

MEDI-CAL MANAGED CARE AND MENTAL HEALTH OFFICE OF THE OMBUDSMAN SENATE BILL 97 FOURTH QUARTER EXECUTIVE SUMMARY

7/1/2025-6/30/2026

INTRODUCTION

This Executive Summary Report is submitted in accordance with Senate Bill (SB) 97 and provides a high-level overview of the activities and outcomes of the Medi-Cal Managed Care and Mental Health Office of the Ombudsman (OMB) during Fiscal Year (FY) 2025-2026. The report highlights key operational areas, including staff training, consumer engagement, and data trends.

1. Staff Training Protocols

- » Includes training in cultural and linguistic competency to ensure equitable and effective service delivery

2. Contact Assessment and Trend Analysis

- » A review of consumer contacts, identification of emerging trends, and actions taken by the Department of Health Care Services (DHCS) in response to those contacts.

3. Consumer Assistance Procedures

- » An outline of protocols, procedures, and referral tools used to support and guide consumers.

4. Demographic Information

- » A summary of demographic information collected through consumer interactions.

5. Managed Care Plan (MCP) Case Data

- » A breakdown of cases by Managed Care Plan to assess volume and distribution.

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

1. Staff Training Protocols

OMB staff receive ongoing training to ensure high-quality service delivery, with a strong emphasis on:

- » Cultural Competency
- » Customer Service
- » Policy and Program Updates

The OMB hires bilingual staff fluent and certified in Spanish. Current staffing levels have ten of twenty one OMB staff certified as Spanish Bilingual Analysts.

To assist members speaking languages other than English and Spanish, OMB staff are fully training in the use of a Language Assistance Line.

New Employees are required to complete a series of mandatory training courses upon hire and at specified intervals thereafter.

- » Medi-Cal processes and procedures, transactions, Customer Service, unit specific training etc. upon hire.
- » Customer Service Training including Telephone Etiquette, Listening vs. Hearing and Managing Difficult Customers.
- » 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. Contact Assessment and Trend Analysis

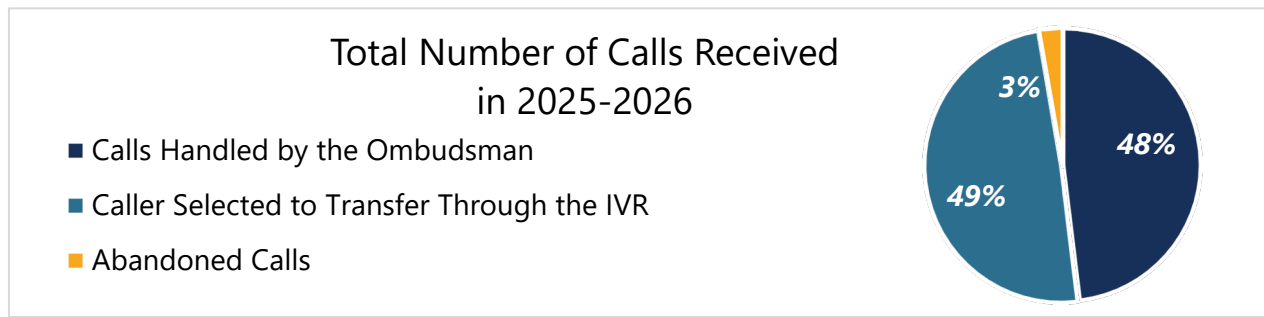
During Fiscal Year (FY) 2025-26, the Office of the Ombudsman (OMB) received a total of 242,858 phone calls and 13,266 emails from Medi-Cal members seeking assistance. To support members effectively, OMB currently utilizes two primary referral systems:

1. Self-Service via Interactive Voice Response (IVR):

The automated IVR system allows members to get referrals on their own, helping those who know the agency they need but do not have its contact information readily available.

2. Direct Referrals through OMB Staff:

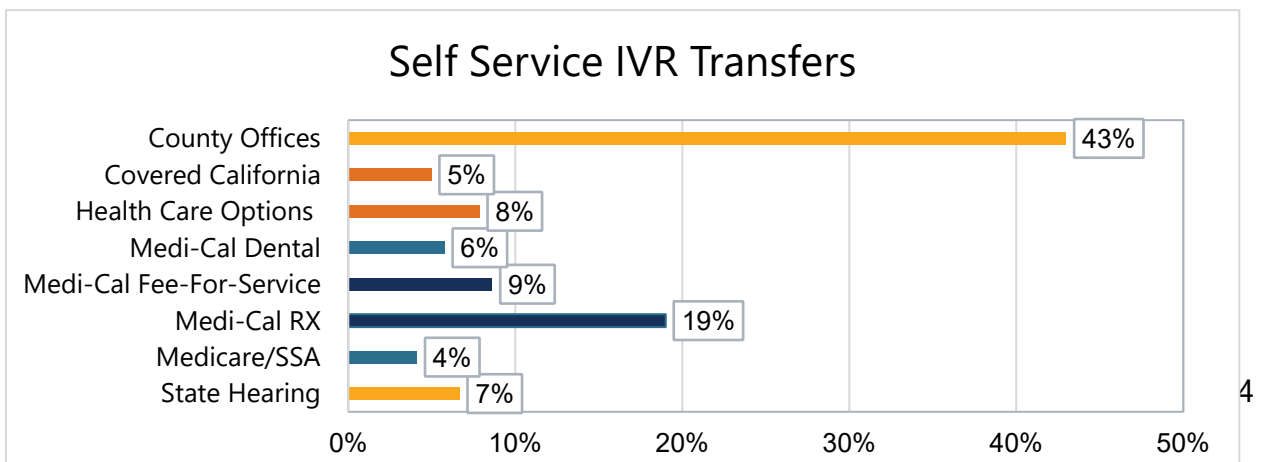
OMB analysts provide personalized referrals based on the member's specific

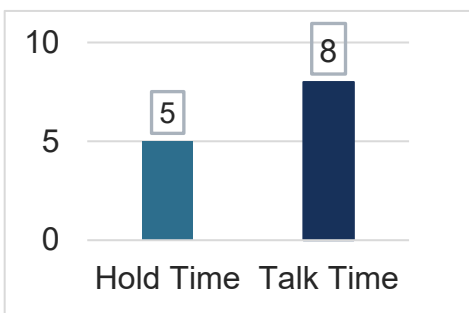


needs, ensuring they are connected to the most appropriate resource for support.

When a member contacts the OMB Call Center, they are first greeted by a comprehensive IVR system. The IVR clearly identifies OMB and provides eight self-service options, enabling callers to be routed directly to the appropriate agency.

The IVR is a critical tool in improving efficiency and member access. Forty four percent of Ombudsman callers use the IVR self-service feature, allowing members to receive faster assistance without waiting to speak with an analyst. This helps streamline call flow, reduces wait times, and ensures that OMB analysts can focus on more complex member issues requiring direct support.





Fifty Six percent of callers do not utilize the self-service IVR options. These callers are placed into the phone queue to speak directly with an OMB analyst.

During Fiscal Year (FY) 2025–26, members who remained on the line experienced an average hold time of five (5) minutes, followed by an average Talk Time of eight (8) minutes with an OMB Analyst.

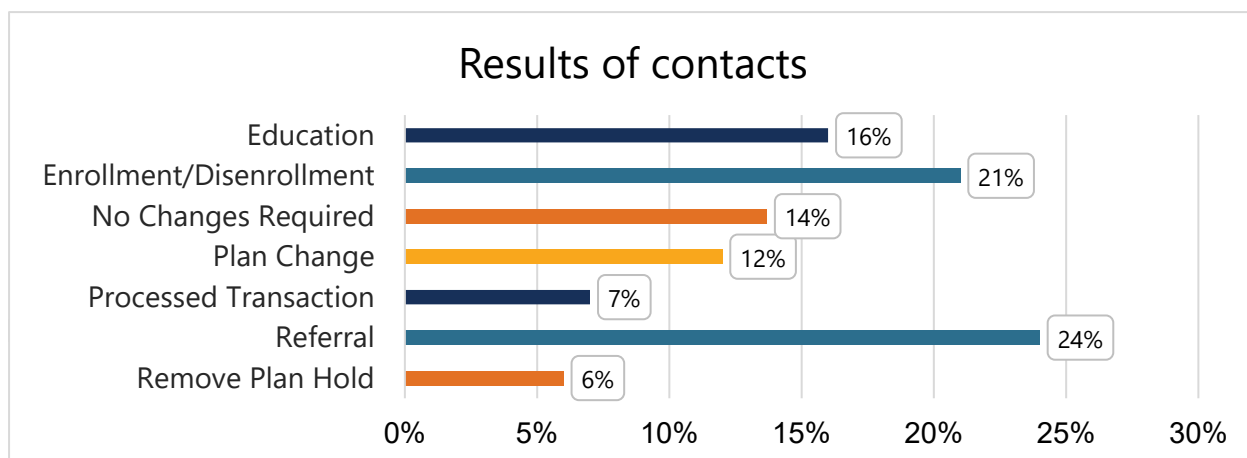
3. Consumer Assistance Procedures

The Office of the Ombudsman (OMB) provides impartial support to help resolve issues between Medi-Cal members and their Managed Care Plans (MCPs). Operating from a neutral standpoint, OMB ensures that members receive all medically necessary, covered services for which MCPs are contractually responsible.

To maintain accountability and consistency, OMB Analysts are required to document each member interaction in Salesforce. Each case record includes:

- » Member information
- » Reason for contact
- » Outcome of the interaction
- » Detailed case notes

Analysts select from seven standardized resolution categories to accurately reflect the outcome of each case. As illustrated in the graph below, the most common outcome of member contacts with the OMB Call Center was a Referral to the appropriate organization for further assistance, followed by an enrollment or disenrollment request, then member education.



RESULT OF CONTRACT – DEFINITIONS

Each case documented by the Office of the Ombudsman (OMB) includes a resolution category selected by the analyst to reflect the outcome of the interaction. The following definitions describe the seven available resolution types:

» **Education**

Indicates calls where the member was provided with information or guidance on topics such as access to care, covered benefits, eligibility requirements, or Medi-Cal policies and procedures.

» **Enrollment / Disenrollment**

Reflects calls from members seeking assistance with enrolling in or disenrolling from a Managed Care Plan (MCP) for the current month.

» **No Changes Required**

Represents calls where the member requested confirmation of their enrollment or disenrollment status, but no updates or changes were necessary.

» **Plan Change**

Captures calls from members requesting assistance with switching from one MCP to another.

» **Processed Transaction**

Refers to calls where a transaction was completed that did not involve enrollment or disenrollment, such as ordering a Benefits Identification Card (BIC) or updating member information.

» **Referral**

Denotes cases where the member was directed to a more appropriate organization or agency for assistance beyond the scope of OMB.

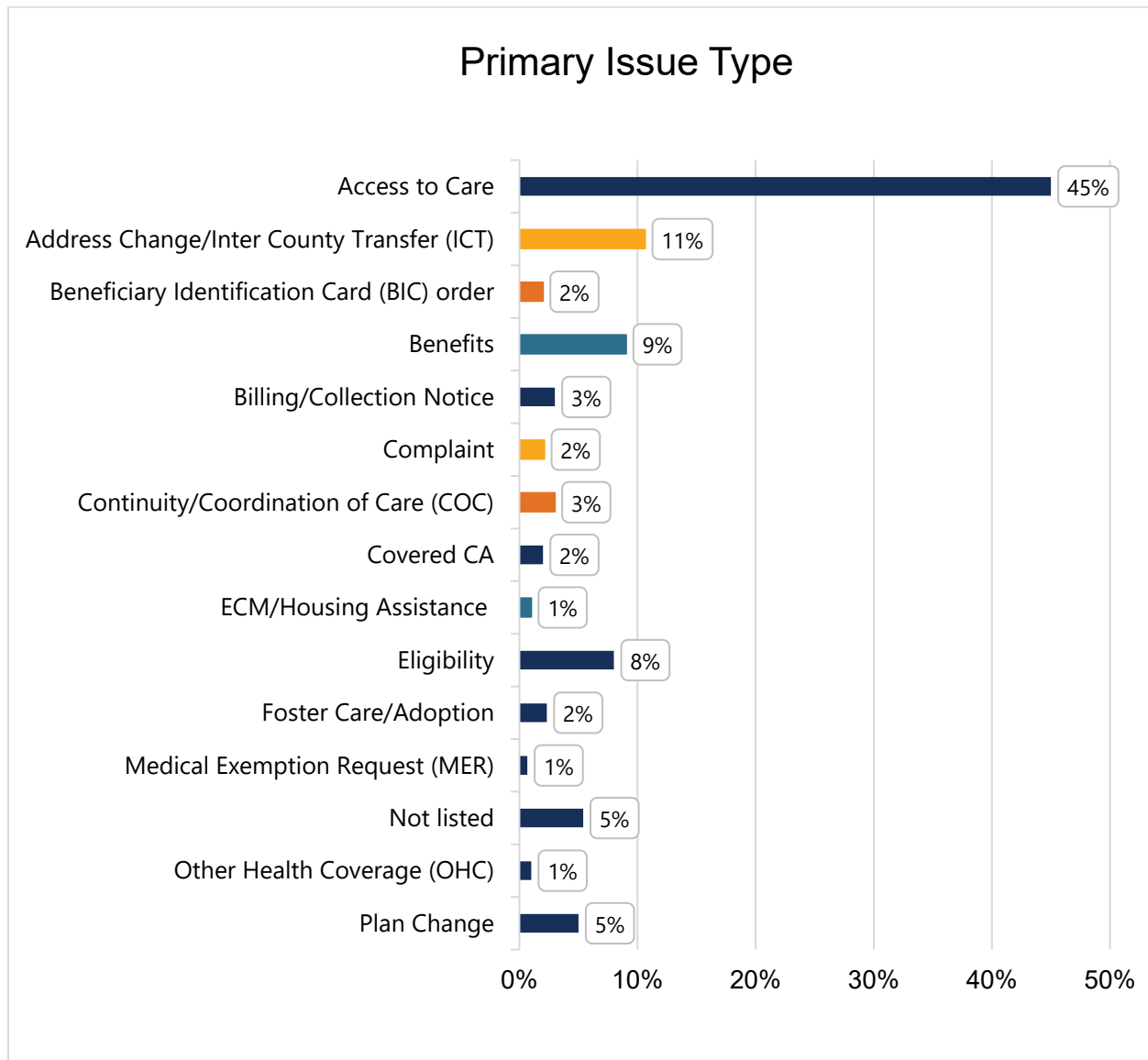
» **Remove Plan Hold**

Applies to cases where OMB assisted a member in removing a hold on their Medi-Cal record that was preventing enrollment or access to services.

Primary Issue

OMB is dedicated to resolving all inquiries received through the Call Center. When an issue cannot be fully addressed by OMB, members are referred to the organization best equipped to assist.

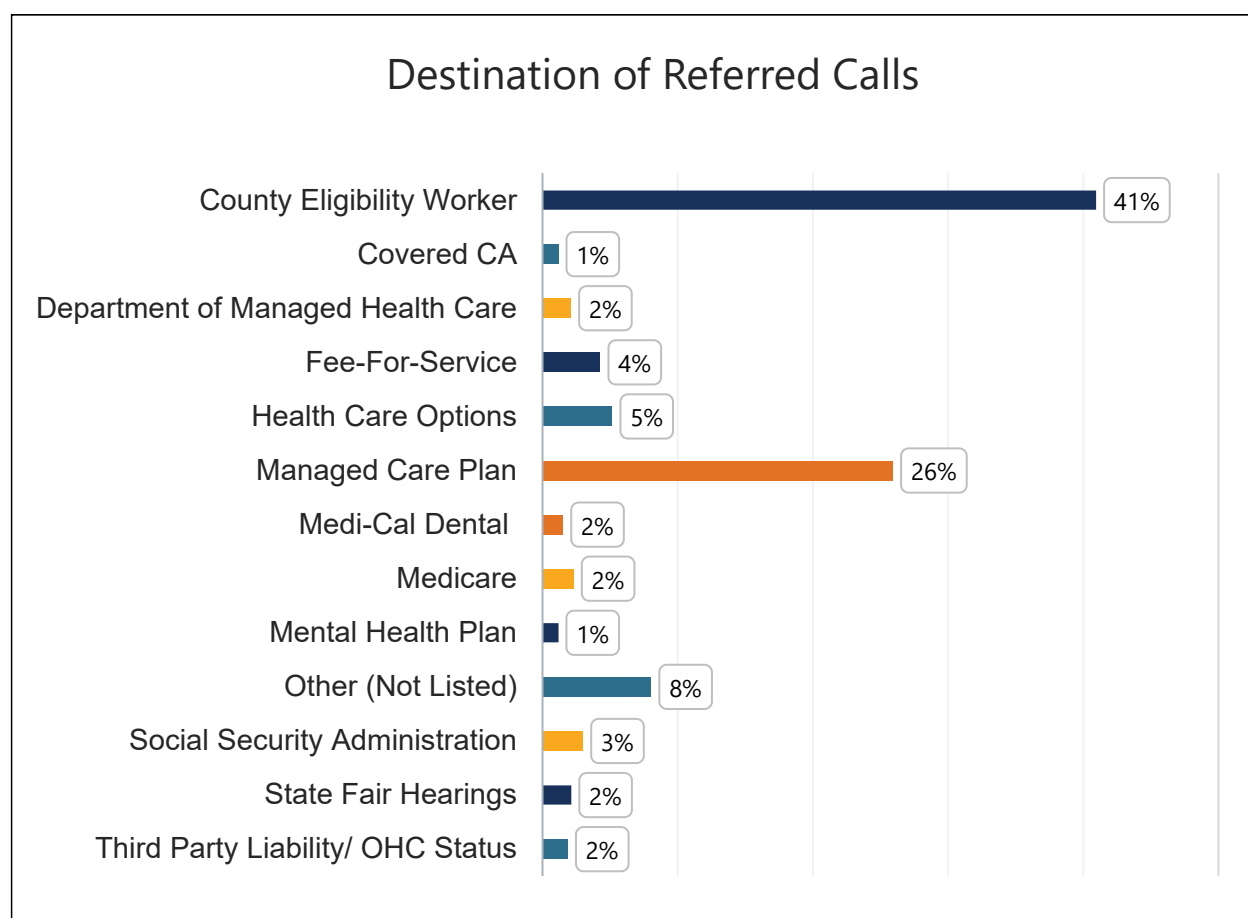
As illustrated in the graph below, the most common reason members contacted the OMB Call Center was to address access-to-care-related inquiries.



Destination of Referred Calls

When the Office of the Ombudsman determines that a member's question or concern falls outside its scope, staff provide a direct referral to the agency or resource best equipped to assist. This process ensures members are connected quickly and accurately to the appropriate support.

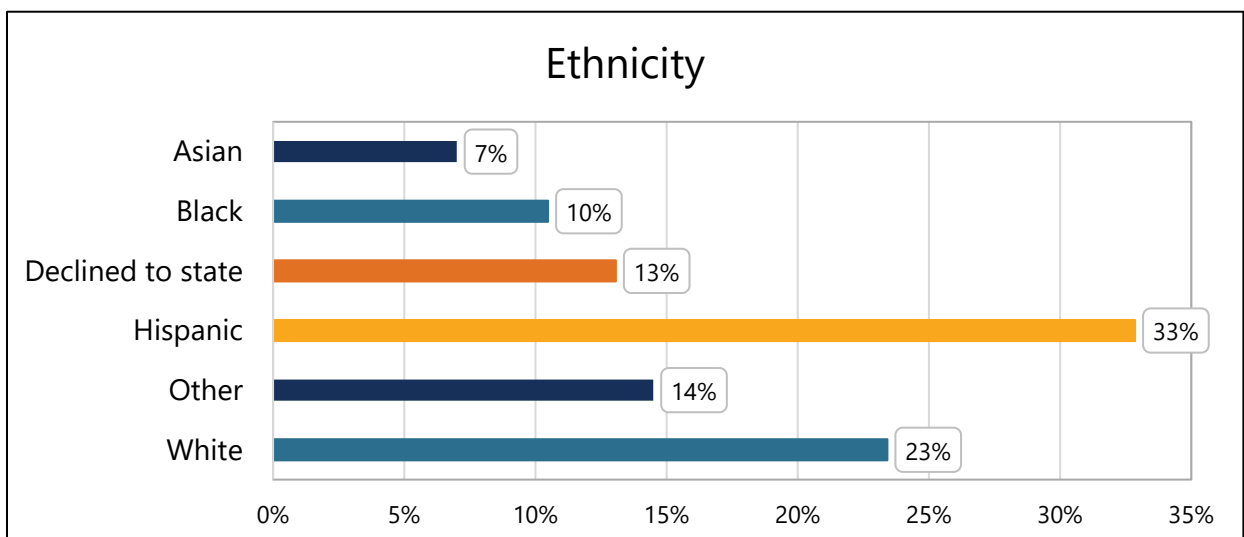
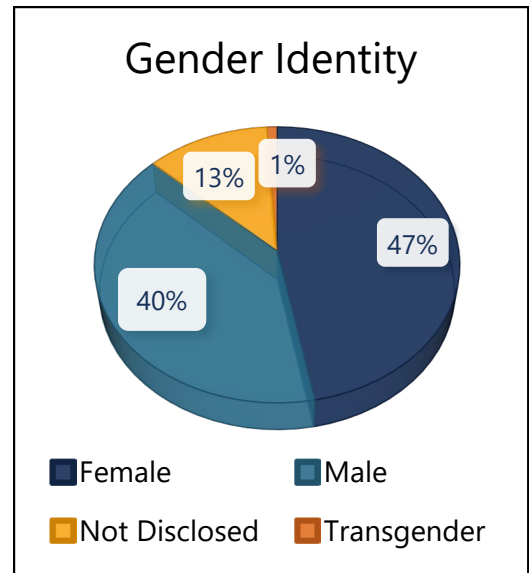
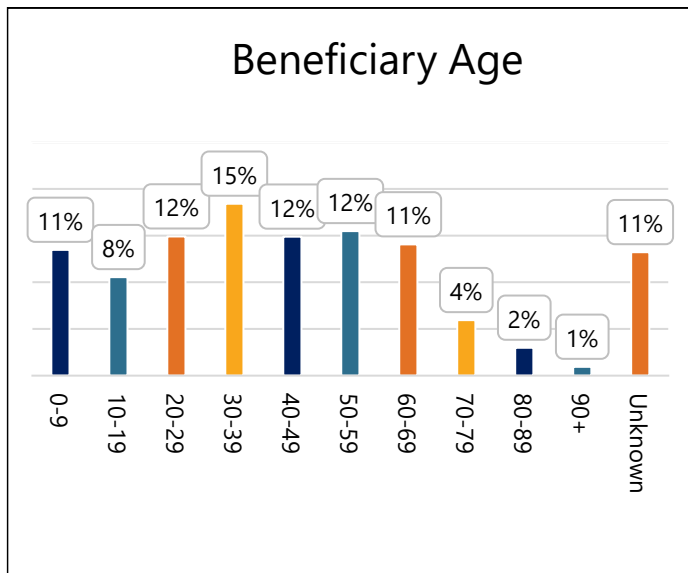
The report's "Destination of Referred Calls" section illustrates both the volume of these referrals and where members were directed for further assistance. These referral patterns offer valuable insight into the types of issues that most frequently require support from external organizations and highlight OMB's role in facilitating timely, accurate navigation across the broader Medi-Cal system.



4. Demographic Information

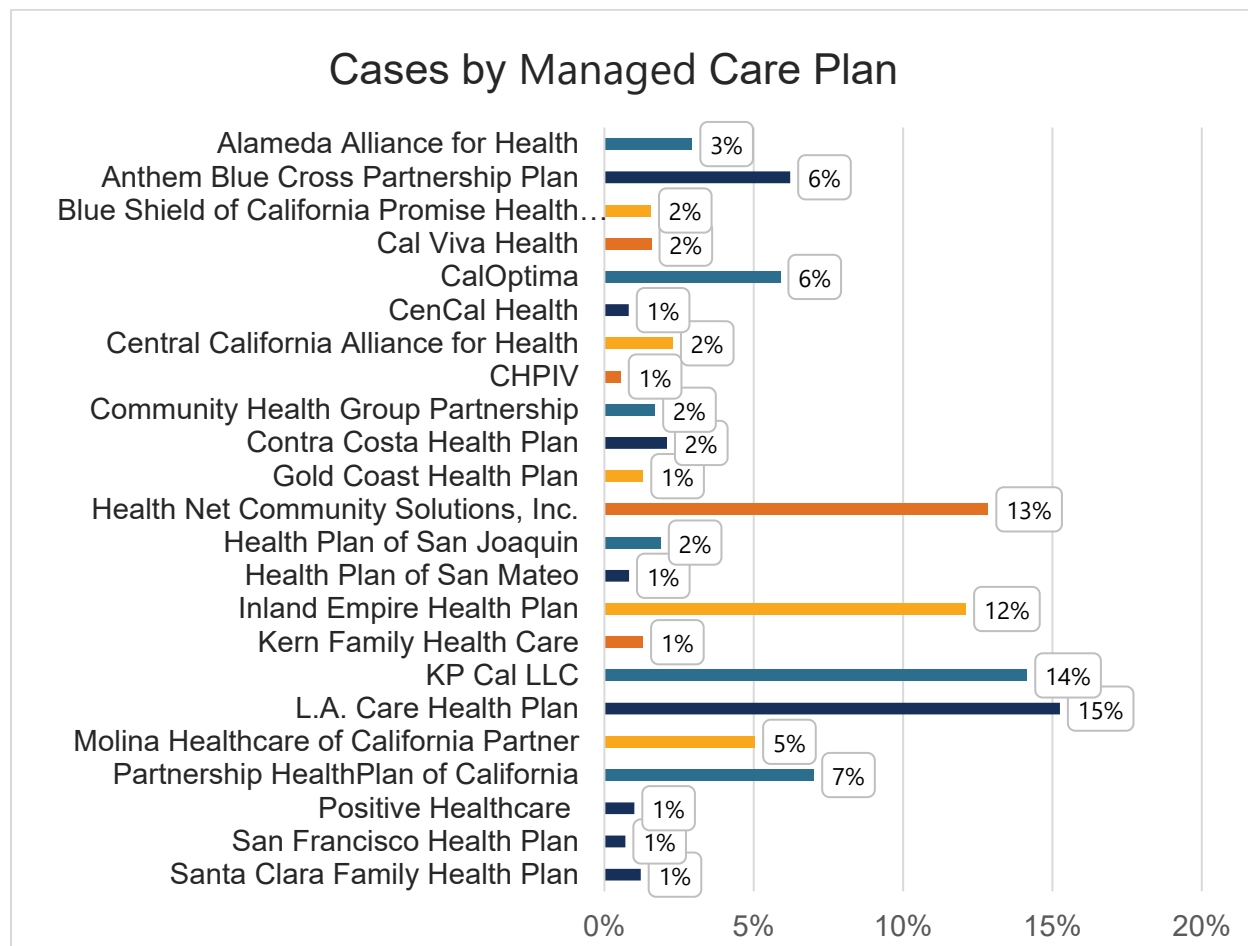
Demographic information for Medi-Cal members is initially captured in the Medi-Cal Eligibility Data System (MEDS) at the time of application. Because this information is controlled at the County level, the OMB cannot update or modify any demographic fields if a member chooses not to disclose them during the application process.

- » **Age** is verified in MEDS using data provided by the Social Security Administration.
- » **Gender identity** is recorded only when voluntarily provided by the member at the time of application.
- » **Ethnicity** is also recorded only when voluntarily disclosed during the application process.



5. Managed Care Plan (MCP) Case Data

OMB is responsible for collecting and reporting case data at the Managed Care Plan (MCP) level. Case information is identified at the MCP level rather than by individual counties. For MCPs that operate across multiple counties, the totals reflect the combined number of cases from all counties in which the plan delivers services. This approach ensures consistent, plan-level visibility into member needs, caseload distribution, and trends across the Medi-Cal managed care system.



*Due to the low call volume, MCP Call Volume less than 1 percent and Dental Plan data is suppressed in accordance with the DHCS DDG v2.2

This report demonstrates the Office of the Ombudsman's ongoing commitment to transparency, accountability, and continuous improvement in its service to Medi-Cal members. OMB remains focused on strengthening its operational processes, enhancing staff training, and collaborating with key partners to address systemic challenges and improve member experience across the Medi-Cal program.