Annual Health Care Complaint Data Report

Baseline Report to the Legislature
Measurement Year 2014

STATE OF CALIFORNIA
Edmund G. Brown Jr., Governor

HEALTH AND HUMAN SERVICES AGENCY
Diana S. Dooley, Secretary

OFFICE OF THE PATIENT ADVOCATE
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Statutory Requirement

Senate Bill 857 (Committee on Budget and Fiscal Review, Chapter 31, Statutes of 2014), added the following provision in law:

Health and Safety Code §136000.

(b)(1)(B) Produce a baseline review and annual report to be made publically available on the office's Internet Web site by July 1, 2015, and annually thereafter, of health care consumer or patient assistance help centers, call centers, ombudsperson, or other assistance centers operated by the Department of Managed Health Care, the Department of Health Care Services, the Department of Insurance, and the Exchange, that includes, at a minimum, all of the following:

(i) The types of calls received and the number of calls.

(ii) The call center's role with regard to each type of call, question, complaint, or grievance.

(iii) The call center's protocol for responding to requests for assistance from health care consumers, including any performance standards.

(iv) The protocol for referring or transferring calls outside the jurisdiction of the call center.

(v) The call center's methodology of tracking calls, complaints, grievances, or inquiries.

(C) (i) Collect, track, and analyze data on problems and complaints by, and questions from, consumers about health care coverage for the purpose of providing public information about problems faced and information needed by consumers in obtaining coverage and care. The data collected shall include demographic data, source of coverage, regulator, type of problem or issue or comparable types of problems or issues, and resolution of complaints, including timeliness of resolution. Notwithstanding Section 10231.5 of the Government Code, the office shall submit a report by July 1, 2015, and annually thereafter to the Legislature. The report shall be submitted in compliance with Section 9795 of the Government Code. The format may be modified annually as needed based upon comments from the Legislature and stakeholders.

(ii) For the purpose of publically reporting information as required in subparagraph (B) and this subparagraph about the problems faced by consumers in obtaining care and coverage, the office shall analyze data on consumer complaints and grievances resolved by the agencies listed in subdivision (c), including demographic data, source of coverage, insurer or plan, resolution of complaints, and other information intended to improve health care and coverage for consumers.

This report is available online at www.opa.ca.gov/Documents/ComplaintDataReport-2014Data.pdf
Data tables from this report are available online at www.opa.ca.gov/Documents/ComplaintDataTables-2014.pdf

Contents

Section 1 – Executive Summary

The Office of The Patient Advocate (OPA) is required to develop and implement a multi-departmental Complaint Data Analysis Report. The authority and specifications for this new public reporting initiative were originally established in AB 922 (Monning, Chapter 552, Statutes of 2011) and further detailed in SB 857 (Committee on Budget and Fiscal Review, Chapter 31, Statutes of 2014). This legislation called for an annual report to collect, analyze, and publicly report health care complaint data from four state entities, specifically the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS), the California Department of Insurance (CDI), and California's state-based Health Benefit Exchange called Covered California (collectively, "reporting entities").

This report constitutes the first annual report and as such it is considered a baseline review of California's health care complaint data. Complaints in this report include written or oral complaints, grievances, appeals, independent medical reviews, hearings, and similar processes to resolve a consumer problem or dispute.

This Baseline Review of Health Care Complaint Data catalogs 27,028 consumer health care complaints closed in 2014. Highlights of the report include:

- DMHC plan enrollment of 61,813,050 enrollees submitted 13,994 complaints
- DHCS plan enrollment of 21,376,642 enrollees submitted 4,589 complaints
- CDI plan enrollment of 2,574,181 enrollees submitted 4,079 complaints
- Covered California plan enrollment of 1,395,929 enrollees submitted 4,366 complaints
- CDI and DMHC complaint data comes from each of their respective call centers. Covered California and DHCS complaint data come from the California Department of Social Services (CDSS), State Hearings Division.
- The reporting entities tracked many data elements (including: age, gender, race, ethnicity, language, county, health plan, mode of contact, product type, source of coverage, type and reason for the complaint, time to resolve the complaint, and the outcome of the complaint filed). It is important to note differences in the reporting entities' time standards and complaint review and tracking protocols which do not allow for meaningful comparison across entities. Because of variances in data collection, analyses about many of these data elements are reported in the respective sections about each reporting entity, rather than aggregated statewide.
- Top 5 statewide complaint reasons:
  - Claim Denial (18%)
  - Quality of Care (11%)
  - Medical Necessity Denial (10%)
  - Co-pay, Deductible, and Co-Insurance Issues (7%)
  - Dis/enrollment (6%)
- Top 5 statewide complaint results:
  - Compromise Settlement/Resolution (24%)
  - Complaint Withdrawn (19%)
  - Health Plan Position Substantiated (14%)

    - Insufficient Information (9%)
    - Health Plan Position Overturned (7%)
- The range of time to resolve a complaint varied between reporting entities.
    - DMHC 6 – 37 days
    - DHCS 12 – 150 days
    - CDI 21 – 157 days
    - Covered California 39 – 50 days
- To provide a better measure of health plan performance, OPA analyzed and displayed health plan complaints as ratios of complaints filed against a particular health plan divided by the health plan's enrollment. These ratios will enable policy makers, departmental managers, and health plans to more fairly gauge the complaints received not strictly by raw numbers of complaints, but in the context of the number of complaints received per covered lives.
- In addition to complaint data, this report includes information submitted by each reporting entity regarding their customer assistance service centers, such as their business hours, staffing, training, protocols, performance standards, overall consumer assistance volumes, average telephone call wait times and call duration. The differences in protocols, procedures, and performance metrics are reflective of the variance in each respective reporting entity's missions and programs.

This inaugural report has identified gaps in data that is due in part to the reporting entities not having previously collected some of the requested data elements. OPA found that performing a comparative analysis across the reporting entities was further limited because the reporting entities did not use common complaint codes and each entity used their own tracking mechanisms. OPA has and will continue to work with each reporting entity to standardize where appropriate the data collection and enable additional analysis in subsequent reports.

Section 2 – Background

California has been at the forefront of recent health care reforms including expanding Medi-Cal eligibility, enacting significant reforms to the private insurance market, and creating its own health insurance marketplace, Covered California, under the Patient Protection and Affordable Care Act of 2010 (ACA). As a result of these reforms, the state also implemented new consumer protections and established additional consumer assistance service centers.

With changes of this magnitude, it is critical to provide baseline information to measure and evaluate this undertaking to ensure greater accountability, transparency, and quality improvement. One important gauge of California's progress with these major reforms is the newly-mandated annual compilation of system-wide data on the problems or complaints reported by health care consumers during the first year of the ACA implementation (2014). This annual reporting of complaint data will enable policymakers to better determine the success of the state's reform efforts and map what improvements and course corrections will be needed.

For purposes of this report "complaints" included written or oral complaints, grievances, appeals, independent medical reviews, hearings, and similar processes to resolve a consumer problem or dispute.

Statutory Mandates of the Office of Patient Advocate

The Office of the Patient Advocate (OPA) has two distinct mandates:

1) To produce online Health Care Quality Report Cards containing clinical performance and patient experience data. Since 2001, the Report Cards evaluate the state's largest health plans and over 200 affiliated medical groups. These commercial health plans are responsible for providing health care services to more than 16 million Californians with employer-based health insurance coverage.

The data for the OPA Report Cards comes from patient satisfaction surveys, clinical performance quality measures, and patient and health industry cost data. It has not included data from consumer complaints or grievances.

2) OPA is statutorily charged with the development and implementation of a multi-departmental complaint data reporting initiative. Through a system-wide endeavor, OPA is required to collect, analyze, and report health care complaint data and related consumer assistance information from four state entities with consumer assistance service-centers, specifically the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), Department of Insurance (CDI), and Covered California (collectively called "reporting entities"). The resulting *Baseline Review of Health Care Complaint Data* is the first Complaint Data Report produced by OPA, evaluating complaints closed January through December 2014, the first data collection

year. Due to different data sources, results should not be compared between the OPA Report Card and the Complaint Data in this report.

The authority and specifications for this new public reporting initiative were originally established in statute through AB 922 (Monning, Chapter 552, Statutes of 2011) and then further expanded upon with the passage of the Fiscal Year 2014-15 Budget Act and associated legislation (SB 857, Chapter 31, Statutes of 2014). AB 922 originally specified DMHC, DHCS, CDI, Covered California, and Managed Risk Medical Insurance Board (MRMIB). Due to the closing of MRMIB in 2014 and the transition of its beneficiaries to DHCS, this reporting entity was not included in this report.

As codified in California Health and Safety Code §136000, OPA's overall goal is to collect data from, coordinate among, and provide assistance to all of the state health agencies' consumer assistance programs and service centers. As it pertains to the Complaint Data Reporting Initiative, OPA is directed to:

- Identify patterns and trends regarding common consumer complaints across four health agencies (DMHC, DHCS, CDI, and Covered California);
- Collect data in handling consumer complaints, make referrals to other agencies, and document standards, protocols and training materials; and
- Analyze the complaint data to help policymakers determine what programmatic and procedural actions should be implemented for health care consumers to ensure that they access the health care services to which they are eligible under law.

Inquiries and Non-Jurisdictional Complaints

The vast majority of consumer requests for assistance do not lead to the filing of a formal complaint with the state service centers. Most often a consumer is simply looking for information or making an inquiry. However, these inquiries do have significant value in that they can indicate what issues consumers are confused about or problems they are having trouble resolving on their own, or through the existing consumer assistance system.

For purposes of this report "inquiries" encompass both of the following types of requests for assistance made by consumers:

- **Jurisdictional Inquiry** – Consumer requires guidance on a topic within the service center's purview (including a status update on an already filed complaint), or assistance with a regular business activity within the service center's authority that is unrelated to a complaint (e.g., initiating an application for coverage).
- **Non-Jurisdictional Inquiry/Complaint** – Consumer requires education and a referral to another entity to address a question or resolve a complaint about a non-jurisdictional topic.

To the extent that this information is available in the baseline year, OPA has included information about the numbers and types of these inquiries and the other agencies to which non-jurisdictional inquiries/complaints are referred.

Review of National Best Practices and OPA's Approach to Complaint Data

OPA conducted a review of national best practices and complaint data analysis and reporting efforts in California by governmental entities and other organizations to learn what were the most successful approaches and techniques. OPA reviewed the literature to become familiar with standards, coding conventions, and approaches used in other states, by the industry, academics, governmental agencies, and professional organizations such as the National Association of Insurance Commissioners (NAIC). OPA conducted a number of follow-up discussions with several of these entities to get additional feedback regarding best practices.

Taking into account its research, OPA developed the following approach for this data analysis report:

1. Adopted Standard Data Elements and Complaint Data Codes
2. Adopted a Standard Data Methodology
3. Developed a Complaint Data Warehouse

OPA presented the approach to the four reporting entities designated in the statute. OPA made a commitment to building on the work already in progress and toward the goal of a more standardized and efficient means for the delivery and tracking of consumer assistance by the state operated service centers. OPA then held a series of consultations with each of the reporting entities to acquire a more in-depth understanding of their current system and practices for complaint tracking and analysis. OPA looked for ways to identify the commonalities across systems. These collaborative discussions with the reporting entities also spurred participants to internally assess their own current data storage and retrieval systems, familiarize themselves with their department's data reporting requirements and retrieval mechanisms.

OPA also initiated the complaint analysis with the coding promulgated by the NAIC but introduced major modifications to that coding system after consultation with the four reporting entities. OPA was assisted in the development and analysis of this report by the National Committee for Quality Assurance, which served as OPA's public reporting contractor.

The Data Elements

Per the California Health and Safety Code, the four reporting entities (DMHC, DHCS, CDI, and Covered California) with health care regulatory and/or purchaser oversight roles are required to annually provide OPA with non-aggregated complaint data from their respective service centers. The statute requires that OPA include the following data in the annual complaint data reports:

- Demographic data on consumers
- Source of coverage
- Insurer or plan
- Regulator
- Type of problem or issue or comparable types of problems or issues

- Resolution of complaints, including timeliness of resolution

The following additional mandated information is required on each of the state's health consumer assistance centers:

- The type of calls received and the number of calls
- The center's role with regard to each type of call, question, complaint, or grievance
- The center's protocol for responding to requests for assistance from health care consumers, including any performance standards
- The protocol for referring or transferring calls outside the jurisdiction of the service center
- The center's methodology for tracking calls, complaints, grievances, or inquiries

Challenges

The service centers operated by DMHC, DHCS, CDI, and Covered California assist consumers with issues within the authority of their departments.

Before the enactment of the legislation mandating the creation of report, California had never attempted the collection of health care complaint data across reporting entities. One of the key challenges for this analysis was that complaint definitions and processes were not standardized across state agencies in terms of definitions, coding, tracking, systems, or performance metrics.

Guidance About the Complaint Data and Resulting Analysis

This Baseline Review of Health Care Complaint Data represents the first concerted effort to catalog consumers' complaints across systems. OPA displayed data from the reporting entities and made all reasonable efforts to validate that data, ask questions of the reporting entities, and resolve apparent discrepancies. OPA is charged with promoting health care coverage and access to services by providing data and analysis to identify system-wide problems and provide for evidence-based improvements. This data also provides information for evaluation of the performance of regulators, state purchasers, health plans and insurance companies in handling consumers' inquiries and complaints.

A pattern of consumer complaints may indicate systemic problems regarding health care coverage and problems with access to care. However, complaint data results can be an imperfect measure, especially when conducting comparisons between reporting entities, coverage types, regulatory agencies, and similar categories. For example, complaint volumes may be affected by barriers within the complaint process itself. Low volume may reflect that consumers have multiple barriers to overcome when trying to register a complaint. Conversely, higher volume may indicate that an issue has received increased media attention which drives increased reporting, but not necessarily increased incidence of the problem.

The annual complaint data report will increase the state's capability to:

- Improve health care customer service to Californians;
- Identify systemic problems through better monitoring of trends and patterns by regulators, purchasers, health plans and insurers, and health care providers;
- Provide a quality measurement of the health plans and insurance companies in how well they respond to consumer complaints; and
- Assess the performance of state health agencies' customer service and enable the reporting entities to gauge the adequacy of resources available for them to provide consumer assistance.

Section 3 – Organization of the Report

The baseline review that follows is organized into four principal sections:

- Methodology (Section 4)
- Statewide Complaint Data (Section 5)
- Reporting Entities' Data (Section 6 – 9)
- Next Steps (Section 10)

Methodology

The Methodology section details the data collection analysis and processes used to generate this report. In addition, information on data limitations and challenges are outlined to provide context when assessing the data. This section will show that each entity has unique responsibilities, structure, and governance that must be considered when comparing reporting them.

Statewide Complaint Data

This Statewide Complaint Data section provides a snapshot of aggregated information on general categories for the four reporting entities including: eligibility, enrollment, health care access, requests for assistance, and protocols.

Reporting Entities' Data

Each reporting entity has a section devoted to it that provides a brief overview of each entity's role, structure, and established protocols as well as complaint data. The complaint data includes: number of complaints, types and reasons for complaints, and the length of time to resolve complaints. These data are shown in a variety of formats. The data exhibited is based on what was submitted by each reporting entity and will therefore vary.

Next Steps

This section highlights where there are opportunities for enhancement of data collection to achieve greater standardization in future reports and suggestions of ways to increase consumer knowledge of the complaint process.

Section 4 – Methodology

To execute the reporting requirements per Health and Safety Code §136000, OPA collected data comprised of a combination of qualitative descriptive information as well as the quantitative records on the actual complaints closed during calendar year 2014.

The type and source of the complaint records that were submitted to OPA for measurement year 2014 include:

- **DMHC** – Standard Complaints, Independent Medical Reviews, Quick Resolutions, and Urgent Nurse Complaints
- **DHCS** – State Fair Hearings [conducted by the California Department of Social Services (CDSS)]
- **CDI –** Standard Complaints and Independent Medical Reviews
- **Covered California** – State Fair Hearings (conducted by CDSS)

Data Analysis

OPA used standard data practices to analyze and report the data. OPA did not publicly report certain data in this report to take into account certain HIPAA restrictions (e.g., data, although not personally identifiable, was not reported in several smaller counties because of the possibility that due to the low population and complaint data numbers in those counties, individuals could be inadvertently identified.) The data findings and qualitative information on the service centers are presented in Sections 5 through 9.

In order to compare the complaint data across health plans, it was necessary to obtain enrollment figures for each health plan during 2014. The health plan enrollment data was provided by the reporting entities as reported to them by the health plans and insurance companies. The enrollment numbers are used to determine the ratio of complaints files concerning a health plan. Complaint ratios allow for more equitable comparison of large versus small health plans. The complaint ratio is calculated by taking the number of closed complaints and dividing it by the number of covered lives the insurer had in place by the end of a specific month in the Spring of 2014. This number is standardized by dividing the ratio by 10,000.

Section 5 – Statewide Complaint Data

A. Overview

The Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), California Department of Insurance (CDI), and Covered California are the primary components of California's state system for health care consumer assistance and serve millions of Californians each year. Their service centers are the help centers, call centers, ombudspersons, or other assistance centers that are operated or contracted by these four state reporting entities.

The service centers assist consumers with a wide range of issues, from enrollment in health care coverage to the delivery of health care services. Each state service center has the authority to resolve consumer requests for assistance that fall under its parent organization's jurisdiction as a health care licensing entity, purchaser, or program administrator.

- DMHC and CDI are state regulators that license and provide oversight of health plans and health insurance products, respectively. Their service centers concentrate on health care delivery issues for consumers who are insured but have difficulties using their health plan or insurance to obtain or pay for services.
- DHCS is the state's Medi-Cal program administrator and a direct health care purchaser. DHCS operates or contracts with multiple service centers that provide consumer assistance to people eligible for Medi-Cal or other DHCS-administered programs. However, county offices are consumers' primary points of contact for most program eligibility and enrollment issues.
- Covered California's service center addresses issues related to applications for health care coverage and subsequent eligibility determinations for low-cost health care programs and tax subsidies, as well as enrollment into health plans sold through Covered California's marketplace. Covered California did not submit health plan complaint data.

The following table displays the number of plans that had at least one complaint, total enrollment numbers, and corresponding number of complaints by reporting entity.

Fig. 5.1
Reporting Entity Plans, Enrollment, and Complaints

Reporting Entity	Number of Plans with at Least One Complaint	Total Number of Enrollees	Number of Complaints
DMHC	63	61,813,050	13,994
DHCS	88	21,376,642	4,589
CDI	103	2,574,181	4,079
Covered CA	N/A	1,395,929	4,366

B. Statewide Consumer Assistance Centers

Roles and Responsibilities by Reporting Entity

The following table illustrates the differences in the types of consumer assistance provided and shows which functions are primary or have a limited role for each reporting entity.

Figure 5.2
Consumer Assistance Roles by Reporting Entity

Chart key: ✓ **Primary function** ✓ **Limited role** – **No authority or role so refers consumers**

Role	Department of Managed Health Care	Department of Health Care Services	Department of Insurance	Covered California
Processes applications and renewals	–	✓ 1	–	✓
Makes eligibility determinations and enrolls	–	✓ 1	–	✓
Resolves complaints on program eligibility determinations	–	✓ 3	–	✓ 4
Resolves complaints on enrollment and disenrollment issues	✓ 2	✓ 3	✓ 2	✓ 4
Administers authorizations for and/or purchases services	–	✓ 5	–	–
Resolves complaints on health care delivery and/or payment for care	✓	✓ 5	✓	–
Regulates health plans or insurers/Enforces related laws	✓	– 6	✓	–

Note:
1- DHCS establishes and oversees systems for Medi-Cal eligibility and enrollment. County offices process applications and make eligibility determinations. A Health Care Options contractor processes plan enrollments.
2- Addresses requirements pertaining to health plans or insurers for underwriting, cancellations, and enrollment/dis-enrollment issues.
3- Complaints are typically initially addressed through county Medi-Cal offices. Formal appeals are through the State Fair Hearing process with the California Department of Social Services.
4- Formal appeals are through the State Fair Hearing process with the California Department of Social Services.
5- Addresses Fee-for-Service claim/authorization issues. Formal appeals are through the State Fair Hearing process with the California Department of Social Services. Complaints about most Medi-Cal Managed Care plans also may be filed with DMHC.
6- DMHC regulates most Medi-Cal Managed Care plans. Although not a state regulator, DHCS provides oversight of its contracts with Medi-Cal Managed Care plans, including with County Operated Health System plans not regulated by DMHC.

The following table provides contact and other information about each of the reporting entity service centers that reported 2014 consumer complaints or inquiries to OPA.

Figure 5.3 **Consumer Assistance Service Centers Listed by Reporting Entity**

Department of Managed Health Care Help Center	
Main Phone Number	1-888-466-2219
TTY / TDD Line	1-877-688-9891
Days/Hours Open	Monday thru Friday, 8:00 am to 6:00 pm After-hours service for urgent issues
Service Center Website	www.healthhelp.ca.gov
DHCS: Medi-Cal Managed Care Office of the Ombudsman	
Main Phone Number	1-888-452-8609
TTY / TDD Line	Not available
Days/Hours Open	Monday thru Friday, 8:00 am to 5:00 pm (except state holidays)
Service Center Website	http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx
DHCS: Mental Health Ombudsman	
Main Phone Number	1-800-896-4042
TTY / TDD Line	1-800-896-2512
Days/Hours Open	Monday thru Friday, 8:00 am to 5:00 pm (except state holidays)
Service Center Website	www.dhcs.ca.gov/services/MH/Pages/MH-Ombudsman.aspx
DHCS: Medi-Cal Telephone Service Center (Contractor: Xerox)	
Main Phone Number	1-800-541-5555
TTY / TDD Line	916-635-6491
Days/Hours Open	Monday thru Friday, 8:00 am to 5:00 pm (beneficiary and provider assistance) Extended hours for provider technical assistance (365 days a year, 6:00 am to Midnight)
Service Center Website	N/A
DHCS: Denti-Cal Telephone Service Center (Contractor: Delta Dental)	
Main Phone Number	1-800-322-6384
TTY / TDD Line	1-800-735-2922
Days/Hours Open	Monday thru Friday, 8:00 am to 5:00 pm Some automated services available through the Interactive Voice Response system 7 days a week, 24 hours a day; Voicemail checked daily
Service Center Website	www.denti-cal.ca.gov
California Department of Insurance Consumer Services Division	
Main Phone Number	1-800-927-HELP (4357) or 213-897-8921 (Consumer Hotline)
TTY / TDD Line	1-800-482-4833
Other Phone Lines	1-800-967-9331 (Licensing Hotline)
Days/Hours Open	Monday thru Friday 8:00 am to 5:00 pm After-hours message center
Service Center Website	www.insurance.ca.gov

Covered California Service Center (Rancho Cordova, Fresno, Contra Costa, and Faneuil Service Centers)

Main Phone Number	1-800-300-1506
TTY / TDD Line	1-888-889-4500
Other Phone Lines	Arabic 1-800-826-6317; Armenian 1-800-996-1009; Chinese 1-800-300-1533; Farsi 1-800-921-8879; Hmong 1-800-771-2156; Khmer 1-800-906-8528; Korean 1-800-738-9116; Lao 1-800-357-7976; Spanish 1-800-300-0213; Russian 1-800-778-7695; Tagalog (Filipino) 1-800-983-8816; Vietnamese 1-800-652-9528
Days/Hours Open	Monday thru Friday, 8:00 am to 6:00 pm Saturday 8:00 am to 5:00 pm
Service Center Website	www.coveredca.com/contact/ http://hbex.coveredca.com/service-center/

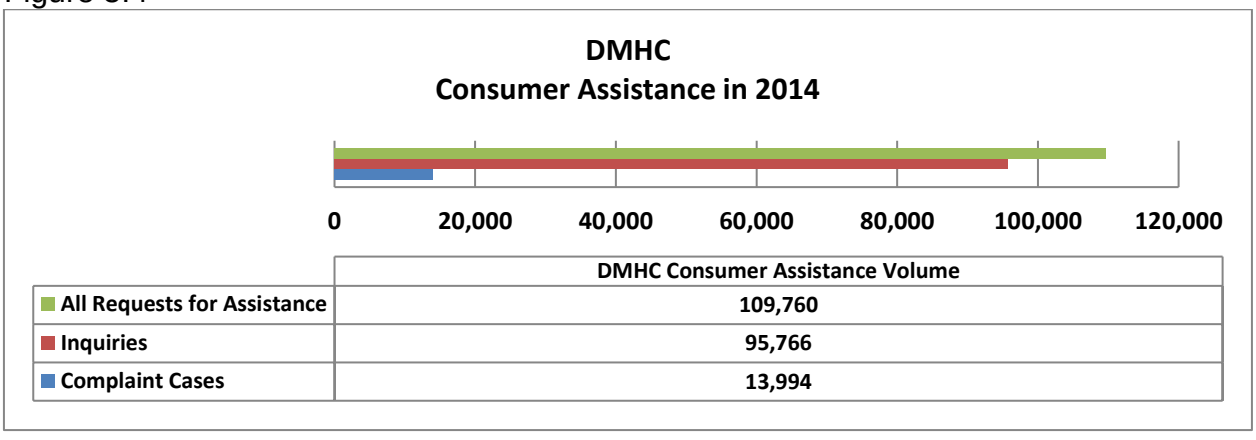
2014 Consumer Assistance Volumes

The reporting entity service centers that reported data to OPA received over five million requests for assistance from consumers in 2014. Requests for assistance encompass the total volume of consumer contacts, including inquiries and contacts to initiate complaints. Most consumers contacted the service centers by telephone.

The vast majority of the requests for assistance received by state service centers were not to initiate a formal complaint, but were inquiries from consumers who sought:

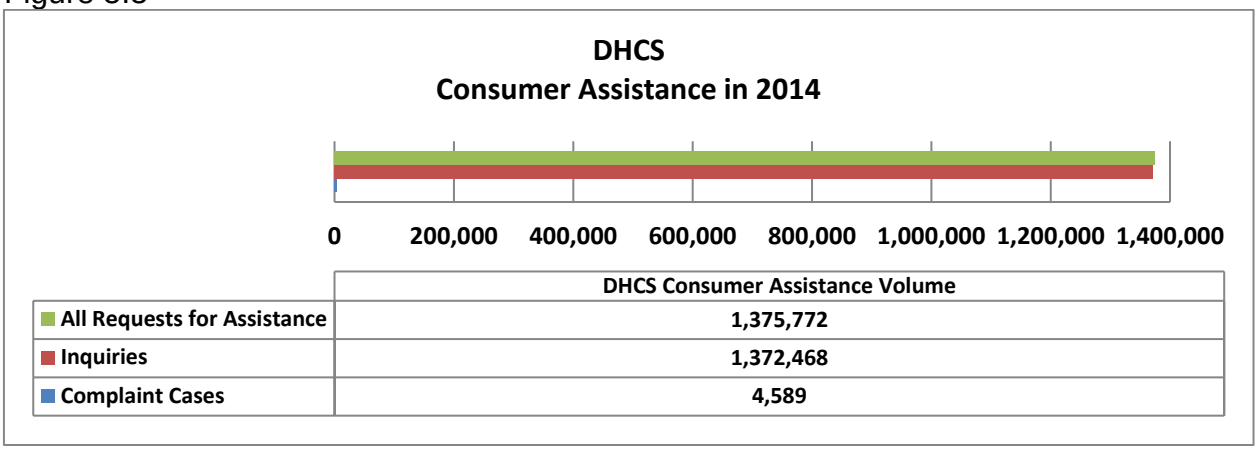
- Assistance with a regular business activity or transaction within the service center's authority and role that is unrelated to a complaint (e.g., a consumer calling to start an application for coverage);
- Guidance or a status update on a topic within the service center's purview (including follow-up contacts regarding the status of a filed complaint); or
- Education and a referral to another entity to address a non-jurisdictional issue.

Figure 5.4



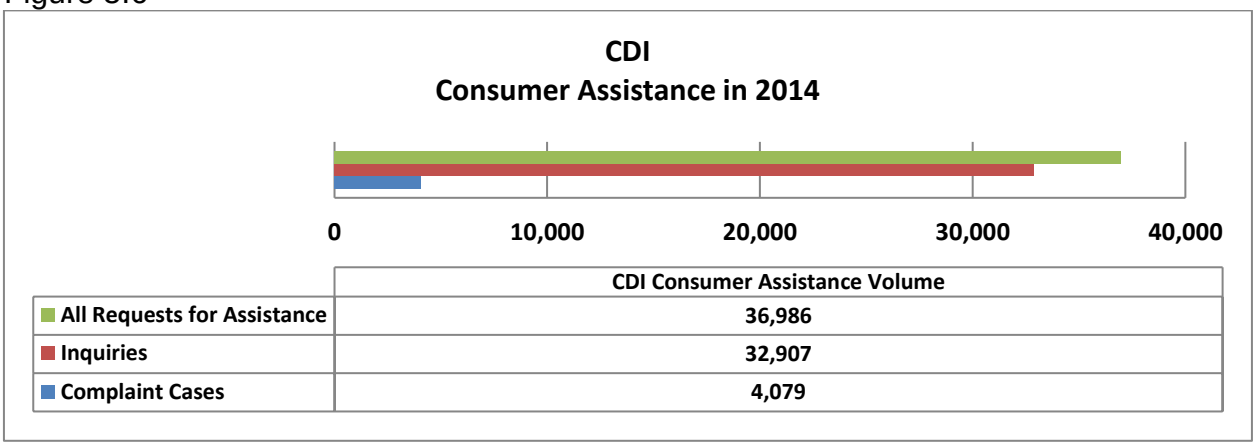
	DMHC Consumer Assistance Volume
All Requests for Assistance	109,760
Inquiries	95,766
Complaint Cases	13,994

Figure 5.5



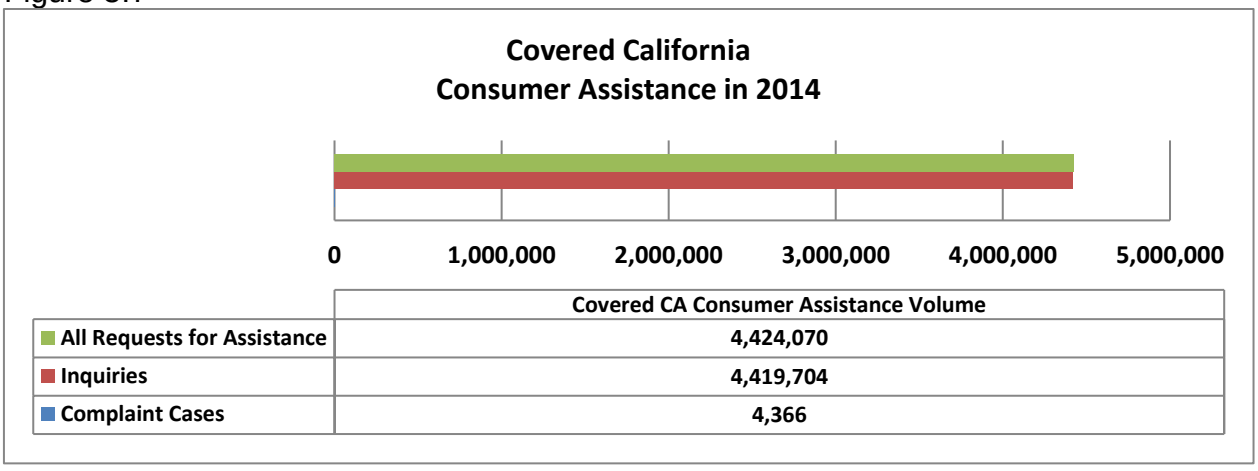
	DHCS Consumer Assistance Volume
All Requests for Assistance	1,375,772
Inquiries	1,372,468
Complaint Cases	4,589

Figure 5.6



	CDI Consumer Assistance Volume
All Requests for Assistance	36,986
Inquiries	32,907
Complaint Cases	4,079

Figure 5.7



	Covered CA Consumer Assistance Volume
All Requests for Assistance	4,424,070
Inquiries	4,419,704
Complaint Cases	4,366

Service Center Protocols

The reporting entities' service centers provided information about their protocols for handling consumer requests for assistance. There is wide variance in protocols and how

they are incorporated into each individual service center's system. Designed to help fulfill distinct organizational missions, these protocols also are affected by statutory or contractual requirements, budgets, staffing resources, and similar factors. The service centers reported implementing their consumer assistance protocols using a variety of tools, including customer relationship management systems, web-based knowledge management systems, policies and procedures manuals, referral guides, phone scripts, and other training materials and customer service representative tools.

The following table reflects survey responses and documentation provided by the reporting entities about their protocols. In some cases, the reporting entity indicated that it could not provide documentation because its protocols are implemented within a complex information technology (IT) system that cannot be easily shared, such as a Customer Relationship Management system or similar call center applications or software. Service center systems are outlined further in Sections 6-9 and Appendix B.

Figure 5.8
Consumer Assistance Protocols Submitted by Reporting Entities to OPA
Chart Key

✓ Service center has a documented protocol

✓ Reporting entity indicated that a protocol exists, but is implemented within an IT platform that cannot be easily shared

✓ Reporting entity indicated that a protocol exists, but did not submit documentation to OPA

– Reporting entity did not report an existing protocol or provide documentation to OPA

Not applicable because the reporting entity indicated that the service center does not resolve complaints

Policies and Procedures	**DMHC Help Center**	**DHCS Medi-Cal Managed Care Office of the Ombudsman**	**DHCS Mental Health Ombudsman**	**DHCS Denti-Cal Telephone Service Center** (Contractor - Delta Dental)	**DHCS Medi-Cal Telephone Service Center** (Contractor - Xerox)	**CDI Consumer Services Division**	**Covered California Service Center**
Jurisdictional Complaints	✓	Not Applicable	Not Applicable	Not Applicable	Not Applicable	✓	✓
Urgent Clinical Complaints	✓	Not Applicable	Not Applicable	Not Applicable	Not Applicable	✓	✓
After-Hours Assistance	✓	–	–	✓	–	✓	–
Language Assistance	✓	–	✓	✓	–	✓	✓
Non-Jurisdictional Issue Referrals	✓	–	✓	✓	–	✓	✓
Performance Standards							
Jurisdictional Complaint Resolution	✓	Not Applicable	Not Applicable	Not Applicable	Not Applicable	✓	–
Non-Jurisdictional Issue Referrals	✓	–	✓	✓	–	✓	–

Figure 5.8 Continued

Customer Service Representative (CSR) Training and Tools							
Training on Jurisdictional Complaints	✓	Not Applicable	Not Applicable	Not Applicable	Not Applicable	✓	✓
Training on Non-Jurisdictional Issues	✓	–	✓	✓	–	✓	✓
CSR Tools for Addressing Jurisdictional Complaints	✓	Not Applicable	Not Applicable	Not Applicable	Not Applicable	✓	✓
CSR Tools for Addressing Referrals	✓	✓	✓	✓	–	✓	✓

C. Statewide Health Care Complaint Data

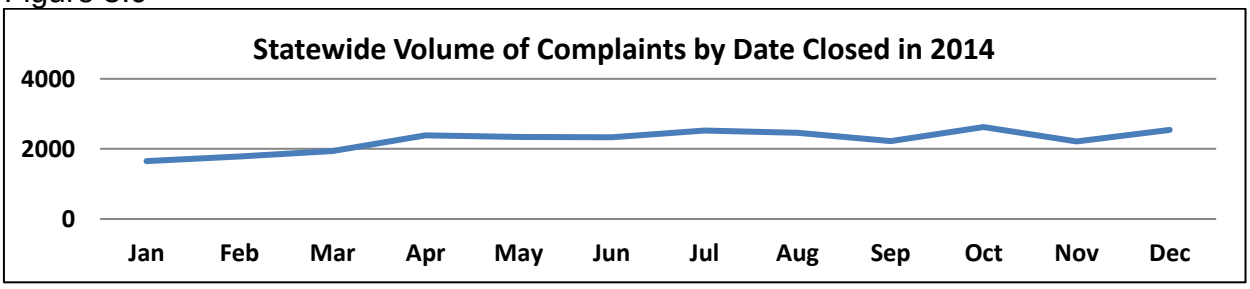
The four reporting entities submitted in total 27,028 consumer complaints to OPA for Measurement Year 2014: 52 percent of complaints were processed by DMHC, 17 percent DHCS, 15 percent CDI, and 16 percent Covered California. The data represents complaints across 45 distinct product types from both commercial and public insurers. A large majority, 45 percent, of consumer complaints were Standard Complaints, while 33 percent were CDSS State Fair Hearing, 16 percent were Independent Medical Reviews, five percent were Quick Resolution Nurse, and one percent was Urgent Nurse Case complaints.

Volume of Closed Complaints

The statewide volume of complaints represents the total number of health care consumer complaints based on service center and CDSS State Fair Hearing submissions to OPA from DMHC, DHCS, CDI, and Covered California.

The chart below shows the monthly volume for closed complaints. It reflects only those cases closed in 2014 and does not include cases opened in previous years if they were closed before 2014 or cases opened in late 2014 but closed in 2015.

Figure 5.9



Resolution Time

The average time to resolve or close a complaint is derived by calculating the number of days between the time a complaint was opened to the time it was closed and then computing the overall average for the total number of complaints processed by each reporting entity. The individual reporting entities resolution times are shown in their individual sections.

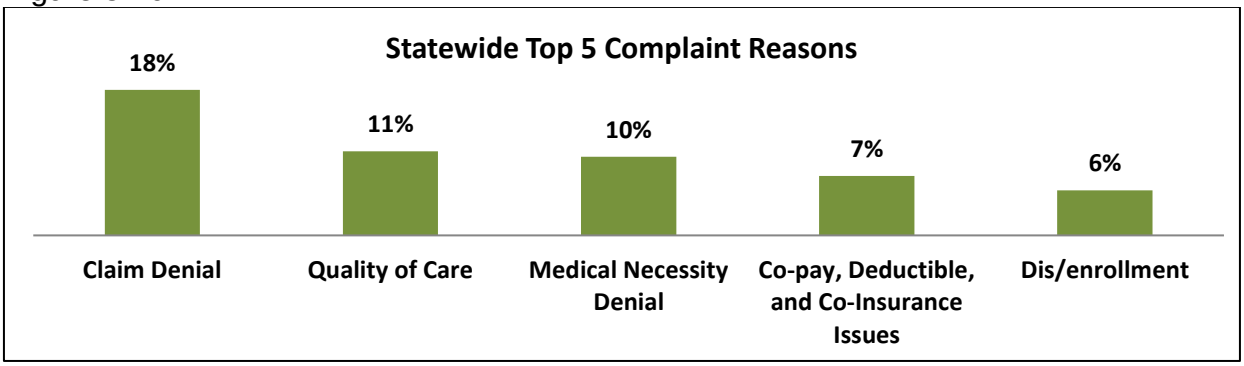
Complaint Reasons

The following chart presents the percentage of the Top 5 reasons statewide for consumer complaints about their coverage. OPA used complaint reasons initially drawn from established codes used nationally by the National Association of Insurance Commissioners (NAIC) Standard Complaint Data Form. OPA then modified these codes and added other codes in collaboration with the four reporting entities. This enabled OPA to add or change the definition of codes that were more reflective of California's marketplace, delivery systems, the prevalence of managed care, and other statewide differences.

The Top 5 complaint reasons represent 14,723 or 52 percent of all submitted complaint reasons. Claim denials reflected in the complaint data submitted by the majority of reporting entities include claim denials for PPO's, mental health, and dental services.

It should be noted that the analyses conducted by the individual entities revealed variations in the top complaints reasons. See Sections 6 through 9 for the individual entity rankings for top complaint reasons.

Figure 5.10



Note: The total number of 28,569 complaint reasons, exceeds the total number of 27,028 complaints. Many consumer complaints involve more than one complaint reason.

Language

Figures 5.11 - 5.14 displays all complaints for the top ten Complaint Reasons by Primary Language for the four state entities. English-language speakers represent the majority of consumers (61%) who submitted complaints to DMHC, DHCS, CDI and Covered California.

The top complaint reason was Claim Denial for English, Spanish, and Other-language consumers. Quality of Care was the top complaint reason for consumers which language data was not gathered or who refused to provide this information.

Medical Necessity Denial ranked among the top three complaint reasons for English, Spanish, and Other language speakers. Further investigation is required to understand if

and why specific complaint reasons may or may not be associated with consumers' primary language.

Figure 5.11 **Statewide Top 10 Complaint Reasons for Primary Language: English**

Complaint Reasons	Volume
Claim Denial	3,046
Medical Necessity Denial	2,356
Co-pay, Deductible, and Co-Insurance Issues	1,791
Dis/enrollment	1,501
Coverage Question	1,277
Cancellation	1,214
Out of Network Benefits	906
Access to Care	771
Provider Attitude and Service	742
Experimental/Investigational Denial	616
Total	14,220

Figure 5.12 **Statewide Top 10 Complaint Reasons for Primary Language: Spanish**

Complaint Reasons	Volume
Claim Denial	181
Eligibility Determination	38
Medical Necessity Denial	33
Out of Network Benefits	26
Access to Care	21
Dis/enrollment	18
Co-pay, Deductible, and Co-Insurance Issues	17
Cancellation	14
Coverage Question	14
Provider Attitude and Service	12
Total	374

Figure 5.13 **Statewide Top 10 Complaint Reasons for Primary Language: Other Languages**

Complaint Reasons	Volume
Claim Denial	110
Medical Necessity Denial	16
Co-pay, Deductible, and Co-Insurance Issues	16
Dis/enrollment	14
Cancellation	13
Eligibility Determination	12
Coverage Question	9
Out of Network Benefits	7
Emergency Services	5
Access to Care	4
Total	206

Figure 5.14

Statewide Top 10 Complaint Reasons for Primary Language: Unknown or Refused

Complaint Reason	Volume
Quality of Care	3,003
Claim Denial	1,849
Unknown	646
Dental Scope of Benefits	616
Unsatisfactory Settlement Offer	612
Medical Necessity Denial	403
Cancellation	344
Out of Network Benefits	342
Premium Notice/Billing	293
Co-pay, Deductible, and Co-Insurance Issues	292
Total	8,400

Product Type

The state reporting entities regulate and have contract oversight for different types of insurance products. The following table displays the jurisdictional and non-jurisdictional complaint Product Types submitted by each of the reporting entities in descending order of total volume of complaints per Product Type.

Figure 5.15

Statewide Descending Volume of Jurisdictional and Non-jurisdictional Complaint Product Types

CDI
Health Only
Dental Combined w/Major Medical
Small Group
Large Group
Grandfathered
Mental Health
Medicare Supplement
Limited Benefits
Exchange
Cancer/Dread Disease
Bronze
Pharmacy Benefits
Dental Stand Alone
Hospital Indemnity
Silver
Autism/PDD
Student Health
Vision
Platinum
Short Term Limited Duration Policy
Other
Accident Only
Gold
Chiropractic
Self-Funded/ERISA
Home Health Care
HIPAA
Medicare Advantage
Disability Income
Catastrophic
Medicare Prescription Drug/Part D
Multi State

Covered California
Silver
Unknown
Bronze
Platinum
Gold
Catastrophic

DMHC
HMO
PPO
EPO
POS
Unknown

DHCS
Medi-Cal Managed Care: Two Plan Model
Dental
Medi-Cal Managed Care: COHS Model
Unknown
Medi-Cal Managed Care: GMC Model
Medi-Cal Managed Care: Other Models (Rural Model, Imperial Model, San Benito Model, Long Term: PACE, Long Term: SCAN)
Medi-Cal Coordinated Care (CCI)

D. Complaint Data Results

The table below show the Statewide Top 10 Complaint Results, which reflect 26,805 out of 28,992 complaints. Some complaint cases submitted had more than one complaint result. There were 26 complaints with an Unknown complaint result.

Figure 5.16
Statewide Top 10 Complaint Results

Complaint Result	Volume and Percent
Health Plan Position Overturned	1,971 (7%)
Claim Settled	1,725 (6%)
Consumer's Money Returned	1,004 (3%)
Compromise Settlement/Resolution	6,988 (24%)
Health Plan Position Substantiated	3,945 (14%)
Health Plan in Compliance	442 (2%)
Complaint Withdrawn	5,616 (19%)
Insufficient Information for Further Investigation	2,673 (9%)
No Action Requested/Required	1,669 (6%)
Question of Fact/Contract/Law Falls Outside Regulator	772 (3%)

Section 6 – Department of Managed Health Care

A. Overview

The Department of Managed Health Care (DMHC) regulates full-service health plans, including most California HMOs and some PPOs, as well as specialized plans such as dental and vision. DMHC regulates more than 90 percent of the commercial health care marketplace in California. DMHC also licenses many of the managed care plans that serve enrollees in publicly funded programs, including Medi-Cal and Covered California plans.

DMHC's Help Center provides consumer assistance on health plan issues to ensure that managed health care enrollees receive the medical care and services to which they are entitled. The DMHC Help Center is staffed by state employees. Within the Help Center:

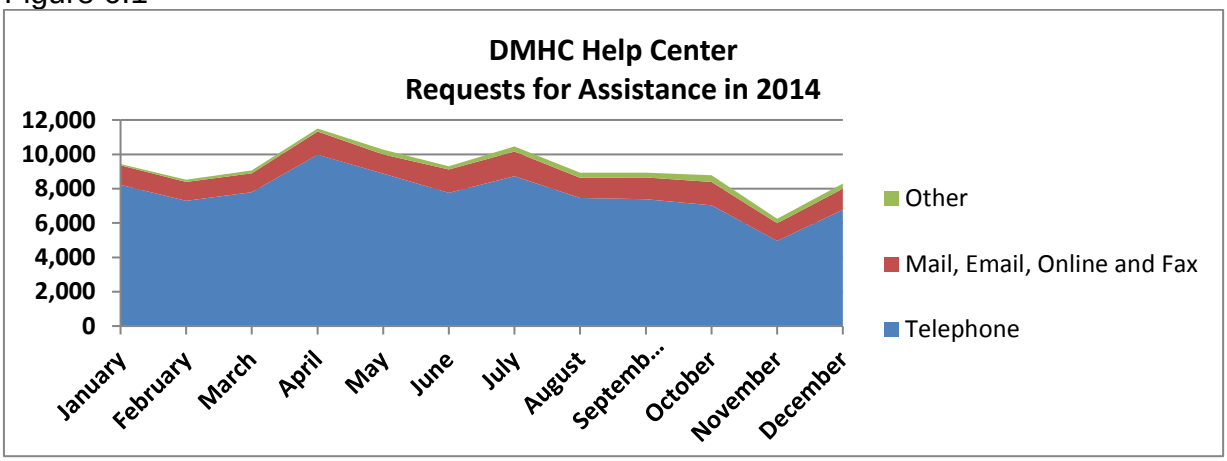
- The Division of Consumer Assistance receives, reviews, and processes all incoming correspondence and telephone calls.
    - The Call Center Branch responds to thousands of calls from consumers requesting general information or assistance.
    - The Initial Review Branch handles all incoming written correspondence, including complaint forms and applications for an Independent Medical Review (IMR).
- The Division of Complaint Management and Clinical Review processes complaint and IMR cases and resolves issues with health plans and their contracted providers.
    - Division nurses address clinical issues and resolve urgent complaints that have been identified as a potential health risk to the consumer.
    - Division staff make determinations on Standard Complaints**.**
    - If Division staff determine that a case meets the criteria for an IMR, a contractor (MAXIMUS) is responsible for conducting the external review and making a decision and communicating that decision to the enrollee.
- The Division of Legal Affairs and Policy Development reviews consumer complaints when needed and determines whether health plans are in compliance with applicable laws.

B. DMHC Consumer Assistance Center

Number of Requests for Assistance by Month and Mode of Contact

The DMHC Help Center received 109,760 requests for assistance from consumers in 2014, mostly (84%) by telephone. The following chart includes consumer contacts for all requests for assistance, including both complaint and inquiry contacts.

Figure 6.1



Note: Other = Language Line and TDD volume

Service Center Telephone Call Metrics

The DMHC Help Center received 92,257 total telephone calls from consumers in 2014. The following table shows the response from DMHC regarding some of its telephone call metrics.

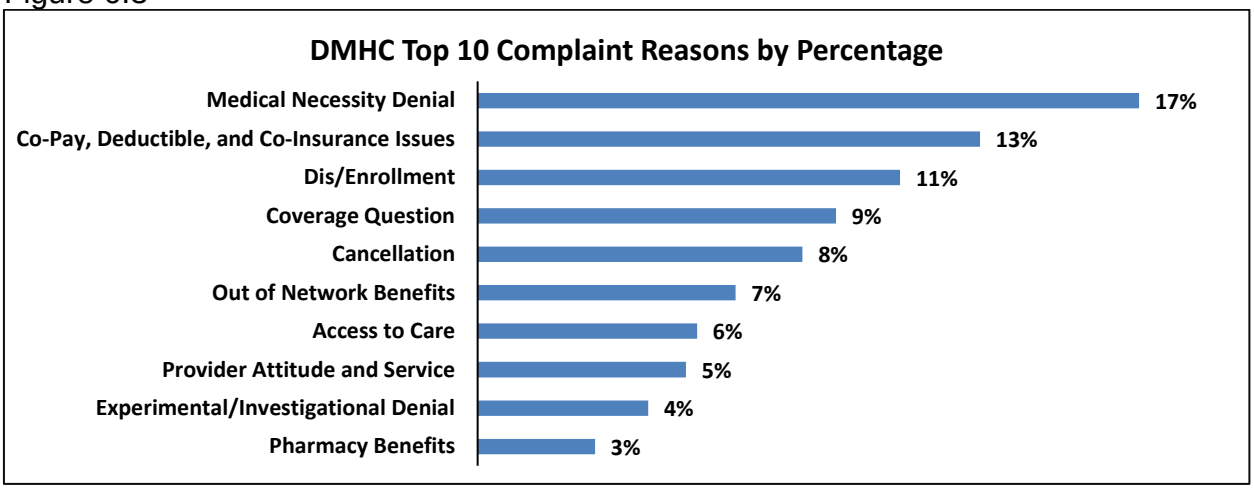
Figure 6.2 **DMHC Help Center – 2014 Metrics**

Metric	Measurement	Reporting Entity Estimated Metric or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	34,470 This includes "positive" abandons where a caller received needed information through the IVR system. DMHC's system cannot presently differentiate positive abandons from those callers that terminate the call prior to reaching a CSR.	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	See above DMHC's system cannot presently differentiate positive abandons from those callers that terminate the call prior to reaching a CSR.	
Number of non-jurisdictional inquiry calls answered by a CSR	7,630 The Call Center utilizes information provided by the consumer to determine if the issue is non-jurisdictional.	Data
Average wait time to reach a CSR	Approximately 18 minutes During the first half of 2014, due to significant increases in call volume, average wait times were significantly higher. By the end of 2014, average call wait times was less than five minutes.	Estimated
Average length of talk time (time between a CSR answering and completing a call)	12:35 minutes This includes jurisdictional and non-jurisdictional complaints. The DMHC system does not allow separate reporting for jurisdictional and non-jurisdictional calls.	Data
Average number of CSRs available to answer calls (during Service Center hours)	From Jan. to May 2014: 9.5 Personnel Years (PYs); From May to Dec. 2014: 14.5 PYs	

Top Ten Reasons for Jurisdictional Complaints

The Top 10 Complaint Reasons shown in the following chart accounted for 11,768 (84%) of all complaint cases closed by DMHC in 2014.

Figure 6.3



Note: Percentage equals 83% due to rounding.

Top Ten Topics for Non-Jurisdictional Inquiries

In 2014, the DMHC Help Center staff responded to 7,630 calls from consumers on topics outside of DMHC's authority to address or resolve. Most of these non-jurisdictional inquiries from consumers pertained to issues regarding Medi-Cal, Covered California, and Medicare coverage.

Figure 6.4

DMHC Help Center Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Referred to
1 (most common)	General Inquiry/Info	Department of Health Care Services (DHCS)
2	Covered California	Covered California
3	Enrollment Disputes	DHCS Covered California
4	Claims/Financial	California Department of Insurance (CDI) Centers for Medicare and Medicaid Services (CMS) Health Insurance Counseling & Advocacy Program (HICAP) Health Consumer Alliance (HCA) partners
5	Coverage/ Benefits Dispute	CDI DHCS U.S. Department of Labor (DOL) HICAP
6	Access Complaints	DHCS CMS HCA partners

Ranking	Inquiry Topic	Referred to
7	Coordination of Care	CMS DHCS HICAP
8	Appeal of Denial - IMR	CDI DOL, ERISA (Employee Retirement Income Security Act) Out-of-State Department of Insurance (DOI)
9	Provider Service/Attitude	California Department of Consumer Affairs DHCS HICAP
10	Plan Service/Attitude	CDI CMS DHCS

Note: Ranking by DMHC based on data.

Consumer Assistance Protocols

The DMHC Help Center has established protocols and performance standards for providing consumer assistance on jurisdictional complaints and for non-jurisdictional referrals. This information is disseminated to Help Center staff through an internal web-based knowledge management system, staff training, and other training tools.

Complaint Protocols

Throughout this report, OPA summarizes complaint protocols based on documentation submitted by the reporting entities. Each reporting entity has different time standards established for completing their complaint review processes, which are determined by applicable statutory and regulatory requirements, as well as internal department policies and procedures. Time standards and resolution times noted in this report are not comparable because of differences in how the reporting entities review consumer complaints and track the initiation and closing of cases.

Figure 6.5
DMHC Help Center Complaint Standards

Complaint Process	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2014
Standard Complaint	*Call Center and Initial Review Branches:* Intake and routing *Complaint Resolution Branch:* Casework *Legal Review and Liaison Branch:* Legal review if needed	30 days from receipt of a completed complaint application	30 days Calculation includes time prior to the completion of the complaint application

Complaint Process	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2014
Independent Medical Review (IMR)	*Call Center and Initial Review Branches:* Intake and routing *Independent Medical and Clinical Review Branch:* Casework *IMR contractor (MAXIMUS):* External Review decision *Legal Review and Liaison Branch:* Legal review if needed	30 days from receipt of a completed IMR application	27 days Calculation includes time prior to the completion of the IMR application
Urgent Clinical	*Call Center and Initial Review Branches:* Intake and routing *DMHC clinical staff:* Casework	7 days from receipt of a completed complaint/IMR application	9 days* Calculation includes time prior to the completion of the complaint/ IMR application
Quick Resolution	*Call Center and Initial Review Branches:* Intake and routing *DMHC clinical staff:* Casework	Standard Complaint or IMR process used if the quick resolution is not possible	7 days

Note: The timeframes for DMHC's time standards are based on the date that the department receives a completed complaint/IMR application. Resolution times were counted from the date that any initial information was received from a consumer. Figures detailing average resolution times are counted from the date that any initial information is received from a consumer.
** DMHC's average resolution time for Urgent Clinical is for reported Urgent Nurse complaints.*

Figure 6.6
DMHC Help Center – Other Protocols

Protocol	Process	Timing (if applicable)
Non-Jurisdictional Referrals	Most referrals are made by the Call Center and Initial Review Branches. Some non-jurisdictional issues are resolved by the Help Center while jurisdiction is being determined.	Referred as soon as the issue is determined to be non-jurisdictional
After-Hours Assistance	After-hours calls are handled by a contracted answering service. • Potentially urgent clinical issues are referred to DMHC clinical staff (a standby nurse) for response. The standby nurse attempts a Quick Resolution, working with established after-hours plan contacts. • Callers with non-urgent issues are encouraged to contact the Help Center during normal business hours. Complaints can be filed online anytime to initiate a Standard Complaint or IMR process.	30 minutes for DMHC to provide a call-back for urgent calls Next business day service for non-urgent calls
Language Assistance	Callers to the Help Center have the option to select their language through the Interactive Voice Response system. Help Center staff use a contracted Language Line to provide interpreter services if needed.	As needed

C. DMHC Complaint Data

Complaint Ratios

The complaint data ratio is used as a performance indicator to compare health plans. Due to variance in the enrollment size among health plans and health programs in California, a complaint ratio allows for a more equitable comparison between small and large health plans and across programs.

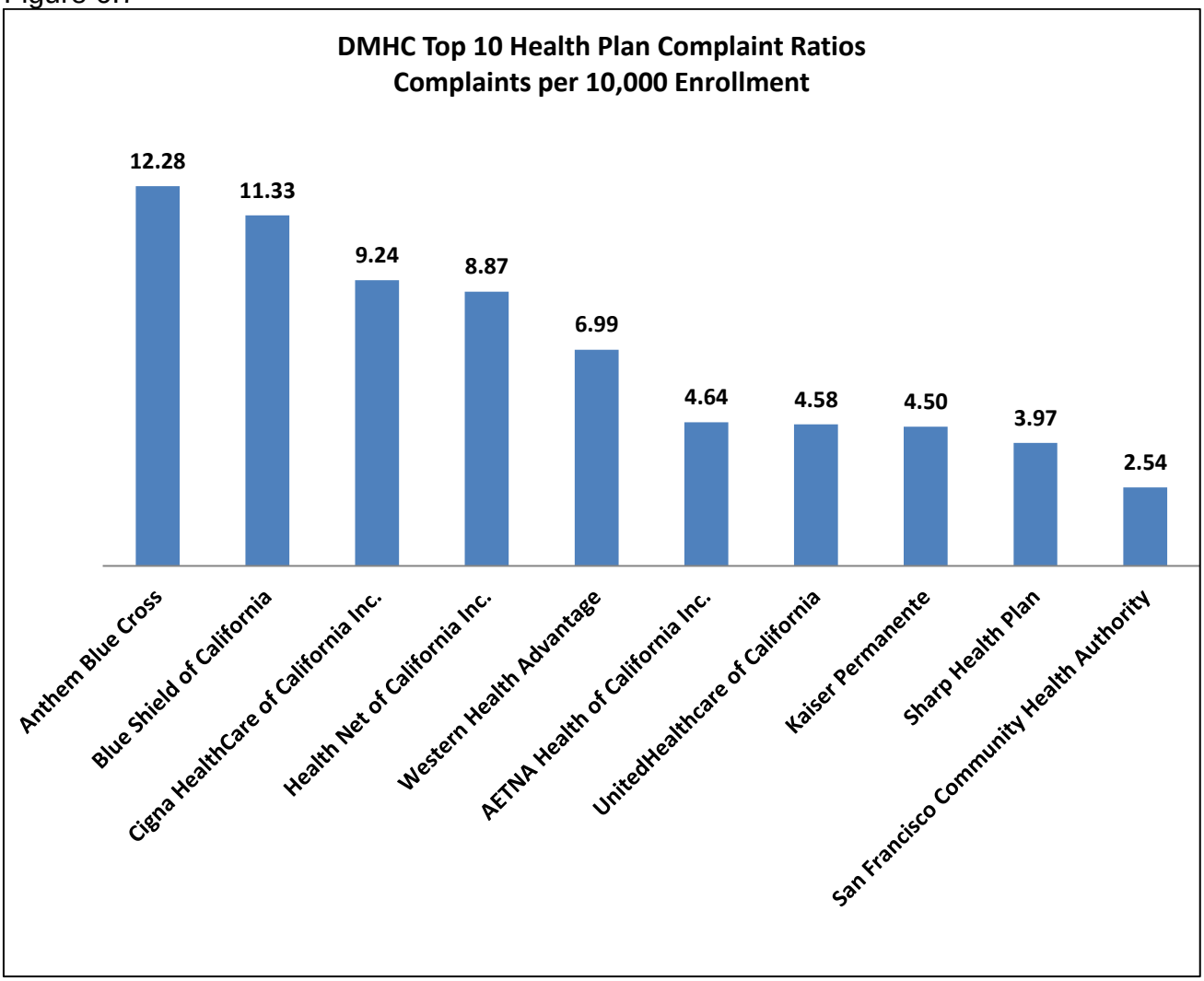
The complaint ratio is calculated by taking the number of closed complaints and dividing it by the number of covered lives the insurer had in place by the end of a specific month in the Spring of 2014. This number is standardized by dividing the ratio by 10,000.

When comparing plans, a lower number of complaints per 10,000 enrollees in a plan indicates that fewer complaints were submitted per capita. A plan with a higher overall number of complaints submitted may still receive fewer complaints per 10,000 enrollees than another plan with fewer overall complaints.

Note that some plans show up in both charts: these plans serve both commercial and Medi-Cal enrollees. The complaint data ratio is used as a performance indicator to compare health plans.

The following chart displays the Top 10 health plan complaint ratios under DMHC's jurisdiction with 2014 enrollment exceeding 70,000 covered lives. There were 63 plans with at least one complaint from the total of 61,813,050 enrollment. This enrollment number likely includes persons enrolled in multiple plans including dental, mental health, and other plan types.

Figure 6.7



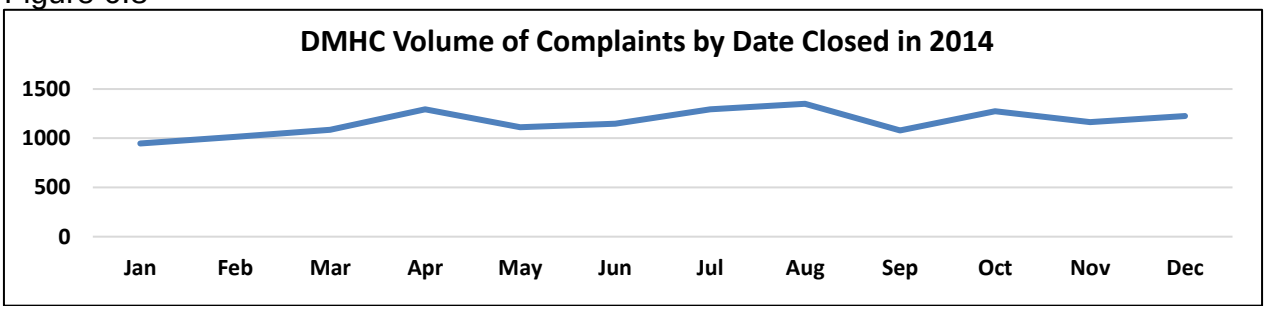
Note: In 2014, the DMHC database's default choice for coverage type was "Small Group". This resulted in an over-reporting of commercial product complaints and an under-reporting of Medi-Cal complaints.

Volume of Closed Complaints

There were 13,994 complaints closed by the DMHC Help Center during 2014. The volume of complaints is the total count of complaints closed in 2014 and does not include cases opened in previous years if they were closed before 2014 or cases opened in late 2014 but closed in 2015.

The volume of complaints is the total count of complaints submitted for the year. The below chart displays the total of 13,994 complaints distributed by month for 2014. These include complaints against health plans that serve commercial and public health plan members, including coverage through Covered California and Medi-Cal Managed Care.

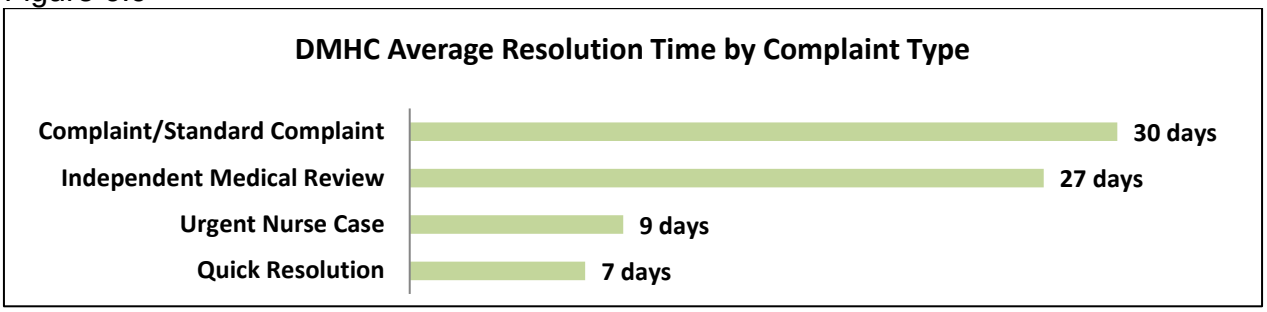
Figure 6.8



Resolution Time

The following three charts display DMHC's average lengths of time to resolve closed complaints in 2014. The resolution time of complaints is calculated by subtracting the date that the complaint was opened from the date the complaint was closed.

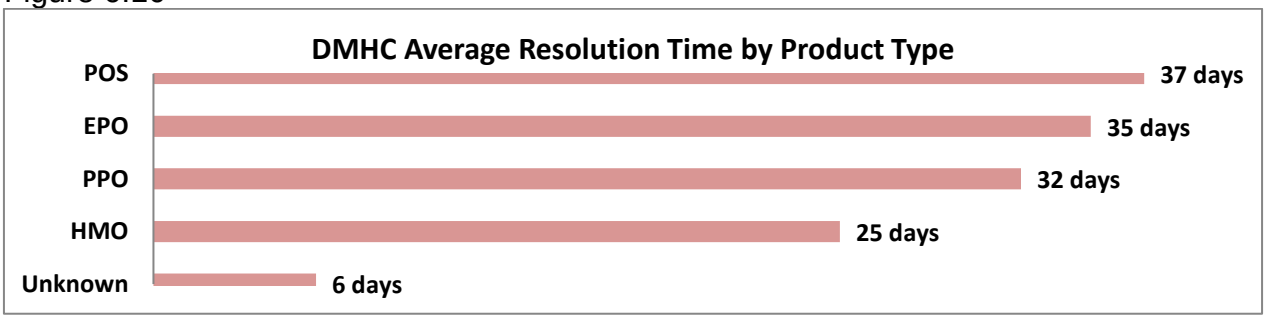
Figure 6.9



Note: These figures detailing average resolution times are counted from the date that any initial information is received from a consumer.

The following chart shows the average length of time to resolve complaints based on the Product Type which includes Point of Sale (POS), Exclusive Provider Organization (EPO), Preferred Provider Organization (PPO), and Health Maintenance Organization (HMO).

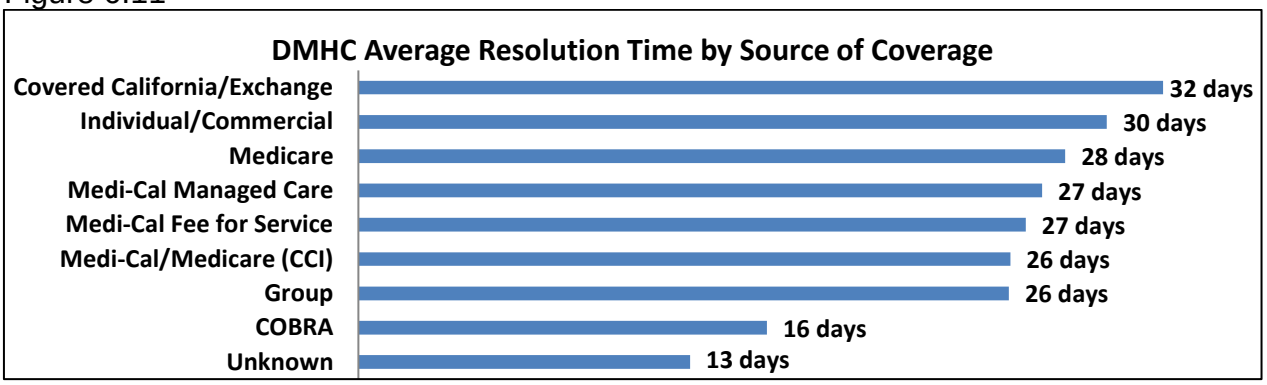
Figure 6.10



Note: These figures detailing average resolution times are counted from the date that any initial information is received from a consumer.

The following chart shows the average length of time for DMHC to resolve complaints based on the Source of Coverage.

Figure 6.11



Note: These figures detailing average resolution times are counted from the date that any initial information is received from a consumer.

Complaint Type

All 13,994 closed complaints were submitted with a Complaint Type: Urgent Nurse Case, Quick Resolution, Independent Medical Review, or Standard Complaint. The most common Complaint Type was Standard Complaint at 9,297 (66%), followed by Independent Medical Review at 3,171 (23%), Quick Resolution at 1,356 (10%), and Urgent Nurse Case at 170 (1%).

Age

Of the 13,994 closed complaint cases submitted, 2,469 were Unknown with respect to age. The top two Complaint Reasons across all age groups were Medical Necessity Denial and Co-Pay, Deductible, and Co-Insurance Issues. The third Complaint Reason across age groups was either Coverage Questions or Dis/Enrollment. For complaints where the age of the complainant was identified as Unknown, the top categories were Cancellation; Dis/Enrollment; and Co-pay, Deductible and Co-Insurance Issues.

Gender

Of the 13,994 complaints closed by the DMHC Help Center in 2014, 6,101 (44%) were made by males, 7,735 (55%) were made by females, and 158 (1%) were gender unknown.

Race and Ethnicity

DMHC did not capture information about race and ethnicity for complaints closed during the 2014 reporting period.

Language

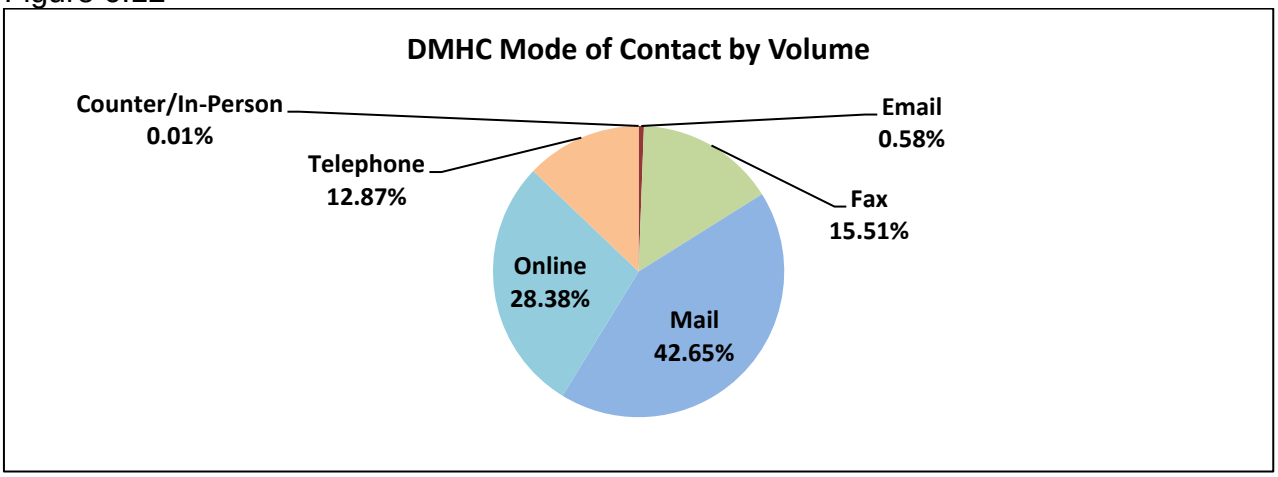
All 13,994 complaints included language information. 13,705 (98%) complaints identified English as their primary language, one percent identified Spanish as their primary language, and one percent identified a language other than English or Spanish as their primary language.

Medical Necessity Denial was the most common complaint for both English and Spanish speakers. Co-Pay, Deductible, and Co-insurance Issues, and Medical Necessity Denials were equally the most common complaints for consumers that identified a language other than English or Spanish.

Mode of Contact

All 13,994 DMHC complaints closed in 2014 included information about the initial mode of contact. Consumers initiated a complaint with DMHC by mail most frequently at 42.65 percent.

Figure 6.12



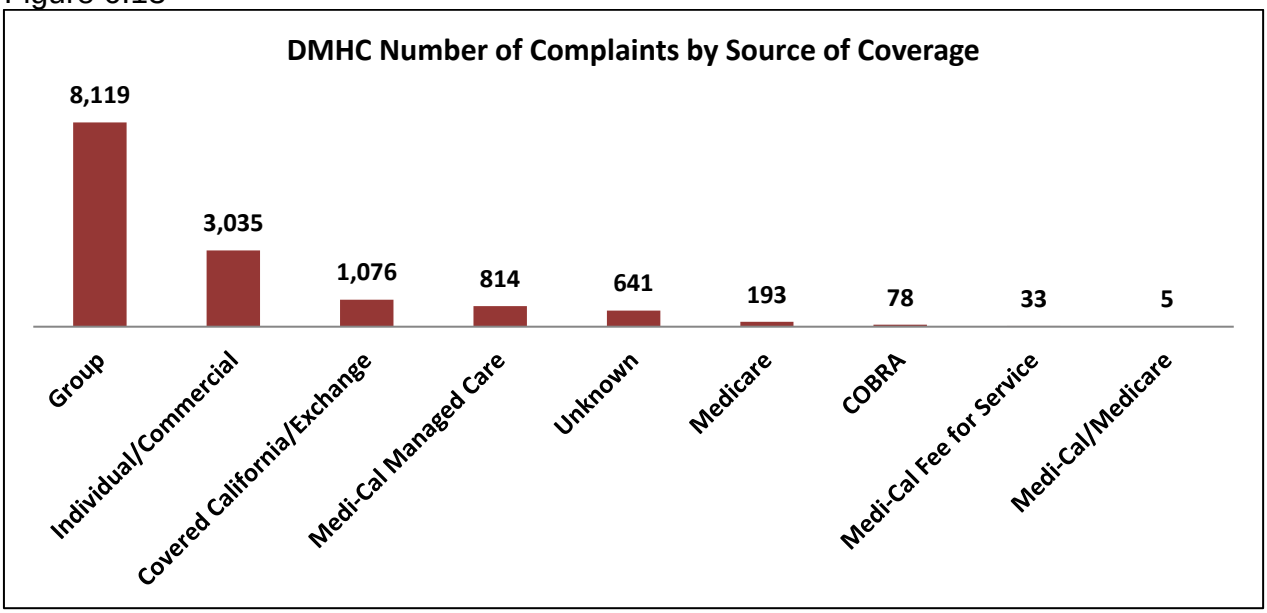
Regulator

All of the 13,994 DMHC complaints closed in 2014 included regulator information for the health plan. DMHC was the state regulator for 95 percent of the complaints it handled, three percent were for coverage regulated by CDI, less than two percent for plans regulated by the federal Department of Labor, and one percent were regulated by Other.

Source of Coverage

Of the 13,994 closed DMHC complaints, 13,365 (95%) included Source of Coverage information. The following chart shows Source of Coverage for complaints closed by DMHC during 2014. Group accounted for 58 percent, followed by Individual/Commercial with 22 percent, Covered California with eight percent, and Medi-Cal Managed Care with six percent. The remaining six percent of complaints were Unknown, Medicare, COBRA, Medi-Cal Fee-for-Service, and Medi-Cal/Medicare.

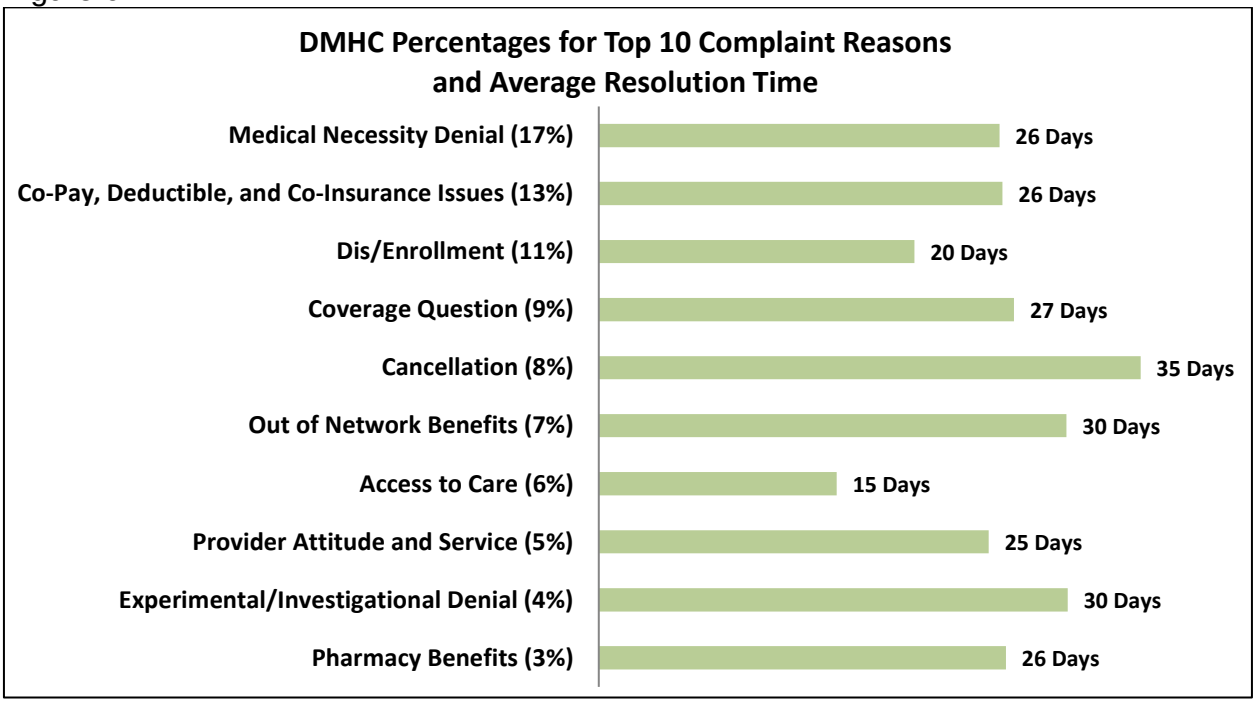
Figure 6.13



Complaint Reasons

The following chart shows the percentages for the ten most frequent complaints reasons and the average number of days for DMHC to close these complaints.

Figure 6.14

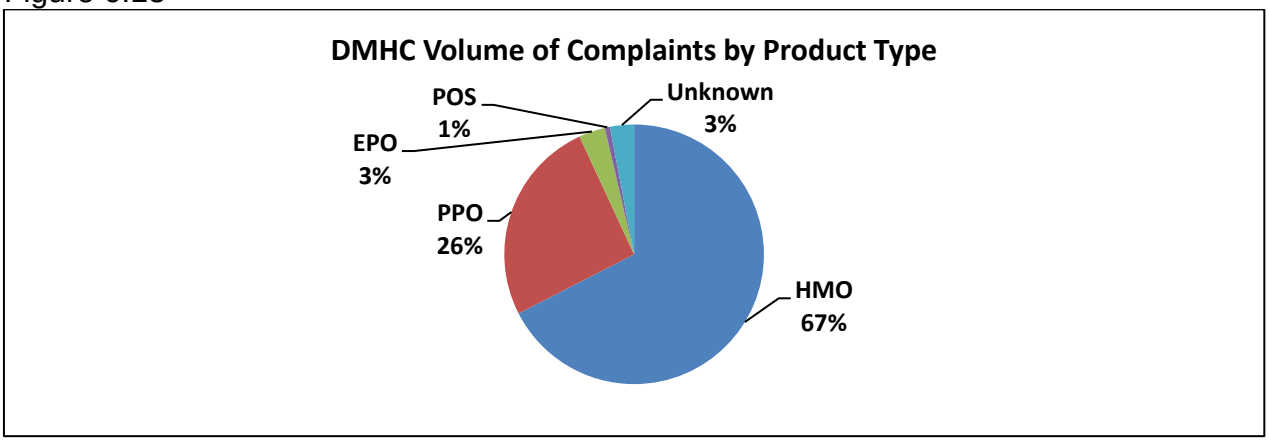


Note: These figures detailing average resolution times are counted from the date that any initial information is received from a consumer.

Volume of Complaints by Product Type

Of the 13,994 complaints closed by DMHC in 2014, 13,575 included information about the Product Type. Complaints about HMOs accounted for 9,442 of all of the complaints submitted, 3,585 were about PPOs, 458 were about EPOs, and 90 were about POS products. 419 of complaints were unknown as to a Product Type.

Figure 6.15



D. DMHC Complaint Data Results

The following table shows all of the 13,994 complaints submitted by DMHC had a complaint result.

Figure 6.16

DMHC Complaint Results

Complaint Result	Volume (Percentage)
Compromise Settlement/Resolution	6,247 (45%)
Claim Settled	1,526 (11%)
Overturned/Health Plan Position Overturned	566 (4%)
Upheld/Health Plan Position Substantiated	879 (6%)
Insufficient Information for Further Investigation	2,641 (19%)
Withdrawn/Complaint Withdrawn	1,747 (12%)
Referred to Other Division for Possible Disciplinary Action	279 (2%)
No Jurisdiction	68 (0.49%)
No Action Requested/Required	41 (0.29%)

Note: The total percentage does not equal 100% due to rounding.
The DMHC utilizes criteria to determine complaint outcomes that does not closely match the NAIC choices. Therefore, the data in this table may not accurately reflect complaint outcomes published by the DMHC.

Section 7 – California Department of Health Care Services

A. Overview

The California Department of Health Care Services (DHCS) provides low income and disabled Californians with access to medical, dental, mental health, and substance use disorder services, as well as long-term services and supports. DHCS administers the federal Medicaid program, known in California as Medi-Cal, and other programs, some of which are mandated by the federal government and others required by state law. About one-third of Californians receive health care services financed or organized by DHCS, making it the largest health care purchaser in California. Within the Medi-Cal program, most beneficiaries receive medical care from a managed care plan.

Medi-Cal Service Centers

DHCS operates or contracts with multiple service centers that provide consumer assistance to beneficiaries in Medi-Cal and other DHCS programs. The California Department of Social Services (CDSS) administers State Fair Hearings for Medi-Cal.

Figure 7.1 **DHCS Service Centers that Reported Inquiry Data to OPA**

Service Center	Primary Audience	Consumer Assistance Role for Eligibility and Enrollment Complaints	Consumer Assistance Role for Health Care Delivery Complaints
Medi-Cal Managed Care Office of the Ombudsman	Medi-Cal managed care plan enrollees	Refers most to: County, Health Care Options, CDSS for Fair Hearing Resolves limited requests made by county offices on behalf of beneficiaries (e.g., for those needing an urgent plan enrollment or disenrollment)	Refers to: Health Plan, CDSS for Fair Hearing, DMHC for IMR
Medi-Cal Telephone Service Center (Fiscal Intermediary Contractor-Xerox)	Medi-Cal fee-for-service providers and beneficiaries	Refers to: County, Medicare, Health Plan	Resolves some complaints regarding claims, billing, and certain other related issues
Medi-Cal Mental Health Ombudsman	Medi-Cal beneficiaries using mental health services	Refers to: County, Health Care Options	Refers to: Provider, DHCS Managed Care Division, DHCS Fiscal Intermediary, CDSS for Fair Hearing, County
Denti-Cal Telephone Service Center (Dental Fiscal Intermediary Contractor-Delta Dental)	Medi-Cal beneficiaries with fee-for-service dental benefits	Refers to: County	Resolves some dental services complaints

Medi-Cal Fair Hearings through the CDSS State Hearings Division

The CDSS State Hearings Division administers State Fair Hearings, a dispute resolution process required by federal and state law for applicants and recipients of public social services, including Medi-Cal.

- The Public Inquiry and Response Bureau (PIAR), within the Human Rights and Community Services Division, records oral requests for State Fair Hearings.
    - PIAR maintains a 24-hour toll-free automated telephone message system to respond to inquiries and complaints from public assistance applicants and/or recipients or their representatives.
    - Medi-Cal beneficiaries are provided notices and communications that include the PIAR phone number to request a State Fair Hearing.
    - PIAR does not provide consumer assistance about Medi-Cal complaints and inquiries, and instead refers people to county offices or the Fiscal Intermediary contractor.
- The State Hearings Division staff arranges hearings and communicates with counties, claimants, and others involved in the hearing process.
- An Administrative Law Judge presides over the hearings and issues a decision.
- For Medi-Cal cases, DHCS may review the judge's decision and issue and implement an alternate decision.

Medi-Cal Managed Care Office of the Ombudsman

The DHCS Medi-Cal Managed Care Office of the Ombudsman's goal is to ensure that Medi-Cal managed care plan members receive all medically necessary covered services for which plans are contractually responsible. The Managed Care Ombudsman provides assistance and guidance to Medi-Cal members to help address complaints regarding health care delivery issues. In addition, after they are contacted by county staff, the Ombudsman staff has the authority to expedite a health plan change, enrollment, or disenrollment for urgent cases that meet certain criteria.

The Ombudsman staff often refers consumers to county offices that administer Medi-Cal for help resolving eligibility and enrollment issues. Consumers also are referred to other organizations for formal complaints, including for the State Fair Hearing process through CDSS or the Independent Medical Review process through DMHC.

The Managed Care Ombudsman is staffed by state employees. Within the Managed Care Operations Division's Internal Operations Branch, the Managed Care Ombudsman consists of two units of analyst staff. The Managed Care Ombudsman analysts:

- Help to resolve issues between Medi-Cal managed care members and managed care health plans;
- Help members with urgent enrollment and disenrollment problems;
- Educate members on how to effectively navigate through the Medi-Cal managed care system;
- Offer information and referrals; and

- Investigate issues with Medi-Cal managed care plans and identify ways to improve the effectiveness of the Medi-Cal managed care program.

Mental Health Ombudsman

The DHCS Mental Health Ombudsman helps Medi-Cal members in need of mental health services navigate through the mental health plan system by providing information and referrals.

The Mental Health Ombudsman is staffed by state employees. Mental Health Ombudsman services are provided by the Beneficiary Support Unit within the DHCS Mental Health Services Division's Program Policy and Quality Assurance Branch. The Beneficiary Support Unit:

- Provides information and assistance to Medi-Cal members seeking mental health services to:
    - Address member concerns or complaints about services;
    - Help members find information in order to access appropriate mental health services; and
    - Connect members with the right person/department to help resolve a problem, local resources in their county, and consumers' rights services.
- Has a role in monitoring access and quality in the Medi-Cal mental health plan system.

The Beneficiary Support Unit was previously known as the Ombudsman Services Unit at the former Department of Mental Health, prior to its transfer to DHCS in July 2012.

Medi-Cal Telephone Service Center

DHCS uses a contractor, Xerox State Healthcare, LLC, to serve as the Fiscal Intermediary (FI) to administer the California Medicaid Management Information System (CA-MMIS). The FI's main role is to process claims submitted by medical providers for services rendered to Medi-Cal Fee-for-Service beneficiaries. To support this role, the FI also operates the Medi-Cal Telephone Service Center, which is sometimes referred to as the Medi-Cal Member and Provider Helpline.

The DHCS CA-MMIS Division is responsible for all activities associated with usage of the CA-MMIS, including the overall administration, management, oversight and monitoring of the FI contract and all services provided under the contract. The FI contractor operates and maintains Medi-Cal Telephone Service Center to:

- Provide education and assistance to Medi-Cal beneficiaries regarding program billing, share-of-cost obligations, and related issues.
- Provide support to medical and pharmacy providers who use automated systems for billing, treatment and other information for Medi-Cal.
- Help providers understand Medi-Cal billing policies and procedures, provider manual information, and claims forms.

Denti-Cal Beneficiary Telephone Service Center (Contractor – Delta Dental)

The Denti-Cal Beneficiary Telephone Service Center is operated by the dental Fiscal Intermediary (FI) contractor, Delta Dental of California. The DHCS Medi-Cal Dental Services Division contracts with the dental FI to manage Fee-for-Service dental benefits for members of Medi-Cal and other DHCS programs. In support of its main functions for processing authorizations and claims, the dental FI contractor operates the Denti-Cal Telephone Service Center, which has separate telephone lines to serve beneficiaries and dental providers.

The Denti-Cal Telephone Service Center provides information to beneficiaries on:

- Dental providers who accept Medi-Cal;
- Clinical screening appointments;
- Dental share-of-cost and co-payments;
- A Treatment Authorization Request (TAR) or related denial notice;
- General information about covered services; and
- How to file a grievance/complaint.

Telephone Service Center staff may refer the beneficiary to individual dental providers, route complaints to supervisors or designated complaints analysts for additional research and response, or mail the beneficiary a complaint form to complete if more information is needed.

- Beneficiaries are usually directed to make their initial complaint to their dental provider as the first step for resolution of issues regarding scope of benefits, quality of care, modification or denial of a TAR, or other aspect of service.
- If a beneficiary is unable to resolve the complaint working with their dental provider, he or she can then register a complaint with the Denti-Cal program through the Telephone Service Center by phone or by submitting a Beneficiary Medi-Cal Dental Program Complaint Form.

Other Consumer Assistance Resources for Medi-Cal Beneficiaries

Some DHCS service centers reported that they also refer Medi-Cal beneficiaries to the organizations described below.

County Offices

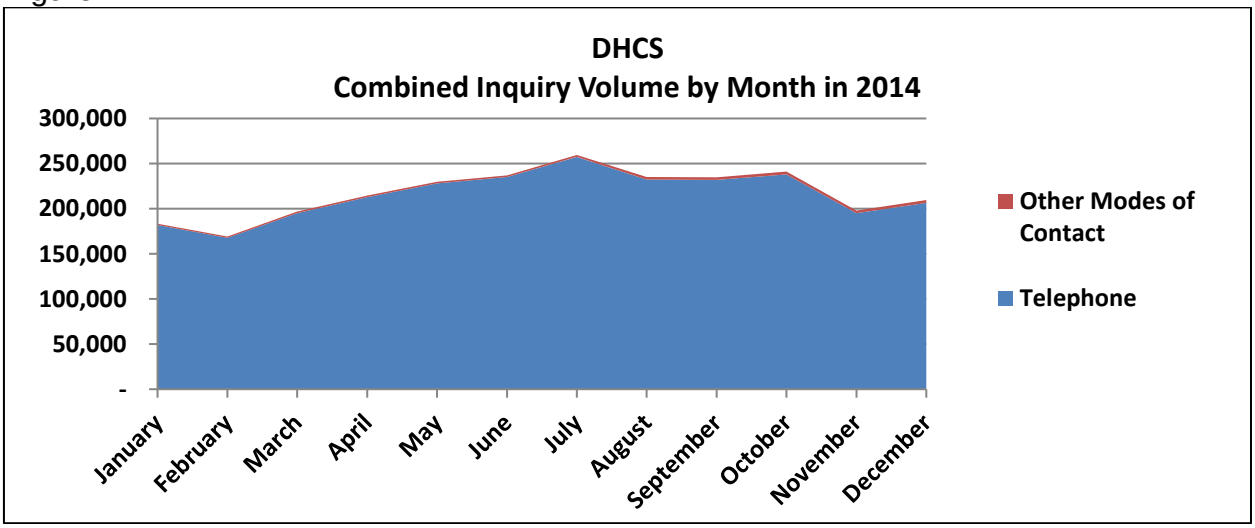
The county offices that administer Medi-Cal eligibility related services are often the first point of contact when a consumer is having problems with Medi-Cal. These offices are typically a part of a county social service or health services department. Beneficiaries report to county eligibility workers for a number of reasons including to report if they: have moved; income has changed; lost their Beneficiary Identification Card; want to appeal a Medi-Cal decision or request a State Fair Hearing; and other issues. The county eligibility worker has the authority to make changes to records that affect a beneficiary's program eligibility and ability to use Medi-Cal health benefits.

Health Care Options (DHCS staff and contracted call center)
DHCS's Health Care Options (HCO) enrollment broker contractor, MAXIMUS, is responsible for processing Medi-Cal medical and dental managed care plan enrollments after beneficiaries have been determined eligible for Medi-Cal by the county. The HCO contractor also is responsible for handling Medical Exemption Requests from Medi-Cal beneficiaries. This contractor provides consumer assistance to Medi-Cal and Cal MediConnect beneficiaries through a call center, by mailing informational materials, and by offering additional education and outreach services to help beneficiaries make plan choices.

B. Department of Health Care Services Consumer Assistance Service Centers

The following chart includes consumer assistance volumes of four DHCS service centers: the Managed Care Ombudsman, Mental Health Ombudsman, Denti-Cal Telephone Service Center, and Medi-Cal Telephone Service Center. This chart reflects inquiries made by consumers, primarily by telephone, and does not include complaints.

Figure 7.2



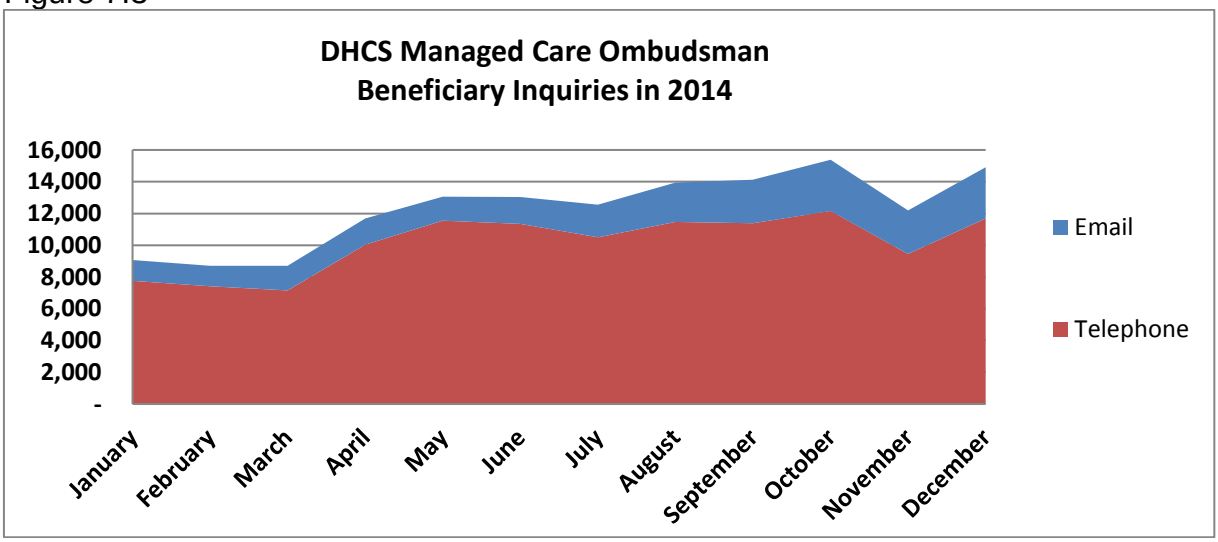
Note: This chart combines consumer inquiry volumes reported by the DHCS Medi-Cal Managed Care Ombudsman, Mental Health Ombudsman, Denti-Cal Telephone Service Center, and Medi-Cal Telephone Service Center. The Managed Care Ombudsman volume reflects consumer assistance provided to Medi-Cal beneficiaries, and does not include general consumer contacts.

B. I. Department of Health Care Services Managed Care Ombudsman Consumer Assistance

Requests for Assistance by Month and Mode of Contact

DHCS reported all consumer requests for assistance made to the Managed Care Ombudsman as inquiries. The following chart displays the 147,352 inquiries received by the Managed Care Ombudsman from Medi-Cal beneficiaries via telephone and email in 2014.

Figure 7.3



Service Center Telephone Call Metrics

The Managed Care Ombudsman received 121,937 telephone calls from Medi-Cal beneficiaries in 2014. The following table shows the response from DHCS regarding some of the Managed Care Ombudsman's telephone call metrics. DHCS indicated that data was unavailable for a number of call metrics due to phone system limitations.

Figure 7.4

DHCS Medi-Cal Managed Care Office of the Ombudsman – 2014 Telephone Metrics

Metric	Measurement	Reporting Entity Estimated Metric or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	N/A	N/A
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	N/A	N/A
Number of non-jurisdictional inquiry calls answered by a CSR	N/A	N/A
Average wait time to reach a CSR	Not tracked. Max allowable is 13 minutes on hold then call is routed to voicemail	N/A
Average length of talk time for jurisdictional complaints (time between a CSR answering and completing a call)	Not applicable	Not applicable
Average length of talk time for non-jurisdictional inquiries (time between a CSR answering and completing a call)	5-10 min	Estimated
Average number of CSRs available to answer calls (during Service Center hours)	10 permanent, 1 Limited-Term, 9 re-directed resources, 5 temporary staff	Data

Note: N/A is not available.

Top Ten Topics for Non-Jurisdictional Inquiries

The following table lists the most common consumer inquiries received by the Managed Care Ombudsman that were referred to other organizations or DHCS entities to address or resolve.

Figure 7.5
DHCS Managed Care Ombudsman Top Ten Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Referred to
1 (most common)	Medi-Cal Eligibility	County Medi-Cal Office
2	Fair Hearings	California Department of Social Services
3	Social Security/ Medicare	Social Security Administration/ 1-800-Medicare
4	Medi-Cal Fee-For-Service	DHCS Fee-For-Service Help line
5	Estate Recovery	DHCS Estate Recovery
6	Other Health Coverage addition/ removal from record	DHCS Other Health Coverage Website
7	Covered California	Covered California
8	Independent Medical Review/ Commercial health plan (not Medi-Cal)	Department of Managed Health Care
9	Denti-Cal	Denti-Cal
10	Mental Health	County Mental Health office

Note: Ranking estimated by DHCS.

Consumer Assistance Protocols

The Managed Care Ombudsman protocols are outlined in staff training materials that address its Customer Relationship Management System; processes for health plan changes, enrollments, disenrollments, and hold removals; and referral resources.

Figure 7.6
DHCS Managed Care Ombudsman Protocols

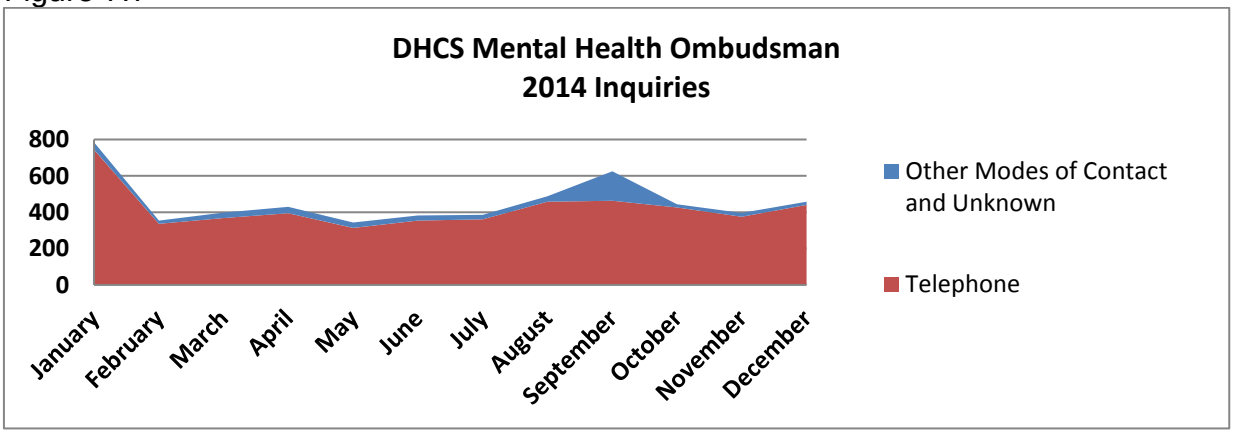
Protocol	Process	Timing (if applicable)
Non-Jurisdictional Referrals	Ombudsman analysts answer calls and emails and determine appropriate referral.	Referred as soon as the issue is determined to be non-jurisdictional
After-Hours Assistance	After-hours calls go to a voicemail system. Ombudsman analysts respond to emails and voicemails during regular business hours.	Response during regular business hours
Language Assistance	Not reported	

B. II. Department of Health Care Services Mental Health Ombudsman Consumer Assistance

Requests for Assistance by Month and Mode of Contact

DHCS reported all consumer requests for assistance made to the Mental Health Ombudsman as inquiries, because this service center's primary role is to educate consumers and refer them to other complaint resolution resources. The Mental Health Ombudsman received 5,487 inquiries in 2014.

Figure 7.7



Service Center Telephone Call Metrics

The Mental Health Ombudsman received 5,036 total telephone calls in 2014. The following table shows the DHCS response regarding some of the Mental Health Ombudsman's telephone metrics.

Figure 7.8

DHCS Mental Health Ombudsman – 2014 Telephone Metrics

Metric	Measurement	Reporting Entity Estimated Metric or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	283	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	0	
Number of non-jurisdictional inquiry calls answered by a CSR	3,525	Estimated
Average wait time to reach a CSR	0	Data
Average length of talk time for jurisdictional complaints (time between a CSR answering and completing a call)	N/A	N/A
Average length of talk time for non-jurisdictional inquiries (time between a CSR answering and completing a call)	3 minutes	Estimated
Average number of CSRs available to answer calls (during Service Center hours)	3	Data

Note: N/A is not applicable.

Top Ten Topics for Non-Jurisdictional Inquiries

The following table lists the most common consumer inquiries received by the Mental Health Ombudsman that were referred to other organizations or DHCS entities to address or resolve.

Figure 7.9
DHCS Mental Health Ombudsman Top Ten Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Referred to
1 (most common)	Status of Medi-Cal application	County Medi-Cal Office
2	Disenrollment	County Medi-Cal Office
3	Remove Hold	Managed Care Division
4	Enrollment	Health Care Options
5	Replace Beneficiary Identification Card	County Medi-Cal Office
6	Substance Use Disorders	County Social Services
7	Conservatorship	County Guardian Office
8	Prescriptions	Provider
9	Housing	County Social Services
10	Treatment Authorization Request (TAR)	Xerox (DHCS Fiscal Intermediary)

Note: Ranking estimated by DHCS.

Consumer Assistance Protocols

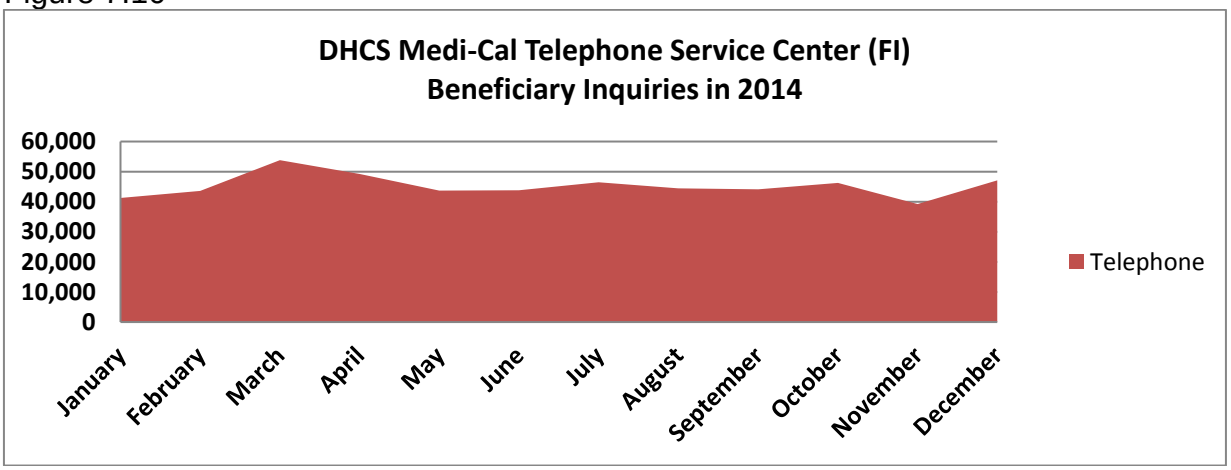
DHCS indicated that its Mental Health Ombudsman has a Policy & Procedure Manual, which DHCS was unable to provide in time for this report and which includes consumer assistance protocols, performance standards, language assistance procedures, and referral tools.

B. III. Medi-Cal Telephone Service Center Consumer Assistance

Requests for Assistance by Month and Mode of Contact

DHCS reported all consumer requests for assistance made to the Fiscal Intermediary's Medi-Cal Telephone Service Center as inquiries. This service center answered 542,792 telephone inquiries from beneficiaries in 2014. This volume does not include abandoned calls or calls resolved by the service center's Interactive Voice Response system without reaching a customer service representative.

Figure 7.10



Service Center Telephone Call Metrics

The Medi-Cal Telephone Service Center answered 542,792 total telephone calls from beneficiaries in 2014. The following table shows the response from DHCS regarding some of the Medi-Cal Telephone Service Center's telephone metrics.

Figure 7.11

DHCS Medi-Cal Telephone Service Center – 2014 Telephone Metrics

Metric	Measurement	Reporting Entity Estimated Metric or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	61,837*	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	1,798,398*	Data
Number of non-jurisdictional inquiry calls answered by a CSR	542,792	Data
Average wait time to reach a CSR	1:57	Data
Average length of talk time for jurisdictional complaints (time between a CSR answering and completing a call)	N/A	N/A
Average length of talk time for non-jurisdictional inquiries (time between a CSR answering and completing a call)	3:59	Data
Average number of CSRs available to answer calls (during Service Center hours)	65	Data

Note: N/A is not applicable.

**The number of abandoned calls and the number of calls resolved by the IVR/phone system include calls from both Medi-Cal beneficiaries and Medi-Cal providers. The beneficiary data cannot be separated.*

Top Ten Topics for Non-Jurisdictional Inquiries

The following table lists the most common consumer inquiries received by the Medi-Cal Telephone Service Center that are outside its authority and referred to other organizations or DHCS entities.

Figure 7.12

DHCS Medi-Cal Telephone Service Center Top Ten Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Referred to
1 (most common)	Beneficiary Inquiry/Eligibility	County Office
2	Beneficiary Inquiry/Eligibility	Managed Care Plan
3	Beneficiary Inquiry/Eligibility	Denti-Cal
4	Beneficiary Inquiry/Eligibility	Medicare
5	Beneficiary Inquiry/Coverage	Pharmacy
6	Beneficiary Inquiry/Coverage	Medicare Part D
7	Beneficiary Inquiry/Coverage	Other Coverage
8	Provider Application Status	Provider Enrollment
9	Beneficiary Inquiry/Coverage	Low-Income Subsidy
10	Technical	Vendor

Note: Ranking by DHCS based on data.

Consumer Assistance Protocols

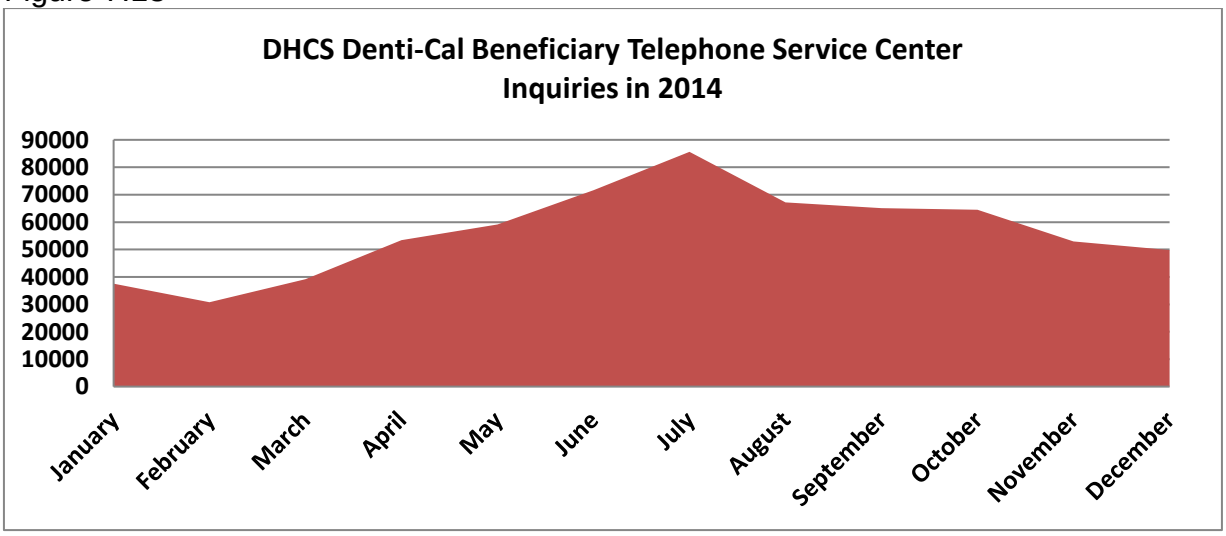
The Medi-Cal Telephone Service Center did not report information on its protocols or performance standards.

B. IV. Denti-Cal Beneficiary Telephone Service Center Consumer Assistance

Requests for Assistance by Month and Mode of Contact

DHCS reported all consumer requests for assistance made to the Denti-Cal Beneficiary Telephone Service Center as inquiries. This service center received 676,837 inquiries from consumers in 2014. Nearly all inquiries (99.9%) were received by telephone.

Figure 7.13



Service Center Telephone Call Metrics

The Denti-Cal Beneficiary Telephone Service Center received 676,394 total telephone calls in 2014 from consumers. The following table shows the response from DHCS regarding some of this service center's telephone metrics.

Figure 7.14
DHCS Denti-Cal Beneficiary Telephone Service Center - 2014 Telephone Metrics

Metric	Measurement	Reporting Entity Estimated Metric or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	100,670	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	358,315	Data
Number of non-jurisdictional inquiry calls answered by a CSR	217,409	Data
Average wait time to reach a CSR	0:03:54	Data
Average length of talk time for jurisdictional complaints (time between a CSR answering and completing a call)	N/A	N/A
Average length of talk time for non-jurisdictional inquiries (time between a CSR answering and completing a call)	0:06:18	Data
Average number of CSRs available to answer calls (during Service Center hours)	74	Data

Note: N/A is not applicable.

Top Topics for Non-Jurisdictional Inquiries

The following table lists the most common consumer inquiries received by the Denti-Cal Beneficiary Telephone Service Center.

Figure 7.15
DHCS Denti-Cal Beneficiary Telephone Service Center Top Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Referred to
1 (most common)	Referrals	County Medi-Cal Office, etc.
2	General Program Information	N/A
3	Eligibility Question	N/A
4	Status of Service Request	N/A
5	Share of Cost	N/A
6	Beneficiary Reimbursement	N/A

Note: Rankings estimated by DHCS.

Consumer Assistance Protocols

The contractor for the Denti-Cal Beneficiary Telephone Service Center has documented written protocols and standards for providing consumer assistance on inquiries, and for maintaining related records.

Figure 7.16
DHCS Denti-Cal Beneficiary Telephone Service Center Protocols

Protocol	Process	Timing (if applicable)
Non-Jurisdictional Referrals	Contractor telephone service representatives determine appropriate referral if possible during the initial call. If additional research is needed, the inquiry may be routed to an inquiry specialist, supervisor, or correspondence specialist for response.	Referred as soon as the issue is determined to be non-jurisdictional
After-Hours Assistance	Voicemail system for the Denti-Cal Beneficiary Telephone Service Center is checked daily by contractor staff	
Language Assistance	Delta Dental uses a contracted Language Line to assist in serving Denti-Cal beneficiaries with limited English proficiency	

B. V. Medi-Cal Fair Hearing through CDSS

Complaint Protocols

Throughout this report, OPA summarizes complaint protocols based on documentation submitted by the reporting entities. Each reporting entity has different time standards established for completing their complaint review processes, which are determined by applicable statutory and regulatory requirements, as well as internal department policies and procedures. Time standards and resolution times noted in this report are not comparable because of differences in how the reporting entities review consumer complaints and track the initiation and closing of cases.

Figure 7.17
Medi-Cal Fair Hearing Standards

Complaint Process	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2014
State Fair Hearing	*CDSS State Hearings Division:* Conducts hearings on Medi-Cal appeals. Administrative Law Judges make decisions.	90 days from the hearing request date	77 days (Managed Care) 31 days (Dental) 66 days (Mental Health)
Urgent Clinical	Cases involving urgent clinical issues may qualify for an expedited Fair Hearing process.	Not reported	Not reported

Note: State Fair Hearing time standard from All County Letter 14-14 issued by CDSS on 2/7/14.

C. DHCS Complaint Data

Complaint Ratios

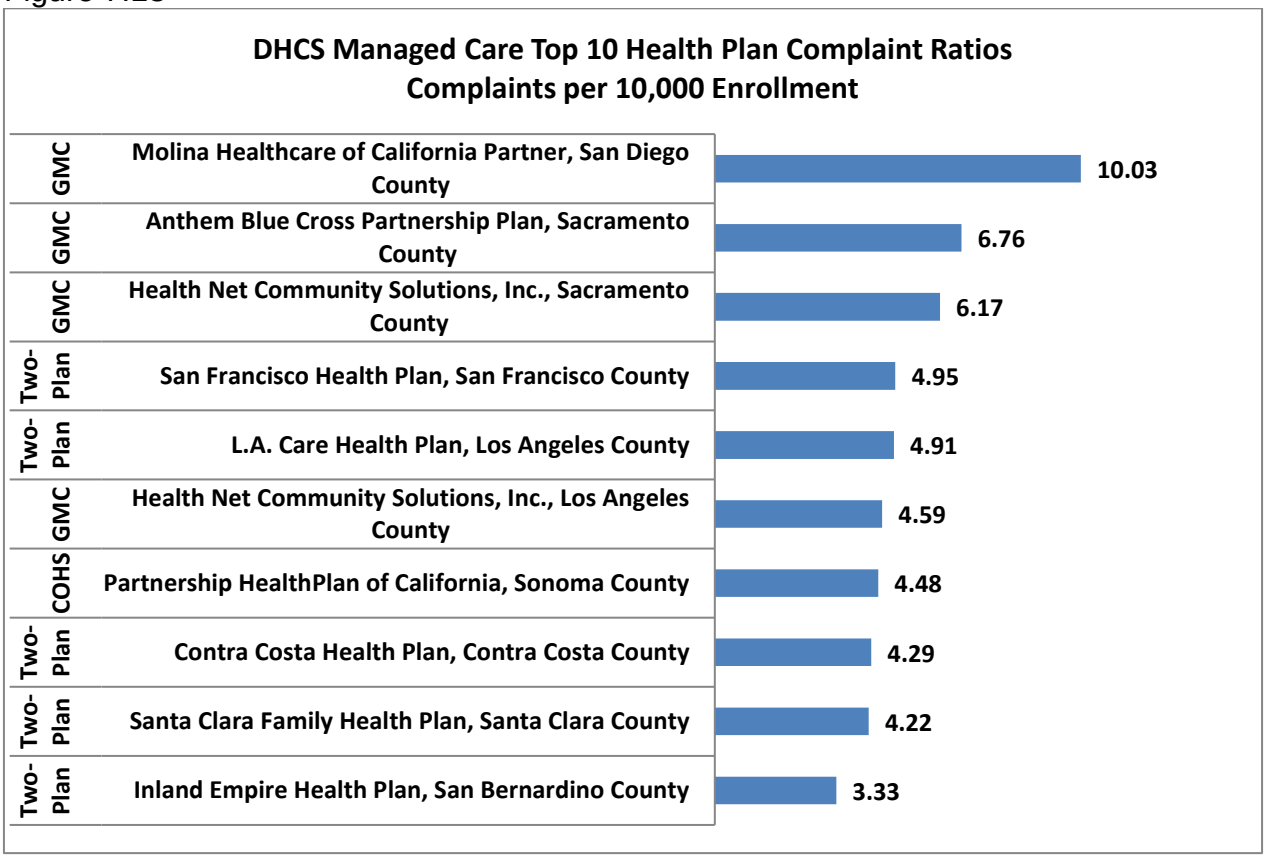
The complaint data ratio is used as a performance indicator to compare health plans. Due to variance in the enrollment size among health plans and health programs in California, a complaint ratio allows for a more equitable comparison between small and large health plans and across programs.

The complaint ratio is calculated by taking the number of closed complaints and dividing it by the number of covered lives the insurer had in place by the end of a specific month in the Spring of 2014. This number is standardized by dividing the ratio by 10,000.

When comparing plans, a lower number of complaints per 10,000 enrollees in a plan indicates that fewer complaints were submitted per capita. A plan with a higher overall number of complaints submitted may still receive fewer complaints per 10,000 enrollees than another plan with fewer overall complaints.

In the chart below, the Managed Care complaint ratios are displayed by the Top 10 Health Plans exceeding 70,000 covered lives. There were 88 plans with at least one complaint from the total of 21,376,642 enrollment.

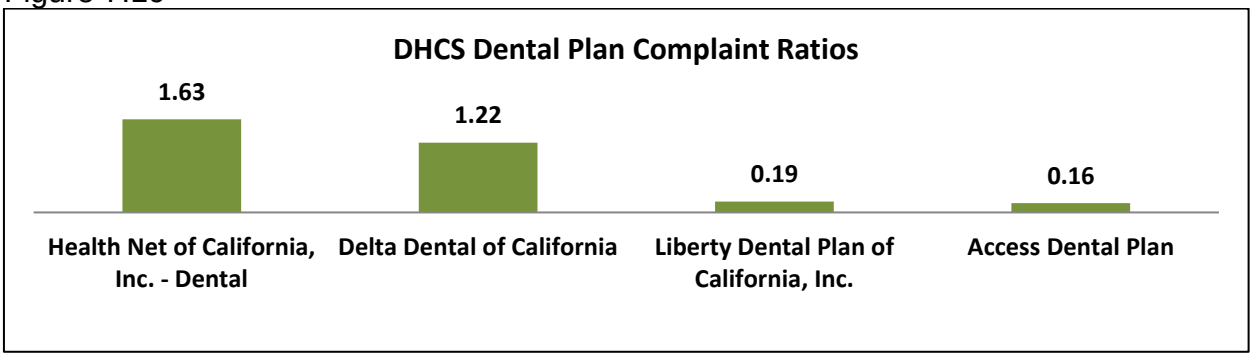
Figure 7.18



Note: Displayed health plans have over 70,000 enrollees

In the chart below, the Dental complaint ratios are displayed by the DHCS Dental Plans. The complaint ratio is calculated by taking the number of closed complaints and dividing it by the number of covered lives the insurer had in place by the end of a specific month in the Spring of 2014. This number is standardized by dividing the ratio by 10,000.

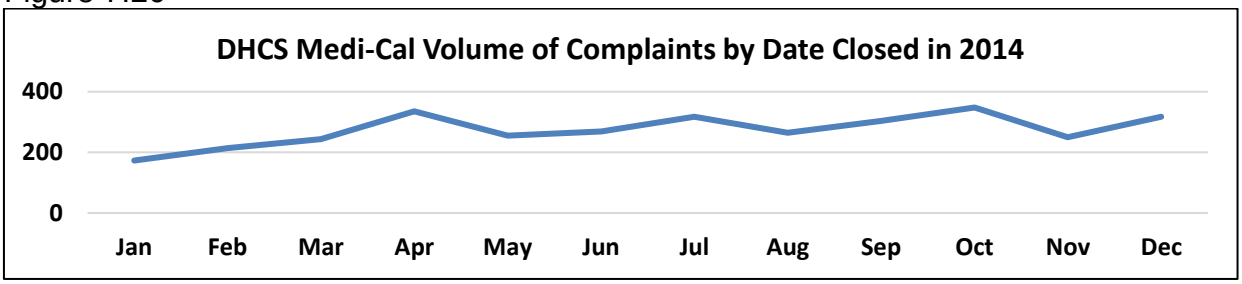
Figure 7.19



Volume of Closed Complaints

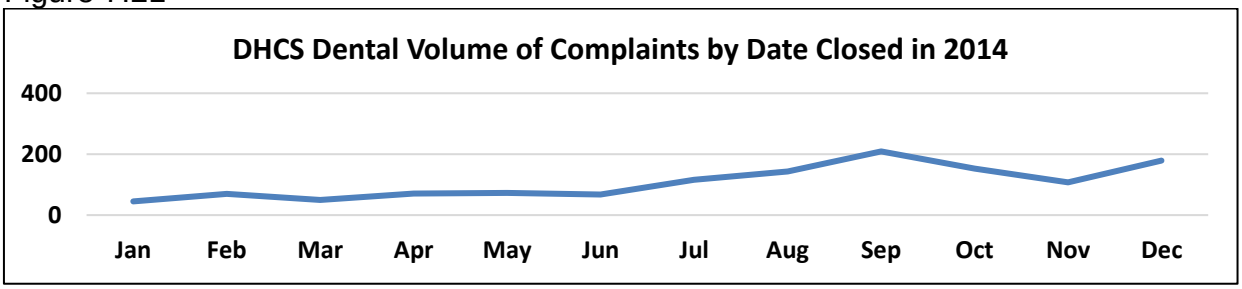
The volume of complaints is the total count of complaints closed in 2014 and does not include cases opened in previous years if they were closed before 2014 or cases opened in late 2014 but closed in 2015. The volume of complaints is the total count of complaints submitted for the year. The chart below displays the total of 3,291 complaints distributed by month for 2014.

Figure 7.20



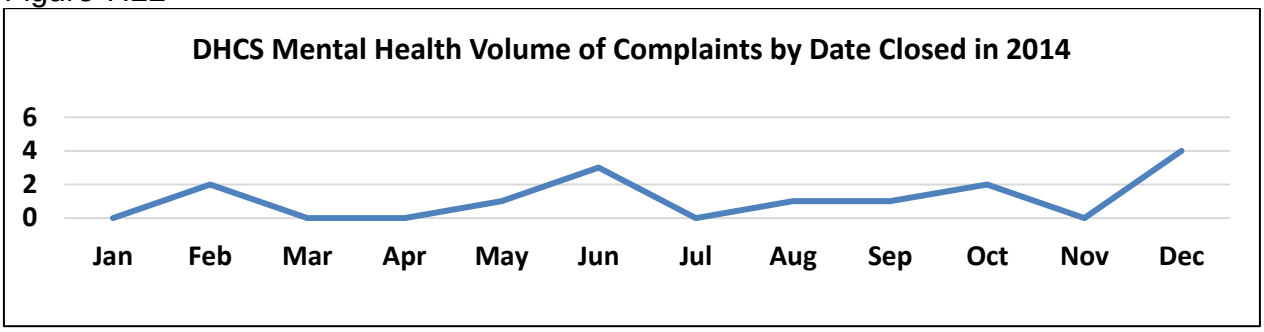
The chart below displays the total of 1,284 DHCS Dental complaints distributed by month for 2014.

Figure 7.21



The chart below displays the total of 14 DHCS Mental Health complaints distributed by month for 2014.

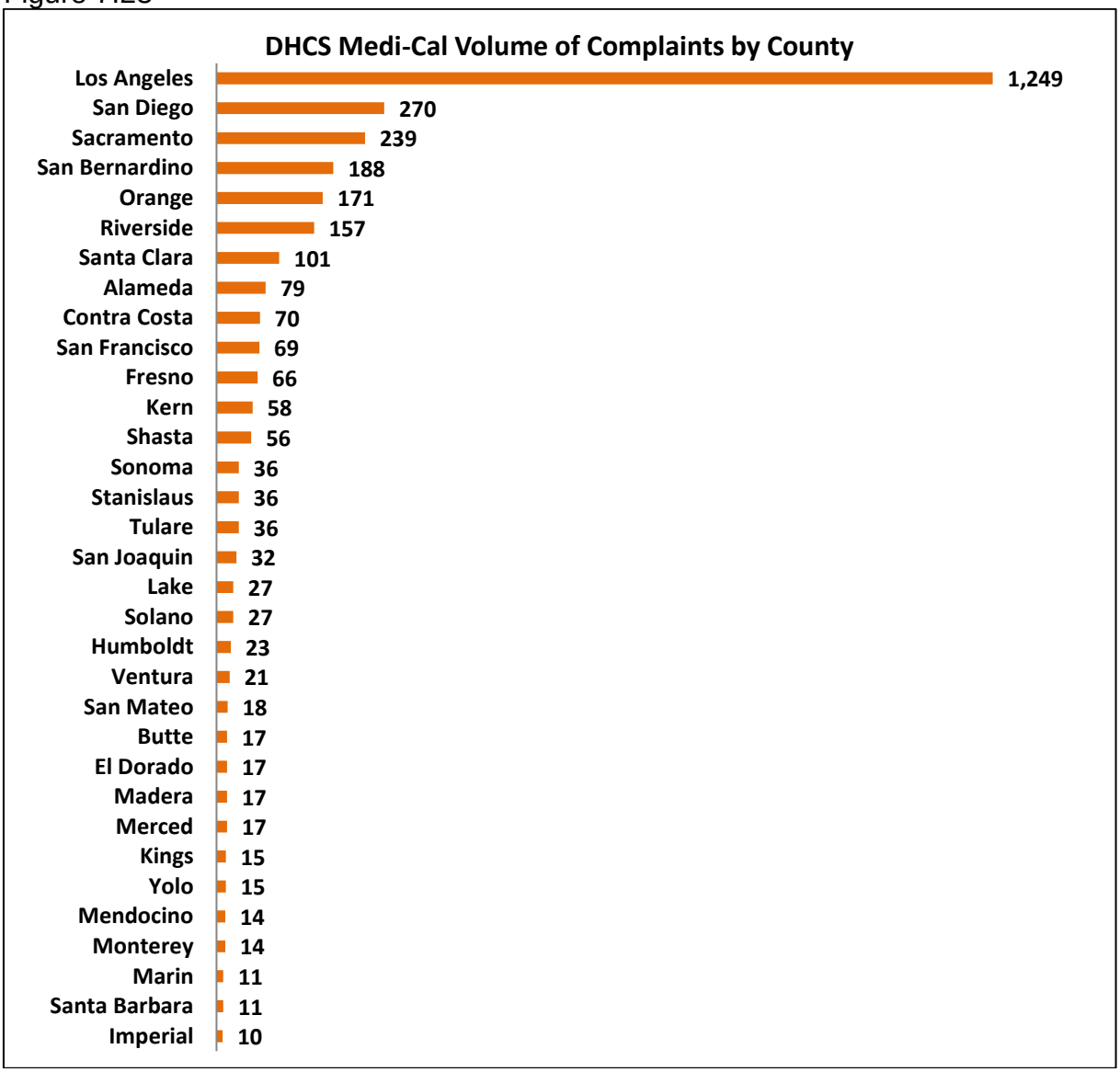
Figure 7.22



Volume of Complaints by County

The following chart displays the volume of complaints by county. The counties not shown each have fewer than ten complaints. There are three complaints with an Unknown county.

Figure 7.23



Note: Counties not shown, which each received fewer than ten complaints, are: Amador, Calaveras, Colusa, Del Norte, Glenn, Inyo, Lassen, Mariposa, Modoc, Napa, Nevada, Placer, San Benito, San Luis Obispo, Santa Cruz, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

Complaint Type

All of the DHCS complaints submitted had the Complaint Type of CDSS State Fair Hearing. The average length of time for DHCS complaints to be resolved based on Type of Complaint is 77 days.

Age

DHCS submitted 3,289 Medi-Cal complaints with an age identified. The majority of complaints are from consumers aged 35 – 54. There were two Unknown age complaints. The complaint reasons for age groups under age 18 through 54 were identical in order of frequency as follows:

1. Quality of Care
2. Plan Subcontractor/Provider Billing/Reimbursement Issue
3. Dis/enrollment
4. Other
5. Access to Care

The complaint reasons were similar in order for the age group 55 – 74 except with Access to Care and Other reversed. For the age group over 74, complaint reasons were Quality of Care, Other, Dis/enrollment, and Plan Subcontractor/Provider Billing/Reimbursement Issue.

Gender, Race, Ethnicity, Language

DHCS did not submit complaint data that identified these categories.

Mode of Contact

Of the 3,291 DHCS Medi-Cal complaints submitted only one identified a Mode of Contact. The known Mode of Contact was by email with the remainder Unknown.

The Dental and Mental Health complaints submitted did not identify the Mode of Contact.

Regulator

DHCS Medi-Cal submitted 3,289 complaints with an identified health plan regulator. DMHC was identified as regulator of 2,294 complaints and 995 were identified as Other. There were two complaints where the regulator was Unknown.

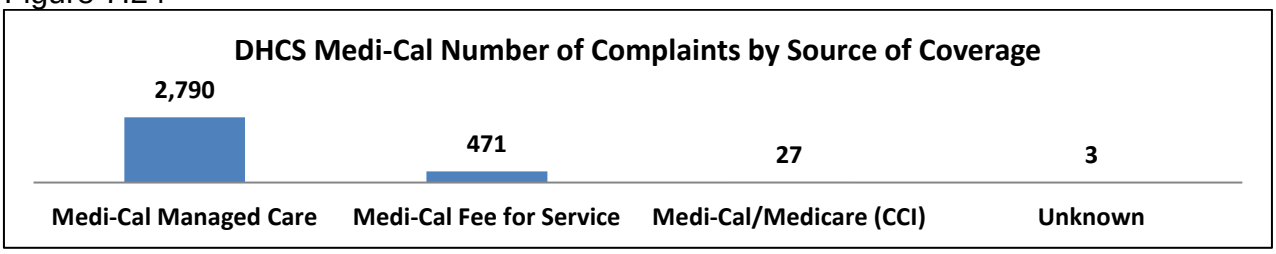
The Dental complaints submitted identified DMHC as the regulator with an average resolution time of 31 days.

The Mental Health complaints submitted did not identify a regulator.

Source of Coverage

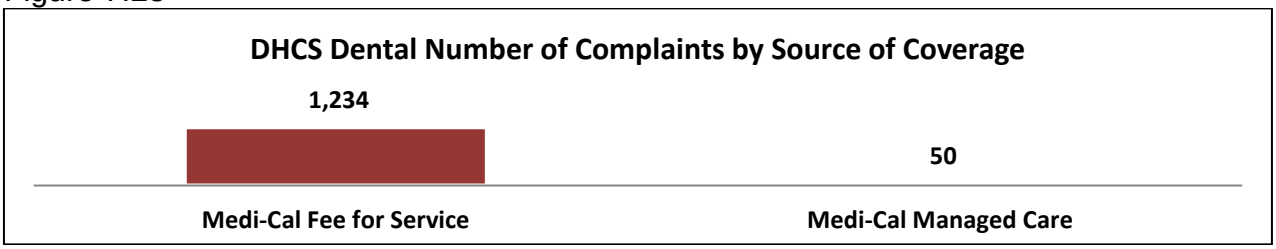
DHCS submitted 3,291 complaints where only three (less than 1%) were Unknown as to Source of Coverage. The following chart shows the Source of Coverage for complaints closed during 2014. Medi-Cal Managed Care accounted for 85 percent, Medi-Cal Fee-for-Service accounted for 14 percent, and Medi-Cal/Medicare (CCI) accounted for one percent.

Figure 7.24



DHCS submitted 1,284 Dental complaints. All of the Dental complaints identified a Source of Coverage shown in the chart below. Dental Managed Care Source of Coverage includes two counties Sacramento (Geographic Managed Care) and Los Angeles (Prepaid Health Plan).

Figure 7.25



Volume of Complaints by Product Type

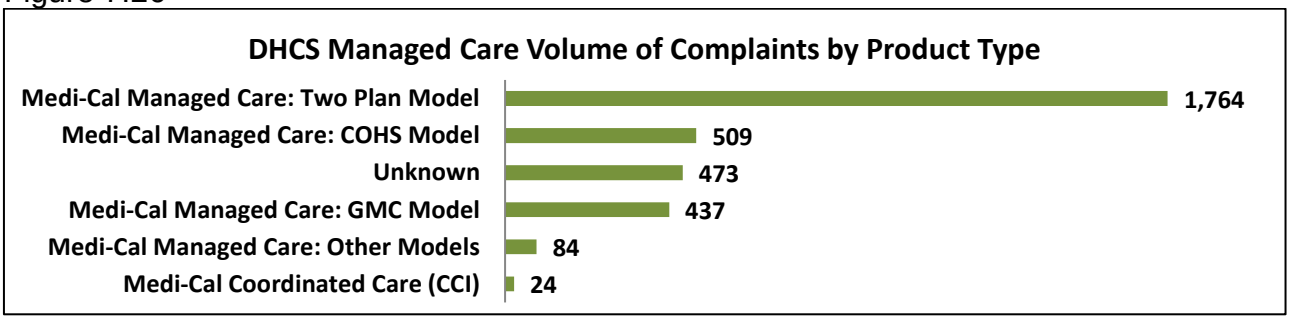
Of the 3,291 complaints submitted by DHCS in 2014, 2,818 included information about Product Type. The Medi-Cal Managed Care: Other Models Product Type includes:

- Medi-Cal Managed Care: Rural Model
- Medi-Cal Managed Care: Imperial Model
- Medi-Cal Managed Care: San Benito Model
- Long Term Care: Program of All-Inclusive Care for the Elderly (PACE)
- Long Term Care: Senior Care Action Network (SCAN)

Complaints about Product Type: Model of Medi-Cal Managed Care: Two Plan Model accounted for 53.60 percent of all of the complaints submitted.

The following chart displays all of the Product Types submitted by Managed Care.

Figure 7.26



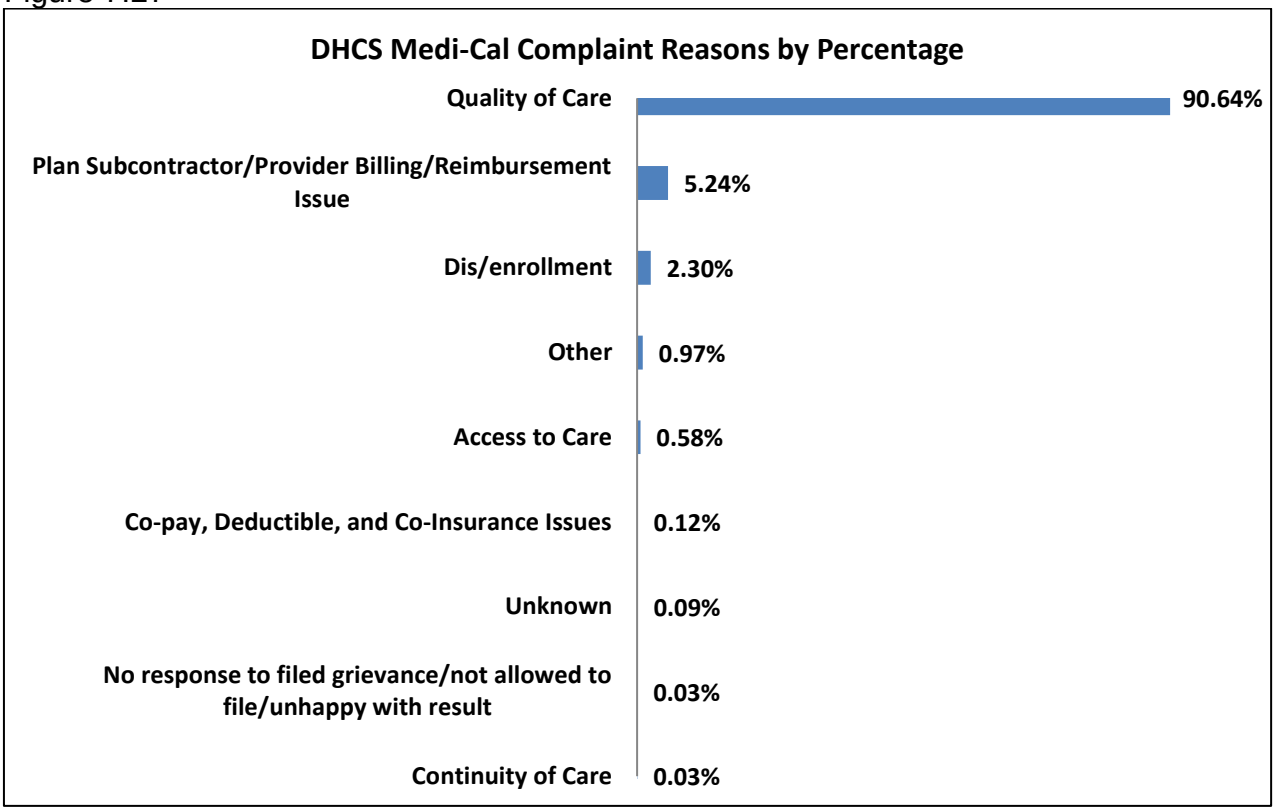
All of the 1,284 Dental complaints submitted by DHCS are identified by the same Product Type of Dental.

All of the 14 Mental Health complaints submitted by DHCS identified a Product Type of Mental Health.

Complaint Reasons

As shown in the chart below, DHCS submitted 3,291 Medi-Cal complaints that identified a complaint reason with some complaints having more than one complaint reason. The most frequent complaint reason was Quality of Care at 2,994, Plan Subcontractor/Provider Billing/Reimbursement Issue at 173, Dis/Enrollment at 76, Other at 32, Access to Care at 19, Co-Pay, Deductible, and Co-Insurance Issues at 4, Unknown at 3, No response to filed grievance/not allowed to file/unhappy with result at 1, and Continuity of Care at 1.

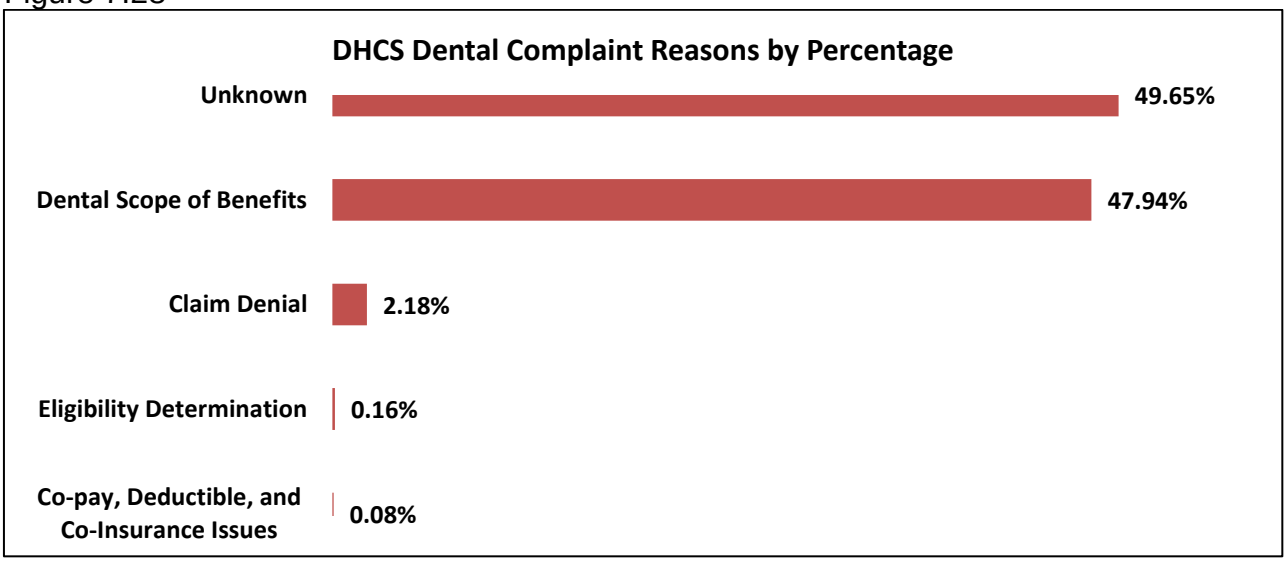
Figure 7.27



Note: The total number of complaints submitted by DHCS Medi-Cal is 3,291. The number of complaint reasons exceeds the total number of complaints because some consumer complaints involved more than one issue.

As shown in the following chart, Dental Scope of Benefits accounted for 47.94 percent of all Complaint Reasons submitted by DHCS Dental in 2014.

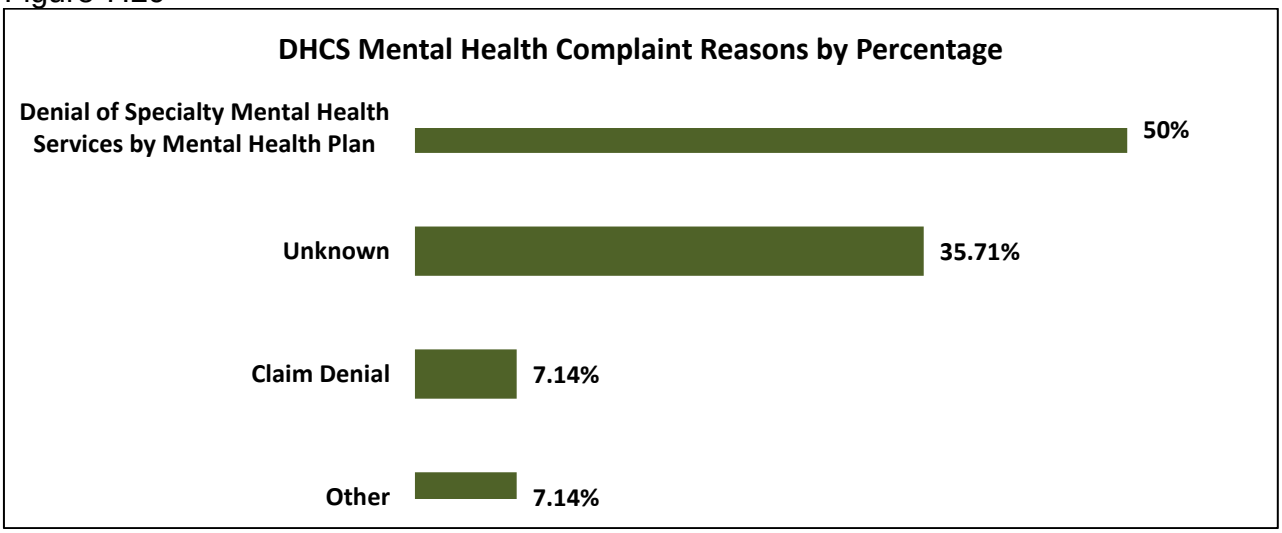
Figure 7.28



Note: The total number of complaints submitted by DHCS Dental is 1,284. The number of complaint reasons exceeds the total number of complaints because some consumer complaints involved more than one issue.

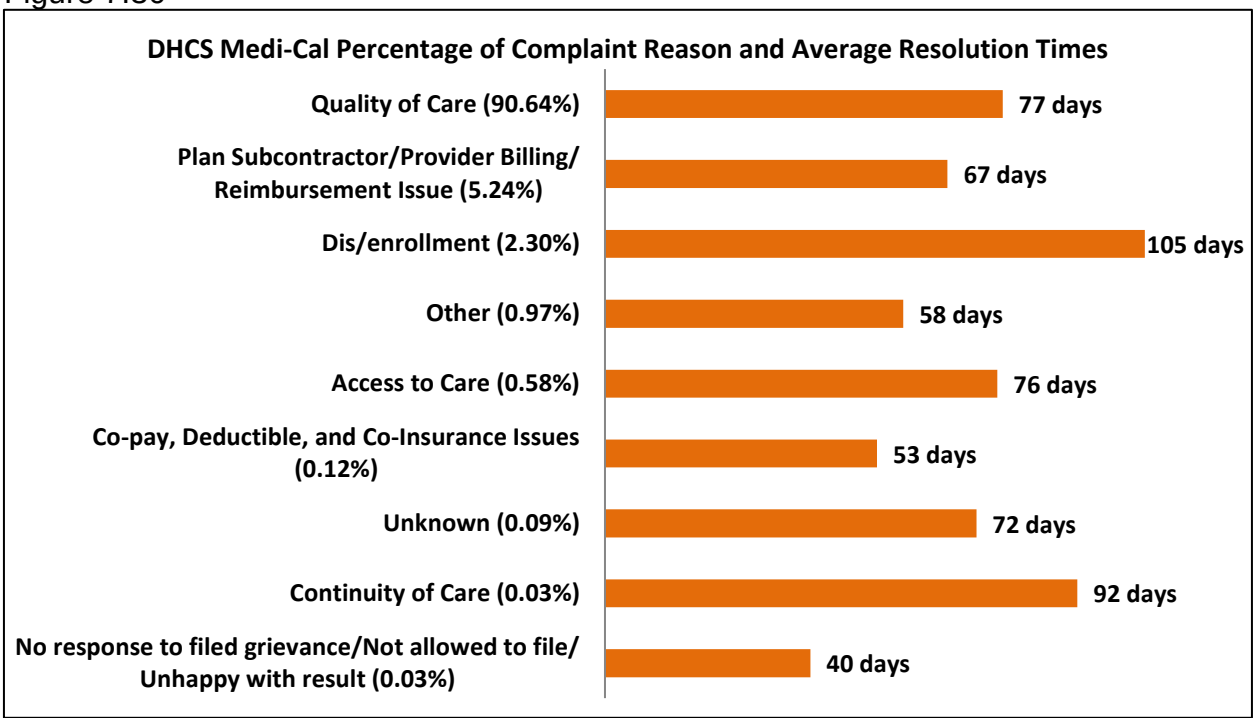
As shown in the chart below, Denial of Specialty Mental Health Services by Mental health Plan accounted 50 percent of Complaint Reasons submitted by DHCS Mental Health in 2014.

Figure 7.29



The following chart displays the percentage of complaint reasons with corresponding average resolution times.

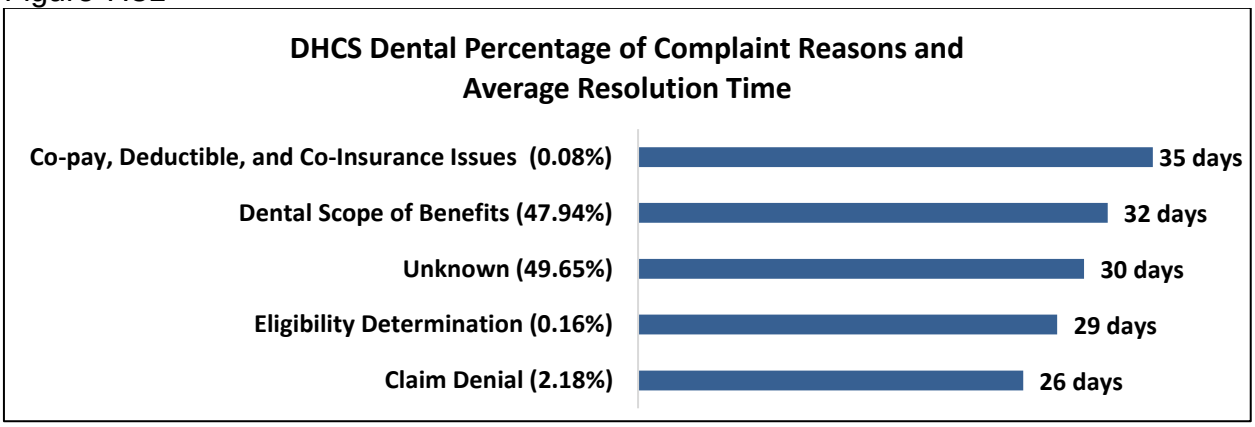
Figure 7.30



Note: The total number of complaints displayed in the chart above represents 3,303 total complaint reasons. The total number of complaints submitted by DHCS Medi-Cal is 3,291. The number of complaint reasons exceeds the total number of complaints because some consumer complaints involved more than one issue.

The chart below displays the 1,285 Dental complaint reasons with corresponding resolution times submitted by DHCS.

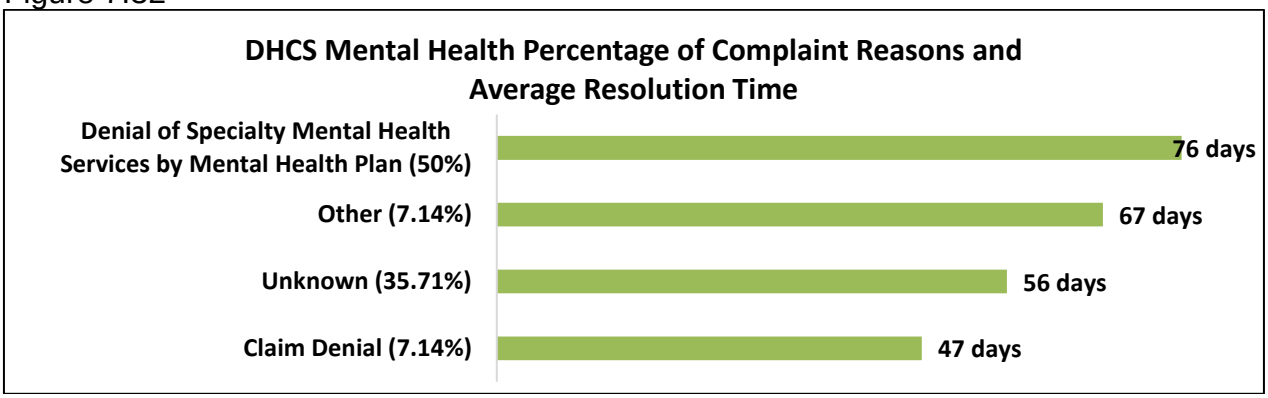
Figure 7.31



Note: The total number of complaints displayed in the chart above represents 1,285 total complaint reasons. The total number of complaints submitted by DHCS Dental is 1,284. The number of complaint reasons exceeds the total number of complaints because some consumer complaints involved more than one issue.

The chart below displays the 14 Mental Health complaint reasons with corresponding resolution times submitted by DHCS.

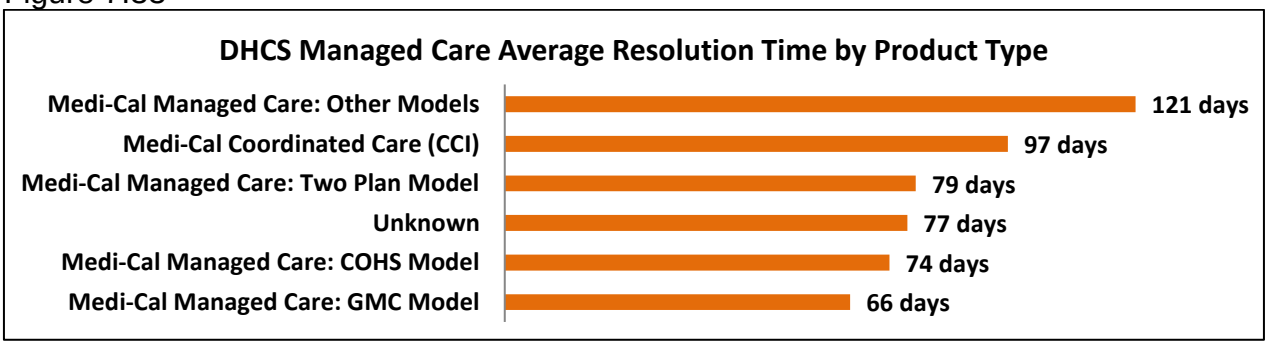
Figure 7.32



Resolution Time

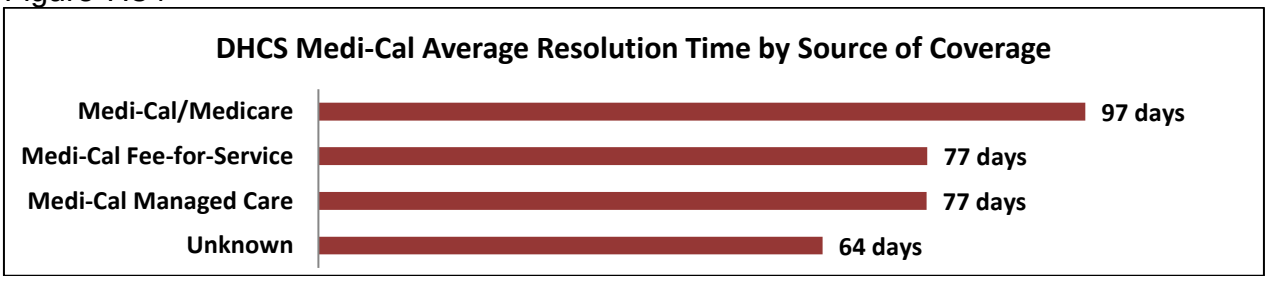
The chart below shows the average length of time to resolve Managed Care complaints in 2014 by Product Type. The resolution time of complaints is calculated by subtracting the date that the complaint was opened from the date the complaint was closed. The average resolution time of complaints under Medi-Cal Managed Care: Other Models is 12 to 150 days.

Figure 7.33



The following chart shows the average length of time for DHCS complaints to be resolved based on Source of Coverage.

Figure 7.34



The chart below shows the average length of time for Dental complaints to be resolved based on Source of Coverage.

Figure 7.35

D. Complaint Results

The following table shows all of the 3,291 complaints submitted by DHCS Medi-Cal with a complaint result.

Figure 7.36

DHCS Medi-Cal Complaint Results

Complaint Results	Volume (Percentage)
Compromise Settlement/Resolution	9 (0.3%)
Overturned/Health Plan Position Overturned	593 (18%)
Upheld/Health Plan Position Substantiated	723 (22%)
Unknown	26 (0.8%)
No Action Requested/Required	821 (25%)
Withdrawn/Complaint Withdrawn	1,119 (34%)

Note: The total percentage does not equal 100% due to rounding

The following table shows all of the 1,284 complaints submitted by DHCS Dental with a complaint result.

Figure 7.37

DHCS Dental Complaint Results

Complaint Results	Volume (Percentage)
Overturned/Health Plan Position Overturned	54 (4.2%)
Upheld/Health Plan Position Substantiated	407 (31.7%)
No Action Requested/Required	195 (15.2%)
Withdrawn/Complaint Withdrawn	628 (48.9%)

The following table shows all of the 14 complaints submitted by DHCS Mental Health with a complaint result.

Figure 7.38

DHCS Mental Health Complaint Results

Complaint Results	Volume (Percentage)
Overturned/Health Plan Position Overturned	3 (21.43%)
Upheld/Health Plan Position Substantiated	6 (42.86%)
No Action Requested/Required	3 (21.43%)
Withdrawn/Complaint Withdrawn	2 (14.29%)

Note: The total percentage does not equal 100% due to rounding

Section 8 – California Department of Insurance

A. Overview

The California Department of Insurance (CDI) oversees more than 1,300 insurance companies and licenses more than 360,000 agents, brokers, adjusters, and business entities. CDI enforces the insurance laws of California and has authority over how insurers and licensees conduct business in California.

The Consumer Services Division (CSD), within CDI's Consumer Services and Market Conduct Branch, is responsible for responding to consumer inquiries and complaints regarding insurance company or producer activities.

The CSD is staffed by state employees. Within the CSD:

- The Consumer Communications Bureau (also known as the Hotline) is responsible for managing the CDI toll-free telephone line, resolving consumer complaints that are time-sensitive in nature, responding to inquiries received through the Department's website, and assisting consumers at the public counter.
- The Health Claims Bureau is responsible for investigating complaints regarding the handling of claims by health insurance companies. The Bureau also administers CDI's Independent Medical Review (IMR) Program. If Bureau staff determine that a case meets the criteria for an IMR, a contractor (MAXIMUS) is responsible for conducting the external review and making a decision.
- The Rating and Underwriting Services Bureau is responsible for investigating all consumer rates and underwriting complaints.

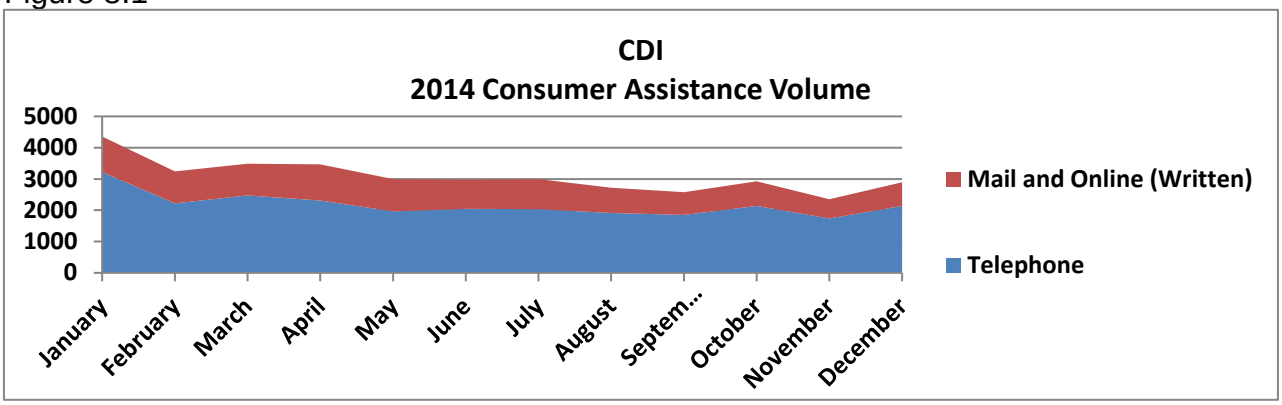
This report only includes CDI's health care coverage complaints, and not those related to other lines of business.

B. CDI Consumer Assistance

Consumer Assistance Volume by Month and Mode of Contact

CDI's service center received 36,986 requests for assistance in 2014, mostly by telephone. The following chart includes the volume of consumer contacts for all requests for assistance, including complaint and inquiry contacts.

Figure 8.1



Service Center Telephone Call Metrics

CDI's service center received 28,314 total telephone calls in 2014, of which 17,862 were related to a health care issue within CDI's jurisdiction. The following table shows the survey response from CDI regarding some of its service center telephone call metrics.

Figure 8.2

CDI Consumer Services Division – 2014 Telephone Metrics

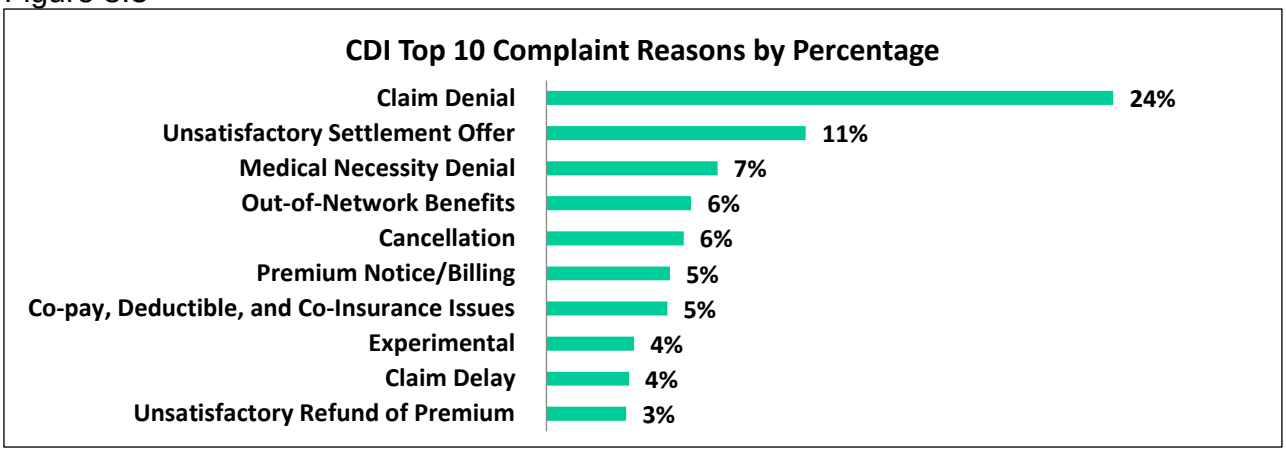
Metric	Measurement	Reporting Entity Estimated Metric or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	1,177 Introductory message recording filters out calls intended for insurers and provides information to callers that often makes talking to a CSR unnecessary. These are considered abandoned calls.	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	1,403	Data
Number of non-jurisdictional inquiry calls answered by a CSR	7,872	Data
Average wait time to reach a CSR	0:15	Data
Average length of talk time for jurisdictional complaints (time between a CSR answering and completing a call)	5:06 (*)	Data
Average length of talk time for non-jurisdictional inquiries (time between a CSR answering and completing a call)	5:06 (*)	Data
Average number of CSRs available to answer calls (during Service Center hours)	Varies based on need	

Note: (*) The CDI system does not differentiate the average talk time between jurisdictional and non-jurisdictional calls. In addition, in order to provide best practice customer service, secondary health officers are added to the health queue depending upon volume of calls received. The data also does not reflect time spent by officer to verify jurisdiction and return call to consumer. Stats reflect time of consumer initial contact only.

Top Ten Reasons for Jurisdictional Complaints

The Top 10 complaint reasons shown in the following chart account for 75 percent of all complaint reasons associated with the complaint cases closed by CDI in 2014. In the remaining 25 percent of complaint reasons there are 61 complaint reasons.

Figure 8.3



Note: Many consumer complaints involve more than one issue, possibly resulting in higher percentages.

Top Ten Topics for Non-Jurisdictional Inquiries

In 2014, CDI's service center staff answered 7,872 non-jurisdictional calls. CDI's most common referrals include inquiries that were referred to the Department of Managed Health Care, Covered California, and the U.S. Department of Labor (DOL).

Figure 8.4

CDI Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Referred to
1 (most common)	Claim Denial	Department of Managed Health Care (DMHC) U.S. Department of Labor (DOL) Centers for Medicare and Medicaid Services (CMS) California Public Employees' Retirement System (CalPERS) Medi-Cal Various Departments of Insurance (DOIs)
2	Copay/Out-of-Pocket Charges	DMHC DOL CMS
3	Out-of-Network Benefits/Usual, Customary, and Reasonable Charges	DMHC
4	Cancellation	Covered California DMHC
5	Enrollment	Covered California CMS DMHC

Ranking	Inquiry Topic	Referred to
6	Premium/Billing	DMHC Various DOIs
7	Claim Handling Delays	DMHC DOL CMS Various DOIs
8	Policyholder Service	Covered California DMHC
9	Preventive Care	DMHC DOL Various DOIs
10	Provider Directory	Covered California DMHC

Note: Ranking estimated by CDI.

Consumer Assistance Protocols

The CDI Division of Consumer Services has established protocols and performance standards for providing consumer assistance on jurisdictional complaints and for non-jurisdictional referrals. Information is disseminated to CDI compliance officers through an internal, centralized web-based information repository, staff training, and other tools. Standard complaint and Independent Medical Review processes have time standards established in state statute.

Complaint Protocols

Throughout this report, OPA summarizes complaint protocols based on documentation submitted by the reporting entities. Each reporting entity has different time standards established for completing their complaint review processes, which are determined by applicable statutory and regulatory requirements, as well as internal department policies and procedures. Time standards and resolution times noted in this report are not comparable because of differences in how the reporting entities review consumer complaints and track the initiation and closing of cases. CDI's time standards include an average of 30 days regulatory review period.

Figure 8.5 **CDI Complaint Standards**

Complaint Process	Primary Unit(s) Responsible and Roles	Time Standard (if applicable)	Average Resolution Time in 2014
Standard Complaint	*Consumer Communications Bureau:* Assistance to callers *Health Claims Bureau and Rating and Underwriting Services Bureau:* Compliance officers respond to written complaints *Consumer Law Unit:* Legal review (if needed)	30 working days, or 60 days (if reviewed concurrently with health plan level review)	73 days Calculation includes time for regulatory review (average 30 days) after the case is closed to the consumer complainant

Complaint Process	Primary Unit(s) Responsible and Roles	Time Standard (if applicable)	Average Resolution Time in 2014
Independent Medical Review (IMR)	*Consumer Communications Bureau:* Assistance to callers *Health Claims Bureau*: Intake and casework *IMR Organization (contractor-MAXIMUS):* Case review and decision *Consumer Law Unit:* Legal review (if needed)	30 working days, or 60 days (if reviewed concurrently with health plan level review)	68 days Calculation includes time for regulatory review (average 30 days) after the case is closed to the consumer complainant. Calculation also includes cases that met urgent clinical criteria.
Urgent Clinical	CDI compliance officers handle case intake and initiate expedited IMRs *IMR Organization (contractor–MAXIMUS):* Case review and decision	IMR: 3 days	Not available

Other Protocols

Figure 8.6
CDI Other Protocols

Protocol	Process	Timing (if applicable)
Non-Jurisdictional Referrals	Consumer Communications Bureau compliance officers try to establish jurisdiction during the initial phone contact and make an immediate referral if needed. For calls referred to DMHC (CDI's most common referral), CDI uses a warm transfer to connect the caller to the DMHC Help Center. If jurisdiction cannot be easily determined, compliance officers contact the insurance company to obtain information needed to review a complaint or make an appropriate referral.	As soon as possible after jurisdiction determined and appropriate referral identified
After-Hours Assistance	Interactive Voice Response system allows callers to leave a phone message. Complaints filed online anytime to initiate a Standard Complaint or IMR process.	Voicemails left by consumers returned next business day
Language Assistance	CDI utilizes bilingual staff and a contracted Language Line to provide interpreter services when needed.	CDI connects to the Language Line as needed

C. CDI Complaint Data

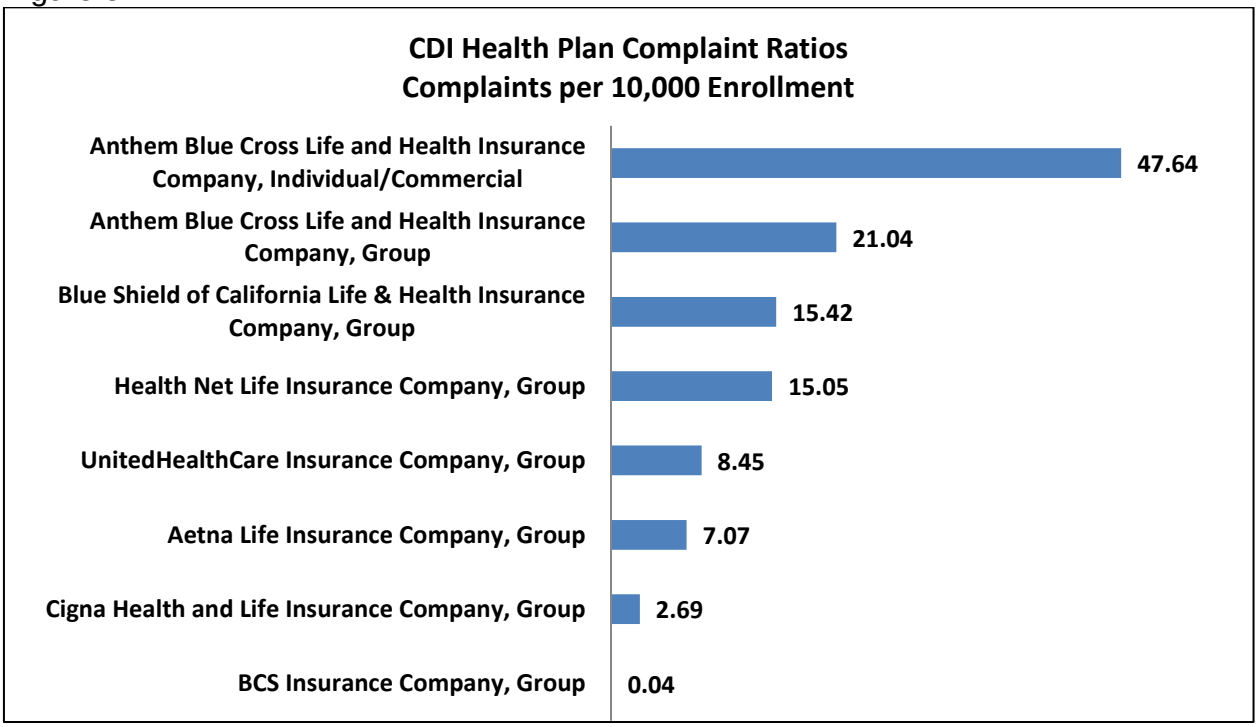
Complaint Ratios

The complaint data ratio is used as a performance indicator to compare health plans. Due to variance in the enrollment size among health plans and health programs in California, a complaint ratio allows for a more equitable comparison between small and large health plans and across programs.

The complaint ratio is calculated by taking the number of closed complaints and dividing it by the number of covered lives the insurer had in place by the end of a specific month in the Spring of 2014. This number is standardized by dividing the ratio by 10,000. When comparing plans, a lower number of complaints per 10,000 enrollees in a plan indicate that fewer complaints were submitted per capita. A plan with a higher overall number of complaints submitted may still receive fewer complaints per 10,000 enrollees than another plan with fewer overall complaints.

The following chart shows the complaint ratios for the largest health plans regulated by CDI with 2014 enrollment exceeding 70,000 covered lives. These include complaints against health plans that serve commercial group and individual health plans, including coverage purchased through Covered California. Many consumer complaints involve more than one issue possibly resulting in higher complaint ratios. There were 103 plans with at least one complaint from the total of 2,574,574 enrollment. This enrollment number likely includes persons enrolled in multiple plans including dental, mental health, and other plan types.

Figure 8.7



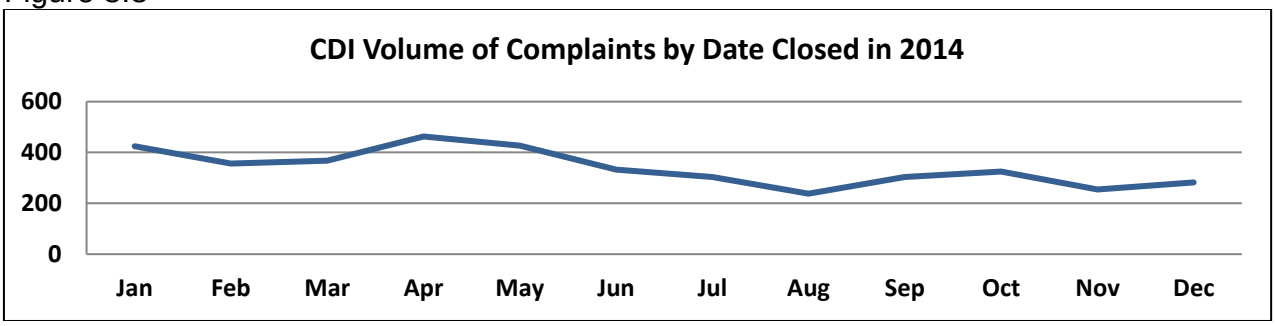
Note: Many consumer complaints involve more than one issue, possibly resulting in higher complaint ratios.

Volume of Closed Complaints

The volume of complaints is the total count of complaints submitted for the year. The below chart displays the total of 4,079 complaints distributed by month for 2014.

This chart reflects the only those cases closed in 2014 and does not include cases opened in previous years if they were closed before 2014 or cases opened in late 2014 but closed in 2015.

Figure 8.8



Resolution Time

The resolution time of complaints by Complaint Type is calculated by subtracting the date complaint opened from the date complaint closed. The averages are displayed in number of days. CDI's complaint duration period reflects the date from the initial receipt of complaint to final regulatory review period, which is 30 days on average. Generally, other reporting entities complete regulatory review after the case is closed to the complainant.

Figure 8.9

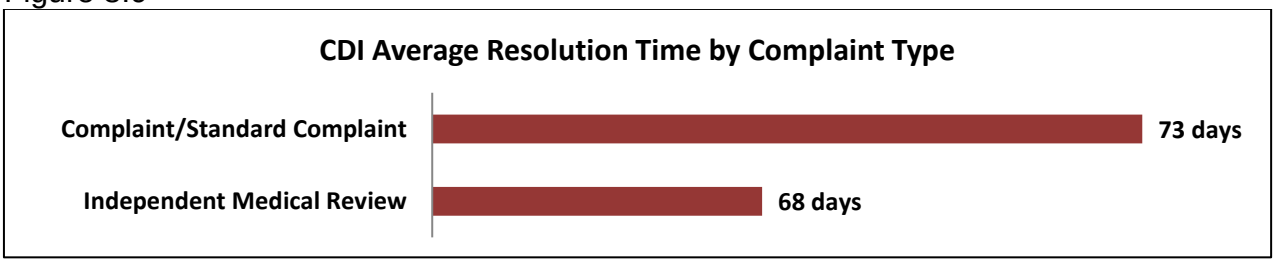
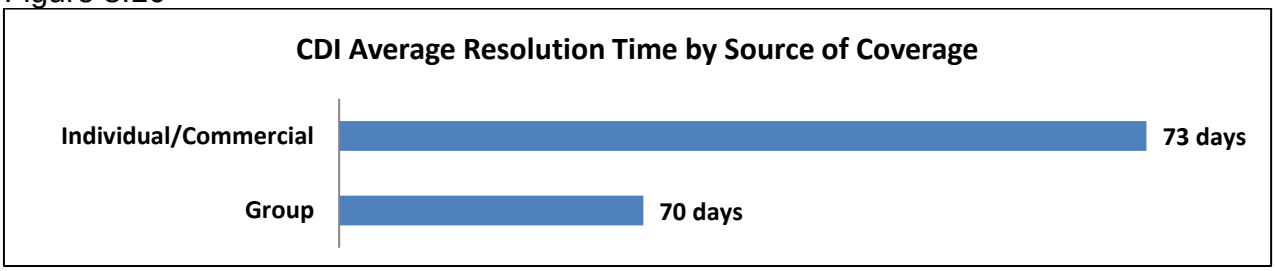


Figure 8.10



Age

The age group "Unknown" accounted for 3,311 complaints submitted. CDI started gathering demographic data in the last quarter of 2014. Therefore, 81 percent of records do not include age data.

The top two Complaint Reasons, Claim Denial and Medical Necessity Denial, were the same across all ages. The Top 3 Complaint Reasons for each age group are as follows:

- Age group Under 18 - 54
  - Claim Denial
  - Medical Necessity Denial
  - Unsatisfactory Settlement Offer
- Age group 55 - 74
  - Claim Denial
  - Medical Necessity Denial
  - Experimental
- Age group Over 74
  - Claim Denial
  - Medical Necessity Denial
  - Premium & Rating

Gender

CDI's demographic data collection started in the last quarter of 2014. Thus, 80 percent (3,278) of the complaint records submitted do not include gender data. Of the 801 Gender identified records submitted with complaint reasons, male and female had the same top three Complaint Reasons:

1) Claim Denial
2) Medical Necessity Denial
3) Unsatisfactory Settlement Offer

Race and Ethnicity

CDI started gathering demographic data in the last quarter of 2014. Therefore, approximately 98 percent of CDI's complaint records for 2014 do not include data for race or ethnicity.

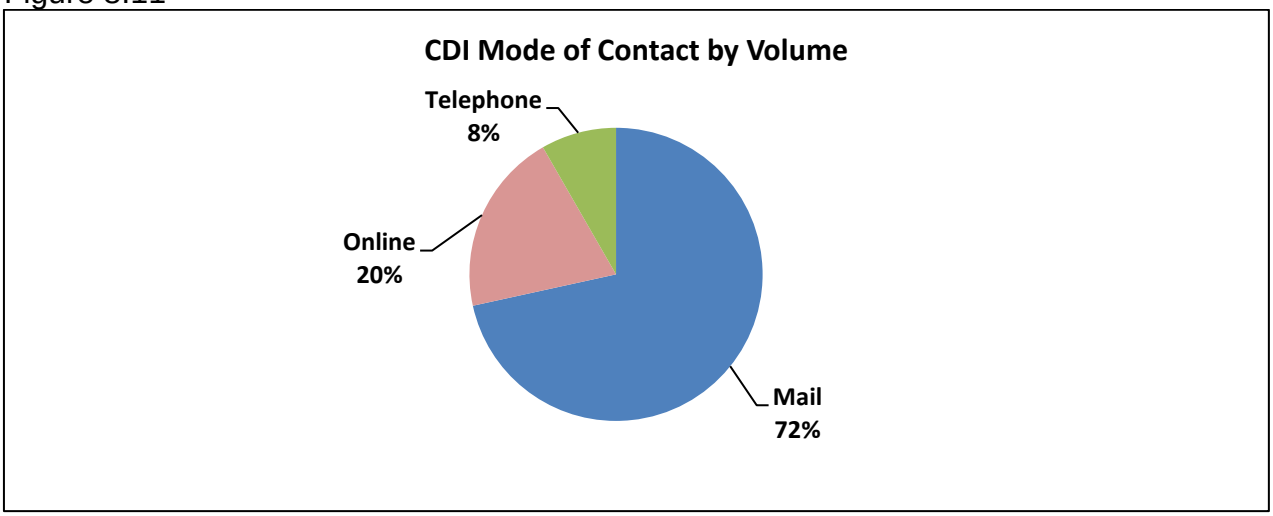
Language

Of the 4,079 complaints submitted, 4,010 did not identify a primary language. For the remaining 69 complaints, English was indicated 46 times, Other was indicated 5 times, and 18 refused to state a language.

Mode of Contact

Of the 4,079 complaints submitted with the Initial Mode of Contact information, consumers most often used mail, followed by online, and telephone.

Figure 8.11



Regulator

Of the 4,079 complaints submitted with regulator information, 99 percent were regulated by CDI while the remaining one percent of the complaints were Unknown.

Source of Coverage

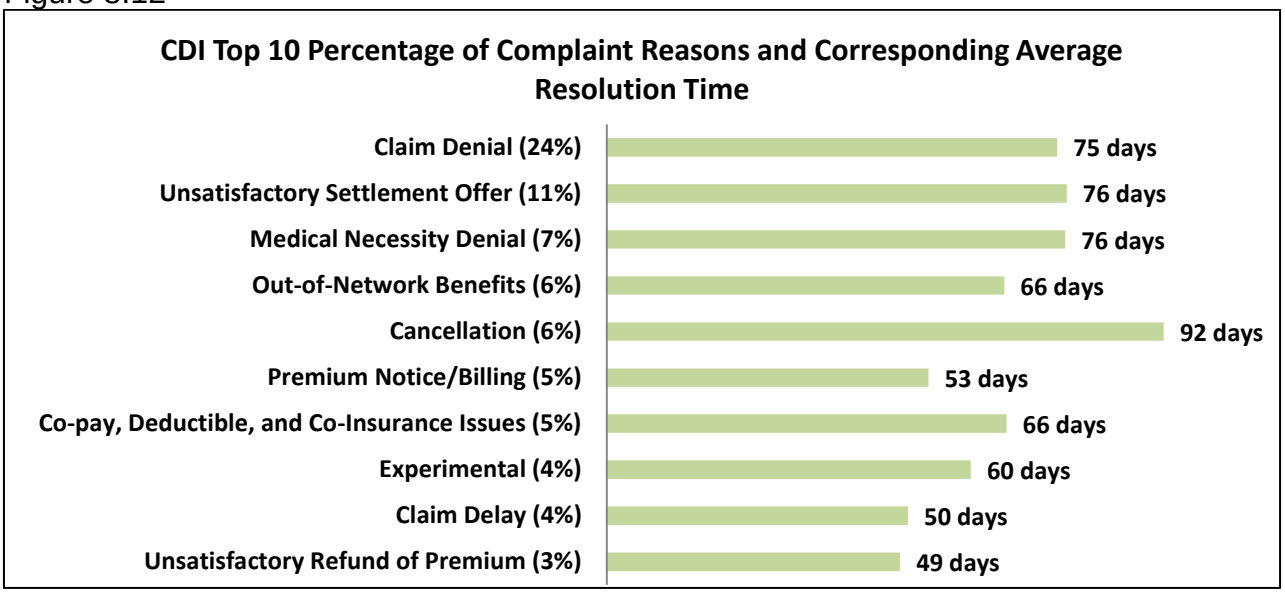
CDI identified two Sources of Coverage: Group and Individual/Commercial. Of the total 4,079 submitted complaints, Group had 2,115 (52%) complaints and Individual/Commercial had 1,964 (48%).

Complaint Reasons

The following chart displays 75 percent of Complaint Reasons submitted by CDI. The chart contains both the type and percentages of the Top 10 Complaint Reasons and the average number of days that CDI took to close those complaints. In the remaining 25 percent of complaint reasons there are 61 complaint reasons.

The CDI complaint duration period reflects the date from initial receipt of complaint to final regulatory review period, which is 30 days on average. Generally, other reporting entities complete regulatory review after the case is closed to the complainant.

Figure 8.12

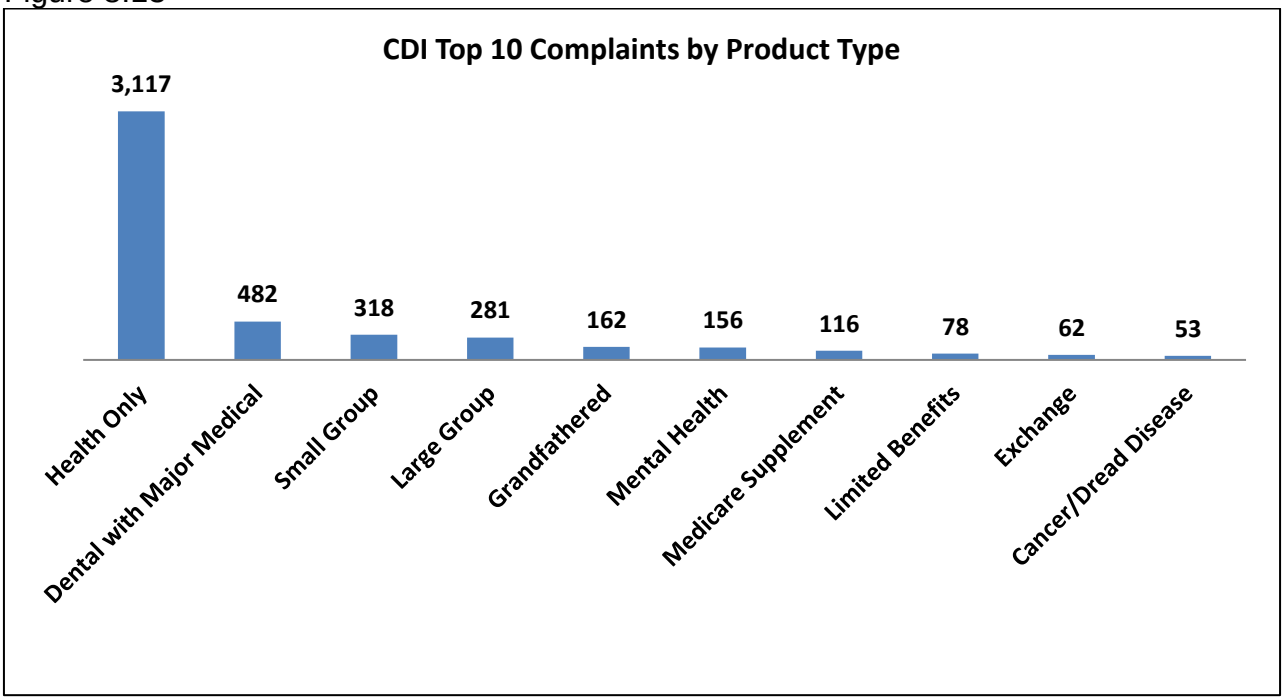


Note: Many consumer complaints involve more than one issue, possibly resulting in higher percentages. CDI complaint duration period reflects the date from initial receipt of complaint to final regulatory review period, which is 30 days on average. Generally, other reporting entities complete regulatory review after the case is closed to the complainant.

Complaint Reasons totaled 5,607 from the 4,079 complaint records submitted. Many consumer complaints involved more than one issue.

The chart below displays the Top 10 Complaints by Product Type.

Figure 8.13



D. CDI Complaint Data Results

The below table shows the 6,043 complaint results submitted by CDI for the 4,079 total complaints. Many consumer complaints include more than one complaint result. The Top 10 total Complaint Result categories constituted approximately 90.6 percent of all submitted Complaint Results. The remainder of 567 complaints, which each have under 2 percent, are not displayed.

Figure 8.14
CDI Top 10 Complaint Results

Complaint Results	Volume (Percentage)
Consumer's Money Returned	1,004 (16.61%)
Advised Complainant	402 (6.65%)
Claim Settled	199 (3.29%)
Additional Payment	187 (3.09%)
Compromise Settlement/Resolution	124 (2.05%)
Health Plan in Compliance	442 (7.31%)
Health Plan Position Substantiated	1,651 (27.32%)
Other	271 (4.48%)
Question of Fact/Contract/Law Falls Outside Regulator	1,196 (19.80%)

Note: The Top 10 Complaint Results are displayed above. The remainder of complaint results (2%) and under is not shown.

Section 9 – Covered California

A. Overview

To implement part of the federal Patient Protection and Affordable Care Act, Covered California (also known as the California Health Benefit Exchange) created a state-based health insurance marketplace to allow consumers to compare health insurance options and choose a health plan that best fits their needs and budget. Covered California serves as an active health care purchaser, selecting and establishing criteria for the health plans and insurance companies that can sell products on the Covered California marketplace.

Consumer assistance is provided by the Covered California Service Center. Its main role is to help consumers apply for health care coverage and associated financial assistance, and to understand coverage options. Covered California Service Center staff address eligibility and enrollment-related issues related to the Covered California application or renewal process, but rely on the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) for eligibility determinations.

- CalHEERS automates determinations regarding eligibility and calculations for tax credits and cost-sharing subsidies.
- Covered California staff use a calculator tool to identify callers who are likely Medi-Cal eligible and route these callers to county Medi-Cal offices to continue the process for final eligibility determination and enrollment into that program.
- Appeals regarding eligibility, as well as eligibility-related enrollment and disenrollment, are addressed through the Covered California appeals process, which includes an Informal Resolution process and the State Fair Hearing process conducted by the California Department of Social Services (CDSS).

The Covered California Service Center is staffed by state employees and contractors at multiple sites, in Rancho Cordova, Fresno, Contra Costa, and Faneuil, Inc. service centers. Contracted staff includes county employees with Contra Costa County's Employment and Human Services Department, as well as private employees with Faneuil, Inc. who assist with peak service times. Covered California also contracted with MAXIMUS to provide call center support services.

- Service Center representatives provide guidance to callers, gather information from callers to input into Covered California's records systems, and route calls to the appropriate internal staff or external county resources to assist the consumer.
- If the Service Center representatives are unable to resolve a consumer's issue during the initial call, they typically escalate the incident to a supervisor.
- Supervisors review escalated cases and transfer appropriate cases to Covered California's External Coordination Unit, Health Plan Hotline team, or internal subject matter experts or staff tasked with problem resolution.
- Covered California's Customer Resolution Teams work to resolve problems with applications or coverage renewals, corrections or updates to household or other case information that affects eligibility (including for the Advance Premium Tax Credit).

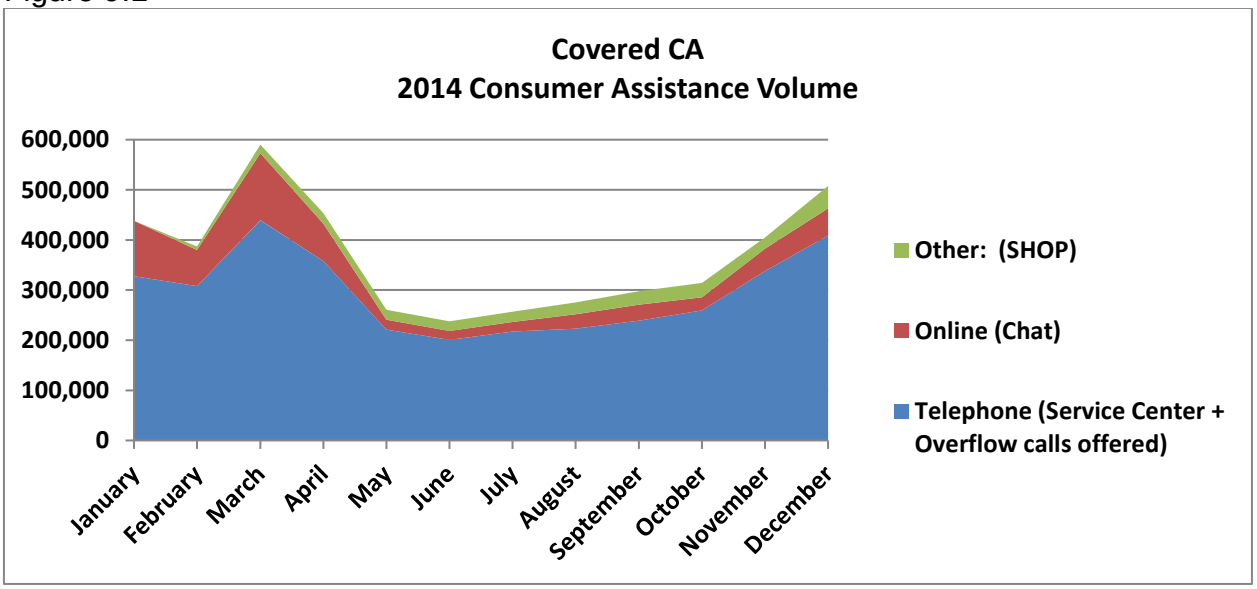
- The Health Plan Hotline team addresses certain issues that the Customer Resolution Teams cannot resolve, such as those pertaining to health plan premium payment and enrollment discrepancies.
- Urgent access to care issues and complaints that cannot be resolved by the Service Center staff or supervisors may be addressed by Covered California's External Coordination Unit or other Back Office Units.
- Appeal requests may be addressed by Covered California's Appeals Unit through the Informal Resolution process in an attempt to obtain resolution without going to State Fair Hearing.
- If a problem outlined in an appeal request cannot be resolved by Covered California informally, the formal appeal is adjudicated by CDSS and an Administrative Law Judge through the State Fair Hearing process. A Covered California hearing representative attends the hearing.

B. Covered California Consumer Assistance

Number of Requests for Assistance by Month and Mode of Contact

Covered California's Service Center received 4,424,070 requests for assistance from consumers via telephone and online chat in 2014. The following chart shows all requests for assistance, including complaint and inquiry contacts.

Figure 9.1



Service Center Telephone Call Metrics

Covered California's Service Center received 3,539,597 telephone calls in 2014. The following table shows the response from Covered California regarding some of its service center telephone call metrics.

Figure 9.2 **Covered California Service Center – 2014 Telephone Metrics**

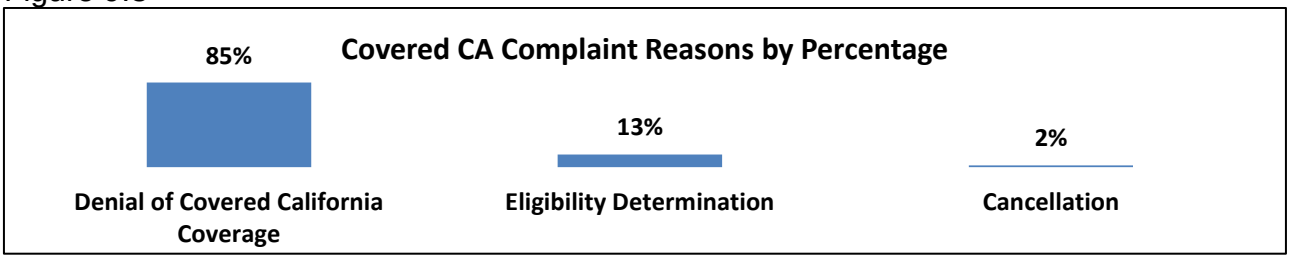
Metric	Measurement	Reporting Entity Estimated Metric or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Sece Representative - CSR)	Not reported*	Based on Customer Relationship Management system data
Number of calls resolved by te IVR/phone system (caller provided and/or received infoo n without involving a CSR)	N/A	Data is not available for Calendar Year 2014, significant IVR improvements were made in Nov./Dec. 2014 to provide this information
Number of non-jurisdictional nquiry calls answered by a CSR	N/A	Data is not available
Average wait time to reach a SR	23:02:00	Average Speed of Answer
Average length of talk time fojurisdictional complaints (time between a CSR anwering and completing a call)	N/A	This data is not available
Average length of talk time fonon -jurisdictional inquiries (time between a CSR answring and completing a call)	N/A	This data is not available
Average number of CSRs availabto answer calls (during Service Center hours)	1,488	By the end of 2014: 1,488 Full Time Service Center staff; 229 other staff related to Service Centers

Note: **Covered California indicated that service center information is reported at Monthly Board Meetings.*

Reasons for Jurisdictional Complaints

As shown in the chart below, three reasons account for 100 percent of all submitted Covered California complaints addressed through the CDSS State Fair Hearing process in 2014.

Figure 9.3



Top Three Topics for Non-Jurisdictional Inquiries

Covered California reported that its Service Center's most common consumer referrals were to other Covered California entities, county Medi-Cal offices, and health plans.

Figure 9.4
Covered California Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Referred to
1 (most common)	Status of enrollment	Covered California DHCS/Counties (if Medi-Cal related) Health Plan Providers
2	Application assistance	
3	Eligibility or disenrollment	

Note: Ranking estimated by Covered California.

Consumer Assistance Protocols

The Covered California Service Center has established protocols for providing consumer assistance on complaints and for non-jurisdictional referrals.

Complaint Protocols

Throughout this report, OPA summarizes complaint protocols based on documentation submitted by the reporting entities. Each reporting entity has different time standards established for completing their complaint review processes, which are determined by applicable statutory and regulatory requirements, as well as internal department policies and procedures. Time standards and resolution times noted in this report are not comparable because of differences in how the reporting entities review consumer complaints and track the initiation and closing of cases.

Figure 9.5
Covered California Complaint Standards

Complaint Process	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2014
Service Center Complaint	*Service Center staff*: Phone representatives provide assistance to callers and escalate issues they cannot resolve to a supervisor. Service center staff or supervisors route calls as needed. *Covered California subject matter experts, customer resolution teams, or Back Office staff:* Casework and resolution of escalated issues that are not appeals.	Not reported	Not reported
Covered California Appeals Informal Resolution	*Covered California Appeals staff*: Review new appeals and provide assistance to consumers and resolve the appeal informally when possible.	Up to 45 days from the date the appeal was filed	Not reported
State Fair Hearing	*CDSS State Hearings Division:* Conducts hearings on Covered California eligibility appeals. Administrative Law Judges make decisions.	No later than 90 days from the date the hearing request was filed	40 days
Urgent Clinical	*Covered California staff:* The Service Center escalates certain non-appeal cases involving consumers with urgent access to care issues to the External Coordination Unit to address. *CDSS State Hearings Division:* For State Fair Hearing appeals, grants expedited appeal status on certain cases involving consumers with urgent clinical issues.	Not reported	Not reported

Note: State Fair Hearing time standard from All County Letter 14-14 issued by CDSS on 2/7/14.

Other Protocols

Figure 9.6
Covered California Other Protocols

Protocol	Process	Timing (if applicable)
Non-Jurisdictional Referrals	Service Center representatives use a "Quick Sort" calculator and other records to identify consumers who are likely Medi-Cal eligible or have an existing Medi-Cal case and transfer these callers to county offices using established procedures. Consumers with health care delivery problems are referred to health plans and/or regulatory agencies to resolve their issues.	Not reported
After-Hours Assistance	Not reported	Not reported
Language Assistance	Callers to the main public line have the option to select their language through an Interactive Voice Response system. Covered California has dedicated public phone lines for Arabic, Armenian, Chinese, Farsi, Hmong, Khmer, Korean, Lao, Russian, Spanish, Tagalog, and Vietnamese. Service Center representatives use a contracted language line to provide interpreter services if internal bilingual staff are not available. For calls transferred to the counties, the language line interpreter remains on the call or the county engages its own language line if needed.	As needed

C. Covered California Complaint Data

The Covered California complaint data is from CDSS, which conducts State Fair Hearings on Covered California eligibility-related appeals. This data includes both cases that were resolved informally before a hearing took place and those that went through the full State Fair Hearing process. This data cannot be separated for this reporting period.

Complaint Ratios

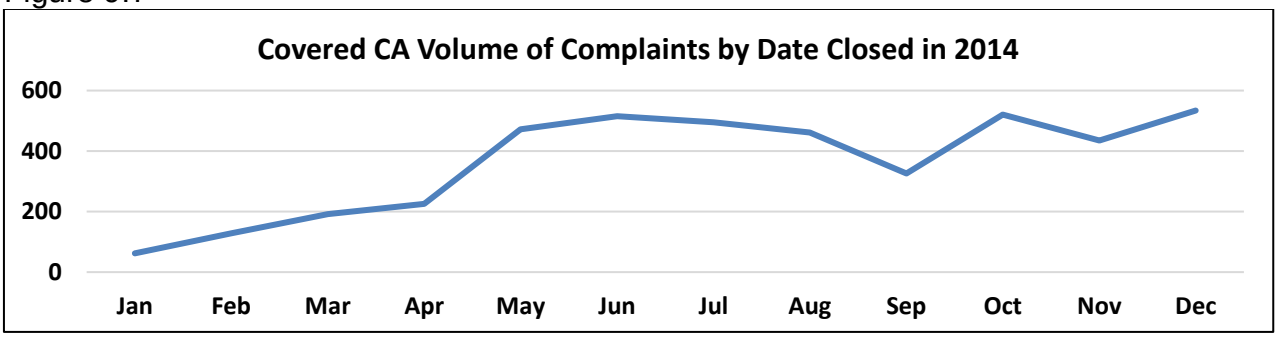
Covered California complaints are regarding eligibility determinations and eligibility related enrollment and disenrollment of Covered California coverage. Once a consumer is enrolled in a Covered California health plan, consumer complaints regarding health care delivery are directed to the health plan or the regulator, either the Department of Managed Health Care or the California Department of Insurance. No health plan information is associated with consumer complaints from Covered California; therefore, there are no complaint ratios by health plan associated with Covered California complaint data from their 1,395,929 enrollment.

Volume of Closed Complaints

The volume of complaints is the total count of complaints closed in 2014 and does not include cases opened in previous years if they were closed before 2014 or cases opened in late 2014 but closed in 2015. The volume of complaints is the total count of complaints submitted for the year.

The below chart displays the total of 4,366 complaints distributed by month for 2014.

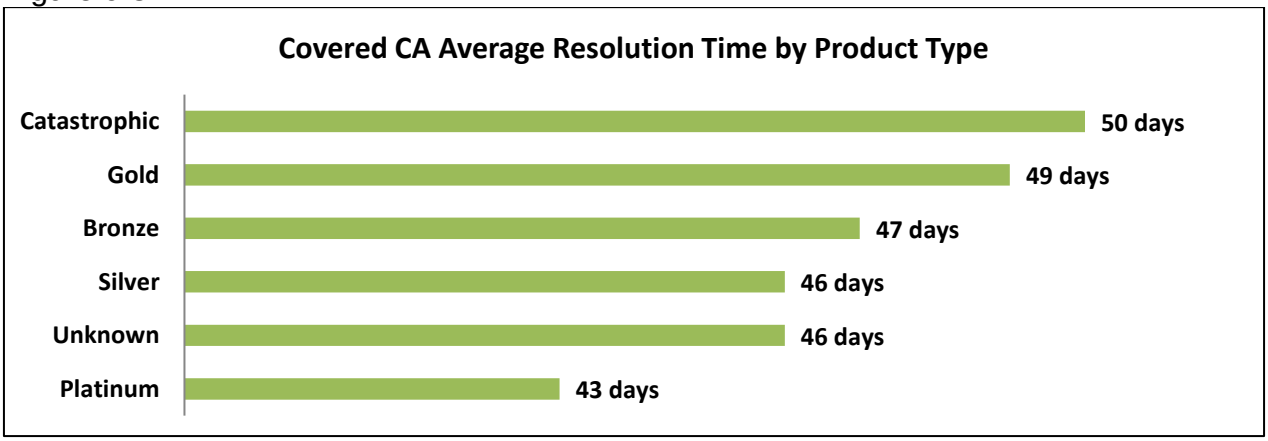
Figure 9.7



Resolution Time

The resolution time of complaints is calculated by subtracting the date complaint opened from the date complaint closed. The averages are in number of days. The chart below displays the average length of time for Covered California to resolve complaints based on Product Type is 46 days.

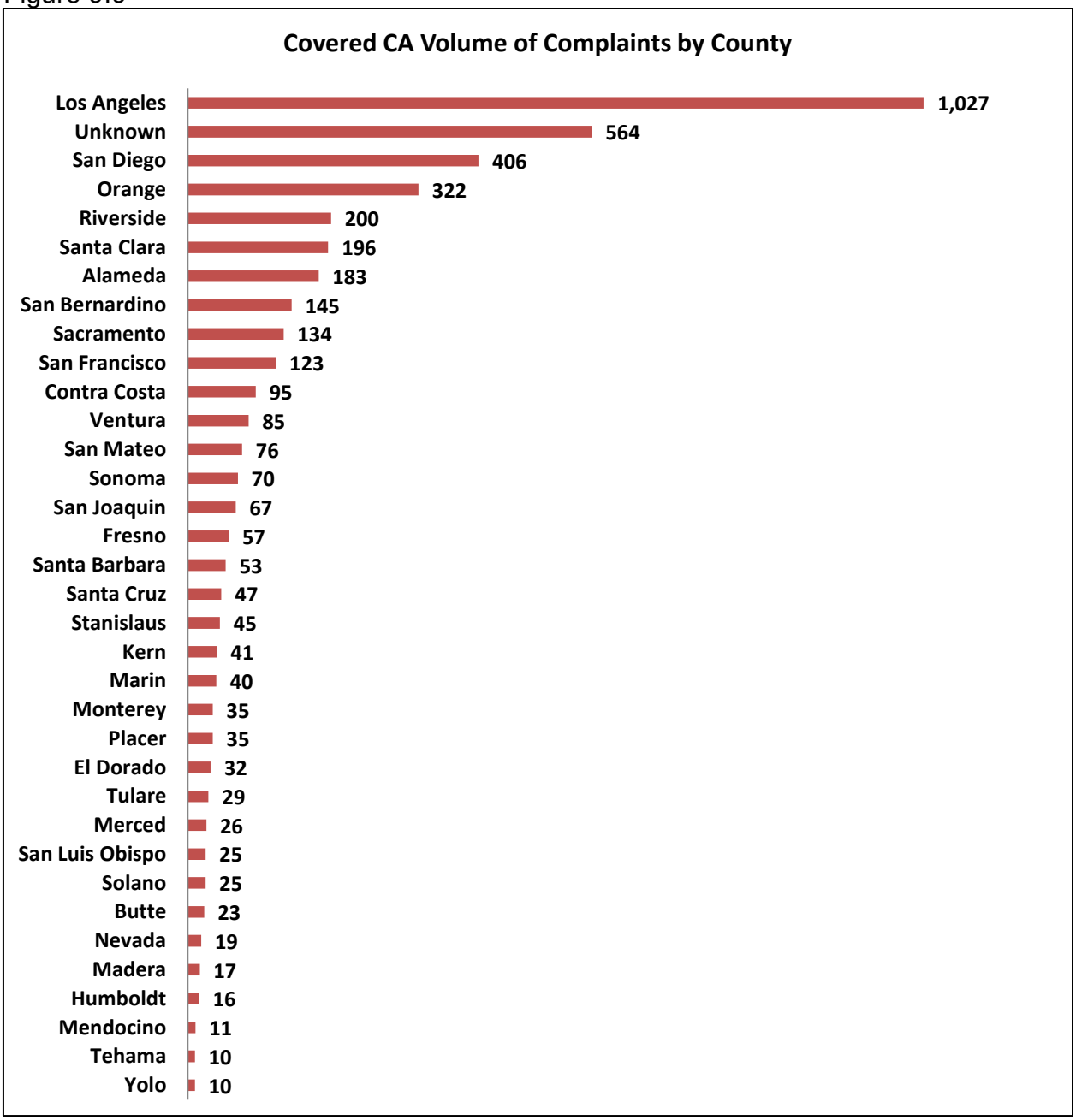
Figure 9.8



Volume of Complaints by County

The following chart displays the volume of complaints by county. The counties not shown each have fewer than ten complaints. There were 600 complaints with an Unknown county.

Figure 9.9



Note: Counties not shown, which each received fewer than ten complaints, are: Alpine, Amador, Calaveras, Colusa, Del Norte, Glenn, Imperial, Inyo, Kings, Lake, Lassen, Mariposa, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Trinity, Tuolumne, and Yuba.

Age

Covered California submitted 4,268 complaints with an age identified. The majority of complaints are from consumers aged 35 – 54. There were 98 Unknown age complaints. The complaint reasons for age groups from under age 18 through 74 were identical in order of frequency as follows:

1. Denial of Covered California Coverage
2. Eligibility Determination

3. Cancellation

Consumers over age 74 did not have a third complaint reason.

Gender

Covered California submitted 4,366 complaints with gender identified. For both male and female the complaint reasons were in the same order of frequency, as follows:

1. Denial of Covered California Coverage
2. Eligibility Determination
3. Cancellation

Race

Covered California submitted 2,851 complaints with race information. Consumers identified as White or Caucasian at 40 percent, Asian at nine percent, Multi-Racial at four percent, Black or African-American at three percent, Native Hawaiian or Other Pacific Islander at two percent, and American Indian or Alaska Native at one percent. There were 1,515 complaints where race was Unknown.

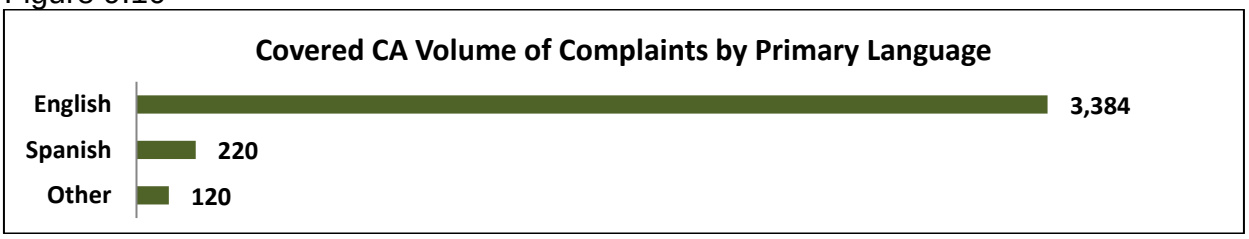
Ethnicity

Of the 3,100 complaints submitted by Covered California with ethnicity information, 2,421 (78%) were Not Hispanic or Latino consumers and 679 (22%) were Hispanic or Latino consumers. There were 1,266 Unknown complaints by ethnicity.

Language

Covered California submitted 3,724 complaints that identified a primary language displayed in the chart below. There were 642 complaints recorded as Unknown by primary language.

Figure 9.10



Mode of Contact

4,305 complaints submitted by Covered California with an identified mode of contact. Consumers contacted Covered California by telephone 2,225 times (51%), followed by 769 emails (18%), 686 faxes (16%), 333 mail (8%), and 235 “Other” contacts (5%). There were 61 complaints where an initial mode of contact was Unknown.

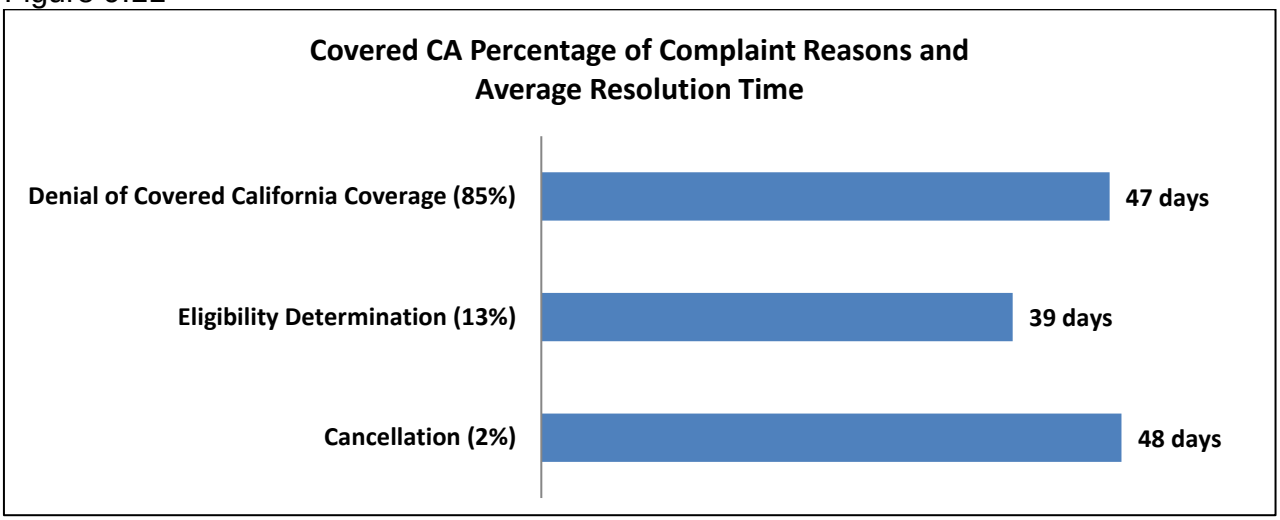
Regulator

Covered California did not report regulator information.

Complaint Reasons

All of the 4,366 eligibility and enrollment complaints submitted by Covered California had a complaint reason. The most frequent complaint reason was Denial of Covered California Coverage at 3,724, Eligibility Determination at 563, and Cancellation at 79. The chart below displays the percentage of complaint reasons with corresponding average resolution times.

Figure 9.11



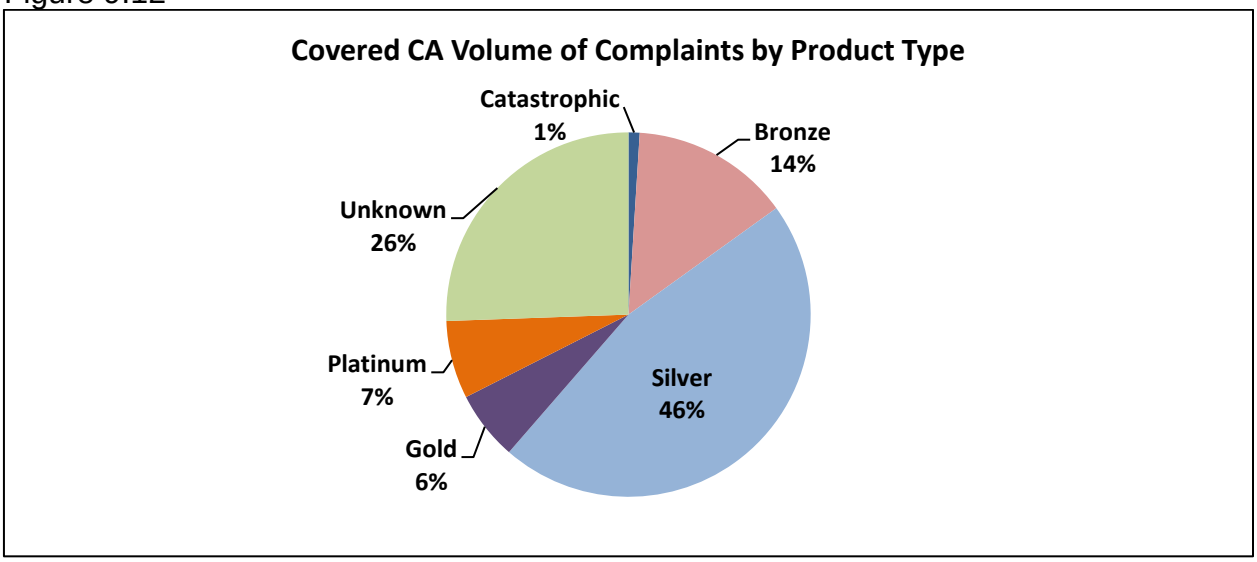
Source of Coverage

Source of Coverage for all 4,366 Covered California complaints was identified as Covered California/Exchange.

Volume of Complaints by Product Type

Covered California has a total volume of 3,250 complaints with five identified product types and 1,116 with an Unknown product type. The largest numbers of complaints, 2,022, are regarding Silver plans. The remaining complaints are regarding Bronze at 615, Platinum at 302, Gold at 268, and Catastrophic at 43.

Figure 9.12



D. Complaint Data Results

The following table shows all of the 4,366 complaints submitted by Covered California included a complaint result.

Figure 9.13

Covered California Complaint Results

Complaint Results	Volume (Percentage)
Covered CA Position Overturned	755 (17%)
Compromise Settlement/Resolution	608 (14%)
Upheld/Covered CA Position Substantiated	279 (6%)
No Action Requested/Required	604 (14%)
Withdrawn/Complaint Withdrawn	2,120 (49%)

Section 10 – Next Steps

The ***Baseline Review of Health Care Complaint Data*** for the first time provides significant information regarding consumer complaints across state health agencies in one state. The Office of the Patient Advocate (OPA) reviewed the data collection process and analyzed the complaint data submitted by the four reporting entities: the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS), the California Department of Insurance (CDI), and Covered California. The following next steps support and enhance OPA's effort to report on consumers' problems in obtaining coverage and care in California.

- OPA will continue to work with the four reporting entities to improve and standardize data definitions and coding, where appropriate. Standardizing data will allow for better collection, tracking, and analyzing data on problems and complaints by consumers. This collaborative process will also improve reporting by adapting to ongoing health care program and customer services changes at these reporting entities.

- As data collection improves, OPA will share findings and trends to improve best practices for consumer assistance. Meaningful data can help to inform the next steps in OPA's statutory requirement for developing model protocols that may be used by service centers for responding to and referring calls that are outside the jurisdiction of the call center, program, or regulator.

- For a significant portion of the 2014 baseline year the entities did not collect demographic data indicating language spoken by the complainant. However, the language data submitted representing the vast majority of the consumers making inquiries or filing complaints to service centers were from English-speaking consumers. In the statewide section of this baseline report, only three percent of callers spoke a language other than English (Figures 5.9 – 5.12) which does not correspond to California's broader language demographics. This finding merits further study in future years to confirm this data and see how the reporting entities' service centers may be able to enhance their outreach to non-English speaking communities.

- Analysis of the baseline data shows the primary mode of contact for the service centers is by telephone. In this era of the internet and the growing predominance of smart phone users among Californians across the age and economic spectrum, these differences merit further analysis into consumer preferences and access to online consumer assistance resources.

As part of its new focus on public reporting, OPA will continue to provide detailed, transparent, and meaningful data and analysis of complaints received by the reporting entities.

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Section 12 – Acknowledgements

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Section 13 – Appendices

Appendix A. Glossary

The glossary includes terms defined by the National Association of Insurance Commissioners (NAIC), Office of the Patient Advocate, and other state entities. Most terms for complaint reasons and results use the NAIC definitions. For the purpose of this report, references within the NAIC definitions to "Department of Insurance," "insurer," and "insured" may also apply to other California reporting entities, health plans, and health plan enrollees, respectively.

Term	Explanation
Abusive Service	Complaint alleging rude, threatening, or other coercive or unprofessional behavior (other than "twisting" or "churning") by the insurer or its representative.
Access to Care	Complaint that needed care is inaccessible due to refusal of primary care doctor to authorize specialist care or due to inadequate provider network.
Accident Only	Health insurance pertaining to only accident coverage.
Additional Payment	The party complained against paid more money (i.e. claims payment) than was initially paid to the policyholder or claimant.
Advanced Premium Tax Credit	Financial assistance that eligible consumers may receive when enrolling in a Covered California health plan to assist them in paying their monthly premium costs. This tax credit is sometimes called premium assistance.
Advised Complainant	A complaint result indicating that the reporting entity informed the complainant of the state position, company status, agent status, or possible course of action.
Authorization Dispute	Complaint alleging that the insurer has improperly denied claim or assessed a penalty on the basis of required preauthorization not having been obtained.
Autism/PDD	Coverage provided for treatment of autism/persuasive developmental disorder in covered children under the age of 19.
BIC (Benefits Identification Card)	People who are eligible for Medi-Cal receive a Benefits Identification Card (BIC), which is used by Medi-Cal providers to check eligibility. Medi-Cal recipients enrolled in a Medi-Cal managed care health plan have both a BIC and a health plan member card.
Bronze	A Covered California health plan product type. Bronze tier indicates a level of coverage provided by a health plan with 60 percent of the total allowed costs of benefits paid by the health plan.
CalHEERS	The California Healthcare Enrollment, Eligibility and Retention System is a web-based system that streamlines the eligibility and enrollment process for all products and programs available through Covered California.
Cal MediConnect	A Department of Health Care Services, Medi-Cal Managed Care three-year demonstration program for dual Medi-Cal/Medicare eligible beneficiaries to receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system. See also Medi-Cal Coordinated Care Initiative.
Cancellation	Complaint alleging the insurer's improper cancellation of a policy and/or coverage before the expiration date.
Cancer/Dread Disease	An insurance product type that only pays benefits for the diagnosis and treatment of cancer and/or other specifically named serious disease or diseases.
Catastrophic	Health plans that meet all the requirements of a qualified health plan but that don't cover any benefits other than three primary care visits per year before the plan's deductible is met.
Chiropractic	Coverage for care provided by a Chiropractor. Normally, not seen as regular health maintenance but as a term recovery plan.
Claim Delay	Complaint alleging that the insurer has unreasonably delayed the investigation and/or processing of a claim.
Claim Denial	Complaint alleging improper claim denial by insurer.
Claim Reopened	Regulated entity or individual has reopened claim for further investigation or settlement negotiation. A final resolution of the claim has not been determined.
Claim Settled	Claim brought to conclusion, in whole or in part, and no other disposition is appropriate.

Term	Explanation
Closed Complaint	A complaint that has been investigated by the state insurance department and given a resolution code. A complaint that has completed a complaint review process by a reporting entity or its official affiliate.
Closed Network/Provider Discrimination	Complaint regarding insurer's refusal to admit provider to network, due to lack of need.
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)	A U.S. statute which requires that employers sponsoring group health plans offer continuation of coverage under the group plan to employees and their dependents who have lost coverage because of the occurrence of a "qualifying event." Qualifying events include reduction in work hours, many types of termination of employment, death, and divorce.
Complaint	A written or oral complaint, grievance, appeal, independent medical review, hearing, or similar process to resolve a consumer problem or dispute.
Complaint Ratio	The number of complaints closed during the calendar year divided by the number of covered lives the insurer had in place by the end of a specific month. For this report the complaint ratio was calculated from complaints closed in 2014 divided by the number of covered lives from Spring 2014 enrollment, and the resulting ratio was divided by 10,000.
Complaint Reason	A complaint data element indicating the primary reasons for the consumer complaint. For this report a single complaint case can have up to three reasons. Examples of complaint reasons include cancellation, medical necessity denial, and claim denial.
Complaint Withdrawn	Complainant requested that the complaint be withdrawn.
Compromise Settlement/Resolution	Complaint resolved voluntarily by an insurer or regulated entity, via additional payment, restored benefit or policy status, and/or other means. No finding by the insurance department that the regulated entity or individual was in violation or otherwise at fault.
Consumer's Money Returned	A return of money or benefits was made to the insured/complainant.
Continuation of Benefits	Complaint regarding COBRA (Comprehensive Omnibus Budget Reconciliation Act) enrollment and/or coverage after the insured no longer qualifies for group coverage.
Continuity of Care	Complaint regarding the transition plan of continuing care.
Coordination of Benefits	Complaint alleging one or both insurers' failure to properly coordinate benefits.
Co-Pay, Deductible, and Co-Insurance Issues	Complaint alleging that the incorrect co-pay, deductible or co-insurance amounts has been applied to a claim.
Cost Containment	Complaint alleging insurer's misapplication of cost-containment measures such as pre-certification, utilization review, concurrent review, managed care, second opinion, etc.
Coverage Question	Complaint alleging insurer's inadequate response to insured's request for information on policy status or coverages, or for interpretation of policy provisions.
Covered California/Exchange/Market place	Coverage provided by a plan issued through a governmental agency or non-profit entity that meets the applicable standards of Tile 45 of the Federal Register and makes qualified health plans available to qualified individuals and/or qualified employers. Covered California is California's state-run exchange.
Covered Lives	Policyholders, subscribers, enrollees, or other individuals participating in a health benefit plan.
CRM (Customer Relationship Management)	A call center technology system to manage and record interactions with people who contact the call center.
Customer Service Representative (CSR)	A person who answers telephone calls in a service center (or communicates with customers through other modes of contact, such as email).
Delay Resolved	A delay in provider service or information was resolved.
Delayed Authorization Decision	Complaint alleging insurer's delayed response to healthcare authorization request.
Delivery of Policy	Complaint alleging insurer's delayed delivery of, or failure to deliver, an insurance policy to the insured.
Denial of Covered California Coverage	Complaint that coverage through Covered California was improperly denied.
Denial of Specialty Mental Health Services by Mental Health Plan	A complaint reason reported by DHCS that encompasses multiple complaint reasons regarding the delivery of mental health services, including access to care, quality of care, medical necessity denials, and others. DHCS indicated that their data currently cannot be separated into more specific standardized report reasons.
Dental Combined with Major Medical	A Product Type reported by CDI. See Dental Only and Major Medical definitions.

Term	Explanation
Dental Scope of Benefits	A complaint reason reported by DHCS that encompasses multiple complaint reasons regarding the delivery of dental services, including access to care, quality of care, medical necessity denials, and others. DHCS indicated that their data currently cannot be separated into more specific standardized report reasons.
Dental Only	A line of business providing dental only coverage; coverage can be on a stand-alone basis or as a rider to a medical policy. If the coverage is as a rider, deductibles or out-of-pocket limits must be set separately from the medical coverage. Does not include self-insured business as well as FEHBP or Medicare and Medicaid programs.
Dental Stand Alone	Coverage provided by a limited scope dental benefits plan through an exchange or in conjunction with a qualified health plan.
Dis/Enrollment	Complaint regarding issues related to enrollment in coverage.
Disability Income	Coverage that provides benefits in case of the insured's inability to perform all or part of his/her occupational duties because of an accident or illness.
Eligibility Determination	Complaint is about a problem with eligibility for health care coverage, typically through a public program.
Emergency Services	Complaint regarding coverage, with respect to an emergency medical condition, arising out of a medical screening examination that is within the capability of an emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize a patient.
EPO (Exclusive Provider Organization)	An EPO is a kind of health plan that requires its members to use an exclusive network of contracted providers, but typically allows members to see network providers without a referral.
ERISA	The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most pension and health benefits voluntarily established by private industry employers to provide protection for individuals in these plans.
Exchange	Coverage provided by a plan issued through a governmental agency or non-profit entity that meets the applicable standards of Tile 45 of the Federal Register and makes qualified health plans available to qualified individuals and/or qualified employers. Covered California is California's state-run Exchange.
Experimental	See definition for Experimental/Investigational Denial.
Experimental/ Investigational Denial	Complaint regarding denial of coverage for a treatment or service that the health plan has determined is experimental.
External review	Complaint alleging insurer's failure to comply with statutory process requirements for external review.
FI (Fiscal Intermediary)	A contracted company that serves as the government's agent for claims processing and managing related systems for administering a public health care program.
59 Hold	Refers to a status code in the Medi-Cal Eligibility Data System (MEDS) indicating that a health plan enrollment is on hold due to a change in the Medi-Cal recipient's status other than Medi-Cal eligibility (e.g., the recipient moved to a different county).
Fraud/Forgery	Complaint alleging some form of claim-related deception or unfair practice by a third party resulting in unfair financial or compensable gain.
Gold	A Covered California health plan product type. The gold tier indicates a level of coverage provided by a health plan with 80 percent of the total allowed costs of benefits paid by the health plan.
Grandfathered	Coverage provided by a group health plan, or a group or individual health insurance issuer, in which the individual was enrolled on March 23, 2010, for as long as it maintains that status under the rules of section 147.140 of Title 45 (Code of Federal Regulations).
Group Health Plan	Health insurance coverage policy purchased by an employer or other employee organization and offered to eligible employees as a benefit. Insurance that is issued to Insurance that is issued against sickness or injury where the group is the policyholder and the individual insured is the certificate holder.
Health Benefit Exchange Board	The Exchange is an independent public entity within state government with a five-member board appointed by the Governor and the Legislature. Two members are appointed by the Governor; one by Senate Rules Committee; and one by Speaker of the Assembly. The Secretary of the Health and Human Services Agency or another designee serves as an ex-officio voting member of the Board. Appointed members serve four year terms.

Term	Explanation
Health Only	Insurance covering sickness only. This can include an HMO (Health Maintenance Organization), who provides basic health care services to enrollees on a prepaid basis except for enrollees' responsibility for co-payments, deductibles, and a PPO (Preferred Providers Organization).
Health Plan/Health Insurer	A health plan or insurer is an entity that provides, offers, or arranges for coverage of designated health services needed by plan members or policy holders for a fixed, prepaid premium. Health plans are licensed to operate in California by the Department of Managed Health Care. Health insurers are licensed by the California Department of Insurance. For this report, health plan may be used to refer to both health plans and health insurers.
Health Plan in Compliance	Complaint result category originally used by the NAIC to indicate that a company's tendencies comply with the state insurance regulations.
Health Plan Position Overturned	Complaint resolved by a regulated entity to ensure compliance with applicable state law/requirement, via additional payment, restored benefit or policy status, and/or other means. Insurance Department found the regulated entity to be in violation or otherwise at fault.
Health Plan Position Substantiated	The regulated entity upheld its original position, and appears to be in compliance with applicable statutes/regulations.
Health Privacy	Complaint regarding the protections (or lack thereof) to ensure privacy of health information.
HIPAA	Health Insurance Portability and Accountability Act. Includes provisions that guarantees that employers are not able to impose preexisting condition limitations in the insurance they offer to new employees who had insurance coverage for at least 12 months with their previous employer.
HMO (Health Maintenance Organization)	A kind of managed care health plan that requires its members to use a network of contracted providers to get health care services.
Home Health Care	Health care provided in the home of the patient, usually by a private nurse or a state-licensed home health care agency. Services are usually limited to part-time or intermittent nursing care and physical or occupational rehabilitation.
Hospital Indemnity	Coverage that provides a predetermined flat benefit for each day of hospitalization regardless of expenses incurred.
Hospitalization	Complaint regarding coverage for expenses arising out of services provided during confinement in a hospital as a patient for diagnostic study and/or treatment.
Independent Medical Review (IMR)	An Independent Medical Review is an external review process for addressing certain qualifying complaints about treatment or service denials or delays. Doctors who aren't part of the complainant's health plan or insurance company conduct the review and make a determination. Under law an IMR must be resolved within 30 days.
Individual Health Plan or Individual/Commercial	Insurance that is issued to an individual insuring one (and one's dependents if on the same policy) against sickness or injury.
Inquiry	A request for assistance made by a consumer to a consumer assistance service center that does not initiate a complaint with the associated reporting entity. For this report, the general category of inquiry is used to refer to jurisdictional inquiries and non-jurisdictional inquiries/complaints.
Insufficient Information for Further Investigation	Complainant failed to provide sufficient information/documentation to warrant further investigation.
Interactive Voice Response (IVR)	A technology system used by telephone service centers that interacts with callers by allowing them to input information using their phone keypad and/or their voice. IVR systems often are used to gather information needed to route the call to the right customer service representative or to provide appropriate pre-recorded information.
Involuntary Termination by Plan	Complaint alleging improper termination of provider contract by insurer.
Jurisdictional	Within the authority of a consumer assistance service center to address or resolve.
Jurisdictional Complaint	Complaint that falls under the authority of the service center to address or resolve.
Language Access	With regards to internal claims and appeals and external review processes and federal health reform requirements to provide relevant notices in a culturally and linguistically appropriate manner, a consumer complaint alleging (1) failure to provide language access or (2) inadequate/improper notice regarding language accessibility.
Language Assistance	Assistance to provide relevant information and services in a culturally and linguistically appropriate manner.

Term	Explanation
Large Group	Coverage provided by a health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and sometimes their dependents) through a group health plan maintained by a large employer, unless otherwise provided under state law.
Limited Benefits	A health insurance policy with limited benefit payments where all benefits have been paid to the beneficiary.
Long Term Care PACE	PACE stands for Program of All-Inclusive Care for the Elderly. PACE is a model of care provided through a DHCS program to coordinate health care, long term care, and other social services to help older adults who would otherwise reside in nursing facilities to remain in their own homes. A PACE organization provides a comprehensive system of health care services for members age 55 and older who are otherwise eligible for nursing home admission. Both Medicare and Medicaid pay for PACE services (on a capitated basis).
Long Term Care SCAN	SCAN stands for Senior Care Action Network. A Medicare Advantage Special Needs Plan provided through a DHCS program to coordinate health care and long term care services for beneficiaries in three counties who are eligible for Medicare and Medi-Cal.
Major Medical	Coverage which, after the limits of coverage have been exhausted under a basic plan, medical expenses relating to room and board, physician fees, miscellaneous expenses such as bandages, operating room expenses, drugs, x-ray, and fluoroscopy, are then met under a major medical plan.
Maternity and Newborn Care	Complaint regarding coverage for expenses arising out of hospital length of stay in connection with childbirth for a mother or her newborn, as described in §146.130 and §148.170 of Title 45.
Medical Exemption Request	A DHCS process for a Medi-Cal beneficiary to request continued medical care from a regular Medi-Cal Fee-for-Service provider who is not a part of a Medi-Cal managed care plan network.
Medi-Cal	California's Medicaid program to provide health coverage to low-income individuals. The Medi-Cal program is administered and overseen by DHCS.
Medi-Cal County Organized Health System (COHS) Model	A Medi-Cal managed care model approved by the federal government under an 1115 Waiver. In the COHS model, DHCS contracts with a health plan created by the County Board of Supervisors. The health plan is run by the county. In a COHS county, everyone is in the same managed care plan.
Medi-Cal Coordinated Care Initiative (CCI)	A Medi-Cal managed care model approved by the federal government under an 1115 Waiver. CCI is a demonstration project in certain counties that promotes coordinated care models where seniors and disabled Medi-Cal beneficiaries receive all benefits in an organized delivery system. It includes medical services, long term support services and behavioral health services.
Medi-Cal Fee-for-Service	A health care delivery system of the Medi-Cal program. Under this model, providers render services to Medi-Cal beneficiaries and then submit claims for payment that are adjudicated, processed, and paid (or denied) by the Medi-Cal program's fiscal intermediary.
Medi-Cal Geographic Managed Care (GMC) Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In GMC counties, DHCS contracts with several commercial plans to provide more choices for beneficiaries. GMC serves Medi-Cal beneficiaries in two counties: Sacramento and San Diego.
Medi-Cal Managed Care	A health care delivery system of the Medi-Cal program. Under managed care models, the Medi-Cal program contracts with managed care plans to provide services to beneficiaries through established networks of organized systems of care.
Medi-Cal Managed Care Imperial Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In this rural Medi-Cal managed care model, there are two commercial plans that contract with DHCS. The Imperial model serves Medi-Cal beneficiaries in Imperial County.
Medi-Cal Managed Care Other Model	A Product Type category reported by DHCS used to display Medi-Cal Managed Care Models: Rural Model, Imperial Model, San Benito Model, Long Term: PACE, and Long Term: SCAN
Medi-Cal Managed Care San Benito Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In this rural Medi-Cal managed care model, there is one commercial plan that contracts with DHCS. Beneficiaries can choose the managed care plan or regular (Fee-for-Service) Medi-Cal. The San Benito Model serves Medi-Cal beneficiaries in San Benito County.
Medi-Cal Managed Care Two Plan Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In this Medi-Cal managed care model, DHCS contracts with a local initiative plan (county organized) and a commercial plan. The Two-Plan Model serves Medi-Cal beneficiaries in 14 counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare.
Medi-Cal/Medicare	A source of coverage category indicating the consumer has dual coverage through the Medi-Cal and Medicare programs.

Term	Explanation
Medical Necessity Denial	Complaint alleging that the insurer has improperly denied covered services as not medically necessary.
Medicare	A source of coverage indicating the consumer has Medicare, a federal government health insurance program for people age 65 years and older and for some people with disabilities.
Medicare Advantage	A source of coverage indicating the consumer has a type of Medicare health plan offered by a private company that contracts with Medicare to provide the consumer with his/her Part A and Part B benefits.
Medicare Prescription Drug/Part D	A source of coverage indicating a stand-alone drug plan that adds prescription drug coverage to Original Medicare and some other Medicare plans.
Medicare Supplement	Coverage that provides accident and health expenses not covered under Medicare. There are various types of standard policy form choices available for Medicare supplemental insurance coverage.
Mental Health	Coverage for professional mental health services. Including psychologist, crisis centers, rehabilitative therapy, etc. An emotional or organic mental impairment (usually excluding senility, retardation or other developmental disabilities, and substance addition); a psychoneurotic or personality disorder; any psychiatric disease identified in a medical manual. (American Psychiatric Association's Diagnostic and Statistical Manual).
Mental Health Parity	With respect to mental health and substance abuse disorder services essential health benefits, including behavioral health treatment services, a complaint regarding improper application of lifetime and annual dollar limits and out of pocket maximums. Mental health parity laws require that health plans and insurers cover benefits for mental health and substance abuse disorders similarly to other health conditions.
Misrepresentation	Complaint alleging that the insurer or representative made misleading or untrue statements about policy terms, benefits, or about insurance during the marketing/sales process.
Mode of Contact	A report data element indicating the communication platform used by a consumer to contact a consumer assistance service center. Examples of modes of contact include telephone, mail, email, chat, and fax.
Multi State	Coverage provided by a health plan that is offered under a contract between the U.S. Office of Personnel Management and the Multi State Plan Program issuer pursuant to section 1334 of the Affordable Care Act and that meets the requirements of Title 45.
No Action Requested/Required	Department of Insurance received only a copy of a complaint that the complainant sent directly to the company, or there was no direct request for assistance.
No Jurisdiction	Complaint does not fall under the regulatory authority of the state's Insurance Department, and was not referred to any outside agency, Department or court system. Includes Action Suspended for litigation and/or formal arbitration.
Non-Jurisdictional	Not within the authority of a consumer assistance service center to address or resolve.
Non-Jurisdictional Inquiry/Complaint	A request for assistance to a consumer assistance service center from a consumer who requires education and a referral to another entity to address a question or resolve a complaint about a non-jurisdictional topic.
Nonrenewal	Complaint alleging insurer’s failure to (or decision not to) offer policy renewal, and/or insurer’s.
Notice Requirements	Consumer complaint alleging non-issuance or improper issuance of notice of grandfathered status and notice of choice of primary care provider.
Other	Indicating a category not fitting into any specific standardized report category.
Other Violation of Insurance Law/Regulation	Complaint about a violation of a provision of law or regulation not specified in another category.
Out of Network Benefits	Complaint regarding dissatisfaction with the administration or determination of benefits on a claim for services that have been requested, received or determined to be out-of-network.
Overturned/Health Plan Position Overturned	Complaint resolved by a regulated entity or individual to ensure compliance with applicable state law/requirement, via additional payment, restored benefit or policy status, and/or other means. Insurance Department found the regulated entity or individual to be in violation or otherwise at fault.
Participating Provider Availability/Timely Access to Care	Complaint alleging that no in-network provider available, and that a claim processed at the out-of-network benefit level should be reprocessed as an in-network claim.

Term	Explanation
Personnel Year	The actual or estimated portion of a position expended for the performance of work. A personnel year is equal to 12 months full-time employment of one person, or 12 persons employed for one month, two persons employed for six months, or any similar combination equal to one personnel year.
Pharmacy Benefits	Complaint regarding coverage for expenses for charges made by a pharmacy, for medically necessary prescription drugs or related supplies ordered by a physician.
Plan Subcontractor/Provider Billing/Reimbursement Issue	A complaint reason reported by DHCS for billing and reimbursement issues involving a managed care plan's subcontractor or provider.
Platinum	A Covered California health plan product type. The platinum tier indicates a level of coverage provided by a health plan with 90 percent of the total allowed costs of benefits paid by the health plan.
Policyholder Service	A general complaint classification that includes multiple complaint reason categories associated with a failure by the insurer to provide adequate and/or timely services to the policyholder. Examples of Policyholder Service complaints include abusive service, inaccessible care, failure to send premium-related notices, and delays in responding to a policyholder request for information.
POS (Point of Service)	A POS plan is a kind of managed care health plan. It combines characteristics of the health maintenance organization (HMO) and the preferred provider organization (PPO).
PPO (Preferred Provider Organization)	A PPO is a kind of managed care health plan. A PPO has a network of contracted providers but offers its members options to go outside of the network for care. In addition, members can see providers without prior approval from the plan.
Premium & Rating	Complaint regarding a disagreement, inquiry, or question about insurer's premium/rating structure, or manual rules (ratings). Includes complaints alleging that the insurer improperly classified the applicant as a higher risk than it should have, resulting in an improperly high premium.
Premium Notice/Billing	Complaints alleging insurer's failure to send notice regarding premium due date, premium increase/decrease, policy lapse, etc.
Preventive Care	Routine health care that includes screenings, check-ups, and patient counseling to prevent illness, disease, and other health problems. Most health plans must cover certain preventive services at no cost to the plan enrollee. Complaint regarding coverage for expenses arising out of preventive care/wellness services and/or chronic disease management, to include complaints about an insurer's assessment of cost-sharing (improper application of co-payments, deductibles, and co-insurance) for such services.
Product Type	A complaint data element used to identify details about specific areas of coverage, such as the health plan's model, structure, benefits, and/or other distinguishing characteristics. In this report, most product types align with NAIC's Type of Coverage/Accident & Health Second Level codes. Examples of product types include HMO, PPO, Silver, Platinum, Health Only, Dental, and Small Group.
Protocols	Performance standards, policies and procedures, and other system requirements that determine a service center's response to a consumer request for assistance.
Provider Attitude and Service	Complaint alleging rude, threatening, or other coercive or unprofessional behavior by a provider or their representative.
Provider Directory	A list of doctors and other providers who participate in a health plan's network. A complaint about a provider directory alleges improper reflection of provider participation status in the insurer's directory (also see Provider Listing Dispute).
Provider Listing Dispute	Complaint alleging improper reflection of provider participation status in insurer's directory.
Question of Fact/Contract/ Provision/Law Fall Outside Regulator	Complaint involves a question of fact, or a question of law involving a contract provision or interpretation thereof, and therefore falls outside the regulatory authority of the Insurance Department.
Quick Resolution (QR)	A complaint type reported by DMHC. QR complaints meet DMHC's Urgent Nurse (see Urgent Nurse definition) screening triggers but a DMHC staff review determines that the issues can be resolved without standard complaint or urgent nurse processes. The QR process includes issues such as requests to file a grievance/appeal, expedited review of a grievance/appeal, access to providers, out of network referrals, second opinion consultation, quality of care complaints, or refill of medication(s).
Quick Sort Calculator	A computer application tool used by Covered California's Service Center staff to decide if a caller is likely eligible for Medi-Cal and should be transferred to the county for further assistance.

Term	Explanation
Referral to Another State's Dept. of Insurance	Complaint falls under the regulatory jurisdiction of another state's insurance department.
Referred to Other Division for Possible Disciplinary Action	Complaint referred elsewhere within regulating agency (Legal, Agent Services, Investigations, etc.) based on apparent or suspected violations of state law, etc.
Referred to Outside Agency/Department	Complaint was referred to a different state agency/department.
Refund	A refund was made to the claimant.
Regulator	A government entity with the authority to oversee and enforce health insurance laws and regulations, including those related to licensing, product regulation, financial regulation, and market conduct. California has two state health insurance regulators, the Department of Insurance and the Department of Managed Health Care.
Reporting Entity	For this report, a state health care department or entity that is statutorily required to provide consumer complaint data and other consumer assistance information to the Office of the Patient Advocate (per Health and Safety Code section 136000). Reporting entities are the Department of Managed Health Care, Department of Health Care Services, Department of Insurance, and the Exchange (Covered California).
Request for Assistance	A call, email, or other contact made to a state reporting entity from a consumer who is looking for help resolving a problem or complaint or who has a question regarding his/her health care coverage. For this report this category includes all consumer contacts for jurisdictional and non-jurisdictional complaints and inquiries.
Resolution Time	The time from the date a complaint was filed by a consumer with a reporting entity to the date that a complaint was closed by that reporting entity. Reporting entities may have different protocols for when they register the opening and closing of a complaint case.
Self-Funded/ERISA	Self-funded refers to the coverage purchaser making financial preparations to meet pure risks by appropriating sufficient funds in advance to meet estimated losses, including enough to cover possible losses more than those estimated did. ERISA refers to the federal law establishing (a) the rights of pension plan participants, (b) standards for the investment of pension plan benefits, and (c) requirements for the disclosure of plan provisions and funding.
Service Center	Health care consumer or patient assistance help centers, call centers, ombudsperson, or other assistance centers. For this report, service centers refer to those operated or contracted by the Department of Managed Health Care, Department of Insurance, Department of Health Care Services, and Covered California.
Short Term Limited Duration Policy	A policy that is less than one year in duration and that is not guaranteed renewable.
Silver	A Covered California health plan product type. The Silver tier indicates a level of coverage provided by a health plan with 70 percent of the total allowed costs of benefits paid by the health plan.
Small Group	Coverage provided by a health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.
Source of Coverage	A complaint data element used to identify a category of a health plan's contracting/purchasing mechanism, which is associated with an insurance market segment and related laws. Examples of coverage sources include Individual/Commercial, Group, Medi-Cal Managed Care, and COBRA.
Standard Complaint	A complaint type category for complaints that undergo the reporting entity's typical complaint review process. Examples of issues that may be addressed as a Standard Complaint include billing problems, cancellation of coverage, and a provider's attitude. Complaints that are urgent or require the intervention of a health care provider may also be addressed as Standard Complaints.
State Fair Hearing	A formal complaint process to adjudicate appeals from California residents who have applied for, have received, or are currently receiving benefits or service from an assistance program administered by the State of California. The California Department of Social Services is authorized to conduct State Fair Hearings for appeals regarding Covered California applications and eligibility determinations, as well as for all Medi-Cal appeals. A State Fair Hearing is sometimes called a State Hearing, Fair Hearing, or Medi-Cal Fair Hearing.
State Specific (Other)	Complaint is about a state specific code: regulatory agency will use a further state-specific code to track data needed for a purpose not shared by other states or the NAIC.

Term	Explanation
Student Health	Coverage provided by a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education (as defined in the Higher Education Act of 1965) and a health insurance issuer, and provided to students enrolled in that institution of higher education and their dependents.
Summary of Benefits	Complaint regarding the improper issuance or non-issuance of a Summary of Benefits and Coverage/Uniform Glossary.
Unknown	A complaint data category indicating data was not identified. Data listed as Unknown were for fields submitted as Unknown or blank (without data), either because the data was not collected by a reporting entity (CDI, Covered California, DHCS, or DMHC) or because there were complainants who did not provide information to a reporting entity.
Unsatisfactory Refund of Premium	Complaint alleging insurer or their representative failed to properly refund an unearned premium.
Unsatisfactory Settlement/Offer	Complaint that insurer's payment or settlement offer is less than or below the amount expected by the insured or claimant.
Upheld/Health Plan Position Substantiated	The regulated entity upheld its original position, and appears to be in compliance with applicable statutes/regulations.
Upheld/Covered California Position Substantiated	A complaint result reported by Covered California. See definition for Upheld/Health Plan Position Substantiated.
Urgent Clinical	An expedited complaint resolution protocol for addressing a complaint potentially involving an urgent medical issue or emergency that puts the complainant's health at risk.
Urgent Nurse Complaint	A complaint type reported by DMHC. DMHC's Urgent Nurse process identifies and addresses complaints involving a potential health risk to the complainant and that may need immediate attention and expedited resolution by DMHC clinical staff, who are experienced in both health care and managed care systems.
Usual, Customary, and Reasonable Charges	The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. Complaint reason alleging that the insurer's "usual, customary and reasonable" reimbursement amounts are inadequate.
Vision	Health insurance coverage for eye examinations and eyeglasses or contact lens prescriptions.
Waiting Periods	Complaint alleging an insurer's improper application of waiting periods. A "waiting period" is defined as the period that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of a plan.
Warm Transfer	A process for transferring a call where the customer service representative who initially answered the call dials the referral phone number for the caller, helps to navigate phone system options, and speaks to the other customer service representative prior to completing the call transfer.
Willing Provider	Complaint alleging insurer's failure to comply with a state's any willing provider law.
Withdrawn/Complaint Withdrawn	Complainant requested that the complaint be withdrawn.

Appendix B. – Service Center Systems for Tracking Complaints and Meeting Standards

The following information outlines the systems used by the state service centers to track consumer assistance activities and ensure appropriate and timely resolution of complaints or referrals to other consumer assistance resources.

DMHC Help Center

Help Center Quality Assurance Program	• Staff Training Program
	• Documented Policies and Procedures
	• Documented Talking Points and Advice Memos on key health topics
	• Ability to have a Supervisor conduct a final review of case file prior to close
	• Internal Quality Improvement Committee
	• Quality Audit Program
	  ○ Monthly random sampling of staff casework
	  ○ Unit-specific audit tools that check staff casework against DMHC's standards

The DMHC Help Center utilizes its Virtual Contact Center, Knowledge Management System, and an SQL database for handling consumer calls, routing calls and complaint cases, and tracking complaints. Help Center managers have system tools to monitor phone call metrics, as well as complaint case volume, status and resolutions.

Help Center staff are trained on policies and procedures and provided written guidelines for documenting complaint information and updating cases within the Help Center's records system. Each Branch within the Help Center that is responsible for handling consumer complaints has its own specific guidelines for ensuring proper review and routing for complaint case response. Complaint case file records can be reviewed by a Help Center supervisor prior to closing the case.

In addition, as part of DMHC's Quality Audit Program, a random case file sampling is reviewed for areas including appropriate:

- Data entry and case documentation;
- Internal routing or external referrals;
- Actions taken according to applicable law and internal policies and procedures; and
- Communications to the consumer and health plan.

DMHC publicly reports the Help Center's complaint and IMR data on the DMHC website through an annual report. In addition, IMR determination results are reported daily and posted online in a searchable database.

DHCS Medi-Cal Managed Care Office of the Ombudsman

Managed Care Ombudsman Staff Training	Training materials topics include:
	• DHCS and Medi-Cal program overview, including regarding Fee-for-Service and managed care models
	• Managed Care Ombudsman Customer Relationship Management system
	• Managed Care Ombudsman processes for Medi-Cal managed care plan changes, enrollments, disenrollments, removal of 59 holds, as wells as related processes specific to:
	  ○ Foster Care, Adoption Assistance Program, or Kinship Guardianship Assistance Payment
	  ○ Intermediate Care Facility for Developmentally Disabled
	• Frequent referral resources

The Managed Care Ombudsman uses a Microsoft Dynamics CRM system to keep track of consumer phone calls and correspondence. An analyst creates a case in the CRM for tracking purposes each time a Medi-Cal beneficiary contacts the Managed Care Ombudsman. The analysts are responsible for data entry into the CRM record regarding case details, status and resolution. Analysts can access the Medi-Cal Eligibility Data System (MEDS) to incorporate its beneficiary information into the CRM case record.

The Managed Care Ombudsman indicated that it can create ad hoc reports using the CRM records. In addition, the Managed Care Ombudsman reported that it has updated its systems to allow for better tracking of consumer calls, including call volumes and other phone metrics.

DHCS Mental Health Ombudsman

The Mental Health Ombudsman uses a basic phone line set-up through AT&T without common call center features and tools, such as Interactive Voice Response and the ability to track call metrics. Consumer assistance records are maintained by staff though a Microsoft Access database. The Mental Health Ombudsman indicated it has the ability to create ad hoc reports using this database.

DHCS Medi-Cal Telephone Service Center (Contractor: Xerox)

In its role as the Fiscal Intermediary, the contractor operates and maintains the California Medicaid Management Information System (CA-MMIS). For the Medi-Cal Telephone Service Center, Xerox uses an Avaya contact management system product that provides for Interactive Voice Response, skills-based call routing, real-time call monitoring, and other features. The Telephone Service Center uses an Oracle CRM product for tracking consumer and provider requests for assistance. Service center staff has tools to assist with appropriate call handling, including call scripts and a knowledge management system. This CRM system has capabilities for building ad-hoc, time-based reports.

DHCS Denti-Cal Beneficiary Telephone Service Center (Contractor: Delta Dental)

Quality Assurance Efforts	• Documented procedures and systems for correspondence and complaint handling, including data entry and record keeping
	• Phone scripts and other staff tools
	• Established complaint case tracking forms
	• Supervisor review:
	  ○ Call monitoring system and escalation processes
	  ○ Case status reports (e.g., Daily Aged Inquiry Report, etc.)

In its role as the Medi-Cal dental Fiscal Intermediary, the contractor operates and maintains the California Dental Medicaid Management Information System (CD-MMIS). For its Telephone Service Center operations, Delta Dental uses an Avaya contact management system and other telephony and database products to track telephone metrics and consumer records, including the integration of data with CD-MMIS. These systems allow the contractor to build time-based and ad-hoc reports on Telephone Service Center call volumes and other call metrics, as well as complaint and inquiry response status reports.

CDI Consumer Services Division

Staff Training	Compliance officers' training includes: • California Insurance Code, and other applicable laws and regulation • Exceptions and similarities between California Insurance Code and Health and Safety Code • Proper jurisdiction identification for referral purposes
Performance Monitoring	Consumer Communications Bureau supervisors monitor compliance officers' phone call responses for: • Accuracy of technical information provided • Soft skills (courtesy, call pace, articulation, etc.) Health Claims Bureau and Rating and Underwriting Services Bureau supervisors provide quality control on complaint files, reviewing for: • Timely, clear and concise consumer communications • Resolution appropriate and thorough • Compliance with applicable laws and regulations • Accurate complaint data coding Supervisors review reports that include information on: number of open cases, days complaint files open, violations issued, justified complaints, etc.
Consumer Surveys	Randomly generated surveys mailed to consumers about their experience with CDI and its complaint process

CDI uses National Association of Insurance Commissioners (NAIC) coding for complaint data entry and its database is programmed to limit the coding of a file to the parameters

established by the NAIC. The system does not allow for deviation or free form entries with regard to the basic case tracking.

- CDI tracks each call received on non-jurisdictional issues to the specific department to which the referral is made. NAIC-based coding used for tracking calls does not extend to all subject matters addressed by other departments.
- CDI initially records each written complaint received on non-jurisdictional issues using the NAIC coding template for the purpose of tracking the consumer case. NAIC coding does not distinguish between the various departments. In instances where this information is needed, the file must be pulled and reviewed manually.

CDI publicly reports Independent Medical Review (IMR) statistics on an ongoing basis as case files are closed, through an online database. In addition, CDI produces an annual report on Company Performance and Comparison Data, and reports on Market Conduct and Enforcement Actions, which are available to the public on the CDI website. Prior to publishing an insurance company's performance statistics, statute requires CDI to provide the information to the licensee at least 30 days prior to the publishing. To ensure accuracy of data, CDI imposes a system of checks and balances through an IT data run. CDI provides companies a list of their complaints and violations, if any. CDI then further refines and reconciles the data to ensure fairness to the carrier and accuracy for the consumer.

Covered California Service Center

Staff Training and Tools	• Training Course on "Providing Consumer Assistance"
	• Documented Service Center Processes and Protocols
	  ○ General consumer assistance processes
	  ○ County transfers
	  ○ Eligibility and enrollment
	  ○ Customer Relationship Management (CRM) system record input and documentation
	  ○ Case escalation and appeals
	• Knowledge Base articles
	• Quick Sort calculator and other tools

Call Quality Processes	• Call recording system • Review of random calls by quality assurance staff, who provide evaluations to supervisors • Supervisor feedback and coaching of Service Center representatives based on phone metrics and recorded call reviews
Supervisor and Management Monitoring	• Supervisor review of escalated cases • CRM system dashboard and tracking of open tasks and escalated cases • Phone metrics reports

Covered California uses Cisco Unified Contact Center Enterprise, Oracle RightNow Customer Relationship Management (CRM), and other technology products for its Service Center, which provide Interactive Voice Response, call routing (based on caller

language), and call-status management features (including near-real-time “reader boards” in the call centers). Service Center representatives are provided computer-assisted tools, including screen pops with caller information, phone scripts, and a searchable knowledge management database.

The Service Center’s CRM maintains records of interactions with consumers who have contacted Covered California for assistance, including by phone or through the live chat function. The Service Center staff document consumer issues within the CRM. Covered California’s Service Center representatives access the California Health Eligibility, Enrollment and Retention System (CalHEERS) to input information when helping a consumer apply for a Covered California plan, or to update account information when a consumer reports a change of information. Staff also use CalHEERS account information to verify and validate callers, as well as to determine the status of the consumer’s application or plan enrollment in order to provide appropriate guidance and assistance.

Covered California’s systems have capabilities for automated and ad-hoc report building of the Service Center data. Service Center volumes and other call center metrics are reported during monthly public meetings of the Health Benefit Exchange Board.

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