COVERED CALIFORNIA

Covered California Ombuds Office Annual Report

FY 2020-2021

Issued April 12, 2022

Contents

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 2020-21.

The work of the Ombuds Office continues to be shaped by the ongoing COVID-19 pandemic. Our staff have adjusted to working remotely and push forward to assure we serve our consumers in a fair and timely manner. Meetings, interviews, and brainstorming sessions occur over our video conferencing service allowing the team to provide a high level of support without skipping a beat. We have maintained our relationships with partners, increased our Ombuds Office educational material training, expanded our Root Cause Analysis efforts, and found new and innovative ways to assist the consumer. As we move forward, the Ombuds Office looks to build on our progress, achievements, and continued success.

Respectfully Submitted,

Darryl Lewis
Director, 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 improvment and/or solution recommendations.

How to contact the Ombuds Office?

- Email: ombuds@covered.ca.gov
- Call toll free: (888) 726-0840
  Assistance 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

COVID and Telecommuting

With the COVID-19 pandemic ongoing, Covered California has supported employees working remotely and the Ombuds Office staff have been fully set up to telecommute. The units in the Ombuds Office have adapted to the remote work environment by using Microsoft Teams to meet regularly to discuss internal processes, department requirements, workloads, and the experiences that add insight to the type of issues consumers are currently submitting. Workplace interactions have been modified from the previous in-person day-to-day exchanges to allow for smooth workflows. Use of Outlook calendars, instant messaging (chat) and emails aid in keeping staff aware of workload priorities, department updates, and coworkers' statuses.

Relationships with Partners

The Ombuds Office continues to work closely with Covered California's Service Center Escalations Resolution and Priority Support units. Cases that are escalated to these units through the Ombuds Office are monitored to ensure timely and fair resolution to consumer requests/inquiries. 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 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 meets with the Customer Relations and Resolution, Escalations Resolution, and Priority Support units to collaborate on cross-divisional issues and objectives. The Ombuds Office continues to solicit participation with counties to strengthen relationships and procedures.

To improve the consumer experience, a new interactive voice response system was implemented to guide consumers to the appropriate channels prior to contacting the Ombuds Office for resolution. If the consumer requests to be transferred, the system directly connects the consumer with the selected entity of their choice.

Training

Root Cause Analysis training videos, produced by Leading Resources, Inc., continue to be added to the Ombuds library to aid in educating analysts. These resources provide examples and explanations of proper methodology to be used when analyzing data.

The Ombuds Office released an eLearning training module for Service Center Representatives on how to properly utilize the office, including referrals and scenarios with active escalations. This specific Ombuds Office module was required for all staff. Ongoing, an in-person overview at the New Employee Training provides the correct process for referring consumers to the Ombuds

Office. The goal is to prevent incorrect referrals of issues that should first go to escalation units for resolution and to educate the new employees on the abilities and responsibilities of the Ombuds Office.

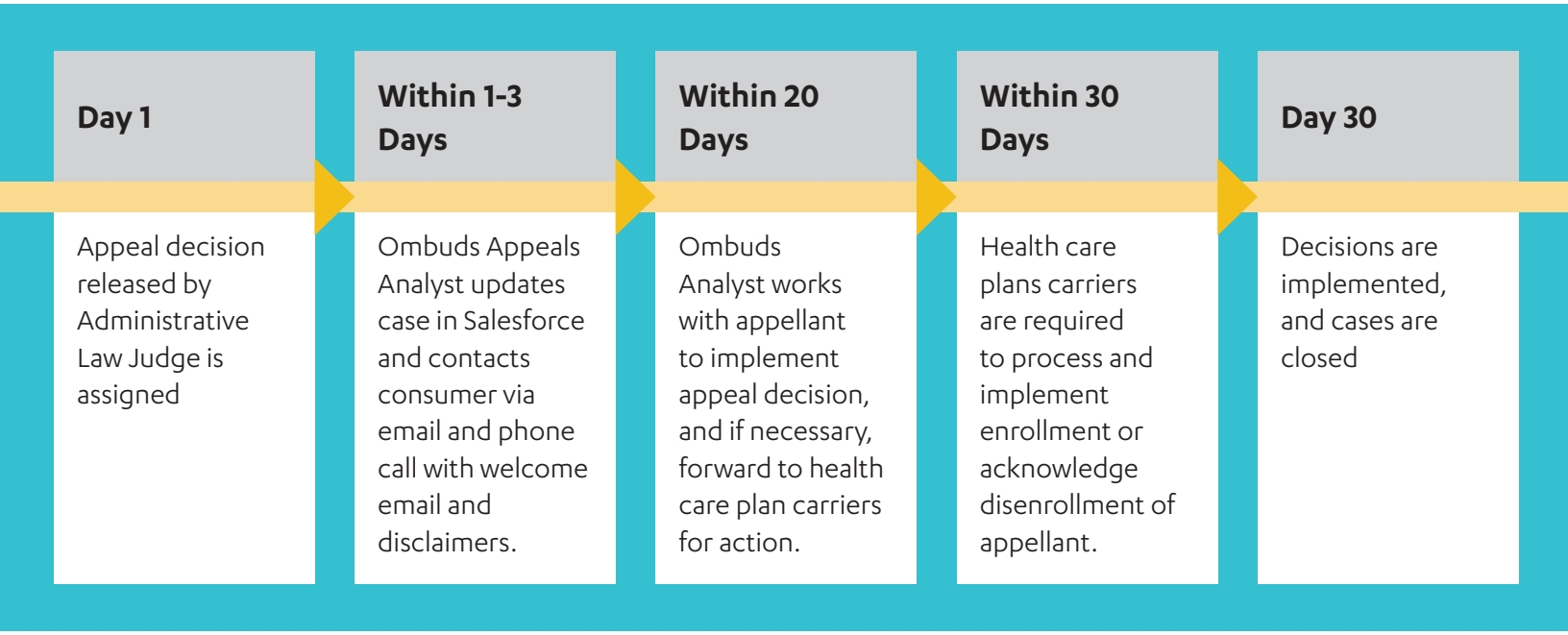
Root Cause Analysis

The Ombuds Office finalized a root cause analysis on dual appeal cases to research situations where Covered California was being included as a party on the appeal but had no position to take, deferred to the county and subsequently had no role in implementing the decision. These cases centered around consumers who were appealing their Medi-Cal eligibility discontinuance or denial. Recommendations from this report were deferred due to changes already in progress. However, the Appeals Fulfillment Unit is monitoring these types of cases to assess whether Covered California continues to be added as a party when there is no role to play.

Another root cause analysis looking into requests for retro-termination of Covered California health coverage is finalizing its recommendations and is expected to be concluded early in fiscal year 21/22.

Appeals Fulfillment Unit

The Process



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.

Decision Implementation

For fiscal year 20-21, the Appeals Fulfillment Unit processed 1554 appeals. Of those, 925 were appeals involving just the consumer and Covered California, known as single appeals, and 629 were dual appeals involving the consumer, Covered California, and the appropriate county. Dual appeals often require action by the county before Covered California can complete their portion of the decision.

Of the 1554 decisions ordered by an Administrative Law Judge, a total of 44% (690) required an action to be taken (Granted, Partial Grant, and Stipulations). The number of decisions that were denied, dismissed, or withdrawn accounted for 32% (505). Non-Appearance cases accounted for 23% (359).

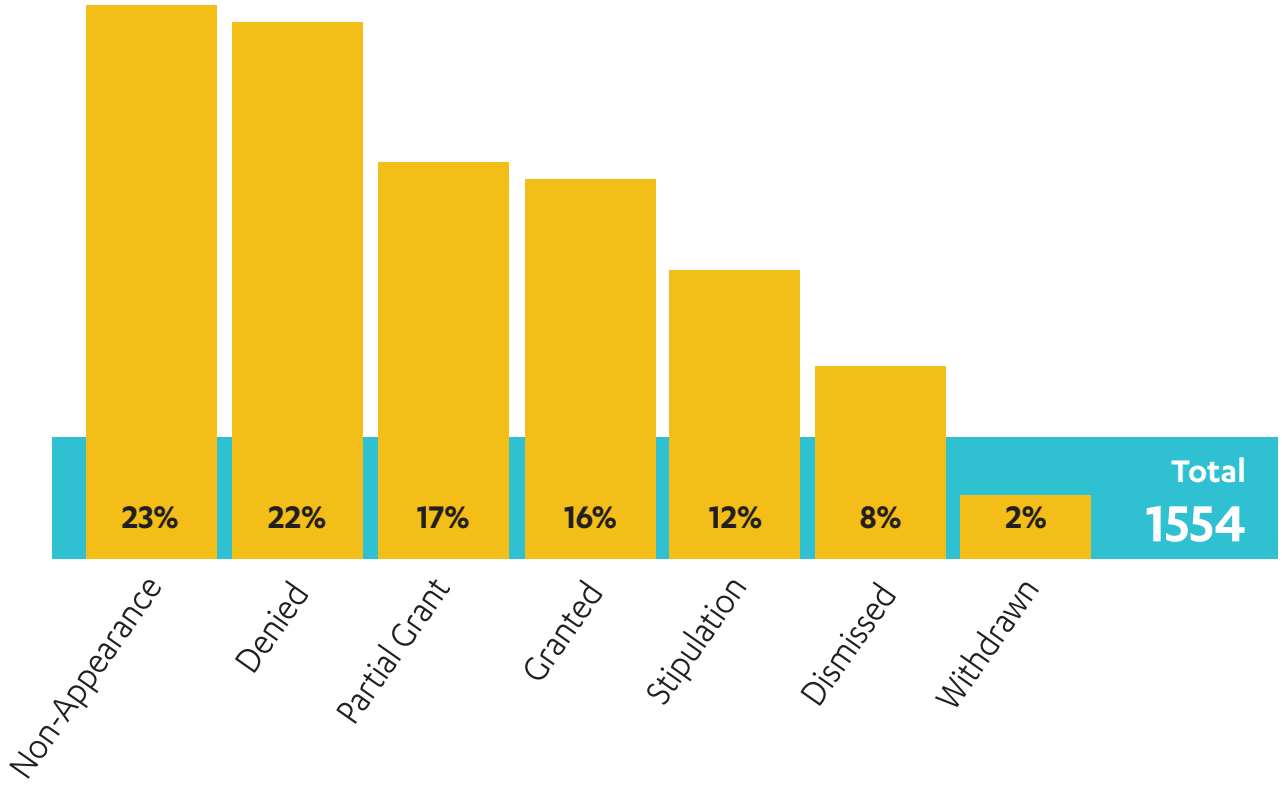
The Appeals Fulfillment Unit completed 92% (1428/1554) of the appeals in 30 days or less as mandated by California Code of Regulations, Title 10, Section 6618(c)(1):

> Upon receiving the appeal decision described in subdivision (b) of this section, the Exchange shall promptly, but no later than 30 days from the date of the appeal decision: (1) Implement the appeal decision...

Delays in implementing a timely decision were primarily due to factors such as a delayed response from consumers or counties.

Covered California also tracks the timing of implementation of cases where the decision requires interaction with health plan carriers. For these cases, Covered California must complete their portion of the appeal decision within 20 days and then contact the carrier to implement enrollment actions. The carriers must contractually implement their required actions within 10 days of receiving the request for the appeal decision to meet the mandated 30-day timeframe. When accounting for situations where the timeframe is impacted by delays from outside partners such as counties or consumers, Covered California met the 20-day timeframe (368/375) 98% of the time. In 64% (239/375) of cases, Covered California complied within 5 days. The primary factor in cases where the turn-around time was not met was system issues.

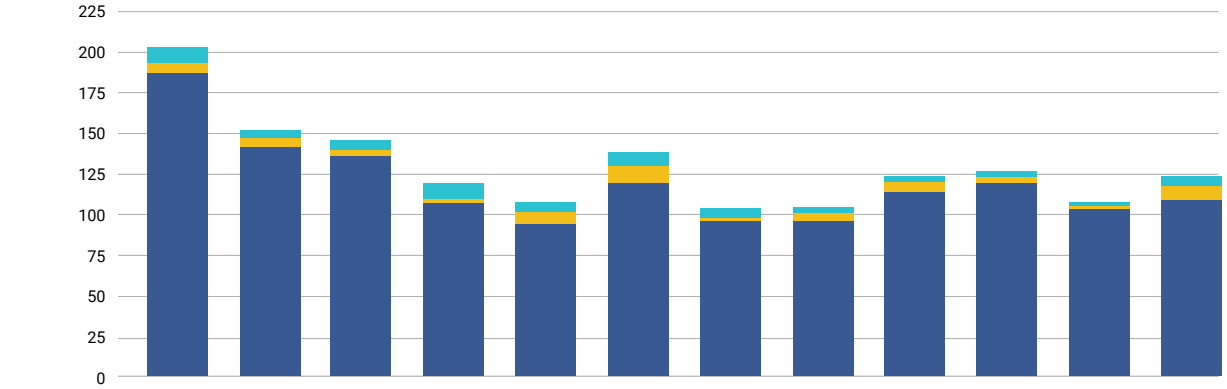
Decision Implementation Fiscal Year 20/21



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 2020-21, 40% of appeals were dual cases (629/1554) 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 92% of cases (1428/1554). Of the cases that were not timely, 53% (67/126) 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 Fiscal Year 20/21



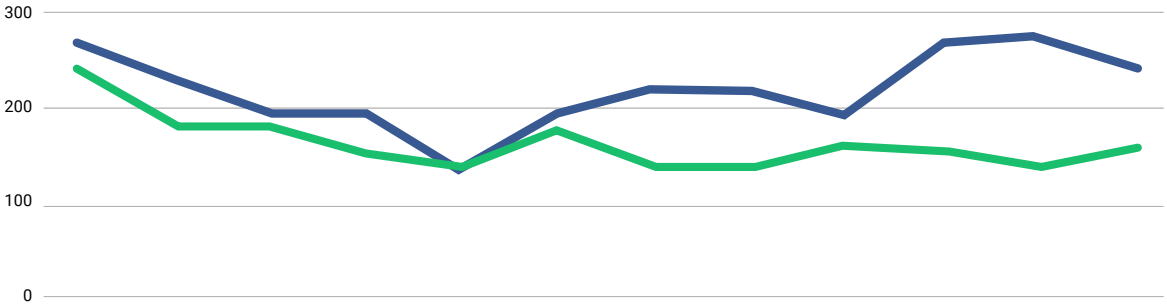
	JUL-20	AUG-20	SEP-20	OCT-20	NOV-20	DEC-20	JAN-21	FEB-21	MAR-21	APR-21	MAY-21	JUN-21
Total	203	152	146	119	107	138	104	104	124	126	107	124
> 30 days dual	10	4	6	9	6	8	6	3	4	3	2	6
> 30 days CC*	6	5	4	3	7	10	2	4	6	3	1	8
Timely	187	143	136	107	94	120	96	97	114	120	104	110

* Covered California

Previous Years Comparison

The number of decisions released each month for fiscal year 2020-21 continued to be at levels below previous fiscal years. While this may be indicative of fewer appeals being filed by Covered California consumers or increased informal resolutions being processed by the Customer Relations and Resolution unit, in March 2020 counties were directed to delay processing of Medi-Cal annual renewals, and defer discontinuances and negative actions based on the declared State and National Emergency due to the COVID-19 public health crisis. As a result, fewer Californians were left without healthcare. Also, to allow for extenuating circumstances that Californians were encountering because of the pandemic, special enrollment periods were provided, in essence having enrollment opportunities extend through the end of the fiscal year.

Decisions Relased by Fiscal Year



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
20/21	203	151	146	119	107	138	104	104	124	126	107	124
19/20	246	209	164	160	98	160	192	191	162	242	258	225

Ombuds Affairs Unit

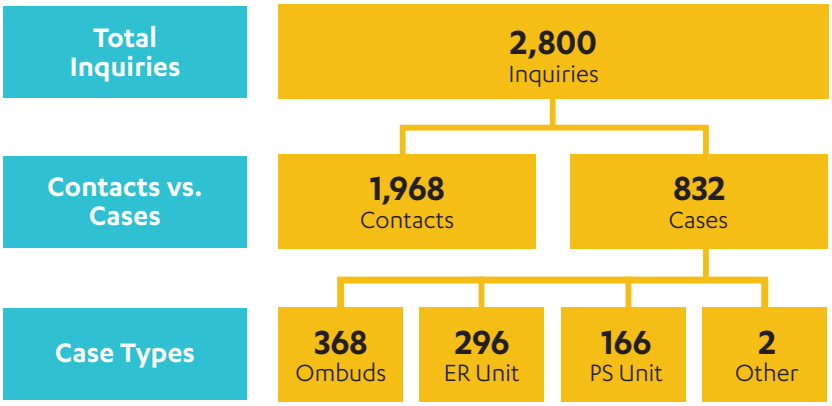
The Process

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

Note: The timeframe may be impacted by how complex the issue is and how much research is required. The 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

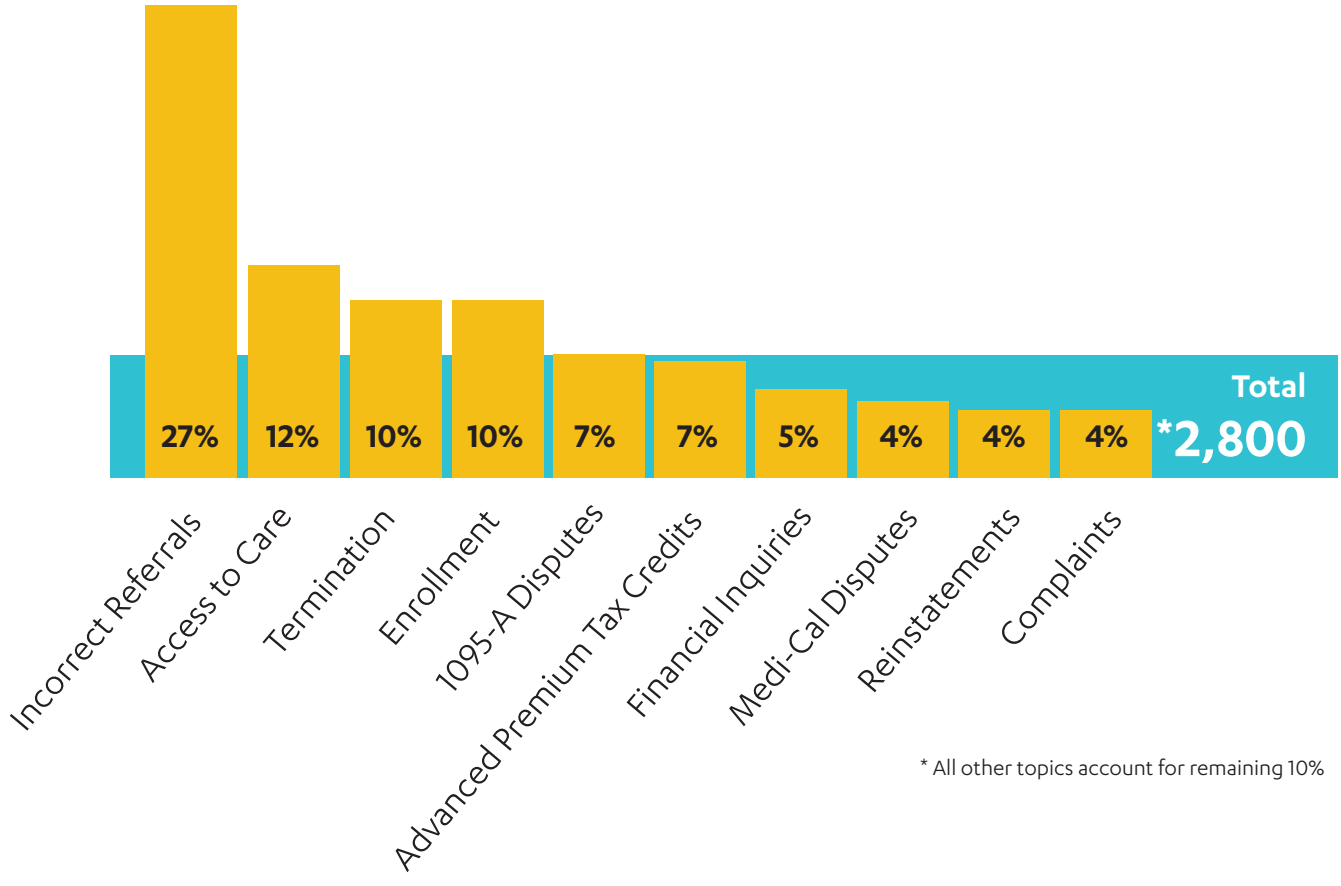
The Ombuds Affairs Unit handled 2800 inquiries throughout the fiscal year. Of those, 1,968 were inquiries that the unit was able to provide information or direction to the consumer and did not require a case to be opened. These are considered "contacts." The remaining 832 inquiries became cases that fell into one of four case types. Depending on the nature of the case, it was either elevated to a specialty unit — Escalations Resolution (ER) Unit, Priority Support (PS) Unit or another appropriate unit — and monitored for resolution or researched in-house. The Ombuds Affairs Unit resolved a total of 368 cases in-house.



Subject Lines

The largest category of subject lines for Inquiries are incorrect referrals. These are consumers who were advised to contact the Ombuds Office without having pursued other resolution methods first, or the issues were outside of the Ombuds Office's jurisdiction, such as coverage related to Medi-Cal or carrier billing issues. These are tracked in order to be able to educate initial points of contacts regarding Ombuds responsibilities and allow for issues to be properly escalated. The second largest category is Access-to-Care issues, which consists primarily of consumers who are transitioning between Covered California and Medi-Cal coverage. This can include situations where the need for care is urgent and the consumer has been unable to achieve resolution for their case quickly and therefore, unable to get medical attention. Termination requests mostly involved cases where the consumer was requesting retro-termination of their coverage due to having obtained employer-sponsored coverage or Medi-Cal/Medicare. At about the same frequency were cases where the subject was regarding enrollment. These cases can be consumers who had general questions about applying, needed understanding of a rule or regulation with their application or already had a case that had been escalated within Covered California and the Ombuds Office was monitoring for resolution.

Top 10 Subjects

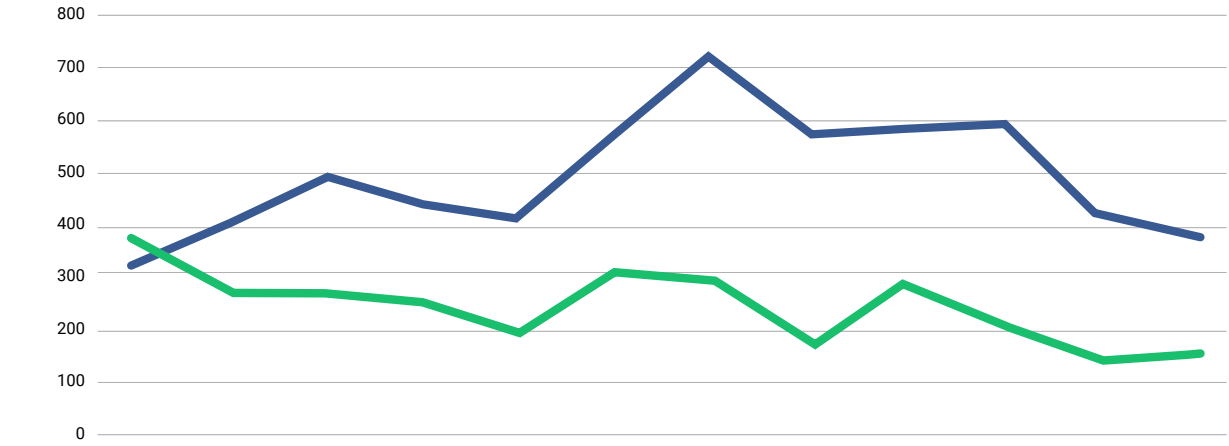


* All other topics account for remaining 10%

Previous Years Comparison

The number of inquiries that were processed by the Ombuds Affairs Unit in fiscal year 2020-2021 dropped significantly from the previous fiscal year. Continued education for the entities that refer consumers to the Ombuds Office may have decreased the number of incoming calls by directing consumers to appropriate resources first. Also, counties were directed to delay processing of Medi-Cal annual renewals, and defer discontinuances and negative actions based on the declared State and National Emergency due to the COVID-19 public health crisis, allowing more Californians to maintain their Medicaid coverage. As well, to allow for extenuating circumstances that Californians were encountering as a result of the pandemic, special enrollment periods were provided, in essence having enrollment opportunities extend through the end of the fiscal year.

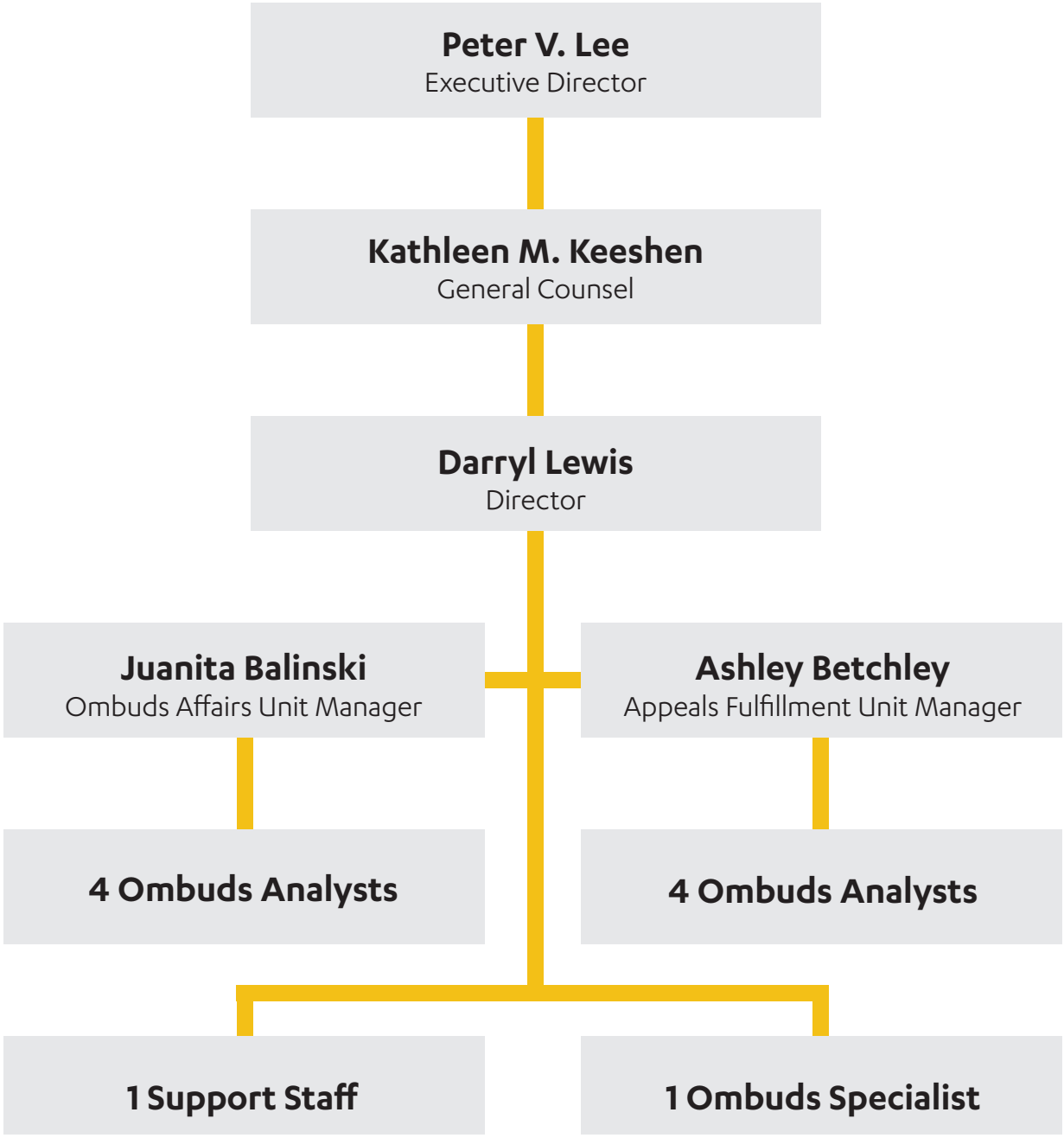
Ombuds Affairs Unit Inquiries by Fiscal Year



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
20/21	355	259	253	242	190	296	278	170	278	187	142	150
19/20	312	396	487	438	409	579	726	571	588	594	412	369

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.