January 14, 2013

Peter Lee, Executive Director
Covered California

Ms. Kim Belshe, Board Member
Secretary Diana Dooley, Board Member
Mr. Paul Fearer, Board Member
Ms. Susan Kennedy, Board Member
Dr. Bob Ross, Board Member

Re: Covered California Service Center Protocols

Dear Board Members:

We have been pleased to offer public comment over the past several months regarding Covered California's continuing work to establish the all-important central Service Center and attendant policies and protocols. We also appreciate the opportunities we have had to meet with staff of the Exchange, Department of Health Care Services, and County Welfare Directors Association to learn more about plans under discussion.

The Service Center—to be accessible through Covered California's toll-free telephone number, in addition to web access—will be the key state portal for consumers seeking health insurance to realize the "no-wrong door" approach to speedy coverage envisioned by the Affordable Care Act (ACA). Our aim is to ensure that consumers opening that door have a truly first-class consumer experience, do not encounter delays in eligibility determination, and are not subjected to duplicative application screenings.

The purpose of this letter, on behalf of the undersigned organizations, is two-fold: to urge the Board to complete a full discussion and evaluation of issues related to the development and execution of Service Center planning, and to more fully describe our substantive concerns with the Service Center protocol proposals.

Background

At its August 23, 2012 meeting, the Covered California Board approved a structure for the Service Center-- a "centralized, multi-site" model, which included the potential for a County serving as one of the sites-- but did not complete consideration of implementing protocols. The staff and Board began discussion of Service Center policy and protocol issues at the August 23, 2012 meeting and continued the discussion at the September 18, 2012 meeting. In both cases, these matters were dealt with as discussion items only, and not as actions. The Board has not voted on the Service Center telephone protocols, nor are we aware that this critical decision was delegated to staff. However, at the December 18, 2012 Board meeting staff reported on developing processes consistent with only one "screen and refer" option: the "quick sort", implying that this is the only option being pursued. We are concerned that the Board has not yet set the policy parameters needed to inform staff direction. We respectfully request that the process of fully vetting all options continue so that the Board can affirmatively decide on core policies and protocols that will enable staff to implement processes that reflect Board principles and priorities. Please see the Addendum for more information on the process to date.

To our knowledge, the Board has not yet had the opportunity to thoroughly evaluate and discuss the many implications of various Service Center options that were presented. Issues such as accountability, projected workload, systemic and human resource readiness and capacity, and cost are key elements of the due diligence required before the Board can compare the protocol options. Importantly, to our knowledge, the Board has not been provided with information about counties' readiness and preparation to assume designated functions.

Considerations Regarding Service Center Protocol Models

The ACA and its federal single streamlined application for all insurance affordability programs rest on the assumption of a smooth, expeditious application process. CalHEERS will be the single rules engine that will facilitate accurate and speedy determinations for affordability programs, making Medi-Cal determinations under the new simplified Modified Adjusted Gross Income ("MAGI") rules for non-elderly and non-disabled individuals extremely simple. Thus, in our view, calls to Covered California's toll-free number, could and should be handled in a streamlined fashion with call transfers only in instances that appear to involve non-MAGI Medi-Cal eligibility for which county specialists are most appropriate, and only after eligibility for other family members has been determined.

However, in the event that the Board decides on a two-step "quick sort" process that will require the transfer of many Service Center callers, it is imperative that those transfers be done as seamlessly as possible, with real-time transfer of entered data, and the opportunity to have the application completed on that same call. The proposed quick sort screening questions are not expected to result in clear, accurate assessments of Exchange or Medi-

Cal eligibility at the outset. Thus, this approach inevitably will generate a duplicative application process, undermining the goal of streamlined eligibility determinations and enrollment. And for callers with limited English proficiency—a large percentage of eligible individuals—unnecessary referrals would compound the confusion and hurdles to coverage they face.

Several Board members have voiced support for the staff recommendation that "warm hand-offs" (with appropriate standards, e.g. an 80%-20 second or 80%-30 second response time requirement) are necessary for any telephone transfers. Clear parameters of what constitutes a warm hand-off must be explicitly defined, and several important considerations need to be decided by the Board to ensure such standards are met, including coordination for families with multiple program eligibility, how/if Exchange enrollments might be handled by counties, performance standards, Exchange cost implications required to support any Covered California Service Center subcontractors, and protocols and contingencies for any call transfers. Contingency planning also needs to encompass development of a plan that spells out how the Covered California Service Center will retain and process calls when a warm hand-off is not available.

Much work remains to be done to ensure that the Service Center is, in fact, ready prior to October 2013, when enrollments will begin. As readiness is evaluated for the Service Center and counties, it will be important to include consideration of other changes counties will be in the process of implementing, including the transfer of 875,000 children from the Healthy Families Program to Medi-Cal, an increase in new Medi-Cal enrollments, the transition of nearly 750,000 dual eligibles to managed care, training on the new, single application for all affordability programs, and the need for significantly amplified handling of telephone applications. A report submitted to the Board dated July 2012 noted the need to address challenges associated with telephone applications and inquiries related to current program rules and on-the-ground processes. The Board must consider the resources that will be necessary to support the anticipated volume of Covered California Service Center applications, including existing and new obligations, to complete applications for Medi-Cal and all insurance affordability programs over the phone.

Recommendations

The undersigned organizations urge the Board of Covered California to take action on, or direct staff to:

1. Continue the discussion begun at the August 23 meeting regarding the eight Service Center issues to be clarified (see Addendum to this letter), request updated information and assessments from staff, and provide direction to staff accordingly

2. Complete a thorough readiness assessment for the Service Center and potential subcontractors, including a current estimation of call volume and resulting workload estimates, as well as any system modifications that would be required to meet performance objectives.

3. Run realistic use cases through all options and scenarios to test capacity and ensure the final protocol decision truly puts the consumer at the center of the equation.

4. Based on these assessments, approve a Service Center Protocol Model that supports a truly first-class consumer experience.

5. If a two-step, “quick sort” process is approved, define and embody in written agreements the standards for a real-time transfer for potential Medi-Cal-eligible individuals (and, inevitably Exchange-eligible individuals), along with the data they have provided, with “warm hand-off” to the relevant county with the opportunity to complete the application on the same call.

6. Establish standards or enrollment policies, and agreements, that provide immediate coverage for eligible individuals regardless of whether the application is processed at the Covered California Service Center or by a subcontracted county.

7. Develop a contingency plan in the event reasonable readiness is not attainable given the estimated or actual workload volume, including having the Covered California Service Center complete the application when a “warm hand-off” in the prescribed timeframe is not feasible.

8. Define policy and referral protocols for ongoing management for multi-program households. Develop the same performance standards for the applications process at the Covered California Service Center and its subcontractors.

9. Provide analysis and recommendations regarding referral and handling of enrollment in Exchange commercial products (with and without subsidies), including full disclosure of terms and conditions, performance standards and mechanisms for ensuring performance for any subcontractors.

10. Establish an ongoing working group on customer service, including representatives of a range of consumer organizations, and/ or re-convene the advisory group mandated by AB 1296 for this purpose. Current advisory groups on outreach, plan management, and the SHOP program do not cover these critical issues. We believe it would be beneficial to Covered California to have early input and ongoing feedback from consumer stakeholders about how the Service Center and any referrals should work and are working.

Conclusion

The key policy issues and facts underlying the Service Center Protocol Models have not yet had the benefit of full disclosure and analysis, or of discussion at a public Board meeting followed by Board action. As we have previously commented, workload projections, as well as capacity and readiness for the Covered California Service Center and all its subcontractors, must be demonstrated as pre-requisite due diligence on the part of Covered California before the Board approves the Service Center protocols. Our strong recommendation is that eligibility and enrollment of callers to the Service Center be handled on that first phone call with no transfer unless absolutely necessary. If the Board decides that callers will be transferred, a timely, real-time and warm hand-off for ALL such transfers should be required.

Our interest in these matters derives solely from our commitment to creating the best possible customer experience for Californians entering this new world of mandated coverage in 2014 and to ensuring the credibility and success of Covered California. We appreciate your ongoing, careful attention to these critical issues and look forward to working with you on them in the coming months.

For more information, please contact:
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Sincerely,

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Addendum: Process to date

At its August 23, 2012 meeting, the Board approved a structure for the Service Center-- a "centralized, multi-site" model, which included the potential for a County serving as one of the sites-- but did not complete consideration of implementing protocols.

At that time, Covered California staff identified eight important "issues to be clarified":

1. Defining the screening and referral protocols for transferring potentially Medi-Cal eligible individuals to their County of residence.

2. Exploration of potential County Service site that agrees to term sheet.

3. Contingencies for upward or downward volume adjustments impacting staffing and other costs.

4. Policy and referral protocols for ongoing management for multi-program households.

5. Design & payment of counties conducting assistance for Exchange eligibility & enrollment of individuals.

6. Refinement of estimated call volumes related to general inquiry, enrollment, and ongoing support.

7. Design and structure of pilot program for testing capacity demands.

8. Explore cost allocation implications of this approach"

At the August meeting, the Board was neither briefed in depth on these issues, including screening and referral protocols, nor asked to take action on them. Rather, as reflected in Board Resolution 2012-49, as amended, it was stated that those matters would be brought back to the Board.

The September 18, 2012 Board meeting agenda set the Service Center Protocol Models as an "action item", but on the day of the meeting a change was announced: that the Agenda item would be for discussion only, and not action. Staff presented three possible approaches for "screening and referral" of potentially Medi-Cal eligible individuals and multi-program households to their County of residence: "quick sort" transfer to a County call center with a "warm hand-off", partial assessment by the Service Center prior to hand-off, and full assessment by the Service Center (presumably with "hand-off" invisible to the consumer, for a final Medi-Cal determination by the County.) It was not apparent that the critical decision of which Model to follow was being delegated to staff.

The next public update to the Board on the Service Center Protocol Models was not until the December 18, 2012 Board meeting. At that meeting, staff reported on developing processes and procedures consistent with only one "screen and refer" option: the "quick sort". Yet, the Board had not acted on the options, nor to our knowledge been provided with the back-up on county capacity and consumer impact to fulfill its "due diligence" obligation. Neither are we aware that this critical decision was delegated to staff.