

Medi-Cal Fee-For-Service Access Analysis: Durable Medical Equipment, Clinical Laboratory, Emergency Medical Transportation, Non-Emergency Medical Transportation, Home Health& Dental Services

The California Department of Health Care Services (DHCS) developed this paper in conjunction with the Department's proposed State Plan Amendment to reduce Medi-Cal provider payments. In this paper, DHCS presents a baseline assessment of the state of access in the Medi-Cal fee-for-service program for six service categories:

- Durable medical equipment;
- Clinical laboratory;
- Emergency medical transportation (Air and ground);
- Non-emergency medical transportation;
- Home Health; and
- Dental services.

This paper follows the information and analysis provided in the paper on physician and clinic services. That paper included information on the size and demographics of the Medi-Cal FFS population as well as an analysis of the access to care for physician and clinic services. It is important to consider the analysis of the physician and clinic services in assessing the access to these other services as most other outpatient and ancillary services are provided at the direction of the physician/clinic.

Overview of Approach

DHCS' assessment of the state of access to these service categories in Medi-Cal FFS is based on evaluating, where available, data for the individual categories of services and focuses on the two key areas of utilization and provider availability. Specifically our analysis includes looking at three measures:

1. 3-year trends in utilization per 1,000 eligible member months
2. Trends in total participating providers
3. 3-Year trends in enrollment

Our assessment includes analyzing the identified data elements both statewide and by two county-based geographic groupings (metropolitan and non-metropolitan). This enabled DHCS to analyze the availability of services and providers both statewide and in similar county regions.

Methodology

Data Sources

For this assessment, DHCS used the best data currently available. The data for the analyses were from three state sources. For utilization information, we utilized data from DHCS administered Medi-Cal '35' paid claims files for calendar years 2007-2009. The Medi-Cal claim files consist of detailed records reflecting payments and services rendered to beneficiaries. We utilized data for 2007 to 2009 to enable a three-year trend analysis using the most complete data available.

We pulled the data on eligible member months from the Medi-Cal MEDS Eligibility System for the same three-year period of 2007 to 2009. A Monthly Medi-Cal Eligibility File (MMEF) is created from this MEDS data system, which contains observations reflecting the benefit history for anyone who received Medi-Cal or other state program benefits in the current and previous twelve months.

Finally, the data on the participating providers was pulled from the Provider Master Files for 2007 to the first quarter of 2011. The Medi-Cal Provider Master File (PMF) contains records for providers who bill services through the fiscal intermediary. The PMF contains information including service addresses, provider type and the categories of service billed by that provider.

Geographic Grouping

In our analysis, we looked at utilization and provider availability statewide, as well as by two separate geographic groups: Metropolitan and Non-Metropolitan Counties. These county groups are defined in the same manner as in the draft physician/clinic access analysis. DHCS developed the Metropolitan and Non-Metropolitan county groups by using the ERS Rural-Urban Continuum Codes. The Rural-Urban Continuum Codes are calculated by examining the size of a county and its proximity to a metropolitan area. Rural-Urban Continuum Codes form a classification scheme that distinguishes metropolitan counties by the population size of their metro area, and nonmetropolitan counties by degree of urbanization and adjacency to a metro area or areas. The table below lists the counties included in these two groups.

Table 1: County Groups Used in Analysis: Metropolitan and Non-Metropolitan Counties

Metropolitan Counties	Non-Metropolitan Counties
Alameda	Alpine
Butte	Amador
Contra Costa	Calaveras
El Dorado	Colusa
Fresno	Del Norte
Imperial	Glenn
Kern	Humboldt
Kings	Inyo
Los Angeles	Lake
Madera	Lassen
Marin	Mariposa
Merced	Mendocino
Monterey	Modoc
Napa	Mono
Orange	Nevada
Placer	Plumas
Riverside	Sierra
Sacramento	Siskiyou
San Benito	Tehama
San Bernardino	Trinity
San Diego	Tuolumne
San Francisco	
San Joaquin	
San Luis Obispo	
San Mateo	
Santa Barbara	
Santa Clara	
Santa Cruz	
Shasta	
Solano	
Sonoma	
Stanislaus	
Sutter	
Tulare	
Ventura	
Yolo	
Yuba	

Description of Measures

DHCS chose the three measures included in this analysis based on available data and because they provided the best means of creating a picture of provider availability and Medi-Cal utilization.

1. **3-Year Trends in Utilization Per 1,000 Member Months:** We examined the volume of care received by Medi-Cal beneficiaries in a 3-year time period, as well as compared various types of service used by different Medi-Cal eligibility subgroups. Data for examining Medi-Cal utilization come from two sources: program enrollment data and claims data. DHCS compiled three years of claims data (calendar years 2007 through 2009) reflecting Medi-Cal beneficiaries' service use. For each of the service areas, healthcare utilization rates were calculated per 1,000 beneficiaries overall as well as using broad age groupings (adult vs. child) and aid codes as a proxy for health and disability status.
2. **Trends in Total Participating Providers:** We analyzed how many providers the FFS-Medi-Cal only population had access to by utilizing the Medi-Cal Provider File information. We defined a participating provider as those who are have an active or rendering status.
3. **3-Year Trends in Enrollment:** An important factor in understanding the other measures and what they represent is considering how enrollment has changed over time. We examined the total number of eligible member months by different Medi-Cal subgroups during the 2007 to 2009 period.

State of Access in Medi-Cal FFS

Enrollment Trends

As noted in the prior section, an important component of an analysis of access must include an understanding of the population in question. The tables below contain information on the enrollment trends by geographic area and sub-population over the three-year time period used in our analysis. Overall California experienced a 6.4% increase for adults and a 2.8% increase for children in Medi-Cal enrollment from 2007 to 2009, with the largest increases for both being in the Families sub-population (14.0% and 9.6%, respectively).

Table 2: 3-Year Trend in Enrollment (Eligible Member Months) by Sub-Population: Statewide

	Total Eligible Member Months			% Change 2007 to 2009
	2007	2008	2009	
<u>Adults</u>				
Aged	677,952	706,188	715,116	5.5%
Blind/Disabled	4,242,264	4,239,648	4,278,480	0.9%
Families	2,684,952	2,811,096	3,060,036	14.0%
Other	626,376	616,536	631,512	0.8%
Undocumented	6,591,072	6,691,524	7,080,348	7.4%
All Adults	14,822,616	15,064,992	15,765,492	6.4%
<u>Children</u>				
Blind/Disabled	998,280	1,013,580	1,024,092	2.6%
Families	6,193,248	6,426,888	6,786,252	9.6%
Foster Care	1,460,220	1,426,404	1,384,116	-5.2%
Other	2,741,064	2,705,412	2,777,184	1.3%
Undocumented	2,730,348	2,621,304	2,541,576	-6.9%
All Children	14,123,160	14,193,588	14,513,220	2.8%

Table 3: 3-Year Trend in Enrollment (Eligible Member Months) by Sub-Population: Metropolitan Counties

	Total Eligible Member Months			% Change 2007 to 2009
	2007	2008	2009	
<u>Adults</u>				
Aged	674,940	702,840	711,360	5.4%
Blind/Disabled	4,033,896	4,025,232	4,058,568	0.6%
Families	2,385,864	2,506,080	2,729,256	14.4%
Other	604,164	595,044	608,988	0.8%
Undocumented	6,541,236	6,638,028	7,019,340	7.3%
All Adults	14,240,100	14,467,224	15,127,512	6.2%
<u>Children</u>				
Blind/Disabled	957,156	971,868	982,584	2.7%
Families	5,588,088	5,808,780	6,125,748	9.6%
Foster Care	1,411,152	1,378,560	1,336,152	-5.3%
Other	2,626,488	2,583,396	2,645,988	0.7%
Undocumented	2,704,068	2,593,020	2,511,996	-7.1%
All Children	13,286,952	13,335,624	13,602,468	2.4%

Table 4: 3-Year Trend in Enrollment (Eligible Member Months) by Sub-Population: Non-Non-Metropolitan Counties

	Total Eligible Member Months			% Change 2007 to 2009
	2007	2008	2009	
Adults				
Aged	3,012	3,348	3,768	25.1%
Blind/Disabled	208,368	214,416	219,912	5.5%
Families	299,100	305,004	330,768	10.6%
Other	22,200	21,492	22,524	1.5%
Undocumented	49,836	53,496	61,008	22.4%
All Adults	582,516	597,756	637,980	9.5%
Children				
Blind/Disabled	41,124	41,700	41,520	1.0%
Families	605,160	618,108	660,504	9.1%
Foster Care	49,068	47,844	47,964	-2.2%
Other	114,564	122,016	131,196	14.5%
Undocumented	26,280	28,296	29,580	12.6%
All Children	836,196	857,964	910,764	8.9%

The remainder of the analysis will refer back to the information above as it helps to illuminate further the results of the utilization and provider trend analyses.

Durable Medical Equipment

We analyzed the use of durable medical equipment over a three-year period by looking at utilization of services per 1000 member months by geographic area and sub-population. A key factor to consider in assessing access to DME services and analyzing utilization trends is the recognition that utilization of DME is primarily driven by access to a physician/clinic services as they serve as the gateway to this type of service. Therefore, in assessing utilization trends, we also need to acknowledge that shifts in utilization are highly driven by physician decisions and member needs and may not reflect issues with access.

Table 5 includes the results of our analysis. Utilization of DME per 1000 beneficiary months for adults has remained relatively constant over time with some fluctuations upward, both statewide and in the two county groups. We can couple this information with the increase in enrollment over time and see that as needs to for services have expanded or the population has expanded, access to DME has been sufficient. The analysis shows that utilization of DME for children has tended to fluctuate over time; however, overall for the three-year period utilization began and ended at similar levels. There is nothing in the analysis that would indicate an access issue for DME exists for children.

Table 5: Total Durable Medical Equipment Utilization per 1,000 Beneficiary Months (2007-2009)

	Statewide			Metropolitan Counties			Non-Metropolitan Counties		
	2007	2008	2009	2007	2008	2009	2007	2008	2009
Adults									
Aged	20.1	20.8	20.5	20.1	20.7	20.4	20.9	37.0	28.9
Blind/Disabled	31.6	37.4	34.8	31.0	36.6	33.7	44.6	52.1	55.7
Families	2.4	2.5	2.7	2.0	2.0	2.0	5.6	6.4	8.1
Other	4.6	4.6	4.3	4.6	4.6	4.4	2.5	2.2	3.2
Undocumented	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0
All Adults	10.6	12.2	11.1	10.3	11.8	10.6	19.0	22.3	23.7
Children									
Blind/Disabled	47.3	66.4	49.2	48.1	67.1	49.9	29.6	52.0	31.6
Families	1.2	1.2	1.2	1.1	1.1	1.1	1.9	2.1	1.8
Foster Care	3.7	5.0	3.9	3.7	5.0	3.8	4.6	6.3	4.5
Other	1.2	1.2	1.1	1.2	1.1	1.1	3.0	3.3	2.5
Undocumented	0.1	0.2	0.1	0.1	0.2	0.1	0.1	0.1	0.0
All Children	4.5	6.1	4.6	4.6	6.2	4.7	3.5	4.8	3.3

The second part of our analysis includes analyzing the total number of DME suppliers over time. Table 6 includes the results of this analysis. The data indicate that from 2007 through the first part of 2011 there has been a 6.1% increase in the number of DME suppliers participating in the Medi-Cal program. Therefore access to DME suppliers has expanded over the time period.

Table 6: Total Participating DME Suppliers (Dec 2007 to Jan 2011)

Provider Type/Group	2007 Dec	2008 Jan	2008 Jul	2009 Jan	2009 Jul	2010 Jan	2010 Jul	2011 Jan	% Change
DME Suppliers	1,708	1,741	1,721	1,761	1,793	1,792	1,795	1,813	6.1%

Based on this analysis, California can implement the proposed payment reduction for durable medical equipment without negatively impacting access.

Clinical Laboratory

We analyzed the use of clinical laboratory services over a three-year period by looking at utilization of services per 1000 member months by geographic area and sub-population. Similar to DME, a key factor to consider in assessing access to these services and analyzing utilization trends is the recognition that utilization of clinical lab services is primarily driven by access to a physician/clinic services as they serve as the gateway to this type of service.

Table 7 includes the results of our analysis. Utilization of clinical lab per 1000 beneficiary months for most subgroups of both adults and children has remained relatively constant over time. The decreases in the utilization trends overall are being driven mostly by the undocumented subgroup, which does not have full-scope services and therefore we would expect utilization to fluctuate. We are also seeing a decrease in utilization for adults in the families subgroup, although it is slight. Given that utilization for these services is driven by the beneficiary's physician/clinic, this slight decrease in utilization is most likely the result in a change in the needs of the population or the actions of the physicians/clinics and does not indicate an issue with access to these services.

Table 7: Total Clinical Lab Services per 1,000 Beneficiary Months (2007-2009)

	Statewide			Metropolitan Counties			Non-Metropolitan Counties		
	2007	2008	2009	2007	2008	2009	2007	2008	2009
Adults									
Aged	146.1	148.0	148.8	146.3	148.3	149.1	113.2	84.8	94.5
Blind/Disabled	143.9	144.6	147.1	146.1	147.4	150.0	101.4	93.7	93.3
Families	88.9	87.9	85.3	91.0	90.7	88.3	71.6	64.7	60.7
Other	259.6	263.0	267.1	264.1	268.1	272.8	137.7	122.9	114.9
Undocumented	58.1	54.0	48.0	58.2	54.2	48.2	37.7	32.3	25.2
All Adults	100.8	98.8	95.5	101.5	99.8	96.5	82.1	74.4	70.7
Children									
Blind/Disabled	32.6	33.1	33.5	33.0	33.4	33.9	25.6	25.7	23.9
Families	19.1	20.0	20.4	19.6	20.7	21.0	15.0	14.1	15.1
Foster Care	37.2	37.5	38.4	37.5	37.8	38.7	30.5	27.8	29.8
Other	50.9	52.8	52.3	52.0	54.3	53.9	24.0	21.8	21.0
Undocumented	24.1	21.8	18.7	24.2	21.9	18.8	15.3	11.7	9.6
All Children	29.1	29.3	28.9	29.8	30.1	29.7	17.7	16.4	16.9

Table 8 includes the data on clinical lab provider participation. There has been an 18.8% increase since 2007 in the number of participating clinical labs, indicating an expansion of access to these services by Medi-Cal beneficiaries.

Table 8: Total Participating Clinical Labs (Dec 2007 to Jan 2011)

Provider Type/Group	2007 Dec	2008 Jan	2008 Jul	2009 Jan	2009 Jul	2010 Jan	2010 Jul	2011 Jan	% Change
Clinical Labs	757	767	815	866	868	878	892	899	18.8%

Based on this analysis, California can implement the proposed payment reduction for clinical laboratory services without negatively impacting access.

Emergency Medical Transportation (Air/Ground)

We analyzed the use of emergency medical transportation over a three-year period by looking at utilization of services per 1000 member months by geographic area and sub-population. The results of this analysis in the table below demonstrates that access to emergency medical transportation services has generally remained relatively constant over the three year period even as the number of beneficiaries has increased.

Table 9: Total Emergency Medical Transportation Services per 1,000 Beneficiary Months (2007-2009)

	Statewide			Metropolitan Counties			Non-Metropolitan Counties		
	2007	2008	2009	2007	2008	2009	2007	2008	2009
Adults									
Aged	10.0	10.2	9.9	10.0	10.2	9.8	13.9	18.2	14.9
Blind/Disabled	38.1	38.4	38.7	38.5	38.8	39.1	30.8	29.8	31.5
Families	7.8	7.7	7.1	7.7	7.6	7.1	7.9	7.9	7.7
Other	13.9	13.6	13.5	14.1	13.7	13.7	9.1	9.0	8.3
Undocumented	2.3	2.4	2.3	2.3	2.4	2.3	3.0	3.8	3.6
All Adults	14.4	14.3	13.9	14.3	14.3	13.8	15.8	15.5	15.6
Children									
Blind/Disabled	9.7	9.3	9.7	9.7	9.3	9.6	9.4	10.5	10.4
Families	3.1	3.0	2.9	3.1	3.0	2.9	3.3	3.3	3.3
Foster Care	4.2	4.2	4.4	4.2	4.2	4.4	4.3	4.4	4.5
Other	3.2	3.0	2.8	3.1	3.0	2.8	4.4	4.4	4.1
Undocumented	1.9	1.8	1.8	1.9	1.8	1.7	3.1	3.2	3.7
All Children	3.5	3.4	3.3	3.4	3.3	3.3	3.8	3.9	3.8

Table 10 includes the results of our trend analysis of provider participation for emergency transportation services. We have included both air ambulance and ground transportation providers. It is important to note that the ground medical transportation providers also include providers of non-emergency medical transportation as they are licensed in the same manner. Although the number of air ambulance providers has decreased and the number of ground medical transportation providers has increased, it is important to acknowledge that any patient, whether Medi-Cal or other, will receive the necessary emergency transportation. Therefore a decline or increase in participation is more reflective of need and not indicative of access.

Table 10: Total Participating Emergency Medical Transportation Providers (Dec 2007 to Jan 2011)

Provider Type/Group	2007 Dec	2008 Jan	2008 Jul	2009 Jan	2009 Jul	2010 Jan	2010 Jul	2011 Jan	% Change
Air Ambulance	47	46	50	51	46	46	46	46	-2.1%
Medical Transportation	1,032	1,043	1,075	1,094	1,095	1,095	1,096	1,106	7.2%

Based on this analysis, California can implement the proposed payment reduction for emergency medical transportation without negatively impacting access.

Non-Emergency Medical Transportation

We analyzed the use of non-emergency medical transportation over a three-year period by looking at utilization of services per 1000 member months by geographic area and sub-population. The results of this analysis are in Table 11. Utilization of non-emergency medical transportation has increased over time for adult beneficiaries, statewide we see an increase from 13.9 units of service per 1,000 beneficiary months in 2007 to 18.5 in 2009. Given that during this same time period California experienced a 6.4% increase in enrollees, this indicates that total utilization of these services has actually increased at a fairly significant rate since both the enrollment increased and the rate per 1,000 member months increased. This demonstrates that access to these services expanded over time to meet the needs of the beneficiaries. The table below also

indicates that these services are utilized very little by children enrolled in Medi-Cal and their utilization rates remained flat.

Table 11: Total Non-Emergency Medical Transportation Services per 1,000 Beneficiary Months (2007-2009)

	Statewide			Metropolitan Counties			Non-Metropolitan Counties		
	2007	2008	2009	2007	2008	2009	2007	2008	2009
Adults									
Aged	42.8	45.7	49.8	42.9	45.9	49.9	0.7	14.6	26.8
Blind/Disabled	33.0	39.2	46.9	34.5	41.1	49.2	5.5	4.2	5.3
Families	2.3	2.7	3.4	2.5	3.0	3.8	0.3	0.1	0.1
Other	18.2	21.3	23.9	18.7	21.9	24.7	3.5	3.8	1.9
Undocumented	2.9	3.5	4.1	2.9	3.6	4.1	0.7	1.2	2.8
All Adults	13.9	16.1	18.5	14.3	16.7	19.1	2.3	1.9	2.4
Children									
Blind/Disabled	1.1	1.6	1.8	1.1	1.7	1.8	0.5	0.5	0.5
Families	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Foster Care	0.1	0.2	0.2	0.1	0.2	0.2	0.1	0.0	0.1
Other	0.1	0.2	0.1	0.1	0.2	0.1	0.1	0.1	0.1
Undocumented	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0
All Children	0.2	0.2	0.3	0.2	0.3	0.3	0.1	0.1	0.1

Table 12 includes again the information on ground medical transportation providers that was included in table 10 as well since the licensing for these types of providers is the same. Overall we see a 7.2% increase in the number of participating medical transportation providers.

Table 12: Total Participating Non-Emergency Medical Transportation Providers (Dec 2007 to Jan 2011)

Provider Type/Group	2007 Dec	2008 Jan	2008 Jul	2009 Jan	2009 Jul	2010 Jan	2010 Jul	2011 Jan	% Change
Medical Transportation	1,032	1,043	1,075	1,094	1,095	1,095	1,096	1,106	7.2%

Based on this analysis, California can implement the proposed payment reduction for non-emergency medical transportation without negatively impacting access.

Home Health

We analyzed the use of home health services over a three-year period by looking at utilization of services per 1000 member months by geographic area and sub-population. The results of this analysis are in Table 13. The utilization rate of home health services has declined for adults and children in every aid group and in all geographic areas.

Table 13: Total Home Health Services per 1,000 Beneficiary Months (2007-2009)

	Statewide			Metropolitan Counties			Non-Metropolitan Counties		
	2007	2008	2009	2007	2008	2009	2007	2008	2009
Adults									
Aged	4.6	4.9	4.4	4.5	4.8	4.4	27.2	24.5	14.3
Blind/Disabled	13.7	11.3	11.9	13.8	11.3	12.0	11.2	11.3	11.0
Families	1.5	1.1	1.0	1.5	1.1	1.0	1.5	1.1	1.1
Other	3.3	3.1	2.8	3.3	3.1	2.7	5.5	3.7	3.9
Undocumented	0.7	0.5	0.4	0.6	0.5	0.4	1.1	0.9	0.7
All Adults	4.8	4.0	3.9	4.8	3.9	3.9	5.2	4.9	4.6
Children									
Blind/Disabled	135.4	85.5	76.5	139.8	87.9	78.5	35.2	28.0	27.8
Families	1.0	0.8	0.7	1.1	0.8	0.7	0.4	0.3	0.2
Foster Care	8.5	5.7	5.1	8.7	5.9	5.2	2.4	2.2	3.0
Other	1.6	1.4	1.0	1.6	1.4	1.1	1.5	1.2	0.5
Undocumented	1.2	1.1	0.8	1.2	1.1	0.8	2.8	2.3	0.9
All Children	11.4	7.5	6.5	12.0	7.9	6.9	2.4	2.0	1.7

Table 14 includes the information on home health service providers. Overall we see a significant increase in the number of participating providers, however as noted above we have seen a simultaneous decrease in the utilization rate.

Table 14: Total Participating Home Health Agencies (Dec 2007 to Jan 2011)

Provider Type/Group	2007 Dec	2008 Jan	2008 Jul	2009 Jan	2009 Jul	2010 Jan	2010 Jul	2011 Jan	% Change
Home Health Agencies	902	931	994	1,065	1,129	1,181	1,285	1,361	50.9%

Based on this analysis, California will not seek implement the proposed 10% payment reduction for home health services at this time. We will continue the 1% reduction currently being implemented as there is no indication that the 1% reduction is negatively impacting access, this is particularly demonstrated by the increased number of participating providers.

Dental

Full scope dental services are only a benefit to those under age 21 in California. Our analysis of these dental services differs from the other services in this analysis do to different data sources and availability.

First, we analyzed the use of dental services over a three-year period by looking at the percentage of children ages 0-20 with an annual dental visit. According to NCQA for 2010 the national average for children 2-21 was 45.74%. The results of this analysis in table 15 below demonstrate that the percentage of children with an annual dental visit has remained increased over the three-year period, indicating increasing access to these services. Additionally, this percentage is in linewith the national average reported by NCQA. The table includes information statewide and by urban and rural counties¹.

¹For this analysis, Urban counties is defined as the following counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Merced, Monterey, Napa, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, Yolo. Rural counties is defined as the following counties: Alpine, Amador, Colusa, Calaveras, Butte, Del Norte, El Dorado, Glenn, Humboldt,

Table 15: Percentage of Children Ages 0-20 with an Annual Dental Visit (2007-2009)

	2007	2008	2009
Statewide	45.3%	47.0%	49.2%
Urban Counties	41.9%	42.8%	44.6%
Rural Counties	45.5%	47.2%	49.5%

Additionally, we analyzed the availability of FFS dental providers by looking at changes in full scope FFS dental enrollment and the number of rendering dental providers in 2007, 2008 and 2009. The results of this analysis, contained in Table 16, indicate that despite increasing population, the population to provider ratio has remained relatively constant, indicating that as the population has expanded so has the provider network. This demonstrates that dental services have been and continue to be adequately accessible to the FFS population.

Table 16: Full Scope FFS Dental Enrollment, Rendering Providers and Population-to-Provider Ratios (2007-2009)

	2007	2008	2009
Full Scope FFS Dental Enrollees	5,226,758	5,443,779	5,749,092
Rendering Providers	13,279	13,936	14,360
Population to Provider Ratio	393.6	390.6	400.4

Based on this analysis, California can implement the proposed payment reduction for dental services without negatively impacting access.