

## 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	<ul style="list-style-type: none"><li>• Staff Training Program</li><li>• Documented Policies and Procedures</li><li>• Documented Talking Points and Advice Memos on key health topics</li><li>• Ability to have a Supervisor conduct a final review of case file prior to close</li><li>• Internal Quality Improvement Committee</li><li>• Quality Audit Program<ul style="list-style-type: none"><li>○ Monthly random sampling of staff casework</li><li>○ Unit-specific audit tools that check staff casework against DMHC’s standards</li></ul></li></ul>
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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: <ul style="list-style-type: none"> <li>• DHCS and Medi-Cal program overview, including regarding Fee-for-Service and managed care models</li> <li>• Managed Care Ombudsman Customer Relationship Management system</li> <li>• Managed Care Ombudsman processes for Medi-Cal managed care plan changes, enrollments, disenrollments, removal of 59 holds, as well as related processes specific to:                         <ul style="list-style-type: none"> <li>○ Foster Care, Adoption Assistance Program, or Kinship Guardianship Assistance Payment</li> <li>○ Intermediate Care Facility for Developmentally Disabled</li> </ul> </li> <li>• Frequent referral resources</li> </ul>
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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 through 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	<ul style="list-style-type: none"> <li>• Documented procedures and systems for correspondence and complaint handling, including data entry and record keeping</li> <li>• Phone scripts and other staff tools</li> <li>• Established complaint case tracking forms</li> <li>• Supervisor review:                         <ul style="list-style-type: none"> <li>○ Call monitoring system and escalation processes</li> <li>○ Case status reports (e.g., Daily Aged Inquiry Report, etc.)</li> </ul> </li> </ul>
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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: <ul style="list-style-type: none"> <li>• California Insurance Code, and other applicable laws and regulation</li> <li>• Exceptions and similarities between California Insurance Code and Health and Safety Code</li> <li>• Proper jurisdiction identification for referral purposes</li> </ul>
Performance Monitoring	Consumer Communications Bureau supervisors monitor compliance officers' phone call responses for: <ul style="list-style-type: none"> <li>• Accuracy of technical information provided</li> <li>• Soft skills (courtesy, call pace, articulation, etc.)</li> </ul> Health Claims Bureau and Rating and Underwriting Services Bureau supervisors provide quality control on complaint files, reviewing for: <ul style="list-style-type: none"> <li>• Timely, clear and concise consumer communications</li> <li>• Resolution appropriate and thorough</li> <li>• Compliance with applicable laws and regulations</li> <li>• Accurate complaint data coding</li> </ul> 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	<ul style="list-style-type: none"> <li>• Training Course on “Providing Consumer Assistance”</li> <li>• Documented Service Center Processes and Protocols               <ul style="list-style-type: none"> <li>○ General consumer assistance processes</li> <li>○ County transfers</li> <li>○ Eligibility and enrollment</li> <li>○ Customer Relationship Management (CRM) system record input and documentation</li> <li>○ Case escalation and appeals</li> </ul> </li> <li>• Knowledge Base articles</li> <li>• Quick Sort calculator and other tools</li> </ul>
Call Quality Processes	<ul style="list-style-type: none"> <li>• Call recording system</li> <li>• Review of random calls by quality assurance staff, who provide evaluations to supervisors</li> <li>• Supervisor feedback and coaching of Service Center representatives based on phone metrics and recorded call reviews</li> </ul>
Supervisor and Management Monitoring	<ul style="list-style-type: none"> <li>• Supervisor review of escalated cases</li> <li>• CRM system dashboard and tracking of open tasks and escalated cases</li> <li>• Phone metrics reports</li> </ul>

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.