



# Medi-Cal Access to Care Quarterly Monitoring Report #4 2012 Quarter 3



## Executive Summary

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## 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. The areas evaluated include changes in Medi-Cal participation, physician supply, service utilization rates per 1,000 member months, and beneficiary help line feedback.

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

### KEY FINDINGS

- Medi-Cal Beneficiaries' participating in the Fee-for-Service (FFS) delivery system continues to decline, particularly among adults in the Aged and Blind/Disabled aid categories. For some beneficiary subpopulations, such as those enrolled in a Foster Care and Other aid category, and in some geographic areas, FFS participation increased in the third quarter of 2012. By September 2012, the largest segment of adult FFS Medi-Cal beneficiaries were those enrolled in Undocumented aid codes.
- The Medi-Cal physician supply grew modestly overall. Physician specialists such as primary care, OB/GYN, and pediatricians also recognized modest growth as well. Site-specific overall physician counts, or total physicians at distinct locations, increased statewide from 107,332 to 109,854, or 2.3%.
- Service utilization, or realized access, was generally within upper and lower expected bounds for most service categories and populations. For some FFS subpopulations, below average utilization of Physician/Clinic and Hospital Inpatient services may be attributed in part to declines in beneficiaries seeking pregnancy-related services, largely due to the national and statewide decline in birth rates. Due to the continuing shift from FFS to managed care, an increased number of service categories continued to be utilized by fewer than 500 beneficiaries. Service utilization is continuing to concentrate among a smaller number of beneficiary subpopulations participating in FFS.
- A large number of beneficiaries participating in FFS continue to call into DHCS' Medi-Cal Managed Care Division's Office of the Ombudsman for assistance. Over 8,500 calls were handled by the Office of the Ombudsman for beneficiaries enrolled in FFS, a 1.24% decrease from the previous study period. However, calls declined significantly in the last quarter of the study period. Smaller call volume during the current quarter is likely the result of fewer changes to Medi-Cal program benefits and services. In the earlier study periods, Medi-Cal transitioned the seniors and persons with disabilities (SPD) from FFS into managed care delivery systems throughout 14 counties.

## Executive Summary

### Background

This Medi-Cal access report is the fourth in a series of reports concerning health care access among Medi-Cal's population. This report provides information for evaluating the early signs of potential health access problems related to beneficiaries eligible for Medi-Cal only<sup>1</sup> and participating in Medi-Cal's Fee-for-Service (FFS) system. This report covers the third quarter of 2012, and presents data from the three previous quarters for comparison purposes. During this study period, Medi-Cal's provider payment reduction proposed by Assembly Bill 97 (AB 97) was not in effect; applicable Medi-Cal providers were not subjected to the 10% payment reduction during the dates-of-service evaluated in this quarterly report.

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

- Change in Medi-Cal participation
- Physician supply
- Service utilization rates per 1,000 member months
- Beneficiary help line feedback

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 incorporating dates-of-service between 2007 and 2009.

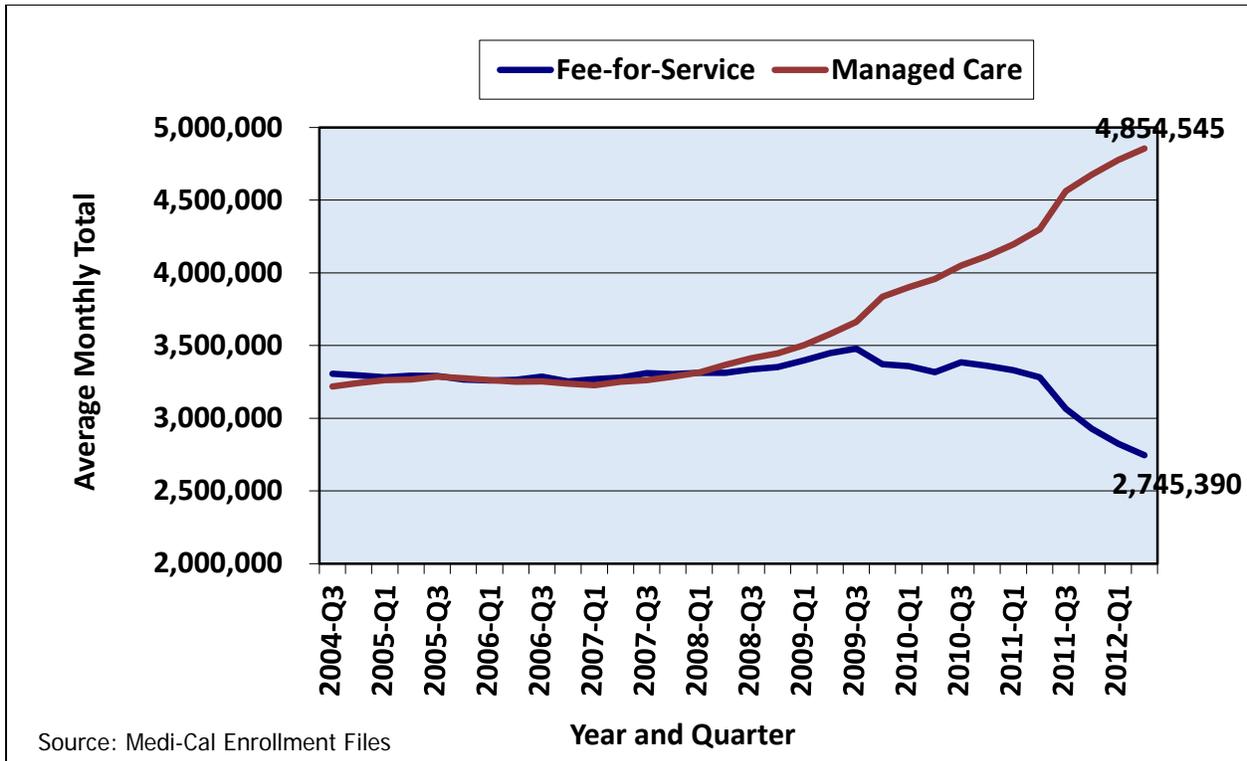
Since 2007, Medi-Cal has undergone dramatic changes brought on by a deep economic recession and continual efforts to restructure its health care delivery system. In some cases, these changes dramatically affected Medi-Cal's FFS population, impacting how beneficiaries receive services. As a result, the present baseline metrics that were established during Medi-Cal's transformational period may not always reflect the new reality. Therefore, the baseline statistics, or benchmarks, will be reconsidered in future reports.

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

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<sup>1</sup> The term "Medi-Cal only" refers to individuals eligible for Medi-Cal but not Medicare.

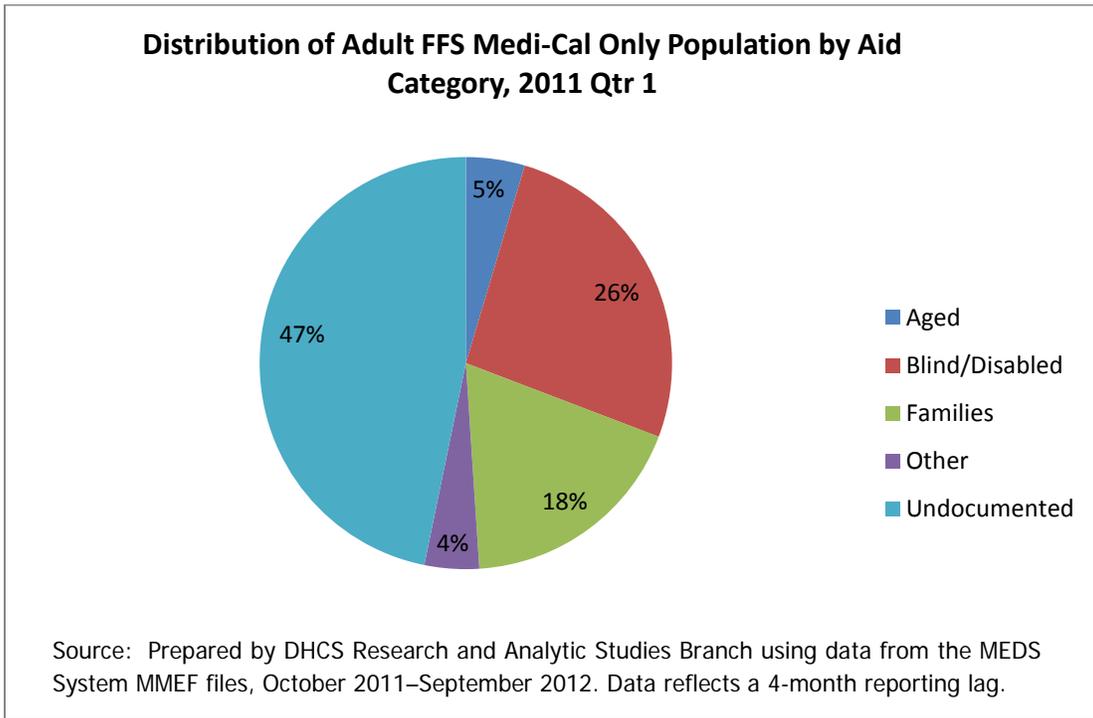
**Figure ES-1 Trend in Quarterly FFS vs Managed Care Participation**



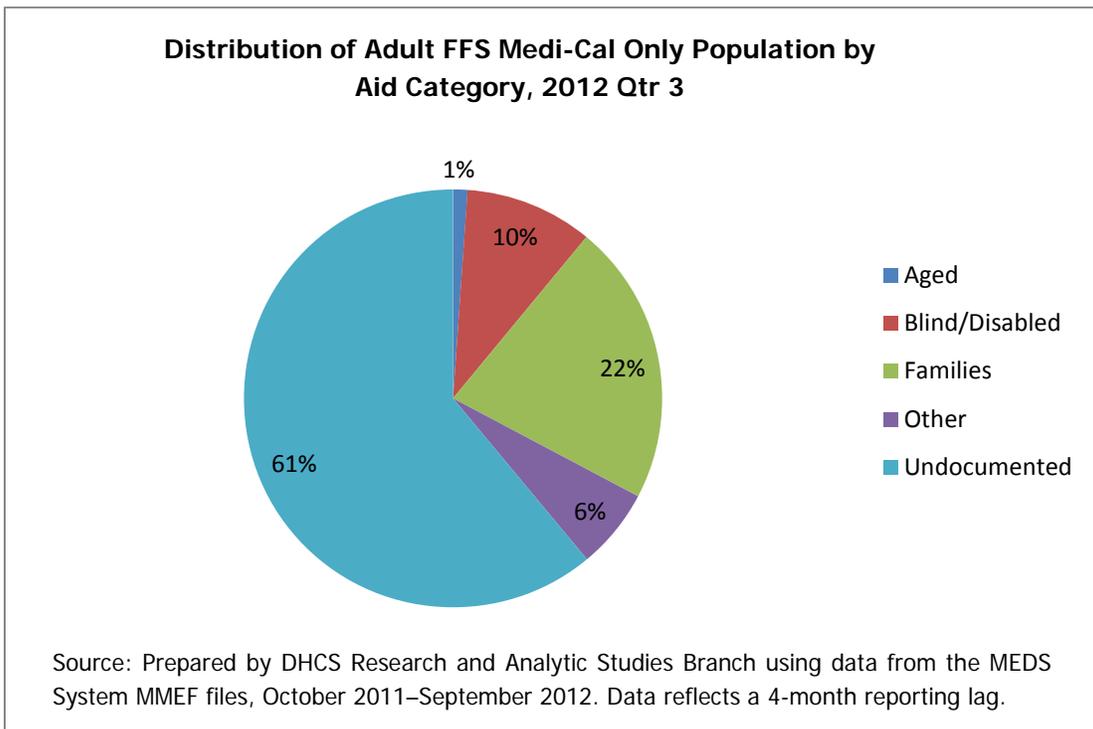
As beneficiaries are transitioned from FFS to managed care, the population evaluated in conjunction with this monitoring effort contracts, and in many cases the population mix is altered.

As the next two figures show, from the first quarter of 2011 to the third quarter of 2012, an increasing percentage of the overall Medi-Cal population is comprised of Undocumented beneficiaries, as subpopulations in the other aid categories shift from FFS to managed care. Since Undocumented beneficiaries are not eligible to enroll in managed care, and as the remaining population continues its shift over to managed care, the percentage of the Medi-Cal FFS population comprised of Undocumented beneficiaries will continue to increase. As of September 2012, nearly two-thirds of the adult FFS Medi-Cal population were enrolled in Undocumented aid codes.

**Figure ES-2 Distribution of Adult FFS Medi-Cal only Population by Aid Category, 2011 Quarter 1**



**Figure ES-3 Distribution of Adult FFS Medi-Cal Only Population by Aid Category, 2012 Quarter 3**



From 2008–2011, San Luis Obispo, Sonoma, Merced, Kings, Madera, Ventura, Mendocino, and Marin Counties were transitioned from FFS to managed care delivery 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.<sup>2</sup>

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 transitioned 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 billion<sup>3</sup> in annual health care spending.

All of these shifts from the FFS to managed care delivery models occurred at the end of the baseline period of 2007–2009 or during the present study period. For example, the SPD transition was phased in from June 2011–May 2012. This means that during most of the current study period of October 2011–September 2012, beneficiaries receiving health care services through the FFS system in the earlier quarters of the study period were now receiving care through managed care plans.

Shifting health care delivery systems materially influenced service utilization 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 service utilization rates per 1,000 member months. When populations transition from FFS to managed care, the potential exists for case mix changes to occur. Beneficiaries who remain in FFS may exhibit very different health characteristics from the pre-shift population, resulting in changes to service utilization rates. In some cases, service utilization rates may rise, if for example, populations that remain in FFS represent high users.

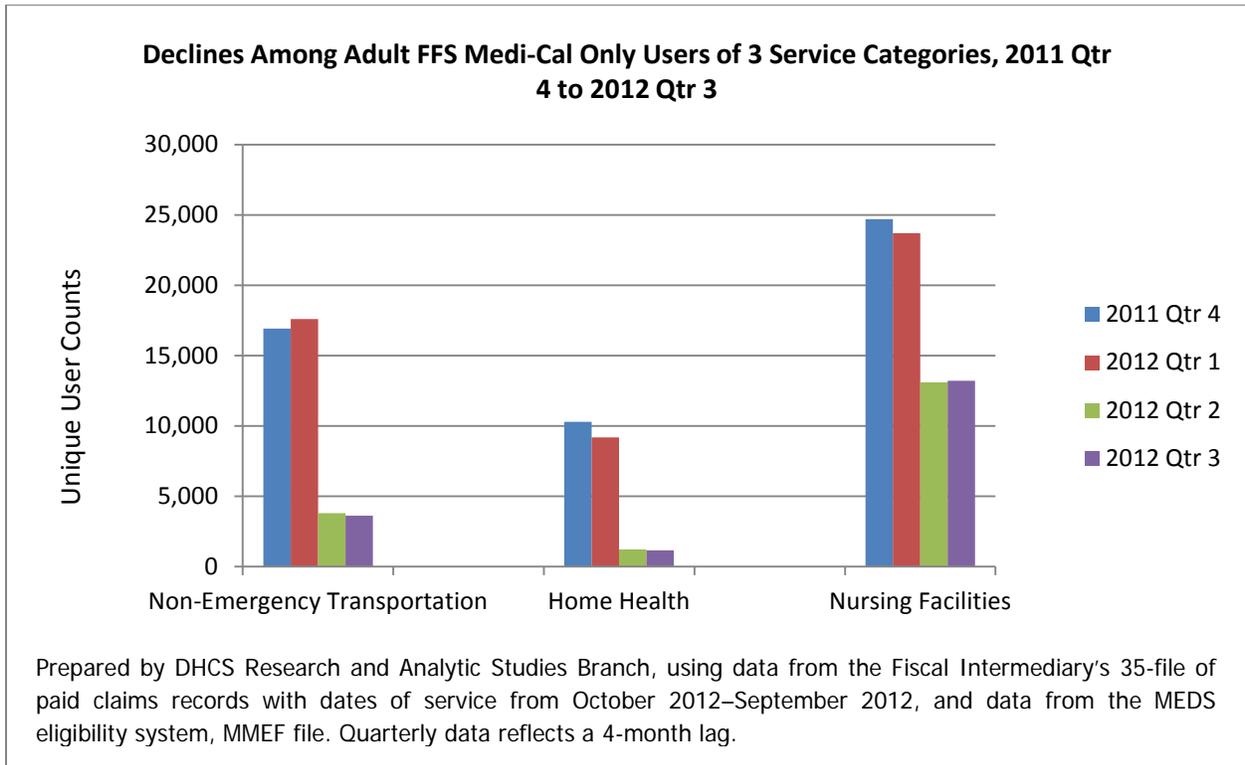
The change in FFS beneficiary case mix, and its result on service utilization, has become increasingly apparent in the analysis of realized access undertaken in the current quarter. As beneficiary subpopulations are moved into managed care plans, fewer adult beneficiaries that remain in the FFS delivery system have health conditions that require services such as Non-Emergency Transportation, Home Health, and Nursing Facility care. [Figure ES-4](#) and [Figure ES-5](#) illustrate this point. For instance, adult FFS beneficiaries in the Aged and Families aid code who utilize services such as Non-Emergency Transportation and Home Health have declined to levels so small that their impact on these services has become inconsequential.

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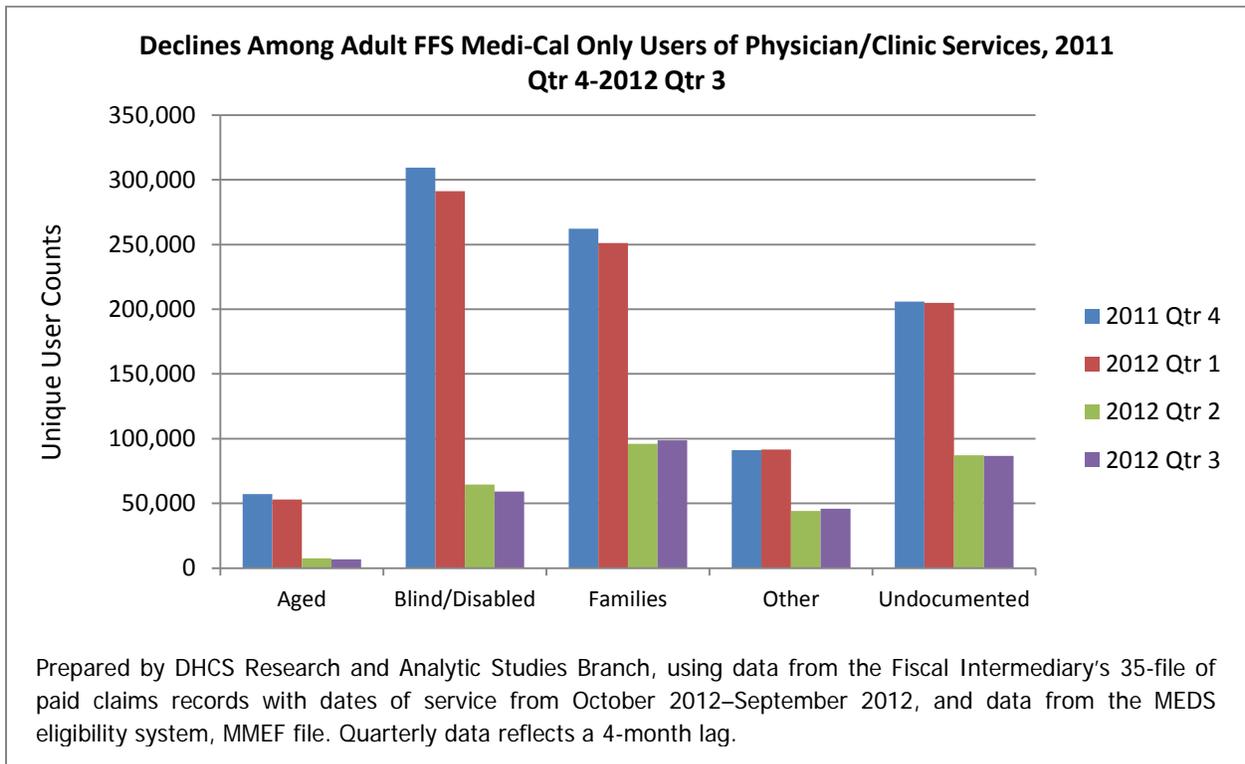
<sup>2</sup> Part of the 306,000 included "Working Disabled" individuals who were transitioned into managed care delivery systems (11,382).

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

**Figure ES-4 Declines in Adult FFS Medi-Cal Only Users of 3 Service Categories**



**Figure ES-5 Declines in Adult FFS Medi-Cal Only Users of Physician/Clinic Services**



As counties are transitioned to managed care delivery systems, the beneficiaries who remain in FFS and the service utilization associated with FFS member months tend to be either those 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.<sup>4</sup>

Beneficiaries exempted from managed care participation through the medical exemption process generally exhibit health care needs greater than the norm. As a result, these individuals will generate higher than average service utilization rates. Similarly, beneficiaries new to the Medi-Cal program may use services during their first couple of months of participation at higher rates than the norm. Utilization of services occurring during retroactive months of participation tends to display significantly different patterns than services used during timely enrollment. Services used during the retroactive period are most likely associated with inpatient acute care services. If a particular county shifts from a FFS to managed care delivery system, service utilization associated with the remaining FFS population will exhibit patterns that, in many cases, 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 subpopulations, beneficiaries in other subpopulations increased in number during the second quarter of 2012. Policies affecting the eligibility of foster care youth may explain some of this increase. The California Fostering 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 the first quarter of 2012 to the second quarter of 2012.

In addition to shifts in participation, Medi-Cal also eliminated optional services that impacted service use 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, including: 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

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<sup>4</sup> 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).

quarterly access report and compared to a baseline level constructed during the initial periods following the enactment of these benefit changes.

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. 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.

The measures selected for monitoring health care service use and beneficiary interaction with Medi-Cal's delivery system have proven to be informative. The policy changes noted above all left some type of footprint in the selected measures evaluated.

## Findings

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

### Physician Supply

The provider supply metric used in this quarterly access report has changed from beneficiary-to-provider ratios to site-specific physician counts. Site-specific physician counts are system wide metrics designed to alert Department management of changes in the number of providers and provider sites over time. Much like an internal control, this metric was designed to identify system-wide trends that may adversely impact access to health care services in the future. Continuously monitoring these trends provides useful early warning signs that adverse changes may be materializing (e.g., number of enrolled Medi-Cal physicians are declining) or that the supply of physicians has been stable over time. This has been the case for the last three quarters—enrolled physicians have been stable during the quarters examined (2011 Q4, 2012 Q1 and Q2) as well as for the current quarter. In these four access snapshots, modest increases in Medi-Cal physician enrollment have been reported.

The aggregate number of primary care physicians increased 1.7% from 39,068 to 39,722 during the four quarters studied.<sup>5</sup>

During the period under study, physician enrollment for each specialty area (primary care, OB/GYN, pediatrics) increased slightly.

This report's findings showed no deterioration in overall physician supply for beneficiaries eligible for Medi-Cal only participating in FFS over the four quarters studied, but did disclose differences among regions of the state. In general, the primarily rural counties using 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.

### Change in Medi-Cal Participation

The number of beneficiaries eligible for Medi-Cal only, participating in FFS, and entitled to full scope benefits decreased 8.6% overall from the fourth quarter of 2011 to the third quarter of 2012, reflective of Medi-Cal's continued shift of beneficiaries to managed care.

The greatest decrease from the fourth quarter of 2011 to the third quarter of 2012 in FFS participation was observed among beneficiaries eligible for full-scope Medi-Cal only benefits, and enrolled in the Aged aid category (64.4%), with adults in Blind/Disabled aid category also significantly decreasing by 52.6%. The decrease in participation among the Aged and

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<sup>5</sup> For details on how "primary care physicians" were defined for this report, see the Physician Supply Section of the current report on the [DHCS-RASB Access Monitoring](#) website

Blind/Disabled 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 uniform across all regions of the state. In fact, when looking at full scope beneficiaries by county, 23 of 58 counties experienced a decline in FFS participation of a magnitude 1% or more, while the remaining half either stayed about the same or increased.

Overall, participation in Medi-Cal FFS decreased in both metropolitan and non-metropolitan areas of the state from the fourth quarter of 2011 to the third 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 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 (9.2%) in participation for 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 nationwide, declines in birthrates among Mexican immigrants, and the residual effects of the recession.<sup>6,7</sup>

### **Service Utilization Rates Per 1,000 Member Months for Adult Beneficiaries<sup>8</sup>**

Medi-Cal's quarterly access monitoring effort also incorporated measures of service 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 the multifaceted phenomenon called access.

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

1. Physician/Clinics;
2. Emergency Transportation;
3. Non-Emergency Transportation;

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<sup>6</sup>Passel, 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/>

<sup>7</sup>Passel, 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/>

<sup>8</sup> Service use for children has been excluded from the Executive Summary but is examined in detail within the Physician Supply report on the [DHCS-RASB website](#).

4. Home Health;
5. Hospital Inpatient;
6. Hospital Outpatient;
7. Nursing Facility;
8. Pharmacy;
9. Other; and
10. Radiology.

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

- As noted in the previous access quarterly reports, adults in the Blind/Disabled aid category continued to place a greater demand on Emergency Transportation, Hospital Inpatient and Outpatient, as well as, Nursing Facility services. Despite experiencing a downward trend in Non-Emergency Transportation services utilization during the last two quarters of the study period, Blind/Disabled adults utilized these services at rates well above the expected baseline ranges. Additionally, after displaying a decline in utilization of Hospital Inpatient and Home Health services in the second quarter of 2012, adults in the Blind/Disabled aid category exhibited increased use of these particular services at the end of the study period.
- Adults in the Families aid category again displayed below average utilization of Emergency Transportation, Hospital Inpatient, Hospital Outpatient, 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 statewide birth rate.
- Adults in the Undocumented aid category, who are only eligible for emergency and pregnancy-related services, also continued to exhibit below average and lower than expected utilization of Emergency Transportation, Physician/Clinic, Hospital Inpatient, and Hospital Outpatient services. This lower service utilization further supports the argument that these utilization patterns may be heavily influenced by the decline in overall births statewide and nationally,<sup>9</sup> which is most noticeable among the immigrant population.<sup>10</sup>
- The continued decline in Medi-Cal's FFS population, which is a result of the transition of Medi-Cal beneficiaries into managed care plans, has directly reduced the pool of users for particular services. For instance, the number of adults in Aged and Families aid categories

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<sup>9</sup> Data from the National Vital Statistics System, found at <http://www.cdc.gov/nchs/data/databriefs/db60.pdf>

<sup>10</sup> Livingston, G., & Cohn, D. (2012, November 29) U.S. Birth Rate Falls to a Record Low; Decline Is Greatest Among Immigrants. *Pew Research Center: Social & Demographic Trends*.

that utilize Non-Emergency Transportation and Home Health services have declined to levels (<500) that render their utilization of these service categories inconsequential to the current analysis. The beneficiary subpopulations that continue to utilize these service categories exhibited utilization patterns that are often times above the range of expected values. These shifts in utilization patterns provide further evidence of how markedly the Medi-Cal FFS population case mix has changed since the baseline period of 2007 to 2009.

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 SPDs 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 utilization 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 users. 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 use 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 utilization 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 service utilization changes presented (e.g., the increase in LTC service utilization rate and decrease in Home Health service utilization rate).

Table ES-1 presents the results of the analysis of the service utilization trends among adults by aid and service categories. Service utilization trends for children are examined in detail within the Service Utilization report on the [DHCS-RASB website](#), but are excluded from this Executive Summary. The table is color coded to identify those cases when a particular cell, which represents service utilization by aid and service category, generated a service utilization rate that was either lower or higher than the established confidence level. Cells highlighted in beige represent service 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 utilization 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, service 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 ES-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	Radiology Services
<b>Aged</b>	Mostly below average and within expected range.	N/A	N/A.	N/A.	Upward trend Nov 2011–May 2012. Mostly above expected range.	Mostly above average and mostly within expected range. Upward trend (Nov-May).	Mostly above expected range. Upward trend (Oct-May).	Below average and mostly below expected range in last 3 quarters. Downward trend (Oct-Jul).	Below average and mostly below expected range.	Above average and mostly above expected range.
<b>Blind/ Disabled</b>	Mostly above average and within expected range.	Above expected range. Downward trend Mar 2012–Sep 2012.	Mostly above average with levels reaching above expected range in last 3 quarters.	Mostly above average and within expected range.	Mostly above average with several months above expected range in last 2 quarters.	Mostly above average with several months above expected range in last quarter. Upward trend (Dec–May).	Mostly above expected range. Upward trend (Oct-May).	Below average with non-consecutive months below the expected Range.	Mostly below average and within expected range.	Above average and mostly above expected range.
<b>Families</b>	Below average and within expected range.	N/A	Mostly below average and within expected range.	N/A	Below average with several non-consecutive months below expected range.	Mostly below average and mostly within expected range.	N/A	Below average and below expected range in last quarter.	Below average and mostly within expected range.	Within expected range.
<b>Other</b>	Mostly above average and within expected range.	Above expected range	Within expected range.	N/A	Below average with 5 consecutive months below expected range.	Within expected range.	Below average with several non-consecutive months outside of the expected range. Decline in last quarter.	Within expected range.	Mostly below average and within expected range.	Within expected range.
<b>Undocu- mented</b>	Below average with several non-consecutive months below expected range.	N/A	Mostly below the expected range with levels reaching within range during last quarter.	N/A	Below the expected range.	Below average and mostly within expected range.	N/A	Mostly above average and within expected range.	Below the expected range.	Mostly below average and within expected range.

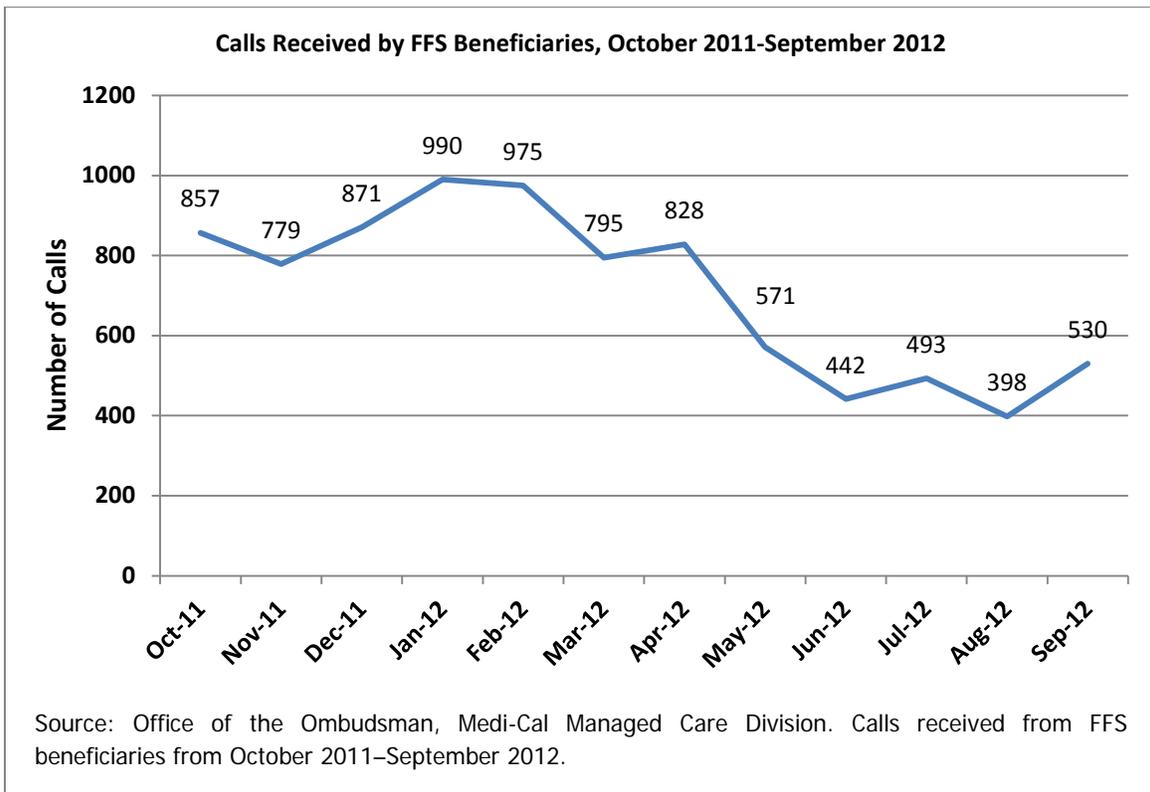
## **Beneficiary Help Line Feedback**

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 at which 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 continues to rely on data obtained from the Office of the Ombudsman for the purpose of monitoring health care access. From the fourth quarter of 2011 to the third quarter of 2012, the Office of the Ombudsman call center documented over 8,500 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 ES-6 presents the trend in calls made by FFS beneficiaries from October 2011 to September 2012 by month. The most significant increase in call volume occurred between October 2011 and December 2011.

**Figure ES-6 Calls Received from FFS Beneficiaries by Month, October 2011–September 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, while calls from beneficiaries in the Families aid category most often pertain to beneficiaries newly eligible for services and seeking assistance with enrolling into a health plan. In fact, a large proportion of calls received by the Ombudsman’s Office from beneficiaries in these two aid categories pertained to Enrollment/Continuity of Care issues. Among Enrollment/Continuity of Care, the most common issues cited were requests for new enrollment, Foster Care/Adoption (Disenrollment Exemption Request) medical exemptions, and requests to change plans or disenroll from managed care. Call volume decreased by half during the first two quarters of 2012 and returned to levels seen prior to the implementation of major Medi-Cal program changes.