

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:

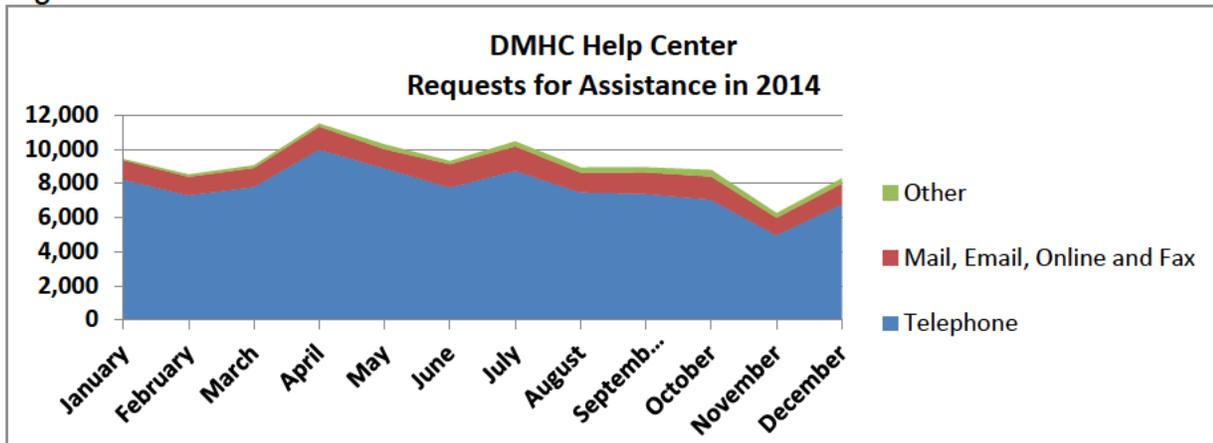
- The Division of Consumer Assistance receives, reviews, and processes all incoming correspondence and telephone calls.
 - The Call Center Branch responds to thousands of calls from consumers requesting general information or assistance.
 - The Initial Review Branch handles all incoming written correspondence, 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.

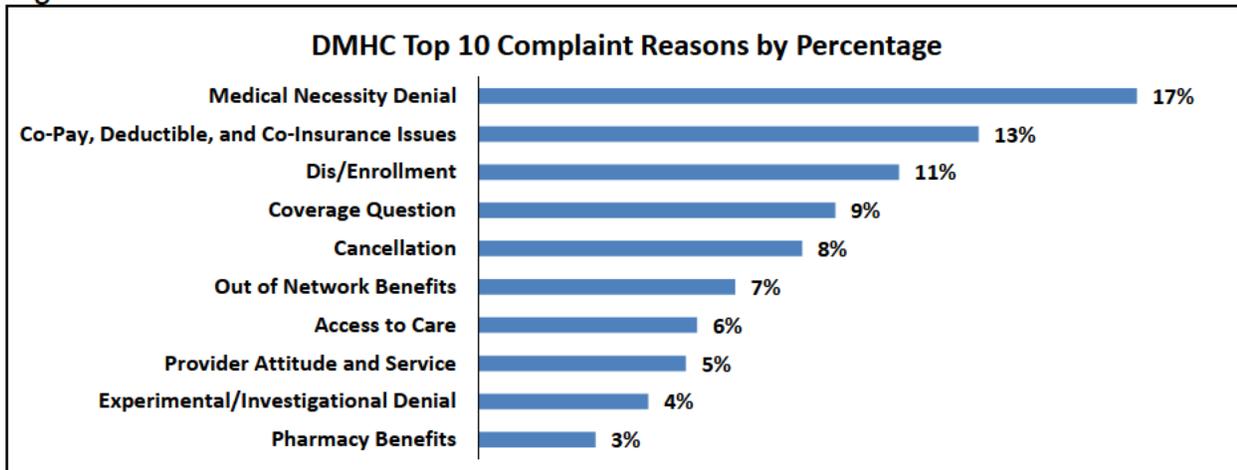
Figure 6.2

DMHC Help Center - 2014 Telephone Metrics		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	Data
Jurisdictional complaint: Non-jurisdictional inquiry:	The DMHC system does not allow separate reporting for jurisdictional and non-jurisdictional calls.	
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

Figure 6.4 Continued

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	<i>Call Center and Initial Review Branches:</i> Intake and routing <i>Complaint Resolution Branch:</i> Casework <i>Legal Review and Liaison Branch:</i> 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

Figure 6.5 Continued

Independent Medical Review (IMR)	<i>Call Center and Initial Review Branches:</i> Intake and routing <i>Independent Medical and Clinical Review Branch:</i> Casework <i>IMR contractor (MAXIMUS):</i> External Review decision <i>Legal Review and Liaison Branch:</i> 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	<i>Call Center and Initial Review Branches:</i> Intake and routing <i>DMHC clinical staff:</i> 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	<i>Call Center and Initial Review Branches:</i> Intake and routing <i>DMHC clinical staff:</i> 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		
Type of 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. <ul style="list-style-type: none"> 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.

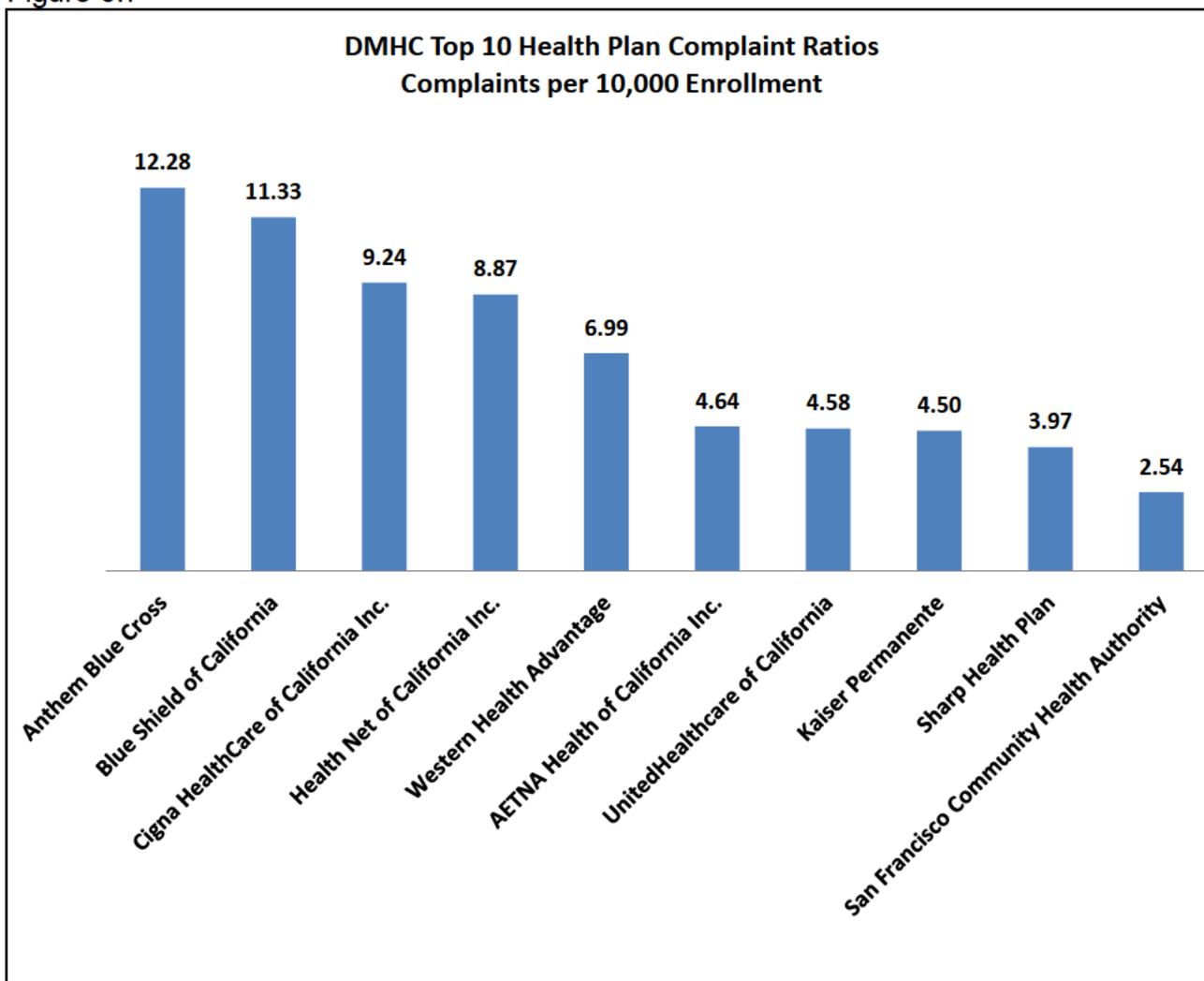
The complaint ratio is calculated by taking the number of closed complaints and dividing it by the number of covered lives the insurer had in place by the end of a specific month in the Spring of 2014. This number is standardized by dividing the ratio by 10,000.

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



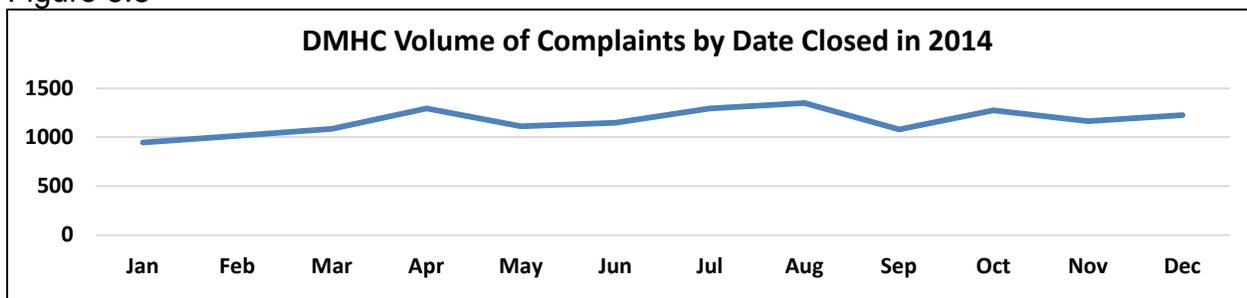
Note: In 2014, the DMHC database's default choice for coverage type was "Small Group". This resulted in an over-reporting of commercial product complaints and an under-reporting of Medi-Cal complaints.

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.

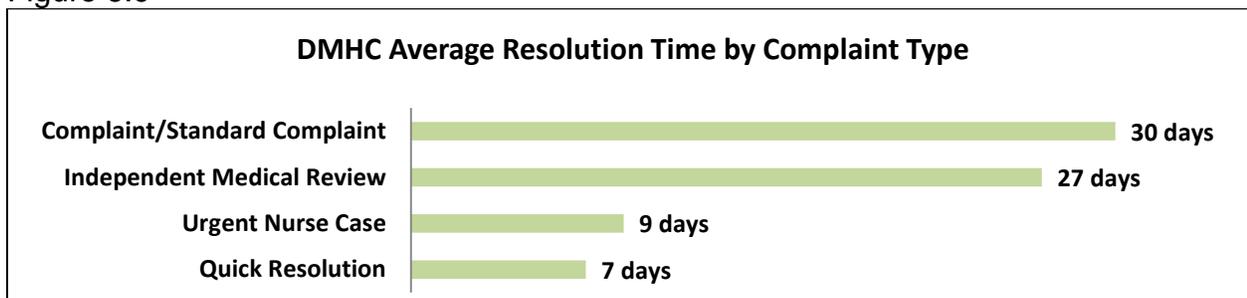
Figure 6.8



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.

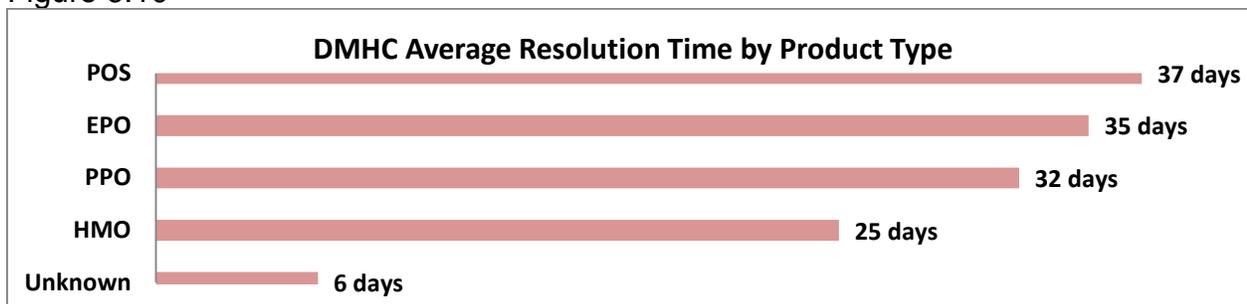
Figure 6.9



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).

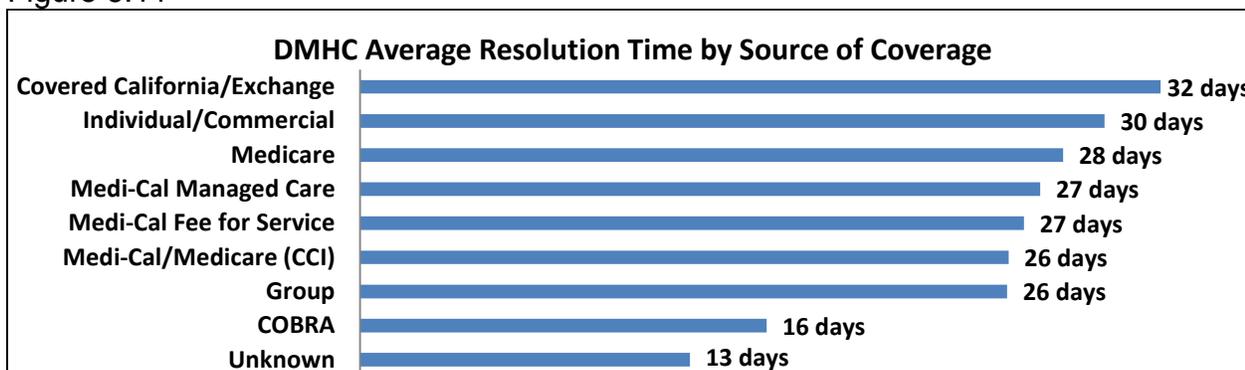
Figure 6.10



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

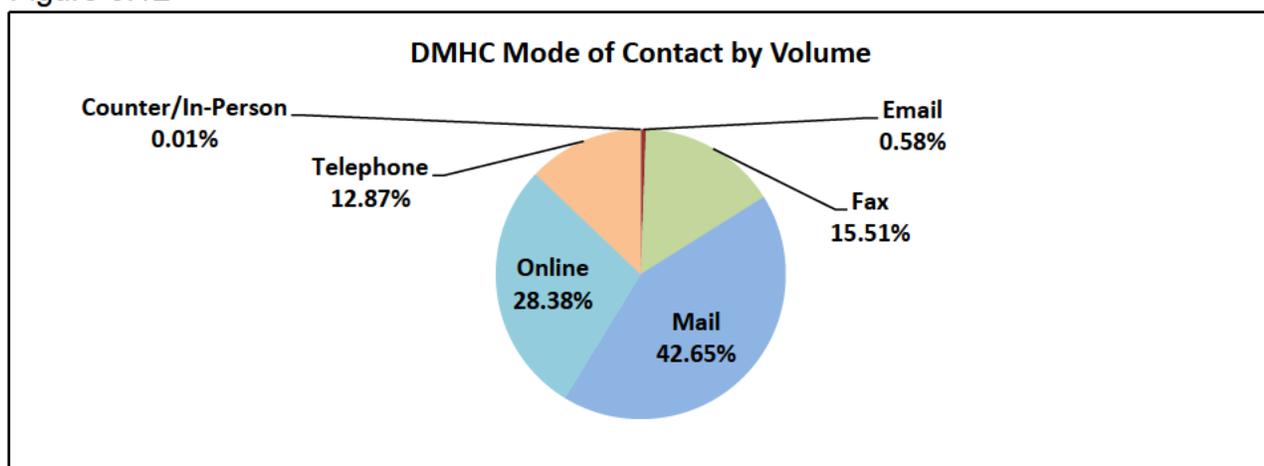
All 13,994 complaints included language information. 13,705 (98%) complaints identified English as their primary language, one percent identified Spanish as their primary language, and one percent identified a language other than English or Spanish as their primary language.

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



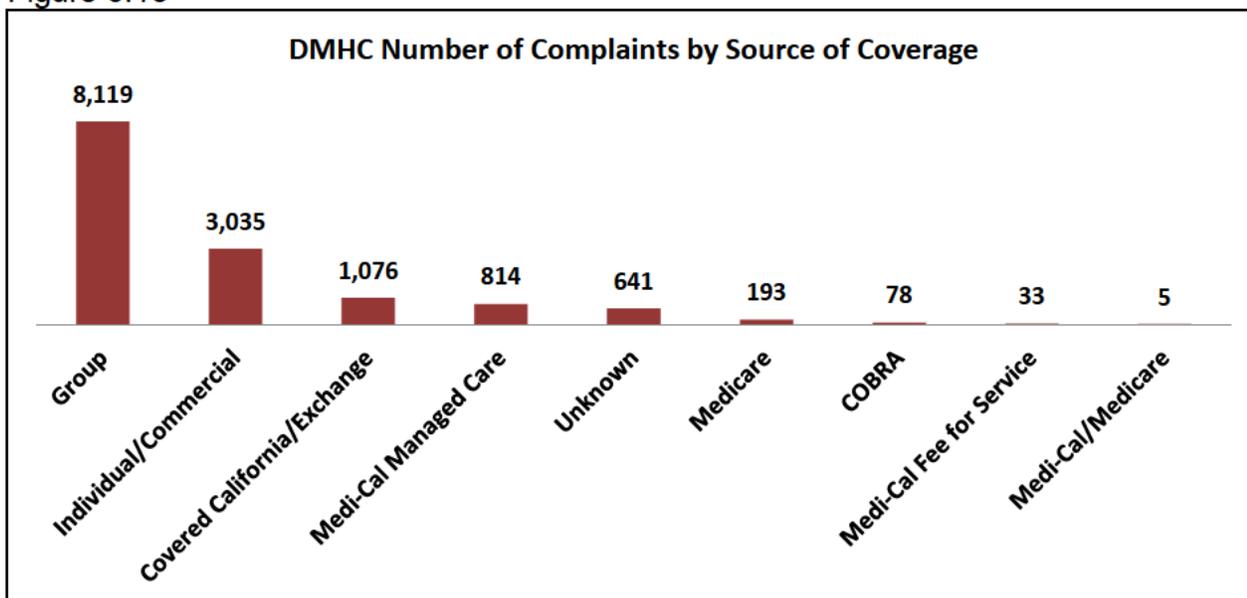
Regulator

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.

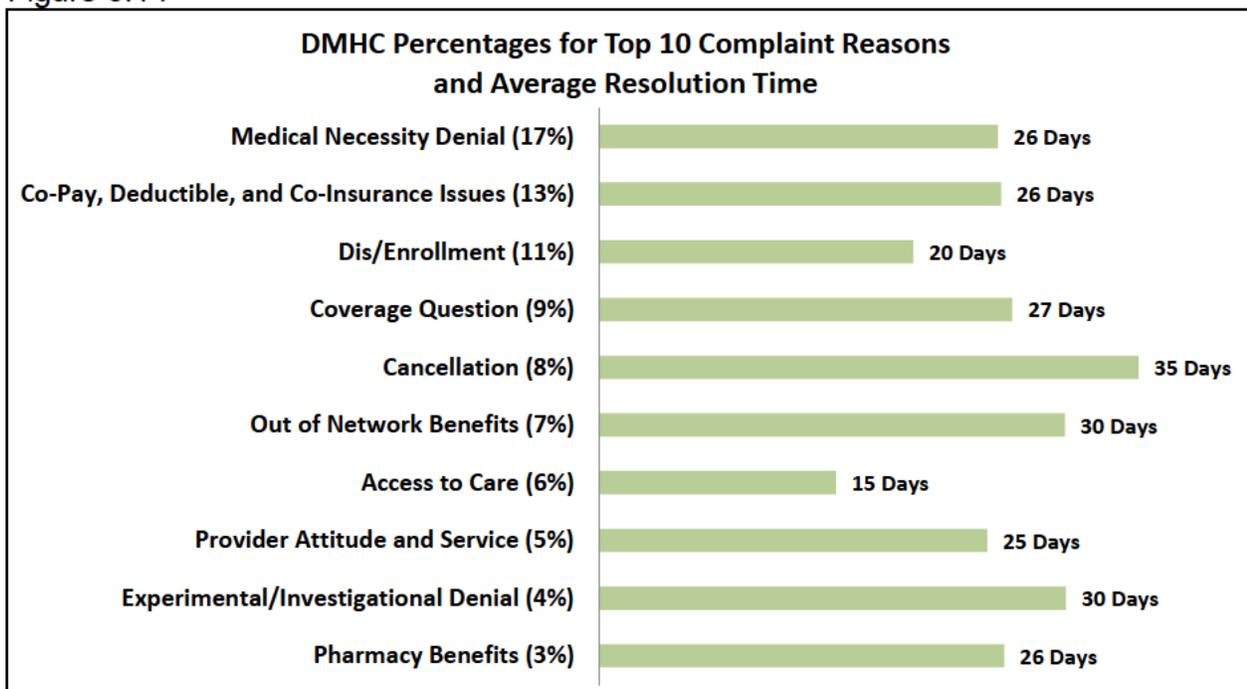
Figure 6.13



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

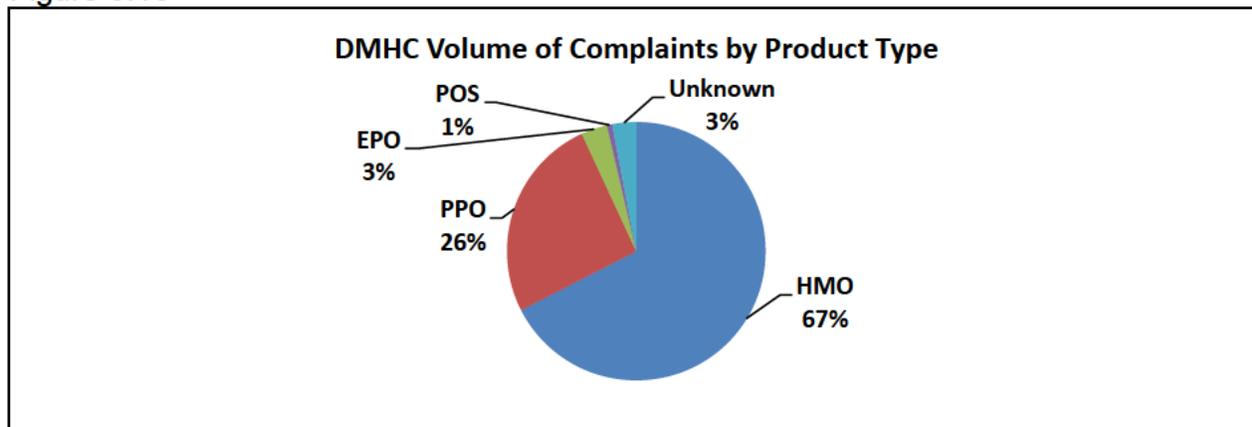


Note: These figures detailing average resolution times are counted from the date that any initial information is received from a consumer.

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	
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.