 DMC Complaints by Category*, shows the relative proportion of complaints by each category. The unduplicated complaints only capture number of complaints filed, not the number of members. If a member has two separate complaints, the complaints are counted twice in this table. 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 2019-20, the majority of DMC complaints were related to Quality of Care/Service with a total of 1,064 complaints. Subsequently, the other types of DMC complaints were related to the Other category with 763 complaints, while the Accessibility category had 428 complaints. Compared with the last SFY 2018-19, complaints in Quality of Care/Service category increased by approximately 10.0 percent, which is mostly from one of the three DMC plans who attributed the increase to interpersonal-related quality of service complaints such as the provider’s lack of care and office staff conduct. This increase is also actively monitored by the plans to identify the providers and take necessary action. Complaints in the Other and Accessibility categories decreased by 8.7 and 27.0 percents respectively because of the less number of overall complaints recorded and the outreach efforts by DMC plans in reaching out to providers on these issues.



*Data Source: DMC Complaint Deliverables from July 2019 to June 2020.*

**Resolution of DMC Complaints**

Figure 4, titled *SFY 2019-20 DMC Complaint Resolution by Category*, shows the percentage breakdown of resolutions for each complaint category. Duplication exists when a complaint falls under two or more categories. Among the 2,249 resolved complaints by category, 73.4 percent of the complaints were resolved in favor of members over the DMC plans. Quality of Care/Service category percentage was split between 67.3 percent in favor of members and 32.7 percent in favor of plans. Similarly, 77.7 percent of Other and 81.0 percent of cases in Accessibility category were resolved in favor of members. Six 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.



*Data Source: DMC Complaint Deliverables from July 2019 to June 2020.*

**Dental FFS Complaints**

For SFY 2019-20, the ASO made changes to the categories and reporting requirements to more accurately capture and label complaints data. The ASO added the new category “Accessibility” and renamed “Provider Billed” to “Provider Billed Member”, “Office Conduct” to “Provider Office Conduct” and “Quality of Care” to “Quality of Care/Treatment. The “Miscellaneous” category was removed as it did not capture complaints. The ASO was able to differentiate counts of complaints versus inquiries using appropriate action codes for all categories except for Medical Necessity, Provider Billed Member and Scope of Coverage. The ASO will continue to refine the reports to delineate complaints versus inquiries in all categories, which will be reflected in the next report. The following are the complaint categories captured during SFY 2019-20:

- **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 5, titled *SFY 2019-20 FFS Complaints by Filing Method*, shows a breakdown of the method members used to file a complaint for SFY 2019-20.

**Figure 5: SFY 2019-20 FFS Complaints by Filing Method**

Complaint Filing Method	Number of Complaints
By Mail	1,065
By Telephone	5,381
<b>Total</b>	<b>6,446</b>

In SFY 2019-20, 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 2019-20, there were a total of 6,446 complaints; of those, 1,065 were by mail and 5,381 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 received the referral, they opened a new complaint and called the member to attempt to resolve it. This method was only applicable 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 2019-20 have duplicates.

Figure 6, titled *SFY 2019-20 FFS Complaints per Quarter Submitted*, presents the quarterly breakdown by category for both mail and telephone complaints in order of greatest to least.

**Figure 6: SFY 2019-20 FFS Complaints per Quarter Submitted**

Category	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Quality of Care/Treatment	1,204	1,170	1,189	544	4,107
Scope of Coverage*	746	272	169	192	1,379
Provider Office Conduct	132	133	180	107	552
Provider Billed Member*	87	65	81	68	301
Clinical Screening Dentist	13	9	21	15	58
Accessibility	6	3	16	8	33
Provider Referral	2	6	0	1	9
Medical Necessity*	0	0	5	2	7
<b>Total</b>	<b>2,190</b>	<b>1,658</b>	<b>1,661</b>	<b>937</b>	<b>6,446</b>

*\*Represents categories with both inquiries and complaints.*

Accessibility is the new complaint category added to the SFY 2019-20 report. Compared with the previous SFY 2018-19, FFS complaints in categories of Scope of Coverage, Provider Billed Member, and Medical Necessity increased due to the system changes and new reporting requirements that include both inquiries and complaints. DHCS is working with the ASO to refine how inquiries and complaints are captured and

anticipates providing an accurate depiction in the next SFY report. During SFY 2019-20, majority of FFS complaints were regarding Quality of Care/Treatment with 63.7 percent (4,107) of the total complaints. Compared with SFY 2018-19, Quality of Care/Treatment complaints increased by approximately 12.2 percent due to the intake process improvements, which allowed members to file complaints via phone without completing a complaint form. This likely contributed to the increase in complaints in all categories as they became easier to submit.

The second most frequent complaint category was Scope of Coverage with 21.4 percent (1,379) due to the inclusion of inquiries, followed by the Provider Office Conduct with 8.6 percent (552). The other complaints were Provider Billed Member 4.7 percent (301) which also includes some inquiries, Clinical Screening Dentist 0.9 percent (58), Accessibility 0.5 percent (33), Provider Referral 0.1 percent (9) and Medical Necessity 0.1 percent (7) with some inquiries included.

## Resolution of Dental FFS Complaints

Figure 7, titled *Percentage of Complaints Resolved within 30 days*, indicates the percent of complaints resolved within 30 days by the end of each quarter for SFY 2019-20.

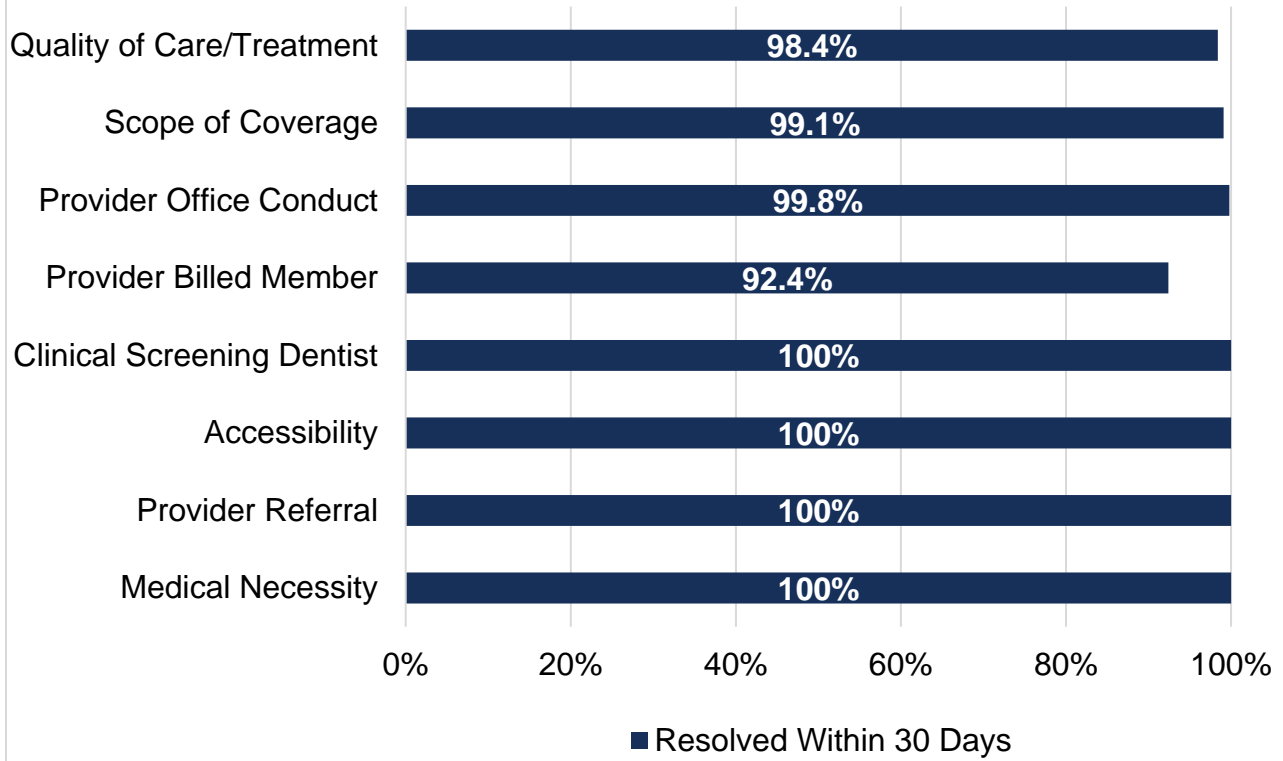
**Figure 7: Percentage of Complaints Resolved within 30 days**

Quarter	Resolution Percentage
Quarter 1	97.2%
Quarter 2	99.0%
Quarter 3	98.9%
Quarter 4	99.7%

All complaints are required to be resolved within 30 days from the day they were received. For SFY 2019-20, on an average, 98.4 percent of the complaints are resolved within 30 days. To capture an accurate snapshot of each quarter’s data, please note that this data does not include rollover complaints from the previous quarter. In general, all complaints are resolved in favor of member as these are the issues of dissatisfaction and there is no outcome in favor of the provider.

Figure 8, titled *SFY 2019-20 FFS Complaints Resolution Outcome by Category*, indicates the percent of complaints resolved within 30 days by the end of SFY 2019-20.

**Figure 8: SFY 2019-20 FFS Complaints Resolution Outcome By Category**



*Data Source: FFS Complaint Deliverables from July 2019 to June 2020.*

Two complaints under the Provider Billed Member category were unresolved by the end of the reporting period. One hundred percent of complaints in Clinical Screening Dentist, Accessibility, Provider Referral, and Medical Necessity categories were resolved within 30 days. Quality of Care/Treatment and Provider Billed Member categories require more time to obtain and review information than any other categories; therefore, 1.6 percent of the Quality of Care/Treatment and 7 percent of the Provider Billed Member cases took longer than 30 days to be resolved. Similarly, 0.9 percent of the Scope of Coverage and 0.2 percent of the Provider Office Conduct cases also took longer than 30 days. Resolution turnaround time for complaints ranged from 0 to 196 days, however, 99.1 percent were resolved within 59 days. The increase in the resolution turnaround was due to 39 complaints in the Quality of Care/Treatment and 18 complaints in the Provider Billed Member categories. Some cases in these categories require gathering more data from members and/or providers and additional time to review. Overall, 98.4 percent were resolved within the required timeframe in all categories.