# Covered California Ombuds Office Inaugural Report 2018

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# A Note from the Ombuds Office Director

The Covered California's Ombuds Office is proud to present this inaugural report. Our first-year priorities focused on hiring, research, training, outreach, and procedural development. Thankfully, we were able to recruit and hire a talented team, with diverse skillsets, that were just right for the job. Coupled with the work of the team and support of other program areas, contractors, and sister agencies, we established a division well prepared to respond to consumer inquiries by January 1, 2018.

The Ombuds Office kicked off its first year with a focus on revamping policies and procedures, building two teams to execute day-to-day operations, and providing consumers with communication avenues to directly connect with our office for assistance. The two teams that were built are the Ombuds Affairs Unit and the Appeals Fulfillment Unit. Through a dedicated phone line and other communication modalities, consumers can reach out to the Ombuds Affairs Unit for specialized assistance and guidance regarding their case. The Appeals Fulfillment Unit assures that Covered California consumer appeal decisions are implemented separately from the appeals process and in an objective and timely manner. Moving forward, both of our teams will conduct in-depth reviews of the cases received to identify systemic issues and make recommendations to prevent future systemic issues from occurring.

2018 was a very fast-paced, exciting, and successful time for the Ombuds Office. We have made tremendous strides in the advancements of our office and look forward to continuing to modernize our services and add to our success. We would like to personally thank all the program areas for their support and assistance in developing a functioning Ombuds Office within a year's time. Also, a special thanks to the entire Ombuds team which works day-to-day to ensure our office operates in an unbiased and objective manner.

Respectfully Submitted,

Darryl Lewis

Director, Ombuds Office

Covered California

# Ombuds Office

## 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. We work independently of other Covered California departments, but share our 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 the heart of the Ombuds. It instills confidence in both the public and our partners.

**Empowerment:**

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

**Excellence:**

The Ombuds Office is accessible to all potential complainants with honesty and fairness. We perform our responsibilities in a manner that engenders respect and confidence. We strive to achieve the highest standards in the work that we do and add value to the organization.

## Ombuds Office 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 Ombuds Affairs Unit handled over 2,300 calls and created 613 cases during the first year.

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. In 2018, the Appeals Fulfillment Unit received and implemented 3,287 decisions.

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

## Ombuds Office Year in Brief: Ombuds Affairs Unit

### Consumer Contacts: Overview

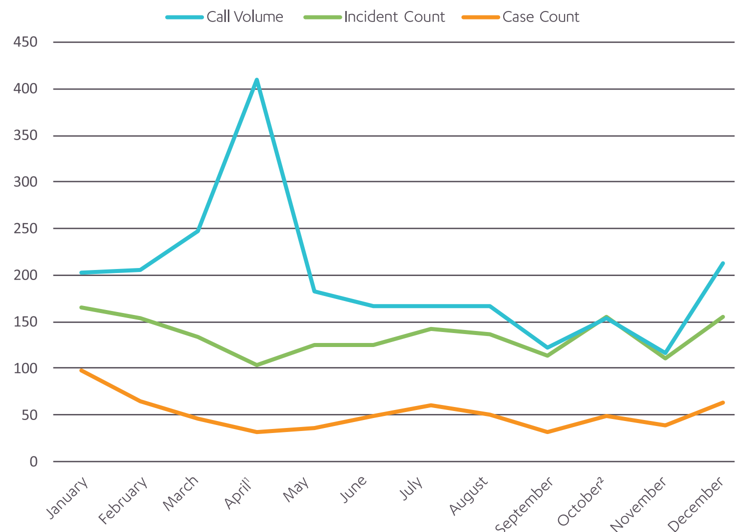
Our phone lines became active in January 2018, and the Ombuds Office took in over 2,300 calls in our first year. Each unique call is documented as an incident within Covered California's Customer Relationship Management tool when a consumer contacts us with a question, concern, or issue. If the call requires further action or follow-up, an Ombuds specific case is created within the Customer Relationship Management system. In its first year, the Ombuds Affairs Unit created more than 1,600 incidents which resulted in 613 Ombuds cases. The remaining 987 incidents were consumer questions, wrong referrals or Medi-Cal questions, and were able to be closed following the call. Two-thirds of all incidents were of the inquiry variety while the remaining one-third were categorized as complaints. The following sections provide a detailed look into the cases and incidents recorded by the Ombuds Affairs Unit team for 2018.

### Consumer Contacts: Monthly Volumes

"Call Volume" refers to the total number of calls that have come into our dedicated phone line, The call volume includes consumer voicemails, multiple calls from the same consumer, and incomplete calls (See Figure 1: Ombuds Affairs Unit Consumer Calls by Month).

The "Incident Count" reflects the number of times a single consumer was assisted. However, each incident may account for multiple calls thus increasing the total call volume and justifying the variance in total calls and incidents created. For example, in Figure 1, the month of April saw the highest call volume, yet saw the lowest number of incidents. The Ombuds Affairs Unit recognized that every call should have had a correlating incident created with it. As a result, the unit prospectively course corrected to accurately capture data.

**Figure 1: Ombuds Affairs Unit Consumer Calls by Month**




[1]Duplicate calls during the month of April accounted for 26 percent of all calls received
[2]October's phone data is incomplete. We omitted information from 10/11/18-10/24/18 due to phone reporting system issues.

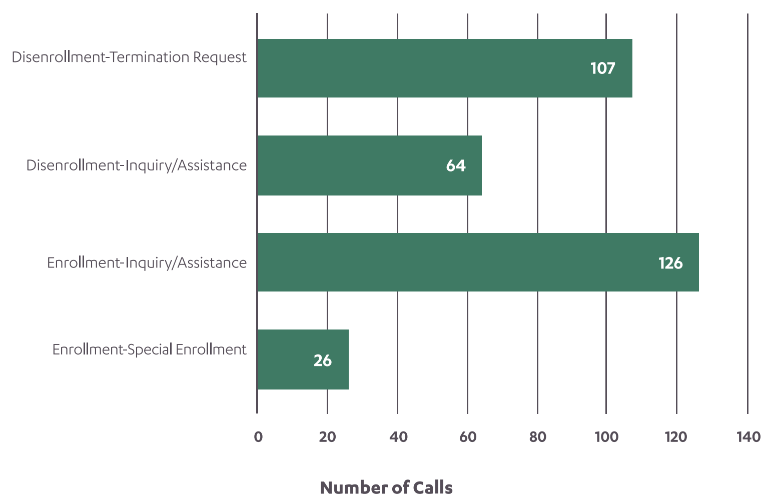
### Consumer Contacts: A Closer Look

To get a better understanding of the types of calls the Ombuds Affairs Unit receives, we have highlighted details for the following categories: disenrollment, enrollment, Medi-Cal, and consumer complaints. The Ombuds Affairs Unit looks at consumer contact categories to identify the need to modify existing or create additional categories to better assist in identifying why consumers are calling.

#### Disenrollment/Enrollment

Disenrollment issues made up 11

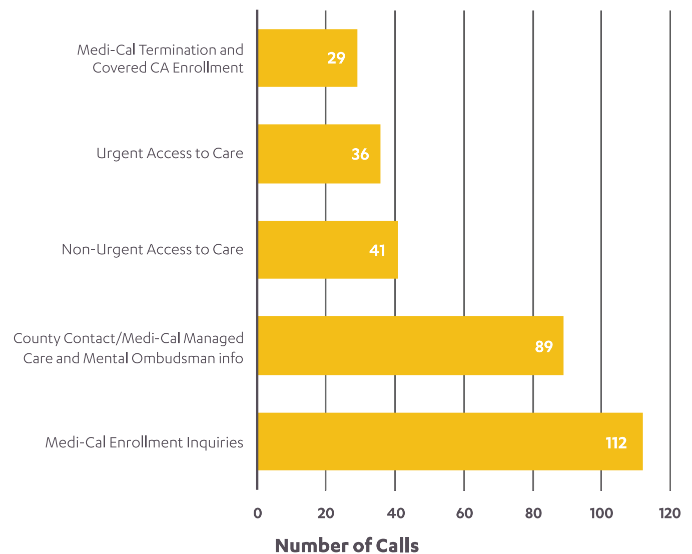
**Figure 2: Covered California Enrollment Related Consumer Issues**



percent of calls to the Ombuds Affairs Unit during this first year. These disenrollment calls ranged from retro-termination requests to acquiring other coverage requests to simple inquiries about the steps to take to cancel a plan in the future.

Consumer contacts regarding enrollment comprised 9 percent of all incoming calls. Questions about how/when to enroll, difficulties with the website enrollment process, changing from one plan to another, and transitioning from Medi-Cal to Covered CA are examples of the types of calls received in this category.

**Figure 3: Medi-Cal Related Consumer Issues**



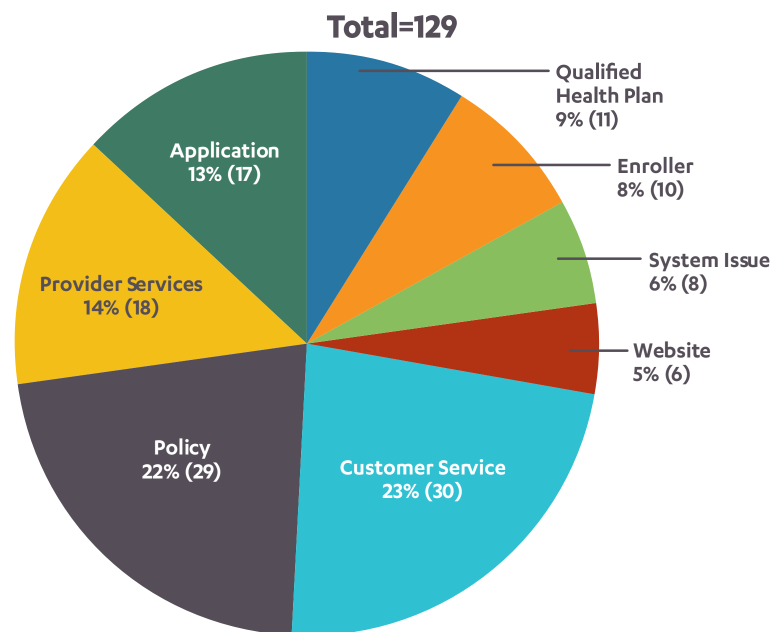

## Medi-Cal

Medi-Cal related issues constituted 19 percent of all calls the Ombuds Affairs Unit received by consumers in 2018, by far the largest category. Medi-Cal issues included enrollment, requests for Medi-Cal Managed Care and Mental Health Office of the Ombudsman, county contact information, access to care issues (both urgent and non-urgent) with county involvement, and enrollment of a Covered California health plan due as a result of a county termination of Medi-Cal.

## Consumer Complaints

A review of the consumer complaints in 2018 revealed Customer Service and Policy each accounted for almost a quarter of all complaints. Other areas that troubled consumers were issues with the online application, qualified health plans, and provider services among others.

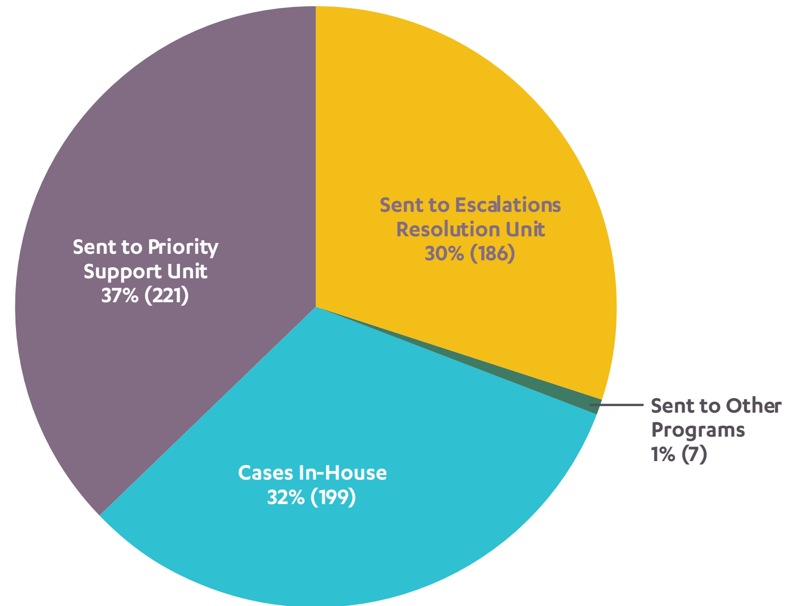
**Figure 4: Covered California Consumer Complaints by Category Total=129**



## Cases

In 2018, the Ombuds Affairs Unit created 613 cases. Of these, the Ombuds Affairs Unit worked on 199 consumer cases, meaning one-third of all cases requiring further investigation were researched within the Ombuds Affairs Unit. The remaining 414 cases were re-directed to the following consumer resolution channels for assistance (See Figure 5: Ombuds Cases):

**Figure 5: Ombuds Cases**
**Total=613**




- 221 cases were sent to the Covered California Service Center's Priority Support Unit to resolve issues with retro-terminations, Advance Premium Tax Credit, and 1095s (to name a few);
- 186 cases were forwarded to Covered California Service Center's Escalations Resolution Unit for help with access-to-care and mixed household cases (consumers with both Medi- Cal and Covered California);
- 7 remaining cases were sent to other Covered California program areas (i.e. External Affairs for constituent assistance and Program Integrity for fraud management)

The average time to close a case created by the Ombuds Affairs Unit was 12 days and 92 percent of all cases closed prior to 30 days.

## Ombuds Office Year in Brief: Appeals Fulfillment Unit

### Administrative Law Judge Decisions: Overview

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 decision 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.

Similar to the Ombuds Affairs Unit, the Appeals Fulfillment Unit records each appeal disposition in the Covered California Customer Relationship Management tool to track status, completion, and compliance of each Administrative Law Judge decision.

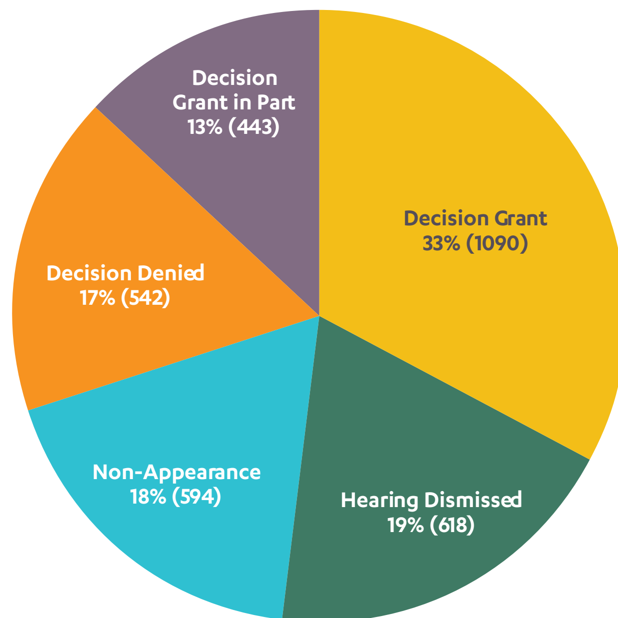
#### Granted and Granted in Part Decisions: A Closer Look

An appeal is the consumer's opportunity to have their issue heard by an Administrative Law Judge. A consumer may file an appeal for a variety of reasons. They may not agree with their eligibility or their tax credits, or a decision made by their county. They may have tried to have their issue resolved through the Service Center and/or an escalation to the Priority Support Unit or Escalations Resolution Unit.

In a **Granted** decision, the judge agrees with the appellant and provides instruction to fulfill the appellant's request. This could be a backdated termination, reinstatement, recalculation of tax credits, the ability to change plans, or granting of a special enrollment period.

In a **Granted in Part** (or Partial Grant), the judge agrees with the appellant, but not completely. This may result in the appellant receiving some of what they asked for, or not the exact terms of what was requested.

**Figure 6: Appeals by Disposition Total=3287**




A common appeal request is a backdated termination. For example: a consumer gained employer coverage in October 2018 but did not contact the Service Center until January 2019. The appellant wants their plan terminated September 30, 2018.

A **Granted** decision would give the appellant the desired termination date of September 30, 2018.

A **Granted in Part** decision might give the appellant a termination date, but not exactly the one they wanted, for example December 31, 2018.

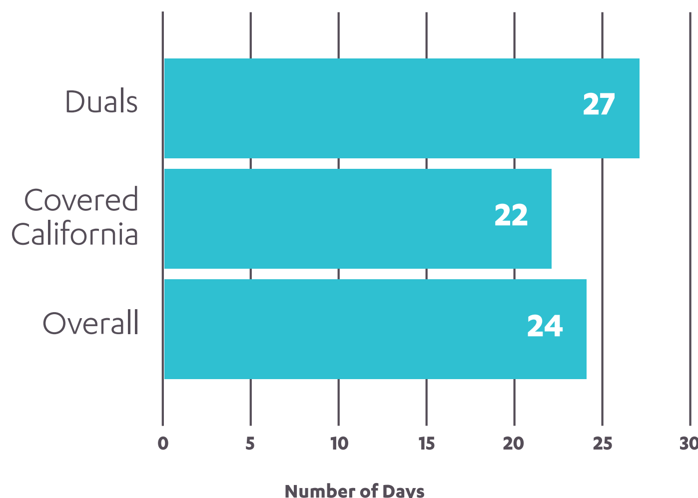
## Administrative Law Judge Decisions: A Closer Look

In 2018, the Appeals Fulfillment Unit received and implemented 3,287 decisions ordered by an Administrative Law Judge. Of the decisions that were implemented, decisions that were "Granted" or ruled in the consumer's favor accounted for over a third of all decisions received. The number of decisions that were "Denied" only accounted for 17 percent of the total decisions received (See Figure 6: Appeals by Disposition).

## Administrative Law Judge Decisions: Timeliness

To remain in compliance with Covered California regulations, appeals decisions must be implemented within 30 calendar days of the date they are released by the administering entity. 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 changes. These situations impact implementation timeframes. For example, 45 percent of decision implementations are dual cases which require action from both the counties 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 most decisions within an average of 24 calendar days (See Figure 7: Average Days to Implement Decisions).

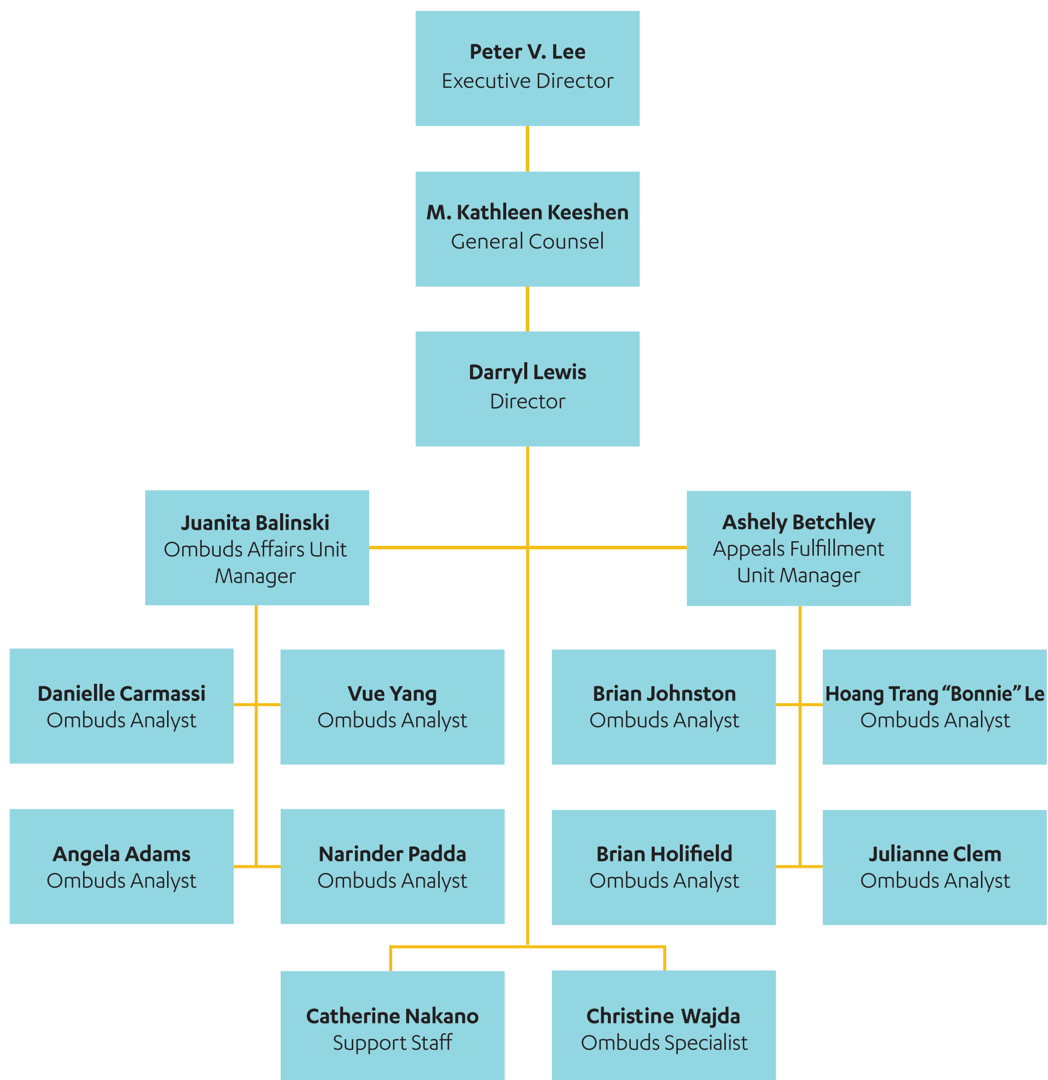
**Figure 7: Average Days to Implement Decisions**




[1] Dual appeal cases include both Covered California and the County (Medi-Cal)

# APPENDIX

## Ombuds Organizational Chart



## 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 we 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?

- Escalate consumers' unresolved issues after all channels have been exhausted.
- Handle and research complaint calls about Covered California and forward 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, just to name a few).
- Explain available options for consumers' unresolved issues or concerns.
- Explain Covered California policies and procedures.
- Help consumers learn about their appeal rights.
- 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.
- Overturn decisions of existing dispute resolution. Make binding decisions or mandate policies.
- Provide legal advice or make recommendations to consumers.
- File appeals for consumers or represent consumers in their appeal.
- File a grievance or complaint with external partners for the consumers.

## 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 eligibility appeals. Covered California is required to implement the final appeal decision no later than thirty (30) calendar days from the appeal decision. The Appeals Fulfillment Unit works directly with the consumer, and the county if applicable, to make the requested 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?

- Work with local county offices in implementing dual appeal cases (that include both Covered California and Medi-Cal) appeals as specified in the final decision.
- 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 the appeal prior to a final decision being released.
- Take actions outside of those specified in the final decision.
- Provide legal advice to consumers.
- Provide tax advice to consumers.

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