

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.