



Covered California Ombuds Office Annual Report **FY 2021-2022**

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A Note from the Ombuds Office Director

I am once again pleased to present the Ombuds Office report, reviewing the fiscal year of 2021-2022.

The Ombuds Office continues its mission of serving Covered California consumers. Through the Ombuds Affairs Unit, we provide specialized support and guidance when assisting with consumer issues and through the Appeals Fulfillment Unit, we assure that appeal decisions are implemented in an objective and timely manner. In this report we include updates on the activities that impacted our work along with metrics about our daily operations. A permanent telecommuting option offered by the department was formally adopted by the Ombuds Office. We continue to refine processes and procedures to assure that while working remotely, we still deliver quality service. Our staff have been committed to providing consumer support from their homes and have done so in an effective and efficient manner. Management and staff keep engagement with one another by meeting frequently through online platforms and, occasionally, in-person. Keeping an engaged and cohesive team has allowed the Ombuds Office to serve our consumers with confidence while remaining in compliance with regulations and our own internal timeframes.



We look forward to continuing to develop our division by using the data we gather to lead with innovative and strategic ways to support and improve the organization.

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 improvement 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 does the Ombuds Office not do?

- Assist with issues pertaining to Medi-Cal enrollment/benefits.
- Provide legal advice.
- Investigate insurance company's products or services.
- Assist with preparing appeal requests or complaint submissions.

Year In Brief

General

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.

Training

Root Cause Analysis training videos, produced by Leading Resources, Inc., are available in the Ombuds library as a resource to aid analysts when conducting research or root cause analysis. The videos provide examples and explanations of proper methodology to be used when analyzing data.

The Ombuds Office provides an in-person overview at the New Employee Training regarding the purpose of the department and 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 is developing a formal root cause analysis process. The process will outline the steps for research, review and presentation of root cause analysis reports and standardize the procedure analysts use when investigating an issue.

Audit

The Ombuds Office underwent a programmatic audit in 2021 conducted by Sjoberg Evashenk Consulting. The audit found that Covered California's Ombuds Office generally complied with applicable federal regulations and internal policies and procedures, and its roles and functions generally aligned with industry standards and peers. It also identified opportunities to better ensure appeal decisions and consumer cases were implemented in a manner consistent with internal policies and procedures, and that supporting documentation was maintained.

COVID and Telecommuting

In February, the Ombuds Office formally adopted a telecommute option offered by Covered California for departments where operational business needs were effectively and efficiently met. Department standards and goals continue to meet and exceed expectations. Staff use Microsoft Teams to meet regularly and instant messaging/chat, Outlook calendars and emails to stay in contact and share workload priorities, department updates, and coworkers' statuses. Staff is required to attend any scheduled in-person meetings as needed.

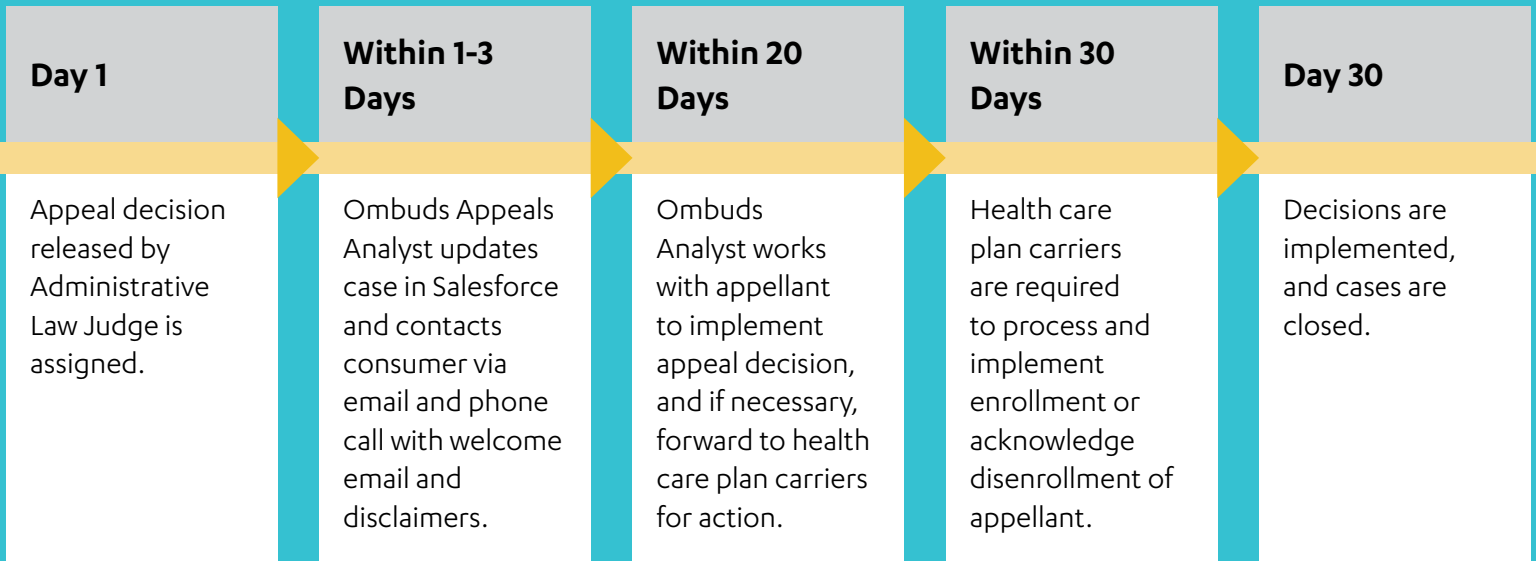
Public Health Emergency

The Ombuds Office participated in planning activities regarding the end of the Public Health Emergency. Updates regarding system and policy changes have been shared with staff in anticipation of possible consumer questions and issues as normal eligibility operations resume, including anticipated losses in coverage and transition from Medi-Cal to subsidized healthcare coverage. Training will be available for staff to attend prior to the implementation of these changes.



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 21-22, the Appeals Fulfillment Unit processed 701 appeals. Of those, 382 were appeals involving only the consumer and Covered California, known as single appeals, and 319 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 701 decisions ordered by an Administrative Law Judge, a total of 48% (340) required an action to be taken (Granted, Partial Grant, and Stipulations). The number of decisions that were denied, dismissed, or withdrawn accounted for 29% (201). Non-Appearance cases (those cases where the claimant did not attend their hearing) accounted for 23% (160).

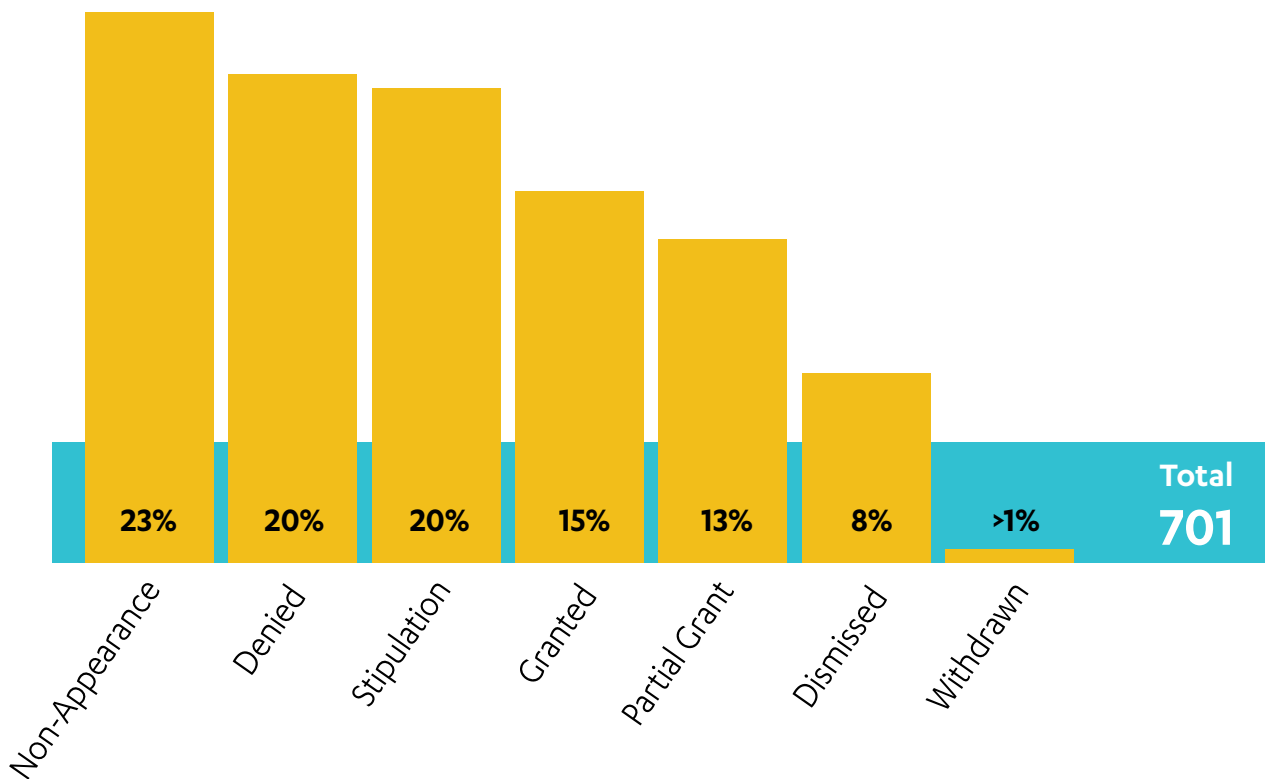
The Appeals Fulfillment Unit completed 90% (633/701) of the appeals in 30 days or less as mandated by California Code of Regulations, Title 10, Section 6618(c)(1):

- 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 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 (204/209) 98% of the time. In 64% (133/209) of cases, Covered California complied within 5 days. Of the five 5 cases where Covered California did not meet the 20-day timeframe, 3 were system issues and 2 were analyst delays.

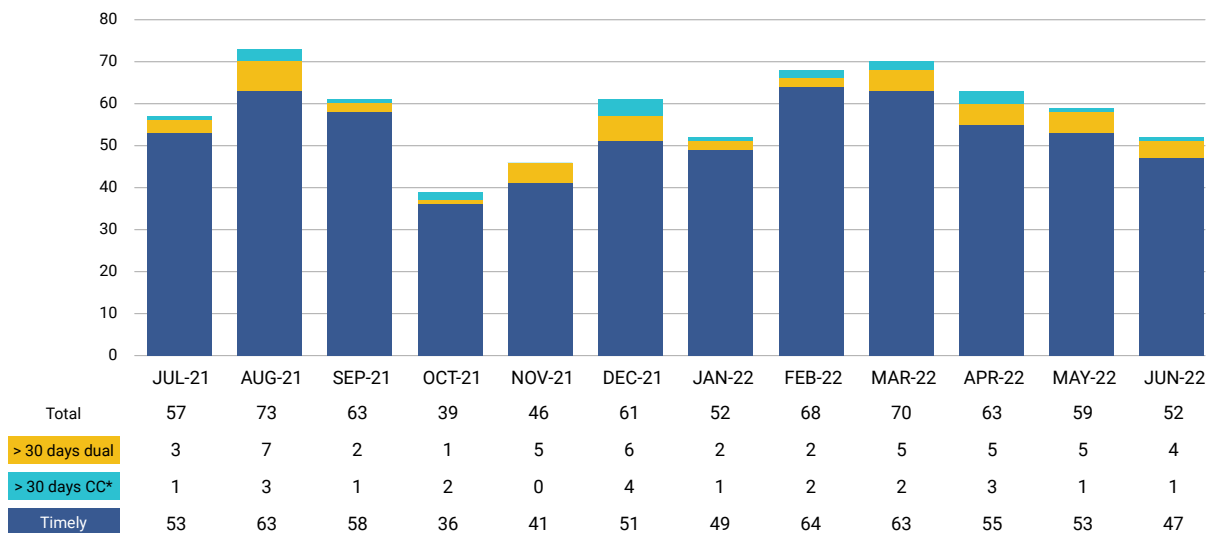
Decision Implementation Fiscal Year 21/22



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 2021-22, 46% of appeals were dual cases (319/701) 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 90% of cases (633/701). Of the cases that were not timely, 71% (48/68) 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 21/22

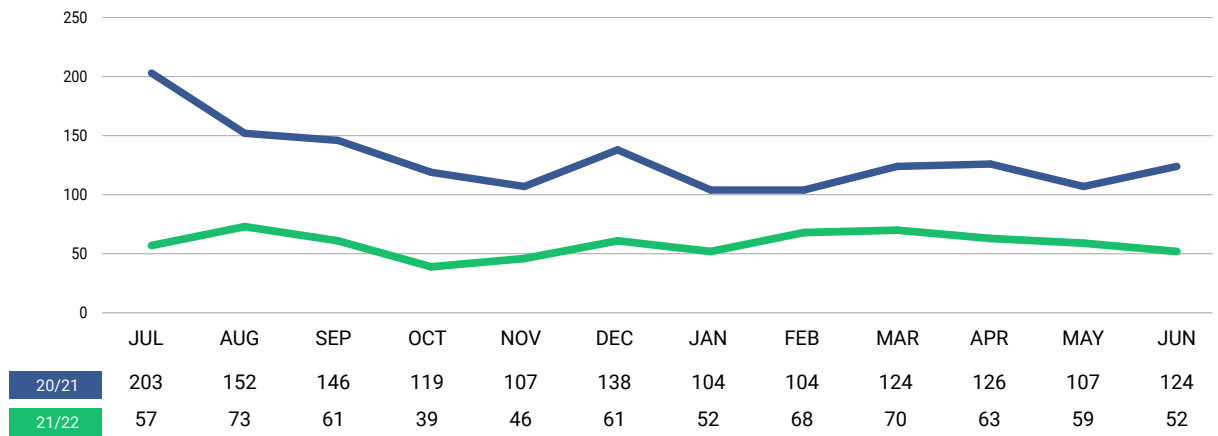


* Covered California

Previous Years Comparison

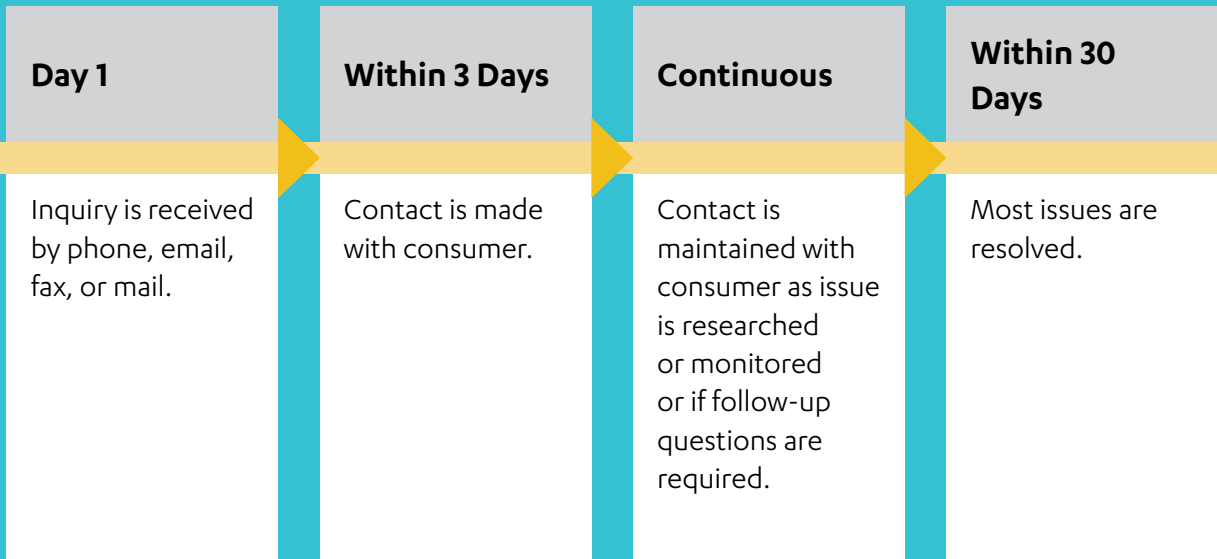
The number of decisions released each month for fiscal year 2021-22 were at levels below previous fiscal years. In March 2020 counties were directed to delay processing of Medi-Cal annual renewals, and defer discontinuances and negative actions based on the declared State and National Emergency due to the COVID-19 public health crisis. As a result, Californians were not discontinued from Medi-Cal, regardless of changes in income. This may have contributed to fewer appeals being filed by Covered California consumers and increased informal resolutions being processed by the Customer Relations and Resolution unit. Also, to allow for extenuating circumstances that Californians were encountering because of the pandemic, Covered California offered a special enrollment period that allowed Californians to enroll in Covered California for all of 2021.

Decisions Released by Fiscal Year



Ombuds Affairs Unit

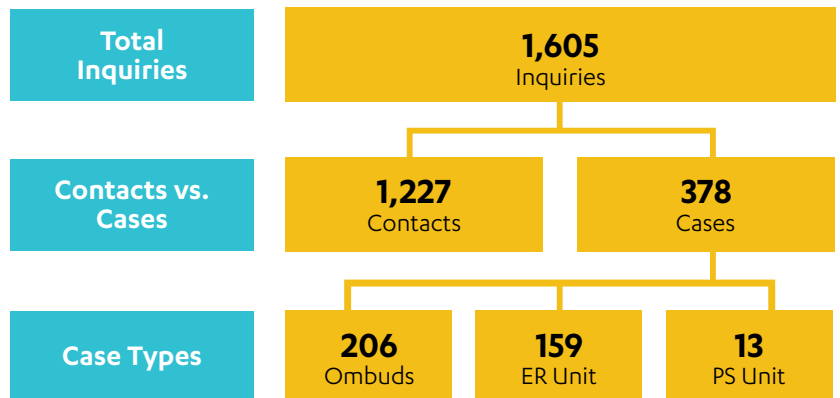
The Process



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

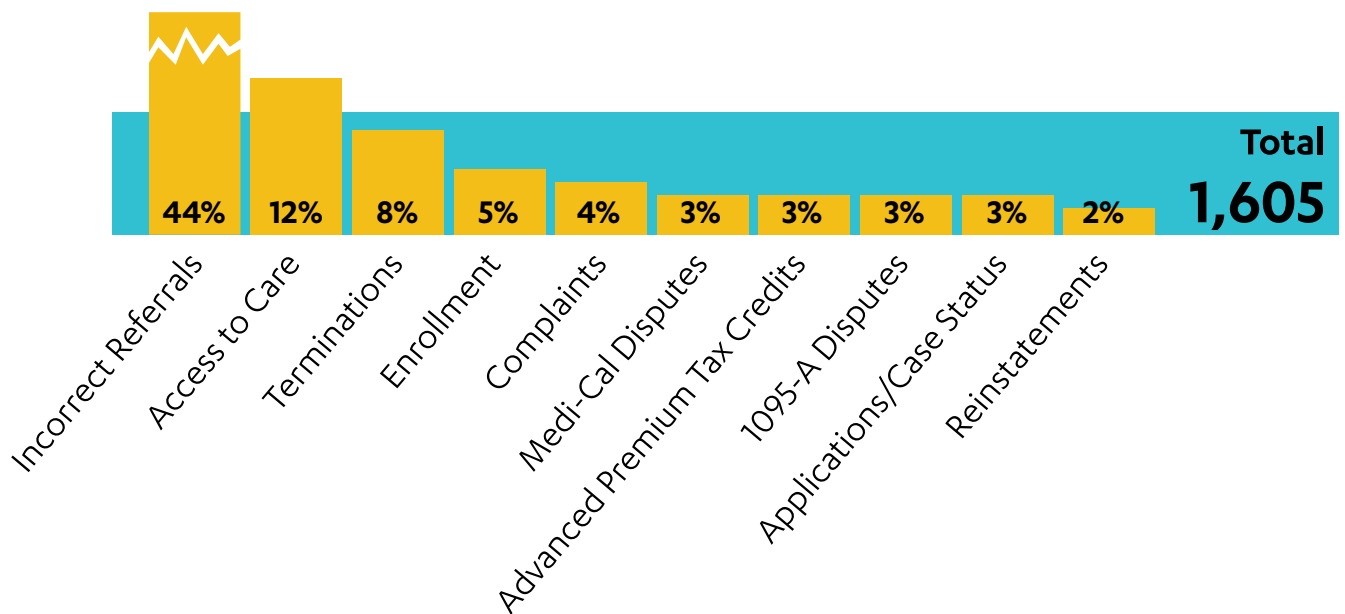
The Ombuds Affairs Unit handled 1605 inquiries throughout the fiscal year. Of those, 1227 were inquiries that the unit was able to provide information or direction to the consumer and did not require a case to be opened. These are considered “contacts.” The remaining 378 inquiries became cases that fell into one of three case types. Depending on the nature of the case, it was either elevated to a specialty unit — Escalations Resolution (ER) Unit or Priority Support (PS) Unit — and monitored for resolution or researched in-house. The Ombuds Affairs Unit resolved a total of 206 cases in-house.



Subject Lines

The largest category of subject lines for Inquiries are incorrect referrals (44%). These are consumers who were advised to contact the Ombuds Office without having pursued other resolution methods first, consumers who called directly without first contacting the Service Center, 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 (12%), 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 (8%) mostly involved cases where the consumer was requesting retro-termination of their coverage due to having obtained employer-sponsored coverage or Medi-Cal/Medicare.

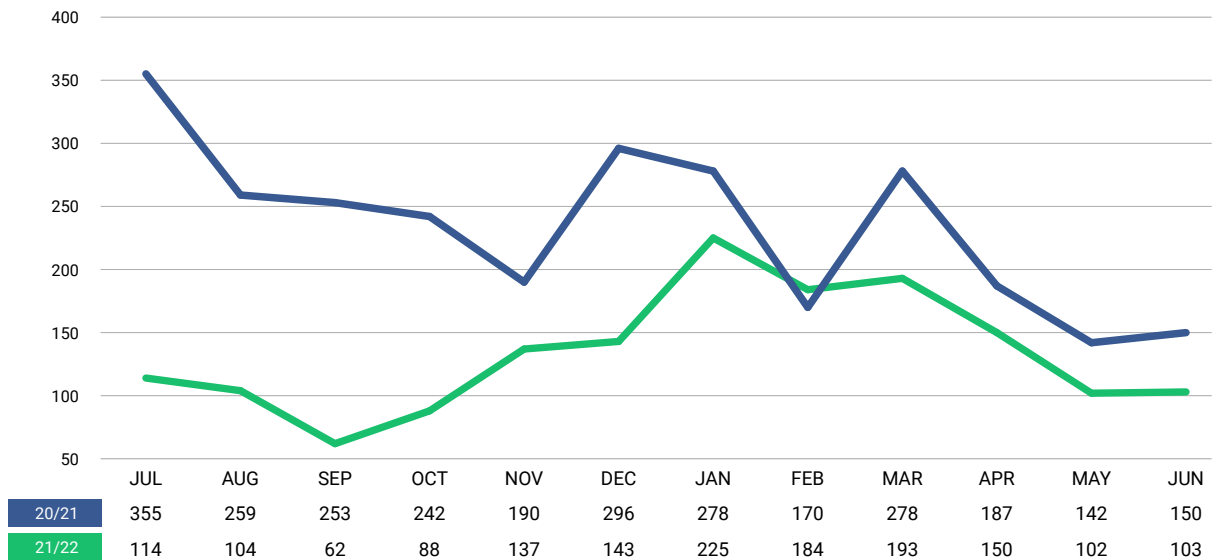
Top 10 Subjects



Previous Years Comparison

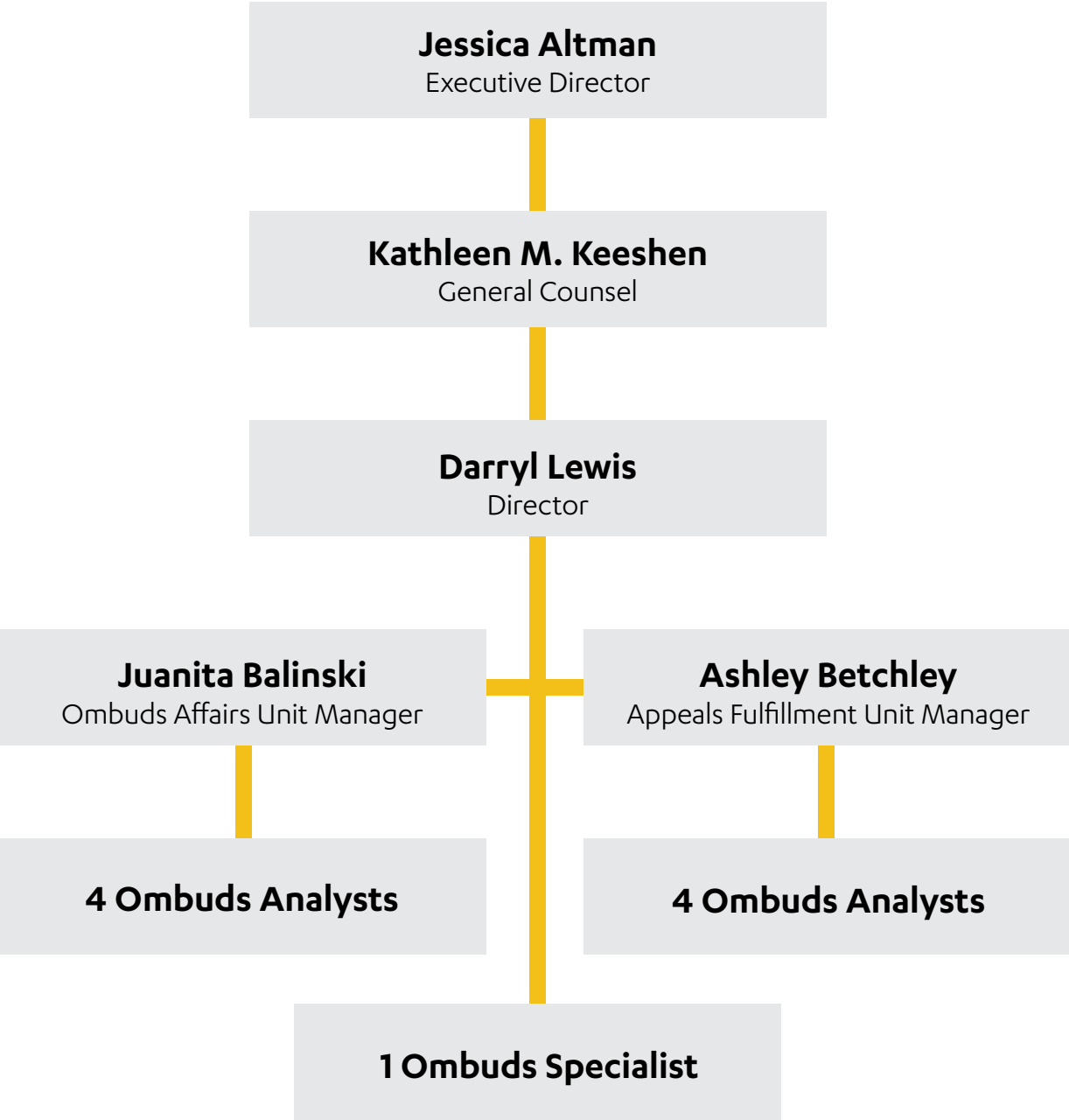
The number of inquiries that were processed by the Ombuds Affairs Unit in fiscal year 2021-2022 dropped significantly from the previous fiscal year. Continued education for the entities that refer consumers to the Ombuds Office may have decreased the number of incoming calls by directing consumers to appropriate resources first. Also, counties were directed to continue delaying the 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. This allowed more Californians to maintain their Medicaid coverage. And, to allow for extenuating circumstances that Californians were continuing to encounter as a result of the pandemic, Covered California offered a special enrollment period that allowed Californians to enroll in Covered California for all of 2021. For the enrollment period for 2022 coverage, the normal enrollment period was observed.

Ombuds Affairs Unit Inquiries by Fiscal Year



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.