



Medi-Cal Access to Care Quarterly Monitoring Report #7 2013 Quarter 2



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

Tables

Table BF-1. Number of Calls Received from FFS Beneficiaries by Quarter, Quarter 3, 2012–Quarter 2, 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 3, 2012–Quarter 2, 2013	11
Table BF-4. Top 4 Reasons for Calls from Family Aid Codes, Quarter 3, 2012–Quarter 2, 2013	14
Table BF-5. Top 4 Reasons for Calls by Call Category from Blind/Disabled Aid Codes, Quarter 3, 2012–Quarter 2, 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.

Highlights

Call volume increased to 9,260 calls in the current study period compared with 8,541 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 April 2013 likely reflects the transition of children in the Healthy Families program into Medi-Cal that began January 1, 2013.

Methods

DHCS relies on data obtained from the Medi-Cal Managed Care Division's Office of the Ombudsman for the purpose of monitoring health care access. The Office of the Ombudsman call center documented 9,260 calls from FFS beneficiaries from the third quarter of 2012 to the second 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.

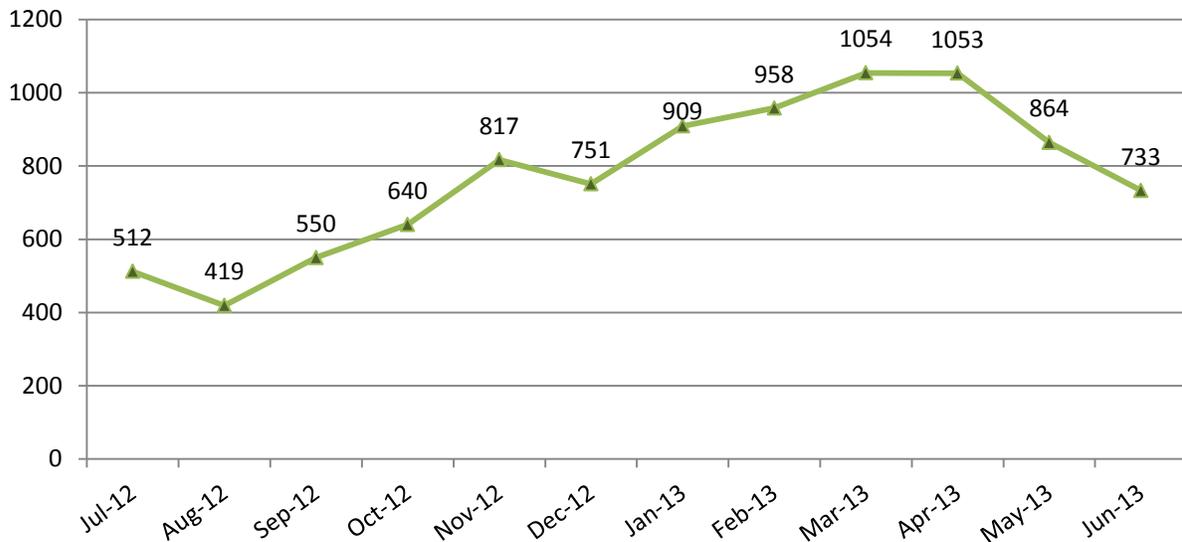
Results

Between July 2012 and June 2013, the Office of the Ombudsman documented a total of 9,260 calls received from Medi-Cal FFS beneficiaries.

FFS call volume was slightly higher this period than for the previous reporting period (8,541 calls for April 2012 to March 2013). 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 beginning in August 2012, with call volume decreasing for the months of May 2013 and June 2013.

Monthly call volume increased from 419 calls in August 2012 to 1,053 calls in April 2013.

Figure BF-1. Calls Received from FFS Beneficiaries by Month, Quarter 3, 2012–Quarter 2, 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 July 2012–June 2013.

Call Volume by Quarter

Table BF-1 presents the number of calls received for each quarter of the current reporting period. From Quarter 3, 2012, to Quarter 1, 2013, call volume increased by double digits, reaching their highest levels during March 2013. Call volume began to decrease slightly at the rate of 9% during the second quarter of 2013.

After significant increases in call volume for quarter 4, 2012, and quarter 1, 2013, call volume decreased 9% in quarter 2, 2013.

Table BF-1. Number of Calls Received from FFS Beneficiaries by Quarter, Quarter 3, 2012–Quarter 2, 2013

Quarter	Total Calls Per Quarter	% Change from Previous Quarter
Jul-Sep 2012	1,481	-23%
Oct-Dec 2012	2,208	49%
Jan-Mar 2013	2,921	32%
Apr-Jun 2013	2,650	-9%

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 July 2012–June 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

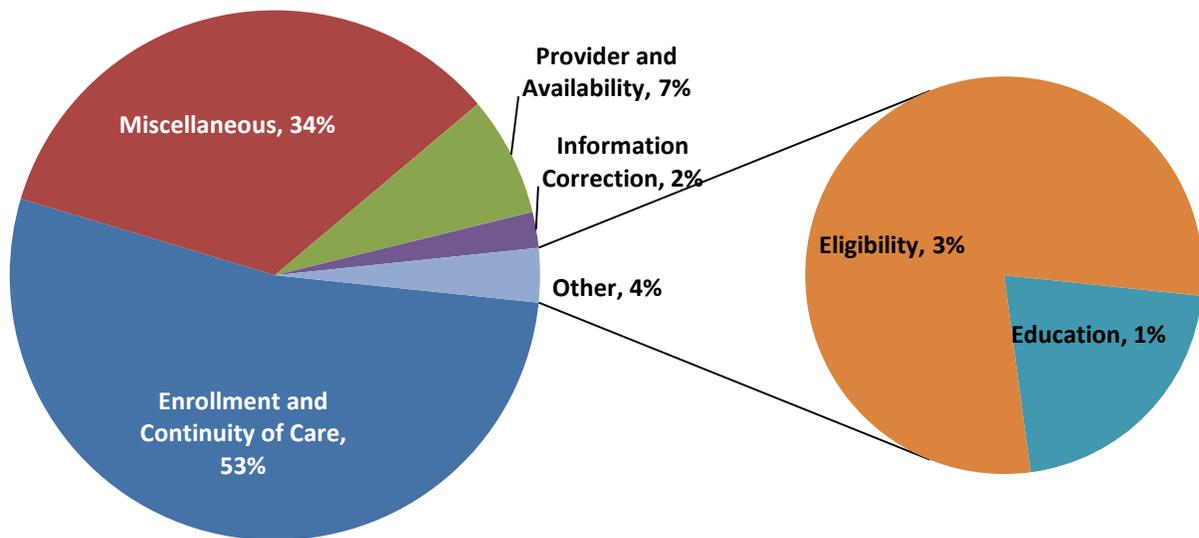
Call Category	Reason for Call
Enrollment and Continuity of Care	<ul style="list-style-type: none"> • Seeking information for new enrollment into plan • Wanting to change plans or disenroll from managed care • Seeking medical exemptions • Emergency plan disenrollment requests • Pregnancy or other qualifying 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 primary care physician/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 from FFS beneficiaries and reasons for their call. Enrollment/Continuity of Care represented 53% of calls, while another 34% of calls were categorized as Miscellaneous. The remaining 13% of calls pertained to Provider and Availability, Information Correction, Education, and Eligibility issues.

Figure BF-2. Calls Received from FFS Beneficiaries by Call Category, Quarter 3, 2012–Quarter 2, 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 July 2012–June 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 4,909 calls categorized as Enrollment/Continuity of Care and 680 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 from 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. Nearly half (49.3%) of all calls received in the Enrollment/Continuity of Care category were from beneficiaries in the Families aid category, followed by beneficiaries in the Blind/Disabled, Other, and Aged aid categories. For Provider/Availability, the greatest percentage of calls came from beneficiaries in the Families and Other aid categories. The calls in the Other aid category are primarily due to the transition of children from the Healthy Families program into Medi-Cal starting January 1, 2013.

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

Aid Category	Call Category			
	Enrollment/Continuity of Care		Provider/Availability	
	Calls	% of Calls	Calls	% of Calls
Families	2,418	49.3%	224	32.9%
Blind/Disabled	1,126	22.9%	136	20.0%
Other	701	14.3%	224	32.9%
Aged	414	8.4%	59	8.7%
Foster Care	234	4.8%	7	1.0%
Undocumented	16	0.3%	30	4.4%
Total	4,909	100.0%	680	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 July 2012–June 2013.

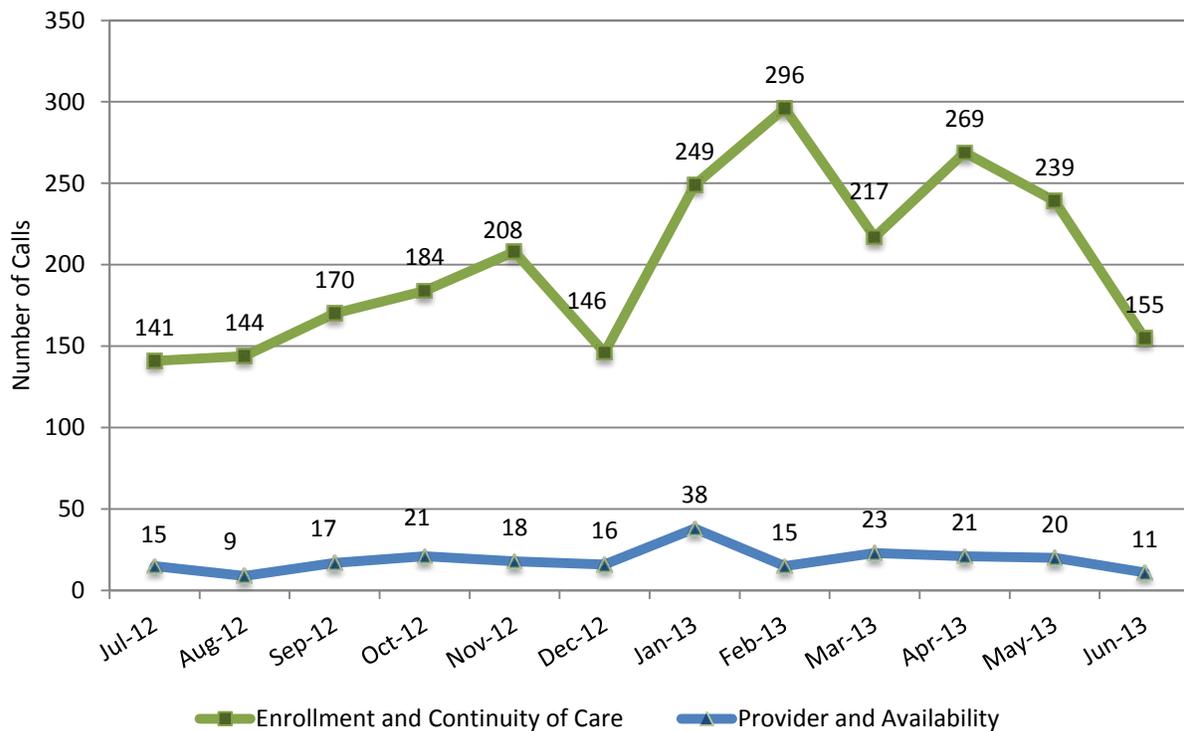
In general, a large proportion of calls received by the Ombudsman's Office pertained to Enrollment/Continuity of Care issues as compared with Provider/Availability issues. However, among beneficiaries enrolled in Undocumented aid codes, a larger volume of calls pertained to Provider/Availability issues.

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 from beneficiaries in these two aid categories, analyzed by month and call category. Although beneficiaries in the Other aid category also accounted for a substantial percentage, the calls are primarily due to the transition of children from the Healthy Families program into Medi-Cal starting January 1, 2013.

Figure BF-3 represents calls made by FFS beneficiaries enrolled in the Families aid category. Calls pertaining to Enrollment/Continuity of Care issues from beneficiaries in the Families aid category increased modestly from July to November 2012, but increased nearly two fold from December 2012 through 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 3, 2012–Quarter 2, 2013

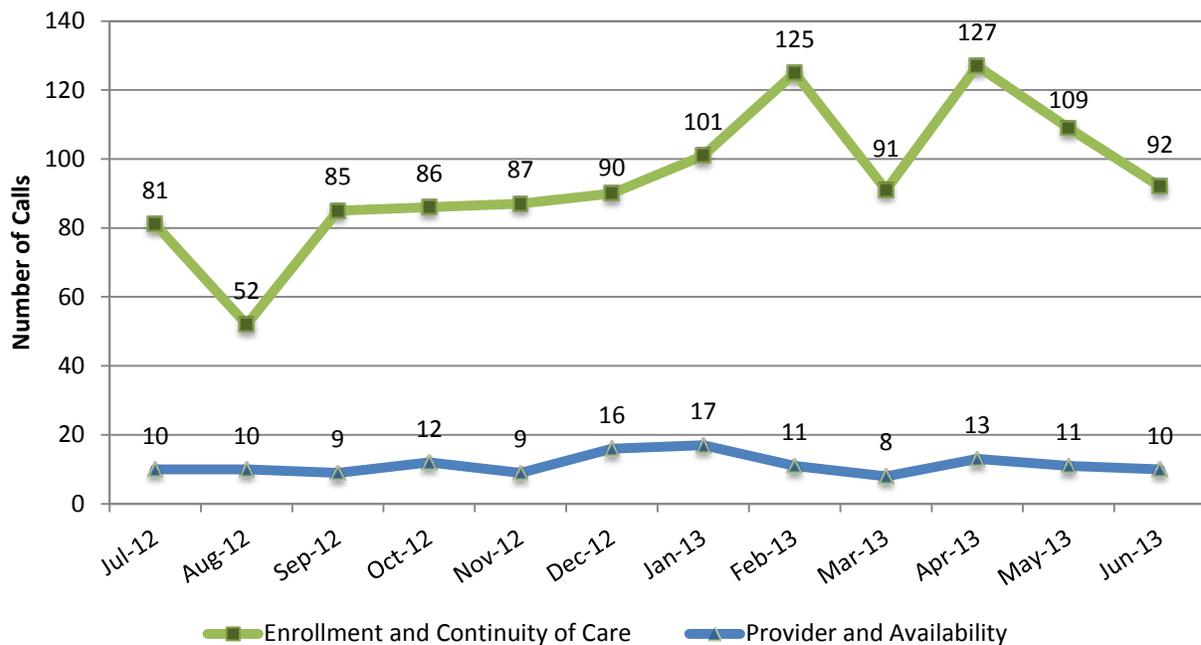


Source: Analysis of FFS calls received by the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Division. Calls received by the Ombudsman for the period July 2012–June 2013.

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 were relatively stable during the 3rd and 4th quarters of 2012, but increased slightly in January and February of 2013. Call volume returned to normal levels at the end of the second quarter 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 3, 2012–Quarter 2, 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 July 2012–June 2013.

Reason for Call

To further investigate calls received from 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 87% of calls categorized as Enrollment and Continuity of Care pertained to requests for new enrollment. Another 3% of Enrollment and Continuity of Care calls were regarding Foster Care disenrollment exemption requests, 2% pertained to requests to disenroll from managed care, and another 2% were calls pertaining to health plan 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 and Availability, over 84% were addressing the termination of Medi-Cal eligibility. Nearly 9% were related to beneficiaries being billed for services, 2% 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 3, 2012–Quarter 2, 2013

Reason for Call	# of Calls	% of All Calls*
Enrollment/Continuity of Care (n=2,418)		
Requesting New Enrollment into Plan	2,091	86.5%
Foster Care/Adoption Disenrollment Exemption Request	81	3.4%
Wants to Disenroll from Plan to Become FFS	56	2.3%
Hold on Plan	51	2.1%
Provider/Availability (n=224)		
Medi-Cal Eligibility Terminated	188	84.3%
Beneficiary Being Billed	19	8.5%
Refusal of Medications	5	2.2%
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 July 2012–June 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. Just over 56% of the calls categorized as Enrollment/Continuity of Care involved callers requesting new enrollment. Thirteen percent concerned Medical Exemption Requests (MERs) or Emergency Disenrollment Exemption Requests (EDERs), nearly 11% pertained to calls from beneficiaries wanting to disenroll from managed care to become a FFS participant, and 4% of calls were pertaining to long term care disenrollment emergency requests.

Of the calls categorized under Provider/Availability, nearly 56% of calls involved termination of Medi-Cal eligibility, just under 18% pertained to refusal of medication, 10% were from beneficiaries who were erroneously billed for services, and 4% were calls about denials of durable medical equipment.

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.

Table BF-5. Top 4 Reasons for Calls by Call Category from Blind/Disabled Aid Codes, Quarter 3, 2012–Quarter 2, 2013

Reason for Call	# of Calls	% of All Calls*
Enrollment/Continuity of Care (n=1,126)		
Requesting New Enrollment into Plan	634	56.3%
Status Checks on Medical Exemptions and Emergency Disenrollments	145	12.9%
Wants to Disenroll from Plan to become FFS	122	10.8%
SPD Medical Exemption or Emergency Disenrollment Denials	43	3.8%
Provider/Availability (n=136)		
Medi-Cal Eligibility Terminated	75	55.6%
Refusal of Medication	24	17.8%
Beneficiary Being Billed	14	10.4%
Denial of Durable Medical Equipment	6	4.4%

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 July 2012–June 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 July 2012 and June 2013, the Ombudsman call center staff documented 9,260 calls from FFS beneficiaries in the Medi-Cal program. Call volume during this 12-month period was slightly higher than for the period April 2012–March 2013.
2. About 53% of the calls pertained to Enrollment/Continuity of Care. Another 34% 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 managed care and changing to FFS. These callers also sought information regarding the termination of their Medi-Cal eligibility, as well as being erroneously 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 requesting disenrollment for managed care and emergency disenrollment from long term care. Other reasons for these calls included termination of Medi-Cal eligibility, refused medications, being billed erroneously for services, and denial of durable medical equipment.