



Medi-Cal Access to Care Quarterly Monitoring Report 2012 Quarter 1

**October 2012
September 2013**



**California Department of Health Care Services
Research and Analytic Studies Branch
MS 1200, P.O. Box 997413
Sacramento, CA 95899-7413**

Contents

Contents	ii
Figures	vi
Tables	xi
Abstract	xii
Executive Summary	xiv
Background	xiv
Findings	xvii
Change in Medi-Cal Participation	xvii
Physician Supply	xviii
Service Rates Per 1,000 Member Months for Adult Beneficiaries	xx
Beneficiary Help Line Calls	xxiv
Introduction	1
Measures of Access to Health Care	1
Medi-Cal Population for Whom These Access Monitoring Activities Are Intended	2
Benefits of a Systematic Approach to Health Care Access Monitoring	3
The Medi-Cal Access Monitoring Framework	4
Predisposing Characteristics of the Population	4
Need	4
Enabling or Impeding Factors	4
Realized Access	5
Access Outcomes	6
Principles of the Medi-Cal Access Monitoring System	6
Limitations of the Medi-Cal Early Warning System	7
Summary of Major Changes to Medi-Cal’s Health Care Delivery System	8
Medi-Cal Physician Supply	12
Introduction	12
Approaches for Measuring Provider Supply	13

Methods	14
Primary Care Provider Enrollment Status.....	14
Data Source.....	15
How Are Physicians Counted?	15
Calculation of the Numerator	16
Results—Primary Care Provider Supply	17
Ratio of Beneficiaries to All Physicians	21
Ratio of Beneficiaries to Primary Care Physicians	24
Ratio of All Non-Elderly, Adult Female Beneficiaries to OB/GYN	26
Ratio of Children to Pediatricians	28
Conclusions—Primary Care Provider Supply	30
Medi-Cal FFS Beneficiary Participation Trends.....	31
Introduction.....	31
Methods	33
Results.....	35
Medi-Cal Full Scope Beneficiaries by Gender and Age	35
Aid Category and Age.....	37
Participation in Metropolitan vs. Non-Metropolitan Counties	39
Distribution of Medi-Cal Only FFS Beneficiaries, by Primary Language Spoken.....	41
Distribution of Medi-Cal Only FFS Beneficiaries, by Race/Ethnicity	42
Distribution of Medi-Cal Only FFS Beneficiaries, by County.....	42
Conclusions—Beneficiary Participation	45
Use of Select Services by Medi-Cal FFS Beneficiaries	47
Introduction.....	47
Methods	47
Physician/Clinic.....	50
Background.....	50
Trend Analysis	51
Trends—Physician/Clinic Services Use, Children, April 2011–March 2012	52
Trends—Physician/Clinic Services Use by Adults, April 2011–March 2012.....	55
Non-Emergency Medical Transportation.....	58
Background.....	58
Trend Analysis	58

Trends—Non-Emergency Medical Transportation Services Use by Children, April 2011–March 2012	60
Trends—Non-Emergency Medical Transportation Services Use by Adults, April 2011–March 2012	61
Emergency Medical Transportation	63
Background	63
Trend Analysis	63
Trends—Emergency Medical Transportation Services Use by Children, April 2011–March 2012.....	65
Trends—Emergency Medical Transportation Services Use by Adults, April 2011–March 2012.....	68
Home Health Services	71
Background	71
Trend Analysis	71
Trends—Home Health Services Use by Children, March 2011–April 2012	73
Trends—Home Health Services Use by Adults, April 2011–March 2012.....	75
Hospital Inpatient Services.....	77
Background.....	77
Trend Analysis	77
Trends—Monthly Hospital Inpatient Services Use, Children, April 2011–March 2012	79
Trends—Hospital Inpatient Services Use by Adults, April 2011–March 2012.....	82
Hospital Outpatient Services	85
Background.....	85
Trend Analysis	85
Trends—Hospital Outpatient Services Use by Children, April 2011–March 2012.....	87
Trends—Hospital Outpatient Services Use by Adults, April 2011–March 2012	90
Nursing Facility Services	93
Background.....	93
Trend Analysis	94
Trends—Nursing Facility Services Use by Children, April 2011–March 2012	95
Trends—Nursing Facility Services Use by Adults, April 2011–March 2012.....	96
Pharmacy Services	98
Background.....	98
Trend Analysis	98
Trends—Pharmacy Services Use by Children, April 2011–March 2012.....	100

Trends—Pharmacy Services Use by Adults, April 2011–March 2012	103
Other Services	106
Background.....	106
Trend Analysis	106
Trends—Other Services Use by Children, April 2011–March 2012.....	108
Trends—Other Services Use by Adults, April 2011–March 2012	111
Summary Tables	114
Conclusions—Service Utilization, Children Participating in FFS.....	117
Conclusions—Service Utilization, Adults Participating in FFS	118
Beneficiary Feedback.....	119
Introduction.....	119
Methods	119
Results.....	120
Primary and Secondary Reasons for Call	121
Calls by Aid Category	124
Calls by County	126
Conclusions.....	127
Appendix A—Overview of Medi-Cal Claims Processing.....	128
Appendix B—Participation Detail Tables	130
Appendix C—Provider Supply Detail Tables	141
Appendix D—Detailed List of Other Providers.....	159
Appendix E—Medi-Cal Aid Codes	161

Figures

Figure 1	Trend in Quarterly FFS vs Managed Care Participation	xv
Figure 2	Calls Received from FFS Beneficiaries by Month, April 2011–March 2012	xxv
Figure 3	Distribution of Medi-Cal Beneficiaries by Delivery of Care Model and Coverage Type, as of January 1, 2012.....	3
Figure 4	Medi-Cal Access Monitoring Model	5
Figure 5	Change in Distribution of Beneficiaries by Delivery of Care Model, January 2011–January 2012	8
Figure 6	Trend in Participation from 2004 Quarter 3 to 2012 Quarter 2, Average Monthly Eligibles by Health Plan Participation Status	9
Figure 7	Change in Number of Beneficiaries by Aid Category, 2007 Quarter 1 to 2010 Quarter 4.....	10
Figure 8	Health Plan Models by County, March 2012.....	19
Figure 9	Primary Care Health Provider Shortage Areas, April 2012 *	20
Figure 10	Ratios of Beneficiaries to All Physicians, by County, March 2012	23
Figure 11	Top Reasons Medi-Cal FFS Beneficiaries Seek Care, by Age and Aid Category, March 2012.....	32
Figure 12	Quarterly Average Member Months for Full Scope FFS Beneficiaries, by Gender and Age Group, Second Quarter 2011 to First Quarter 2012.....	35
Figure 13	Change in FFS Participation among Full Scope Beneficiaries, by Gender and Age, Second Quarter 2011 to First Quarter 2012.....	36
Figure 14	Change in FFS Participation among All Beneficiaries, by Aid Category and Age, Quarter 2, 2011 to Quarter 1, 2012.....	37
Figure 15	Change in FFS Participation among Medi-Cal Beneficiaries, by Aid Category and Age, Metropolitan Counties, Quarter 2, 2011 to Quarter 1, 2012	39
Figure 16	Change in FFS Participation among Medi-Cal Beneficiaries, by Age and Aid Category, Non-Metropolitan Counties, Quarter 2, 2011 to Quarter 1, 2012	40
Figure 17	Distribution of FFS Beneficiaries in Medi-Cal Only Population, by Primary Language Spoken, Quarter 1, 2012.....	41
Figure 18	Distribution of FFS Beneficiaries by Race/Ethnicity, Quarter 1, 2012.....	42
Figure 19	Comparison of FFS Participation by Medi-Cal Only Beneficiaries, Quarter 1, 2012 to Quarter 2, 2011.....	43
Figure 20	Comparison of FFS Participation by Medi-Cal Only Beneficiaries, Quarter 1, 2012 to Previous Quarter	44
Figure 21	Monthly Physician/Clinic Use Rates, Children Age 0-20, Blind/Disabled, April 2011–March 2012	52
Figure 22	Monthly Physician/Clinic Use Rates, Children Age 0-20, Families, April 2011– March 2012.....	52
Figure 23	Monthly Physician/Clinic Use Rates, Children Age 0-20, Foster Care, April 2011– March 2012	53
Figure 24	Monthly Physician/Clinic Use Rates, Children Age 0–20, Other, April 2011–March 2012.....	53
Figure 25	Monthly Physician/Clinic Use Rates, Children Age 0-20, Undocumented, April 2011–March 2012	54

Figure 26	Monthly Physician/Clinic Use Rates, Adults Age 21+, Aged, April 2011– March 2012	55
Figure 27	Monthly Physician/Clinic Use Rates, Adults Age 21+, Blind/Disabled, April 2011– March 2012	55
Figure 28	Monthly Physician/Clinic Use Rates, Adults Age 21+, Families, April 2011– March 2012	56
Figure 29	Monthly Physician/Clinic Use Rates, Adults age 21+, Other, April 2011– March 2012	56
Figure 30	Monthly Physician/Clinic Use Rates, Adults Age 21+, Undocumented, April 2011– March 2012	57
Figure 31	Monthly Non-Emergency Medical Transportation Use Rates, Children Age 0–20, Blind/Disabled, April 2011–March 2012.....	60
Figure 32	Monthly Non-Emergency Medical Transportation Use Rates, Adults Age 21+, Aged, April 2011–March 2012	61
Figure 33	Monthly Non-Emergency Medical Transportation Use Rates, Adults Age 21+, Blind/Disabled, April 2011–March 2012.....	61
Figure 34	Monthly Non-Emergency Medical Transportation Use Rates, Adults Age 21+, Families, April 2011–March 2012.....	62
Figure 35	Monthly Non-Emergency Medical Transportation Use Rates, Adults Age 21+, Other, April 2011–March 2012	62
Figure 36	Monthly Emergency Transportation Use Rates, Children Age 0–20, Blind/Disabled, April 2011–March 2012	65
Figure 37	Monthly Emergency Transportation Use Rates, Children Age 0–20, Families, April 2011–March 2012	65
Figure 38	Monthly Emergency Transportation Use Rates, Children Age 0–20, Foster Care, April 2011–March 2012	66
Figure 39	Monthly Emergency Transportation Use Rates, Children Age 0–20, Other, April 2011–March 2012	66
Figure 40	Monthly Emergency Transportation Use Rates, Children Age 0–20, Undocumented, April 2011–March 2012	67
Figure 41	Monthly Emergency Medical Transportation Use Rates, Adults Age 21+, Aged, April 2011–March 2012	68
Figure 42	Monthly Emergency Medical Transportation Use Rates, Adults Age 21+, Blind/Disabled, April 2011–March 2012.....	68
Figure 43	Monthly Emergency Medical Transportation Use Rates, Adults age 21+, Families, April 2011–March 2012	69
Figure 44	Monthly Emergency Medical Transportation Use Rates, Adults Age 21+, Other, April 2011–March 2012	69
Figure 45	Monthly Emergency Medical Transportation Use Rates, Adults Age 21+, Undocumented, April 2011–March 2012	70
Figure 46	Monthly Home Health Services Use Rates, Children Age 0–20, Blind/Disabled, April 2011–March 2012	73
Figure 47	Monthly Home Health Services Use Rates, Children Age 0–20, Families, April 2011– March 2012	73

Figure 48	Monthly Home Health Services Use Rates, Children Age 0–20, Other, April 2011– March 2012	74
Figure 49	Monthly Home Health Use Rates, Adults Age 21+, Aged, April 2011–March 2012....	75
Figure 50	Monthly Home Health Use Rates, Adults Age 21+, Blind/Disabled, April 2011– March 2012	75
Figure 51	Monthly Home Health Use Rates, Adults Age 21+, Families, April 2011–	76
Figure 52	Monthly Home Health Use Rates, Adults Age 21+, Other, April 2011–March 2012 .	76
Figure 53	Monthly Hospital Inpatient Use Rates, Children Age 0–20, Blind/Disabled, April 2011–March 2012	79
Figure 54	Monthly Hospital Inpatient Use Rates, Children Age 0–20, Families, April 2011– March 2012	79
Figure 55	Monthly Hospital Inpatient Use Rates, Children Age 0–20, Foster Care, April 2011– March 2012	80
Figure 56	Monthly Hospital Inpatient Use Rates, Children Age 0–20, Other, April 2011– March 2012	80
Figure 57	Monthly Hospital Inpatient Use Rates, Children Age 0–20, Undocumented, April 2011–March 2012	81
Figure 58	Monthly Hospital Inpatient Use Rates, Adults Age 21+, Aged, April 2011–March 2012	82
Figure 59	Monthly Hospital Inpatient Use Rates, Adults Age 21+, Blind/Disabled, April 2011– March 2012	82
Figure 60	Monthly Hospital Inpatient Use Rates, Adults Age 21+, Families, April 2011–March 2012.....	83
Figure 61	Monthly Hospital Inpatient Use Rates, Adults Age 21+, Other, April 2011–.....	83
Figure 62	Monthly Hospital Inpatient Use Rates, Adults Age 21+, Undocumented, April 2011– March 2012	84
Figure 63	Monthly Hospital Outpatient Use Rates, Children Age 0-20, Blind/Disabled, April 2011–March 2012	87
Figure 64	Monthly Hospital Outpatient Use Rates, Children Age 0-20, Families, April 2011– March 2012	87
Figure 65	Monthly Hospital Outpatient Use Rates, Children Age 0-20, Foster Care, April 2011– March 2012	88
Figure 66	Monthly Hospital Outpatient Use Rates, Children Age 0-20, Other, April 2011– March 2012	88
Figure 67	Monthly Hospital Outpatient Use Rates, Children Age 0-20, Undocumented, April 2011–March 2012	89
Figure 68	Monthly Hospital Outpatient Use Rates, Adults, Age 21+, Aged, April 2011–March 2012.....	90
Figure 69	Monthly Hospital Outpatient Use Rates, Adults, Age 21+, Blind/Disabled, April 2011–March 2012	90
Figure 70	Monthly Hospital Outpatient Use Rates, Adults, Age 21+, Families, April 2011– March 2012	91

Figure 71	Monthly Hospital Outpatient Use Rates, Adults Age 21+, Other, April 2011–March 2012.....	91
Figure 72	Monthly Hospital Outpatient Use Rates, Adults Age 21+, Undocumented, April 2011–March 2012	92
Figure 73	Monthly Nursing Facility Use Rates, Children Age 0–20, Blind/Disabled, April 2011–March 2012	95
Figure 74	Monthly Nursing Facility Use Rates, Adults Age 21+, Aged, April 2011–March 2012	96
Figure 75	Monthly Nursing Facility Use Rates, Adults Age 21+, Blind/Disabled, April 2011–March 2012	96
Figure 76	Monthly Nursing Facility Use Rates, Adults Age 21+, Families, April 2011–March 2012.....	97
Figure 77	Monthly Nursing Facility Use Rates, Adults Age 21+, Other, April 2011–March 2012 .	97
Figure 78	Monthly Pharmacy Use Rates, Children Age 0–20, Blind/Disabled, April 2011–March 2012	100
Figure 79	Monthly Pharmacy Use Rates, Children Age 0–20, Families, April 2011–March 2012	100
Figure 80	Monthly Pharmacy Use Rates, Children Age 0–20, Foster Care, April 2011–March 2012.....	101
Figure 81	Monthly Pharmacy Use Rates, Children Age 0–20, Other, April 2011–	101
Figure 82	Monthly Pharmacy Use Rates, Children Age 0–20, Undocumented, April 2011–March 2012	102
Figure 83	Monthly Pharmacy Use Rates, Adults Age 21+, Aged, April 2011–March 2012	103
Figure 84	Monthly Pharmacy Use Rates, Adults Age 21+, Blind/Disabled, April 2011–March 2012.....	103
Figure 85	Monthly Pharmacy Use Rates, Adults Age 21+, Families, April 2011–	104
Figure 86	Monthly Pharmacy Use Rates, Adults Age 21+, Other, April 2011–March 2012	104
Figure 87	Monthly Pharmacy Use Rates, Adults Age 21+, Undocumented, April 2011–March 2012.....	105
Figure 88	Monthly Other Services Use Rates, Children Age 0–20, Blind/Disabled, April 2011–March 2012	108
Figure 89	Monthly Other Services Use Rates, Children Age 0–20, Families, April 2011–March 2012.....	108
Figure 90	Monthly Other Services Use Rates, Children Age 0–20, Foster Care, April 2011–March 2012	109
Figure 91	Monthly Other Services Use Rates, Children Age 0–20, Other, April 2011–March 2012.....	109
Figure 92	Monthly Other Services Use Rates, Children Age 0–20, Undocumented, April 2011–March 2012	110
Figure 93	Monthly Other Services Use Rates, Adults Age 21+, Aged, April 2011–March 2012	111
Figure 94	Monthly Other Services Use Rates, Adults Age 21+, Blind/Disabled, April 2011–March 2012	111

Figure 95	Monthly Other Services Use Rates, Adults Age 21+, Families, April 2011–March 2012	112
Figure 96	Monthly Other Services Use Rates, Adults Age 21+, Other, April 2011–March 2012....	112
Figure 97	Monthly Other Services Use Rates, Adults Age 21+, Undocumented, April 2011– March 2012	113
Figure 98	Calls Received by FFS Beneficiaries by Month, April 2011–March 2012.....	121
Figure 99	Calls Received by FFS Beneficiaries by Primary Reason for Call, April 2011–March 2012.....	122
Figure 100	Calls Received by FFS Beneficiaries, Primary Reason for Call, by Month, April 2011– March 2012	123
Figure 101	Calls Received by FFS Beneficiaries by Aid Category, April 2011–March 2012.....	124
Figure 102	Calls Received by FFS Beneficiaries, Aid Category by Month, April 2011–March 2012	125

Tables

Table 1	Summary of Service Utilization Trends Among Adults by Aid Category and Service Category	xxiii
Table 2	Transition of Counties and Groups from Fee-for-Service to Managed Care Model	11
Table 3	Summary and Description of Physician Supply Tables	17
Table 4	Physician Supply, All Enrolled Physician Sites, FFS, Medi-Cal Only	21
Table 5	Physician Supply, All Enrolled Physician Sites, All Medi-Cal Only Beneficiaries	22
Table 6	Primary Care Physician Supply, All Enrolled Physician Sites, FFS, Full Scope, Medi-Cal Only	24
Table 7	Physician Supply, Physicians with an OB/GYN Specialty, FFS, Medi-Cal Only, Non-Elderly, Adult Females	26
Table 8	Physician Supply, Physicians with a Pediatric Specialty, FFS, Full Scope, Medi-Cal Only Children	28
Table 9	Summary of Service Utilization Trends Among Children by Aid Category and Service Category	115
Table 10	Summary of Service Utilization Trends Among Adults by Aid Category and Service Category	116
Table 11	Average Number of Calls by Quarter, April 2011–March 2012	120
Table 12	Calls Received from FFS Beneficiaries, Top 10 Counties	126
Table 13	Claim Lag Times for Select Services	129
Table 14	FFS Beneficiaries, Medi-Cal Only, Average Member Months per Quarter, by County	130
Table 15	FFS Full Scope Beneficiaries, Medi-Cal Only, by County	132
Table 16	FFS Full Scope Children Age 0–17, Average Member Months by County	134
Table 17	FFS Women Age 18–64 Covered by Medi-Cal Only, Average Member Months by County	136
Table 18	FFS Full Scope, Average Member Months by Gender and Age Group	138
Table 19	FFS Restricted Scope, Average Member Months by Gender and Age	138
Table 20	FFS Average Member Months by Age and Aid Category	139
Table 21	FFS Average Member Months, by Age and Aid Category, Metropolitan Counties	139
Table 22	FFS Average Member Months by Age and Aid Category, Non-Metropolitan Counties	140
Table 23	Physician Supply, All Enrolled Physicians, FFS Medi-Cal Only Beneficiaries	141
Table 24	Physician Supply, All Enrolled Physicians, All Medi-Cal Only Beneficiaries	144
Table 25	Primary Care Physician Supply, All Enrolled Physicians, FFS, Full Scope, Medi-Cal Only Beneficiaries	147
Table 26	Physician Supply, Physicians with an OB/GYN Specialty, FFS, Medi-Cal Only, Non-Elderly, Adult Females	150
Table 27	Physician Supply, Physicians with a Pediatric Specialty, FFS, Full Scope, Medi-Cal Only Children	153

Abstract

The Department of Health Care Services' (DHCS) quarterly analysis includes an evaluation of four areas identified as providing a means of detecting the early signs of health care access disruptions. These areas included: evaluating changes in Medi-Cal participation, evaluating beneficiary-to-provider ratios, evaluating service rates per 1,000 member months, and evaluating beneficiary help line calls.

Medi-Cal's assessment of health care access for the first quarter of 2012 disclosed that, for the most part, participation trends, provider supply, and utilization rates were within expected ranges. When comparing the results of the current report to those reported for the fourth quarter of 2011, similar patterns were identified in all four areas under study. Key findings regarding these study areas are summarized below:

- Beneficiaries' participation in the Medi-Cal Fee-for-Service (FFS) delivery system continues to decline, but at a much slower rate than was observed in the last reporting period. For some beneficiary subpopulations, such as those enrolled in a Foster Care aid category, and in some geographic areas, FFS participation increased in the early months of 2012.
- The Medi-Cal physician supply was found to contain an adequate number of overall physicians as well as primary care physicians. Physician counts statewide increased from 105,978 to 109,049, or 2.9%, from the second quarter of 2011 to the first quarter of 2012.
- Utilization, or realized access, was generally within upper and lower expected bounds for most service categories and populations. For some FFS subpopulations and among certain service categories, downward trends noted in the previous report were reversed and approached service use levels that were more in line with expected levels.
- A large number of FFS beneficiaries continue to call into DHCS' Medi-Cal Managed Care Division's Office of the Ombudsman for assistance. Over 8,000 calls were handled by the Office of the Ombudsman for beneficiaries enrolled in FFS, a 25% increase from the previous reporting period. This increase is likely due to calls pertaining to the elimination of ADHC benefits and the transition of roughly 300,000 Seniors and Persons with Disabilities to managed care plans.

The findings reported above were the result of analysis that accounted for the substantial changes in the Medi-Cal program over the study period. DHCS continues to transform its Medi-Cal program away from the traditional FFS delivery system towards managed care delivery systems. Shifting health care delivery systems materially influenced the measurement of health care access in the areas of physician supply and service use. In addition, baseline standards used as benchmarks were found to be materially influenced by recent Medi-Cal program changes. In some cases, the changes occurring between 2007 and 2009—in response to the national recession—dramatically impacted utilization in the observed period when compared to the baseline. The elimination of optional benefits, effective July 2009, represents an example of such a change.

While Medi-Cal's transformation and policy changes added additional complexity to the analysis of the selected access measures, the changing nature of the program provided an opportunity for

assessing whether measures selected for monitoring beneficiary access to health care services are informative. The known policy changes all left some type of footprint in the health care access data evaluated and did move the dial, indicating that the measures selected have the ability to detect the impact of policy changes in the Medi-Cal program.

Executive Summary

Background

This Medi-Cal access report is the second in a series of reports concerning health care access among Medi-Cal's population. This report was designed to provide information for evaluating the early signs of potential health access problems related to beneficiaries who are eligible for Medi-Cal only¹ and participating in Medi-Cal's Fee-for-Service (FFS) system. This report covers the first quarter of 2012, and presents data from quarters two, three, and four in 2011 for comparison purposes. During 2011, Medi-Cal's provider payment reduction enacted by Assembly Bill (AB 97) was not in effect; applicable Medi-Cal providers were not subjected to the 10% payment reduction during the dates-of-service constituting the evaluation period for this quarterly report.

DHCS' quarterly health care access monitoring report encompasses four specific *early warning* measures as follows:

- Change in Medi-Cal participation
- Population-to-provider ratios
- Service rates per 1,000 member months
- Beneficiary help line calls

Recent changes to the Medi-Cal program have impacted benefits, health care delivery, and FFS population characteristics. All of these changes influenced the measures evaluated in Medi-Cal's quarterly access report. The DHCS systematic access monitoring system required the establishment of baseline statistics. These baseline statistics were established using data which incorporated dates of service occurring between 2007 and 2009. Since 2007, Medi-Cal evolved in response to recessionary pressures and efforts directed at reforming its health care delivery system, an evolutionary process which continues today. In some cases, these changes dramatically affected Medi-Cal's FFS population, impacting how beneficiaries receive services and the benefits they receive. As a result, the present baseline metrics, which were established during Medi-Cal's transformational period, may not always reflect the new reality. Therefore, the baseline statistics, or benchmarks, should be reconsidered for future reports.

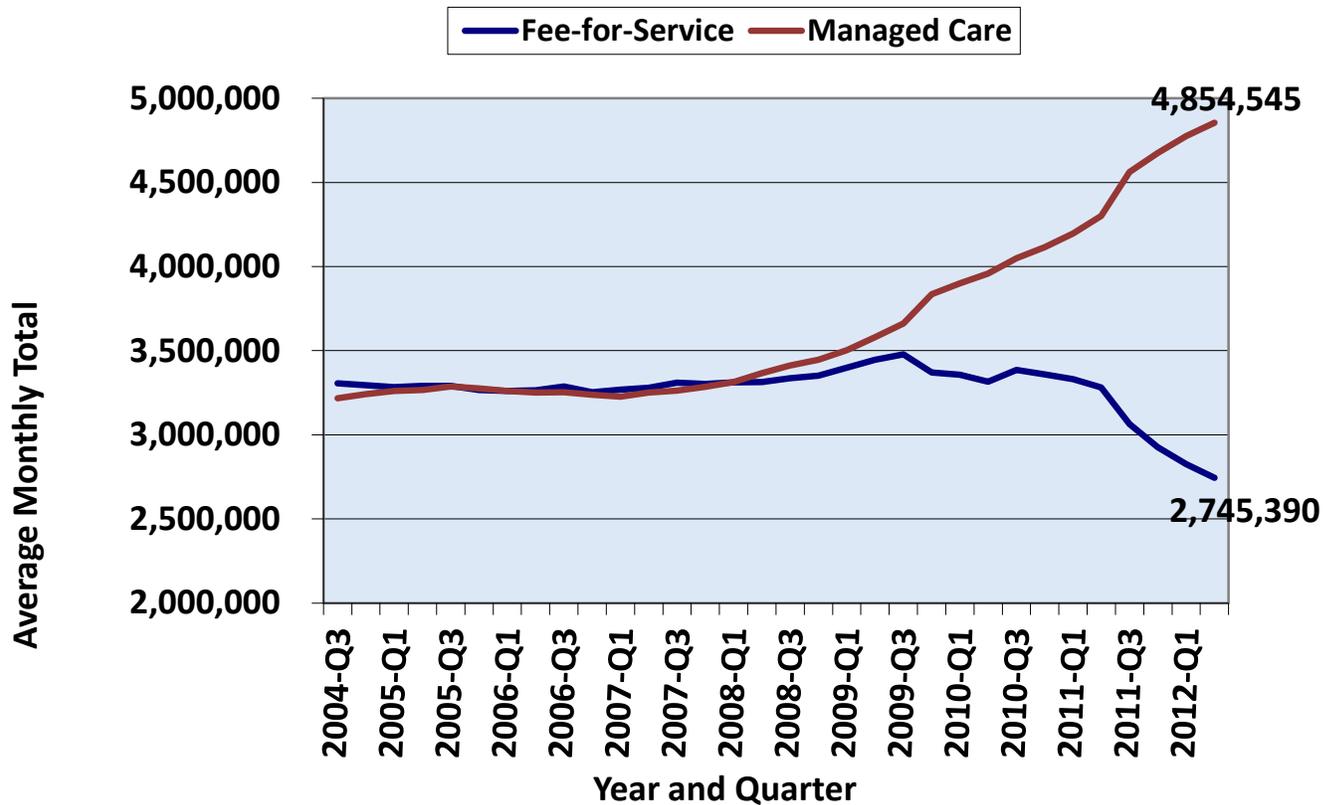
Between 2008 and 2011, significant changes occurred within Medi-Cal's delivery system that impacted participation distributions between Medi-Cal's traditional FFS system and managed care. These shifts in participation significantly impacted the number of beneficiaries for whom this quarterly access monitoring effort is directed towards (see Figure 1); access monitoring efforts focus on beneficiaries who are eligible for Medi-Cal only and participating in the FFS system.

As beneficiaries are transitioned from FFS to managed care, the population evaluated in conjunction with this monitoring effort contracts and in many cases the population mix is altered. From 2008 through 2011, the counties of San Luis Obispo, Sonoma, Merced, Kings, Madera, Ventura, Mendocino, and Marin were transitioned from FFS to managed care delivery

¹ The term "Medi-Cal only" refers to individuals who are eligible for Medi-Cal but not for Medicare.

models. In these counties, roughly 306,000 beneficiaries formerly receiving health care services through Medi-Cal’s FFS system were enrolled in managed care plans.²

Figure 1 Trend in Quarterly FFS vs Managed Care Participation



Source: Medi-Cal Enrollment Files

In addition to the establishment of managed care models within former FFS counties, Medi-Cal also directed seniors and persons with disabilities (SPD), who were formerly receiving care through the FFS system, into Medi-Cal managed care plans in the Two-Plan and Geographic Managed Care (GMC) counties. Roughly 300,000 SPD beneficiaries were directed from FFS to managed care as a result of this policy. The SPD population represents one of Medi-Cal’s most costly and medically complex groups, accounting for more than \$3.8 billion³ in annual health care spending. All of these shifts from the FFS to managed care delivery models occurred during either the baseline period of 2007–2009 or during the present measurement period. For example, the SPD transition commenced in June 2011 and was phased in over 12 months through the end of May. This means that during the first quarter of 2012, beneficiaries who received health care services through the FFS system in the earlier quarters of the study period were now receiving care through managed care plans.

² Part of the 306,000 included “Working Disabled” individuals who were transitioned into managed care delivery systems (11,382).

³ This figure includes only DHCS-administered services. If services administered by other departments are included, the total rises to \$5.7 billion.

Shifting health care delivery systems materially influenced FFS physician supply and utilization access measures. For example, in those counties that shifted from a FFS delivery system to a managed care model, the number of beneficiaries participating in Medi-Cal's FFS system declined significantly. The impact of these changes was recognized in measures such as the beneficiary-to-primary-care-provider ratio and service rates per 1,000 member months.

Because Medi-Cal physician supply did not decline over this period, the ratio of beneficiary-to-providers actually improved. Measuring the ratio of population to overall physician supply showed that the number of physicians increased slightly from the second quarter of 2011 to the first quarter of 2012. However, the most significant driver in the improvement of the beneficiary-to-provider ratio was the reduction in the numerator, or number of beneficiaries eligible for Medi-Cal only and participating in FFS.

Shifts in participation from FFS to managed care may also materially alter utilization rates. When populations are shifted from FFS to managed care, the potential exists for case mix changes to occur. Beneficiaries who remain in FFS may exhibit health characteristics that are very different from the pre-shift population, resulting in changes to utilization rates. In some cases, utilization rates may rise, if for example, populations that remain in FFS tend to represent high utilizers. As counties are transitioned to managed care delivery systems, the beneficiaries who remain in FFS and the utilization associated with FFS member months tend to be either those who are exempted out of managed care participation, those initially eligible for Medi-Cal and not yet established in a plan, or the FFS member months may be associated with months of eligibility occurring during retroactive months of eligibility.⁴

Beneficiaries exempted from managed care participation through the medical exemption process generally exhibit health care needs that are greater than the norm. As a result, these individuals will generate higher than average utilization rates. Similarly, beneficiaries who are new to the Medi-Cal program may utilize services during their first couple of months of participation at higher rates than the norm. Use of services occurring during retroactive months of participation tends to display significantly different patterns than services used during timely enrollment. Services occurring during the retroactive period are most likely associated with inpatient acute care services. If a particular county is shifted from a FFS to managed care delivery system, utilization associated with the remaining FFS population will exhibit patterns that, in many cases, will deviate significantly from the pre-shift FFS population.

An additional consequence of the declining number of beneficiaries participating in the FFS delivery system is the impact it leaves on service utilization rates solely due to the reduction in the denominator. When the denominator, or counts of beneficiaries, declines significantly from one month to the next, service utilization rates may exhibit significant variation or wide swings above and below the "norm."

While participation in the FFS system declined for some beneficiary subgroups, beneficiaries in other subgroups increased in number during the first part of 2012. Policies affecting the eligibility of foster care youth may explain some of this increase. The California Fostering

⁴ Individuals applying for Medi-Cal in a given month may request retroactive coverage for unpaid medical expenses for three months prior to the month of application if the individual was otherwise eligible for Medi-Cal coverage during those three months. (22 CCR 50197 Retroactive Eligibility).

Connections to Success Act was signed into law September 30, 2010, through Assembly Bill 12. Effective January 1, 2012, the bill allows foster care eligible youth to extend foster care coverage they receive through Medi-Cal beyond age 18 and continue to receive services and supports up to age 21. Children in the Foster Care aid category were one of two populations to increase in FFS participation from fourth quarter of 2011 to the first quarter of 2012.

In addition to shifts in participation, Medi-Cal also eliminated optional services that impacted service utilization rates. Assembly Bill X35 (Chapter 20, Statutes of 2009) added Section 14131.10 of the Welfare and Institutions Code (WIC) to exclude several optional benefit categories from coverage under the Medi-Cal program as of July 1, 2009. The following optional benefits were excluded from coverage under the Medi-Cal program: acupuncture, adult dental, audiology, chiropractic, incontinence creams and washes, optometric and optician services, podiatry, psychology, and speech therapy. These eliminated services were evaluated in this quarterly access report and compared to a baseline level constructed during the initial periods following the enactment of these benefit changes.

In some cases, these changes distorted the data and utilization trends. The baseline used to establish control limits included the effect of the benefit elimination. The benefits were eliminated in July 2009, while the baseline period included 2007–2009. Because the benefit elimination occurred late in the baseline period, utilization levels used to establish the baseline were higher than would be anticipated after the elimination. As the benefit change is absorbed into the system, the utilization settles to a “stable” level that oscillates around the mean. Baseline control limits established during major program changes may not truly reflect the new reality, and may require additional analysis in the future to adjust the mean and control limits. Similarly, these benefit changes and shifts in systems of care also influenced beneficiary call center activity.

While Medi-Cal’s transformation and policy changes resulted in interpretation complexity, the changing nature of the program did disclose that the measures selected for monitoring health care utilization and beneficiary interaction with Medi-Cal’s delivery system are informative. The policy changes noted above all left some type of footprint in the selected measures evaluated. In some cases a definitive reason for observed trends could be identified. In other cases, additional analyses and assessment in future reports will provide further clarity.

Findings

Presented below are summary findings for the four measures evaluated in this quarterly access report.

Change in Medi-Cal Participation

The number of beneficiaries eligible for Medi-Cal only, participating in FFS, and entitled to full scope benefits decreased 25.5% overall from the second quarter of 2011 to the first quarter of 2012, reflective of Medi-Cal’s continued shift of beneficiaries to managed care.

The greatest decrease from the second quarter of 2011 to the first quarter of 2012 in FFS participation was observed among beneficiaries eligible for Medi-Cal only, entitled to full scope benefits, and enrolled in the Aged aid category (68%). The decrease in participation in this

subpopulation was expected due to DHCS' initiative aimed at transitioning SPDs into managed care plans.

Though overall participation in the FFS delivery system declined, these declines were not experienced uniformly across all regions of the state. In fact, when looking at full scope beneficiaries by county, only two-thirds of counties experienced a decline in FFS participation of a magnitude 1% or more, while the remaining one-third either stayed the same or increased.

Overall, participation in Medi-Cal FFS decreased in both metropolitan and non-metropolitan areas of the state from the second quarter of 2011 to the first quarter of 2012, with metropolitan areas experiencing larger decreases in FFS participation than non-metropolitan areas. However, the declines among FFS participants residing in metropolitan areas was greatest among certain subpopulations, such as the Aged and Blind/Disabled aid categories, than among these same subpopulations residing in non-metropolitan counties.

Children in Undocumented aid codes residing in non-metropolitan counties also experienced significant declines in participation, particularly during the last two quarters of the study period. Unlike the populations discussed previously, shifts in system participation from FFS to managed care were not responsible for the declines recognized in the undocumented population. Undocumented beneficiaries are generally not eligible to participate in Medi-Cal managed care plans. Rather, declines recognized in the undocumented population were the result of their declining enrollment in the Medi-Cal program overall, a trend that may be explained in part by changing immigration patterns nation-wide.^{5,6}

Physician Supply

DHCS evaluated beneficiaries eligible for Medi-Cal only participating in the FFS system with respect to overall physician supply within all 58 counties. The findings indicate that the supply of physicians was adequate.

The beneficiary-to-provider ratios⁷ disclosed no deterioration in overall physician supply for beneficiaries eligible for Medi-Cal only participating in FFS over the four quarters evaluated, but did disclose differences among regions of the state. In general, the primarily rural counties utilizing the FFS model reported the lowest physician supply relative to the target population. Counties utilizing the Two-Plan managed care model and having a more urbanized population reported greater physician supply compared to Two-Plan counties in more rural areas. In this respect, physician supply for Medi-Cal beneficiaries mirrored that of the entire state population.

The aggregate number of primary care physicians increased from 38,373 to 39,426, or 2.7%, during the four quarters evaluated. This modest expansion in the supply of program physicians occurred at the same time FFS participation among Medi-Cal beneficiaries declined, leading to a

⁵Passel, Jeffrey, Pew Hispanic Center, "Net Migration from Mexico Falls to Zero-and Perhaps Less," April 23, 2012, <http://www.pewhispanic.org/2012/04/23/net-migration-from-mexico-falls-to-zero-and-perhaps-less/>

⁶Passel, Jeffrey, Pew Hispanic Center, "Unauthorized Immigrants: 11.1 Million in 2011," December 6, 2012, <http://www.pewhispanic.org/2012/12/06/unauthorized-immigrants-11-1-million-in-2011/>

⁷Physician supply was measured as a ratio of the count of beneficiaries to the count of individual physicians at distinct service locations providing specific categories of service. See [Methods](#) section of Medi-Cal Physician Supply for more details.

greater supply of physicians than was demonstrated in the last report. From the second quarter of 2011 to the first quarter of 2012, the beneficiary-to-primary-care-physician ratios declined from 40.4 to 29.4, or 27.2%. In no case did the beneficiary-to-primary-care-physician ratio exceed commonly referred to provider shortage benchmarks such as those established by the Health Resources and Services Administration.

Based on the beneficiary population eligible for FFS Medi-Cal only and a panel size of 2,100 patients,⁸ the Medi-Cal program would need a primary care physician supply totaling about 551. With a current supply of Medi-Cal primary care providers at 39,426 and current level of full scope Medi-Cal FFS participation at 1,157,139, enrolled primary care physicians need only dedicate 1.4% of their practice or each see an estimated 29 Medi-Cal patients to meet the current needs of the program. This does not, however, consider specific geographic regions, patient mix, and the concentration of beneficiaries among providers. Nor does it take into consideration that these same providers may also participate in other health networks, including commercial plans. It does, however, provide some context for the size of the Medi-Cal potential physician capacity.

During the period under study, physician enrollment for each specialty area investigated (primary care, OB/GYN, pediatrics) increased slightly, leading to favorable beneficiary-to-provider supply ratios. For example, for non-elderly adult women participating in the Medi-Cal FFS system and entitled to full scope services, the beneficiary-to-OB/GYN-provider ratio improved from 132.6 to 109.5, indicating an increased supply for this provider type. Likewise, the ratio of beneficiary-to-pediatric providers improved from 71.4 to 58.7 for children eligible for full scope Medi-Cal benefits and participating in the FFS system.

⁸ Panel size is defined as the number of individual patients under care of a specific provider.

Service Rates Per 1,000 Member Months for Adult Beneficiaries⁹

Medi-Cal's quarterly access monitoring effort also incorporated measures of utilization, or realized access. While evaluating physician supply and potential access trends is an integral part of evaluating access, considering what is actually occurring is vitally important in assessing this multifaceted phenomenon called access.

Evaluating FFS utilization across all Medi-Cal provider types was an integral element of the quarterly monitoring effort. DHCS grouped all provider types into nine unique service categories:

1. Physician/Clinics;
2. Emergency Transportation;
3. Non-Emergency Transportation;
4. Home Health;
5. Hospital Inpatient;
6. Hospital Outpatient;
7. Nursing Facility;
8. Pharmacy; and
9. Other.

DHCS constructed control charts for each service category based on historical utilization patterns and established the mean value as well as upper and lower bounds. The unit of measurement represented the utilization rate per 1,000 beneficiaries. For example, Physician/Clinic services were measured in terms of visits per 1,000 beneficiaries, while Pharmacy services were measured in prescriptions per 1,000 beneficiaries. In general, utilization rates found within the upper and lower bounds were considered within expected ranges.

- As noted in the previous access quarterly report, adults in the Aged and Blind/Disabled aid categories continued to place a greater demand on services such as Emergency and Non-Emergency Transportation, and Nursing Facility services. Although Hospital Inpatient and Home Health service use among adults in the Aged and Blind/Disabled aid categories fell below average in previous quarters, utilization rates for these services increased in the first quarter of 2012. Increases in the utilization of Hospital Outpatient and Physician/Clinic services were also reported during the first quarter of 2012, but remained within the expected ranges observed during the baseline period.
- Adults in the Families aid category displayed below average utilization of Emergency Transportation, Home Health, Hospital Inpatient, and Physician/Clinic services throughout most of the study period. The utilization of these services among younger adults (age <65) in the Families aid category is most likely correlated with continued

⁹ Service use for children has been excluded from the Executive Summary but is examined in detail within the report.

declines in the statewide birth rate, particularly for service categories such as Physician/Clinic, Emergency Transportation, and Hospital Inpatient.

- Adults in the Undocumented aid category, who are only eligible for emergency and pregnancy-related services, also continue to exhibit below average and below expected use of Physician/Clinic, Hospital Inpatient, Hospital Outpatient, and Emergency Transportation services, further strengthening the argument that these utilization patterns may be heavily influenced by the decline in births statewide and nationally.
- Also of note is the continued demand for Nursing Facility and Non-Emergency Transportation services among a small group of adults (500<N<900) in the Families aid category. Among this subpopulation, utilization of these two services remains above average and in some cases above the expected ranges that were established during the baseline period of 2007-2009. These utilization patterns would require additional studies to identify factors that influence these utilization shifts.
- Among adults in the Aged aid category, use of Home Health services for the first quarter of 2012 began to stabilize or approach levels within expected ranges after exhibiting disruptive use patterns for previously reported quarters. This may be due, in part, to the decelerating declines in FFS participation among this beneficiary subpopulation.

The findings above were potentially impacted by several changes in Medi-Cal enrollment policies. For example, under the terms of California's Section 1115 "Bridge to Reform" waiver with the Federal government, SPDs were mandatorily enrolled in managed care plans. This means that SPD beneficiaries residing in Two-Plan and GMC counties are now required to enroll into managed care plans, unless a medical exemption is secured or a beneficiary is a member of a group that is exempted. This policy change resulted in a significant alteration in the case mix relative to Medi-Cal's traditional FFS system. Starting in June 2011, all newly eligible SPD were required to enroll into a managed care plan.

After the initiation of the mandatory enrollment of SPD beneficiaries in Two-Plan and GMC counties, the beneficiaries who remained in Medi-Cal's FFS system were generally those who received a medical exemption or who were members of a group that was exempted from mandatory managed care participation. This influenced service use among those remaining in FFS. For example, the SPD beneficiaries remaining in FFS most likely represented beneficiaries who were medically compromised and suffering from severe chronic health conditions. In turn, they represented a group most likely to become long-term care (LTC) service utilizers. In addition, current Medi-Cal managed care policy only places the plan at risk for LTC services for the month of admission plus one additional month. After this timeframe, the beneficiary is enrolled into Medi-Cal's FFS system and LTC services are then reimbursed through the FFS system. During the study period, LTC utilization rates among the SPD or disabled actually increased.

The shift to managed care plans also impacted Home Health services. SPD beneficiaries newly eligible for Medi-Cal are mandatorily enrolled into managed care plans. In most cases, this occurs within 45 days of becoming eligible for Medi-Cal. Therefore, these newly eligible SPDs

will most likely not utilize Home Health services during their initial two-month FFS participation. During the study period evaluated, the participation shifts from FFS to managed care plans resulted in significant changes in both the numerator (visits or days) and denominator (member months in 1,000s). The newly eligible SPDs added to the denominator, but did not add Home Health service use to the numerator. The SPD beneficiaries who remained in Medi-Cal's FFS system (e.g., those medically exempted) were shifting away from Home Health services and towards LTC services, resulting in a decrease in the numerator. These events most likely contributed to the utilization changes presented (e.g., the increase in LTC service utilization rate and decrease in Home Health utilization rate).

The shift to managed care plans also impacted Home Health services. SPD beneficiaries newly eligible for Medi-Cal are mandatorily enrolled into managed care plans. In most cases, this occurs within 45 days of becoming eligible for Medi-Cal. Therefore, these newly eligible SPDs will most likely not utilize Home Health services during their initial two-month FFS participation. During the study period evaluated, the participation shifts from FFS to managed care plans resulted in significant changes in both the numerator (visits or days) and denominator (member months in 1,000s). The newly eligible SPDs added to the denominator, but did not add Home Health service use to the numerator. The SPD beneficiaries who remained in Medi-Cal's FFS system (e.g., those medically exempted) were shifting away from Home Health services and towards LTC services, resulting in a decrease in the numerator. These events most likely contributed to the utilization changes presented (e.g., the increase in LTC service utilization rate and decrease in Home Health utilization rate).

Table 1 presents the results of the analysis of the utilization trends among adults by aid and service categories. Service utilization trends for children are examined in detail within the document, but have been excluded from this Executive Summary. The table is color coded to identify those cases when a particular cell, which represents utilization by aid and service category, generated a utilization rate that was either lower or higher than the established confidence level. Cells highlighted in beige represent utilization rates that were found to be within the expected confidence intervals, while those highlighted in green were found to be outside of the expected confidence level at some point during the study period. Cells highlighted in light green represent service use for specific subpopulations that were outside baseline thresholds at some point during the four quarters evaluated, but reached levels within expected ranges during the final quarter of analysis. In some cases, utilization rates were found to be greater than expected. As noted above, there are a number of reasons why this might occur, such as changes in population mix.

Table 1 Summary of Service Utilization Trends Among Adults by Aid Category and Service Category

Service Category Aid Category	Physician/ Clinic Visits	Non-Emergency Transportation	Emergency Medical Transportation	Home Health Services	Hospital Inpatient Services	Hospital Outpatient Services	Nursing Facility Services	Pharmacy Services	Other Services
Aged	Within Expected Range. Increase in Last Quarter.	Upward trend and Above Expected Range.	Upward Trend (Jul-Mar). Mostly Within Expected Range, with Sharp Increase in Last Quarter.	Below Expected Range, Increase in Last Quarter.	Sharp Increase in Last Quarter Reaching Levels Above Expected Range.	Within Expected Range. Increase in Last Quarter.	Upward Trend (Jul-Mar). Mostly Outside of Expected Range.	Downward Trend (Aug-Mar). Below Average and Below Expected Range in Last Quarter.	Several Non-Consecutive Points Below Expected Range.
Blind/ Disabled	Within Expected Range. Increase in Last Quarter.	Above Expected Range.	Levels Reaching Above Expected Range in Last Quarter.	Within Expected Range. Slight Upward Trend Noted.	Within Expected Range. Increase in Last Quarter.	Within Expected Range. Increase in Last Quarter.	Upward Trend (Apr-Mar). Mostly Outside of Expected Range.	Within Expected Range.	Within Expected Range. Increase in Last Quarter
Families	Within Expected Range.	Above Expected Range. Decreasing in Last Quarter.	Downward Trend (Jul-Dec). Within Expected Range.	Mostly Below Expected Range.	Mostly Within Expected Range.	Within Expected Range.	Upward Trend with Several Non-Consecutive Points Above Expected Range.	Mostly Within Expected Range.	Mostly Within Expected Range.
Other	Within Expected Range.	Above Expected Range.	Within Expected Range.	Within Expected Range.	Mostly Within Expected Range.	Within Expected Range.	Mostly Within Expected Range.	Within Expected Range.	Within Expected Range.
Undoc- umented	Four Consecutive Months Below Expected Range.	N/A	Mostly Below Expected Range.	N/A	Below Expected Range.	Mostly Within Expected Range.	N/A	Within Expected Range.	Below Expected Range.

Beneficiary Help Line Calls

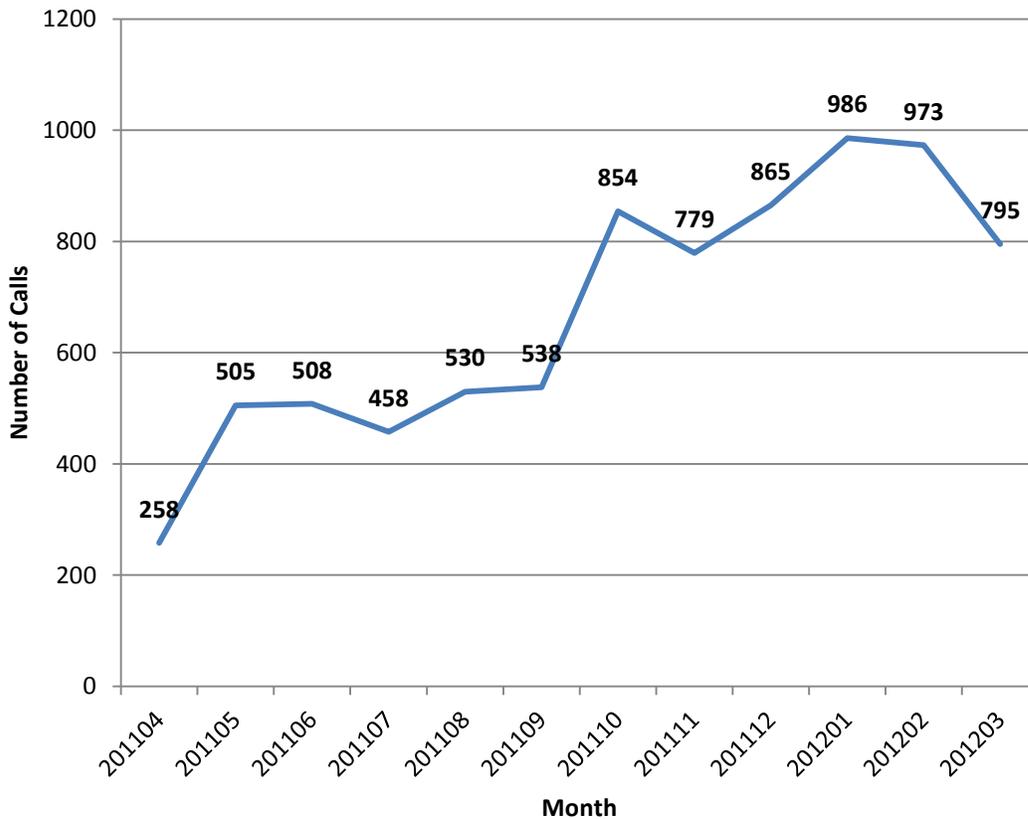
The Centers for Medicare and Medicaid Services (CMS) strongly encouraged DHCS to implement a beneficiary help line as part of a comprehensive health care access monitoring plan. The Medi-Cal beneficiary help line was implemented in December 2011 and is similar to the Medi-Cal Managed Care Division's (MMCD) Office of the Ombudsman call center, which addresses the needs of Medi-Cal managed care beneficiaries. The rate that Medi-Cal FFS beneficiaries contact the help line for information and complaints provides DHCS with one measure of how well the program is meeting the needs of its FFS beneficiaries and solving problems when they arise.

DHCS' Medi-Cal FFS beneficiary call center only began receiving calls at the end of December 2011. During the early operational months of this call center, a large volume of questions and complaints from FFS beneficiaries continued to be addressed by the Office of the Ombudsman. From the second quarter of 2011 to the first quarter of 2012, the Office of the Ombudsman call center documented over 8,000 calls from FFS beneficiaries seeking help with various aspects of their enrollment and care. For each of these calls, the call center recorded the date and time of call, beneficiary aid category, county of residence, and reasons for the call. Data for these calls were summarized by month received, county, six aid category groupings (Families, Blind/Disabled, Aged, Foster Care, Undocumented, and Other), and reason for call.

Figure 2 presents the trend in calls made by FFS beneficiaries from April 2011 to March 2012 by month. Call volume nearly tripled from April 2011 (258) to March 2012 (795). The increase in call volume observed in May 2011 is likely due to the call center's addition of five operators to their current staff level. The increase in staffing capacity enabled the call center to receive and handle more calls that were anticipated with the transition of SPDs into managed care plans. Beginning in June 2011 and scheduled through June 2012, DHCS began the process of enrolling SPDs residing in Two-Plan and GMC counties into health plans in compliance with California's "Bridge to Reform" waiver. The addition of the five call center staff may have helped stabilize and maintain the call center's ability to handle more calls, which possibly explains the relatively steady call levels seen from May–September.

The significant increase in call volume beginning in October 2011 coincides with the elimination of the Adult Day Health Care (ADHC) benefits. Though these benefits were scheduled to end in early 2012, beneficiaries received notices that the ADHC benefit would be eliminated beginning in late August. In Two-Plan and GMC counties, beneficiaries received an enrollment packet that informed them they would be enrolled into managed care on October 1. Notices such as these contain the contact information of the Office of the Ombudsman for beneficiaries to obtain assistance and information. This factor most likely contributed to the significant increase in calls received by the Ombudsman call center beginning in October.

Figure 2 Calls Received from FFS Beneficiaries by Month, April 2011–March 2012



Source: Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received from FFS beneficiaries from April 2011–March 2012.

The Ombudsman’s Office received an increase in calls from FFS beneficiaries during the last quarter of 2011 and continuing through the first quarter of 2012. This increase in call volume was driven primarily by beneficiaries in the Blind/Disabled and Families aid categories. Some of this increase can be attributed to DHCS initiatives that transitioned the SPD population into managed care plans. A large proportion of calls that were received by the Ombudsman’s Office from FFS beneficiaries were pertaining to Enrollment/Disenrollment issues; however, the data in most cases were too ambiguous to identify whether beneficiaries encountered health care access problems.

Introduction

In 2011, the California Legislature passed, and the governor signed into law, Assembly Bill (AB) 97, that required the Department of Health Care Services (DHCS) to implement up to a 10% Medi-Cal provider payment reduction.¹⁰ Prior to implementation, DHCS amended its Medicaid State Plan to incorporate the proposed provider rate reductions, and developed a monitoring system for its Medi-Cal fee-for-service (FFS) beneficiaries to ensure that access to needed services would not be impaired. On October 27th, 2011, the Centers for Medicare & Medicaid Services (CMS), the federal agency which oversees State Medicaid programs, approved California's State Plan Amendment (SPA) and health care access monitoring system.

The health care access monitoring system developed by DHCS incorporates long-standing and widely accepted methods for measuring and evaluating health care access as reported in the literature, and includes health care access and quality monitoring recommendations described by national agencies and expert workgroups.¹¹ DHCS' framework for monitoring health care access incorporates the idea that:

“Access is the act of linking a population to needed and appropriate health care services, and that monitoring access to health care services requires the identification of various factors inhibiting access.”¹²

The following is DHCS' *Access to Care Quarterly Monitoring Report 2012 Quarter 1*, for beneficiaries receiving care through Medi-Cal's traditional FFS delivery model.

Measures of Access to Health Care

The health care access monitoring system emphasizes four key areas:

1. Unique characteristics and health care needs of Medi-Cal enrollees;
2. Availability of Medi-Cal providers;
3. Appropriate utilization of health care services by Medi-Cal beneficiaries; and
4. Resulting health outcomes.

DHCS selected 23 measures identified within these four key areas. Combined, these access measures provide a multidimensional portrayal of health care access in the Medi-Cal program, while taking into account the limitations of readily available data sources. DHCS will report on

¹⁰ Addressed in AB 97 are all services except contract acute hospital inpatient services, critical access hospitals, federal rural referral centers, federally qualified health centers (FQHCs), rural health clinics (RHCs), services provided through the Breast and Cervical Cancer Treatment and Family PACT programs, hospice services, facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services, and federal payments generated by certified public expenditures and intergovernmental transfers.

¹¹ Among the authoritative bodies consulted were the Institute of Medicine, the Agency for Health Care Research and Quality, and the Medicaid and CHIP Payment and Access Commission (MACPAC), a federal commission established by Congress to study and make recommendations on beneficiary access to care in the Medicaid and Children's Health Insurance Program (CHIP).

¹² DHCS' health care access monitoring framework is discussed in detail in the following document, "Monitoring Access to Medi-Cal Covered Health Care Services," located at www.dhcs.ca.gov/Documents/Rate%20Reductions/CA%20-%20Developing%20a%20Healthcare%20Access%20Monitoring%20System%20092811.pdf

all 23 measures annually, but has also identified a subset of early warning measures or signals¹³ for identifying potential health care access problems. These early warning measures, which will be reported from the second quarter of 2011 to the first quarter of 2012, encompass the following:

1. Change in Medi-Cal participation;
2. Population-to-provider ratios;
3. Service rates per 1,000 member months; and
4. Beneficiary helpline calls.

When considered together, these four early warning measures are designed to provide DHCS with an analytic tool that has the potential to detect, if and when, Medi-Cal beneficiaries are experiencing barriers to accessing medically necessary health care services.

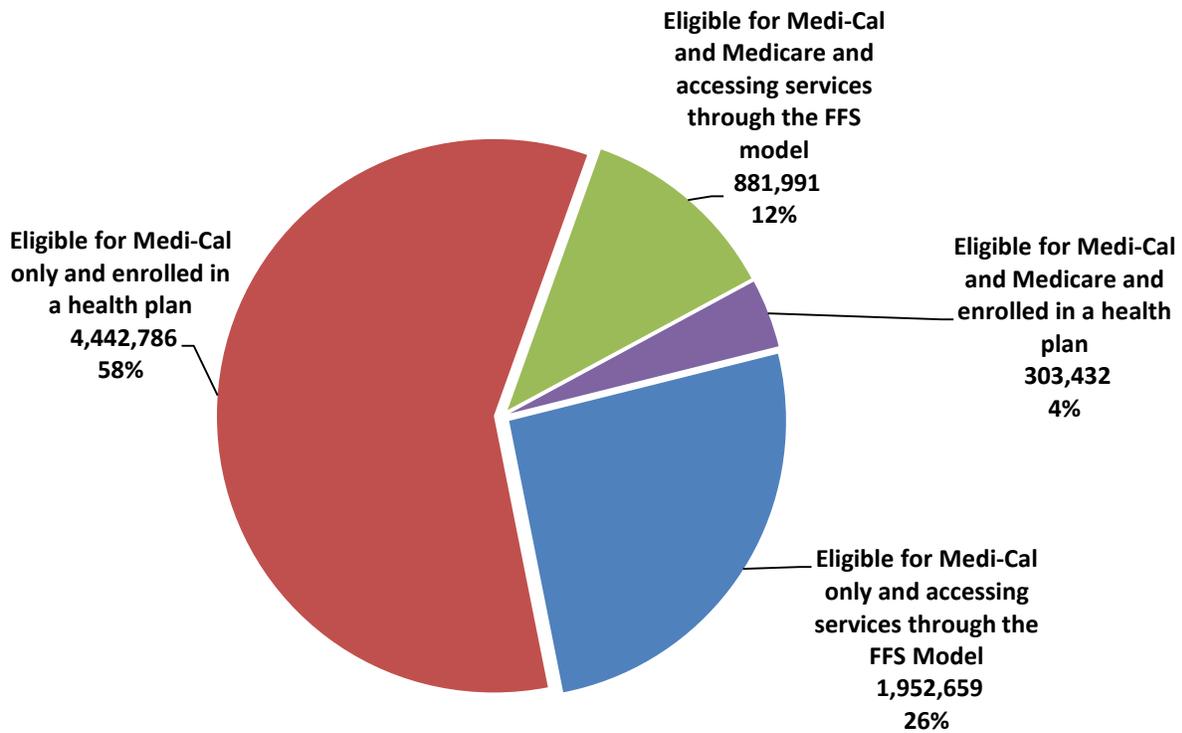
Medi-Cal Population for Whom These Access Monitoring Activities Are Intended

DHCS' quarterly monitoring effort is designed to evaluate health care access among beneficiaries participating in Medi-Cal's FFS system. Beneficiaries in managed care delivery systems are excluded from this analysis. On January 1, 2012, there were 7,559,147 certified eligibles¹⁴ enrolled in the Medi-Cal program, of whom nearly 63% were enrolled in Medi-Cal managed care health plans and the remaining 37% received care through the traditional FFS delivery of care model. For beneficiaries enrolled in Medi-Cal managed care plans, the DHCS' Medi-Cal Managed Care Division monitors access and enforces contractual requirements designed to ensure that enrolled beneficiaries receive timely and medically necessary care. DHCS is also responsible for ensuring health care access to individuals who are disenrolled from managed care plans or for some reason remain outside the reach of Medi-Cal managed care plan enrollment. These beneficiaries are generally those who have been exempted from managed care enrollment or who are newly eligible for Medi-Cal and spend the first 45 days or so in the FFS system.

¹³ Bindman, A.B., & Smith, V. (2010). *MACPAC: Developing a Framework for an Early Warning System (EWS) on Access. Medicaid and CHIP Payment and Access Commission URL: http://www.macpac.gov/home/meetings/2010_12*

¹⁴ The term *certified eligible* includes beneficiaries who have been determined eligible for Medi-Cal based on a valid eligibility determination. *Certified Eligibles* do not include beneficiaries who may be eligible to enroll in Medi-Cal, but have not enrolled. In addition, the definition used here only includes beneficiaries who are eligible to receive Medi-Cal covered health care services during the month. This means that beneficiaries with a SOC obligation, but who have not met their monthly SOC obligation are not included in these counts. And finally, specific populations, such as California's Family PACT¹⁴ and Presumptive eligibles¹⁴, are also not included in the *certified eligible* counts.

Figure 3 Distribution of Medi-Cal Beneficiaries by Delivery of Care Model and Coverage Type, as of January 1, 2012



Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files, January 2012.

Benefits of a Systematic Approach to Health Care Access Monitoring

Monitoring health care access provides DHCS administrators with a better understanding of whether there are sufficient Medi-Cal providers available to beneficiaries, and whether or not beneficiaries appropriately use and receive high-quality and efficient care. Evaluating health care access can also assist DHCS in determining whether Medi-Cal FFS programs are positively affecting beneficiary health outcomes. For example, studies have shown that people who live in communities with high levels of primary care physician supply tend to have lower mortality rates, longer life expectancy, and better birth outcomes. Other studies acknowledge that people who have a usual source of health care are more likely to gain access to routine primary care and preventive services, which reduces disease complications, and lowers morbidity and mortality.

The Medi-Cal Access Monitoring Framework

DHCS developed a health care access monitoring framework, which adapts the work of several sources, including work from the MACPAC¹⁵ report to congress, Agency for Healthcare Research and Quality Safety Net Monitoring Initiative, and published works of health services researchers, including Andersen.¹⁶ The framework, depicted in Figure 4, incorporates the idea that “access” is the act of linking a population to needed and appropriate health care services. When beneficiaries successfully navigate the system or overcome access barriers, then appropriate and timely health care services are used, and positive health outcomes follow. The key elements of the access framework discussed in this report are detailed below.

Predisposing Characteristics of the Population

Predisposing characteristics such as age, gender, race/ethnicity, primary language spoken, and disability status often drive the need for health care services. For example, a population comprised of women of reproductive age places demand on obstetric and gynecological services, while a population of older adults places demand on a different set of services, such as those to manage chronic conditions. Individual health beliefs and attitudes are also believed to contribute to a person’s propensity for health care utilization.

Need

Need refers to how individuals perceive that their condition demands medical care, whether they think such care is of value, and the extent to which a health care professional believes an individual needs care.

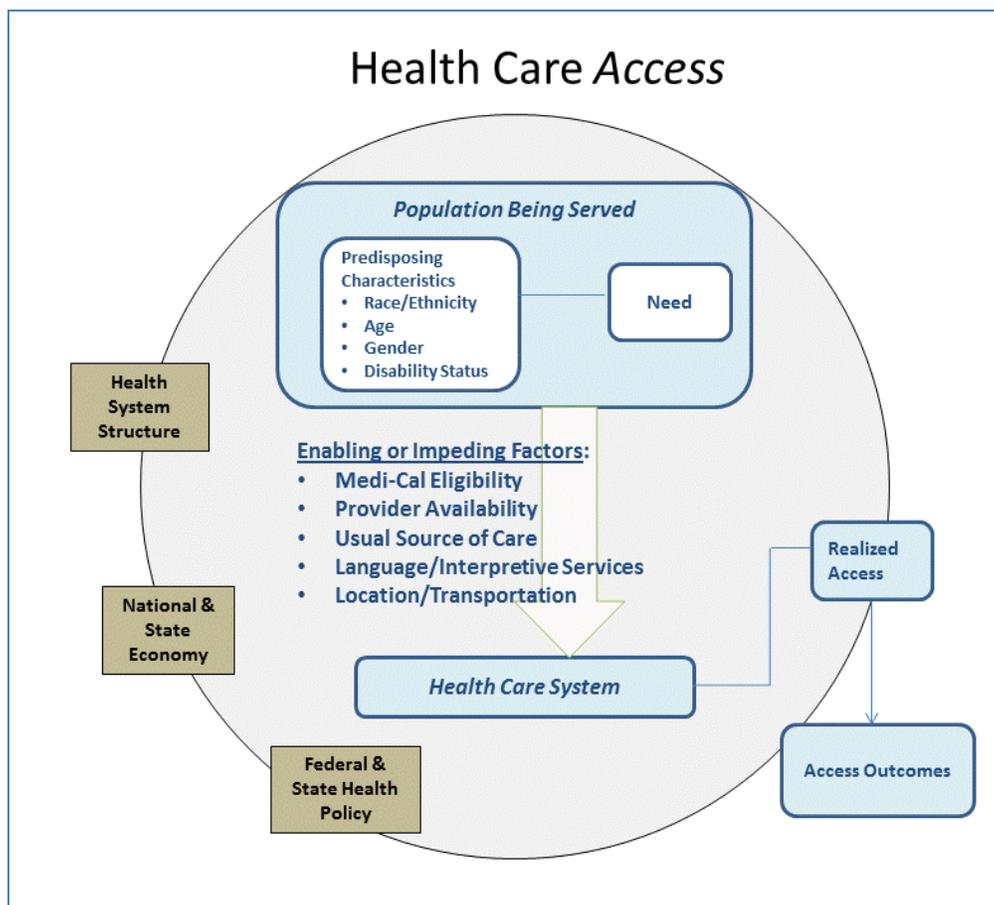
Enabling or Impeding Factors

Many factors, including national and state economic and political influences, financial, as well as health system factors, can impact access to health care services. In the process of obtaining services, beneficiaries may encounter many enabling or impeding factors along the pathway to realized access, such as inadequate provider networks, the burden of long transportation times and out-of-pocket expenses, availability of interpretive services, geographic location of services, and lack of accommodations for physically-disabled beneficiaries.

¹⁵ MACPAC’s Report to Congress contains recommendations derived from reviewing over 30 years of health services literature, and parallels healthcare access strategies proposed by the Institute of Medicine, the Agency for Healthcare Research and Quality, and other national health organizations. These strategies include many elements of the Andersen Behavioral Model of Health Service Use. Andersen’s model has been used widely in the health administration and health services research fields to explain utilization of health services. The original model postulates that people’s use of health services was a function of their predisposing characteristics, the resources that enabled or impeded their use of services, and their need for care.

¹⁶ The Andersen Behavioral Model of Health Service Use has been used widely in the health administration and health services research fields to explain utilization of health services. The original model postulates that people’s use of health services was a function of their predisposing characteristics, the resources that enabled or impeded their use of services, and their need for care.

Figure 4 Medi-Cal Access Monitoring Model



Source: Adapted from Anderson and Davidson, *Improving Access to Care in America*, in *Changing the U.S. Health Care System: Key Issues in Health Services Policy and Management*, 3rd edition, 2007.

Realized Access

DHCS will use data pertaining to health encounters, claims, etc. to serve as outputs or evidence that health care access was realized. Examples of realized access identified through administrative data include claims reflecting physician visits, dental visits, emergency room visits, hospital inpatient stays, and other health care services. Realized access also includes data reflecting a beneficiary's experience with the Medi-Cal system. For example, information on health care experiences may include whether beneficiaries experienced delays in obtaining health care services, whether beneficiaries had problems obtaining appointments with specialists, or how satisfied beneficiaries are with their providers. DHCS has recently implemented a call center to help beneficiaries navigate the system and to field complaints and address health care access problems. Data obtained from this call center will provide DHCS with information regarding beneficiaries who are experiencing problems accessing health care services, and reasons for these access difficulties.

Access Outcomes

Outcomes refer to the effectiveness of appropriate and timely use of health care services. When Medi-Cal beneficiaries successfully participate in the health care system and receive services that are most appropriate for their particular health care needs, the best possible health outcomes are achieved. DHCS will monitor health outcomes as an indication of successful health care access, using indicators such as positive birth outcomes (low proportions of preterm and low birth weight deliveries), and rates of preventable hospitalizations. These health outcomes will be reported in the DHCS' annual access report.

The framework developed by DHCS provides the necessary basis for examining a myriad of issues that may impact health care access in the Medi-Cal program.¹⁷ DHCS has created the current report, and will evaluate access and any deficiencies in access to health care services in light of this framework.

Principles of the Medi-Cal Access Monitoring System

DHCS' access monitoring system is modeled after a public health surveillance system. The Centers for Disease Control and Prevention (CDC) define a public health surveillance system as “the ongoing and systematic collection, analysis, and interpretation of data for use in the planning, implementation, and evaluation of public health practice.”¹⁸ By this definition, a surveillance system includes the capacity for data collection and analysis, as well as the timely dissemination of information to persons or groups who can take effective actions to prevent or control factors that have a harmful effect on a population's health.

DHCS will continuously monitor health care access for its FFS beneficiaries through the reporting of a subset of access measures on a quarterly basis, and will disseminate this information to DHCS expert program staff. DHCS will use the quarterly access monitoring report as a tool to identify whether a change has occurred in light of past data reporting.

These quarterly access monitoring efforts have been designed to achieve the best portrayal of health care access, while considering cost-efficiency and the availability of data. Data collected and analyzed for the DHCS' quarterly health care access monitoring efforts may potentially identify significant shifts in participation or service utilization trends, but may not identify small changes in access to health care services. Systems or tools designed to detect deviations in processes, volume, output, etc., are all designed to specific sensitivity thresholds. Systems designed to detect even the slightest deviation—even immaterial or insignificant deviations—would not be cost effective in most circumstances. Therefore, most systems designed for these endeavors must balance cost and sensitivity. The system should identify meaningful deviations in a cost-effective manner, with the understanding that some sensitivity must be sacrificed. In addition to cost, a system that identifies insignificant deviations time after time, or false positives, will also create program disruption and lead to confusion for all stakeholders.

¹⁷ For details of DHCS' health care access monitoring framework, see Monitoring Access to Medi-Cal Covered Health Care Services at www.dhcs.ca.gov/Documents/Rate%20Reductions/CA%20-%20Developing%20a%20Healthcare%20Access%20Monitoring%20System%20092811.pdf

¹⁸ Thacker SB, Berkelman RL. Public health surveillance in the United States. *Epidemiol Rev.* 1988;10:164–190.

Limitations of the Medi-Cal Early Warning System

DHCS' quarterly health care access monitoring reports primarily consist of data points covering the most recent quarter that DHCS has data for, as well as the three previous quarters, to allow for comparisons over time. Administrative data is the primary source used for calculating population-to-provider ratios, participation, and service utilization trends. Administrative claims data sources used to capture program service use are considered "complete" when 12 months has elapsed between the date of service and date of payment. Similarly, to ensure the most complete eligibility data set, a sufficient time lag must be achieved, generally 12 months.

There are two primary reasons to allow for this 12-month lag in the reporting of administrative data. With regards to participation, changes and updates to the participation records for a specific month may be made subsequent to that month, reflecting the addition of beneficiaries with retroactive eligibility, as well as other changes to the participation record as information is updated at the county level. Beneficiaries usually are eligible for Medi-Cal before services are used. However, a significant percent of all beneficiaries become eligible retroactively, after medical costs are incurred.¹⁹ The effect is a significant growth in eligibility counts after a given month of eligibility. And, while providers have a strong incentive to submit claims data in order to receive reimbursement for services, these claims are not always submitted in a timely manner or may undergo a lengthy adjudication process (see [Appendix A](#)). For example, although 99% of all pharmacy claims are processed and paid within four months of the date of service, only 82% of non-emergency medical transportation claims are complete within the same time period.

In order to continuously monitor health care access for its beneficiaries, DHCS opted to examine program participation and service use data on a quarterly basis, creating analytic data files with a 4-month lag. This shortened lag period was chosen to allow DHCS to balance data completeness with timeliness.

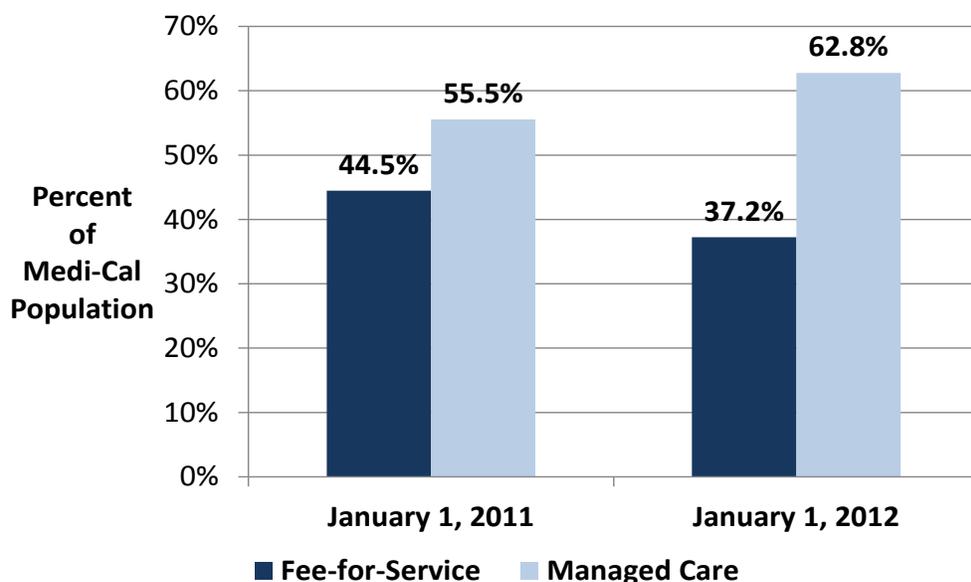
¹⁹ Medi-Cal eligibility begins on the first day of the month of the application date provided the eligibility criterion is met. If the criterion is not met during the month of application, eligibility begins on the first day of the subsequent month that the eligibility criterion is met. (22 CCR 50193 Beginning Date of Eligibility). Also retroactive eligibility may start up to three months prior to the month of application or reapplication if an individual is otherwise eligible during the retroactive period (22 CCR 50197 Retroactive Eligibility). After an application or restoration has been approved, Medi-Cal eligibility is redetermined at least once every 12 months (22 CCR 50189 Redetermination – Frequency and Process).

Summary of Major Changes to Medi-Cal’s Health Care Delivery System

The Medi-Cal program has steadily transformed its health care delivery system from a traditional FFS system to managed care. On January 1, 2012, there were 7,559,147 certified eligible beneficiaries enrolled in the Medi-Cal program. Roughly 4.7 million, or 62.8%, of these beneficiaries were enrolled in Medi-Cal managed care health plans, while 2.8 million, or 37.2%, received care under Medi-Cal’s traditional FFS delivery of care model (See Figure 5).

Overall there was a net shift of 575,694 beneficiaries, or 7.3% of the Medi-Cal population, from the FFS to the managed care delivery model between January 2011–January 2012.

Figure 5 Change in Distribution of Beneficiaries by Delivery of Care Model, January 2011–January 2012



Source: Medi-Cal Enrollment Files

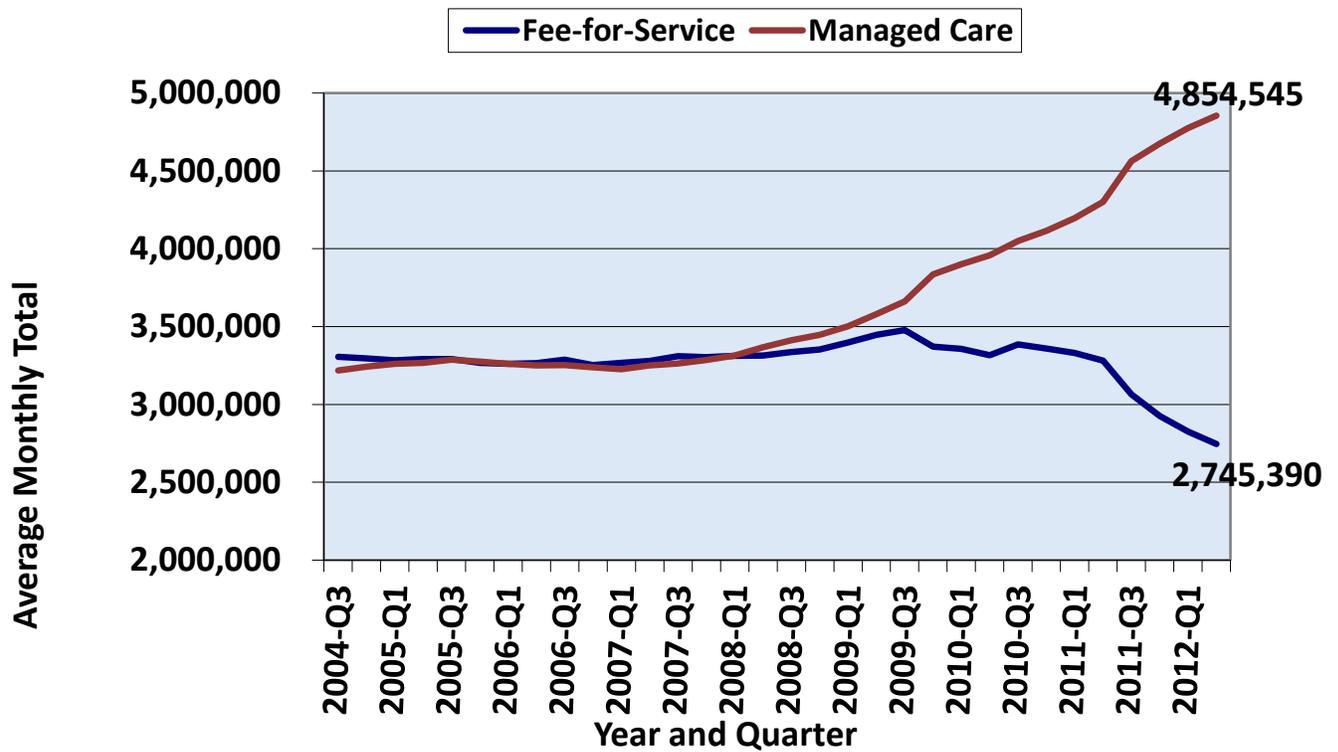
The Medi-Cal managed care program has developed over the years to include three different county plan model types: the County Organized Health Care System (COHS), the Two-Plan Model (Commercial and Local Initiative), and Geographic Managed Care (GMC).²⁰ By 2004, the Medi-Cal program had expanded its use of managed care to provide services to roughly 3.25

²⁰ The two-plan model is the newest of California’s Medi-Cal managed care models. In use since 1996, it was developed to provide some protection for traditional providers while also encouraging broader provider participation in the Medi-Cal program. Under the two-plan model, Medi-Cal beneficiaries can enroll in either a local initiative plan—a county-operated or community-based entity that is required to contract with traditional providers—or a commercial plan. In the GMC model, the state contracts with multiple commercial health plans on a capitated basis to provide services within a designated geographic area. It was first implemented by Sacramento County in 1994, followed by San Diego County in 1998. Currently, these are the only two counties using the GMC model. In Sacramento County, the state contracts with six plans; in San Diego County, it contracts with seven. (“Managed Care and Low-Income Populations: A Case Study of Managed Care in California” Henry J. Kaiser Foundation, December 1999),

million, or half of the beneficiaries in the Medi-Cal program. The distribution of beneficiaries in FFS and managed care between 2004 and 2007 remained constant, at a roughly fifty-fifty split.

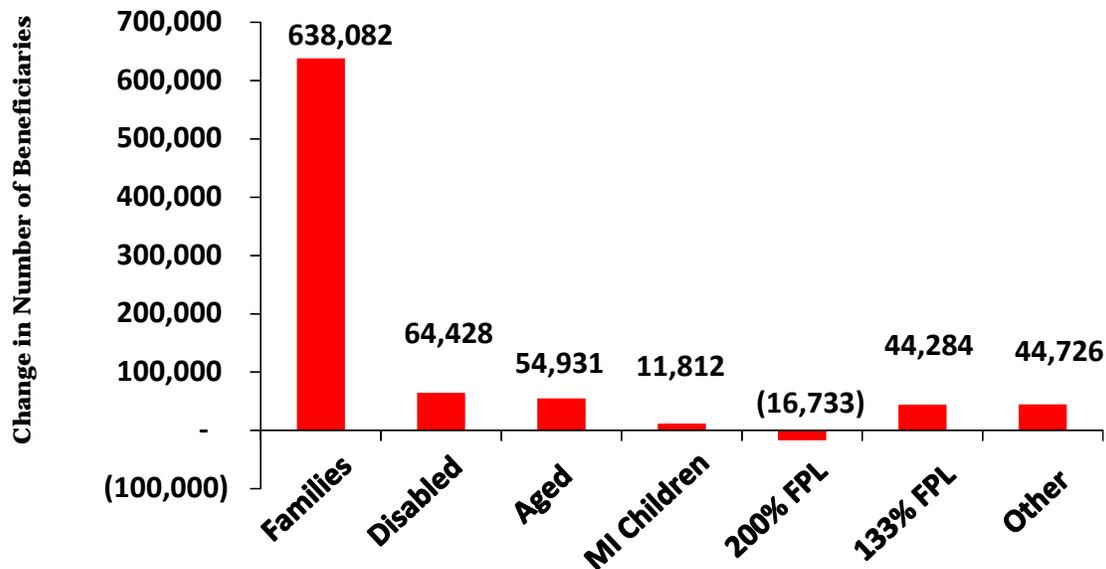
However, in 2008, a surge in managed care participation began (See Figure 6). This broad trend in increased enrollment in the managed care model reflects several developments. First, the majority of new beneficiaries enrolled in Medi-Cal after 2007 due to the economic downturn qualified for coverage under the Family aid category codes. These aid category codes required mandatory participation in managed care health plans in all managed care counties. Second, rising managed care participation also reflected the transition of additional counties from the FFS to the managed care model (See Table 2).

Figure 6 Trend in Participation from 2004 Quarter 3 to 2012 Quarter 2, Average Monthly Eligibles by Health Plan Participation Status



Source: Medi-Cal Enrollment Files

Figure 7 Change in Number of Beneficiaries by Aid Category, 2007 Quarter 1 to 2010 Quarter 4



Source: Medi-Cal Budget estimate

As noted, there was a net shift of 575,694 beneficiaries, or 7.3%, of the Medi-Cal population from the traditional FFS to the managed care delivery of care model between January 2011 and January 2012 (see Figure 5). Two initiatives are primarily responsible for this shift. Under the terms of California’s Section 1115 “Bridge to Reform” waiver, the managed care participation requirement for beneficiaries enrolled in one of 23 distinct Aged, Blind and Disabled aid codes, a subpopulation known as Seniors and Persons with Disabilities (SPD), was transformed from “voluntary” to “mandatory.”²¹ During June 1, 2011-May 31, 2012, DHCS enrolled SPDs residing in Two-Plan and GMC counties into managed care health plans over the course of twelve scheduled monthly increments. In the month prior to mandatory participation (i.e., May 2011), there were approximately 394,582 SPD beneficiaries enrolled in Medi-Cal’s traditional FFS system in Two-Plan and GMC counties.

Also in 2011, the counties of Ventura, Marin, and Mendocino shifted Medi-Cal populations from the FFS delivery system to the County Organized Health System managed care model, moving an additional 140,944 beneficiaries from the FFS model into health plans. (see Table 2).

²¹ See Special Terms and Conditions (STCs) for California’s Bridge to Reform section 1115(a) Medicaid Demonstration, 77. Mandatory Enrollment of SPDs. URL: <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CA%20Special%20Terms%20%20Conditions.pdf>

Table 2 Transition of Counties and Groups from Fee-for-Service to Managed Care Model

County or Group	Plan Model Type	Implementation Date	Estimated Total Annual Member Months	Average Monthly Eligibles
San Luis Obispo	COHS	Mar 1, 2008	206,224	25,778
Working Disabled	Mixed	July 1, 2009	136,583	11,382
Sonoma	COHS	Oct. 1, 2009	529,872	44,156
Merced	COHS	Oct. 1, 2009	767,364	63,947
Kings	Two-Plan	Oct. 1, 2010	286,768	23,897
Madera	Two-Plan	Oct. 1, 2010	333,975	27,831
Seniors and Persons with Disabilities (Not Medicare Eligible)	Two-Plan, GMC	June 2011– May 2012	4,734,984	394,582
Ventura	COHS	July 1, 2011	1,193,784	99,482
Mendocino	COHS	July 1,, 2011	257,040	21,420
Marin	COHS	July 1 2011	195,984	16,332

Medi-Cal Physician Supply

Introduction

Physician availability is an important first step in accessing health care, increasing the likelihood that patients receive preventive services and timely referrals to needed care. Studies have reported that a higher supply of primary care physicians is associated with lower mortality rates, longer life expectancy, and better birth outcomes. Physicians have, consequently, been described as the epicenter of health care delivery, providing patients with a gateway into the health system and affecting how 90% of all health care dollars are spent.

Physician supply provides a measure of the number of physicians who are “potential” care providers, but does not represent the number of providers who are actively rendering care. Evaluating physician supply is designed to provide decision makers with a sense of whether Medi-Cal’s network of physicians is decreasing, increasing, or remaining stable over time. In addition, a system’s provider supply can also be evaluated by geographic region, allowing those charged with maintaining an adequate network to assess differences throughout the state. Significant changes in the supply of physicians combined with other information may provide insight into various aspects of health care access. Long-term trends may help decision makers evaluate policies that may be inhibiting physician supply.

The beneficiary-to-provider ratios report the number of beneficiaries enrolled under the FFS delivery of care model who have Medi-Cal only coverage for every provider. A low ratio indicates that there are a greater number of providers relative to the population, while a high ratio indicates that there are fewer providers relative to the population. Beneficiary-to-provider ratios are useful for identifying differences in physician supply from one geographic area to another, from one measurement period to another, or between the study population and another population or normative benchmark.

$$\text{Ratio} = \frac{\text{Beneficiaries (Numerator)}}{\text{Providers (Denominator)}}$$

The counts of physicians in this report represent **physician supply**, or the number of physicians **potentially** available to provide services to Medi-Cal beneficiaries. The term physician supply is not to be confused with the concept of **physician participation**. The concept of physician supply is *prospective*. It is a measure that reports the number of physicians who enrolled and were potentially available to provide services. The concept of physician participation is *retrospective*. It reports the number of physicians who actually provided or rendered services to Medi-Cal beneficiaries as measured from paid claims data.

Approaches for Measuring Physician Supply

There are three complementary methodologies available for evaluating the adequacy of physician supply. These include relative benchmarking, normative benchmarking and economic analysis of the physician labor market.²²

Relative Benchmarking

Relative benchmarking compares the ratio of certain types of providers to the population in the geographic area of interest to other geographic areas.

Normative Benchmarking

Another approach towards evaluating adequacy of physician supply is normative benchmarking which compares a pre-determined desired ratio of beneficiary to physician against the actual ratio measured. The Health Professional Shortage Areas (HPSA)²³ population-to-primary-care-physician ratio of 3,500:1 as a benchmark for “high need” is an example of a normative ratio. Of course, such ratios vary by provider type and demand for services by each specialty. For example, the number of visits to pediatricians or family practice physicians per thousand members is likely to be greater than the number of visits to dermatologists or ophthalmologists.

A variation of the normative benchmark is physician “panel” size. Panel size is simply defined as the number of individual patients under the care of a specific physician; in other words, panel size is the number of patients for which each physician can realistically be accountable. While the maximum panel size is typically defined as 2,000-2,500 patients per physician, there are limitations to using panel size as a normative benchmark. For example, some physicians may have other physicians or physician extenders (Physician Assistants and Nurse Practitioners) available at their location, giving them the potential to manage a larger panel size. Physicians may also contract with a commercial health plan, Medicare, and Medi-Cal. In these cases, Medi-Cal will only assess the panel size relative to the Medi-Cal patient load and cannot assess the patient load associated with the commercial health plan, Medicare, or any other potential buyer. Physicians who are at the location may not be full-time-equivalent (FTE) clinical providers, but may devote a portion of their time spent on non-appointment or nonclinical duties such as hospital rounds, operating room duties, procedures, management duties, and meeting time. Another consideration in determining panel size is the health status of patients seen by the physician. A panel of 2,000 elderly patients represents a much different workload than 2,000 patients in their 20s and 30s. Patients who suffer from complex health conditions and multiple comorbidities may garner greater resources.

Beneficiary-to-provider ratios evaluated strictly in terms of absolute numbers may also fail to take into account unique cultural characteristics of beneficiaries that may limit the actual

²² Janet Coffman, Brian Quinn, Timothy T. Brown, Richard Scheffler, “Is There a Doctor in the House? An Examination of the Physician Workforce in California over the Past 25 Years”, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare at the University of California, Berkeley 2004

²³ *As defined by the Public Health Service Act, Health professional(s) shortage area* means any of the following which the Secretary determines has a shortage of health professional(s): (1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility. For additional information concerning HPSAs please refer to the Health Resources and Services Administration website at <http://bhpr.hrsa.gov/shortage/>

number of suitable providers. For example, the communication between physicians and patients, which is essential for the effective delivery of treatment, may require that the physician or a member of his team be fluent in a foreign language, or be familiar with unique social dynamics or environmental issues that may impact health in a particular community.

Economic Analysis

The third approach towards evaluating physician supply adequacy is through analysis of the provider “market,” and the impact of reimbursement rates and compensation, as various health care organizations compete for the limited supply of physician services by offering higher payments. However, as our previous discussion on participation by different types of providers illustrates, not all share the same sensitivity, or elasticity, to price. Some physicians are able to accommodate a greater number of Medi-Cal beneficiaries as a percentage of their overall practice than others. As noted by Peter J. Cunningham and Len M. Nichols in *The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective*: “Although high fee levels increase the probability that individual physicians will accept Medicaid patients, high fee levels do not necessarily lead to high levels of physician Medicaid acceptance in an area. Numerous other physician practice, health system, and community characteristics also affect Medicaid acceptance. The effects of Medicaid fees on Medicaid acceptance are substantially lower in areas with high Medicaid managed care penetration and for physicians who practice in institutional settings. The results suggest that a broad range of factors need to be considered to increase access to physicians for Medicaid enrollees.”²⁴

Many provider market analyses seek to build in estimates based on future events to determine whether physician shortages may occur in the years ahead. These analyses look at such variables as the number of medical school graduates choosing specialty medicine over primary care, the attractiveness of medicine as a profession and number of future physicians overall, the aging of the population that will need to access services, and the growth of the economy.²⁵ The impact of the Affordable Care Act and the resulting expansion of the population with health care coverage is a recent addition to this list.

Methods

Physician Enrollment Status

The numbers of physicians reported and reflected in the beneficiary-to-provider ratios are those physicians who have gone through the Medi-Cal provider application and enrollment process²⁶ and who have a current “Active” (Billing) or “Indirect” (Rendering) enrollment status for the period reported. Physicians with an “Active” status directly bill Medi-Cal. Physicians with an “Indirect/Rendering” status render services on behalf of a medical group or clinic that bills for the services rendered.

²⁴ Peter J. Cunningham, Len M. Nichols, “The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective,” Center for Studying Health System Change, December 2005.

²⁵ David Blumenthal, “New Steam from an Old Cauldron—The Physician-Supply Debate,” *New England Journal of Medicine*, April 22, 2004

²⁶ “Provider Enrollment Regulations, California Code of Regulations, Title 22, Division 3; URL: https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/05enrollment_regulations.pdf

Physicians who want to treat Medi-Cal beneficiaries must apply for a Medi-Cal provider number. Applications are reviewed and processed in accordance with Medi-Cal provider enrollment statutes. The review of a physician’s application package is a complex process that requires assessment of many elements of the application, including a review of the required supporting documentation, to determine eligibility for enrollment into the Medi-Cal program. DHCS may conduct a background check of an applicant for the purpose of verifying information. This background check may include an unannounced onsite inspection, a review of business records, and data searches to ensure that the applicant or provider meets enrollment criteria.^{27,28}

Data Source

The Medi-Cal Provider Master Enrollment File (PMF) was used as the primary data source for measuring physician supply. Physicians were identified in the PMF as providers with a provider type of “026” (physician). Primary care physicians were identified using the primary care indicator on the PMF and selecting from a narrow range of specialty areas: General Medicine, Family Practice, Gynecology, Obstetrics, Geriatrics, Internal Medicine, Pediatrics, and Clinics with mixed specialties. Quarterly counts are presented in this report, based on the first month of each quarter. Only physicians enrolled and coded with a valid California county were included. The PMF presents providers in one of these enrollment statuses: 1-Active, 2-InActive, 3-Pending, 4-Deceased, 5-Rejected, 6-Suspended, 7-Indirect/Rendering, or 9-Temp Suspension. This report presents only counts of physicians that have a current “Active” (Billing) or “Indirect” (Rendering) enrollment status for the period reported.

How Are Physicians Counted?

There are various ways to count physicians, each of which produces different totals. Physicians can be counted as the:

1. Number of distinct individual physicians or physician groups;
2. Number of physicians at distinct service locations; and
3. Number of physicians at distinct service locations providing specific categories of service.

Some physicians may practice at multiple sites or locations. For the purpose of evaluating beneficiary access to care using beneficiary-to-provider ratios, the last method is most appropriate, since geographic accessibility and appropriateness of care are two major elements of access. The reporting unit for physicians in this report is the unique combination of the physician provider ID, physician location identifier, and physician type. For individual physicians, the provider ID number is their license number as reported to the Medical Board of California. All other providers, including physician groups, are traced back to their original provider number, usually to one that pre-dates the onset of the National Provider ID (NPI).

²⁷ “Medi-Cal Provider Enrollment, Frequently Asked Questions,” URL: <http://www.dhcs.ca.gov/provgovpart/Pages/PEDFrequentlyAskedQuestions.aspx>

²⁸ Medi-Cal Provider Agreement; URL: http://files.medi-cal.ca.gov/pubsdoco/provappsenroll/02enrollment_DHCS62o8.pdf

This method is necessary in order to avoid double-counting physicians who have successfully applied for multiple NPI's, a common occurrence that has a cumulative effect over time.

However, counting distinct physicians in combination with their location may overstate physician supply in some cases. For example, if a physician practices in one office location two days per week, and another office location the remainder of the week, but both offices are located within Sacramento County, the physician will be represented as two full-time equivalent physicians in the tables presented in this report. This scenario only modestly inflates overall as well as county-specific Medi-Cal physician supply in this report by a magnitude of roughly 400 physicians per quarter or <2% of total physician counts.

Calculation of the Numerator

The numerator for the beneficiary-to-provider ratios is the population of Medi-Cal beneficiaries eligible for Medi-Cal only and participating in Medi-Cal's FFS delivery of care model. Beneficiaries dually eligible for both Medicare and Medicaid benefits are excluded from the numerator for this analysis.

The reader should be aware that the population eligible for Medi-Cal only and participating in the FFS system is not static, and shifts of the population from FFS to managed care delivery systems may be responsible for differences or changes in beneficiary-to-provider ratios between different counties or different periods of measurement. For this reason, both the number of physicians and the ratios are displayed.

Results—Physician Supply

The following tables report the number of physicians, primary care physicians, and other physician specialists, as well as beneficiaries(population)-to-provider ratios. The tables cover four consecutive quarters from the second quarter of 2011 to the first quarter of 2012 and indicate the magnitude of change over this period. You can view county level detail of tables 4–8 in tables 23–27 in [Appendix C](#).

Table 3 Summary and Description of Physician Supply Tables

Tables	Denominator	Numerator
Table 4	All Enrolled Physicians with an Active or Indirect status at a given location. Includes both Primary Care and Specialty physicians.	Beneficiaries entitled to full scope services, covered by Medi-Cal only, and participating in FFS.
Table 5	All Enrolled Physicians with an Active or Indirect status at a given location. Includes both Primary Care and Specialty physicians.	Beneficiaries entitled to full scope services, covered by Medi-Cal only, and participating in either FFS or Managed Care.
Table 6	All Enrolled Primary Care Physicians with an Active or Indirect status at a given location. Primary Care Physicians include those with specialties listed as General Medicine, Family Practice, Gynecology, Obstetrics, Geriatrics, Internal Medicine, Pediatrics, and Clinics with mixed specialties.	Beneficiaries entitled to full scope services, covered by Medi-Cal only, and participating in FFS.
Table 7	All Physicians with an OB/GYN Specialty and an Active or Indirect status at a given location.	Non-elderly, adult women , covered by Medi-Cal only, and participating in FFS.
Table 8	All Physicians with a Pediatrics Specialty and an Active or Indirect status at a given location.	Children entitled to full scope services, covered by Medi-Cal only, and participating in FFS.

The DHCS calculated site-specific physician counts and beneficiary-to-provider ratios, both by county and by plan model type, in order to detect changes over the four quarters and to discern differences between counties and between plan model types. Plan model type is determined by county of enrollment. Figure 8 shows the distribution of plan model types by county.

As summarized above, these tables present beneficiary-to-provider ratios for those eligible for Medi-Cal only and participating in the FFS system. Tables 4 and 5 include site-specific counts of all enrolled physicians identified in the Provider Master File. Tables 6, 7, and 8 include only those physicians identified in the Provider Master File with a given specialty area. It is important to note that, for the identification of “primary care” physicians, the current report

employs a methodology that is more conservative than what has been employed in previous healthcare access reports.²⁹

DHCS also aggregated the count of physicians and ratios for each of the four county plan model types utilized by Medi-Cal. Differences in the ratios for the four models reflected differences in both beneficiaries and physicians. The COHS counties, where health plan enrollment is mandatory for all beneficiaries but the Undocumented, had the smallest FFS populations and therefore the lowest FFS-beneficiary-to-provider ratios. The Two Plan and GMC counties that include both managed care and FFS populations had higher ratios of FFS-beneficiaries-to-providers than the COHS counties, but significantly lower than the 28 primarily rural counties utilizing the FFS model which had the highest ratios of beneficiaries to providers. These trends remained unchanged from the previous report.

However, the higher beneficiary-to-provider ratios in the 28 primarily rural FFS counties appeared to not only reflect a greater number of beneficiaries relative to physicians, but also fewer physicians overall. This finding is consistent with other research and survey data that has reported that rural areas are also frequently health provider shortage areas. Figure 9 displays the location of areas designated as primary care Health Provider Shortage Areas.

²⁹ Previous healthcare access reports identify primary care physicians as those with a primary indicator flag of “Yes” in the Provider Master File. For this report, primary care physician counts have been restricted to those physicians having a specialty area listed as General Medicine, Family Practice, Gynecology, Obstetrics, Geriatrics, Internal Medicine, Pediatrics, and Clinics with mixed specialties.

Figure 8 Health Plan Models by County, March 2012

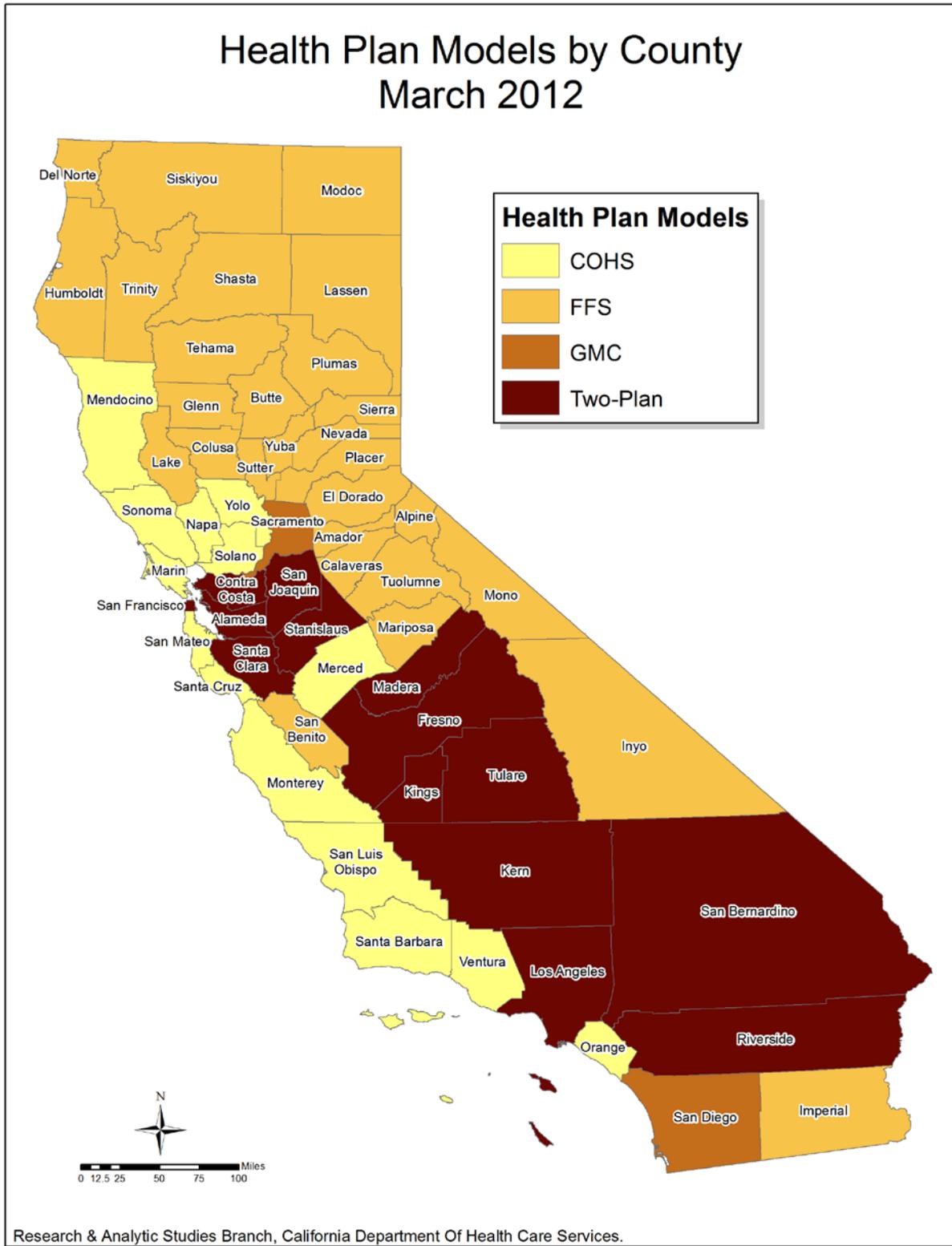
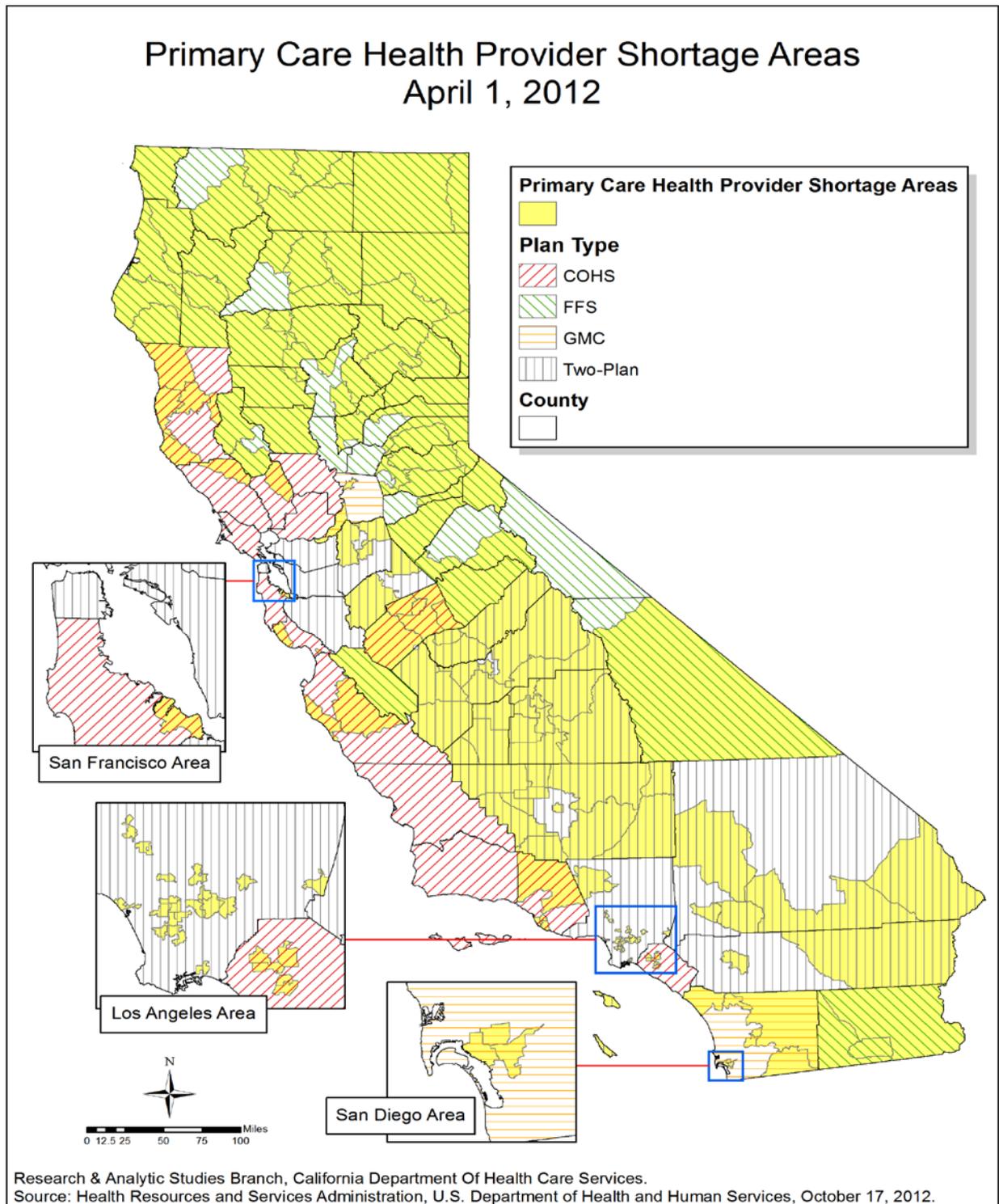


Figure 9 Primary Care Health Provider Shortage Areas, April 2012 *



*Data identifying health provider shortage areas are from the Health Resources and Services Administration as of April 2012.

Ratio of Beneficiaries to All Physicians

Table 4 presents site-specific counts of all enrolled physicians and the ratios of full scope FFS beneficiaries eligible for Medi-Cal only to all enrolled physicians by county plan model type. Site-specific physician counts statewide increased from 105,978 to 109,049, or 2.9%. Average counts for counties over the four quarters ranged from as few as two in Alpine County and fewer than 20 in four other counties, to 29,800 in Los Angeles County (see Table 23 in [Appendix C](#) for county level detail). Glenn County had the highest average ratio of beneficiaries to provider (249.6) and San Mateo County had the lowest ratio, averaging only 1.1. Imperial County was the only other county with over 200 beneficiaries per provider. Full summaries by county are available in [Appendix C](#).

Table 4 Physician Supply, All Enrolled Physician Sites, FFS, Medi-Cal Only

	Number of Physicians					Beneficiaries-to-Provider Ratio				
	2011 Qtr 2	2011 Qtr 3	2011 Qtr 4	2012 Qtr 1	% Change 2011 Qtr 2–2012 Qtr 1	2011 Qtr 2	2011 Qtr 3	2011 Qtr 4	2012 Qtr 1	% Change 2011 Qtr 2–2012 Qtr 1
Statewide	105,978	107,332	108,057	109,049	2.9%	14.6	12.7	11.6	10.6	-27.4%
County Plan Model Type										
County Organized Health System (COHS)	20,350	20,560	20,670	20,824	2.3%	7.8	2.3	2.0	2.0	-74.4%
Fee-for-Service (FFS)	4,072	4,100	4,132	4,143	1.7%	77.0	76.3	74.9	74.6	-3.1%
Geographic Managed Care (GMC)	15,699	15,976	16,108	16,252	3.5%	10.3	9.4	8.6	7.7	-25.2%
Two-Plan (Commercial Plan and Local Initiative)	65,857	66,696	67,147	67,830	3.0%	13.9	12.8	11.4	10.1	-27.3%

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag) and counts of physicians with Active and Indirect enrollment status from the Medi-Cal Provider Master File, for the months of April 2011, August 2011, October 2011, and January 2012.

Statewide and plan type beneficiary-to-provider ratios showed small to large decreases for the study period. The statewide ratio decreased by 27.4% and the plan type ratios decreased from as little as 3.1% for FFS counties to 74.4% for COHS counties. The large decreases in the FFS beneficiary-to-provider ratios are due to the movement of FFS beneficiaries into the newly-created COHS counties of Ventura, Mendocino, and Marin as of July 2011.

Counties were more variable. In 50 counties the beneficiary-to-provider ratios decreased, from 0.1% for San Benito County to about 95% for Mendocino, Marin, and Ventura Counties. As previously mentioned, the creation of COHS in Mendocino, Marin, and Ventura Counties greatly reduced the size of the FFS population in those counties, and ultimately impacted beneficiaries-to-provider measurement. The next highest decrease was 45.2% for San Francisco County. Seven counties experienced some increase in their ratios ranging from 0.7% for Plumas County to 6.1% for Alpine County. Santa Cruz County did not change during the four quarters. Figure 10 illustrates the overall beneficiary-to-physician ratios by county.

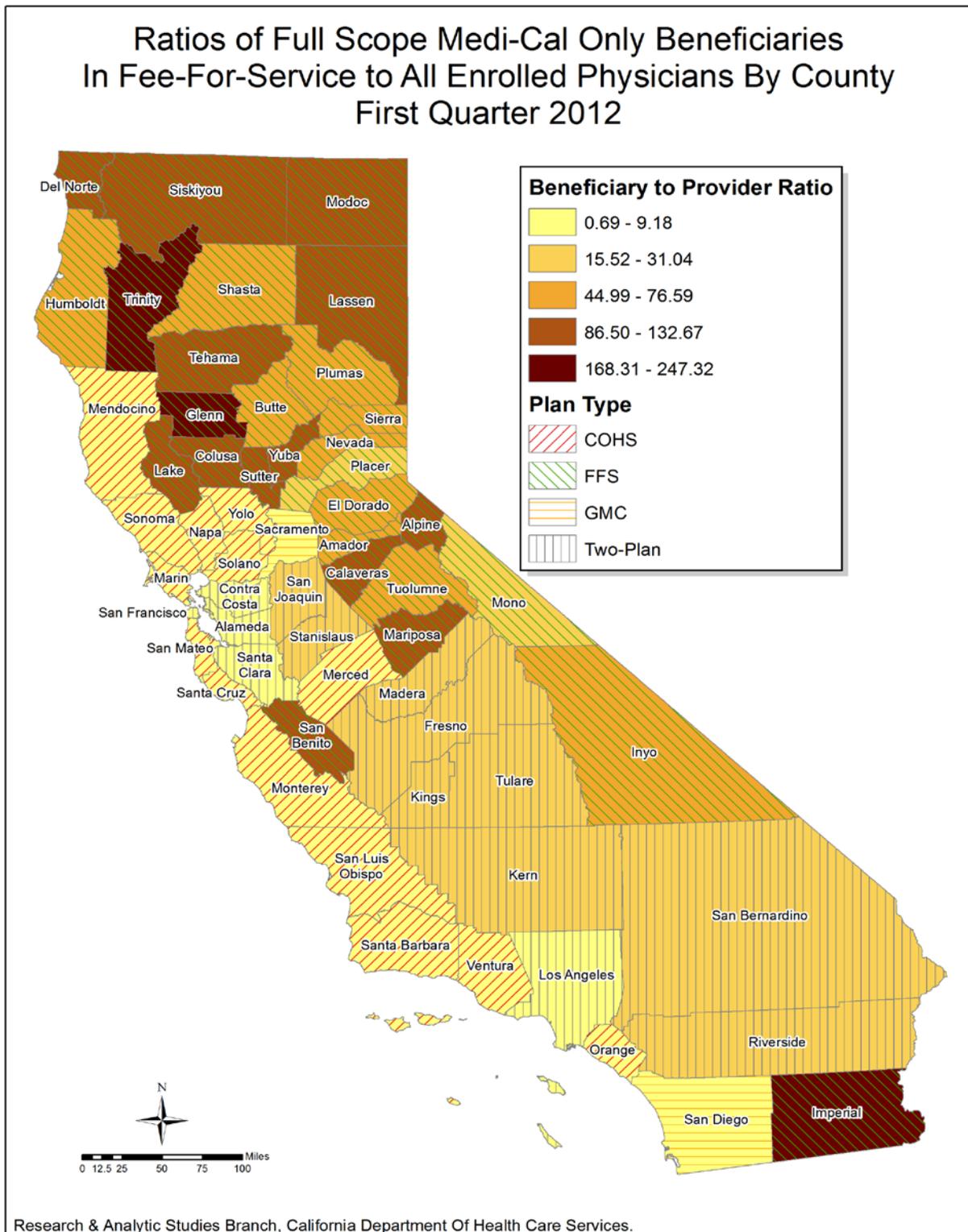
A version of Table 4 that includes full scope Managed Care beneficiaries follows (See [Appendix C](#) for county level detail of Table 5). This table is included for comparison purposes only, since network adequacy for beneficiaries enrolled in Managed Care health plans is governed by separate statutory and contractual requirements and enforced and monitored by Medi-Cal's Managed Care Division.

Table 5 Physician Supply, All Enrolled Physician Sites, All Medi-Cal Only Beneficiaries

	Number of Physicians					Beneficiaries-to-Provider Ratio				
	2011 Qtr 2	2011 Qtr 3	2011 Qtr 4	2012 Qtr 1	% change 2011 Qtr 2–2012 Qtr 1	2011 Qtr 2	2011 Qtr 3	2011 Qtr 4	2012 Qtr 1	% Change 2011 Qtr 2–2012 Qtr 1
Statewide	105,978	107,332	108,057	109,049	2.9%	52.8	52.6	52.1	51.6	2.3%
County Plan Model Type										
County Organized Health System (COHS)	20,350	20,560	20,670	20,824	2.3%	42.5	42.5	42.1	42.0	1.2%
Fee-for-Service (FFS)	4,072	4,100	4,132	4,143	1.7%	77.3	76.7	75.4	75.1	2.8%
Geographic Managed Care (GMC)	15,699	15,976	16,108	16,252	3.5%	37.7	37.3	37.1	36.7	2.7%
Two-Plan (Commercial Plan and Local Initiative)	65,857	66,696	67,147	67,830	3.0%	58.1	57.9	57.3	56.7	2.4%

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag) and counts of physicians with Active and Indirect enrollment status from the Medi-Cal Provider Master File, for the months of April 2011, August 2011, October 2011, and January 2012.

Figure 10 Ratios of Beneficiaries to All Physicians, by County, March 2012



Ratio of Beneficiaries to Primary Care Physicians

Table 6 includes the counts of all enrolled primary care physicians and the ratios of full scope beneficiaries eligible for Medi-Cal only to all enrolled primary care physicians by county and county plan model type. Statewide, primary care physician enrollment showed some improvement from the second quarter of 2011 to the first quarter of 2012, increasing from 38,373 to 39,426, or 2.7%. Average counts ranged from less than one in Alpine County, and 10 or fewer in three other counties, to 11,340 in Los Angeles County (see Table 25 in [Appendix C](#) for county level detail). It is important to note that, although there are counties with very few registered primary care physicians, Federally Qualified Health Clinics (FQHC), Rural Health Clinics (RHC), and other clinics are able to provide primary care services in these communities. Table 28 in [Appendix C](#) displays the total number of clinics by county available to serve Medi-Cal beneficiaries.

Imperial County had the highest average beneficiary-to-primary-care-physician ratio with 749.3 beneficiaries per primary care physician throughout the study period, while San Mateo County had the lowest average ratio at 3.1.

Table 6 Primary Care Physician Supply, All Enrolled Physician Sites, FFS, Full Scope, Medi-Cal Only

	Number of Providers				Population-to-Provider Ratio			
	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	2012-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	2012-1st Quarter
Statewide	38,373	38,833	39,068	39,426	40.4	35.2	32.1	29.4
County Plan Model Type								
County Organized Health System (COHS)	7,231	7,315	7,369	7,425	22.1	6.4	5.7	5.5
Fee-for-Service (FFS)	1,738	1,744	1,758	1,759	180.3	179.3	176.1	175.8
Geographic Managed Care (GMC)	5,341	5,418	5,458	5,494	30.3	27.8	25.3	22.7
Two-Plan (Commercial Plan and Local Initiative)	24,063	24,356	24,483	24,748	38.1	35.1	31.1	27.6

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag) and counts of primary care physicians with Active and Indirect enrollment status from the Medi-Cal Provider Master File, for the months of April 2011, August 2011, October 2011, and January 2012.

Note: This table was updated using new methodology as outlined in the 2012-Quarter 4 report.

The beneficiary-to-primary-care-physician ratio declined statewide by 27.2% during the study period. The ratios by plan type declined from 2.5% for FFS counties to 75.1% for COHS counties. The change in county level FFS ratios across the four quarters showed declines for 51 counties, ranging from 0.2% for Trinity County to about 95% for Marin, Mendocino, and Ventura Counties, all new COHS counties. Six counties showed some increase in their ratios, ranging from 0.6% for Plumas County to 6.1% for Alpine County. Santa Cruz County showed no overall change.

Ratio of All Non-Elderly, Adult Female Beneficiaries to OB/GYN Physicians

Table 7 presents site-specific counts of all enrolled OB/GYN physicians and the ratios of all female full scope and limited scope beneficiaries between age 18–64 to OB/GYN physicians. Statewide, OB/GYN physicians increased 2.3% from 6,379 to 6,524 during the study period. Los Angeles County had an average of 1,793.8 OB/GYNs enrolled in Medi-Cal (see Table 26 in [Appendix C](#) for county level detail). However, 19 counties had five or fewer, and four counties had no physicians with an OB\GYN designation. All such counties are rural with small populations and offer only the FFS plan model. Such low physician counts result in widely varying (and sometimes nonexistent) beneficiary-to-provider ratios by county. These counties have little or no OB/GYN physician presence according to California’s Medical Board physician counts.

Table 7 Physician Supply, Physicians with an OB/GYN Specialty, FFS, Medi-Cal Only, Non-Elderly, Adult Females

	Number of Physicians					Beneficiaries-to-Provider Ratio				
	2011 Qtr 2	2011 Qtr 3	2011 Qtr 4	2012 Qtr 1	% Change 2011 Qtr 2–2012 Qtr 1	2011 Qtr 2	2011 Qtr 3	2011 Qtr 4	2012 Qtr 1	% Change 2011 Qtr 2–2012 Qtr 1
Statewide	6,379	6,422	6,456	6,524	2.3%	132.6	122.3	115.3	109.5	-17.4%
County Plan Model Type										
County Organized Health System (COHS)	1,334	1,341	1,341	1,357	1.7%	90.1	70.2	68.8	68.6	-23.9%
Fee-for-Service (FFS)	228	230	232	232	1.8%	416.1	409.9	401.6	401.3	-3.6%
Geographic Managed Care (GMC)	799	810	817	822	2.9%	89.5	81.5	73.9	67.2	-24.9%
Two-Plan (Commercial Plan and Local Initiative)	4,018	4,041	4,066	4,113	2.4%	139.1	131.4	122.6	115.0	-17.4%

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag) and counts of OB/GYN physicians with Active and Indirect enrollment status from the Medi-Cal Provider Master File, for the months of April 2011, August 2011, October 2011, and January 2012.

The average beneficiary-to-OB/GYN-physician ratios for the study period ranged from 32.9 for San Francisco County to 1,661 for Calaveras County. Six counties had ratios over 1,000. The ratios of four counties could not be calculated because there were no registered OB/GYN physicians (Alpine, Mariposa, Sierra, and Trinity counties). This does not necessarily mean that beneficiaries do not have access to gynecological health care services. Federally Qualified Health Clinics (FQHC), Rural Health Clinics (RHC) and other clinics, and general care physicians with a specialty other than OB/GYN may provide OB/GYN services to beneficiaries residing in these communities. Table 28 in [Appendix C](#) displays the total number of clinics by county available to serve Medi-Cal beneficiaries.

Beneficiary-to-OB/GYN-physician ratios declined statewide by 17.4%. Ratios by plan type declined from 3.6% for FFS counties to 23.9% and 24.9% for COHS and GMC counties,

respectively. At the county level, 47 counties showed declines in their ratios, spanning from a low of 0.6% for Del Norte County to a high of 80.5% for Mendocino County (a new COHS county). Five counties showed small increases in their ratios, with 0.6% for San Benito County to 4.2% for Amador County. One county, Mono, had no change in ratios and four counties, Alpine, Mariposa, Sierra, and Trinity, had no physicians registered in the OB/GYN specialty area.

Ratio of Children to Pediatricians

Table 8 includes site-specific counts of all enrolled pediatric physicians and the ratios of full scope children under age 18 and eligible for Medi-Cal only to all enrolled pediatric physicians by county plan model type. Enrollment increased statewide from 10,769 pediatricians in the second quarter of 2011 to 11,089 in the first quarter of 2012, for a 3.0% increase. Los Angeles County had the highest average number of pediatricians with 2,954.8 (see Table 27 in [Appendix C](#) for county level detail). In 13 counties there were fewer than ten pediatricians and zero in seven other counties. The 20 counties with low counts or no count of pediatricians are all FFS plan counties and primarily rural. As with the OB/GYN specialty, FQHCs, RHCs and other clinics, and general care physicians with a specialty other than pediatrics may render pediatric services in these communities. Table 28 in [Appendix C](#) displays the total number of clinics by county available to serve Medi-Cal beneficiaries.

Table 8 Physician Supply, Physicians with a Pediatric Specialty, FFS, Full Scope, Medi-Cal Only Children.

	Number of Physicians					Beneficiaries-to-Provider Ratio				
	2011 Qtr 2	2011 Qtr 3	2011 Qtr 4	2012 Qtr 1	% Change 2011 Qtr 2–2012 Qtr 1	2011 Qtr 2	2011 Qtr 3	2011 Qtr 4	2012 Qtr 1	% Change 2011 Qtr 2–2012 Qtr 1
Statewide	10,769	10,921	11,007	11,089	3.0%	71.4	64.3	61.2	58.7	-17.8%
County Plan Model Type										
County Organized Health System (COHS)	1,926	1,944	1,948	1,959	1.7%	54.9	17.0	14.8	13.9	-74.7%
Fee-for-Service (FFS)	271	274	275	277	2.2%	633.6	627.5	619.2	613.7	-3.1%
Geographic Managed Care (GMC)	1,449	1,462	1,484	1,493	3.0%	51.9	51.6	50.1	48.3	-7.0%
Two-Plan (Commercial Plan and Local Initiative)	7,123	7,241	7,300	7,360	3.3%	58.5	58.3	54.8	51.9	-11.2%

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag) and counts of pediatricians with Active and Indirect enrollment status from the Medi-Cal Provider Master File, for the months of April 2011, August 2011, October 2011, and January 2012.

The average child-to-pediatrician ratio from the second quarter of 2011 to the first quarter of 2012 ranged from 7.1 for San Mateo County to 1,694.6 for Glenn County. Eight counties had ratios over 1,000. The ratios of seven counties could not be calculated because there were no pediatricians registered. As with the OB/GYNs, low physician counts resulted in widely varying and sometimes nonexistent beneficiary-to-physician ratios by county.

The child-to-pediatrician ratio declined statewide during the study period by 17.8% to 58.74. Ratios by plan type dropped from 3.1% for FFS counties to 74.7% for COHS counties. The ratios for 43 counties declined by 0.2% for San Benito County to about 95% and 96% for the new COHS counties of Marin, Mendocino, and Ventura (see Table 27 in [Appendix C](#)). Seven counties showed increases in their ratios, ranging from 0.5% for Glenn County to 6.1% for Santa Clara

County. One county, Del Norte, showed no change, and seven counties had no physicians registered in the pediatric specialty area.

The distribution of child-to-pediatrician ratios by plan model type follows the same pattern as with the OB/GYNs. The lowest physician counts are all in rural, FFS plan counties and the highest child-to-pediatrician ratios are in FFS plan counties as a whole.

Conclusions—Physician Supply

1. DHCS evaluated all 58 counties and plan model types (i.e., Two-Plan, GMC, and FFS) with respect to physician supply from the second quarter of 2011 to the first quarter of 2012. The findings indicate that the statewide supply of physicians potentially available to beneficiaries eligible for full scope Medi-Cal only and participating in FFS was more than adequate.
2. The statewide beneficiary-to-provider ratios disclosed small increases in overall physician supply potentially available to Medi-Cal's FFS population (105,978 to 109,049, or 2.9%). However, there were significant differences in these ratios between regions of the state. In general, the primarily rural counties utilizing the FFS model reported lower site-specific physician numbers and significantly higher beneficiary-to-provider ratios than counties utilizing other health plan models. In general, counties utilizing the Two-Plan managed care model and having a more urbanized population reported lower beneficiary-to-provider ratios compared to Two-Plan counties in more rural areas.
3. The statewide number of primary care physicians increased from 38,373 to 39,426, or by 2.7%. The beneficiary-to-primary-care-physician ratio improved by 27.2%, from 40.4 in the second quarter of 2011 to 29.4 in the first quarter of 2012. This ratio indicates that statewide the supply of primary care physicians was more than adequate to meet demand. In no case did the beneficiary-to-provider ratio exceed commonly referred to health provider shortage benchmarks.
4. Based on the beneficiary population eligible for FFS Medi-Cal only and a panel size of 2,100 patients, the Medi-Cal program would need a primary care physician supply totaling about 551. With a current supply of Medi-Cal primary care physicians at 39,426 and current level of full scope Medi-Cal FFS participation at 1,157,139, an enrolled primary care physician need only dedicate 1.4% of his practice or see an estimated 29 Medi-Cal patients to meet the current needs of the program. This does not, however, consider specific geographic regions, patient mix, and the concentration of beneficiaries among providers. Nor does it take into consideration that these same providers may also participate in other health networks, including commercial plans. It does, however, provide some context for the size of the Medi-Cal potential physician capacity.

During the period under study, physician enrollment for each specialty area investigated (primary care, OB/GYN, pediatrics) increased slightly, leading to favorable beneficiary-to-provider supply ratios. For example, for non-elderly adult women participating in the Medi-Cal FFS system and entitled to full scope services, the beneficiary-to-OB/GYN-physician ratio declined from 132.6 to 109.5, indicating an increased supply for this physician specialty area. Likewise, the ratio of child-to-pediatricians declined from 71.4 to 58.7 for children eligible for full scope Medi-Cal benefits and participating in the FFS system.

Medi-Cal FFS Beneficiary Participation Trends

Introduction

Compared to those covered by private insurance, the Medi-Cal program provides health care coverage to a fairly heterogeneous and disadvantaged population. The Medi-Cal population is comprised of individuals with unique demographic characteristics, clinical needs, and benefit packages, which are reflective of complex eligibility and administrative rules.

Historically, Medi-Cal eligibility was subject to categorical restrictions that limited enrolled coverage to the elderly, persons with disabilities, members of families with dependent children, pregnant women and children, certain women with breast or cervical cancer, and uninsured individuals with tuberculosis. To qualify, an individual's income and resources had to meet specific thresholds. While many of Medi-Cal's initial eligibility pathways were tied to receipt of cash assistance under programs such as Aid to Families with Dependent Children, or the SSI program, program changes in recent years have shifted eligibility determination to an income-based approach.

The range of benefits offered by the Medi-Cal program also varies among groups. For example, some groups may gain access to Medi-Cal services only after experiencing an acute care hospital admission, in which case individuals are not eligible for Medi-Cal at the time of admission but gain it retroactively. Other groups, such as undocumented immigrants, are only entitled to a limited scope of health care services.

Understanding the unique complexities of the Medi-Cal subpopulations is crucial for administrators to develop suitable policies and processes that will ensure appropriate access to care for all beneficiaries. Population characteristics such as age and health care needs must be carefully evaluated when considering health system capacity and service use, since each subpopulation will present different clinical needs and thus require specific services and provider types. In addition, how the population is distributed throughout the state geographically relative to providers is also vitally important. Figure 11 shows the most prevalent clinical conditions affecting various Medi-Cal subpopulations.

The degree of responsibility for ensuring access to care may vary depending on the subpopulation and type of service. For example, approximately one-third of the beneficiaries participating in Medi-Cal's traditional FFS system and not eligible for Medicare are undocumented aliens who are entitled only to pregnancy-related care and emergency services. For these beneficiaries, DHCS is responsible for ensuring access to prenatal care, obstetrical, and emergency department services only. The remaining beneficiaries participating in Medi-Cal's FFS system who are not eligible for Medicare qualify for full-scope services. Roughly one-half of this population is enrolled in Family aid categories, while one-fourth is enrolled in Blind/Disabled aid categories.

Figure 11 Top Reasons Medi-Cal FFS Beneficiaries Seek Care, by Age and Aid Category, March 2012

Aid Category	Adults (21+ years)		Aid Category	Children (0–21 years)
Aged (65+ years)	Essential hypertension Diabetes mellitus with and without complication Disorders of lipid metabolism Lower respiratory diseases Chest pain Deficiency and other Anemia Cardiac Dysrhythmias		Blind/Disabled	Rehabilitative care; fitting of prostheses Developmental disorders Paralysis Upper respiratory infections Other congenital anomalies Nutrition, endocrine and other metabolic disorders Epilepsy
Blind/Disabled	Essential hypertension Spondylosis; intervertebral disc disorders; other back problems Diabetes mellitus without complications Lower respiratory diseases Non traumatic joint disease Abdominal pain		Foster Care	Upper respiratory infections Blindness and vision defects Attention-deficit conduct and disruptive behavior Medical exams and evaluations Asthma Developmental disorders
Families	Pregnancy-related conditions Medical exams, evaluations and screening for suspected conditions Abdominal pain Spondylosis; intervertebral disc disorders; other back problems Contraceptive and procreative management Upper respiratory diseases		Families	Upper and lower respiratory infections Otitis media and related conditions Acute bronchitis Blindness and vision defects Liveborn infant care Disorders of the teeth and jaw
Other	Pregnancy-related conditions Medical exams, evaluations and screening for suspected conditions Breast cancer Contraception and procreative management Diabetes Essential hypertension		Other	Upper and lower respiratory infections Liveborn infant care Hemolytic and perinatal jaundice Other perinatal conditions Otitis media and related conditions Normal pregnancy and delivery Nutritional, endocrine and metabolic disorders
Undocumented	Pregnancy-related conditions Medical exams, evaluations and screening for suspected conditions Abdominal pain Injuries and conditions due to external causes Contraceptive and procreative management Chest Pain		Undocumented	Liveborn infant care Normal pregnancy and delivery Hemolytic and perinatal jaundice Other perinatal conditions Complications of pregnancy and birth Abdominal pain

The distribution of beneficiaries enrolled in FFS and managed care was approximately fifty-fifty between 2004–2007. Subsequent to 2007, managed care has become the predominant health care delivery model, accounting for 62.8% of all Medi-Cal beneficiaries as of January 1, 2012.

Between January 2011–January 2012 there was a net shift of 575,695 beneficiaries, or 7.2%, of the Medi-Cal population from FFS to the managed care delivery model. Two developments are responsible for the shift in participation between the two health care delivery models:

1. Under the terms of California’s Section 1115 “Bridge to Reform” waiver, beneficiaries enrolled in Seniors and Persons with Disabilities” (SPDs) aid categories were required to enroll in managed care programs. From May 1, 2011–January 1, 2012, the number of SPD beneficiaries participating in Medi-Cal’s FFS system decreased from 394,582 to 158,771.
2. An expansion in the number of counties that transitioned from the FFS to the managed care model. Between January 2011–January 2012, Ventura, Mendocino, and Marin Counties shifted a total of 140,944 Medi-Cal beneficiaries from the FFS to the managed care model.

Methods

The access monitoring activities that DHCS has undertaken and described here are directed at beneficiaries participating in Medi-Cal’s FFS delivery system only and excludes beneficiaries eligible for both Medicare and Medi-Cal. In addition, only those beneficiaries who become “certified” by meeting their monthly share of cost are included in the analysis.

Beneficiary participation summaries were derived from the Medi-Cal Eligibility System Monthly Extract File (MMEF). This data source provides information on a monthly basis on a beneficiaries’ length of participation, aid category under which they are eligible for services, and demographic data, including age, gender, race/ethnicity, and primary language spoken. In addition, the MMEF file contains geographic variables, which allow examination of the data by county, metropolitan designation, or Medical Service Study Area (MSSA).

In this report, Medi-Cal participation in the FFS health care delivery system was measured as ‘Member Months,’ representing the number of months a beneficiary has been in the Medi-Cal FFS delivery system during the reporting period. Average quarterly member months were calculated for all Medi-Cal beneficiaries included in the selection criteria. To reveal potential differences in participation based on specific health care needs, beneficiaries participating in Medi-Cal’s FFS system and not eligible for Medicare were grouped into homogeneous subpopulations based on one of six eligibility categories: Blind/Disabled, Families, Aged, Foster Care, Undocumented, and Other. See [Appendix E](#) for more detailed information on aid categories and codes.

Additional criteria include whether beneficiary receives full or restricted scope of Medi-Cal services, and their age group (0–17, 18–65, 65+ years old). Statistics reflecting the gender, race/ethnicity, and primary language spoken among beneficiaries are also presented since these factors have been known to influence health service use. Furthermore, geographic variations in

Medi-Cal enrollees were explored stratifying beneficiaries by county and metropolitan designation.³⁰

Change in participation in the FFS health care delivery system was evaluated by calculating the difference in the number of Medi-Cal beneficiaries (average member months) across quarters, as a percentage of total beneficiaries participating from the second quarter of 2011 to the first quarter of 2012. Additional comparisons were made between the current quarter being studied to the previous quarter.

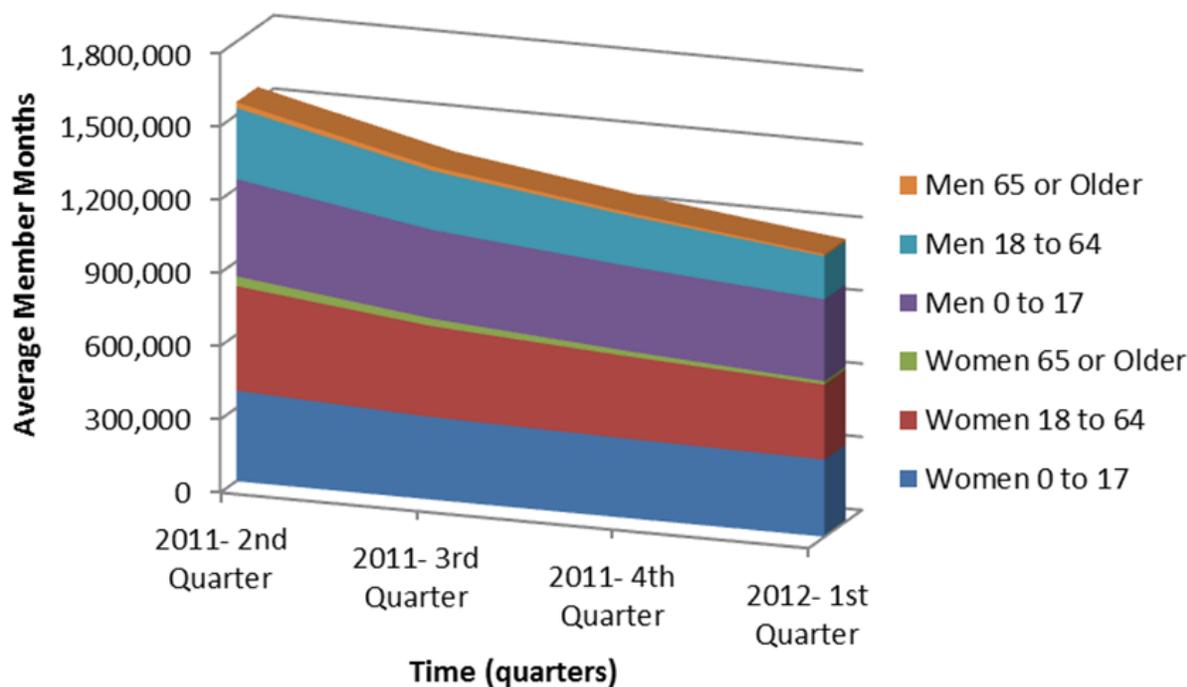
³⁰ Metropolitan designations were identified using ERS Rural-Urban Continuum Codes. The Rural-Urban Continuum Codes are calculated by examining the size of a county and its proximity to a metropolitan area. Rural-Urban Continuum Codes form a classification scheme that distinguishes metropolitan (metro) counties by the population size of their metro area, and nonmetropolitan (nonmetro) counties by degree of urbanization and adjacency to a metro area or areas.

Results

Medi-Cal Full Scope Beneficiaries by Gender and Age

Participation in the FFS health care delivery system for Medi-Cal beneficiaries who were eligible for full scope services decreased for all age and gender groups from the second quarter of 2011 to the first quarter of 2012 (see Figure 12). Overall, FFS participation declined 25.5% during the 12-month period, from 1,553,252 to 1,157,139. The highest rate of reduction in FFS participation (12%) occurred between the second and third quarters of 2011. Declines in FFS program participation were smaller at the end of the study period, changing at a rate of 7.6% between the fourth quarter of 2011 and the first quarter of 2012.

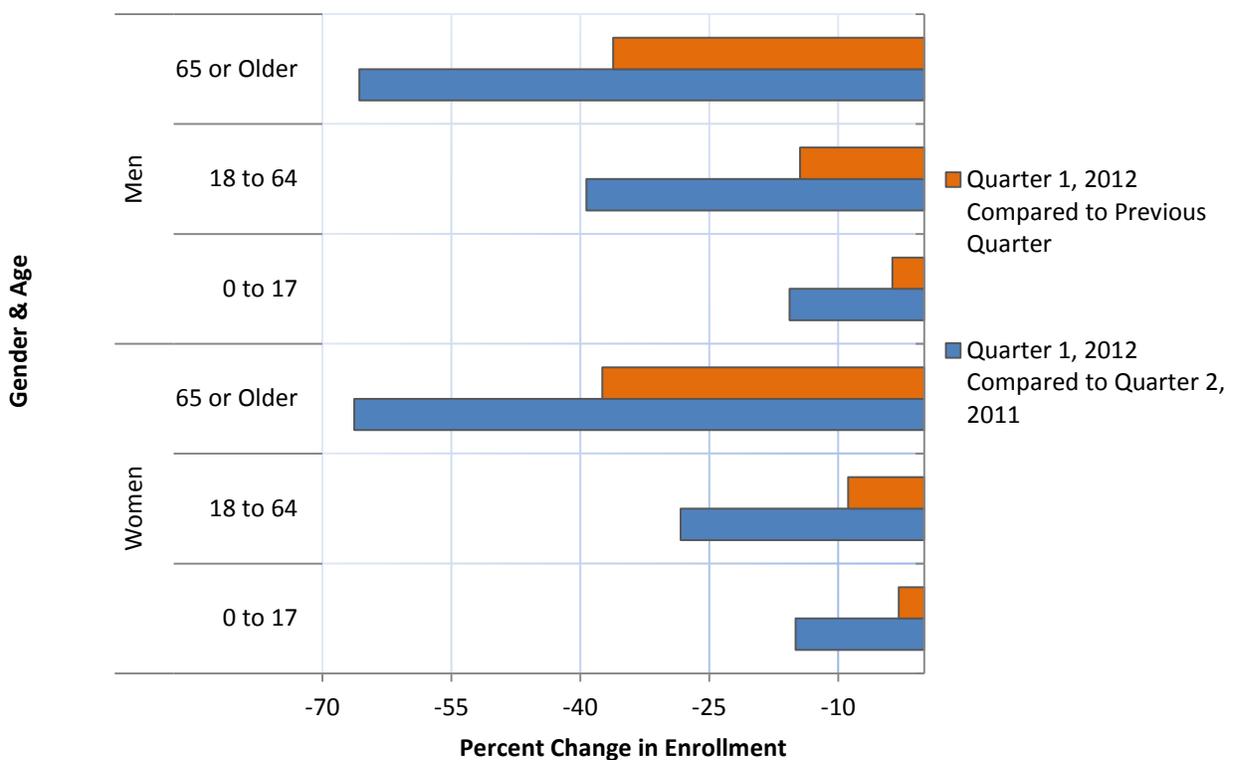
Figure 12 Quarterly Average Member Months for Full Scope FFS Beneficiaries, by Gender and Age Group, Second Quarter 2011 to First Quarter 2012



Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag).

The largest decrease in FFS participation from the second quarter of 2011 to the first quarter of 2012 was among individuals 65 years and older (66.1%) (see Figure 13). This reduction affected both gender groups equally. Among young adults age 18–64, males experienced a larger decrease (39.3%) in FFS participation than women (28.3%) across this same 12-month study period. A large number of beneficiaries participating in the FFS health care delivery system with full scope benefits are age 0-17, but this same group experienced the lowest declines in FFS participation (15.3%).

Figure 13 Change in FFS Participation among Full Scope Beneficiaries, by Gender and Age, Second Quarter 2011 to First Quarter 2012



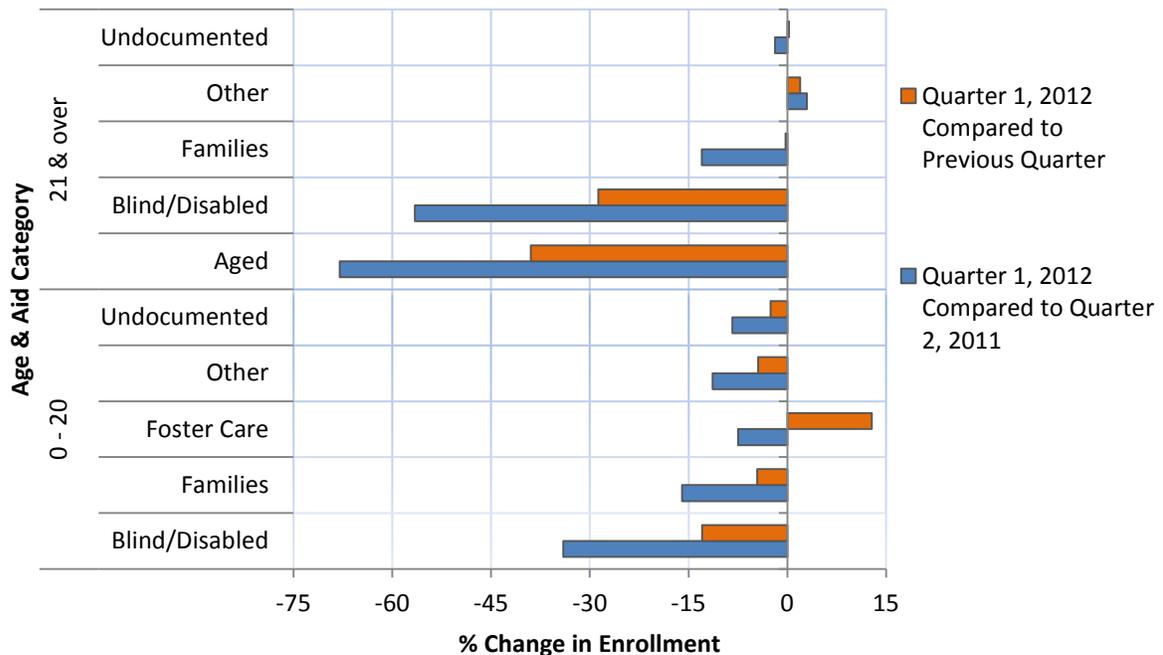
Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag).

Aid Category and Age

Figure 14 displays the change in FFS participation for beneficiaries with Medi-Cal only by age and aid category for the second quarter of 2011 to the first quarter of 2012. Across this 12-month period, FFS participation declined gradually for all aid categories and age groups, with the exception of children enrolled in Foster Care aid codes and adults in the Other aid category. The largest declines in FFS participation occurred for beneficiaries in the Aged aid category (68%) when comparing participation changes from the second quarter of 2011 to the first quarter of 2012, and 39% when comparing changes from the fourth quarter of 2011 to the first quarter of 2012. The next largest declines in FFS participation were observed among adult beneficiaries in the Blind/Disabled aid category, with a 56.6% decline from the second quarter of 2011 to the first quarter of 2012, and a 28.7% decline from the fourth quarter of 2011 to the first quarter of 2012.

Among children, the largest decrease in FFS participation was in the Blind/Disabled group, with a 34% decline from the second quarter of 2011 to the first quarter of 2012, and a 12.9% decline from the fourth quarter of 2011 to the first quarter of 2012. The drop in FFS participation among the Aged and Blind/Disabled populations reflects the implementation of the Bridge to Reform Waiver by which seniors and persons with disabilities (SPDs) were mandatorily shifted from the traditional FFS to the managed care delivery model. These large shifts in beneficiary participation from FFS to managed care occurred predominantly in 2011 and have since diminished in size during the most recent quarter studied.

Figure 14 Change in FFS Participation among All Beneficiaries, by Aid Category and Age, Quarter 2, 2011 to Quarter 1, 2012



Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag).

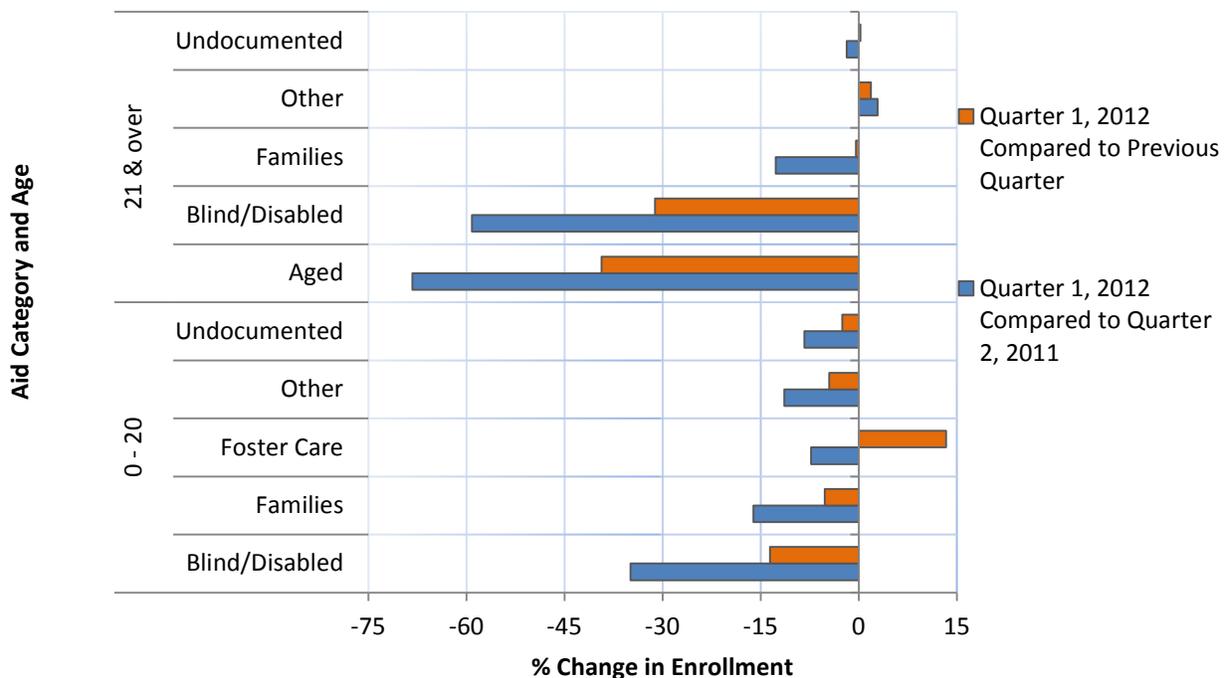
FFS participation for beneficiaries enrolled in Foster Care aid codes experienced downward trends for 2011, but increased 12.8% from the fourth quarter of 2011 to the current quarter. This trend can be explained by Assembly Bill 12 (AB 12) California Fostering Connections to Success, effective January 1, 2012, which optionally extends foster care benefits up to age 21 if specific age and program conditions are met.

Participation in FFS for adults over age 21 who are eligible for Medi-Cal under the Other aid category rose by 1.9% during the first quarter of 2012, and by 3% during the entire study period. The Other aid category represents a variety of aid codes, including Refugee Assistance, Long-Term Care, and Breast and Cervical Cancer Treatment Program. DHCS hypothesizes that the increase in FFS participation for adults eligible under Other aid category might have been driven by beneficiaries in long-term care assistance programs who had been previously shifted from FFS to the managed care delivery system after implementation of the Bridge to Reform, and who later were “carved out” from managed care back into FFS in order to access long-term care benefits. Further evaluation will be needed in order to confirm this hypothesis.

Participation in Metropolitan vs. Non-Metropolitan Counties

The overall decline in FFS participation from the second quarter of 2011 to the first quarter of 2012 was relatively similar among beneficiaries residing in metropolitan and non-metropolitan counties (18.2% and 13.4%, respectively) (see Table 21 and Table 22 in [Appendix B](#)). However, FFS participation differed substantially among the different subpopulations evaluated in metropolitan and non-metropolitan counties. For beneficiaries residing in metropolitan counties, the drop in participation varied greatly, from 1.8% for adults in the Undocumented aid category, to 68.3% for those in the Aged aid category (see Figure 15). A significant decrease in FFS participation was also seen for Blind/Disabled adults and children residing in metropolitan counties (59.2% and 34.9%, respectively). By contrast, FFS beneficiaries residing in non-metropolitan areas experienced smaller changes in FFS participation across the different subpopulations, ranging from a 5.4% decline among Undocumented adults, to a 26% decline among those in the Aged aid category (see Figure 16).

Figure 15 Change in FFS Participation among Medi-Cal Beneficiaries, by Aid Category and Age, Metropolitan Counties, Quarter 2, 2011 to Quarter 1, 2012



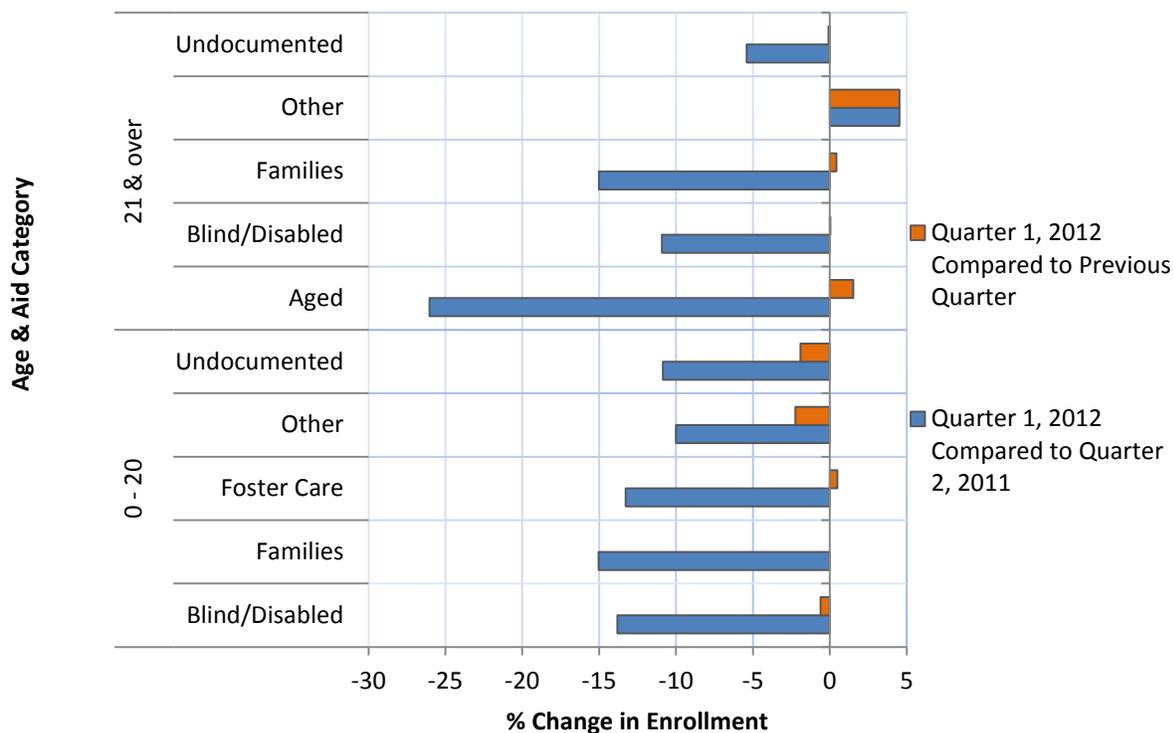
Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag).

A similar trend was observed when inspecting FFS participation changes occurring between the first quarter of 2012 and the previous quarter. In this case, however, changes in FFS participation were almost negligible for all subpopulations residing in non-metropolitan counties, whereas some subpopulations residing in metropolitan areas, such as adults in Aged

and Blind/Disabled aid categories, continued to experience significant declines in FFS participation.

Several aid categories experienced an increase in FFS participation during the current quarter under study—those in Foster Care, Families age 21 and older, Aged, and Other aid categories. With respect to children in the Foster Care aid category, the majority of this increase can be attributed to those residing in metropolitan counties (see Figure 15). By contrast, the increase in FFS participation by adults in the Other aid category was higher in non-metropolitan than in metropolitan counties. From the second quarter of 2011 to the first quarter of 2012, only those beneficiaries enrolled in the Other aid category experienced an increase in FFS participation both in metropolitan and non-metropolitan counties

Figure 16 Change in FFS Participation among Medi-Cal Beneficiaries, by Age and Aid Category, Non-Metropolitan Counties, Quarter 2, 2011 to Quarter 1, 2012

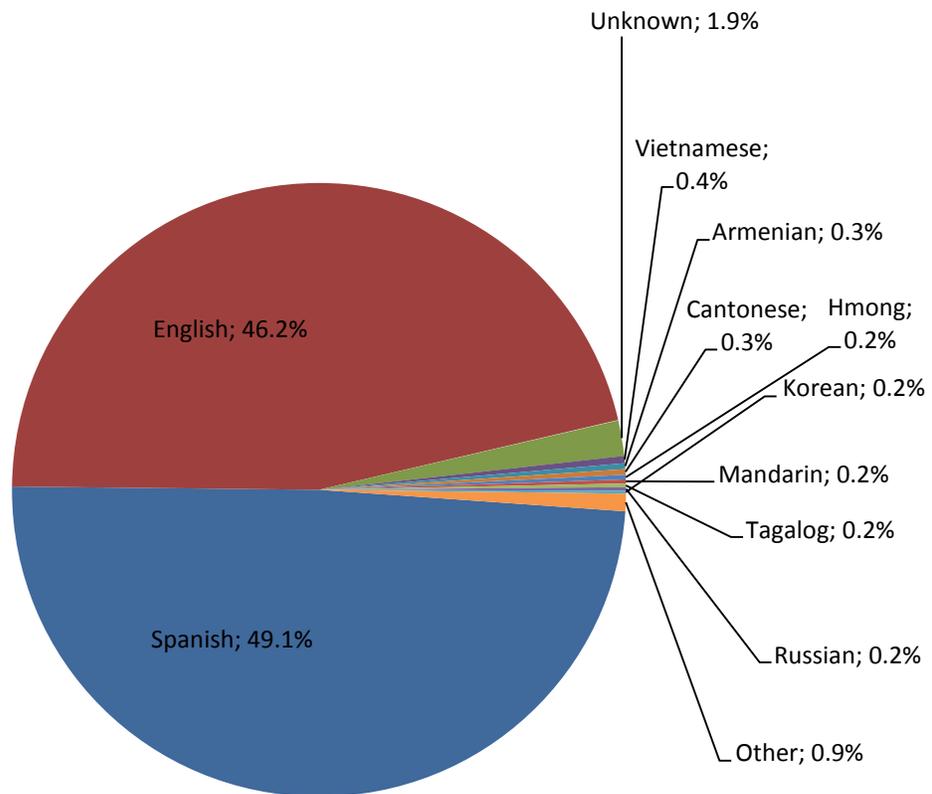


Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag).

Distribution of Medi-Cal Only FFS Beneficiaries, by Primary Language Spoken

As displayed in Figure 17, Spanish was self-reported as the primary language spoken by 49.1 % of FFS Medi-Cal only beneficiaries for the first quarter of 2012. English was the primary language used by 46.2% of FFS Medi-Cal beneficiaries. The remaining 4.7% spoke a variety of primary languages, including Vietnamese, Armenian, Hmong, Cantonese, Mandarin, Tagalog, and Russian.

Figure 17 Distribution of FFS Beneficiaries in Medi-Cal Only Population , by Primary Language Spoken, Quarter 1, 2012

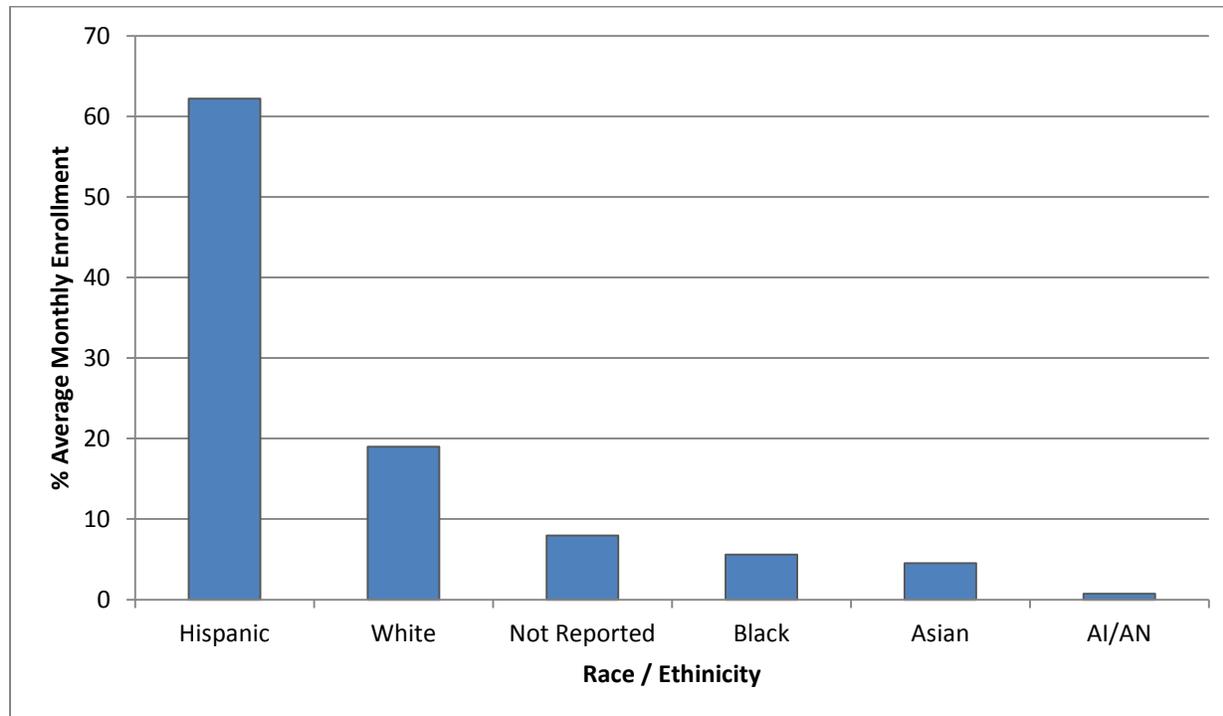


Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag).

Distribution of Medi-Cal Only FFS Beneficiaries, by Race/Ethnicity

Hispanics represented 62.2% of the total FFS Medi-Cal only population for the first quarter of 2012. Whites accounted for 19% of all FFS Medi-Cal beneficiaries, while African American and Asian/Pacific Islander beneficiaries represented a much smaller portion of the overall population (5.6% and 4.5%, respectively). An additional 8% of the FFS Medi-Cal population had no race/ethnic data.

Figure 18 Distribution of FFS Beneficiaries by Race/Ethnicity, Quarter 1, 2012



Distribution of Medi-Cal Only FFS Beneficiaries, by County

As shown in Figure 19, most counties experienced a decline in FFS participation from the second quarter of 2011 to the first quarter of 2012. A handful of counties experienced a modest increase in participation, most notably Alpine and San Mateo Counties (6.1% and 1.9%, respectively). The steepest decline in FFS participation occurred in Mendocino, Ventura, and Marin Counties (87%, 82%, and 71%, respectively).

When comparing the first quarter of 2012 with the previous quarter, FFS participation remained stable for most counties, with negligible changes ranging from -1.2% to +1.1% for 21 out of the 58 counties. The remaining counties experienced modest changes in participation in both directions (see Figure 20). For example, 20 counties had declines in FFS participation above 1.2%, with San Francisco and Alameda Counties showing the highest decrease (13% and 8%, respectively). By contrast, seven counties experienced increases in FFS participation above 1.1%, with Alpine, Monterey, and Mono Counties showing the top increases (6.8%, 3.7%, and 3.6%, respectively).

Figure 19 Comparison of FFS Participation by Medi-Cal Only Beneficiaries, Quarter 1, 2012 to Quarter 2, 2011

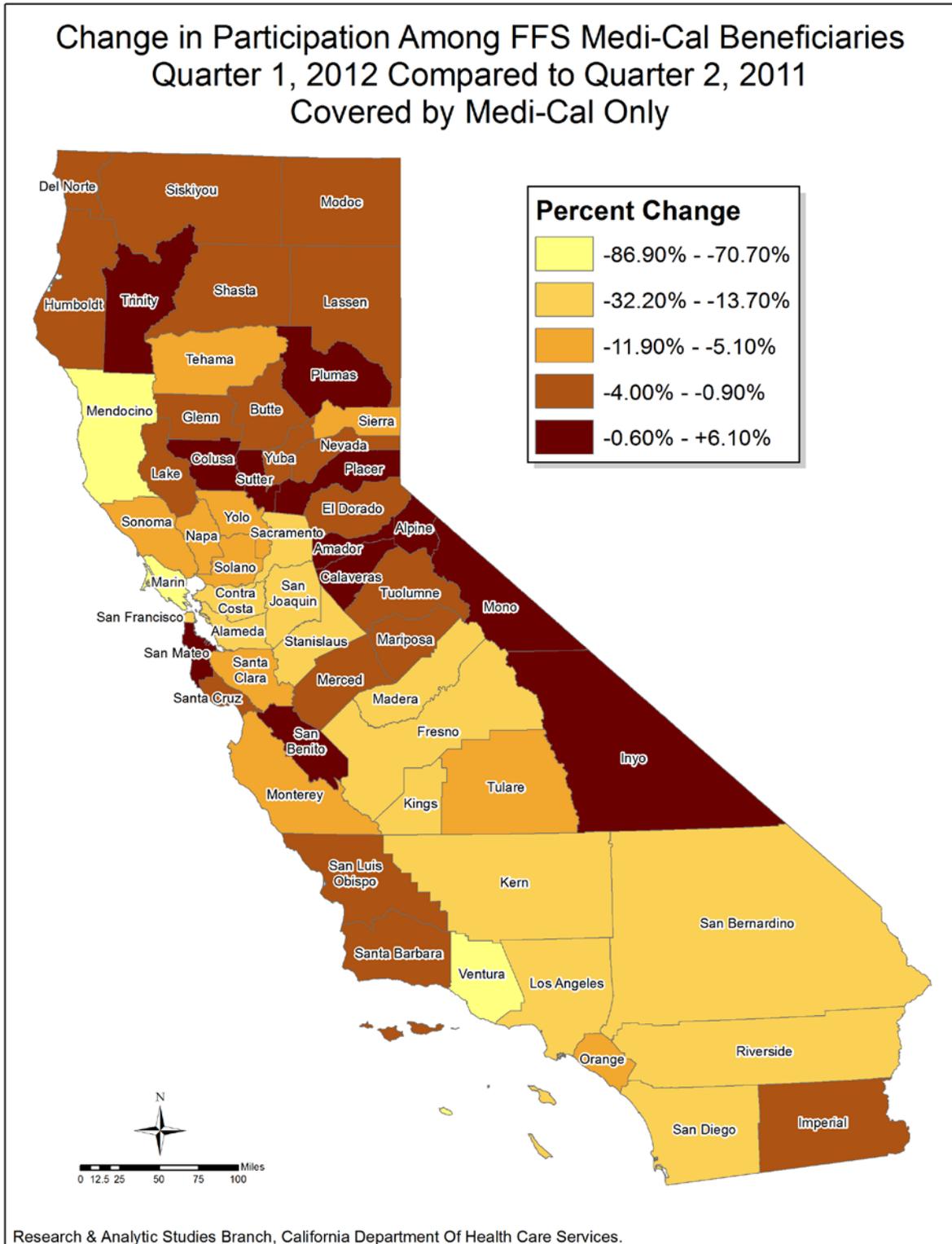
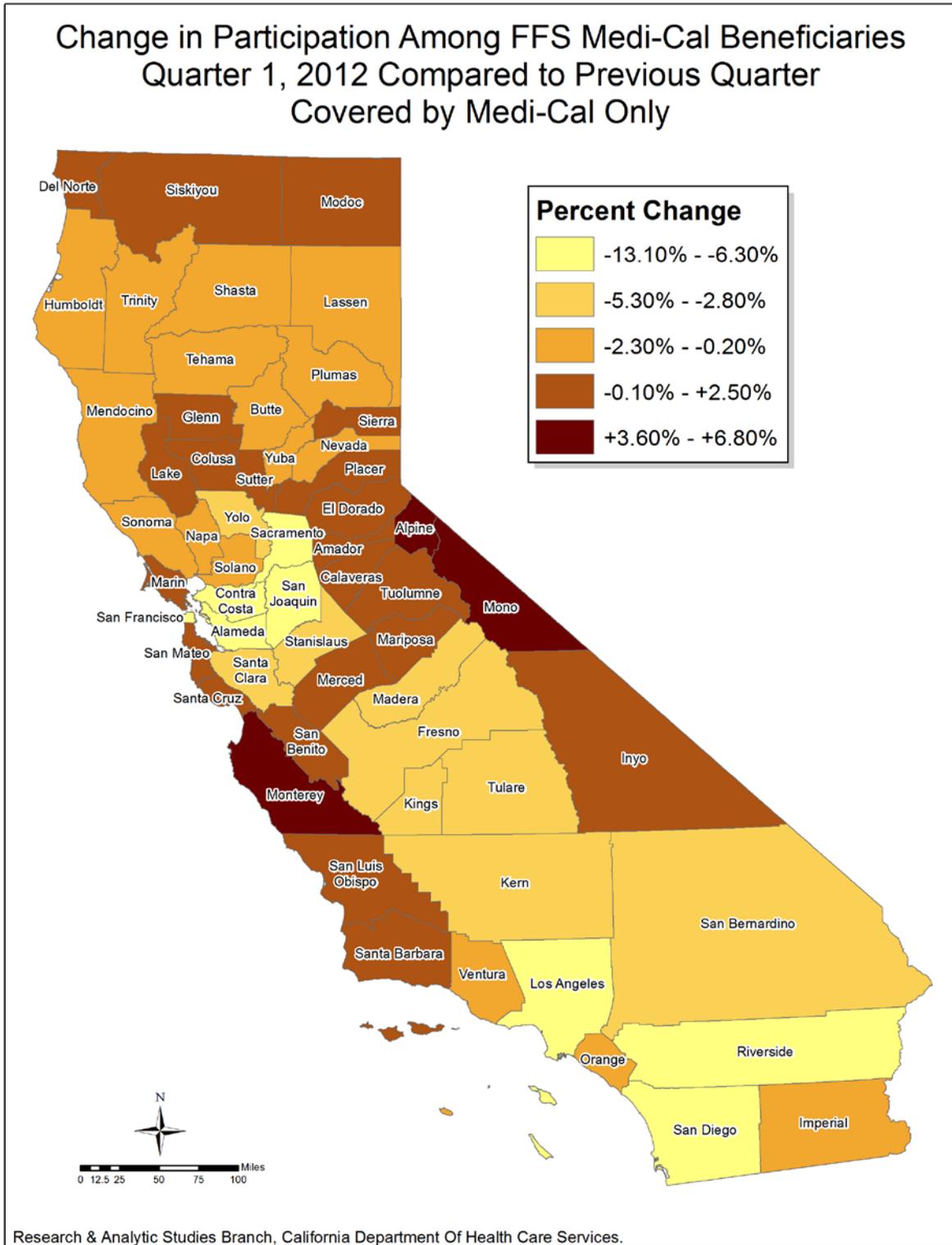


Figure 20 Comparison of FFS Participation by Medi-Cal Only Beneficiaries, Quarter 1, 2012 to Previous Quarter



Conclusions—Beneficiary Participation

1. Beneficiaries eligible for Medi-Cal only and participating in the FFS system are a culturally and ethnically diverse population. The majority describe themselves as Hispanic. About half speak Spanish as their primary language.
2. Several Medi-Cal subpopulations participating in FFS were transitioned into managed care delivery models. During late 2010 and 2011, Kings, Madera, Ventura, Mendocino, and Marin Counties were transitioned from FFS to managed care delivery models. In addition, roughly 300,000 seniors and persons with disabilities were mandatorily enrolled in managed care health plans in the Two-Plan and GMC counties. These changes to Medi-Cal's health delivery system resulted in a decline in the number of beneficiaries participating in the FFS health care model.
3. The number of FFS beneficiaries eligible for Medi-Cal only and entitled to full scope FFS benefits decreased 7.6% between the first quarter of 2012 and the previous quarter, and 25.5% when comparing participation for the second quarter of 2011 to the first quarter of 2012, reflective of Medi-Cal's shift to managed care.
4. The greatest decrease in FFS participation among Medi-Cal only beneficiaries with full scope benefits was observed in those enrolled in Aged and Blind/Disabled aid categories. The decrease in participation among these subpopulations was expected, given DHCS initiative aimed at transitioning SPDs into managed care plans.
5. Overall, participation trends for Medi-Cal's FFS population were similar in metropolitan and non-metropolitan counties when comparing participation changes between the first quarter of 2012 and the second quarter of 2011. When comparing the first quarter of 2012 with the previous quarter, large declines in FFS participation continue to be reported among beneficiaries living in metropolitan counties, whereas smaller changes were noted for non-metropolitan counties.
6. Beneficiaries enrolled in the Aged aid category experienced the greatest decline in FFS participation across all quarters evaluated regardless of their residence in metropolitan or non-metropolitan counties. Undocumented children statewide also experienced significant declines in FFS participation over the 12-month period. Unlike the populations discussed previously, shifts in system participation (i.e., from FFS to managed care) were not responsible for the declines recognized in the undocumented population since they are not eligible for Medi-Cal managed care participation. These declines are most likely the result of declining participation in the Medi-Cal program.
7. Children in the Foster Care aid category residing in metropolitan counties experienced a 12.8% increase in FFS participation in the first quarter of 2012, reflective of legislation effective January 1, 2012, which optionally extends foster care benefits up to age 21. Similarly, FFS participation of adults in the "Other" aid category also increased, possibly as a result of the need for long-term care services which are only paid by managed care plans for the first 30 days.

8. During the first quarter of 2012, the downwards trend in FFS participation that had been observed in all counties during 2011 was reversed for a few counties (e.g., Alpine, Monterey, and Mono), or stabilized for about a third of counties.

Use of Select Services by Medi-Cal FFS Beneficiaries

Introduction

Studying trends in service use provides DHCS with information regarding Medi-Cal beneficiaries' receipt of services, whether those services or service settings were appropriate, and may help identify areas where health care access gaps exist.

There are many factors that affect health care use and the type of health care used by a given population. One of those factors is adequate access to care. Limitations on the scope of benefits provided under a health plan, cost-sharing requirements, and gaps in health plan coverage may all contribute to underutilization of health care services. Other factors that influence health care use include the prevalence of chronic disease in the population, provider practice patterns, recommended medical practice guidelines for specific subpopulations (e.g., cancer screenings for women, immunization schedules, and developmental assessments for children), and cultural acceptance of medical practices among the population.

Age is also associated with health care use patterns. For example, advanced age increases functional limitations and the prevalence of chronic conditions. The elderly have higher use rates for inpatient and long-term care services, many medical procedures, and are prescribed more medications, such as glucose-lowering or antihypertensive drugs. In general, children have lower health care use rates than the elderly. However, infants born at low birth weight (<2500 grams, or 5.5 lbs), and children with chronic health conditions and disabilities have both higher rates of health care use and utilize more costly services than their counterparts. Children in foster care are particularly vulnerable to physical, emotional, or developmental problems stemming from abuse or neglect, substance abuse by their mothers during pregnancy, or their own substance abuse issues. A majority of these children have at least one physical or emotional health problem, and as many as 25% suffer from three or more chronic health conditions. Consequently, examining health care use patterns should be undertaken with specific thought given to the characteristics of a population.

Methods

In this report, DHCS examines utilization trends for nine different provider types:

1. Physician/Clinics
2. Non-Emergency Transportation
3. Emergency Transportation
4. Home Health
5. Hospital Inpatient
6. Hospital Outpatient
7. Nursing Facility
8. Pharmacy services
9. Other

Service use was measured in various ways, depending upon the provider type. The unit of measure for Physician/Clinic, Home Health, and Hospital Outpatient services was the number

of unique visits or patient encounters. The unit of measure for Pharmacy services was the unit counts of prescriptions. Individual encounters were used as the measure for both Emergency and Non-Emergency Transportation services, while the length of stay as measured in days was the unit of measure for Hospital Inpatient and Nursing Facility service use. Service rates were calculated per 1,000 member months for each of these service types and for beneficiaries eligible for Medi-Cal only and participating in FFS. Beneficiaries were classified into broad age groupings (children age 0–20 vs. adults age 21+) and aid categories as a proxy for health and disability status, factors which are known to influence use patterns.

DHCS plotted monthly service use rates per 1,000 member months for the study period of April 2011–March 2012. DHCS used Shewhart control charts to identify whether health care service use rates changed over this time period and compared to low and high use thresholds calculated from the baseline period January 1, 2007–December 31, 2009.³¹ These thresholds or control limits have been set at three standard deviations from the mean, and define the natural range of variability expected from the plotted measures. Upper and lower threshold levels are represented in each control chart, with “UCL” representing upper control limits, “LCL” representing lower control limits, and “x” representing the mean. Comparing the plotted measures to the mean and upper and lower control limits can lead to inferences regarding whether the data are within an expected or predictable range, or whether there are marked changes in the data over time. Potential marked changes include:

- Eight or more consecutive points all either above or below the mean line indicate a shift in use patterns.
- Six or more consecutive points all going in the same direction (either up or down) indicate a trend.
- Two or more consecutive points plotted outside of these established limits will provide a signal indicating that health care use has deviated markedly from the expected range.

Changes in participation and provider capacity are important factors influencing health care use trends. When evaluating use trends, some basic paradigms should be considered. Under the first paradigm, if participation increases within a subpopulation and the network of health care providers cannot absorb the increased demand, beneficiaries may experience difficulties accessing health care services.³² In that case, one would expect to detect a decline in service use rates, as beneficiaries forego health care services.

Under the second paradigm, if participation increases and the network of providers is able to absorb additional demand, then one would expect service use rates to remain constant, increase, or to experience no significant decreases.³³

Under the third paradigm, if participation decreases within a subpopulation and those that remain in the health care system have a significantly different case mix than the initial

³¹ See various health care service utilization baseline analysis on the DHCS website at www.dhcs.ca.gov/pages/RateReductionInformation.aspx

³² Assumes populations who enroll exhibit similar health needs as those who were enrolled prior. If the newly enrolled individuals are a much healthier population with low health service use, utilization rates may actually decline. This decline may be driven more by the health characteristics than access difficulties.

³³ Assumes populations who enroll exhibit similar health needs as those who were enrolled prior.

population, one would expect marked changes in health care use. For example, if the subpopulation that remains in the health care system has significantly greater medical needs than the initial population, one would expect service use rates to increase. However, if the subpopulation that remains is healthier, one would expect service use rates to decrease. Certain shifts in populations, from one health care system to another, such as FFS to managed care, might result in a significant change in the mix of patients. This in turn may result in significant changes in use trends.

The sections that follow present health care use trends for each of the nine service categories studied. Each section is introduced with a discussion that presents background material related to each unique service category. This background provides the reader with some introductory information regarding the types of services associated with the category, historical use, and types of providers, where applicable, contained within the service category. The reader should note that the background sections present service use information that relates to 2010 and includes all FFS use, regardless of health care system participation in FFS or managed care. In addition, utilization statistics associated with the background sections includes utilization associated with dual eligibles. Following the background information, utilization trends for each service category is presented. The utilization trends display statistics associated with beneficiaries eligible for Medi-Cal only and participating in Medi-Cal's FFS system.

Physician/Clinic

Background

It is important for any health care delivery system to monitor trends in physician service use among its patients, because physicians are the first point of contact for most health care needs. Once contact is made in a physician's office, numerous other services may be accessed, such as prescription drugs, lab services, and referrals to specialty care. Receiving regular ambulatory health care visits has been widely recognized as a fundamental measure of successful health care access.

In the Medi-Cal program, beneficiaries may see a physician in solo practice, physicians affiliated with a physician group, or those affiliated with a Federally Qualified Health Clinic (FQHC), Rural Health Clinic (RHC), or some other clinical setting. A large proportion of Medi-Cal beneficiaries with paid claims in the FFS system (> 5 million) receive at least one physician or clinic visit throughout the year.

FQHCs are nonprofit, community-based organizations or public entities that offer primary and preventive health care and related social services to the medically underserved and uninsured population, regardless of their ability to pay. FQHCs receive funding under the Public Health Service Act, Section 330, which is determined by the US Department of Health and Human Services.

RHCs are organized outpatient clinics or hospital outpatient departments located in rural shortage areas as designated by the US Department of Health and Human Services. To qualify as an RHC, a clinic must be located in a non-urbanized area or area currently designated by the Health Resources and Services Agency (HRSA) as a federally designated or certified shortage area.

Indian Health Services Clinics are those authorized by the US Secretary of Health, Education and Welfare, to contract services to tribal organizations. Services available under the IHS provider type are more extensive than under the FQHC or RHC provider type, and include the following services: physician and physician assistant, nurse practitioner and nurse midwife, visiting nurse, clinical psychology and social work, comprehensive perinatal care, Early Periodic Screening, Diagnosis and Treatment (EPSDT), ambulatory, and optometry.

Other clinics in the Medi-Cal program include: Free Clinics, Community Clinics, Surgical Clinics, Clinics Exempt from Licensure, Rehabilitation Clinics, County Clinics not associated with a hospital, and Alternative Birthing Centers. All of these various clinics are included in this analysis.

Many users of Physician/Clinic services are either being seen in physician group practices (2,413,502, or 46%) or in an FQHC or RHC (2,040,980, or 38.8%). Nearly half of all Physician/Clinic services are provided to children under age 20, and many are eligible for benefits under the Families aid category. Most users of these services (75%) have on average one to five visits annually.

Trend Analysis

Among children age 0–20 in the Medi-Cal FFS program, monthly Physician/Clinic services utilization rates ranged from 172.8–693.9 visits per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. The Physician/Clinic services utilization rates continued to be notably higher among children in the Blind/Disabled aid category, most likely due to their inherent complex medical needs. The utilization rates for children in the Undocumented aid category again fell well below the anticipated ranges observed in the baseline period of 2007–2009. Additionally, children in the Blind/Disabled aid category exhibited normal fluctuation in service use that remained within the expected baseline ranges, while children in the Families, Foster Care, and Other aid categories displayed lower than average utilization rates during the first three quarters of 2011. These lower utilization rates coincide with the decrease in participation in the Medi-Cal FFS delivery system among beneficiaries in this age group over the same time period. Of particular note, children in most aid categories, with the exception of those in the undocumented immigrants aid category, exhibited a distinct increase in Physician/Clinic services utilization during the first quarter of 2012.

The monthly Physician/Clinic services utilization rates for adults age 21 and older ranged from 217.1–1,359.0 visits per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. Similar to the Physician/Clinic services utilization trends identified in the previous report, adults in the Blind/Disabled and Other aid categories again exhibited noticeably higher utilization rates than adult beneficiaries in other aid subpopulations. The utilization trends among most adults, with the exception of those in the Undocumented aid category, fell within the expected ranges. Additionally, adults in the Aged and Families aid categories displayed mostly below average utilization throughout 2011. The lower utilization rates for adults in the Aged and Families aid categories also coincide with the decline in the number of beneficiaries participating in the Medi-Cal FFS delivery system during the same time frame. Adults in the Aged and Blind/Disabled aid categories exhibited a noticeable increase in Physician/Clinic services utilization in the first quarter of 2012.

Adults in the Families and Undocumented aid categories continue to exhibit lower than average and lower than expected use of Physician/Clinic services, which may be explained in part by the continued declines in national and state birth rates. This continues the trend of national birth rates experiencing their sharpest decline in over thirty years from 2007–2009,³⁴ and preliminary national vital statistics data indicating a continued decline in the birth rate for 2011 and into 2012. Given that many beneficiaries in the Undocumented aid category become eligible for services because they are pregnant, it can be hypothesized that the demand for Physician/Clinic services, particularly as it pertains to prenatal care and delivery, has decreased due to the decline in birth rates among this subpopulation. A definitive explanation for these service use patterns can only be reached by undertaking further analysis.

The following figures 22-31 represent the control chart analysis for both children and adults from the second quarter of 2011 to the first quarter of 2012.

³⁴Data from the National Vital Statistics System, found at <http://www.cdc.gov/nchs/data/databriefs/db60.pdf>

Trends—Physician/Clinic Services Use, Children, April 2011–March 2012

Figure 21 Monthly Physician/Clinic Use Rates, Children Age 0-20, Blind/Disabled, April 2011–March 2012

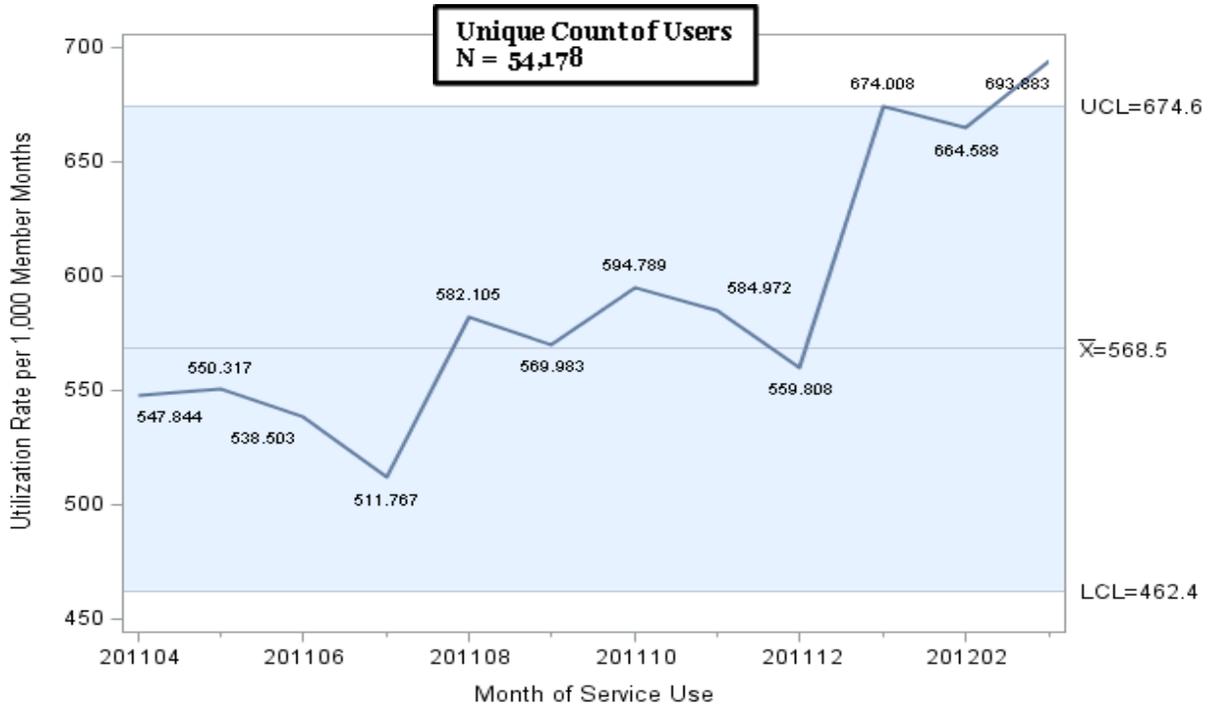


Figure 22 Monthly Physician/Clinic Use Rates, Children Age 0-20, Families, April 2011–March 2012

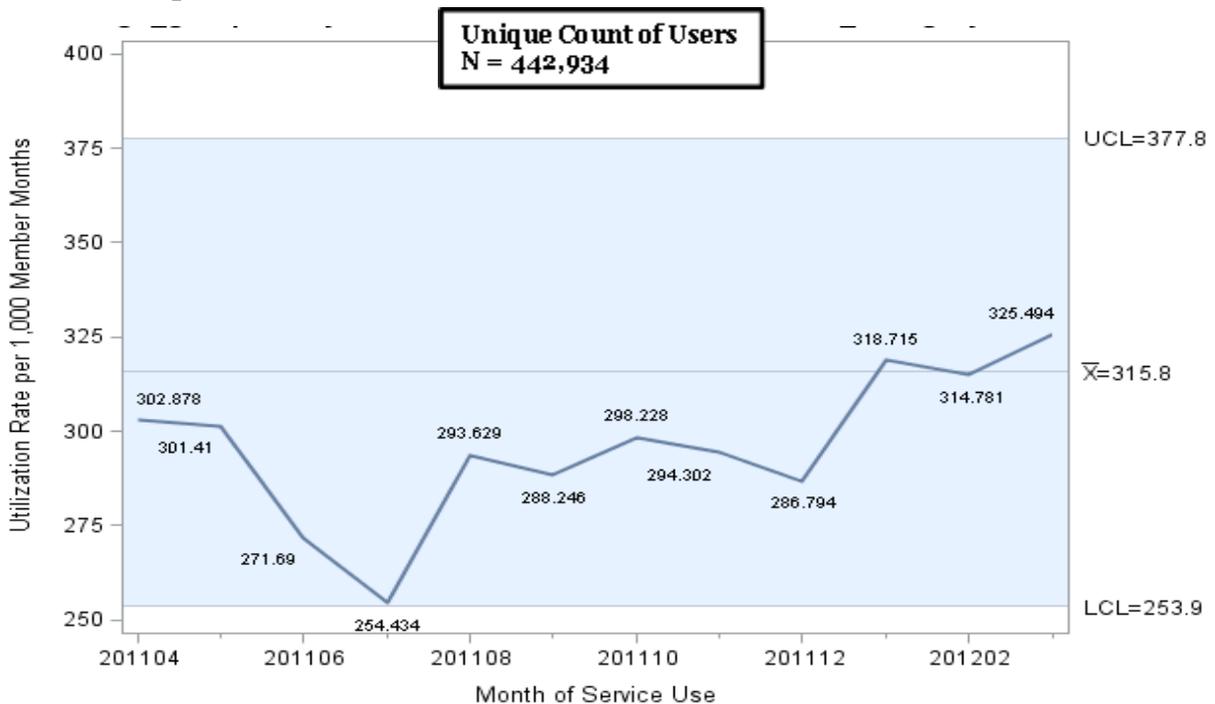


Figure 23 Monthly Physician/Clinic Use Rates, Children Age 0-20, Foster Care, April 2011–March 2012

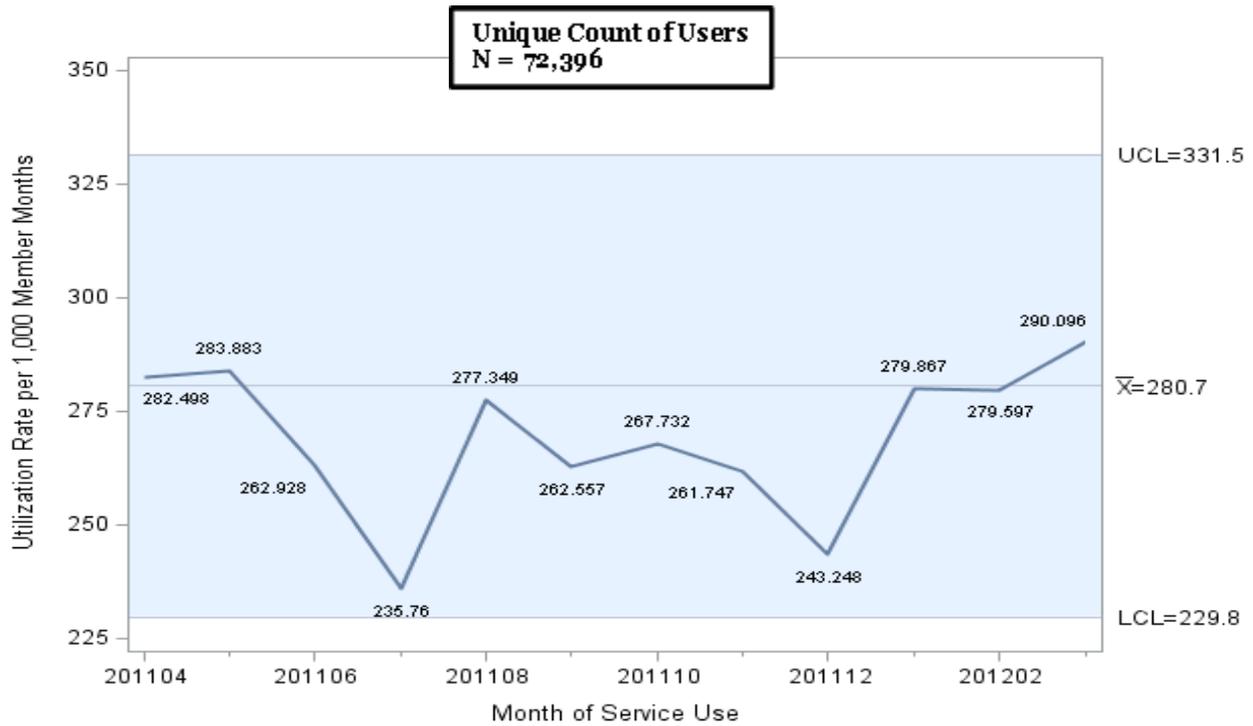


Figure 24 Monthly Physician/Clinic Use Rates, Children Age 0-20, Other, April 2011–March 2012

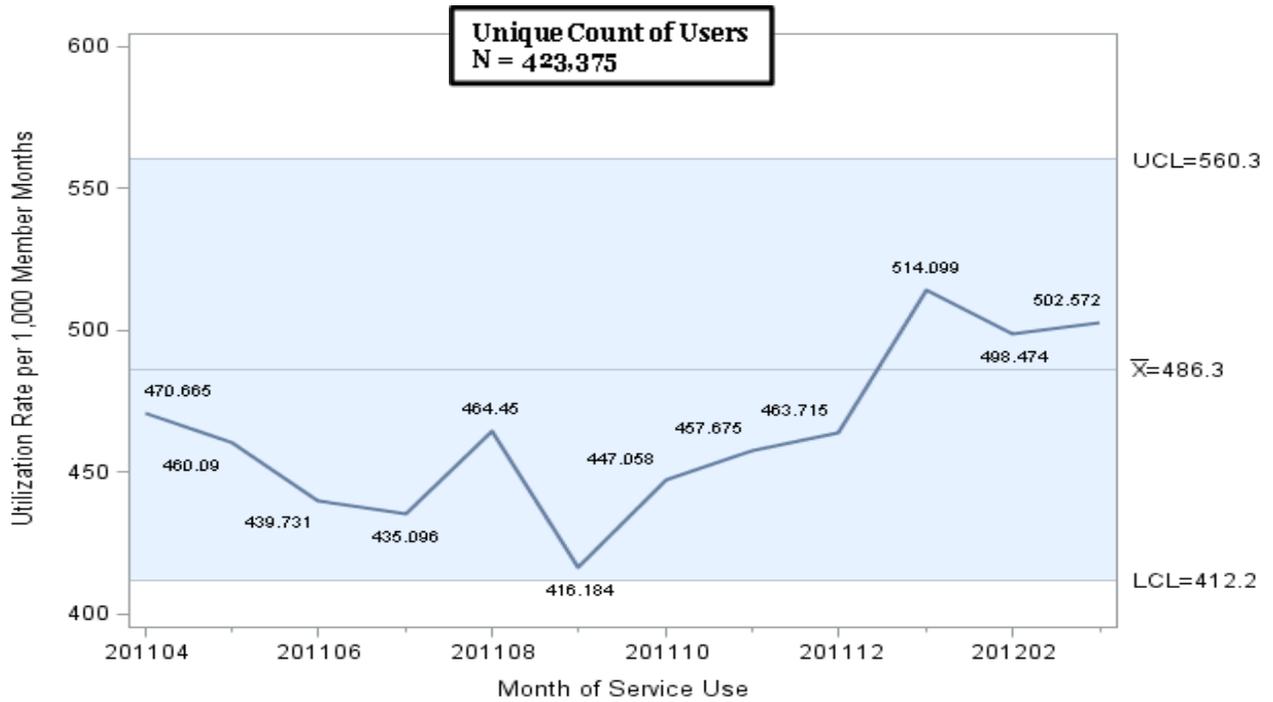
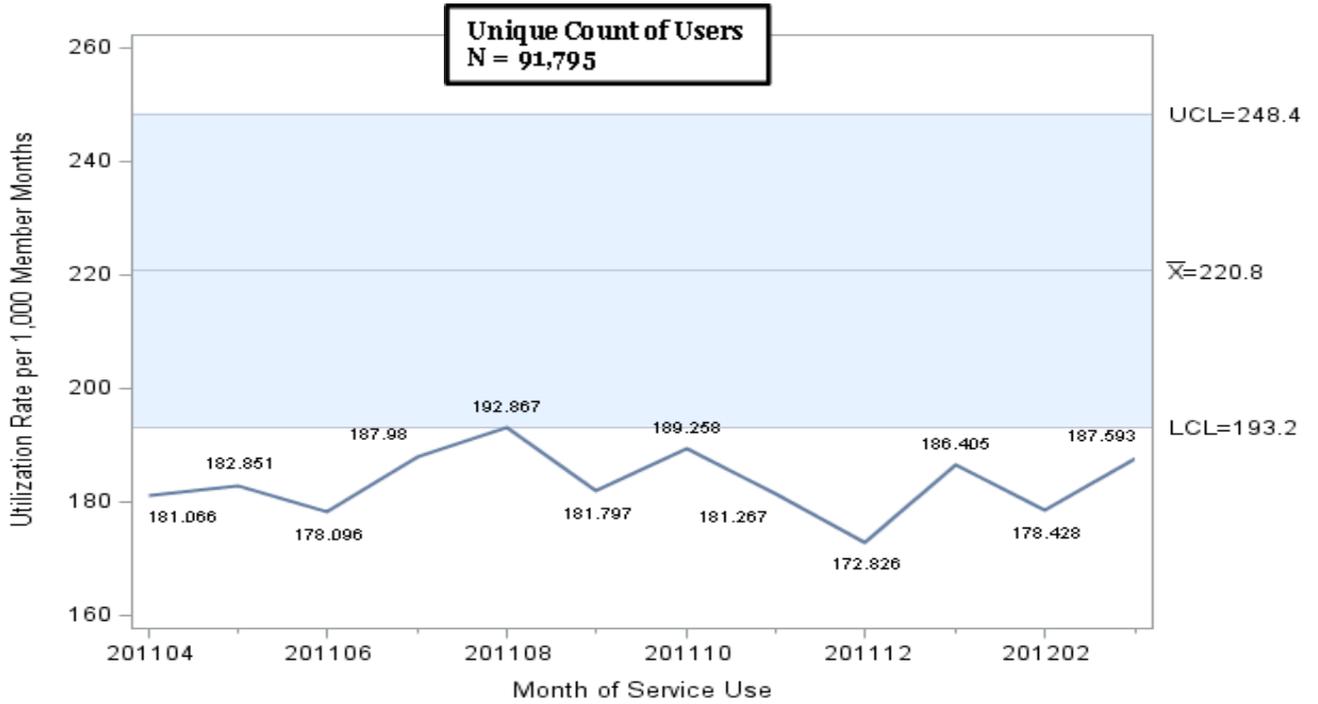


Figure 25 Monthly Physician/Clinic Use Rates, Children Age 0-20, Undocumented, April 2011–March 2012



Source: Data for figures 22–26 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Physician/Clinic Services Use by Adults, April 2011–March 2012

Figure 26 Monthly Physician/Clinic Use Rates, Adults Age 21+, Aged, April 2011–March 2012

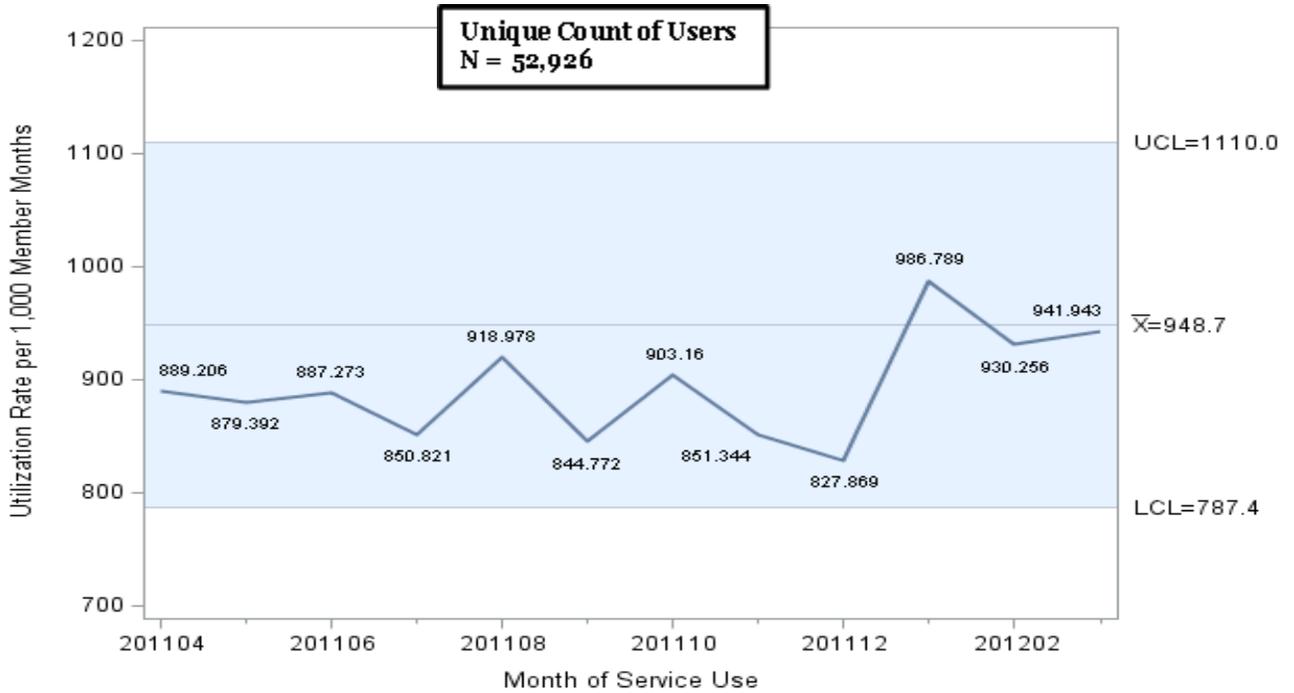


Figure 27 Monthly Physician/Clinic Use Rates, Adults Age 21+, Blind/Disabled, April 2011–March 2012

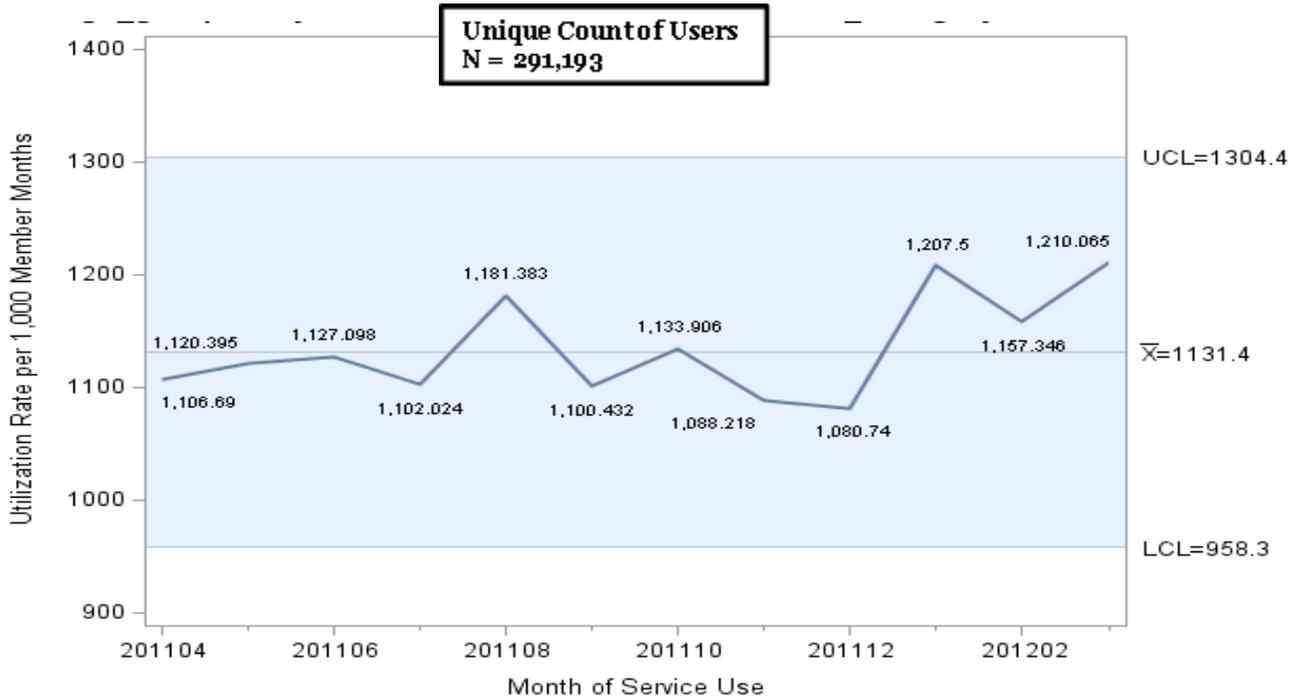


Figure 28 Monthly Physician/Clinic Use Rates, Adults Age 21+, Families, April 2011–March 2012

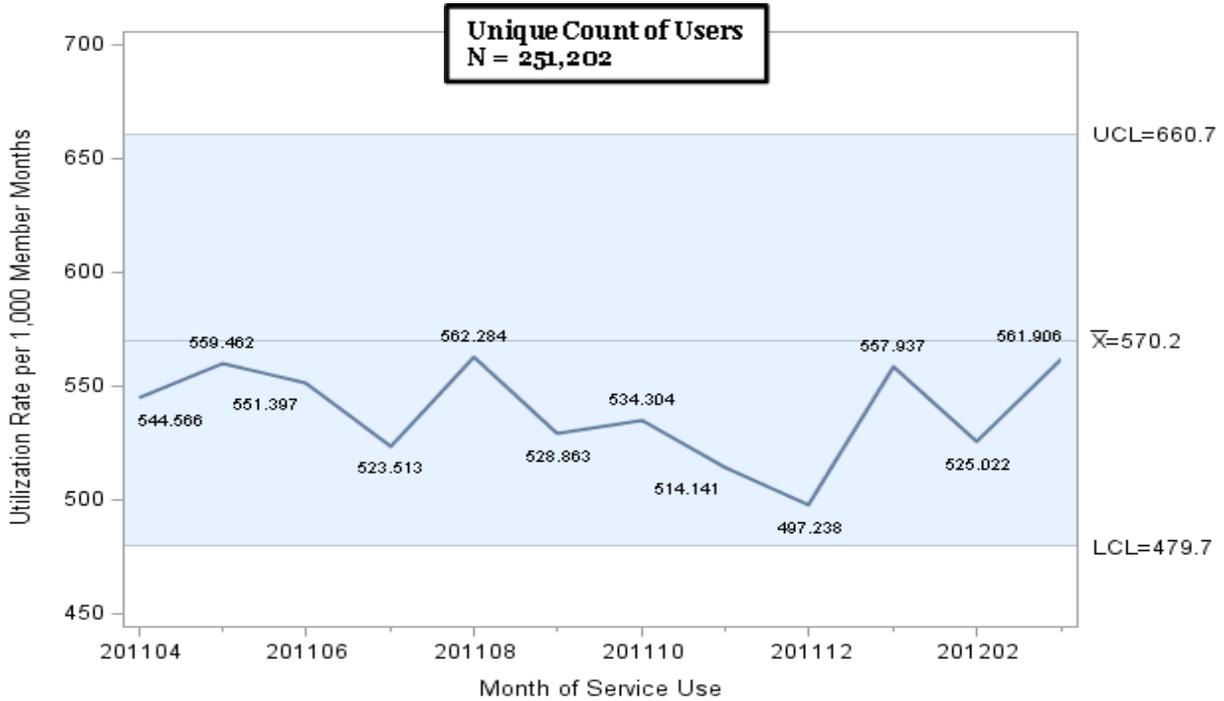


Figure 29 Monthly Physician/Clinic Use Rates, Adults age 21+, Other, April 2011–March 2012

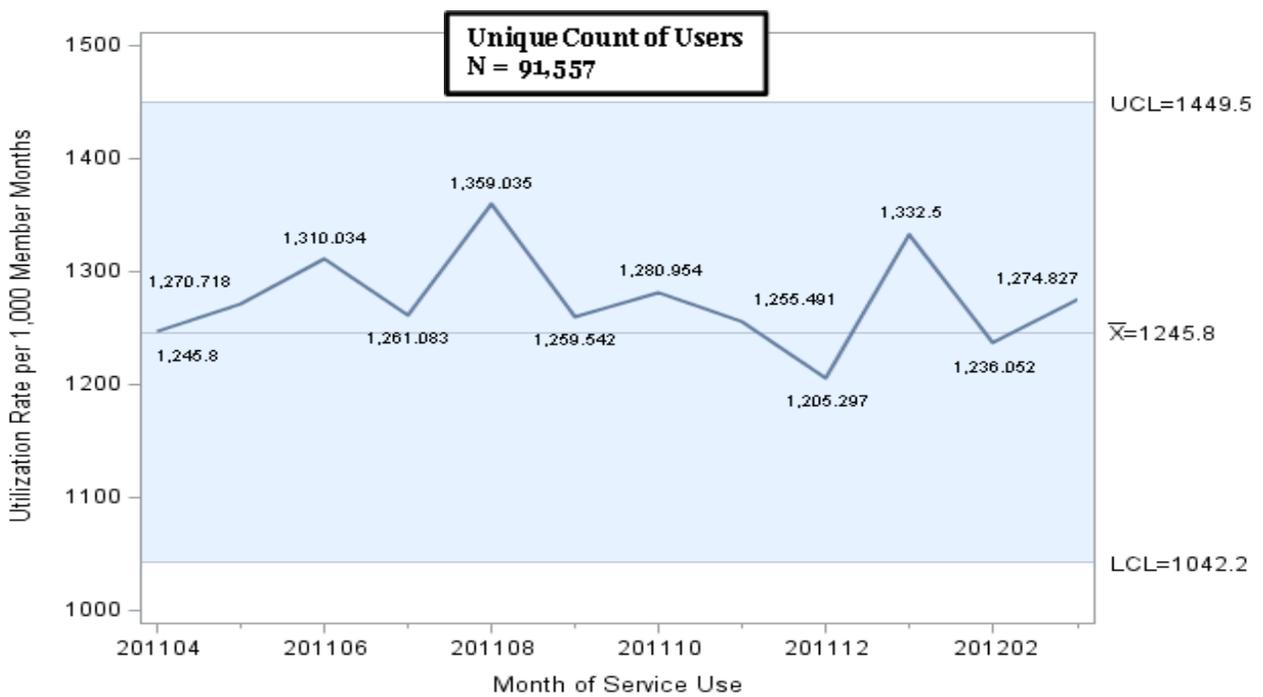
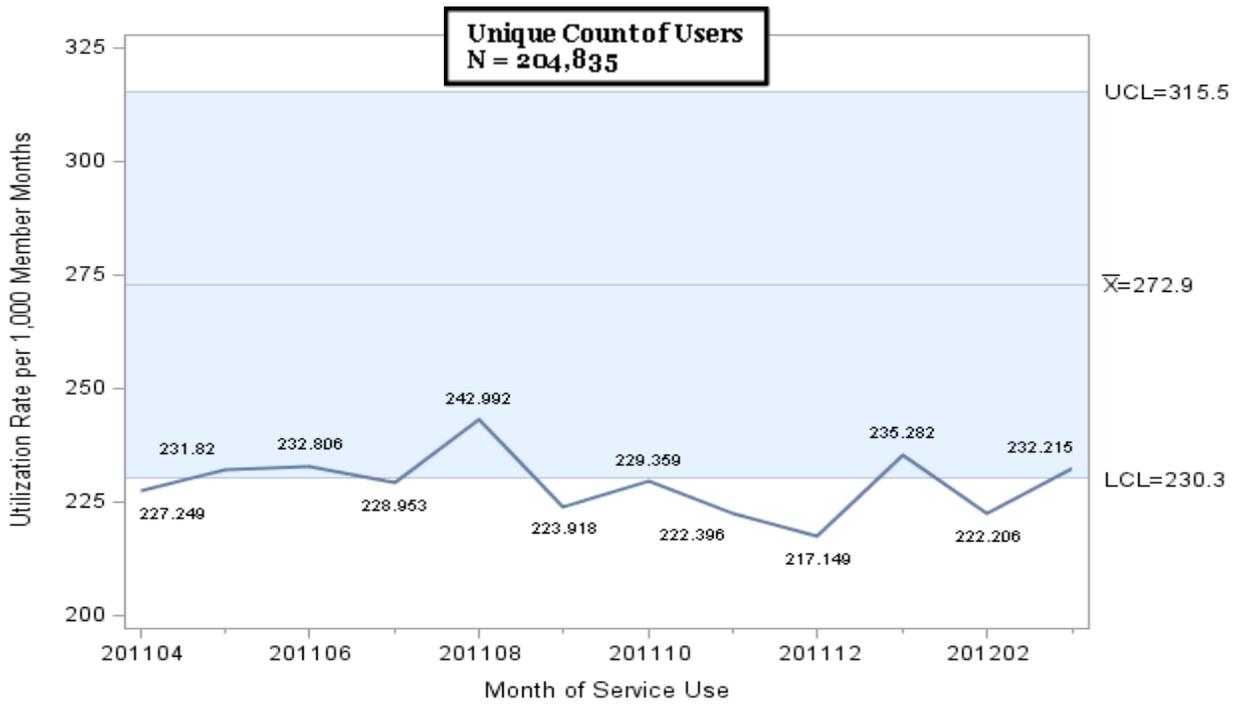


Figure 30 Monthly Physician/Clinic Use Rates, Adults Age 21+, Undocumented, April 2011–March 2012



Source: Data for figures 27–31 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Non-Emergency Medical Transportation

Background

Non-emergency transportation is the transportation of the sick, injured, invalid, convalescent, infirmed, or otherwise incapacitated persons when access to medical treatment is needed, but when the condition is not immediately life-threatening. An example of non-emergency transportation would be transport by litter van or wheelchair van to a doctor or clinic. Transportation services are also provided through air ambulance services. For non-emergencies, medical transportation by air is only covered when the medical condition of the patient or practical considerations make ground transportation impractical.

The Medi-Cal program covers medical transportation when a beneficiary cannot obtain medical services using ordinary means of transportation. Non-emergency transportation requires previous authorization and is covered only in limited situations. While most insurance plans apart from Medi-Cal provide their members with emergency medical transportation, non-emergency transportation is only covered by other plans in a limited form. For example, private insurance companies may cover non-emergency transportation when transferring a patient being discharged from the hospital, or when plan members seek specific treatment such as organ transplantation services.

There are over 200,000 Medi-Cal beneficiaries that access some form of medical transportation service paid through the Medi-Cal FFS claiming system annually. Fewer than 40% of medical transportation service recipients are users of non-emergency medical transportation. Approximately 70% of beneficiaries using non-emergency medical transportation services have between one and five service encounters annually and are predominantly age 65+ (58%). Many beneficiaries who use these services are covered under Disabled (45%), Aged (30%), and Long-Term Care (18%) aid categories, and are seen for conditions such as renal failure, brain damage, congestive heart failure and other serious illnesses. Beneficiaries who use non-emergency medical transportation services six or more times annually represent a small segment of users (16%), a majority of whom have been diagnosed with renal failure (55%).

Trend Analysis

This analysis only focuses on Non-Emergency Medical Transportation services utilization rates among Medi-Cal children age 0–20 participating in the FFS program and enrolled in the Blind/Disabled aid category. The monthly Non-Emergency Medical Transportation services utilization rates for children in the Blind/Disabled aid category ranged from 2.1 to 4.7 visits per 1,000 member months from the second quarter of 2011 to the first quarter of 2012, which is a twofold increase over this one-year period. Similar to service use patterns identified in the previous report, children in the Blind/Disabled aid category exhibited Non-Emergency Medical Transportation services utilization rates well above the expected ranges observed in the baseline period of 2007–2009. Utilization for these services increased substantially at the beginning of 2012.

Among adults 21 and older, monthly Non-Emergency Medical Transportation services utilization rates ranged from 3.9–91.7 visits per 1,000 member months from the second quarter

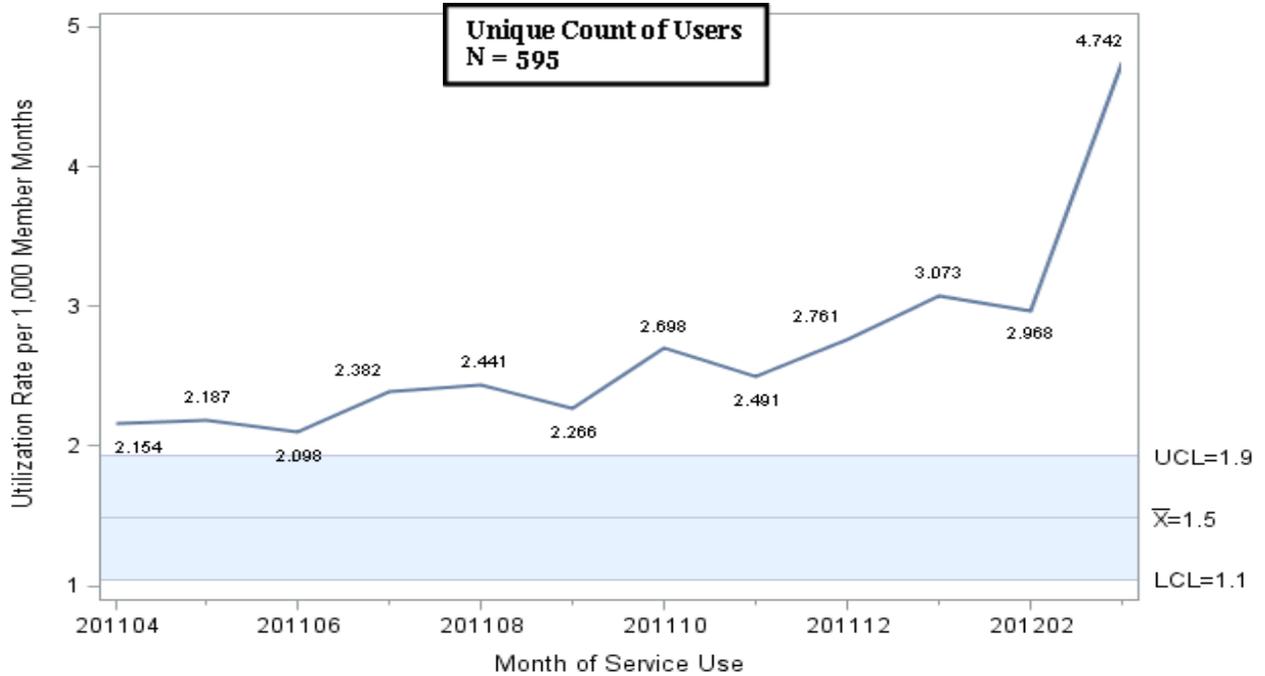
of 2011 to the first quarter of 2012. The Non-Emergency Medical Transportation services utilization rates among adults across all of the analyzed aid categories were similar to the previous report. For instance, adults in the Aged and Blind/Disabled aid categories exhibited noticeably higher utilization, with rates ranging from 55.4–91.6 visits per 1,000 member months, while a small group of adults in the Families aid category (3.8–5.7 visits per 1,000 member months) utilized these services less frequently, with a notable decline in use at the beginning of 2012. Overall, Non-Emergency Medical Transportation utilization trends for adults in all aid categories exhibited rates that continued to be well above the expected baseline ranges.

Medi-Cal FFS beneficiaries in the Undocumented aid category were excluded from this analysis because they are not entitled to Non-Emergency Medical Transportation services. Additionally, children in the Families, Foster Care, and Other aid code categories were excluded because of their relatively small user counts (<500).

The following figures 32–36 represent the control chart analysis for both children and adults from the second quarter of 2011 to the first quarter of 2012

Trends—Non-Emergency Medical Transportation Services Use by Children, April 2011–March 2012

Figure 31 Monthly Non-Emergency Medical Transportation Use Rates, Children Age 0-20, Blind/Disabled, April 2011–March 2012



Source: Data for figure 32 prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Non-Emergency Medical Transportation Services Use by Adults, April 2011–March 2012

Figure 32 Monthly Non-Emergency Medical Transportation Use Rates, Adults Age 21+, Aged, April 2011–March 2012

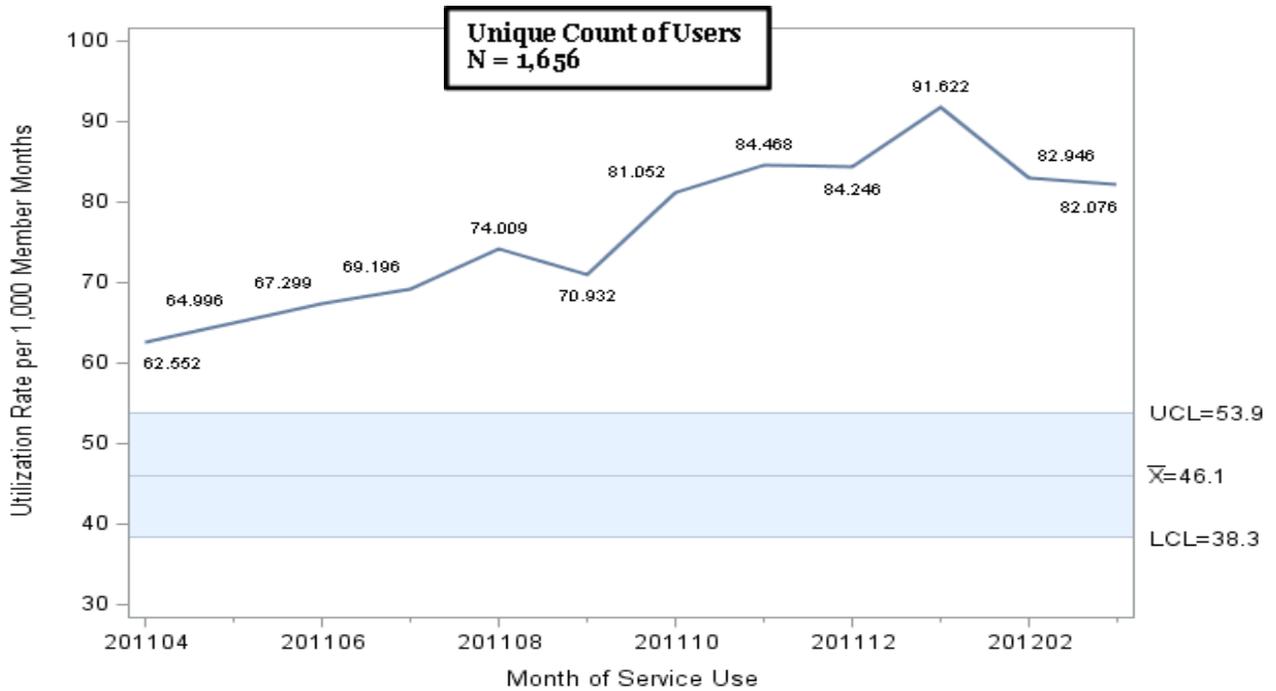


Figure 33 Monthly Non-Emergency Medical Transportation Use Rates, Adults Age 21+, Blind/Disabled, April 2011–March 2012

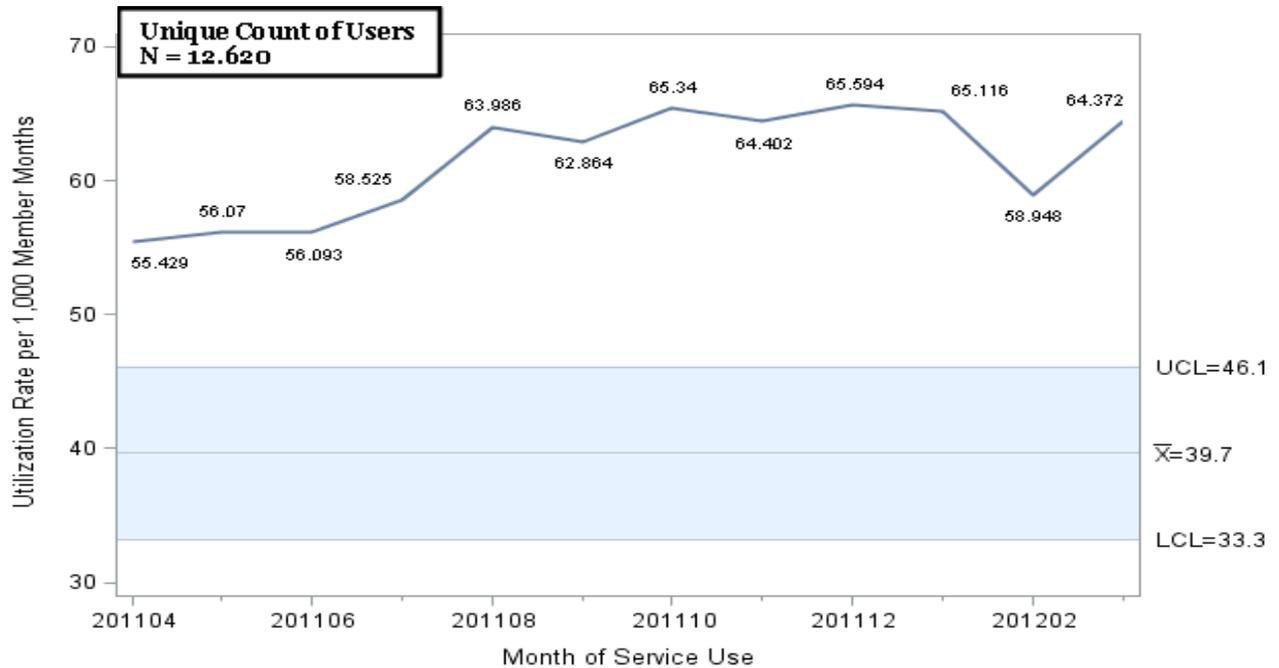


Figure 34 Monthly Non-Emergency Medical Transportation Use Rates, Adults Age 21+, Families, April 2011–March 2012

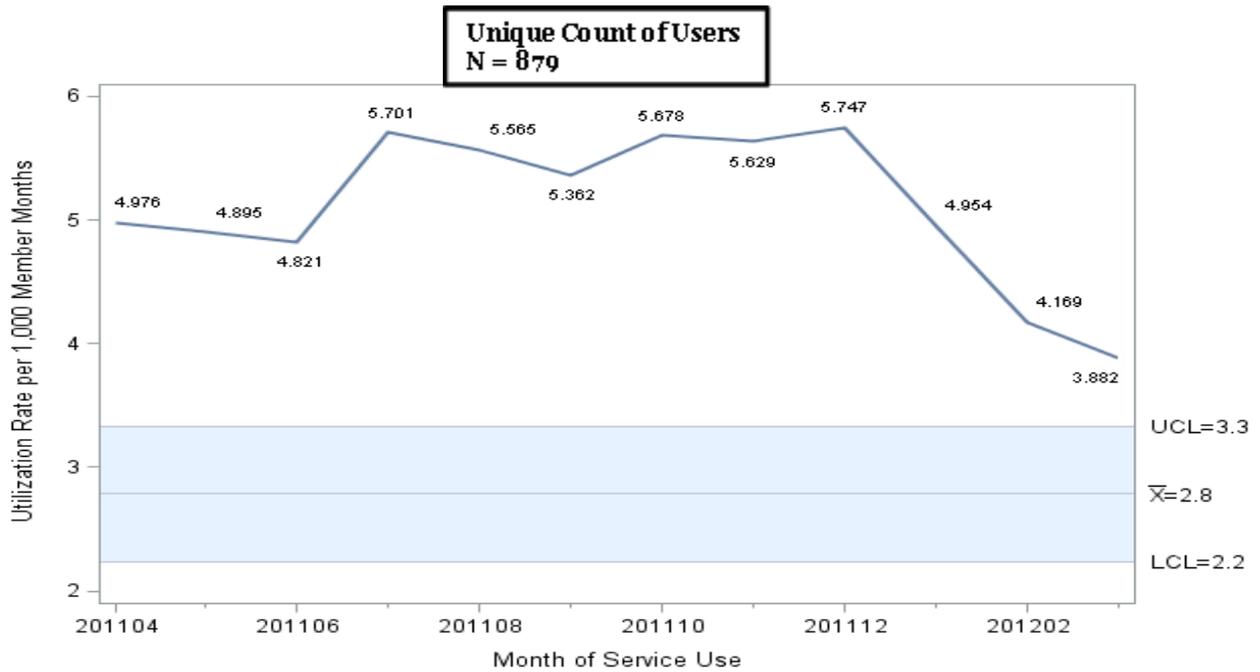
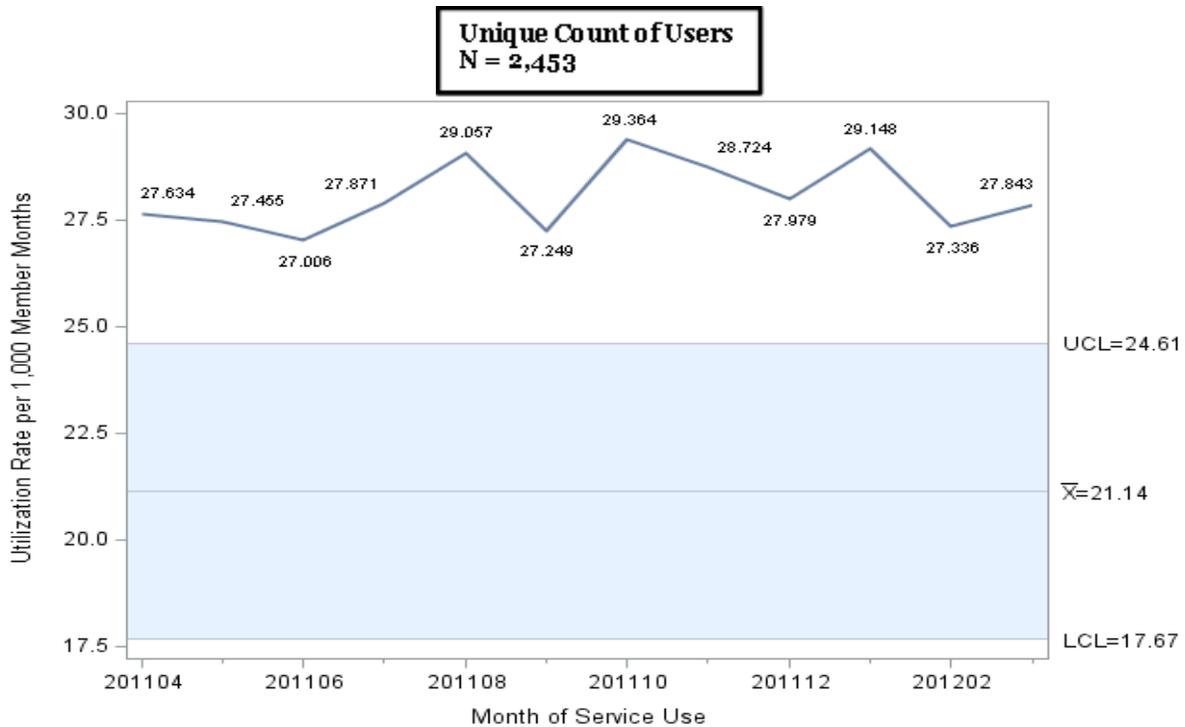


Figure 35 Monthly Non-Emergency Medical Transportation Use Rates, Adults Age 21+, Other, April 2011–March 2012



Source: Data for figures 33–36 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Emergency Medical Transportation

Background

Emergency transportation is the transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated persons for medical treatment needed in life-threatening situations. Similar to non-emergency transportation, emergency transportation services are provided through air ambulance services and ground medical transportation providers. Transportation by air is covered for emergencies if the medical condition of the patient contraindicates using other means of transportation, or if either the patient, or the nearest hospital capable of attending to the patient's medical needs are inaccessible to ground transportation. Approximately 2.5% of all emergency transportation services are provided via air ambulance.

Emergency transportation is covered by Medi-Cal. Although this type of transportation does not require prior authorization, each claim must include a justification for the emergency transportation.

Of the 213,796 Medi-Cal beneficiaries that accessed medical transportation services in 2010, 69% used emergency transportation at a cost of \$56,777,111, or 32.3%, of the total medical transportation expenditures. A large proportion of emergency medical transportation users utilize services just once annually (69%), while a small proportion (5%) have six or more emergency medical transportation service encounters annually. The predominant user groups of emergency transportation services are adults between age 21–64 (66%), in Disabled aid categories (50%), and being treated for abdominal and chest pain, injuries, epilepsy or convulsions, spondylosis and other back problems, and schizophrenia or other psychotic disorders.

Trend Analysis

Among children age 0–20 in the Medi-Cal FFS program, monthly Emergency Medical Transportation services utilization rates ranged from 1.2–9.9 visits per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. Patterns of service use among children in all of the analyzed aid categories followed those identified in the previous report. For instance, Emergency Medical Transportation services utilization was noticeably higher among children in the Blind/Disabled aid category, with rates ranging from 7.8–9.9 visits per 1,000 member months. In contrast, utilization rates for children in the Families and Other aid categories ranged from 2.0–2.9 visits per 1,000 member months. Children in the Blind/Disabled, Families, Other, and Undocumented aid categories continued to exhibit below average utilization rates. Children in the Foster Care aid category had utilization rates within the expected ranges observed in the baseline period of 2007–2009, while children in the Undocumented aid category again had two or more consecutive months of Emergency Medical Transportation services utilization below the baseline ranges. Additionally, while children in the Other aid category displayed utilization rates below the expected ranges, their utilization of Emergency Medical Transportation services increased to rates approaching average during the first quarter of 2012.

The monthly Emergency Medical Transportation services utilization rates for adults age 21 and older ranged from 1.6–44.2 visits per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. Similar to the previous report, the utilization rates were noticeably higher for adults in the Blind/Disabled aid category, while adults in the Undocumented aid category again rarely utilized these services. Adults in the Aged and Blind/Disabled aid categories exhibited a noticeable increase in utilization in the first quarter of 2012. Adults in the Families and Other aid categories exhibited Emergency Medical Transportation services utilization patterns that were below average but within the expected baseline ranges, whereas adults in the Aged and Blind/Disabled aid categories had above average use of these services and experienced rates that were, at times, above the baseline ranges. The Emergency Medical Transportation services utilization patterns for adults in the Undocumented aid category again fell below the anticipated baseline ranges during the entire study period.

The following figures 37–46 represent the control chart analysis for both children and adults from the second quarter of 2011 to the first quarter of 2012.

Trends—Emergency Medical Transportation Services Use by Children, April 2011–March 2012

Figure 36 Monthly Emergency Transportation Use Rates, Children Age 0–20, Blind/Disabled, April 2011–March 2012

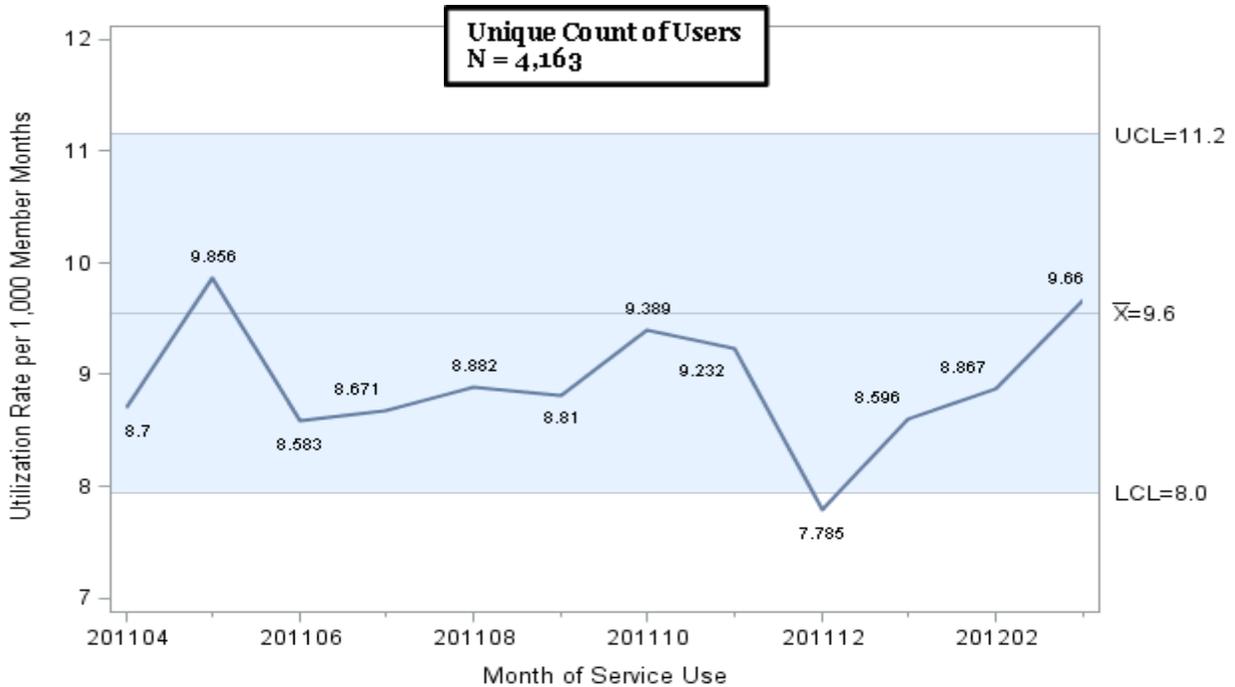


Figure 37 Monthly Emergency Transportation Use Rates, Children Age 0–20, Families, April 2011–March 2012

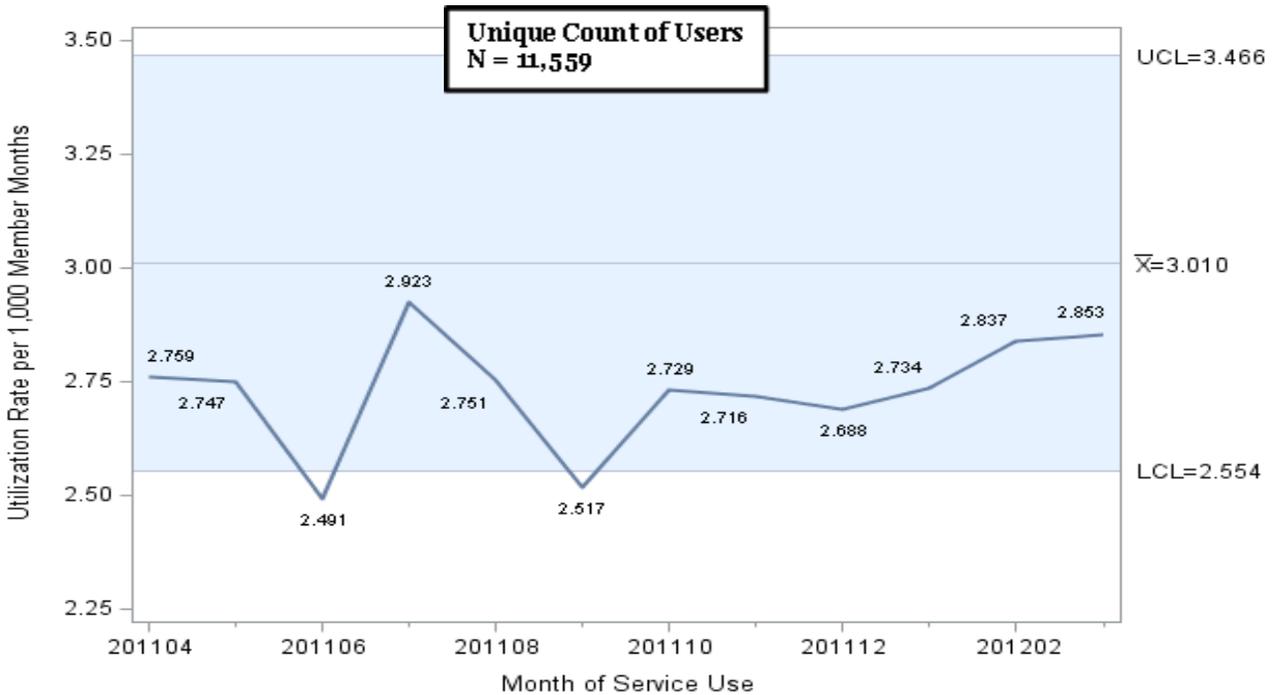


Figure 38 Monthly Emergency Transportation Use Rates, Children Age 0–20, Foster Care, April 2011–March 2012

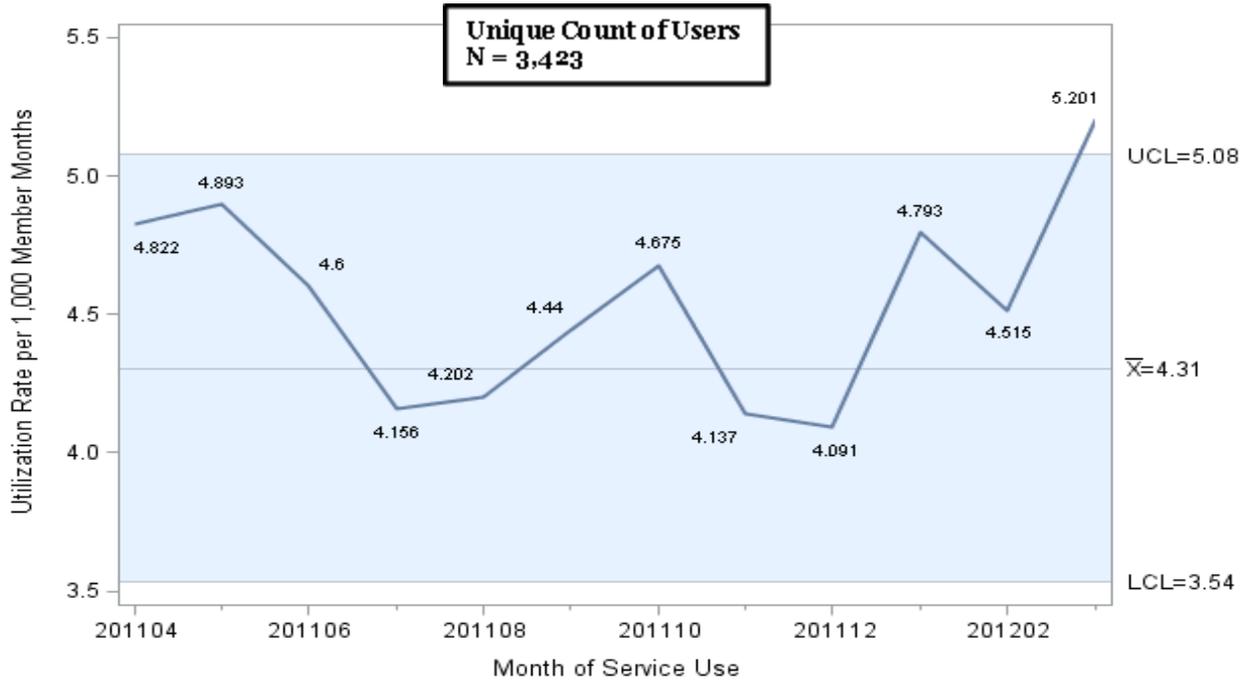


Figure 39 Monthly Emergency Transportation Use Rates, Children Age 0–20, Other, April 2011–March 2012

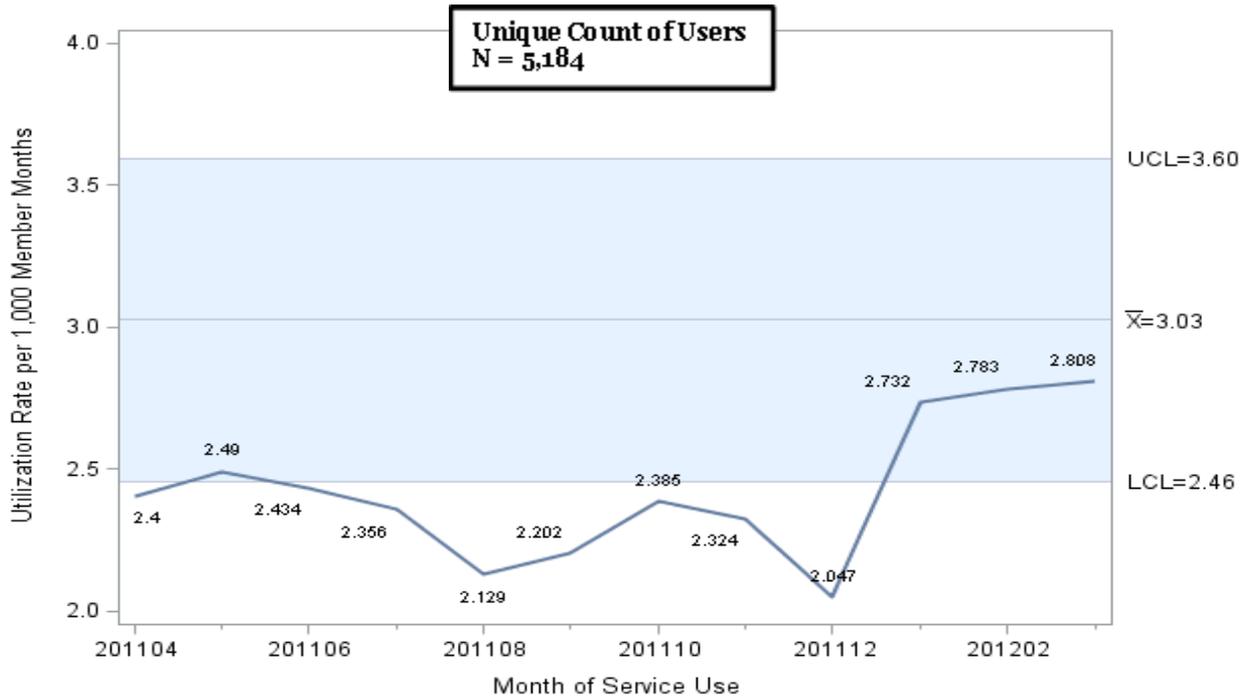
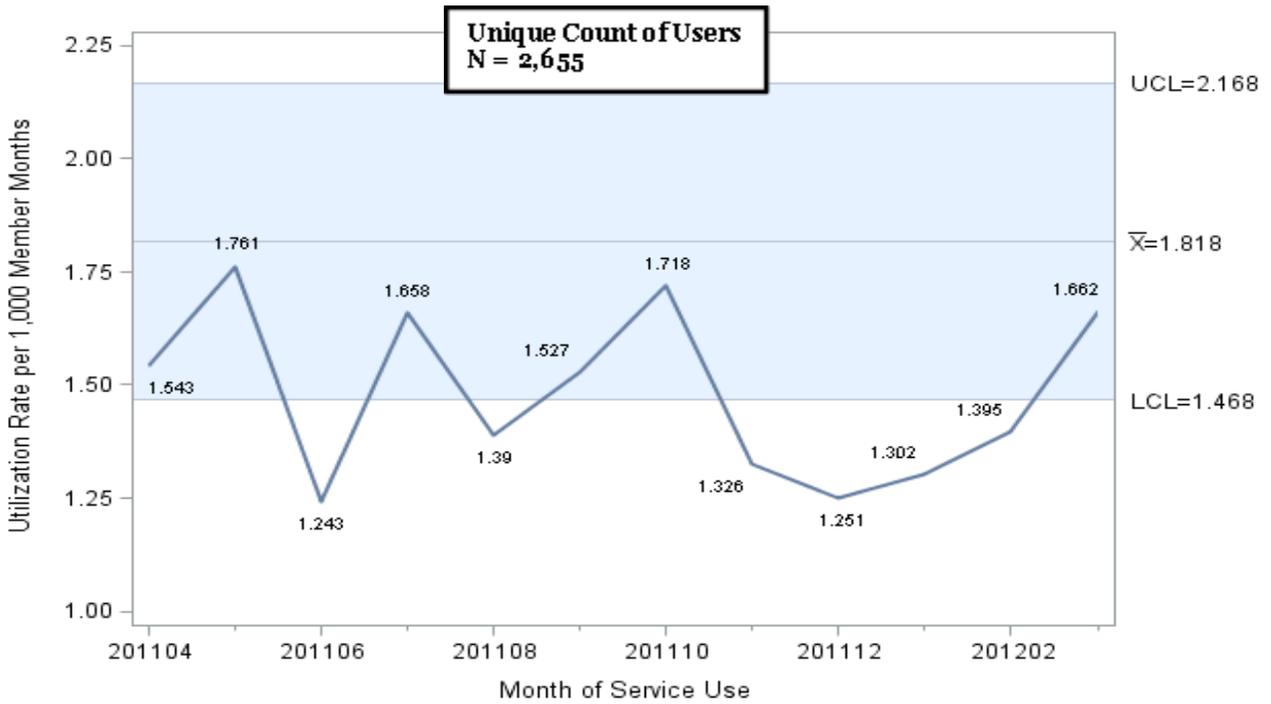


Figure 40 Monthly Emergency Transportation Use Rates, Children Age 0–20, Undocumented, April 2011–March 2012



Source: Data for figures 37–41 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Emergency Medical Transportation Services Use by Adults, April 2011–March 2012

Figure 41 Monthly Emergency Medical Transportation Use Rates, Adults Age 21+, Aged, April 2011–March 2012

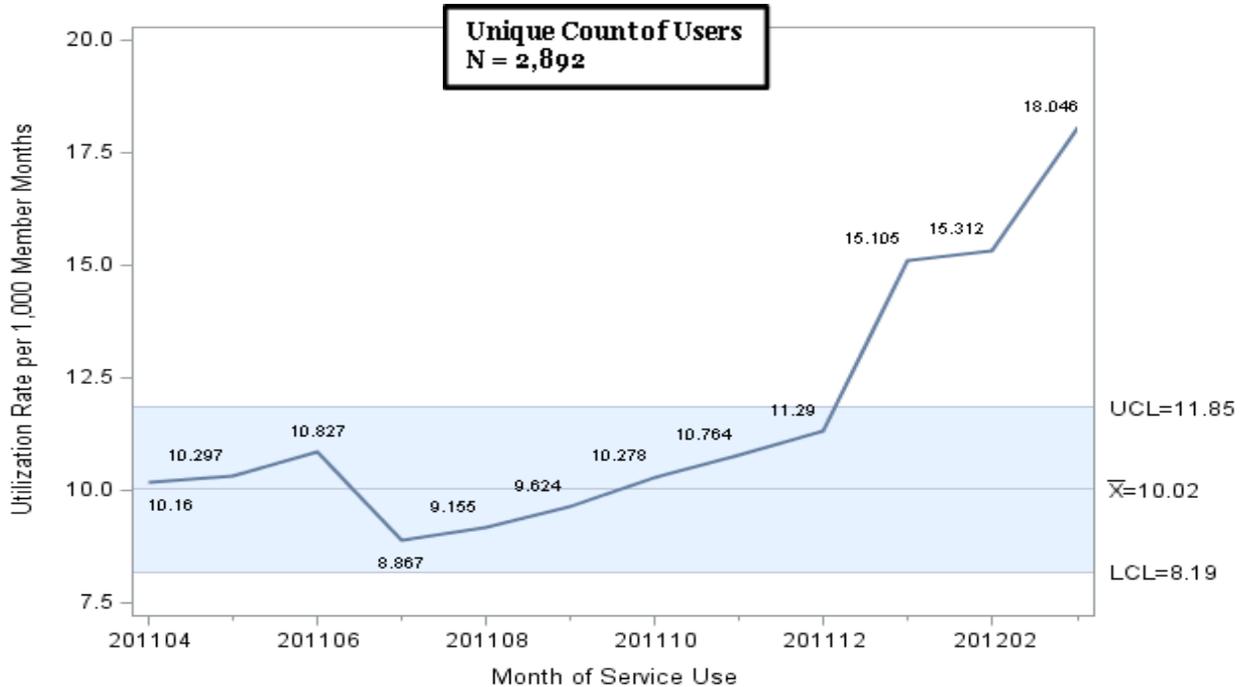


Figure 42 Monthly Emergency Medical Transportation Use Rates, Adults Age 21+, Blind/Disabled, April 2011–March 2012

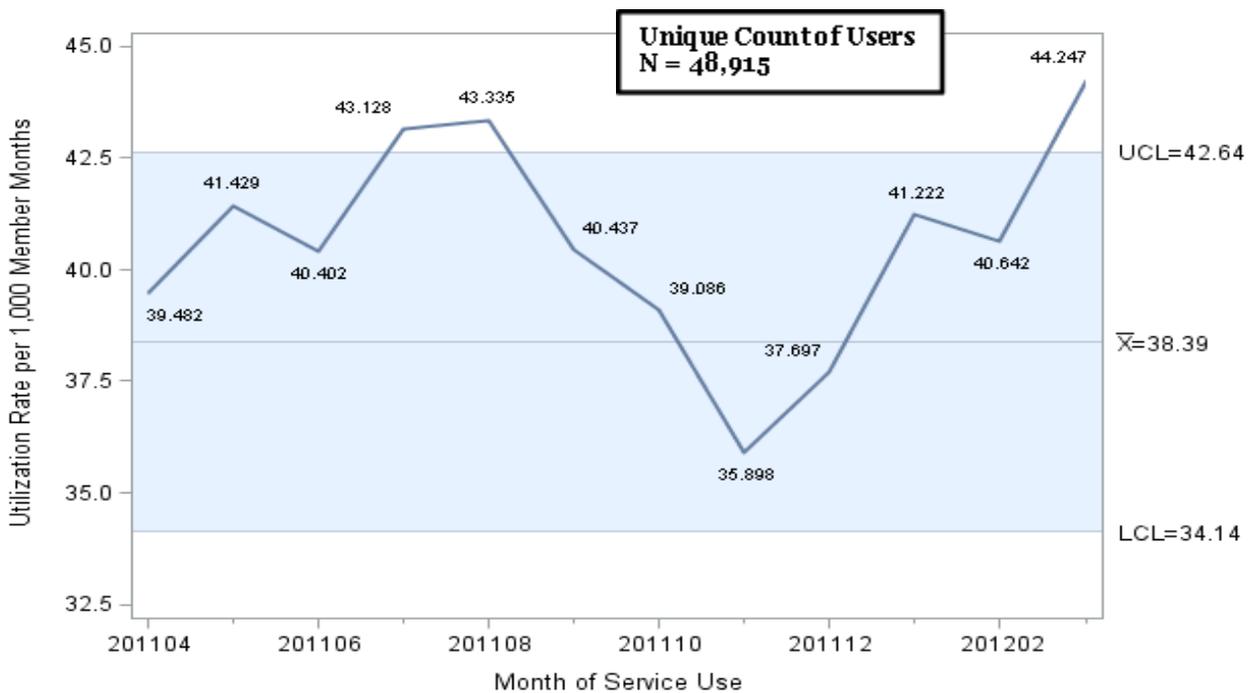


Figure 43 Monthly Emergency Medical Transportation Use Rates, Adults age 21+, Families, April 2011–March 2012

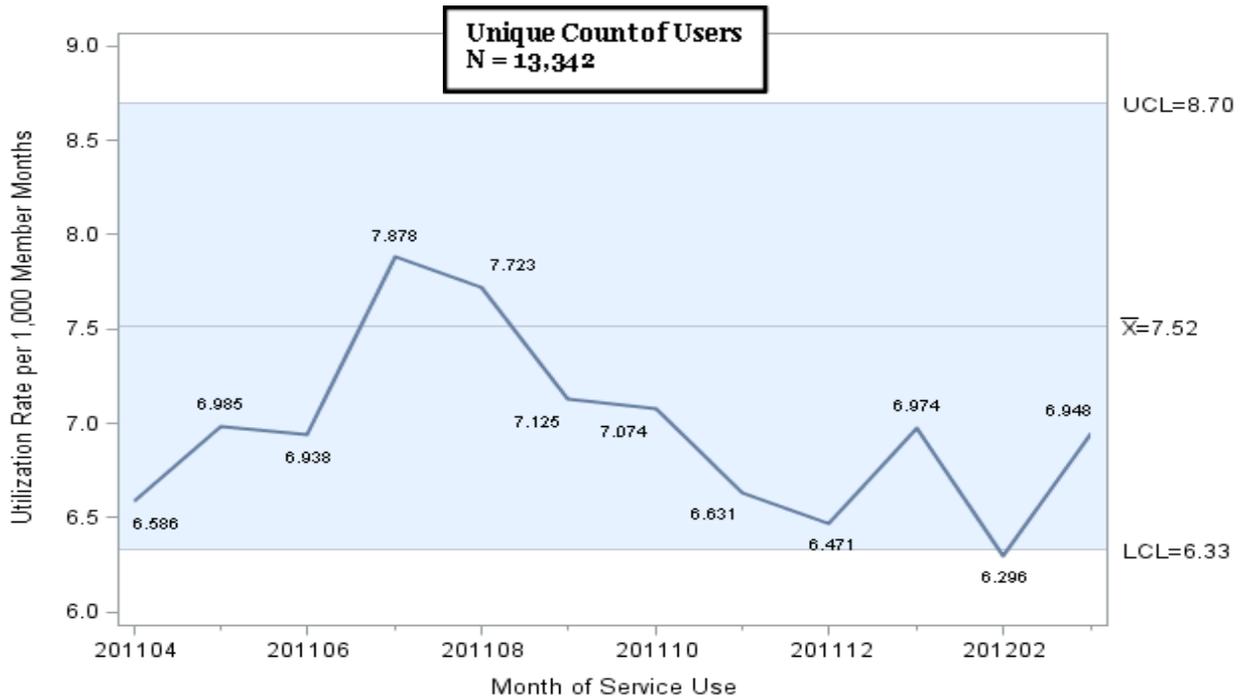


Figure 44 Monthly Emergency Medical Transportation Use Rates, Adults Age 21+, Other, April 2011–March 2012

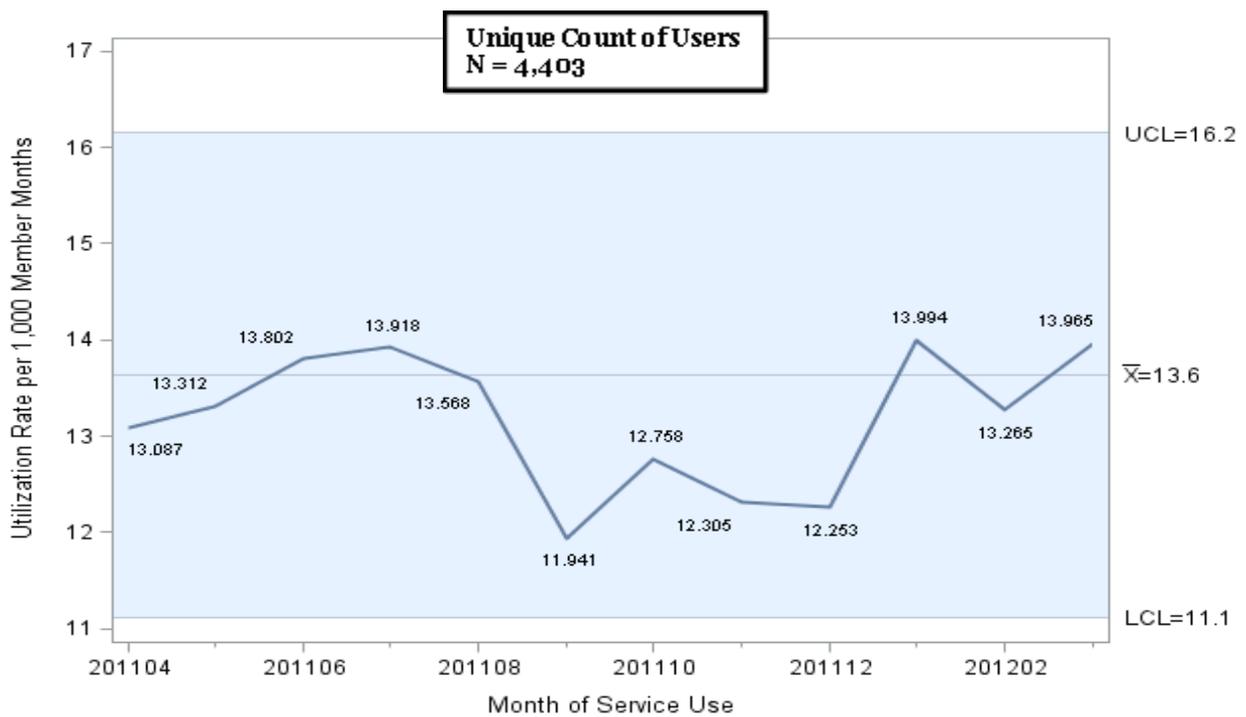
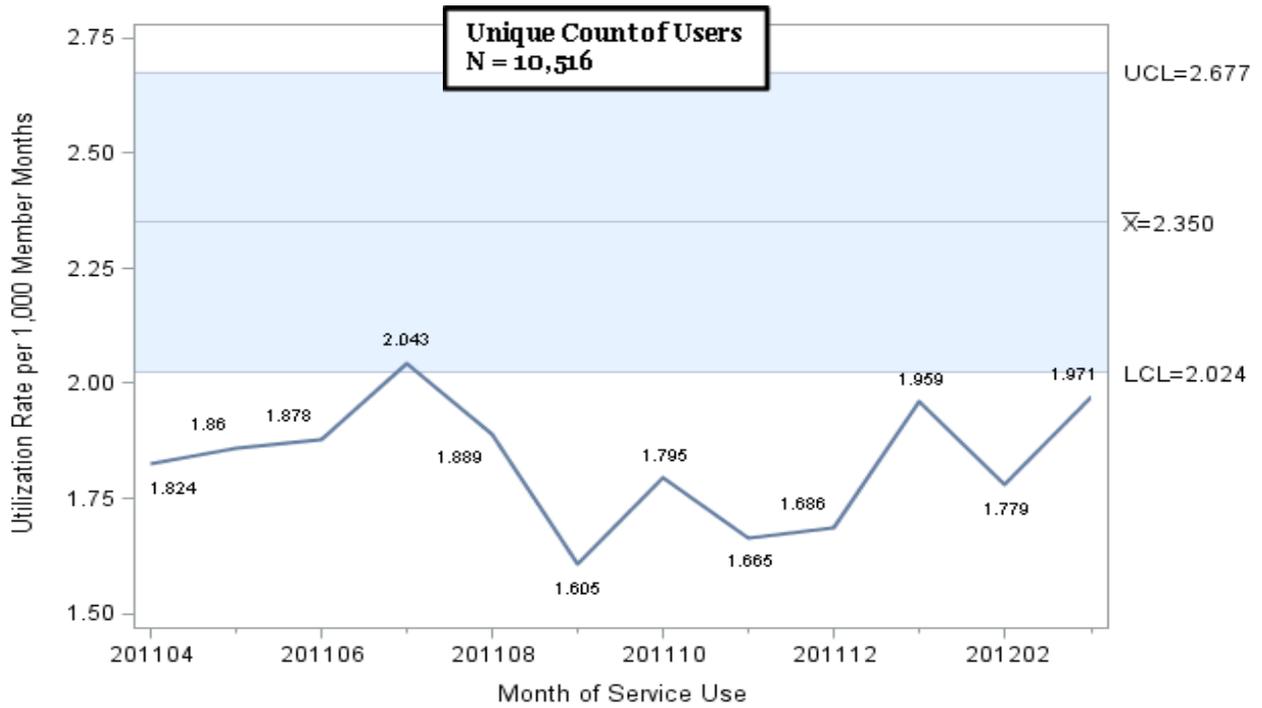


Figure 45 Monthly Emergency Medical Transportation Use Rates, Adults Age 21+, Undocumented, April 2011–March 2012



Source: Data for figures 42–46 prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Home Health Services

Background

Home Health services provide outpatient care to Medi-Cal beneficiaries on an intermittent or part-time basis. Services include:

- Part-time or intermittent skilled nursing by licensed nursing personnel;
- In-home medical care;
- Physical, occupational, or speech therapy;
- Home health aide;
- Provision of medical supplies, excluding drugs and biological;
- Medical social services; and
- Use of medical appliances.

These services must be prescribed by a physician under a written plan renewed every 60 days, and be provided at the recipient's place of residence. Most services require prior authorization, except for services related to case evaluations and early discharge follow-up visits.

Home Health services paid through FFS Medi-Cal comprise any claim paid under provider type "014"—Home Health Agency, which covers a variety of services, including services provided by home health agencies, home- and community-based services, residential care and home health under the assisted living waiver, and pediatric palliative care waiver services.

In any given year there are approximately 26,000 unique users of Home Health agency services paid through FFS Medi-Cal. Most Home Health services users are adults age 21 and older (69%), while the remaining 31% are children. Though children represent a small proportion of home health users, their expenditures are significant, accounting for 73% of total Home Health service costs. Most of these expenditures are attributable to EPSDT private duty nursing that provides care for children with paralysis, nervous system disorders, epilepsy, and other congenital anomalies and hereditary conditions.

Private duty nursing and home- and community-based waiver populations receive long-term Home Health services averaging 9.3 months. Most individuals receiving long-term services have more chronic conditions, are under age 21, and are covered under Disabled aid categories. Intermittent Home Health services users received an average of 1.76 months of visits for such things as rehabilitative care, mother-baby checks, and other aftercare treatment.

Nearly 50% of all Home Health services users are in Disabled aid categories, and approximately 25% are in medically needy Families and Undocumented aid categories and most likely receive services for postpartum follow-up care.

Trend Analysis

The monthly Home Health services utilization rates for children age 0–20 in the Medi-Cal FFS program ranged from .57–124.7 visits per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. Home Health services utilization continued to be higher for

children in the Blind/Disabled aid category with rates ranging from 78.6–124.7 visits per 1,000 member months, whereas children in the Families and Other aid categories rarely utilized these services. The Home Health services utilization rates for children in the Other aid category was noticeably below average at the beginning of second quarter 2011, and increased toward the baseline average in the first quarter of 2012. An upward trend in service use continued for children in the Blind/Disabled aid category; however, utilization rates for children in all analyzed aid categories were, for the most part, within the expected ranges observed in the baseline period of 2007–2009.

Among adults 21 and older, monthly Home Health services utilization rates ranged from .58–13.1 visits per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. Adults exhibited much lower overall Home Health services utilization rates than children. The utilization rates were noticeably higher for adults in the Blind/Disabled aid category. This subpopulation of beneficiaries displayed noticeable upward trends in Home Health services utilization during the study period, but remained within expected ranges established during the baseline period. Home Health services use among adults in the Aged, Families, and Other aid categories fell below average and below expected ranges, at times, but use increased for adults in the Aged aid category and reached service use rates that fell within baseline ranges.

Medi-Cal FFS beneficiaries in the Undocumented aid category were excluded from this analysis because, except for postpartum care, they are not entitled to Home Health services. Additionally, children in the Foster Care aid code category were excluded because of their relatively small user counts (<500).

The following figures 47-53 represent the control chart analysis for both children and adults from the second quarter of 2011 to the first quarter of 2012.

Trends—Home Health Services Use by Children, March 2011–April 2012

Figure 46 Monthly Home Health Services Use Rates, Children Age 0–20, Blind/Disabled, April 2011–March 2012

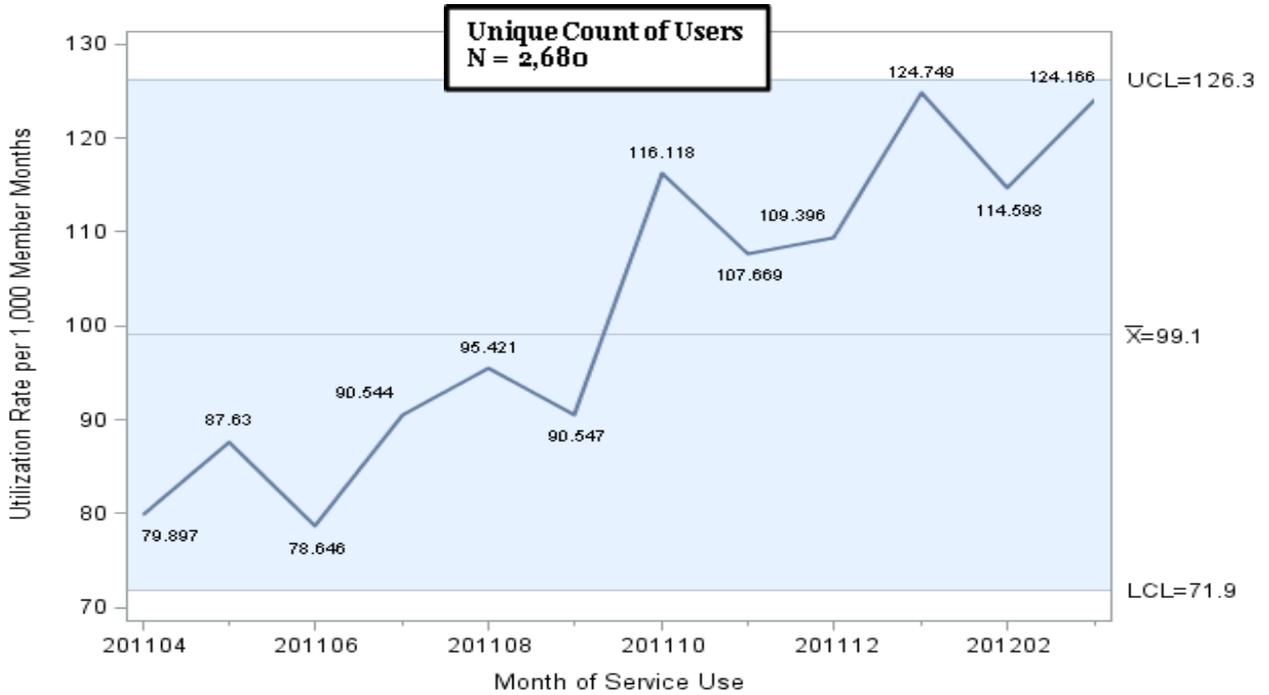


Figure 47 Monthly Home Health Services Use Rates, Children Age 0–20, Families, April 2011–March 2012

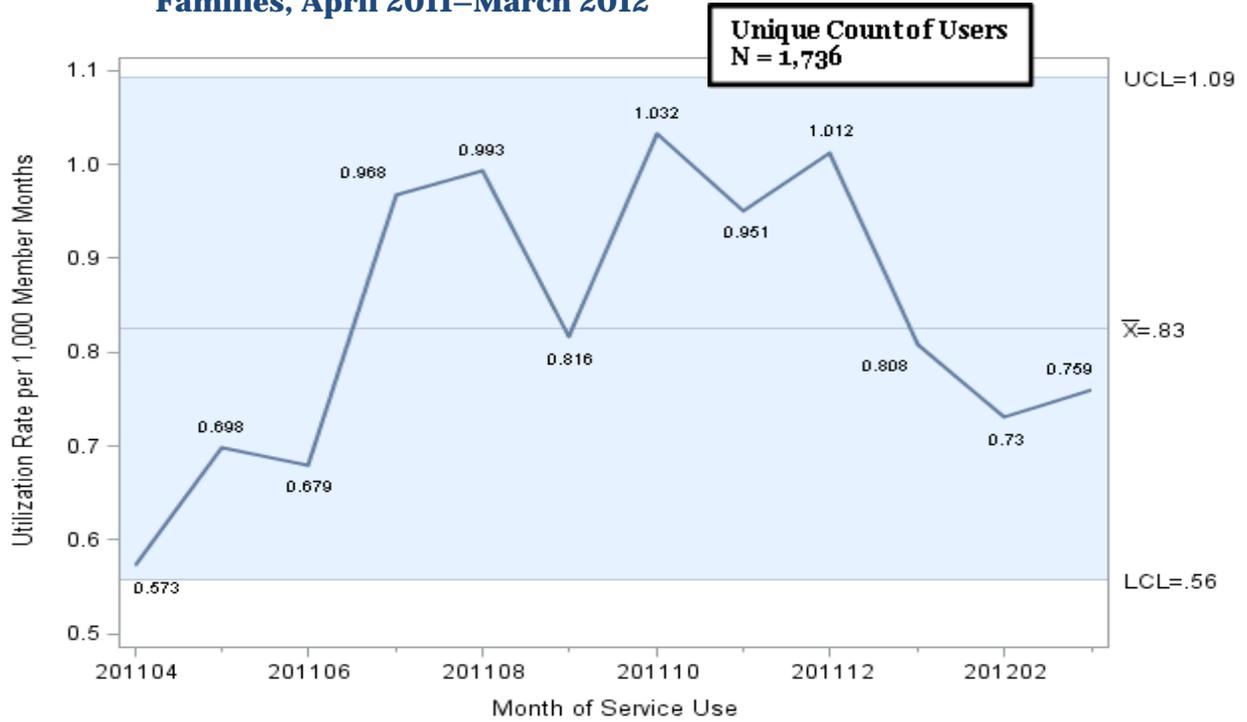
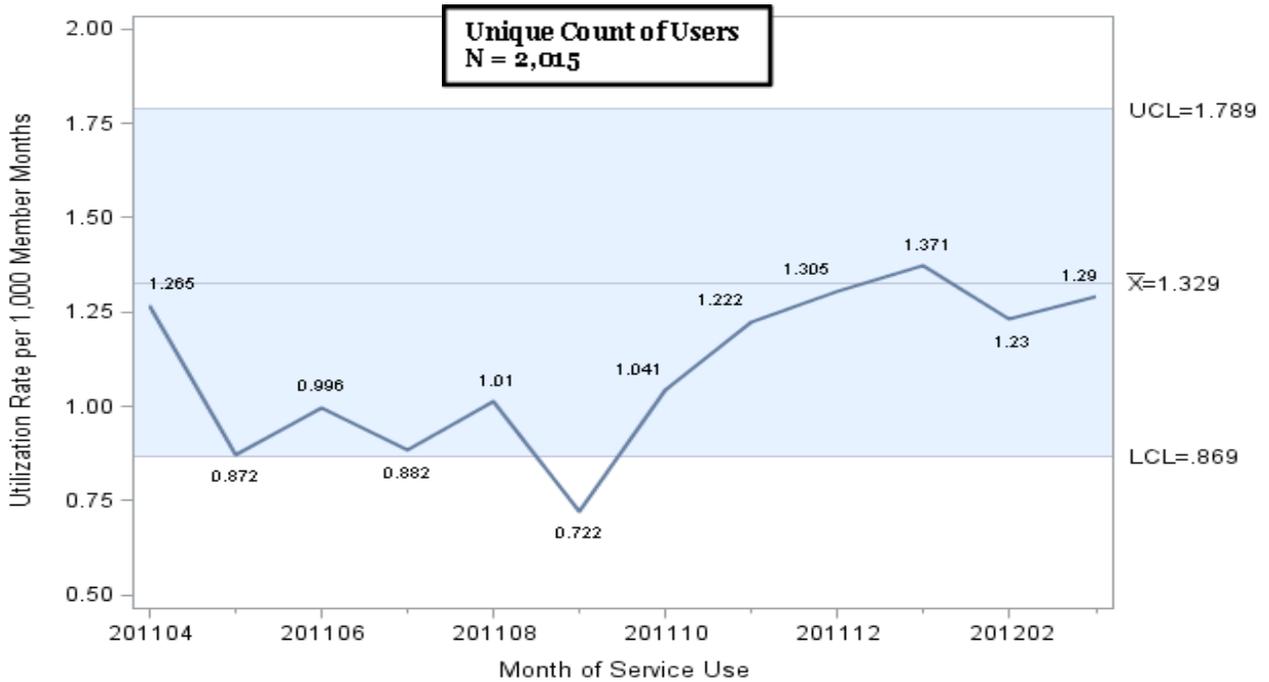


Figure 48 Monthly Home Health Services Use Rates, Children Age 0–20, Other, April 2011–March 2012



Source: Data for figures 47–49 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Home Health Services Use by Adults, April 2011–March 2012

Figure 49 Monthly Home Health Use Rates, Adults Age 21+, Aged, April 2011–March 2012

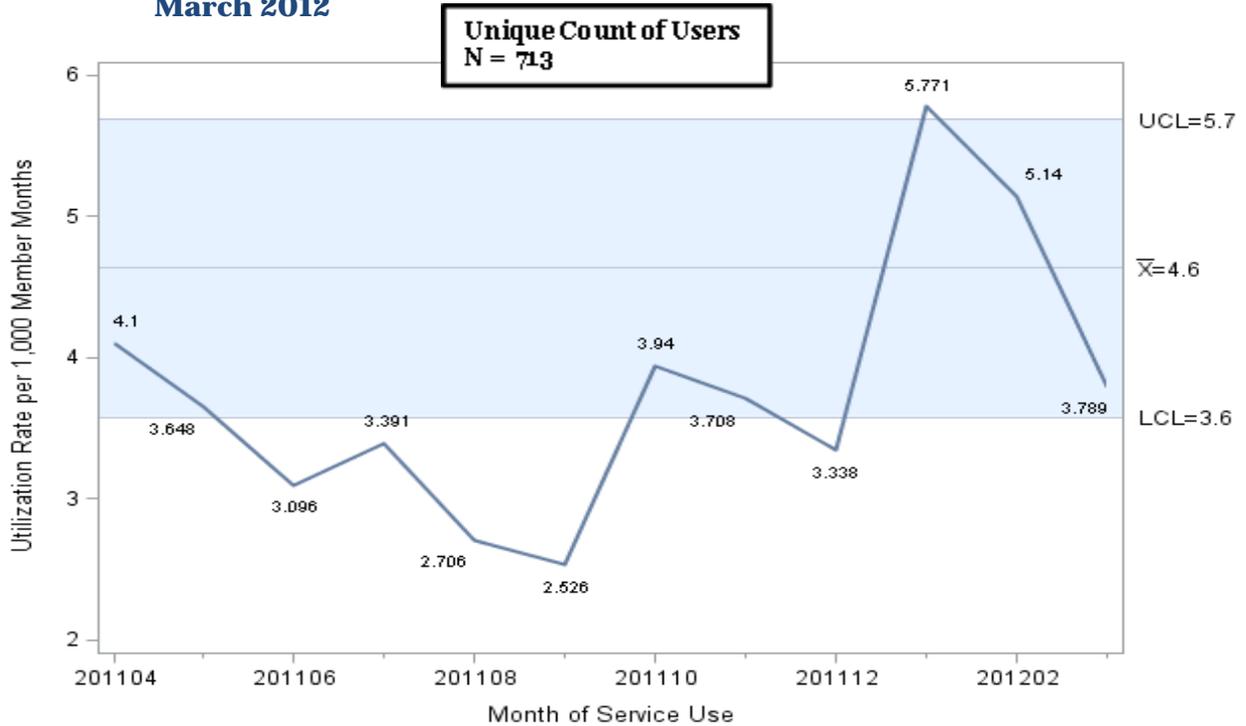


Figure 50 Monthly Home Health Use Rates, Adults Age 21+, Blind/Disabled, April 2011–March 2012

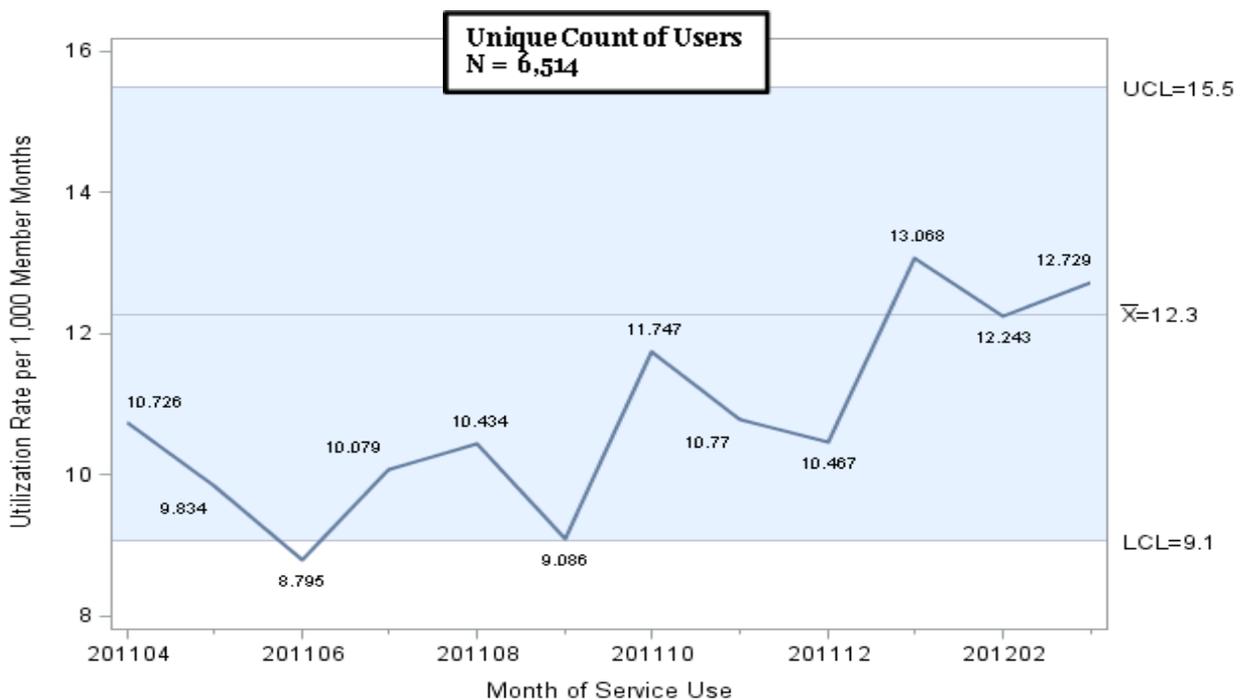


Figure 51 Monthly Home Health Use Rates, Adults Age 21+, Families, April 2011–March 2012

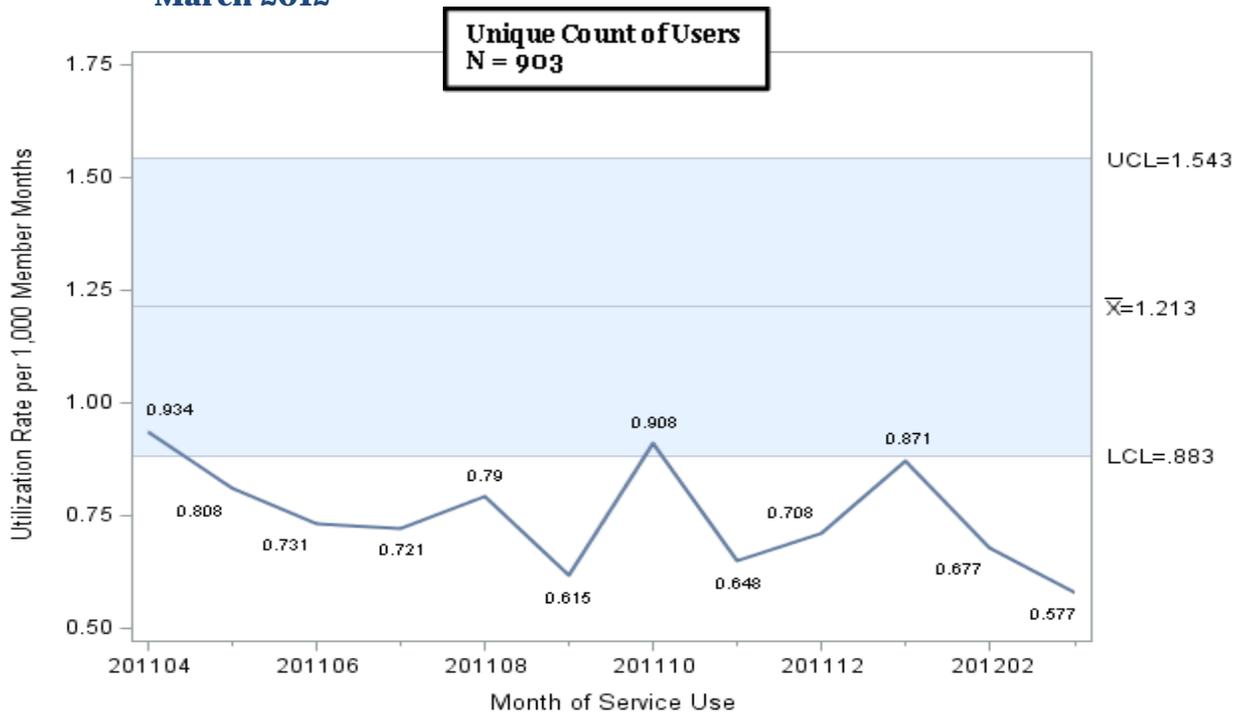
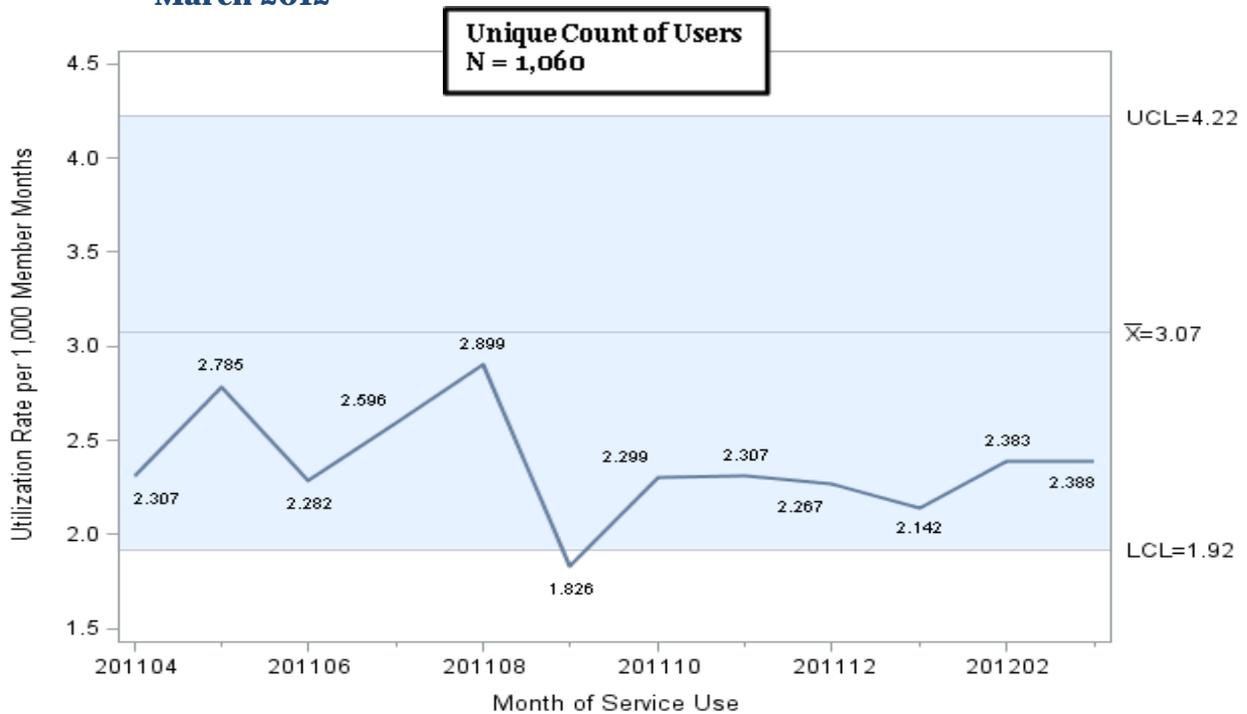


Figure 52 Monthly Home Health Use Rates, Adults Age 21+, Other, April 2011–March 2012



Source: Data for figures 50–53 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Hospital Inpatient Services

Background

Hospital Inpatient services are those services provided by a physician to patients admitted to the hospital at least overnight or who are transferred to another facility in the same day. Hospital Inpatient services do not include skilled nursing and intermediate care services furnished by a hospital with a swing-bed approval.

The general public is ensured access to emergency medical services, regardless of their ability to pay, under the Emergency Medical Treatment and Active Labor Act (EMTALA). Under this act, individuals who present to hospitals having emergency rooms must be appropriately screened and examined to determine whether or not an emergency medical condition exists, and must receive stabilizing treatment when medically needed. Emergency medical conditions include women in active labor. This provision is equally applicable to Medi-Cal beneficiaries seeking emergency and pregnancy-related services, including beneficiaries who are in restricted scope aid categories with limited benefits.

There are over 700,000 hospital admissions in the Medi-Cal FFS program annually, with nearly one third of these admissions originating in a hospital emergency room. The most common reason for Hospital Inpatient admissions among the Medi-Cal FFS population is for child birth and pregnancy-related services.

A large proportion of hospital admissions are to Medi-Cal FFS beneficiaries between age 21–64 (52%), and those in the Undocumented and Families aid categories (33%). An additional 33% of hospital inpatient service users are beneficiaries in Disabled and Aged aid categories. Over 90% of beneficiaries admitted to the hospital during the year have only one hospital inpatient stay, while a small proportion (7%) are admitted three or more times.

Beneficiaries who are hospitalized multiple times during the year are predominantly in the Aged and Disabled aid categories (>70%), and are hospitalized for reasons such as septicemia, pneumonia, congestive heart failure, complications of devices or implants, chronic obstructive pulmonary disease, and diabetes with complications.

Trend Analysis

The monthly Hospital Inpatient services utilization rates for children age 0-20 in the Medi-Cal FFS program ranged from 12.5–128.2 days per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. Hospital Inpatient services utilization continued to be higher among children in the Blind/Disabled aid category with rates 2 to 2.5 times higher than for children in the Families, Other, and Undocumented aid categories, and five to six times higher than for children in the Foster Care aid category. Children in the Blind/Disabled aid category exhibited Hospital Inpatient services utilization rates that were within expected baseline ranges, increasing in the later part of 2011 and into 2012. Children in most other aid categories exhibited below average utilization of Hospital Inpatient services. Though utilization patterns for children in the Blind/Disabled aid category increased in 2012, their use of Hospital Inpatient services mostly fell within the expected ranges observed in the baseline period of 2007–2009. In

contrast, children in the Families and Foster Care aid categories exhibited below average utilization rates for most of the study period, and those within the Undocumented and Other aid categories exhibited service use patterns that were below baseline ranges.

Among adults 21 and older, monthly Hospital Inpatient services utilization rates ranged from 33.7–228.1 days per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. As reported in the previous report, Hospital Inpatient services use was again noticeably higher for adults in the Other and Blind/Disabled aid categories. Though Hospital Inpatient services utilization rates for adults in the Aged and Blind/Disabled aid categories were predominantly below average for most of 2011 and at times reached levels below the established baseline ranges, their use of Hospital Inpatient services sharply increased beginning in 2012 to rates that climbed above baseline thresholds. Adults in the Family, Other, and Undocumented aid categories exhibited Hospital Inpatient utilization rates that were well below average and often below expected ranges. Declines in Hospital Inpatient services use among these subpopulations may be influenced, in part, by the continued decline in the birth rate as seen in preliminary reports of national vital statistics.³⁵

The following figures 54–63 represent the control chart analysis for both children and adults from the second quarter of 2011 to the first quarter of 2012.

³⁵Data from the National Vital Statistics System, found at <http://www.cdc.gov/nchs/data/databriefs/db60.pdf>

Trends—Monthly Hospital Inpatient Services Use, Children, April 2011–March 2012

Figure 53 Monthly Hospital Inpatient Use Rates, Children Age 0–20, Blind/Disabled, April 2011–March 2012

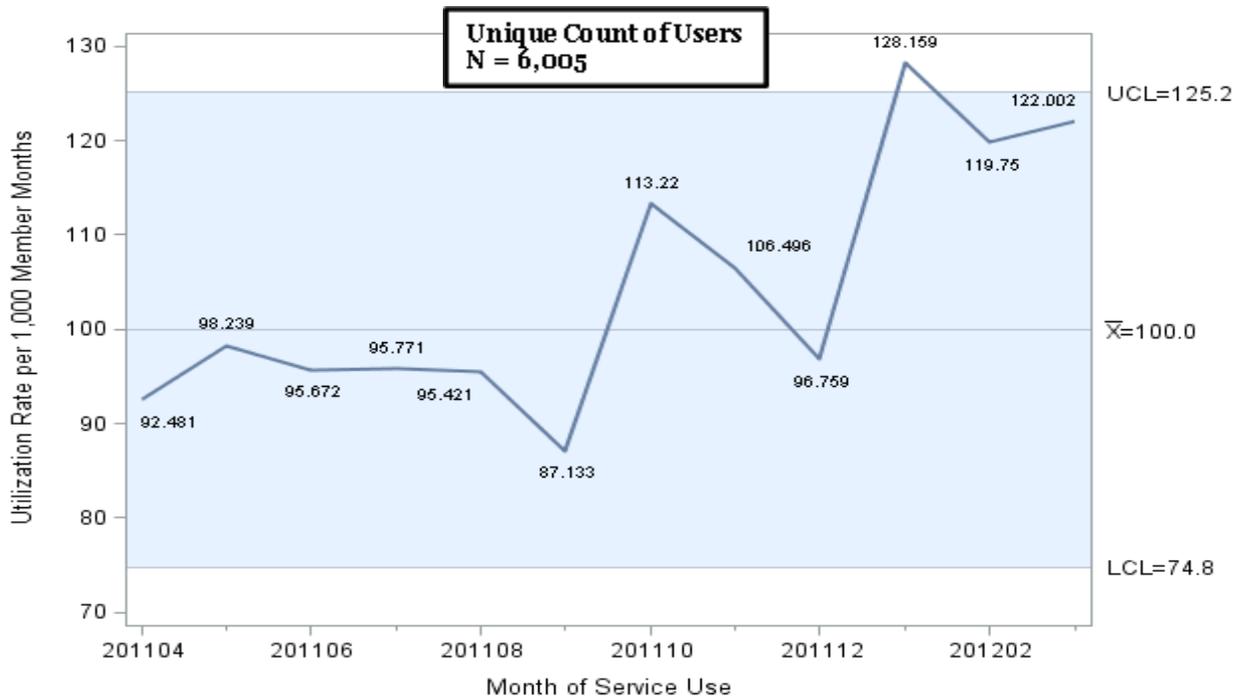


Figure 54 Monthly Hospital Inpatient Use Rates, Children Age 0–20, Families, April 2011–March 2012

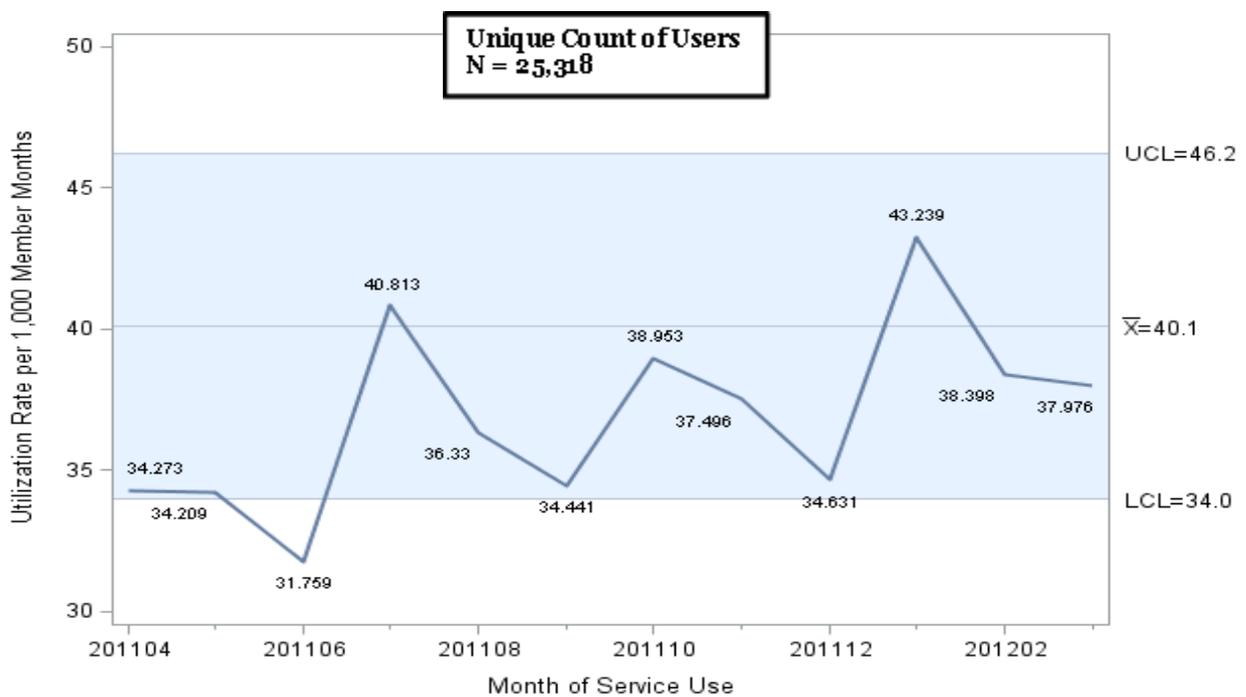


Figure 55 Monthly Hospital Inpatient Use Rates, Children Age 0–20, Foster Care, April 2011–March 2012

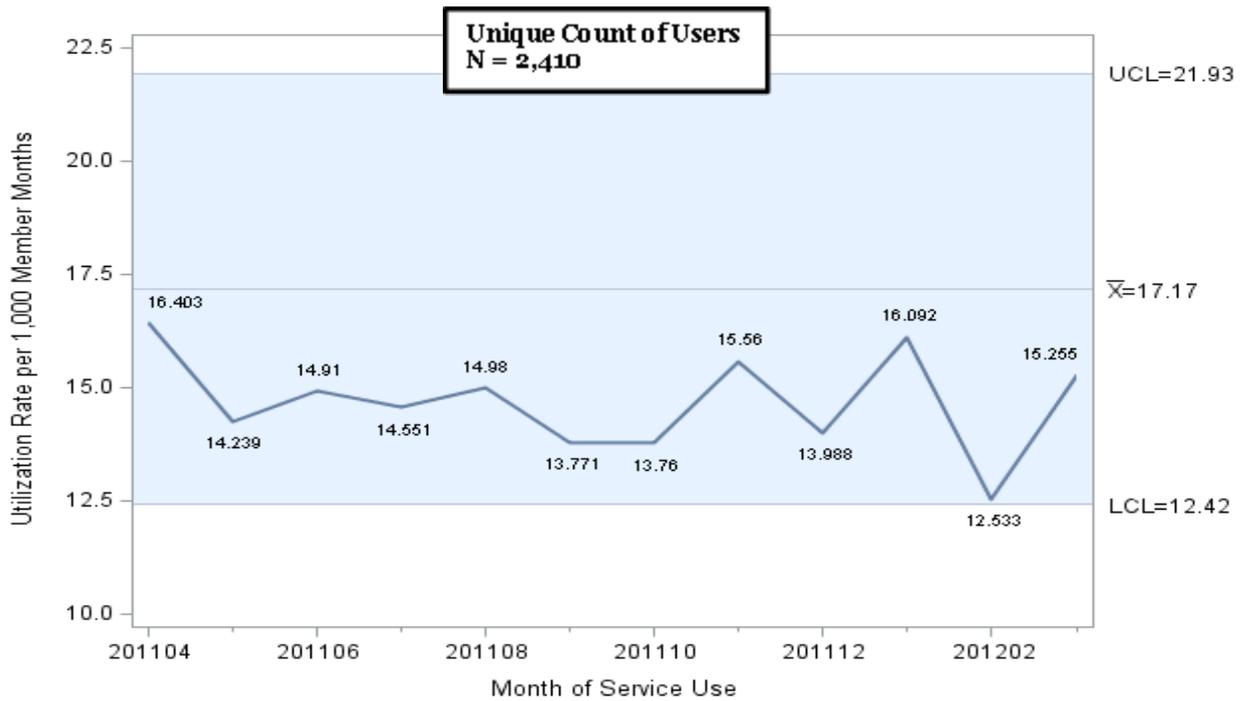


Figure 56 Monthly Hospital Inpatient Use Rates, Children Age 0–20, Other, April 2011–March 2012

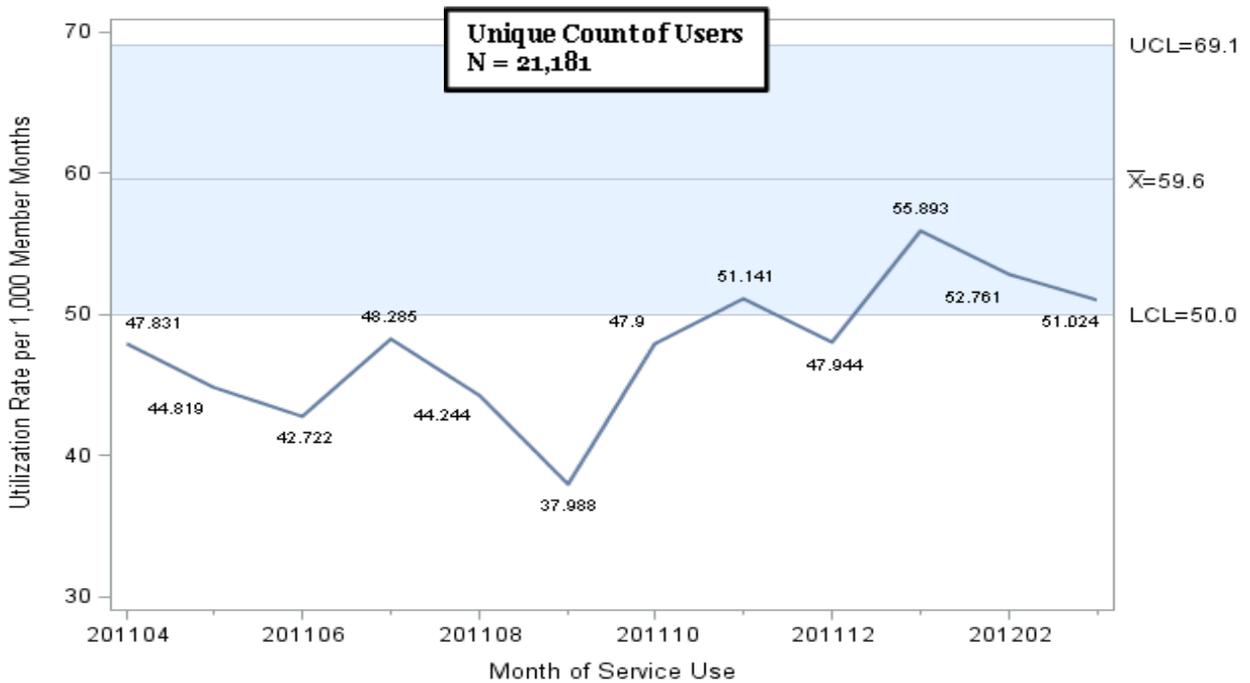
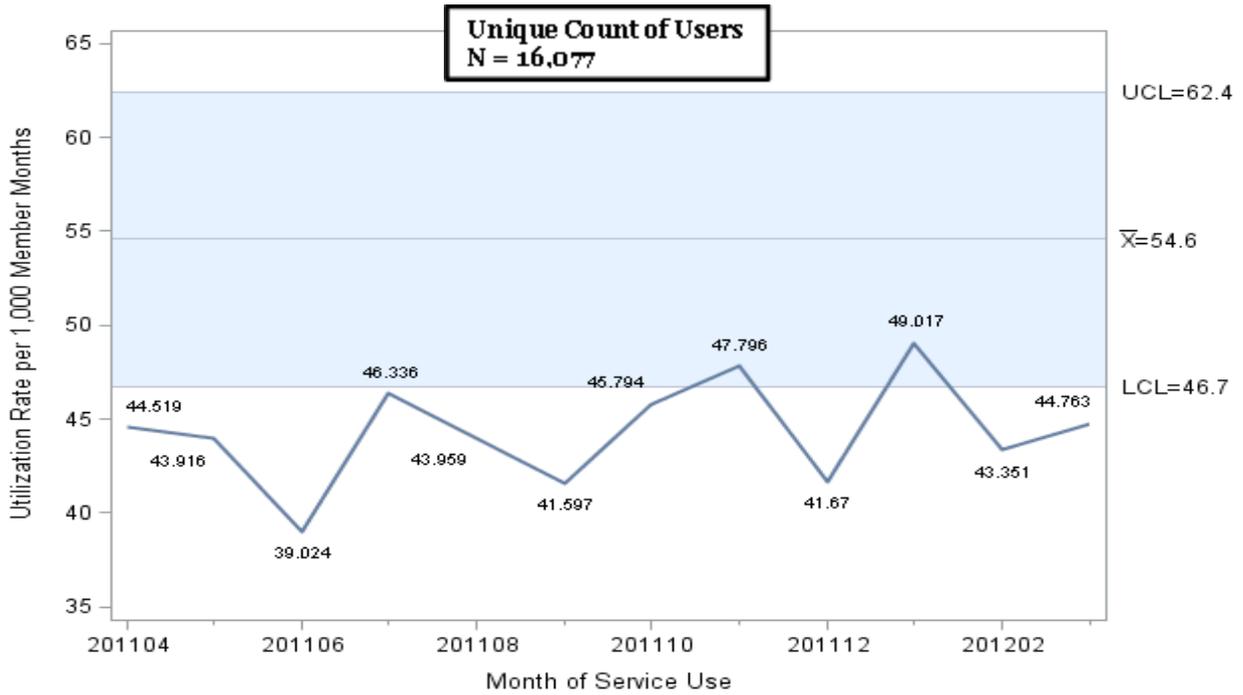


Figure 57 Monthly Hospital Inpatient Use Rates, Children Age 0–20, Undocumented, April 2011–March 2012



Source: Data for figures 54–58 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Hospital Inpatient Services Use by Adults, April 2011–March 2012

Figure 58 Monthly Hospital Inpatient Use Rates, Adults Age 21+, Aged, April 2011–March 2012

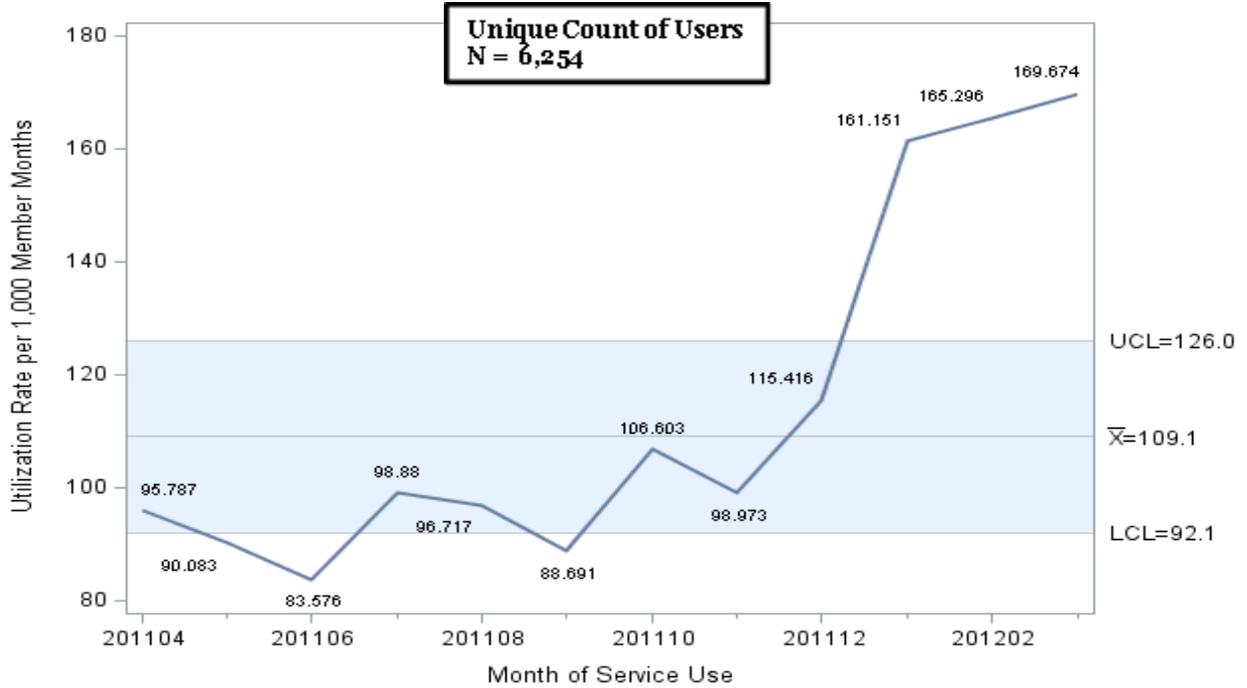


Figure 59 Monthly Hospital Inpatient Use Rates, Adults Age 21+, Blind/Disabled, April 2011–March 2012

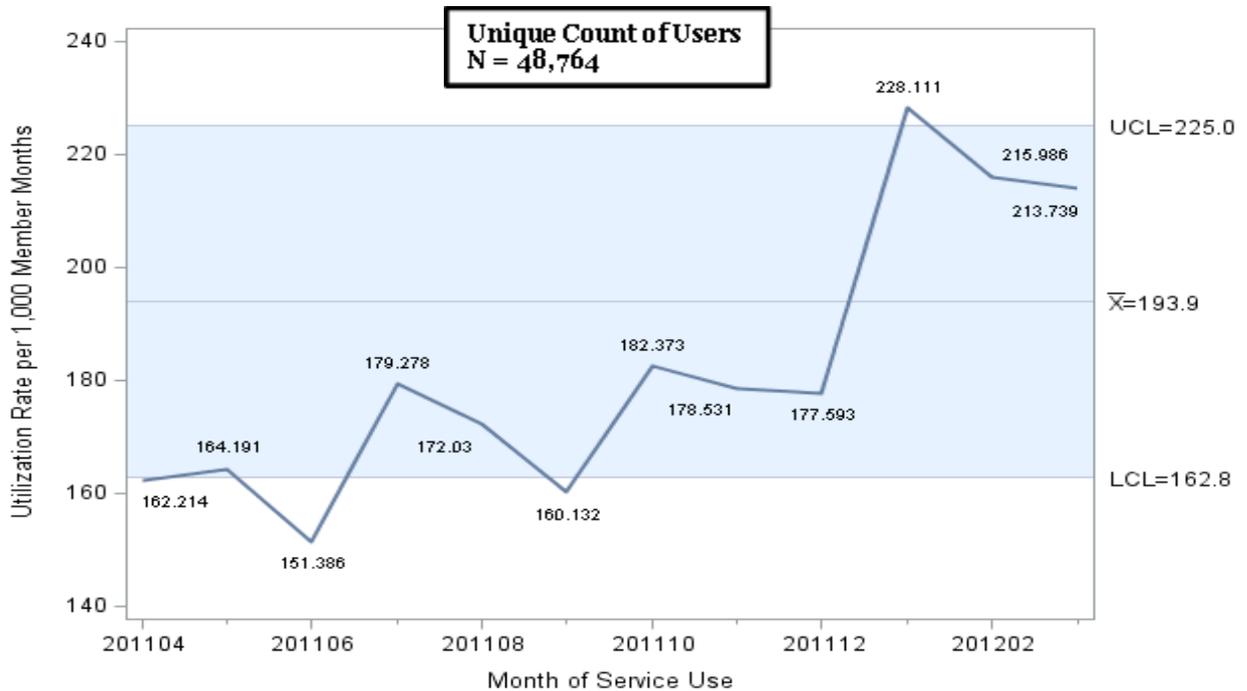


Figure 60 Monthly Hospital Inpatient Use Rates, Adults Age 21+, Families, April 2011–March 2012

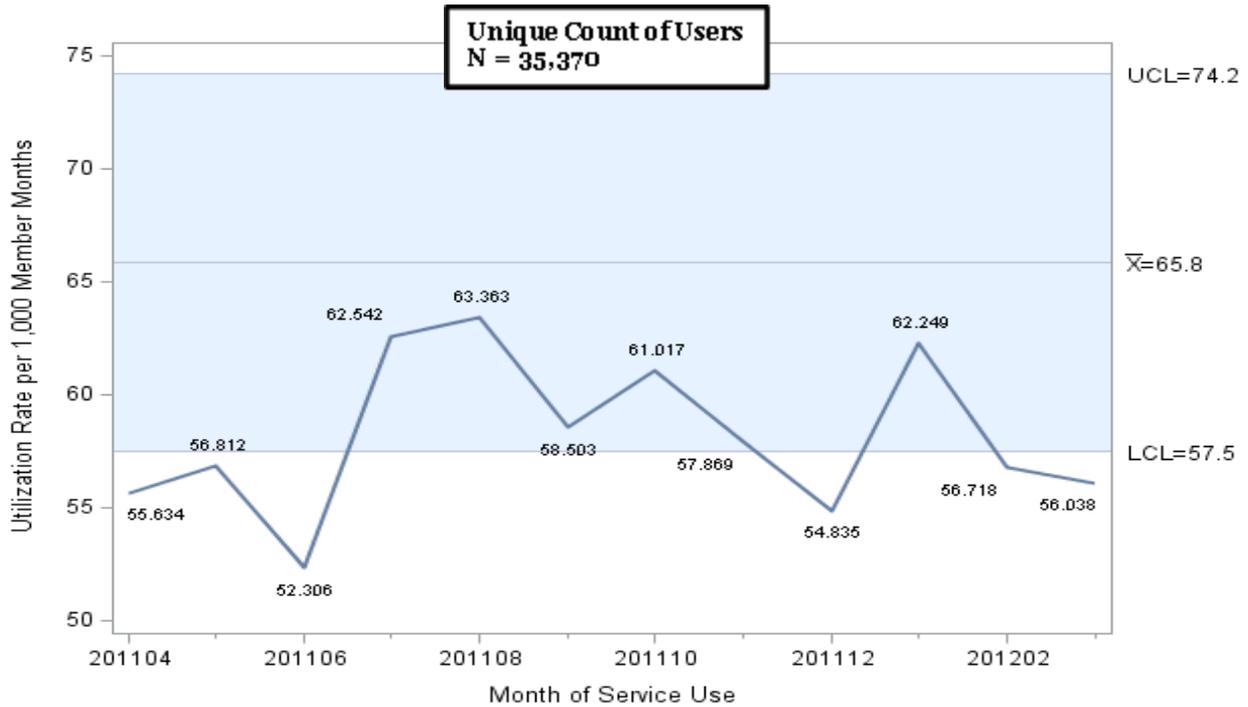


Figure 61 Monthly Hospital Inpatient Use Rates, Adults Age 21+, Other, April 2011–March 2012

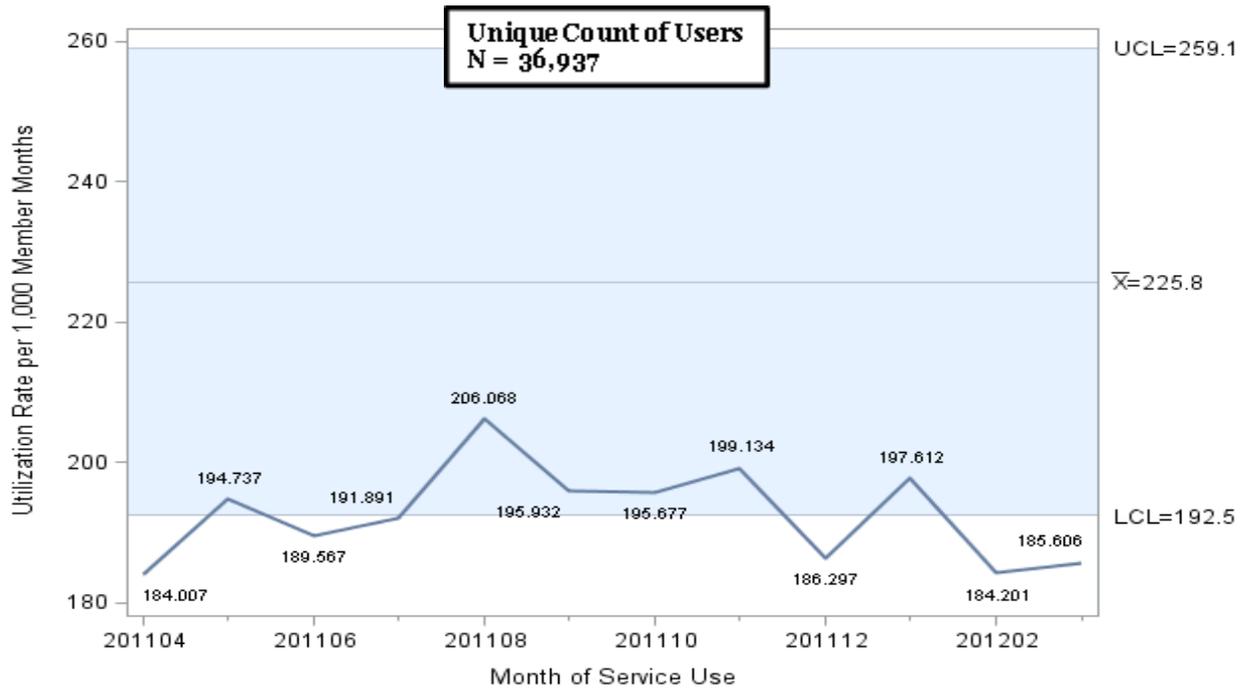
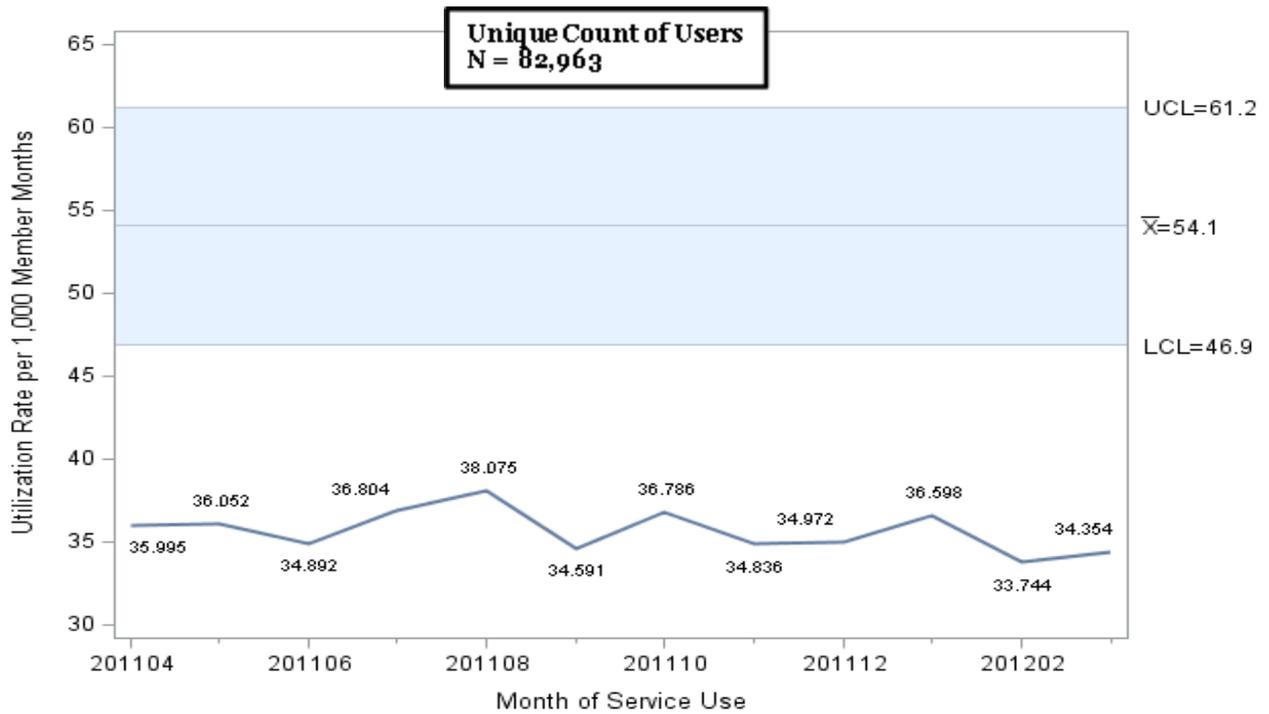


Figure 62 Monthly Hospital Inpatient Use Rates, Adults Age 21+, Undocumented, April 2011–March 2012



Source: Data for figures 59–63 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Hospital Outpatient Services

Background

Hospital Outpatient services are diagnostic, preventative, or therapeutic services furnished on an outpatient basis on the premises of a hospital. These services are rendered on the expectation that a patient will not require services beyond a 24-hour period. Hospital Outpatient services may include visits to an emergency room, as well as scheduled procedures that do not require overnight hospitalization.

The general public is ensured access to emergency medical services under EMTALA, regardless of their ability to pay. Under this act, individuals who present to hospitals having emergency rooms must be appropriately screened and examined to determine whether or not an emergency medical condition exists, and must receive stabilizing treatment when medically needed. Emergency medical conditions include women in active labor. This provision is equally applicable to Medi-Cal beneficiaries seeking emergency and pregnancy-related services, including beneficiaries who are in restricted scope aid categories with limited benefits.

There are over 1,600,000 beneficiaries in the Medi-Cal program that use Hospital Outpatient services at any given time during the year, only 16% of whom utilize emergency services. A large proportion of beneficiaries who use Hospital Outpatient services use these services only once during the year (44%), while more than half are repeat users of these services (56%).

Nearly 40% of non-emergency Hospital Outpatient service users are age 20 and younger, another 40% are age 21–64, and an additional 20% are elderly beneficiaries age 65 and over. Many users of non-emergency hospital services are enrolled in Families and Undocumented (40%), or in Aged and Disabled aid categories (34%). Beneficiaries who use emergency Hospital Outpatient services are predominantly adults between age 21–64 (60%), and in Undocumented aid categories (45%).

Trend Analysis

Among children age 0–20 in the Medi-Cal FFS program, monthly Hospital Outpatient services utilization rates ranged from 57.4–218.7 visits per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. Hospital Outpatient services use continued to be higher among children in the Blind/Disabled aid category with rates ranging from two to three times higher than for children in any other aid category. Children in the Foster Care aid category exhibited patterns of Hospital Outpatient services use that remained within the expected ranges for the entire study period. In contrast, children in the Families, Other, and Undocumented aid categories exhibited below average utilization during most of the study period, with utilization rates for those in the Other aid category reaching levels below the expected range. Children in the Blind/Disabled aid category exhibited an increase in Hospital Outpatient service use beginning in August 2011, reaching levels above the baseline.

The monthly Hospital Outpatient services utilization rates for adults age 21 and older ranged from 50.1–308.7 visits per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. As noted in the previous report, Hospital Outpatient services utilization rates

were noticeably higher for adults in the Blind/Disabled and Other aid categories. Adults in the Aged and Blind/Disabled aid categories exhibited above average utilization of Hospital Outpatient services, with sharp increases noted beginning in 2012. Adults in the Families, Other, and Undocumented aid categories exhibited below average use of services, but utilization rates remained mostly within expected ranges for all three of these subpopulations.

The following figures 64–73 represent the control chart analysis for both children and adults from the second quarter of 2011 to the first quarter of 2012.

Trends—Hospital Outpatient Services Use by Children, April 2011–March 2012

Figure 63 Monthly Hospital Outpatient Use Rates, Children Age 0-20, Blind/Disabled, April 2011–March 2012

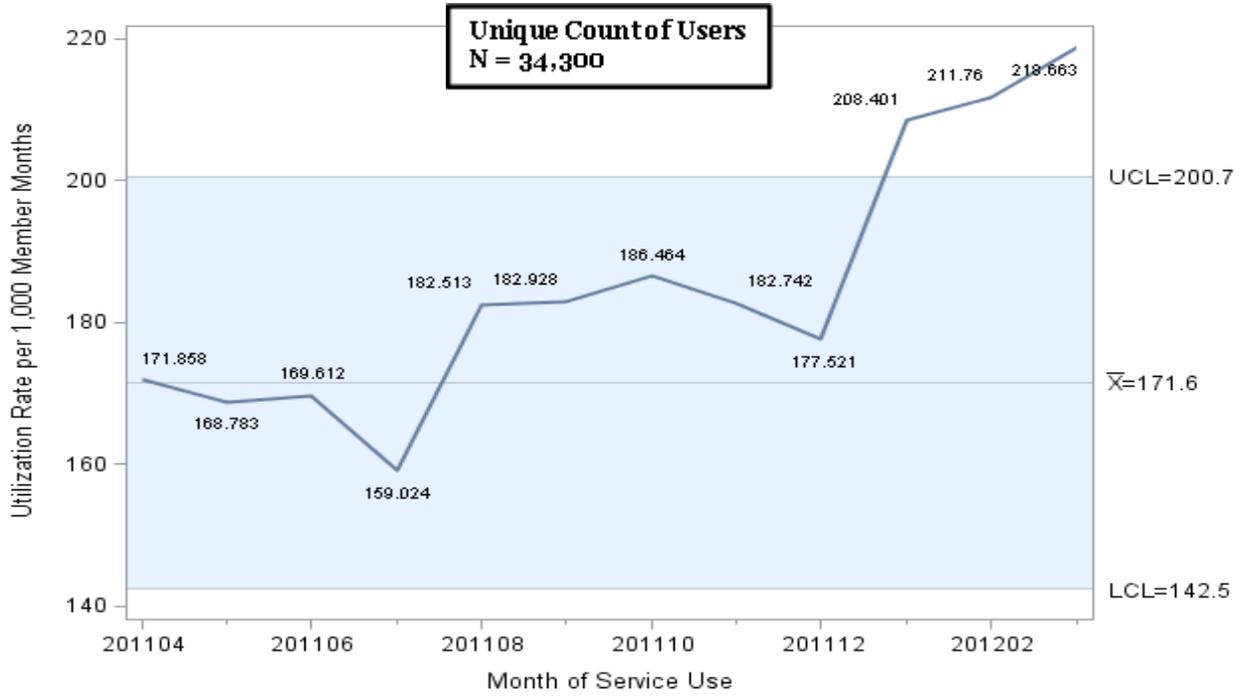


Figure 64 Monthly Hospital Outpatient Use Rates, Children Age 0-20, Families, April 2011–March 2012

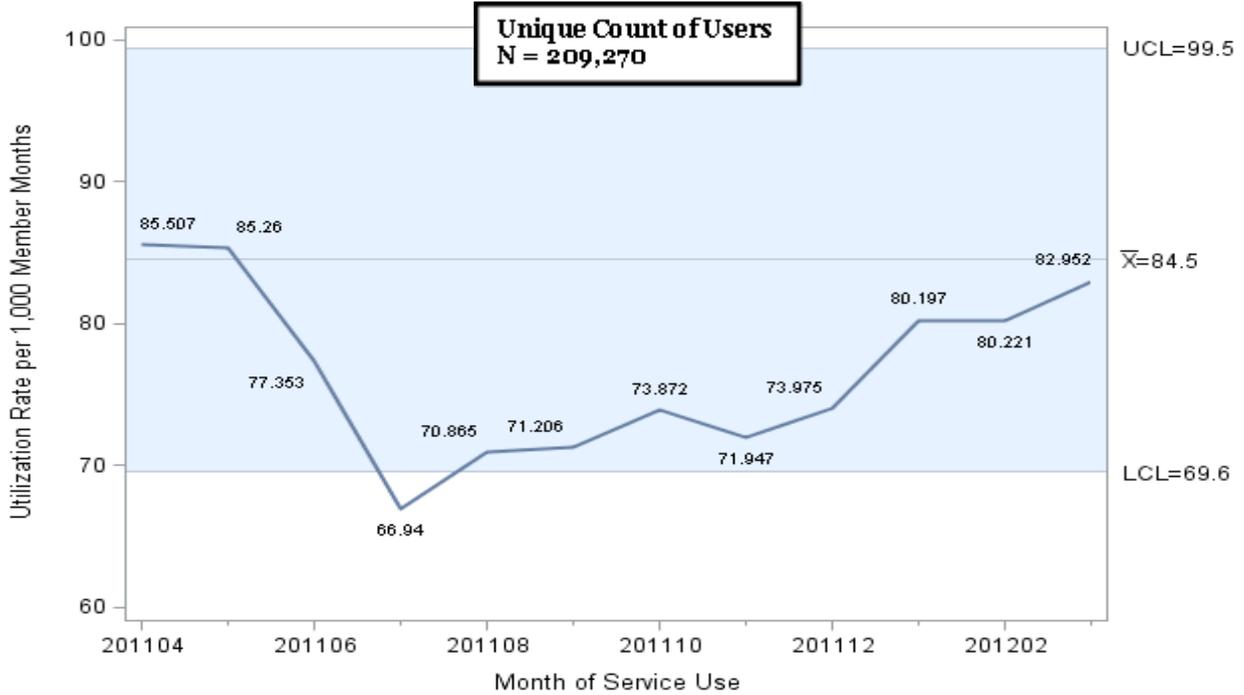


Figure 65 Monthly Hospital Outpatient Use Rates, Children Age 0-20, Foster Care, April 2011–March 2012

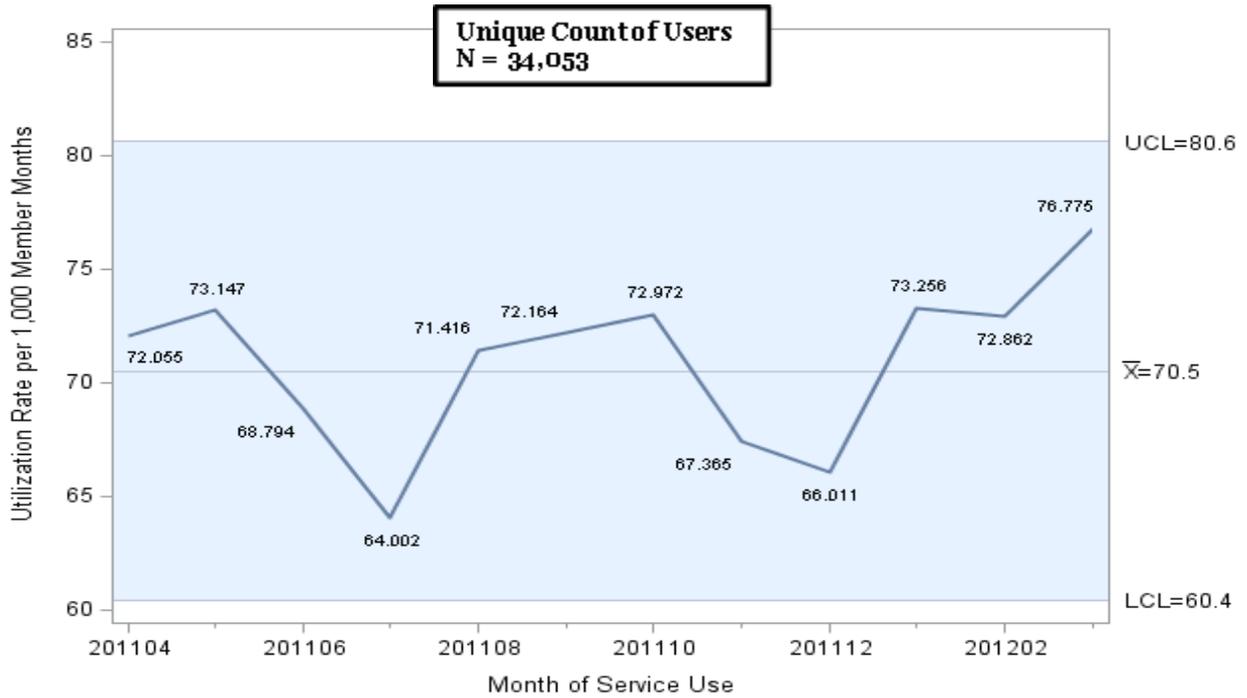


Figure 66 Monthly Hospital Outpatient Use Rates, Children Age 0-20, Other, April 2011–March 2012

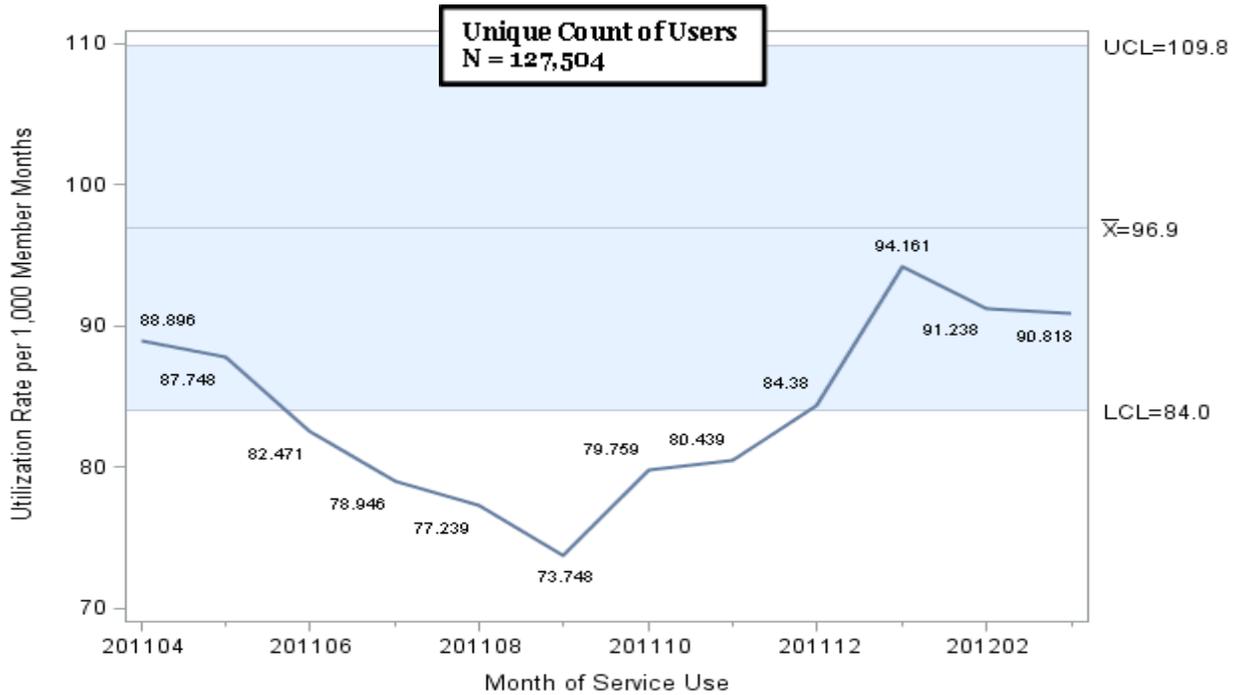
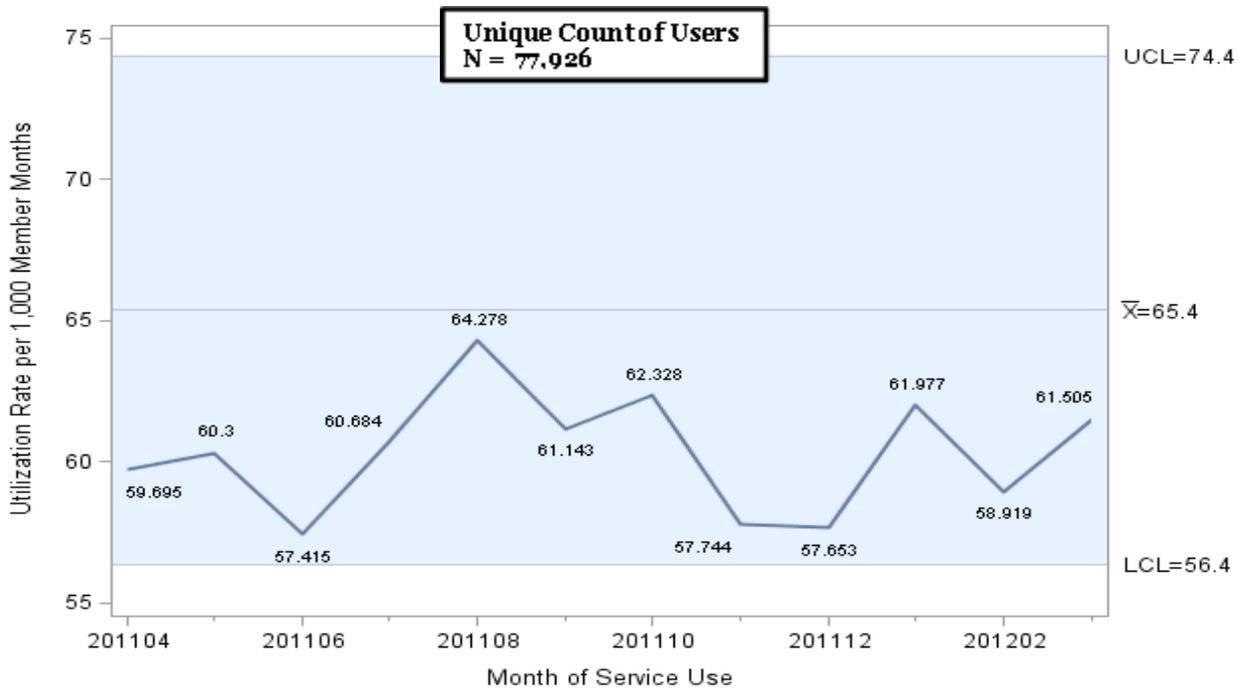


Figure 67 Monthly Hospital Outpatient Use Rates, Children Age 0-20, Undocumented, April 2011–March 2012



Source: Data for figures 64–68 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Hospital Outpatient Services Use by Adults, April 2011–March 2012

Figure 68 Monthly Hospital Outpatient Use Rates, Adults, Age 21+, Aged, April 2011–March 2012

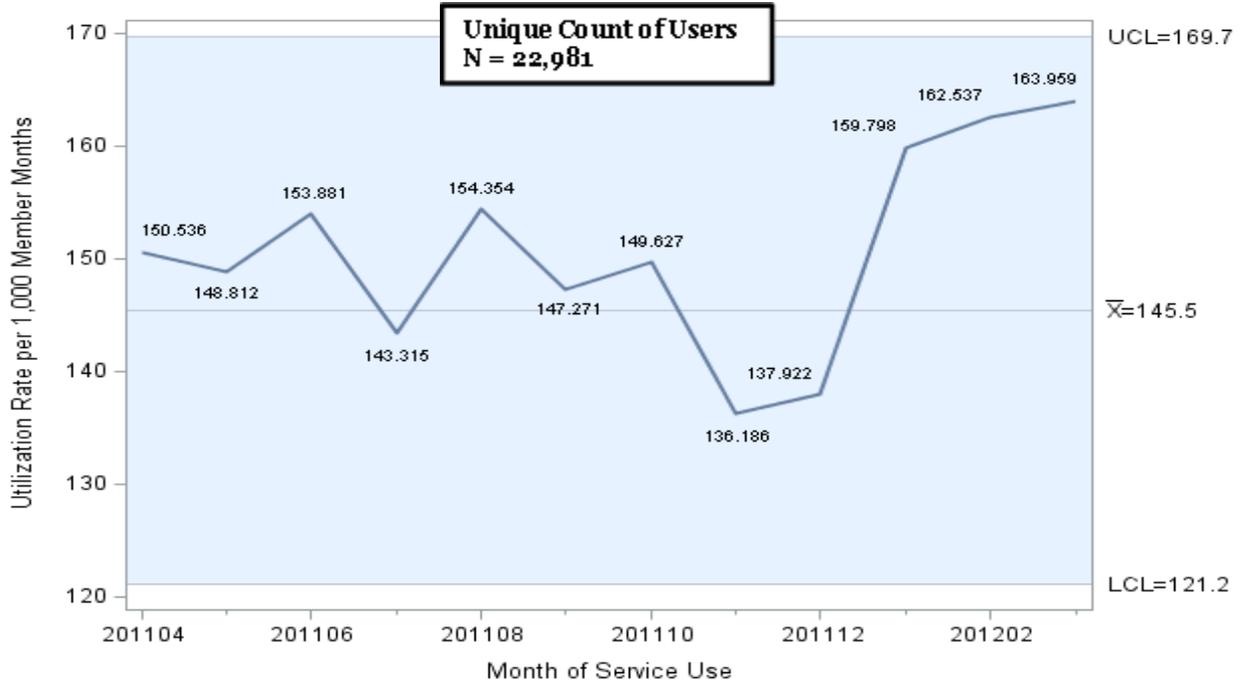


Figure 69 Monthly Hospital Outpatient Use Rates, Adults, Age 21+, Blind/Disabled, April 2011–March 2012

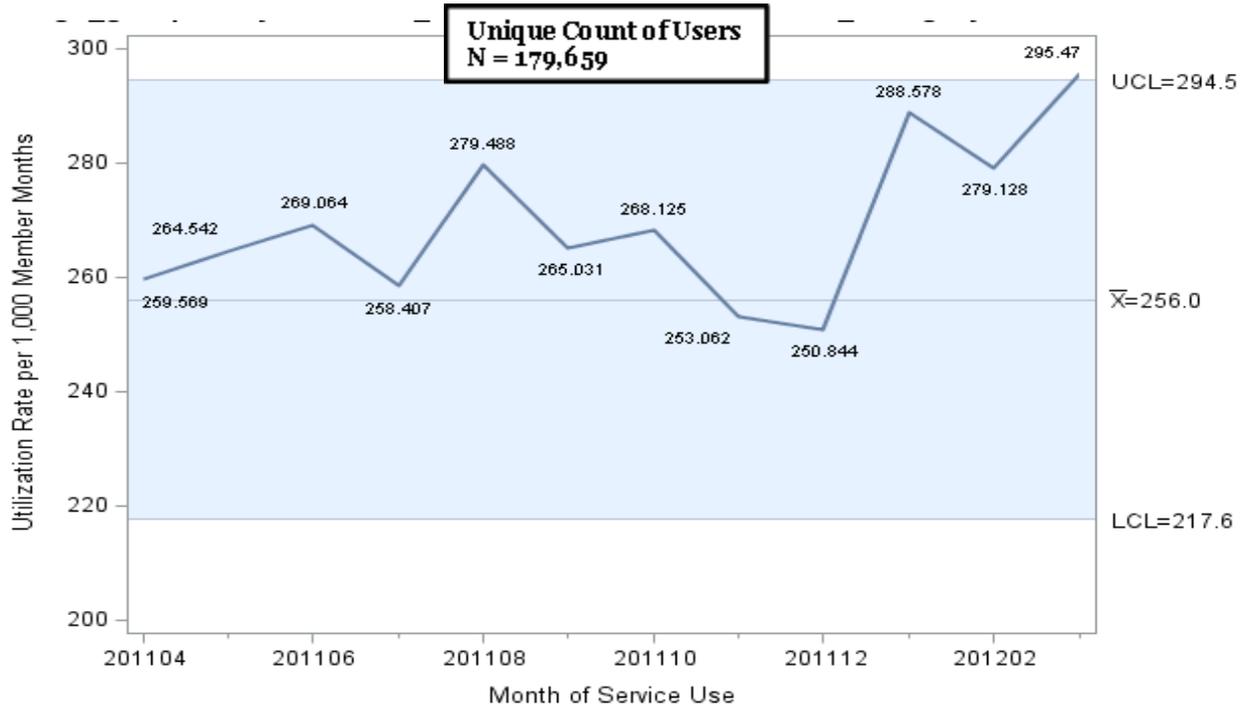


Figure 70 Monthly Hospital Outpatient Use Rates, Adults, Age 21+, Families, April 2011–March 2012

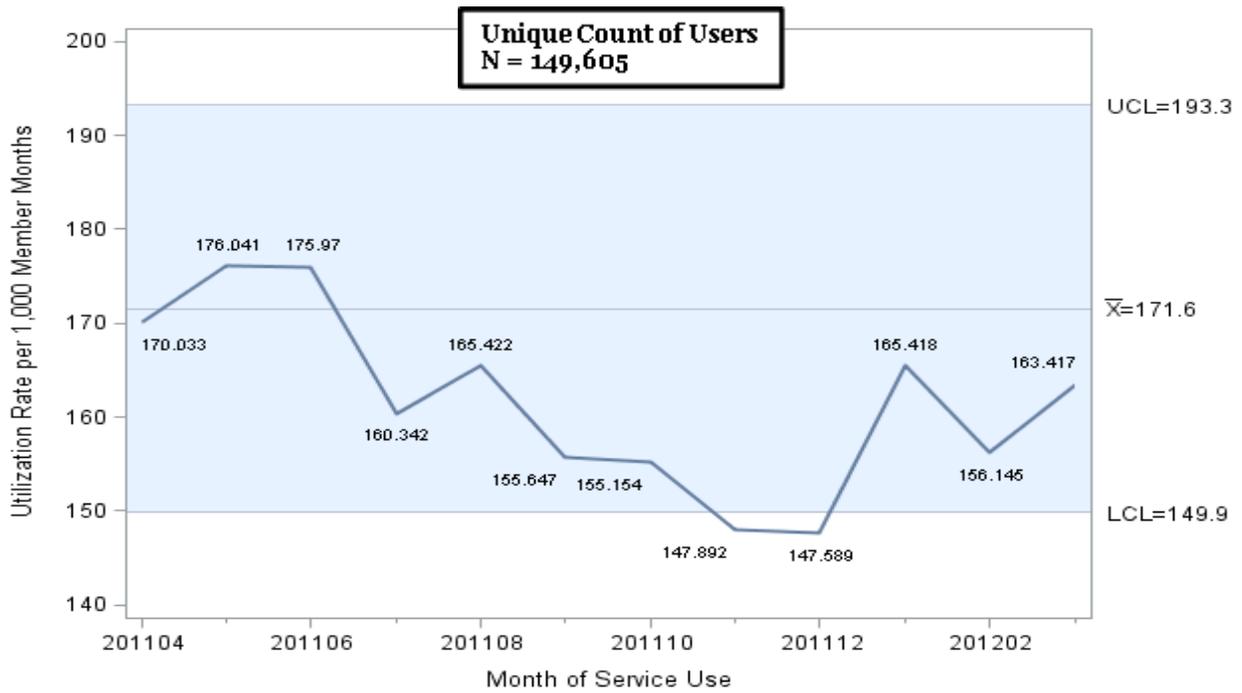


Figure 71 Monthly Hospital Outpatient Use Rates, Adults Age 21+, Other, April 2011–March 2012

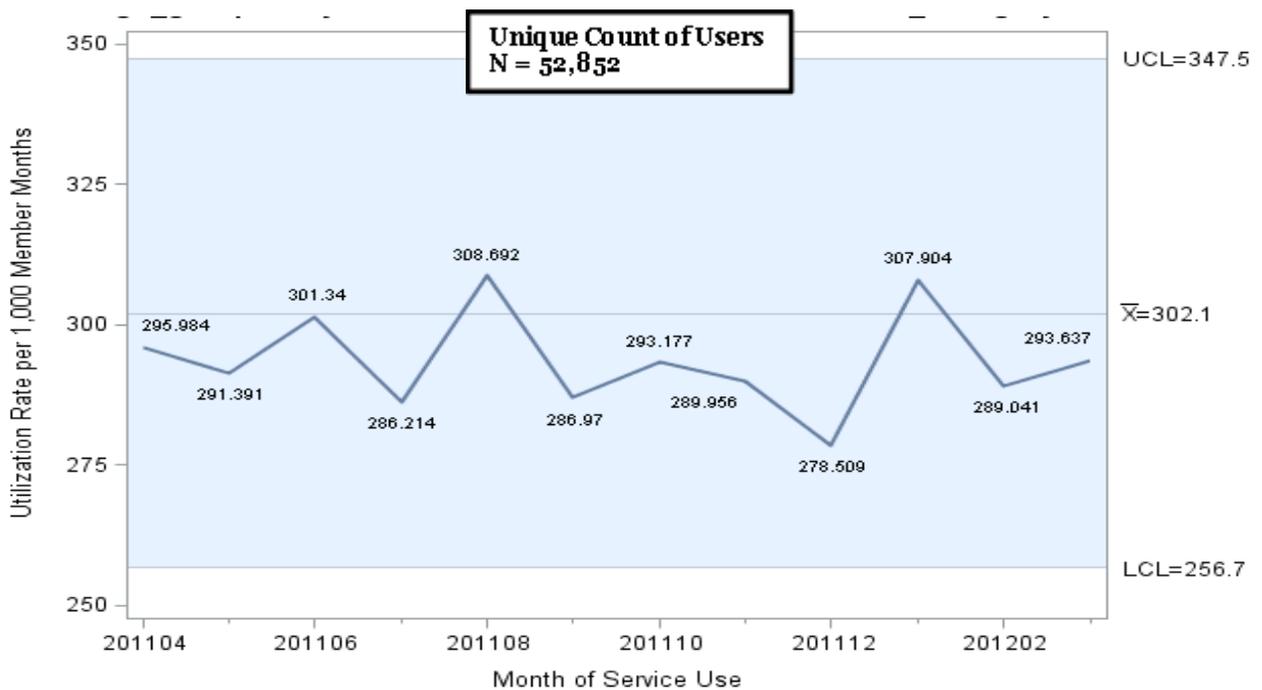
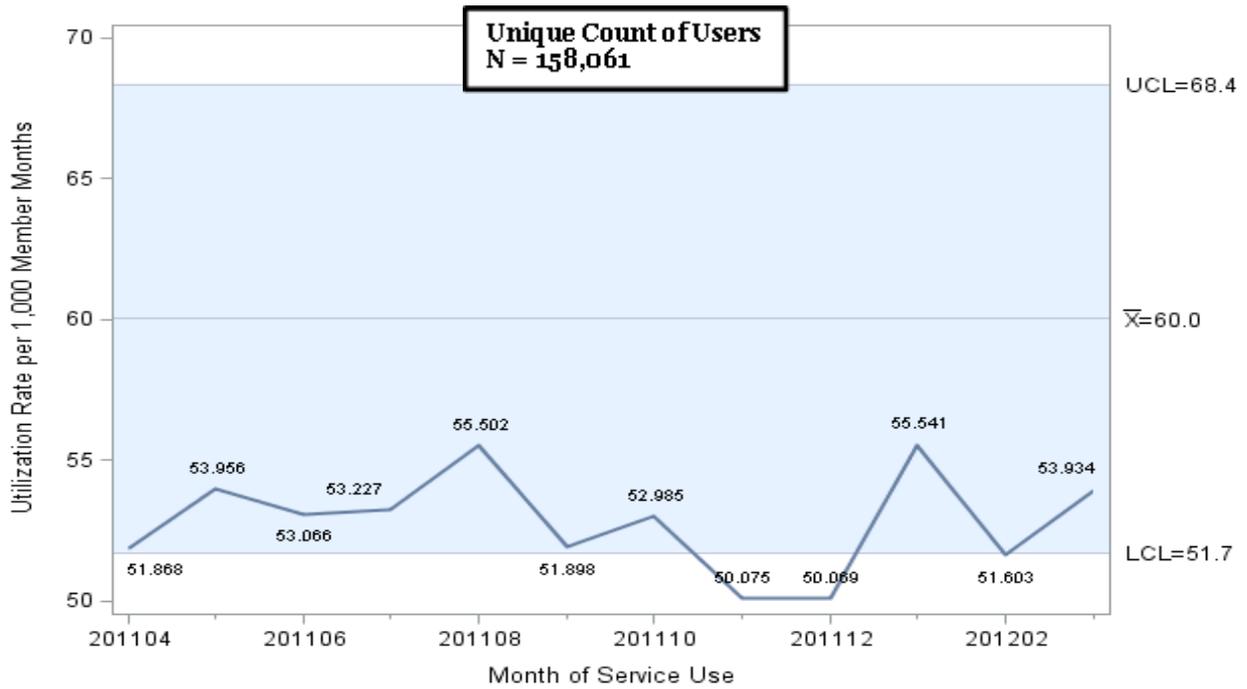


Figure 72 Monthly Hospital Outpatient Use Rates, Adults Age 21+, Undocumented, April 2011–March 2012



Source: Data for figures 69–73 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Nursing Facility Services

Background

Nursing Facility services offered under the Medi-Cal program encompass a variety of provider types, including intermediate care facilities for the developmentally disabled (ICF/DD), nursing facility Level A and B care, and certified hospice services.

ICF/DD facilities provide 24-hour personal, habilitation, developmental, and supportive health care to clients who need developmental services and who have a recurring but intermittent need for skilled nursing services. There are three types of ICF/DD facilities, which are distinguished by the different levels of developmental and skilled nursing services they provide. ICF/DD facilities primarily provide developmental services for individuals who may have a recurring, intermittent need for skilled nursing. ICF/DD–Habilitation facilities provide developmental services to 15 or fewer clients who do not require the availability of continuous skilled nursing care. ICF/DD–Nursing facilities offer the same services as those found in an ICF/DD–Habilitation facility, but focus their services on medically-frail persons requiring a greater level of skilled nursing care.

There are approximately 6,500 unique users of ICF/DD services, representing 4.5% of all nursing facility service recipients. Many of these recipients are adults age 21–64 (82%), and enrolled in long-term care (54.4%) and Disabled (41.6%) aid categories.

Nursing Facility Level A (NF-A) provides intermediate care for non-developmentally disabled clients. These facilities provide inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision, need supportive care, but who do not require the availability of continuous skilled nursing care. Approximately 3% of all nursing facility recipients use NF-A services annually.

Skilled Nursing Facility Level B (SNF-B) provides skilled nursing and supportive care to patients whose primary need is for continuous care on an extended basis, such as those with physical and/or mental limitations and those requiring subacute care. Recipients of SNF-B services are the predominant user group of Nursing Facility services, representing about 80% of all users in this service category.

A large proportion of Medi-Cal beneficiaries who use NF-A or SNF-B services are covered under Long-Term Care (51.2%), Aged (25.4%), and Disabled (18.6%) aid categories, and are primarily older adults age 65 and older (76.1%).

Certified hospice services are designed to meet the unique needs of terminally ill individuals who opt to receive palliative care versus care to treat their illness. The following providers may render hospice services to program beneficiaries: hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, and licensed Medi-Cal health providers who are certified by *Medicare* to provide hospice services. Hospice services may include: nursing and physician services, medical social and counseling services, home health aide and homemaker services, bereavement counseling, and any additional item that may otherwise be paid under the Medi-Cal program. There are approximately 15,000 users of hospice care, representing just over

10% of recipients of Nursing Facility services. Most hospice recipients are elderly beneficiaries over age 65 (71.3%) and are covered under Long-Term Care (39.3%), Aged (27.5%), and Disabled (20.9%) aid categories.

Trend Analysis

This analysis focuses only on Nursing Facility services utilization rates among Medi-Cal children age 0–20 participating in the FFS program and enrolled in the Blind/Disabled aid category. Children in this aid category experienced monthly Nursing Facility services utilization rates ranging from 136.8–169.4 days per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. These children continued to place additional demand for Nursing Facility services over the course of the study period, exhibiting upward trends in service use. Though children in the Blind/Disabled aid category experienced two or more consecutive months of utilization below the baseline levels during 2011, Nursing Facility service use for these children reached levels within expected ranges during 2012.

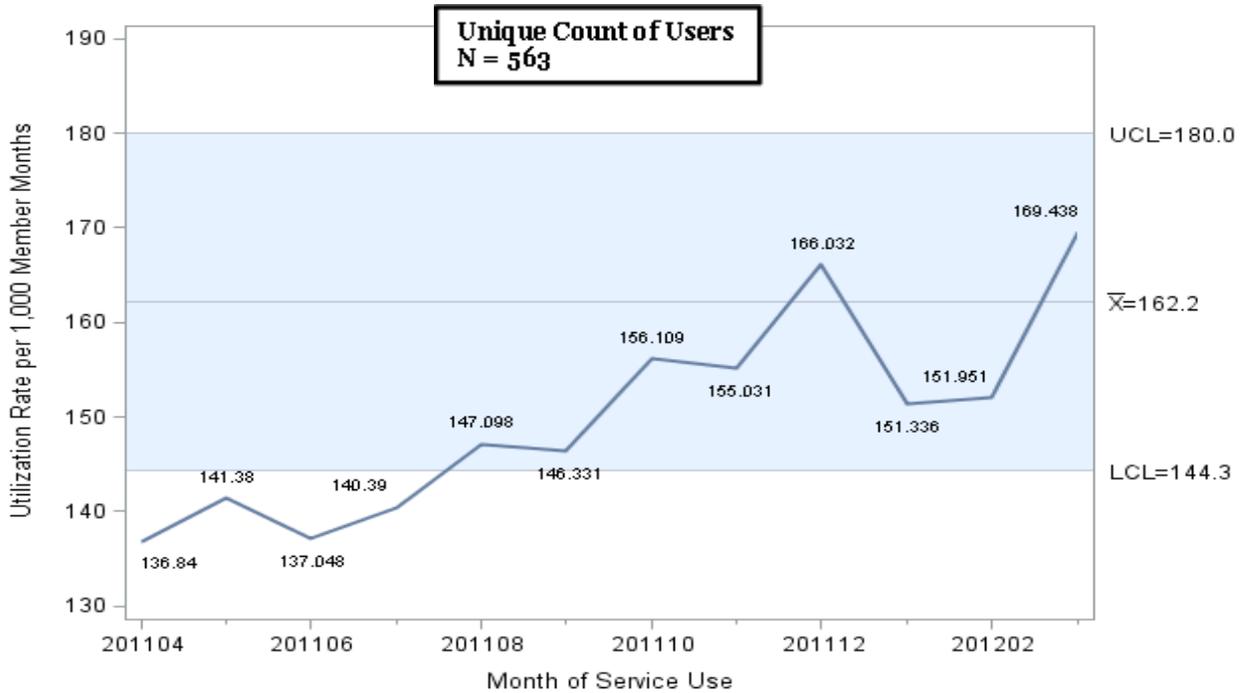
The monthly Nursing Facility services utilization rates for adults age 21 and older ranged from 7.6–2,211.7 days per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. The Nursing Facility services utilization rates were again noticeably higher for adults in the Other aid category, which is understandable given that this subpopulation contains beneficiaries enrolled in long-term care aid codes. Though adults in the Other aid category used Nursing Facility services at rates much higher than other beneficiary subpopulations, their use of these services continues to be below average rates established during the baseline period. Adults in the Aged, Blind/Disabled, and Families aid categories continue to display upward trends in utilization of Nursing Facility services, reaching levels well above those established during the baseline period.

Medi-Cal FFS beneficiaries in the Undocumented aid category were excluded from this analysis because they are not eligible for Nursing Facility services. Additionally, children in the Families, Foster Care, and Other aid code categories were excluded because of their relatively small user counts (<500).

The following figures 74–78 represent the control chart analysis for both children and adults from the second quarter of 2011 to the first quarter of 2012.

Trends—Nursing Facility Services Use by Children, April 2011–March 2012

Figure 73 Monthly Nursing Facility Use Rates, Children Age 0–20, Blind/Disabled, April 2011–March 2012



Source: Data for figure 74 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Nursing Facility Services Use by Adults, April 2011–March 2012

Figure 74 Monthly Nursing Facility Use Rates, Adults Age 21+, Aged, April 2011–March 2012

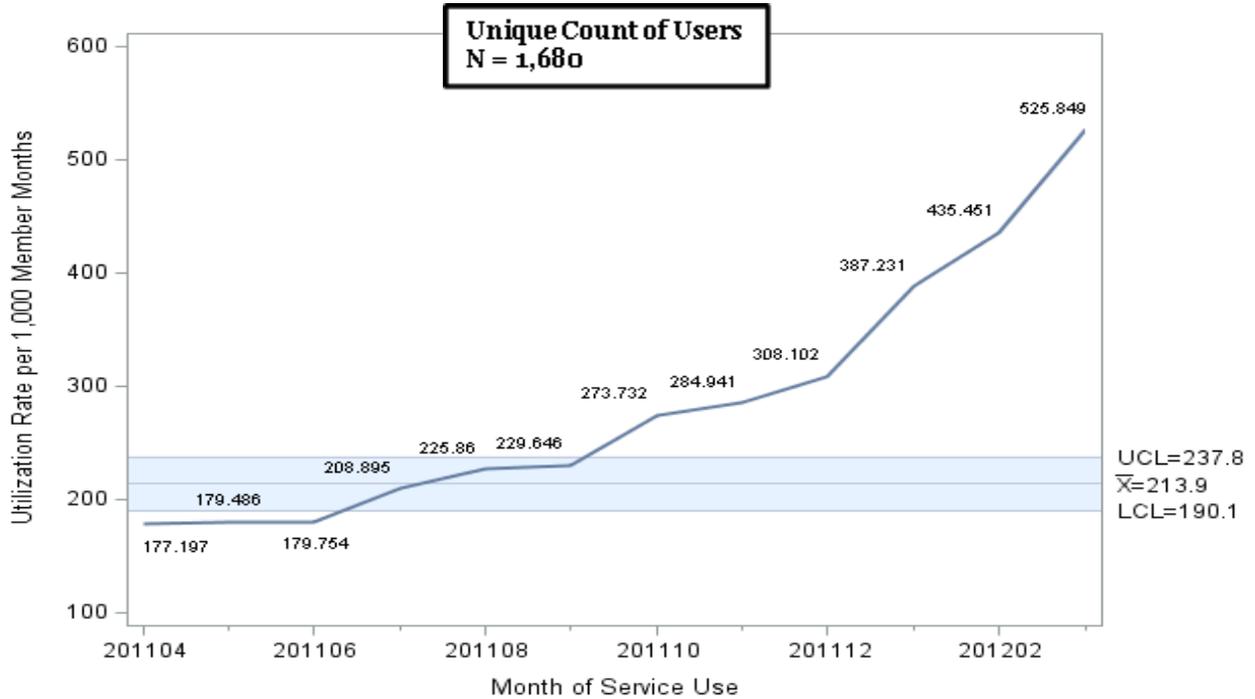


Figure 75 Monthly Nursing Facility Use Rates, Adults Age 21+, Blind/Disabled, April 2011–March 2012

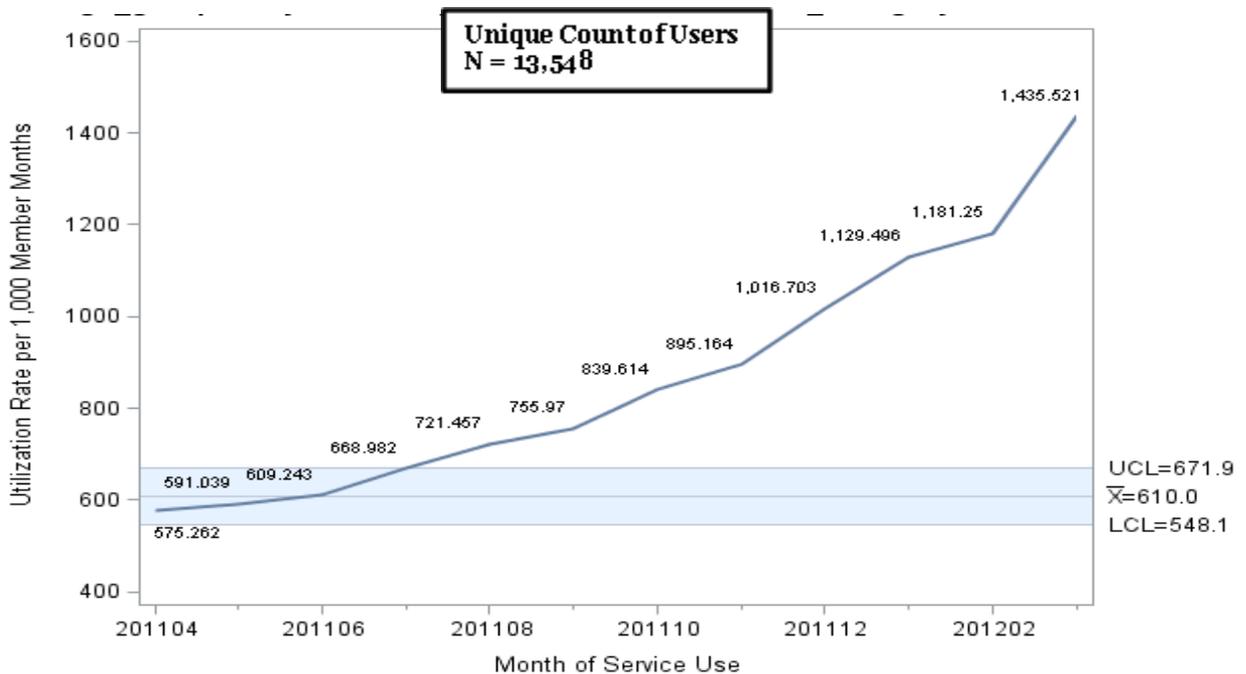


Figure 76 Monthly Nursing Facility Use Rates, Adults Age 21+, Families, April 2011–March 2012

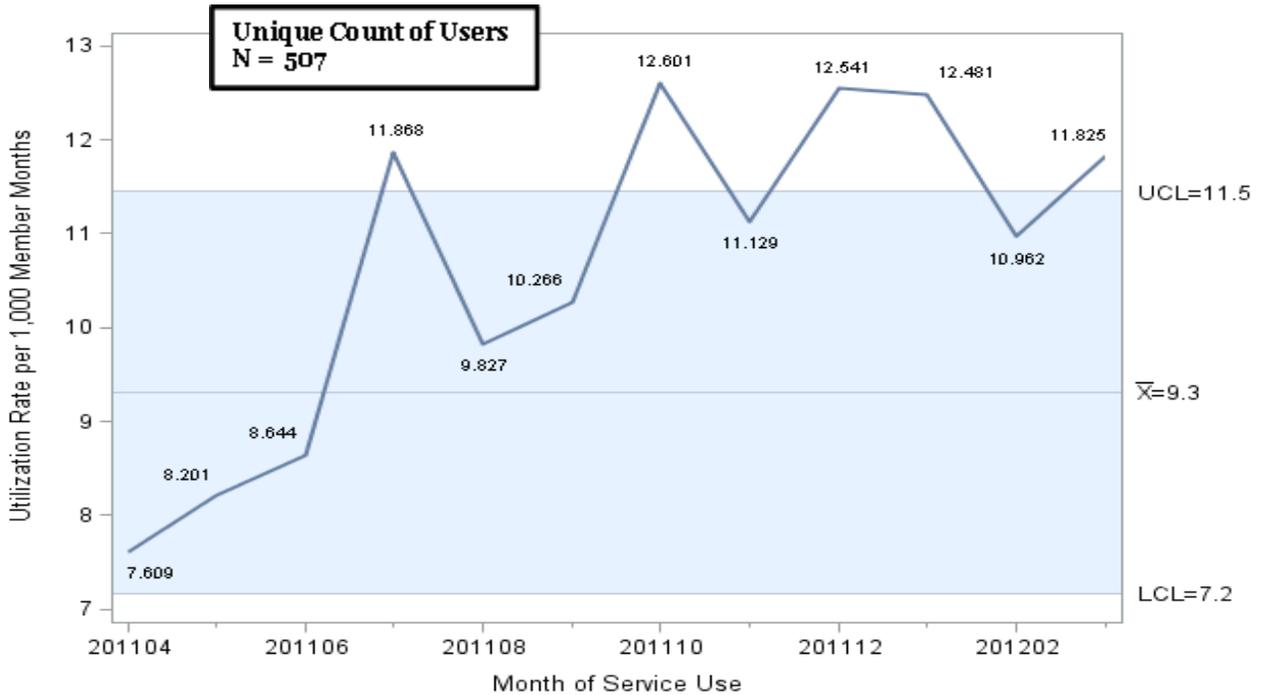
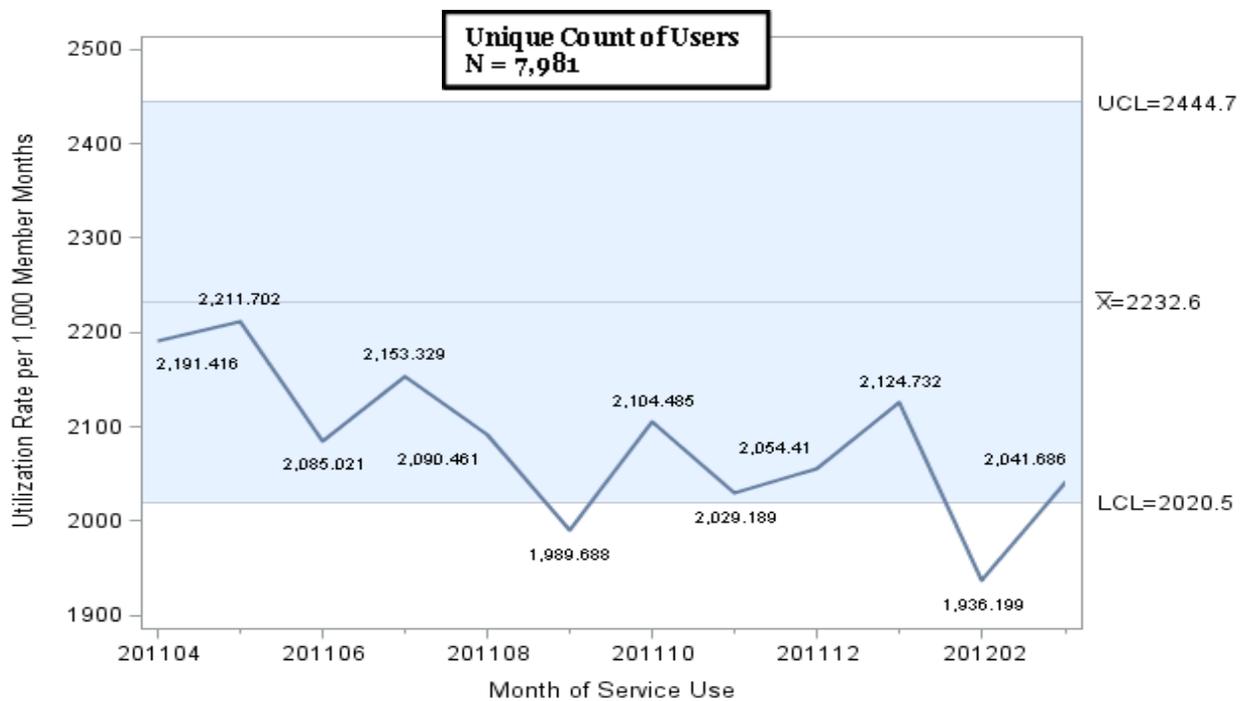


Figure 77 Monthly Nursing Facility Use Rates, Adults Age 21+, Other, April 2011–March 2012



Source: Data for figures 75–78 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Pharmacy Services

Background

Pharmacy services are the most frequently used Medi-Cal benefit and the fastest growing portion of the Medi-Cal budget. Pharmacy coverage is a significant proportion of the benefits received by the elderly and for beneficiaries with a disability, mental illness, or chronic condition.

Pharmacy providers not only dispense prescription drugs, they also bill for over-the-counter drugs, enteral formula, medical supplies, incontinent supplies, and durable medical equipment. Most outpatient prescription drug claims are billed by pharmacy providers. Physicians and clinics may also bill for drugs administered in their office and prenatal care vitamins that are distributed through Comprehensive Perinatal Services Program providers.

Pharmacy services for beneficiaries eligible for FFS Medi-Cal only are restricted to six prescriptions per month per beneficiary for most drugs. Previous authorization is needed to obtain coverage beyond the six-prescription cap. A copayment of \$1 per prescription is required for most beneficiaries, although beneficiaries cannot be denied coverage if they can't afford the copayment. Federal law prohibits states from imposing cost sharing on children, pregnant women, and institutionalized beneficiaries, and for family planning services, hospice services, emergencies, and Native Americans served by an Indian health care provider.

Assembly Bill 97 enacted mandatory copayments of \$3 per prescription for preferred drugs, and \$5 per prescription for non-preferred drugs. DHCS has proposed changing the copayment requirement to \$3.10 for non-preferred drugs. This copayment requirement is pending approval by CMS, with a proposed implementation date of January 1, 2013.

In 2010, there were over 3 million beneficiaries who received at least one Pharmacy service through the Medi-Cal FFS program. The majority of Pharmacy service users (99%) accessed prescription drugs. Young beneficiaries under age 20 represent 35% of Pharmacy service users, while adults age 21–64 represent 43%, and an additional 22% are Pharmacy service users over age 65. Beneficiaries who utilize Pharmacy services are predominantly found in the Families (27.6%), Disabled (24.5%), Aged (10%), and Undocumented (10%) aid categories. The most frequently dispensed pharmacy products are non-steroidal anti-inflammatory drugs (NSAIDs), penicillin, and analgesics.

Trend Analysis

The monthly Pharmacy services utilization rates for children age 0–20 in the Medi-Cal FFS program ranged from 68.6–1,522.0 prescriptions per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. Similar to the previous report, the utilization of Pharmacy services again was noticeably higher among children in the Blind/Disabled aid category with rates two to three times higher than children in the Foster Care aid category and four to five times higher than children in the Families and Other aid categories. Children in the Blind/Disabled, Families, and Other aid categories displayed distinct upward trends in utilization starting in July 2011, reaching levels above baseline ranges for children in the

Blind/Disabled aid category. Despite this increase in utilization, children in the Families and Other aid categories mostly displayed below average utilization throughout the study period, while children in the Foster Care aid category exhibited service use rates that continue to be above the average rates established at baseline.

Among adults 21 and older, monthly Pharmacy services utilization rates ranged from 181.0–3,428.3 prescriptions per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. Similar to the trends identified in the previous report, Pharmacy services utilization was again noticeably higher among adults in the Aged and Blind/Disabled aid categories. Additionally, adults in the Other aid category exhibited significant utilization rates of pharmacy services, while adults in the Undocumented aid category utilized these services at much lower rates. Among adults in the Aged and Blind/Disabled aid categories, noticeable downward trends in utilization were experienced starting in August 2011, reaching levels below baseline during 2012 among adults in the Aged aid category. Overall, Pharmacy services utilization rates fell within expected ranges.

The following figures 79–88 represent the control chart analysis for both children and adults from the second quarter of 2011 to the first quarter of 2012.

Trends—Pharmacy Services Use by Children, April 2011–March 2012

Figure 78 Monthly Pharmacy Use Rates, Children Age 0–20, Blind/Disabled, April 2011–March 2012

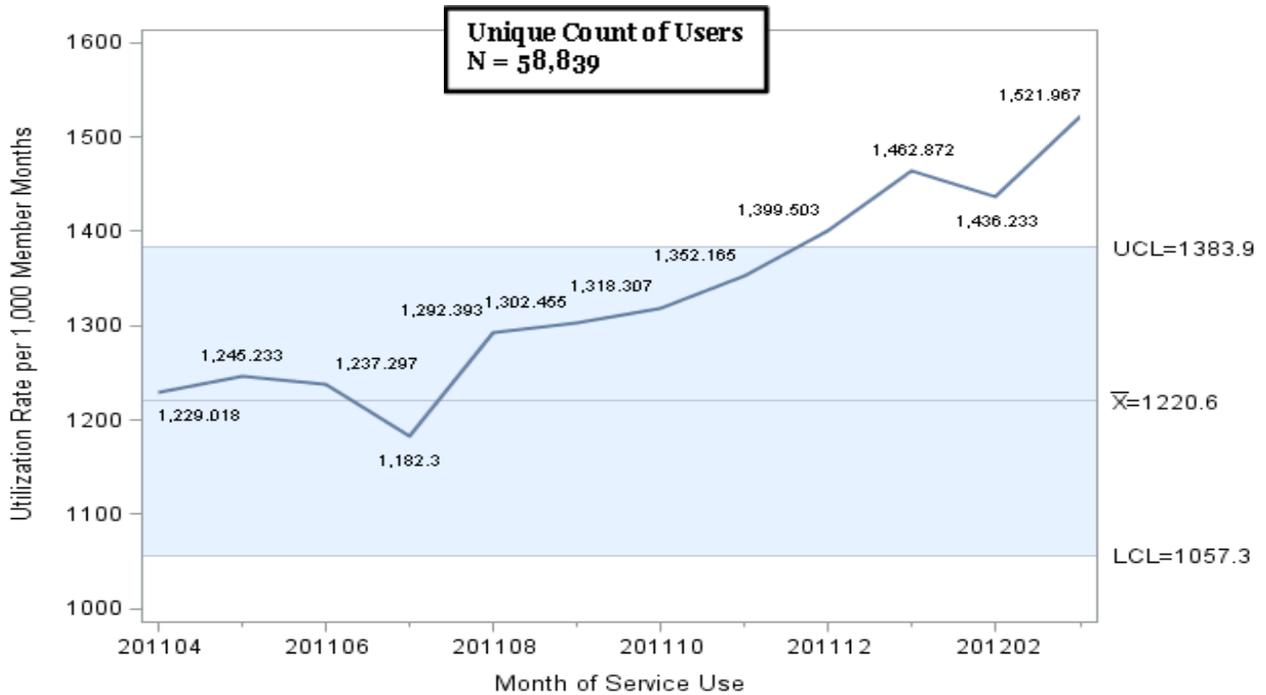


Figure 79 Monthly Pharmacy Use Rates, Children Age 0–20, Families, April 2011–March 2012

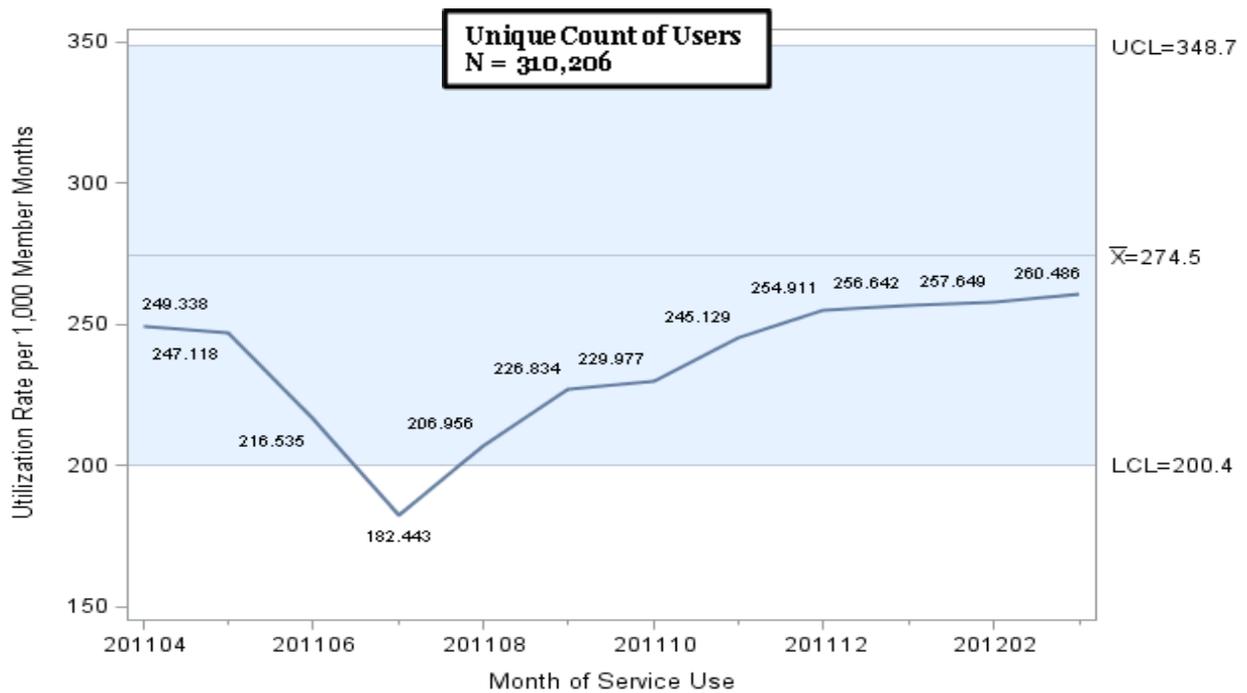


Figure 80 Monthly Pharmacy Use Rates, Children Age 0–20, Foster Care, April 2011–March 2012

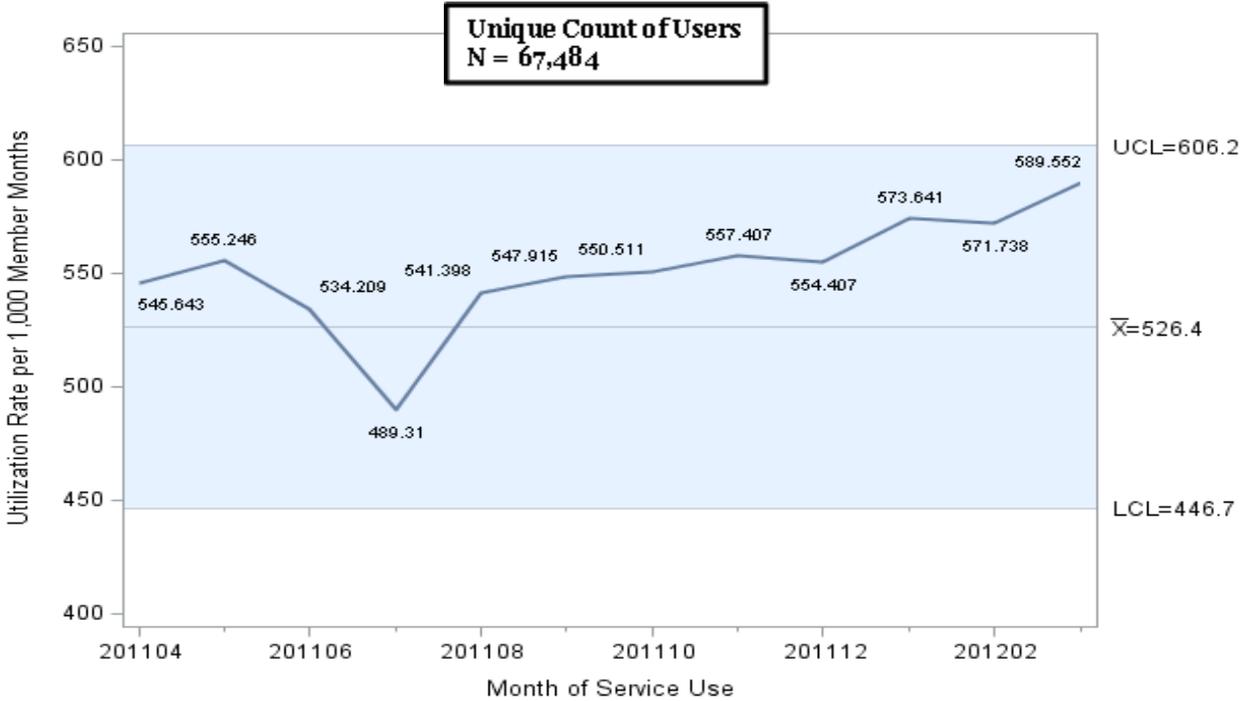


Figure 81 Monthly Pharmacy Use Rates, Children Age 0–20, Other, April 2011–March 2012

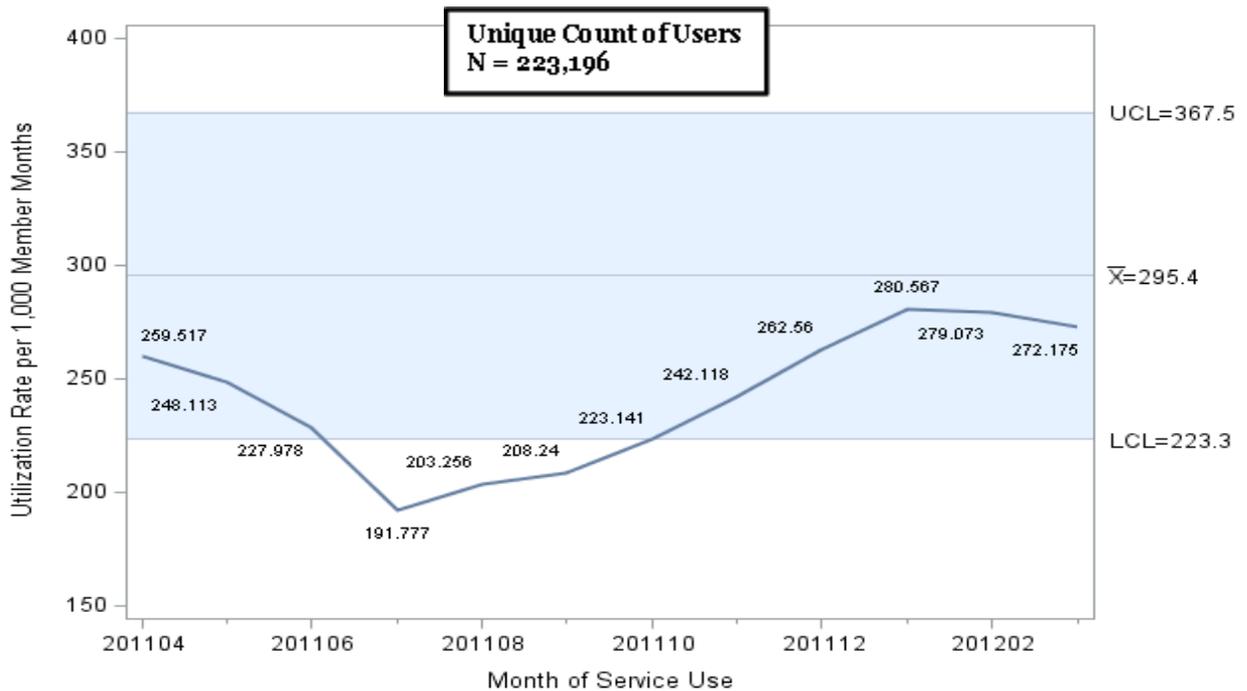
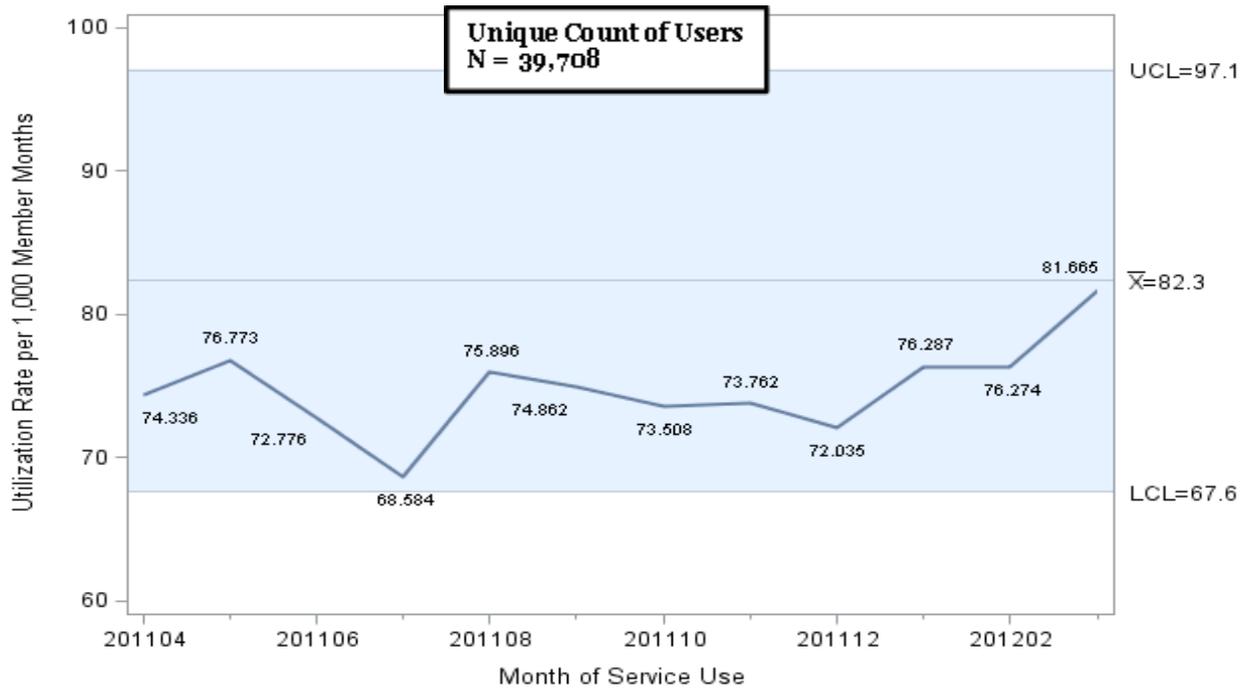


Figure 82 Monthly Pharmacy Use Rates, Children Age 0–20, Undocumented, April 2011–March 2012



Source: Data for figures 79–83 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Pharmacy Services Use by Adults, April 2011–March 2012

Figure 83 Monthly Pharmacy Use Rates, Adults Age 21+, Aged, April 2011–March 2012

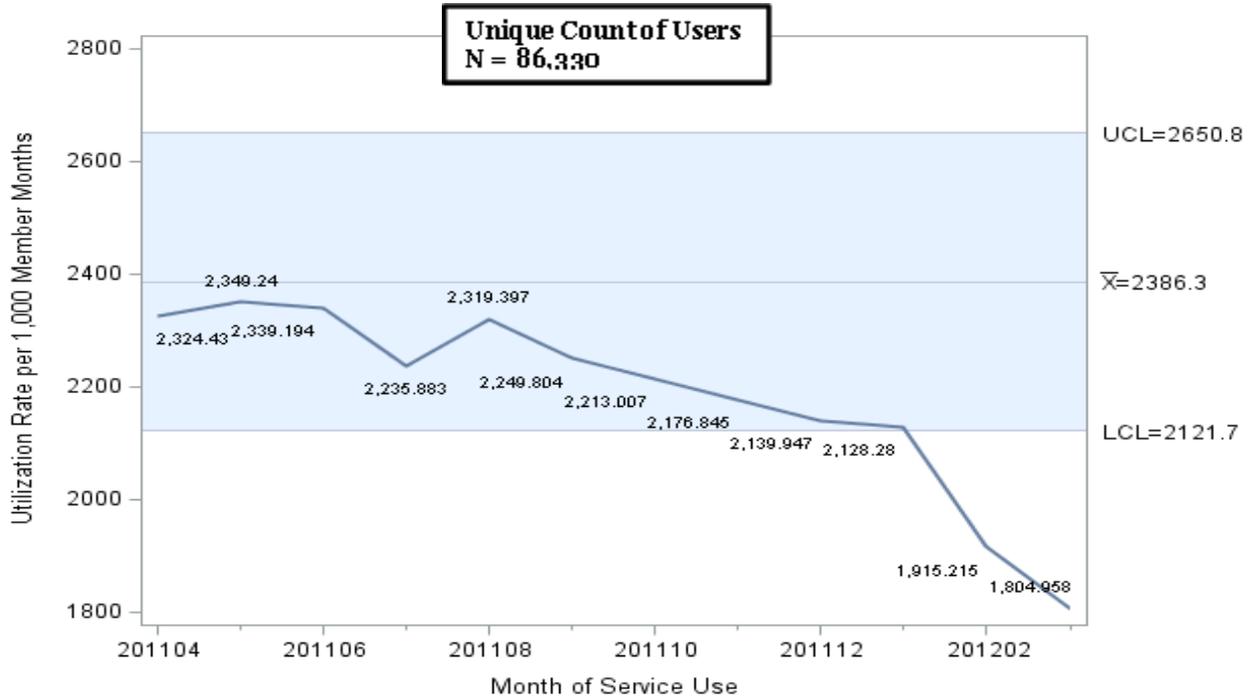


Figure 84 Monthly Pharmacy Use Rates, Adults Age 21+, Blind/Disabled, April 2011–March 2012

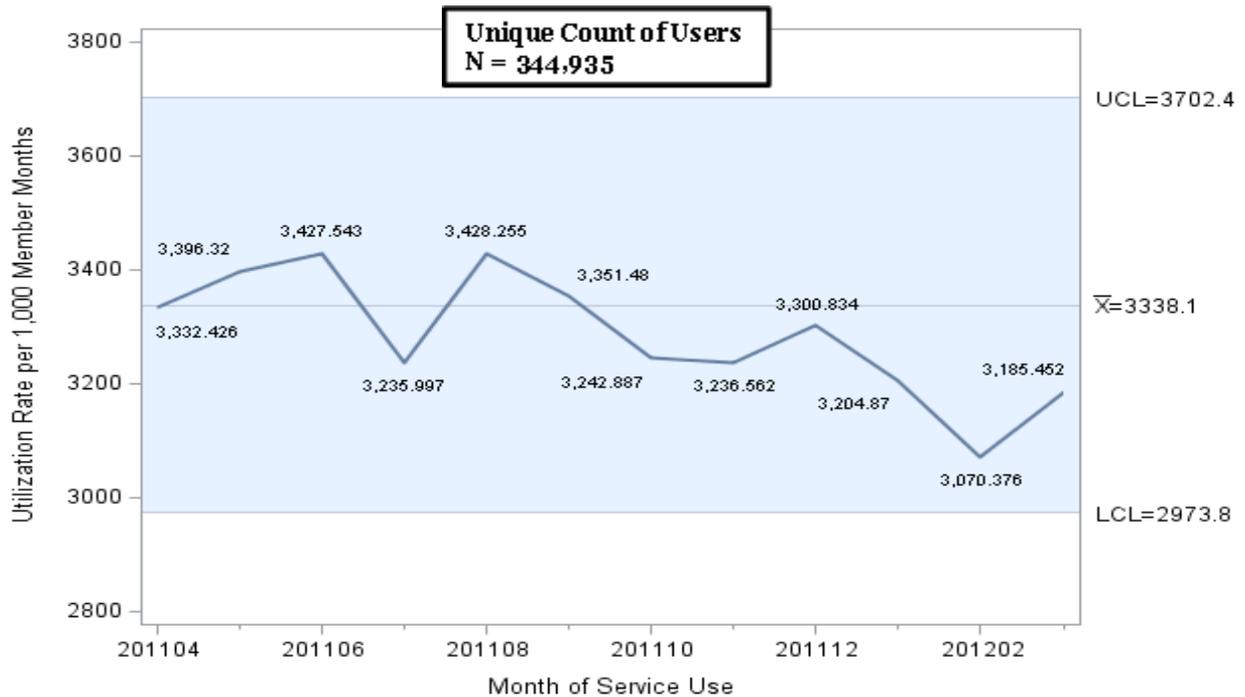


Figure 85 Monthly Pharmacy Use Rates, Adults Age 21+, Families, April 2011–March 2012

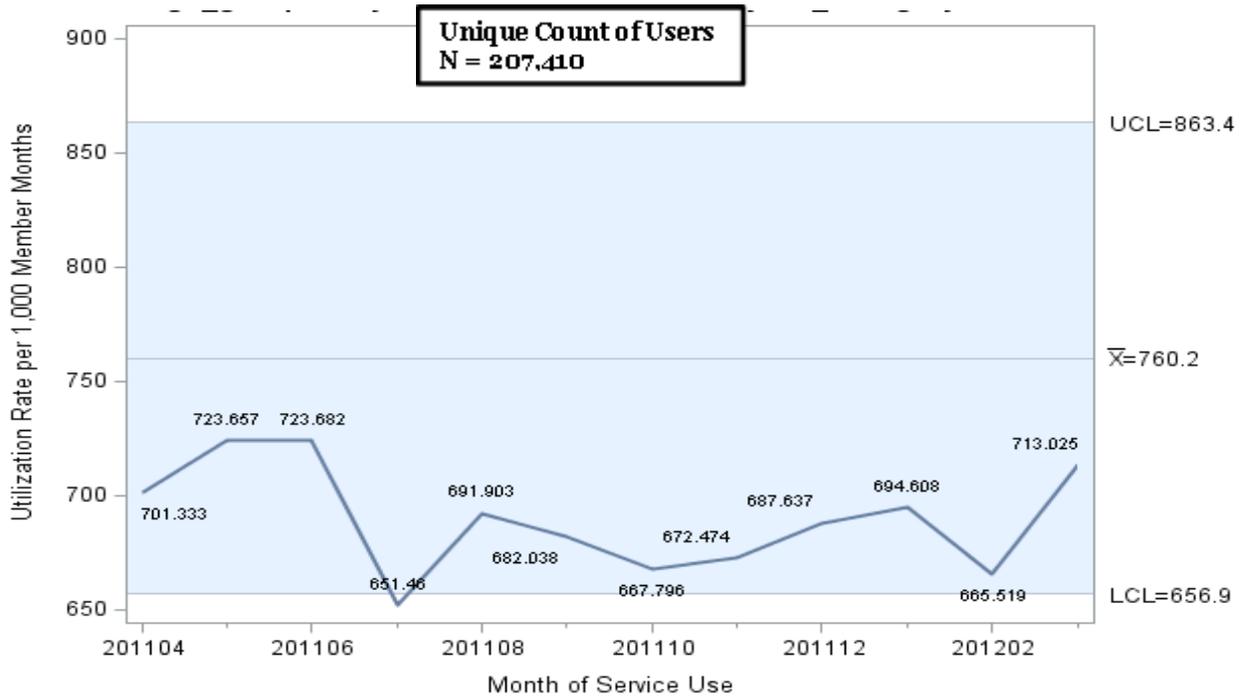


Figure 86 Monthly Pharmacy Use Rates, Adults Age 21+, Other, April 2011–March 2012

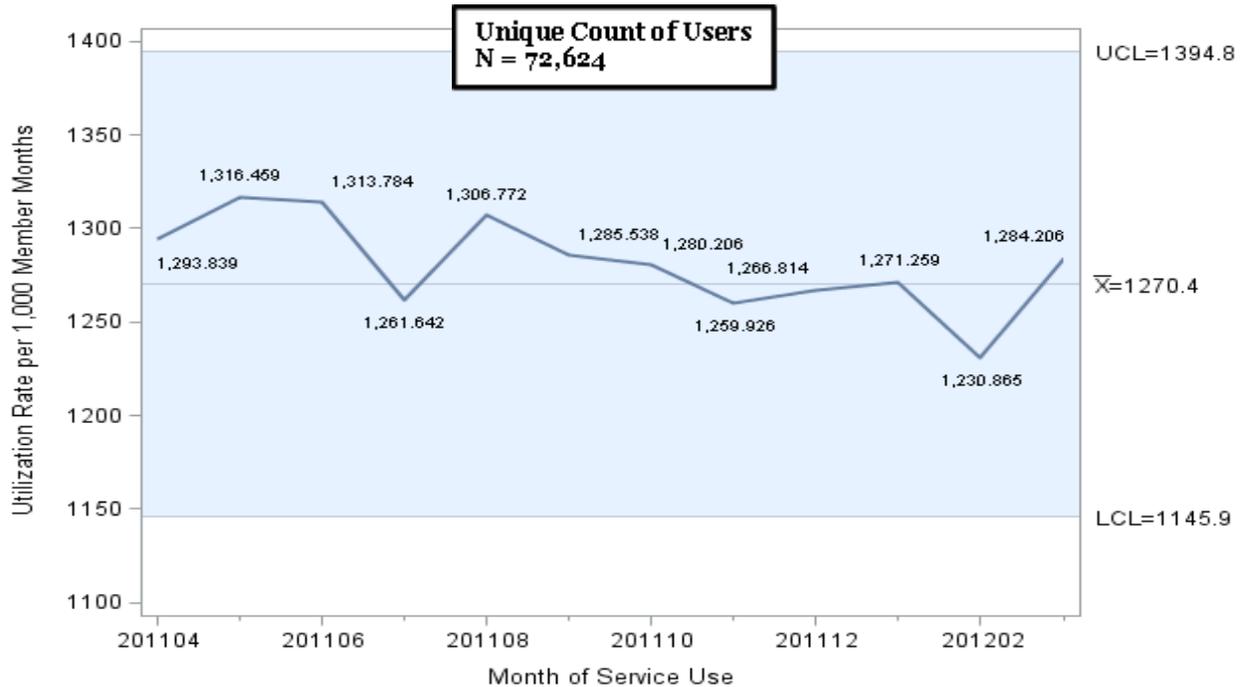
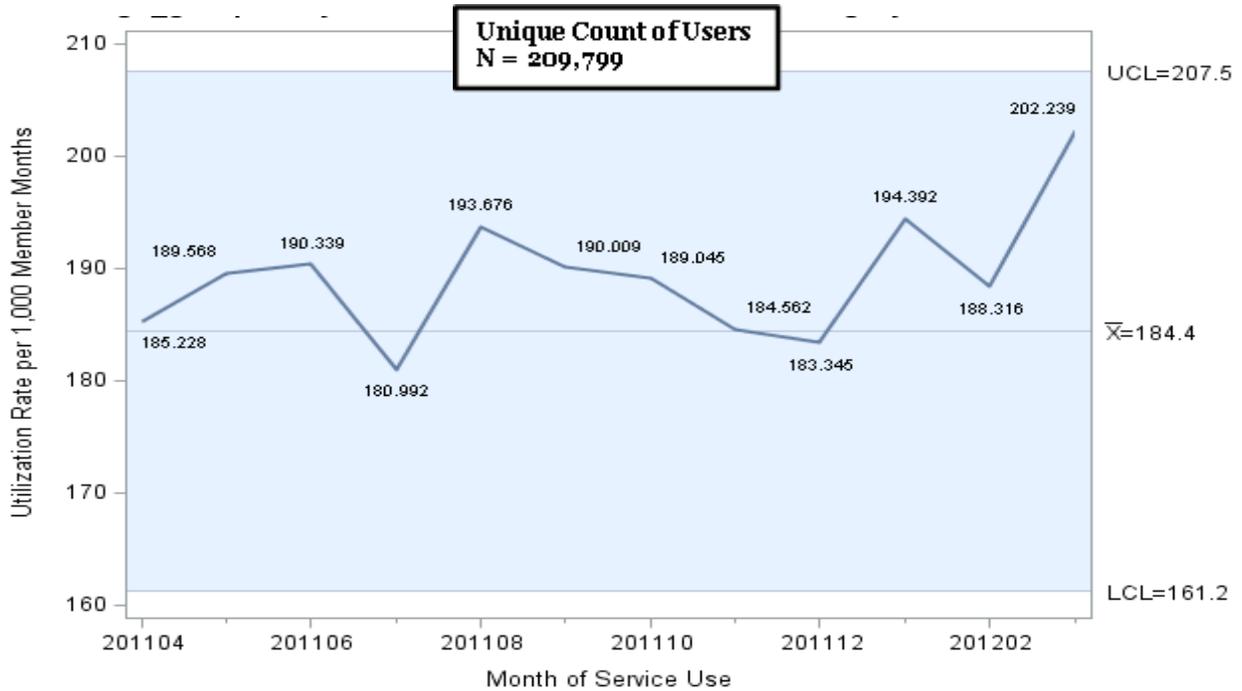


Figure 87 Monthly Pharmacy Use Rates, Adults Age 21+, Undocumented, April 2011–March 2012



Source: Data for figures 84–88 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Other Services

Background

Service providers covered under the “Other” aid category include the following partial list:

- Community-Based Adult Services Program (formerly called Adult Day Health Care)
- Assistive Device and Sick Room Supply Dealers
- Audiologists and Hearing Aid Dispensers
- Certified Nurse Practitioners, Pediatric Nurse Practitioners
- Physical, Occupational and Speech Therapists
- Orthotists and Prosthetists
- Podiatrists
- Psychologists
- Genetic Disease Testing
- Local Education Agency (LEA)
- Respiratory Care Practitioners
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services Providers
- Health Access Program (HAP)

For a full list of provider types, see [Appendix D](#).

It is important to note that beginning in July 2009, several optional benefits were excluded from the Medi-Cal program. These benefits comprise of the following list and impact most beneficiaries except those eligible for EPSDT services, beneficiaries in skilled nursing facilities or residing in intermediate care facilities for the developmentally disabled (ICF/DD), and beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly (PACE):

- Acupuncture
- Adult Dental Services
- Audiology Services
- Chiropractic Services
- Incontinence Creams and Washes
- Dispensing Optician Services
- Fabricating Optical Laboratory Services
- Podiatric Services
- Psychology Services
- Speech Therapy

Trend Analysis

Among children age 0–20 in the Medi-Cal FFS program, monthly utilization rates for Other services ranged from 14.3–1,121.0 visits per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. Similar to the previous report, utilization of Other services was again noticeably higher among children in the Blind/Disabled aid category with rates four to five times higher than for children in the Foster Care aid category and ten times higher than for children in the Families and Other aid categories. Additionally, children in the Blind/Disabled, Families, Foster Care, and Other aid categories exhibited mostly normal utilization of Other services. In contrast, children in the Undocumented aid category exhibited below average use and had several months of utilization below the expected ranges observed in the baseline period of 2007–2009.

The monthly utilization rates for Other services among adults age 21 and older ranged from 42.2–347.1 visits per 1,000 member months from the second quarter of 2011 to the first quarter of 2012. Consistent with the trends identified in the previous report, Other services utilization rates were noticeably higher for adults in the Aged, Blind/Disabled, and Other aid categories and lowest among adults in the Undocumented aid category. Adults in all of the analyzed aid categories exhibited mostly below average use of Other services during the study period, falling below expected ranges for those in the Aged, Families, and Undocumented aid categories. Additionally, adults in the Aged and Blind/Disabled aid categories exhibited a noticeable increase in utilization for the first quarter of 2012.

The following figures 89–98 represent the control chart analysis for both children and adults from the second quarter of 2011 to the first quarter of 2012.

Trends—Other Services Use by Children, April 2011–March 2012

Figure 88 Monthly Other Services Use Rates, Children Age 0–20, Blind/Disabled, April 2011–March 2012

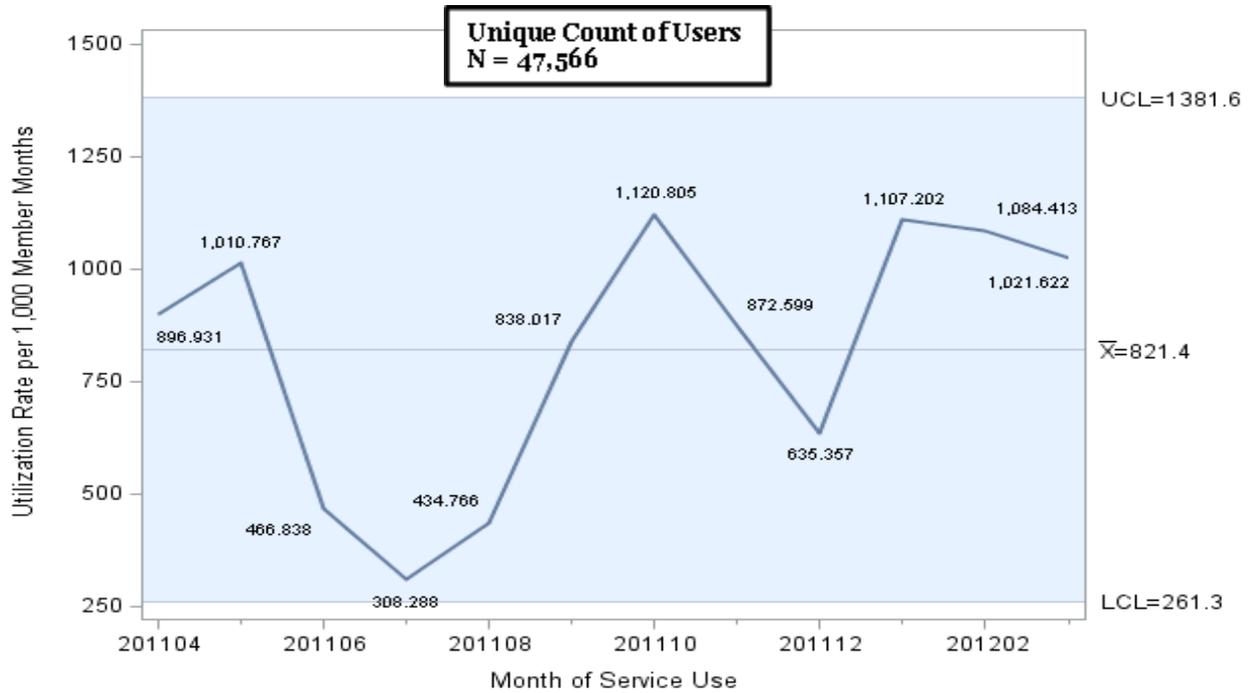


Figure 89 Monthly Other Services Use Rates, Children Age 0–20, Families, April 2011–March 2012

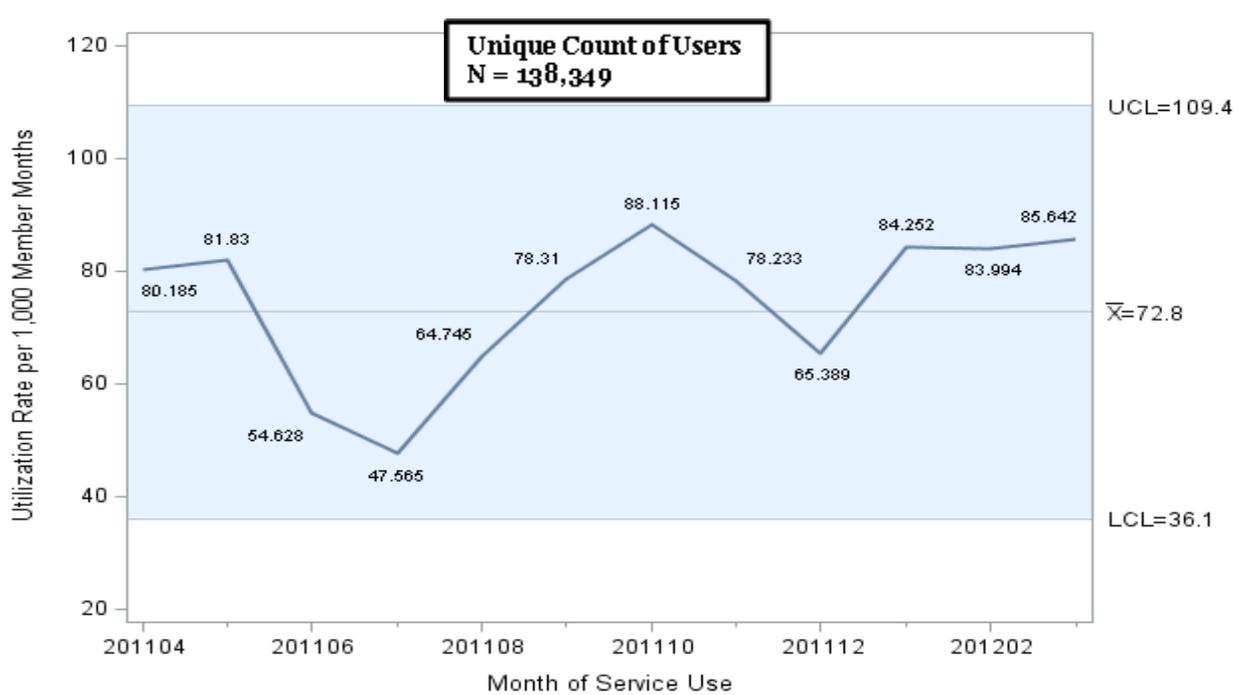


Figure 90 Monthly Other Services Use Rates, Children Age 0–20, Foster Care, April 2011–March 2012

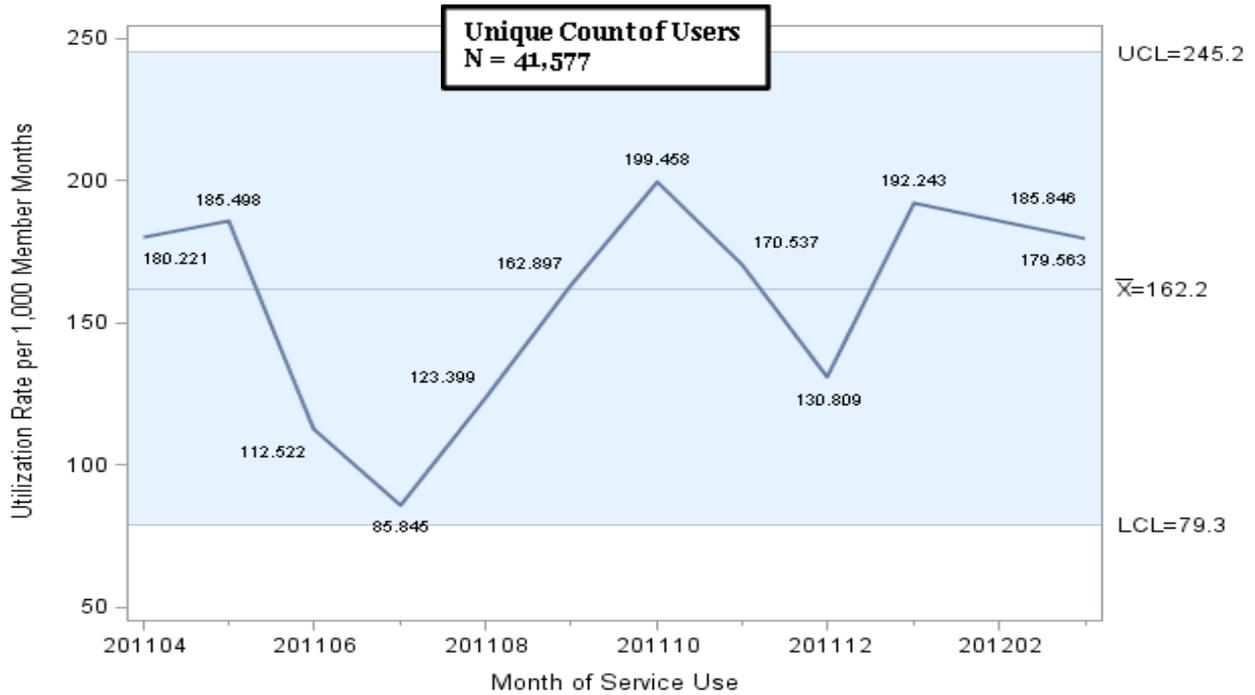


Figure 91 Monthly Other Services Use Rates, Children Age 0–20, Other, April 2011–March 2012

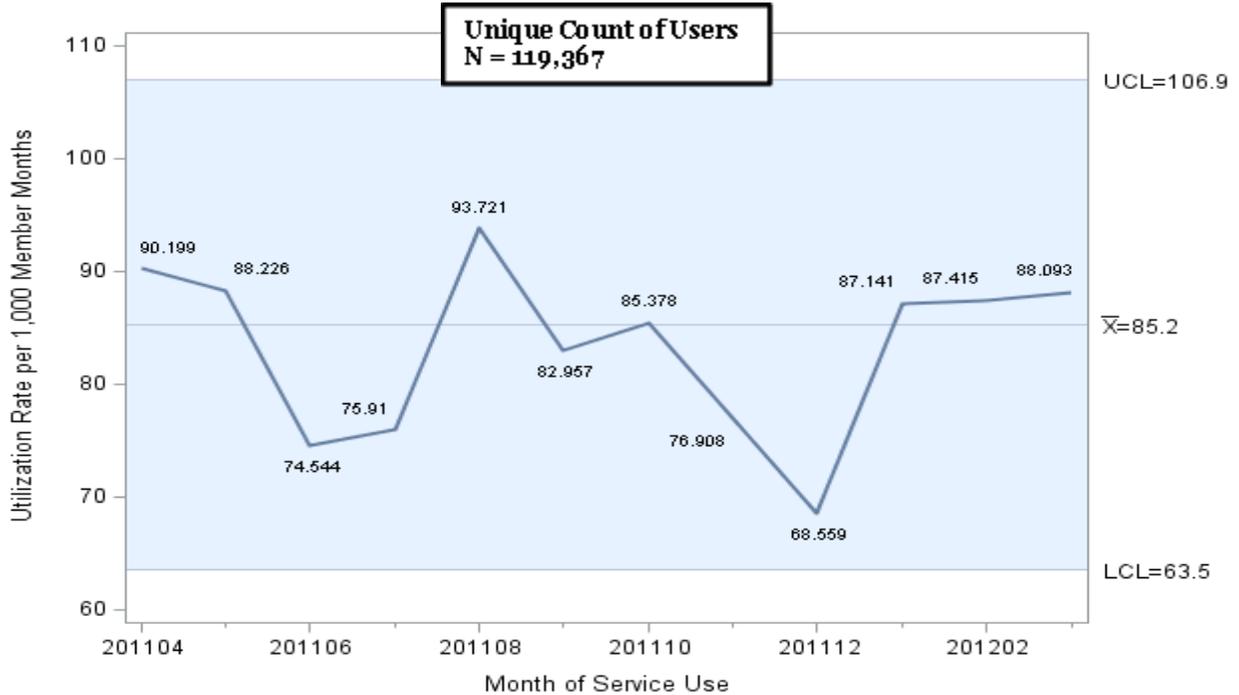
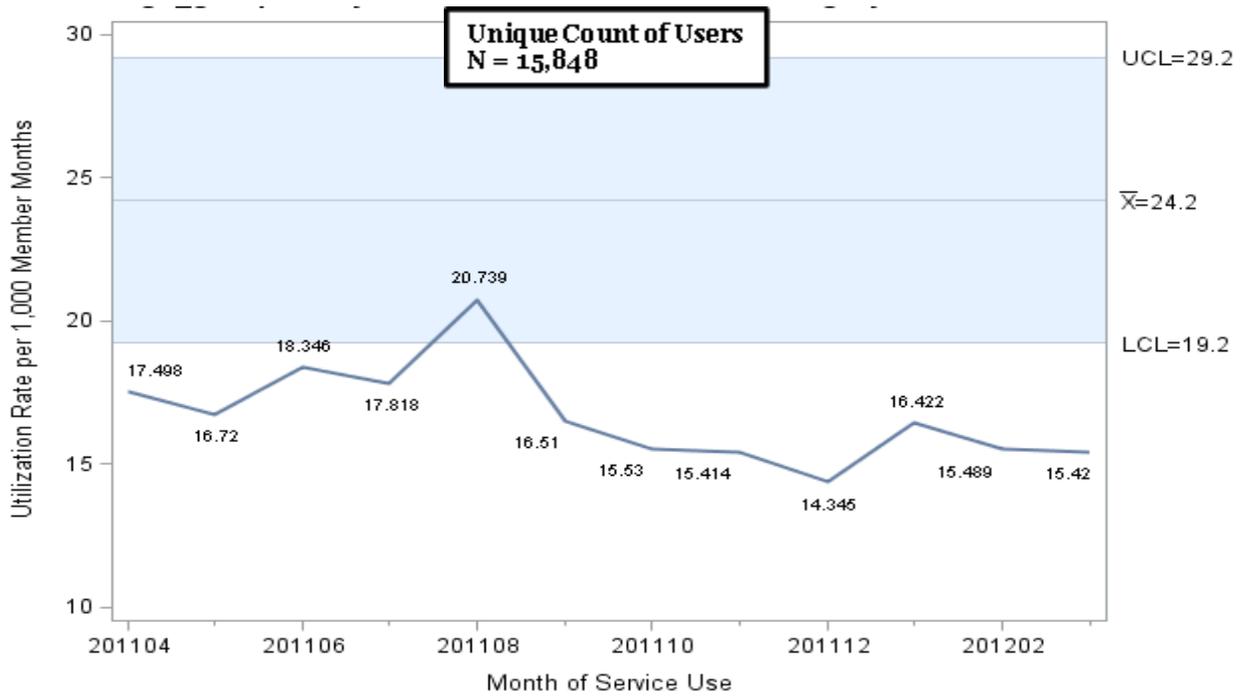


Figure 92 Monthly Other Services Use Rates, Children Age 0–20, Undocumented, April 2011–March 2012



Source: Data for figures 89–93 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2011–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Other Services Use by Adults, April 2011–March 2012

Figure 93 Monthly Other Services Use Rates, Adults Age 21+, Aged, April 2011–March 2012

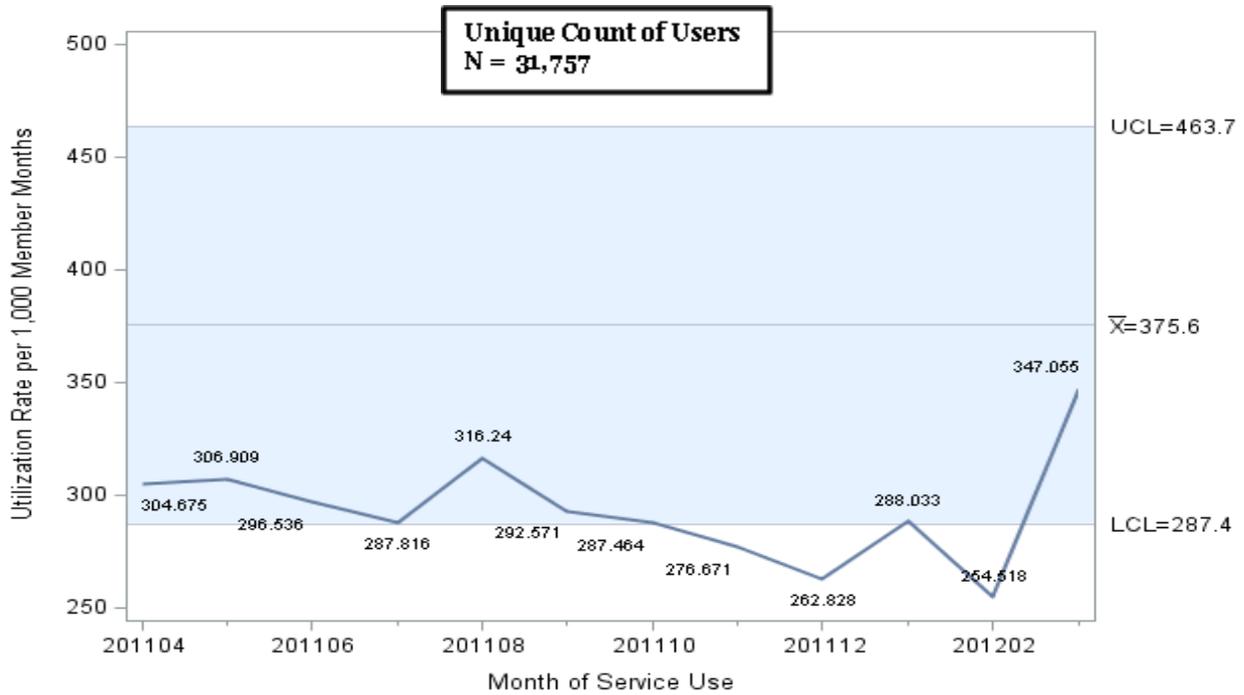


Figure 94 Monthly Other Services Use Rates, Adults Age 21+, Blind/Disabled, April 2011–March 2012

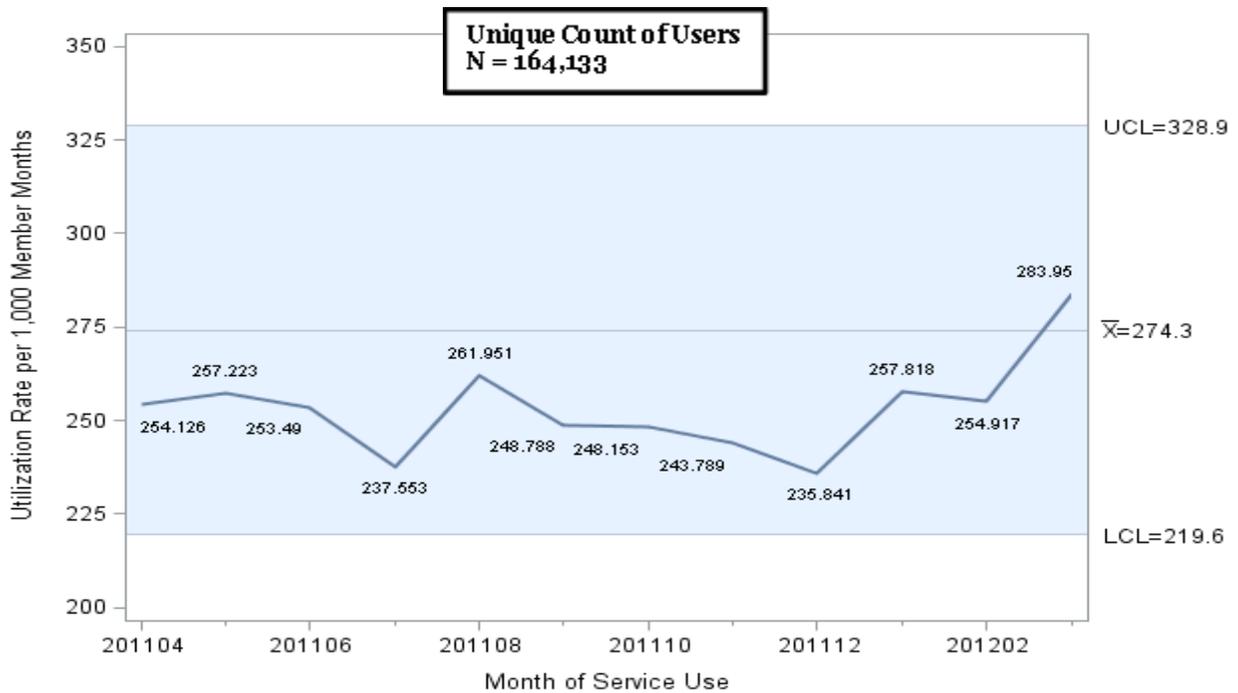


Figure 95 Monthly Other Services Use Rates, Adults Age 21+, Families, April 2011–March 2012

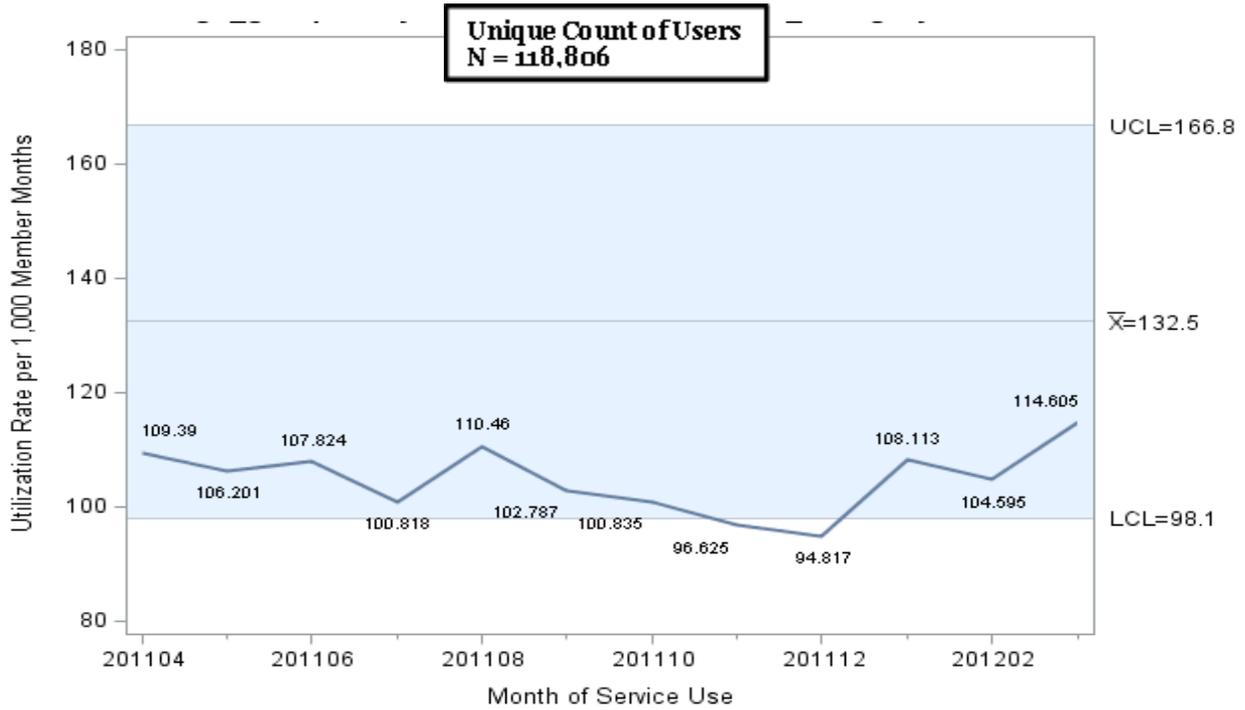


Figure 96 Monthly Other Services Use Rates, Adults Age 21+, Other, April 2011– March 2012

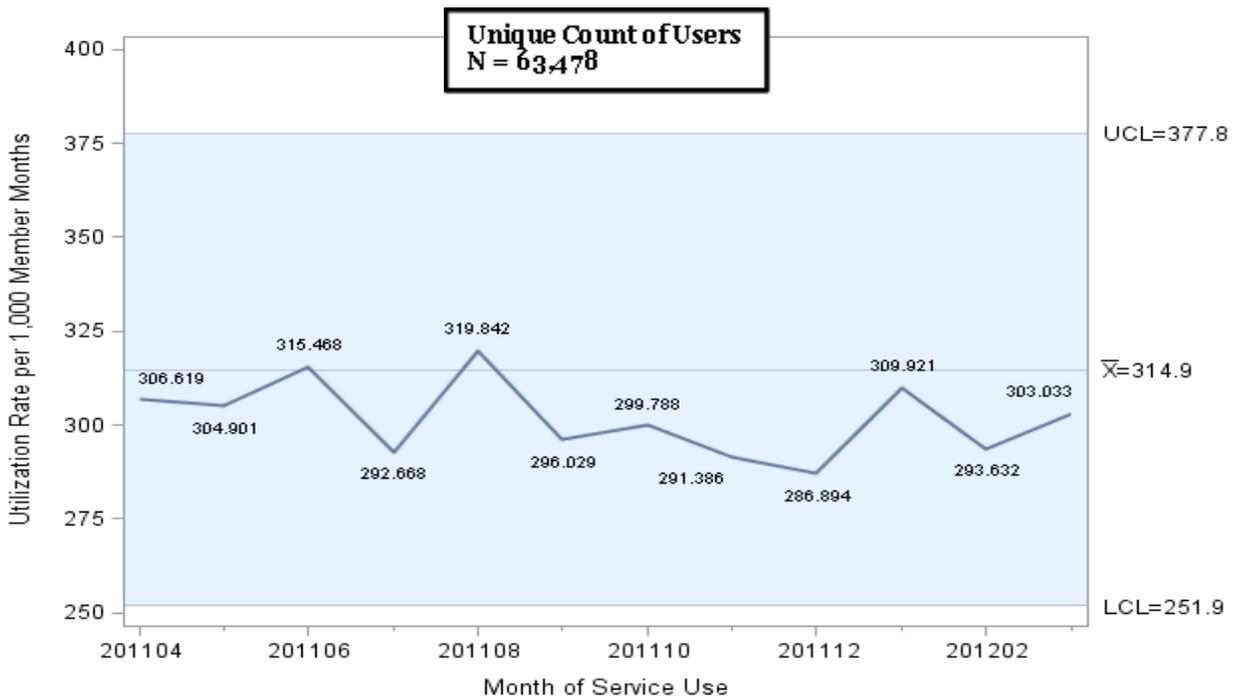
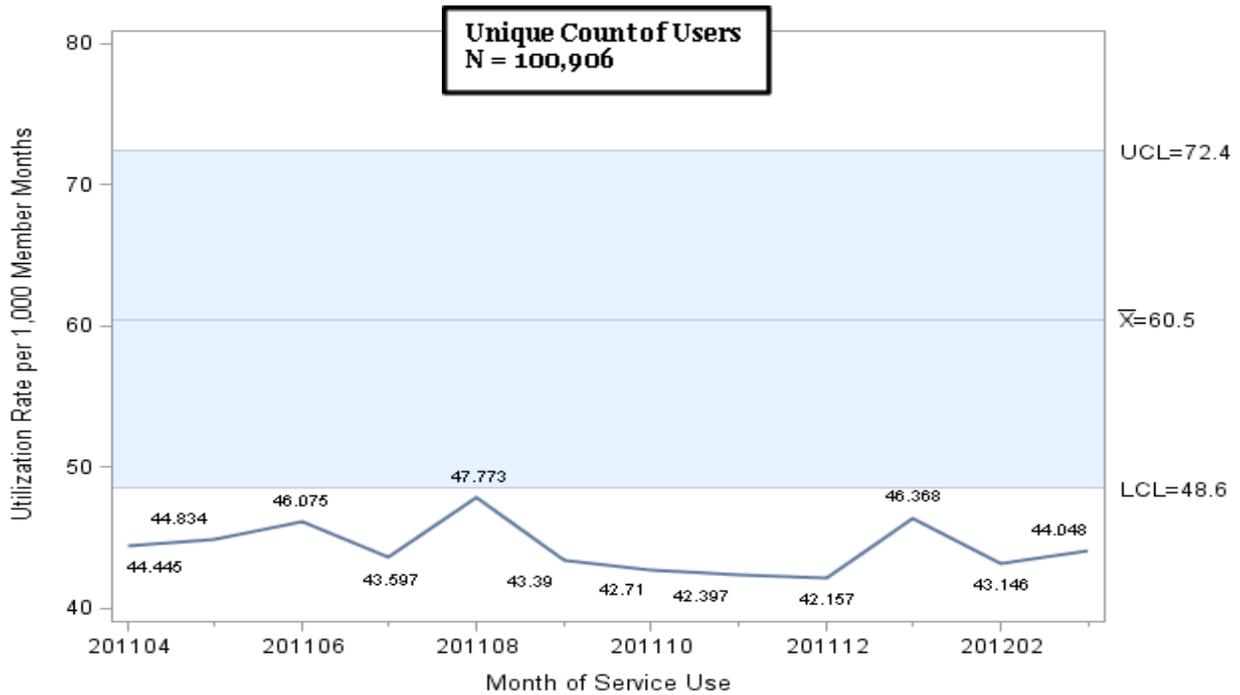


Figure 97 Monthly Other Services Use Rates, Adults Age 21+, Undocumented, April 2011–March 2012



Source: Data for figures 94–98 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from April 2012–March 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Summary Tables

Table 9 and Table 10 present the results of DHCS' analysis of the utilization trends among children and adults, respectively, by aid and service categories. The tables are color coded to identify those cases when a particular cell, which presents utilization by aid and service categories, generated a utilization rate that was either lower or higher than the established confidence level.

- Beige—Represents utilization rates found to be within the expected confidence intervals.
- Light Green—Represents utilization rates found to be outside of expected ranges earlier in the study period, but returning to rates within baseline ranges for the current quarter.
- Green—Represents utilization rates found to be outside of the expected confidence level.

In some cases, the utilization rate was found to be greater than expected. As noted above, there are a number of reasons why this might occur, such as changes in population mix.

Table 9 Summary of Service Utilization Trends Among Children by Aid Category and Service Category

Service Category Aid Category	Physician/ Clinic Visits	Non- Emergency Transportation	Emergency Medical Transportation	Home Health Services	Hospital Inpatient Services	Hospital Outpatient Services	Nursing Facility Services	Pharmacy Services	Other Services
Blind/ Disabled	Within Expected Range with Sharp Increase in Last Quarter	Above Expected Range with Sharp Increase in Last Quarter.	Mostly Below Average and Within Expected Range.	Upward Trend but Within Expected Range.	Mostly Within Expected Range. Upward Trend Beginning in Oct 2011.	Mostly Above Average Reaching Levels Above Expected Range Beginning in 2012.	Upward Trend but Within Range 2011 Q3 and Q4, and Beginning in 2012.	Upward Trend, Reaching Levels Above Expected Range in 2012.	Within Expected Range.
Families	Mostly Below Average and Within Expected Range, Increase in Last Quarter.	N/A	Below Average and Mostly Within Expected Range.	Within Expected Range, Decreasing in Last Quarter.	Mostly Within Expected Range.	Below Average and Within Expected Range.	N/A	Upward Trend (Jul-Mar). Below Average and Mostly Within Expected Range.	Within Expected Range.
Foster Care	Mostly Below Average but Within Expected Range, Increase in Last Quarter.	N/A	Within Expected Range.	N/A	Below Average and Within Expected Range.	Within Expected Range.	N/A	Mostly Above Average but Within Expected Range.	Within Expected Range.
Other	Mostly Below Average and Within Range, Increase in Last Quarter.	N/A	Below Average with 7 Consecutive Months Below Expected Range. Within Expected Range in Last Quarter.	Below Average but Approaching Average Range in Last Quarter. Mostly Within Expected Range.	Below Average and Below Expected Range in 2011 Q2, Q3 and Q4. Within Range Beginning in 2012.	Downward Trend (Apr-Sep). Below Average with 6 Consecutive Months Below Expected Range. Within Range Beginning in 2012.	N/A	Upward Trend (Jul-Jan). Below Average with 3 Consecutive Months Below the Expected Range.	Within Expected Range.
Undocumented	Below Expected Range.	N/A	Below Average with 4 Consecutive Months Below Expected Range.	N/A	Below Average with 7 Consecutive Months Below Range.	Below Average and Within Expected Range.	N/A	Below Average and Within Expected Range.	Mostly Below Expected Range.

Table 10 Summary of Service Utilization Trends Among Adults by Aid Category and Service Category

Service Category Aid Category	Physician/ Clinic Visits	Non-Emergency Transportation	Emergency Medical Transportation	Home Health Services	Hospital Inpatient Services	Hospital Outpatient Services	Nursing Facility Services	Pharmacy Services	Other Services
Aged	Mostly Below Average and Within Expected Range. Increase in Last quarter.	Upward Trend and Above Expected Range.	Upward Trend (Jul-Mar). Mostly Above Average and Above Expected Range, with Sharp Increase in Last Quarter.	Mostly Below Average and below Expected Range, Increase in Last Quarter.	Mostly Below Average with Sharp Increase in Last Quarter Reaching Levels Above Expected Range.	Within Expected Range. Increase in Last Quarter.	Upward Trend (Jul-Mar). Mostly Outside of Expected Range.	Downward Trend (Aug-Mar). Below Average and below Expected Range in Last Quarter.	Below Average with Several Non Consecutive Points Below Expected Range.
Blind/ Disabled	Within Expected Range. Increase in Last Quarter.	Above Expected Range.	Mostly Above Average with Levels Reaching Above Expected Range in Last Quarter.	Mostly Below Average and Within Expected Range. Slight Upward Trend Noted.	Mostly Below Average and Within Expected Range. Increase in Last Quarter.	Above Average and Within Expected Range. Increase in Last Quarter.	Upward Trend (Apr-Mar). Mostly Outside of Expected Range.	Within Expected Range.	Mostly Below Average and Within Expected Range. Increase in Last Quarter
Families	Below Average and Within Expected Range.	Above Expected Range, Decreasing in Last Quarter.	Downward Trend (Jul-Dec). Mostly Below Average and Within Expected Range.	Mostly Below Expected Range	Below Average but Mostly Within Expected Range.	Mostly Below Average but Within Expected Range.	Upward Trend with Several Non Consecutive Points Above Expected Range.	Below Average and Mostly Within Expected Range.	Below Average but Mostly Within Expected Range.
Other	Mostly Above Average and Within Expected Range.	Above Expected Range.	Within Expected Range.	Below Average and Within Expected Range.	Below Average but Mostly Within Expected Range.	Mostly Below Average and Within Expected Range.	Below Average and Mostly Within Expected Range.	Within Expected Range.	Mostly Below Average and Within Expected Range.
Undocu- mented	Below Average with 4 Consecutive Months Below Expected Range.	N/A	Mostly Below Expected Range.	N/A	Below Expected Range.	Below Average but Mostly Within Expected Range.	N/A	Mostly Above Average but Within Expected Range.	Below the Expected Range.

Conclusions—Service Utilization, Children Participating in FFS

1. Overall, service utilization patterns for children in most aid code categories followed the patterns identified in the previous report. For example, Hospital Outpatient services use was again noticeably higher among children in the Blind/Disabled aid category with rates ranging from two to three times higher than for children in any other aid category. Other services utilization among children in the majority of the analyzed aid categories fell within expected ranges. The utilization of Home Health services among children was again predominantly within the expected baseline ranges for those in the Families aid category, exhibiting a drop in utilization during the first quarter of 2012. Service utilization rates for Emergency Transportation were predominantly below average for children in most aid codes, and in some cases fell below rates established during the baseline study period.
2. Children in the Blind/Disabled aid category continue to place a greater demand on all types of services under study. Upward trends were noted in this population's use of Home Health, Nursing Facility, and Pharmacy services, as well as above average use of Hospital Outpatient services, and an increase in the use of Hospital Inpatient services, Non-Emergency Transportation, and Physician/Clinic visit use during the first quarter of 2012. Though many children in the Blind/Disabled aid category transitioned into managed care during 2011, those that remain in the Medi-Cal FFS delivery system continue to place a disproportionate demand on services of all kinds, most likely due to their complex medical needs.
3. During the last report period, Physician/Clinic service use patterns among children in most of the evaluated aid categories fell below average rates established during the baseline period, but were within expected ranges. With the exception of those in the Undocumented aid category, children in most aid categories exhibited a rise in Physician/Clinic services utilization beginning in 2012.
4. Among children in the Other aid category, utilization of most services were below average or below expected ranges established during the baseline period. However, beginning in the fourth quarter of 2011 or first quarter of 2012, service use among this subpopulation increased for most services types (e.g. Hospital Outpatient and Inpatient, Pharmacy, Home Health, Emergency Transportation, and Physician/Clinic visits).

Conclusions—Service Utilization, Adults Participating in FFS

1. As noted in the previous access quarterly report, adults in the Aged and Blind/Disabled aid categories continued to place a greater demand on services such as Emergency and Non-Emergency Transportation, and Nursing Facility services. Although Hospital Inpatient and Home Health service use among adults in these two aid categories fell below average in previous quarters, utilization rates for these services increased in the first quarter of 2012. Increases in the utilization of Hospital Outpatient and Physician/Clinic services were also reported during the first quarter of 2012, but remained within the expected ranges observed during the baseline period.
2. Adults in the Families aid category again displayed below average utilization of Emergency Transportation, Home Health, Hospital Inpatient, and Physician/Clinic services throughout most of the study period. The utilization of these services among younger adults (age <65) in the Families aid category is most likely correlated with continued declines in the birth rate, particularly for service categories such as Physician/Clinic visits, Emergency Transportation, and Hospital Inpatient services.
3. Adults in the Undocumented aid category, who are eligible for emergency and pregnancy-related services only, also continue to exhibit below average and below expected use of Physician/Clinic, Hospital Inpatient and Outpatient, and Emergency Transportation services, further strengthening the argument that these utilization patterns may be heavily influenced by the decline in births statewide and nationally.
4. Also of note is the continued demand for Nursing Facility and Non-Emergency Transportation services among a small group of adults (500<N<900) in the Families aid category. Among this subpopulation, utilization of these two services remains above average and in some cases above the expected ranges that were established during the baseline period of 2007-2009. These utilization patterns would require additional studies to identify factors that influence these utilization shifts.

Beneficiary Feedback

Introduction

In 2011, the Centers for Medicare and Medicaid Services strongly encouraged DHCS to implement a beneficiary help line as part of the DHCS' comprehensive health care access monitoring plan. Though DHCS has several administrative data sources that can be used to monitor health care access, there is no ongoing mechanism in place allowing beneficiaries to provide feedback pertaining to their experiences, including difficulties finding a provider, receiving referrals to specialists, and their difficulties with enrollment. In addition, though data from claims provides DHCS with information regarding services that were utilized by its members, beneficiaries who encounter factors that impede their use of services cannot be accounted for using this data source. The DHCS help line will address this gap in the information for monitoring health care access, and provide needed assistance to FFS beneficiaries having difficulties navigating the health care system.

The Medi-Cal beneficiary help line was implemented in December 2011, and is similar to the Medi-Cal Managed Care Division's Office of the Ombudsman call center that addresses the needs of Medi-Cal managed care beneficiaries. Beneficiary calls to the FFS help line will capture data pertaining to difficulties in accessing care, and provide data pertaining to health care access issues in the Medi-Cal FFS program. The rate that Medi-Cal FFS beneficiaries contact the help line for information and complaints can offer one measure of how well the program is meeting the needs of its FFS beneficiaries and solving problems when they arise.

Data collected for this purpose will provide DHCS with the only source of "real time" data pertaining to health care access problems encountered by beneficiaries in the FFS delivery model, and will enable DHCS to identify and correct health care access problems soon after they arise.

Methods

The Medi-Cal FFS beneficiary help line only began receiving calls at the end of December 2011. A large volume of calls from FFS beneficiaries continue to be addressed by the Office of the Ombudsman. Therefore, data from FFS beneficiaries calling into the Office of the Ombudsman were obtained for the purpose of this report. The Office of the Ombudsman call center documented over 6,000 calls from FFS beneficiaries during 2011. For each of these calls, the call center recorded the date and time of call, beneficiary aid category, county of residence, and reasons for the call. Data for these calls were summarized by month received, county, six aid category groupings (Families, Blind/Disabled, Aged, Foster Care, Undocumented, and Other), and reason for call.

Results

During April 2011–March 2012, the Office of the Ombudsman documented a total of 8,049 calls received from Medi-Cal FFS beneficiaries. This total number of calls represented a 25% increase from the previous reporting period. Table 11 presents the average call volume for each quarter from the second quarter of 2011 to the first quarter of 2012. Call volume per quarter increased from an average of 424 in the second quarter of 2011 to 918 for the current quarter, representing a 117% increase.

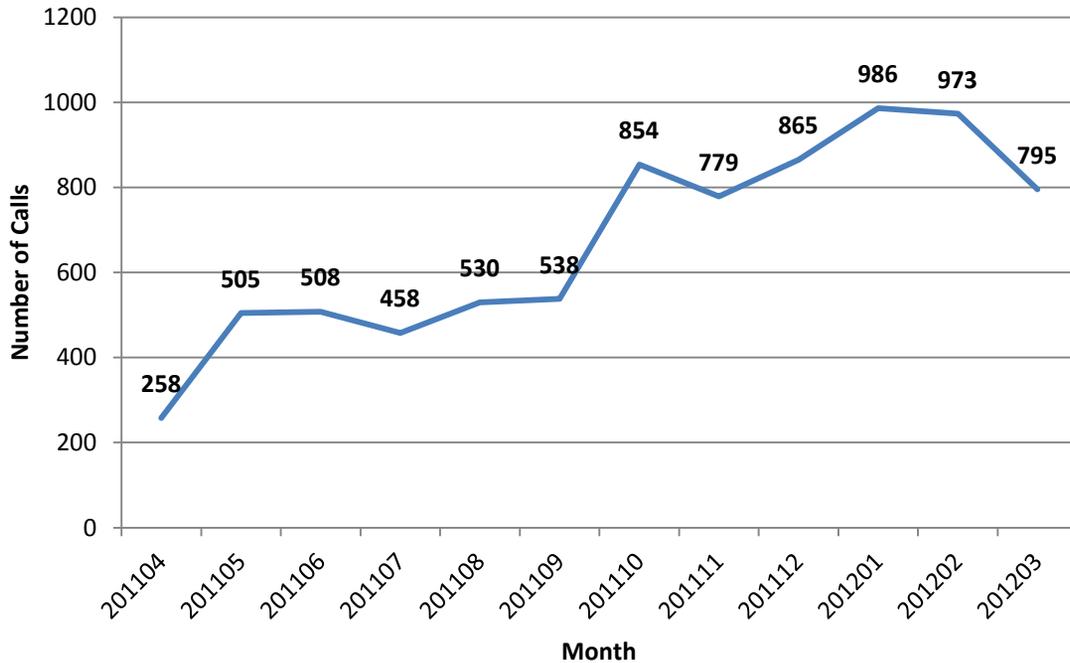
Table 11 Average Number of Calls by Quarter, April 2011–March 2012

Quarter	Average # of Calls
2011 Quarter 2	424
2011 Quarter 3	509
2011 Quarter 4	833
2012 Quarter 1	918

Source: Office of the Ombudsman, Medi-Cal Managed Care Division. Calls Received from FFS Beneficiaries, April 2011–March 2012.

Figure 98 provides a graph of the total calls received during April 2011–March 2012 by month. While a generally upward trend in call volume was observed during the last three quarters of 2011, a slight downward trend occurred toward the end of the most recent quarter reported (there was an 18% decrease in March 2012). A significant increase in calls that occurred in May 2011 (95% increase from the previous month) was likely due to the call center's increase in staffing resources at this time in anticipation of the transition of SPDs into managed care plans.

Figure 98 Calls Received by FFS Beneficiaries by Month, April 2011–March 2012



Source: Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received from FFS beneficiaries, April 2011–March 2012

Following this increase in call handling capacity was a relatively stable period of call volume from May to September 2011. The next significant increase in call volume that began in October 2011 (59% increase from the previous month) was likely due to the elimination of the Adult Day Health Center (ADHC) benefit that was scheduled for the end of 2011. Beneficiaries received notices of the scheduled elimination of the ADHC benefit at the end of August 2011. Subsequently, call volume remained relatively high and reached nearly 1,000 calls a month by the beginning of 2012.

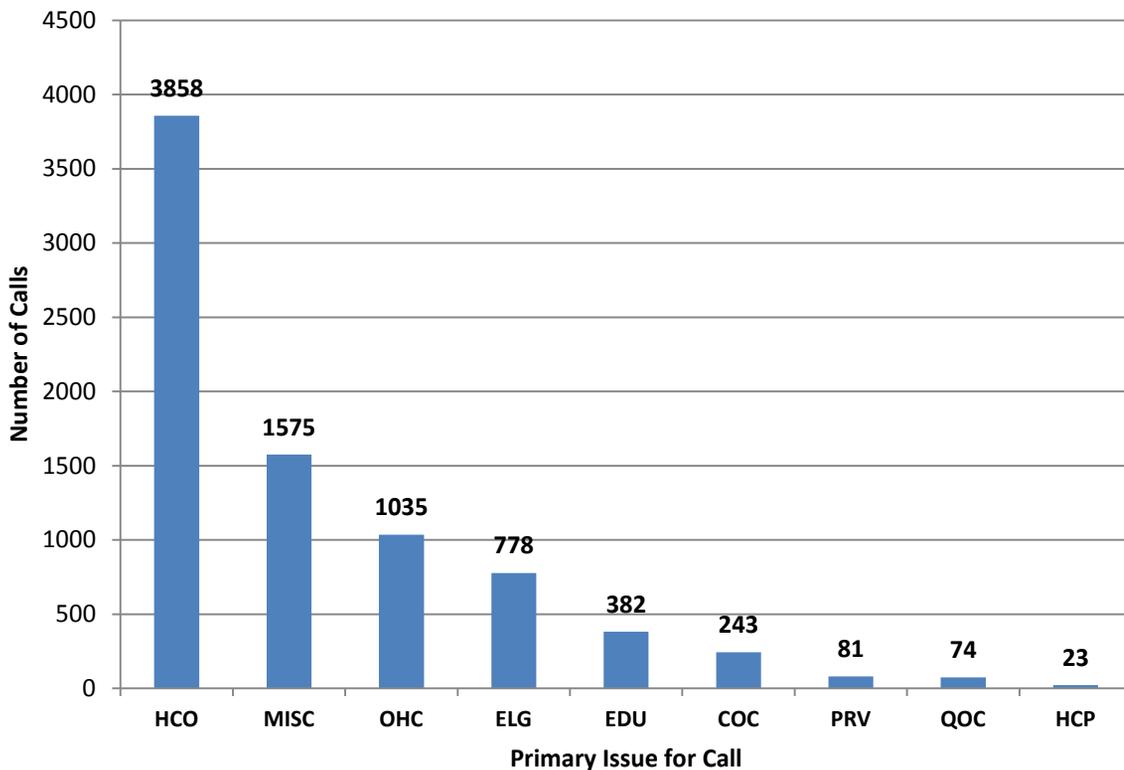
Primary and Secondary Reasons for Call

For each call received, Ombudsman call center staff assign one of the following categories based on the primary reason for each call:

- Continuity of Care
- Education & Outreach
- Eligibility
- Enrollment/Disenrollment
- Health Care Plan Issues
- Other Health Coverage
- Plan Subcontractor/Provider Issues
- Quality of Care
- Miscellaneous Issues

Figure 99 provides a breakdown of the calls received from FFS beneficiaries by primary reason for call. Over the study period, the largest proportion of calls received (48%) pertained to Enrollment/Disenrollment matters, followed by Miscellaneous issues (20%), Other Health Coverage issues (13%), and Eligibility issues (10%). The remaining 10% of calls were categorized as Education and Outreach (5%), Continuity of Care (3%), Plan Subcontractor/Provider Issues (1%), Quality of Care (1%), and Health Care Plan Issues (0.3%). This distribution of calls by primary reason closely resembles the distribution of calls for the previous reporting period of 2011.

Figure 99 Calls Received by FFS Beneficiaries by Primary Reason for Call, April 2011–March 2012

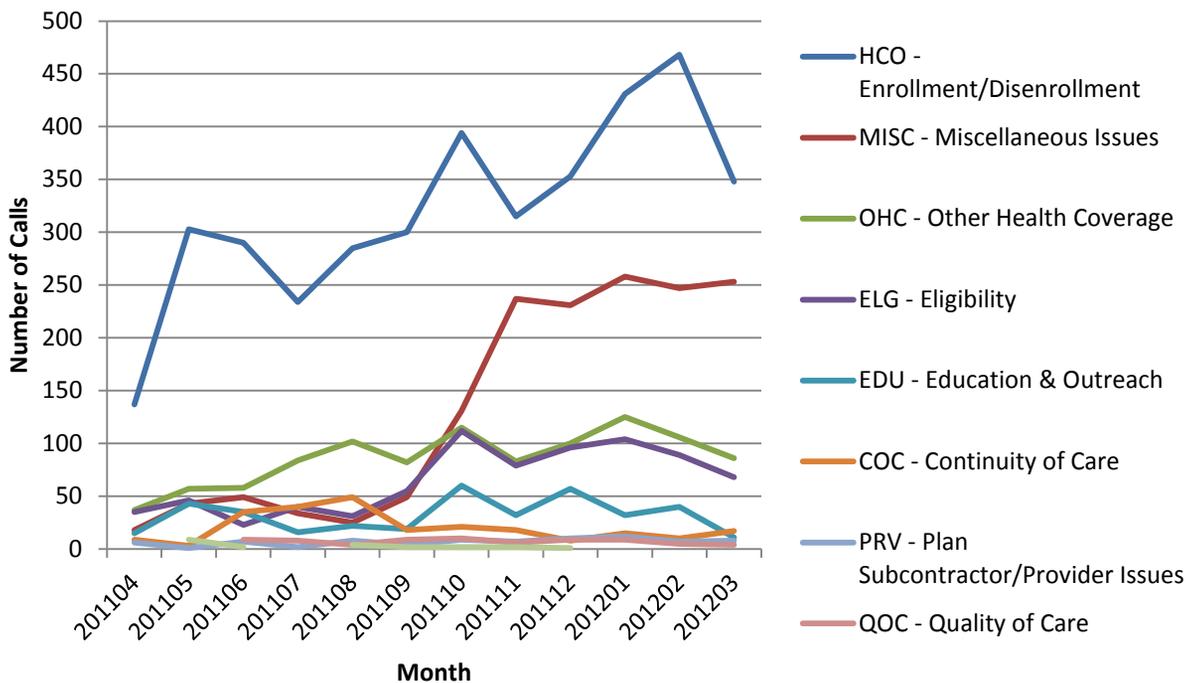


Source: Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received from FFS beneficiaries April 2011–March 2012. Definitions: COC–Continuity of Care, EDU–Education & Outreach, ELG–Eligibility, HCO–Enrollment/Disenrollment, HCP–Health Care Plan Issues, MISC–Miscellaneous Issues, OHC–Other Health Coverage, PRV–Plan Subcontractor/Provider Issues, QOC–Quality of Care.

As displayed in Figure 100, call volume patterns varied according to primary reason for call and month. Throughout the 12-month study period, the majority of calls pertained to Enrollment/Disenrollment issues. During the second and third quarters of 2011, Miscellaneous calls averaged less than 40 calls per month. Beginning in October 2011, Miscellaneous calls rose significantly, occurring at the same time as notices were sent to beneficiaries regarding the elimination of the ADHC benefit. These types of calls do not easily fit in any other primary reason category, and may explain the elevated call volume in the Miscellaneous category. After

the initial increase in October, Miscellaneous calls stabilized to an average of 250 calls per month for the remainder of the reporting period.

Figure 100 Calls Received by FFS Beneficiaries, Primary Reason for Call, by Month, April 2011–March 2012



Source: Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received from FFS beneficiaries, April 2011–March 2012

Calls for Other Health Coverage, Eligibility, and Education and Outreach rose slightly during the third quarter of 2011, but only comprised a relatively small portion of the total calls. Following the sharp increase in Miscellaneous calls in October 2011 and through the remainder of the reported months, the majority of calls received per month concerned issues labeled as Miscellaneous and Enrollment/Disenrollment. During this same period of time, calls for Other Health Coverage and Eligibility made up the next largest portion of calls.

These trends are fairly similar to those observed in 2011, with a few noticeable differences during the first quarter of 2012. From February to March 2012, a decrease in calls with issues concerning Enrollment/Disenrollment, Other Health Coverage, and Eligibility was observed, which reflects the decline observed in total calls received during this time.

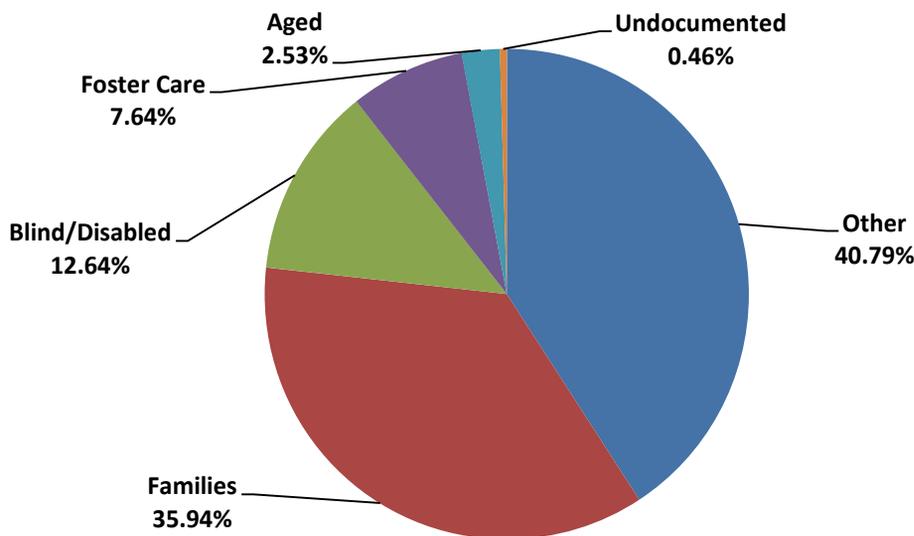
In addition to assigning each call received with a primary reason for the call, Ombudsman staff have the option to assign a secondary reason to the call. The top calls by primary reason (Enrollment/Disenrollment, Miscellaneous, and Other Health Coverage) were analyzed to explore the secondary reasons assigned to these calls. Among calls assigned with a primary reason of Enrollment/Disenrollment, the vast majority (63%) were assigned a secondary reason of “Requesting new enrollment into Plan,” followed by “Medical Exemption Request/Emergency

Medical Exemption Request” and “Wants to Disenroll from Plan to become FFS.” Of the calls that were labeled with a primary reason as Miscellaneous, the top secondary reasons assigned to these calls were “Other” (36%), “Voice Mail Call–No Answer” (26%), and “Voice Mail Call–Issue Resolved” (25%). Unfortunately these categories are too ambiguous to interpret. Among calls categorized under the primary reason, Other Health Coverage, the majority of calls were assigned a secondary reason as “Conflicting Information about Other Health Coverage Status” (71%).

Calls by Aid Category

The Medi-Cal aid categories reported by FFS beneficiary callers were collapsed into six aid categories. Figure 101 provides a distribution of calls received by aid category. Over the 12-month study period, the majority of calls were from beneficiaries in Family or Blind/Disabled aid categories (41% and 36%, respectively). The remaining 23% of calls were from beneficiaries in Aged, Foster Care, Undocumented, and Other aid categories. These findings are similar to those observed for the previous study period of 2011.

Figure 101 Calls Received by FFS Beneficiaries by Aid Category, April 2011–March 2012

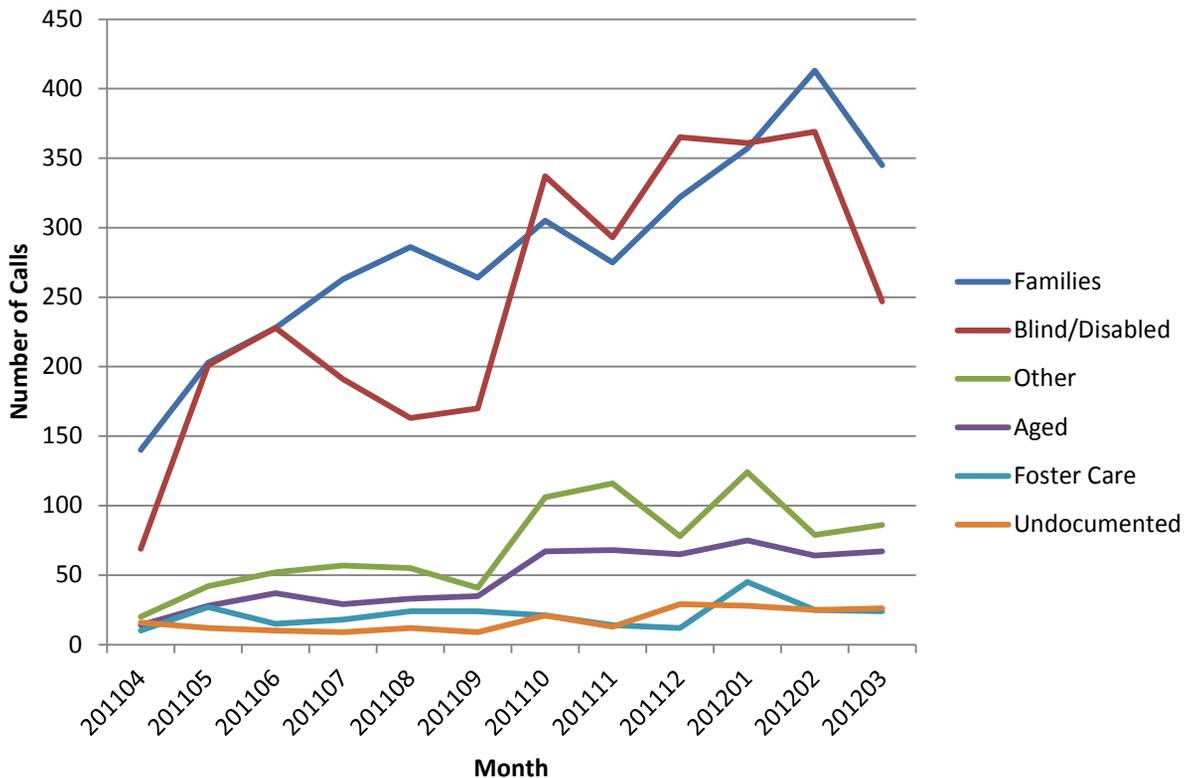


Source: Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received from FFS beneficiaries April 2011–March 2012.

Figure 102 summarizes calls by aid category and month. Across the 12-month study period, the majority of calls each month were from beneficiaries in Family or Blind/Disabled aid categories. An upward trend was observed in calls received each month from beneficiaries in Family aid categories. An upward trend in call volume was also observed for beneficiaries in Blind/Disabled aid categories. Calls from beneficiaries in Blind/Disabled aid categories rose sharply during the

second quarter of 2011, which corresponds to the increased Ombudsman staffing levels implemented to assist with the SPD transition. Calls from beneficiaries in Blind/Disabled aid categories increased again in October 2011 and remained relatively high until March 2012 when call volume declined. Calls from Blind/Disabled aid categories increased by 191% from April to May 2011, which corresponds to the increase in Ombudsman staffing resources to assist with the SPD transition. Additionally, calls from Blind/Disabled aid categories increased by 98% from September to October 2011. Following October 2011, calls from Blind/Disabled aid categories remained relatively high until they decreased by 33% from February to March 2012. Calls from beneficiaries in Aged, Foster Care, Undocumented, and Other aid categories made up a smaller portion of calls each month, with the proportion of calls from the Aged and Other aid categories increasing slightly beginning in October 2011.

Figure 102 Calls Received by FFS Beneficiaries, Aid Category by Month, April 2011–March 2012



Source: Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received by FFS beneficiaries April 2011–March 2012.

Further investigation was undertaken to explore whether primary reasons for calls varied by aid category. From the second quarter of 2011 to the first quarter of 2012, the majority of calls from each aid category were assigned a primary reason of Enrollment/Disenrollment issue, except among calls from Undocumented aid codes where the primary reason for calls was most frequently assigned as Other Health Coverage. Among each aid category, the following

secondary reasons were also frequently assigned to calls: Other Health Coverage, Miscellaneous, and Eligibility.

Calls by County

When examining call volume by county of caller residence, similar trends from the previous study period of 2011 continued. The highest volume of calls were received by FFS beneficiaries residing in Los Angeles County (29%), followed by San Bernardino (12%) and Riverside (12%) Counties. Table 12 reports call volume by the most commonly reported counties of residence reported by callers. These 10 counties and their respective order is similar to the previous study period, with one exception. San Joaquin was the 10th most reported county in the previous report and is now the 7th most reported county in the current report.

When examining reason for call by the callers' county of residence, the primary reason for calls did not vary greatly among the top 10 counties. Among each of these counties, the most common reasons for calls were Enrollment/Disenrollment, Other Health Coverage, Eligibility, and Miscellaneous. These findings are very similar to the overall trend among calls received during the 12-month period, regardless of county (see Figure 100).

Table 12 Calls Received from FFS Beneficiaries, Top 10 Counties

County	Number of Calls Received	Percent of Total Calls Received
Los Angeles	2,427	29.23%
San Bernardino	1,015	12.23%
Riverside	955	11.50%
San Diego	890	10.72%
Alameda	479	5.77%
Sacramento	474	5.71%
San Joaquin	313	3.77%
Contra Costa	283	3.41%
Santa Clara	271	3.26%
Orange	200	2.41%

Source: Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received from FFS beneficiaries, April 2011–March 2012

Conclusions

1. During April 2011-March 2012, the Ombudsman call center documented over 8,000 calls received from FFS beneficiaries in the Medi-Cal program. Total call volume during this 12-month period increased by 25% from the previous reporting period of 2011.
2. Upward trends in call volume were observed, with a slight decrease occurring in the first quarter of 2012. The largest increase in calls occurred in May 2011, where call volume increased by 95% from the previous month. Calls made to the Office of the Ombudsman were down by 18% in March 2012 from the previous month, perhaps due to the competing resources of the newly established FFS help line.
3. The majority of calls were made by beneficiaries who reported a Family (41%) or Blind/Disabled (36%) aid category. A smaller portion of calls were from Aged (10%) or Other (7%) aid categories.
4. The most common reason for FFS beneficiaries placing calls to the Office of the Ombudsman was for an enrollment/disenrollment issue. Those whose calls pertained to this issue were most often requesting new enrollment information, requesting a medical exemption, or were seeking information on how to disenroll from a plan.

Appendix A—Overview of Medi-Cal Claims Processing

Medi-Cal claims can be processed either through a hard-copy or electronic claim submission process. Hard copy claim submissions require staff at the Fiscal Intermediary to manually examine the documents for completeness and sort for data entry. If the claim is neatly-typed or computer-printed, it can be scanned into the system. All other claim forms must be entered manually by key data entry operators. Once it is entered into the system, the claim can be adjudicated. Electronic claim submission bypasses the claims examination and data entry process, allowing claims to be adjudicated almost immediately as in the case of most pharmacy claims.

The original Medi-Cal claim must be received by the Fiscal Intermediary within six months following the month in which the services were rendered. Late submissions are subject to a payment cut-back and eventually denied if submitted twelve months following the date of service.

Claims entering the adjudication process are examined on a line-by-line basis except for inpatient hospital claims. Inpatient claims are adjudicated based on the entire claim. Each claim is subject to various edits to determine if the claim should be paid, denied or suspended for manual review by a claims examiner or medical professional. As part of the adjudication process, claims are verified for items such as provider/recipient eligibility, any third party liability, duplication of claims, and authorization requirements.

If a claim suspends for a manual review and an input error is detected, the error must be corrected and the claim continues processing. If there is questionable or missing information on the claim, a Resubmission Turnaround Document (RTD) is sent to the provider. This document allows providers to add or correct the requested information before the claim is denied. If the provider does not return the document within a 60-day period, the claim is automatically denied.

If a claim can be adjudicated, the claims processing system makes a determination on payment. Claims can be paid, denied, or adjusted. Paid claims/claim lines passing the final adjudication process may be reimbursed as submitted or at reduced amounts based on Medi-Cal program specifications. Denied claims/claim lines are deemed unacceptable for payment if they reflect a non-Medi-Cal program benefit, the claim information cannot be validated by the Fiscal Intermediary, the line item fails the edit process, or the provider fails to return the RTD in the 60-day period. Claims/claim lines may be adjusted if an error in payment occurs. The original claim/claim line will be voided and a new claim/claim line will reflect the adjusted payment.

The provider can submit a Claims Inquiry Form (CIF) if the provider is requesting an adjustment, reconsideration of a denied claim, or if the provider requests a tracer on a status of a claim. In cases of adjustments and reconsideration of the denied claim, the provider has six months from the date of action to submit the CIF. Tracers may be submitted at any time.

If the provider is unable to resolve a claim issue to their satisfaction, the provider may submit an appeal. Appeals may be submitted for unsatisfactory responses to the processing, payment, and resubmission of a claim or claim inquiry. Providers must submit their appeal in writing within

90 days of the action/inaction precipitating the complaint; otherwise it is an automatic denial. If the provider is not satisfied with the appeal decision, they can seek judicial relief by filing a suit in the local court, naming DHCS as the defendant. The provider has one year after the appeal decision to file a suit.

Due to the complex and sometimes lengthy claims adjudication process as described above, there may be a significant time lag between the date that Medi-Cal beneficiaries receive a service and the actual final reporting/payment on the claim. Time lags between the date of payment and date of services were analyzed for each service category contained in this Quarterly Report, and are presented in the table below. Service utilization data in this Quarterly Report are based on a 4-month lag period.

Table 13 Claim Lag Times for Select Services

Regular <u>Visit</u> Lags - Services Provided During Fiscal Year 2007–08												
Service Category	Months between Service Date and Date Claims were Paid											
	Same Month	+1	+2	+3	+4	+5	+6	+7	+8	+9	+10	+11
Home Health	0.0551	0.3126	0.6147	0.7679	0.8563	0.9065	0.9386	0.9610	0.9738	0.9842	0.9917	1.0000
Hospital Inpatient	0.0450	0.4822	0.6933	0.8082	0.8687	0.9050	0.9312	0.9497	0.9646	0.9761	0.9859	1.0000
Hospital Outpatient	0.0964	0.5919	0.7770	0.8561	0.8972	0.9227	0.9420	0.9566	0.9681	0.9776	0.9860	1.0000
Nursing Facility	0.2770	0.7908	0.8798	0.9300	0.9586	0.9720	0.9824	0.9874	0.9920	0.9948	0.9974	1.0000
Pharmacy	0.4532	0.9530	0.9764	0.9849	0.9900	0.9933	0.9957	0.9971	0.9979	0.9985	0.9990	1.0000
Physician/Clinic	0.1039	0.5802	0.7627	0.8430	0.8907	0.9206	0.9423	0.9577	0.9696	0.9794	0.9880	1.0000
ER Transportation	0.0596	0.4656	0.6869	0.7942	0.8544	0.8914	0.9199	0.9420	0.9611	0.9753	0.9853	1.0000
Non-ER Transportation	0.1680	0.4933	0.6566	0.7558	0.8249	0.8748	0.9098	0.9385	0.9549	0.9692	0.9839	1.0000

Appendix B—Participation Detail Tables

Table 14 FFS Beneficiaries, Medi-Cal Only, Average Member Months per Quarter, by County

County Name	Average Member Months				Percent Change	
	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	2011 Qtr 2– 2012 Qtr 1	2011 Qtr 4– 2012 Qtr 1
Alameda	70,664	65,975	60,254	54,958	-22.2	-8.8
Alpine	163	152	162	173	6.1	6.8
Amador	3,645	3,651	3,650	3,675	0.8	0.7
Butte	42,496	41,917	41,425	41,269	-2.9	-0.4
Calaveras	5,545	5,577	5,530	5,542	-0.1	0.2
Colusa	4,004	4,012	3,965	3,980	-0.6	0.4
Contra Costa	43,246	40,453	37,882	35,443	-18.0	-6.4
Del Norte	6,788	6,757	6,725	6,730	-0.9	0.1
El Dorado	15,889	15,757	15,603	15,588	-1.9	-0.1
Fresno	70,601	67,728	63,439	60,918	-13.7	-4.0
Glenn	6,134	6,084	5,999	6,066	-1.1	1.1
Humboldt	21,902	21,923	21,777	21,678	-1.0	-0.5
Imperial	46,545	46,416	46,091	45,972	-1.2	-0.3
Inyo	2,920	2,935	2,899	2,916	-0.1	0.6
Kern	71,154	67,869	62,891	60,974	-14.3	-3.0
Kings	10,170	9,431	8,776	8,332	-18.1	-5.1
Lake	14,245	14,115	13,923	13,945	-2.1	0.2
Lassen	4,228	4,252	4,199	4,101	-3.0	-2.3
Los Angeles	717,924	692,151	639,689	594,787	-17.2	-7.0
Madera	15,027	13,625	12,891	12,440	-17.2	-3.5
Marin	17,485	5,356	5,118	5,126	-70.7	0.2
Mariposa	2,291	2,273	2,198	2,205	-3.8	0.3
Mendocino	18,930	2,582	2,493	2,488	-86.9	-0.2
Merced	10,569	10,594	10,178	10,282	-2.7	1.0
Modoc	1,648	1,625	1,589	1,587	-3.7	-0.1
Mono	1,240	1,233	1,210	1,253	1.0	3.6
Monterey	21,890	21,104	19,951	20,691	-5.5	3.7
Napa	2,729	2,754	2,621	2,591	-5.1	-1.1
Nevada	9,244	9,213	9,213	9,161	-0.9	-0.6
Orange	74,876	75,536	72,060	70,628	-5.7	-2.0
Placer	24,780	24,978	24,872	24,906	0.5	0.1
Plumas	2,408	2,419	2,434	2,427	0.8	-0.3
Riverside	113,636	109,459	102,091	95,248	-16.2	-6.7
Sacramento	76,346	70,796	65,340	60,481	-20.8	-7.4
San Benito	8,959	8,924	8,796	8,908	-0.6	1.3
San Bernardino	139,775	134,580	125,853	119,133	-14.8	-5.3
San Diego	128,045	121,431	113,309	104,763	-18.2	-7.5
San Francisco	36,053	31,915	28,143	24,448	-32.2	-13.1
San Joaquin	48,349	44,403	40,627	38,061	-21.3	-6.3
San Luis Obispo	4,327	4,198	4,050	4,152	-4.0	2.5
San Mateo	13,892	13,854	13,853	14,150	1.9	2.1
Santa Barbara	16,370	16,122	15,626	15,758	-3.7	0.8
Santa Clara	75,544	71,686	69,287	66,585	-11.9	-3.9

County Name	Average Member Months				Percent Change	
	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	2011 Qtr 2– 2012 Qtr 1	2011 Qtr 4– 2012 Qtr 1
Santa Cruz	6,781	6,578	6,443	6,552	-3.4	1.7
Shasta	33,351	33,444	32,745	32,557	-2.4	-0.6
Sierra	368	343	334	334	-9.2	0.0
Siskiyou	8,523	8,371	8,277	8,350	-2.0	0.9
Solano	7,001	6,951	6,714	6,640	-5.2	-1.1
Sonoma	9,291	9,153	8,841	8,670	-6.7	-1.9
Stanislaus	43,638	41,442	39,031	37,588	-13.9	-3.7
Sutter	19,476	19,606	19,546	19,557	0.4	0.1
Tehama	15,217	15,025	14,455	14,376	-5.5	-0.5
Trinity	2,211	2,199	2,217	2,204	-0.3	-0.6
Tulare	42,324	41,187	39,495	38,383	-9.3	-2.8
Tuolumne	6,478	6,495	6,378	6,391	-1.3	0.2
Ventura	107,279	20,583	19,606	19,453	-81.9	-0.8
Yolo	4,025	4,050	3,892	3,725	-7.5	-4.3
Yuba	17,972	17,921	17,559	17,352	-3.4	-1.2

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files, April 2011–March 2012. Data reflects a 4-month reporting lag.

Table 15 FFS Full Scope Beneficiaries, Medi-Cal Only, by County

County Name	Average Member Months				Percent Change	
	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	2011 Qtr 2– 2012 Qtr 1	2011 Qtr 4– 2012 Qtr 1
Alameda	49,634	44,954	39,254	33,910	-31.7	-13.6
Alpine	163	152	162	173	6.1	6.8
Amador	3,515	3,517	3,537	3,568	1.5	0.9
Butte	40,984	40,507	40,103	39,979	-2.5	-0.3
Calaveras	5,396	5,412	5,370	5,380	-0.3	0.2
Colusa	3,527	3,557	3,524	3,524	-0.1	0.0
Contra Costa	28,468	25,929	23,575	21,320	-25.1	-9.6
Del Norte	6,586	6,564	6,540	6,558	-0.4	0.3
El Dorado	14,675	14,597	14,506	14,507	-1.1	0.0
Fresno	40,495	38,207	34,230	31,524	-22.2	-7.9
Glenn	5,461	5,429	5,367	5,441	-0.4	1.4
Humboldt	21,203	21,260	21,143	21,064	-0.7	-0.4
Imperial	45,377	45,294	45,029	44,952	-0.9	-0.2
Inyo	2,602	2,610	2,576	2,586	-0.6	0.4
Kern	46,601	43,841	39,547	37,492	-19.5	-5.2
Kings	6,740	6,132	5,591	5,142	-23.7	-8.0
Lake	13,502	13,387	13,230	13,269	-1.7	0.3
Lassen	4,082	4,110	4,074	3,984	-2.4	-2.2
Los Angeles	391,886	367,363	319,603	277,081	-29.3	-13.3
Madera	7,409	6,303	5,645	5,195	-29.9	-8.0
Marin	12,556	582	531	537	-95.7	1.1
Mariposa	2,218	2,203	2,133	2,139	-3.6	0.3
Mendocino	17,149	804	740	712	-95.8	-3.8
Merced	2,319	2,455	2,179	2,310	-0.4	6.0
Modoc	1,567	1,548	1,518	1,507	-3.8	-0.7
Mono	975	975	980	1,012	3.8	3.3
Monterey	3,317	3,368	2,802	2,779	-16.2	-0.8
Napa	668	706	636	609	-8.8	-4.2
Nevada	8,889	8,848	8,859	8,818	-0.8	-0.5
Orange	16,662	17,948	15,423	14,130	-15.2	-8.4
Placer	23,566	23,804	23,746	23,747	0.8	0.0
Plumas	2,349	2,357	2,373	2,366	0.7	-0.3
Riverside	83,746	79,802	72,758	66,351	-20.8	-8.8
Sacramento	61,054	5,6012	50,891	46,002	-24.7	-9.6
San Benito	7,800	7,803	7,712	7,792	-0.1	1.0
San Bernardino	105,668	100,730	92,566	86,416	-18.2	-6.6
San Diego	100,609	94,624	87,141	78,876	-21.6	-9.5
San Francisco	26,769	22,648	18,845	15,086	-43.6	-19.9
San Joaquin	33,196	29,510	26,112	23,607	-28.9	-9.6

County Name	Average Member Months				Percent Change	
	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	2011 Qtr 2– 2012 Qtr 1	2011 Qtr 4– 2012 Qtr 1
San Luis Obispo	1,284	1,273	1,233	1,279	-0.4	3.7
Santa Barbara	3,302	3,422	3,253	3,178	-3.8	-2.3
Santa Clara	40,761	37,650	35,664	33,090	-18.8	-7.2
Santa Cruz	1,552	1,564	1,552	1,564	0.8	0.8
Shasta	32,862	32,958	32,298	32,139	-2.2	-0.5
Sierra	362	340	331	330	-8.8	-0.3
Siskiyou	8,331	8,201	8,112	8,182	-1.8	0.9
Solano	1,942	1,979	1,856	1,798	-7.4	-3.1
Sonoma	3,006	2,947	2,772	2,639	-12.2	-4.8
Stanislaus	32,364	30,464	28,363	27,103	-16.3	-4.4
Sutter	17,833	17,980	17,953	17,968	0.8	0.1
Tehama	14,088	13,942	13,444	13,400	-4.9	-0.3
Trinity	2,192	2,182	2,202	2,188	-0.2	-0.6
Tulare	22,514	21,763	20,415	19,186	-14.8	-6.0
Tuolumne	6,405	6,425	6,319	6,334	-1.1	0.2
Ventura	90,885	4,962	4,603	4,540	-95.0	-1.4
Yolo	1,663	1,790	1,699	1,606	-3.4	-5.5
Yuba	16,830	16,803	16,474	16,275	-3.3	-1.2

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012. Data reflects a 4-month reporting lag.

Table 16 FFS Full Scope Children Age 0–17, Average Member Months by County

County Name	Average Member Months				Percent Change	
	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	2011 Qtr 2– 2012 Qtr 1	2011 Qtr 2– 2012 Qtr 1
Alameda	19,419	19,028	18,452	17,441	-10.2	-5.5
Alpine	83	81	84	89	7.2	6.0
Amador	1,879	1,866	1,861	1,865	-0.7	0.2
Butte	21,448	21,187	20,963	20,851	-2.8	-0.5
Calaveras	2,773	2,804	2,802	2,790	0.6	-0.4
Colusa	2,381	2,391	2,351	2,336	-1.9	-0.6
Contra Costa	12,030	11,590	11,649	11,388	-5.3	-2.2
Del Norte	3,362	3,336	3,334	3,363	0.0	0.9
El Dorado	8,131	8,111	8,083	8,084	-0.6	0.0
Fresno	18,536	18,903	17,956	17,561	-5.3	-2.2
Glenn	3,382	3,397	3,380	3,398	0.5	0.5
Humboldt	10,912	11,037	11,002	10,926	0.1	-0.7
Imperial	25,653	25,695	25,541	25,583	-0.3	0.2
Inyo	1,494	1,528	1,518	1,507	0.9	-0.7
Kern	24,929	24,812	23,168	22,930	-8.0	-1.0
Kings	3,600	3,462	3,290	3,164	-12.1	-3.8
Lake	6,971	6,949	6,831	6,862	-1.6	0.5
Lassen	2,127	2,155	2,141	2,107	-0.9	-1.6
Los Angeles	167,937	174,068	162,774	151,970	-9.5	-6.6
Madera	3,935	3,554	3,386	3,173	-19.4	-6.3
Marin	7,960	374	330	335	-95.8	1.5
Mariposa	1,176	1,170	1,128	1,132	-3.7	0.4
Mendocino	9,512	475	420	390	-95.9	-7.1
Merced	1,599	1,718	1,453	1,539	-3.8	5.9
Modoc	829	830	817	804	-3.0	-1.6
Mono	663	674	673	681	2.7	1.2
Monterey	2,484	2,488	1,967	1,955	-21.3	-0.6
Napa	447	467	398	393	-12.1	-1.3
Nevada	4,675	4,652	4,657	4,632	-0.9	-0.5
Orange	11,911	13,175	10,850	9,665	-18.9	-10.9
Placer	13,674	13,835	13,802	13,871	1.4	0.5
Plumas	1,228	1,250	1,280	1,248	1.6	-2.5
Riverside	45,859	46,574	43,674	41,362	-9.8	-5.3
Sacramento	25,342	25,269	25,310	25,055	-1.1	-1.0
San Benito	4,959	4,976	4,904	4,950	-0.2	0.9
San Bernardino	54,960	55,158	51,995	49,966	-9.1	-3.9
San Diego	49,889	50,130	49,085	46,992	-5.8	-4.3
San Francisco	6,028	5,982	5,788	5,599	-7.1	-3.3
San Joaquin	16,074	15,157	14,190	13,647	-15.1	-3.8

County Name	Average Member Months				Percent Change	
	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	2011 Qtr 2– 2012 Qtr 1	2011 Qtr 2– 2012 Qtr 1
San Luis Obispo	796	791	778	800	0.5	2.8
Santa Clara	16,154	16,477	17,406	17,670	9.4	1.5
Santa Cruz	1,030	1,027	1,020	988	-4.1	-3.1
Shasta	17,006	17,097	16,788	16,649	-2.1	-0.8
Sierra	186	167	157	161	-13.4	2.5
Siskiyou	4,283	4,235	4,206	4,210	-1.7	0.1
Solano	1,218	1,276	1,217	1,121	-8.0	-7.9
Sonoma	1,993	2,009	1,872	1,749	-12.2	-6.6
Stanislaus	15,736	15,443	14,971	14,825	-5.8	-1.0
Sutter	10,532	10,697	10,629	10,693	1.5	0.6
Tehama	8,138	8,061	7,792	7,753	-4.7	-0.5
Trinity	1,071	1,054	1,076	1,073	0.2	-0.3
Tulare	11,348	11,899	11,603	11,336	-0.1	-2.3
Tuolumne	3,279	3,277	3,216	3,225	-1.6	0.3
Ventura	61,106	3,333	3,027	2,979	-95.1	-1.6
Yolo	1,198	1,305	1,227	1,145	-4.4	-6.7
Yuba	9,416	9,418	9,268	9,149	-2.8	-1.3

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012. Data reflects a 4-month reporting lag.

Table 17 FFS Women Age 18–64 Covered by Medi-Cal Only, Average Member Months by County

County Name	Average Member Months				Percent Change	
	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	2011 Qtr 2– 2012 Qtr 1	2011 Qtr 4– 2012 Qtr 1
Alameda	25,244	23,714	21,908	20,332	-19.5	-7.2
Alpine	46	39	45	47	2.2	4.4
Amador	1,084	1,105	1,113	1,130	4.2	1.5
Butte	12,406	12,267	12,114	12,105	-2.4	-0.1
Calaveras	1,668	1,668	1,653	1,655	-0.8	0.1
Colusa	1,002	1,004	1,005	1,020	1.8	1.5
Contra Costa	15,441	14,535	13,590	12,799	-17.1	-5.8
Del Norte	1,980	1,992	1,978	1,969	-0.6	-0.5
El Dorado	4,571	4,494	4,462	4,463	-2.4	0.0
Fresno	26,738	25,325	23,970	23,016	-13.9	-4.0
Glenn	1,672	1,645	1,607	1,642	-1.8	2.2
Humboldt	6,547	6,495	6,432	6,441	-1.6	0.1
Imperial	13,512	13,444	13,431	13,366	-1.1	-0.5
Inyo	846	831	815	826	-2.4	1.3
Kern	24,339	22,885	21,350	20,672	-15.1	-3.2
Kings	3,505	3,215	2,993	2,790	-20.4	-6.8
Lake	4,263	4,180	4,141	4,127	-3.2	-0.3
Lassen	1,263	1,269	1,247	1,209	-4.3	-3.0
Los Angeles	282,572	271,222	254,311	240,781	-14.8	-5.3
Madera	5,651	5,188	4,894	4,818	-14.7	-1.6
Marin	5,341	2,687	2,591	2,624	-50.9	1.3
Mariposa	666	664	655	647	-2.9	-1.2
Mendocino	5,495	1,075	1,061	1,072	-80.5	1.0
Merced	4,599	4,577	4,543	4,598	0.0	1.2
Modoc	488	470	445	452	-7.4	1.6
Mono	323	309	301	323	0.0	7.3
Monterey	10,142	9,862	9,597	9,971	-1.7	3.9
Napa	1,281	1,297	1,266	1,256	-2.0	-0.8
Nevada	2,798	2,796	2,799	2,775	-0.8	-0.9
Orange	37,013	36,780	36,123	36,100	-2.5	-0.1
Placer	6,800	6,829	6,763	6,766	-0.5	0.0
Plumas	729	728	724	735	0.8	1.5
Riverside	38,377	35,992	33,958	31,868	-17.0	-6.2
Sacramento	27,281	24,715	22,157	19,933	-26.9	-10.0
San Benito	2,449	2,430	2,410	2,463	0.6	2.2
San Bernardino	47,787	45,279	42,675	40,500	-15.2	-5.1
San Diego	44,245	41,300	38,252	35,339	-20.1	-7.6
San Francisco	13,269	11,814	10,605	9,437	-28.9	-11.0
San Joaquin	16,555	15,181	13,967	1,3122	-20.7	-6.0
San Luis Obispo	1,897	1,846	1,798	1,845	-2.7	2.6
San Mateo	6,495	6,462	6,537	6,679	2.8	2.2
Santa Barbara	7,880	7,697	7,541	7,645	-3.0	1.4
Santa Clara	28,918	27,591	26,814	26,082	-9.8	-2.7
Santa Cruz	3,365	3,270	3,197	3,307	-1.7	3.4

County Name	Average Member Months				Percent Change	
	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	2011 Q2– 2012 Q1	2011 Q4– 2012 Q1
Shasta	9,917	9,926	9,695	9,654	-2.7	-0.4
Sierra	102	97	96	97	-4.9	1.0
Siskiyou	2,542	2,467	2,442	2,485	-2.2	1.8
Solano	3,090	3,041	2,944	2,981	-3.5	1.3
Sonoma	4,348	4,250	4,137	4,096	-5.8	-1.0
Stanislaus	14,899	14,013	13,021	12,500	-16.1	-4.0
Sutter	5,210	5,188	5,190	5,165	-0.9	-0.5
Tehama	4,231	4,172	4,013	4,018	-5.0	0.1
Trinity	694	696	687	674	-2.9	-1.9
Tulare	15,716	15,012	14,410	14,064	-10.5	-2.4
Tuolumne	1,970	1,999	1,968	1,951	-1.0	-0.9
Ventura	27,632	9,731	9,418	9,398	-66.0	-0.2
Yolo	1,557	1,526	1,495	1,474	-5.3	-1.4
Yuba	5,087	5,074	4,941	4,888	-3.9	-1.1

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012. Data reflects a 4-month reporting lag.

Table 18 FFS Full Scope, Average Member Months by Gender and Age Group

Full Scope		Average Member Months				Percent Change	
Gender	Age Category	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	2011 Qtr 2– 2012 Qtr 1	2011 Qtr 2– 2012 Qtr 1
Women	0–17	371,148	338,311	325,196	315,590	-15.0	-3.0
	18–64	429,068	372,547	337,321	307,470	-28.3	-8.8
	65 or Older	40,177	30,650	21,625	13,530	-66.3	-37.4
Men	0–17	398,077	364,202	348,627	335,766	-15.7	-3.7
	18–64	290,922	241,765	206,396	176,600	-39.3	-14.4
	65 or Older	23,860	18,115	12,821	8,183	-65.7	-36.2
All	0–17	769,225	702,513	673,823	651,356	-15.3	-3.3
	18–64	719,990	614,312	543,717	484,070	-32.8	-11.0
	65 or Older	64,037	48,765	34,446	21,713	-66.1	-37.0
Total		1,553,252	1,365,590	1,251,986	1,157,139	-25.5	-7.6

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012. Data reflects a 4-month reporting lag.

Table 19 FFS Restricted Scope, Average Member Months by Gender and Age

Restricted Scope		Average Member Months				Percent Change	
Gender	Age Category	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	2011 Qtr 2– 2012 Qtr 1	2011 Qtr 4– 2012 Qtr 1
Women	0–17	68,447	66,456	64,082	62,164	-9.2	-3.0
	18–64	412,971	412,814	406,976	406,723	-1.5	-0.1
	65 or Older	10,945	10,861	10,863	11,015	0.6	1.4
Men	0–17	70,058	68,054	65,712	63,583	-9.2	-3.2
	18–64	225,549	222,727	219,832	221,180	-1.9	0.6
	65 or Older	5,371	5,380	5,451	5,555	3.4	1.9
All	0–17	138,505	134,510	129,794	125,747	-9.2	-3.1
	18–64	638,520	635,541	626,808	627,903	-1.7	0.2
	65 or Older	16,316	16,241	16,314	16,570	1.6	1.6
Total		793,341	786,292	772,916	770,220	-2.9	-0.3

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012. Data reflects a 4-month reporting lag.

Table 20 FFS Average Member Months by Age and Aid Category

Statewide		Average Member Months				Percent Change	
Age Group	Aid Category	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	2011 Qtr 2– 2012 Qtr 1	2011 Qtr 4– 2012 Qtr 1
0–20	Blind/Disabled	81,192	70,342	61,535	53,567	-34.0	-12.9
	Families	467,258	412,180	411,342	392,609	-16.0	-4.6
	Foster Care	105,655	87,688	86,623	97,736	-7.5	12.8
	Other	214,797	221,541	199,278	190,436	-11.3	-4.4
	Undocumented	178,027	173,069	167,425	163,190	-8.3	-2.5
21 & over	Aged	58,593	44,294	30,720	18,744	-68.0	-39.0
	Blind/Disabled	337,458	270,616	205,577	146,531	-56.6	-28.7
	Families	230,397	203,053	201,017	200,428	-13.0	-0.3
	Other	55,325	55,853	55,871	56,960	3.0	1.9
	Undocumented	617,893	612,510	604,809	606,310	-1.9	0.2
Total		2,346,614	2,151,164	2,024,217	1,926,524	-17.9	-4.8

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012. Data reflects a 4-month reporting lag.

Table 21 FFS Average Member Months, by Age and Aid Category, Metropolitan Counties

Metropolitan County		Average Member Months				Percent Change	
Age Group	Aid Category	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	2011 Qtr 2– 2012 Qtr 1	2011 Qtr 4– 2012 Qtr 1
0–20	Blind/Disabled	77,747	67,306	58,547	50,597	-34.9	-13.6
	Families	405,555	359,085	358,921	340,187	-16.1	-5.2
	Foster Care	101,708	84,283	83,218	94,314	-7.3	13.3
	Other	205,162	212,552	190,410	181,767	-11.4	-4.5
	Undocumented	175,909	171,011	165,499	161,301	-8.3	-2.5
21 & over	Aged	58,233	44,027	30,457	18,477	-68.3	-39.3
	Blind/Disabled	319,355	254,494	189,458	130,405	-59.2	-31.2
	Families	198,548	175,641	174,066	173,365	-12.7	-0.4
	Other	53,805	54,353	54,350	55,371	2.9	1.9
	Undocumented	612,440	607,155	599,646	601,152	-1.8	0.3
Total		2,208,481	2,029,928	1,904,591	1,806,949	-18.2	-5.1

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012. Data reflects a 4-month reporting lag.

Table 22 FFS Average Member Months by Age and Aid Category, Non-Metropolitan Counties

Non-Metropolitan County		Average Member Months				Percent Change	
Age Group	Aid Category	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	2011 Qtr 2– 2012 Qtr 1	2011 Qtr 4– 2012 Qtr 1
0–20	Blind/Disabled	3,446	3,036	2,988	2,970	-13.8	-0.6
	Families	61,703	53,095	52,421	52,421	-15.0	0.0
	Foster Care	3,946	3,405	3,405	3,422	-13.3	0.5
	Other	9,634	8,989	8,868	8,669	-10.0	-2.2
	Undocumented	2,119	2,058	1,926	1,889	-10.9	-1.9
21 & over	Aged	361	266	263	267	-26.0	1.5
	Blind/Disabled	18,103	16,121	16,119	16,126	-10.9	0.0
	Families	31,849	27,411	26,951	27,064	-15.0	0.4
	Other	1,521	1,500	1,521	1,590	4.5	4.5
	Undocumented	5,453	5,355	5,163	5,158	-5.4	-0.1
Total		138,134	121,236	119,626	119,575	-13.4	0.0

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012. Data reflects a 4-month reporting lag.

Appendix C—Physician Provider Supply Detail Tables

Table 23 Physician Supply, All Enrolled Physicians, FFS Medi-Cal Only Beneficiaries

	Number of Physicians						Beneficiaries-to-Provider Ratio						
	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Physicians	Percent Change for 2011 Qtr 2– 2012 Qtr 1	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Avg. Ratio	Percent Change for 2011 Qtr 2– 2012 Qtr 1	
Statewide	105,978	107,332	108,057	109,049	107,604.0	2.9%	14.6	12.7	11.6	10.6	12.4	-27.5%	
County Plan Model Type													
County Organized Health System (COHS)	20,350	20,560	20,670	20,824	20,601.0	2.3%	7.8	2.3	2.0	2.0	3.5	-75.1%	
Fee-for-Service (FFS)	4,072	4,100	4,132	4,143	4,111.8	1.7%	77.0	76.3	74.9	74.6	75.7	-3.0%	
Geographic Managed Care (GMC)	15,699	15,976	16,108	16,252	16,008.8	3.5%	10.3	9.4	8.6	7.7	9.0	-25.4%	
Two-Plan (Commercial Plan and Local Initiative)	65,857	66,696	67,147	67,830	66,882.5	3.0%	13.9	12.8	11.4	10.1	12.0	-27.7%	
County													
Alameda	Two-Plan	4,699	4,724	4,755	4,786	4,741.0	1.9%	10.6	9.5	8.3	7.1	8.9	-32.9%
Alpine	FFS	2	2	2	2	2.0	0.0%	81.5	76.0	81.0	86.5	81.3	6.1%
Amador	FFS	55	56	57	57	56.3	3.6%	63.9	62.8	62.1	62.6	62.8	-2.0%
Butte	FFS	510	516	519	522	516.8	2.4%	80.4	78.5	77.3	76.6	78.2	-4.7%
Calaveras	FFS	50	49	49	49	49.3	-2.0%	107.9	110.5	109.6	109.8	109.4	1.7%
Colusa	FFS	41	40	40	39	40.0	-4.9%	86.0	88.9	88.1	90.4	88.4	5.0%
Contra Costa	Two-Plan	2,852	2,863	2,872	2,905	2,873.0	1.9%	10.0	9.1	8.2	7.3	8.6	-26.5%
Del Norte	FFS	53	53	54	54	53.5	1.9%	124.3	123.9	121.1	121.4	122.7	-2.3%
El Dorado	FFS	273	280	283	283	279.8	3.7%	53.8	52.1	51.3	51.3	52.1	-4.6%
Fresno	Two-Plan	1,983	2,002	2,014	2,031	2,007.5	2.4%	20.4	19.1	17.0	15.5	18.0	-24.0%
Glenn	FFS	21	22	22	22	21.8	4.8%	260.1	246.8	244.0	247.3	249.5	-4.9%
Humboldt	FFS	406	409	411	413	409.8	1.7%	52.2	52.0	51.4	51.0	51.7	-2.3%
Imperial	FFS	213	216	225	225	219.8	5.6%	213.0	209.7	200.1	199.8	205.7	-6.2%
Inyo	FFS	39	39	39	38	38.8	-2.6%	66.7	66.9	66.1	68.1	66.9	2.0%
Kern	Two-Plan	1,767	1,789	1,793	1,802	1,787.8	2.0%	26.4	24.5	22.1	20.8	23.4	-21.1%

		Number of Physicians						Beneficiaries-to-Provider Ratio					
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Physicians	Percent Change for 2011 Qtr 2– 2012 Qtr 1	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Avg. Ratio	Percent Change for 2011 Qtr 2– 2012 Qtr 1
Kings	Two-Plan	188	189	194	195	191.5	3.7%	35.9	32.4	28.8	26.4	30.9	-26.4%
Lake	FFS	121	120	121	121	120.8	0.0%	111.6	111.6	109.3	109.7	110.5	-1.7%
Lassen	FFS	29	31	31	32	30.8	10.3%	140.8	132.6	131.4	124.5	132.3	-11.6%
Los Angeles	Two-Plan	29,370	29,737	29,910	30,182	29,799.8	2.8%	13.3	12.4	10.7	9.2	11.4	-31.2%
Madera	Two-Plan	284	288	294	295	290.3	3.9%	26.1	21.9	19.2	17.6	21.2	-32.5%
Marin *	COHS	754	770	773	777	768.5	3.1%	16.7	0.8	0.7	0.7	4.7	-95.9%
Mariposa	FFS	19	19	19	19	19.0	0.0%	116.7	116.0	112.3	112.6	114.4	-3.6%
Mendocino *	COHS	203	206	206	206	205.3	1.5%	84.5	3.9	3.6	3.5	23.9	-95.9%
Merced	COHS	364	366	371	373	368.5	2.5%	6.4	6.7	5.9	6.2	6.3	-2.8%
Modoc	FFS	14	14	14	14	14.0	0.0%	111.9	110.6	108.4	107.6	109.6	-3.8%
Mono	FFS	45	45	45	45	45.0	0.0%	21.7	21.7	21.8	22.5	21.9	3.8%
Monterey	COHS	907	911	916	919	913.3	1.3%	3.7	3.7	3.1	3.0	3.4	-17.5%
Napa	COHS	378	379	379	379	378.8	0.3%	1.8	1.9	1.7	1.6	1.7	-9.0%
Nevada	FFS	195	194	195	196	195.0	0.5%	45.6	45.6	45.4	45.0	45.4	-1.3%
Orange	COHS	8,264	8,350	8,400	8,462	8,369.0	2.4%	2.0	2.2	1.8	1.7	1.9	-17.3%
Placer	FFS	751	753	760	765	757.3	1.9%	31.4	31.6	31.2	31.0	31.3	-1.1%
Plumas	FFS	35	35	35	35	35.0	0.0%	67.1	67.3	67.8	67.6	67.5	0.7%
Riverside	Two-Plan	2,927	2,957	2,978	3,023	2,971.3	3.3%	28.6	27.0	24.4	22.0	25.5	-23.3%
Sacramento	GMC	5,737	5,851	5,889	5,933	5,852.5	3.4%	10.6	9.6	8.6	7.8	9.2	-27.2%
San Benito	FFS	67	67	67	67	67.0	0.0%	116.4	116.5	115.1	116.3	116.1	-0.1%
San Bernardino	Two-Plan	4,517	4,578	4,625	4,722	4,610.5	4.5%	23.4	22.0	20.0	18.3	20.9	-21.8%
San Diego	GMC	9,962	10,125	10,219	10,319	10,156.3	3.6%	10.1	9.4	8.5	7.6	8.9	-24.4%
San Francisco	Two-Plan	6,330	6,485	6,525	6,584	6,481.0	4.0%	4.2	3.5	2.9	2.3	3.2	-45.9%
San Joaquin	Two-Plan	1,471	1,488	1,496	1,516	1,492.8	3.1%	22.6	19.8	17.5	15.6	18.9	-31.0%
San Luis Obispo	COHS	480	483	485	486	483.5	1.3%	2.7	2.6	2.5	2.6	2.6	-1.9%
San Mateo	COHS	2,859	2,876	2,888	2,906	2,882.3	1.6%	1.1	1.1	1.0	1.0	1.0	-8.3%
Santa Barbara	COHS	1,153	1,159	1,163	1,168	1,160.8	1.3%	2.9	3.0	2.8	2.7	2.8	-4.9%

		Number of Physicians						Beneficiaries-to-Provider Ratio					
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Physicians	Percent Change for 2011 Qtr 2– 2012 Qtr 1	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Avg. Ratio	Percent Change for 2011 Qtr 2– 2012 Qtr 1
Santa Clara	Two-Plan	7,454	7,560	7,627	7,702	7,585.8	3.3%	5.5	5.0	4.7	4.3	4.9	-21.4%
Santa Cruz	COHS	630	635	636	639	635.0	1.4%	2.5	2.5	2.4	2.5	2.5	-0.4%
Shasta	FFS	486	491	493	496	491.5	2.1%	67.6	67.1	65.5	64.8	66.3	-4.2%
Sierra	FFS	5	5	5	5	5.0	0.0%	72.4	68.0	66.2	66.0	68.2	-8.8%
Siskiyou	FFS	88	88	89	89	88.5	1.1%	94.7	93.2	91.2	91.9	92.7	-2.9%
Solano	COHS	1,308	1,313	1,322	1,351	1,323.5	3.3%	1.5	1.5	1.4	1.3	1.4	-10.1%
Sonoma	COHS	1,142	1,157	1,161	1,174	1,158.5	2.8%	2.6	2.6	2.4	2.3	2.5	-14.4%
Stanislaus	Two-Plan	1,285	1,300	1,323	1,335	1,310.8	3.9%	25.2	23.4	21.4	20.3	22.6	-19.4%
Sutter	FFS	168	168	169	168	168.3	0.0%	106.2	107.0	106.2	107.0	106.6	0.8%
Tehama	FFS	101	101	101	101	101.0	0.0%	139.5	138.0	133.1	132.7	135.8	-4.9%
Trinity	FFS	13	13	13	13	13.0	0.0%	168.6	167.9	169.4	168.3	168.5	-0.2%
Tulare	Two-Plan	730	736	741	752	739.8	3.0%	30.8	29.6	27.6	25.5	28.4	-17.3%
Tuolumne	FFS	105	107	106	105	105.8	0.0%	61.0	60.1	59.6	60.3	60.2	-1.1%
Ventura *	COHS	1,441	1,485	1,497	1,506	1,482.3	4.5%	63.1	3.3	3.1	3.0	18.1	-95.2%
Yolo	COHS	467	470	473	478	472.0	2.4%	3.6	3.8	3.6	3.4	3.6	-5.6%
Yuba	FFS	167	167	168	168	167.5	0.6%	100.8	100.6	98.1	96.9	99.1	-3.9%

*Shifted from FFS to COHS Model on July 1, 2011

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of April 2011, August 2011, October 2011, and January 2012.

Table 24– Physician Supply, All Enrolled Physicians, All Medi-Cal Only Beneficiaries

		Number of Physicians					Beneficiaries-to-Provider Ratio						
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Physicians	Percent Change 2011 Qtr 2– 2012 Qtr 1	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Ratio	Percent Change 2011 Qtr 2– 2012 Qtr 1
Statewide		105,978	107,332	108,057	109,049	107,604.0	2.9%	14.6	12.7	11.6	10.6	12.4	-27.4%
County Plan Model Type													
County Organized Health System (COHS)		20,350	20,560	20,670	20,824	20,601.0	2.3%	7.8	2.3	2.0	2.0	7,756.0	-74.4%
Fee-for-Service (FFS)		4,072	4,100	4,132	4,143	4,111.8	1.7%	77.0	76.3	74.9	74.6	75.7	-3.1%
Geographic Managed Care (GMC)		15,699	15,976	16,108	16,252	16,008.8	3.5%	10.3	9.4	8.6	7.7	9.0	-25.2%
Two-Plan (Commercial Plan and Local Initiative)		65,857	66,696	67,147	67,830	66,882.5	3.0%	13.9	12.8	11.4	10.1	12.1	-27.3%
County													
Alameda	Two-Plan	4,699	4,724	4,755	4,786	4,741.0	1.9%	10.6	9.5	8.3	7.1	8.9	-33.0%
Alpine	FFS	2	2	2	2	2.0	0.0%	81.5	76.0	81.0	86.5	81.3	6.1%
Amador	FFS	55	56	57	57	56.3	3.6%	63.9	62.8	62.1	62.6	62.9	-2.0%
Butte	FFS	510	516	519	522	516.8	2.4%	80.4	78.5	77.3	76.6	78.2	-4.7%
Calaveras	FFS	50	49	49	49	49.3	-2.0%	107.9	110.5	109.6	109.8	109.5	1.8%
Colusa	FFS	41	40	40	39	40.0	-4.9%	86.0	88.9	88.1	90.4	88.4	5.1%
Contra Costa	Two-Plan	2,852	2,863	2,872	2,905	2,873.0	1.9%	10.0	9.1	8.2	7.3	8.7	-27.0%
Del Norte	FFS	53	53	54	54	53.5	1.9%	124.3	123.9	121.1	121.4	122.7	-2.3%
El Dorado	FFS	273	280	283	283	279.8	3.7%	53.8	52.1	51.3	51.3	52.1	-4.6%
Fresno	Two-Plan	1,983	2,002	2,014	2,031	2,007.5	2.4%	20.4	19.1	17.0	15.5	18.0	-24.0%
Glenn	FFS	21	22	22	22	21.8	4.8%	260.1	246.8	244.0	247.3	249.6	-4.9%
Humboldt	FFS	406	409	411	413	409.8	1.7%	52.2	52.0	51.4	51.0	51.7	-2.3%
Imperial	FFS	213	216	225	225	219.8	5.6%	213.0	209.7	200.1	199.8	205.7	-6.2%
Inyo	FFS	39	39	39	38	38.8	-2.6%	66.7	66.9	66.1	68.1	67.0	2.1%
Kern	Two-Plan	1,767	1,789	1,793	1,802	1,787.8	2.0%	26.4	24.5	22.1	20.8	23.5	-21.2%

		Number of Physicians						Beneficiaries-to-Provider Ratio					
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Physicians	Percent Change 2011 Qtr 2– 2012 Qtr 1	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Ratio	Percent Change 2011 Qtr 2– 2012 Qtr 1
Kings	Two-Plan	188	189	194	195	191.5	3.7%	35.9	32.4	28.8	26.4	30.9	-26.5%
Lake	FFS	121	120	121	121	120.8	0.0%	111.6	111.6	109.3	109.7	110.6	-1.7%
Lassen	FFS	29	31	31	32	30.8	10.3%	140.8	132.6	131.4	124.5	132.3	-11.6%
Los Angeles	Two-Plan	29,370	29,737	29,910	30,182	29,799.8	2.8%	13.3	12.4	10.7	9.2	11.4	-30.8%
Madera	Two-Plan	284	288	294	295	290.3	3.9%	26.1	21.9	19.2	17.6	21.2	-32.6%
Marin *	COHS	754	770	773	777	768.5	3.1%	16.7	0.8	0.7	0.7	4.7	-95.8%
Mariposa	FFS	19	19	19	19	19.0	0.0%	116.7	116.0	112.3	112.6	114.4	-3.5%
Mendocino *	COHS	203	206	206	206	205.3	1.5%	84.5	3.9	3.6	3.5	23.9	-95.9%
Merced	COHS	364	366	371	373	368.5	2.5%	6.4	6.7	5.9	6.2	6.3	-3.1%
Modoc	FFS	14	14	14	14	14.0	0.0%	111.9	110.6	108.4	107.6	109.6	-3.8%
Mono	FFS	45	45	45	45	45.0	0.0%	21.7	21.7	21.8	22.5	21.9	3.7%
Monterey	COHS	907	911	916	919	913.3	1.3%	3.7	3.7	3.1	3.0	3.4	-18.9%
Napa	COHS	378	379	379	379	378.8	0.3%	1.8	1.9	1.7	1.6	1.8	-11.1%
Nevada	FFS	195	194	195	196	195.0	0.5%	45.6	45.6	45.4	45.0	45.4	-1.3%
Orange	COHS	8,264	8,350	8,400	8,462	8,369.0	2.4%	2.0	2.2	1.8	1.7	1.9	-15.0%
Placer	FFS	751	753	760	765	757.3	1.9%	31.4	31.6	31.2	31.0	31.3	-1.3%
Plumas	FFS	35	35	35	35	35.0	0.0%	67.1	67.3	67.8	67.6	67.5	0.7%
Riverside	Two-Plan	2,927	2,957	2,978	3,023	2,971.3	3.3%	28.6	27.0	24.4	22.0	25.5	-23.1%
Sacramento	GMC	5,737	5,851	5,889	5,933	5,852.5	3.4%	10.6	9.6	8.6	7.8	9.2	-26.4%
San Benito	FFS	67	67	67	67	67.0	0.0%	116.4	116.5	115.1	116.3	116.1	-0.1%
San Bernardino	Two-Plan	4,517	4,578	4,625	4,722	4,610.5	4.5%	23.4	22.0	20.0	18.3	20.9	-21.8%
San Diego	GMC	9,962	10,125	10,219	10,319	10,156.3	3.6%	10.1	9.4	8.5	7.6	8.9	-24.8%
San Francisco	Two-Plan	6,330	6,485	6,525	6,584	6,481.0	4.0%	4.2	3.5	2.9	2.3	3.2	-45.2%
San Joaquin	Two-Plan	1,471	1,488	1,496	1,516	1,492.8	3.1%	22.6	19.8	17.5	15.6	18.9	-31.0%
San Luis Obispo	COHS	480	483	485	486	483.5	1.3%	2.7	2.6	2.5	2.6	2.6	-3.7%
San Mateo	COHS	2,859	2,876	2,888	2,906	2,882.3	1.6%	1.1	1.1	1.0	1.0	1.1	-9.1%

		Number of Physicians						Beneficiaries-to-Provider Ratio					
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Physicians	Percent Change 2011 Qtr 2– 2012 Qtr 1	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Ratio	Percent Change 2011 Qtr 2– 2012 Qtr 1
Santa Barbara	COHS	1,153	1,159	1,163	1,168	1,160.8	1.3%	2.9	3.0	2.8	2.7	2.9	-6.9%
Santa Clara	Two-Plan	7,454	7,560	7,627	7,702	7,585.8	3.3%	5.5	5.0	4.7	4.3	4.9	-21.8%
Santa Cruz	COHS	630	635	636	639	635.0	1.4%	2.5	2.5	2.4	2.5	2.5	0.0%
Shasta	FFS	486	491	493	496	491.5	2.1%	67.6	67.1	65.5	64.8	66.3	-4.1%
Sierra	FFS	5	5	5	5	5.0	0.0%	72.4	68.0	66.2	66.0	68.2	-8.8%
Siskiyou	FFS	88	88	89	89	88.5	1.1%	94.7	93.2	91.2	91.9	92.8	-3.0%
Solano	COHS	1,308	1,313	1,322	1,351	1,323.5	3.3%	1.5	1.5	1.4	1.3	1.4	-13.3%
Sonoma	COHS	1,142	1,157	1,161	1,174	1,158.5	2.8%	2.6	2.6	2.4	2.3	2.5	-11.5%
Stanislaus	Two-Plan	1,285	1,300	1,323	1,335	1,310.8	3.9%	25.2	23.4	21.4	20.3	22.6	-19.4%
Sutter	FFS	168	168	169	168	168.3	0.0%	106.2	107.0	106.2	107.0	106.6	0.8%
Tehama	FFS	101	101	101	101	101.0	0.0%	139.5	138.0	133.1	132.7	135.8	-4.9%
Trinity	FFS	13	13	13	13	13.0	0.0%	168.6	167.9	169.4	168.3	168.6	-0.2%
Tulare	Two-Plan	730	736	741	752	739.8	3.0%	30.8	29.6	27.6	25.5	28.4	-17.2%
Tuolumne	FFS	105	107	106	105	105.8	0.0%	61.0	60.1	59.6	60.3	60.3	-1.1%
Ventura *	COHS	1,441	1,485	1,497	1,506	1,482.3	4.5%	63.1	3.3	3.1	3.0	18.1	-95.2%
Yolo	COHS	467	470	473	478	472.0	2.4%	3.6	3.8	3.6	3.4	3.6	-5.6%
Yuba	FFS	167	167	168	168	167.5	0.6%	100.8	100.6	98.1	96.9	99.1	-3.9%

* Shifted from FFS to COHS Model on July 1, 2011

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of April 2011, August 2011, October 2011, and January 2012.

Table 25 Primary Care Physician Supply, All Enrolled Physicians, FFS, Full Scope, Medi- Cal Only Beneficiaries

		Number of Providers					Population-to-Provider Ratio						
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Providers	% Change In # of Providers	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Avg Ratio	% Change in Ratio
Statewide		38,373	38,833	39,068	39,426	38,925	2.7%	40.4	35.2	32.1	29.4	34.3	-27.2%
County Plan Model Type													
County Organized Health System (COHS)		7,231	7,315	7,369	7,425	7,335	2.7%	22.1	6.4	5.7	5.5	9.9	-75.1%
Fee-for-Service (FFS)		1,738	1,744	1,758	1,759	1,750	1.2%	180.3	179.3	176.1	175.8	177.9	-2.5%
Geographic Managed Care (GMC)		5,341	5,418	5,458	5,494	5,428	2.9%	30.3	27.8	25.3	22.7	26.5	-25.1%
Two-Plan (Commercial Plan and Local Initiative)		24,063	24,356	24,483	24,748	24,413	2.8%	38.1	35.1	31.1	27.6	33.0	-27.6%
County													
Alameda	Two-Plan	1,624	1,634	1,639	1,651	1,637	1.7%	30.6	27.5	24.0	20.5	25.7	-33.0%
Alpine	FFS	1	1	1	1	1	0.0%	163.0	152.0	162.0	173.0	162.5	6.1%
Amador	FFS	31	33	33	33	33	6.5%	113.4	106.6	107.2	108.1	108.8	-4.7%
Butte	FFS	193	192	190	190	191	-1.6%	212.4	211.0	211.1	210.4	211.2	-0.9%
Calaveras	FFS	25	24	25	25	25	0.0%	215.8	225.5	214.8	215.2	217.8	-0.3%
Colusa	FFS	31	30	30	30	30	-3.2%	113.8	118.6	117.5	117.5	116.9	3.3%
Contra Costa	Two-Plan	1,088	1,096	1,100	1,109	1,098	1.9%	26.2	23.7	21.4	19.2	22.6	-26.7%
Del Norte	FFS	25	25	26	26	26	4.0%	263.4	262.6	251.5	252.2	257.4	-4.3%
El Dorado	FFS	101	103	103	103	103	2.0%	145.3	141.7	140.8	140.8	142.2	-3.1%
Fresno	Two-Plan	730	733	738	749	738	2.6%	55.5	52.1	46.4	42.1	49.0	-24.1%
Glenn	FFS	9	9	9	9	9	0.0%	606.8	603.2	596.3	604.6	602.7	-0.4%
Humboldt	FFS	181	183	184	184	183	1.7%	117.1	116.2	114.9	114.5	115.7	-2.2%
Imperial	FFS	57	57	63	65	61	14.0%	796.1	794.6	714.8	691.6	749.3	-13.1%
Inyo	FFS	18	18	18	18	18	0.0%	144.6	145.0	143.1	143.7	144.1	-0.6%
Kern	Two-Plan	692	703	701	704	700	1.7%	67.3	62.4	56.4	53.3	59.9	-20.8%
Kings	Two-Plan	79	79	83	82	81	3.8%	85.3	77.6	67.4	62.7	73.3	-26.5%

		Number of Providers						Population-to-Provider Ratio					
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Providers	% Change In # of Providers	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Avg Ratio	% Change in Ratio
Lake	FFS	48	47	48	48	48	0.0%	281.3	284.8	275.6	276.4	279.5	-1.7%
Lassen	FFS	14	14	14	15	14	7.1%	291.6	293.6	291.0	265.6	285.5	-8.9%
Los Angeles	Two-Plan	11,195	11,327	11,363	11,476	11,340	2.5%	35.0	32.4	28.1	24.1	29.9	-31.1%
Madera	Two-Plan	64	64	65	65	65	1.6%	115.8	98.5	86.9	79.9	95.3	-31.0%
Marin *	COHS	306	309	310	309	309	1.0%	41.0	1.9	1.7	1.7	11.6	-95.9%
Mariposa	FFS	12	12	12	12	12	0.0%	184.8	183.6	177.8	178.3	181.1	-3.5%
Mendocino *	COHS	71	71	71	71	71	0.0%	241.5	11.3	10.4	10.0	68.3	-95.9%
Merced	COHS	160	162	166	167	164	4.4%	14.5	15.2	13.1	13.8	14.2	-4.8%
Modoc	FFS	11	11	11	11	11	0.0%	142.5	140.7	138.0	137.0	139.6	-3.9%
Mono	FFS	19	19	19	19	19	0.0%	51.3	51.3	51.6	53.3	51.9	3.9%
Monterey	COHS	335	336	339	339	337	1.2%	9.9	10.0	8.3	8.2	9.1	-17.2%
Napa	COHS	112	112	112	110	112	-1.8%	6.0	6.3	5.7	5.5	5.9	-8.3%
Nevada	FFS	88	88	88	88	88	0.0%	101.0	100.6	100.7	100.2	100.6	-0.8%
Orange	COHS	2,676	2,699	2,717	2,743	2,709	2.5%	6.2	6.7	5.7	5.2	6.0	-16.1%
Placer	FFS	346	348	352	353	350	2.0%	68.1	68.4	67.5	67.3	67.8	-1.2%
Plumas	FFS	25	25	25	25	25	0.0%	94.0	94.3	94.9	94.6	94.5	0.6%
Riverside	Two-Plan	1,184	1,192	1,198	1,218	1,198	2.9%	70.7	67.0	60.7	54.5	63.2	-22.9%
Sacramento	GMC	1,934	1,970	1,975	1,986	1,966	2.7%	31.6	28.4	25.8	23.2	27.3	-26.6%
San Benito	FFS	24	23	24	23	24	-4.2%	325.0	339.3	321.3	338.8	331.1	4.2%
San Bernardino	Two-Plan	1,832	1,860	1,878	1,913	1,871	4.4%	57.7	54.2	49.3	45.2	51.6	-21.7%
San Diego	GMC	3,407	3,448	3,483	3,508	3,462	3.0%	29.5	27.4	25.0	22.5	26.1	-23.7%
San Francisco	Two-Plan	1,948	2,005	2,019	2,040	2,003	4.7%	13.7	11.3	9.3	7.4	10.4	-46.0%
San Joaquin	Two-Plan	541	553	556	562	553	3.9%	61.4	53.4	47.0	42.0	51.0	-31.6%
San Luis Obispo	COHS	162	164	165	165	164	1.9%	7.9	7.8	7.5	7.8	7.8	-1.3%
San Mateo	COHS	970	976	983	992	980	2.3%	3.2	3.2	2.9	2.9	3.1	-9.4%
Santa Barbara	COHS	353	354	356	356	355	0.8%	9.4	9.7	9.1	8.9	9.3	-5.3%
Santa Clara	Two-Plan	2,308	2,330	2,355	2,383	2,344	3.2%	17.7	16.2	15.1	13.9	15.7	-21.5%

		Number of Providers						Population-to-Provider Ratio					
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Providers	% Change In # of Providers	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Avg Ratio	% Change in Ratio
Santa Cruz	COHS	242	242	242	243	242	0.4%	6.4	6.5	6.4	6.4	6.4	0.0%
Shasta	FFS	202	205	205	205	204	1.5%	162.7	160.8	157.6	156.8	159.5	-3.6%
Sierra	FFS	5	5	5	5	5	0.0%	72.4	68.0	66.2	66.0	68.2	-8.8%
Siskiyou	FFS	38	38	39	38	38	0.0%	219.2	215.8	208.0	215.3	214.6	-1.8%
Solano	COHS	533	537	542	556	542	4.3%	3.6	3.7	3.4	3.2	3.5	-11.1%
Sonoma	COHS	487	494	498	499	495	2.5%	6.2	6.0	5.6	5.3	5.8	-14.5%
Stanislaus	Two-Plan	518	520	530	536	526	3.5%	62.5	58.6	53.5	50.6	56.3	-19.0%
Sutter	FFS	78	77	79	79	78	1.3%	228.6	233.5	227.3	227.4	229.2	-0.5%
Tehama	FFS	49	48	48	48	48	-2.0%	287.5	290.5	280.1	279.2	284.3	-2.9%
Trinity	FFS	5	5	5	5	5	0.0%	438.4	436.4	440.4	437.6	438.2	-0.2%
Tulare	Two-Plan	260	260	258	260	260	0.0%	86.6	83.7	79.1	73.8	80.8	-14.8%
Tuolumne	FFS	42	44	42	40	42	-4.8%	152.5	146.0	150.5	158.4	151.9	3.9%
Ventura *	COHS	606	642	649	650	637	7.3%	150.0	7.7	7.1	7.0	43.0	-95.3%
Yolo	COHS	218	217	219	225	220	3.2%	7.6	8.3	7.8	7.1	7.7	-6.6%
Yuba	FFS	60	60	60	61	60	1.7%	280.5	280.1	274.6	266.8	275.5	-4.9%

*Shifted from FFS to COHS Model on July 1, 2011

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of April 2011, August 2011, October 2011, and January 2012.

Table 26 Physician Supply, Physicians with an OB/GYN Specialty, FFS, Medi-Cal Only, Non-Elderly, Adult Females

		Number of Physicians					Beneficiaries-to-Provider Ratio						
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Physicians	Percent Change for 2011 Q2– 2012 Q1	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Avg. Ratio	Percent Change for 2011 Q2– 2012 Q1
Statewide		6,379	6,422	6,456	6,524	6,445.3	2.3%	132.6	122.3	115.3	109.5	119.9	-17.4%
County Plan Model Type													
County Organized Health System (COHS)		1,334	1,341	1,341	1,357	1,343.3	1.7%	90.1	70.2	68.8	68.6	74.4	-23.9%
Fee-for-Service (FFS)		228	230	232	232	230.5	1.8%	416.1	409.9	401.6	401.3	407.2	-3.6%
Geographic Managed Care (GMC)		799	810	817	822	812.0	2.9%	89.5	81.5	73.9	67.2	78.1	-24.9%
Two-Plan (Commercial Plan and Local Initiative)		4,018	4,041	4,066	4,113	4,059.5	2.4%	139.1	131.4	122.6	115.0	127.0	-17.4%
County													
Alameda	Two-Plan	291	294	298	303	296.5	4.1%	86.8	80.7	73.5	67.1	77.0	-22.7%
Alpine	FFS	-	-	-	-	-	-	-	-	-	-	-	-
Amador	FFS	5	5	5	5	5.0	0.0%	216.8	221.0	222.6	226.0	221.6	4.2%
Butte	FFS	31	31	32	32	31.5	3.2%	400.2	395.7	378.6	378.3	388.2	-5.5%
Calaveras	FFS	1	1	1	1	1.0	0.0%	1,668.0	1,668.0	1,653.0	1,655.0	1,661.0	-0.8%
Colusa	FFS	1	1	1	1	1.0	0.0%	1,002.0	1,004.0	1,005.0	1,020.0	1,007.8	1.8%
Contra Costa	Two-Plan	147	146	147	150	147.5	2.0%	105.0	99.6	92.5	85.3	95.6	-18.8%
Del Norte	FFS	3	3	3	3	3.0	0.0%	660.0	664.0	659.3	656.3	659.9	-0.6%
El Dorado	FFS	15	15	15	15	15.0	0.0%	304.7	299.6	297.5	297.5	299.8	-2.4%
Fresno	Two-Plan	127	129	131	132	129.8	3.9%	210.5	196.3	183.0	174.4	191.1	-17.2%
Glenn	FFS	1	1	1	1	1.0	0.0%	1,672.0	1,645.0	1,607.0	1,642.0	1,641.5	-1.8%
Humboldt	FFS	18	19	19	19	18.8	5.6%	363.7	341.8	338.5	339.0	345.8	-6.8%
Imperial	FFS	18	19	19	19	18.8	5.6%	750.7	707.6	706.9	703.5	717.2	-6.3%
Inyo	FFS	3	3	3	3	3.0	0.0%	282.0	277.0	271.7	275.3	276.5	-2.4%
Kern	Two-Plan	105	106	106	106	105.8	1.0%	231.8	215.9	201.4	195.0	211.0	-15.9%
Kings	Two-Plan	11	11	11	11	11.0	0.0%	318.6	292.3	272.1	253.6	284.2	-20.4%

		Number of Physicians						Beneficiaries-to-Provider Ratio					
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Physicians	Percent Change for 2011 Q2– 2012 Q1	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Avg. Ratio	Percent Change for 2011 Q2– 2012 Q1
Lake	FFS	4	4	4	4	4.0	0.0%	1,065.8	1,045.0	1,035.3	1,031.8	1,044.4	-3.2%
Lassen	FFS	1	1	1	1	1.0	0.0%	1,263.0	1,269.0	1,247.0	1,209.0	1,247.0	-4.3%
Los Angeles	Two-Plan	1,782	1,787	1,794	1,812	1,793.8	1.7%	158.6	151.8	141.8	132.9	146.2	-16.2%
Madera	Two-Plan	15	15	15	15	15.0	0.0%	376.7	345.9	326.3	321.2	342.5	-14.7%
Marin *	COHS	33	33	33	33	33.0	0.0%	161.9	81.4	78.5	79.5	100.3	-50.9%
Mariposa	FFS	-	-	-	-	-	-	-	-	-	-	-	-
Mendocino *	COHS	22	22	22	22	22.0	0.0%	249.8	48.9	48.2	48.7	98.9	-80.5%
Merced	COHS	22	22	22	22	22.0	0.0%	209.1	208.1	206.5	209.0	208.2	0.0%
Modoc	FFS	1	1	1	1	1.0	0.0%	488.0	470.0	445.0	452.0	463.8	-7.4%
Mono	FFS	1	1	1	1	1.0	0.0%	323.0	309.0	301.0	323.0	314.0	0.0%
Monterey	COHS	75	75	75	75	75.0	0.0%	135.2	131.5	128.0	133.0	131.9	-1.7%
Napa	COHS	15	16	16	16	15.8	6.7%	85.4	81.1	79.1	78.5	81.0	-8.1%
Nevada	FFS	14	14	14	14	14.0	0.0%	199.9	199.7	199.9	198.2	199.4	-0.8%
Orange	COHS	611	613	613	624	615.3	2.1%	60.6	60.0	58.9	57.9	59.3	-4.5%
Placer	FFS	52	52	53	53	52.5	1.9%	130.8	131.3	127.6	127.7	129.3	-2.4%
Plumas	FFS	1	1	1	1	1.0	0.0%	729.0	728.0	724.0	735.0	729.0	0.8%
Riverside	Two-Plan	194	197	199	204	198.5	5.2%	197.8	182.7	170.6	156.2	176.8	-21.0%
Sacramento	GMC	291	295	295	296	294.3	1.7%	93.8	83.8	75.1	67.3	80.0	-28.2%
San Benito	FFS	4	4	4	4	4.0	0.0%	612.3	607.5	602.5	615.8	609.5	0.6%
San Bernardino	Two-Plan	245	247	247	252	247.8	2.9%	195.1	183.3	172.8	160.7	178.0	-17.6%
San Diego	GMC	508	515	522	526	517.8	3.5%	87.1	80.2	73.3	67.2	76.9	-22.9%
San Francisco	Two-Plan	341	344	344	345	343.5	1.2%	38.9	34.3	30.8	27.4	32.9	-29.7%
San Joaquin	Two-Plan	111	112	113	115	112.8	3.6%	149.1	135.5	123.6	114.1	130.6	-23.5%
San Luis Obispo	COHS	33	33	33	33	33.0	0.0%	57.5	55.9	54.5	55.9	56.0	-2.7%
San Mateo	COHS	136	136	137	137	136.5	0.7%	47.8	47.5	47.7	48.8	47.9	2.1%
Santa Barbara	COHS	79	79	79	79	79.0	0.0%	99.8	97.4	95.5	96.8	97.4	-3.0%
Santa Clara	Two-Plan	497	501	505	510	503.3	2.6%	58.2	55.1	53.1	51.1	54.4	-12.1%

		Number of Physicians						Beneficiaries-to-Provider Ratio					
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Physicians	Percent Change for 2011 Q2– 2012 Q1	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Avg. Ratio	Percent Change for 2011 Q2– 2012 Q1
Santa Cruz	COHS	40	40	40	41	40.3	2.5%	84.1	81.8	79.9	80.7	81.6	-4.1%
Shasta	FFS	19	19	19	19	19.0	0.0%	522.0	522.4	510.3	508.1	515.7	-2.7%
Sierra	FFS	-	-	-	-	-	-	-	-	-	-	-	-
Siskiyou	FFS	4	4	4	4	4.0	0.0%	635.5	616.8	610.5	621.3	621.0	-2.2%
Solano	COHS	77	77	77	79	77.5	2.6%	40.1	39.5	38.2	37.7	38.9	-6.0%
Sonoma	COHS	62	63	63	64	63.0	3.2%	70.1	67.5	65.7	64.0	66.8	-8.7%
Stanislaus	Two-Plan	74	74	75	76	74.8	2.7%	201.3	189.4	173.6	164.5	182.2	-18.3%
Sutter	FFS	14	14	14	14	14.0	0.0%	372.1	370.6	370.7	368.9	370.6	-0.9%
Tehama	FFS	5	5	5	5	5.0	0.0%	846.2	834.4	802.6	803.6	821.7	-5.0%
Trinity	FFS	-	-	-	-	-	-	-	-	-	-	-	-
Tulare	Two-Plan	78	78	81	82	79.8	5.1%	201.5	192.5	177.9	171.5	185.8	-14.9%
Tuolumne	FFS	8	8	8	8	8.0	0.0%	246.3	249.9	246.0	243.9	246.5	-1.0%
Ventura *	COHS	101	104	103	104	103.0	3.0%	273.6	93.6	91.4	90.4	137.2	-67.0%
Yolo	COHS	28	28	28	28	28.0	0.0%	55.6	54.5	53.4	52.6	54.0	-5.3%
Yuba	FFS	4	4	4	4	4.0	0.0%	1,271.8	1,268.5	1,235.3	1,222.0	1,249.4	-3.9%

*Shifted from FFS to COHS Model on July 1, 2011

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files January through December 2011 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of April 2011, August 2011, October 2011, and January 2012.

Table 27 Physician Supply, Physicians with a Pediatric Specialty, FFS, Full Scope, Medi-Cal Only Children

		Number of Physicians					Beneficiaries-to-Provider Ratio						
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Physicians	Percent Change for 2011 Q2– 2012 Q1	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Avg. Ratio	Percent Change for 2011 Q2– 2012 Q1
Statewide		10,769	10,921	11,007	11,089	10,946.5	3.0%	71.4	64.3	61.2	58.7	63.9	-17.8%
County Plan Model Type													
County Organized Health System (COHS)		1,926	1,944	1,948	1,959	1,944.3	1.7%	54.9	17.0	14.8	13.9	25.2	-74.6%
Fee-for-Service (FFS)		271	274	275	277	274.3	2.2%	633.6	627.5	619.2	613.7	623.5	-3.1%
Geographic Managed Care (GMC)		1,449	1,462	1,484	1,493	1,472.0	3.0%	51.9	51.6	50.1	48.3	50.5	-7.0%
Two-Plan (Commercial Plan and Local Initiative)		7,123	7,241	7,300	7,360	7,256.0	3.3%	58.5	58.3	54.8	51.9	55.9	-11.2%
County													
Alameda	Two-Plan	731	735	741	747	738.5	2.2%	26.6	25.9	24.9	23.4	25.2	-12.1%
Alpine	FFS	-	-	-	-	-	-	-	-	-	-	-	-
Amador	FFS	2	2	2	2	2.0	0.0%	939.5	933.0	930.5	932.5	933.9	-0.7%
Butte	FFS	25	25	25	25	25.0	0.0%	857.9	847.5	838.5	834.0	844.5	-2.8%
Calaveras	FFS	2	2	2	2	2.0	0.0%	1,386.5	1,402.0	1,401.0	1,395.0	1,396.1	0.6%
Colusa	FFS	-	-	-	-	-	-	-	-	-	-	-	-
Contra Costa	Two-Plan	241	241	241	242	241.3	0.4%	49.9	48.1	48.3	47.1	48.4	-5.7%
Del Norte	FFS	5	5	5	5	5.0	0.0%	672.4	667.2	666.8	672.6	669.8	0.0%
El Dorado	FFS	15	17	17	17	16.5	13.3%	542.1	477.1	475.5	475.5	492.5	-12.3%
Fresno	Two-Plan	183	184	186	187	185.0	2.2%	101.3	102.7	96.5	93.9	98.6	-7.3%
Glenn	FFS	2	2	2	2	2.0	0.0%	1,691.0	1,698.5	1,690.0	1,699.0	1,694.6	0.5%
Humboldt	FFS	16	16	17	17	16.5	6.3%	682.0	689.8	647.2	642.7	665.4	-5.8%
Imperial	FFS	20	20	20	20	20.0	0.0%	1,282.7	1,284.8	1,277.1	1,279.2	1,280.9	-0.3%

		Number of Physicians						Beneficiaries-to-Provider Ratio					
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Physicians	Percent Change for 2011 Q2– 2012 Q1	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Avg. Ratio	Percent Change for 2011 Q2– 2012 Q1
Inyo	FFS	5	5	5	5	5.0	0.0%	298.8	305.6	303.6	301.4	302.4	0.9%
Kern	Two-Plan	139	143	144	142	142.0	2.2%	179.4	173.5	160.9	161.5	168.8	-10.0%
Kings	Two-Plan	12	12	12	12	12.0	0.0%	300.0	288.5	274.2	263.7	281.6	-12.1%
Lake	FFS	6	6	6	6	6.0	0.0%	1,161.8	1,158.2	1,138.5	1,143.7	1,150.5	-1.6%
Lassen	FFS	2	2	2	2	2.0	0.0%	1,063.5	1,077.5	1,070.5	1,053.5	1,066.3	-0.9%
Los Angeles	Two-Plan	2,893	2,949	2,973	3,004	2,954.8	3.8%	58.1	59.0	54.8	50.6	55.6	-12.9%
Madera	Two-Plan	137	140	142	141	140.0	2.9%	28.7	25.4	23.9	22.5	25.1	-21.7%
Marin *	COHS	67	71	71	72	70.3	7.5%	118.8	5.3	4.7	4.7	33.3	-96.1%
Mariposa	FFS	-	-	-	-	-	-	-	-	-	-	-	-
Mendocino *	COHS	14	14	14	14	14.0	0.0%	679.4	33.9	30.0	27.9	192.8	-95.9%
Merced	COHS	23	23	24	24	23.5	4.3%	69.5	74.7	60.5	64.1	67.2	-7.8%
Modoc	FFS	-	-	-	-	-	-	-	-	-	-	-	-
Mono	FFS	5	5	5	5	5.0	0.0%	132.6	134.8	134.6	136.2	134.6	2.7%
Monterey	COHS	88	88	87	88	87.8	0.0%	28.2	28.3	22.6	22.2	25.3	-21.3%
Napa	COHS	23	23	23	23	23.0	0.0%	19.4	20.3	17.3	17.1	18.5	-12.0%
Nevada	FFS	11	11	11	11	11.0	0.0%	425.0	422.9	423.4	421.1	423.1	-0.9%
Orange	COHS	894	902	906	910	903.0	1.8%	13.3	14.6	12.0	10.6	12.6	-20.3%
Placer	FFS	88	88	88	90	88.5	2.3%	155.4	157.2	156.8	154.1	155.9	-0.8%
Plumas	FFS	-	-	-	-	-	-	-	-	-	-	-	-
Riverside	Two-Plan	237	239	240	243	239.8	2.5%	193.5	194.9	182.0	170.2	185.1	-12.0%
Sacramento	GMC	519	525	534	536	528.5	3.3%	48.8	48.1	47.4	46.7	47.8	-4.3%
San Benito	FFS	4	4	4	4	4.0	0.0%	1,239.8	1,244.0	1,226.0	1,237.5	1,236.8	-0.2%
San Bernardino	Two-Plan	513	517	521	528	519.8	2.9%	107.1	106.7	99.8	94.6	102.1	-11.7%
San Diego	GMC	930	937	950	957	943.5	2.9%	53.6	53.5	51.7	49.1	52.0	-8.5%
San Francisco	Two-Plan	664	682	689	693	682.0	4.4%	9.1	8.8	8.4	8.1	8.6	-11.0%

		Number of Physicians						Beneficiaries-to-Provider Ratio					
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Physicians	Percent Change for 2011 Q2– 2012 Q1	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Avg. Ratio	Percent Change for 2011 Q2– 2012 Q1
San Joaquin	Two-Plan	122	123	125	126	124.0	3.3%	131.8	123.2	113.5	108.3	119.2	-17.8%
San Luis Obispo	COHS	51	51	51	51	51.0	0.0%	15.6	15.5	15.3	15.7	15.5	0.5%
San Mateo	COHS	273	275	275	275	274.5	0.7%	7.4	7.4	6.7	6.7	7.1	-9.7%
Santa Barbara	COHS	96	97	97	97	96.8	1.0%	25.6	26.8	25.1	24.5	25.5	-4.1%
Santa Clara	Two-Plan	1,089	1,110	1,118	1,125	1,110.5	3.3%	14.8	14.8	15.6	15.7	15.2	5.9%
Santa Cruz	COHS	44	44	44	45	44.3	2.3%	23.4	23.3	23.2	22.0	23.0	-6.2%
Shasta	FFS	22	22	22	22	22.0	0.0%	773.0	777.1	763.1	756.8	767.5	-2.1%
Sierra	FFS	-	-	-	-	-	-	-	-	-	-	-	-
Siskiyou	FFS	3	3	3	3	3.0	0.0%	1,427.7	1,411.7	1,402.0	1,403.3	1,411.2	-1.7%
Solano	COHS	120	121	121	121	120.8	0.8%	10.2	10.6	10.1	9.3	10.0	-8.8%
Sonoma	COHS	66	67	67	69	67.3	4.5%	30.2	30.0	27.9	25.4	28.4	-16.1%
Stanislaus	Two-Plan	80	83	84	84	82.8	5.0%	196.7	186.1	178.2	176.5	184.4	-10.3%
Sutter	FFS	12	12	12	12	12.0	0.0%	877.7	891.4	885.8	891.1	886.5	1.5%
Tehama	FFS	9	10	10	10	9.8	11.1%	904.2	806.1	779.2	775.3	816.2	-14.3%
Trinity	FFS	-	-	-	-	-	-	-	-	-	-	-	-
Tulare	Two-Plan	82	83	84	86	83.8	4.9%	138.4	143.4	138.1	131.8	137.9	-4.8%
Tuolumne	FFS	10	10	10	10	10.0	0.0%	327.9	327.7	321.6	322.5	324.9	-1.6%
Ventura *	COHS	123	123	123	124	123.3	0.0%	496.8	27.1	24.6	24.0	143.1	-95.2%
Yolo	COHS	44	45	45	46	45.0	0.0%	27.2	29.0	27.3	24.9	27.1	-8.6%
Yuba	FFS	7	7	7	7	7.0	0.0%	1,345.1	1,345.4	1,324.0	1,307.0	1,330.	-2.8%

*Shifted from FFS to COHS Model on July 1, 2011

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of April 2011, August 2011, October 2011, and January 2012.

Table 28 Outpatient Clinics

		Number of Rural/FQHC Clinics						Number of Other Clinics					
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Clinics	Percent Change In Number of Clinics	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Clinics	Percent Change In Number of Clinics
Statewide		950	961	959	957	956.8	0.7%	1,586	1,624	1,638	1,656	1,626.0	4.4%
County Plan Model Type													
County Organized Health System (COHS)		183	189	186	187	186.3	2.2%	394	410	419	423	411.5	7.4%
Fee-for-Service (FFS)		192	195	196	197	195.0	2.6%	212	215	216	218	215.3	2.8%
Geographic Managed Care (GMC)		80	80	80	79	79.8	-1.3%	188	191	192	195	191.5	3.7%
Two-Plan (Commercial Plan and Local Initiative)		495	497	497	494	495.8	-0.2%	792	808	811	820	807.8	3.5%
County													
Alameda	Two-Plan	37	39	38	39	38.3	5.4%	54	54	54	55	54.3	1.9%
Alpine	FFS	1	1	1	1	1.0	0.0%	1	1	1	1	1.0	0.0%
Amador	FFS	4	4	4	4	4.0	0.0%	6	6	6	6	6.0	0.0%
Butte	FFS	19	19	19	19	19.0	0.0%	26	26	26	26	26.0	0.0%
Calaveras	FFS	7	7	7	7	7.0	0.0%	3	3	3	3	3.0	0.0%
Colusa	FFS	2	4	4	4	3.5	100.0%	5	4	3	3	3.8	-40.0%
Contra Costa	Two-Plan	16	16	16	16	16.0	0.0%	30	30	30	30	30.0	0.0%
Del Norte	FFS	4	4	4	4	4.0	0.0%	3	3	3	3	3.0	0.0%
El Dorado	FFS	6	6	6	6	6.0	0.0%	8	8	8	8	8.0	0.0%
Fresno	Two-Plan	63	64	65	58	62.5	-7.9%	39	40	40	40	39.8	2.6%
Glenn	FFS	11	11	12	12	11.5	9.1%	2	2	2	2	2.0	0.0%
Humboldt	FFS	29	30	30	30	29.8	3.4%	14	14	14	14	14.0	0.0%
Imperial	FFS	10	10	10	10	10.0	0.0%	6	6	6	6	6.0	0.0%
Inyo	FFS	6	6	6	6	6.0	0.0%	5	5	5	5	5.0	0.0%
Kern	Two-Plan	34	34	34	35	34.3	2.9%	40	40	41	41	40.5	2.5%

		Number of Rural/FQHC Clinics						Number of Other Clinics					
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Clinics	Percent Change In Number of Clinics	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Clinics	Percent Change In Number of Clinics
Kings	Two-Plan	18	18	18	19	18.3	5.6%	10	13	13	13	12.3	30.0%
Lake	FFS	10	10	10	10	10.0	0.0%	8	10	11	11	10.0	37.5%
Lassen	FFS	5	5	6	5	5.3	0.0%	2	2	2	2	2.0	0.0%
Los Angeles	Two-Plan	147	146	146	147	146.5	0.0%	331	338	339	345	338.3	4.2%
Madera	Two-Plan	12	12	12	12	12.0	0.0%	7	7	7	7	7.0	0.0%
Marin *	COHS	5	5	5	5	5.0	0.0%	21	25	25	25	24.0	19.0%
Mariposa	FFS	4	4	4	4	4.0	0.0%	2	2	2	2	2.0	0.0%
Mendocino *	COHS	24	23	23	23	23.3	-4.2%	8	8	8	9	8.3	12.5%
Merced	COHS	25	29	26	26	26.5	4.0%	11	11	11	11	11.0	0.0%
Modoc	FFS	4	4	4	4	4.0	0.0%	3	3	3	3	3.0	0.0%
Mono	FFS	1	1	1	1	1.0	0.0%	2	2	2	2	2.0	0.0%
Monterey	COHS	21	21	21	21	21.0	0.0%	23	23	23	23	23.0	0.0%
Napa	COHS	2	2	2	2	2.0	0.0%	14	18	22	22	19.0	57.1%
Nevada	FFS	2	2	2	2	2.0	0.0%	18	19	19	19	18.8	5.6%
Orange	COHS	15	15	15	15	15.0	0.0%	131	133	134	135	133.3	3.1%
Placer	FFS	3	3	3	3	3.0	0.0%	14	14	14	15	14.3	7.1%
Plumas	FFS	6	6	6	6	6.0	0.0%	5	5	5	5	5.0	0.0%
Riverside	Two-Plan	23	23	23	23	23.0	0.0%	46	48	48	49	47.8	6.5%
Sacramento	GMC	9	9	9	8	8.8	-11.1%	85	87	88	89	87.3	4.7%
San Benito	FFS	3	3	3	3	3.0	0.0%	3	3	3	3	3.0	0.0%
San Bernardino	Two-Plan	13	13	13	13	13.0	0.0%	60	60	62	62	61.0	3.3%
San Diego	GMC	71	71	71	71	71.0	0.0%	103	104	104	106	104.3	2.9%
San Francisco	Two-Plan	30	30	30	30	30.0	0.0%	50	50	51	51	50.5	2.0%
San Joaquin	Two-Plan	7	7	8	8	7.5	14.3%	35	35	34	34	34.5	-2.9%
San Luis Obispo	COHS	10	12	12	12	11.5	20.0%	18	20	19	19	19.0	5.6%

		Number of Rural/FQHC Clinics						Number of Other Clinics					
		2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Clinics	Percent Change In Number of Clinics	2011 Quarter 2	2011 Quarter 3	2011 Quarter 4	2012 Quarter 1	Average Number of Clinics	Percent Change In Number of Clinics
San Mateo	COHS	16	16	16	16	16.0	0.0%	33	33	33	33	33.0	0.0%
Santa Barbara	COHS	16	17	17	17	16.8	6.3%	30	30	30	30	30.0	0.0%
Santa Clara	Two-Plan	22	22	22	22	22.0	0.0%	49	51	51	51	50.5	4.1%
Santa Cruz	COHS	8	8	8	8	8.0	0.0%	17	17	17	17	17.0	0.0%
Shasta	FFS	16	16	16	16	16.0	0.0%	28	28	28	28	28.0	0.0%
Sierra	FFS	2	2	2	2	2.0	0.0%	2	2	2	2	2.0	0.0%
Siskiyou	FFS	12	12	12	12	12.0	0.0%	8	8	8	8	8.0	0.0%
Solano	COHS	8	8	8	8	8.0	0.0%	21	20	20	22	20.8	4.8%
Sonoma	COHS	15	15	15	16	15.3	6.7%	31	33	35	35	33.5	12.9%
Stanislaus	Two-Plan	26	26	26	26	26.0	0.0%	26	26	25	25	25.5	-3.8%
Sutter	FFS	4	4	4	4	4.0	0.0%	13	13	14	15	13.8	15.4%
Tehama	FFS	8	8	8	8	8.0	0.0%	5	6	6	6	5.8	20.0%
Trinity	FFS	2	2	2	3	2.3	50.0%	2	2	2	2	2.0	0.0%
Tulare	Two-Plan	47	47	46	46	46.5	-2.1%	15	16	16	17	16.0	13.3%
Tuolumne	FFS	4	4	4	4	4.0	0.0%	15	15	15	15	15.0	0.0%
Ventura *	COHS	12	12	12	12	12.0	0.0%	28	31	32	32	30.8	14.3%
Yolo	COHS	6	6	6	6	6.0	0.0%	8	8	10	10	9.0	25.0%
Yuba	FFS	7	7	6	7	6.8	0.0%	3	3	3	3	3.0	0.0%

*Shifted from FFS to COHS Model on July 1, 2011

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files April 2011–March 2012 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of April 2011, August 2011, October 2011, and January 2012.

Appendix D—Detailed List of Other Providers

Community-Based Adult Services Program (formerly called Adult Day Health Care) (PT 001)

Assistive Device and Sick Room Supply Dealers (PT 002)

Audiology Services—Audiologists (PT-003), Hearing Aid Dispensers (PT-013)

Blood Banks- (PT 004)

Certified Nurse Midwife- (PT 005)

Chiropractors- (PT 006)

Certified Nurse Practitioner (PT 007), Group Certified Family/Pediatric Nurse Practitioners (PT 010)

Christian Science Practitioner (PT 008)

Fabricating Optical Lab (PT 011), Dispensing Opticians (PT 012), Optometrists (PT 020), and Optometric Groups (PT 023)

Nurse Anesthetists (PT 018)

Physical Therapist (PT 025), Occupational Therapist (PT 019), Speech Therapist (PT 037)

Orthotists (PT 021), Prosthetists (PT 029)

Podiatrists (PT 027)

Portable X-Ray (PT 028)

Psychologists (PT 031)

Certified Acupuncturist (PT 032)

Genetic Disease Testing (PT 033)

Medicare Crossover Provider Only (PT 034)

Outpatient Heroin Detoxification Center (PT 051)

Local Education Agency (LEA) (PT 055)

Respiratory Care Practitioner (056) and Respiratory Care Practitioner Group (PT 062)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services Provider (PT 057)

Health Access Program (HAP)(PT 058)

Home and Community-Based Services (HCBS) Waiver Programs (Multiple Provider Types):

HCBS Nursing Facility (Congregate Living Health Facilities with Type A licensure) (PT 059)

HCBS Licensed Building Contractors (PT 063)

HCBS Employment Agency (PT 064)

HCBS Personal Care Agency (PT 066)

HCBS Benefit Provider (Licensed Clinical Social Worker, Licensed Psychologist, or Marriage and Family Therapist) (PT 068)

HCBS Professional Corporation (PT 069)

AIDS Waiver (PT 073)

Multipurpose Senior Services Program Waiver (PT 074)

Assisted Living Waiver-Facility (PT 092)

Assisted Living Waiver-Care Coordinator (PT 093)

HCBS Private Non-Profit (PT 095)

Pediatric Subacute Care/LTC (PT 065)

RVNS Individual Nurse Providers (PT 067)

CCS/GHPP Non-Institutional Providers (PT 080)

CCS/GHPP Institutional Providers (PT 081)

Independent Diagnostic Testing Facility Crossover (PT 084)

Clinical Nurse Specialist Crossover Provider (PT 085)

Out of State Providers (PT 090)

Appendix E—Medi-Cal Aid Codes

Aid codes are assigned to each Medi-Cal beneficiary based on how they become eligible for Medi-Cal services. Factors such as age, income, or disability status are some of the criteria used to assess an individual's eligibility for program services. There are over 170 different aid codes that enable DHCS to gain an understanding of how beneficiaries might use Medi-Cal program services.

The aid code categories used for this analysis were intended to group beneficiaries with similar ages, disability status, and benefit scope into groups that might place similar demands on program services. However, some aid categories represent a heterogeneous population that might use Medi-Cal services in quite different ways.

For example, beneficiaries in the Families aid category are mostly comprised of no- or low-income young adults with children who have routine health care needs. However, this aid category also includes families who earn incomes above the Medi-Cal limit, but have a “Medically Needy” individual with one or more serious conditions requiring medical treatment exceeding the family's income. This subpopulation would place stronger demands on program services than others in the Families aid category. Likewise, the Other aid category is comprised of a diverse population, such as individuals in the Breast and Cancer Cervical Treatment Program who have access to a restricted scope of benefits, long-term care recipients, and the medically indigent, among other populations. See table below.

A more detailed breakdown of aid codes within each category can be found at http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/aidcodes_z01c00.doc

Detail Aid Category	Rolled up Aid Category	Aid Codes
BCCTP	Other	0L, 0M, 0N, 0P, 0R, 0T, 0U, 0V, 0W, 0X, 0Y
Inmates	Other	F1, F2, F3, F4, G1, G2, G3, G4
Hurricane Katrina Evacuees	Other	65
MI - Adoption or Foster Care	Foster Care	03, 04, 06, 45, 46, 4A, 4K, 4M, 5K
MI – Adult	Other	81, 86, 87
MI - Child	Other	82, 83, 5E, 7T, 8U, 8V, 8W
MI - LTC	Other	53
MN - Aged	Aged	14, 17, 1D, 1H, 1X, 1Y
MN - Blind	Blind/Disabled	24, 27, 2D, 2H
MN - Disabled	Blind/Disabled	64, 67, 6D, 6H, 6S, 6V, 6W, 6X, 6Y, 8G
MN - Families	Families	34, 37, 39, 54, 59, 3D, 3N, 5X, 6J, 6R, 7J
MN - LTC	Other	13, 23, 63
Other	Other	01, 02, 08, 44, 47, 51, 52, 56, 57, 71, 72, 73, 76, 79, 80, 0A, 2A, 2V, 4V, 5V, 6G, 7A, 7F, 7G, 7H, 7M, 7N, 7P, 7R, 7V, 8E, 8P, 8R
PA - Adoption or Foster Care	Foster Care	40, 42, 43, 77, 78, 4C, 4F, 4G, 4H, 4L, 4T
PA - Aged	Aged	10, 16, 18, 1E
PA - Blind	Blind/Disabled	20, 26, 28, 2E, 6A
PA - Disabled	Blind/Disabled	36, 60, 66, 68, 6C, 6E, 6N, 6P
PA - Families	Families	30, 32, 33, 35, 38, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3P, 3R, 3U, 3W
Undocumented	Undocumented	07, 48, 49, 55, 58, 69, 70, 74, 75, 1U, 3T, 3V, 5F, 5G, 5J, 5N, 5R, 5T, 5W, 6U, 7C, 7K, 8N, 8T, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, 5H, 5M, 5Y