Customer Service Center Quick Sort Transfers to Counties/Consortia: Service Standards and Contingencies

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Agenda

- 1. Customer Service Center Principles
- 2. Structure of the Customer Service Center
- 3. Consortia-Based Customer Service Centers
- 4. Quick Sort Protocol
- 5. Implementation Changes for Counties
- 6. County Readiness
- 7. Key Elements of Service Levels
- 8. Service Level Measurements/Cure/Corrective Actions
- 9. Contingency Plans
- 10. Background Information

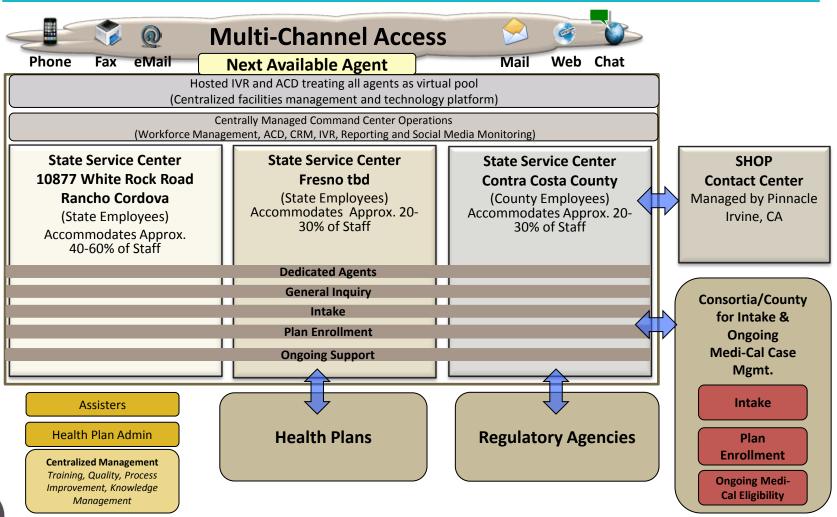


Customer Service Center Principles for the Consumer Experience

- 1. Provide a first-class consumer experience
- 2. Accessible, user-friendly web-site and forms that are easy to use/navigate
- 3. Culturally and linguistically appropriate communication channels
- 4. Protect customer privacy and security of their data
- 5. Demonstrate public services at their best
- 6. One touch and done
- 7. Provide clear, accurate, responsive information tailored to the consumers needs

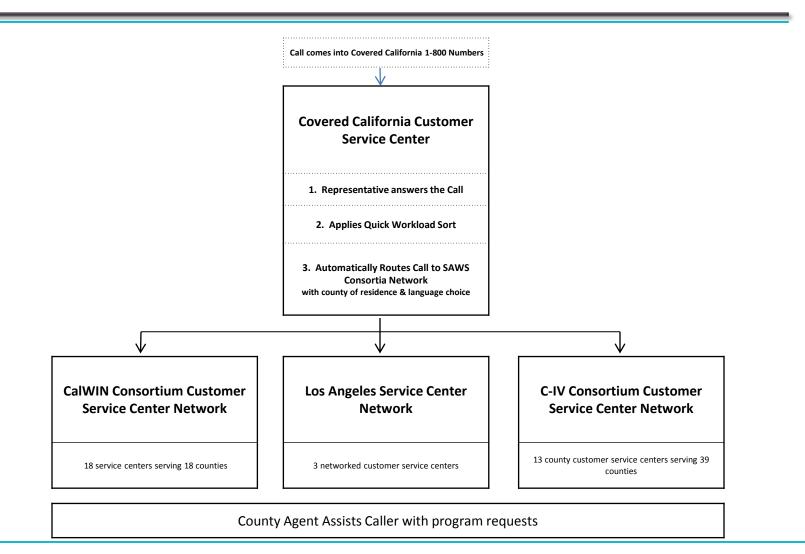


Centralized Multi-Site Service Center Model Medi-Cal Determination Hybrid





Consortia-Based Network





Consortia-Based County Customer Service Center Network

- Each SAWS Consortium ties participating county customer service centers into a network
- Covered California Customer Service Center routes callers to Consortia network based on the caller's county of residence, with language choice
- Consortia routes calls automatically, invisibly, and instantaneously to participating county customer service centers for a warm hand-off
- Calls go to county of residence, if agent is available, or another available agent in that network
- Counties answer calls in 30 seconds (or applicable Service Level) and then complete eligibility determination (and plan enrollment if applicable)
- Consortia provide performance metrics to both Covered California and DHCS



Implementation Changes for Counties

Selected Affordable Care Act implementation issues are being planned for by the County Eligibility and Enrollment Workgroup

- Impact of new application processes
- Eligibility workflow changes for eligibility workers
- Interactions with the Customer Service Center
- Implications of new workflow for training
- County Readiness plans and reporting
- Performance Standards, metrics, and reporting



Quick Sort Protocol for Workload Management

Quick Sort of Service Center phone calls for eligibility:

- Minimal sample questions to sort: (pending Federal review)
 - 1. Number of people in your family
 - 2. Anyone seeking coverage under age 19 or pregnant?
 - 3. Anyone seeking coverage elderly or disabled?
 - 4. Annual income?

The questions will be refined during design and continuously, based on experience

- Initial cut off points for sort to County:
 - 1. Single, childless adult 138% Federal Poverty Level (FPL) (final level to be set based on Medi-Cal eligibility with potential for small "margin" to best reflect MAGI)
 - 2. Pregnant women 200% FPL
 - 3. Child of a adult not applying for coverage 250% FPL
 - 4. Persons who are elderly or have a disability
- Continuous review, on a weekly basis, of referral metrics to determine the need for adjustments
- Process for first year, then full review and revise as appropriate
- Protocol is pending Federal Review



"Quick Sort" Sample

The Service Center Representative will ask the consumer for the minimum information necessary. Any appropriate cases will be immediately transferred to the County of residence along with delegation of client application processing. If not transferred, appropriate cases will be handled by the Exchange.

- If consumer is not specifically calling for health care benefits, the Service Center will handle the call as a General Inquiry
- Smart Calculator determines if this an
 Exchange consumer or County of residence
 consumer
 - If Smart Calculator identifies referral to Medi-Cal Specialist, then County of Residence selected and system autopopulates an agreed upon transfer protocol (e.g. address, phone number, call transfer, assisters)

	Smart Calculat	<u>or</u>		
1.	Are you calling the Exchange to underst your healthcare benefit options?	tand [Yes	
2.	How many people are in your family?		5	
3.	How many children are under the age of 19?	of [3	
4.	Are any of your family members pregna	ant?	No	
5.	Are any of your family members elderly	/?	No	
6.	Are any of your family members disable	ed?	No	
7.	What is your annual income?		\$24,000	
	Submit 2 Resu	lt:	Refer to Medi-Cal Specialist	3
	ne Smart Calculator indicates the consumer sho	uld be	referred to a Medi	i-
Cal or Medi-Cal specialist we ask: 1. What is your county of residence?			Yuba	4
	Submit 5 Resu	lt:	Transfer To 877-123-4567	6



Consortia Operational Readiness

Timelines and milestones are being developed for the following areas:

- Functioning and tested phone network system and IT Infrastructure
 - System connectivity established to all sites
 - Consortia Interactive Voice Response systems (IVR) fully tested
 - Language, County of residence, and unique tracer data connection established
 - Unique tracer reporting verified
- Staffing capacity to meet anticipated demand
 - Consortia staffed based on anticipated projections needed to meet anticipated volumes for Quicksort handoffs
 - Schedules/Resources committed to Quick Sort Transfers
- Completed staff training
 - Allocated staff training completed
- Pilot testing prior to launch
 - Completed by September 6th, 2013



Key Elements for Service Standards

The following are the key elements of the Memorandum Of Understanding under discussion among the parties: Covered California, DHCS, Consortia/LA County

- Terms and Conditions
- Service Standards
 - Operational Readiness
 - Service Levels
 - Corrective Actions



Service Level Measurements being Considered

Expectations of CMS for Covered California delegation of authority to the counties include: short measurement timeframes, short cure periods and service level adherence

Performance Standard		Options		
		Measurement Period	Cure Period	
QuickSort Service Level 80%/30 Seconds Answer Time: 80% of calls transferred from Covered California to the Consortia/Counties must be answered by County Workers trained to do eligibility and enrollment of both Medi-Cal and Covered California eligible individuals within 30 seconds				
Abandoned Calls equal to or less than 3% The abandonment rate when transferring calls to Consortia/County should be equal to or less than 3% of those calls that have been in the IVR for longer than 20 seconds. Not included are callers that disconnect to take advantage of offered self-service options (i.e. web self-service, call back, etc.)		To be Det	ermined	
No Busy Signals Customers shall not receive a busy signal when calling the Customer Service Center or when transferred to a County Representative with the exception of third party communication provider outages				

Considerations:

1. What is the right measurement period and implications for consumers, work management and federal approval?



Corrective Actions

If service levels are not met for the defined measurement period, correction action plans would be required

Performance Standard	Potential Corrective Actions
Corrective Action Plan Covered California and County/Consortia to develop Corrective Action Plan to support service level achievement	 Demonstrate Problem Resolution to meet Performance Standard Root Cause Analysis of Issue by responsible party Documented and Actionable Plans Executable Timeline to Resolution

Consideration:

1. During the cure period, do we handle calls differently? If so, how?



Opportunities To Cure

The corrective action plan would include cure actions that would be carried out during the cure period

Performance Standard	Potential Cure Actions				
Quick Sort Service Level 80%/30 Seconds	 Demonstrate Problem Resolution to meet Performance Standard such as: Invoke overtime for staff Leverage staff from other programs Add Staffing Resources 				
Abandoned Calls equal to or less than 3%	Demonstrate Problem Resolution to meet Performance Standard such as Invoke overtime for staff Leverage staff from other programs Add Staffing Resources				
No Busy Signals	 Demonstrate Problem Resolution to meet Performance Standard Proactive Cloud Level Messaging Route to Different County /Consortia Reduce/Eliminate Internal Transfers Secure Additional Phone Line Capacity 				

Considerations:

- 1. What additional potential "corrective actions" should be considered?
- 2. If the Performance measurement period is longer than a week or two; how should the "Busy Signal" standard and cures be addressed?
- 3. If corrective actions are not successful, what is the process to demonstrate readiness to undertake a new round of performance measurement?



Contingencies: Issues and Options under Discussion

- Covered California is aspiring to answering 80% of the calls within 30 seconds
 - Covered California monitors the service levels, in real-time, for Covered California and the County/Consortia
- For those call that are Quick-Sorted, the service center will transfer the call and be on the phone for up to 30 seconds
 - We cannot hold indefinitely without impacting other customers
 - On a dynamic basis we will know if the wait time is over X minutes (e.g. 2 minutes or 5 minutes, etc.)
 - 2 possible contingencies for when call wait hits "x" minutes:
 - Covered California Service Center handles the call
 - Call is transferred to another Consortia for handling

Considerations:

- 1. What, if any, is the right wait time that balances requirements for consistent service with demand, and allows work-flow management by Counties?
- 2. What are the consumer, technology, training, management and policy issues raised by transferring calls to another Consortia?
- 3. What are the consumer, technology, training, management and policy issues raised if Covered California serves as back-up for defined contingency circumstances?



Background Slides

- 1. Federal Rules
- 2. Service Center Assessment and Transfer Principles
- 3. General Operating Parameters



Federal Rules that Frame Covered California's Approach

45 CFR 155.302

• The Exchange must *either* conduct an eligibility determination for Medicaid and CHIP OR conduct an assessment of potential eligibility rather than an eligibility determination based on applicable eligibility standards. The Exchange and the State Medicaid agency must enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for Medicaid and CHIP.

45 CFR 155.405

• Single streamlined application for enrollment in a QHP, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, and CHIP.

45 CFR 155.110

• The Exchange may enter into an agreement with an eligible entity to carry out one or more responsibilities of the Exchange. ... The Exchange remains responsible that all federal requirements related to contracted functions are met.

45 CFR 155.345

The Agreement must clearly delineate each program's responsibilities to:

- Follow a streamlined process for eligibility determinations;
- Minimize the burden on individuals;
- Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay;
- Not require submission of another application;
- Not duplicate any eligibility and verification findings; and
- Not request information or documentation from the individual already provided.



Service Center Assessment and Transfer Principles

- 1. Conduct assessment, eligibility review and enrollment in a seamless manner for all consumers
- 2. Transfer consumers who are potentially MAGI Medi-Cal and non-MAGI Medi-Cal eligible to their County/Consortium as quickly and seamlessly as possible, after the minimal amount of inquiry and/or data collection
- 3. Maximize the accuracy of each call and enrollment handled by the Service Center in order to have the fewest possible Exchange eligible individuals referred to Counties, and the fewest possible MAGI Medi-Cal individuals served by Service Center
- 4. Minimize the duplication of work and effort
- 5. Continuous improvement of protocols based on metrics to determine timeliness, accuracy and precision of referrals and service
- 6. The Exchange, the Department of Health Care Services (DHCS), and other State partners will meet the obligations for which they are responsible under the Affordable Care Act, other federal and state eligibility requirements and state law.



General Operating Parameters

- CalHEERS will determine eligibility and facilitate plan enrollment for consumers (Medi-Cal and Exchange)
- Counties handle walk-in customers, including Exchange and County programs
- Drive to completion of enrollment from any point of entry into the system
- Minimize "bouncing" the customer back an forth use one warm handoff at most
- Ongoing cases handled at the "agency of record" (e.g., Medi-Cal handled by counties; Exchange by Central Service Center)

