Department of Health Care Services

Medi-Cal Dental Services

Complaints and Grievances Report

Prepared March 2019

Reporting Period: State Fiscal Year 2017-2018

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, including the outcome.

This report summarizes complaints and grievances received from both Medi-Cal Dental Managed Care (DMC) and dental Fee-For-Service (FFS) delivery systems, reported during State Fiscal Year (SFY) 2017-18, which covers the period from July 1, 2017 through June 30, 2018. This report does not include cases opened in 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*.

Figure 1, titled SFY *2017-18 Medi-Cal Dental Complaints and Grievances by Delivery System*, shows the total number of complaints and grievances and total number of members by delivery system for SFY 2017-18.

Figure 1: SFY 2017-18 Medi-Cal Dental Complaints and Grievances by Delivery System

Delivery System	Number of Complaints	Number of Members*
DMC	2396	988,410
Dental FFS	4657	12,400,440
Total	**7053**	**13,388,850**

*Members who were enrolled in the same DMC plan for at least 90 continuous days during the SFY with full scope and no share of cost.
*Data current as of September 2018

Key Findings

DMC

- The majority of complaints recorded for DMC were related to Quality of Care/Service, at 40 percent of the total number of complaints received. The other main categories of complaints were related to Accessibility and Other (second level complaints, appeals, expedited complaints, eligibility, and administrative issues), at 32 percent and 28 percent of the total complaints received, respectively.
- Among 2,478 resolved complaints, 70 percent of the complaints were resolved in favor of Medi-Cal members over the DMC plans. Quality of Service category percentage was evenly split, 92 percent of Accessibility and 74 percent of cases

in Other category were resolved in favor of members. Six other complaints were unresolved.

Dental FFS

- Complaints regarding Quality of Care, which included complaints regarding the services rendered (i.e., ill-fitting dentures), were the highest recorded category.
    - 55 percent of *telephone* complaints were related to Quality of Care.
    - 69 percent of *written* complaints were related to Quality of Care.
- All complaints were resolved for the following categories:
    - Provider Referral
    - Clinical Screening Dentist
    - Scope of Coverage
- Among 5,833 resolved complaints, 90 percent were resolved. Complaints regarding Quality of Services, Miscellaneous, Office Conduct, Medical Necessity, Quality of Care and Providers Billing Members had unresolved complaints at the end of SFY 2017-18.

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 2017-18 reporting period. Specifically, the FI was inconsistent in its disposition, complaint categorization, and recordkeeping 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. Through oversight and monitoring activities of the ASO, DHCS determined the ASO's complaint response process maintained many of the same deficiencies as the prior FI contract, and in March 2018, DHCS began working with the ASO contractor to mitigate and correct the deficiencies in its complaint response process. As of the end of this reporting period, the ASO contractor remediated the disposition and record keeping of complaint response deficiencies; however, the ASO was still working on a correction to the complaint category categorization. DHCS anticipates the ASO will be fully compliant in the SFY 18-19 reporting period.

Medi-Cal Dental Delivery System Background

There were 13.4 million Californians enrolled in Medi-Cal for at least three continuous months in SFY 2017-18. . 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.

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

In 2017, the Dental FI contractor administered the dental FFS delivery system and operated a Telephone Service Center (TSC), which received and processed member complaints and grievances, and provided summary reports to DHCS. 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 Medi-Cal dental providers and members, operating the TSC, and processing member complaints and grievances. The FI contractor is responsible for the California Dental Medicaid Management Information System, which processes claims and issues payments to Medi-Cal dental FFS providers.

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, 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

Beginning SFY 2017-18, DHCS removed two categories, Benefits/Coverage and Referral, from the DMC reporting template to align with the complaint data captured for dental FFS complaints. For DMC plans, complaints are now 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; and 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; 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, appeals, expedited complaints, eligibility, and administrative issues.

In SFY 2017-18, the DMC plans recorded a total of 2,396 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 DMC services to Medi-Cal members.

Figure 2: SFY 2017-18 Number of Unduplicated Complaints by DMC Plan

DMC Plan / County	Unduplicated Complaints	DMC Plan Totals
Access/Los Angeles County	109	198
Access/Sacramento County	89	
Health Net/Los Angeles County	786	1,323
Health Net/Sacramento County	537	
LIBERTY/Los Angeles County	246	875
LIBERTY/Sacramento County	629	
	Total Complaints	**2,396**

Figure 3, titled *SFY 2017-18 DMC Complaints by Category*, shows the relative proportion of complaints by each category. In the event that a complaint falls into multiple categories, each complaint was counted and placed into the applicable category to reflect the total data percentages, which may result in duplication. During this reporting period, the majority of DMC complaints were related to Quality of Care/Service with a total of 978 complaints, down from last year's total of 1,183. Subsequently, the other types of DMC complaints were related to Accessibility with 794 complaints, while the Other category had a total of 695 complaints.

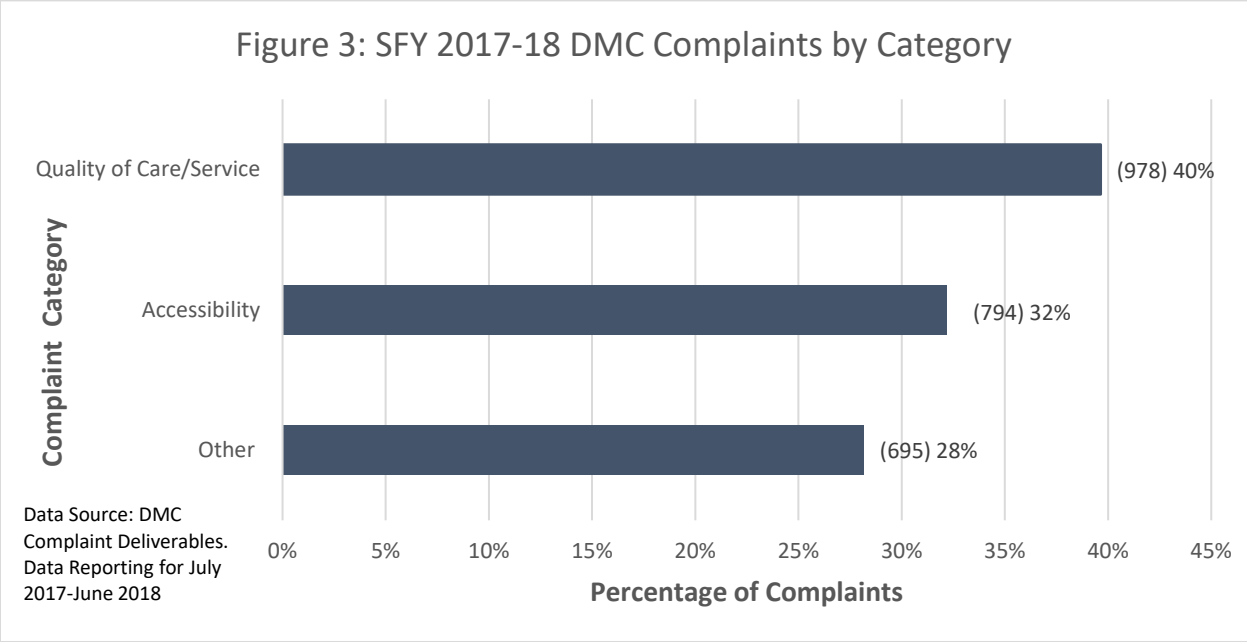
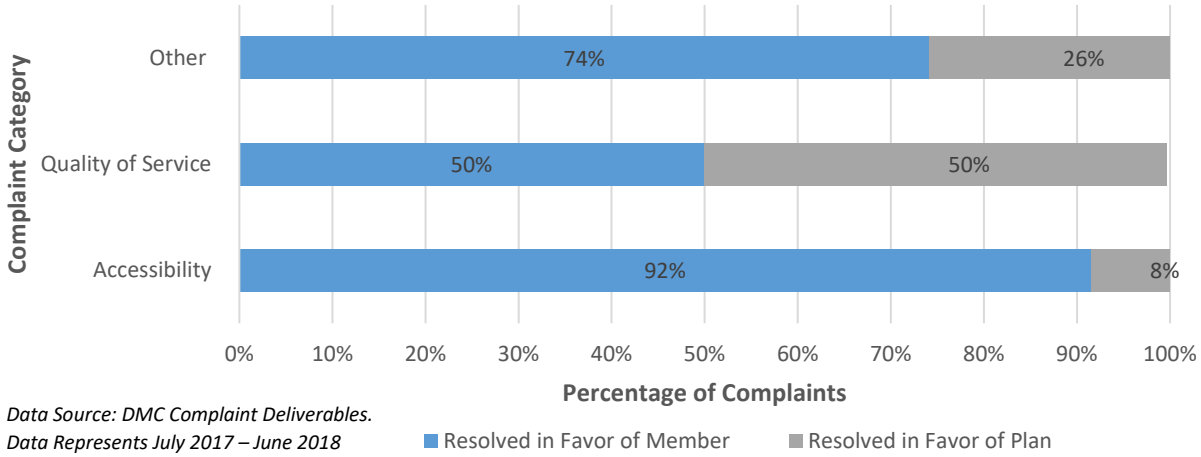


Figure 4, titled *SFY 2017-18 DMC Complaint Resolution by Category*, shows the percentage breakdown of resolutions for each complaint type. Among 2,478 resolved complaints, 70 percent of the complaints were resolved in favor of members over the DMC plans. The Quality of Service category percentage was evenly split, 92 percent of cases in the Accessibility category and 74 percent of cases in the Other category were resolved in favor members. Six other complaints were unresolved. Figure 4 displays the outcome of resolved cases.

Figure 4: SFY 2017-18 DMC Complaint Resolution by Category



Data Source: DMC Complaint Deliverables.
Data Represents July 2017 – June 2018

Dental FFS Complaints

The Dental ASO categorized complaints as follows:

- **Provider Referral:** Complaint related to the provider a member was referred to by ASO 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 (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 benefits that the individual is eligible for, given their Aid Code.

- **Provider Billed:** Complaint because a member 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 *SFY 2017-18 FFS Complaints by Category and Filing Method,* shows a breakdown of the method members used to file a complaint, by category for SFY 2017-18.

Figure 5: SFY 2017-18 FFS Complaints by Category and Filing Method		
Category	**Written**	**Telephone**
Provider Referral	8	1
Clinical Screening Dentist	0	155
Quality of Care	1,184	2,544
Office Conduct	6	166
Scope of Coverage	2	427
Provider Billed	2	251
Medical Necessity	2	8
Quality of Service	5	198
Miscellaneous	498	907
Total	**1,707**	**4,657**

In SFY 2017-18, the Dental ASO received complaints via telephone and in writing. According to the ASO process at the time, 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 processed, the total number of unduplicated complaints in SFY 2017-18 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 ASO'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 member. 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 ASO, 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 *SFY 2017-18 FFS Complaints per Quarter Submitted,* presents the quarterly breakdown by category for both written and telephone complaints in order of greatest to least.

Figure 6: SFY 2017-18 FFS Complaints per Quarter Submitted				
Category	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Quality of Care	970	891	806	1,061
Miscellaneous	269	250	419	467
Provider Billed	73	45	61	74
Quality of Service	68	39	48	48
Office Conduct	33	25	47	67
Clinical Screening Dentist	12	6	55	82
Scope of Coverage	1	0	210	218
Medical Necessity	1	0	5	4
Provider Referral	0	1	2	6
Total	**1,427**	**1,257**	**1,653**	**2,027**

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 Dental FFS Complaints

Figure 7, titled *SFY 2017 FFS Complaints Resolution Outcome by Category,* indicates the percent of complaints resolved by the end of SFY 2017-18.

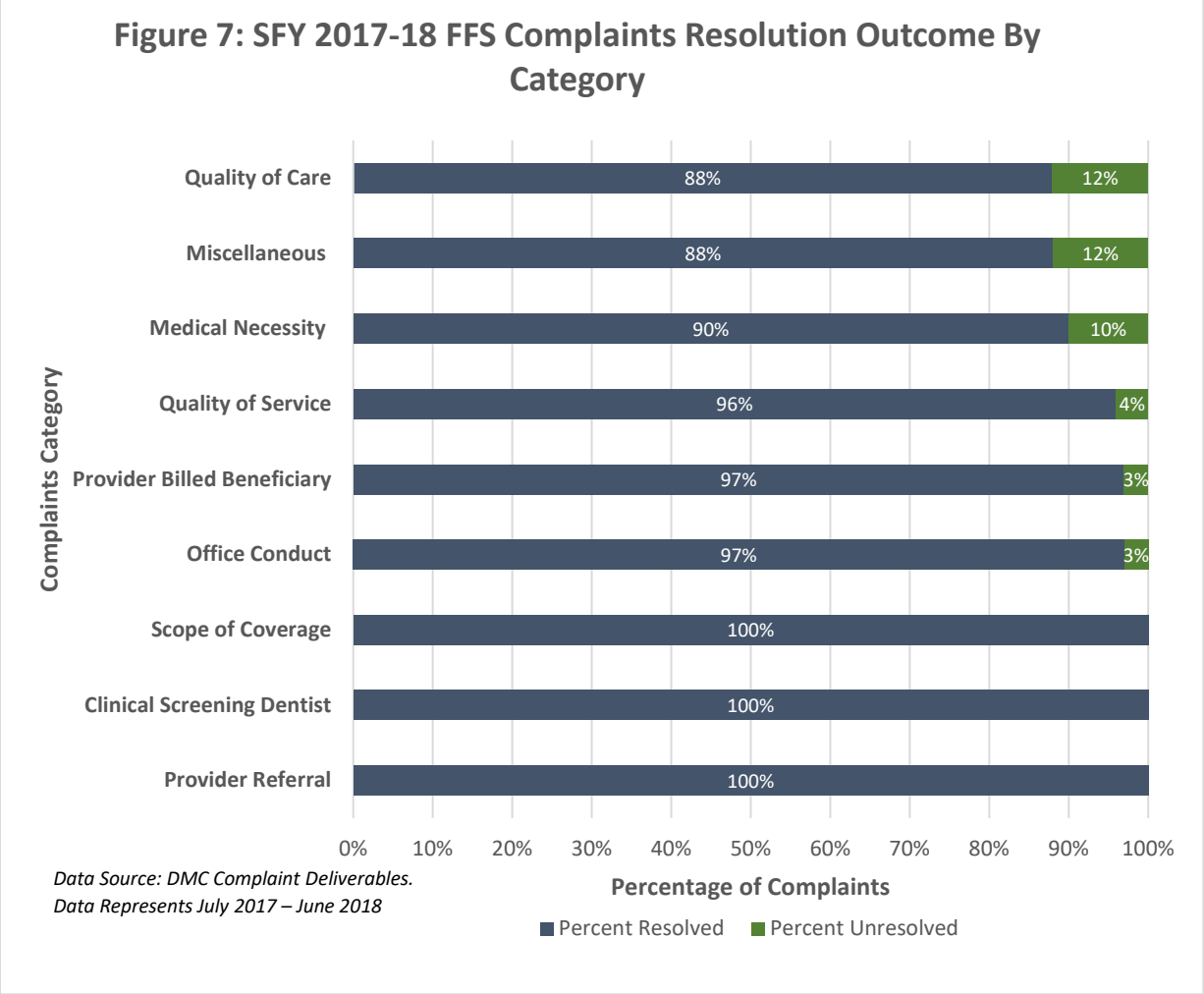


Figure 8, titled *SFY 2017-18 FFS Resolution of Complaints by Category per Quarter,* shows the percent of dental FFS complaints resolved per category for each quarter. To capture an accurate snapshot of each quarter's data, please note that this data does not include rollover complaints from a previous quarter. If there were more complaints resolved than received for a particular subcategory, it was 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. All complaints are required to be resolved within 30 days from the day they were received.

Figure 8: SFY 2017-18 FFS Resolution of Complaints by Category per Quarter

Quarter 1			**Quarter 2**		
Complaint Category	**Resolved**	**Unresolved**	**Complaint Category**	**Resolved**	**Unresolved**
Quality Of Care	79%	21%	Quality Of Care	83%	17%
Miscellaneous	90%	10%	Miscellaneous	77%	23%
Provider Billed Members	95%	5%	Provider Billed Members	94%	6%
Office Conduct	100%	N/A	Office Conduct	96%	4%
Quality Of Service	91%	9%	Quality Of Service	100%	N/A
Clinical Screening Dentist	100%	N/A	Clinical Screening Dentist	100%	N/A
Medical Necessity	N/A*	100%	Medical Necessity	N/A	N/A
Provider Referral	N/A	N/A	Provider Referral	100%	N/A
Scope Of Coverage	100%	N/A	Scope Of Coverage	N/A	N/A
Quarter 3			**Quarter 4**		
Complaint Category	**Resolved**	**Unresolved**	**Complaint Category**	**Resolved**	**Unresolved**
Quality Of Care	99%	1%	Quality Of Care	94%	6%
Miscellaneous	96%	4%	Miscellaneous	N/A*	100%
Provider Billed Members	98%	2%	Provider Billed Members	99%	1%
Office Conduct	100%	N/A	Office Conduct	94%	6%
Quality Of Service	100%	N/A	Quality Of Service	N/A*	100%
Clinical Screening Dentist	100%	N/A	Clinical Screening Dentist	100%	N/A
Medical Necessity	100%	N/A	Medical Necessity	100%	N/A
Provider Referral	100%	N/A	Provider Referral	100%	N/A
Scope Of Coverage	100%	N/A	Scope Of Coverage	100%	N/A

Please note that 100% and N/A apply for some categories that had one or no complaints. For example, Medical Necessity in Quarter 1 had one telephone complaint and it was unresolved, therefore, it shows 100% unresolved.