



# Medi-Cal Access to Care Quarterly Monitoring Report #3 2012 Quarter 2



## Beneficiary Feedback

January 2013

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# 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.

## Methods

DHCS continues to rely on data obtained from the Office of the Ombudsman for the purpose of monitoring health care access until such time that data from the newly-implemented Call Center becomes available. The Office of the Ombudsman call center documented 8,616 calls from FFS beneficiaries from the third quarter of 2011 to the second quarter of 2012. 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.

### Highlights

Calls increased 7%, from 8,049 to 8,616, over the previous study period.

Calls significantly decreased by the end of the study period, with just 441 calls in June 2012, compared with nearly 1,000 calls in January 2012.

The largest percentage (48%) of calls were regarding Enrollment/Continuity of Care.

Among Enrollment/Continuity of Care and Provider/Availability call categories, those in Families and Blind/Disabled aid categories were the top two groups of callers.

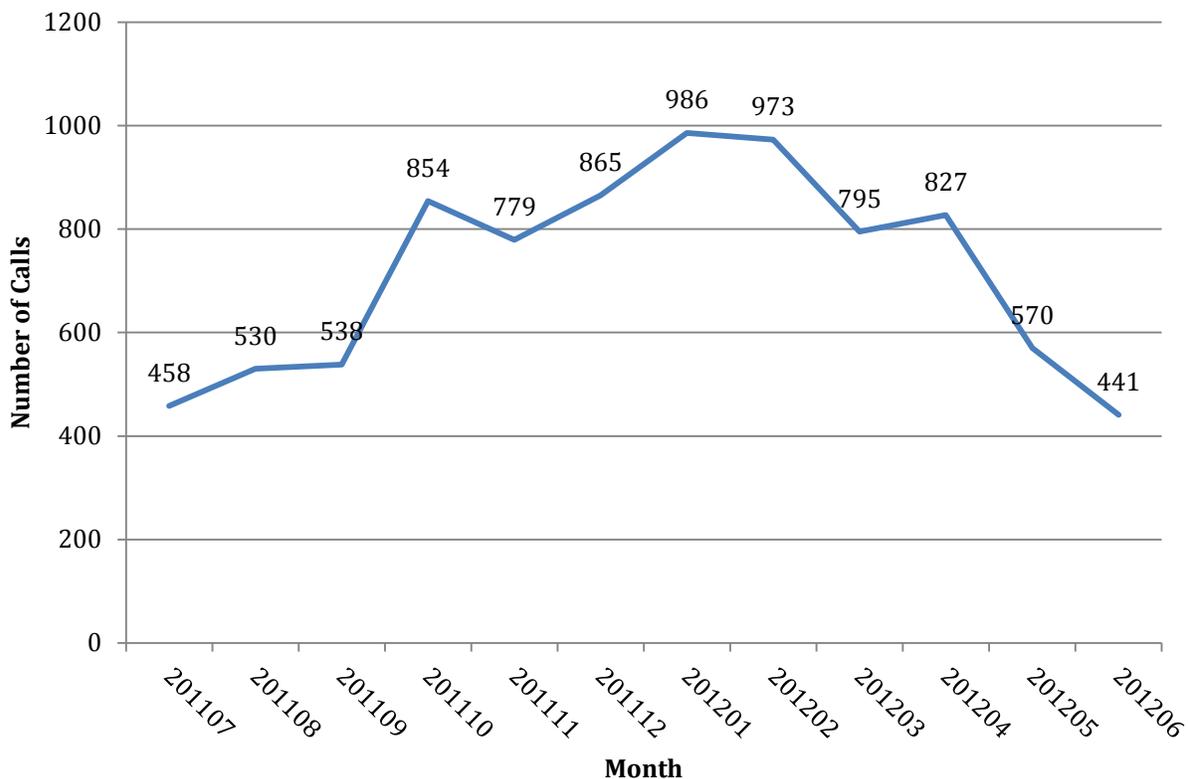
## Results

Between July 2011 and June 2012, the Office of the Ombudsman documented a total of 8,616 calls received from Medi-Cal FFS beneficiaries.

This total number of calls represented a 7% increase from the previous reporting period (8,049 calls for April 2011–March 2012). Figure BF-1 provides a graph of the total calls received during the current reporting period by month. An upward trend in call volume was observed during the third and fourth quarters of 2011, followed by a generally downward trend in the first and second quarters of 2012.

The most significant increase in calls occurred between September and October 2011, with a 59% increase likely due to the elimination of ADHC services.

**Figure BF-1 Calls Received by FFS Beneficiaries by Month, July 2011–June 2012**



Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Branch. Calls Received from FFS Beneficiaries, July 2011–June 2012.

The most significant increase in calls occurred between September and October 2011 (59% increase in calls between the two months). This increase was likely due to the elimination of the Adult Day Health Center (ADHC) benefit that was scheduled for the end of 2011. At the end of August 2011, beneficiaries received notices of the scheduled elimination of the ADHC benefit and the notices contained the contact information of the Ombudsman call center. The ADHC

benefit would be replaced by the Community-Based Adult Services (CBAS). Subsequently, call volume remained relatively high and reached nearly 1,000 calls a month by the beginning of 2012.

In the first and second quarters of 2012, call volume decreased each month, except for April 2012 when calls increased slightly. The most significant decrease in calls occurred between April and May 2012, with a 31% decrease in calls between the two months. There were no known policy changes or changes to the Medi-Cal program during the first two quarters of 2012 that could explain the reason for the gradual decrease in call volume.

Table BF-1 presents the average number of calls received for each quarter of the current reporting period. Average call volume for the fourth quarter of 2011 increased by 64% from the previous quarter. By the first quarter of 2012, call volume continued to increase at a slower rate (10% increase from the previous quarter). There was a 33.2% decrease in the second quarter of 2012 from the previous quarter.

There was a 33.2% decrease in calls between the second quarter of 2012 and the previous quarter.

**Table BF-1 Quarterly Average Number of Calls Received from FFS Beneficiaries, July 2011– June 2012**

Quarter	Avg Calls	Percent Change from Previous Quarter
2011 Q3	509	---
2011 Q4	833	63.7%
2012 Q1	918	10.2%
2012 Q2	613	-33.2%

Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by the DHCS Research and Analytic Studies Branch. Calls received from FFS beneficiaries, July 2011– June 2012.

## **Modified Call Categories**

To help them monitor whether managed care health plans are operating in line with their contractual obligation, the Ombudsman call center staff assigns codes to each call based on the reason for the call. The codes fall under certain categories such as “Enrollment/Disenrollment” and “Quality of Care,” which enables the Ombudsman to identify potential problems among particular health plans or counties that may need investigating.

While the coding scheme used by the Ombudsman is helpful for overseeing health plans, call groupings are categorized differently for the purpose of this report, to better identify whether beneficiaries are having problems accessing the care they need, including whether they are able to find a provider, continue with the same provider as their “usual source of care,” and access specialty services when needed.

Table BF-2 on the next page presents these groupings and a description of the codes that fall within each category. The first two categories, Enrollment/Continuity of Care and Provider/Availability Issues, are key elements in understanding whether beneficiaries are experiencing access-related problems.

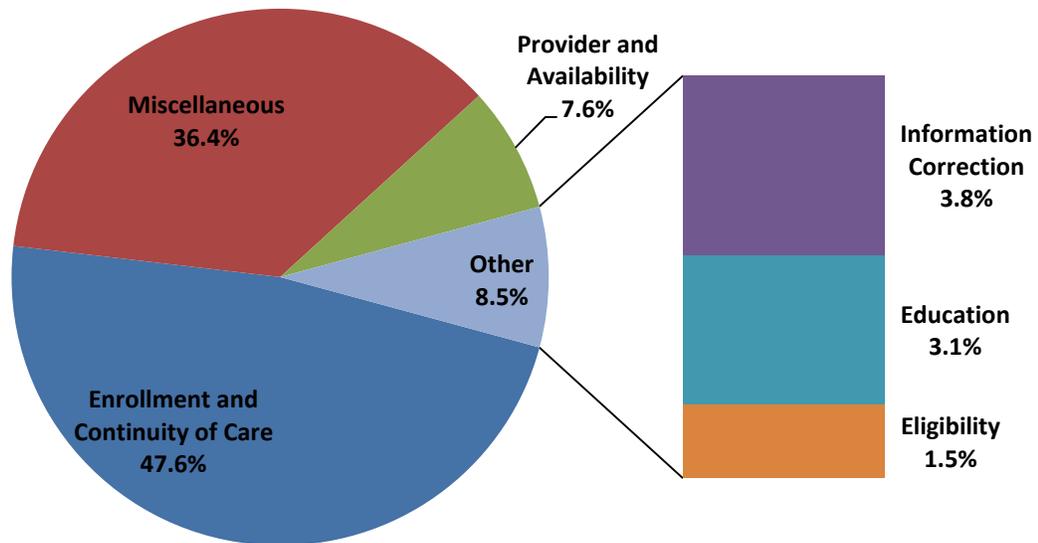
**Table BF-2 Modified Call Categories**

Call Category	Reason for Call
<b>Enrollment and Continuity of Care</b>	<ul style="list-style-type: none"> <li>• Seeking information for new enrollment into plan</li> <li>• Wanting to change plans or disenroll from managed care</li> <li>• Seeking medical exemptions</li> <li>• Emergency plan disenrollment requests</li> <li>• Pregnancy or other qualifying conditions</li> <li>• Enrollment issues for specific beneficiary groups such as Seniors and Persons with Disabilities (SPDs), foster care</li> <li>• Mandatory enrollment issues</li> <li>• Change or default into other managed care plan</li> <li>• Issues regarding dental plan enrollment</li> </ul>
<b>Provider and Availability Issues</b>	<ul style="list-style-type: none"> <li>• Medi-Cal eligibility was terminated</li> <li>• Seeking to obtain or change provider</li> <li>• Issue with transportation or distance to provider</li> <li>• Issue with disability/physical access</li> <li>• Was refused care or given inappropriate care</li> <li>• Was refused medications, Durable Medical Equipment (DME), or medical supplies</li> <li>• Delayed referral or appointment</li> <li>• Unable to access PCP/specialist/provider</li> <li>• Language access issues</li> <li>• Delay of prior authorization</li> </ul>
<b>Information Correction</b>	<ul style="list-style-type: none"> <li>• Need to correct beneficiary information (aid code, county code, address)</li> <li>• Need to fix provider billing issues</li> </ul>
<b>Education</b>	<ul style="list-style-type: none"> <li>• Seeking information about Medi-Cal program (e.g., Adult Day Health Center, Healthy Families)</li> <li>• Seeking information regarding notice of action</li> </ul>
<b>Eligibility</b>	<ul style="list-style-type: none"> <li>• Beneficiary has share of cost (SOC) or restricted aid code</li> <li>• Beneficiary resides in a restricted or carved out zip code</li> </ul>
<b>Miscellaneous</b>	<ul style="list-style-type: none"> <li>• Voicemail calls</li> <li>• Complaints about plan/provider staff</li> <li>• Referrals to external organizations such as Social Security Administration, County Eligibility, Medicare</li> <li>• Other issues</li> </ul>

## Distribution of Calls by Call Category

Figure BF-2 presents the distribution of total calls received by FFS beneficiaries by the modified call categories. Almost half of calls (48%) pertained to Enrollment/Continuity of Care. Another 36% of calls were categorized as Miscellaneous. The remaining 16% of calls pertained to issues regarding Provider/Availability, Information Correction, Education, and Eligibility.

**Figure BF-2 Calls Received by FFS Beneficiaries by Call Category, July 2011–June 2012**



Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Branch. Calls received from FFS beneficiaries, July 2011–June 2012.

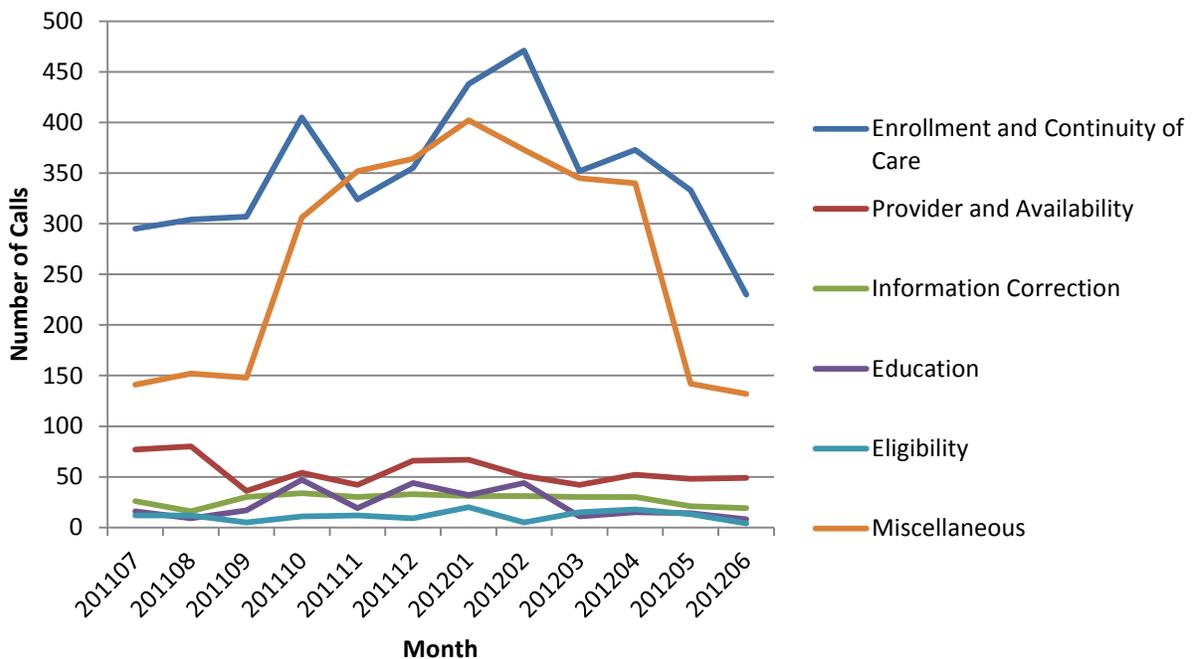
## Distribution of Calls by Call Category and Month

Figure BF-3 presents the total calls received by call category and month. Throughout the reporting period, the majority of calls pertained to Enrollment/Continuity of Care. The next most frequently reported category was Miscellaneous. There were fluctuations in the number of calls related to Enrollment/Continuity of Care, with an average of nearly 350 calls per month.

Of the 8600+ calls recorded, 4,187 (48%) were categorized under Enrollment/Continuity of Care.

Calls labeled as Miscellaneous did not increase until October 2011 and continued to rise, reaching an average of 362 from November 2011 to April 2012. The increase in call volume categorized as Miscellaneous was likely due to the elimination of the ADHC benefit. These types of calls would not fit in any other code used by the Ombudsman, which explains why they would be assigned to a Miscellaneous category. Miscellaneous calls then decreased significantly to less than 145 calls a month during May and June 2012, possibly coinciding with the end of the transition of ADHC services to CBAS.

**Figure BF-3 Calls by Call Category and Month FFS Beneficiaries, July 2011–June 2012**



Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Branch. Calls received from FFS beneficiaries, July 2011– June 2012

Calls for issues related to Provider/Availability, Information Correction, Education, and Eligibility comprised a relatively small portion of the total calls. In July and August 2011, calls for Provider/Availability averaged 79 calls a month and then dropped to an average of 51 calls for the remainder of the reporting period.

As key elements in understanding whether beneficiaries are experiencing access-related problems, the remainder of this analysis will focus on two categories: Enrollment/Continuity of Care, and Provider/Availability Issues. Of the total calls received, there were 4,187 (48%) categorized as Enrollment/Continuity of Care and 664 (8%) categorized as Provider/Availability. Although calls categorized as Miscellaneous comprised the next largest amount of calls (3,197 calls, or 36%), the descriptions of these calls are too ambiguous to interpret. Therefore, these calls will not be further analyzed.

## Calls by Aid Code Category

The Medi-Cal aid codes reported by FFS beneficiary callers were collapsed into six aid code categories. Table BF-3 presents the calls received by call category and aid category.

**Table BF-3 Calls for Enrollment/Continuity of Care and Provider/Availability, by Aid Category, July 2011–June 2012**

Aid Category	Call Category			
	Enrollment and Continuity of Care		Provider and Availability	
	# of Calls	% of Calls	# of Calls	% of Calls
Families	2,036	48.6%	272	41.0%
Blind/Disabled	1,368	32.7%	178	26.8%
Other	373	8.9%	132	19.9%
Aged	210	5.0%	52	7.8%
Foster Care	188	4.5%	9	1.4%
Undocumented	12	0.3%	21	3.2%
Total	4,187	100.0%	664	100.0%

Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Branch. Calls received from FFS beneficiaries July 2011–June 2012.

The pattern in call volume by aid category was similar between the two call categories. The majority of calls for each call category were received from callers in Family aid codes, followed by callers in the Blind/Disabled, Other, and Aged aid categories. For Enrollment/Continuity of Care calls, there were more calls from Foster Care aid codes than Undocumented; the reverse was observed in Provider/Availability calls, with more calls received from Undocumented aid codes than Foster Care.

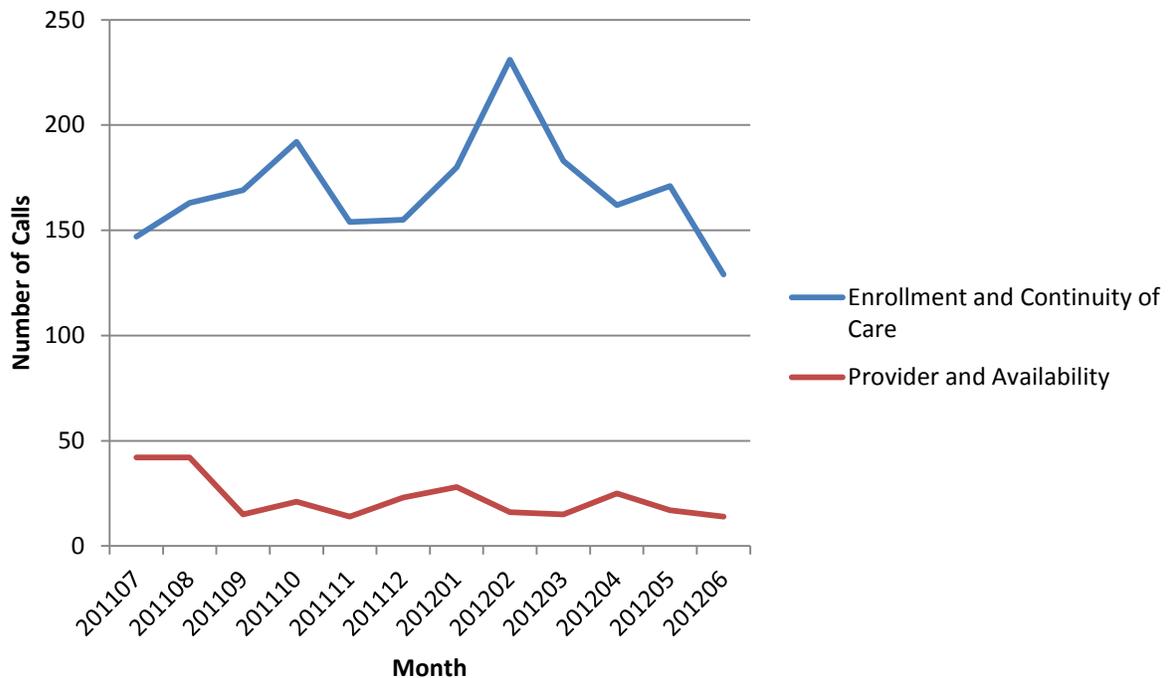
## Distribution of Calls from Family Aid Codes by Call Category

Since the majority of calls were received from callers in Family and Blind/Disabled aid codes, 79% of calls from these beneficiary subpopulations were analyzed separately by month and call category.

The majority of calls categorized under Enrollment/Continuity of Care and Provider/Availability were from beneficiaries in Families and Blind/Disabled aid codes.

Figure BF-4 presents the distribution of calls from Family aid codes by call category and month. Calls pertaining to Enrollment and Continuity of Care increased during the third quarter of 2011 and reached as high as 231 calls in February 2012. Beginning in March 2012, these calls decreased each month, reaching 129 calls in June 2012.

**Figure BF-4 Calls from Family Aid Codes, Call Category by Month, July 2011–June 2012**



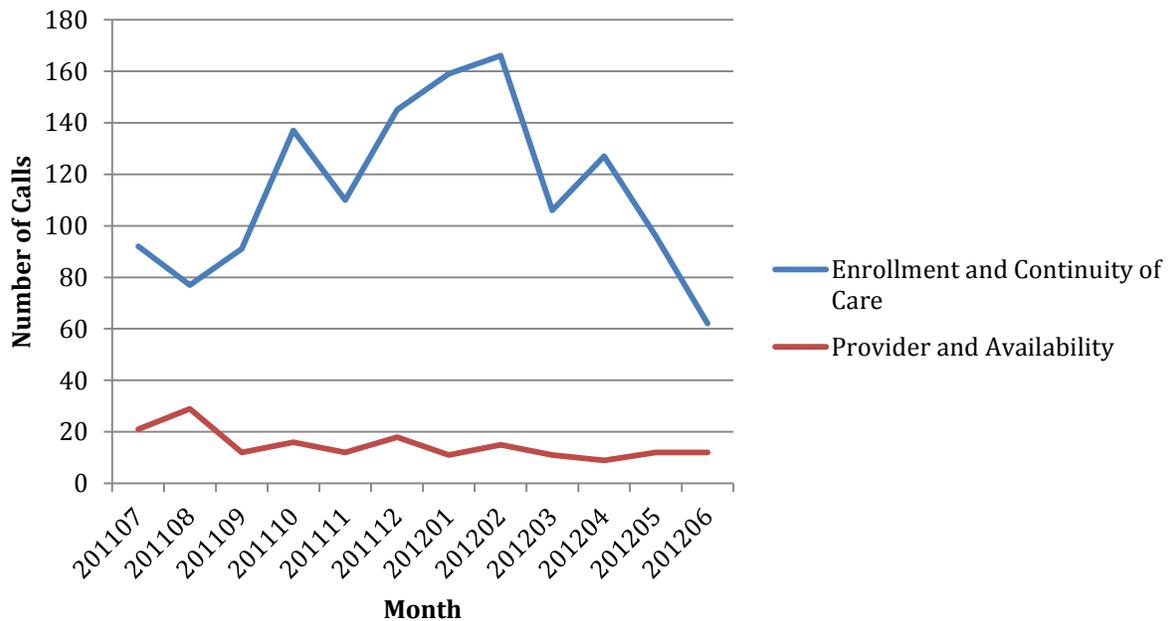
Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Branch. Calls received from FFS beneficiaries July 2011–June 2012.

Calls from Family aid codes pertaining to Provider/Availability issues decreased after August 2011. Beginning in September 2011, these calls averaged 19 calls per month for the remainder of the reporting period.

## Distribution of Calls from Blind/Disabled Aid Codes by Call Category

Figure BF-5 presents the distribution of calls from Blind/Disabled aid codes by call category and month. There were fluctuations in the number of calls pertaining to Enrollment/Continuity of Care throughout the reporting period. These calls first averaged 87 calls per month during the third quarter of 2011. Calls then increased, reaching 166 calls in February 2012. Beginning in March 2012, calls decreased each month, except for a slight increase in April 2012.

**Figure BF-5 Calls from Blind/Disabled Aid Codes, Call Category by Month, July 2011–June 2012**



Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Branch. Calls received from FFS beneficiaries July 2011–June 2012.

## Calls by County

The top 10 counties reported by callers are presented for calls pertaining to Enrollment/Continuity of Care (see Table BF-4) and Provider/Availability (see Table BF-5). Eight counties made it to the top 10 list for both call categories. For each call category, Los Angeles was the top county, representing a quarter of calls. San Bernardino made the top three counties of each list.

**Table BF-4 Calls for Enrollment and Continuity of Care by County, Top 10 Counties, July 2011–June 2012**

County	# of Calls	% of All Calls
Los Angeles	1,120	26.7%
San Bernardino	600	14.3%
Riverside	538	12.8%
San Joaquin	339	8.1%
San Diego	333	8.0%
Alameda	245	5.9%
Sacramento	188	4.5%
Contra Costa	145	3.5%
Orange	145	3.5%
Fresno	105	2.5%

Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Branch. Calls received from FFS beneficiaries, July 2011–June 2012

**Table BF-5 Calls for Provider/Availability Issues by County, Top 10 Counties, July 2011–June 2012**

County	#of Calls	% of All Calls
Los Angeles	163	24.5%
San Diego	79	11.9%
San Bernardino	77	11.6%
Sacramento	74	11.1%
Riverside	69	10.4%
Alameda	31	4.7%
Contra Costa	19	2.9%
Fresno	17	2.6%
Kern	14	2.1%
Santa Clara	13	2.0%

Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by the DHCS Research and Analytic Studies Branch. Calls received from FFS beneficiaries, July 2011–June 2012

## Reason for Call

To further investigate calls received by FFS beneficiaries, the top reasons for calls under each call category were identified. Table BF-6 presents the top three reasons for each call category among calls received from Family aid codes. The majority of calls (80%) categorized as Enrollment/Continuity of Care pertained to requests for new enrollment. Another 11% of Enrollment/Continuity of Care calls were related to disenrollment requests and wanting to change plans or disenroll from a plan.

Of the calls categorized under Provider/Availability, 60% were related to the termination of Medi-Cal eligibility. Another 28% were related to issues accessing a provider and 11% concerned a denial of services, including medications, care, and referrals or appointments.

Among beneficiaries in Family aid codes, 80% of calls regarding Enrollment/Continuity of Care were requests for new enrollment.

**Table BF-6 Calls from Family Aid Codes, Top 3 Reasons for Calls, July 2011–June 2012**

Reason for Call	# of Calls	% of All Calls*
<b>Enrollment and Continuity of Care (n=2,036)</b>		
Requesting new enrollment into Plan	1,626	79.9%
Emergency plan disenrollment requests	109	5.4%
Wanting to change plans or disenroll from managed care	108	5.3%
<b>Provider and Availability (n=272)</b>		
Medi-Cal eligibility terminated	163	59.9%
Unable to access PCP/specialist	77	28.3%
Denied services	30	11.0%

Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Branch. Calls received from FFS beneficiaries, July 2011–June 2012

\*Percents are based on all calls received during the study period. Only the top three call subcategories are displayed here, so percentages will not add up to 100%.

Table BF-7 presents the top three reasons for calls for each call category among calls received from Blind/Disabled aid codes. Approximately half of the calls categorized as Enrollment/Continuity of Care involved callers requesting new enrollment. Another 31% concerned medical exemptions and 11% pertained to callers wanting to change plans or disenroll from a plan. Of the calls categorized as Provider/Availability, 44% of calls involved beneficiaries being unable to access a provider. A quarter of these calls pertained to the termination of Medi-Cal eligibility, and another quarter pertained to the denial of services.

Among beneficiaries in the Blind/Disabled aid codes, 44% of calls pertaining to provider availability were due to inability to access a PCP or specialist.

**Table BF-7 Calls from Blind/Disabled Aid Codes, Top 3 Reasons for Calls, July 2011–June 2012**

Reason for Call	# of Calls	% of all Calls*
<b>Enrollment and Continuity of Care (n=1,368)</b>		
Requesting new enrollment into plan	687	50.2%
Seeking medical exemptions	421	30.8%
Wanting to change plans or disenroll from managed care	145	10.6%
<b>Provider and Availability (n=178)</b>		
Unable to access PCP/specialist	79	44.4%
Medi-Cal eligibility terminated	47	26.4%
Denied services	45	25.3%

Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Branch. Calls received from FFS beneficiaries, July 2011–June 2012

\*Percents are based on all calls received during the study period. Only the top three call subcategories are displayed here, so percentages will not add up to 100%.

## Conclusions

1. Between July 2011 and June 2012, the Ombudsman call center staff documented over 8,600 calls received from FFS beneficiaries in the Medi-Cal program. The call total during this 12-month period increased by 7% from the previous reporting period (April 2011 to March 2012).
2. Almost half of the calls received pertained to Enrollment/Continuity of Care. Another 36% of calls were categorized under Miscellaneous. Due to the ambiguity of Miscellaneous calls, they were not further analyzed. The focus of the analyses were on calls related to Enrollment/Continuity of Care and Provider/Availability as these key elements help identify access-related issues experienced by beneficiaries.
3. Among calls categorized as Enrollment/Continuity of Care and Provider/Availability, the majority of calls received were from Family and Blind/Disabled aid categories. Additionally, Los Angeles County was the most frequently reported county of residence, regardless of call category.
4. Callers in Family aid codes were primarily concerned with requesting new enrollment. Other important issues included emergency disenrollment requests and disenrolling from or changing plans. These callers were also seeking information regarding the termination of their Medi-Cal eligibility and being unable to reach a provider or receive needed care and services.
5. Callers from Blind/Disabled aid codes were concerned with requesting new enrollment. These callers also were seeking medical exemptions and wanting to disenroll from or change plans. Other reasons for these calls included not being able to access a provider, the termination of Medi-Cal eligibility, and being denied services.