Center for Data Insights and Innovation

Annual Health Care Complaint Data Report - Background and Methodology for Measurement Year 2022

Complaint Data Report Background

The Center for Data Insights and Innovation (CDII) is statutorily mandated to produce an annual Complaint Data Report according to California Health and Safety Code section 130204. The original reporting requirements to produce the state's first multi-departmental health care complaint report were tasked to the Office of the Patient Advocate (OPA) through legislation enacted in 2011 (AB 922) and amended through a 2014 budget trailer bill (SB 857). After enactment of AB 172 in October 2021, OPA's programs transitioned to CDII.

CDII now is responsible for annually reporting 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), Department of Insurance (CDI), and the California Health Benefit Exchange (Covered California) – (collectively called "reporting entities").

When OPA began the complaint data reporting initiative, there was an absence of standardized complaint definitions and coding across the state reporting entities. OPA worked closely with the reporting entities to address differences and make ongoing improvements toward collecting and reporting comparable data. After rounds of testing and fine-tuning of collection tools, the reporting entities provided their first complaint data submissions to OPA in March 2015 containing records of complaints closed in 2014. The first Complaint Data Report, the *Baseline Report to the Legislature for Measurement Year 2014*, was issued in May 2016. Over 100,000 complaint records were submitted for the baseline year.

In the subsequent rounds of Measurement Year (MY) data submissions, OPA continued to adjust the coding to allow for the unique types of complaints and processes used by the reporting entities. The MY 2019 report was the final Annual Complaint Data Report produced and issued by OPA.

Released in May 2022, the MY 2020 report was the first issued by CDII but was based on data originally collected and analyzed by OPA. CDII took over data collection starting with MY 2021.

The MY 2022 report is the ninth Annual Complaint Data Report and the third issued by CDII.

New for MY 2022

- DHCS reported consumer assistance data for the first time for its new Medi-Cal Rx Customer Service Center, which assumed full operations in January 2022. Medi-Cal Rx is a new centralized fee-for-service delivery system for pharmacy benefits and services.
    - Pharmacy services that Medi-Cal members previously received through managed care plans were transitioned to Medi-Cal Rx.
    - Medi-Cal Rx also serves California Children's Services and the Genetically Handicapped Persons Program.
- New county complaint ratios are shown based on DMHC and CDI complaint data.

Measurement Year 2022 Data Sources

This ninth annual Complaint Data Report evaluates consumer health care complaints closed during MY 2022 (January 1 through December 31, 2022). The report provides some comparisons of MY 2022 data with previous measurement years, including data transferred to CDII from OPA.

DMHC, DHCS, CDI, and Covered California are statutorily required to annually provide CDII (and previously OPA) with non-aggregated complaint data and other consumer assistance information. The MY 2022 report was developed by CDII using data and other information collected from these reporting entities. The complaint types and data sources for the MY 2022 complaint records are outlined below.

DMHC

- **Complaint Types**: Standard Complaints, Independent Medical Reviews, Quick Resolutions, and Urgent Nurse
- **Data Source**: The DMHC complaint data and supplemental survey submissions were provided by the department's Help Center.

DHCS

- **Complaint Type:** State Fair Hearings (conducted by the California Department of Social Services [CDSS])
- **Data Sources:** The DHCS Enterprise Data and Information Management program coordinated the department's complaint data and supplemental survey submissions. The complaint data was sourced from various DHCS divisions that maintain records about State Fair Hearings conducted by the CDSS State Fair Hearings Division involving the DHCS programs. DHCS also provided supplemental survey information about the Office of the Ombudsman, Medi-Cal Telephone Service Center, Medi-Cal Dental Telephone Service Center, and Medi-Cal Rx Customer Service Center.
    - The following DHCS divisions contributed data: Behavioral Health, Benefits, California Medicaid Management Information System Operations, Clinical Assurance, Integrated Systems of Care, Managed Care Operations, Managed Care Quality and Monitoring, Medi-Cal Behavioral Health Oversight and Monitoring, Medi-Cal Dental Services, and Pharmacy Benefits.

CDI

- **Complaint Types**: Standard Complaints and Independent Medical Reviews
- **Data Source:** The CDI complaint data and supplemental survey submissions were provided by the department's Consumer Services Division.

Covered California

- **Complaint Types:** State Fair Hearings (conducted by CDSS) and State Fair Hearings: Informal Resolution (referred by CDSS for resolution by Covered California without a hearing)
- **Data Sources:** Covered California's Policy, Eligibility and Research Division coordinated the department's complaint data and supplemental survey submissions. The complaint data was sourced from the CDSS State Fair Hearings Division about State Fair Hearings and includes data about Administrative Law Judge adjudicated hearings and hearing requests referred back to Covered California for informal resolution. The supplemental survey data was from the Covered California Service Center Division.

Data Collection Tools

MY 2022 was the second annual data collection completed by CDII. For trend analysis, CDII also relies on older data previously collected by OPA.

To execute the reporting requirements, CDII and OPA used three primary tools to collect data from the reporting entities: 1) Complaint Data Validation Application, 2) Complaint Data Workbook, and 3) Consumer Assistance Supplemental Survey.

These tools are used to collect information about the service centers operated by CDI, DMHC, DHCS, and Covered California and about the complaints made by health care consumers to these reporting entities' complaint review systems. The complaint data collected is comprised of a combination of qualitative descriptive information as well as the quantitative records on the actual complaints closed during the measurement year.

The 2014-2016 complaint data was previously obtained through a biannual submission process, with separate submissions of Quarters 1-2 data and Quarters 3-4 data at different times during the year. Based on feedback from the reporting entities on ways to improve the efficiency of the reporting process, OPA moved to an annual submission process starting for MY 2017 data collection. After taking over the MY 2021 collection, CDII continued to use an annual submission process.

Other information about the reporting entities' service centers is collected each year through the Consumer Assistance Supplemental Survey.

Complaint Data Validation Application and Workbook

MY 2022 complaint data was submitted to CDII using a web-based application that validated data based on the data categories and elements established for the measurement year collection. Complaint data submissions must meet an established error rate threshold to be accepted through validation. The Complaint Data Workbook spreadsheet is provided to the reporting entities as the reference document of acceptable data elements.

For MY 2014, the Complaint Data Workbook spreadsheet served as the primary data collection tool to create the cumulative database of complaint cases submitted by CDI, DHMC, DHCS, and Covered California. Starting with MY 2015, OPA began using a web-based validation application collection tool to improve the efficiency and accuracy of the data collection process. CDII transitioned the validation application to a new data-sharing platform for the MY 2021 collection and continued its use for subsequent MYs.

Most of the complaint data collection categories and elements are based on standard complaint codes used by the National Association of Insurance Commissioners (NAIC) for its Complaints Database System. Through collaborations with the reporting entities and stakeholders, CDII (and previously OPA) evaluated and adjusted its standard data elements each year to meet reporting objectives and better align with the state reporting entities' systems.

See Appendix A for more information about the valid MY 2022 complaint data elements and associated analysis for the data collection categories.

Also find definitions within the annual report Glossary posted through: www.cdii.ca.gov/consumer-reports/complaint-data-reports/annual-complaint-data-reports/

Consumer Assistance Supplemental Survey

Through an annual Consumer Assistance Supplemental Survey, the reporting entities provide additional data and other information about their consumer assistance service centers. The reporting entities also submit health plan enrollment data for the coverage they administer or regulate.

See Appendix B for details about the survey.

Data Quality Assurance

The MY 2022 complaint data submissions from the reporting entities had to meet an error rate threshold of one percent or less to be accepted through the web-based validation application. This collection tool validated data submissions based on established data categories and elements and acceptable standard formats.

CDII and its public reporting contractor, the National Committee for Quality Assurance (NCQA), conducted additional quality assurance reviews to validate the complaint submissions while preparing the data for analysis. Reporting entities provided guidance or resubmitted data corrections as needed to address any issues noted through the validation and quality assurance activities.

CDII's data analysis was reviewed by NCQA. The reporting entities also validated this Report's analysis regarding their respective programs.

Requests for Assistance and Inquiry Methodology

Requests for assistance volumes represent the full volume of consumer assistance reported by each entity, encompassing both complaints and inquiries. CDII calculates requests for assistance and inquiry volumes depending on the role of its service center(s) for processing the entity's reported complaints.

For DMHC and CDI, which reported complaint data about complaints handled directly by their respective service centers:

- The service center volume reported through the Supplemental Survey is counted as the entity's requests for assistance volume.
- Each entity's inquiry volume is calculated by subtracting the volume of complaints reported from the overall service center volume.

For DHCS and Covered California, which reported complaint data about State Fair Hearings that are handled by CDSS rather than initiated through their respective service centers:

- The service center volume(s) reported through the Supplemental Survey is counted as the entity's inquiry volume.
    - DHCS reported inquiry data from multiple service centers, which was totaled for the overall DHCS inquiry volume.
- Each entity's requests for assistance volume is calculated by adding the volume of complaints reported to the service center volume(s).

Jurisdictional and Non-Jurisdictional Complaints

Complaints are considered as jurisdictional if they fall within the authority of the reporting entity to resolve.

- All complaints submitted by DHCS and Covered California are jurisdictional.
- CDI first submitted non-jurisdictional cases within its MY 2017 complaint dataset and continued to report non-jurisdictional cases in the subsequent MYs. CDI's non-jurisdictional complaints have the result reported as either "Referred to Outside Agency/Dept." or "No Jurisdiction."
- DMHC's complaint datasets have included non-jurisdictional cases since the baseline reporting year of MY 2014, but these cases could not be separated until MY 2018. As a result, DMHC's non-jurisdictional volumes are typically still included within trend analysis and related displays.

Health Plan Complaint Ratios

To provide a more equitable comparison of health plans of various sizes, CDII calculated MY 2022 health plan complaint ratios by taking the 2022 volume of closed complaints attributed to each health plan and dividing it by the number of the health plan's enrollees in 2022. For chart displays, the ratios are shown as complaints per 10,000 members.

The reporting entities provided enrollment figures for the health plans associated with each entity's jurisdiction. Report displays exclude health plans with enrollment under 70,000 members in 2022 and/or fewer than 11 complaints in 2022.

Enrollment figures may not be fully comparable between reporting entities or across MYs due to timing and other differences in reporting entities' enrollment data methodologies.

For MY 2022, like the previous reporting year, DMHC and CDI provided December enrollment data, DHCS provided March enrollment data and Covered California provided June enrollment data. DMHC and CDI enrollment data were based on the covered lives under the health care service plans and health insurance plans regulated by those departments. The DHCS health plan figures were from the monthly Medi-Cal Managed Care Enrollment Report. Covered California's health plan figures exclude applicants who had not paid their health plan premium to effectuate their coverage.

Like the previous year, the CDI MY 2022 health plan ratios were calculated based on complaint totals CDI provided for its health plans that had 25 or more complaints closed during the MY. CDI submitted its MY 2017-2022 complaint records without health plans identified. In years prior to MY 2017, OPA determined the health plan complaint totals from CDI's submitted complaint dataset.

Reason-to-Result Analysis

For MY 2022, CDII analyzed the complaint results for the top three complaint reasons reported by DMHC, DHCS, and Covered California. CDII's data collection fields allowed for reporting entities to submit up to three reasons and up to three results for each complaint record.

A reason-to-result analysis was produced for three of the four reporting entities. This analysis was possible for:

- DHCS because its cases involving its most common complaint reasons predominantly had a single result recorded and the few cases with multiple results had a limited number of results combinations.
- Covered California because all its cases had a single complaint reason with a single result. A three-year trend comparison also was possible for Covered California's displays due to the stability of its reporting to the reason and results collection categories.
- DMHC because its cases with multiple reasons and multiple results are submitted with a direct reason-to-result match (e.g., the reason entered in reason column 2 ended up with the result entered in result column 2). A DMHC MY 2018 complaint tracking system update made it possible for the department to record the direct attributions for its cases with multiple reasons and multiple results.

CDI submitted more complex datasets containing many complaint records with multiple reasons and multiple results, which cannot be separated into a single reason-to-single-result breakdown. The complaints with multiple reasons and results cannot be omitted from the analysis without skewing the findings.

County Complaint Ratios

CDII calculated MY 2022 county complaint ratios to provide a more equitable comparison of counties of various sizes.

For ratios based on DHCS and Covered California data, the number of closed complaints associated with a county was divided by the number of the county's program enrollees in 2022. The county complaint totals were based on the complainants' identified resident county within the complaint dataset. CDII used Medi-Cal enrollment by county submitted by DHCS and Covered California plans' total enrollment by county submitted by Covered California.

For ratios based on DMHC and CDI data, the number of closed complaints associated with a county was divided by the county population. The county complaint totals were based on the complainants' identified resident county within the complaint dataset. CDII used county population estimates for January 1, 2023, from the California Department of Finance Demographic Research Unit's *Population and Housing Estimates for Cities, Counties, and the State*, Report E-1 that was released May 1, 2023. This target date was chosen as it is closest in alignment with the last day of MY 2022 on December 31, 2022. Full county populations were used since county-level breakdowns on DMHC and CDI covered lives were not readily available.

For public display of the county ratios in the complaint data reports, CDII established thresholds of at least 70,000 county residents (DMHC and CDI ratios) or program members (DHCS and Covered California ratios) and over 10 complaints by the county residents during the measurement year.

Privacy Considerations

CDII follows California Health & Human Services Agency (CalHHS) guidelines to ensure that publicly reported complaint data meets privacy requirements of the California Information Practices Act and the Health Insurance Portability and Accountability Act. In addition, Data Usage Agreements with DHCS and Covered California include privacy requirements for handling of those entities' data.

Data is de-identified prior to public reporting according to the "CalHHS Data De-Identification Guidelines" document, which is available for download through the online CalHHS Data Playbook Resource Library. Categories with complaint volumes under 11 complaints are not publicly displayed, unless aggregated into a larger category grouping. Multivariate analysis involving demographic categories also is limited to reduce disclosure risk.

Additional Guidance about the Complaint Data and Resulting Analysis

One of the ongoing challenges for meaningful analysis of health care complaint data across reporting entities is the differences in data collection and complaint systems, which are not standardized in terms of definitions, coding, tracking, or performance metrics. CDII continues to facilitate collaboration with the reporting entities to improve and standardize the reporting of complaint data.

- Analyses of many data categories remain in separate reporting entity sections rather than aggregated statewide due to complaint system differences. CDII urges caution on comparing these categories across reporting entities or aggregating data into a statewide metric.
- Meaningful comparisons between measurement years may be limited due to annual adjustments made for standardization or alignment improvements.
- Although a pattern or emergence of consumer complaints may indicate systemic issues, complaint data can be an imperfect measure when comparing findings by reporting entity, coverage type, and similar categories.

Appendix A. Complaint Data Collection Categories and Elements for Measurement Year 2022

The reporting entities submitted data using the following standardized data categories and elements that are largely based on complaint coding established by the National Association of Insurance Commissioners. In collaboration with the reporting entities, CDII (and previously the Office of the Patient Advocate) has made annual adjustments to the accepted data elements to better align with the data collected by DMHC, DHCS, CDI, and Covered California. Significant Measurement Year reporting updates are also noted under the applicable category.

Case ID

Required field. The Case ID must be unique for each reported complaint record.

Type of Complaint

Required field. There are six accepted elements:

- Complaint/Standard Complaint: STD
- DSS State Fair Hearing
- DSS State Fair Hearing: Informal Resolution
- Independent Medical Review: IMR
- Quick Resolution: QRN
- Urgent Nurse Case: URG

Standard Elements Changes

“DSS State Fair Hearing: Informal Resolution” was first reported for MY 2015 by Covered California, but officially added as a valid data element for MY 2016.

Initial Mode of Contact

Required field. There are eight accepted elements:

- Counter/In-Person
- Email
- Fax
- Mail
- Online
- Other
- Telephone
- Unknown

Date of Birth

Required field if Age isn't submitted. There are two accepted elements and one accepted date format:

Date in format of mm/dd/yyyy
Refused
Unknown

Age

Required field if Date of Birth isn't submitted. There are one accepted element and one accepted numeric format:

Any numeric entry
Unknown

Reporting Notes

This Report includes analysis based on Age for the following age groups: Under 18,18-34, 35-54, 55-64, 65-74, 75 and older, and Unknown.

For complaint records where the Date of Birth was provided instead of Age, the complainant's age was calculated as of December 31st of the Measurement Year. Records submitted without Age or Date of Birth identified were displayed under the "Unknown" element.

Gender

Required field. There are eight accepted elements:

Female
Male
Nonbinary
Other
Refused
Transgender Female
Transgender Male
Unknown

Standard Elements Changes

For MY 2017 collection, “Transgender Male,” “Transgender Female” and “Nonbinary” were added as new elements.

Reporting Notes

For MY 2021, DMHC indicated that the department changed its demographic collection process in 2021 to be more respectful and reflective of the complainant’s gender identity.

DHCS noted that it reports data collected about sex under the gender category.

Race

Required field. There are 10 accepted elements:

American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian
Native Hawaiian or Other Pacific Islander
Other
Other Pacific Islander
Refused
Unknown
White

Standard Elements Changes

“Native Hawaiian” and “Other Pacific Islander” were added as separate elements in MY 2017. The combined “Native Hawaiian or Other Pacific Islander” element remains an option for reporting entities that cannot separate. Where appropriate, the report analysis may roll up the separate elements into the combined element for trending and other comparisons.

Starting MY 2016, entities reported complaints under “Other” that were reported in prior years under “Multi-racial” (this element was retired that Measurement Year).

Reporting Notes

Race elements with low volumes of complaints were combined for the report analysis and displayed under the “Other” element to ensure de-identification of complainants.

Ethnicity

Required field. There are four accepted elements:

- Hispanic or Latino
- Not Hispanic or Latino
- Refused
- Unknown

Primary Language

Required field. There are 18 accepted elements:

- Arabic
- Armenian
- Cambodian
- Cantonese
- English
- Farsi
- Hmong
- Japanese
- Korean
- Mandarin
- Other
- Other Chinese
- Refused
- Russian
- Spanish
- Tagalog
- Unknown
- Vietnamese

Primary Language elements with low volumes of complaints were combined for the report analysis and displayed under the “Other” element to ensure de-identification of complainants.

Resident County

Required Field. There are 61 accepted elements, including for the 58 California counties:

Alameda
Alpine
Amador
Butte
Calaveras
Colusa
Contra Costa
Del Norte
El Dorado
Fresno
Glenn
Humboldt
Imperial
Inyo
Kern
Kings
Lake
Lassen
Los Angeles
Madera
Marin
Mariposa
Mendocino
Merced
Modoc
Mono
Monterey
Napa
Nevada
Orange
Placer
Plumas
Riverside
Sacramento

San Benito
San Bernardino
San Diego
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Santa Cruz
Shasta
Sierra
Siskiyou
Solano
Sonoma
Stanislaus
Sutter
Tehama
Trinity
Tulare
Tuolumne
Ventura
Yolo
Yuba
Out of State
Refused
Unknown

Reporting Notes

For records where a Resident Zip Code was identified instead of a Resident County, CDII referenced a United States Postal Service Zip Code Database to determine the Resident County. Non-California counties were counted under the “Out of State” element. Records without Resident County submitted and with an invalid zip code (ones that did not match a valid zip code within the USPS reference document) were counted as “Unknown”.

Resident Zip Code

Required Field. There are two accepted zip code formats and three accepted elements:

xxxxx or xxxxx-xxxx (numeric five or nine-digit zip code)
No Residence
Refused
Unknown

Standard Element Changes

“No Residence” was added as a valid Zip Code element for MY 2020 collection based on a request from DHCS to be able to designate cases where the complainant is experiencing homelessness and does not have a residence. In these cases, the Resident County may still be reported to indicate the county where the individual receives health care services or has applied for coverage.

Insurer or Plan

Although suggested company names were shared with the reporting entities for standardization purposes, any entry was permitted for this category.

Source of Coverage

Required field. There are 12 accepted elements:

0505 Individual/Commercial
0510 Group
0517 State Specific (Other)
0522 Covered California/Exchange
0557 COBRA
CalPERS
Covered California/MAGI Medi-Cal
Medi-Cal
Medi-Cal/Medicare
Medicare
Uninsured
Unknown

Standard Element Changes

For MY 2019 collection, “Covered California/MAGI Medi-Cal” was added at Covered California’s request. Covered California’s State Fair Hearings include dual agency appeals where eligibility for two coverage sources is addressed.

"Uninsured" was first reported by DMHC in MY 2017, but officially added to the collected elements list in MY 2018. Due to a March 2017 data collection change, DMHC re-categorized complaints as Uninsured that were previously identified under the source of coverage the complainant sought or from which the complainant was cancelled. OPA used the new element for DMHC data within the MY 2017 report. Other reporting entities continue to categorize by the coverage the complainant lost or was seeking.

For MY 2016 collection, "Medi-Cal" was added and "Medi-Cal Fee for Service" and Medi-Cal Managed Care" were removed. This update was made to better align with DHCS reporting preferences. DHCS and DMHC first reported Managed Care and Fee for Service designations under Product Type for MY 2015.

Coverage Product Type

Required field for the first product type selection. Up to three selections allowed. There are 42 accepted elements:

0521 Grandfathered
0522 Exchange
0523 Pharmacy Benefits
0524 Catastrophic
0526 Bronze
0527 Silver
0528 Gold
0529 Platinum
0530 Health Only
0531 Small Group
0532 Large Group
0533 Child Only
0534 Multi State
0537 Stand Alone Dental
0538 Autism/PDD
0539 Student Health
0540 Long Term Care
0541 Home Health Care
0542 Short Term Limited Duration Policy
0543 Mental Health
0545 Dental
0547 Limited Benefits
0548 Chiropractic

0550 Hospital Indemnity
0551 Vision
0555 Cancer/Dread Disease
0556 Self-Funded/ERISA
0558 HMO
0559 PPO
0560 State Specific Other
0576 Medicare Prescription Drug
0577 Medicare Supplement
Discount
EPO
Fee for Service
HMO with Deductible
Managed Care
Medi-Cal Coordinated Care (CCI)
POS
PPO with Deductible
Uninsured
Unknown

Standard Element Changes

For MY 2022, nine elements were removed: “0552 HIPAA,” “0554 Pre-existing Condition,” “CCS Demonstration Project (MCO),” “Medi-Cal Managed Care: COHS Model.” “Medi-Cal Managed Care: GMC Model,” “Medi-Cal Managed Care: Imperial Model,” “Medi-Cal Managed Care: Rural Model,” “Medi-Cal Managed Care: San Benito Model,” and “Medi-Cal Managed Care: Two Plan Model.”

“0576 Medicare Prescription Drug” and “0577 Medicare Supplement” were added in MY 2018 at the request of CDI to better align with its collection categories.

“0535 Medicare Supplement” was removed for MY 2018 and entities were advised to remap data to the newly added “0577 Medicare Supplement” element.

“Discount” and “Uninsured” also were added as valid elements for MY 2018 to better align with data collection changes made by DMHC starting in March 2017.

- DMHC first reported “Uninsured” and “Discount” as product types in MY 2017, which OPA accepted for inclusion in the MY 2017 report. Records identified as “Uninsured” were previously reported by DMHC under the source of coverage

the complainant sought or from which the complainant was cancelled. Records identified as “Discount” were previously reported by DMHC as either “HMO” or “PPO,” depending on the Discount plan product.

- Other reporting entities continue to categorize by the coverage the complainant lost or was seeking.

“0540 Long Term Care” was added as MY 2017 collection element, replacing the DHCS-oriented “Long Term Care: PACE” and “Long-Term Care: SCAN” elements. OPA’s MY 2016 report analysis included “Long Term Care” for the first time, aligning with data submitted by DHCS that did not correspond to the PACE and SCAN designations.

“Fee for Service” and “Managed Care” elements were added under Product Type for MY 2016 collection and analysis to align with DHCS reporting preferences for categorizing its delivery systems, as well as the data reported by DHCS and DMHC for MY 2015. These designations were previously reported under Source of Coverage.

“HMO with Deductible” was added for MY 2016 collection to align with data collected by DMHC.

Reporting Notes

DHCS reports its health care services delivery systems as product types. In MY 2021, DHCS began reporting new State Fair Hearing data for the California Children’s Services program under “0533 Child Only” product type. Data for the DHCS California Children’s Services program is counted as “Child Only” for the statewide analysis but may be displayed using the California Children’s Services program name within the DHCS-specific analysis. Similarly, data for the DHCS Breast and Cervical Cancer Program is counted as “Cancer/Dread Disease” for the statewide analysis but may be displayed using the program name within the DHCS-specific analysis.

For report analysis, “HMO with Deductible” and “0558 HMO” are combined and reported as “HMO” and “PPO with Deductible” and “0559 PPO” are combined and reported as “PPO”.

Plan Regulator

Required field. There are nine accepted elements:

CDI
CMS

DMHC
DOL
No Regulator
OPM
Other
Out of State DOI
Unknown

Standard Elements Changes

Starting in MY 2017, “No Regulator” was added as a collection element and “CalPERS” was removed.

Complaint Reason

Required field for the first complaint reason selection. Up to three selections allowed. There are 107 accepted elements:

0805 Premium & Rating
0807 Dependent Age
0809 Waiting Periods
0810 Refusal to Insure
0815 Cancellation
0816 Nonrenewal
0820 Underwriting Delays
0822 Policy Audit Dispute
0828 Rescission
0840 Continuation of Benefits
0845 State Specific Other - Underwriting
0846 Dependent Coverage to Age 26
0902 Unfair Discrimination
0904 Financial Privacy
0905 Misleading Advertising
0906 Health Privacy
0910 Agent Handling
0911 Unauthorized Entity
0913 Fiduciary Theft
0915 Misrepresentation
0922 High Pressure Tactics
0923 Duplication of Coverage

0929 Fraud/Forgery
0930 Other Marketing and Sales
0933 Failure to Submit Application
0934 Premiums Misquoted
0935 Other Violation of Insurance Law/Regulation
0937 Using an Unlicensed Name
0938 Summary of Benefits
1001 Adjuster Handling
1002 Prompt Pay
1004 Participating Provider Availability/Timely Access to Care
1005 Unsatisfactory Settlement/Offer
1006 Pre-existing Condition
1007 Medical Necessity Denial
1015 Claim Denial
1017 Usual, Customary, Reasonable (UCR) Charges
1018 Out of Network Benefits
1019 Co-pay, Deductible, and Co-Insurance Issues
1020 Coordination of Benefits
1021 Authorization Dispute
1022 Primary Care Physician Referral
1023 Utilization Review
1025 Claim Delay
1027 Experimental
1028 Assignment of Benefits
1030 Cost Containment
1035 State Specific (Other)
1036 Appeal Non-compliance
1037 Claim Recoding/Bundling
1038 Recoupment
1039 Annual Limit
1040 Essential Health Benefit
1041 External Review
1042 Internal Appeal
1043 Lifetime Limit
1044 Preventive Care
1045 Pharmacy Benefits
1046 Maternity and Newborn Care
1047 Emergency Services

1048 Mental Health Parity
1049 Maximum Out of Pocket
1050 Ambulatory Patient Services
1051 Hospitalization
1052 Rehabilitative/Habilitative Care
1053 Pediatric Care
1054 Laboratory Services
1101 Closed Network/Provider Discrimination
1105 Premium Notice/Billing
1115 Delays/No Response
1117 Information Requested
1118 Delivery of Policy
1120 Unsatisfactory Refund of Premium
1123 Payment Not Credited
1125 Coverage Question
1126 Access to Care
1127 Quality of Care
1128 Company/Agent Dispute
1129 Abusive Service
1130 State Specific (Other)
1132 Involuntary Termination by Plan
1133 Provider Listing Dispute
1135 Delayed Authorization Decision
1136 Access to Fee Schedule/Rates
1137 Inadequate Reimbursement/Rates
1138 Unfair Negotiation
1139 Premium Subsidy
1140 Wellness Program
1141 Essential Community Provider
1142 Choice of PCP (Primary Care Provider)
1143 Disabled Individuals' Access
1144 MLR (Medical Loss Ratio) Rebate
1145 Language Access
1147 Continuity of Care
Billing/Reimbursement Issue
Denial of Coverage
Denied Services
Dis/Enrollment

Documentation Requests/Disputes
Eligibility Determination
Experimental/Investigational Denial
Medical Records Dispute
Plan/Staff Attitude and Service
Provider Attitude and Service
Scope of Benefits
Unknown

Standard Elements Changes

For MY 2022 collection, 17 elements were removed: “0823 Health Status,” “0834 COBRA,” “0835 Group Conversion,” “0837 MIB Reports,” “0912 Internet Related,” “0917 Policy Delivery,” “0918 Misappropriation of Premium,” “0919 Not appointed with Company,” “0921 Deceptive Cold Lead Advertising,” “0926 Misstatement of Application,” “1003 Willing Provider,” “1010 Post Claim Underwriting,” “1012 Subrogation,” “1107 Surrender Problem,” “1134 Delayed Appeal Consideration,” “1146 Notice Requirements,” and “Reporting Wrongful Loss of Healthcare Coverage.”

“Denial of Coverage” was added as a standard collection element for MY 2017, replacing the “Denial of Covered California Coverage” element. The MY 2016 report displayed “Denial of Covered California Coverage” as “Denial of Coverage”.

The following elements were removed from MY 2017 collection (the suggested replacements are noted):

- Denial of Covered California Coverage (map to Denial of Coverage)
- 0806 Continuity of Care (map to 1147 Continuity of Care)
- 0808 Pre-existing Condition (map to 1006 Pre-existing Condition)
- 0825 Unfair Discrimination (map to 0902 Unfair Discrimination)
- 1009 Fraud (map to 0929 Fraud/Forgery)

Starting in MY 2016, “Experimental/Investigational Denial,” “Denied Services,” “Billing/Reimbursement Issue” and “Scope of Benefits” were added as standard elements to align with reporting entity data preferences.

The following elements were removed from OPA’s MY 2016 accepted options:

- 1096 Access to Fee Schedule/Rates
- 1097 Inadequate Reimbursement/Rates (HCB only – CA code)

- 1098 Unfair Negotiation – Provider Contract
- 1099 Continuity of Care (map to “1147 Continuity of Care”)
- Dental Scope of Benefits
- Denial of Specialty Mental Health Services by Mental Health Plan
- No Response to Filed Grievance/Not Allowed to File/Unhappy with Result
- Plan Subcontractor/Provider Billing/Reimbursement Issue

Reporting Notes

For MY 2020, DMHC remapped some of its collection elements previously submitted as “1019 Co-Pay, Deductible, and Co-Insurance Issues” to the “Billing/Reimbursement Issue” element.

For MY 2019, DMHC remapped all complaints previously reported as “Experimental/Investigational Denial” to the “1027 Experimental” element. For OPA’s MY 2019 report, MY 2019 data for “1027 Experimental” and displayed as “Experimental” were trended with data previously reported as “Experimental/Investigational Denial” in the analysis for the DMHC and statewide sections. For OPA’s MY 2016-2018 reports, “1027 Experimental” was combined with and displayed as “Experimental/Investigational Denial” in the statewide section analysis.

For MY 2017 and later years, DHCS made reporting updates to remap some collection elements to different standard reasons for some of its delivery systems. For MY 2020, some collection elements that DHCS previously reported as “Denied Services” or “Scope of Benefits” were remapped to the “1045 Pharmacy Benefits” and “1007 Medical Necessity Denial” elements. For MY 2018, some collection elements previously reported as “Quality of Care” were categorized under other reasons. For MY 2017, some collection elements previously reported as other complaint reasons were remapped to the “Denied Services” element.

Complaint Result (Disposition)

Required field for the first complaint reason selection. Up to three selections allowed. There are 20 accepted elements:

1201 Policy Not in Force
1207 Advised Complainant
1208 Compromise Settlement/Resolution
1225 Claim Reopened
1230 Claim Settled

1235 No Action Requested/Required
1240 Referred to Outside Agency/Dept.
1253 Information Furnished/Expanded
1257 Fine Assessed
1280 Referred to Other Division for Possible Disciplinary Action
1290 Question of Fact/Contract/Provision/Legal Issue
1293 Company in Compliance
1295 Upheld/Company Position Substantiated
1300 No Jurisdiction
1305 Insufficient Information
1310 State Specific (Other)
1311 Overturned/Company Position Overturned
1312 Withdrawn/Complaint Withdrawn
Consumer Received Requested Service
Unknown

Standard Elements Changes

For MY 2022 collection, 12 elements were removed: “1205 Policy Issued/Restored,” “1210 Additional Payment,” “1215 Refund,” “1220 Coverage Extended,” “1223 Unable to Assist,” 1250 Underwriting Practice Resolved,” “1255 Delay Resolved,” 1260 Cancellation Notice Withdrawn,” “1270 Prem Problem Resolved,” “1277 Deductible Refunded,” “1287 Rating Problem Resolved,” and “1303 Recovery.”

For MY 2017 collection, the following standard elements were removed (the suggested replacements are noted):

- 1217 Entered into Arbitration/Mediation (map to 1290 Question of Fact/Contract/Provision/Legal Issue)
- 1227 Cancellation Upheld (map to 1295 Upheld/Company Position Substantiated)
- 1233 Filed Suit/Retained Attorney (map to 1290 Question of Fact/Contract/Provision/Legal Issue)
- 1239 Referral to Another State's Dept. of Insurance (map to 1240 Referred to Outside Agency/Dept.)
- 1285 Question of Fact (map to 1290 Question of Fact/Contract/Provision/Legal Issue)

“1257 Fine” was updated to “1257 Fine Assessed” for OPA’s MY 2016 collection.

"Consumer Received Requested Service" was added as a standard element for OPA's MY 2016 collection after being first reported by DMHC in MY 2015.

For MY 2021, DMHC remapped some collection elements previously reported as "1295 Upheld/Company Position Substantiated", "1230 Claim Settled", and "1305 Insufficient Information" to the "1208 Compromise Settlement/Resolution" element. DMHC noted that a MY 2021 collection change allowed the department to identify results more accurately for cases with multiple reasons where part of the case resulted in a benefit provided.

For MY 2021, DHCS recategorized some collection elements under "1235 No Action Requested/Required" for its Medi-Cal Fee-for-Service Pharmacy cases.

For MY 2020, DHCS remapped some collection elements previously reported as "1312 Withdrawn/Complaint Withdrawn" to the "1208 Compromise Settlement/Resolution" element.

For MY 2019, DMHC remapped some collection elements previously submitted under other standard results to "1207 Advised Complainant," "1312 Withdrawn/Complaint Withdrawn" and "1300 No Jurisdiction".

Date Complaint Opened

Required field. To be valid, the date opened must be before or on the date closed and on or after the DOB (if one is provided).

There is one accepted date format:

mm/dd/yyyy

Date Complaint Closed

Required field. To be valid, the closed date must on or after the date opened and fall on or between January 1 and December 31 of the Measurement Year.

There is one accepted date format:

mm/dd/yyyy

Appendix B. Consumer Assistance Supplemental Survey Data Collection for Measurement Year 2022

The following Consumer Assistance Supplemental Survey was used to collect data and information about the reporting entities' consumer assistance activities through their service center or centers.

Overview and General Instructions

The Center for Data Insights and Innovation (CDII) is required to produce and publish an annual report to the Legislature about health care complaints and consumer assistance provided by state service centers. CDII took over these requirements from the Office of the Patient Advocate in October 2021. This Supplemental Survey follows requirements outlined in Health and Safety Code §130204 to collect information about the services of health care consumer or patient assistance help centers, call centers, ombudsperson, or other assistance centers operated by the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), Department of Insurance (CDI), and Covered California.

For the 2022 data collection, please use this Supplemental Survey to provide information about your department's consumer assistance service center(s).

Service Center Survey

Overview Fields

- Department
- Service Center Name
- Public Phone Number - Main Line
- TTY / TDD Line
- Other Public Phone Lines and Target Audience
- Days/Hours Open
- Website of the Service Center

I. Number and types of requests for assistance received (complaints and inquiries) - §130204(b)(1)

1. Number of Requests for Assistance by Month and Mode of Contact (January 1 - December 31, 2022)

Include full consumer assistance volumes of complaints and inquiries.

2022	Telephone	Mail	Email	Online	Fax	Counter / In-Person	Other	Unknown	Monthly Total
January									
February									
March									
April									
May									
June									
July									
August									
September									
October									
November									
December									
Total Annual									

2. Telephone Call Overview (January 1 – December 31, 2022)

- Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)
- Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)
- Number of jurisdictional inquiry calls
- Number of non-jurisdictional calls
- Average number of calls received per jurisdictional complaint case (e.g., follow-up calls by the consumer after a complaint is filed, either to relay additional information for the case review or to check status)
- Average wait time to reach a CSR
- Average length of talk time (time between a CSR answering and completing a call)

- Average number of CSRs available to answer calls (during Service Center hours) -- Please indicate Full Time Equivalents (FTEs). You may also indicate staffing variations by season, month or weekday, if needed.

3. Top 10 Topics for Non-Jurisdictional Inquiries/Complaints (January 1 – December 31, 2022)

Please list as many as possible of your service center's most-commonly received non-jurisdictional inquiries/complaints topics and the most frequent referral destination organization(s) for each inquiry topic.

Ranking	Non-Jurisdictional Inquiry/Complaint Topic	Organization(s) that these Inquiries were Typically Referred to	Volume
1 (most common)			
2			
3			
4			
5			
6			
7			
8			
9			
10			
Indicate if the column information is based on data or estimated:			

II. Service center's protocols and systems §130204(b)(2) to (5)

- Service center's role with regard to each type of call, question, complaint, or grievance. §130204(b)(2)
- Service center's protocol for responding to requests for assistance from health care consumers, including any performance standards. §130204(b)(3)
- The protocol for referring or transferring calls outside the jurisdiction of the service center. §130204(b)(4)
- The service center's methodology of tracking calls, complaints, grievances, or inquiries. §130204(b)(5)

1. Service Center Organizational Structure and Role

- Please submit the current organization chart(s) for the Service Center with positions and classifications listed.
- In addition, please provide an organization chart displaying the Service Center's position in the Department's overall structure.
- If the Service Center's role or authority changed in 2022, please briefly describe the change and list the associated legislation, regulation, all plan letter, or similar policy.
- Are there any other issues to be noted that could affect 2022 data findings or trending comparisons? (E.g., Changes to protocols or standards, reduced Service Center staffing or hours, etc.)

2. Service Center Protocols

For this section, please submit document(s) that best demonstrate enterprise-wide consumer assistance protocols currently used by the Service Center. If any written protocols have been added or updated since last year's submission, submit the new document electronically. List any new or updated documents by title below, indicate if the document is publicly available, and identify the major elements addressed in each document.

- Document Title
- Indicate if currently publicly available (Yes /No)
- Indicate below which of the following elements are addressed in the document (Yes/No)
    - Performance Standards for Complaints (e.g., response times, customer service standards or guidelines, etc.)
    - General Protocols and Procedures (e.g., description of the step-by-step process - intake to resolution)
    - Language Assistance Protocols and Procedures
    - Urgent Case Protocols and Procedures
    - After-Hours Protocols and Procedures
    - CSR or Case Reviewer Training
    - CSR or Case Reviewer job aid or tools (Referral guides, phone scripts, etc.)

3. Service Center's Current Phone/Customer Relationship Management/Database Systems

If any Service Center systems have changed or been updated since last year's submission, please complete any relevant fields. Otherwise please note "No Changes" in the first field.

- System Name Used by the Service Center
- Product Name(s) if different than the system name (e.g., proprietary products used in system development)
- Developer Name (internal IT unit and/or contractor)
- Date Established
- Date of Last Significant Upgrade
- New Features/Enhancements/Other Changes (Please Describe)

4. Methodology: Data Collection, Analysis, and Reporting

For this section, please submit any updates to methodology documents currently used by the Service Center staff in an electronic format (in Microsoft Word whenever possible). Methodology documents include those that establish system controls and processes to ensure that data collection and related reporting is standardized and accurate.

- Data Collection -- Submit updated form(s) used by the Service Center to record complaint information (e.g., online complaint form, other intake forms or templates)
- Data Analysis Quality Assurance and Methodology -- Submit new reference documents (e.g., Data dictionary, quality assurance procedures, or other policies for ensuring accurate data; crosswalk mapping data to CDII categories; etc.)
- Have there been any data collection changes for your Service Center that would affect CDII's 2022 data analysis and trending with other Measurement Years?

III. Enrollment / Covered Lives

Please provide 2022 enrollment information for your program and the health plans/insurers your department oversees. Please submit enrollment calculated using the same methodology as last year if possible. You are welcome to use a separate Excel spreadsheet to report enrollment breakdowns instead of adding data below.

For the enrollment dataset(s) submitted, indicate:

- Enrollment month submitted
- Enrollment report date
- Description of dataset (e.g., source, exclusions/inclusions, etc.)
- Same methodology used as last year? (Yes/No) -- If no, please describe the change.

IV. Additional Department Information

Varied by reporting entity