COVERED CALIFORNIA

Covered California Ombuds Office Annual Report

FY 2022-2023

Issued May 13, 2024

Contents

A Note from the Ombuds Office Director

It is my pleasure to submit the Covered California Ombuds Office Annual Report. The report covers the fiscal year of 2022-23.

The two units in the Ombuds Office offer very different services with a single goal. One unit implements State Hearing decisions and the other investigates requests that reach the office after having exhausted other avenues. Their common goal is to provide timely and professional assistance while still complying with the policies and regulations that govern the office. To this end, I want to recognize the Ombuds staff and their professional commitment to investigate, implement, and address all cases independently and impartially to meet this goal.

As we move forward and the environment around health care continues to evolve, we will evolve with it in order to honor our mission and that of Covered California.

Respectfully Submitted,

Darryl Lewis
Director, Ombuds Office

COVERED CALIFORNIA™

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.

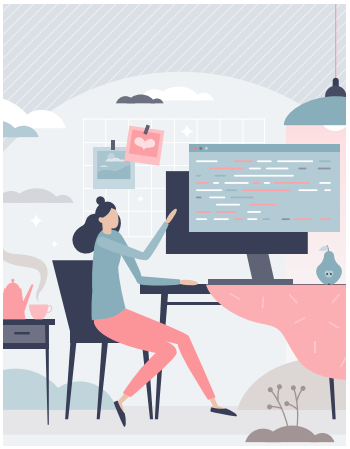
Impartiality:
The Ombuds Office is committed to reviewing consumer issues without bias or preconception and always treat individuals in a fair and objective manner. Impartiality is at the heart of the Ombuds. It instills confidence in both the public and its partners.

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 is out of scope for the Ombuds Office?

- Providing legal advice.
- Insurance company's products or services.
- Assisting 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 has met with the Customer Relations and Resolution, Escalations Resolution unit to collaborate on cross-divisional issues and objectives.

Training

The Ombuds Office continues to provide an 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 educate new employees on the abilities and responsibilities of the Ombuds Office and ensure referrals to the Ombuds Office are done appropriately.

Public Health Emergency

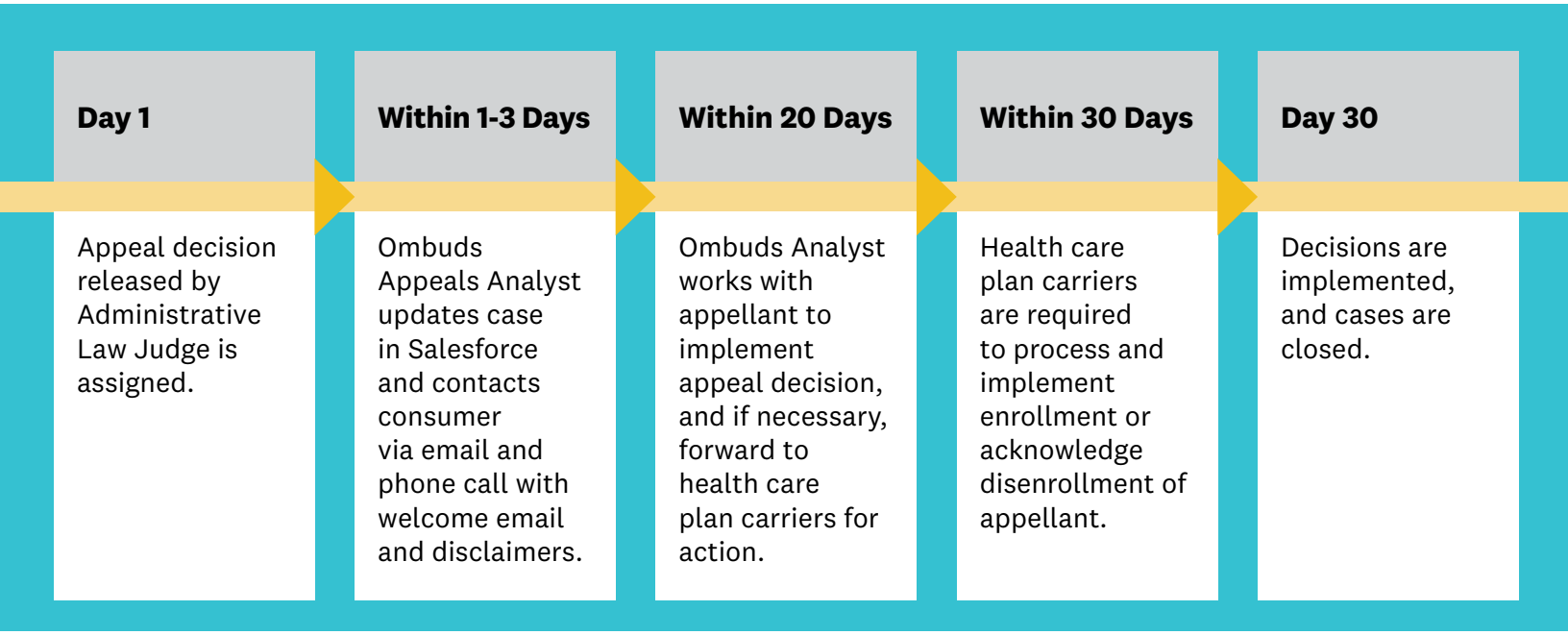
California's COVID-19 State of Emergency ended by Governor Newson's proclamation issued on February 28, 2023. The federal Public Health Emergency (PHE) for COVID-19 ended on May 11, 2023. The Ombuds Office participated in planning activities regarding the end of the PHE. System updates and policy changes have been reviewed with staff in preparation of consumer questions and issues as normal eligibility operations resume, including anticipated losses in coverage and transition from Medi-Cal to subsidized healthcare coverage. Staff attended trainings prior to the implementation of these changes. Reviews for Medi-Cal eligibility resumed in June with the first eligible cases transitioning in July.

Communications

In an effort to expand the ways consumers can contact the Ombuds Office, a new online document was created and posted to the Covered California website. The form was designed and developed to provide consumers with an electronic form that automatically creates a case within the Ombuds Office case management system.

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 22-23, the Appeals Fulfillment Unit processed 742 appeals. Of those, 450 were appeals involving only the consumer and Covered California, known as single appeals, and 292 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 742 decisions ordered by an Administrative Law Judge, a total of 48% (354) required an action to be taken (Granted, Partial Grant, and Stipulations). The number of decisions that were denied, dismissed, or withdrawn accounted for 31% (233). Non-Appearance cases (those cases where the claimant did not attend their hearing) accounted for 21% (155).

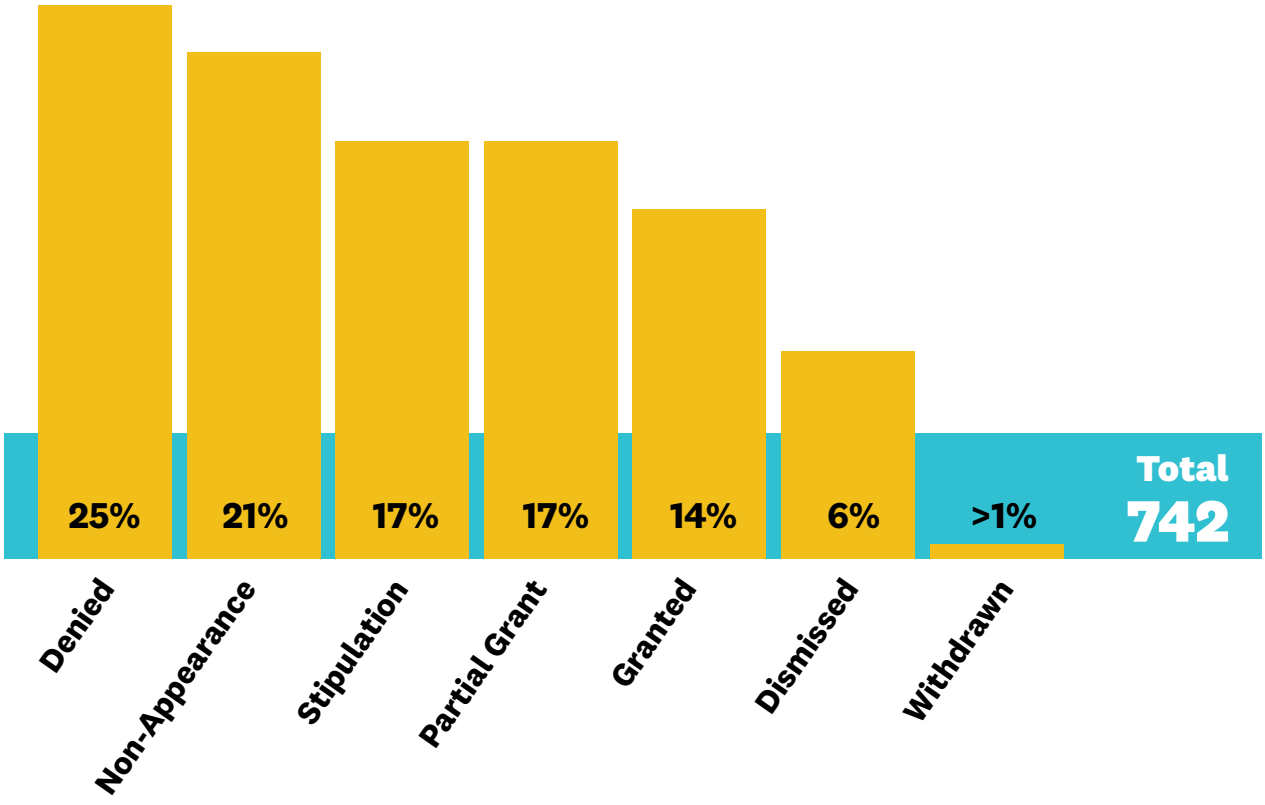
The Appeals Fulfillment Unit completed 90% (666/742) of the appeals in 30 days or less as mandated by California Code of Regulations, Title 10, Section 6618(c)(1):

> 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 (192/194) 99% of the time. In 69% (134/194) of cases, Covered California complied within 5 days. Of the two cases where Covered California did not meet the 20-day timeframe, one was a system issue and one was an analyst delay.

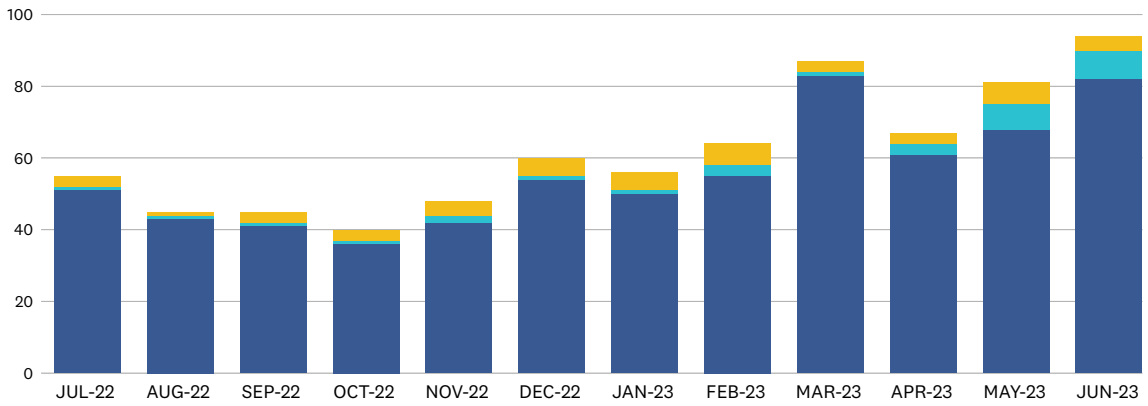
Decision Implementation Fiscal Year 22/23



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 2022-23, 39% of appeals were dual cases (292/742) 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 (666/742). Of the cases that were not timely, 61% (46/76) 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 22/23



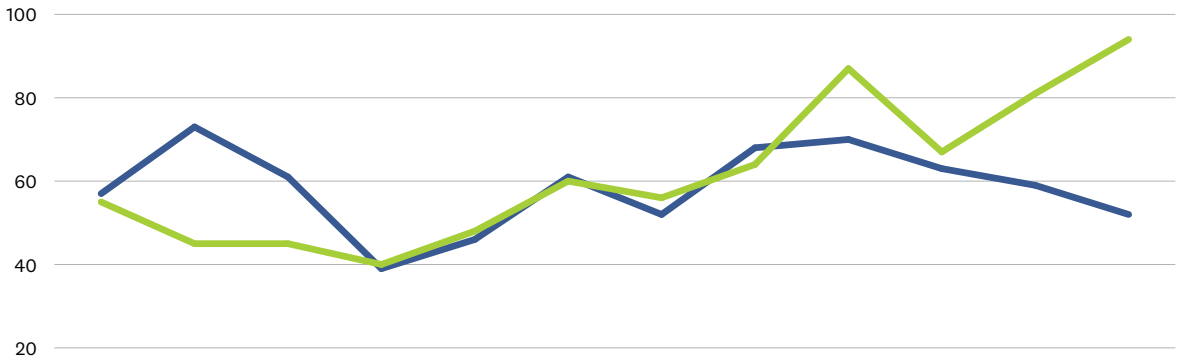
	JUL-22	AUG-22	SEP-22	OCT-22	NOV-22	DEC-22	JAN-23	FEB-23	MAR-23	APR-23	MAY-23	JUN-23
Total	55	45	45	40	48	60	56	64	87	67	81	94
> 30 days dual	3	1	3	3	4	5	5	6	3	3	6	4
> 30 days CC*	1	1	1	1	2	1	1	3	1	3	7	8
Timely	51	43	41	36	42	54	50	55	83	61	68	82

* Covered California

Previous Years Comparison

The number of decisions released each month for fiscal year 2022-23 were at levels comparable to the previous fiscal year. Because of the declared State and National Emergency due to the COVID-19 public health crisis, counties continued to delay processing of Medi-Cal annual renewals, and deferred discontinuances and negative actions. As a result, Californians were not discontinued from Medi-Cal, regardless of changes in income. Per Governor Newsom's proclamation on February 28, 2023, counties began the process in June of redeterminations for Medi-Cal consumers and processing discontinuances and negative actions. The impact of the redeterminations may be a factor in the upcoming fiscal year.

Decisions Released by Fiscal Year



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
21/22	57	73	61	39	46	61	52	68	70	63	59	52
22/23	55	45	45	40	48	60	56	64	87	67	81	94

Ombuds Affairs Unit

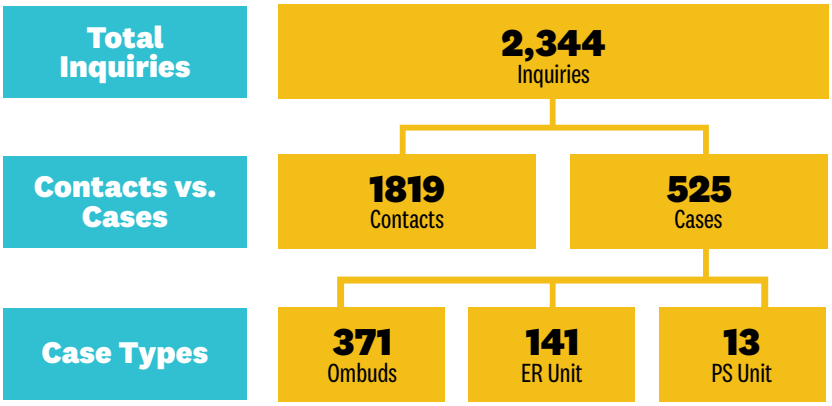
The Process

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

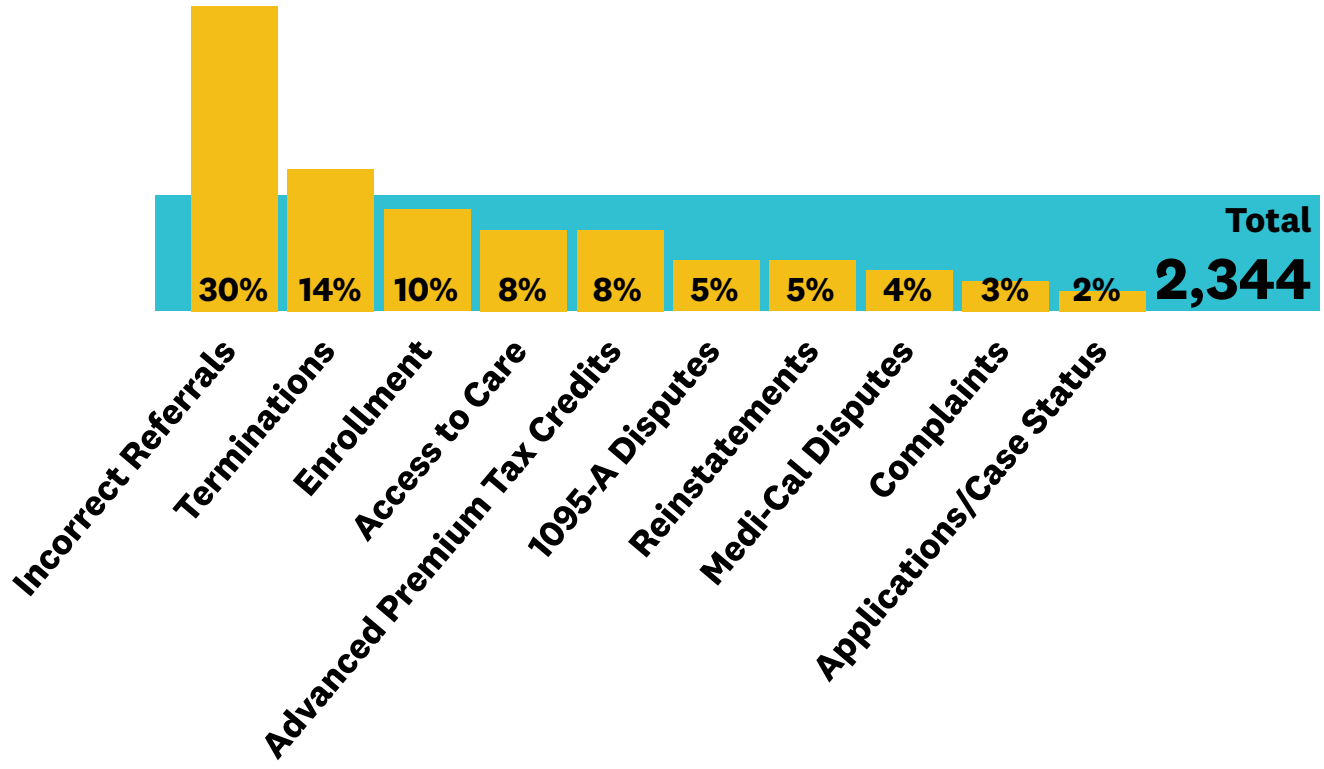
The Ombuds Affairs Unit handled 2344 inquiries throughout the fiscal year. Of those, 1819 were inquiries that the unit was able to provide information or direction to the consumer and did not require a case to be opened. These are considered "contacts." The remaining 525 inquiries became cases that fell 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 371 cases in-house.



Subject Lines

The largest category of subject lines for Inquiries are incorrect referrals (30%). 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 retro-terminations of coverage (this requires an appeal to be filed), coverage related to Medi-Cal enrollment or eligibility, or carrier billing issues. These are tracked 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 Termination issues (14%) which primarily involved cases where the consumer was requesting retro-termination of their coverage due to having obtained employer-sponsored coverage or Medi-Cal/Medicare. Access-to-Care issues (10%) consists of consumers who are transitioning between Covered California and Medi-Cal coverage and need access to their provider or plan. 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, is unable to get medical attention.

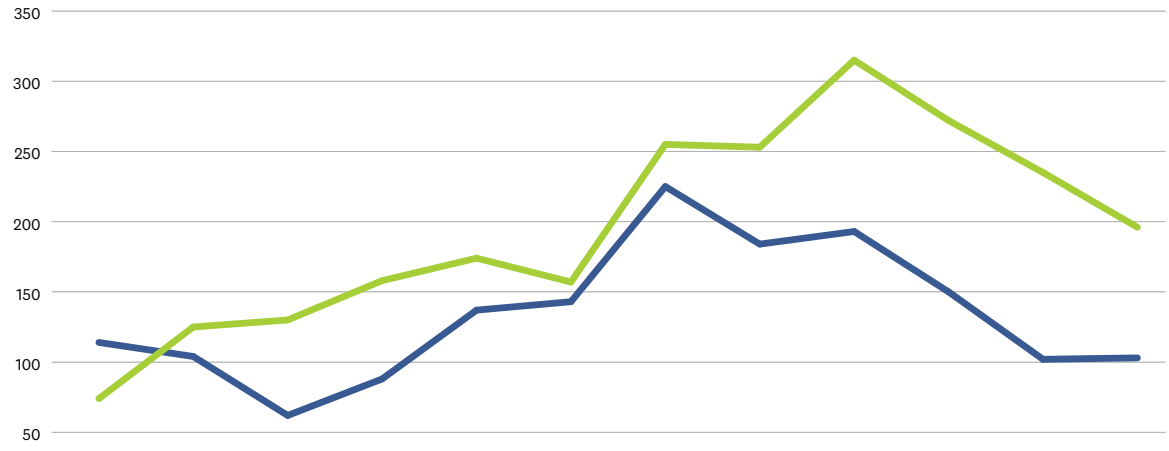
Top 10 Subjects



Previous Years Comparison

The number of inquiries that were processed by the Ombuds Affairs Unit in fiscal year 2022-2023 rose significantly from the previous fiscal year. This increase may have been due to the observation of the normal 2022 and 2023 open enrollment periods. (Covered California offered and extended special enrollment periods in 2021 that allowed Californians to enroll in Covered California for all of 2021.) For the current fiscal year, consumer enrollment and termination issues were seen at much higher rates. Discontinuances and negative actions for Medi-Cal were still deferred based on the declared State and National Emergency due to the COVID-19 public health crisis and consumers with Medi-Cal coverage had to actively request discontinuances and adjustments to their coverage. To help consumers who needed assistance with their Medi-Cal enrollment, the Ombuds Affairs Unit took an active role in mediating between consumers and their county. The purpose was to resolve enrollment issues in a timely manner to avoid more complicated issues down the line, such as access-to-care or financial responsibilities due to incorrect information.

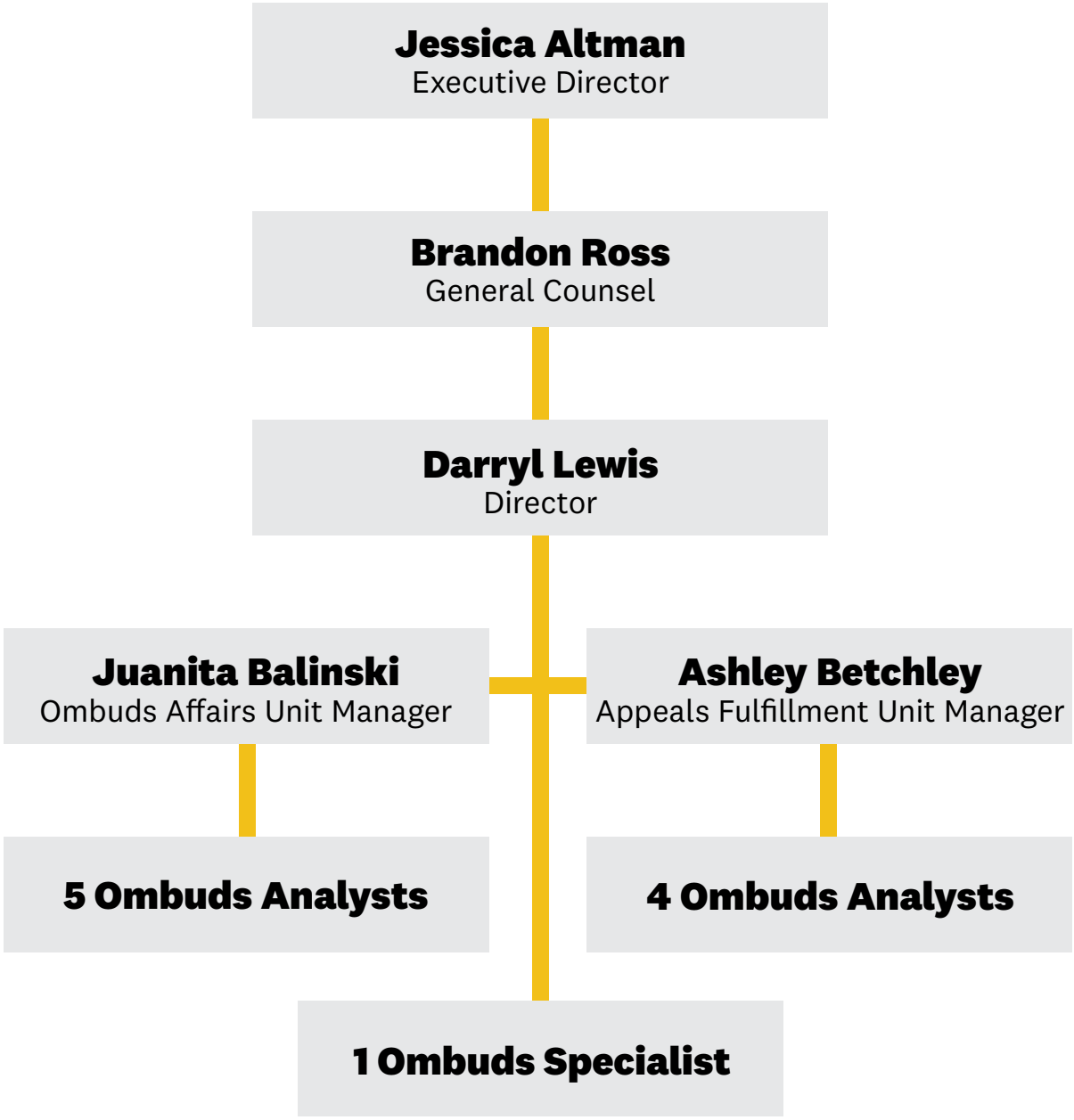
Ombuds Affairs Unit Inquiries by Fiscal Year



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
21/22	114	104	62	88	137	143	225	184	193	150	102	103
22/23	74	125	130	158	174	157	255	253	315	272	235	196

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 CoveredCalifornia 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 the 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.