Department of Health Care Services

Medi-Cal Dental Services

Complaints and Grievances Report

Prepared May 2020

Reporting Period: State Fiscal Year 2018-2019

Submitted by the
California Department of Health Care Services

Table of Contents

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) 2018-19, which covers the period from July 1, 2018 through June 30, 2019. 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*. 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 January 2018, the dental FFS complaint processing responsibilities transitioned to the new ASO contract. Through oversight and monitoring activities of the ASO, DHCS determined the ASO's complaint response process had many deficiencies including inconsistencies in its disposition, categorization, and recordkeeping of complaints. Once the deficiencies were identified, DHCS began working with the ASO contractor to mitigate and correct its complaint response process. As of the end of this reporting period, the ASO contractor remediated the disposition and recordkeeping of complaint response deficiencies.

Figure 1, titled SFY *2018-19 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 2018-19. Please note, due to the ASO's various effort to correct their recordkeeping of complaints by using Inquiry and Action codes, the number of complaints and grievances have decreased from last SFY.

Delivery System	Number of Members*	Number of Complaints	Percentage of Complaints
DMC	917,301	2,338	37%
Dental FFS	11,877,580	3,981	63%
Total	**12,794,881**	**6,319**	**100%**

**Represents members who were enrolled in the same plan for at least 90 continuous days during the SFY who have full scope no cost Medi-Cal. Data current as of December 2019.*

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 25 percent and 35 percent of the total complaints received, respectively.
- Among 2,338 resolved complaints, 79 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 68 percent in favor of members and 32 percent in favor of plans; and 92 percent of Accessibility and 74 percent of cases in Other category were resolved in favor of members. Three complaints were unresolved.

Dental FFS

- The majority of complaints recorded for Dental FFS were related to Quality of Care, which included services rendered (i.e., ill-fitting dentures), at 91.9 percent.
- The other main categories of complaints were related to Provider Office Conduct, Clinical Screening Dentist, and Provider Billed Member, at 7.6 percent (303), 0.4 percent (14), and 0.1 percent (4), respectively.
- Among 3,981 resolved complaints, 99.1 percent were resolved within 30 days. All complaints were resolved within 30 days for Provider Office Conduct, Provider Billed Member, and Clinical Screening Dentist.

Medi-Cal Dental Delivery System Background

There were 12.8 million Californians enrolled in Medi-Cal for at least three continuous months in SFY 2018-19. 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 licensed by the Department of Managed Health Care. DMC plans operate member services phone lines to process member complaints and grievances.

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 and grievances.

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

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, appeals, expedited complaints, eligibility, and administrative issues.

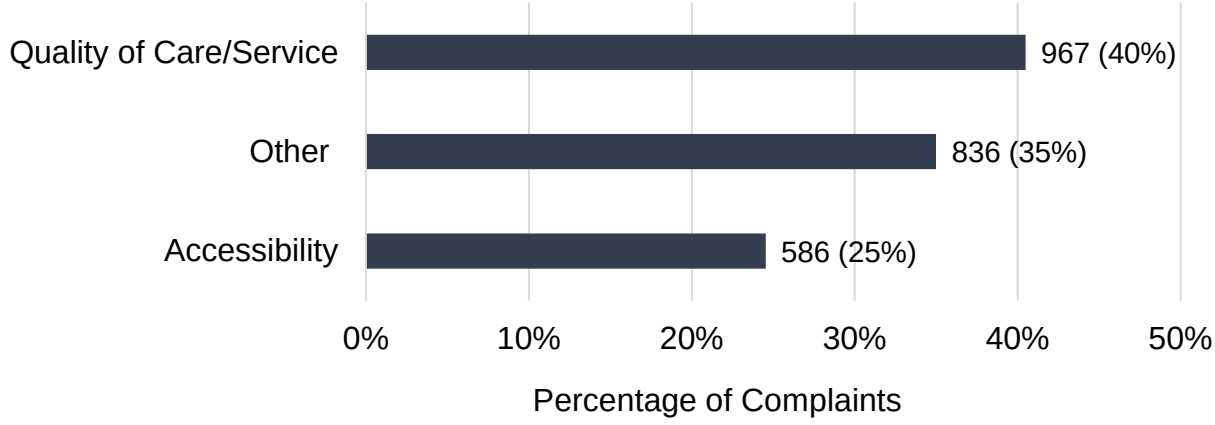
In SFY 2018-19, the DMC plans recorded a total of 2,338 unduplicated complaints.

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

DMC Plans	GMC (Sacramento County)	PHP (Los Angeles County)	Plan Total	Percentage of Total DMC Complaints
Access	92	92	184	7.87%
Health Net	497	719	1,216	52.01%
LIBERTY	738	200	938	40.12%
Total Complaints	**1,327**	**1,011**	**2,338**	**100%**

Figure 3, titled *SFY 2018-19 DMC Complaints by Category*, shows the relative proportion of complaints by each category. The unduplicated complaints only captured 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 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 967 complaints, down from last SFY's total of 978. Subsequently, the other types of DMC complaints were related to Other category with 836 complaints, while the Accessibility category had 586 complaints.

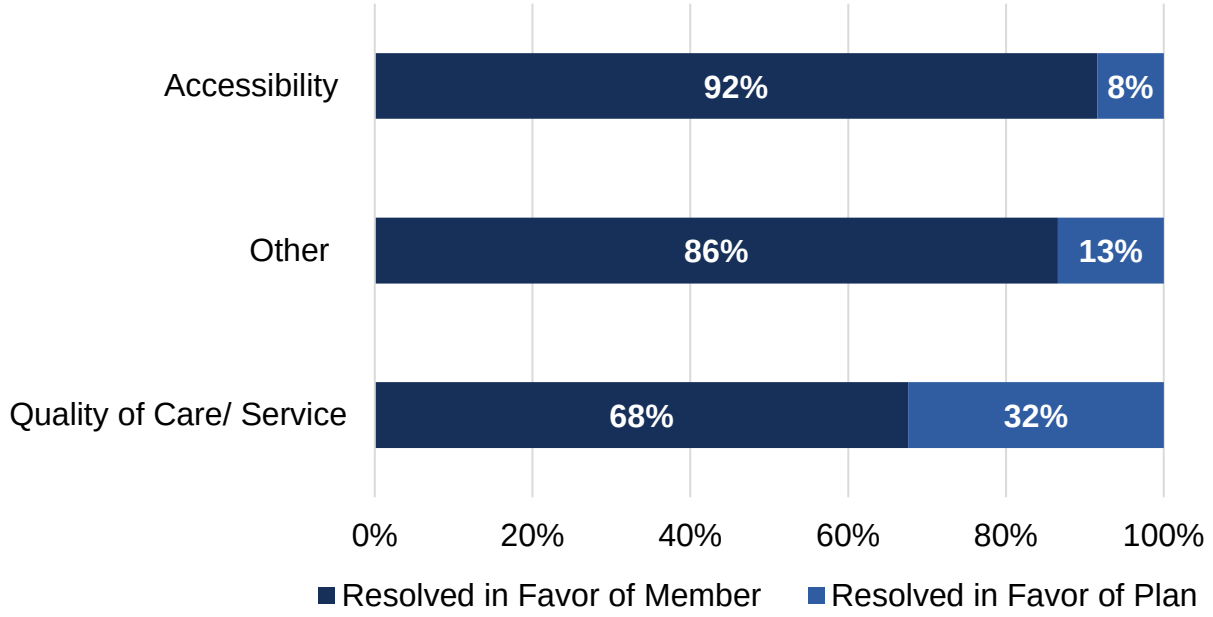
Figure 3: DMC Complaints by Category



Data Source: DMC Complaint Deliverables from July 2018 to June 2019.

Figure 4, titled *SFY 2018-19 DMC Complaint Resolution by Category*, shows the percentage breakdown of resolutions for each complaint type. Among 2,338 resolved complaints, 79 percent of the complaints were resolved in favor of members over the DMC plans. Ninety-two percent of Accessibility and 86 percent of cases in Other category were resolved in favor of members; while Quality of Care/Service category percentage was split between 68 percent in favor of members and 32 percent in favor of plans. Three complaints were unresolved. 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 and grievances in accordance with federal law.

Figure 4: DMC Complaint Resolution by Category



Data Source: DMC Complaint Deliverables from July 2018 to June 2019.

Dental FFS Complaints

The 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 s (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 criteria for medical necessity for the provision dental services, as defined in the Provider Handbook.

- **Miscellaneous:** This category is used to designate a record received or in process and is not a punitive complaint issue.

Figure 5, titled *SFY 2018-19 FFS Complaints by Filing Method,* shows a breakdown of the method members used to file a complaint for SFY 2018-19.

Complaint Filing Method	Number of Complaints
By Mail	1,170
By Telephone	2,811
Total	3,981

In SFY 2018-19, 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 2018-19, there were a total of 3,981 complaints; of those, 1,170 were by mail and 2,811 were by telephone.

In addition, if a complaint was not resolved by telephone, TSC agents referred it to the correspondence unit and closed out the telephone call service form. When the correspondence unit received the referral, they opened a correspondence service form and called the member to attempt to resolve the quality of care issue. This was only applicable to quality of care complaints. All other telephone complaints were handled by TSC agents. At this time, the ASO does not have the capability of keeping 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 2018-19 have duplicates.

However, the ASO is developing a process to accurately capture the number of complaints and we anticipate the duplicate issue will be corrected for the SFY 2019-2020 report.

Figure 6, titled *SFY 2017-18 FFS Complaints per Quarter Submitted,* presents the quarterly breakdown by category for both mail and telephone complaints in order of greatest to least.

Category	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Quality of Care	1,014	794	863	989	3,660
Provider Office Conduct	81	82	67	73	303
Clinical Screening Dentist	2	1	8	3	14
Provider Billed Member	1	1	1	1	4
Provider Referral	0	0	0	0	0
Scope of Coverage	0	0	0	0	0
Medical Necessity	0	0	0	0	0
Miscellaneous	0	0	0	0	0
Total	**1,098**	**878**	**939**	**1,066**	**3,981**

Consistent with last SFY's report, a majority of FFS complaints were regarding Quality of Care with 91.9 percent (3,660) of the total complaints. The second most frequent complaint category was Provider Office Conduct with 7.6 percent (303). The other complaints were Clinical Screening Dentist 0.4 percent (14) and Provider Billed Member 0.1 percent (4). There were no complaints received for Provider Referral, Scope of Coverage, Medical Necessity, and Miscellaneous.

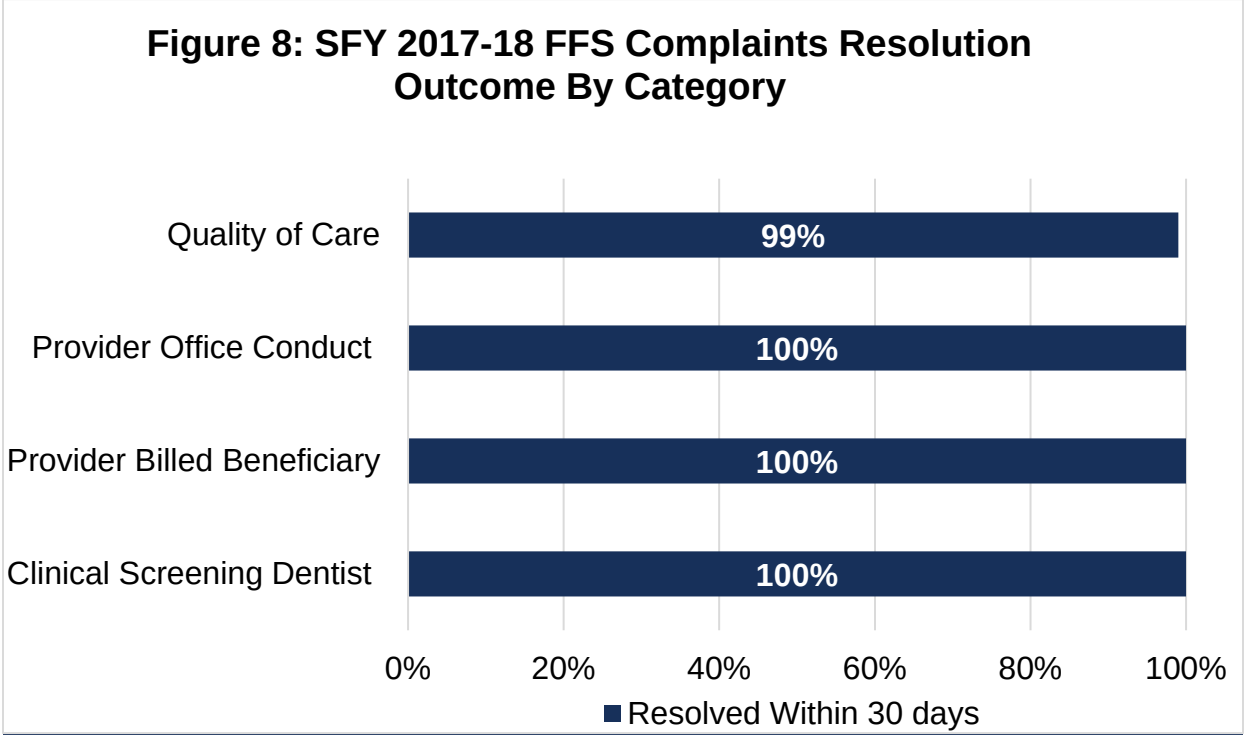
Resolution of Dental FFS Complaints

Figure 7, titled *Percentage of Complaints/Grievances Resolved Within 30 days,* indicates the percent of complaints resolved within 30 days by the end of each quarter for SFY 2018-19.

Quarter	Resolution Percentage
Quarter 1	99.4%
Quarter 2	99.2%
Quarter 3	98.6%
Quarter 4	99.6%
Average	**99.1%**

All complaints are required to be resolved within 30 days from the day they were received. For SFY 2018-19, on average, 98.7 percent of the complaints and grievances were 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 a previous quarter. Additionally, the ASO currently does not have a mechanism in place to capture whether the outcome resolution was in the favor of the provider or member. However, the ASO is in the process of correcting this deficiency and will be reflected in the SFY 2019-2020 report.

Figure 8, titled *SFY 2017 FFS Complaints Resolution Outcome by Category,* indicates the percent of complaints resolved within 30 days by the end of SFY 2018-19.



Data Source: FFS Complaint Deliverables from July 2018 to June 2019.

All complaints and grievances received were resolved in SFY 2018-2019. One hundred percent of Provider Bill Member, Provider Office Conduct, and Clinical Screening Dentist complaints and grievances were resolved within 30 days. There were more Quality of Care complaints and grievances than any other categories, therefore, one percent of the cases took longer than 30 days to be resolved. Resolved turnaround time for complaints ranged from 0 to 76 days. Overall, 99.3 percent were resolved within the required timeframe.