



Medi-Cal Access to Care Quarterly Monitoring Report #6 2013 Quarter 1



Beneficiary Feedback

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Contents

Contents	1
Figures	2
Tables	3
Beneficiary Help Line Feedback	4
Introduction	4
Highlights.....	4
Methods.....	5
Results	6
Call Volume by Quarter	7
Modified Call Categories	8
Distribution of Calls by Call Category	10
Calls by Aid Code Category.....	11
Distribution of Calls from Family Aid Codes by Call Category.....	12
Distribution of Calls from Blind/Disabled Aid Codes by Call Category	13
Reason for Call.....	14
Conclusions	16

Figures

Figure BF-1. Calls Received by FFS Beneficiaries by Month, Quarter 2, 2012–Quarter 1, 2013	6
Figure BF-2. Calls Received by FFS Beneficiaries by Call Category, Quarter 2, 2012–Quarter 1, 2013	10
Figure BF-3. Monthly Call Volume from Family Aid Codes by Call Category, Quarter 2, 2012–Quarter 1, 2013	12
Figure BF-4. Monthly Calls from Blind/Disabled Beneficiaries by Call Category, Quarter 2, 2012–Quarter 1, 2013	13

Tables

Table BF-1. Number of Calls Received from FFS Beneficiaries by Quarter, Quarter 2, 2012–Quarter 1, 2013	7
Table BF-2. Modified Call Categories	9
Table BF-3. Calls for Enrollment/Continuity of Care and Provider/Availability Issues by Aid Category, Quarter 2, 2012–Quarter 1, 2013	11
Table BF-4. Top 4 Reasons for Calls from Family Aid Codes, Quarter 2, 2012–Quarter 1, 2013	14
Table BF-5. Top 4 Reasons for Calls by Call Category from Blind/Disabled Aid Codes, Quarter 2, 2012–Quarter 1, 2013	15

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 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 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 at which 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

Call volume remained nearly the same with 8,541 calls in the current study period compared with 8,532 calls in the last study period.

The three top call categories continued to be related to issues regarding Provider/Availability, Miscellaneous, and Enrollment/Continuity of Care.

The majority of calls for Enrollment/Continuity of Care and Provider/Availability issues were received from beneficiaries in Families and Blind/Disabled aid categories.

The increase in call volume that began in September 2012 and continued through the first quarter of 2013 likely reflects the transition of children in the Healthy Families program into Medi-Cal that began January 1, 2013.

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 8,541¹ calls from FFS beneficiaries from the second quarter of 2012 to the first quarter of 2013. 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 (Families, Blind/Disabled, Aged, Foster Care, Undocumented, and Other), and reason for call.

¹ 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%–6%) in Quarter 4, 2012, and Quarter 1, 2013, reports than noted in previous access quarterly reports.

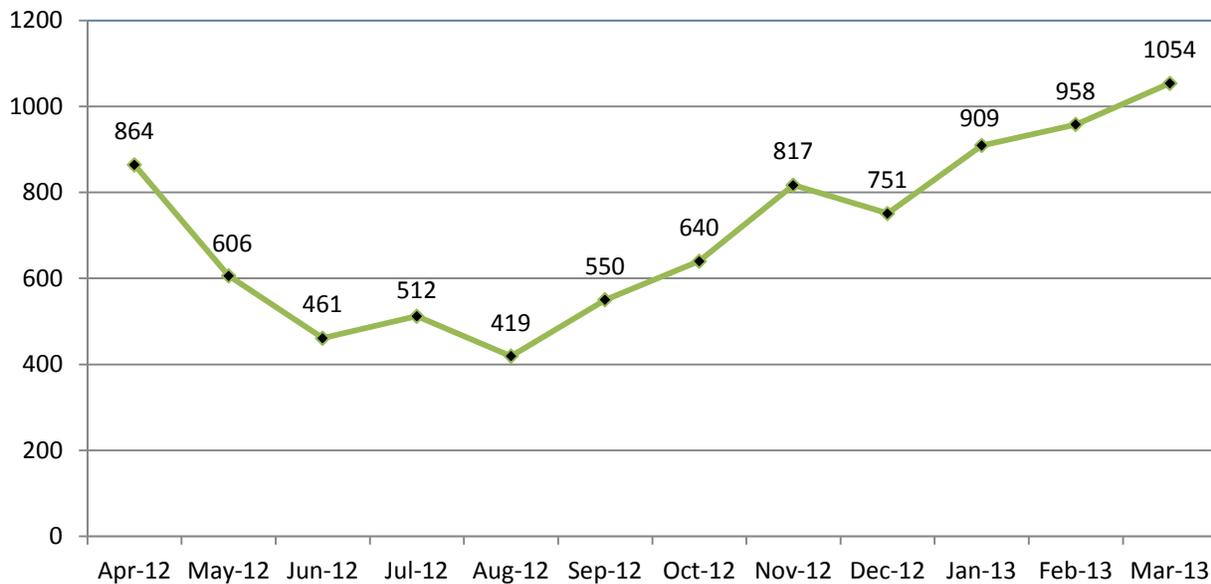
Results

Between April 2012 and March 2013, the Office of the Ombudsman documented a total of 8,541 calls received from Medi-Cal FFS beneficiaries.

The total number of calls remained relatively the same as for the previous reporting period (8,532 calls for January-December 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 during the first half of the reporting period (April-August 2012), with call volume experiencing an upward trend beginning in September 2012.

Monthly call volume increased August 2012–March 2013, with call volume increasing from 419 calls in August 2012 to 1,054 calls in March 2013.

Figure BF-1. Calls Received by FFS Beneficiaries by Month, Quarter 2, 2012–Quarter 1, 2013



Source: Analysis of FFS calls received by the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Division. Calls received by the Ombudsman for the period April 2012–March 2013.

The increase in call volume that began in September 2012 was driven by calls categorized as “miscellaneous” (data not shown). This increase in call volume may be the result of the Department’s transitioning of children served by the Healthy Families Program into Medi-Cal that began January 1, 2013. However, a definitive explanation of this rise in call volume can only be reached upon further investigation.

Call Volume by Quarter

Table BF-1 presents the number of calls received for each quarter of the current reporting period. Call volume decreased 23% from Quarter 2 to Quarter 3 of 2012, and then increased by 49% between Quarter 3 and Quarter 4 of 2012. Call volume continued to rise during the first quarter of 2013 at a rate of 32%.

Call volume increased 49% and 32% over the last two quarters of the study period.

Table BF-1. Number of Calls Received from FFS Beneficiaries by Quarter, Quarter 2, 2012–Quarter 1, 2013

Quarter	Total Calls Per Quarter	% Change from Previous Quarter
Apr-Jun 2012	1,931	
Jul-Sep 2012	1,481	-23%
Oct-Dec 2012	2,208	49%
Jan-Mar 2013	2,921	32%

Source: Analysis of FFS calls received by the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Division. Calls received by the Ombudsman for the period April 2012–March 2013.

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

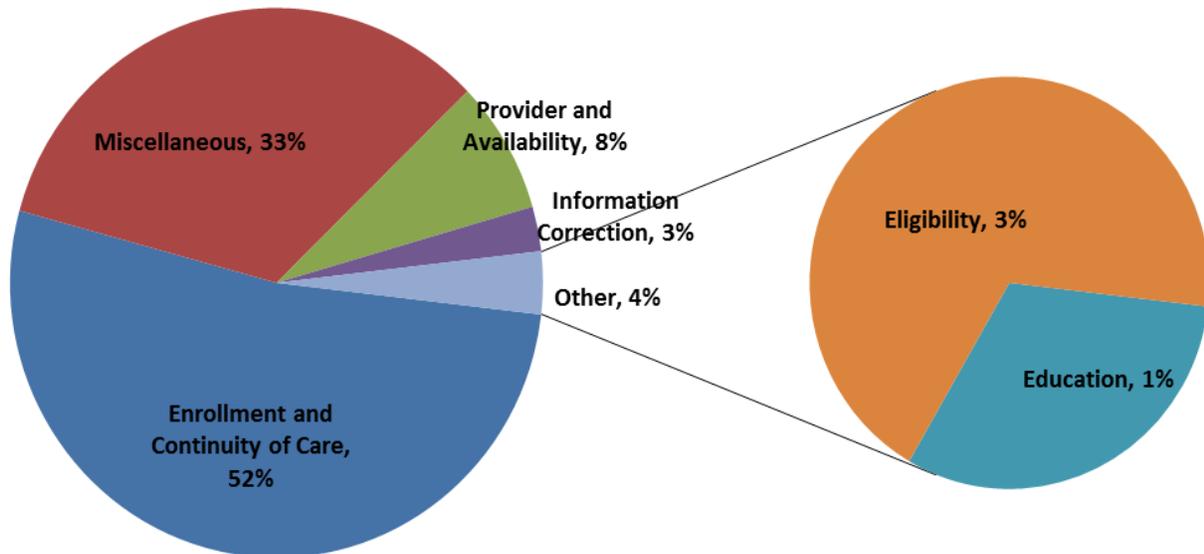
Call Category	Reason for Call
Enrollment and Continuity of Care	<ul style="list-style-type: none"> • Seeking information for new enrollment into plan • Wanting to change plans or disenroll from managed care • Seeking medical exemptions • Emergency plan disenrollment requests • Pregnancy or other qualifying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

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 52% of calls, while another 33% of calls were categorized as Miscellaneous. The remaining 15% of calls pertained to Provider and Availability, Information Correction, Education, and Eligibility issues.

Figure BF-2. Calls Received by FFS Beneficiaries by Call Category, Quarter 2, 2012–Quarter 1, 2013



Source: Analysis of FFS calls received by the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Division. Calls received by the Ombudsman for the period April 2012–March 2013.

As key elements in understanding whether beneficiaries are experiencing access-related problems, the remainder of this analysis will focus on two call categories: Enrollment/Continuity of Care and Provider/Availability issues. Of the total calls received, there were 4,475 calls categorized as Enrollment/Continuity of Care and 667 calls categorized as Provider/Availability.

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 FFS beneficiaries based on the primary access issue (Enrollment/Continuity of Care and Provider/Availability) and aid code in which the beneficiary was enrolled.

The majority of calls for both call categories were received from beneficiaries in the Families aid category.

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.

Table BF-3. Calls for Enrollment/Continuity of Care and Provider/Availability Issues by Aid Category, Quarter 2, 2012–Quarter 1, 2013

Aid Category	Call Category			
	Enrollment/Continuity of Care		Provider/Availability	
	Calls	% of Calls	Calls	% of Calls
Families	2,241	50.1%	231	34.6%
Blind/Disabled	1,094	24.5%	137	20.5%
Other	550	12.3%	204	30.6%
Aged	355	7.9%	60	9.0%
Foster Care	220	4.9%	10	1.5%
Undocumented	15	0.3%	25	3.8%
Total	4,475	100.0%	667	100.0%

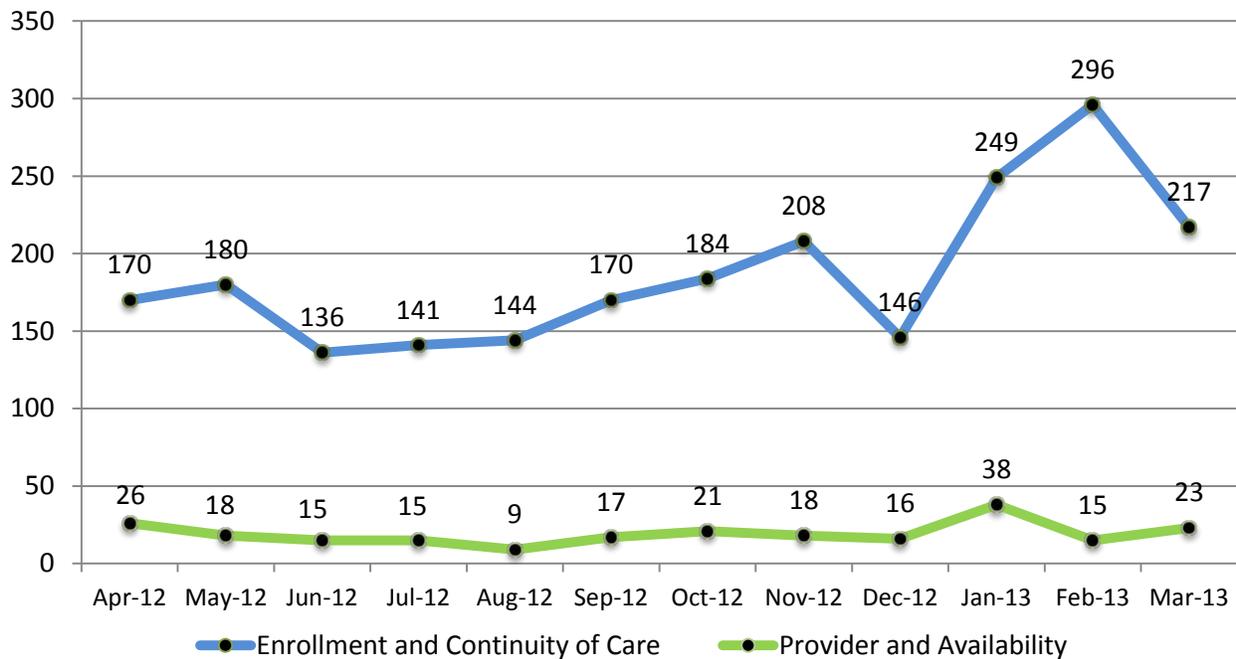
Source: Analysis of FFS calls received by the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Division. Calls received by the Ombudsman for the period April 2012–March 2013.

In general, a large proportion of calls received by the Ombudsman's Office pertained to Enrollment/Continuity of Care issues as compared with Provider/Availability issues. However, among beneficiaries enrolled in Undocumented and Other aid codes, a larger volume of calls pertained to Provider/Availability issues.

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, the following sections of the report will focus on calls received by beneficiaries in these two aid categories, analyzed by month and call category. Figure BF-3 represents calls made by FFS beneficiaries enrolled in the Families aid category. Calls pertaining to Enrollment/Continuity of Care issues made by beneficiaries in the Families aid category fluctuated modestly from April to September 2012, but increased for the months of October, November, January and February. Calls pertaining to Provider/Availability issues were less frequent but stable during the period under study.

Figure BF-3. Monthly Call Volume from Family Aid Codes by Call Category, Quarter 2, 2012–Quarter 1, 2013

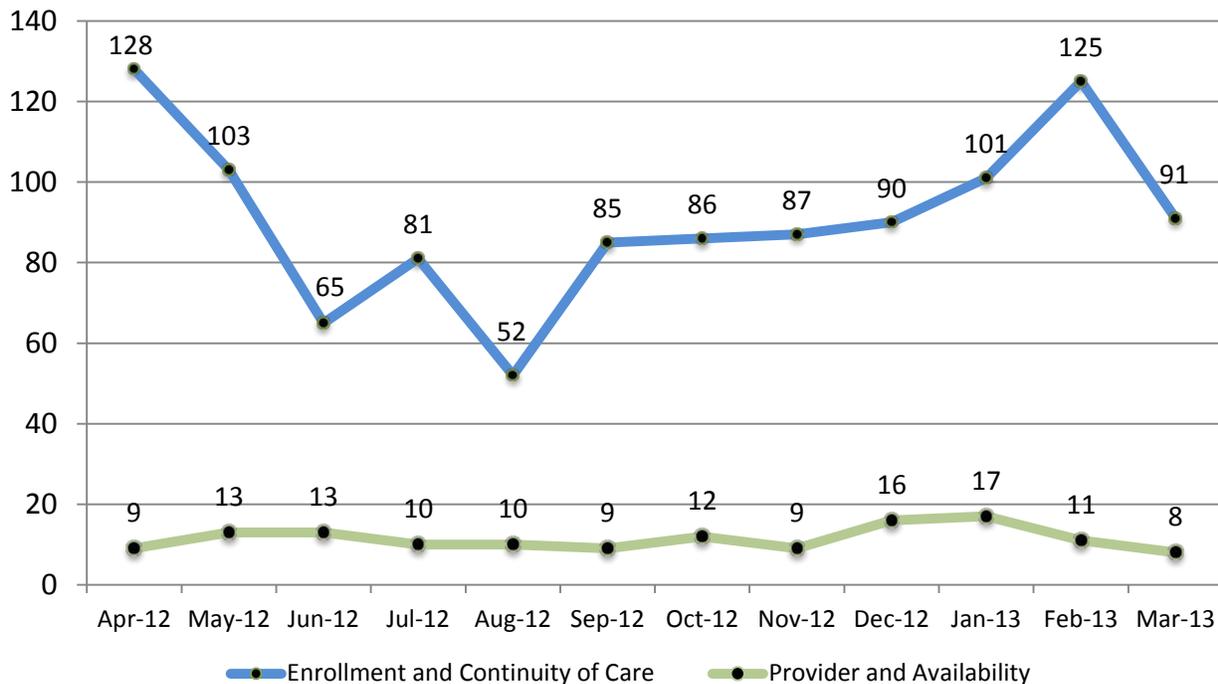


Source: Analysis of FFS calls received by the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Division. Calls received by the Ombudsman for the period April 2012–March 2013.

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

Figure BF-4 presents the distribution of calls from FFS beneficiaries in Blind/Disabled aid codes by call category and month. Among this beneficiary subgroup, calls pertaining to Enrollment/Continuity of Care experienced a notable decline from April to August 2012, but stabilized during the last four months of 2012 before increasing slightly in January and February of 2013. Calls pertaining to Provider/Availability issues were infrequent but stable for most of the study period.

Figure BF-4. Monthly Calls from Blind/Disabled Beneficiaries by Call Category, Quarter 2, 2012–Quarter 1, 2013



Source: Analysis of FFS calls received by the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Division. Calls received by the Ombudsman for the period April 2012–March 2013.

Reason for Call

To further investigate calls received by FFS beneficiaries, the top reasons for calls under each call category were identified. Table BF-4 presents the top four reasons for calls among calls received from beneficiaries in the Family aid category. Nearly 84% of calls categorized as Enrollment/Continuity of Care pertained to requests for new enrollment. Another 5% of Enrollment/Continuity of Care calls were regarding Foster Care/Adoption issues, 2% were requests to disenroll from managed care, and another 2% were calls pertaining to health plans with holds.

Requesting New Enrollment into Plan was the top reason for calls under the Enrollment/Continuity of Care call category; Medi-Cal Eligibility Terminated was the top reason under the Provider/Availability call category.

Of the calls categorized under Provider/Availability, over 85% were addressing the termination of Medi-Cal eligibility. Over 7% of calls were related to beneficiaries being billed for services, nearly 3% concerned refusal of medications, and another 1% pertained to delays or denials of referrals or appointments.

Table BF-4. Top 4 Reasons for Calls from Family Aid Codes, Quarter 2, 2012–Quarter 1, 2013

Reason for Call	# of Calls	% of All Calls*
Enrollment/Continuity of Care (n=2,241)		
Requesting New Enrollment into Plan	1,879	83.9%
Foster Care/Adoption Disenrollment Exemption Request	106	4.7%
Wants to Disenroll from Plan to Become FFS	52	2.3%
Hold on Plan	46	2.1%
Provider/Availability (n=231)		
Medi-Cal Eligibility Terminated	198	85.7%
Beneficiary Being Billed	17	7.4%
Refusal of Medications	6	2.6%
Delay/Denial of Referrals or Appointments	3	1.3%

Source: Analysis of FFS calls received by the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Division. Calls received by the Ombudsman for the period April 2012–March 2013.

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

Table BF-5 presents the top four reasons for calls among calls received from beneficiaries in the Blind/Disabled aid category. Approximately 54% of the calls categorized as Enrollment/Continuity of Care involved callers requesting new enrollment. Just over 13% concerned Medical Exemption Requests (MERs) or Emergency Disenrollment Exemption Requests (EDERs), 11% pertained to calls from beneficiaries wanting to disenroll from managed care to become a FFS participant, and 5% of calls were from Seniors and Persons with Disabilities aid codes with concerns pertaining to denied medical exemptions and emergency disenrollment exemption requests.

Requesting New Enrollment into Plan was the top reason for calls under the Enrollment/Continuity of Care category; Medi-Cal Eligibility Terminated was the top reason for calls under the Provider/Availability call category.

Of the calls categorized under Provider/Availability, 50% of calls involved termination of Medi-Cal eligibility, 16% pertained to refusal of medication, 11% were from beneficiaries who were erroneously billed for services, and 7% were calls reporting that a provider was not part of the beneficiaries' plan.

Table BF-5. Top 4 Reasons for Calls by Call Category from Blind/Disabled Aid Codes, Quarter 2, 2012–Quarter 1, 2013

Reason for Call	# of Calls	% of All Calls*
Enrollment/Continuity of Care (n=1,094)		
Requesting New Enrollment into Plan	589	53.8%
Status Checks on Medical Exemptions and Emergency Disenrollments	145	13.3%
Wants to Disenroll from Plan to become FFS	121	11.1%
SPD Medical Exemption or Emergency Disenrollment Denials	59	5.4%
Provider/Availability (n=137)		
Medi-Cal Eligibility Terminated	69	50.4%
Refusal of Medication	22	16.1%
Beneficiary Being Billed	15	11.0%
Provider not a Plan Partner	10	7.3%

Source: Analysis of FFS calls received by the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Division. Calls received by the Ombudsman for the period April 2012–March 2013.

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

Conclusions

1. Between April 2012 and March 2013, the Ombudsman call center staff documented 8,541 calls from FFS beneficiaries in the Medi-Cal program. The call total during this 12-month period remained similar to calls reported for the period January–December 2012.
2. About 52 percent of the calls pertained to Enrollment/Continuity of Care. Another 33 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 FFS beneficiaries enrolled in Family, Blind/Disabled, and Other aid categories.
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 a FFS delivery system. These callers also sought information regarding the termination of their Medi-Cal eligibility, as well as being billed for services and refusal of medications.
5. Callers from Blind/Disabled aid codes were primarily concerned with requesting new enrollment. These callers also requested medical exemptions and emergency disenrollment exemption requests, as well as following up on denied requests for exemptions. Other reasons for these calls included termination of Medi-Cal eligibility, provider not being a plan participant, and refused medications.