Covered California Ombuds Office Annual Report FY 2019-2020

Issued June 9, 2021

COVERED CALIFORNIA

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A Note from the Ombuds Office Director

I am pleased to present the Covered California Ombuds Office Annual Report. The report covers the fiscal year of 2019-20.

As we were working hard to meet the expectations of the Ombuds Office, little did we know that we would face an unparalleled health crisis in the form of COVID-19. Our staff was forced to adapt to a new home/work environment within a matter of days. They rose to the occasion, displaying the ability to stay nimble, adjust, and discover new and innovative ways to meet consumer needs. Staff altered their personal and professional lives to continue to perform their daily functions and provide support to our consumers, while meeting contractual obligations.

Despite the many challenges that came with the pandemic, the Ombuds Office pushed forward and focused on enhancing internal procedures, partnerships, and the consumer's experience, while still delivering the scope of Ombuds functions our office offers. In this report, we highlight some of our enhancement activities as well as data that is representative of our core mission work.

Looking forward, the Ombuds Office will continue to work on being more proficient in Ombuds-specific functions and providing services with a neutral, fair and objective lens.

Respectfully Submitted,

Darryl Lewis

Director, Ombuds Office

Executive Summary

The Ombuds Office continues to serve as a resource for Covered California consumers to:

- Resolve issues when other resolution or consumer service channel options have been exhausted,
- Implement the appeal decisions of the Administrative Law Judge, and
- Identify systemic challenges affecting consumers in order to promote solutions.

In fiscal year 2019-20, the Ombuds Office Appeals Fulfillment Unit implemented 2,305 appeal decisions ordered by Administrative Law Judges. The unit maintained an 89 percent timely (within 30 days) implementation for all cases. This metric included the time the external partners required to process their portion of the decision.

The Ombuds Affairs Unit handled a total of 5,882 inquiries. Of these, 4,399 were contacts, which are the inquiries where the unit was able to provide information or direction to the consumer and did not require a case to be opened. The rest, 1,483, were cases that required research and resolution. The Ombuds Affairs Unit elevated 593 to specialty units at the Covered California Service Center and 890 were handled in-house. Inquiries were at an increase over the previous fiscal year's total of 2,063. The Ombuds Affairs Unit worked closely with other units and partners to ensure prompt and fair resolutions to consumer requests and inquiries, especially while Californians experienced record losses of jobs, income and health insurance due to the COVID-19 pandemic.

A prototype of the Ombuds page for Covered California's redesigned website was reviewed and updated, and changes were made to the Customer Relationship Management System (Salesforce) to make it more efficient, consistent and accurate for reporting purposes.

Ongoing, the Ombuds Office expects to continue to update Salesforce in order to produce the most accurate and useful reports for reviews and investigations. Detailed case and root-cause analysis will provide critical insight to trends and/or systemic issues that need to be addressed. The goal of being a resource for Covered California consumers and improve the consumer experience guides the direction and purpose of the Ombuds Office.

Introduction

Background

The Ombuds Office started assisting consumers in January of 2018. The two units of the Ombuds Office are the Ombuds Affairs Unit and the Appeals Fulfillment Unit. Although both units share the mission and core values of the Ombuds Office, each offers very distinct resources to the consumer.

The Ombuds Affairs Unit assists consumers that reach out to the Ombuds Office with issues which have not been able to be resolved through regular channels. Assistance is provided by educating consumers, escalating cases to proper units (if necessary), coordinating between consumers and plans or county workers, and when appropriate, updating the system to reflect correct information provided by the consumer.

The Appeals Fulfillment Unit works with appellants who have submitted an appeal and have received an Administrative Law Judge's decision. They implement the decision, working with the appellant to ensure that the appellant is aware of their options and responsibilities.

Note: More detailed information about the Ombuds Office Units can be found in the appendix.

Mission

The Mission of the Covered California Ombuds Office is to serve as an objective, unbiased, and accessible resource tasked with assisting Covered California consumers in resolving an issue when other resolution or consumer service channel options have been exhausted, while also identifying systemic challenges affecting consumers and promoting solutions to prevent issues from recurring.

Core Values

Independence:

The Ombuds Office is free from outside control and influence. Independence is the core defining principle of an effective and credible Ombuds Office. It works independently of other Covered California departments, but shares findings with Covered California executives.

Impartiality:

The Ombuds Office is committed to reviewing consumer issues without bias or preconception and always treat individuals in a fair and objective manner. Impartiality is at the heart of the Ombuds. It instills confidence in both the public and its partners.

Empowerment:

The Ombuds Office is committed to providing a range of responsible options to the consumer to make an educated decision. It strives to listen to consumers to understand their views and be sensitive to their concerns.

Excellence:

The Ombuds Office is accessible to all potential complainants with honesty and fairness. It performs its responsibilities in a manner that engenders respect and confidence. The Ombuds Office strives to achieve the highest standards in the work that it does and add value to the organization.

How the Ombuds Office Works:

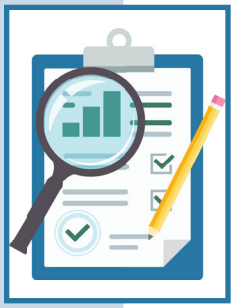
Who should contact the Covered California Ombuds Office?

Covered California consumers who:

- Have contacted the Covered California Service Center, have had their issue escalated and the timeframe for resolution has passed. The Service Center should provide an incident or reference number for these contacts.
- Have filed an appeal and a decision from the Administrative Law Judge has been issued.
- Have filed a Covered California complaint and it has been more than 30 days and they have not received an update.

What does the Ombuds Office do?

- Follow up on the escalated issues.
- Recommend solutions or resources.
- Assist consumers with appeal decision implementations.
- Research and report on complaint statuses.
- Analysis of trending system issues for improvement and/or solution recommendations.

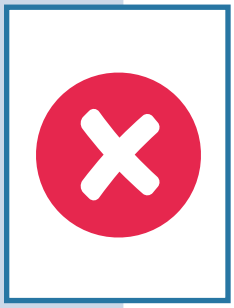


How to contact the Ombuds Office?

- Email: ombuds@covered.ca.gov
- Call toll free: (888) 726-0840 - Assistance is available in multiple languages.
- Fax: (888) 726-0841
- Mail: Covered California
  Attn: Ombuds Office
  1601 Exposition Blvd.
  Sacramento, CA 95815

What is out of scope for the Ombuds Office?

- Issues pertaining to Medi-Cal enrollment/benefits.
- Providing legal advice.
- Insurance company's products or services.
- Assisting with preparing appeal requests or complaint submissions.



Year in Brief

General

- Appeal Decision Compliance Reporting
- Relationships with Partners
- Root Cause Analysis
- COVID and Telecommuting
- Webpage Beta Testing
- Salesforce Updates & Impacts

Reporting

Starting January 2020, a pilot program was initiated where a report is generated monthly for the Plan Management Department that calculates and documents the contractual compliance of the Ombuds Office and health care plan providers in processing appeal decisions released by the Department of California Social Services Administrative Law Judges. The report provides carriers with the percentages of cases that are processed under 5 days (which provides the carriers with a financial incentive), those cases that are within the contractual time requirement of 10 days, and the cases that are over 10 days (resulting in penalties). It also documents the percentage of cases that are processed by the Ombuds Office within the required 20-day turn-around time, for a case total of 30 days, mandated by California Code of Regulations, Title 10 § 6618(c). During the pilot program the incentives and penalties are not applied. After review of the pilot program, projected to be at the end of the calendar year 2020, it is expected that the report will be used to monitor contract compliance and appropriate incentives/penalties will apply. (Compliance rate is addressed in more detail in the *Appeals Fulfillment Unit, Compliance Reporting* section.)

Relationships with Other Units/Partners

The Ombuds Office works closely with Covered California's Service Center Escalations Resolution and Priority Support units to ensure timely and fair resolution to consumer requests/inquiries by monitoring escalated cases to these units.

When a backlog of cases exists in these units, the Ombuds Office will, upon request, assist by working internally to resolve the cases. The Ombuds Affairs Unit took an active role in escalation resolution during an extended open enrollment period (due to an ad campaign to inform consumers of a new California tax penalty for non-coverage for calendar year 2020) in February 2020. The Ombuds Office also stopped escalating cases to other units in late March 2020 when, due to the COVID-19 crisis, Covered California began to set up telecommuting practices for the organization while experiencing elevated requests for enrollment. The Ombuds Office was one of the first to set up and be able to take consumer calls. (See *COVID/Telecommuting* section below.)

The Ombuds Office also interacts with the counties, carriers, and the Covered California County Liaison Hotline team to assist consumers who have been unable to resolve issues with the county offices. These issues often prevent the consumer from being able to act on their Covered California accounts. The liaisons are also critical in assisting with appeal decisions that require county intervention prior to Covered California's implementation of the decision.

The Ombuds Office began meeting monthly with the Customer Relations and Resolution, Escalations Resolution, and Priority Support units to collaborate on cross-divisional issues and objectives including, for example, Salesforce releases, process improvement for exemptions workgroups, and subsidy processes. A half-day workshop with Sacramento County was held to explain and discuss transitions from Medi-Cal to Covered California and from Covered California to Medi-Cal. Screenshots and back-end procedures were shared to increase knowledge and improve processes. The Ombuds Office will continue to solicit participation with other counties to strengthen relationships and procedures.

Root Cause Analysis

Root cause analysis (RCA) is an essential function of the Ombuds Office. The process of discovering the root cause of a system issue allows for the identification of appropriate solutions or improvements.

The Ombuds Office participated in training with Leading Resources, Inc. for an Ombuds-focused RCA overview and is currently in the process of conducting research on two pilot RCA reviews. Additional training, review, and support from the RCA experts was provided during these reviews to build up the overall RCA process.

One RCA is regarding the appeal processes where Covered California is included as a responsible entity along with the respective county (these are referred to as "dual appeals"). The research is focusing on whether the process needlessly requires Covered California participation when Covered California has no informal resolution to offer, position to defend or resolution to implement. These cases concern Medi-Cal eligibility and enrollments. Findings and possible recommendations could impact Covered California's involvement in Medi-Cal appeal cases.

The other RCA is looking at appeal decisions regarding retroactive terminations of enrollments and whether the decisions granting these requests are in accordance with laws, regulations or policy and applied consistently. Findings and recommendations could impact how the retroactive terminations are considered prior to reaching the level of an appeal.

Moving forward, the expectation is to use the information gained from the RCAs to improve or implement processes as a result of the recommendations made. This allows for a better consumer experience by enhancing the tools and systems used by not only the consumer, but Covered California staff and it s partners. Future RCA projects can be compared to these established procedures and methodologies so year over year progress can be achieved.

COVID/Telecommuting

Staff were required to start working remotely from home (shelter-in-place) per the Covered California Executive Director's directive on Tuesday, March 17. By Monday, March 23, the Ombuds Office staff were fully set up to telecommute and were among the first groups to begin taking calls from consumers. Along with the Ombuds responsibilities, the staff also worked with consumers who were unable to reach the Covered California Service Center or escalation teams to ensure proper resolution to urgent access-to-care requests. The Escalations Resolution unit was fully staffed on March 27th and the Service Center became fully staffed on April 10th. Even with these teams fully

staffed, the Ombuds Office continued to work alongside them to address the backlog of requests and the urgent need for coverage due to the impact of job losses amid the COVID-19 pandemic crisis. Beginning March 17 through the end of the May, the Ombuds office responded to 915 inquiries and opened 369 cases. The Ombuds Office worked and resolved 91 percent (335 of 369) of these cases, meaning the cases weren't sent to other appropriate units for resolution, compared to 65 percent (228/353) of cases from the timeframe of January to March 16, prior to the telecommuting directive.

Webpage (Beta Testing)

In May, the CoveredCa.com Development Team unveiled a proposed, updated Covered California Marketplace (CoveredCA.com) website for beta-testing. The Ombuds Office reviewed and provided feedback/suggestions on the sections regarding the Ombuds Office and services. The updated website is anticipated to be launched to the public in September 2020.

Customer Relationship Management System (Salesforce) Updates and Impacts

Salesforce is the Customer Relationship Management System used by Covered California to track consumer interactions, including calls, inquiries, complaints, and appeal actions. It is useful in following the progress of a consumer request or case, creating internal reports, and identifying trends that impact the implementation of proper coverage.

To make Salesforce more efficient, consistent and accurate for reporting purposes, the Ombuds Office requests and implements updated processes. Some of the updates implemented include:

- User permissions – Updated so that Appeals Fulfillment Unit users could cross functionally assist with Ombuds Affairs Unit cases without disrupting either workload and accurately capturing each case type (Appeals vs Ombuds).
- Automatic child case creation – System update to automatically populate fields to aid staff in creating child cases to minimize errors and duplication of effort. Automatically links parent/child cases together.
- Ombuds case indicator – Allows other Covered California business partners accessing Salesforce to see that there is an Ombuds case created and being worked on, without allowing access to notes.
- Required Household field – Ombuds requested that call center representatives be required to select a household when an agent calls to better track issues for consumers.
- New Decision Disposition and Sub-Disposition fields – Added fields to align the disposition captured in Salesforce with the California Department of Social Services data for reporting purposes and to capture the appeal decision at the start of a case instead of at the closing.
- New Decision Compliance field – Added dropdown field that allows the user to select 30 or 60 days as the due date, depending on if there is a special enrollment period. This field auto-populates a milestone in the workspace.
- New Resolution Reason – Added "Final Decision Received" to the selection of resolution reasons to lead to new field "Appeal Outcome."
- Required Decision Received field – Required the Decision Received field to be populated on all cases to support consistent data to measure timeframes.

Appeals Fulfillment Unit

Process

Day 1	Appeal decision released by Administrative Law Judge is assigned.
Within 1-3 Days	Ombuds Appeals Analyst updates case in Salesforce and contacts consumer via email and phone call with welcome email and disclaimers.
Within 20 Days	Ombuds Analyst works with appellant to implement appeal decision, and if necessary, forward to health care plan carriers for action.
Within 30 Days	Health care plans carriers are required to process and implement enrollment or acknowledge disenrollment of appellant.
Day 30	Decisions are implemented, and cases are closed

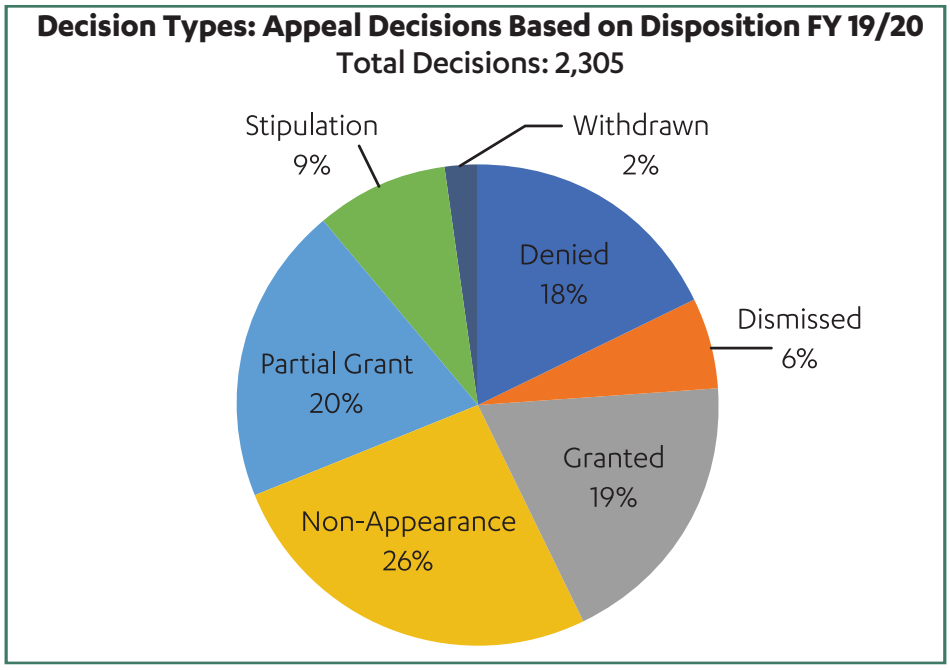
Note: *Special enrollment periods and grace periods required by certain transactions may prolong the timeline. This includes dual appeals and cases with Aid Paid Pending that can take up to four (4) months to implement.*

Decisions

A consumer can request a fair hearing to appeal a Covered California eligibility determination with the California Department of Social Services. Once the consumer's hearing has concluded, the presiding Administrative Law Judge will provide their judgement or decision on the consumer's case. If the consumer disagrees with the 1st level appeal decision, a 2nd level appeal may be filed with the Health and Human Services Agency. A decision resulting from either a 1st level state appeal or 2nd level federal appeal must be implemented by the Appeals Fulfillment Unit. Each appeal received is given one of the following dispositions:

- Decision Granted — The appellant's request was approved.
- Hearing Dismissed — The appellant's request was not an appealable issue or was outside the Administrative Law Judge's jurisdiction.
- Non-Appearance — The appellant did not appear for the hearing, so the Administrative Law Judge dismissed the request.
- Decision Denied — The appellant's request was not approved.
- Decision Granted in Part — The Administrative Law Judge granted some of the actions requested by the appellant but not all.
- Stipulation — The appellant, the Administrative Law Judge, and the hearing analyst came to an agreement at the hearing.
- Withdrawn — The appellant requested the appeal to be withdrawn either because their request was achieved in Informal Resolution or another reason not specified.

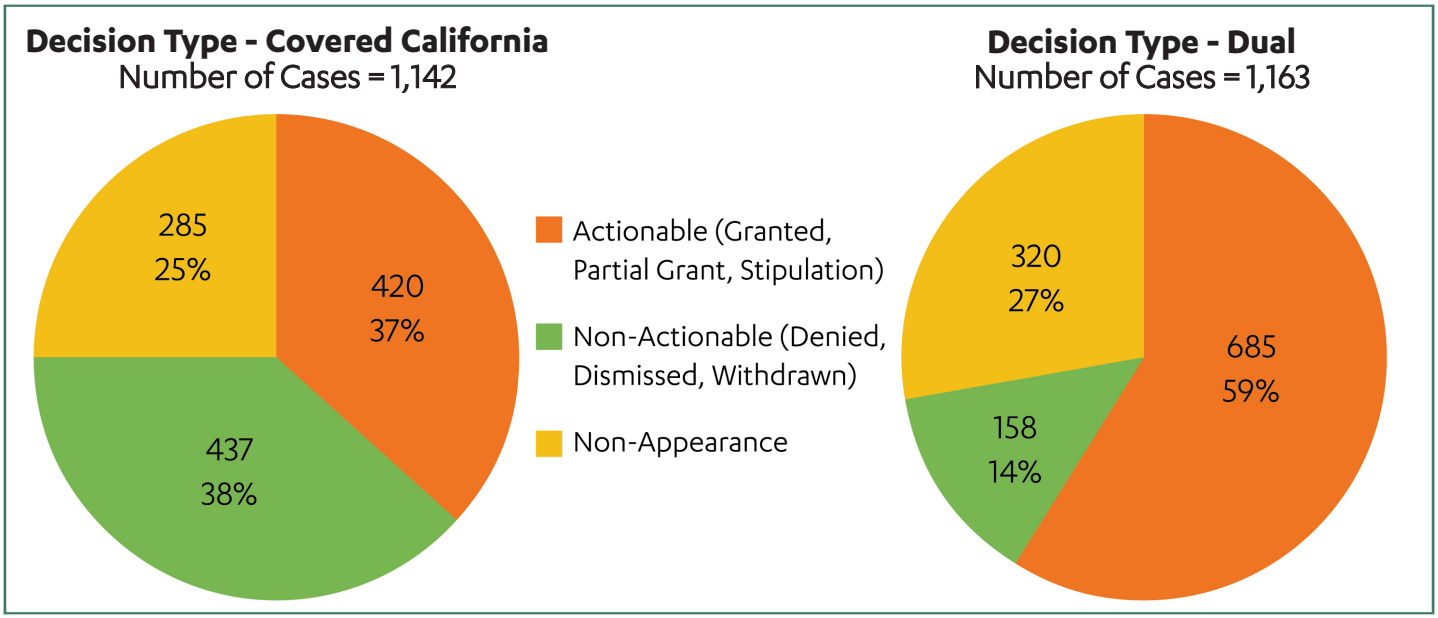
In fiscal year 2019-20, the Appeals Fulfillment Unit received and implemented 2,305 decisions ordered by an Administrative Law Judge. Decisions that required action to be taken (Granted, Partial Grant, and Stipulation) accounted for 48 percent (1105) of appeals that went to hearing. The number of decisions that were "Denied" only accounted for 18 percent of the total decisions received. Non-Appearance cases accounted for the largest population (26 percent) of decision types.



Case Types – Dual Cases vs Covered California Cases

Appeal cases have responsible agencies that represent the position that the appellant is appealing. When the responsible agencies include a county and Covered California, these are referred to as dual cases. These cases require that both the county and Covered California submit a statement of position supporting the action being appealed.

When decision types are separated by the responsible agency, Covered California cases with actionable decisions (Granted, Partial Grant, and Stipulation) only account for 37 percent of all decisions while for dual cases, actionable decisions account for 59 percent of all decisions. Decisions that are non-actionable

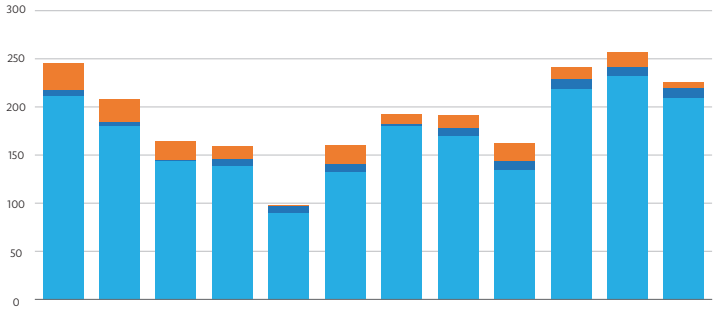


(Denied, Dismissed or Withdrawn) for Covered California account for 38 percent of the cases compared to 14 percent for dual cases. These statistics support the assumption that Covered California initial eligibility determinations are properly processed since so many are denied and so few are actionable in comparison to dual cases.

Timeliness:

To remain in compliance with Covered California regulations, appeal decisions must be implemented within 30 calendar days of the date they are released by the administering entity, the California Department of Social Services. This timeframe does not make extra allowances for special requests needed to modify a consumer's enrollment account or the time taken by health plans, consumers or the county to process or communicate desired changes. These situations impact implementation timeframes. For fiscal year 2019-20, 50 percent of appeals were dual cases which may have required action from both the county and Covered California. Typically, Covered California is not able to implement its part of the decision until after the county acts. Notwithstanding, the Ombuds Office was still able to implement decisions in a timely manner in 89 percent of cases (2,042/2,305). Of the cases that were not timely, 69 percent (181/263) were dual cases. These timeframes start from the time the appeal decision is released to when the decision is implemented, and the case is closed.

Appeals Fulfillment Unit Timely Statistics



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Total	246	208	164	159	98	160	192	191	162	242	257	226
>30 days Dual	28	23	19	13	1	19	10	13	18	13	15	6
>30 days CC	7	5	1	7	7	8	2	8	9	10	10	10
Timely	211	180	144	139	90	133	180	170	135	219	232	210

Compliance Reporting:

In January 2020, the Ombuds Office began providing contractual compliance data to the Plan Management Department, for a pilot program, reporting compliance timeframes for appeal decision implementation for health plan carriers and for the Ombuds Office. Covered California (through the Ombuds Office) has 20 days to forward a request to a carrier for implementation after consultation with the appellant. The carrier then has 10 days to implement the request. This combined timeframe of 30 days is mandated by Covered California regulations (California Code of Regulations, Title 10, § 6618(c)), as adopted with the County regulations.

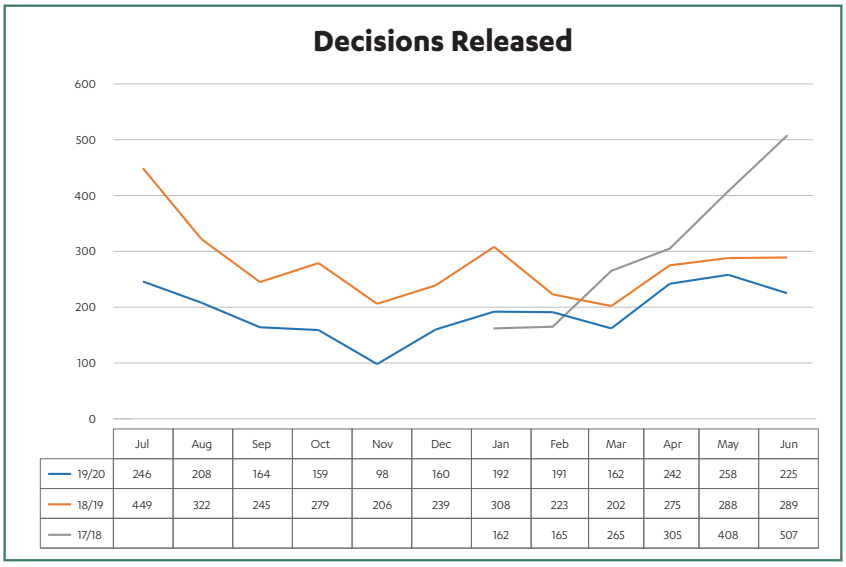
Cases exceeding the 20-day limit provided for Covered California to take action were reviewed and, if necessary, adjusted to eliminate turn-around-times adversely impacted by:

- The consumer being temporarily covered by Medi-Cal;
- A special enrollment period was opened (that exceeded the 20-day timeframe) and a decision wasn't finalized by the consumer prior to the period ending; or
- The consumer or county was unresponsive or late in responding.

No adjustments were made to cases where the turn-around time was due to an analyst's delay or a system defect. After adjusting the turn-around times, and since these timeframes have been tracked, the Ombuds Office has maintained a 98 percent compliance rate.

Previous Years Comparison:

The number of decisions released each month for fiscal year 2019-20 continues to be at levels below the previous fiscal year. This may be indicative of fewer appeals being filed or increased informal resolutions processed by the Customer Relations and Resolution unit being successful and, therefore, not resulting in a hearing.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
19/20	246	208	164	159	98	160	192	191	162	242	258	225
18/19	449	322	245	279	206	239	308	223	202	275	288	289
17/18							162	165	265	305	408	507

Ombuds Affairs Unit

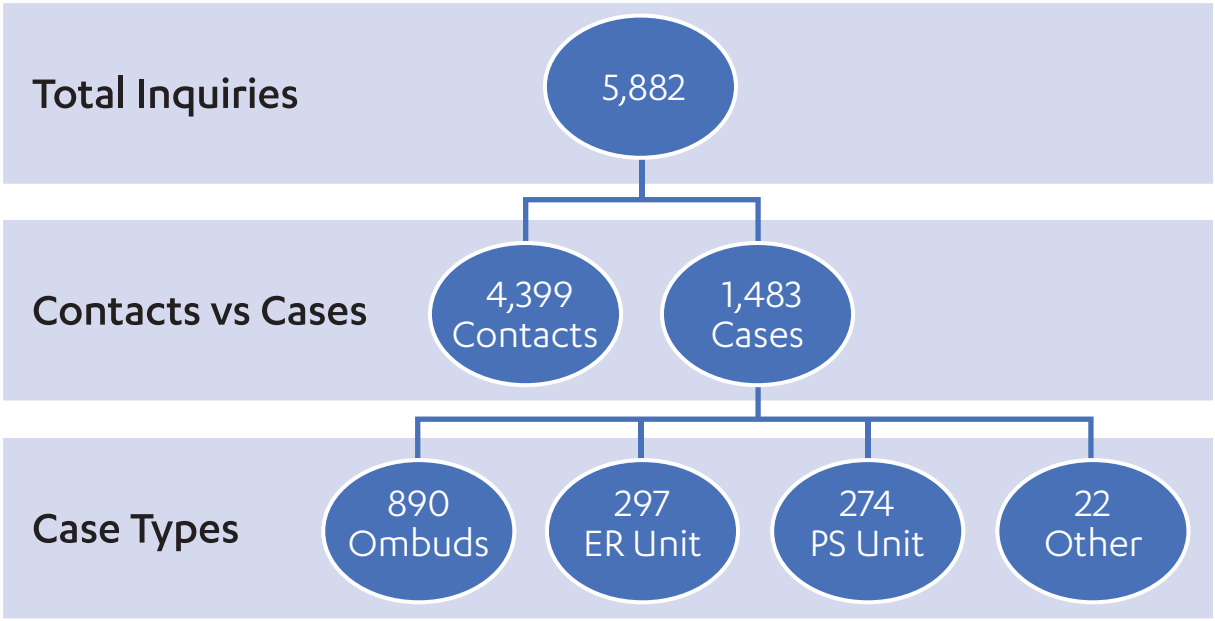
Process

Day 1	Inquiry is received by phone, email, fax or mail.
Within 3 Days	Contact is made with consumer.
Continuous	Contact is maintained with consumer as issue is researched or monitored or if follow-up questions are required
Within 30 Days	Most issues are resolved.

Note: *The timeframe may be impacted by how complex the issue is and how much research is required. Ombuds is not governed by a regulation that specifies resolution timeframes as cases may be left open as part of monitoring systemic resolutions.*

By the Numbers

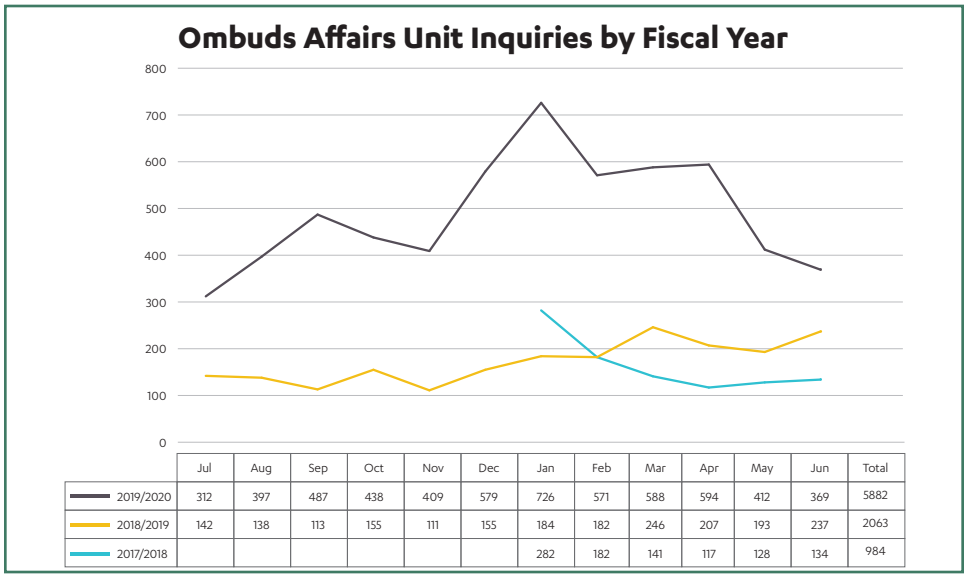
July 2019 – June 2020:



The Ombuds Affairs Unit handled 5,882 inquiries throughout the fiscal year. Of those, 4,399 were inquiries that the unit was able to provide information or direction to the consumer and did not require a case to be opened. These are considered "contacts." The remaining 1,483 inquiries became cases that fell into one of four case types. Depending on the nature of the case, it was either elevated to a specialty unit (Escalations Resolution Unit, Priority Support Unit or another appropriate unit) or researched in-house. The Ombuds Affairs Unit resolved a total of 890 cases in-house.

Previous year comparisons:

The number of inquiries that were processed by the Ombuds Affairs Unit in fiscal year 2019 -2020 increased by 185 percent compared to the previous fiscal year, going from 2,063 to 5,882 inquiries.

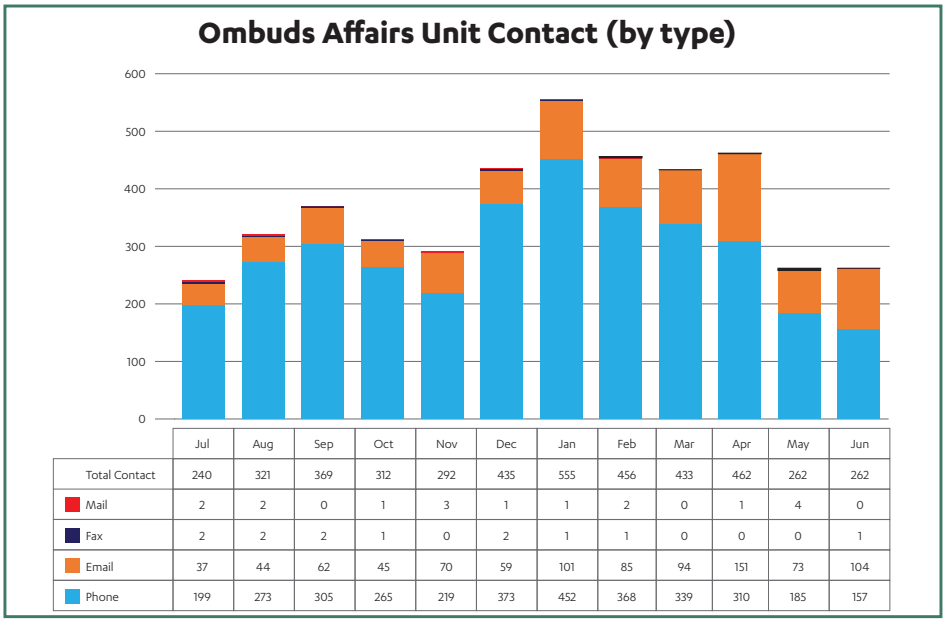


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
2019/2020	312	397	487	438	409	579	726	571	588	594	412	369	5882
2018/2019	142	138	113	155	111	155	184	182	246	207	193	237	2063
2017/2018							282	182	141	117	128	134	984

Contacts

Source of Contacts:

Inquiries which become contacts come into the Ombuds Office primary through the phone line or email. Occasionally, the request for assistance comes by a form submitted by fax or through correspondence received by mail.



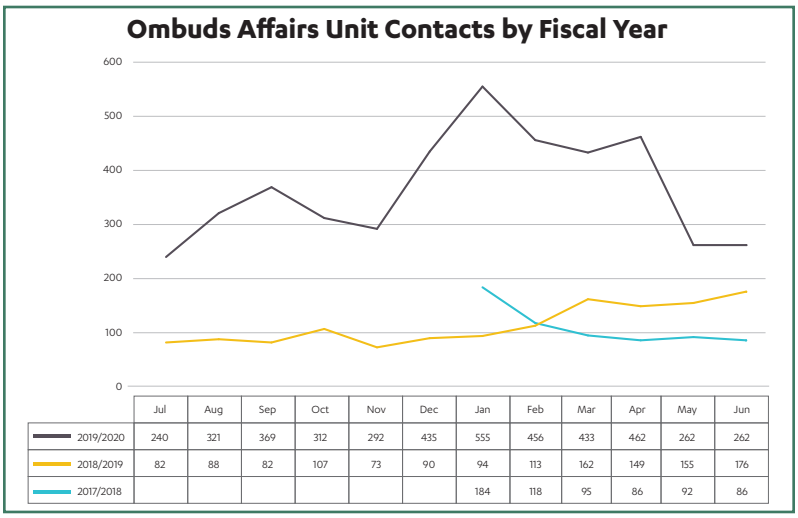
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Total Contact	240	321	369	312	292	435	555	456	433	462	262	262
Mail	2	2	0	1	3	1	1	2	0	1	4	0
Fax	2	2	2	1	0	2	1	1	0	0	0	1
Email	37	44	62	45	70	59	101	85	94	151	73	104
Phone	199	273	305	265	219	373	452	368	339	310	185	157

How the Ombuds Affairs Unit helps:

Contacts accounted for 4,399 of the inquiries. The Ombuds Office provides information to the consumer so that they can: direct their questions to the proper entity for resolution, complete the proper process to fix issues themselves, or use resources to find the help necessary to address their issue.

Previous year comparisons

The Ombuds Affairs Unit continues to see an increase in contacts as compared to previous years. The spike in the figure below that starts in December 2019 may be due, in part, to the open enrollment period and the reinstated mandate requiring health care coverage for all Californians. The following spike in April 2020 can be attributed to staff shifting to telecommuting practices while sheltering-in-place during the COVID-19 pandemic. During the time the Covered California Service Center was not accessible (while they set up to work remotely), consumers were reaching out directly to the Ombuds Office for assistance. The contacts for May and June of 2020 are more in line with the figures from the beginning of the fiscal year. (See figure below.)

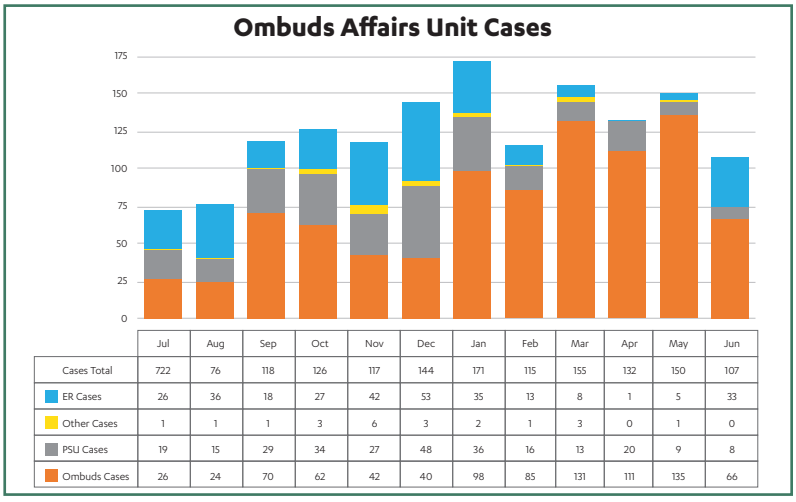


	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2019/2020	240	321	369	312	292	435	555	456	433	462	262	262
2018/2019	82	88	82	107	73	90	94	113	162	149	155	176
2017/2018							184	118	95	86	92	86

Cases

Types:

Cases created by the Ombuds Office are ones where a review of the consumer's issue takes place and then, appropriate action is taken to resolve the issue. The case may be elevated to a specialty unit for resolution (usually Escalations Resolution or Priority Support) or the Ombuds Office may work on them internally. When a backlog exists in the specialty units, the Ombuds Office will assist with case resolutions. In March, the Ombuds Affairs Unit was essential in processing cases while the specialty units were setting up to work remotely and, also for the next couple of months while addressing the backlog created by the increased requests for coverage due to the COVID-19 pandemic, which left many Californians without insurance or without the ability to pay their premiums. (See the figure below.)



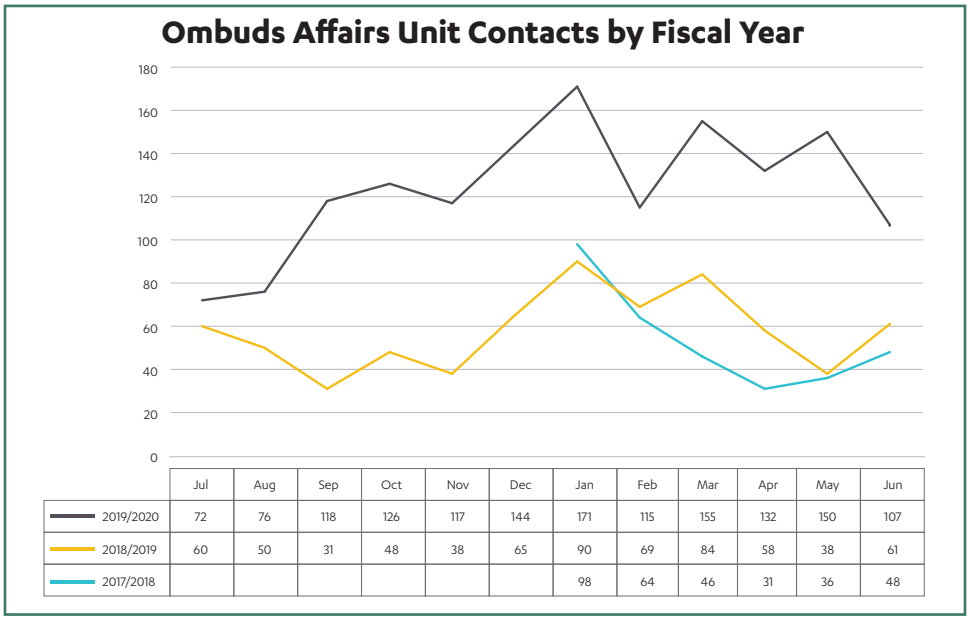
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Cases Total	722	76	118	126	117	144	171	115	155	132	150	107
ER Cases	26	36	18	27	42	53	35	13	8	1	5	33
Other Cases	1	1	1	3	6	3	2	1	3	0	1	0
PSU Cases	19	15	29	34	27	48	36	16	13	20	9	8
Ombuds Cases	26	24	70	62	42	40	98	85	131	111	135	66

How the Ombuds Office assists

The Ombuds Affairs Unit researches a consumer's request or inquiry and makes changes or adjustments to the consumer's case, if appropriate. If the case has already been escalated to one of the specialty units, the unit will track the progress of the case and serve as a point of contact for the consumer, providing updates and communicating with the specialty unit. Resolution to a case may also include a recommendation to file an appeal if the desired resolution falls outside of the ability of the Ombuds Office to implement.

Previous Years Comparisons

Cases created by the Ombuds Affairs Unit continue to be above levels experienced in the previous fiscal year.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2019/2020	72	76	118	126	117	144	171	115	155	132	150	107
2018/2019	60	50	31	48	38	65	90	69	84	58	38	61
2017/2018							98	64	46	31	36	48

In-Depth Reviews

The goal of the Ombuds Affairs Unit is to provide in-depth reviews of issues or complaints consumers experience when they aren't in agreement with the resolution already provided. These in-depth studies require the analyst to research prior actions taken (or not taken) and make an unbiased and objective recommendation based on the information. Input from the legal department may also be considered. These recommendations require approval from management and executive staff. The resolution may also require participation and consent from the health care plan carriers.

Next Steps/Opportunities

Customer Relationship Management System (Salesforce):

The Ombuds Affairs Unit will continue to seek opportunities to improve Salesforce in order to work more efficiently with Covered California divisions, partners and consumers.

In-Depth Case Review:

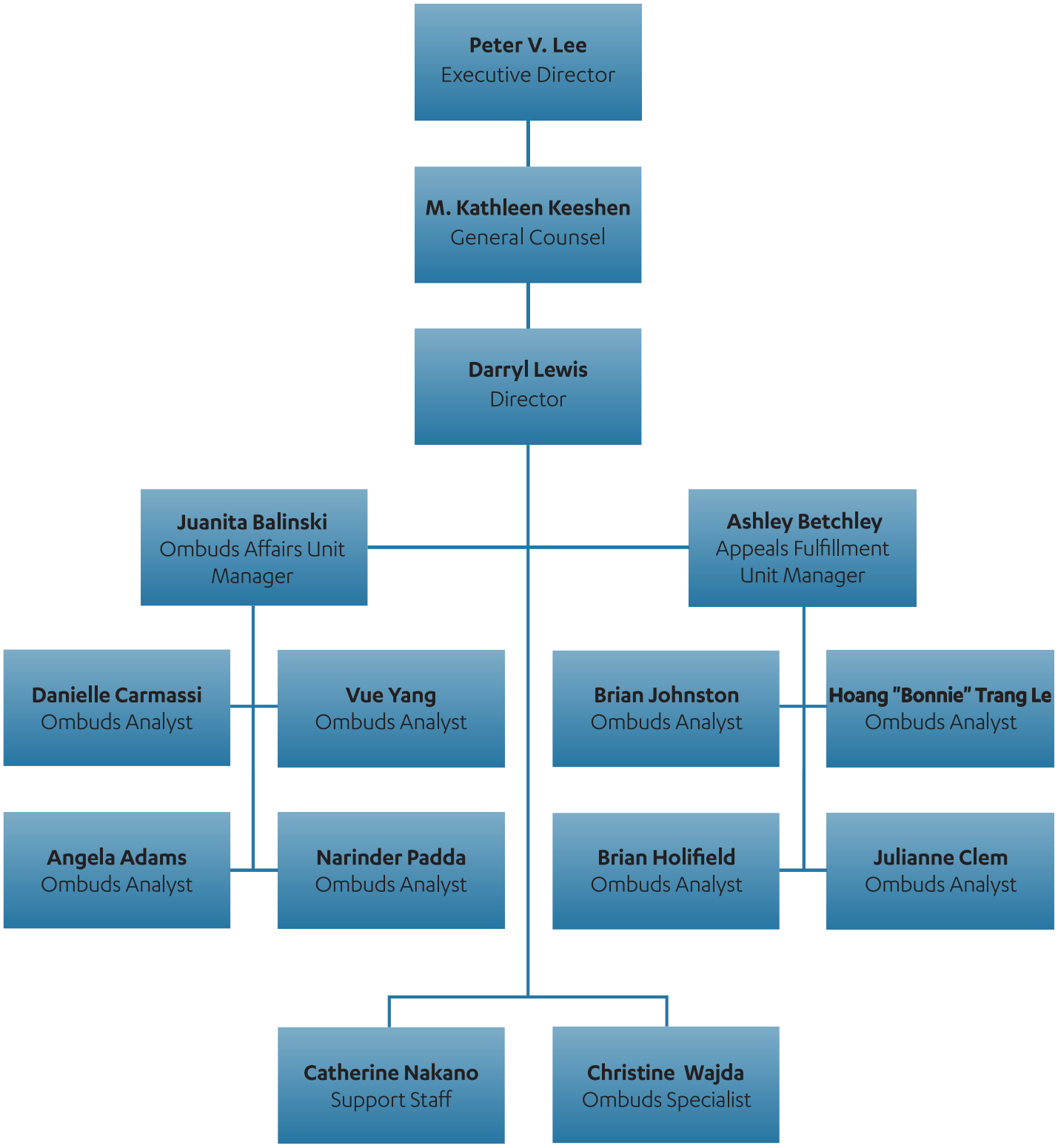
Effective June 2020, the Ombuds Affairs Unit began a new process of doing in-depth case reviews on all cases being kept in-house. These cases must have already gone through the escalation/ appeal process or should've been escalated but weren't. The analysis will present findings and recommendations and will require approval prior to implementing any adjustments to a consumer's account. This new process will be monitored for effectiveness. The goal is to align the work to the mission of the Ombuds Office. It is expected that the write-ups will also identify trends and/or systemic issues that would require a root-cause analysis to be performed.

Root-Cause Analysis:

The Appeals Fulfillment Unit expects to continue to refine processes and procedures using the root cause analysis approach. The current pilot analyses (Dual Appeals and Retroactive Terminations) are anticipated to be completed and closed out. The Ombuds Office will keep looking for more opportunities to improve the Covered California system.

Appendix

Ombuds Organizational Chart



Appeals Fulfillment Unit

The Appeals Fulfillment Unit was created to independently implement consumer appeal decisions. Prior to the Appeals Fulfillment Unit, the Covered California Service Center Appeals Unit reviewed consumer appeals, participated in the appeal hearing and implemented the appeals decision. In order to eliminate a conflict of interest for Covered California, the Office of Legal Affairs and the Ombuds Office created separate units to take these actions after the hearing: review the appeals decision for validity and implement the decision.

What is the role of the Appeals Fulfillment Unit?

The Appeals Fulfillment Unit serves as an objective resource in implementing appeal decisions. Covered California is required to implement the final appeal decision no later than thirty (30) calendar days from the date the appeal decision is released. The Appeals Fulfillment Unit works directly with the consumer, and the county and carrier if applicable, to make the required change to a consumer's case when an appeal decision is received.

What does it mean to be objective?

The Appeals Fulfillment Unit is considered an objective entity because they are not a party to the hearing, the filing, or informal resolution process of an appeal.

What does the Appeals Fulfillment Unit do?

- Implement 1st and 2nd level final appeal decisions ordered by an Administrative Law Judge in a manner that ensures compliance with Covered California's 30-day mandated implementation timeline.
- Work with local county offices in implementing dual (requires Covered California and Medi-Cal involvement) appeal cases as specified in the final decision.
- Track the county process in implementing Medi-Cal actions prior to completing Covered California's actions for dual appeals.
- Work with Qualified Health Plans in coordinating system updates to reflect changes to a consumer's account as a result of a final decision.
- Review appeal cases to identify systemic challenges affecting consumers in order to promote solutions and prevent issues from recurring.

What does the Appeals Fulfillment Unit NOT do?

- Work on appeals prior to a final decision being released.
- Take actions outside of those specified in the final decision.
- Implement Small Business appeals.
- Provide legal advice to consumers.
- Provide tax advice to consumers.

Ombuds Affairs Unit

What is the role of the Ombuds Affairs Unit?

The Ombuds Affairs Unit was created to act as a neutral and objective resource for Covered California consumers who need help resolving highly complex issues and have been unable to do so through other customer service channels. The Ombuds Affairs Unit documents each consumer interaction.

What does it mean to be neutral?

Neutral, by definition, means to not help or support either side in a conflict or disagreement. For reference, objective means to not be unduly influenced by personal feelings or opinions in considering and representing facts. For the Ombuds Affairs Unit, this means to facilitate a fair and unbiased review of the consumer's concern, reduce the chances of miscommunication between the consumer and service channel, and assure that management and/or involved parties appropriately respond to consumer inquiries as required by procedures, policies, and regulations.

What does the Ombuds Affairs Unit do?

- Investigate consumers' unresolved issues after all channels have been exhausted.
- Respond to and research inquiries about Covered California and escalate to proper department and/or management.
- Refer consumers to external partners as needed (e.g. Department of Managed Health Care, Health Consumer Alliance, Department of Health Care Service).
- Explain available options for consumers' unresolved issues or concerns.
- Explain Covered California policies and procedures.
- Identify systemic issues and areas of improvement for Covered California.

What does the Ombuds Affairs Unit NOT do?

- Serve in any role that compromises our neutrality.
- Serve as an advocate for management, employees, consumers or third parties.
- Act on a consumer issue until the Service Center or responsible unit/entity has an opportunity to resolve the issue first.
- Order the county to make changes or have system permissions to make changes on behalf of the county.
- Overturn decisions of existing dispute resolution.
- Make binding decisions or mandate policies.
- Provide legal advice or make recommendations to consumers.
- File or assist with filing appeals for consumers or represent consumers in their appeal.
- File or assist with filing a grievance or complaint with external partners for the consumers.

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