



**Medi-Cal Fee-for-Service
Access to Care
Quarterly Monitoring Report #8
2013 Quarter 3**

Executive Summary

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Abstract

The California Department of Health Care Services' (DHCS) quarterly analysis of access in the Medi-Cal Fee-for-Service (FFS) delivery system includes an evaluation of four measures identified as a means of detecting the early signs of health care access disruptions. The areas evaluated include changes in physician supply, Medi-Cal beneficiary participation, service utilization rates per 1,000 member months, and beneficiary feedback.

Medi-Cal's assessment of health care access for the third quarter of 2013 disclosed that for the most part participation trends, provider supply, and service utilization rates were within expected ranges. Key findings regarding these study areas are summarized below.

Key Findings

- Overall findings indicate that the statewide supply of physicians potentially available to full-scope Fee-for-Service (FFS) Medi-Cal Only beneficiaries continued to grow modestly during the study period. For instance, the site-specific overall physician supply, or total physicians at distinct locations, increased 3.0% statewide, from 76,766 to 79,062. Physician specialists such as primary care, Obstetrics and Gynecology, and Pediatricians also experienced modest growth.
- Overall, FFS Medi-Cal participation by full-scope beneficiaries increased 3.0% during the study period, from 1,127,039 to 1,161,207 average monthly eligibles. However, the participation of FFS Medi-Cal Only beneficiaries entitled to full-scope benefits declined 2.7% between the second quarter of 2013 and the third quarter of 2013.
- Service utilization patterns for both children and adults in most aid categories primarily followed the patterns identified in the previous access quarterly report. The shifts in utilization observed in this report may be attributable to a combination of factors such as a change in population case mix, a declining birth rate, the expansion of the County Organized Health Systems (COHS), and the transition of the Healthy Families Program (HFP) into Medi-Cal. Of particular note, as beneficiary participation continued to shift away from the FFS delivery system and into managed care, many service categories experienced a noticeable decline in user counts that made the data unsuitable for analysis.
- Beneficiaries participating in FFS continue to call into DHCS' Medi-Cal Managed Care Division's Office of the Ombudsman for assistance. During the study period, the Office of the Ombudsman received 10,633 calls from FFS Medi-Cal beneficiaries, which marks an increase in call volume from the previous study period. The increase in call volume in 2013 likely reflects the transition of children from the Healthy Families Program into Medi-Cal that began January 1, 2013, as well as the establishment of County Organized Health Systems in eight counties during September 2013.

Introduction

DHCS is directly responsible for ensuring access to health care providers for beneficiaries enrolled in the FFS delivery system, where the Medi-Cal program serves as the primary source of coverage. This report is the eighth in a series of quarterly reports analyzing health care access for FFS Medi-Cal Onlyⁱ beneficiaries. The information presented in this report serves as an early-warning mechanism for alerting State administrators to potential deficiencies in accessing FFS Medi-Cal services.

This report covers the third quarter of 2013, and presents data from the three previous quarters for comparison purposes. This DHCS quarterly health care access monitoring report presents the following four specific early warning measures:

- Physician Supply
- Medi-Cal Beneficiary Participation
- Service Utilization per 1,000 Member Months
- Beneficiary Helpline Feedback

Background

Assembly Bill 97

In March 2011, Assembly Bill (AB) 97 was signed into law and instituted a 10% reduction in Medi-Cal reimbursements to select providers. A court injunction delayed the implementation of AB 97 until September 2013.

The reimbursement reductions do not apply to all Medi-Cal providers and services. Providers and services that are exempt from the 10% reduction in Medi-Cal reimbursement rates include but are not limited to:

- Physician services to children ages 0-20;
- Hospital inpatient and outpatient services;
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).^{ii,iii,iv}

Baseline Comparisons

The DHCS access monitoring system required the establishment of baseline statistics for trend comparisons. 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, thus 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

ⁱ The term "Medi-Cal Only" refers to individuals eligible for Medi-Cal but not Medicare.

ⁱⁱ California Assembly Bill 97, (2011).

ⁱⁱⁱ California Department of Health Care Services, Implementation of AB97 Reductions. Retrieved from <http://www.dhcs.ca.gov/Documents/AB97ImplementationAnnouncemen081413.pdf>

^{iv} California Department of Health Care Services, State Plan Amendment, SPA 11-009.

reality. Therefore, the baseline statistics, or benchmarks, will be recalculated for use in the Medi-Cal Access to Care Quarterly Monitoring Report, 2013 Quarter 4.

Medi-Cal Enrollment Transitions

Significant program changes have occurred within Medi-Cal that impacted participation distributions between Medi-Cal's traditional FFS system and managed care.

Expansion of Medi-Cal Managed Care – Several subpopulations transitioned from the FFS health delivery system into Medi-Cal managed care plans during the study period. For instance, 81,488 FFS Medi-Cal Only beneficiaries transitioned into a Medi-Cal managed care plan in September 2013 due to the establishment of COHS in Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity counties (Table ES-1).

Table ES-1: FFS Medi-Cal Only Beneficiaries Shifting to Medi-Cal Managed Care in September 2013

Transition County	Transition Type	Approximate Number of Beneficiaries
Del Norte	Managed Care – COHS	5,837
Humboldt	Managed Care – COHS	19,913
Lake	Managed Care – COHS	12,749
Lassen	Managed Care – COHS	3,507
Modoc	Managed Care – COHS	1,376
Shasta	Managed Care – COHS	28,430
Siskiyou	Managed Care – COHS	7,736
Trinity	Managed Care – COHS	1,940
Total:		81,488

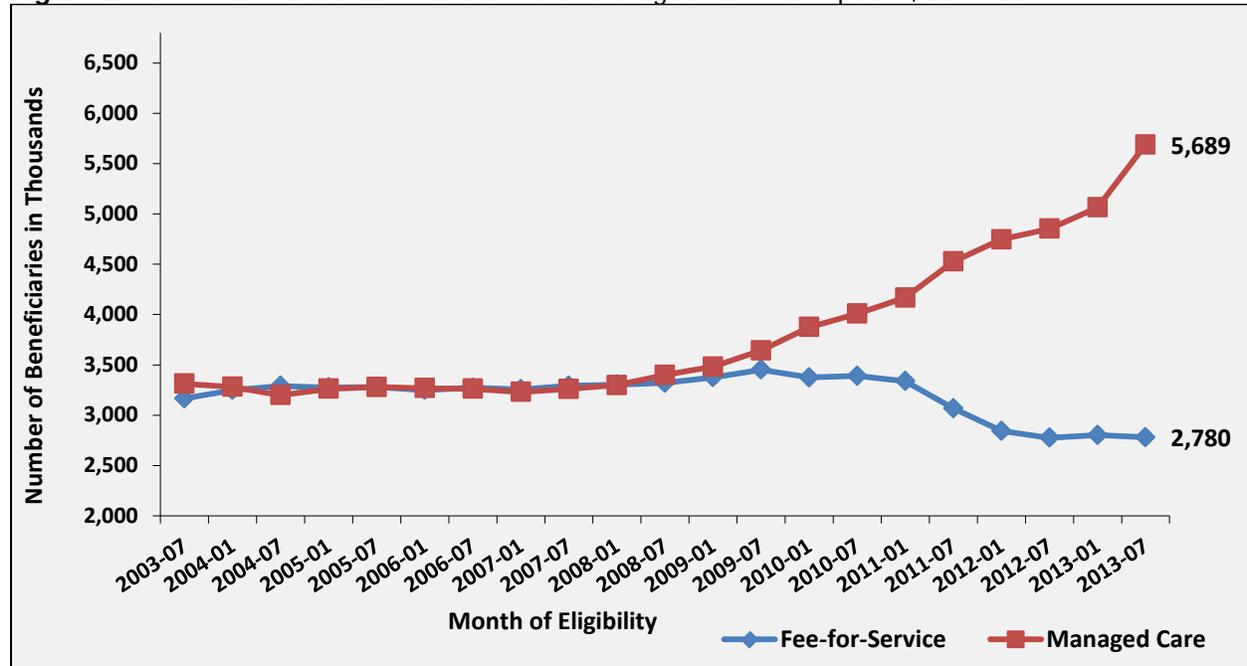
Source: Created by DHCS' Research and Analytic Studies Division (RASD) using data from the Management Information System/Decision Support System's (MIS/DSS) eligibility tables for September 2013. Data were extracted from MIS/DSS 4-months after corresponding time period to allow for updates to enrollment.

Healthy Families Transition – On January 1, 2013, DHCS began the first of four phases in 2013 to transition approximately 860,000 children from the HFP into Medi-Cal. To ensure minimal disruption to coverage, DHCS assigned certain children presumptive eligibility for Medi-Cal benefits under the FFS health delivery system until the date of their annual eligibility review for Medi-Cal. These children with presumptive eligibility under the FFS health delivery system are classified under the Other aid category in this report. Participation rates for these children are expected to decline throughout 2013 and beyond as they are redetermined into aid codes that require enrollment in a Medi-Cal managed care health plan.

Medi-Cal Program Composition

The continued transition of beneficiaries from FFS to managed care has greatly impacted the composition of the overall Medi-Cal program (Figure ES-1).

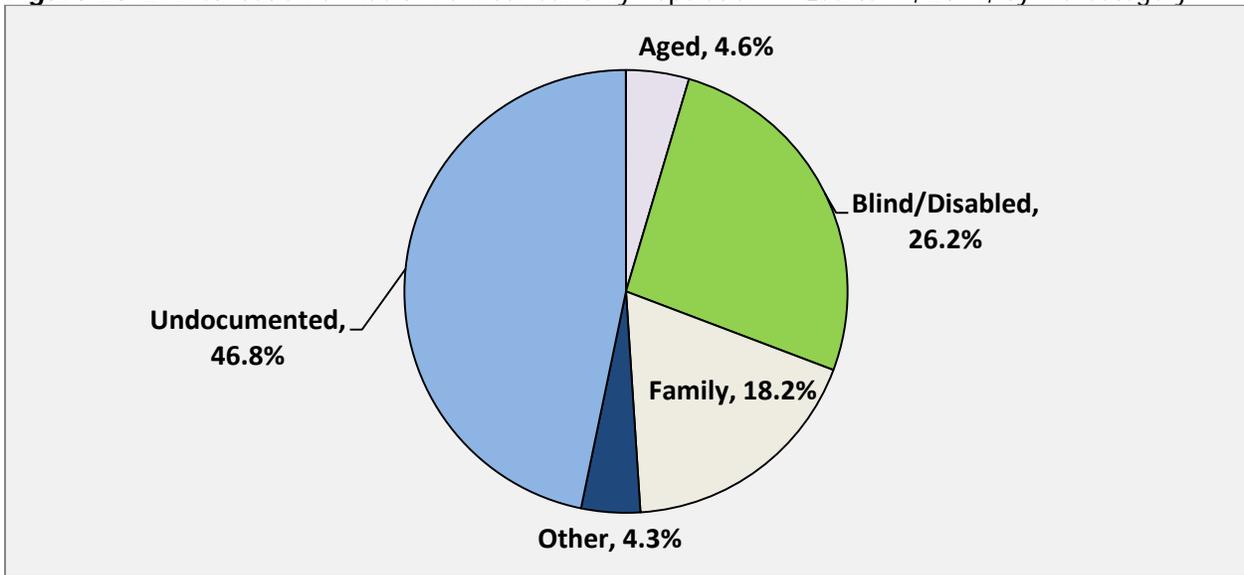
Figure ES-1: Trend in Biannual Medi-Cal FFS vs Managed Care Participation, 2004–2013



Source: Created by DHCS' RASD using data from the MIS/DSS eligibility tables for September 2013. Data were extracted from MIS/DSS 4-months after corresponding time period to allow for updates to enrollment.

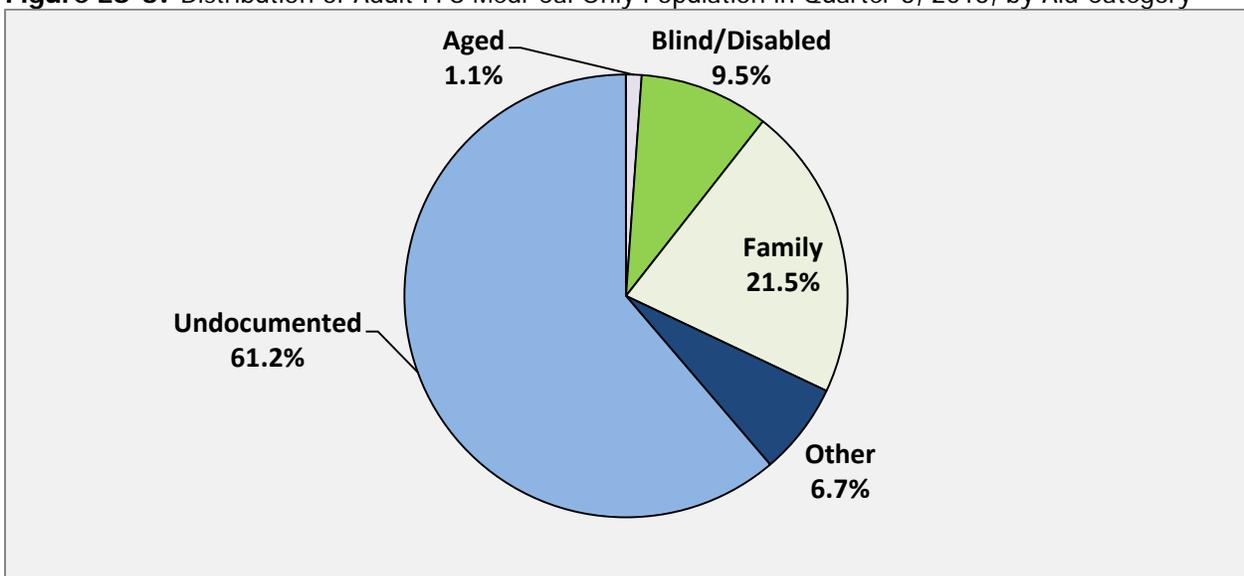
As beneficiaries are transitioned from FFS to managed care, the size and case mix of subpopulations evaluated in this report are altered. For instance, from the first quarter of 2011 to the third quarter of 2013, an increasing percentage of the overall FFS Medi-Cal population is comprised of Undocumented beneficiaries. At the start of 2011, less than half of the FFS Medi-Cal population was comprised of beneficiaries in Undocumented aid codes, while as of September 2013 over 60% of the adult FFS Medi-Cal population were Undocumented beneficiaries (Figures ES-2, ES-3).

Figure ES-2: Distribution of Adult FFS Medi-Cal Only Population in Quarter 1, 2011, by Aid Category



Source: Created by DHCS' RASD using data from the MIS/DSS eligibility tables for January 2011. Data were extracted from MIS/DSS 4-months after corresponding time period to allow for updates to enrollment.

Figure ES-3: Distribution of Adult FFS Medi-Cal Only Population in Quarter 3, 2013, by Aid Category



Source: Created by DHCS' RASD using data from the MIS/DSS eligibility tables for September 2013. Data were extracted from MIS/DSS 4-months after corresponding time period to allow for updates to enrollment.

As counties transition 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 but not yet established in a plan, or the FFS member months may be associated with months of eligibility occurring during retroactive months of eligibility.^v

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.”

Medi-Cal Benefits Modifications

The Medi-Cal program eliminated particular optional services. AB 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 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 for evaluating service rates 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. Therefore, the baseline statistics, or benchmarks, will be recalculated for use in the Medi-Cal Access to Care Quarterly Monitoring Report, 2013 Quarter 4.

^v 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)

Findings

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

Physician Supply

This measure used site-specific physician counts as the primary provider supply metric in this quarterly access report. 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., the number of enrolled Medi-Cal physicians is declining) or that the supply of physicians has been stable over time.

In addition, DHCS calculated the ratio of beneficiaries to physicians statewide and by county. 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.

The total number of physicians increased 3.0% overall, from 76,766 to 79,062 physicians. The aggregate number of primary care physicians increased 2.9%, from 40,214 to 41,395 physicians. Similarly, the total of primary care physicians, as well as physicians with specialties in Obstetrics and Gynecology (OB/GYN) and Pediatrics also slightly increased during the study period. The statewide beneficiary-to-physician ratios for full-scope FFS Medi-Cal only beneficiaries showed no significant change during the study period.

This report's findings showed no deterioration in overall physician supply for FFS Medi-Cal Only beneficiaries 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.

In this report, DHCS evaluated and refined the criteria used to classify primary care physicians, including OB/GYNs and Pediatricians. While not impacting the count of total overall physicians, this methodology revision affected the number of primary care physicians presented. In particular, this adjustment resulted in an increase in the number of primary care physicians reported. The information on primary care physicians presented in this report differs from previously reported counts. Because the counts presented in this measure are not comparable with prior reports, historical trending on available primary care physicians can only be done using the revised counts.

Beneficiary Participation

Overall, the number of FFS Medi-Cal Only beneficiaries entitled to full-scope benefits increased 3.0% from the fourth quarter of 2012 to the third quarter of 2013. However, participation declined 2.7% between the second quarter of 2013 and the third quarter of 2013 most likely due to the COHS expansion during September 2013.

A majority of counties saw an increase in FFS participation, with San Mateo County representing the greatest increase. Eighteen counties experienced a decline in FFS participation. Overall, a total of eight counties experienced less than one percentage point change in either direction over the 12-month study period.

Decreases in participation among FFS Medi-Cal Only beneficiaries occurred in the Blind/Disabled, Family, Foster Care, and Undocumented aid categories. The decline in participation among beneficiaries in the Family and Blind/Disabled aid categories is likely due to the COHS expansion in September 2013.

In contrast, increases in FFS participation mainly affected those enrolled in the Other aid category. The sharp increase among children ages 0-20 in the Other aid category was most likely due to the transition of children from the HFP into Medi-Cal that started in January 2013.

Participation trends for Medi-Cal's FFS population were somewhat different in metropolitan and non-metropolitan areas. The most significant difference between metropolitan and non-metropolitan areas was the greater decline in FFS participation for most non-metropolitan adults from the fourth quarter of 2012 to the third quarter of 2013. Additionally, declines in FFS participation among children were greater in non-metropolitan areas, especially among those enrolled in the Blind/Disabled and Foster Care aid categories.

FFS Medi-Cal participation among children in Undocumented aid codes residing in both metropolitan (6.9%) and non-metropolitan (8.9%) areas declined during the study period. Unlike the populations discussed previously, shifts in system participation from FFS to managed care were not responsible for the reductions recognized in the undocumented population. Undocumented beneficiaries are not eligible to participate in Medi-Cal managed care plans. Rather, the downward trend recognized in the undocumented population was 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 birth rates among Mexican immigrants, and the residual effects of the recession.^{vi,vii}

^{vi}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/>

^{vii}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/>

Service Utilization

Medi-Cal's quarterly access monitoring effort also incorporates 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 service utilization across all Medi-Cal provider types is 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
4. Home Health
5. Hospital Inpatient
6. Hospital Outpatient
7. Nursing Facility
8. Pharmacy
9. Other
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 member months. For example, Physician/Clinic services are measured in terms of visits per 1,000 member months, while Pharmacy services are measured in prescriptions per 1,000 member months. In general, service utilization rates found within the upper and lower bounds were considered within expected ranges.

Several factors can impact service utilization. These factors include but are not limited to: birth trends, population case mix, Medi-Cal Program changes, and the transition of beneficiaries from FFS into a managed care plan. Influential factors that occurred during the study period include the COHS expansion and the HFP transition. The shifts in utilization observed in this report may be attributable to a combination of the factors noted above.

The key findings for both children and adults are as follows:

Children Ages 0-20

- Overall, service utilization patterns for children in most aid categories primarily followed the patterns identified in the previous access quarterly report. For example, the utilization rates for children in the Foster Care aid group across all of the analyzed service categories were once more observed to be within the expected ranges. Children in the Blind/Disabled, Other, and Undocumented aid categories again exhibited predominantly below-average Emergency Transportation services utilization. Additionally, children in the Blind/Disabled aid category continued to place a disproportionate demand on services of all kinds.
- After displaying decreased utilization in Emergency Medical Transportation, Hospital Inpatient, Hospital Outpatient, and Pharmacy services, as well as Physician/Clinic visits during the second quarter of 2013, Blind/Disabled children exhibited slight increases in utilization of these service categories at the end of the study period.
- Physician/Clinic service use patterns among children in most of the evaluated aid categories again fell below the average rates established during the baseline period.
- The utilization of all the evaluated services by children in the Other aid category again mostly fell below either the average rates or the expected ranges established during the baseline period. Of particular note, this subpopulation's utilization of Emergency Transportation, Radiology, and Pharmacy services, as well as Physician/Clinic visits, noticeably declined below the expected ranges starting in February 2013.
- As beneficiary participation shifted away from the FFS delivery system and into managed care, many service categories (e.g., Non-Emergency Transportation, Home Health, and Nursing Facility services) again experienced a noticeable decline in user counts that made the data unsuitable for analysis.

Adults Ages 21 and Older

- As noted in the previous access quarterly reports, adults in the Blind/Disabled aid category continued to place a higher demand on Emergency Transportation, Hospital Inpatient, Hospital Outpatient, Non-Emergency Transportation, Nursing Facility, and Radiology services.
- Physician/Clinic service use patterns among adults in all of the analyzed aid categories again fell below either the average rates or the expected ranges established during the baseline period.
- Adults in the Family aid category continued to display below-average utilization of Emergency Transportation and Hospital Inpatient services, as well as Physician/Clinic visits, throughout most of the study period.

- 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 use of Emergency Transportation and Hospital Inpatient services, as well as Physician/Clinic visits.
- 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 the Aged and Family aid categories that utilize Non-Emergency Transportation and Home Health services have declined to levels (<500) that render their use of these service categories inconsequential to the current analysis. The beneficiary subgroups that continue to use these service categories exhibited utilization patterns at above-average rates that often fell above the expected ranges.

The following tables present the results of the analysis of the service utilization trends among children and adults, by aid and service categories. The tables are 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. 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 the case mix of a population.

Table ES-2: Summary of Service Utilization Trends Among FFS Medi-Cal Children Ages 0-20, by Aid Category and Service Category

Aid Category \ Service Category	Physician/Clinic Visits	Emergency Medical Transportation	Home Health Services	Hospital Inpatient Services	Hospital Outpatient Services	Pharmacy Services	Other Services	Radiology Services
Blind/ Disabled	Below-Average and Within Expected Range.	Mostly Below-Average and Mostly Within Expected Range. Slight Downward Trend (Jan 2013–June 2013).	Above Expected Range.	Mostly Above-Average with Several Months Above Expected Range.	Within Expected Range.	Above-Average and Within Expected Range.	Mostly Within Expected Range.	Mostly Below-Average and Mostly Within Expected Range.
Family	Mostly Below-Average and Mostly Within Expected Range.	Mostly Within Expected Range.	N/A	Mostly Above-Average. Increase Above Expected Range in Last Quarter (July 2013–Sept 2013).	Mostly Below-Average with 4 Consecutive Months Below Expected Range (June 2013–Sept 2013). Downward Trend (Jan 2013–June 2013).	Below-Average with 4 Consecutive Months Below Expected Range (June 2013–Sept 2013). Downward Trend (Jan 2013–July 2013).	Within Expected Range.	Mostly Within Expected Range.
Foster Care	Mostly Below-Average and Mostly Within Expected Range.	Mostly Above-Average and Mostly Within Expected Range. Increase in Last Quarter.	N/A	Mostly Below-Average and Mostly Within Expected Range.	Mostly Below-Average and Mostly Within Expected Range.	Mostly Within Expected Range. Increase in Last Quarter.	Within Expected Range.	Within Expected Range.
Other	Below-Average with 8 Consecutive Months Below Expected Range (Feb 2013 – Sept 2013).	Below-Average with 8 Consecutive Months Below Expected Range (Feb 2013 – Sept 2013).	N/A	Mostly Below-Average with 5 Consecutive Months Below Expected Range (Feb 2013 – June 2013). Increase Back into Expected Range in Last Quarter.	Below Expected Range. Slight Downward Trend (Jan 2013–June 2013).	Below-Average with 8 Consecutive Months Below Expected Range (Feb 2013–Sept 2013).	Mostly Below-Average and Mostly Within Expected Range.	Below-Average with 8 Consecutive Months Below Expected Range (Feb 2013 – Sept 2013).
Undocumented	Below Expected Range.	Mostly Below-Average and Within Expected Range.	N/A	Mostly Below-Average with 5 Consecutive Months Below Expected Range (Feb 2013 – June 2013). Increase Above Expected Range in Last Quarter.	Below-Average and Mostly Within Expected Range.	Mostly Below-Average and Mostly Within Expected Range. Downward Trend (Jan 2013 – June 2013).	Below Expected Range.	Mostly Below-Average and Within Expected Range.

Note: Children were excluded from analyses of Non-Emergency Medical Transportation and Nursing Facility services utilization due to low user counts (n<500).

Table ES-3: Summary of Service Utilization Trends Among FFS Medi-Cal Adults Ages 21+, 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
Aged	Below-Average and Mostly Within Expected Range.	N/A	N/A	N/A	Above Expected Range.	Mostly Above-Average and Within Expected Range.	Above Expected Range.	Below Expected Range.	Below Expected Range.	Mostly Above Expected Range.
Blind/Disabled	Below-Average and Mostly Within Expected Range.	Above Expected Range.	Above-Average with 5 Consecutive Months Above Expected Range.	Mostly Above-Average and Within Expected Range.	Above Expected Range.	Mostly Above-Average and Mostly Within Expected Range.	Above Expected Range.	Mostly Below Expected Range.	Mostly Below-Average and Within Expected Range.	Mostly Above Expected Range.
Family	Below Expected Range.	N/A	Mostly Below-Average and Within Expected Range.	N/A	Mostly Below-Average with Several Months Below Expected Range.	Below Expected Range.	N/A	Mostly Below Expected Range.	Below-Average with Several Months Below Expected Range.	Within Expected Range.
Other	Below-Average and Mostly Within Expected Range.	Above Expected Range.	Within Expected Range.	N/A	Below-Average with 5 Consecutive Months Below Expected Range (Feb 2013–June 2013).	Below-Average with Several Months Below Expected Range.	Mostly Below-Expected Range.	Mostly Below-Average and Within Expected Range.	Mostly Below-Average and Within Expected Range.	Mostly Above-Average and Within Expected Range.
Undocumented	Below Expected Range.	N/A	Below-Average with Several Months Below Expected Range.	N/A	Below Expected Range.	Mostly Below Expected Range.	N/A	Mostly Above-Average. Within Expected Range.	Below Expected Range.	Within Expected Range.

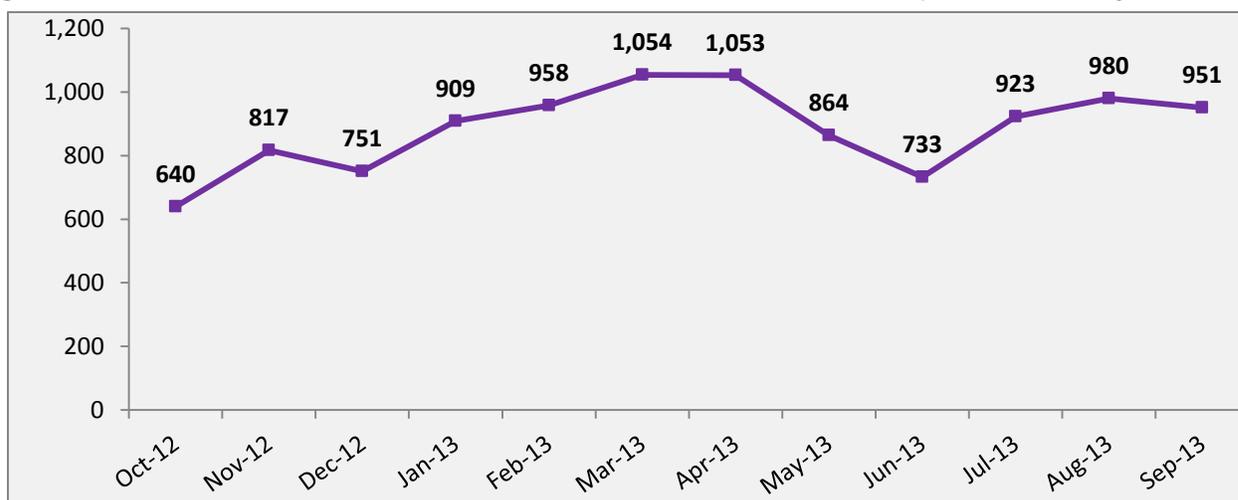
Beneficiary Feedback

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 relies on data obtained from the Office of the Ombudsman for the purpose of monitoring health care access. From the fourth quarter of 2012 to the third quarter of 2013, the Office of the Ombudsman call center documented 10,633 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, six aid category groupings (Family, Blind/Disabled, Aged, Foster Care, Undocumented, and Other), and reason for call.

FFS call volume was slightly higher for this period than the previous reporting period (9,260 calls from July 2012 to June 2013). An upward trend in call volume was observed beginning in November 2012, with call volume decreasing for the months of May 2013 and June 2013 before resuming an upward trend in July 2013. Additionally, the increase in call volume from July to September 2013 likely reflects the establishment of COHS in eight counties in September 2013, as well as the final phase of the HFP transition (Figure ES-4).

Figure ES-4: Calls^{viii} Received from FFS Beneficiaries Between October 2012-September 2013, by Month



Source: Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received from FFS beneficiaries, October 2012–September 2013.

^{viii} A different data extraction method was used by the Office of the Ombudsman to identify calls made by FFS beneficiaries using data obtained by this new method. Call counts are slightly higher (3% to 6%) than noted in previous access quarterly reports.