

PUTTING ALL THE INGREDIENTS TOGETHER

**A Recipe for Getting Ready for Health Reform,
Based on Results from a Consumer Assistance Assessment Survey
Of California State Health Agencies**

A **HEALTH ACCESS FOUNDATION** Report
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Executive Summary

THE URGENCY: With the enactment of the Affordable Care Act, millions of California consumers are becoming eligible for health insurance with new options, new benefits and new consumer protections as we approach full implementation in 2014. To maximize the benefit for Californians, it is critical that the state be able to provide effective assistance to consumers to help them navigate the system, exercise their rights and protections, and make informed health care choices.

THE SURVEY: Health Access, the statewide consumer advocacy coalition, undertook a baseline assessment of currently available consumer assistance in four state health agencies in California. The staff of Health Access conducted a disguised observation study to measure how these agencies (California's Department of Insurance, Department of Managed Health Care, Department of Health Care Services, and Managed Risk Medical Insurance Board) performed in providing assistance to Californians.

By posing as consumers, the staff made over 200 calls (a minimum of 50 to each agency) to measure accessibility, efficiency, accuracy, and professionalism of each agency in responding to common consumer questions. They asked for help in filing for Medi-Cal, Healthy Families, and the Pre-existing Condition Insurance Programs, or they also presented themselves as covered by health insurance, but asking for guidance about how to find a primary care physician, get a second opinion, or obtain a prompt referral to a specialist. The results of the calls were meticulously recorded to measure quantitative data, evaluate the accuracy of answers provided, and assess the overall tone and professionalism of the customer assistance staff.

THE FINDINGS: For the most part, the surveyors got useful, timely, and accurate answers from key state health agencies. The results were generally consistent, if uneven, with standards set for similar hotlines, such as those run by Medicare and Social Security.

- State agencies averaged 10 seconds for time to first connection, with the best agency at 7.3 seconds. In most cases, consumers only needed to go through two automated response units (ARUs) to reach a live person.
- While over 80% of the calls reached a live person, none of the agencies met the 94% standard that Social Security sets for itself. The average wait time to get a live person was less than 5 minutes, with most agencies averaging at 2:20 minutes.
- Our evaluators gave their average customer service ratings on accuracy, promptness, and knowledge a 3.7, on a scale of 1-5, with the best departments getting a 4.3.

None of the agencies excelled in every customer service measure nor did any fail in achieving every gauge of customer service. Health Access designed the study as a baseline measurement of current service levels in the state.

LIMITATIONS: Health Access acknowledges that there are limitations to the study's findings. We hope future studies will be able to overcome these limitations:

- While the survey includes over 200 calls, the results are not statistically significant;
- Surveyors were given the numbers to call—and thus did not test how easy or difficult it was to locate the proper telephone number to contact each agency;
- The study design did not measure after-hours access;
- The callers did not explore the full range of likely consumer questions; the study did not pose questions that required the agency to call the consumer back or initiate a third-party contact which might be beneficial; the study was not able to assess some typical consumer complaints or questions because Health Access did not have real claims or payment data, and;
- The study design did not explore obtaining customer assistance answers in languages other than English.

RECOMMENDATIONS: This study provides preliminary data that helps the state assess its performance in the critical areas of access, timeliness, accuracy, and professionalism. In addition, the results of this study include recommendations for adoption of statewide customer service standards based on those currently in use by other government agencies that provide similar consumer assistance and industry practices. The report also identifies strengths and weaknesses, and suggests improvements and recommendations for the coordination and integration across the health agencies in California.

Many of the departments did well in at least some aspects of consumer assistance, exhibiting the positive ingredients that can be pulled together for a renewed focus. To meet the coming challenge and opportunities under health reform in the next few years, the report offers a “recipe” for California to making the needed statewide improvements for providing quality consumer assistance. It starts with setting clear standards in the following areas, standards that various agencies have already met:

1. Access

- ability to reach a CSR close to 95% of the time (Model Agency: CDI)
- answer calls quickly and short hold times – wait for a live CSR should be no longer than 4 min (Model Agencies CDI, MRMIB)
- ability to answer consumer questions without significant delay (Models: DMHC, DHCS)

2. Training

- customer service representatives that are knowledgeable – score at least 4 out of 5 by callers rating CSR Knowledge (Model Agencies: MRMIB, DMHC)
- continual training to keep staff informed of changes in policy and answer questions correctly within 24 hours (Model Agency: MRMIB)

3. Performance Management

- continually monitor quality of call center operations and service with clear mechanisms in place to evaluate the quality of the customer service their CSRs provide, with regular audits and evaluations (Model Agency: CDI)

4. World Class Customer Service

- provide consumers with excellent customer service, act as advocates for consumers, and provide warm hand-offs when consumers need help from other places (Model Agency: DMHC)

Authors

HEALTH ACCESS is the statewide health care consumer advocacy coalition working for quality, affordable health care for all Californians. Health Access Foundation's mission is to work toward expanding coverage, protecting consumers, ensuring quality care, guaranteeing affordability and security, and promoting health and wellness. Health Access has helped lead the movement for health reforms in California and played a crucial role in the passage of the Patient Protection and Affordable Care Act. As a coalition organization, Health Access undertakes public education, applied research, policy analysis and advocacy, and supports evidence-based regulations to advance reforms benefiting California's health care consumers, both insured and uninsured.

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Purpose

As the nation embarks on the biggest change in health care since the inception of Medicare and Medicaid in 1965, millions of Californians who have not had access to health insurance before will be covered under coverage expansions and brand new programs. Tens of millions more will have new options, new benefits, and new consumer protections. It will be crucial that the state provide effective assistance to consumers to help them navigate the system and make informed health care choices. The purpose of this survey was to establish a baseline of information to document the level of consumer assistance given by the four essential state health agencies in California.

The project is a data-based assessment of the current levels of access to assistance and the quality of responses to consumer inquiries and problems as performed by each of the four agencies. The assessment measured the wait times, telephone demeanor, accuracy of answers provided, and the general responsiveness of the customer service staffs (or contractors) at the four principal health agencies in California. These agencies are:

- **California Department of Health Care Services (DHCS)**—the state agency that oversees the federal/state partnership of the Medicaid program, in California called “Medi-Cal,” for low-income adults and children. Customer service is provided by state employees.
- **California Department of Insurance (DOI)**—one of two insurance regulators in the state, CDI oversees insurance companies who offer indemnity, fee-for-service, and certain preferred provider (PPO) network products in the commercial market. CDI oversees about 10% of the health care marketplace in California. Customer service is provided by state employees.
- **California Department of Managed Health Care (DMHC)**—one of two insurance regulators in the state, DMHC is responsible for oversight of managed care/health maintenance organizations (HMOs) and certain PPO products in the commercial market. DMHC oversees about 90% of the health care marketplace in California. Customer service is provided by state employees.
- **Managed Risk Medical Insurance Board (MRMIB)**—the state agency that administers California’s state children’s health insurance program called Healthy Families, the new federal High Risk Pool called the Pre-Existing Condition Insurance Program (PCIP), and two other state programs with smaller enrollments. MRMIB has contracted out the consumer assistance function to a commercial vendor.

The areas of consumer interest that were measured in this survey are:

1. How accessible is the consumer assistance line? (e.g., how available are staff to answer questions and resolve problems during business hours and how difficult it is to be able to reach a real person.)
2. How quickly and efficiently can consumers receive answers to their questions?
3. How accurate are the answers that consumers are given?
4. How “consumer friendly” are the staff that answer these questions?

5. How much initiative do the customer service representatives (CSRs) undertake to resolve problems?

Health Access designed the survey with no bias toward or against any particular agency, and with safeguards against preconceptions about the performance of any agency. Researchers were trained to conduct the survey objectively across agencies.

The California Context

The Affordable Care Act (ACA) requires the state of California to deliver accessible, high quality customer service to all Californians. California was the first state to pass legislation establishing the Exchange after the enactment of the ACA and has undertaken many of the early steps toward the implementation of the ACA. However, it should be noted that there are some unique challenges for California to provide world-class customer service, including the facts that California:

- Is the largest state in the country with more than 10% of the nation's population so that sheer numbers and the impact of changes potentially take longer to effectuate and are more complicated to implement.
- Is the only state that has two insurance regulators, the Department of Insurance (CDI) and the Department of Managed Health Care (DMHC) which requires special coordination between the regulators.
- Has the highest penetration of managed care of any state in the country, which has resulted in a high level of coordinated care models in an innovative and sophisticated marketplace.
- Has a higher uninsured population in California than many other states have entire populations.
- Has 13 languages deemed by California's Medicaid (Medi-Cal) program as "threshold languages" because they represent a large enough block of the population to require vital documents be translated into those languages. One measure is that there are 144 languages spoken in the Los Angeles school district. This makes any effort to communicate with the public hugely more complex.
- Is the first state in the nation to have statutory and regulatory requirements for health care to be delivered to individual consumers in "a culturally and linguistically appropriate manner."
- Is the first state to establish an explicit right for consumers to have timely access to health care outside of a hospital emergency room.
- Has renewed its Section 1115 Medicaid Waiver with CMS that approves a significant movement of seniors and people with disabilities from fee-for-service medicine into Medicaid managed care. This move is designed to save the state money, but has raised significant concerns regarding the access to and the quality of medical care delivered in the state.
- Has expanded the county-based health programs into virtually every county to take

advantage of the new Low Income Health Programs (LIHPs), expansions of Medi-Caid coverage for low-income adults without children in advance of 2014.

- Has contracted to run the federal high-risk program that provides transitional health coverage for people who cannot afford or cannot purchase health insurance based on their pre-existing conditions.

With all the new requirements and expansions of coverage, this makes it critically important for the state to provide enhanced consumer assistance for its population to make informed decisions about their health care choices.

Performance Evaluation Criteria

The four state health agencies have different functions and do not all have goals regarding customer service evaluation that are publicly available, congruent or compatible. In order to evaluate the level of customer assistance in the four agencies, the authors developed baseline performance targets based on contractual standards used by MRMIB, the Social Security Administration, and the 1-800-MEDICARE program at CMS. Below is a comparison of the standards selected and the expectations of other agencies where applicable.

Survey Standard	Reference Standards
Customers should wait no more than 10 seconds for the first connection, whether to an automatic response unit (ARU) or a customer service representative (CSR).	*no public industry standards, however since most calls are answered by ARUs and not CSRs, there should be no reason to put customers on hold
Customers should reach a CSR 95% of the time	MRMIB: 97% SSA: 94%
Wait time for CSR should not exceed 4 minutes	SSA: 242 seconds (4 minutes 22 seconds) 1-800-Medicare: 5 minutes MRMIB: 25 seconds
CSRs should achieve a score of 4 out of 5 for customer service in the following areas: <ul style="list-style-type: none"> • The accuracy of CSR's answer • The speed and promptness of CSR's answer • The knowledge of the CSR • The overall customer service rating including tone, professionalism, patience, etc. 	SSA requires that CSRs achieve "good", "very good", or "excellent" customer service scores at least 83.5% of the time.

Methodology

Health Access staff initiated over 200 phone calls, with a minimum of 50 to each agency, directed to the customer service help lines at the four principal health agencies in California, posing as consumers or inquiring on behalf of consumers.

These calls were made by thirteen employees ranging in age from 21 to 64 during July and August 2011. This was a disguised observation study where callers did not identify themselves as Health Access employees and used cell phones so that customer service representatives were not aware they were being observed. Neither Health Access' executive director nor policy director participated in the survey, as they were potentially recognizable as longstanding spokespeople for the organization (and also not to unwittingly influence the other callers in any direction). Survey protocols were established in order to ensure a level of standardization of the questions posed so that there would be consistency in the analysis and recommendations. Callers were trained in the protocol and monitored throughout the duration of the study.

The calls were completed over a two-month period in order to provide an assessment during a period that would not be influenced by minor staffing shortages or spikes in calls and would be representative of the agency's typical customer service. The calls were proportionally distributed across the workweek, Monday morning through Friday afternoon, with oversampling on Mondays to assess the impact of an assumed higher call volume on Mondays.

The survey tool, completed in real time on the Google Forms platform, required researchers to document the day and time of the call, the wait time, call time, the length and number of Automated Response Units (ARUs) encountered. Callers recorded time data using cell phone timers or stopwatches and recorded all data in real time to reduce errors in information recall. Callers were instructed to assess the quality, timeliness, and appropriateness of the answers given, and to score each call based on several quality measures including accuracy, professionalism, and knowledge.

Some objective data points that were recorded include:

- the elapsed time before calls were first answered by a CSR or ARU,
- the number of ARUs that the caller had to navigate before they could talk to a CSR,
- the total time from first ring until the end of the call, and
- the length of time it took the CSR to provide an understandable answer to the caller, including consumers' follow-up or clarifying questions.

Additionally, callers were asked to rate their customer service experience based on Likert-type scales. The measures documented included:

- a rating of the accuracy of the assistance provided on a scale of 1 (poor) to 5 (outstanding),
- a rating of the courtesy and professionalism of the customer service represented on a scale of 1 (poor) to 5 (outstanding), and
- the details about the question posed by the caller, the level of helpfulness to the consumer, the degree of knowledge demonstrated, and/or the initiative demonstrated by the CSR.

Callers were instructed to choose from two relatively uncomplicated, common complaints, specific to each agency, in order to minimize the burden on the state agencies or their contracted providers. The authors intentionally selected scenarios that should require no lengthy research, no referrals to more senior level CSRs, no intervention with health service plans or insurers, or return calls. Callers compared the responses given by the CSRs to the "answer key" provided

which contained the accurate and complete responses to those scenarios according to California and federal law. Based on that comparison, callers assigned numeric values that corresponded to several values, including:

- promptness of the response (i.e. the CSR knew the answer and could relay the information in understandable language to the consumer without referral to other staff, extensive research, other absences from the call, or other lengthy consultation),
- the correctness of the response, and
- courtesy/professionalism demonstrated by the CSR

Answers were rigorously documented, tabulated, and analyzed. Callers then rated the answers received according to the scale of 1 ("terrible") to 5 ("terrific"). Generally speaking, the individual call was rated a "3" (satisfactory or average) if correct information was given in a courteous and professional manner. A call response was rated a "4" or a "5" proportionately if the CSR provided an above average response, such as being especially knowledgeable and helpful or if they went out of their way to assist the consumer. Any call rated "1" or "2" reflected a below average response, either that the CSR gave an incomplete or inaccurate response, employed "legalistic" or hard to understand explanations, or lacked empathy, patience, or courtesy. The callers were instructed to pose as average consumers, to not use acronyms or legal terminology, nor be especially knowledgeable about the health care delivery or complaint system. The intent was to approximate a typical question framed by a regular consumer that will form the bulk of current and anticipated questions put to California health agencies.

The survey coordinators conducted an initial orientation for all Health Access staff callers to familiarize them with the survey tool. Two days into the survey, the coordinators held a feedback session with all callers to identify and adjust for any problems encountered, such as could "X" be construed as a correct answer? Alternatively, could "Y" scenario/answer be incorporated to test an important consumer issue?

After the initiation of this project, weekly check-ins were established with the entire calling team regarding progress on the number and timing of calls made, any adjustments to calling protocols, and any policy questions that arose. Occasionally, the callers raised policy questions that required further research to confirm the correct answers.

There was no discussion about the study outside of the calling team within Health Access, nor with the study agencies, nor with any other outside entities during the time the data was being collected to assure the most even-handed measurement of the agencies' performance.

Limitations of the Study

Health Access acknowledges that the state agencies are being evaluated during an extraordinary period of change. The survey was conducted in the first year of new leadership for each of these agencies: Governor Jerry Brown and Insurance Commissioner Dave Jones had just been elected and sworn in on in January of that year; DHCS Director Toby Douglas, DMHC Director Brent Barnhart, and MRMIB Director Janette Casillas all were appointed at different times later in the year.

However, the importance of the decisions regarding the funding and placement of resources, the expectations regarding the service delivery, and the incredible importance that Californians make well-informed decisions in light of the new health care law, override any argument in favor of a delay in the assessment of customer service in California. However, some of these changes are noted below to provide context, but not to excuse mediocre or limited services. The challenges California faces include the fact that agencies are:

- experiencing heavier demands on their services due to the recession without commensurate increases in staffing and other resources,
- facing the difficulties of operationalizing new federal and state rules,
- having to serve less sophisticated clients with generally lower levels of health literacy, in many cases dealing with people with less facility with conducting business in English, and/or who are likely to have less familiarity with enrollment in public programs and/or the exercise of consumer protections,
- receiving more scrutiny in light of budget constraints, and
- operating under the direction of new political leadership, and/or a change in state oversight and/or reporting responsibilities.

In addition, the authors acknowledge some limitations of the study. These include:

- The resources available to Health Access did not permit a more ambitious study of the agencies' performance. Consequently, the study's sample size was not adequate to achieve full statistical significance. Throughout the survey, data tracking, and analysis, the utmost attention was paid to the highest standard of ethics and scientific rigor of the test model and protocol.
- The study did not measure the time that it would take an average consumer to locate the correct phone number at the correct agency to call for help. The authors provided the survey team with the appropriate numbers to call to make their survey inquiries. The authors found these phone numbers by searching agency websites and making test calls to verify the numbers. Some agencies featured consumer assistance lines prominently while others required considerable research and tests calls to locate. Some agencies have numerous "customer service telephone numbers" that do not appear to have easily recognizable differentiation as to their specific audience or purpose. Other consumers would not have ready access to the Internet.

- The callers did not explore the full range of likely consumer questions; the study was not able to assess some typical consumer complaints or questions because Health Access did not have real claims or payment data.
- The study did not pose questions that required the agency to call the consumer back or initiate a third-party contact, despite consumer advocates' frustration about some agencies' lengthy response times. However, the timeliness of a call back in response to the inability to reach a CSR was not part of the survey protocol. The authors believed it would extend the length of time devoted to each call interaction and could place an undue burden on the agencies itself; it could have disclosed Health Access as the originator of the calls when the CSR called them back and thus compromise the study.
- The study did not evaluate the advisability of having state employees provide customer service directly or contract out this function. Making that decision would require tracking of additional data that was not collected and should span a longer period of time to assure validity.
- The study did not measure "warm hand-offs" between agencies. Consumers generally have little understanding of which state agency their problem falls under, and the question of what happens if consumers call the wrong agency is an important one. In a post-2014 world of even greater options, it will be important that consumer assistance take a "no wrong door" approach.
- There was no opportunity to test the responsiveness of each agency's consumer assistance systems to people with limited English proficiency. The callers reported that one phone system included instructions in English to limited English speakers to enter an ARU system for assistance in their language of choice. The consumer was then required to select their preferred language from an oral list, announced alphabetically in English. The list of language prompts was extensive, exhausting, and cumbersome to use. There was no provision for the consumer to just pronounce their language to access options in that language. More research is needed to assess whether this provides adequate and meaningful access to consumers with those language needs.
- The survey did not evaluate the services for people with disabilities, either in the format to answer a question (e.g. large font, Braille, or TTY facilities) or for the consumer to determine if facilities themselves were available to the people with access or mobility limitations.
- There was no attempt to collect data on or evaluate individual consumer representatives. While it is critical for agency management to assess the importance of their individual staff members for training needs, recruitment, retention, promotional potential, complaint investigation, and resource management, it was beyond the capacity and scope of this study.

Despite its limitations, the study serves to inform public policy and budget discussions about how the state would meet its customer service responsibilities. This data should be considered as supplemental information in consideration of the allocation of resources, the placement of functions within state government or to responsibly contract outside of government for these services, and to help determine the appropriate regulatory agency.

Results

The tabulation of average survey results is as follows. While the results are presented in a chart format, the data is not necessarily comparable between departments.

Some Departments have one central hotline for all questions and issues; others, like DHCS, have specific phone numbers for specific issues, and the survey focused on only one number. Also, the questions were different, depending on the department's role--and thus they had different answers and degrees of difficulty in dealing with those queries.

Summary Data from the Consumer Assistance Assessment Tool

Percentages and Wait Times When Unable to Speak with a Customer Service Representative (CSR)

Agency	Total Calls	Time to First Connection (in seconds)	Number of Automated Response Units (ARUs)	Percentage of Calls Where No CSR Reached	Total Wait Time When Unable to Speak with CSR (Minutes/Seconds)
DHCS	51	8.6	2.6	44%	13:16
MRMIB	51	7.3	2.2	16%	4:54
CDI	50	9.4	1.2	8%	1:51
DMHC	50	15.0	2	14%	3:01
Total CA State Health Agencies	202	10.0	2	21%	8:23

Wait Times and Call Duration When Able to Reach a CSR

Agency	Total Wait Time to Speak with CSR (Minutes/Seconds)	Total Call Time When Able to Speak with CSR (Minutes/Seconds)
DHCS	7:54	10:57
MRMIB	2:21	5:02
CDI	2:20	5:25
DMHC	2:23	5:54
Total CA State Health Agencies	4:51	6:19

**Composite of Access and Wait Times
By Day and Time**

Day and Time	Unable to Reach a CSR (Percentages)	Wait Time to Speak with a CSR (Minutes/Seconds)
Monday AM	20%	1:19
Monday PM	50%	3:25
Tuesday-Friday AM	10%	3:29
Tuesday-Friday PM	35%	4:11
Average	21%	3:31

**Accuracy, Speed of Answer, Knowledge, and Customer Service Ratings on a Scale of 1
(Poor) to 5 (Excellent) When Able to Speak with a CSR**

Agency	Accuracy of CSR Answer	Speed and Promptness of CSR Answer	Knowledge of CSR	Overall Customer Service Rating
DHCS	3.5	4.1	3.5	3.4
MRMIB	4.4	4.3	4.4	4.3
CDI	2.4	3.4	2.6	2.8
DMHC	4.3	4.1	4.1	4.3
Agencies' Average Rating	3.7	4.0	3.7	3.7

When reviewing this data, the qualitative data is not comparable between departments. Based on their authority, some agencies got questions on enrollment; others on dealing with their private insurer. Even among the two regulators, the underlying law and regulations are different, and so even the same question would elicit different correct responses—and had different degrees of difficulty based on the frequency of the question as well.

Analysis of Individual Agencies

DEPARTMENT OF HEALTH CARE SERVICES

This review of DHCS took place during a time of major transition. Beginning as of July 1, 2012, DHCS will begin the process of shifting millions of seniors and people with disabilities to managed care. Although this reassignment from fee-for-service providers to managed care plans is seen by some as a way to lower costs for the state and improve coordination of care, there are concerns about the adequacy of provider networks especially in light of the complicated medical conditions of this population. The restrictions on choice of providers, the reduction of provider reimbursement rates, and the enormity of this transition has the potential for an adverse impact on the continuity of care for these consumers.

Access

DHCS Access	
Total Calls	51
Time to First Connection (in seconds)	8.6
Number of Automated Response Units (ARUs)	2.6
Percentage of Calls Where No CSR Reached	44%
Total Wait Time When Unable to Speak with CSR (Min/Sec)	13:16
Total Wait Time to Speak with CSR (Min/Sec)	7:54
Total Call Time When Able to Speak with CSR (Min/Sec)	10:57

At the outset of this study, Health Access identified 14 telephone numbers on various parts of the DHCS website for the public to call for information. Although the study designers hypothesize that a significant amount of additional time would be required for consumers to find the correct number to call, this was not assessed as part of this study. Callers were given one direct number to call for purposes of this survey. Presumably, locating the proper contact number would be a source of confusion for consumers with real questions and problems and would deter them from seeking assistance or, at the very least, generally make it more time-consuming to determine how to contact the agency.

When Health Access presented the study's preliminary findings to DHCS management, DHCS officials wondered whether these calls would have been naturally made to the ombudsman telephone number used in the study as opposed to other published numbers, or to a state's contractor, or to personnel in the counties. The fact that there were a multitude of telephone numbers that could have been used in this study reinforces the complexity for consumers to contact the "right" place to get assistance. This is particularly important to resolve at a time when The ACA requires a "no wrong door" approach and streamlined enrollment and eligibility to public programs.

The quantitative results for DHCS were as follows: the time from placing the call until the first connection was 8.6 seconds and, depending on the type of question asked, callers had to navigate 2.6 Automatic Response Units (ARUs). Both of these numerics fall within the range

of acceptable customer service. However, callers were unable to reach a Consumer Service Representative (CSR) in 44% of the calls placed, more than two and one-half times the closest agency in the study and five times more than the first ranked agency. This is an unacceptably high percentage. It is important to note that because of the more limited accessibility to the state agency, the results from the qualitative measures are based on a smaller number of calls.

On the calls where a CSR was not reached, callers were kept on hold for average of 13 minutes 16 seconds before the call was defaulted to a voicemail answering machine. The dropped message explained that DHCS was experiencing a high call volume and asked for a brief description of the problem and re-contact information. The survey callers did not leave their number for a CSR to call them back, and as a result, the promptness of callbacks was considered beyond the scope of this study and was not measured. This is a result that would be very frustrating for consumers.

DHCS averaged significantly higher wait times to speak with a CSR and longer total call times for the duration of the call. The length of wait time for those calls where a CSR was reached was 7 minutes 54 seconds on average, whereas the other agencies wait times averaged around 2 minutes 21 seconds. The length of the call itself when a CSR was reached at DHCS was almost 11 minutes. This was significantly higher than the average for the other three state health agencies service that averaged less than six minutes.

The study demonstrates that DHCS experiences both higher wait times to speak with a CSR and longer talk times once they are connected with a CSR. Although the length of the talk time with a CSR could reflect the complexity of the inquiries, there could be other explanations. These longer talk times could indicate a lack of knowledge by the CSR or lack of efficiency in making appropriate referrals to counties, or contracted entities. If the typical questions that DHCS receives require more time with each caller, which in turn affects the initial wait times to talk to a CSR, DHCS should take appropriate actions regarding appropriate staffing and management attention to reduce these times.

Quality

DHCS Quality	
Accuracy of CSR Answer	3.5
Speed and Promptness of CSR Answer	4.1
Knowledge of CSR	3.5
Overall Customer Service Rating	3.4

The average score on the quality of DHCS' CSRs answers was 3.5. That represented a score that was third in accuracy of the four agencies and needs improvement. The rating of the speed and promptness of the CSR's answer was 4.1 that tied for second among the four agencies. However, the rating of knowledge for the CSR was 3.5, third out of four agencies. DHCS' overall customer service rating was 3.4, third out of four.

Overall

These results reflect that callers were not able to reach a CSR in a significant number of calls (44%) and had to remain on hold for an average over 13 minutes before learning that no one was available to speak with them. The assessment of the access measures revealed that DHCS was harder to reach than others and took the longest time on hold before actually speaking with a representative. The quality of the responses to the scenarios was uneven. Some of the calls took longer, in part because of the complexity of the eligibility and enrollment in the program. However, in some calls with DHCS, there was confusion on the part of the CSR on questions that they should be fairly quickly able to answer. These included questions regarding general eligibility requirements, where or how someone could actually sign up based on their zip code, or where they could receive help in a language other than English. Based on the upcoming huge influx of eligibles to the Medicaid program, and the vulnerability of that population, DHCS should focus on improving these performance measures.

When presented with the study's preliminary findings, DHCS management acknowledged that customer assistance had not been the top priority for them due to budgetary and resource limitations, and an understanding that the main consumer assistance was done by counties. They argued that the state agency was a secondary partner in providing such assistance. They did not provide their own internal detailed tracking data for calls received by the agency by day or time nor did they account for the assignment of staff according to call patterns or call volume. They also had not devoted significant resources to measuring the quality of CSR answers for training or performance management purposes.

In contrast, Health Access believes that DHCS should determine where the sole or joint responsibility for customer assistance should be placed for Medicaid applicants and beneficiaries. They then should undertake to staff that function internally or contract it externally with counties or do more with community and nonprofit groups. Once the responsibilities are clear, they should measure and evaluate how it is functioning in providing improved access and accurate, helpful answers. It is critical that the expansion of this program under the ACA should be accompanied by available, knowledgeable, helpful customer service to help consumers successfully navigate their eligibility and enrollment to Medi-Cal and exercise their appeal rights.

MANAGED RISK MEDICAL INSURANCE BOARD

Access

MRMIB Access	
Total Calls	51
Time to First Connection (in seconds)	7.3
Number of Automated Response Units (ARUs)	2.2
Percentage of Calls Where No CSR Reached	16%
Total Wait Time When Unable to Speak with CSR (Min/Sec)	4:54
Total Wait Time to Speak with CSR (Min/Sec)	2:21
Total Call Time When Able to Speak with CSR (Min/Sec)	5:02

The time from placing the call until the first connection was 7.3 seconds and, depending on the type of question asked, it required navigation through 2.2 ARUs. Both of these values fall within a range of acceptable customer service. However, callers were unable to reach a CSR in 16% of the calls placed, which was twice as high as the first ranked agency.

On the calls where a CSR was not reached, the average hold time was almost 5 minutes before the call was defaulted to a voicemail answering machine. While not the highest in the study, it exceeded the targeted time.

MRMIB averaged just less than two and a half minutes to speak with a CSR and the duration of the call was just over 5 minutes. These wait times and call times were in line with three of the four agencies and within customer service goal targets. Although the scenarios developed for MRMIB could be considered slightly simpler and more straightforward than those for the other agencies in the study, the results for these timeliness metrics were good.

Quality

MRMIB Quality	
Accuracy of CSR Answer	4.4
Speed and Promptness of CSR Answer	4.3
Knowledge of CSR	4.4
Overall Customer Service Rating	4.3

The average score on the quality of MRMIB's CSRs' answers was 4.4. That represented the highest accuracy of the four agencies. The rating of the speed and promptness of the CSR's answer was 4.3 which was second among the four agencies. The rating of the knowledge of the CSR was 4.4.

It should be further noted that during the time the survey was being conducted, there was a significant federal policy change that affected the MRMIB PCIP program. To their credit, they were to quick incorporate that policy change into their customer service answers.

Overall

MRMIB's overall customer service rating was a good 4.3. Although the requirements for the level of customer service knowledge at MRMIB (questions posed principally dealt with the PCIP program) is considered simpler than the questions posed to the other agencies, and thus easier to grasp, it still represented generally timely and knowledgeable customer service. The only area of concern was reflected in two access measures: the fact that in 16% of the calls made, the callers were unable to reach a CSR and when they did not ultimately connect with a CSR, they had to wait almost 5 minutes before we were told that no one was available. As this is the only health agency surveyed that contracts its services out to a vendor (Maximus), no such conclusions can or should be drawn from this survey about the comparative effectiveness of state workers or contract vendors in general. In each measurement, at least one agency with call centers staffed by public employees met or exceeded the performance level of MRMIB, even if others did not. That said, MRMIB set clear performance standards and goals by necessity as part of the contract; some other agencies did not have clearly set standards—which is a practice they could adopt.

CALIFORNIA DEPARTMENT OF INSURANCE

Access

CDI Access	
Total Calls	50
Time to First Connection (in seconds)	9.4
Number of Automated Response Units (ARUs)	1.2
Percentage of Calls Where No CSR Reached	8%
Total Wait Time When Unable to Speak with CSR (Min/Sec)	1:51
Total Wait Time to Speak with CSR (Min/Sec)	2:20
Total Call Time When Able to Speak with CSR (Min/Sec)	5:25

At CDI the time from placing the call until the first connection was 9.4 seconds and, depending on the type of question asked, callers had to navigate 1.2 ARUs. Based on previously established standards, they met the standard in these areas. Callers were unable to reach a CSR in just 8% of attempts and in especially busy times had to wait for less than 2 minutes before they were told they would not be able to speak with a CSR. While ideally an even higher percentage of callers would have been able to speak with a CSR, both of these measurements were the best of the four agencies studied.

CDI averaged comparable wait times to speak with a CSR and similar total call times for the duration of the call with two state agencies of the four in the study. These meet and/or exceed previously defined standards.

Quality

CDI Quality	
Accuracy of CSR Answer	2.4
Speed and Promptness of CSR Answer	3.4
Knowledge of CSR	2.6
Overall Customer Service Rating	2.8

CDI did not fare as well in the quality measures as they did in the assessment of access to their call center. While the questions posed were not comparable, CDI had lower scores regarding the accuracy of the CSR's answer (2.4 score on a 5-point scale), speed and promptness of the CSR's answer (3.4 score), the knowledge of the CSR (2.6 score), and the overall customer service rating (2.8 score).

When provided these findings, CDI appropriately points out that the questions posed were rare to the Department of Insurance, given the structure of CDI-regulated plans, which often don't restrict access to providers up front, and where problems more often are with non-payment and reimbursement issues for services provided on the back end. CDI indicates that they do not have any complaints about timely access to care going back in their system for several years. CDI does not believe they should be evaluated based on survey questions they consider atypical. Health Access acknowledges these were questions were rarer and thus tougher, but more

typical questions on reimbursement issues were not possible under this study's "secret shopper" methodology, without the benefit of hundreds of actual contested claims to test.

While the survey asked questions that are rarer under plans regulated by CDI, the framework for training CSRs should not be exclusively driven by consumer complaints received. Several federal regulatory agencies (notably HHS, SSA, and Treasury) predicate their regulatory framework and assessment procedures based on random sampling, focused reviews, and targeted case reviews. They do not rely exclusively upon consumer complaints because the public does not uniformly and aggressively pursue all complaint and other redress avenues available to them, due to a lack of understanding and various administrative impediments. Complaints are triggered by publicity about new laws and regulations, media stories about the successful (or unsuccessful) exercise of those rights, or a change in the individual's life circumstances that brings these provisions to light (e.g. loss of a job, the onset of a serious illness or injury.) Research¹ has shown that consumers call their regulator to complain when they believe a determination has not been fair or according to what they believe they are entitled to. Unfortunately, consumers do not always have a perfect understanding of what those rights are, and even when they do complain, those complaints can be inadvertently misinterpreted or mis-categorized.

Furthermore, it would be extremely challenging to perform a disguised observation study based on what CDI considers their most common consumer calls, denied claims or denials of coverage. This is because such a study would require reliance on CDI records of claims and/or submission of documentation that does not exist. Health Access designed the survey using questions that test various dimensions of customer service, and selected scenarios for our callers that serve as legitimate proxies for determining the level of customer service.

Overall

While CDI's access scores were by far the best of the four agencies, they should aim for the percentage of calls where the consumer could not reach a CSR to be 5% or less to meet the targeted percentage goal.

However, their quality suffered as measured by the numeric scores on quality measures. There could be several reasons for this lower performance, beyond the fact that these were rarer questions and thus tougher for CSRs to answer. While this has been changing recently, CDI has historically had relatively fewer CSRs at their call center devoted to health issues, and their call center is designed to field calls on numerous issues involving life, disability, home, auto, brokers/agents as well as health. Because health is not the principal subject matter over which they have regulatory oversight responsibility, it likely does not have the focus that would naturally occur at the other three agencies that exclusively have a health focus. It could also reflect the emphasis that they place in their training curriculum, resulting in perhaps less focus on consumer appeal rights and the additional protections afforded in the Affordable Care Act. An example of less specific health knowledge was when the callers complained about an insurer refusing to pay for a "second opinion" regarding a major diagnosis or experimental procedure. A CSR maintained,

¹ Schwarcz, Daniel B., *Reevaluating Standardized Insurance Policies* (October 5, 2010). *University of Chicago Law Review*, Vol. 78, p. 1263, 2011; *Minnesota Legal Studies Research Paper No. 10-65*. Available at SSRN: <http://ssrn.com/abstract=1687909>

even when they were pressed on the answer, that consumers could have a second opinion, but only at their own cost (which is contrary to California law).

In addition, callers found that in some cases the CSRs' answers were limited, even one-dimensional or perfunctory and there were clearly some expressions of impatience and frustration. Health Access believes the best customer service from a regulatory agency is an intersession with an insurance company to resolve a problem where the regulator acts directly on behalf of the consumer. A so-called "warm hand-off" consists of offering to have a three-way conversation where the regulator would call the insurance company with the consumer on the line and relay the consumer's concern to the company. The regulator would remain on the line during the discussion of the consumer's problem and be in a position to affirm or interpret the insurer's answer to ensure complete understanding and responsiveness. In addition, the regulator would specifically reinforce any additional steps or options the consumer could or should take.

At CDI, however, the most frequent response from the CSRs would be to tell the consumer to re-contact the insurance company to pursue the problem on their own. Consumers were directed to do this without any offer of assistance or even acknowledgement that their complaint had validity. This was their practice, even in circumstances where the caller stated they had already attempted (unsatisfactorily) to resolve the problem with the insurance company. The additional assistance provided by other agencies studied in the form of a "warm hand-off" would likely result in some longer call times for some complex problems. However, it would undoubtedly improve the "overall customer service" score.

CDI management, like the other three agencies, were presented with preliminary survey data prior to the publication of this report. As described above, CDI does not believe that the quality ratings are an accurate reflection of the service they provide.

Also, CDI has implemented a series of improvements to their customer assistance in the department beginning in November 2011. They have instituted a telephone (as opposed to written) complaint procedure and have what they believe is an effective tracking of complaints. They tape their customer assistance calls for training and performance management purposes. The seriousness with which the new management of CDI has reviewed this survey's findings and recommendations of the study has been commendable.

DEPARTMENT OF MANAGED HEALTH CARE

Access

DMHC Access	
Total Calls	50
Time to First Connection (in seconds)	15.0
Number of Automated Response Units (ARUs)	2
Percentage of Calls Where No CSR Reached	14%
Total Wait Time When Unable to Speak with CSR (Min/Sec)	3:01

Total Wait Time to Speak with CSR (Min/Sec)	2:23
Total Call Time When Able to Speak with CSR (Min/Sec)	5:54

At DMHC, the time from placing the call until the first connection was 15 seconds and callers had to navigate two automatic response units (ARUs) to speak with a consumer service representative (CSR). DMHC should aim to achieve a first connection within the 10-second target time. The utilization of 2 ARUs is considered acceptable. However, it is concerning that callers were unable to reach a CSR in 14% of the calls placed; this represented almost twice the percentage achieved by the first-ranked agency.

In the instances where callers were not able to reach a CSR, they remained on hold for average of 2 minutes 23 seconds before the call was defaulted to a voicemail answering machine. DMHC averaged almost 6 minutes for the duration of the call. These wait times and call times were in line with three of the four agencies and within customer service goal targets.

Based on the study criteria, this represented good performance in light of the somewhat greater complexity of the scenarios developed for DMHC and the number of calls they handle for other programs (e.g. Medicaid). This performance is especially noteworthy since DMHC regularly offered to intercede with the health service plans to resolve an enrollment, appeal, or coverage issue while the consumer stayed on the line. In fact, one of the very striking differences in conducting this study of customer service at the DMHC Help Line was their willingness to call the plan for a "warm hand-off." These offers were made by DMHC's CSRs in situations where the consumer had already raised the issue with their plan, and the plan did not give them the correct information or declined to provide coverage or agree to make an appointment. The most typical situations were based on a denial of coverage of a second opinion, problems of timely access to care, or the plan's unwillingness to provide services in a language the consumer could understand (all required by California law). While the callers never availed themselves of the CSRs' offer to call the health plan, their initiative and willingness to intercede on behalf of the enrollee was impressive.

Quality

DMHC Quality	
Accuracy of CSR Answer	4.3
Speed and Promptness of CSR Answer	4.1
Knowledge of CSR	4.1
Overall Customer Service Rating	4.3

The average score on the quality of the DMHC CSRs' answers was 4.3 (on a 5-point scale). That represented the second highest in accuracy of the four agencies. The rating of the speed and promptness of the CSR's answer was 4.1 that tied for second among the four agencies. The rating of the knowledge of the CSR was 4.1, second out of four agencies. The overall customer service rating was 4.3 (on a 5-point scale) which tied for first among the four agencies.

Overall

DMHC's measures of access were generally good in terms of time to first connection and a relatively few number of ARUs to navigate. They are somewhat higher on the percentage of calls where the consumer could not reach a CSR and the length of time consumers had to wait before being told that no CSR was available. DMHC should work to improve these access measures.

DMHC's overall customer service rating was 4.3, tied for first. This reflected generally good customer service especially due to the complexity and scope of the questions regularly referred to their help line and the likely spillover effect of their staff having to answer questions for other agencies. When presented the preliminary data from this study, DMHC management expressed satisfaction with their expedited, targeted problem resolution with health plans. Over the years they have established and maintained plan contacts specifically empowered to resolve consumer complaints when their CSR intercedes with the plan. These "warm hand-off" calls in many cases result in resolution of the problem without exercising appeal rights and make the consumer believe that the regulator listened to their problem and took action on their behalf "without a lot of 'red tape.'"

Overall Recommendations: A Recipe for Meeting Future Consumer Assistance Challenges

Health Access believes that the undertaking of a timeliness and accuracy study of customer service functions at the four health agencies in California is particularly relevant now when customer service will be receiving more inquiries and the marketplace of health options under the ACA changes. It is anticipated that it will be more common for Californians to be eligible for more than one program during any year based on changes to their employment, their income, and other life transitional events. Consequently, it is essential that the kind of service consumers receive is of the highest level and is consistent among programs. Additional demands on the system will require greater responsiveness and accuracy as the rules change for existing programs and new options emerge. Even existing programs will afford greater consumer coverage and protections.

Key decisions will be made in the next few months on the state's consumer assistance capacity. This includes:

- in the **state budget allocations for each of the four departments** (including not just involving general fund dollars, but resources supported by federal funds, by grants under the Affordable Care Act, and by the fees on insurers that fund state regulators);
- at the **California Health Benefits Exchange**, which needs to build its own navigation and consumer assistance infrastructure, and which will consider issues around consumer assistance and setting up its service call center in their June meeting;
- in the **Administration's revamping of the Office of the Patient Advocate** as part of its implementation of AB922 (Monning) passed last year.

The intent of AB922 (Monning) is to streamline and improve consumer assistance in California, by augmenting the Office of Patient Advocate (OPA) as a “no wrong door” call center for such assistance—especially when consumers may not know which agency of many to call. The hope is that Californians get clear and understandable consumer information and assistance by strengthening current programs consistent with the federal requirements.

The results of the survey indicate that each agency has unique strengths, and there is an opportunity for collaboration between agencies in order to ensure that every access point leads to a world-class customer service experience for consumers. This study demonstrates that the solutions to many emerging customer service needs can already be found within some of our state health care agencies if they each adopt a collaborative, strengths-based approach to alignment and improvement. To that end, the following are the authors' recommendations:

1. SET STRONG, CONSISTENT, AND TRANSPARENT STANDARDS

- Agencies should establish clear, public goals and track whether they are met. The respective agencies should establish (or make public, if already established) strong consumer goals and targets for both **access** to customer assistance and the **quality** of customer service that are consistent within the state. The agencies should conduct their own periodic (at least annual) formal surveys of adherence to these stated goals and targets and make the results of their internal reviews public. We suggest the following goals, which various state agencies have already achieved:

1. Access

- ability to reach a CSR close to 95% of the time (Model Agency: CDI)
- answer calls quickly and short hold times – wait for a live CSR should be no longer than 4 min (Model Agencies CDI, MRMIB)
- ability to answer consumer questions without significant delay (Models: DMHC, DHCS)

2. Training

- customer service representatives that are knowledgeable – score at least 4 out of 5 by callers rating CSR Knowledge (Model Agencies: MRMIB, DMHC)
- continual training to keep staff informed of changes in policy and answer questions correctly within 24 hours (Model Agency: MRMIB)

3. Performance Management

- continually monitor quality of call center operations and service with clear mechanisms in place to evaluate the quality of the customer service their CSRs provide, with regular audits and evaluations (Model Agency: CDI)

4. World Class Customer Service

- provide consumers with excellent customer service, act as advocates for consumers, and provide warm hand-offs when consumers need help from other places (Model Agency: DMHC)

- Agencies should standardize their practices so consumers consistently receive a “world-class customer service experience” at every point of entry. The roles of these four agencies have to be better coordinated to build on their strengths and minimize their weaknesses. There should be a renewed effort to standardize practices, consumer orientation, training practices, and other joint efforts across all agencies in light of the advent of the Affordable Care Act. Because of the complexity of the new health care delivery system, it should be standard to have a process for the state agency/regulator to offer to intercede with the insurers and plans on questions and problem resolution, commonly referred to as a “warm hand-off” which is a very effective customer assistance practice.

2. CONDUCT REGULAR EVALUATION

- Agencies should evaluate equipment and staffing to assure regular, reliable service throughout its business hours with an emphasis on aforementioned standards. The data for the composite of all four agencies reveal that during some times during the workweek, it is particularly difficult to reach a CSR for information or assistance. These especially busy times are weekday afternoons, especially Monday afternoons, followed second by Tuesday through Friday afternoons. Each agency should evaluate equipment and staffing to assure they are meeting access standards throughout the workweek. The study did not measure access during non-business hours. It is acknowledged that not all health care questions are routine and not all emergencies occur between 9:00 am and 5:00 pm Monday through Friday. Only DMHC provides service during regular non-business hours and weekends. Each agency should evaluate how they can provide responsive customer service during these after-hours and weekend time slots as part of the stated goal of health care reform to provide “world class customer service.”
- Agencies should conduct their own, more in depth review of their customer service operations. While Health Access conducted this study to the greatest extent that resources allowed, each agency should undertake a formal internal assessment of their performance to validate this assessment and determine which recommendations should be implemented first that would be most appropriate to improve their service. Their internal review should also include evaluation and feedback to individual CSRs based on their performance.
- Agencies should commission a thorough external, statistically valid evaluation of their customer service performance. Although Health Access was not able to conduct this study to achieve true statistical reliability because of the resources required, the responsible agency should enlist the resources of foundations or other sources for a more thoroughgoing assessment or follow-up study in light of the demand for these services in 2012 and thereafter.

3. COLLABORATIVE COMMITMENT TO WORLD CLASS CUSTOMER SERVICE

- Agencies, especially DHCS, should improve consumers’ access to expert help with questions and problems. The ability of consumers to access assistance varies across state health agencies, and will get more challenged as more questions come in as a result of changes in the health system. Most notably, DHCS is inaccessible to too large a number of their new applicants and current consumers (44%), and requires a recommitment

and the resources to provide sufficient staff to answer questions and avoid lengthy wait times. This is particularly important because DHCS serves some of the most vulnerable Californians and those with dual entitlement and dual diagnoses that inevitably result in longer wait and talk times.

- **Agencies, especially CDI, should undertake efforts to improve the customer service orientation and the accuracy of the answers provided by their call center.** All agencies can improve, especially since the service provided will be an important way that consumers experience the changes coming with health reform. The Department of Insurance should continue its changes to improve its ratings on their customer service scores and general consumer orientation, since a higher percentage of their answers were wrong or very limited. Their performance would likely be improved by additional training on provisions in the ACA and California law, as well as reinforcing a stronger consumer orientation among their call center staff as health questions have increased (and will continue to increase further) in volume and complexity.
- **Agencies should institute, upgrade, and/or publicize their internal tracking mechanisms to emphasize their commitment to “world class customer service.”** A robust measurement system that analyzes their agency's customer service also provides excellent data for internal training and performance management. The Department of Insurance has in place several data systems to track, analyze, and categorize their various customer service functions. Although some agencies have many of these metrics in place, others clearly do not or their systems are rudimentary at best. Each agency should have in place ways to measure the important performance measures in a way that is consistent across similar agencies and departments. Consistency of definitions and measurement tools can enhance the goal of achieving unparalleled customer service and commonality of purpose in serving its customers.
- **Agencies should update, coordinate, and reinforce their joint training efforts in light of the ACA.** The knowledge about new provisions of the ACA, particularly in the California context, requires additional training across the four agencies. Agencies could consider approaching this as a joint effort. California already has strong consumer laws and consumer options and protections are greatly increased under the ACA. There will be an increased value placed on cross-programmatic knowledge. In addition, it will likely be common that newly eligible consumers will not become eligible for just one program and remain enrolled over a period of time. This is because their life circumstances will likely change and, as a result, their eligibility will fluctuate. It will be far more likely that Californians will become eligible/enrolled in different programs over the course of a year based on changes in life circumstances, income fluctuations, and other transitional events. This requires an increased baseline level of understanding about not only each agency's own programs, but also the eligibility and enrollment requirements for other California health and social service programs.
- **Agencies should partner with nonprofit and community organizations.** Clearly, agencies can work with on-the-ground groups to better inform consumers and communities about the availability of help on health coverage and care issues. These groups can also be partners in consumer assistance, navigation, and enrollment, as envisioned by the Affordable Care Act. Under the law, for example, new consumer assistance resources are augmenting not just agency hotlines but nonprofit help centers like the Health Consumer

Alliance. Other partnerships are also envisioned under the Office of Patient Advocate as AB922 is implemented

4. ADDITIONAL RECOMMENDATIONS FOR CONSUMER ACCESS

Though some of these issues were outside of the scope of this survey, the authors and callers noted several specific challenges consumers face when seeking assistance. They include:

- **Prominent Placement of Customer Service Phone Numbers** on agency websites is an absolute necessity. Finding the correct numbers was a significant early challenge for the authors, who are internet savvy and well-versed in the health care system, and substantial improvement can be achieved to make this process easier for everyday consumers.
- **Improve Access to Limited English Speakers** Recorded instructions listing languages in English in alphabetical order is cumbersome and is not be the best approach for limited English proficient consumers. As it is projected that communities of color will make up a large percentage of new health care consumers under the new world of health reform, a more thoughtful and accessible approach language access is recommended.
- **Implement “No Wrong Door” Consumer Assistance Referral Processes** A new array of health care options that will be available with the advent of health reform will make coordination between agencies, including the new California Health Benefit Exchange, even more crucial. Consumers will undoubtedly be confused as to which programs they qualify for and which agencies to call for those programs. World-class customer service should consist of warm hand-offs between agencies in difficult or complicated situations if the CSR cannot provide the necessary help to the consumer themselves. The implementation of AB922 (Monning) provides the opportunity to implement this goal.

The Affordable Care Act will result in huge and transformational improvements in healthcare coverage, delivery systems, and payment mechanisms. One of the linchpins of successful implementation of this landmark legislation is available, responsive, and accurate customer service. While the state of California has some unique challenges in putting this law into place, it also stands to realize tremendous benefits for its people. These benefits include enhanced insurance coverage, elimination of marketing abuses, establishment of more pro-consumer protections, a new marketplace in which to purchase insurance, greater access to care, and improved health outcomes. One essential cornerstone of the purchase and delivery of health care coverage and access to care is that the state must be able to deliver on the promise of “world class customer service.” While four essential state agencies currently provide customer service, it is uneven in its availability to consumers, the accuracy of the answers given, and the initiative taken to explain key provisions and rights. This study should serve as the first step in making a data-based assessment of the customer service currently in place and outlining steps for improvements in access, training, staffing, and focus.

The authors can be contacted with questions, comments, or requests for more information about this study. They can be reached at Health Access in Sacramento at (916) 497-0923, ext. 201 (Elizabeth Abbott) or ext. 206 (Linda Leu).

APPENDIX 1. Consumer Assistance Assessment Tool Survey Form

CAATS Script and Response Form

Thanks for helping us assess the customer service capacity in our health services agencies. Before you begin, please note:

- + You should have this form open in front of you so you can fill in the answers as you go.
- + It may also be helpful to have the CAATS Questions and Scenarios document handy.
- + You will need to keep track of time, so either use a phone that times your calls, or have a stopwatch or clock in front of you. Please answer time questions in minutes and seconds if possible. Remember that you are playing the part of a health care consumer, so find your motivation and ready that award acceptance speech.

* Required

Time of Call *

Caller Name *

Agency Called *

DHCS - Department of Health Care Services

MRMIB - Managed Risk Medical Insurance Board

CDI - California Department of Insurance

DMHC - Department of Managed Health Care

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[Based on the above selection, callers were directed to a landing page with one of the following instructions and scenarios.]

CAATS Script and Response Form

* Required

MRMIB - Managed Risk Medical Insurance Board

MRMIB is the state agency that administers the Healthy Families Program and the High Risk Pools, both the state's own and the federal high risk pool. These pools are for people who cannot purchase health insurance because of the cost of their care and because they often have pre-existing conditions and are denied by insurance companies. It stands for the Managed Risk Medical Insurance Board that oversees the administration of these programs and two other smaller health insurance programs in California. Please select ONE of the following scenarios:

SCENARIO ONE - PCIP How can I sign up for the pre-existing condition insurance program? I have a health condition [asthma, diabetes, arthritis, melanoma or whatever]. I have turned 26 and could not continue on my parents' health insurance policy. I have been denied coverage on my own due to my pre-existing condition. 1-877-428-5060 M-F 8a-8p, Sat 8a-5p **NOTE NEW INFORMATION: As of August 1, 2011 MRMIB changed eligibility requirements such that a note from a doctor can replace the insurance company denial letter requirement. If they tell you that you need a denial letter or a high premium quote but don't mention that you can have a doctor's note instead, the answer is INCORRECT.

SCENARIO TWO - HEALTHY FAMILIES How do I enroll my child in Healthy Families? You are the parent of a young child, do not have insurance, and have limited income. 1-800-880-5305 M-F 8a-8p, Sat 8a-5p (Please see the CAATS Questions and Scenarios document for further details.)

DHCS - Department of Health Care Services

The Department of Health Care Services is the state agency that oversees the federal/state partnership of the Medicaid program (Medi-Cal) for low-income adults and children. Beginning July 1, 2011, millions of seniors and people with disabilities will be mandatorily shifted to managed care which has restrictions on providers and the potential for an adverse impact on the continuity of care. 1-888-452-8609 M-F 8a-5p

SCENARIO ONE - ENROLLMENT How do I enroll myself (or sister, cousin, etc.) in Medi-Cal? (You/they do not have health insurance and have little or no income due to unemployment etc.)

SCENARIO TWO - PRIMARY CARE PHYSICIAN My mother/friend/cousin just got on Medi-Cal and can't find a primary care physician who will take her. Can you help? (This is a big problem in already underserved areas, so it might be helpful to say that they live somewhere like Inyo, Bakersfield, Turlock, Shasta, etc.)

CDI - California Department of Insurance

The California Department of Insurance regulates insurance companies and brokers in the state. They also use the acronym DOI or Department of Insurance. They oversee about 10% of the health insurance marketplace. 800-927-HELP (4357)

PLEASE CHOOSE FROM THE FOLLOWING SCENARIOS

SCENARIO ONE - SECOND OPINION I am uneasy about the course of treatment my doctor has recommended. Aren't I entitled to a second opinion regarding my medical condition [heart condition, MS, upcoming surgery or whatever]? (You have already complained to your insurance company (Blue Cross, Blue Shield, HealthNet, United, Cigna, Aetna etc., but not Kaiser) and they told you to follow your doctor's advice.)

SCENARIO TWO - SPECIALIST My doctor has referred me to a specialist (neurologist, orthopedist, gastroenterologist etc.) and I cannot get an appointment within a reasonable period of time for urgent care. (You already complained to your insurance company (Blue Cross, Blue Shield, HealthNet, United, Cigna, Aetna etc., but not Kaiser) but they said I just have to wait until an appointment is available, no matter how long it takes.) (Please see the CAATS Questions and Scenarios document for further details.)

DMHC - Department of Managed Health Care

DMHC regulates health maintenance organizations in the state. They oversee about 90% of the health insurance marketplace. 1-888-466-2219

PLEASE CHOOSE FROM THE FOLLOWING SCENARIOS

SCENARIO ONE - SECOND OPINION I am uneasy about the course of treatment my doctor has recommended. Aren't I entitled to a second opinion regarding my medical condition [heart condition, MS, upcoming surgery or whatever]? (You have already complained to your health plan (Kaiser, Blue Cross, Blue Shield, HealthNet, Cigna, Aetna etc. and they told you to follow your doctor's advice.)

SCENARIO TWO - SPECIALIST My doctor has referred me to a specialist (neurologist, orthopedist, gastroenterologist etc.) and I cannot get an appointment within a reasonable period of time for urgent care [within a week]. (You already complained to your plan Kaiser, Blue Cross, Blue Shield, HealthNet,

Cigna, Aetna etc. but they said I just have to wait until an appointment is available.) (Please see the CAATS Questions and Scenarios document for further details.)

Call Answer Time *How long did you wait before your call was answered by either a live person or ARU?

Number of ARUs *How many ARUs did you go through before getting to a live person? If you did not ever get a live person, please still provide the number of ARUs. If you speak with a live person, skip the next 2 questions.

If you did NOT reach a live person, what happened?

- I was eventually disconnected.
- I was directed to a voice mail box.
- Other:

If you did NOT reach a live person, what was your total call time?

If your call was answered by a live person, how much time elapsed between the first ring and the time you reached the person?

If you DID speak with a live person, please rate the accuracy with which they answered your question. (Compare to desired response on the CAAT Questions and Scenarios document)

1 2 3 4 5

Incorrect or Unacceptable Answer Exemplary Answer

If you DID speak with a live person, please rate the efficiency/speed which they answered your question.

1 2 3 4 5

It took forever Short and sweet

If you DID speak with a live person, please rate the knowledge of the customer service representative.

1 2 3 4 5

Huh? Very Knowledgeable

If you DID speak with a live person, please rate the quality of customer service you received.

1 2 3 4 5

Terrible Exceptional

If you DID speak with a live person, WHAT WAS YOUR TOTAL CALL TIME?(From first ring to hang up)

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Additional Information

Additional Comments. Please share any additional comments or concerns from this call.



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APPENDIX 2. Consumer Assistance Assessment Tool Caller Scenarios

Consumer Assistance Assessment Tool (CAAT) Scenarios and Questions

SCENARIO: Health Access staff will call the state health agencies posing as consumers asking one of the questions shown below. They will document the day, time, and duration of the call, whether they could reach a customer service representative, and the responsiveness and accuracy of the answer received. In most cases, the caller will make their inquiry as if they are a *new applicant* on behalf of a family member or friend so that there is no requirement to actually complete an application or furnish a pending claim number. This should also enable the caller to determine the responsiveness of the answer without committing to a lengthy interview.

These calls will be spaced throughout the business week and be recorded by time quadrant. The study will take place during the period July 11, 2011 through August 31, 2011. The information and assessment of the calls will be compiled and analyzed drawing conclusions and making recommendations.

This study will be conducted with general adherence to sampling protocols so that the conclusions drawn and the assessments made will have validity. The fact that we are conducting a study of consumer assistance responsiveness should not be discussed outside of Health Access. Neither the true identity of the caller nor or the organization should be revealed in order to capture the most reliable measure of the state agency's customer service.

Health Access will print the final report and it will be presented to the respective agency heads and/or legislators.

TERMS:

- **Healthy Families Program**—the name of the program for children in California that is part of the federal/state partnership that provides health insurance for children of low income, generally working families under the State Childrens' Health Insurance Program (S-CHIP).
- **Medi-Cal**—the name of the program in California that provides health insurance (Medicaid) that is part of the federal/state partnership for very low income families. A large group of Medi-Cal beneficiaries are mothers and children. This program also pays for much of nursing home care for seniors.
- **Medicaid**—the general name of the program of health insurance for very low income families, called Medi-Cal in California.
- **Medicare**—this is the federal health insurance program that began July 1, 1966 that provides reimbursement for health care expenses for seniors over age 65 and some younger people with disabilities. It is administered by the Social Security Administration (entitlement and enrollment) and The Centers for Medicare and Medicaid (CMS) (customer service and financial administration). There is no state administration or state dollars spent on these beneficiaries' health care (and we are not evaluating the customer

service provided because it is not done by a state agency.

- **PCIP**—or the Pre-existing Condition Insurance Program, the federal high risk insurance pool that is funded by the federal government as part of the ACA as a transition to 2014, but administered by the state of California. It provides health insurance for people who are unable to obtain health insurance, generally because of the cost and the fact that they have a pre-existing condition. It is more generous than the state’s high risk pool based on premium costs and does not have a maximum benefit limit.

AGENCIES:

- **CDI**—the California Department of Insurance who regulate insurance companies and brokers in the state. They also use the acronym **DOI** or Department of Insurance. They oversee about 10% of the health insurance marketplace.
- **DMHC**—the Department of Managed Health Care who regulate health maintenance organizations in the state. They oversee about 90% of the health insurance marketplace.
- **MRMIB**—the acronym for the state agency that administers the Healthy Families Program and the High Risk Pools, both the state’s own and the federal high risk pool. These pools are for people who cannot purchase health insurance because of the cost of their care and because they often have pre-existing conditions and are denied by insurance companies. The agency stands for the Managed Risk Medical Insurance Board that oversees the administration of these programs and two other smaller health insurance programs in California.
- **DHCS**—the Department of Health Care Services which administers the Medi-Cal (Medicaid) program in California.

QUESTIONS:

State Agency	Program	Question	Facts	Preferred Answer
MRMIB	PCIP	“How can I sign up for the pre-existing condition insurance program? I have a health condition [asthma, diabetes, arthritis, melanoma or whatever]. I have turned 26 and could not continue on my parents’ health insurance policy. I have been denied coverage on my own due to my pre-existing condition.”	Give your facts (applicant may be any age), but must have a medical condition that would preclude coverage and have not had coverage for six months.	They agree to complete an application, or mail you forms, or refer you to their website.
MRMIB	Healthy Families	“How do I enroll my child for the Healthy Families Program?”	You are the parent of a young child, do not have insurance, and have limited income.	They agree to complete an application, or mail you forms, or refer you to their website.

DHCS	Medi-Cal	"How do I (or your sister, your cousin etc.) enroll for the Medi-Cal program?"	You do not have health insurance and have very low income (laid off, unemployed, or whatever)	They agree to complete an application, or mail you forms, or refer you to the county welfare office.
DHCS	Medi-Cal	"I can't find a family doctor who will take my mother (or father or sister) as a patient under Medi-Cal. Can you help me find someone for them?"	You don't know your relative's Medi-Cal number (since one does not exist.) You will have to tell them your/ your relative's city/ county of residence for referrals. Often doctors are listed as Medi-Cal providers, but are not taking new patients.	They agree to refer you to their provider website, or mail you a provider directory or otherwise make suggestions regarding a specific PCP who is taking new patients.
DMHC	Managed care plan through employer	"My doctor has referred me to a specialist (neurologist, orthopedist, gastroenterologist etc.) and I cannot get an appointment within a reasonable period of time for urgent care."	I complained to my plan Kaiser, Blue Cross, Blue Shield, HealthNet, Cigna, Aetna etc., but they said I just have to wait until an appointment is available.	If you furnish your membership number, they will intervene with your plan because it is the law in CA that you are entitled to emergency specialist care within 96 hours of the referral. *
DMHC	Managed care plan through employer	"I am uneasy about the course of treatment my doctor has recommended. I thought I was entitled to a second opinion regarding my medical condition [heart condition, MS, upcoming surgery or whatever]."	I complained to my plan (Kaiser, Blue Cross, Blue Shield, HealthNet, Cigna, Aetna etc., but they said I just should follow my doctor's advice. There is no entitlement to a second opinion.	They can help you with your health plan because it is the law in CA that you are entitled to a second opinion. *
CDI	Fee-for-service plan or Preferred Provider Organization (PPO)	"My doctor has referred me to a specialist (neurologist, orthopedist, gastroenterologist etc.) and I cannot get an appointment within a reasonable period of time for urgent care."	I complained to my health insurer (Blue Cross, Blue Shield, HealthNet, United, Cigna, Aetna etc., but <u>not</u> Kaiser), but they said I just have to wait until an appointment is available.	They can help you with your insurance company because it is the law in CA that you are entitled to prompt urgent specialist care. *

<p>CDI</p>	<p>Fee-for-service plan or Preferred Provider Organization (PPO)</p>	<p>I am uneasy about the course of treatment my doctor has recommended. I thought I was entitled to a second opinion regarding my medical condition [heart condition, MS, upcoming surgery or whatever].</p>	<p>I complained to my plan (Blue Cross, Blue Shield, HealthNet, United, Cigna, Aetna etc., but <u>not</u> Kaiser) but they said I just should follow my doctor's advice. There is no entitlement to a second opinion.</p>	<p>They can help you with your insurance company because it is the law in CA that you are entitled to a second opinion. *</p>
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*Do not file a formal application or register an official consumer complaint.

Prepared: July 8, 2011
 Beth Abbott, Linda Leu, and Rick Pavich

APPENDIX 3. Consumer Assistance Phone Numbers

Consumer Assistance Phone Numbers for Health Care Consumers

PCIP (Pre-Existing Conditions Insurance Program) 1-877-428-5060

Healthy Families 1-800-880-5305

DHCS (Medi-Cal Ombudsman) 1-888-452-8609

Department of Managed Health Care Help Line 1-888-466-2219

California Department of Insurance 800-927-HELP (4357)