

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



## Beneficiary Feedback

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



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# Beneficiary Help Line 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. 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.

### Highlights

Calls decreased 1.24%, from 8,616 to 8,509 from the fourth quarter of 2011 to the third quarter of 2012.

Calls significantly decreased by the end of the reporting period, with nearly 400 calls in August 2012 compared with nearly 1,000 calls in January 2012.

The largest percentage (45%) 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.

## **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 8,509 calls from FFS beneficiaries from the fourth quarter of 2011 to the third 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.

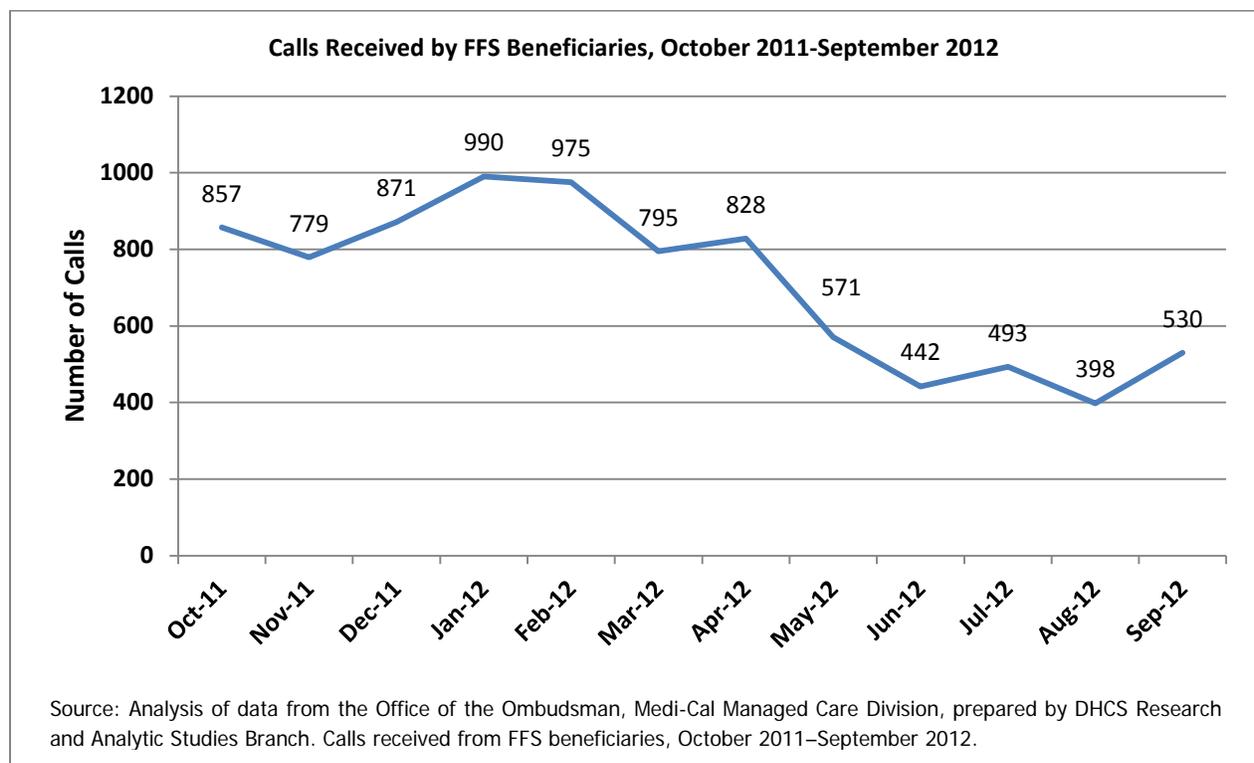
## Results

Between October 2011 and September 2012, the Office of the Ombudsman documented a total of 8,509 calls received from Medi-Cal FFS beneficiaries.

This total number of calls represented a 1.24% decrease from the previous reporting period (8,616 calls for July 2011-June 2012). Figure BF-1 provides a graph of the total calls received during the current reporting period by month. A general downward trend in call volume was observed beginning in January 2012, and continued through September 2012.

A significant decrease in calls occurred between January and August 2012, decreasing from 990 calls to 398 calls.

**Figure BF-1 Calls Received by FFS Beneficiaries by Month, Oct. 2011–Sept. 2012**



Call volume peaked from October 2011 to January 2012, a period which coincides with the elimination of Adult Day Health Center (ADHC) benefits (see previous access quarterly reports). Call volume fluctuated throughout the reporting period, with an overall decline from the first to third quarter of 2012. The gradual decline in call volume during this reporting period is likely due to a lack of major Medi-Cal program or policy changes implemented after January 2012.

Table BF-1 presents the average number of calls received for each quarter of the current reporting period. Average call volume for the last two quarters under study (Quarters 2 and 3 of 2012) decreased from levels observed earlier in the year. From the first quarter to the second

quarter of 2012, call volume decreased by 33.3%. Call volume continued to decline from the second quarter to the third quarter of 2012, decreasing by 22.8%.

Calls decreased 22.8% from the second to third quarter of 2012.

**Table BF-1 Quarterly Average Number of Calls Received from FFS Beneficiaries, Oct. 2011–Sept. 2012**

Quarter	Average Calls per Quarter	% Change from Previous Quarter
Oct-Dec 2011	833	---
Jan-Mar 2012	918	10.25%
Apr-Jun 2012	613	-33.26%
Jul-Sep 2012	473	-22.80%

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, October 2011– September 2012.

## **Modified Call Categories**

To help 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/Continuity of Care” 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 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**

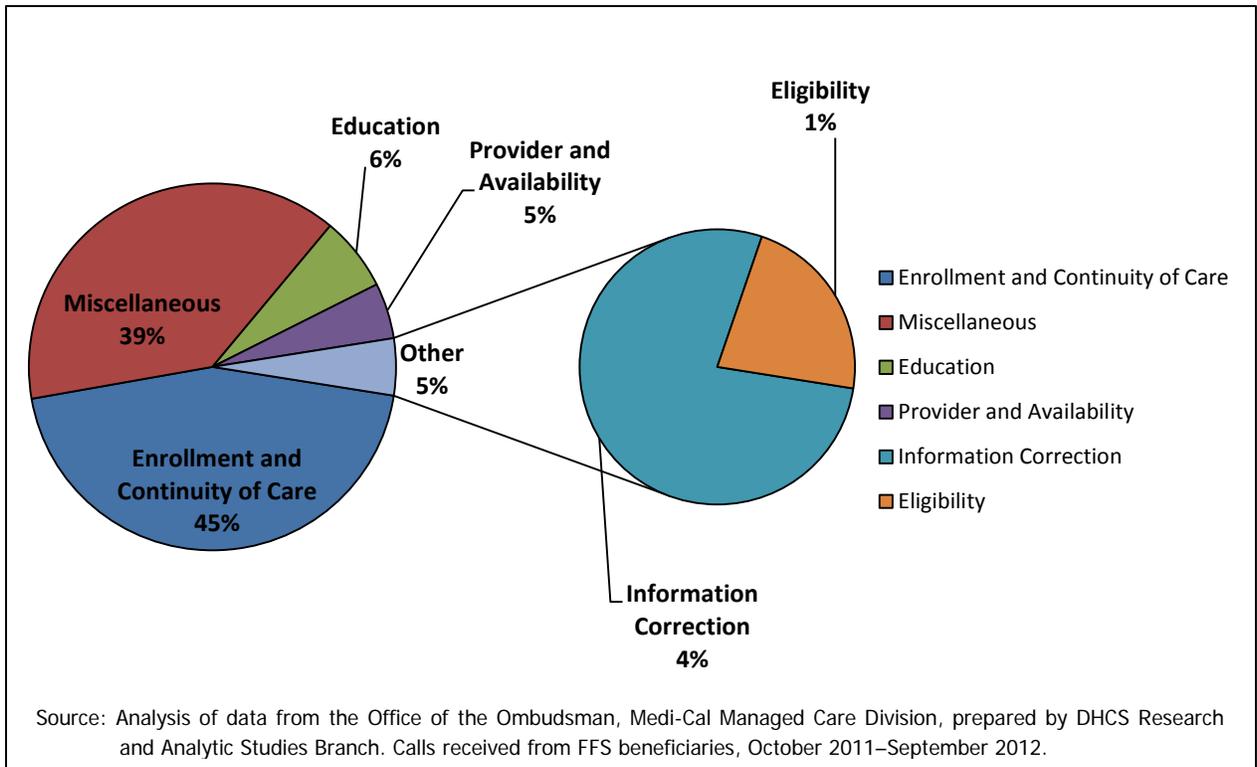
Call Category	Reason for Call
<b>Enrollment and Continuity of Care</b>	<ul style="list-style-type: none"> <li>• Seeking information for new enrollment into plan</li> <li>• Wanting to change plans or disenroll from managed care</li> <li>• Seeking medical exemptions</li> <li>• Emergency plan disenrollment 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>

Note: These modified call categories in the first column were developed based on the reasons for call in the second column, which are the call codes used by the Ombudsman.

## Distribution of Calls by Call Category

Figure BF-2 presents the distribution of total calls received by FFS beneficiaries and reasons for their call. Enrollment/Continuity of Care represented 45% of calls, while another 39% of calls were categorized as Miscellaneous. The remaining 16% of calls pertained to Provider/Availability, Information Correction, Education, and Eligibility issues.

**Figure BF-2 Calls Received by FFS Beneficiaries by Call Category, Oct. 2011–Sept. 2012**



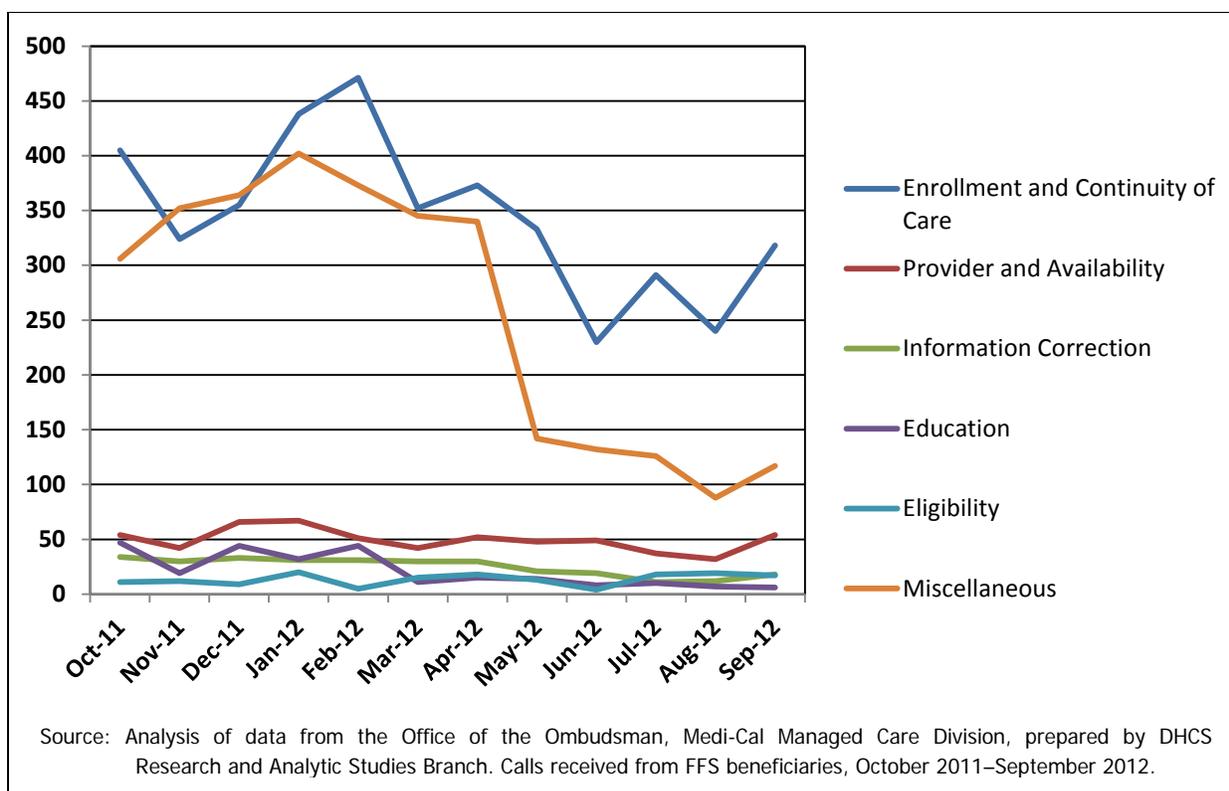
## Distribution of Calls by Call Category and Month

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 4,130 calls categorized as Enrollment/Continuity of Care and 594 categorized as Provider/Availability issues.

Of the 8,509 calls recorded, 4,130 (45%) were categorized under Enrollment/Continuity of Care.

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. Although calls categorized as Miscellaneous comprised the next largest amount of calls (3,087 calls, or 39%), the descriptions of these calls are too ambiguous to interpret. Therefore, these calls will not be further analyzed.

**Figure BF-3 Calls by Call Category and Month, FFS Beneficiaries, Oct. 2011–Sept. 2012**



Calls related to Provider/Availability, Information Correction, Education, and Eligibility issues comprised a relatively small portion of the total calls. Over the reporting period, Provider/Availability issues averaged 49.5 calls a month, with all four call categories averaging a combined 109 calls a month.

## Calls by Aid Code Category

The Medi-Cal aid codes reported by FFS beneficiary callers were collapsed into six aid code categories. Figure 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, Oct. 2011–Sept. 2012**

Aid Category	Call Category			
	Enrollment and Continuity of Care		Provider and Availability	
	# of Calls	% of Calls	# of Calls	% of Calls
<b>Families</b>	1,998	48.38%	214	36.03%
<b>Blind/Disabled</b>	1,315	31.84%	144	24.24%
<b>Other</b>	378	9.15%	151	25.42%
<b>Aged</b>	234	5.67%	54	9.09%
<b>Foster Care</b>	192	4.65%	8	1.35%
<b>Undocumented</b>	13	0.31%	23	3.87%
<b>Total</b>	4,130	100.00%	594	100.00%

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 October 2011–September 2012.

Patterns of call volume by aid category were similar between Enrollment/Continuity of Care and Provider/Availability. The majority of calls for each call category were received from beneficiaries in the Families aid category, followed by beneficiaries in the Blind/Disabled, Other, and Aged aid categories.

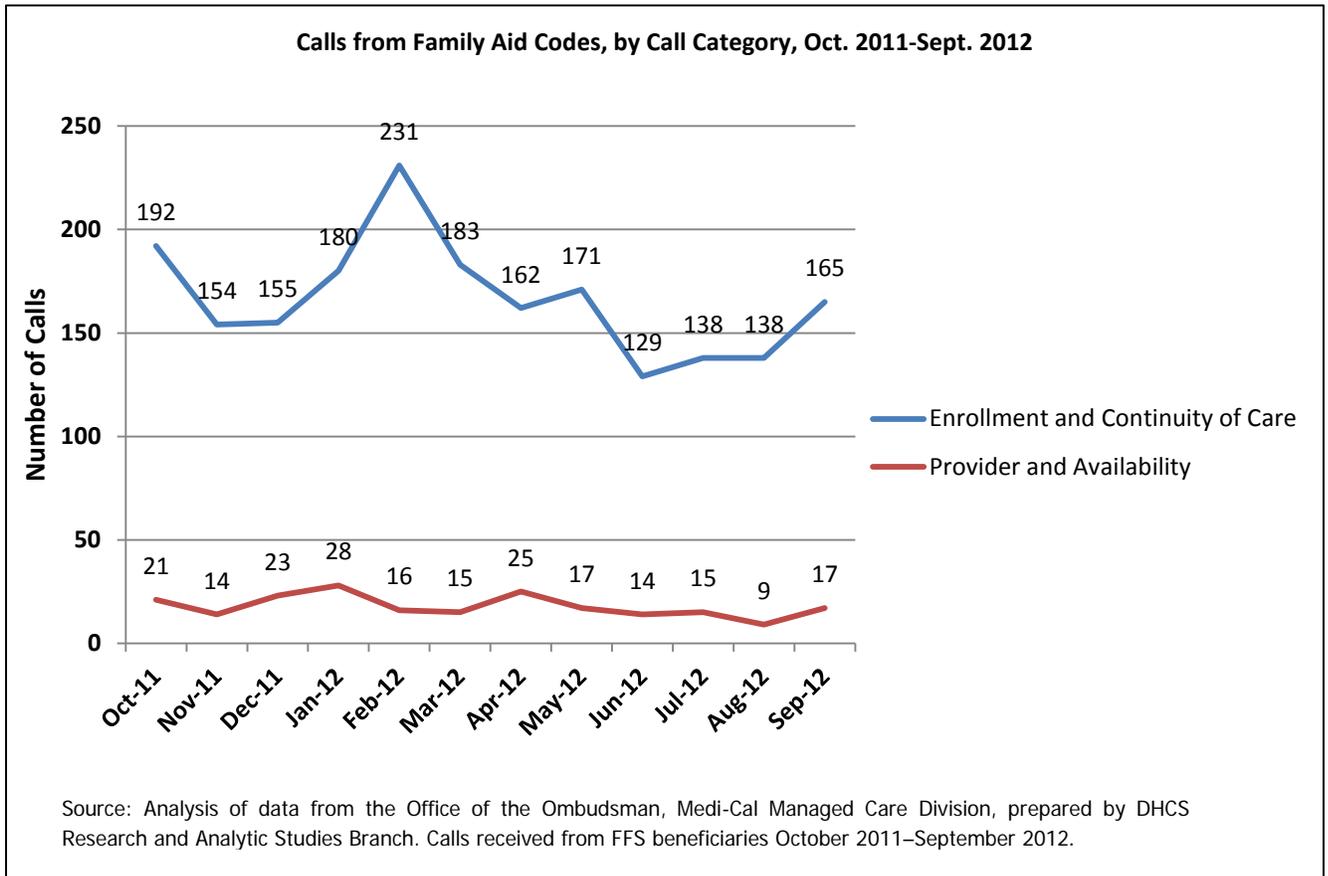
For Enrollment and Continuity of Care calls, there were more calls from beneficiaries in the Foster Care than Undocumented aid category; the reverse was observed for Provider and Availability calls, with more calls received from beneficiaries in Undocumented aid codes than Foster Care.

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

Since the majority of calls for each call category were received from callers in Family and Blind/Disabled aid codes, these calls were analyzed by month and call category. 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 reached 231 calls in February 2012 before decreasing to 129 calls in June 2012.

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

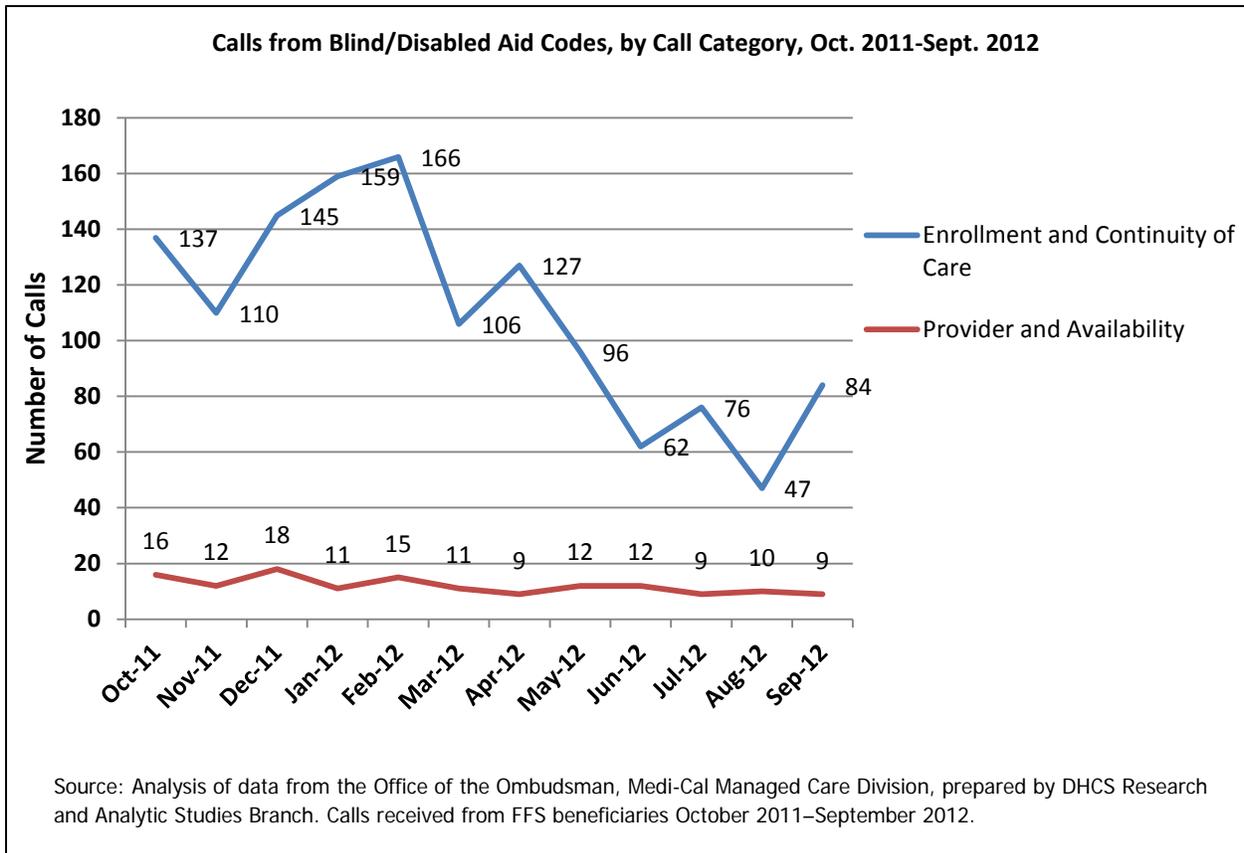
**Figure BF-4 Calls from Family Aid Codes, Call Category by Month, Oct. 2011–Sept. 2012**



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

Figure BF-5 presents the distribution of calls from beneficiaries in 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, with call volume reaching 166 calls in February 2012, and then declining to 47 calls in August 2012.

**Figure BF-5 Calls from Blind/Disabled Beneficiaries, by Call Category, Oct. 2011–Sept. 2012**



## Calls by County

The top 10 counties with the largest call volume are presented below 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 for both categories.

**Table BF-4 Calls for Enrollment and Continuity of Care, Top 10 Counties, Oct. 2011–Sept. 2012**

County	# of Calls	% of All Calls
Los Angeles	1,080	26.15%
San Bernardino	578	14.00%
Riverside	523	12.66%
San Joaquin	391	9.47%
San Diego	332	8.04%
Alameda	204	4.94%
Sacramento	199	4.82%
Orange	173	4.19%
Contra Costa	127	3.08%
Fresno	86	2.08%

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, October 2011–September 2012

**Table BF-5 Calls for Provider/Availability Issues, Top 10 Counties, Oct. 2011–Sept. 2012**

County	# of Calls	% of All Calls
Los Angeles	145	24.41%
San Diego	85	14.31%
Sacramento	74	12.46%
San Bernardino	52	8.75%
Riverside	50	8.42%
Alameda	19	3.20%
Orange	19	3.20%
Fresno	17	2.86%
Kern	16	2.69%
Santa Clara	16	2.69%

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, October 2011–September 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 calls among calls received from beneficiaries in the Family aid category. Nearly 80% of calls categorized as Enrollment and Continuity of Care pertained to requests for new enrollment. Another 6% of Enrollment and Continuity of Care calls were regarding Foster Care/Adoption issues, and 3% were disenrollment requests.

Of the calls categorized under Provider and Availability, over 85% inquired about the termination of Medi-Cal eligibility. Another 4.6% were related to delayed or denied referrals to specialists, and 4.2% concerned refusal of medications.

Among beneficiaries in Family aid codes, nearly 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, October 2011–September 2012**

Reason for Call	# of Calls	% of All Calls*
<b>Enrollment and Continuity of Care (n=1998)</b>		
Requesting New Enrollment into Plan	1,591	79.63%
Foster Care/Adoption (Disenrollment Exemption Request)	117	5.86%
Wants to Disenroll from Plan to Become FFS	59	2.95%
<b>Provider and Availability (n=214)</b>		
Medi-Cal Eligibility Terminated	183	85.51%
Specialist Referral Delayed or Denied	10	4.67%
Refusal of Medications	9	4.21%

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, October 2011–September 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 among calls received from beneficiaries in the Blind/Disabled aid category. Approximately 45% of the calls categorized as Enrollment/Continuity of Care involved callers requesting new enrollment. Another 22.1% concerned Medical Exemption Requests (MERs) or Emergency Disenrollment Exemption Requests (EDERs), and nearly 11% pertained to calls from beneficiaries in the Sention and Persons with Disabilities aid codes with concerns pertaining to denied medical exemptions and emergency disenrollment exemption requests.

Among beneficiaries in the Blind/Disabled aid codes, 41% of those categorized as Provider and Availability issues called about termination of Medi-Cal eligibility.

Of the calls categorized under Provider/Availability, over 40% of calls involved termination of Medi-Cal eligibility. Another 20% of these calls pertained to a provider not being part of the beneficiaries' plan, and another 18% were regarding the refusal of medications.

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

Reason for Call	# of Calls	% of All Calls*
<b>Enrollment and Continuity of Care (n=1,315)</b>		
Requesting New Enrollment into Plan	590	44.87%
Status Checks on MERs/EDERs	291	22.13%
Denial of SPD MERs/EDERs	140	10.65%
<b>Provider and Availability (n=144)</b>		
Medi-Cal Eligibility Terminated	59	40.97%
Provider Not a Plan Partner	29	20.14%
Refusal of Medications	26	18.06%

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, October 2011–September 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 October 2011 and September 2012, the Ombudsman call center staff documented 8,509 calls from FFS beneficiaries in the Medi-Cal program. The call total during this 12-month period decreased 1.24 percent from the July 2011–June 2012 reporting period.
2. About 45 percent of the calls pertained to Enrollment/Continuity of Care. Another 39 percent 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 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 foster care/adoption issues and disenrolling from or changing to an FFS plan. These callers also sought information regarding the termination of their Medi-Cal eligibility, as well as delayed or denied referrals to specialists, and refused medications.
5. Callers from Blind/Disabled aid codes were primarily concerned with requesting new enrollment. These callers also inquired about medical exemptions and emergency disenrollment exemption requests, as well as denied requests for exemptions. Other reasons for these calls included termination of Medi-Cal eligibility, provider not being a plan participant, and refused medications.