Medi-Cal Managed Care
Office of the Ombudsman
Assembly Bill 113 (Senate Bill 97)-
Fourth Quarter Executive Summary

Pursuant to Senate Bill (SB) 97, the following Executive Summary Report is designed to provide a snap shot of what occurred during the Fiscal Year (FY) 2020-21 in the Office of the Ombudsman (OMB). The areas covered are as follows:

1) Training protocols for staff, including cultural and linguistic competency.

2) Assessment of contacts trends and actions taken by the State Department of Health Care Services as a result of contacts received.

3) Consumer assistance protocols, procedures, and referral tools.

The following provides detail on each of the areas defined above.

1) Training protocols for staff, including cultural and linguistic competency.

1) The OMB hires bilingual staff fluent and certified in Spanish. Current staffing levels have seven of twenty OMB staff Spanish bilingual.

2) To assist beneficiaries speaking languages other than English and Spanish, OMB staff are fully trained in the use of the Language Line.

3) OMB staff are required to complete the following training classes:
   - Medi-Cal processes and procedures, transactions, unit specific training etc. upon hire
   - Privacy Training - Within 30 days of hire and annually thereafter.
   - Sexual Harassment Prevention Training - Within the first six months of hire and every two years thereafter.
   - Ethics Training - Within the first six months of hire and every two years thereafter.
   - Preventing Workplace Violence - Within six months of hire and every two years thereafter.
   - Defensive Driving Training - Within six months of hire and every 4 years thereafter.
   - Accessibility Compliance - Within twelve months of hire.
   - Cultural and Linguistic Competency - Within twelve months of hire and annually thereafter.

2) Assessment of contacts trends and actions taken by the State Department of Health Care Services as a result of contacts received.

As illustrated in the graph below the highest contacts made by beneficiaries to the OMB contact center resulted in managed care plan (MCP) enrollment / disenrollment. This is followed by Education and Referrals to the appropriate organization.
Beneficiaries are able to request a queued callback during busy times. They may also request a call back from management at any time. If the beneficiary is not available at the time of callback, the call is logged as No Answer/Left Voicemail.

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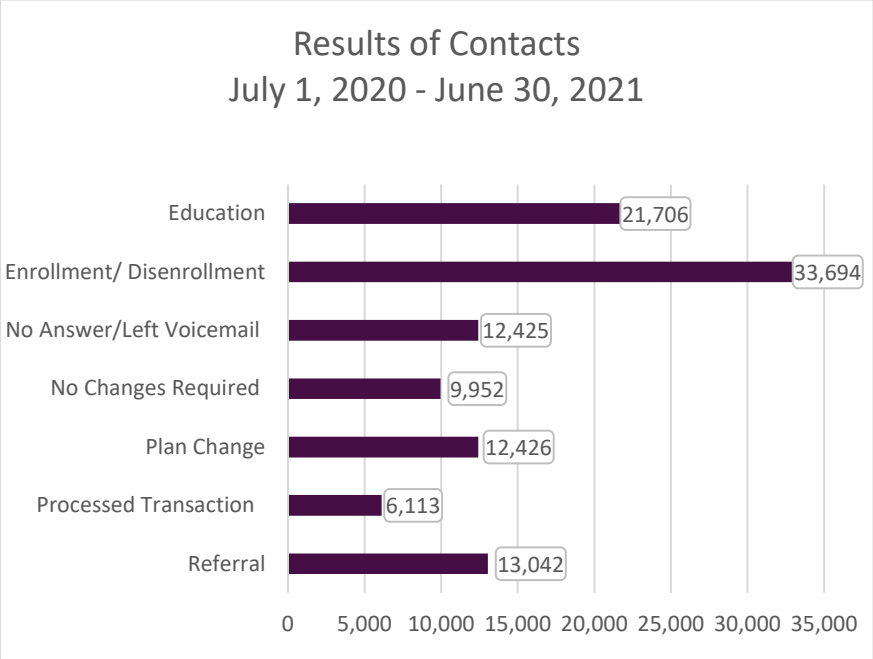
"Processed Transaction" and "No Changes Required" are "Results of Contact" categories that were added 4th Quarter 2019-20. This is the first report with 12 months of data in these categories.

"Processed Transaction" represents a transaction that is Medi-Cal related, but not enrollment related such as ordering a Benefits Identification Card (BIC).

"No Changes Required" represent cases that did not require transactional changes such as follow up calls.



A complete list of the various categories and definitions is below.

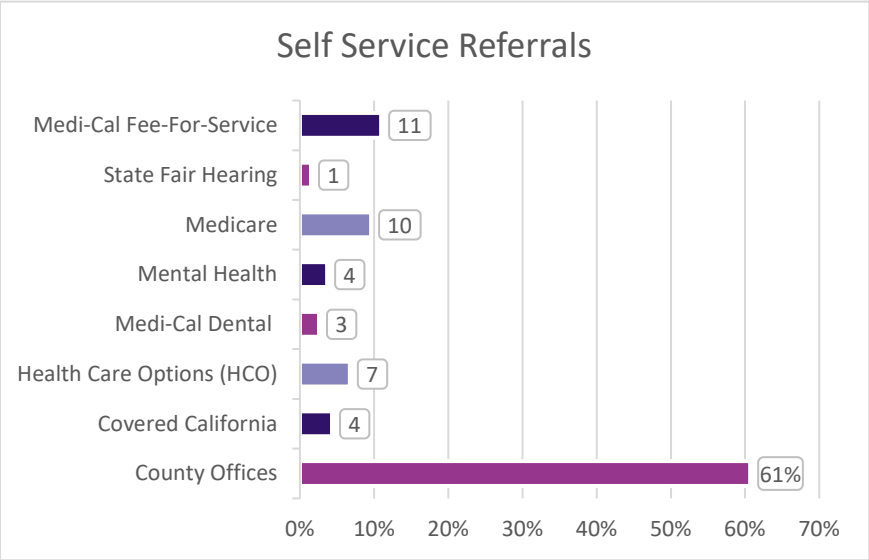
Initial Reason For Call	
Education	Represents the number of calls involving the need for assistance or education on the beneficiary's next steps on various subjects, including access care.
Enrollment / Disenrollment	Represents the number of calls received from beneficiaries in need of assistance with current month MCP enrollments or disenrollment.
No Answer / Left Voicemail	Represents the number of callers who requested a call back but were unable to answer the phone at the callback time. OMB agents leave a message whenever there is a voicemail or answering machine available identifying that the call was returned and the phone number for OMB if assistance is still required.
No Changes Required	Represents the number of callers who requested confirmation of enrollment or disenrollment that resulted in no action taking place on their account.
Plan Change	Represents the number of calls received from beneficiaries in need of assistance changing from one MCP to another.
Processed Transaction	Represents the number of calls where a transaction or update was processed that did not result in an enrollment or disenrollment including ordering BIC Cards.
Referral	Represents the number of beneficiaries who were referred to a more appropriate organization.

3) Consumer assistance protocols, procedures, and referral tools.

The OMB helps solve problems from a neutral standpoint to ensure that our beneficiaries receive all medically necessary covered services for which Medi-Cal managed plans are contractually responsible. We serve as an objective resource to resolve issues between beneficiaries and their managed care health plans.

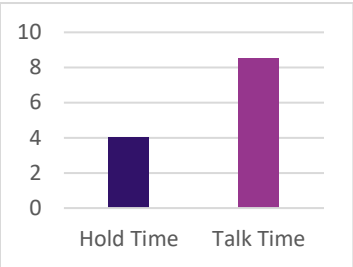
Currently we have two systems in place to assist beneficiaries with referrals: Self Service through our Interactive Voice Response (IVR) phone system and referrals due to a contact with OMB.

When a beneficiary contacts OMB call center, they are greeted with a robust IVR. The IVR identifies OMB as well as eight other programs with which to self-refer. The IVR is set up to assist beneficiaries who know which agency they want to speak with but may not have the phone number available. Approximately four out of ten people who contact the OMB toll free number utilize the self-service option.



The breakdown of callers using the IVR in lieu of speaking to OMB show sixty one percent transfer to their local county Medi-Cal Eligibility worker for assistance. The remaining thirty nine percent of beneficiaries transfer to one of the seven other IVR options.

Callers who do not use the self-service option are placed in the phone queue and will speak directly with an OMB representative.



For FY 2020-2021, beneficiaries who remained on the line to speak directly with an OMB representative waited on hold for an average of four (4) minutes and spoke to that representative for an average of eight (8) minutes.

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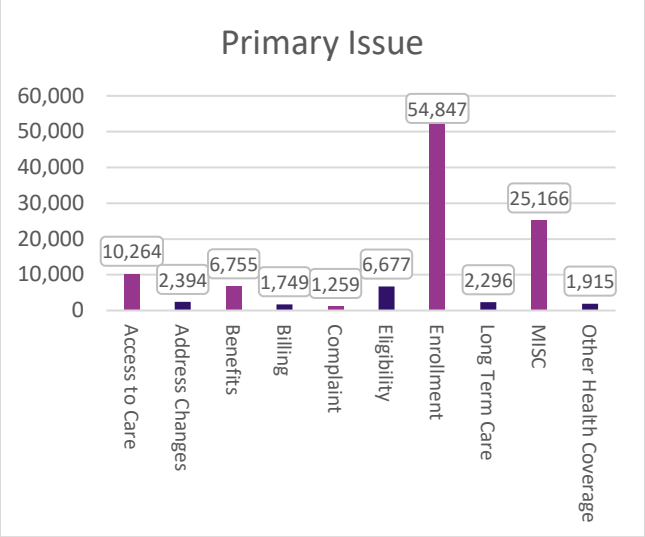
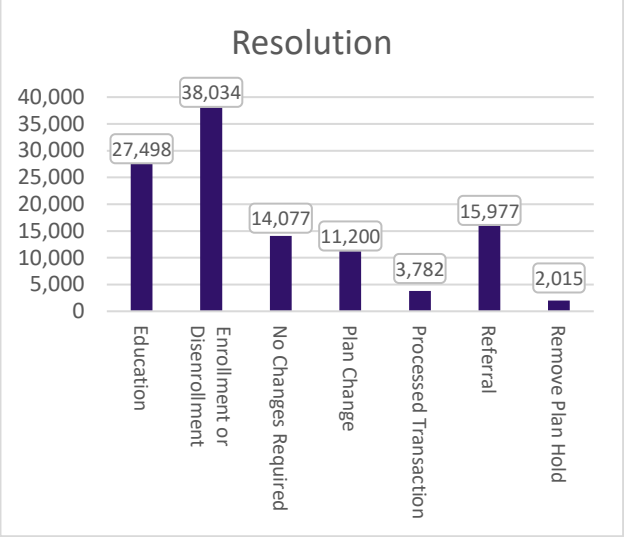
On March 1, 2020, OMB upgraded from Microsoft Customer Relations Management (CRM) system to Salesforce. This change has allowed us to broaden our reporting categories and will help to improve our ability to identify new data trends.

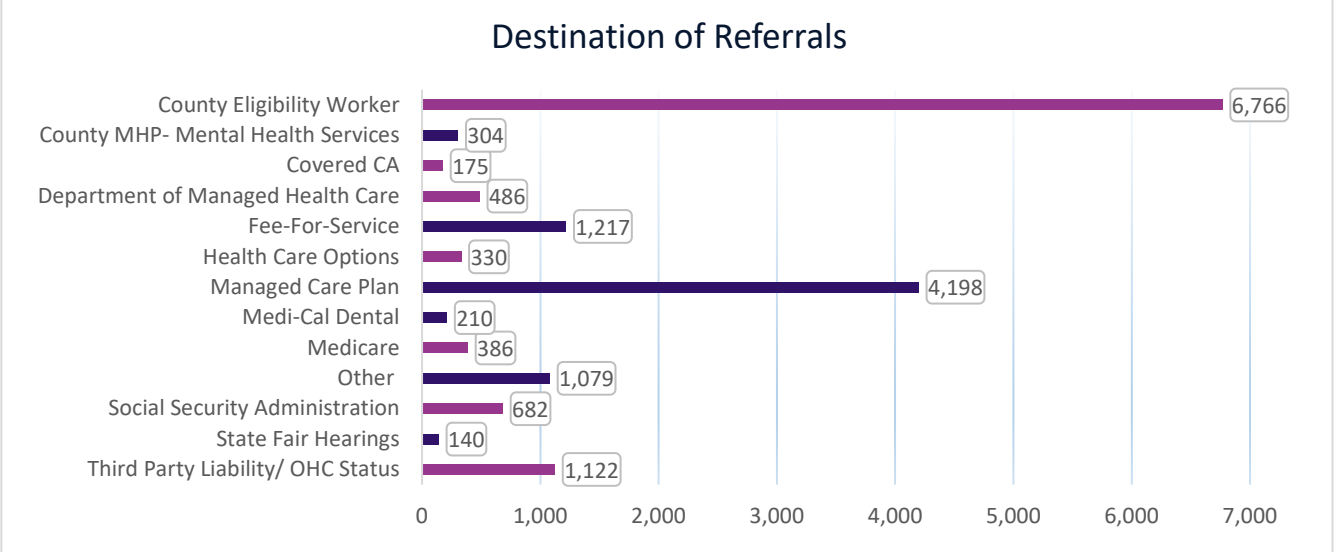
In order to be considered complete, each case is required to contain both a Primary Issue (call reason) and a Resolution. Cases cannot be closed without this information.





The OMB will attempt to resolve any call that is received in the call center. If the OMB is unable to fully assist a beneficiary, the OMB will provide a referral, and whenever possible a warm transfer to the organization that is more suited to assist in resolving the issue.

Calls made to OMB that resulted in an direct referral to an outside organization for further assistance are illistrated in the graph below.



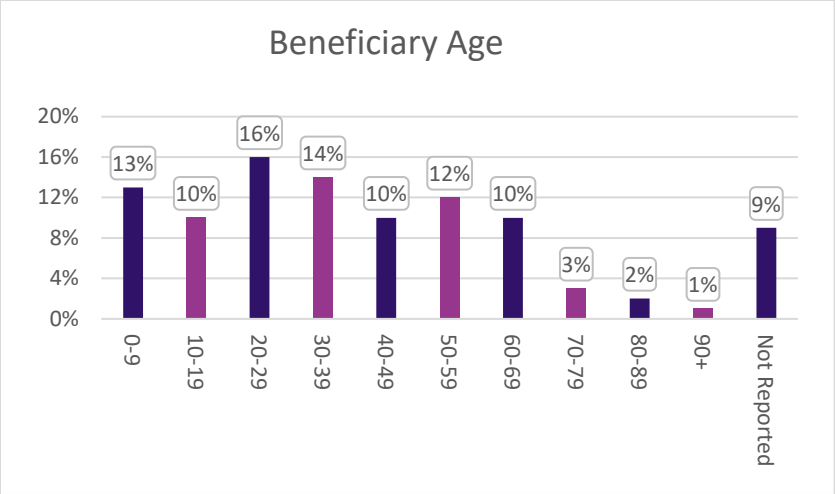
4) Demographic Information.

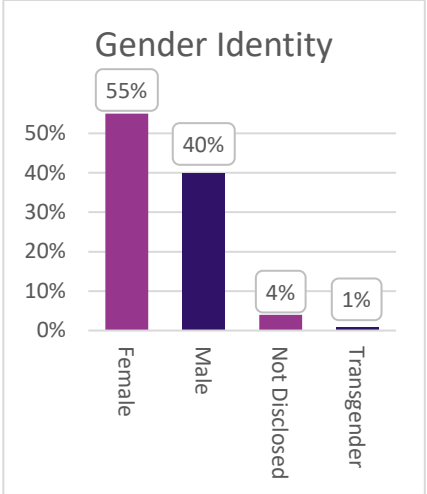
Demographic information is entered into the Medi-Cal Eligibility Data System (MEDS) at the time of Medi-Cal application. If the beneficiary declines to state their Gender Identity or Ethnicity, OMB is not able to update that information. Age is verified in MEDS through the Social Security Administration.

Demographic Information is being captured on both the quarterly reports and the annual summary (Age, Gender and Ethnicity) for the first time this FY.

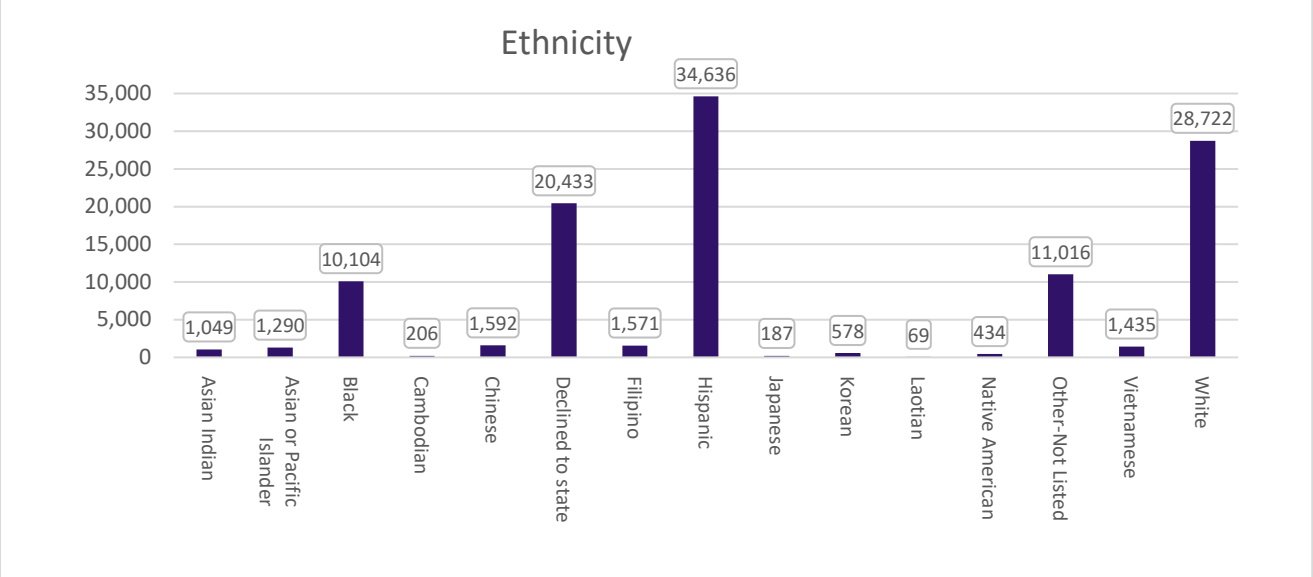
*Beneficiary Age data is from FY 2020-21

*Due to system limitations we were unable to capture Gender Identity Information until 1/1/2021. The data below is for the period of 1/2021-6/2021 only.



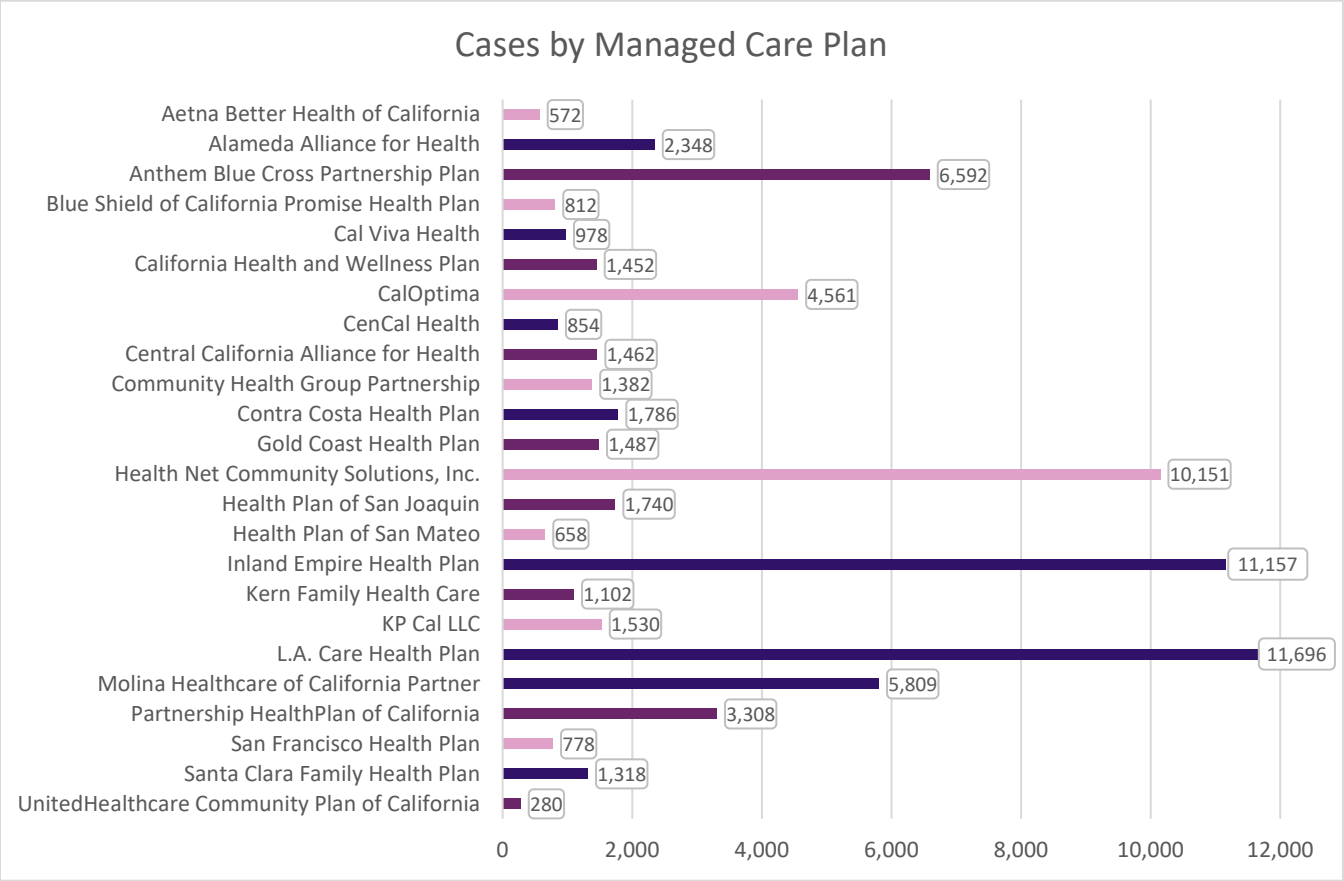


*Ethnicity data is for FY 2020-21



5) Managed Care Plan Information.

Additionally, OMB is now able to capture and report cases at the Managed Care Plan (MCP) level. This case detail is plan specific not county specific. If a plan operates in multiple counties, the count below is the total across all counties the MCP operates in.



*Due to the low call volume, Dental Plans and Cal-Medi Connect (CMC) Plans are not illustrated in the graph above.