Annual Health Care Complaint Data Report

Report to the Legislature for Measurement Year 2022

Center for Data Insights and Innovation

STATE OF CALIFORNIA
Gavin Newsom, Governor

HEALTH AND HUMAN SERVICES AGENCY
Kim Johnson, Secretary

CENTER FOR DATA INSIGHTS AND INNOVATION
John Ohanian, Director and Chief Data Officer

Statutory Requirement

Assembly Bill 172 (Chapter 696, Statutes of 2021) transitioned annual reporting requirements to the Center for Data Insights and Innovation under Health and Safety Code section 130204:

> (b) The center shall produce an annual report to be made publicly available on the center's internet website by December 31, 2022, and annually thereafter, of health care consumer or patient assistance help centers, call centers, ombudsperson, or other assistance centers operated by the Department of Managed Health Care, the State Department of Health Care Services, the Department of Insurance, and the Exchange, that includes, at a minimum, all of the following:
>
> (1) The types of calls received and the number of calls.
>
> (2) The call center's role with regard to each type of call, question, complaint, or grievance.
>
> (3) The call center's protocol for responding to requests for assistance from health care consumers, including any performance standards.
>
> (4) The protocol for referring or transferring calls outside the jurisdiction of the call center.
>
> (5) The call center's methodology of tracking calls, complaints, grievances, or inquiries.
>
> (c) (1) The center may collect and analyze data on problems and complaints by, and questions from, consumers about health care coverage for the purpose of providing public information about problems faced and information needed by consumers in obtaining coverage and care. The data collected shall include demographic data, insurer or plan data, appeals, source of coverage, regulator, type of problem or issue or comparable types of problems or issues, and resolution of complaints, including timeliness of resolution. Notwithstanding Section 10231.5 of the Government Code, the center shall submit a report by December 31, 2022, and annually thereafter to the Legislature. The report shall be submitted in compliance with Section 9795 of the Government Code. The format may be modified annually as needed based upon comments from the Legislature and stakeholders.
>
> (2) The Department of Managed Health Care, the State Department of Health Care Services, the Department of Insurance, the Exchange, and any other public health coverage programs shall provide to the center data concerning call centers to meet the reporting requirements in this section in the time, data elements, manner, and format requested by the center.
>
> (3) For the purpose of publicly reporting information as required in paragraph (1) and this paragraph about the problems faced by consumers in obtaining care and coverage, the center shall analyze data on consumer complaints, appeals, and grievances resolved by the agencies listed in subdivision (b), including demographic data, source of coverage, insurer or plan, resolution of complaints, and other information intended to improve health care and coverage for consumers.

The Annual Complaint Data Reports and associated documents are available through the CDII website: www.cdii.ca.gov/consumer-reports/complaint-data-reports/

Contents

Section 1 - Executive Summary

The Center for Data Insights and Innovation (CDII) is statutorily required to produce an annual Complaint Data Report under the authority and specifications established by AB 172 (Chapter 696, Statutes of 2021). The reporting requirements transitioned to CDII from the Office of the Patient Advocate (OPA), which had originally been mandated to develop a baseline Complaint Data Report and annual report thereafter by AB 922 (Chapter 552, Statutes of 2011). Current statute lists four state entities that are required to provide data to CDII: the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), California Department of Insurance (CDI), and the California Health Benefit Exchange (Covered California).

Complaints addressed through this report include written or oral complaints, grievances, appeals, independent medical reviews, hearings, and similar processes to resolve a consumer's problem or dispute. DMHC and CDI reported complaint data from their respective consumer assistance divisions. DHCS and Covered California reported complaint data from the California Department of Social Services (CDSS) State Fair Hearings Division.

This ninth annual Complaint Data Report catalogs 29,537 jurisdictional complaints for Measurement Year 2022 (complaints closed January 1 – December 31, 2022). A reporting entity's jurisdictional complaints are those that fall under its authority to address or resolve. The 2022 jurisdictional complaint volumes submitted for the four reporting entities:

- DMHC – 17,200
- DHCS – 4,217
- CDI – 3,704
- Covered California – 4,416

The 2022 top five statewide complaint reasons:

1. Denial of Coverage (11.7% of complaint reasons)
2. Medical Necessity Denial (10.3%)
3. Co-Pay, Deductible, and Co-Insurance Issues (10.2%)
4. Delays/No Response (6.1%)
5. Out-of-Network Benefits (5.3%)

The 2022 top five statewide complaint results:

1. Upheld/Health Plan Position Substantiated (31.2% of complaint results)
2. Compromise Settlement/Resolution (19.9%)
3. Complaint Withdrawn (15.4%)
4. Advised Complainant (10.2%)
5. No Jurisdiction (6.2%)

The order of the top results is not directly associated with the order of the top reasons.

The average time for the departments to resolve complaints continued to fall, with the statewide annual average resolution time decreasing each year since 2016. The 2022 complaint resolution times:

- Statewide – 32 days on average, ranging from 0 (same day) to 1,205 days
- DMHC – 31 days on average, ranging from 0 to 456 days
- DHCS – 41 days on average, ranging from 1 to 1,205 days
- CDI – 40 days on average, ranging from 0 to 496 days
- Covered California – 25 days on average, ranging from 0 to 1,001 days

Differences in complaint systems make direct comparisons between the reporting entities inexact for many of the complaint categories. Because of this, much of the data analyses are shown separately in the respective sections about each reporting entity rather than within an aggregated statewide analysis. In addition, some differences between measurement years may be due in part to changes in data collection and reporting rather than changes in incidence or performance.

Section 2 - Background and Methodology

The Center for Data Insights and Innovation (CDII) is charged under California Health and Safety Code section 130204 with the implementation of a multi-departmental complaint data reporting initiative. CDII took over this requirement from the Office of the Patient Advocate (OPA) in October 2021 after the enactment of AB 172 (Chapter 696, Statutes of 2021). OPA produced the baseline Complaint Data Report based on 2014 data. CDII is now required to annually report health care complaint data and related consumer assistance information from four state entities – the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), California Department of Insurance (CDI), and California Health Benefit Exchange (Covered California) (collectively referred to as "reporting entities" within this report).

This ninth annual Complaint Data Report addresses health care complaints closed during Measurement Year 2022, the period January 1 through December 31, 2022, as well as other information about the reporting entities consumer assistance activities. Some measurement year comparisons rely on data previously collected by OPA.

DMHC, DHCS, CDI, and Covered California report non-aggregated complaint data to CDII through an annual submission process using standardized data categories and elements. The reporting entities also provide overall consumer assistance volumes, protocols details, and other service center information. The 2022 complaint types submitted within the complaint datasets were:

- DMHC – Standard Complaints, Independent Medical Reviews, Quick Resolutions, and Urgent Nurse Complaints
- DHCS – State Fair Hearings (conducted by the California Department of Social Services [CDSS])
- CDI – Standard Complaints and Independent Medical Reviews
- Covered California – State Fair Hearings (conducted by CDSS) and State Fair Hearings with Informal Resolutions (referred by CDSS for resolution by Covered California without a hearing)

CDII and the reporting entities remain dedicated to collaborating to standardize and enhance reporting. Ongoing data collection changes and reporting improvements can make measurement year comparisons inexact. In addition, due to differences in complaint systems, the data presented in this report may still provide an imperfect comparison between reporting entities, coverage types, and other categories. As such, many data categories are shown separately within the reporting entity sections rather than an aggregated statewide display.

Additional details about the report methodology and the glossary of terms are available through the CDII website: www.cdii.ca.gov/consumer-reports/complaint-data-reports/

Section 3 - Statewide Complaint Data

A. Overview

The Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), California Department of Insurance (CDI), and California Health Benefit Exchange (Covered California) serve millions of Californians each year through health care coverage and regulatory oversight programs. The Center for Data Insights and Innovation (CDII) received data from these four reporting entities about consumer complaints and other information about their consumer assistance service centers.

Sections 4-7 have additional information about individual reporting entities. CDII urges caution about drawing conclusions when comparing information across entities and coverage sources due to differences in functions, complaint systems, and data availability.

- DMHC reported complaints about health plans regulated by the department, including for commercial plans, most plans sold through the Covered California marketplace, and certain Medi-Cal managed care plans.
- DHCS reported formal State Fair Hearings about Medi-Cal and other DHCS health care delivery programs, including eligibility, enrollment, and delivery system issues.
- CDI reported complaints about the health insurance companies and producers it regulates. CDI also submitted data about non-jurisdictional health care complaints the department referred to other entities.
- Covered California reported State Fair Hearings requested about eligibility determinations and enrollment issues, including dual agency appeals involving Covered California and Modified Adjusted Gross Income (MAGI) Medi-Cal.

The following table shows the volume of complaints submitted by each reporting entity as well as the number of people with health care coverage overseen by the entities.

Figure 3.1 Reporting Entity 2022 Complaint and Enrollment Volumes

Reporting Entity	Complaint Volume	Total Number of Enrollees
DMHC	17,200	29,672,050
DHCS	4,217	14,794,568
CDI	8,329	2,066,167
Covered California	4,416	1,582,815

Note: Due to differences in timing and reporting methodologies, the data in this table may not match data published by the reporting entities in other reports. Direct comparisons across entities are inexact due to variances in entity systems and methodologies. Enrollment volumes likely include individuals who are counted more than once from being enrolled in multiple plans or because oversight over their coverage is handled by more than one entity. The DMHC and CDI complaint totals include non-jurisdictional complaints. The DMHC and CDI enrollment figures represent the covered lives in December 2022 with health care coverage licensed by each department. The DHCS enrollment figure is the number of Medi-Cal certified eligibles in March 2022 (as of August 10, 2023). The Covered California enrollment figure represents individuals who have paid their health plan premiums to effectuate coverage in June 2022.

B. Statewide Consumer Assistance Centers

In addition to their complaint data submissions, the reporting entities provided consumer assistance information from the following state service centers:

- DMHC Help Center
- DHCS Office of the Ombudsman
- DHCS Medi-Cal Telephone Service Center (no website reported)
- DHCS Medi-Cal Dental Telephone Service Center
- DHCS Medi-Cal Rx Customer Service Center
- CDI Consumer Services Division
- Covered California Service Center

The four reporting entities received 6,008,101 requests for assistance from consumers in 2022, including 29,537 jurisdictional complaints and 5,978,564 other inquiries made to these seven state service centers. Requests for assistance volumes include all consumer encounters for both complaints and inquiries. Inquiries include consumer questions or requests for information as well as consumer contacts for normal course of operations related to health care coverage and services. Non-jurisdictional complaints are considered as inquiries since the consumer is typically provided information and a referral to another entity to have their complaint addressed.

- DHCS reported information about the Medi-Cal Rx Customer Service Center for the first time, reflecting a transition to a centralized delivery system for Medi-Cal pharmacy benefits and the Medi-Cal Rx full assumption of operations on January 1, 2022. Additional details about this service center can be found in Section 5.

- For 2021 and prior, most DHCS inquiries regarding pharmacy benefits would have been handled by contracted Medi-Cal managed care plans rather than by a state service center that provides data for this report.

Compared to the prior year, the 2022 service center inquiry volumes:

- Rose for both regulators: DMHC (5.6% increase) and CDI (2.0% increase).
- Rose for two of three DHCS service centers: Medi-Cal Telephone Service Center (2.0% increase), Office of the Ombudsman (13.7% increase), and Medi-Cal Dental Service Center (9.2% decrease). The new Medi-Cal Rx Customer Service Center does not have 2021 data for comparison.
- Fell for Covered California (11.3% decrease).

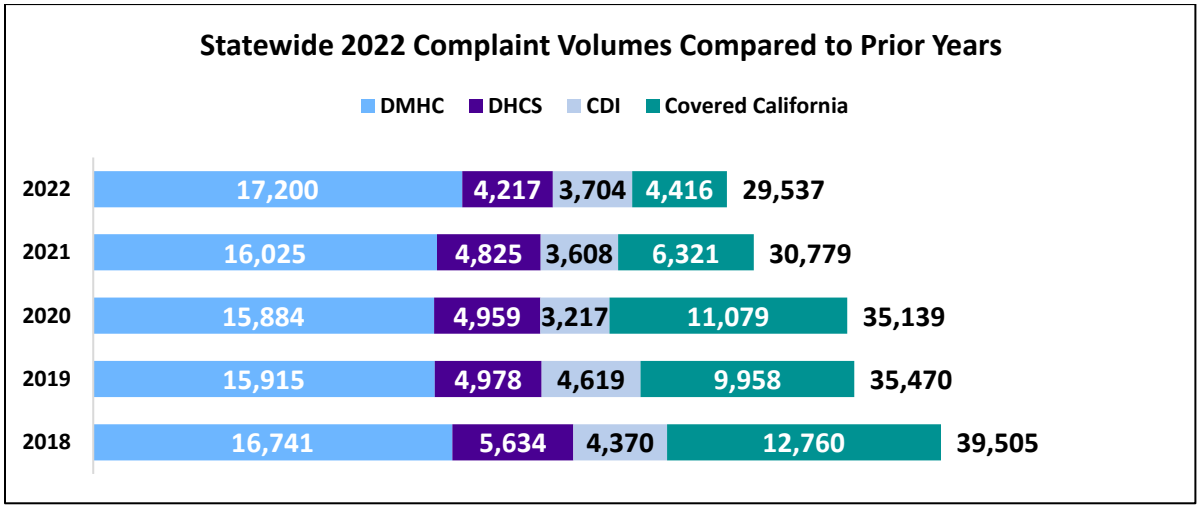
C. Statewide Health Care Complaint Data

DMHC, DHCS, CDI, and Covered California submitted 29,537 jurisdictional complaints that were closed in 2022. The statewide jurisdictional complaint total has decreased annually since the high of 55,923 complaints in 2016.

- For trend displays in this report, differences between measurement years may be due in part to changes in data collection and reporting rather than changes in incidence. Annual comparisons should be interpreted with caution.
- Unless otherwise indicated, the charts in this section address jurisdictional complaints, excluding non-jurisdictional complaints reported by CDI.

The following chart shows the 2022 statewide complaint volumes compared to prior years, including breakdowns by reporting entity.

Figure 3.2

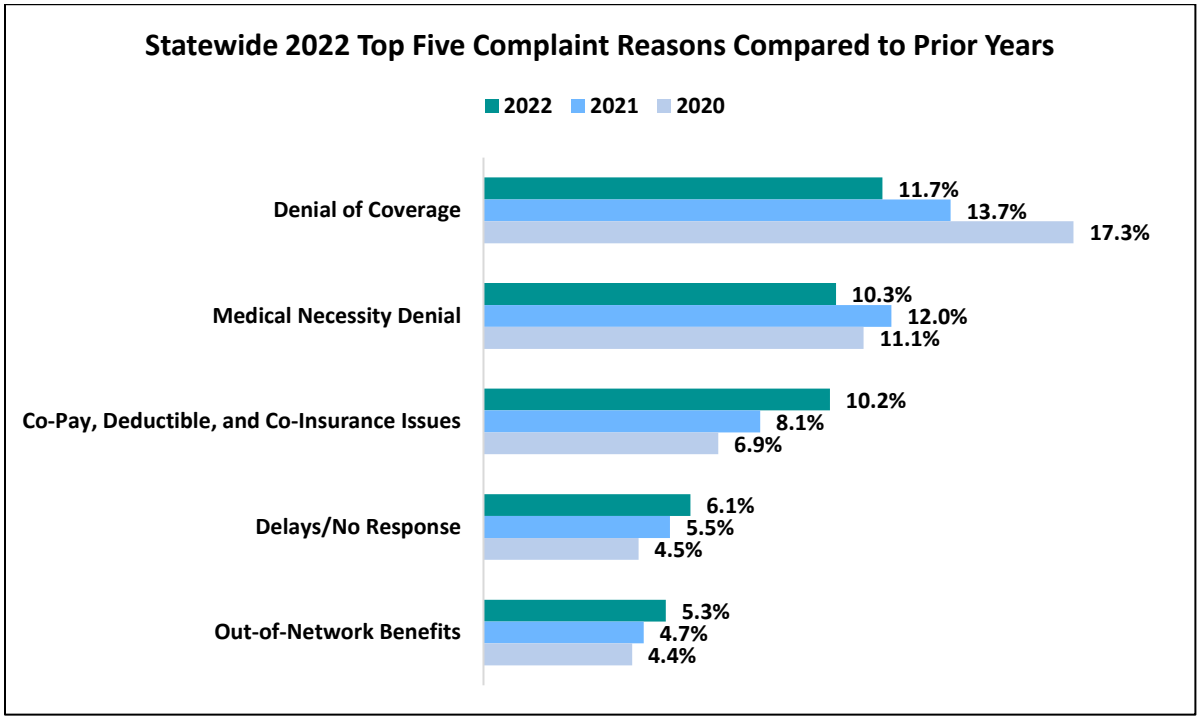


Note: Due to methodology differences, the complaint figures shown may vary from complaint volumes published by the reporting entities in other reports. CDI's non-jurisdictional volumes were excluded from trend displays. DMHC totals include some non-jurisdictional complaints.

Complaint Reasons

The following chart displays the most common reasons for the 29,537 jurisdictional complaints closed in 2022, along with the 2020 and 2021 data for the same reasons.

Figure 3.3



Note: The number of reasons exceeded the number of complaints because some complaints had more than one reason submitted. There were 38,687 reason entries from the 29,537 complaints in 2022.

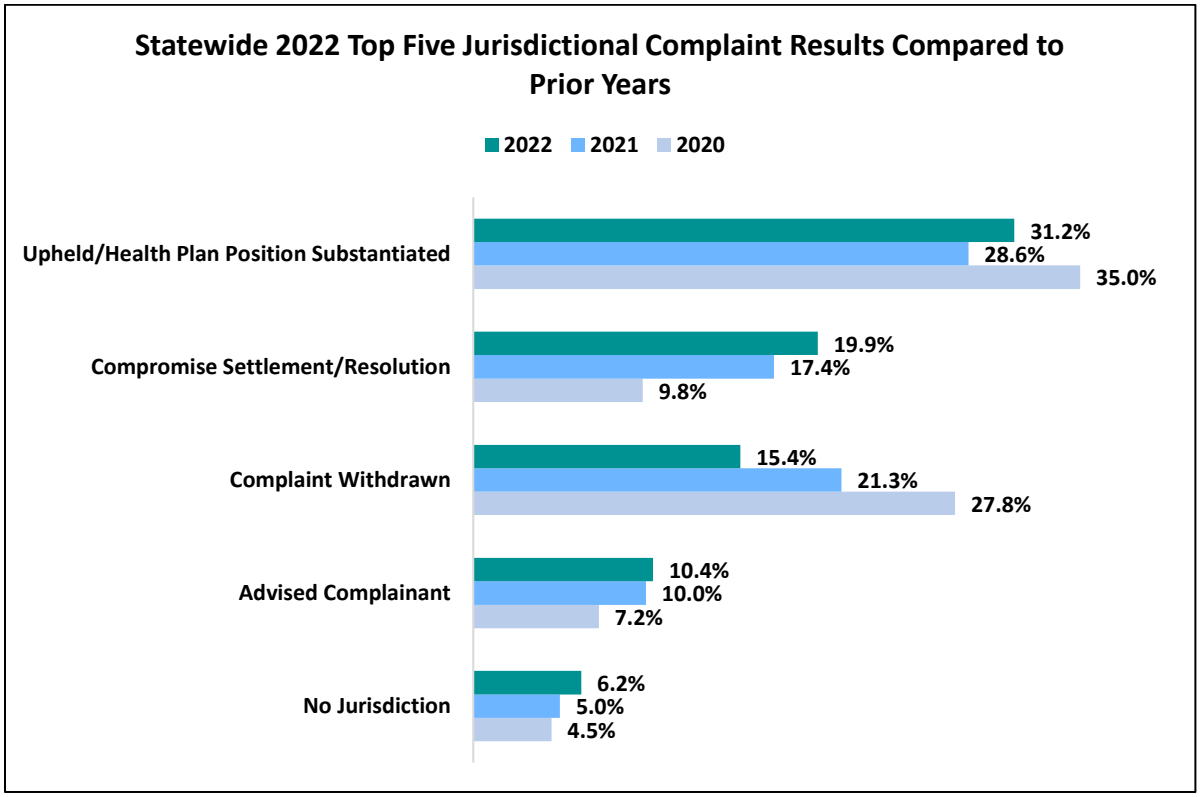
Complaint Results

The following chart displays the most common results for the complaints closed in 2022, along with the 2020 and 2021 data for the same results.

- Compromise Settlement/Resolution is considered as favorable to the complainant. This does not necessarily mean that the complaint was substantiated against the health plan or medical provider but indicates that the consumer received services or a similar positive outcome.
- Upheld/Health Plan Position Substantiated is considered as favorable to the health plan.
- The favorability of the other results categories is neutral or cannot be determined.
    - Complaint Withdrawn is a category where favorability cannot necessarily be determined. However, some Complaint Withdrawn results for the State Fair Hearing complaint type likely include cases that were withdrawn

because the consumer's issue was already resolved by their medical provider or health plan administrator before the hearing date.

Figure 3.4



Note: The number of results exceeded the number of complaints because some cases had more than one result reported. There were 37,433 results entries from the 29,537 complaints in 2022.

Resolution Time

The 2022 statewide average complaint resolution time was 32 days, one day fewer than the prior year average.

Figure 3.5 2022 Complaint Resolution Times (in Days) by Reporting Entity

Reporting Entity	Minimum Duration	Maximum Duration	Average Resolution Time
DMHC	0 (same day)	456	31
DHCS	1	1,205	41
CDI	0	496	40
Covered California	0	1,001	25

Note: The analysis excludes CDI's non-jurisdictional complaints, which took four days on average to resolve in 2022.

CDII urges caution in comparing reporting entities' complaint resolution times and drawing conclusions about performance. Complaint review times can be affected by

differences in complaint review protocols and tracking systems. For example, longer durations may be due to:

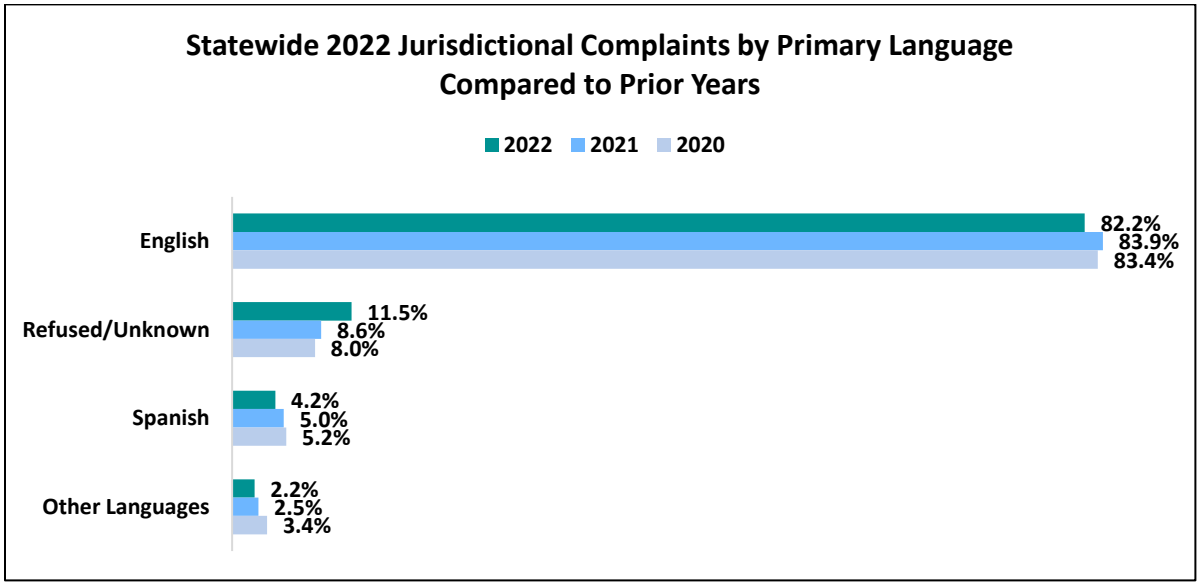
- Close dates representing when oversight or enforcement activities were completed rather than when the case was closed to the consumer.
- Open dates representing an initial filing date rather than a re-open date.
- Open dates representing the date the consumer first contacted the entity rather than when their case satisfied conditions for a complaint review (e.g., all forms completed, 1st level reviewer decision received, etc.)
- A complaint review at an initial stage of an overall complaint process rather than at a later stage for additional levels of appeals. Earlier stages typically require more time to gather all information pertinent to the complaint review from the involved parties.

Demographic and Other Complaint Categories

Sections 4-7 outline additional details about demographic information and other complaint data elements submitted by each reporting entity.

The following chart shows the 2022 statewide complaint distribution by primary language of the complainant compared to the 2020 and 2021 data for the same language categories.

Figure 3.6



Note: Other Languages combines language elements with low volumes (under 1%) of reported complaints in 2022: Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Japanese, Korean, Mandarin, Other, Other Chinese, Russian, Tagalog, and Vietnamese. Refused/Unknown combines complaints originally reported under separate Refused and Unknown elements.

The following table displays the top complaint reasons by primary language, along with each reason's percentage distribution for the specified language category.

Figure 3.7 Statewide 2022 Top Five Complaint Reasons by Primary Language

Rank	English (% of English)	Spanish (% of Spanish)	Other Languages (% of Other)	Refused/Unknown (% of Refused/Unknown)
1 (most common)	Co-Pay, Deductible, and Co-Insurance Issues (11.3%)	Denial of Coverage (13.6%)	Denial of Coverage (11.3%)	Denial of Coverage (27.2%)
2	Medical Necessity Denial (10.9%)	Medical Necessity Denial (11.8%)	Co-Pay, Deductible, and Co-Insurance Issues (10.9%)	Claim Denial (16.9%)
3	Denial of Coverage (9.8%)	Quality of Care (8.8%)	Quality of Care (9.3%)	Pharmacy Benefits (9.4%)
4	Delays/No Response (6.8%)	Co-Pay, Deductible, and Co-Insurance Issues (7.5%)	Medical Necessity Denial (6.8%)	Information Requested (6.9%)
5	Out-of-Network Benefits (6.0%)	Scope of Benefits (7.1%)	Claim Denial (6.0%)	Medical Necessity Denial (5.9%)

Section 4 - Department of Managed Health Care

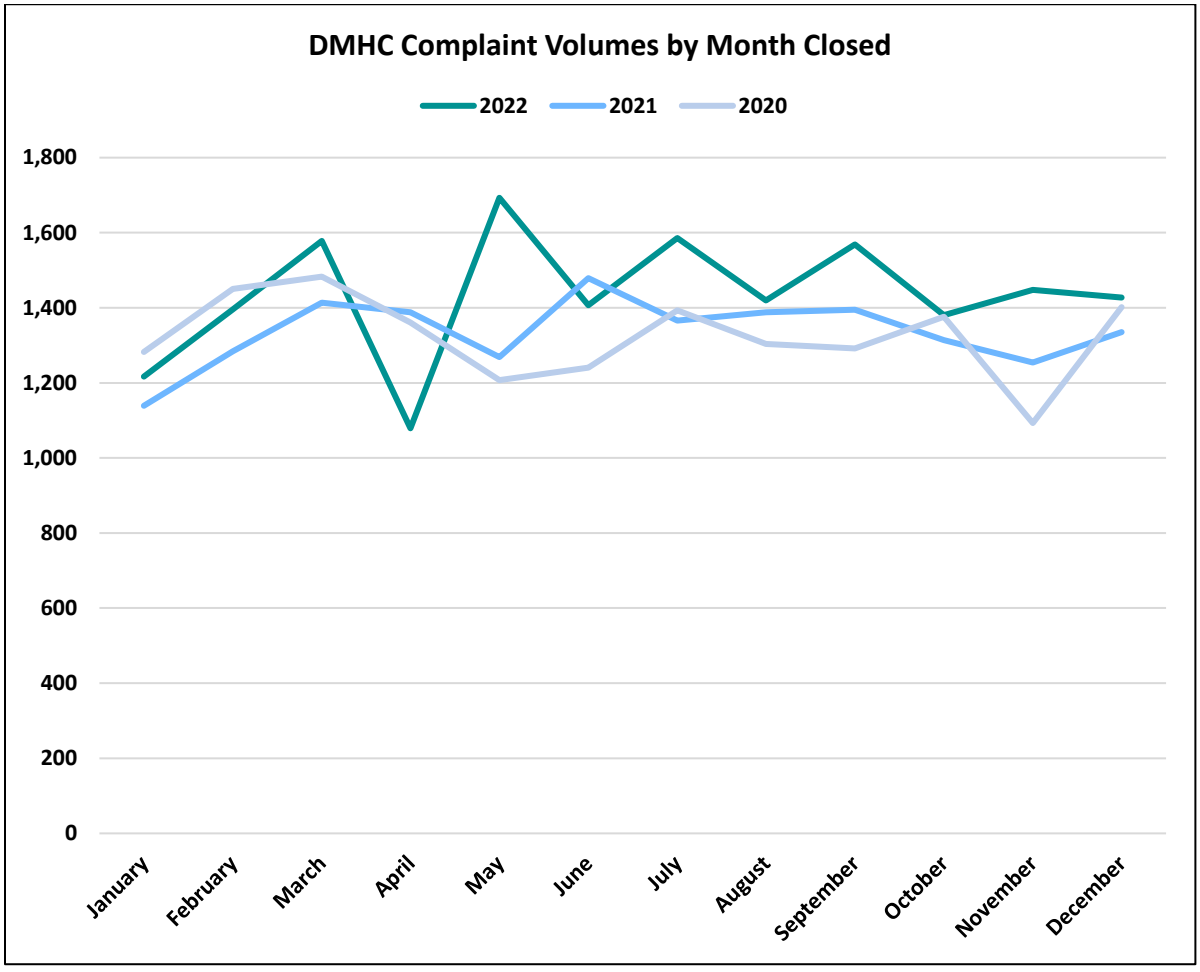
A. Overview

The Department of Managed Health Care (DMHC) regulates 96 percent of enrollment in state-regulated commercial and public health plans. DMHC's Help Center educates consumers about their health care rights, resolves consumer complaints, helps consumers navigate and understand their coverage, and assists consumers in getting timely access to appropriate health care services.

DMHC's Help Center received 137,795 requests for assistance from consumers in 2022, including 17,200 complaints and 120,595 inquiries. Compared to 2021, volumes rose in 2022 for both complaints (7.3% increase) and inquiries (5.6% increase).

The following chart shows DMHC's monthly complaint volumes for 2022 compared to the monthly volumes in 2020 and 2021.

Figure 4.1 DMHC Complaint Volumes by Month Closed



The following table outlines information about DMHC's four reported complaint types. The complaint type category typically indicates the process used to review the complaint. Most of DMHC's 2022 complaints were a Standard Complaint (75.4% of the 17,200 complaints), followed by Independent Medical Review (20.8%), Quick Resolution (3.6%), and Urgent Nurse Case (under 1%).

Figure 4.2 DMHC Help Center Complaint Types Overview

Complaint Type	Primary Unit(s) Responsible	Time Standard	Average Resolution Time in 2022
Standard Complaint	Contact Center: Intake and routing Independent Medical Review/Complaint Branch: Casework to resolution Legal Affairs Branch: Legal review if needed	30 days, from receipt of a completed complaint application	34 days
Independent Medical Review (IMR)	Contact Center: Intake and routing Independent Medical Review/Complaint Branch: Casework IMR Contractor (MAXIMUS): External Review decision Legal Affairs Branch: Legal review if needed	45 days, from receipt of a completed IMR application 7 days for cases that qualify for an expedited IMR	22 days
Quick Resolution	Contact Center: Intake and casework to resolution	N/A	5 days
Urgent Nurse	Contact Center: Intake, initial casework, and routing Independent Medical Review/Complaint Branch: Casework to resolution if possible, may open an IMR if an external review is needed	N/A	10 days

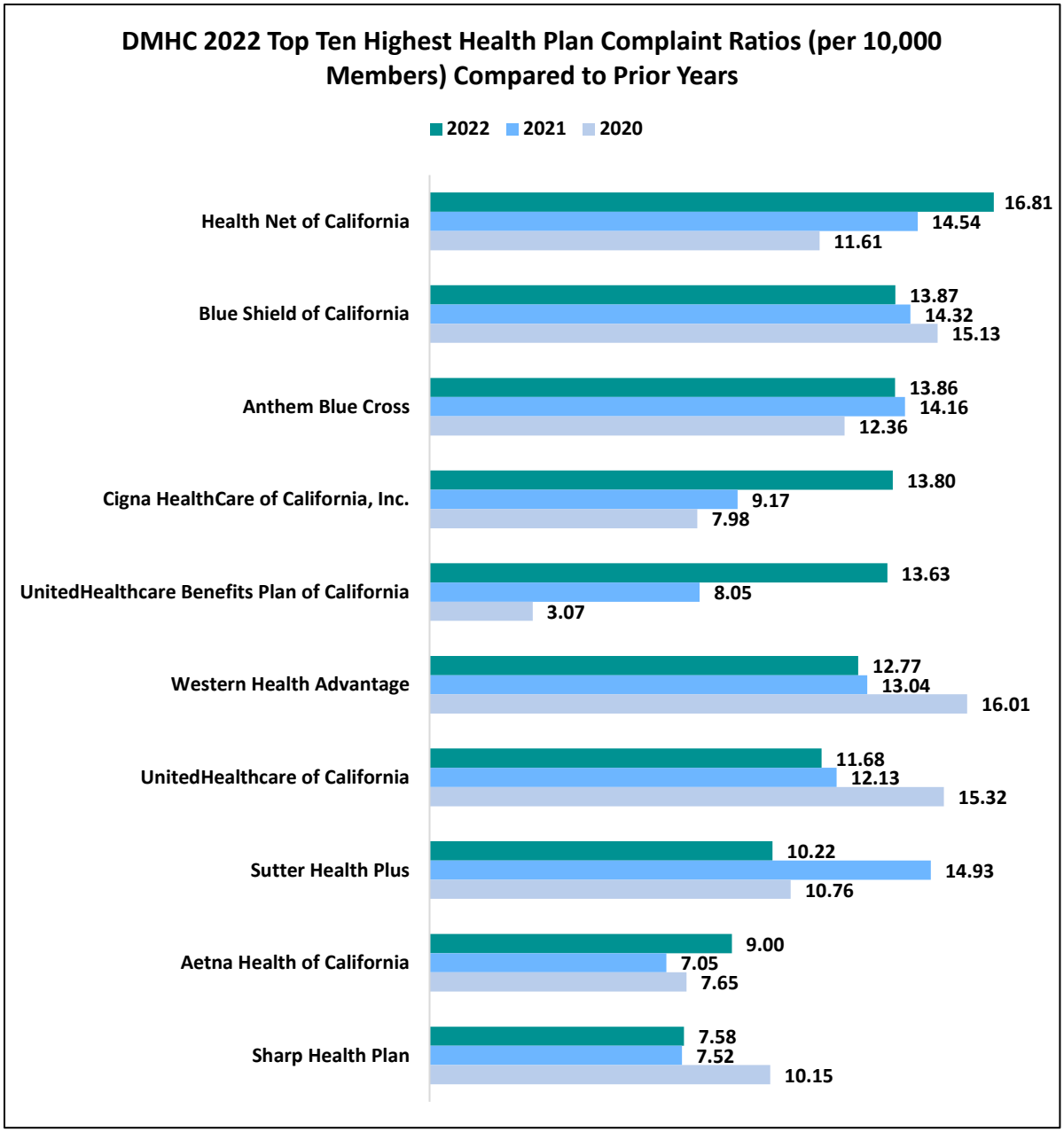
Note: The timeframes for DMHC's time standards are based on the open date for when the department receives a completed complaint/IMR application, which is not necessarily the date when the consumer first contacted the department. DMHC may review complaints involving consumers with urgent clinical issues as an Urgent Nurse case or through expedited IMR or Standard Complaint processes.

B. Complaint Ratios, Reasons, and Results

Health Plan Complaint Ratios

The following chart displays the DMHC-regulated full-service health plans with the highest complaint ratios in 2022 among plans with enrollment over 70,000 members.

Figure 4.3

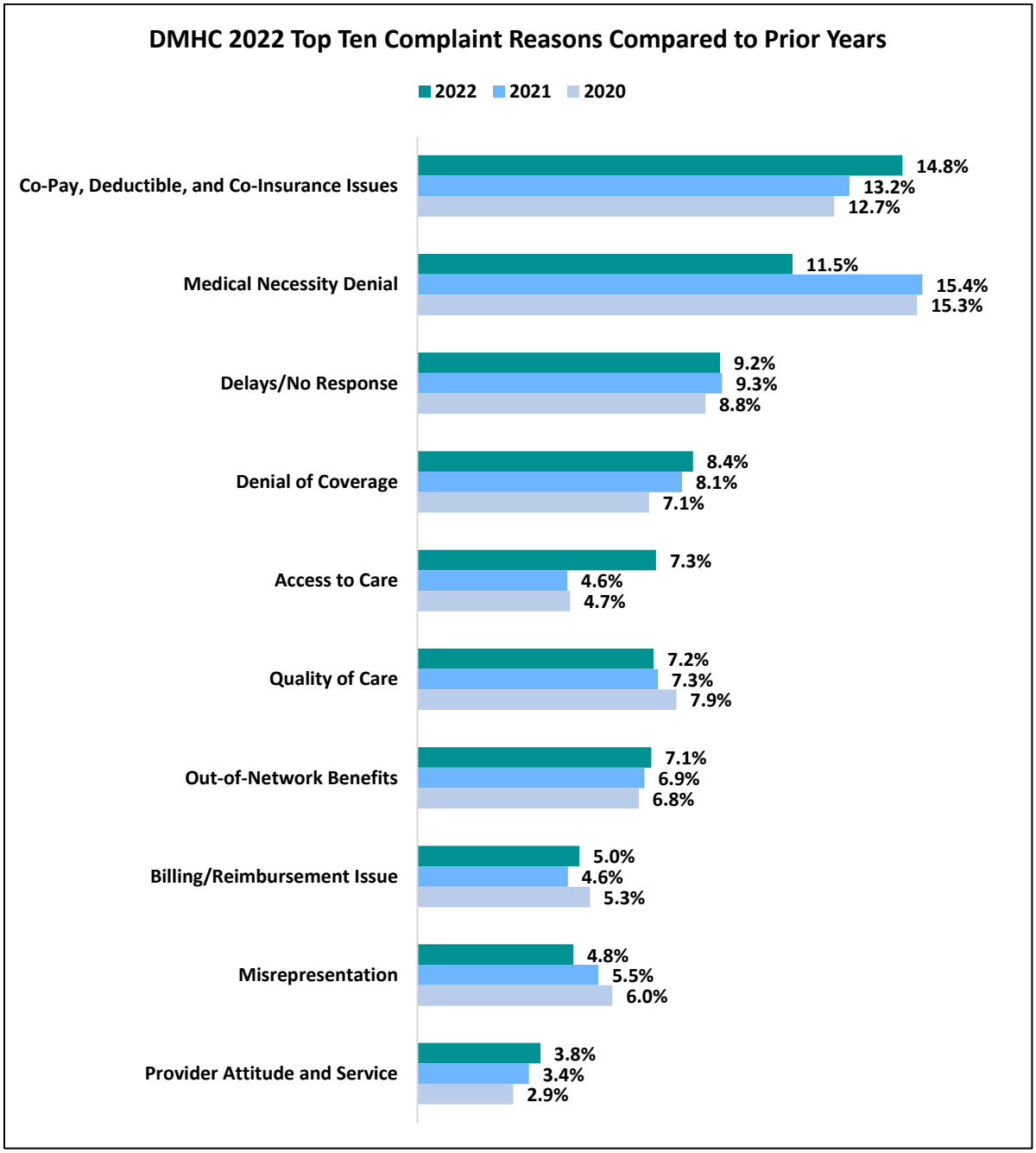


Note: The above display excludes health plans with enrollment under 70,000 in 2022. Due to a change in methodology to separate Blue Cross of California Partnership Plan data from Anthem Blue Cross, the 2020 and 2021 figures for Anthem Blue Cross vary from prior year reports.

Complaint Reasons

The following chart displays the most common reasons reported by DMHC for complaints closed in 2022, as well as the 2020 and 2021 data for those same reason categories.

Figure 4.4



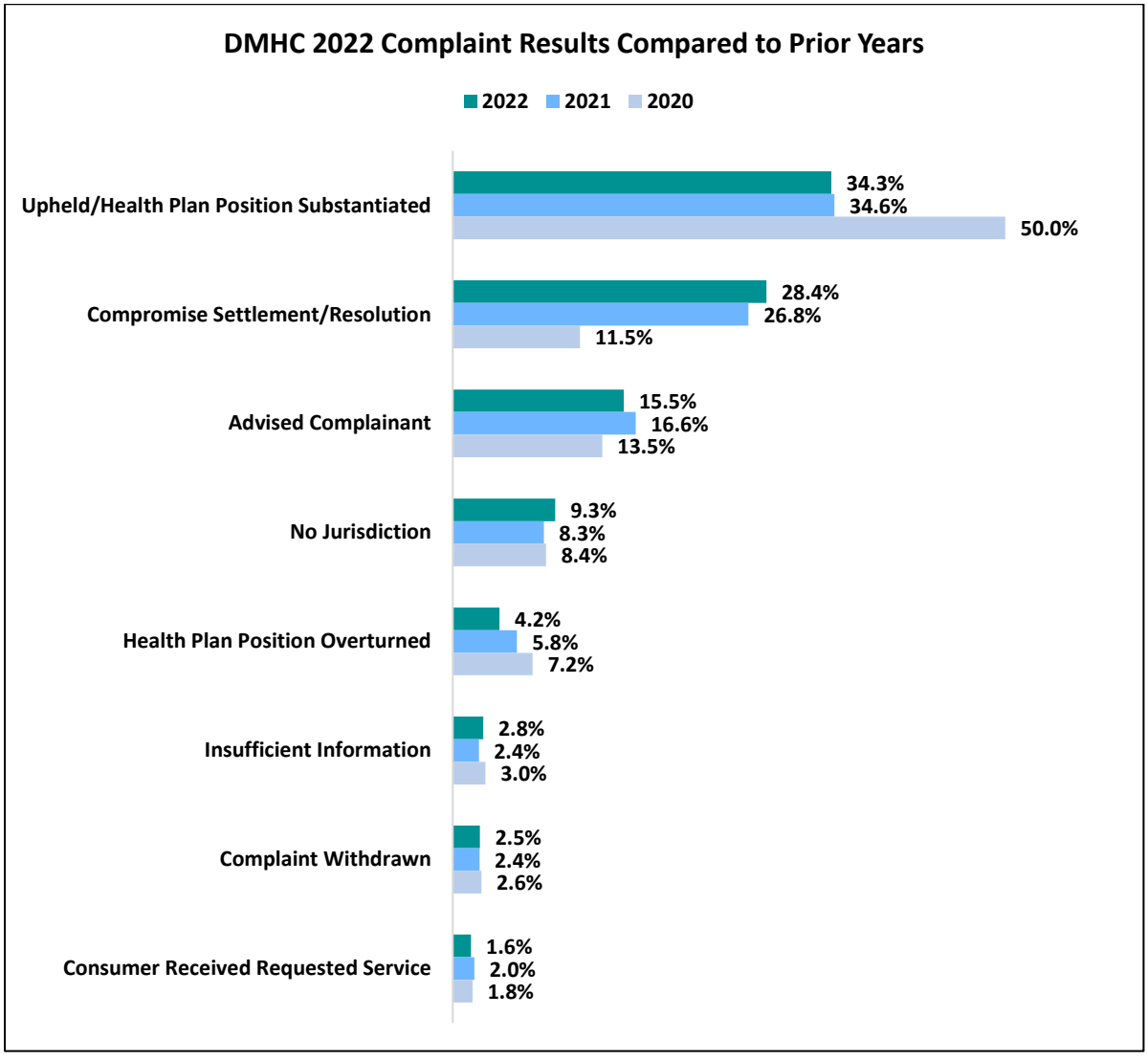
Note: The volume of reasons exceeded the number of complaints because some cases had more than one reason reported. There were 25,095 reason entries from the 17,200 complaints in 2022.

DMHC noted that the Union that represents the Kaiser mental health clinicians initiated a strike in August 2022. The department received an increase in complaints related to Access to Care during this time.

Complaint Results

The following chart shows DMHC's the results of complaints closed in 2022, along with the 2020 and 2021 data for those same results categories.

Figure 4.5



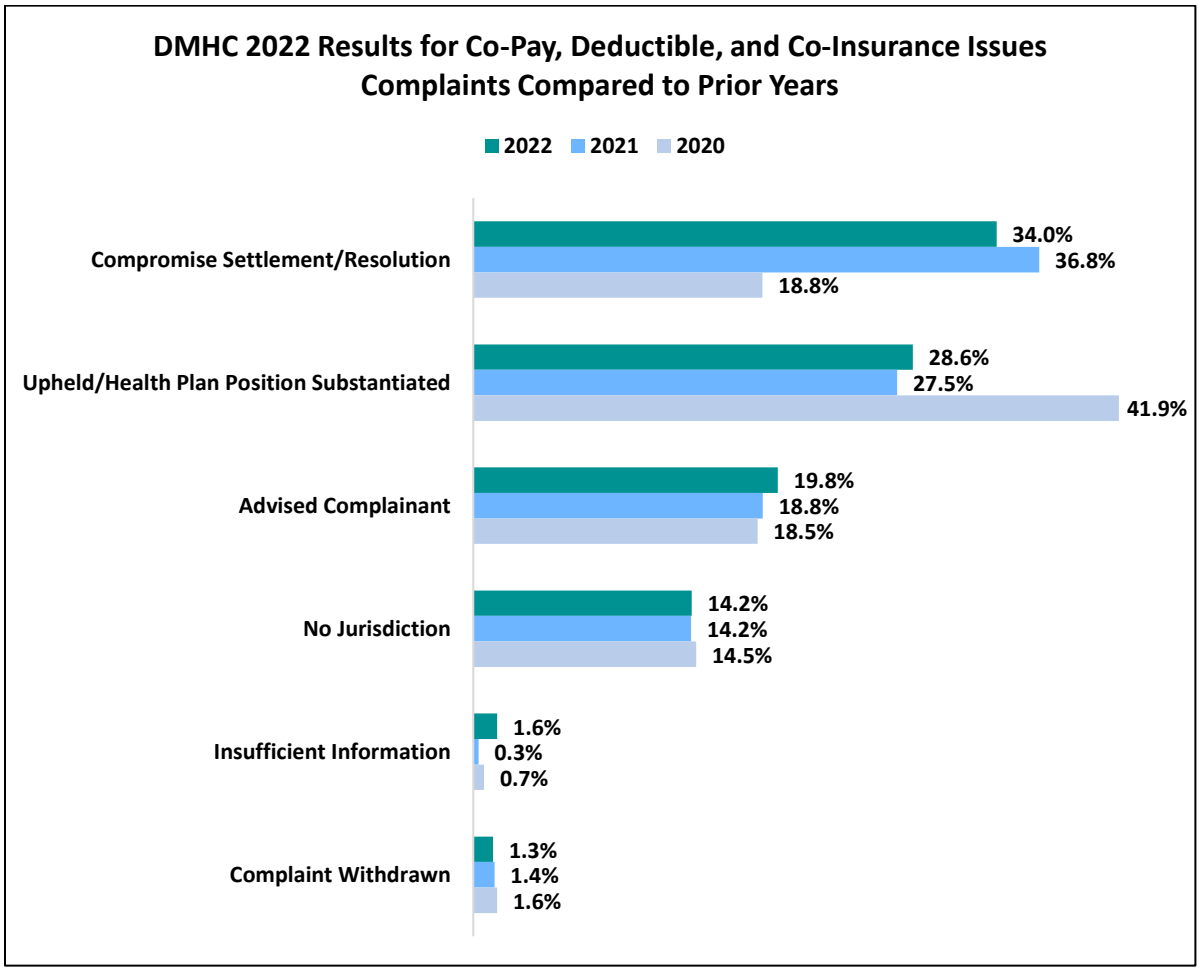
Note: Three results categories with low volumes (under 1%) were excluded from the display. Results considered to be favorable to the consumer include: Compromise Settlement/Resolution, Health Plan Position Overturned, and Consumer Received Requested Service. Results considered to be favorable to the health plan include: Upheld/Health Plan Position Substantiated. The favorability of the other categories shown is neutral or cannot be determined. For some categories, favorable to the consumer does not necessarily mean that the complaint was substantiated against the health plan but indicated that the consumer received services or a similar positive outcome.

Some differences between measurement years may be due in part to changes in data collection and reporting.

- For example, starting in MY 2021 DMHC more accurately identified cases with multiple complaints where part of the complainant's case resulted in a benefit provided. Due to this data collection change, complaints that would have previously been reported as Upheld/Health Plan Position Substantiated, Claim Settled, or Insufficient Information were reported as Compromise Settlement/Resolution.

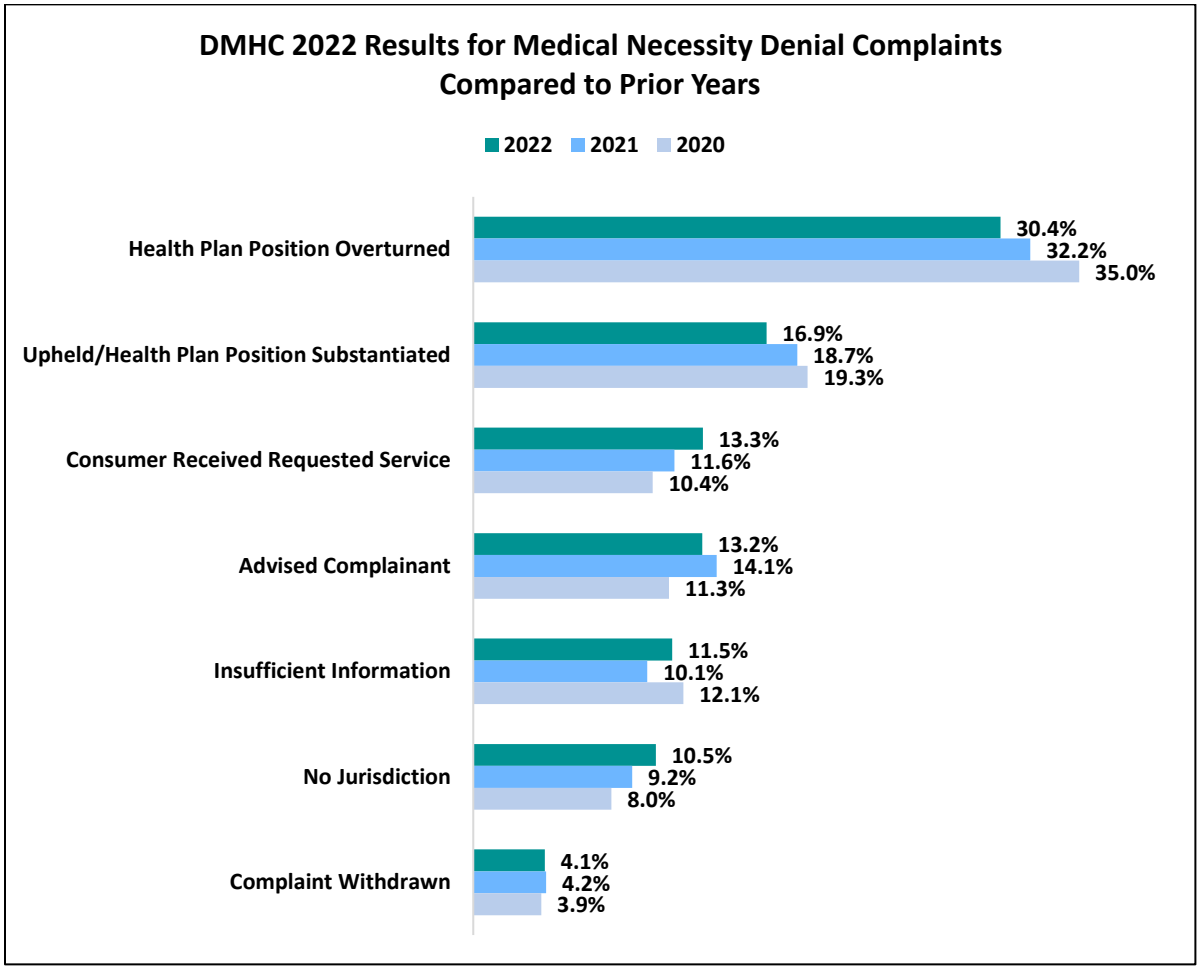
The following three charts display the 2022 results for DMHC's most commonly reported complaint reasons, as well as the 2020 and 2021 results data for the same reasons.

Figure 4.6



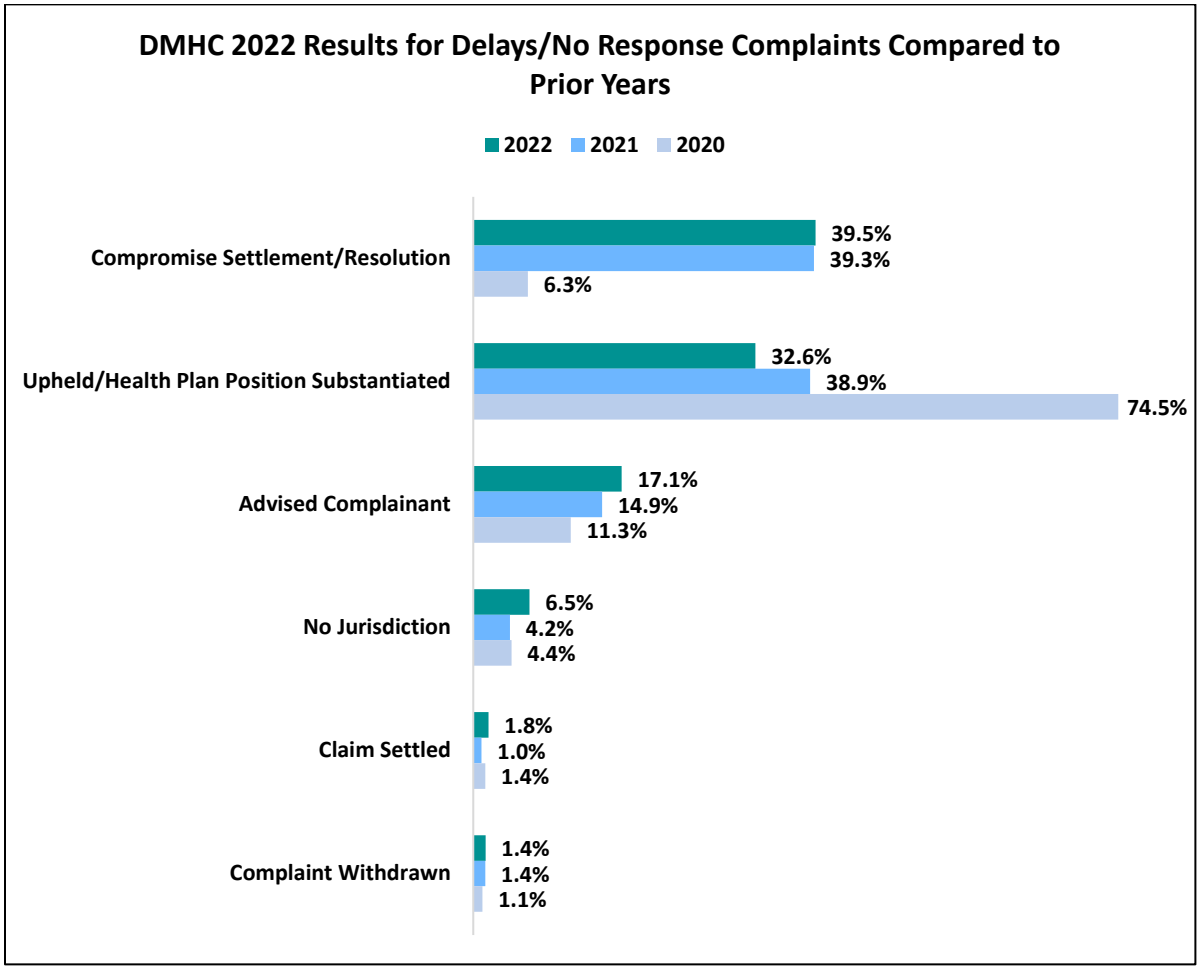
Note: The display above excludes results categories with low volumes in 2022.

Figure 4.7



Note: The display above excludes results categories with low volumes in 2022.

Figure 4.8

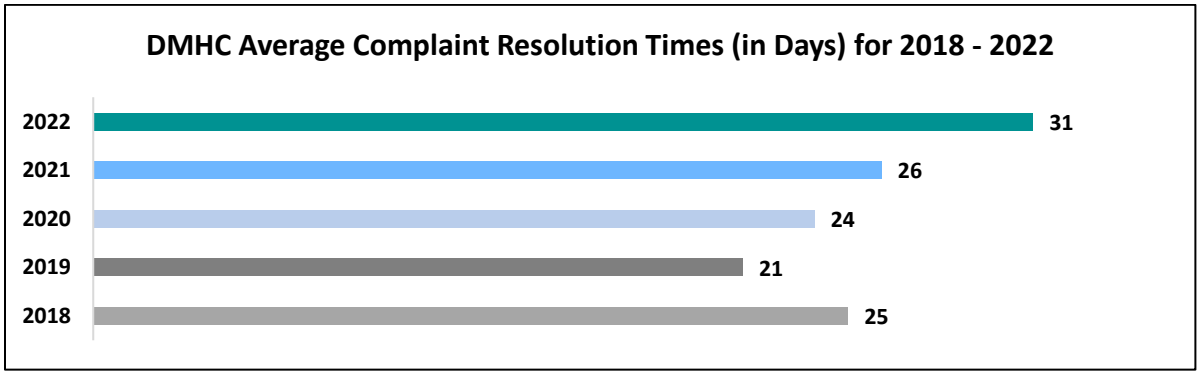


Note: The display above excludes results categories with low volumes in 2022.

Resolution Time

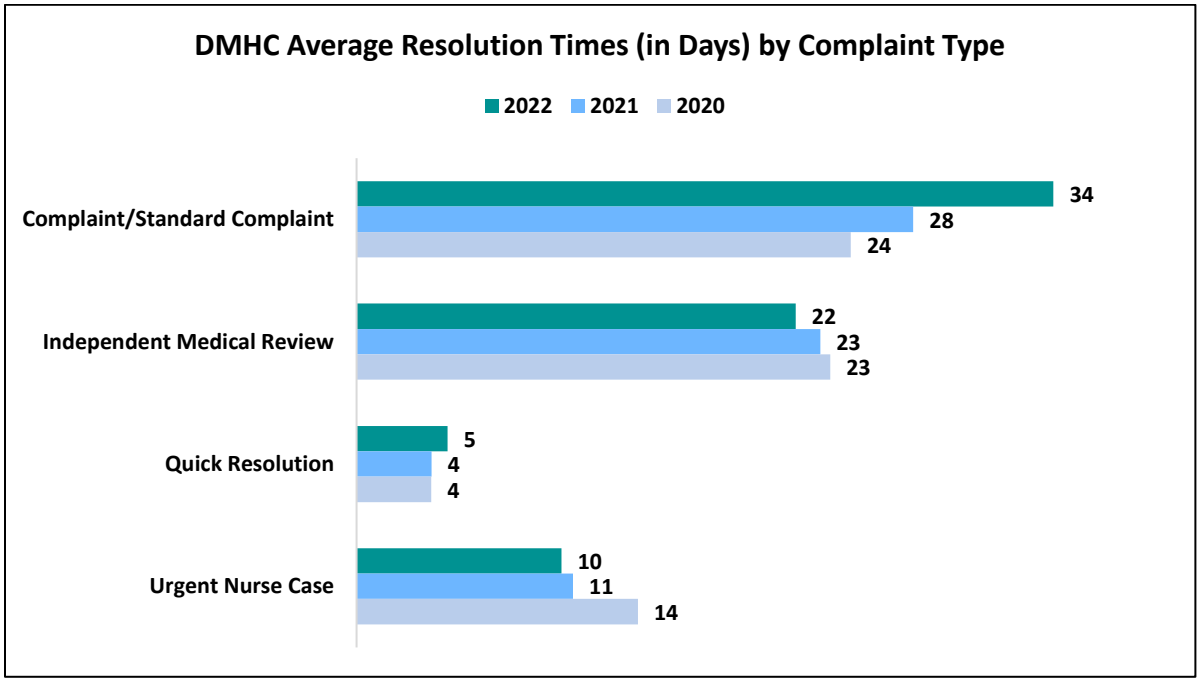
The following chart displays the average number of days for DMHC to complete a complaint review and close a case in 2022 compared to prior years.

Figure 4.9



The following figure displays the average complaint resolution times by complaint type for 2022 compared to prior years.

Figure 4.10



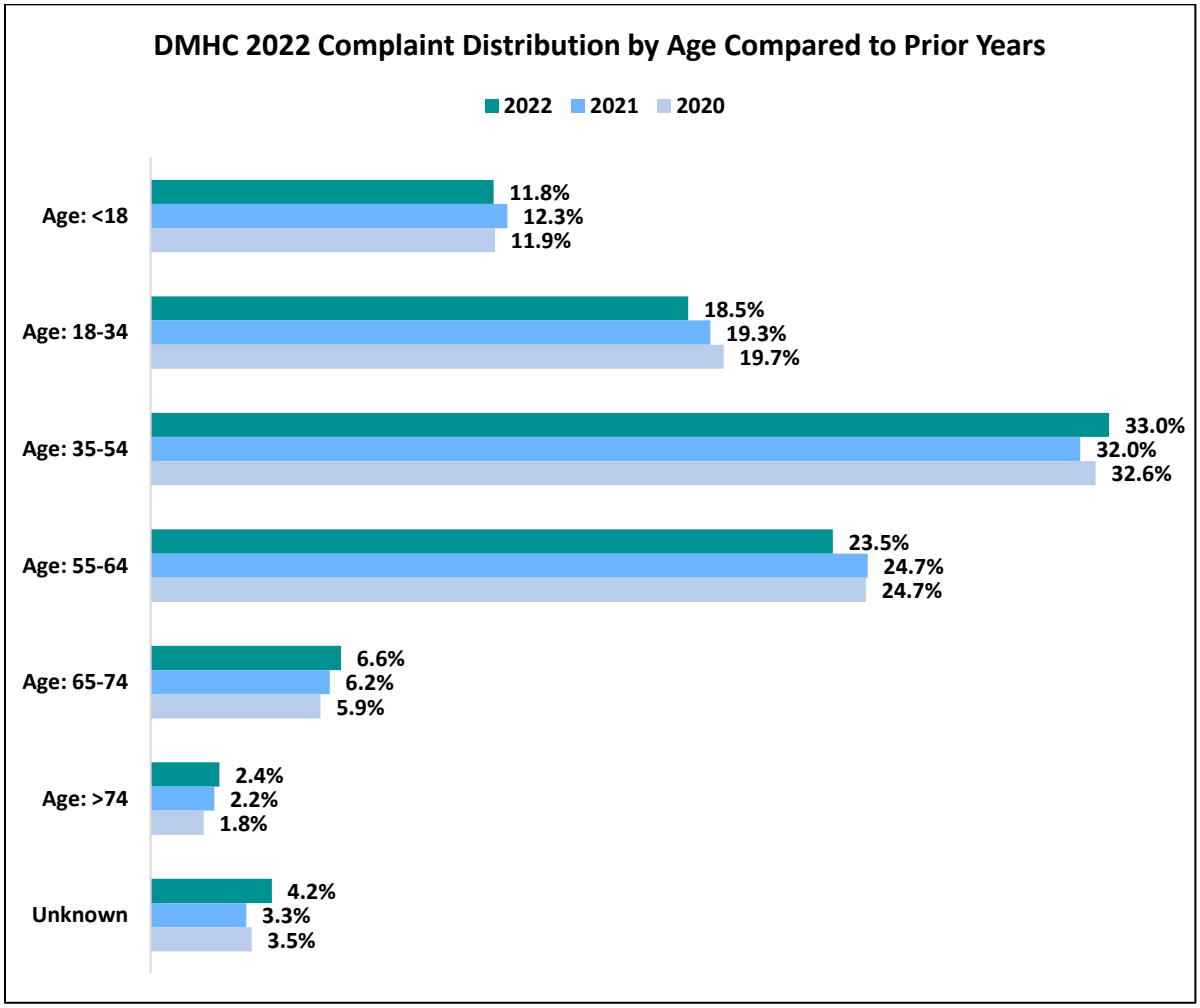
Note: The timeframes for DMHC's time standards are based on the open date for when the department receives a completed complaint/IMR application, which is not necessarily the date when the consumer first contacted the department.

C. Demographics and Other Complaint Characteristics

Age

The following chart shows the distribution of DMHC's 2022 complaints by age, along with the 2020 and 2021 data for the same age group categories.

Figure 4.11



Gender

The number of complaints submitted with Gender reported as Unknown increased for the second year. DMHC noted that there was a demographic data collection change for gender identity in 2021 that resulted in an increase in Unknown for both 2021 and 2022.

Of the DMHC 2022 complaints, half were from complainants identified as Female (50.5% of the 17,200 complaints), over a third Male (35.4%), and under one percent another gender. Thirteen percent did not have gender submitted (13.3% Unknown).

Race and Ethnicity

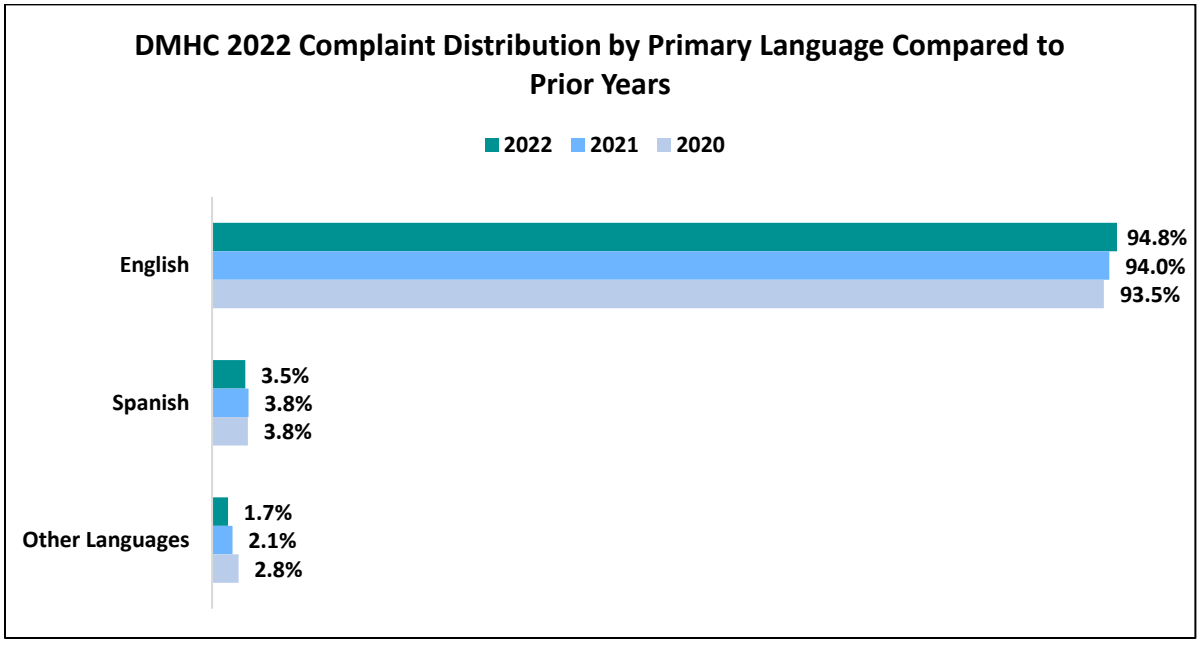
Nearly 39 percent of the DMHC 2022 complaints did not have either Race or Ethnicity identified (38.7% Refused).

- Half (50.2%) of the complainants' ethnicity was submitted as Not Hispanic or Latino. These complainants had race submitted as:
  - White (33.9% of the 17,200 complaints)
  - Asian (6.4%)
  - Black or African American (4.7%)
  - Other Races Combined (5.2%)
- Eleven percent of the complainants were identified as Hispanic or Latino.

Primary Language

The following chart shows the 2022 complaint distribution by the complainant's primary language, along with the 2020 and 2021 data for those language categories.

Figure 4.12



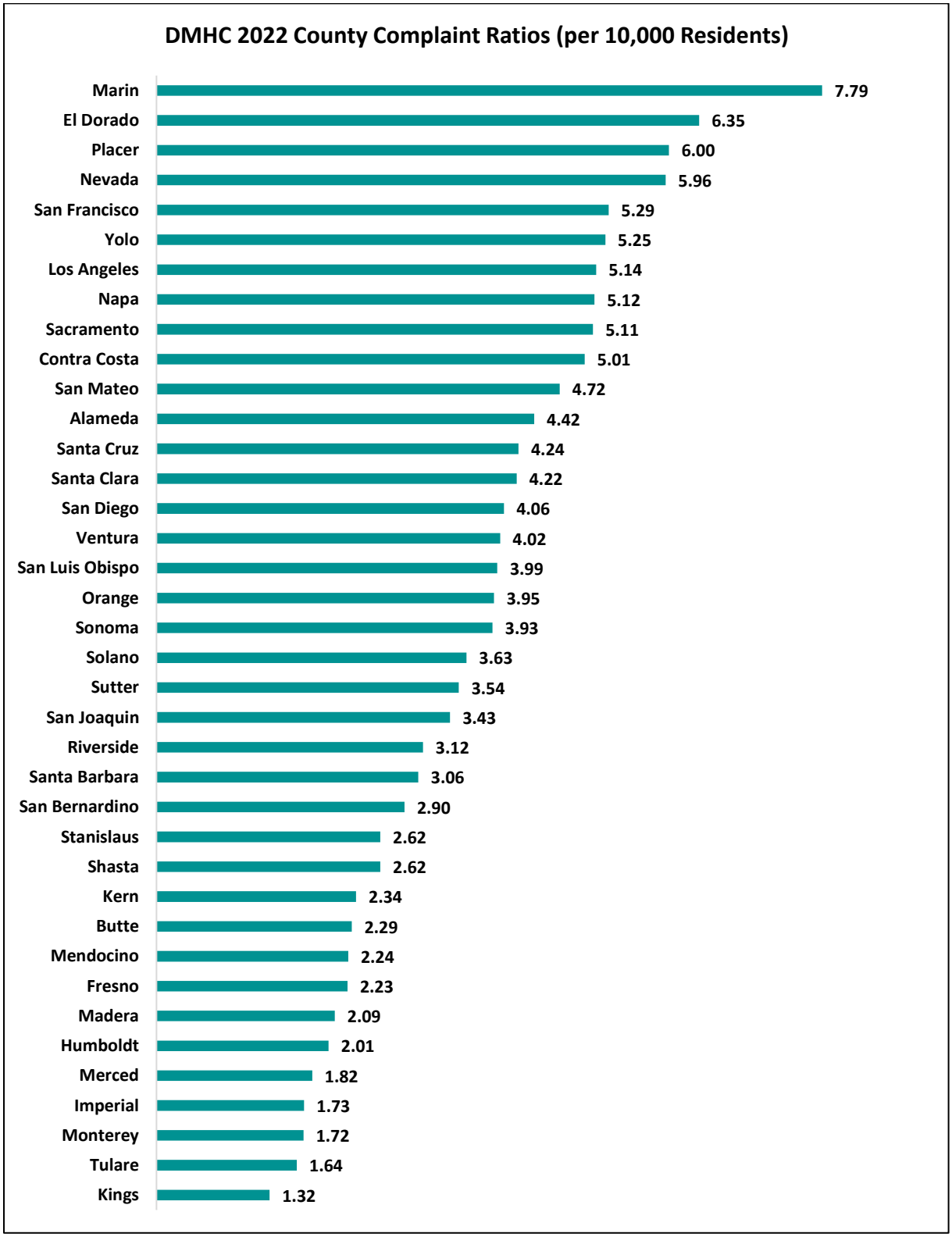
Note: Other Languages combines the following language categories with low reported complaint volumes: Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Japanese, Korean, Mandarin, Other, Other Chinese, Russian, Tagalog, and Vietnamese.

Co-Pay, Deductible, and Co-Insurance Issues was the most common complaint reason for complainants whose primary language was identified as English (14.8% of the English reasons) and for Other Languages (20.0% of the reasons for Other Languages). For complainants with the primary language of Spanish, Quality of Care was the most common complaint reason (13.4% of the Spanish reasons).

Resident County

The following chart shows ratios of complaint volumes by county of residence per the county population in 2022.

Figure 4.13



Note: The display excludes counties with populations under 70,000 people and/or fewer than 11 complaints in 2022.

Initial Mode of Contact

DMHC's 2022 complaint distribution by the mode of contact to initiate a complaint with the department was similar to prior years' distributions. Online continued to be the most common initial mode of contact (58.5% of the 17,200 complaints), followed by Mail (19.7%), Fax (10.8%), Email (7.2%), and Telephone (3.7%).

Regulator

DMHC's 2022 complaint distribution by the health coverage regulator was similar to prior years' distributions. DMHC was the regulator for ninety percent of the 17,200 complaints (89.6%), followed by the United States Department of Labor (2.8%), Centers for Medicare and Medicaid Services (2.3%), Other (1.9%), California Department of Insurance (1.0%), Out-of-State Department of Insurance (0.9%), No Regulator (0.9%), United States Office of Personnel Management (0.4%) and Unknown (0.1%).

Source of Coverage

DMHC's 2022 complaint distribution by the source of coverage was similar to prior years' distributions. Half of the complaints were identified as involving the Group source of coverage (50.2% of the 17,200 complaints), followed by Medi-Cal (16.6%), Individual/Commercial (13.0%), Covered California/Exchange (11.4%), CalPERS (3.2%), Medicare (2.5%), and Medi-Cal/Medicare (1.4%). Unknown and three other source of coverage categories were reported with low volumes (under 1%).

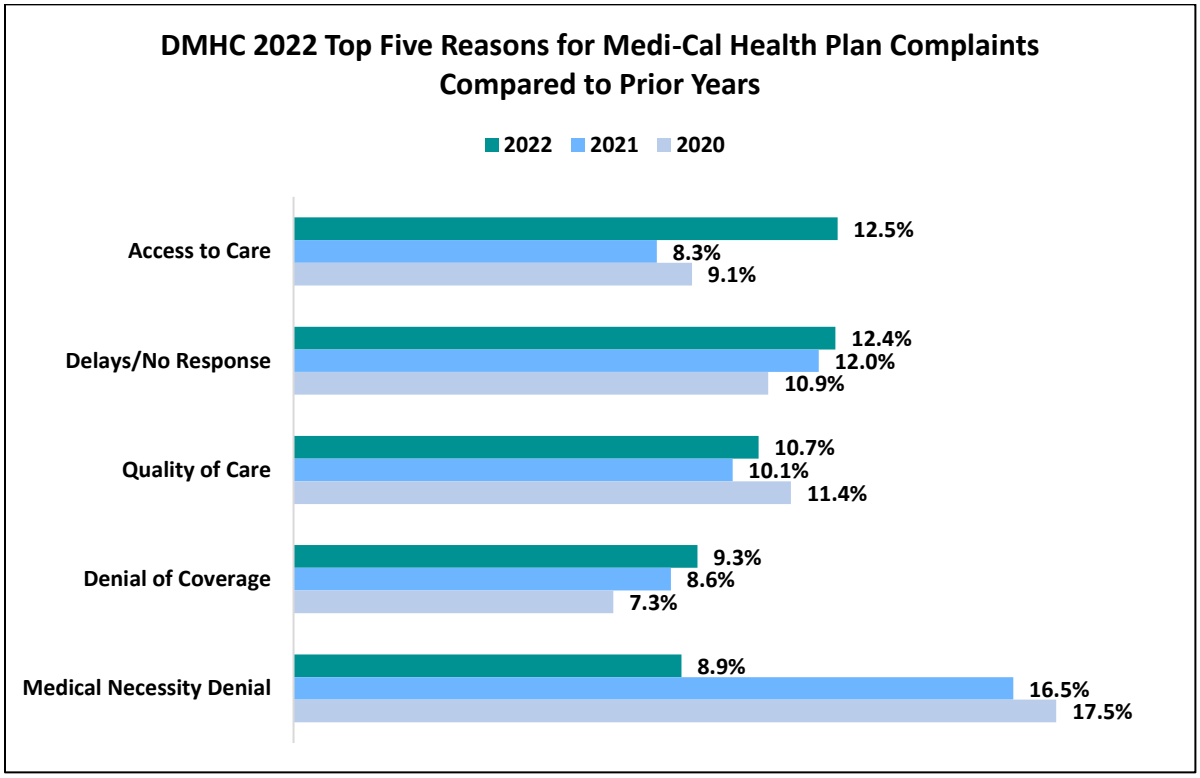
Compared to the prior year, complaint volumes increased for all known sources of coverage. Only the Unknown category decreased.

Medi-Cal Health Plan Complaints

Medi-Cal was identified as the source of coverage for 2,856 complaints DMHC closed in 2022.

The following chart displays the top reasons for these Medi-Cal health plan complaints, along with the 2020 and 2021 data for the same reason categories.

Figure 4.14



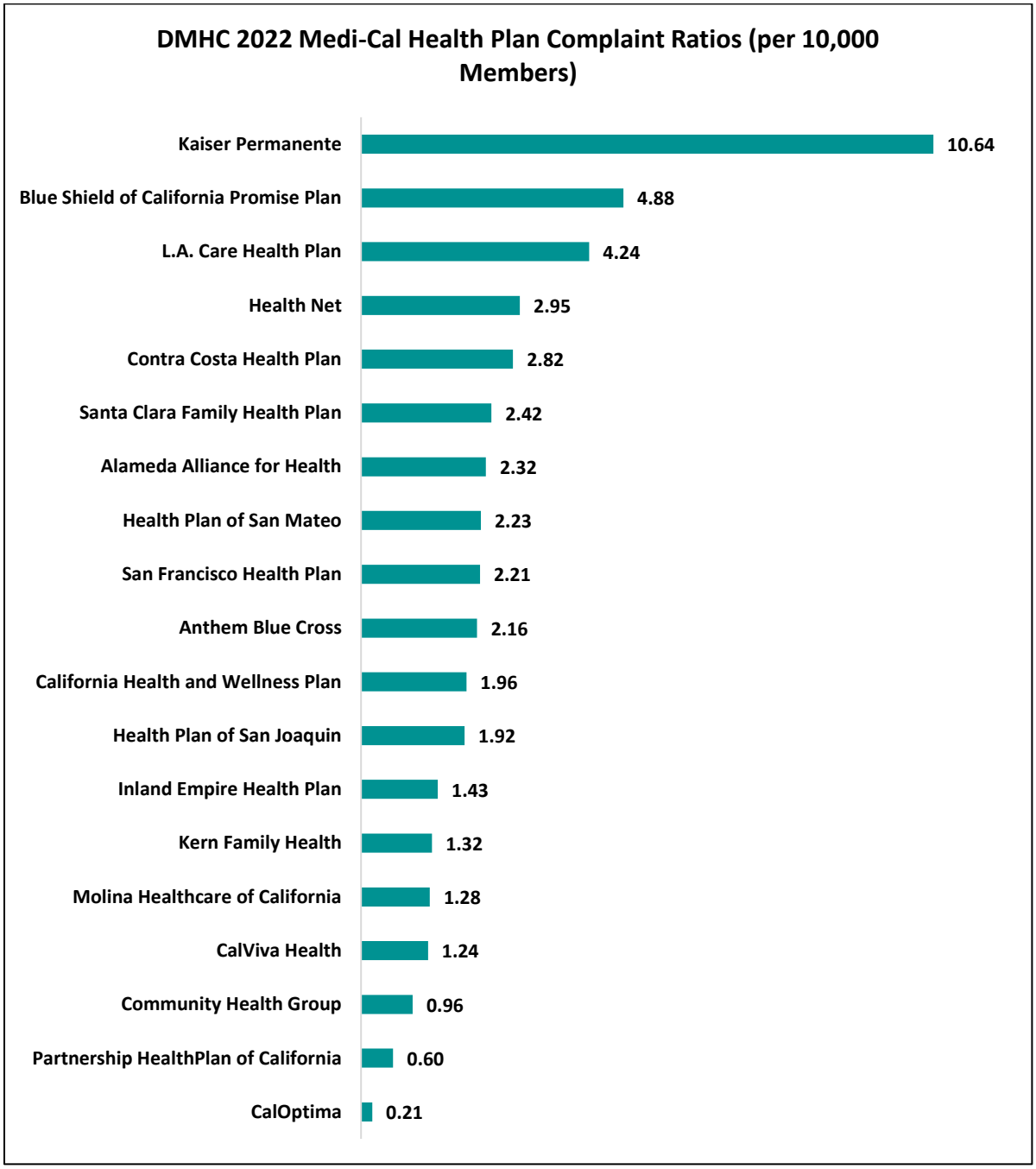
Note: The number of reasons exceeded the number of complaints because some cases had more than one reason reported. There were 4,363 reason entries from the 2,856 Medi-Cal plan complaints in 2022. Differences between measurement years may be due in part to changes in data reporting rather than changes in incidence.

DMHC noted that the Union that represents Kaiser mental health clinicians initiated a strike in August 2022. The department received an increase in complaints related to Access to Care during this time.

DMHC also indicated that the 2022 decrease in Medical Necessity Denial complaints for Medi-Cal plan members was primarily due to a Medi-Cal delivery system change. Effective January 1, 2022, Medi-Cal pharmacy benefits and services were transitioned from managed care to fee-for-service. The Medi-Cal pharmacy benefits and services administered by DHCS in the fee-for-service delivery system is identified collectively as “Medi-Cal Rx”. Under this model, medical necessity appeals relating to Medi-Cal pharmacy benefits utilized the standard State Fair Hearing process and are no longer eligible for the Independent Medical Review (IMR) process with the DMHC. As a result, the DMHC experienced a decrease in pharmacy-related IMRs for Medi-Cal members.

The following chart displays ratios of complaints per 10,000 plan members for Medi-Cal health plans with complaints closed by DMHC in 2022.

Figure 4.15



Note: The display excludes Medi-Cal health plans with enrollment under 70,000 members and/or fewer than 11 complaints in 2022. Some Medi-Cal managed care plans are not regulated by DMHC.

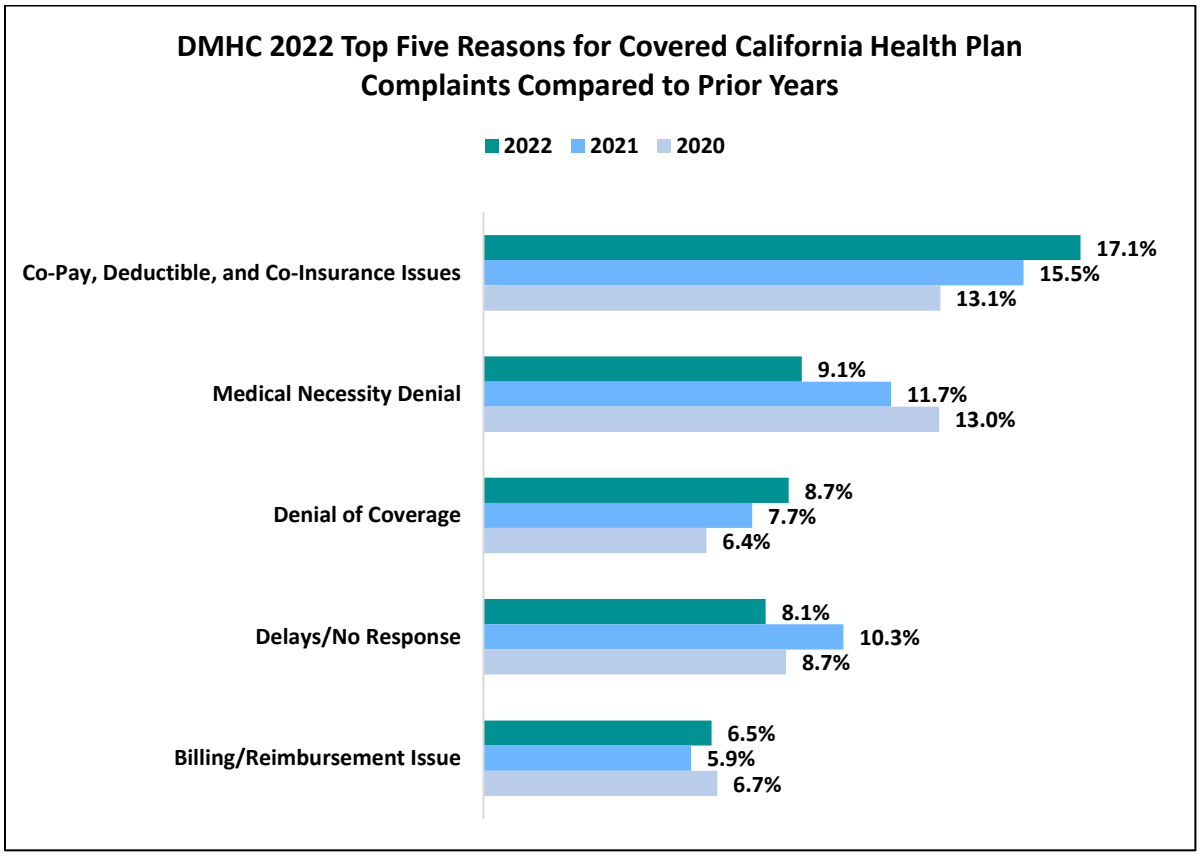
- DMHC noted that the Union that represents Kaiser mental health clinicians initiated a strike in August 2022. The department received an increase in Kaiser complaints related to Access to Care during this time.

Covered California Health Plan Complaints

Covered California/Exchange was identified as the source of coverage for 1,967 complaints DMHC closed in 2022.

The following chart displays the top reasons for these Covered California health plan complaints, along with the 2020 and 2021 data for the same reason categories.

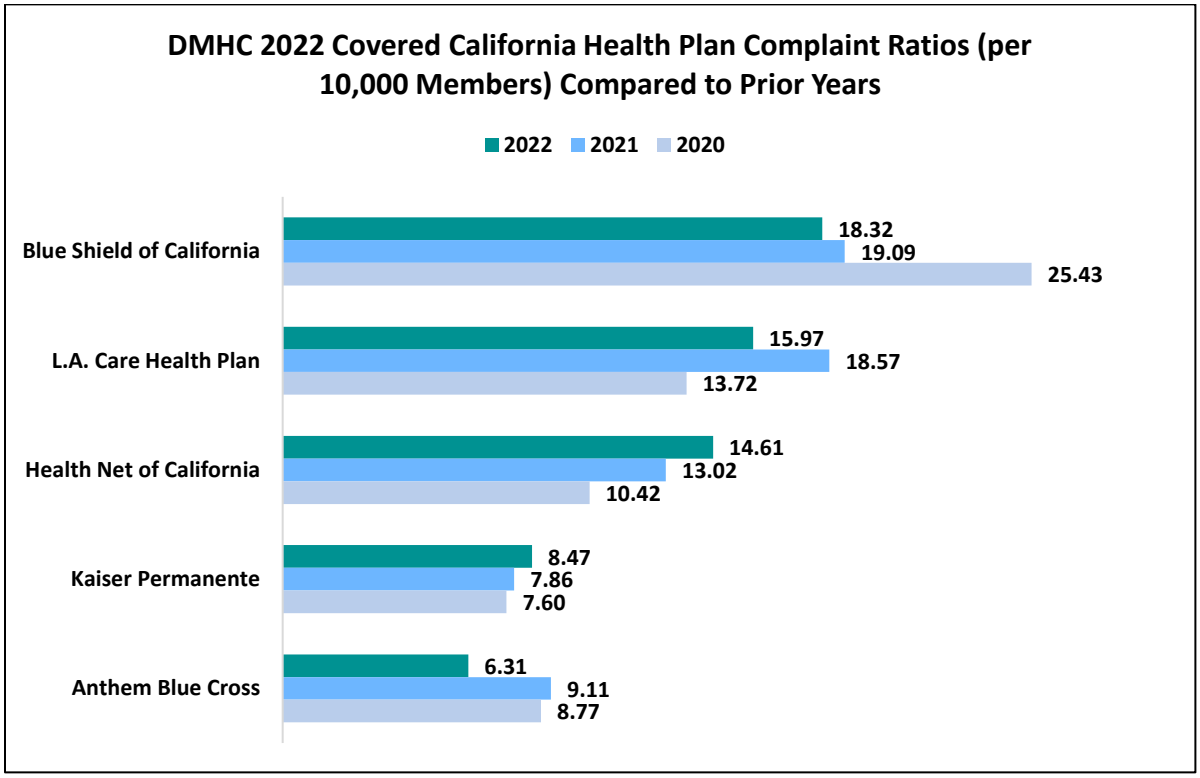
Figure 4.16



Note: The number of reasons exceeded the number of complaints because some cases had more than one reason reported. There were 2,896 reason entries from the 1,967 Covered California plan complaints in 2022. Differences between measurement years may be due in part to changes in data reporting rather than changes in incidence.

The following chart shows the ratios of complaints per 10,000 plan members for Covered California health plans with complaints closed by DMHC in 2022, along with the 2020 and 2021 ratios for those same plans.

Figure 4.17



Note: The display excludes Covered California health plans with enrollment under 70,000 members and/or fewer than 11 complaints in 2022.

Product Type

DMHC reported health plan models under product type. DMHC's 2022 complaint distribution by product type was similar to prior years. Most of the complaints were regarding Health Maintenance Organization (HMO) plans (62.8%), followed by Preferred Provider Organization (PPO) (30.5%), Exclusive Provider Organization (EPO) (3.3%), Point-of-Sale (POS) (1.8%), and Other (under 1%). Approximately one percent of the complaints did not have a product type identified.

D. Consumer Assistance Center Details

The DMHC Help Center received 137,795 requests for assistance from consumers in 2022, including 111,205 requests by telephone, 9,650 online, 9,012 by mail, 5,546 by email, and 2,382 by fax.

Call Metrics

The following table outlines metrics for the 111,205 requests for assistance made by telephone in 2022.

Figure 4.18 DMHC Help Center – 2022 Telephone Metrics

Yearly Metrics	Measurement
Number of Abandoned Calls (terminated by callers prior to reaching a Customer Service Representative – CSR)	3,552
Number of Calls Resolved by the Interactive Voice Response (IVR)/Phone System (caller's needs addressed without involving a CSR)	73,950
Number of Jurisdictional Inquiry Calls*	16,296
Number of Non-Jurisdictional Calls*	6,289
Average Number of Calls Received per Jurisdictional Complaint Case (including follow-up calls after a complaint is filed)	4.61
Average Wait Time to Reach a CSR	6:02 (362 sec)
Average Length of Talk Time (time between a CSR answering and completing a call)	9:10 (550 sec)
Average Number of CSRs Available to Answer Calls (during Service Center hours)	8

*The Help Center agents handled 33,703 calls in 2022, of which 22,585 were inquiries recorded as jurisdictional (16,296) and non-jurisdictional (6,289). The remaining 11,118 agent-handled calls were for other inquiries where jurisdiction was not determined or were related to a complaint initiation.

Inquiry Topics and Referrals

The following table displays the most common topics of consumer inquiries in 2022, including complaints that were outside of DMHC's jurisdiction to address. For each inquiry topic, referral organizations are listed in order of most common to least common referral.

The volumes shown are only those inquiries addressed by the DMHC Help Center staff and exclude certain common calls addressed within the department's Interactive Voice Response system, such as for automated referrals to Covered California, Health Care Options, and some health plans.

Figure 4.19 DMHC Help Center 2022 Top Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Volume	Organization(s) Referred To
1 (most common)	General Inquiry/Info	3,493	Department of Health Care Services (DHCS), Covered California, California Department of Insurance (CDI)
2	Provider Service/Attitude	789	Department of Consumer Affairs (DCA), Health Insurance Counseling and Advocacy Program (HICAP), California Department of Public Health (CDPH)
3	Claims/Financial	613	CDI, HICAP, Out-of-State Department of Insurance (DOI)
4	Access Complaints	430	HICAP, DHCS, Centers for Medicare and Medicaid Services (CMS)
5	Coverage/Benefits Dispute	425	HICAP, DHCS, CDI
6	Enrollment Disputes	287	Covered California, DHCS, HICAP
7	Plan Service/Attitude	170	HICAP, CMS, DHCS
8	Coordination of Care	138	HICAP, DHCS, CMS
9	Appeal of Denial - IMR	28	CDI, Out-of-State DOI, U.S. Department of Labor (DOL) - North, HICAP

Note: The volumes in this table reflect a total count of issues within an inquiry call case. In the Help Center's customer relationship management system, a case can record up to three issues. As a result, the total number of inquiry issues identified is greater than the total number of non-jurisdictional call cases shown in Figure 4.17.

Consumer Assistance Protocols and Systems

DMHC reported the following updates made in 2022 by the Help Center to its consumer assistance protocols and systems:

- A new Independent Medical Review and Complaint Branch desk reference for case reviews pertaining to COVID-19 diagnostic and screening testing to ensure health plans cover costs to meet their requirements under associated All Plan Letters and Senate Bill 510, which became effective January 1, 2022.
- New training for Help Center staff who input and maintain demographic records on the complainants' gender, language, and race/ethnicity within the case tracking system.
- Updates to the Independent Medical Review Application/Complaint Form for better accessibility.

Section 5 - Department of Health Care Services

A. Overview

The Department of Health Care Services (DHCS) operates the Medi-Cal program, which is a public health care program that provides comprehensive health care services at no or low-cost for low-income Californians. In 2022, more than 14 million people were members of the Medi-Cal program. At the time of this report publication, this number is nearly 15 million.

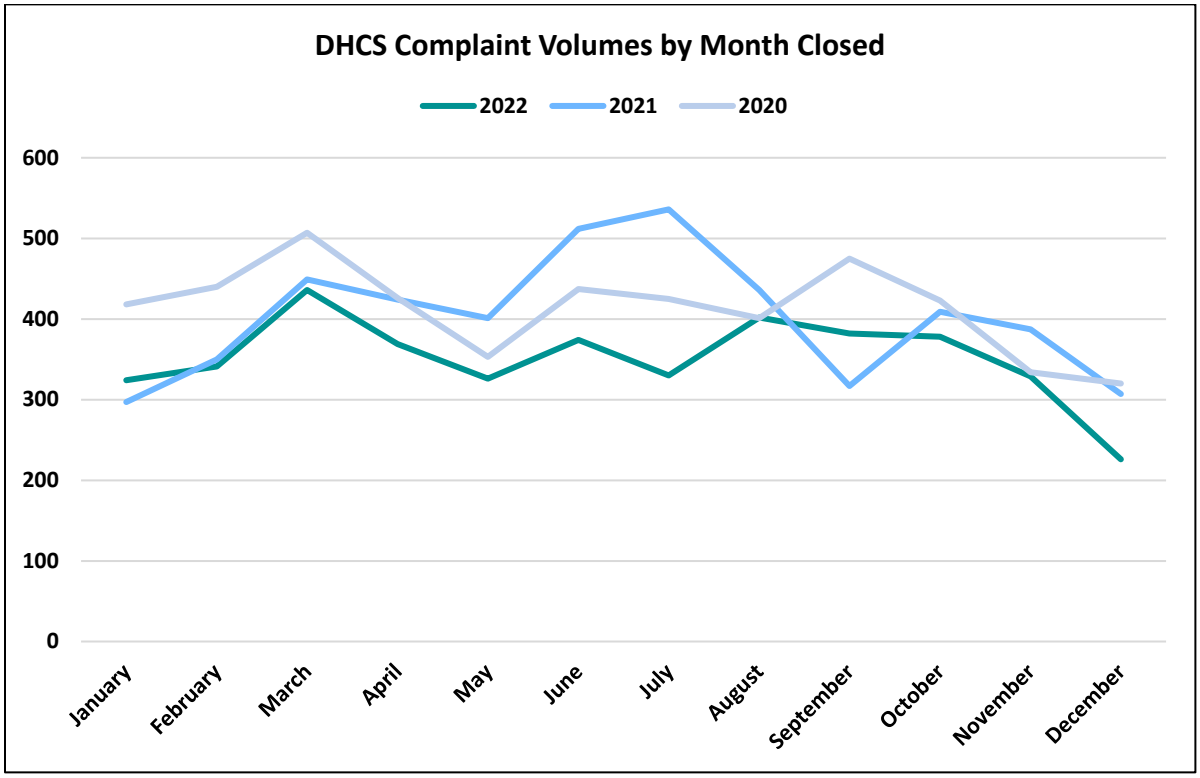
For this report, DHCS provided complaint data for Medi-Cal issues addressed through the State Fair Hearing process, a dispute resolution process conducted by the California Department of Social Services (CDSS) State Hearings Division. DHCS also reported data on inquiries and other consumer assistance information from four consumer assistance service centers: the Office of the Ombudsman, Medi-Cal Telephone Service Center, Medi-Cal Dental Telephone Service Center, and Medi-Cal Rx Customer Service Center.

DHCS submitted 2,028,588 requests for assistance from consumers in 2022, including 4,217 complaints and 2,024,371 inquiries to the four DHCS service centers.

- Data was submitted for the first time for the Medi-Cal Rx Customer Service Center, which began full operations January 1, 2022.
- For total combined inquiry volume for the other three service centers (1,292,893 inquiries in 2022) slightly decreased (0.9%) compared to the prior year total.
    - The decrease in the total was due to a significant decrease in inquiries to the Medi-Cal Dental Telephone Service Center (fell by 9.2% from 2021 to 2022).
    - The Office of the Ombudsman inquiry volume increased by nearly 14 percent (13.7%).
    - The Medi-Cal Telephone Service Center inquiry volume increased by two percent (2.0%).

The following chart displays the monthly volumes by close date for the 4,217 complaints closed in 2022, along with the 4,959 complaints in 2020 and the 4,825 complaints in 2021.

Figure 5.1



The following table displays information about the complaint type submitted by DHCS for all of its complaints: State Fair Hearing. The complaint type category typically indicates the process used to review the complaint.

Figure 5.2 DHCS Complaint Type Overview: Medi-Cal State Fair Hearings

Complaint Type	Primary Unit(s) Responsible	Time Standard	Average Resolution Time in 2022
State Fair Hearing	CDSS State Hearings Division: Conducts hearings on Medi-Cal appeals. Administrative Law Judges make decisions. Urgent clinical issues may qualify for an expedited hearing.	90 days, from the hearing request date	41 days

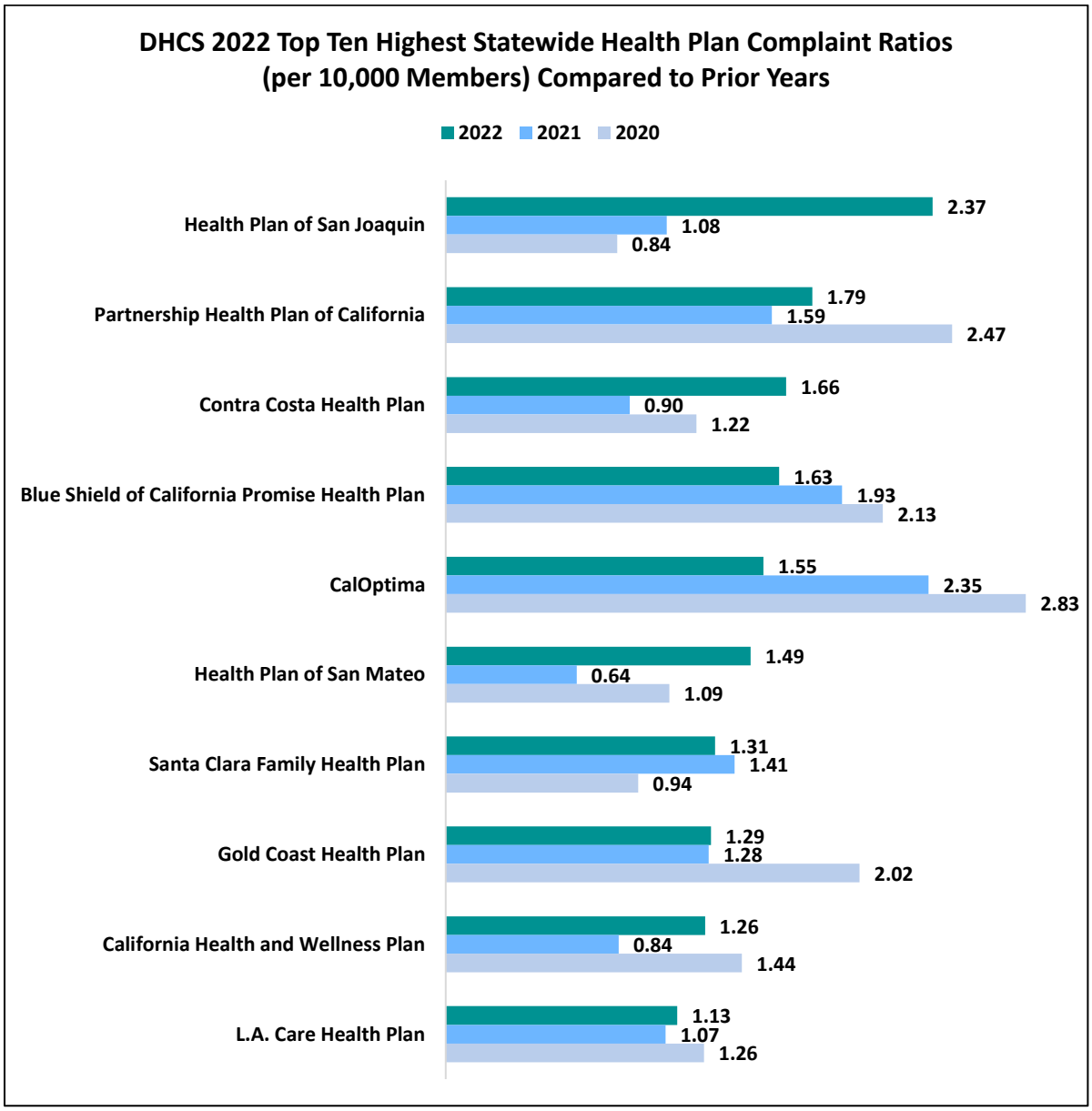
Note: The State Fair Hearing time standard is from All County Letter 14-14 issued by CDSS on 2/17/2014.

B. Complaint Ratios, Reasons, and Results

Health Plan Complaint Ratios

The following chart displays ratios of Medi-Cal managed care plans' State Fair Hearings per 10,000 plan members.

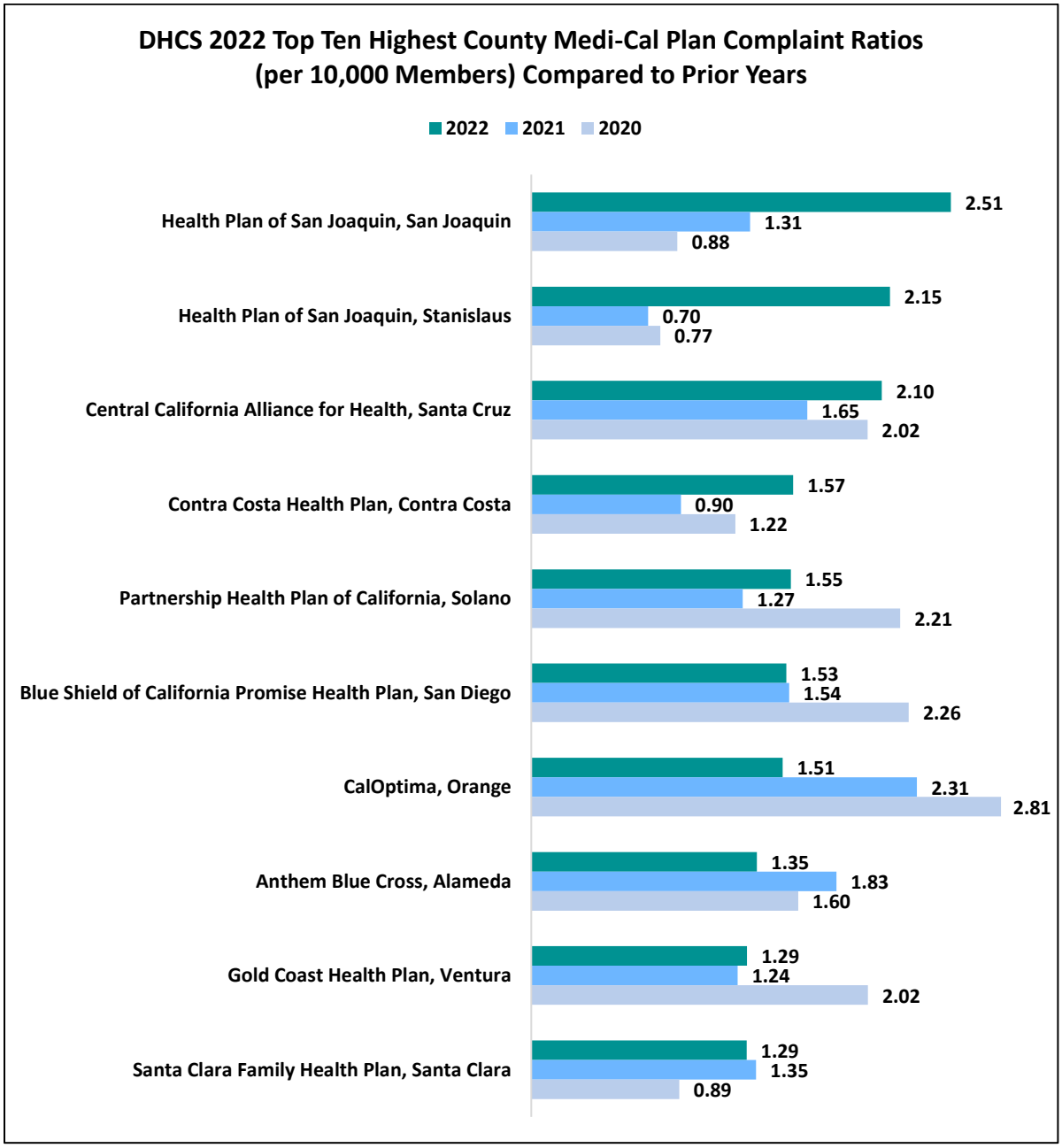
Figure 5.3



Note: The display excludes Medi-Cal plans with 2022 statewide enrollment under 70,000 members and/or fewer than 11 complaints. CDII combined data each plan that serves multiple counties, including under different Medi-Cal contract models. DHCS reports may vary because the department typically monitors quality issues by county contract.

The following chart shows ratios of the Medi-Cal managed care plans' State Fair Hearings per 10,000 plan members for the county plans with the highest ratios.

Figure 5.4

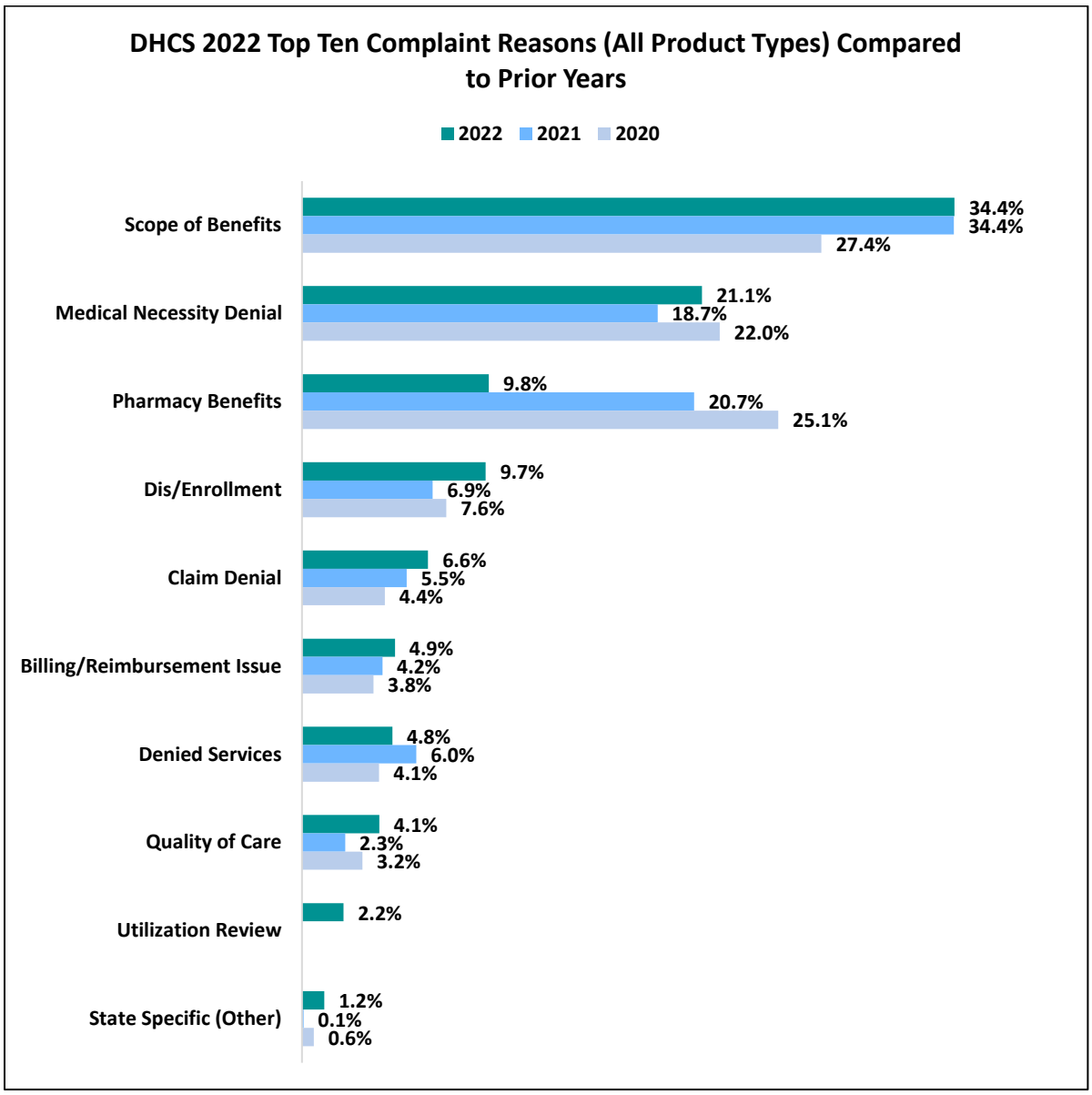


Note: The display excludes Medi-Cal plans with 2022 county enrollment under 70,000 members and/or fewer than 11 complaints. Multiple managed care contract models are represented. County Organized Health System (COHS): Central California Alliance for Health, Santa Cruz; Partnership Health Plan of California, Solano; CalOptima, Orange; and Gold Coast Health Plan, Ventura. Geographic Managed Care: Blue Shield of California Promise Health Plan, San Diego. Two-Plan Model Commercial: Anthem Blue Cross, Alameda. Two-Plan Model Local Initiative: Health Plan of San Joaquin, San Joaquin and Stanislaus; Contra Costa Health Plan, Contra Costa; and Santa Clara Family Health Plan, Santa Clara.

Complaint Reasons

The following chart displays the top complaint reasons in 2022 for all submitted DHCS delivery systems, which were reported to CDII as product types. Differences between measurement years may be due in part to changes in reporting rather than changes in incidence.

Figure 5.5



Note: The number of complaint reasons exceeded the number of complaints because some cases had more than one reason reported. There were 4,246 reason entries from the 4,217 complaints in 2022. DHCS submitted Utilization Review for the first time for 2022 due to tracking system improvements that changed denial reason categorizations.

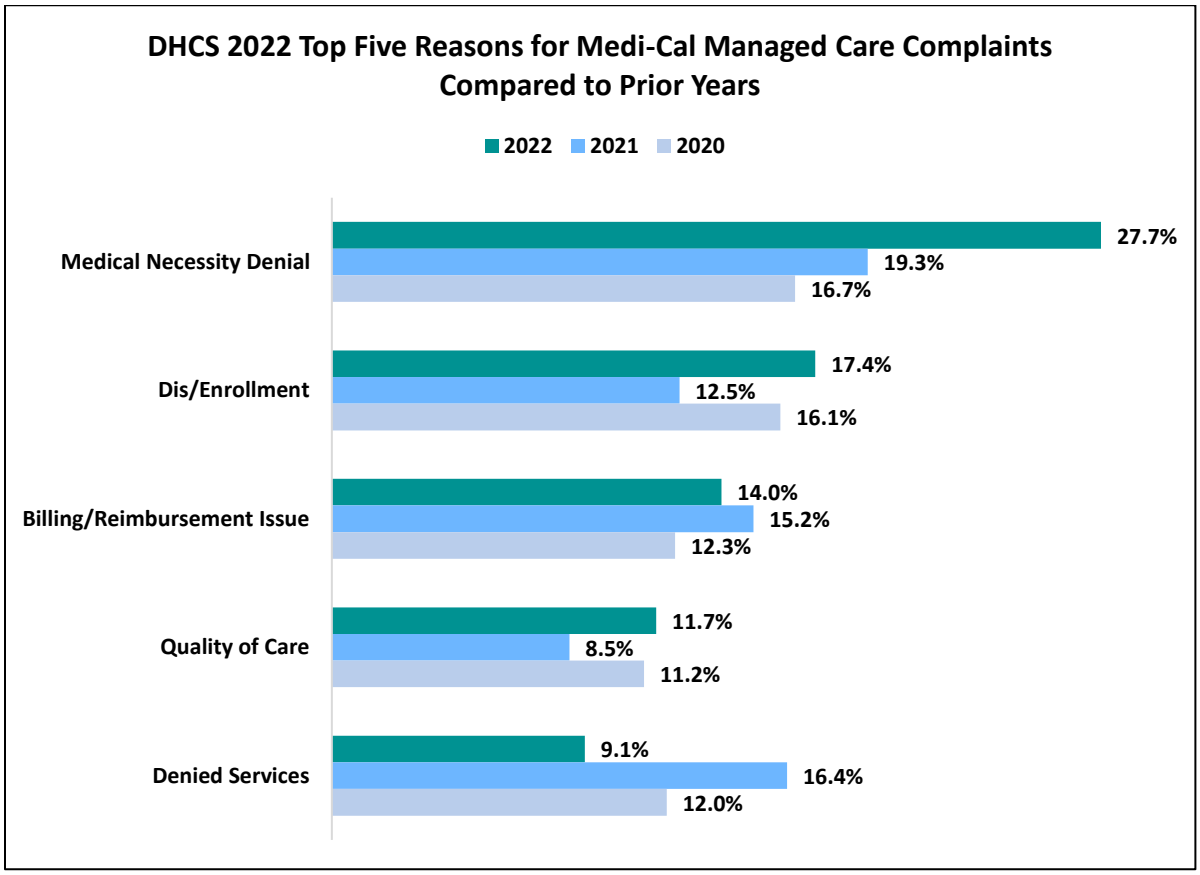
DHCS indicated that the significant decrease in Pharmacy Benefits complaints was associated with the implementation of Medi-Cal Rx and policy changes to improve covered benefits.

The top complaint reason for each delivery system reported by DHCS (with the top reason's distribution for the specified delivery system).

- Dental – Scope of Benefits (76.6%)
- Managed Care – Medical Necessity Denial (27.7%)
- Fee-for Service – Pharmacy Benefits (36.6%)
- Mental Health – Denied Services (100.0%)
- Unknown Delivery System – Denied Services (88.2%)
- Medi-Cal Coordinated Care – Too few to report

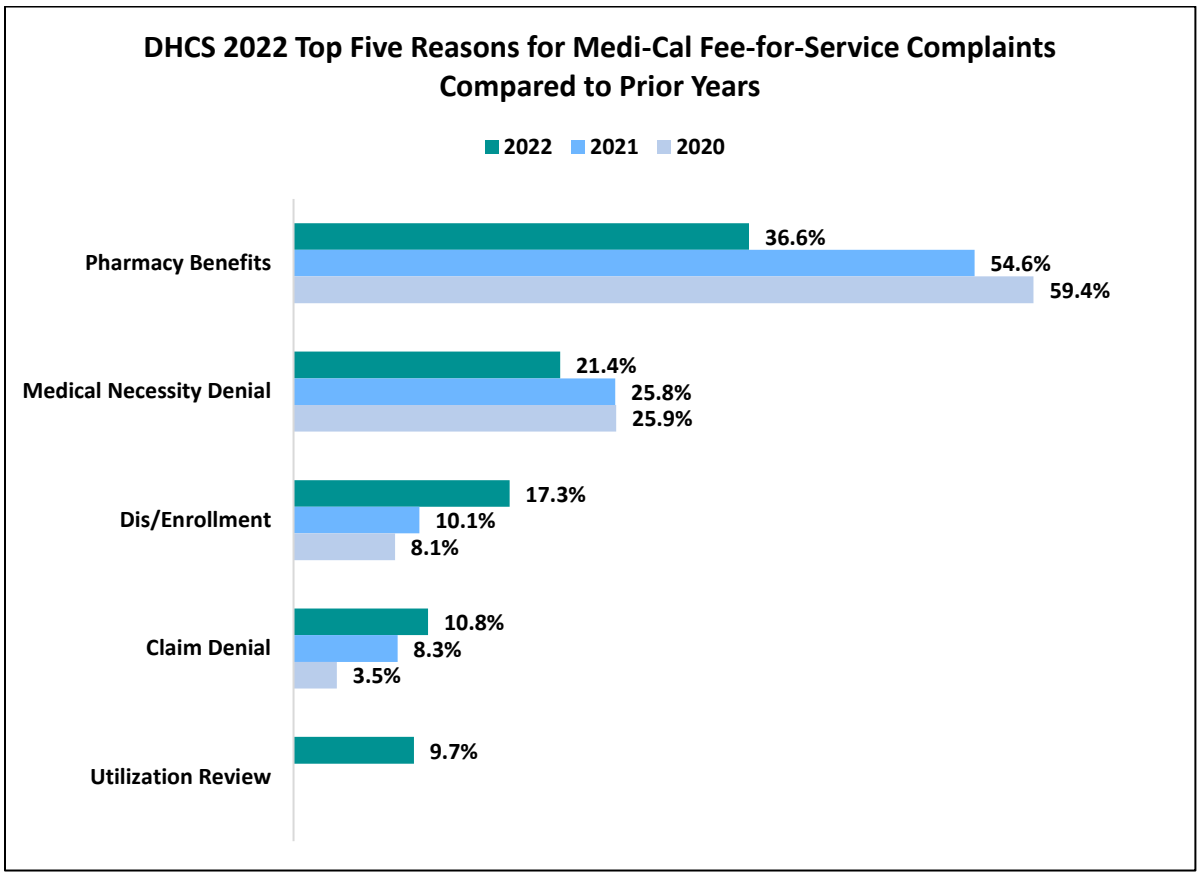
The following chart shows the most common complaint reasons for the Medi-Cal Managed Care delivery system in 2022, as well as the 2020 and 2021 data for those same reason categories.

Figure 5.6



The following chart shows the most common complaint reasons for the Medi-Cal Fee-for-Service delivery system in 2022, as well as the 2020 and 2021 data for those same reason categories.

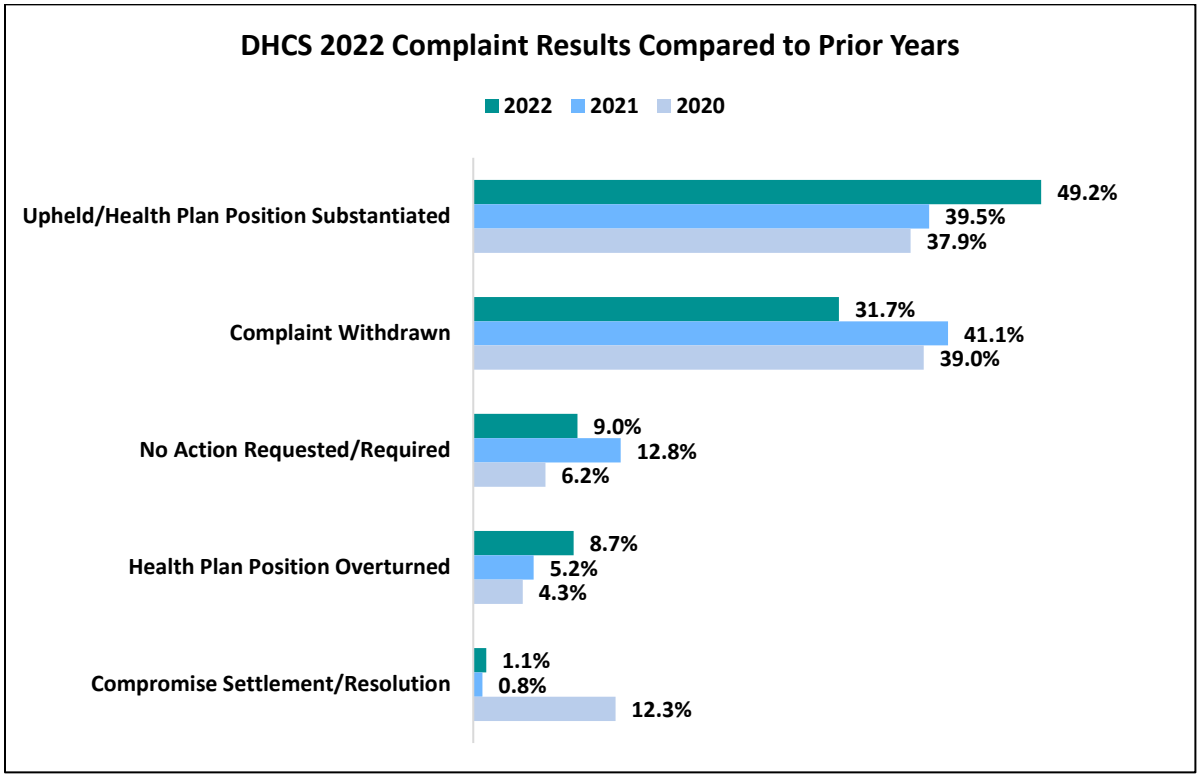
Figure 5.7



Complaint Results

The following chart displays the most common results of the DHCS complaints closed in 2022, as well as the 2020 and 2021 data for the same results categories.

Figure 5.8

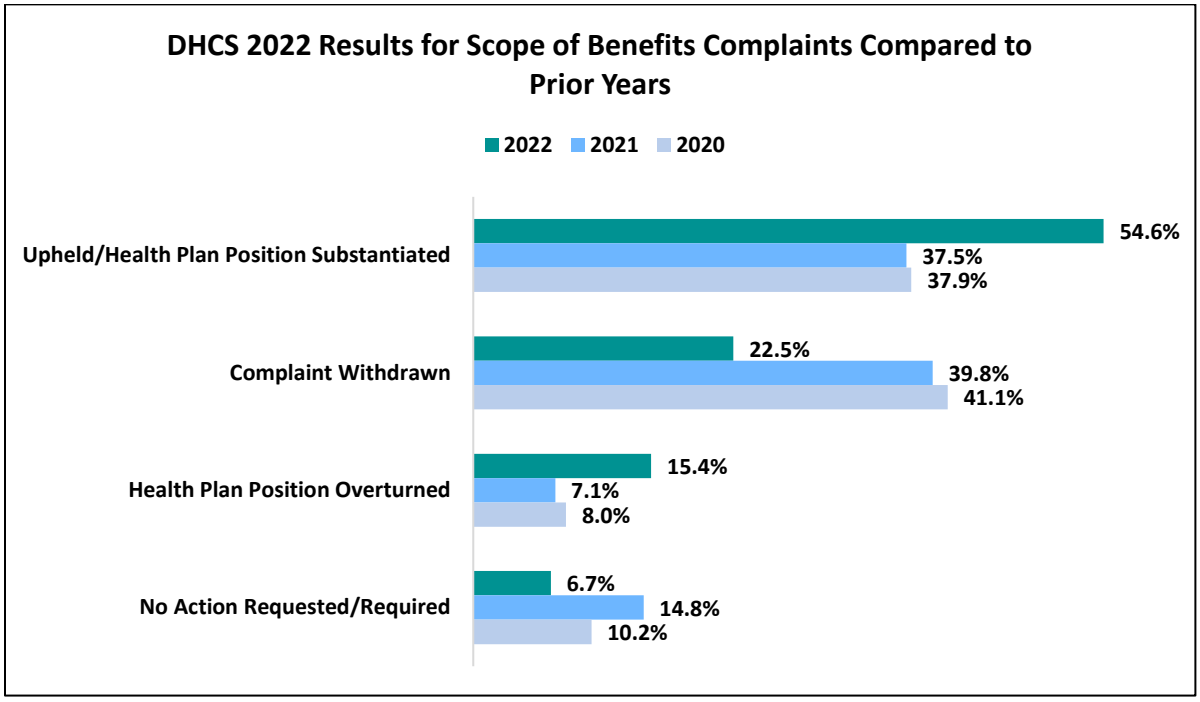


Note: The display excludes results categories with low volumes in 2022. The number of results exceeded the number of complaints because some cases had more than one result reported each measurement year. There was only one case with more than one result in 2022. The result categories considered as favorable to the complainant: Health Plan Position Overturned and Compromise Settlement/Resolution. The result category considered as favorable to the health plan: Upheld/Health Plan Position Substantiated. The favorability of the other categories is neutral or cannot be determined. For some categories, favorable to the complainant does not necessarily mean that the complaint was substantiated against the health plan. For DHCS, No Action Requested/Required indicates that the case was dismissed either administratively or because the complainant did not appear for the hearing.

DHCS indicated that the 2022 increase in Upheld/Health Plan Position Substantiated results is primarily associated with complaints involving the transition of Fee-for-Service members to Medi-Cal managed care plans. DHCS also noted that many of the Complaint Withdrawn results involve a deferred services issue resolved by the complainant's medical provider before the hearing date and with a favorable outcome for the complainant.

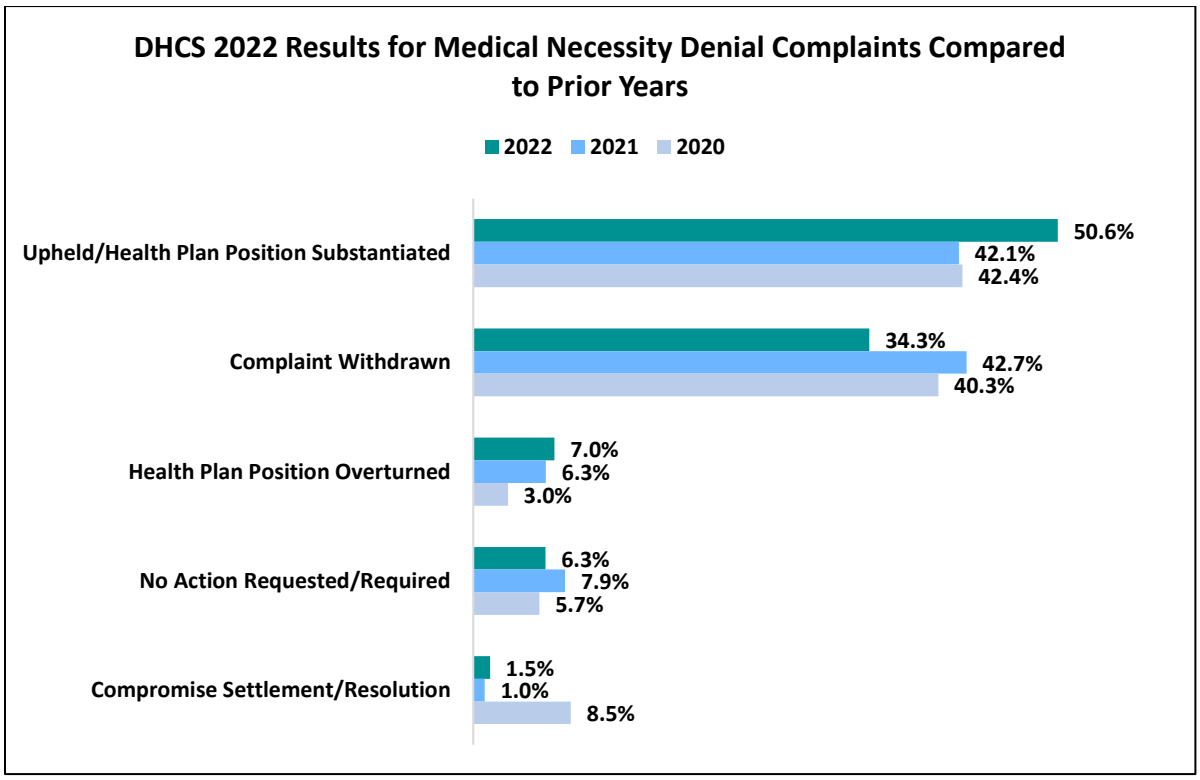
Figures 5.9 – 5.12 display the 2022 results for the most common complaint reasons reported by DHCS, along with the 2020 and 2021 data for the same results categories.

Figure 5.9



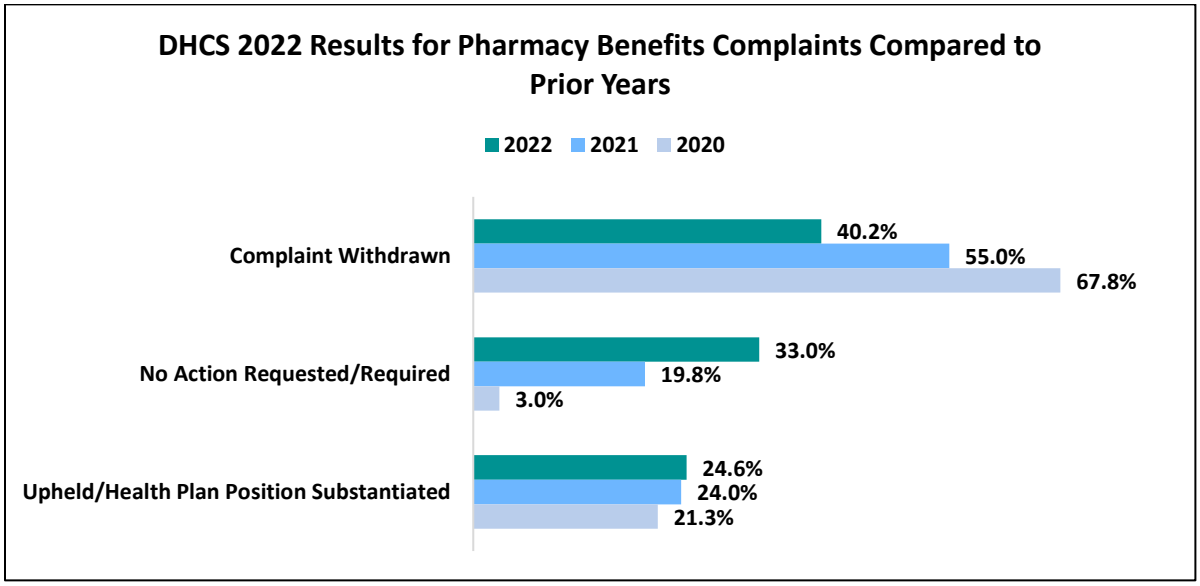
Note: The above display excludes results categories with low volumes in 2022.

Figure 5.10



Note: The above display excludes results categories with low volumes in 2022.

Figure 5.11

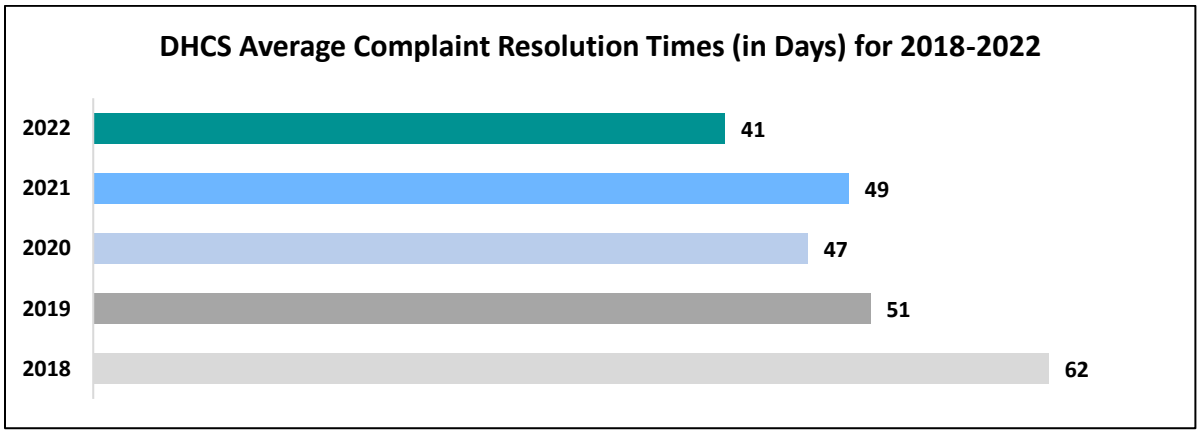


Note: The above display excludes results categories with low volumes in 2022.

Resolution Time

The following chart displays the average number of days for the DHCS State Fair Hearings to be completed for cases closed in 2022 compared to prior years.

Figure 5.12



The 2022 average resolution times by DHCS delivery system:

- Mental Health – 61 days
- Managed Care – 53 days
- Medi-Cal Coordinated Care – 40 days
- Fee-for-Service – 36 days
- Pharmacy Benefits – 35 days
- Dental – 34 days

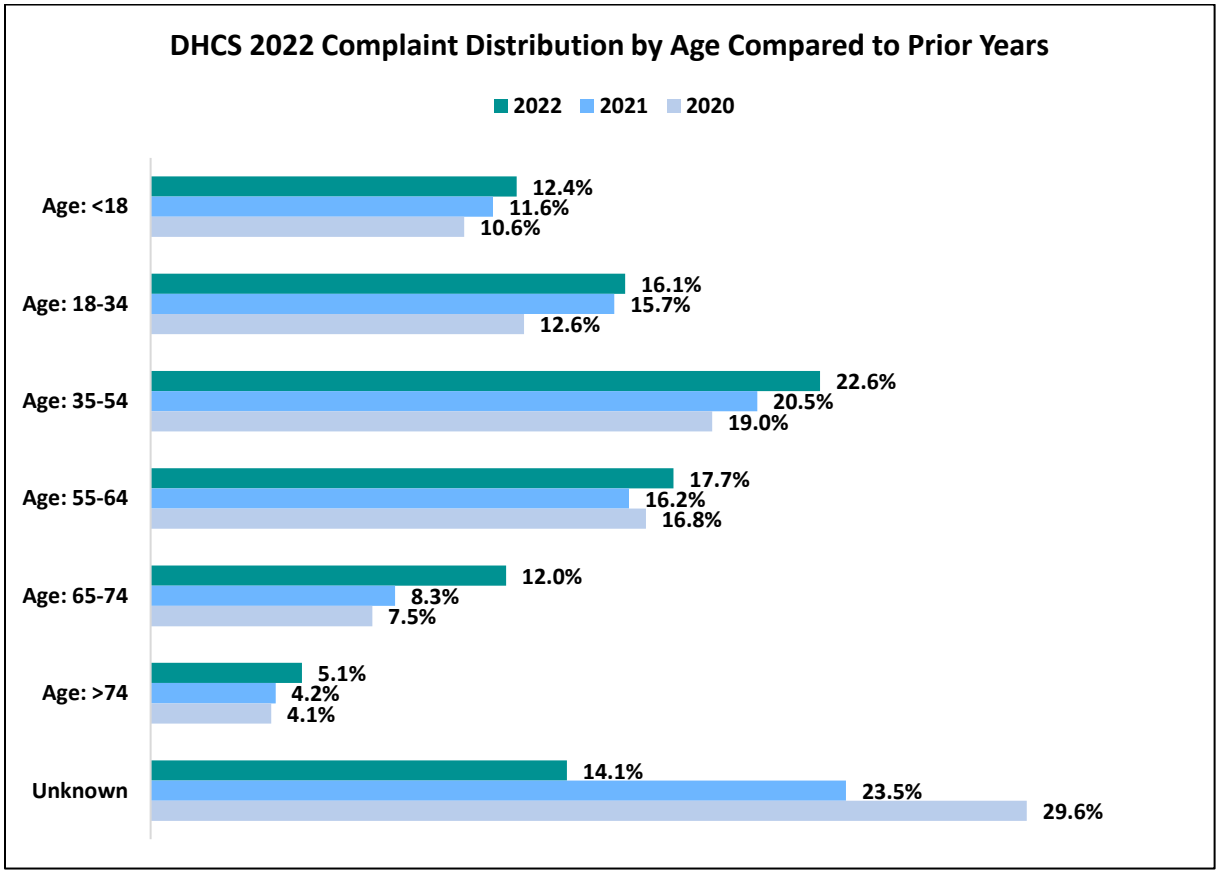
C. Demographics and Other Complaint Characteristics

DHCS noted that many demographic categories had decreases in Unknown and increases in known demographic elements from 2021 to 2022 due to the transition of Medi-Cal Fee-for-Service members to Medi-Cal Managed Care, which has more robust data reporting for its hearings.

Age

The following figure shows the DHCS 2022 complaint distribution by age group, along with the 2020 and 2021 data for those same age groups.

Figure 5.13



For 2022, the most common complaint reason for children under 18 continued to be Medical Necessity Denial (56.2% of the Under 18 reasons), while Scope of Benefits was the top reason for adults 18 and over (ranging from 37.3% to 55.8% of reasons for those age groups). Unknown's top reason was Pharmacy Benefits (54.5%).

- DHCS noted that the difference between the reasons for children and adults may continue to be attributable to State Fair Hearings related to dental services under Medi-Cal, which has a high level of age data capture and is the delivery system

accounting for the highest volume of the DHCS reported complaints. Within Medi-Cal, some types of dental services are more limited for adults than for children, resulting in more adults facing denials due to the scope of the covered benefits.

Gender

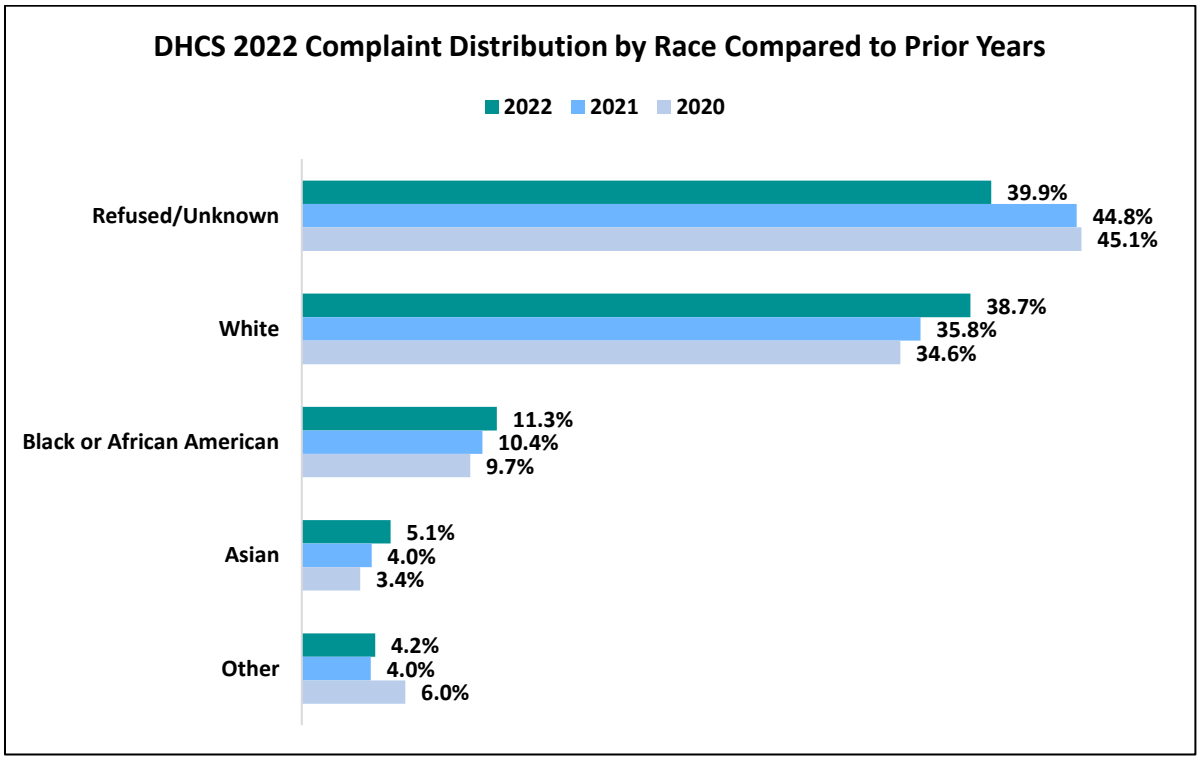
DHCS collects limited gender data as part of the online Medi-Cal enrollment process, while CDSS does not collect gender data for State Fair Hearing filings. The data submitted to CDII under gender represents data collected about sex. This data does not reflect sexual orientation or gender identity.

Half of the DHCS complaints in 2022 identified the complainant as Female (50.6% of the 4,217 complaints) and over a third were identified as Male (34.9%). With more than 14 percent Unknown and Refused combined (14.5%), the number of complaints without gender identified fell for the second year.

Race

The following chart displays the 2022 complaints by the submitted race of the complainant. Nearly 40 percent did not have race identified (34.2% Unknown and 5.7% Refused).

Figure 5.14



Note: The chart excludes race categories with low volumes in 2022.

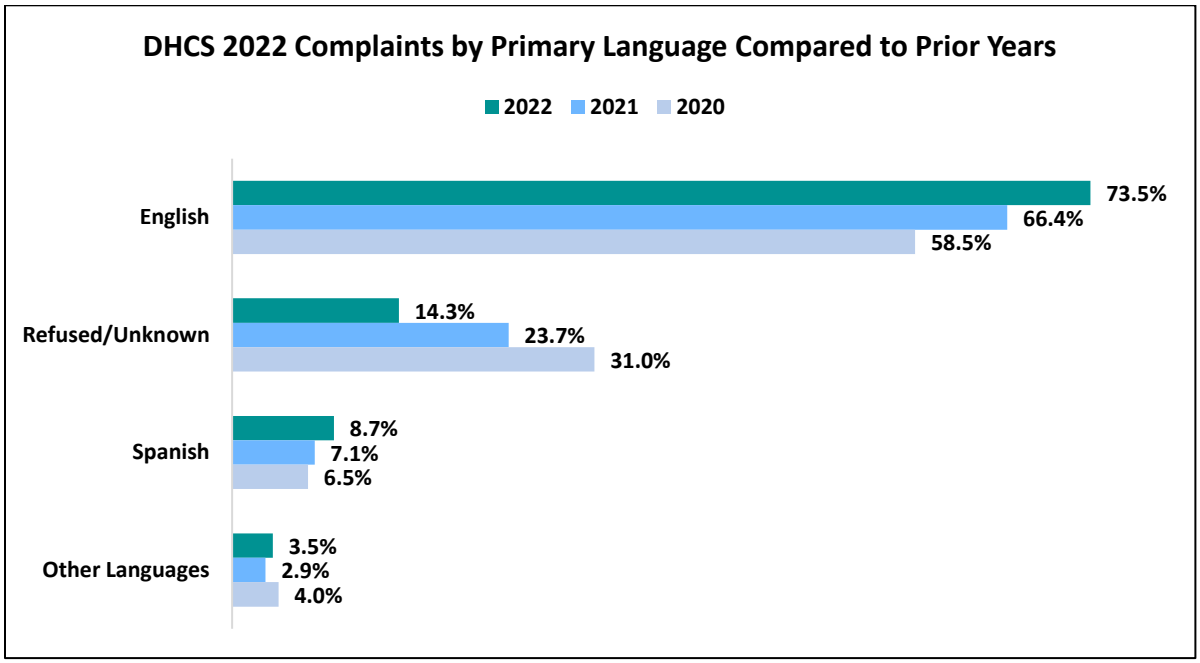
Ethnicity

Nearly 43 percent of the DHCS 2022 complaints identified the complainant's ethnicity as Not Hispanic or Latino (42.9% of the 4,217 complaints). Twenty two percent were submitted as Hispanic or Latino (22.0%). Approximately 35 percent did not have the complainant's ethnicity identified (29.4% Unknown and 5.7% Refused).

Primary Language

The following chart displays the DHCS 2022 complaints by the complainant's primary language, along with the 2020 and 2021 data for the same language categories.

Figure 5.15

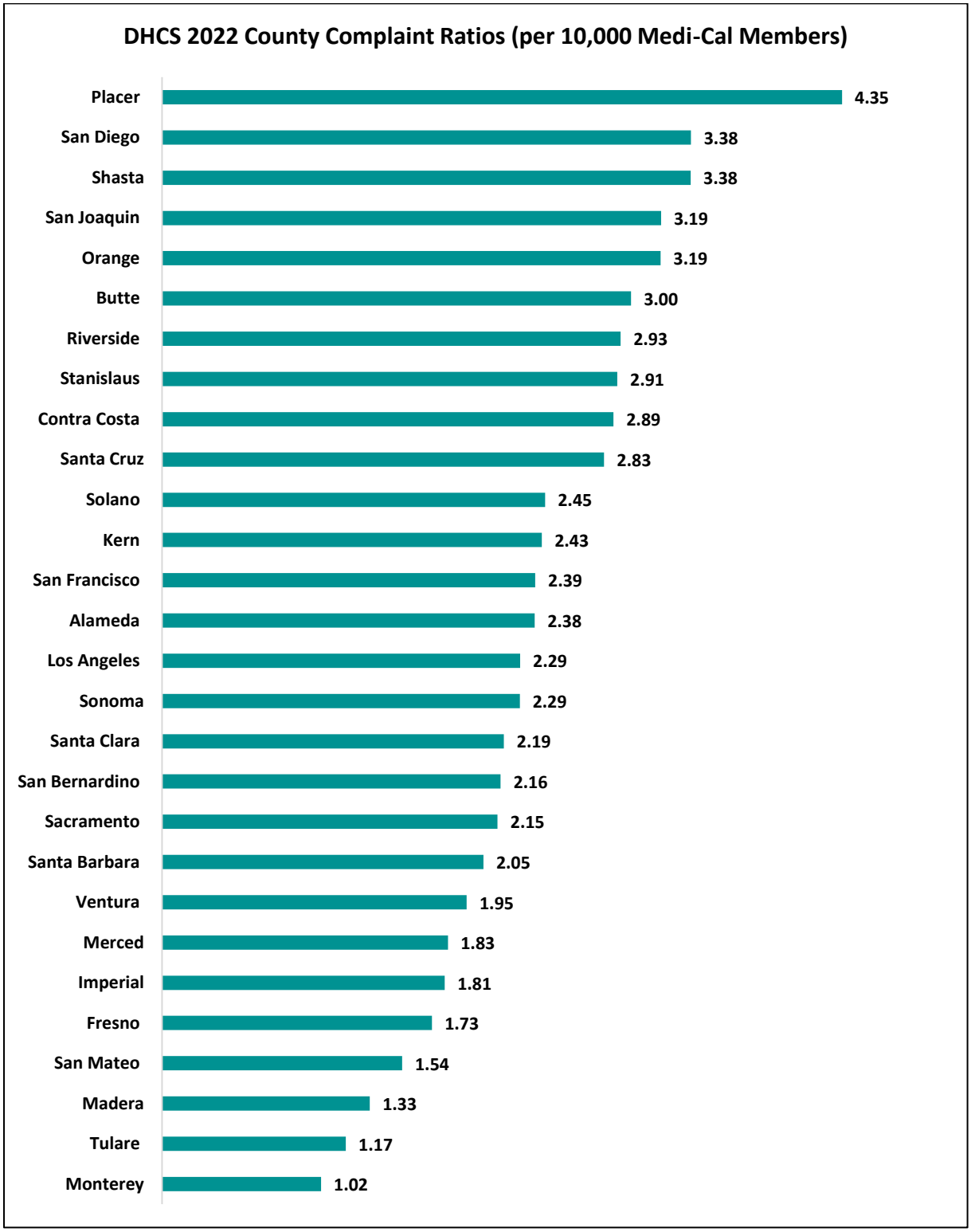


Note: Other Languages combines language categories with low volumes of complaints: Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Japanese, Korean, Mandarin, Other, Other Chinese, Russian, Tagalog, and Vietnamese.

Resident County

The following chart shows county ratios based on each county's volume of 2022 DHCS complaints by its residents divided by the number of Medi-Cal members in the county in the same year.

Figure 5.16



Note: The chart excludes counties with Medi-Cal enrollment under 70,000 members and/or fewer than 11 complaints in 2022.

Initial Mode of Contact

For the DHCS 2022 complaints, telephone was the most common mode of contact used to initiate a complaint (40.4% of the 4,217 complaints), following by Mail (21.5%) and Online (1.1%). Nearly 37 percent of the complaints did not have an initial mode of contact identified (36.9% Unknown).

Regulator

The coverage regulator reported for most of the DHCS 2022 complaints was Other (67.5%) while DMHC was identified for nearly a third of the complaints (32.5%).

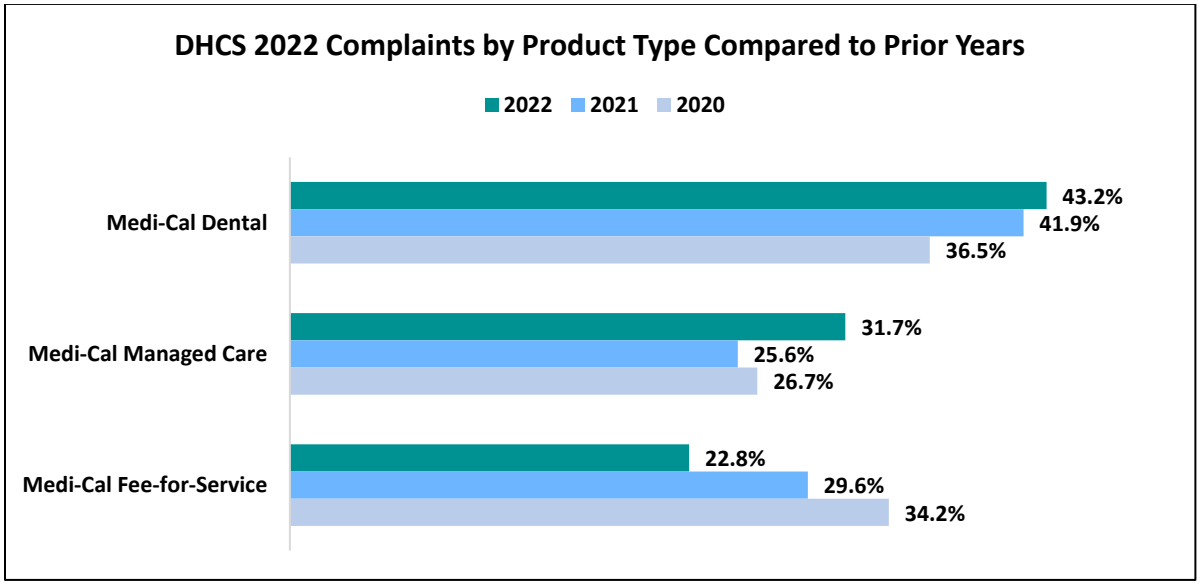
Source of Coverage

Like in previous measurement years, nearly all of the DHCS 2022 complaints were associated with the Medi-Cal source of coverage (98.8% of the 4,217 complaints). Approximately one percent (1.2%) of the complaints identified Medi-Cal/Medicare as the source of coverage.

Product Type

DHCS reports its health care delivery systems under product type. The following chart displays the DHCS 2022 complaints by product type, along with the 2020 and 2021 data for the same product type categories.

Figure 5.17



Note: The chart excludes product type categories with low volumes: Long-Term Care, Medi-Cal Coordinated Care, Mental Health, and Unknown.

D. Consumer Assistance Center Details

In addition to its State Fair Hearings data, DHCS submitted information for Measurement Year 2022 from four consumer assistance service centers: the Office of the Ombudsman, Medi-Cal Telephone Service Center, Medi-Cal Dental Telephone Service Center, and Medi-Cal Rx Customer Service Center. There were 2,024,371 inquiries made to the four service centers in 2022. All of the requests for assistance to these service centers are categorized as inquiries because the service centers do not make determinations for the complaints submitted by DHCS for this report.

- The Office of the Ombudsman's inquiry volume increased by nearly 14 percent (13.7%) from the prior year to 191,257 inquiries in 2022.
- The Medi-Cal Telephone Service Center's inquiry volume increased by two percent from the prior year to 634,134 inquiries in 2022.
- The Medi-Cal Dental Telephone Service Center's inquiry volume decreased by more than nine percent (9.2%) from the prior year to 463,285 inquiries in 2022.
- In its first year of full operations, the Medi-Cal Rx Customer Service Center received 735,695 inquiries in 2022.

Figures 5.18-5.21 display the service centers' monthly inquiry volumes in 2022, along with the 2020 and 2021 data if available.

Figure 5.18

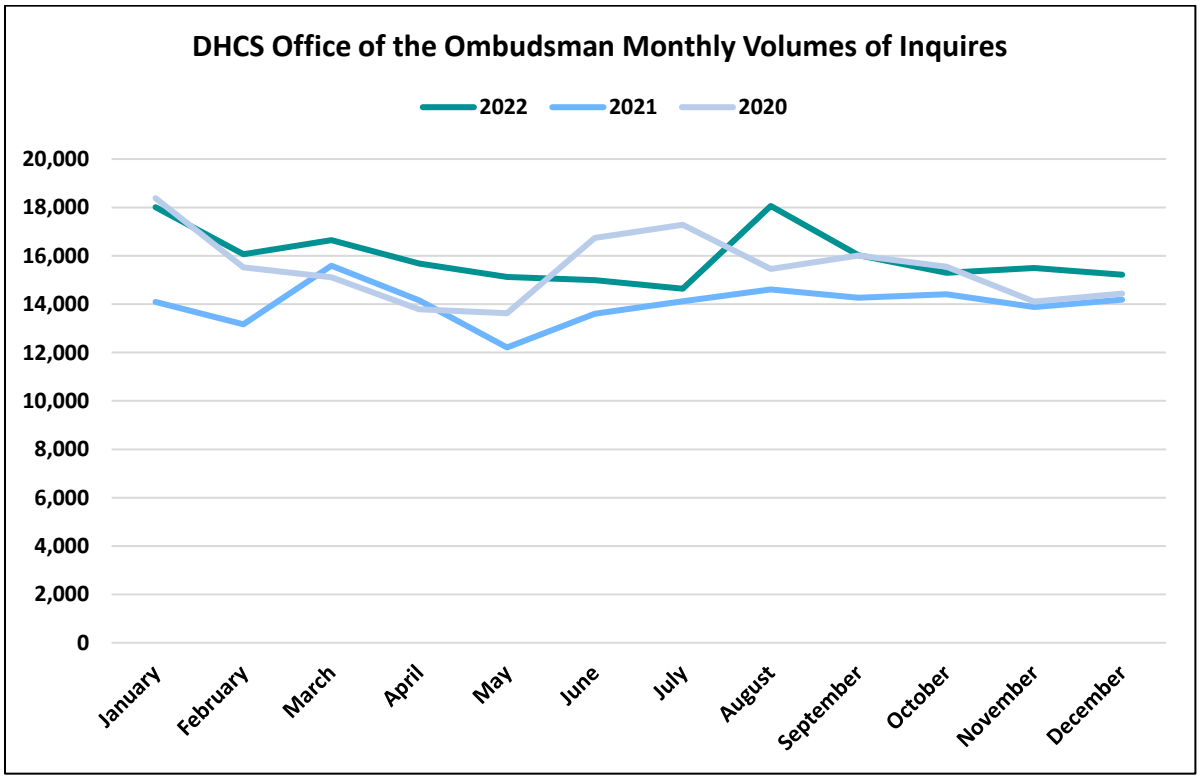


Figure 5.19

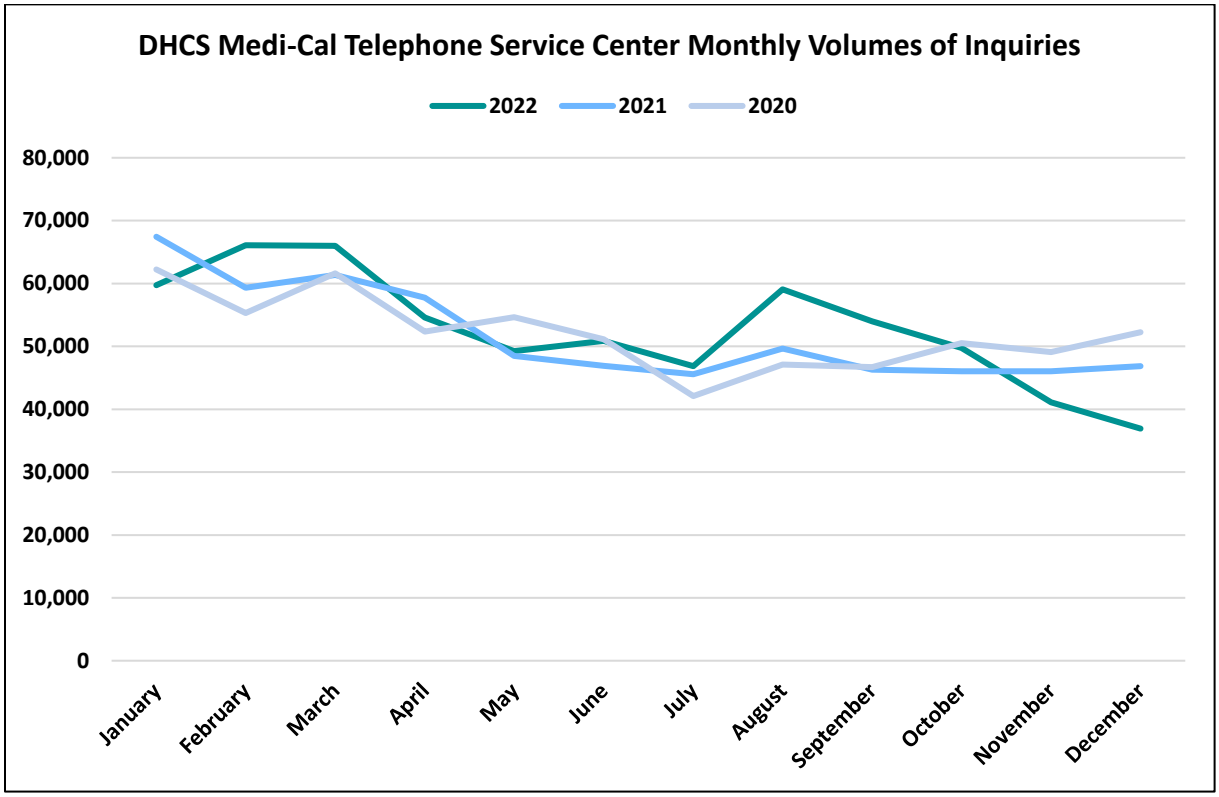


Figure 5.20

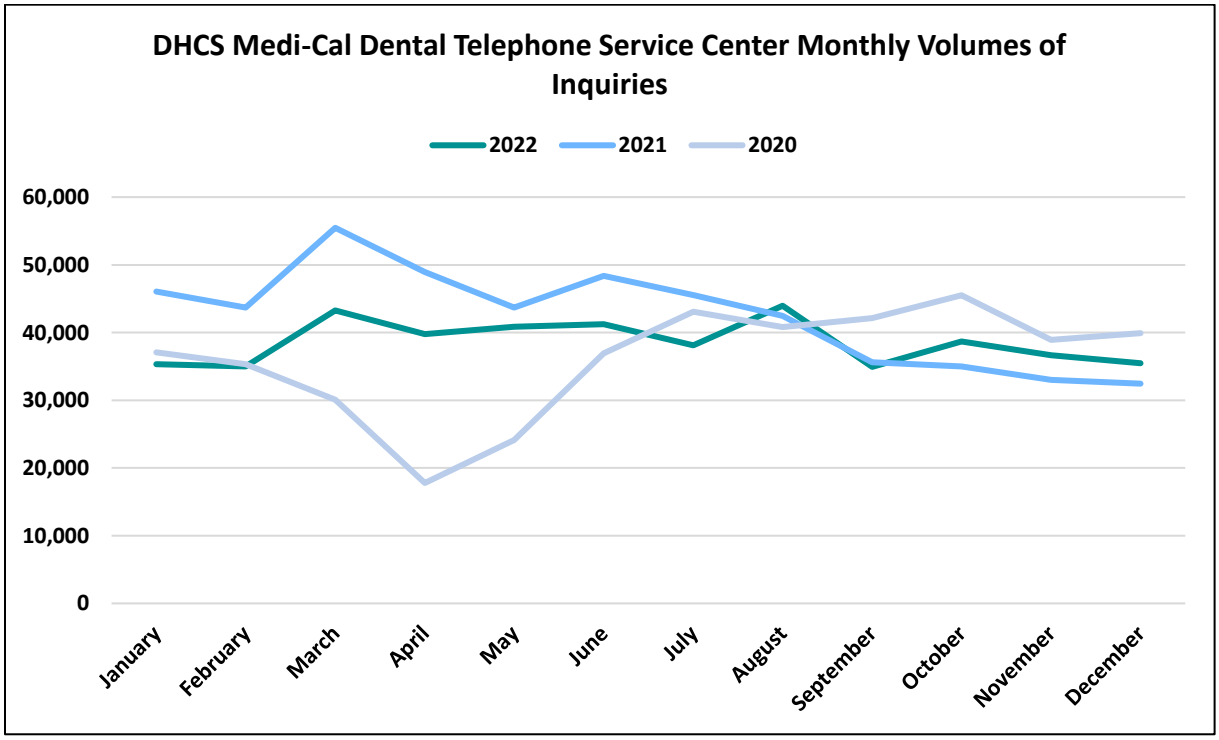
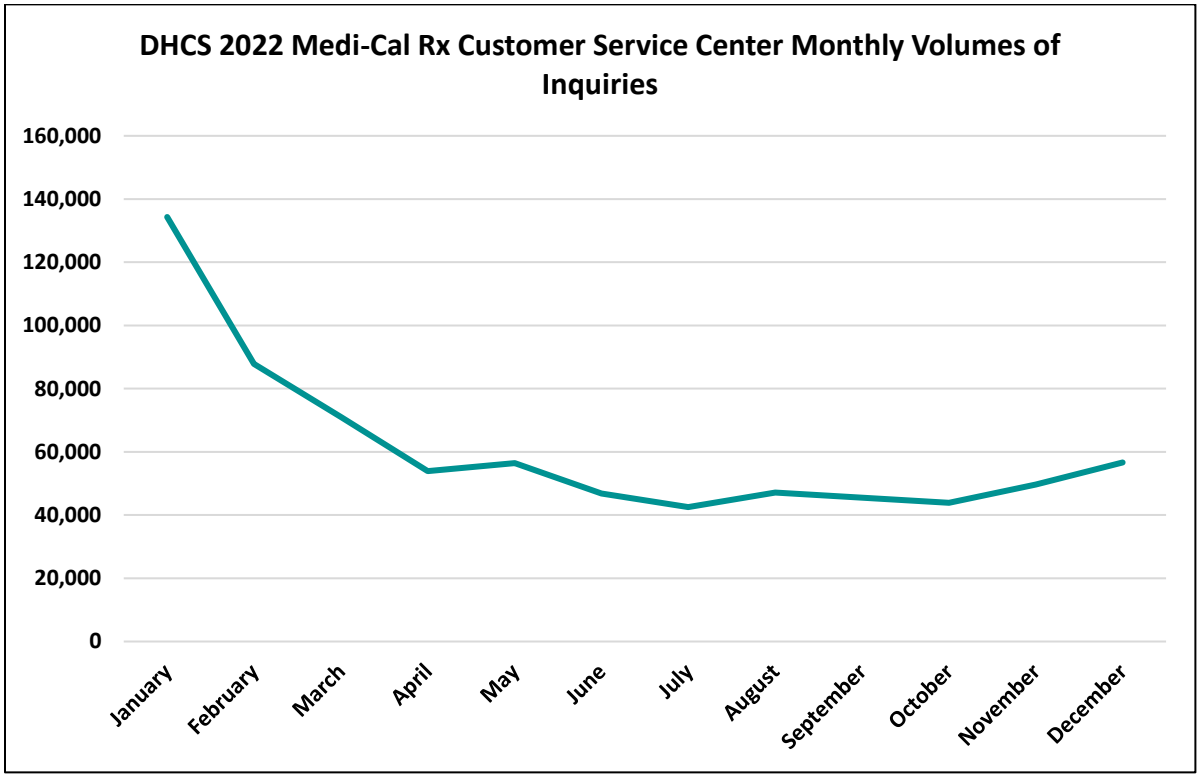


Figure 5.21



Note: Prior year data for comparison is not available since the Medi-Cal Rx Customer Service Center did not begin full operations until January 2022.

DHCS noted that a significant portion of the Medi-Cal Rx Customer Service Center's call volumes during the initial months of 2022 were abandoned calls due to the Medi-Cal Rx assumption of operations issues and issues with the implementation.

- Of the 2022 volumes, there were 28,842 abandoned calls in January and 17,370 in February.
- Operational changes significantly reduced the number of abandoned calls in the proceeding months (monthly volumes ranging from zero to 48 abandoned calls during the rest of 2022).

Call Metrics

DHCS reported that its four service centers received 1,763,563 telephone calls in 2022.

The following table outlines metrics about these telephone calls for each of the four service centers.

Figure 5.22 DHCS Service Centers' 2022 Telephone Metrics

Metric	Office of the Ombudsman	Medi-Cal Telephone Service Center	Medi-Cal Dental Telephone Service Center	Medi-Cal Rx Customer Service Center
Telephone Call Volume	178,301	634,134*	456,491	494,610
Number of Abandoned Calls (incoming calls ended by callers prior to reaching a Customer Service Representative – CSR)	8,126	47,368	25,361	46,342
Number of Calls Resolved by the Interactive Voice Response (IVR)/ Phone System	71,053	2,456,280**	165,520	4,291
Number of Jurisdictional Inquiry Calls	99,122	634,134	449,337	488,813
Number of Non-Jurisdictional Calls	Considered the same as calls resolved by the IVR	Not available	7,291	1,506
Average Wait Time to Reach a CSR	2.5 Minutes	2:26 (146 sec)	1:40 (100 sec)	5:11 (311 sec)
Average Length of Talk Time (Between a CSR answering and completing a call)	7 Minutes	6:32 (392 sec)	10:25 (625 sec)	9:35 (575 sec)
Average Number of CSRs Available to Answer Calls (during service center hours)	18	55	161	223

*The Medi-Cal Telephone Service Center telephone call volume only includes jurisdictional inquiries from Medi-Cal members.

**The Medi-Cal Telephone Service Center's reported IVR volume includes calls from both Medi-Cal members and Medi-Cal providers because the member data could not be separated for reporting.

Inquiry Topics and Referrals

Figures 5.23 – 5.26 show the most common inquiry topics consumers contacted the DHCS service centers about in 2022 as well as the organizations to which consumers were referred.

Figure 5.23 Office of the Ombudsman 2022 Top Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	2022 Volume	Organization(s) Referred To
1 (most common)	Medi-Cal Eligibility	44,709	County Medi-Cal Office
2	Fee-for-Service	7,119	Medi-Cal Telephone Service Center
3	Health Care Options	4,858	Health Care Options
4	Medicare	4,840	Medicare
5	Mental Health	3,239	County Mental Health Program
6	Covered California	3,311	Covered California
7	Dental	1,925	Medi-Cal Dental Division
8	State Fair Hearings	1,052	California Department of Social Services

Figure 5.24 Medi-Cal Telephone Service Center 2022 Top Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Organization(s) Referred To
1 (most common)	Member Inquiry/Eligibility	County Medi-Cal Office
2	Member Inquiry/Eligibility	Managed Care Plan
3	Member Inquiry/Eligibility	Medi-Cal (dental benefits)
4	Member Inquiry/Eligibility	Medicare
5	Member Inquiry/Coverage	Pharmacy
6	Member Inquiry/Coverage	Medicare Part D
7	Member Inquiry/Coverage	Other Coverage
8	Member Inquiry/Coverage	Low Income Subsidy
9	Member Inquiry/Eligibility	Managed Care Plan CalAIM Initiative
10	Member Inquiry/Coverage	County Office; 1095-B

Note: The Medi-Cal Telephone Service Center ranking information was estimated by DHCS and so does not have reported volumes.

Figure 5.25 Medi-Cal Dental Telephone Service Center 2022 Top Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	2022 Volume	Organization(s) Referred To
1 (most common)	Complaint about Care or Treatment Performed	4,963	California Dental Board
2	Complaint about Provider Office Conduct	1,416	California Dental Board
3	Complaint about Office or Staff	368	California Dental Board
4	Complaint about a Clinical Screening Dentist	226	California Dental Board
5	Complaint - Member Website	134	Member Outreach
6	Mail not Received	57	Correspondence Unit
7	Medical Necessity	54	California Department of Social Services - State Fair Hearing
8	Lack of primary care provider availability	28	Care Coordination Unit

Ranking	Inquiry Topic	2022 Volume	Organization(s) Referred To
9	Excessive long wait time/appt schedule time	24	Care Coordination Unit
10	Received Records	21	Correspondence Unit

Figure 5.26 Medi-Cal Rx 2022 Top Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	2022 Volume	Organization(s) Referred To
1 (most common)	Medi-Cal Eligibility Status	37,554	County Medi-Cal Office
2	Other Health Provider - MCP	31,342	Managed Care Plan
3	Other Health Provider - Primary Coverage	18,842	Other Health Care Provider or County Medi-Cal Office
4	Changes to Eligibility Information	14,766	County Medi-Cal Office

Consumer Assistance Protocols and Systems

DHCS reported a new service center that came into full operation on January 1, 2022, as part of Medi-Cal Rx and provided information about its protocols and systems.

Medi-Cal Rx Overview

Medi-Cal Rx is the name DHCS has given to the collective pharmacy benefits and services that are administered through a fee-for-service delivery system, provided via a pharmacy. To meet requirements under Governor Gavin Newsom's Executive Order N-01-19, pharmacy services that Medi-Cal members previously received through managed care plans were transitioned to the Medi-Cal Rx delivery system. Medi-Cal Rx also serves California Children's Services and the Genetically Handicapped Persons Program. Medi-Cal Rx was not applied to Programs of All-Inclusive Care for the Elderly, Senior Care Action Network, Cal MediConnect health plans, and Major Risk Medical Insurance Program.

Medi-Cal Rx Customer Service Center

The Medi-Cal Rx Customer Service Center assists Medi-Cal members, pharmacies, prescribers, Medi-Cal managed care plan representatives and other interested parties. This service center provides services related to Medi-Cal pharmacy benefit, eligibility, prior authorization, and claims/reimbursement.

- The DHCS contractor (Magellan Medicaid Administration, LLC in 2022, as of the date of this report, the contractor is Prime Therapeutics) that administers the Medi-Cal Rx delivery system operates the Customer Service Center.
- The Customer Service Center (1-800-977-2273) is available 24 hours a day, 7 days a week, 365 days per year, excluding approved holidays, or unless otherwise directed DHCS.

- An interactive voice response (IVR) system provides recorded information, self-service options, and the ability for callers to request follow-up from customer service.

Medi-Cal Rx Complaints/Grievances Resolution Processes

DHCS new Medi-Cal Rx Complaints and Grievances Policy does not change the existing State Fair Hearing process through CDSS for addressing Medi-Cal appeals. However, after January 1, 2022, the Medi-Cal Rx Customer Service Center took over the responsibility for triaging, research, and resolution of pharmacy-related complaints/grievances from the Medi-Cal managed care plans.

- The change in the Medi-Cal managed care plans' responsibilities also is likely to affect some complaint filings through DMHC.
    - Before the new policy, Medi-Cal members with a DMHC-regulated health plan who disagreed with their plan's determination on a pharmacy-related grievance could file a complaint or apply for an Independent Medical Review through DMHC.
    - Because the Medi-Cal managed care plans are no longer responsible for pharmacy services or related grievance reviews, DMHC would no longer provide oversight over those particular health plan issues.

The new policy differentiates complaints and grievances from appeals.

- **A complaint/grievance** is defined as when a Medi-Cal beneficiary, an authorized representative or other interested party (e.g., an anonymous submitter) is expressing dissatisfaction relative to the Medi-Cal pharmacy benefit and/or its administration, other than an "Appeal", as described below. Examples of complaint/grievance topics include:
    - Dissatisfaction with the Medi-Cal Rx coverage policy, quality of care, and/or timeliness of care;
    - Concerns about being provided incorrect or misleading information by a Medi-Cal Rx representative;
    - A missed service commitment by Medi-Cal Rx, such as a failure by the service center to mail a requested form, unauthorized disclosures, or other lack of compliance; and
    - Mistreatment by a Medi-Cal Rx representative or pharmacy provider, ranging from rudeness or unprofessional conduct to discrimination.
- **An appeal** is defined as when an individual disagrees with a benefit or eligibility-related decision, such as coverage disputes or disagreeing with a determination on a request for prior authorization involving medical necessity.

The Medi-Cal Rx Customer Service Center handles intake of pharmacy-related complaints/grievances from Medi-Cal members or from other parties filing on behalf of a member, including an authorized patient representative, provider, or DHCS.

- The Customer Service Representative (CSR) will handle intake, including gathering information and logging the complaint into the tracking system.
- The CSR will attempt to resolve the issue with the caller during the initial contact and during the intake process.
- If the CSR cannot resolve the issue, the CSR will route the complaint to the Medi-Cal Rx Complaints and Grievances Unit within three calendar days of the complaint initiation.
- The Complaints and Grievances Unit investigates further and resolves complaint/grievance cases.
- For certain complaints about rudeness, mistreatment, or discrimination by a medical professional, the CSR will escalate the issue to the Complaints and Grievances Unit and inform the caller of their right to file an additional complaint with the appropriate licensing board (e.g., California State Board of Pharmacy or the Medical Board of California).
- There is a 30 calendar days target for resolution to be reached and a decision letter sent to the complainant.

Medi-Cal Rx Referrals of Appeals and Other Issues

For calls related to a Medi-Cal appeal issue, the Medi-Cal Rx Customer Service Center CSR will direct the caller to resources to request a State Fair Hearing, including by providing contact information for CDSS or by mailing a form.

For other complaints or inquiries outside the jurisdiction of the Medi-Cal Rx Customer Service Center, the CSR will provide a referral to the appropriate organization. This includes:

- For non-pharmacy health care issues, the CSR will refer the caller to the member's Medi-Cal managed care plan.
- For callers with a Medi-Cal fee-for-service complaint, the CSR will refer the caller to the Medi-Cal Telephone Service Center.
- For health care facility complaints, the CSR will refer the caller to the California Department of Public Health.

Other DHCS Consumer Assistance Service Center Changes in 2022

DHCS reported that in 2022 the Medi-Cal Dental Telephone Service Center updated:

- The Medi-Cal Dental Member Handbook, including to reflect that members of the Health Plan of San Mateo will get dental services through that plan effective January 1, 2022.
- Medi-Cal Dental's Customer Relationship Management Procedure Manual's screen shots and process descriptions to help improve the Medi-Cal Dental contractor staff efficiency in managing contact tracking and case workflows.

- Medi-Cal Dental's Provider Suspense and Error Manual to help improve the processing of corrections to suspended claims and Treatment Authorization Requests by the Medi-Cal Dental contractor and DHCS.

DHCS did not report any changes to consumer assistance protocols or systems in 2022 for the Office of the Ombudsman or the Medi-Cal Telephone Service Center.

Section 6 - California Department of Insurance

A. Overview

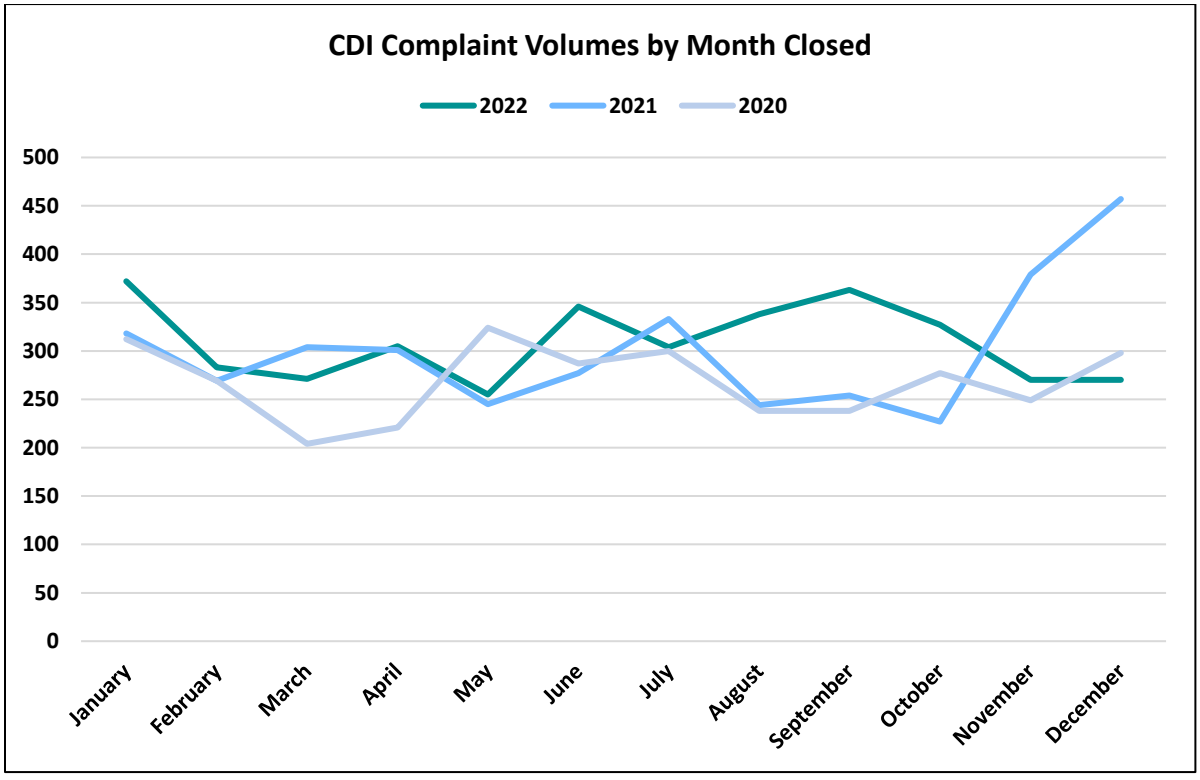
The California Department of Insurance (CDI) licenses and regulates more than 1,400 insurance companies and more than 485,000 insurance agents, brokers, adjusters, bail agents, and business entities. The Consumer Services Division (CSD), within CDI's Consumer Services and Market Conduct Branch, is responsible for responding to consumer inquiries and complaints regarding insurance companies or producers.

This report addresses CDI's health care coverage complaints, and not those related to life insurance, long term care, or other lines of business. For standardization purposes, this report refers to the health insurance companies licensed by CDI as health plans.

CDI reported 23,939 requests for assistance from health care consumers in 2022, including 3,704 jurisdictional complaints, 4,625 non-jurisdictional complaints, and 15,610 other inquiries. Unless indicated otherwise, the figures and analysis within Section 6 address CDI's jurisdictional complaints.

The following chart displays CDI's monthly volumes of the 3,704 complaints in 2022, compared to the 3,217 complaints in 2020 and the 3,608 complaints in 2021.

Figure 6.1



The following table addresses the two different complaint types reported by CDI: Standard Complaint and Independent Medical Review (IMR).

Figure 6.2 CDI Complaint Types Overview

Complaint Type	Primary Unit(s) Responsible and Roles	Time Standard	Average Resolution Time in 2022
Standard Complaint	Consumer Communications Bureau: Assistance to callers Health Claims Bureau and Underwriting Services Bureau: Compliance Officers respond to written complaints Consumer Law Unit: Legal review (if needed)	30 business days, or 60 days if reviewed concurrently with the health plan review	38 days
Independent Medical Review (IMR)	Consumer Communications Bureau: Assistance to callers Health Claims Bureau: Intake and casework IMR Organization (contractor – Maximus): Case review and decision Consumer Law Unit: Legal review (if needed) Urgent clinical issues that qualify are addressed through an expedited IMR process	30 business days, or 60 days if reviewed concurrently with the health plan review	60 days

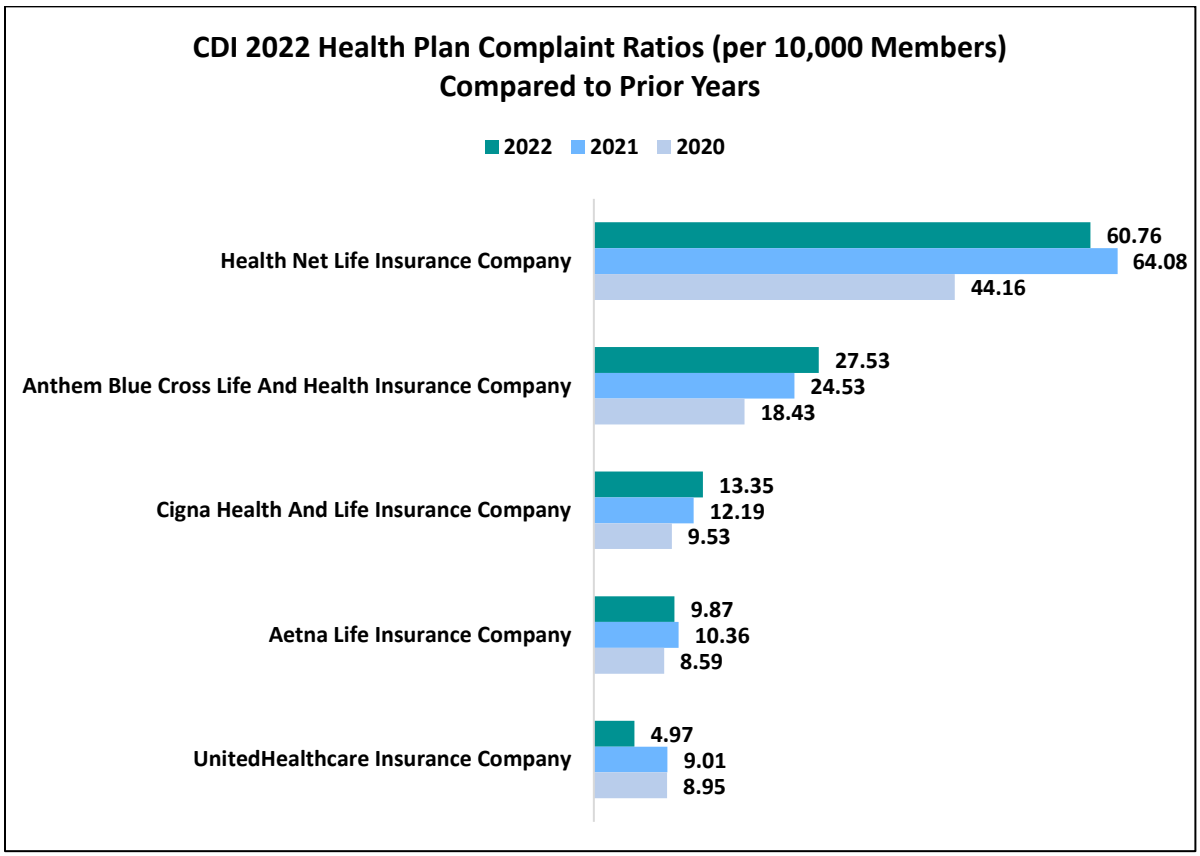
Note: CDI's complaint average resolution time calculation reflects case durations from the date of initial receipt of the complaint to the date the complaint was closed after completion of the final regulatory review. CDI will open a complaint even if the complaint has not yet undergone the health insurer grievance review and/or if the case requires more time for gathering pertinent information from the involved parties.

B. Complaint Ratios, Reasons, and Results

Health Plan Complaint Ratios

The following chart displays 2022 ratios of health plan complaints per 10,000 health plan members, along with the 2020 and 2021 ratios for the same health plans.

Figure 6.3

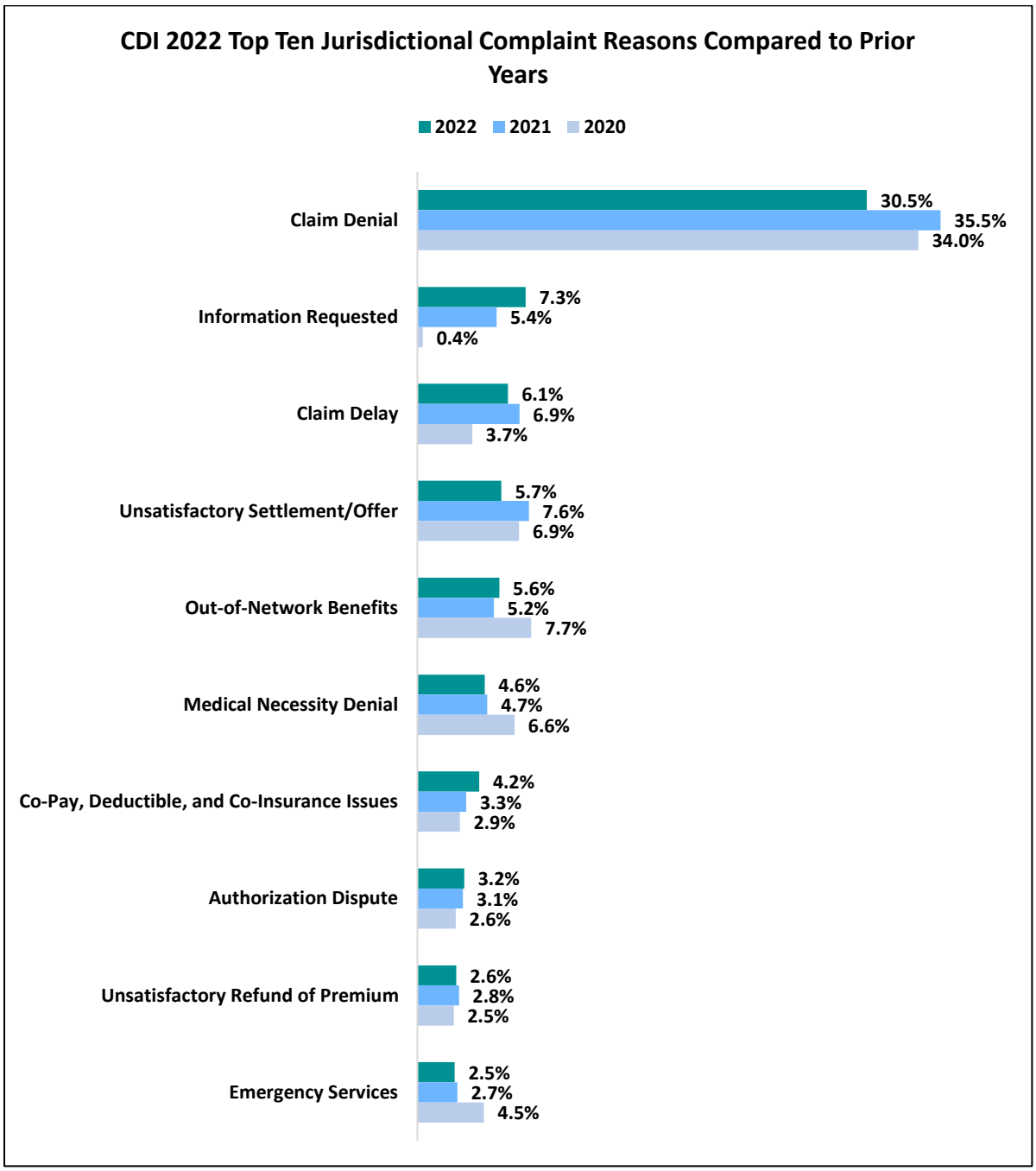


Note: The above chart excludes health plans with enrollment under 70,000 members and/or fewer than 88 complaints in 2022.

Complaint Reasons

The following chart displays the most common reasons for CDI's complaints in 2022, along with the 2020 and 2021 data for the same reason categories.

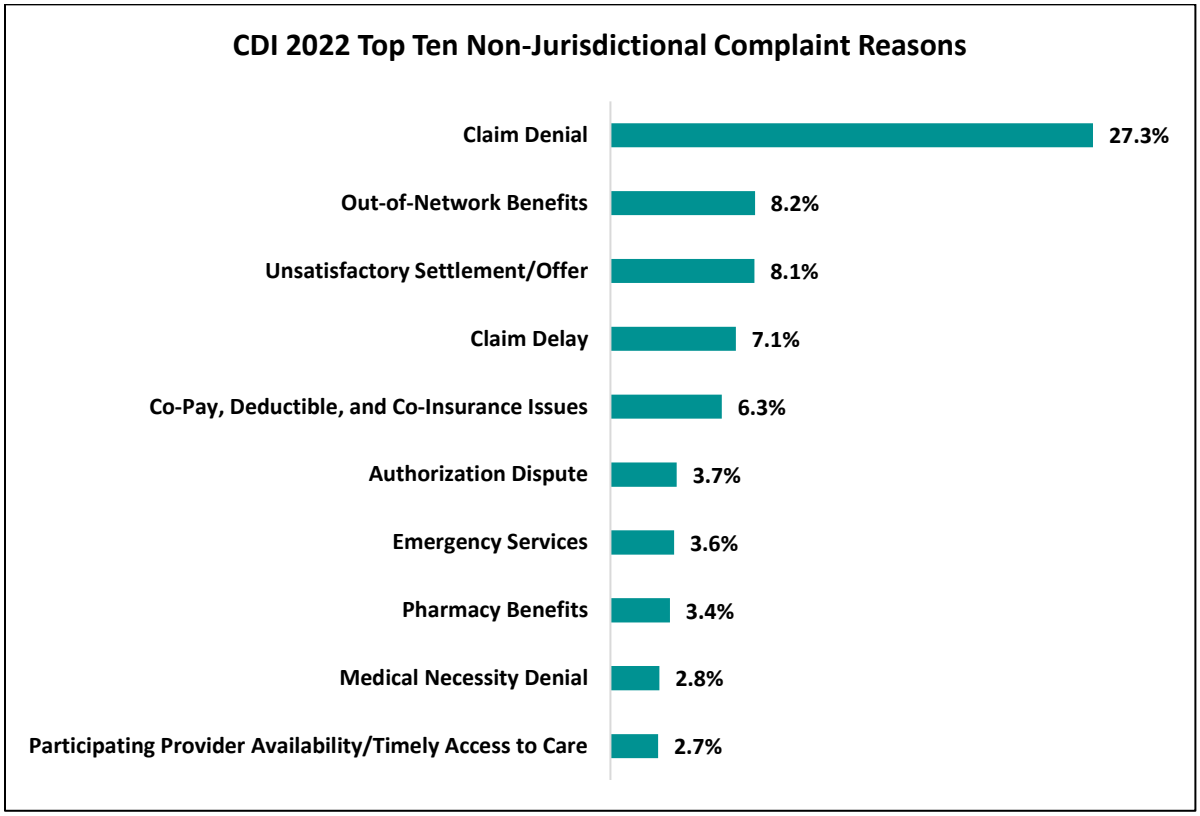
Figure 6.4



Note: The volume of reasons exceeded the number of complaints because some cases had more than one reason reported. There were 4,930 reason entries from the 3,704 complaints in 2022.

The following chart displays CDI's most common reasons for non-jurisdictional complaints in 2022. CDI refers most non-jurisdictional complaints to a different agency or department.

Figure 6.5

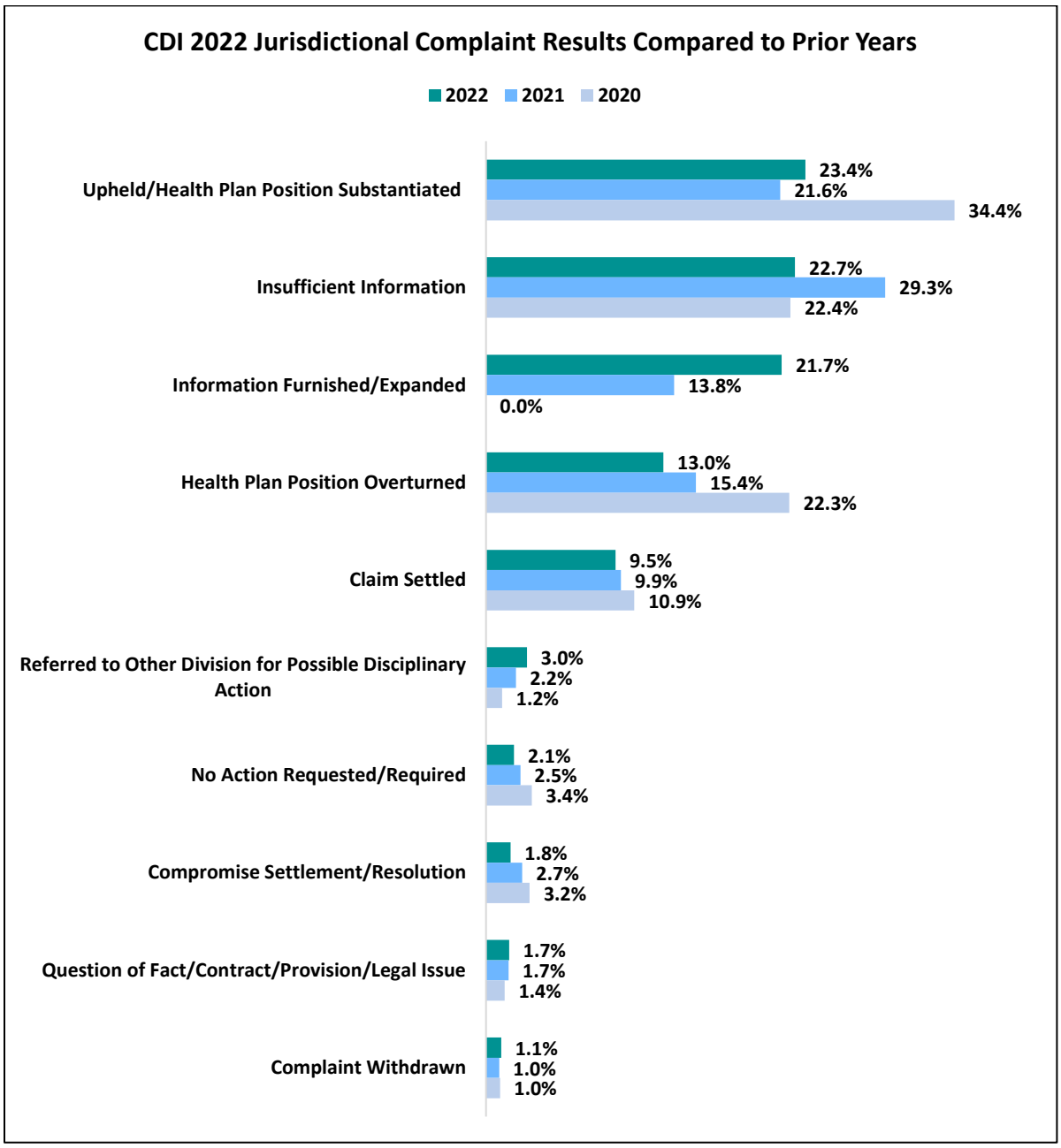


Note: The volume of reasons exceeded the number of complaints because some cases had more than one reason reported. There were 6,540 reason entries from the 4,625 non-jurisdictional complaints in 2022.

Complaint Results

The following chart displays the 2022 results for CDI's 3,704 jurisdictional complaints, along with the 2020 and 2021 data for the same categories.

Figure 6.6

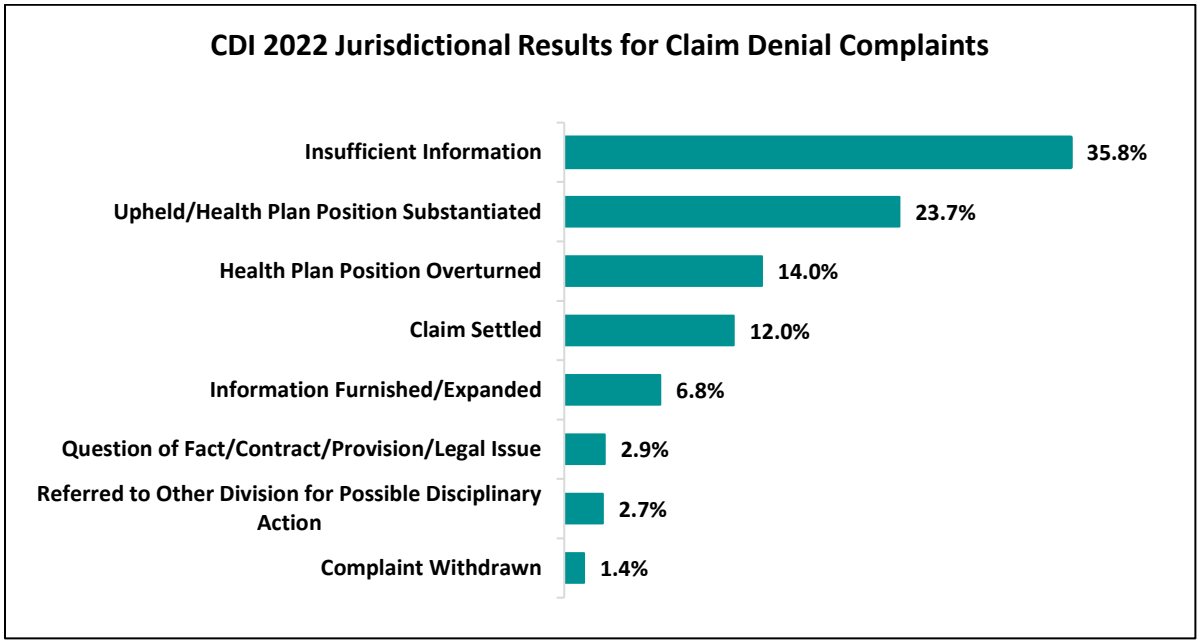


Note: Results categories considered to be favorable to the complainant include: Health Plan Position Overturned, Claim Settled, Compromise Settlement/Resolution, and Referred to Other Division for Possible Disciplinary Action. Results categories considered as favorable to the health plan include: Upheld/Health Plan Position Substantiated. The favorability of other categories shown is neutral or cannot be determined.

Approximately 90 percent of CDI's non-jurisdictional complaints in 2022 had the result of Referred to Outside Agency/Department (90.6% of the 4,625 non-jurisdictional complaints). The rest were submitted with the result No Jurisdiction.

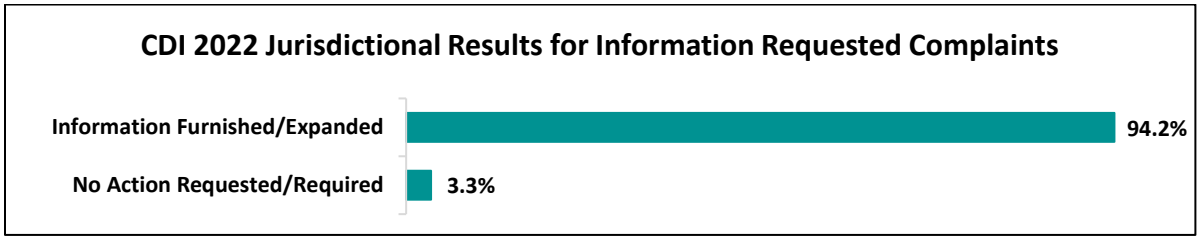
The following three charts display the 2022 results for CDI's most commonly reported complaint reasons.

Figure 6.7



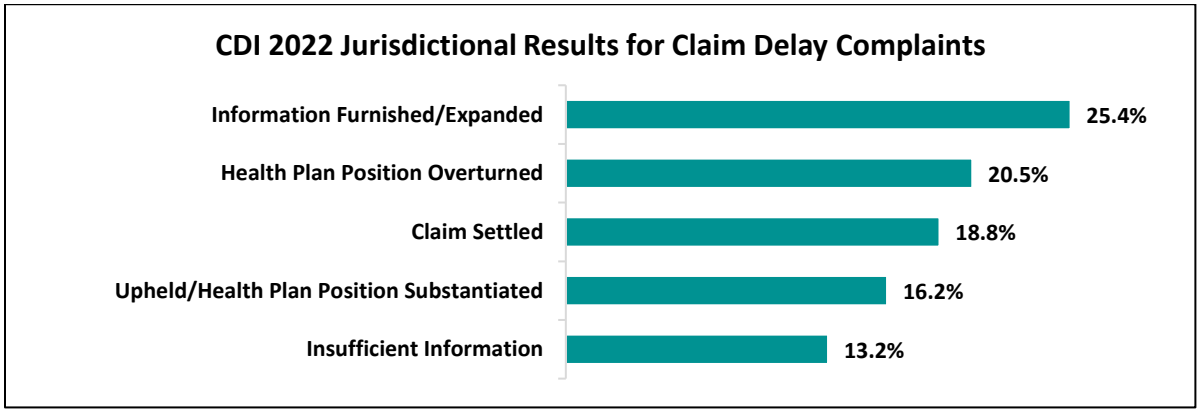
Note: Results with low volumes were excluded from display.

Figure 6.8



Note: Results with low volumes were excluded from display.

Figure 6.9



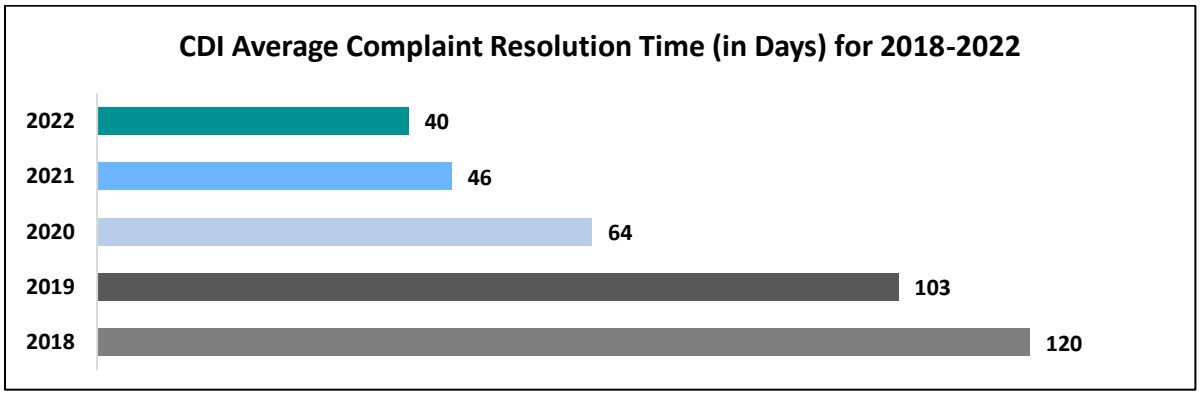
Note: Results with low volumes were excluded from display.

Resolution Time

CDI completed its Measurement Year 2022 complaint reviews in 40 days on average for jurisdictional complaints and 4 days on average for non-jurisdictional complaints. The CDI complaint duration period reflects the open date when the department received the initial complaint through the date when the department completed its final regulatory review.

The following chart shows the average durations of CDI's jurisdictional complaints for Measurement Years 2018 through 2022.

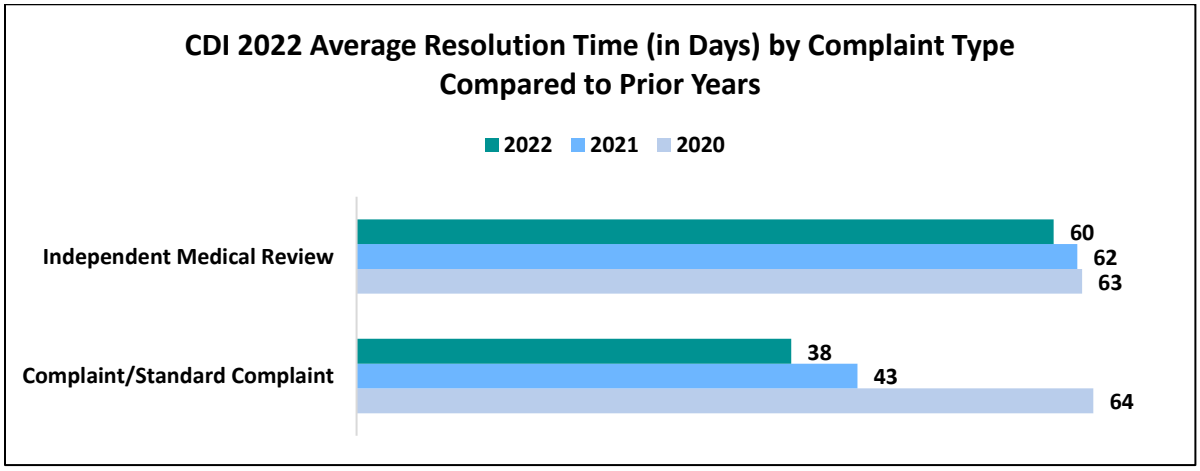
Figure 6.10



Note: The average duration calculations for the above chart excluded CDI's non-jurisdictional complaints, which averaged between three and four days for the displayed measurement years. Since CDI allows for concurrent review, the duration for some complaints includes time during the health plan grievance period before the health plan concluded its review. The close date for many complaints reflects the conclusion of the department's regulatory investigation period after the complaint was already closed to the complainant. CDI indicated that this regulatory review period is 30 days on average.

The following chart displays the 2022 average resolution times for CDI's two complaint types, along with the 2020 and 2021 data for the same categories.

Figure 6.11

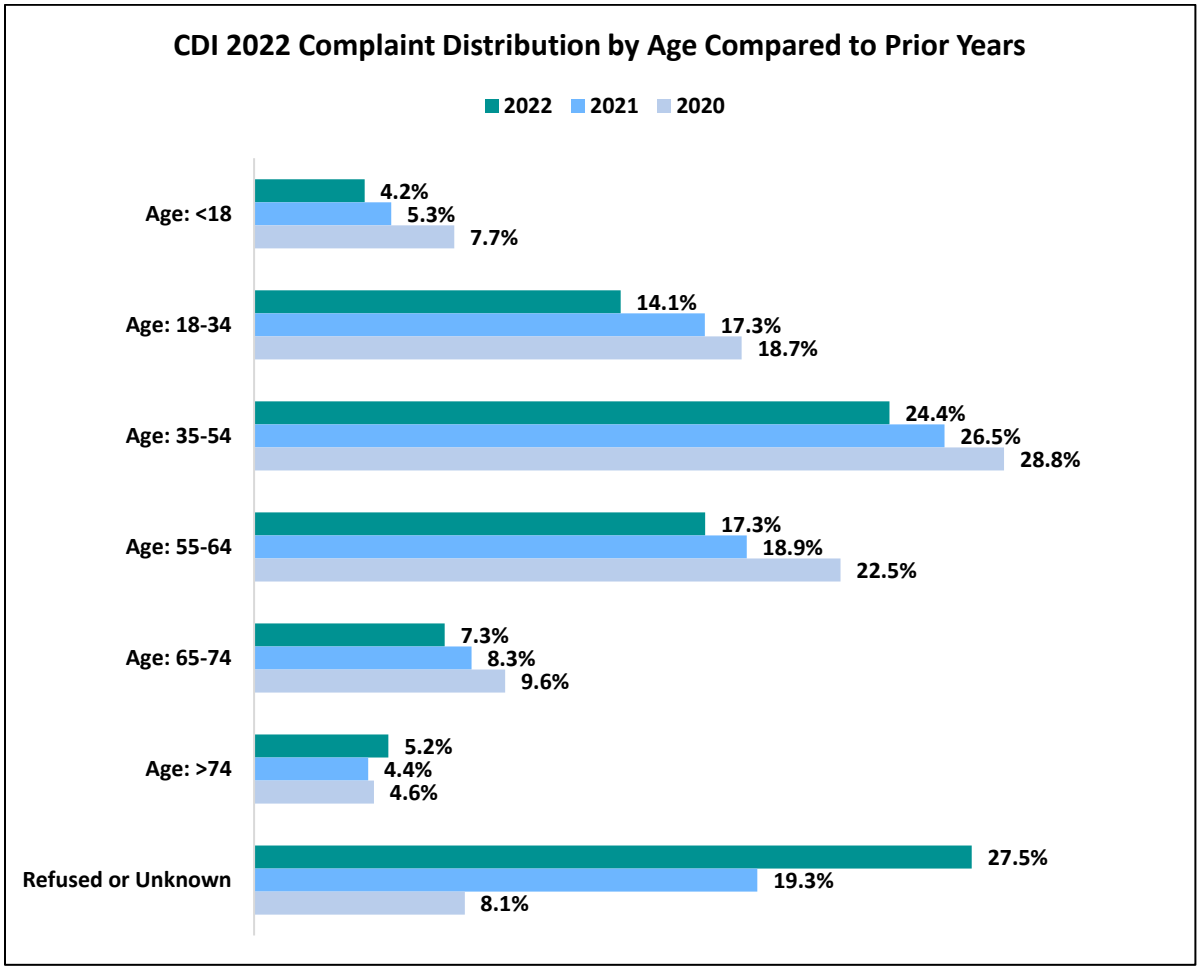


C. Demographics and Other Complaint Characteristics

Age

The following chart displays CDI's 2022 complaint distribution by age group, along with the 2020 and 2021 data for the same age group categories. The volume of complaints where the Age was not identified increased by 34 percent from 2021 to 2022. The increase in Unknown likely contributed to decreases for the known age groups, however the size of the impact on each age group cannot be determined.

Figure 6.12



Gender

CDI's 2022 complaint distribution by gender was similar to prior years, with a majority of the complainants identified as Female (53.9%) and the rest identified as Male (46.1%).

Race

More than half of CDI's 2022 complaints did not have the complainant's race identified (33.2% Refused and 23.3% Unknown). Of the 3,704 complaints, the complainant was identified as White for approximately 29 percent (28.9%), as Asian for nearly six percent (5.7%), and as Black or African American for nearly three percent (2.7%). Two categories accounted for less than one percent: American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander.

Ethnicity

More than half of CDI's 2022 complaints did not have the complainant's ethnicity identified (33.2% Refused and 23.3% Unknown). Of the 3,704 complaints, the complainant was identified as Not Hispanic or Latino for 38 percent (38.0%) and as Hispanic or Latino for over five percent (5.5%).

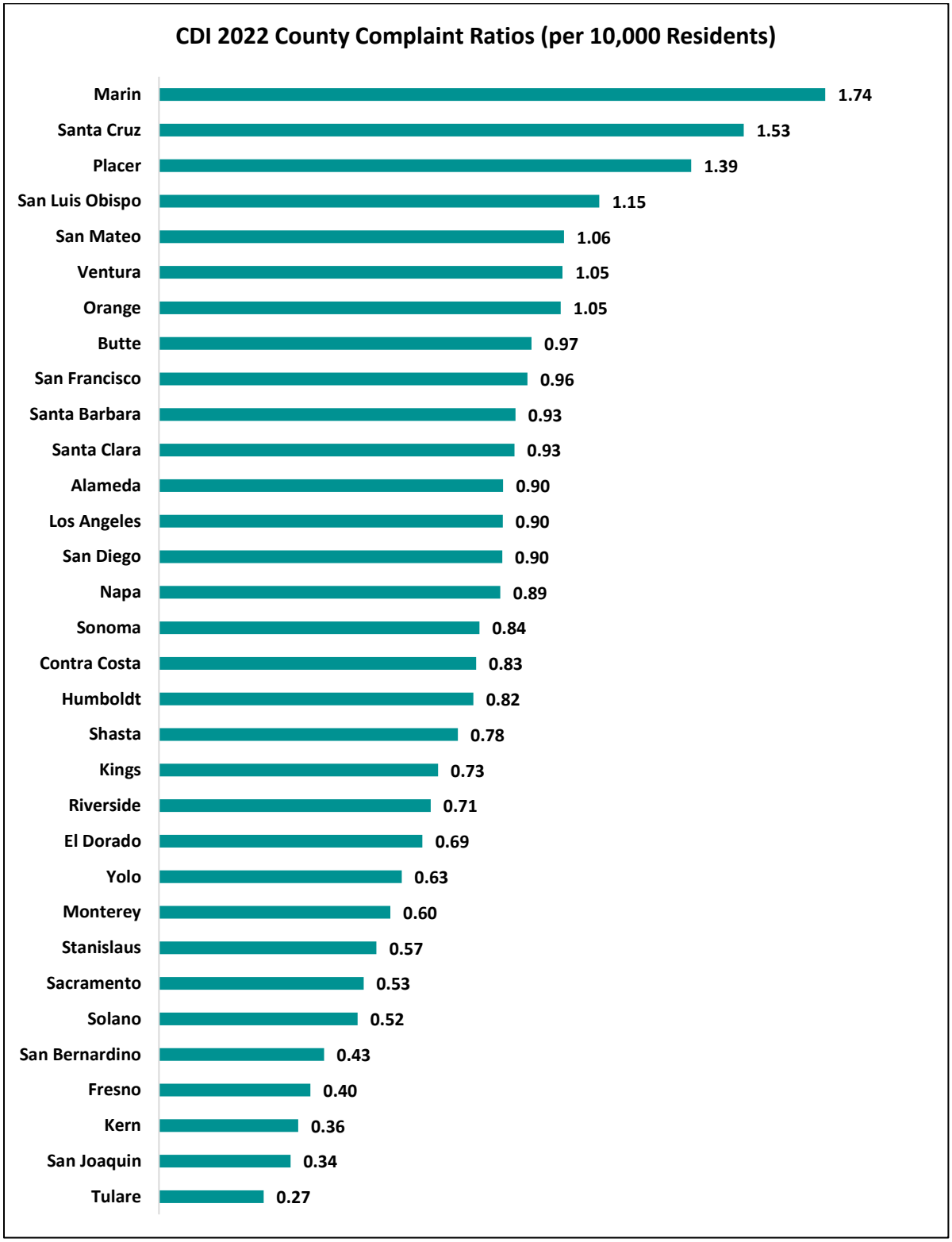
Primary Language

Approximately 40 percent of CDI's 2022 complaints did not have the complainant's primary language identified (20.4% Refused and 19.2% Unknown). English was identified as the complainant's primary language for most of the complaints (57.6% of the 3,704 complaints) and Spanish was identified for approximately one percent (0.9%). Eleven other languages were reported with low volumes, accounting for nearly two percent (1.9%) combined.

Resident County

The following chart shows ratios of complaint volumes by the complainant's county of residence per the county population in 2022.

Figure 6.13



Note: The above display excludes counties with a population under 70,000 and/or fewer than 11 complaints in 2022.

Initial Mode of Contact

CDI reported that consumers initiated most of the 2022 complaints through the Online mode of contact (63.5% of the 3,704 complaints), followed by Mail (34.6%) and Telephone (1.9%). The Online mode of contact reached its highest-ever volume in 2022 compared to previous Measurement Years through 2014.

Regulator

CDI continued to be the reported regulator for all the department's complaints.

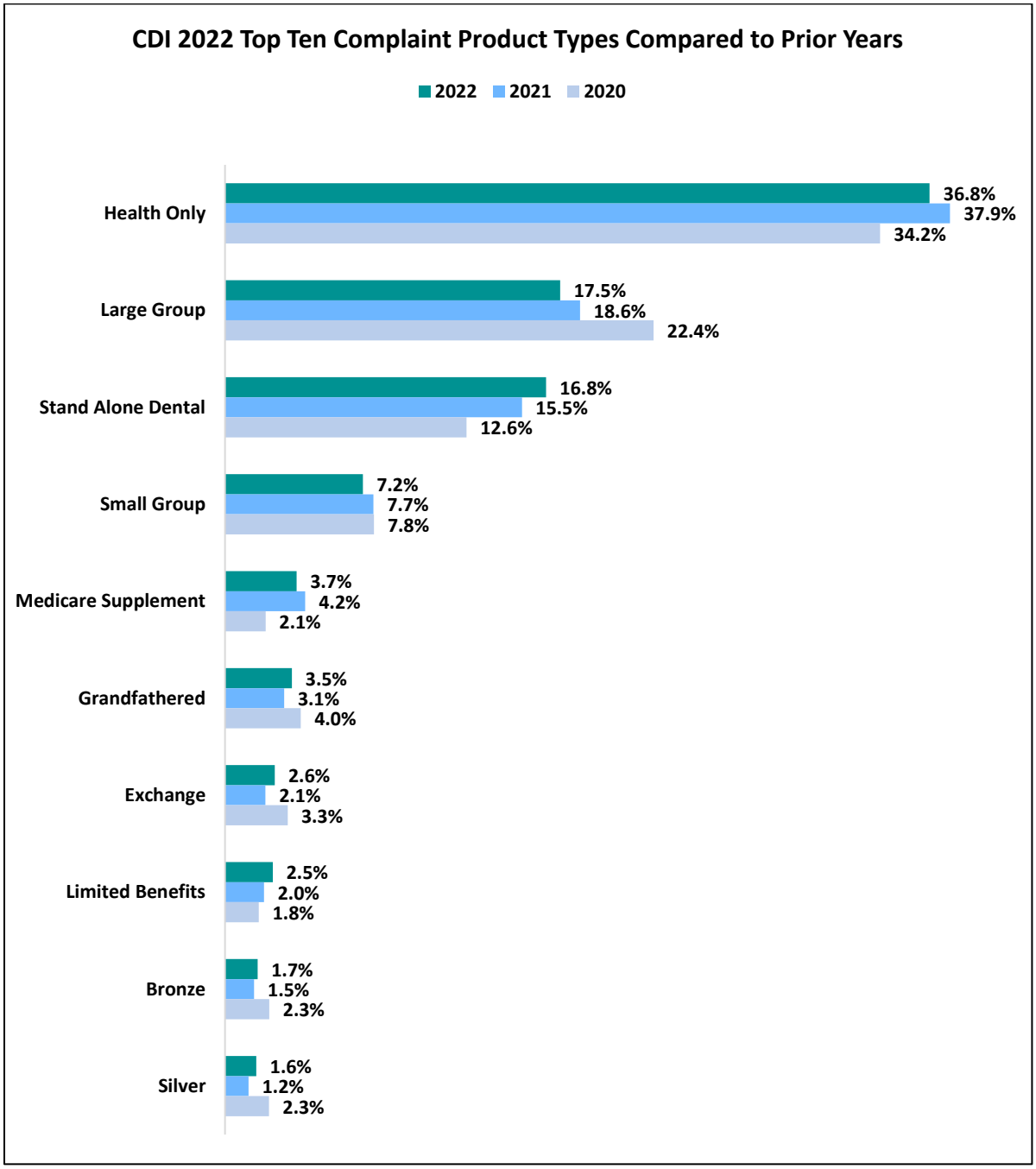
Source of Coverage

CDI's 2022 complaint distribution by the source of coverage was similar to the prior year, with Group coverage accounting for approximately 51 percent (51.2%) and Individual/Commercial coverage accounting for approximately 49 percent (48.8%).

Product Type

The following chart displays the product types with the most complaints closed by CDI in 2022, along with the 2020 and 2021 data for the same product type categories. CDI identified 26 different product type categories within the 2022 complaints.

Figure 6.14



Note: The product type volumes exceed the volume of complaints because some CDI complaint cases had more than one product type submitted. There were 5,620 product type entries from the 3,704 complaints in 2022.

D. Consumer Assistance Center Details

CDI's Consumer Services Division reported 23,939 requests for assistance from consumers in 2022, including 15,679 by telephone, 2,160 by mail, 6,057 online, and 43 via counter/in-person contact.

Call Metrics

The following table outlines the metrics regarding the 15,679 requests for assistance made to CDI by telephone in 2022.

Figure 6.15 CDI Consumer Services Division – 2022 Telephone Metrics

Yearly Metrics	Measurement
Number of Abandoned Calls (terminated by callers prior to reaching a Customer Service Representative – CSR)	204
Number of Calls Resolved by the Interactive Voice Response (IVR)/Phone System (caller's needs addressed without involving a CSR)	297
Number of Jurisdictional Inquiry Calls	10,782
Number of Non-Jurisdictional Calls	4,785
Average Wait Time to Reach a CSR	0:15 (15 sec)
Average Length of Talk Time (time between a CSR answering and completing a call)	5:04 (304 sec)*
Average Number of CSRs Available to Answer Calls (during Service Center hours)	Varies based on need**

*The data does not reflect time spent by CDI's compliance officers to make return calls to consumers after verifying jurisdiction. The metrics only reflect time of consumers' initial contacts.

** Secondary health officers may be added to the health queue depending on the volume of calls received.

Inquiry Topics and Referrals

The following table outlines CDI's most common topics for consumer inquiry referrals, as well as the organizations to which those inquiries were referred. These estimated rankings exclude the non-jurisdictional complaints represented in Figure 6.5.

Figure 6.16 CDI Top Ten Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Organization(s) Referred to
1 (most common)	Claim Denial	Department of Managed Health Care (DMHC), U.S. Department of Labor (DOL), Centers for Medicare & Medicaid Services (CMS), Various Out-of-State Departments of Insurance (DOIs)
2	Claim Delay	DMHC, DOL, CMS, Various DOIs
3	Unsatisfactory Settlement/Offer	DOL, CMS, Various DOIs
4	Co-Pay/Deductible/Co-Insurance Issues	DMHC, DOL, Various DOIs
5	Out-of-Network Benefits	DMHC, DOL, CMS, Various DOIs
6	Medical Necessity Denial/Experimental	DMHC, DOL, Various DOIs
7	Unsatisfactory Refund of Premium	DMHC, Various DOIs
8	Cancellation	DOL, CMS, Various DOIs
9	Participating Provider Availability/Timely Access to Care	DMHC, DOL, Various DOIs
10	Authorization Dispute	DMHC, CMS, DOL

Consumer Assistance Protocols and Systems

CDI did not report any changes to its service center's protocols or systems for 2022.

Section 7 - Covered California

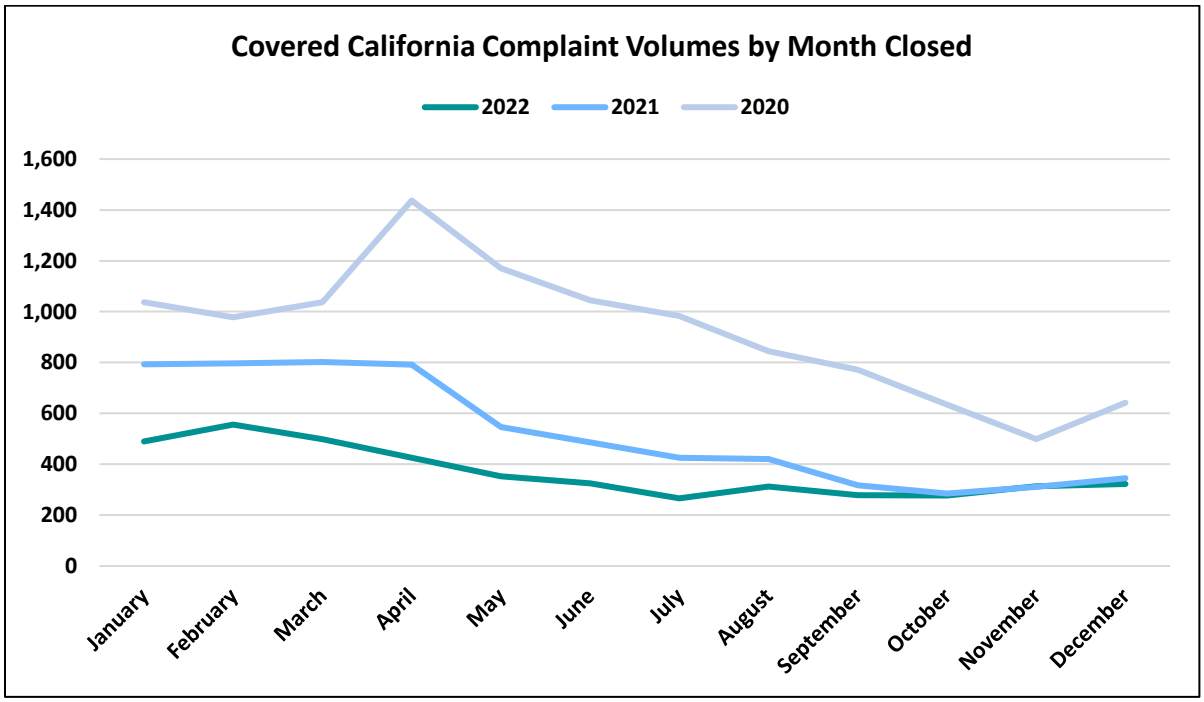
A. Overview

The California Health Benefit Exchange (Covered California) provides a state-based marketplace for consumers to buy health insurance and qualify for financial assistance to help pay their insurance costs. This report addresses information submitted by Covered California regarding:

- Covered California complaints that were adjudicated by the California Department of Social Services (CDSS) through the State Fair Hearing process with a decision from an Administrative Law Judge.
- Complaints filed as State Fair Hearing requests that were resolved informally by Covered California without completing the hearing process.
- Consumer assistance provided by the Covered California Service Center to help Californians understand their health care coverage options and apply for coverage and associated financial assistance.

Covered California reported 3,818,184 requests from assistance from consumers in 2022, comprised predominantly of inquiries (3,813,768) about coverage rather than contacts to initiate a complaint (4,416). The following figure displays volumes by month closed for the 4,416 complaints in 2022, 6,321 complaints in 2021, and 11,079 complaints in 2020.

Figure 7.1



The following table outlines the two complaint types reported by Covered California. The complaint type category typically indicates the process used to review the complaint. Most of Covered California's 2022 complaints were identified as the State Fair Hearing: Informal Resolution complaint type (85.5% of the 4,416 complaints).

Figure 7.2 Covered California Complaint Types Overview

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard	Average Resolution Time in 2022
State Fair Hearing	CDSS State Hearings Division: Conducts hearing on eligibility appeals. Administrative Law Judges make decisions. Expedited appeal status may be granted for certain appeals involving urgent health issues. Covered California: Participates in the hearing with the Administrative Law Judge.	90 days from the date the hearing request was filed	56 days
State Fair Hearing: Informal Resolution	CDSS State Hearings Division: Reviews hearing requests and refers some complaints to Covered California instead of conducting a hearing with an Administrative Law Judge. Covered California: Reviews and resolves referred cases. Appeals that Covered California cannot informally resolve in accordance with regulations are heard before an Administrative Law Judge as a formal State Fair Hearing.	45 days from the date the appeal was filed	19 days

Note: The State Fair Hearing time standard is from All County Letter 14-14 issued by CDSS in February 2014. The Covered California staff address Service Center complaints that are not State Fair Hearing appeals, and escalate issues to internal supervisors, subject matter experts, and customer resolution teams as needed. Covered California's External Coordination Unit addresses certain cases escalated by the Service Center that involve consumers with urgent access to care issues.

B. Complaint Ratios, Reasons, and Results

Covered California reported 4,416 complaints closed in 2022, including 639 adjudicated State Fair Hearings and 3,777 State Fair Hearings resolved informally.

Covered California's annual complaint volume decreased for the second year. The 2022 volume was approximately 30 percent (30.1%) lower compared to 2021 and 60 percent (60.1%) lower compared to 2020.

Health Plan Complaint Ratios

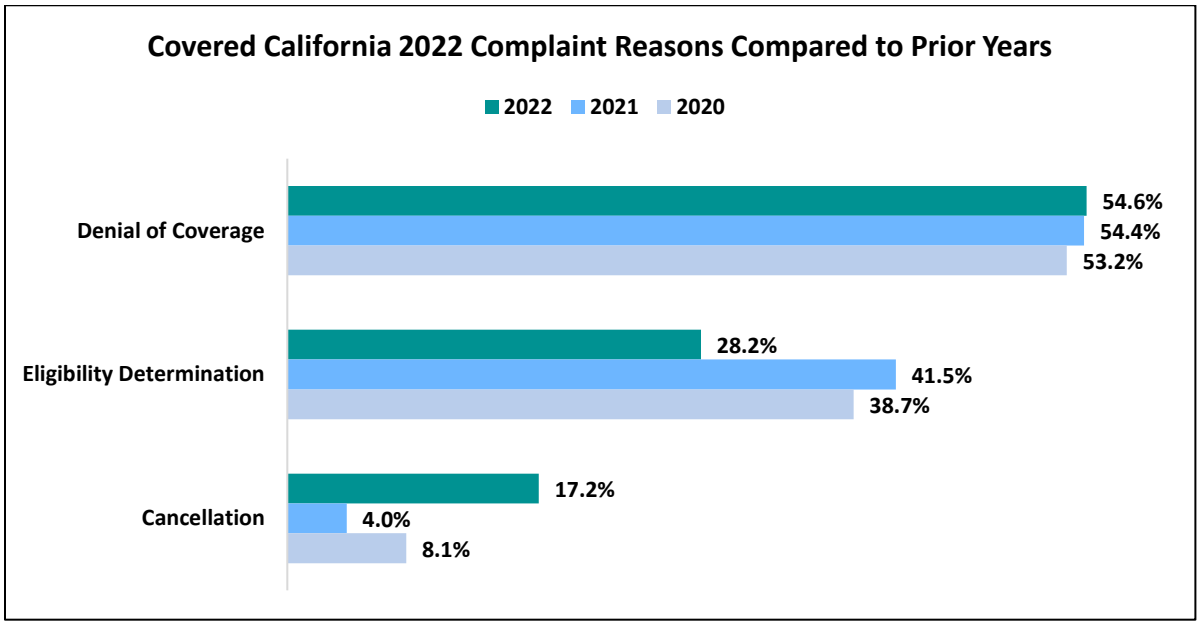
See Section 4.C. for information about the Covered California health plan complaints resolved by the Department of Managed Health Care (DMHC).

- Covered California health plan complaints are addressed through health plan grievance and insurance regulator complaint review processes rather than through a State Fair Hearing.
- DMHC regulates most of the plans sold on the Covered California marketplace.

Complaint Reasons

The following chart displays the annual complaint reason distributions for nearly all 4,416 complaints in 2022, 6,321 complaints in 2021, and 11,079 complaints in 2020.

Figure 7.3

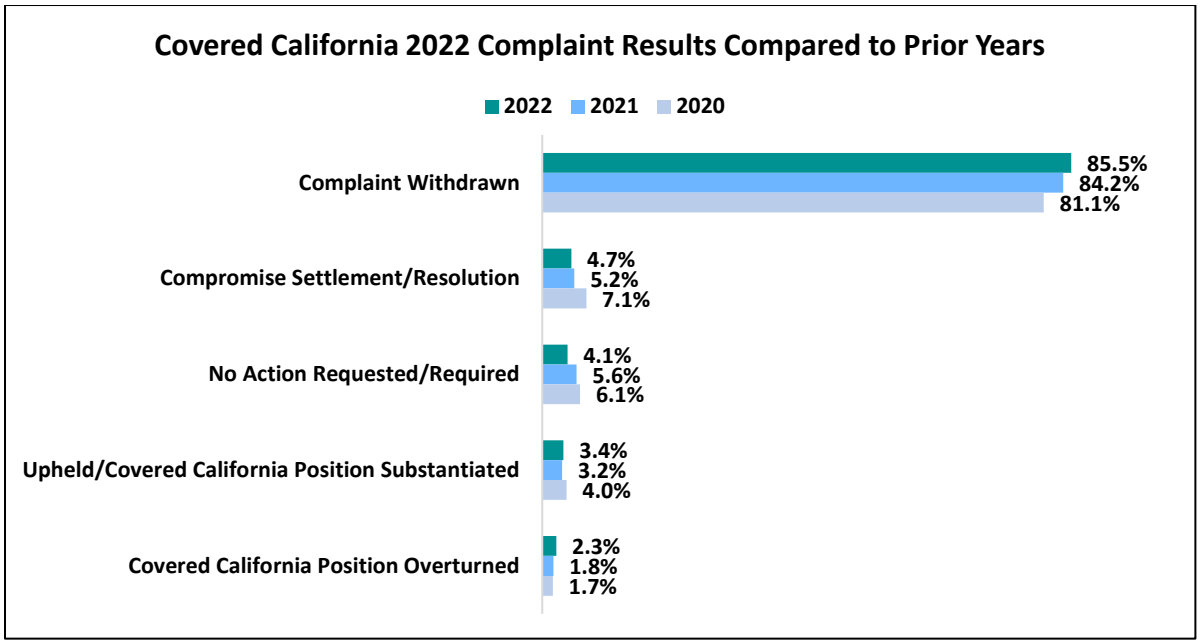


Complaint Results

The following figure shows the 2022 results for all 4,416 complaints, along with the 2020 and 2021 data for the same results categories.

- Complaint volumes decreased for all results categories from 2021 to 2022.
- Covered California noted that the Complaint Withdrawn result was submitted for cases where the complainant's issue was resolved informally prior to completion of the State Fair Hearing.

Figure 7.4



Note: Results categories considered favorable to the complainant include: Compromise Settlement/Resolution and Covered California Position Overturned. Results categories considered favorable to Covered California include: Upheld/Covered California Position Substantiated. The favorability of the other categories is neutral or cannot be determined. For some categories, favorable to the complainant does not necessarily mean that the complaint was substantiated against Covered California but indicates that the consumer received services or a similar positive outcome.

Figures 7.5-7.7 show the 2022 results for each of the complaint reasons submitted by Covered California, along with the 2020 and 2021 data for those same categories.

Figure 7.5

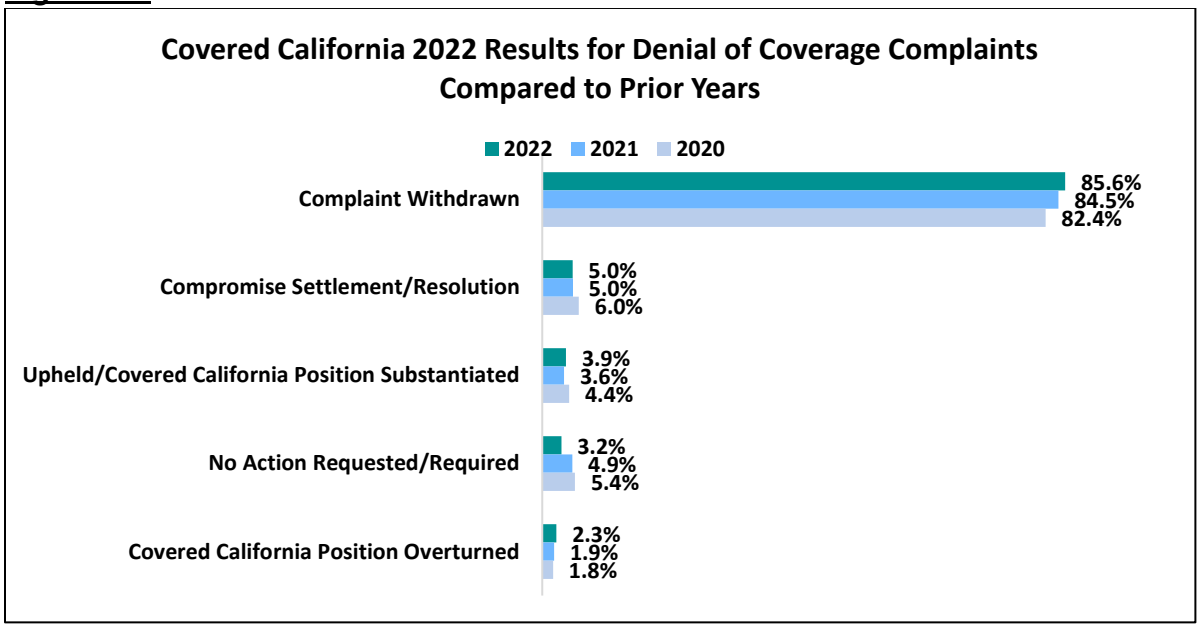


Figure 7.6

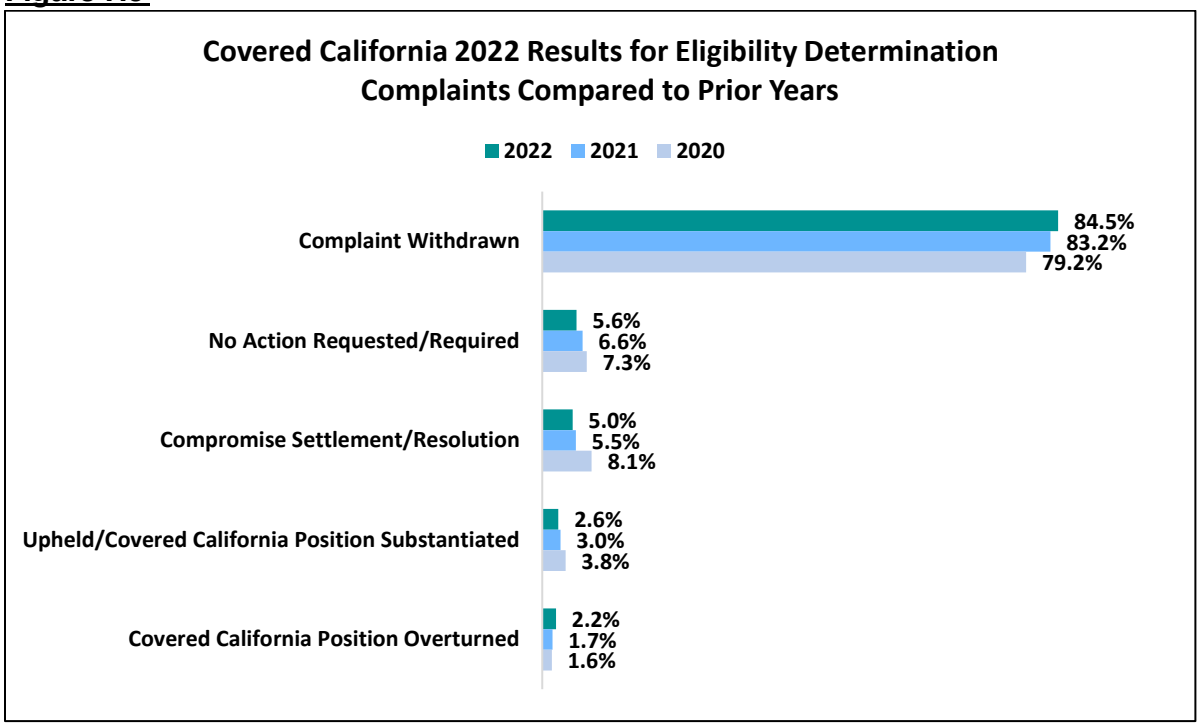
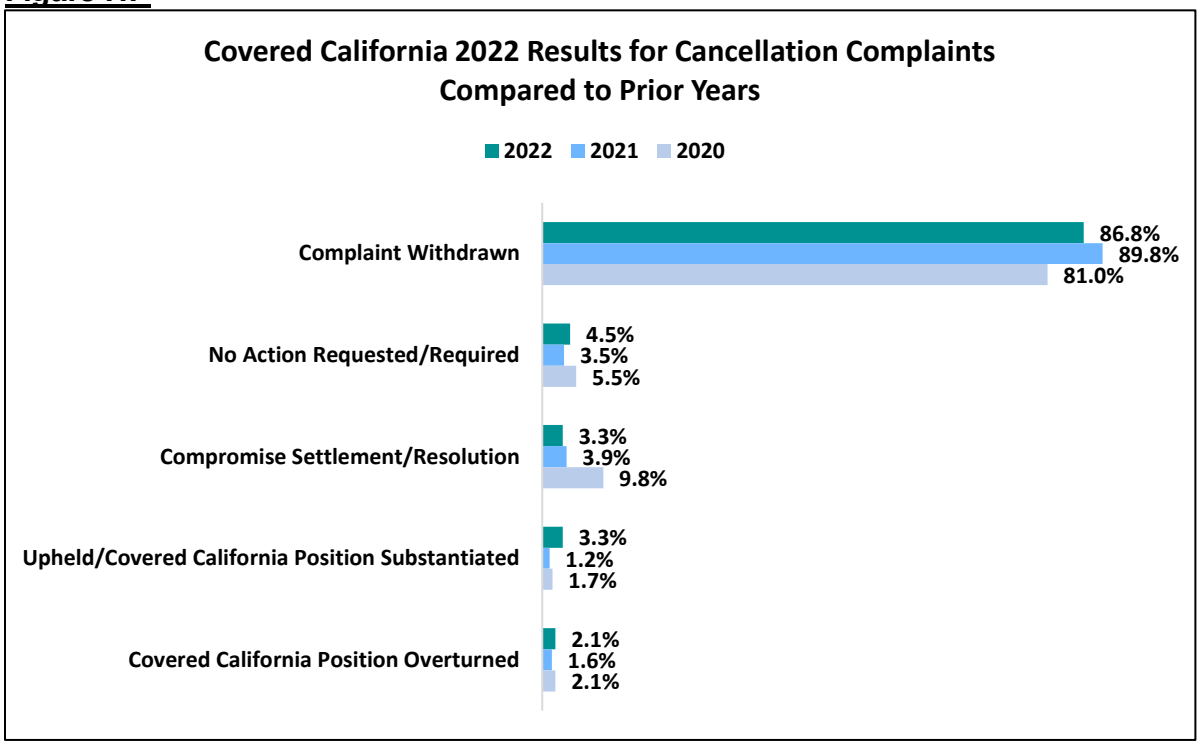
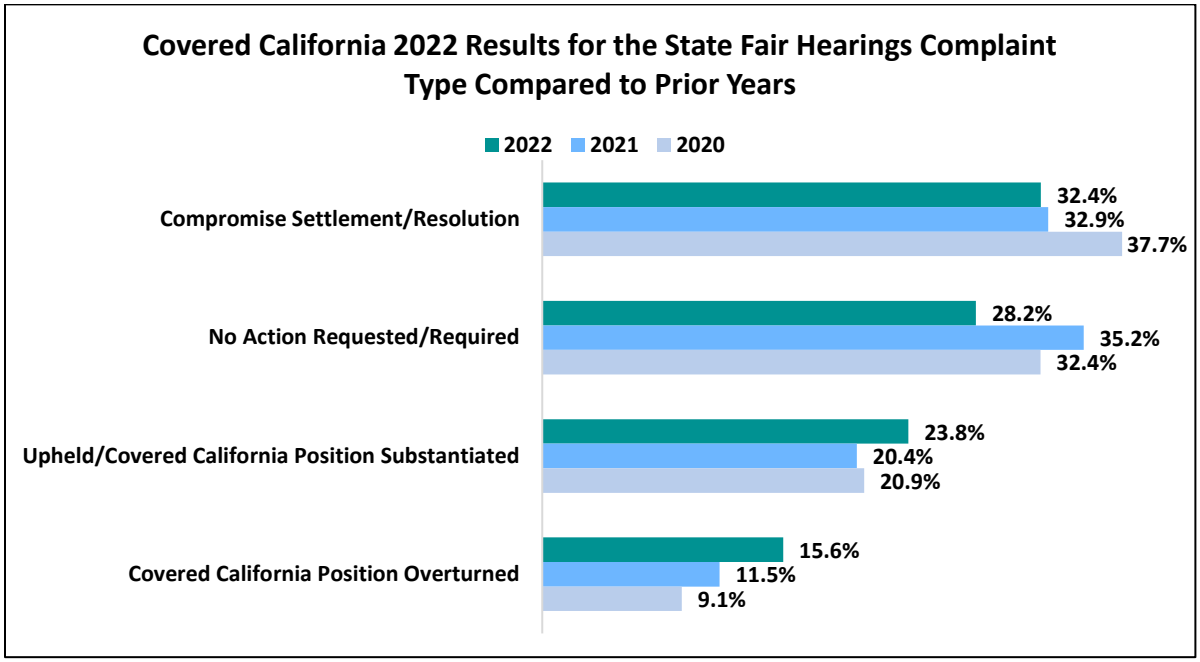


Figure 7.7



The following chart displays the results reported for the State Fair Hearing complaint type, excluding complaints with an informal resolution.

Figure 7.8



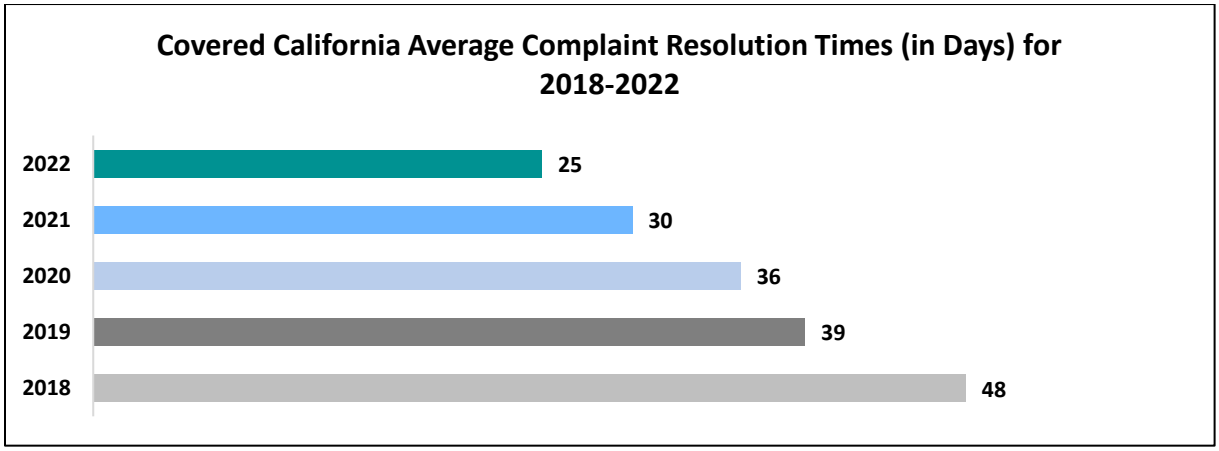
Note: The above display is only for adjudicated State Fair Hearings and excludes complaints reported as the State Fair Hearing: Informal Resolution complaint type, which all had the Complaint Withdrawn result.

Resolution Time

Covered California's average time to resolve a complaint fell for the fifth straight year, with an average complaint duration of 25 days in 2022 down from the high of 66 days in 2017.

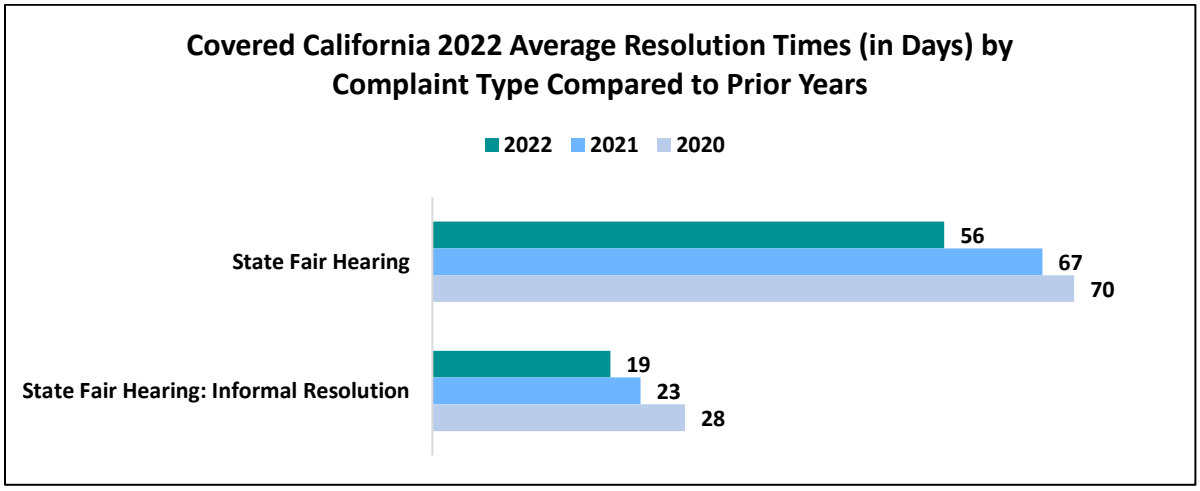
The following chart shows the average resolution times of Covered California's complaints for Measurement Years 2018 through 2022.

Figure 7.9



The following chart displays the 2022 average resolution times for Covered California's two complaint types, along with the corresponding 2020 and 2021 data.

Figure 7.10



C. Demographics and Other Complaint Characteristics

Age

The age group of Ages 35-54 continued to account for most of Covered California's complaints (25.1% of the 4,416 complaints in 2022) where age was reported, followed by Ages 18-34 (22.3%), Ages 55-64 (17.6%), and Ages 65-74 (4.3%). Under 18 and Ages 75 and Older accounted for under one percent. Thirty percent were age Unknown.

Gender

Approximately 38 percent of Covered California's complainants in 2022 were identified as Female (38.3%) and nearly 32 percent as Male (31.9%). The rest did not have gender submitted (30.4% Unknown).

Race

Nearly half of Covered California's 2022 complaints did not have the complainant's race identified. Complainants were identified as White for nearly 29 percent (28.5%) of the complaints, followed by Other (10.7%), Asian (9.7%), and Black or African American (2.8%). Two categories accounted for under one percent: American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander.

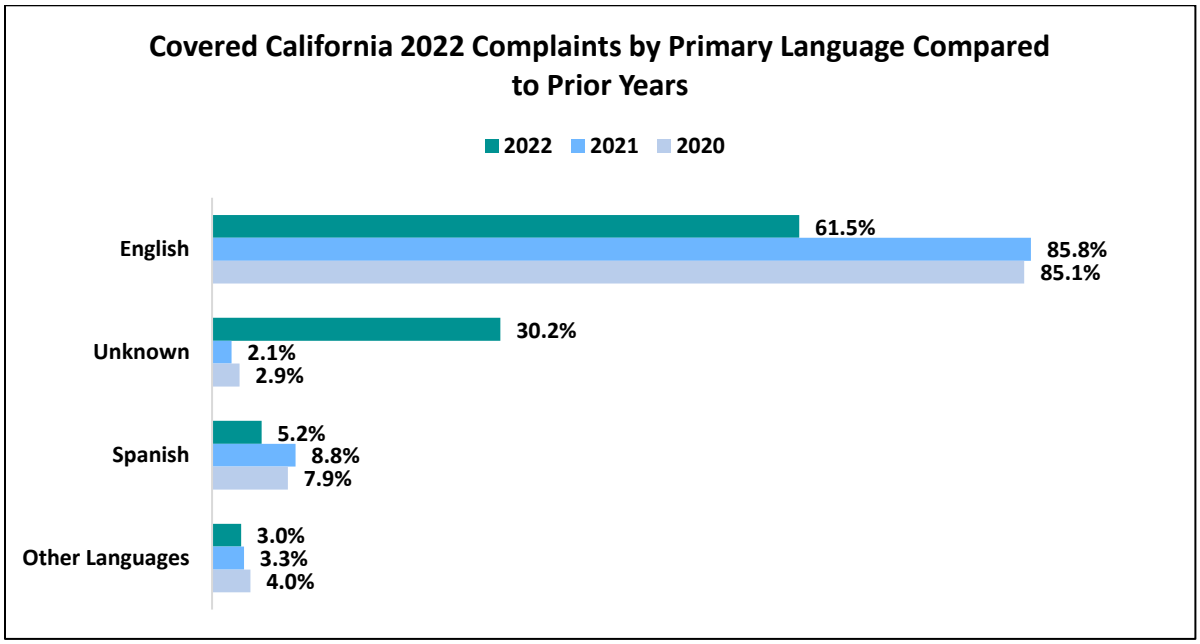
Ethnicity

Of Covered California's 2022 complaints, nearly half identified the complainant's ethnicity as Not Hispanic or Latino (49.6%). Nearly 17 percent were Hispanic or Latino (16.8%). One third did not have the complainant's ethnicity identified (33.6% Unknown).

Primary Language

The following chart displays Covered California's 2022 complaint distribution by the primary language of the complainant, along with the 2020 and 2021 data for the same language categories.

Figure 7.11



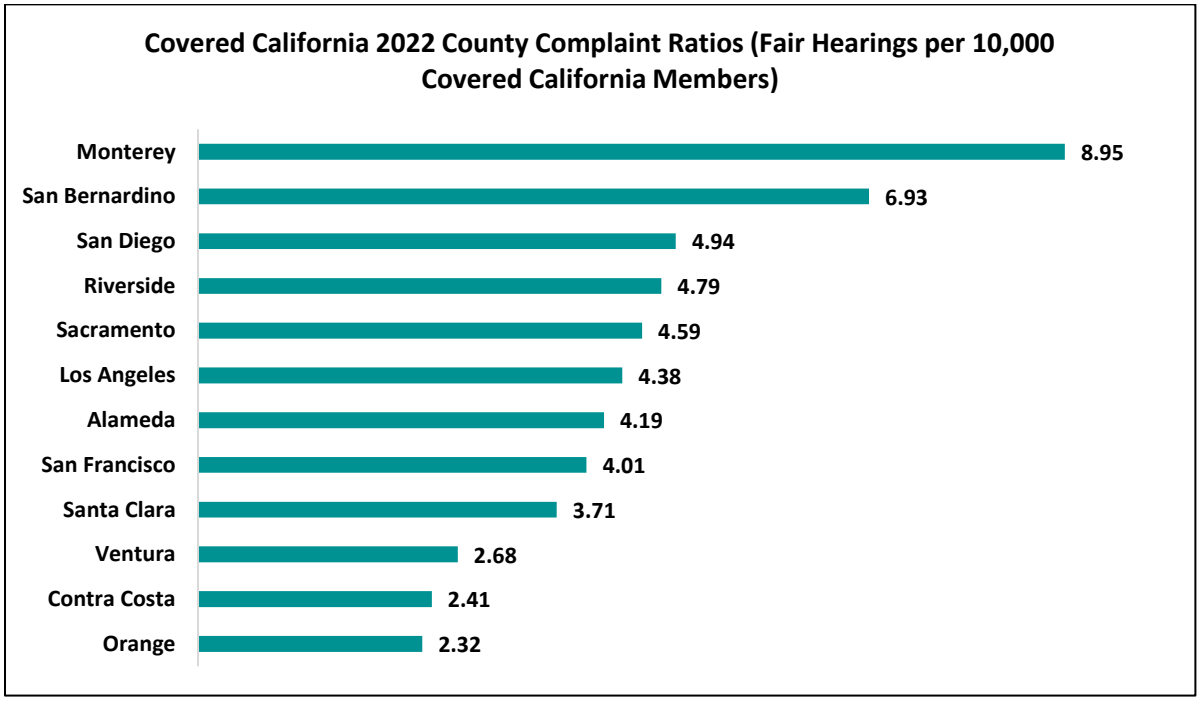
Note: Other Languages combines language categories with low reported volumes: Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Mandarin, Russian, Tagalog, and Vietnamese.

County of Residence

The following chart displays ratios of Covered California's formal State Fair Hearings per 10,000 county residents enrolled in a Covered California plan. The complaint volumes used for this calculation were based on the counties of residence of the complainants and exclude the State Fair Hearing: Informal Resolution complaint type.

- Most counties (51 out of 58) had a complaint ratio in 2022 that was lower or equal to the prior year ratio.

Figure 7.12



Note: The above display excludes counties with fewer than 10,000 Covered California plan members and/or fewer than 11 State Fair Hearings in 2022.

Initial Mode of Contact

Nearly 45 percent of Covered California's 2022 complaints were initiated by Telephone (44.9%), followed by Email (36.9%) and Online (18.2%).

Regulator

Covered California's complaints do not address health plan issues and so do not have attributable regulator information. For 2022, Covered California indicated that 99 percent of its health plan members were enrolled in coverage regulated by DMHC and one percent were enrolled in coverage regulated by the California Department of Insurance.

Source of Coverage

Nearly seventy-five percent of Covered California's complaints in 2022 had Covered California identified as the complainant's source of coverage (74.5%). A quarter of the complaints did not have source of coverage identified (25.5% Unknown).

Covered California noted that 34 percent of its complaints in 2022 were dual agency appeals to address its eligibility determinations involving both Medi-Cal and Covered California sources of coverage.

- Covered California's application system is an entry point for consumers seeking low-cost health care coverage.
- Applicants are screened for eligibility for Modified Adjusted Gross Income (MAGI) Medi-Cal and Covered California's financial assistance. Those who qualify for Medi-Cal cannot qualify for Covered California's subsidized coverage.
- Covered California refers those determined to be likely eligible for Medi-Cal to local counties for the final eligibility determination and enrollment in that program.

Product Type

Covered California submits product types indicating the level of coverage selected by the Covered California member, ranging from the lowest level of Catastrophic to the highest metal tier of Platinum. As the metal tier increases, so does the percentage of medical expenses that a health plan coverage compared with what the plan member is expected to pay in co-pays and deductibles.

Nearly 43 percent of Covered California's 2022 complaints were identified as involving a Silver plan (42.7%), followed by Bronze (18.1%), Gold (7.9%), Platinum (5.2%), and Catastrophic (under 1%). One quarter of the complaints did not have a product type identified (25.5% Unknown).

- The order corresponds to the popularity of the product types, with the highest number of Covered California members choosing Silver-level plans and the fewest members qualifying for and choosing Catastrophic (minimum coverage) plans.
- Covered California noted that, when comparing complaints and membership tier distribution, members who have selected higher actuarial value plans (higher metal tier) are slightly more likely to file complaints.

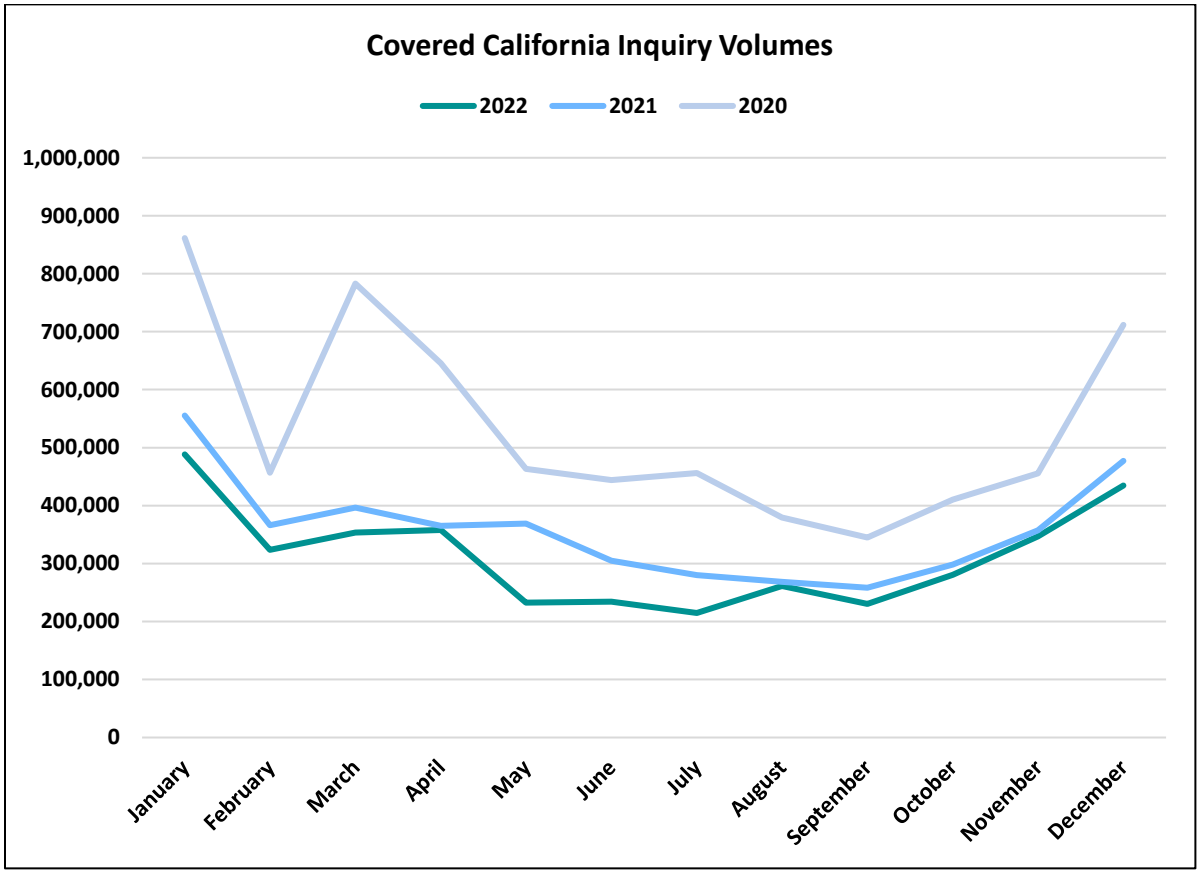
D. Consumer Assistance Center Details

With 3,813,768 inquiries from consumers in 2022, the Covered California Service Center's annual inquiry volume fell for the second year. Most of the consumer inquiries to the Service Center were made by telephone (87.3%). Approximately six percent were inquiries via online chat with the Service Center staff and another six percent were via chat sessions with Covered California's Chatbot.

The following chart displays Covered California's monthly inquiry volumes in 2022, along with the 2020 and 2021 monthly data.

- Covered California's inquiry volumes typically increase starting in the late fall during its annual open enrollment period, when its Service Center assists new applicants signing up for coverage and current members renewing coverage for the upcoming year.

Figure 7.13



Call Metrics

The following table displays telephone metrics associated with the 3,330,908 inquiry calls made to the Covered California Service Center in 2022.

Figure 7.14 Covered California Service Center – 2022 Telephone Metrics

Yearly Metrics	Measurement
Number of Abandoned Calls (terminated by callers prior to reaching a Customer Service Representative – CSR)	74,921
Number of Calls Resolved by the Interactive Voice Response (IVR)/Phone System (caller's needs addressed without involving a CSR)	1,304,745
Average Wait Time to Reach a CSR	01:42 (102 sec)
Average Length of Talk Time (time between a CSR answering and completing a call)	20:03 (1,203 sec)
Average Number of CSRs Available to Answer Calls (during Service Center hours)	511 Full-Time Equivalent (estimated)

Covered California noted that a decrease in available staff contributed to an increase in abandoned calls and average wait times from 2021 to 2022.

Inquiry Topics and Referrals

The following table outlines the Covered California Service Center's most common topics for consumer inquiries for both jurisdictional and non-jurisdictional topics. Most consumer contacts with the Service Center are jurisdictional inquiries that do not have to be referred to another organization.

Figure 7.15 Covered California Service Center Top Ten Topics for Inquiries

Ranking	Inquiry Topic	Volume
1 (most common)	Enrollment Status	266,917
2	Provided County Contact Information*	174,124
3	Plan Inquiry	141,085
4	Online Account Assistance Inquiry	113,472
5	Enrollment	90,073
6	Report A Change – Income Change	89,200
7	Eligibility Inquiry/Discrepancy	80,928
8	1095-A Inquiry	75,722
9	Payment Inquiry	75,556
10	Gained Employer-Sponsored Minimum Essential Coverage	69,696

* Provided County Contact Information inquiries were referred to the Medi-Cal program. This was the only inquiry topic in the top ten that was referred externally.

Consumer Assistance Protocols and Systems

Covered California did not report any changes to its consumer assistance protocols or systems for 2022.

Section 8 - Conclusion

This section highlights issues that were noteworthy for the ninth year of this Annual Health Care Complaint Data Report. The Center for Data Insights and Innovation (CDII) reviewed data about complaints closed in 2022 and other consumer assistance information submitted by four reporting entities: the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), California Department of Insurance (CDI), and California Health Benefit Exchange (Covered California).

Volume of Complaints

DMHC, DHCS, CDI, and Covered California reported 29,537 jurisdictional complaints closed from January 1 to December 31, 2022. The combined statewide volume has decreased annually since the high of 55,923 complaints in 2016.

- DMHC's complaint volume increased by approximately seven percent, from 16,025 complaints in 2021 to 17,200 complaints in 2022.
- The DHCS annual complaint volume fell for the sixth straight year, reaching 4,217 complaints in 2022 after a more than 12 percent (12.6%) decrease from 2021.
- CDI's complaint volume increased by nearly three percent (2.7%) compared to the prior year, with 3,704 complaints in 2022.
- Covered California's complaint volume decreased by 30 percent (30.1%), falling to 4,416 complaints in 2022 and reaching its lowest volume since 2015.

Complaint Reasons

Accounting for nearly 12 percent of the statewide volume in 2022, Denial of Coverage has been the most common statewide complaint reason since 2016.

- Denial of Coverage has been Covered California's top reason since the report's inception (2014), accounting for nearly 55 percent (54.6%) of the Covered California 2022 volume.
- DMHC's top reason in 2022 was Co-Pay, Deductible, and Co-Insurance Issues, accounting for nearly 15 percent (14.8%) of the DMHC 2022 volume.
- Scope of Benefits has been the top reason for DHCS complaints since 2018, accounting for 34 percent (34.4%) of the DHCS 2022 volume.
- Claim Denial has been CDI's top reason since the report's inception (2014), accounting for over 30 percent (30.5%) of the CDI 2022 volume.

Medical Necessity Denial continued to be the second most common statewide reason (10.3% of the 2022 volume) and was reported by three departments, ranking 2nd for DMHC, 2nd for DHCS, and 6th for CDI.

Complaint Results and Resolution Times

Upheld/Health Plan Position Substantiated (31.2% of the statewide complaint results in 2022) has been the most common statewide result since 2015.

- Upheld/Health Plan Position Substantiated was the most common result in 2022 for DMHC (34.3% of the DMHC results), DHCS (49.2% of the DHCS results), and CDI (23.4% of the CDI results).
- Complaint Withdrawn was Covered California's top result (85.5% of the Covered California 2022 results) and had dropped to the 2nd ranking for DHCS (31.7%)

The 2022 average complaint resolution times decreased for three of the reporting entities, decreasing the overall statewide average to 32 days. That statewide average has decreased each year since 2016. The 2022 average complaint durations per entity (with a comparison to the 2021 average noted) were:

- DMHC – 31 days on average (increase of 5 days)
- DHCS – 41 days on average (decrease of 8 days)
- CDI – 40 days on average (decrease of 6 days)
- Covered California – 25 days on average (decrease of 5 days)

Data Limitations

CDII continues to urge caution in making comparisons between reporting entities and measurement years due to differences in coverage products, complaint systems, and reporting. The data from the four state entities only partially represent the various and differing levels of complaint outlets available to consumers. For example, Covered California reported a type of informal complaint resolved at the initial service center level not represented for the other coverage sources. Medicare, self-insured plans, and certain other coverage types are not fully represented in this report as they are not overseen by the state entities that submit data for this report. In addition, each reporting entity may use different methodologies and criteria for similar subjects addressed in their departmental reports.

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