



**Medi-Cal Access to Care
Quarterly Monitoring Report #8
2013 Quarter 3
Beneficiary Feedback**

October 2014

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Contents

Figures.....	iii
Tables.....	iv
Key Points	1
Introduction	1
Background	1
Assembly Bill 97	1
Medi-Cal Enrollment Transitions	2
Methods.....	3
Limitations	3
Results.....	4
Call Volume by Quarter.....	5
Modified Call Categories	5
Distribution of Calls by Call Category.....	7
Calls by Aid Code Category	8
Distribution of Calls from Family Aid Codes by Call Category	9
Distribution of Calls from Blind/Disabled Aid Codes by Call Category	10
Reason for Call	11
Conclusions	13

Figures

Figure BF-1: Calls Received from FFS Beneficiaries from Quarter 4, 2012 to Quarter 3, 2013, by Month	4
Figure BF-2: Calls Received from FFS Beneficiaries Quarter 4, 2012–Quarter 3, 2013, by Call Category	7
Figure BF-3: Monthly Call Volume from Family Aid Codes from Quarter 4, 2012 to Quarter 3, 2013, by Call Category	9
Figure BF-4: Monthly Calls from Blind/Disabled Beneficiaries from Quarter 4, 2012 to Quarter 3, 2013, by Call Category	10

Tables

Table BF-1: FFS Medi-Cal Only Beneficiaries Shifting to Medi-Cal Managed Care in September 2013	2
Table BF-2: Number of Calls Received from FFS Beneficiaries from Quarter 4, 2012 to Quarter 3, 2013, by Quarter	5
Table BF-3: Modified Call Categories	6
Table BF-4: Calls for Enrollment/Continuity of Care and Provider/Availability Issues from October 2012 to September 2013, by Aid Category	8
Table BF-5: Top Four Reasons for Calls from Family Aid Codes from Quarter 4, 2012 to Quarter 3, 2013	11
Table BF-6: Top Four Reasons for Calls from Blind/Disabled Aid Codes from Quarter 4, 2012 to Quarter 3, 2013, by Call Category.....	12

Key Points

- Call volume increased to 10,633 calls in the current study period compared with 9,260 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 Family and Blind/Disabled aid categories.
- The increase in call volume that began in October 2012 and continued through April 2013 likely reflects the transition of children from the Healthy Families Program (HFP) into Medi-Cal that began January 1, 2013.
- The increase in call volume from July to September 2013 likely reflects the transition of 110,000 beneficiaries to Medi-Cal managed care in eight California counties on September 1, 2013, as well as the final phase of the HFP transition.

Introduction

In 2011, the Centers for Medicare & Medicaid Services strongly encouraged the California Department of Health Care Services (DHCS) to implement a beneficiary help line as part of the Department's 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. A DHCS help line would address this gap in information for monitoring health care access, and provide needed assistance to Fee-for-Service (FFS) beneficiaries having difficulties navigating the health care system.

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).^{i,ii,iii}

Medi-Cal Enrollment Transitions

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 beneficiaries transitioned into a Medi-Cal managed care plan in September 2013 due to the establishment of County Organized Health Systems (COHS) in Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity counties (Table BF-1).

Table BF-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.

ⁱ California Assembly Bill 97, (2011).

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

ⁱⁱⁱ California Department of Health Care Services, State Plan Amendment, SPA 11-009.

Healthy Families Transition – On January 1, 2013, DHCS began the first of four phases in 2013 to transition approximately 860,000 children from the Healthy Families Program (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.

Methods

DHCS relies on data obtained from the Medi-Cal Managed Care Office of the Ombudsman for the purpose of monitoring health care access.

Upon receiving a call, the Office of the Ombudsman identifies whether a beneficiary is enrolled in FFS by their Medi-Cal identification number. The Office of the Ombudsman call center documented 10,633 calls from FFS beneficiaries from the fourth quarter of 2012 through the third 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 (Family, Blind/Disabled, Aged, Foster Care, Undocumented, and Other), and reason for call.

Limitations

There is currently no help line dedicated specifically to FFS beneficiaries for them to provide feedback pertaining to their experiences, including difficulties finding a provider, receiving referrals to specialists, and their challenges with enrollment.

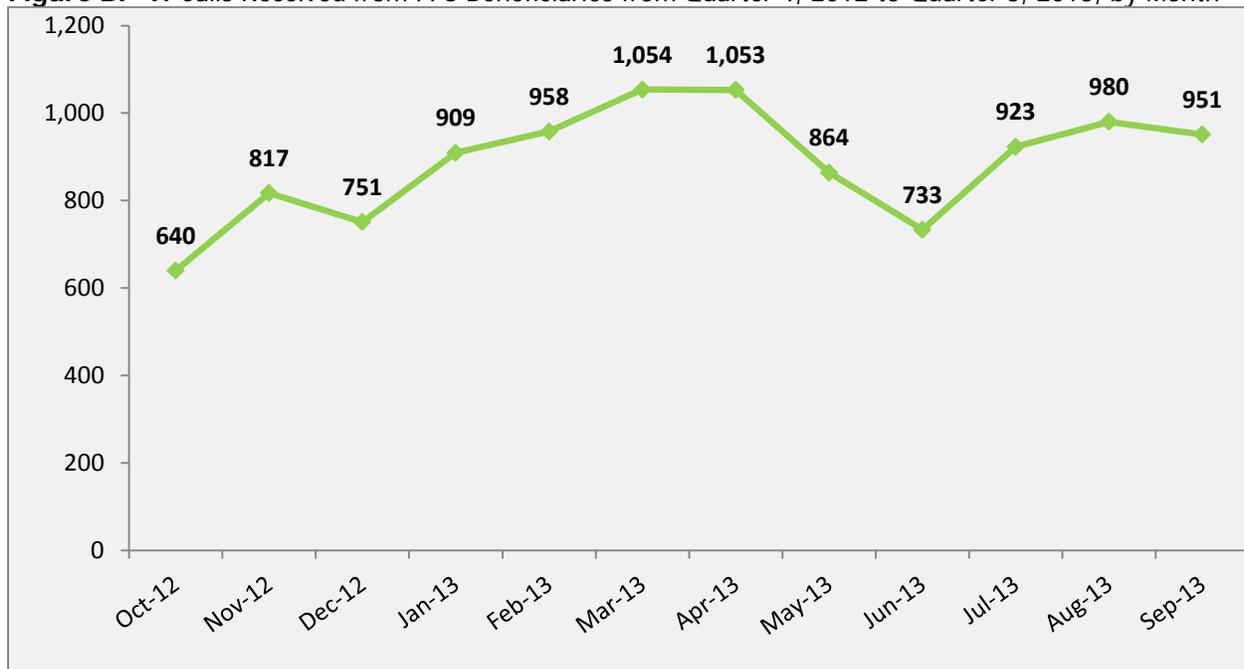
In the absence of a FFS-specific help line, this report presents data from the Office of the Ombudsman call center. As the number for the Office of the Ombudsman call center is listed on notices for managed care transitions, calls received from FFS beneficiaries may be skewed in reflecting transition-related issues, such as questions about their pending enrollment or whether their FFS provider will be available to them in managed care.

Results

Between October 2012 and September 2013, the Office of the Ombudsman documented a total of 10,633 calls received from Medi-Cal FFS beneficiaries (Figure BF-1).

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 BF-1).

Figure BF-1: Calls Received from FFS Beneficiaries from Quarter 4, 2012 to Quarter 3, 2013, by Month



Source: DHCS' RASD's analysis of FFS calls received October 2012–September 2013 by the Office of the Ombudsman, Medi-Cal Managed Care Division.

Call Volume by Quarter

Call volume increased 32% from the fourth quarter of 2012 to the first quarter of 2013, and reached its highest level during March 2013. Call volume decreased 9% during the second quarter of 2013 and then increased 8% during the third quarter of 2013 (Table BF-2).

Table BF-2: Number of Calls Received from FFS Beneficiaries from Quarter 4, 2012 to Quarter 3, 2013, by Quarter

Quarter	Total Calls per Quarter	% Change from Previous Quarter
Oct-Dec 2012	2,208	49%
Jan-Mar 2013	2,921	32%
Apr-Jun 2013	2,650	-9%
Jul-Sept 2013	2,854	8%

Source: DHCS' RASD's analysis of FFS calls received October 2012–September 2013 by the Office of the Ombudsman, Medical Managed Care Division.

Modified Call Categories

To help monitor whether managed care health plans are operating in line with their contractual obligations, 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 FFS 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-3 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-3: Modified Call Categories

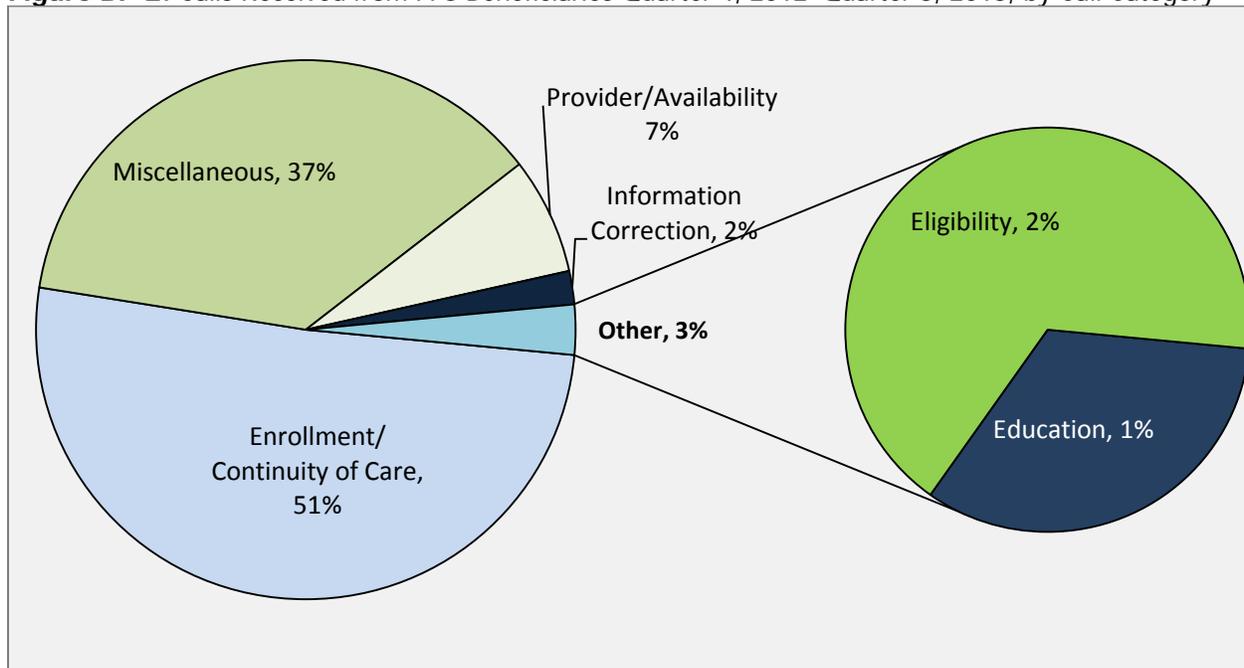
Call	Reason for Call
Enrollment and Continuity of Care	<ul style="list-style-type: none"> • Seeking information for new enrollment into plan • Wanting to change plans or disenroll from managed care • Seeking medical exemptions • Emergency plan disenrollment requests • Pregnancy or other qualifying conditions • Enrollment issues for specific beneficiary groups such as Seniors and Persons with Disabilities 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, 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 (e.g., 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 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 offices, and Medicare • Other issues

Note: The 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

Enrollment/Continuity of Care represented 51% of calls, while another 37% of calls were categorized as Miscellaneous. The remaining 12% of calls pertained to Provider/Availability, Information Correction, Education, and Eligibility issues (Figure BF-2).

Figure BF-2: Calls Received from FFS Beneficiaries Quarter 4, 2012–Quarter 3, 2013, by Call Category



Source: DHCS' RASD's analysis of FFS calls received October 2012–September 2013 by the Office of the Ombudsman, Medical Managed Care Division.

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 5,456 calls categorized as Enrollment/Continuity of Care and 702 calls categorized as Provider/Availability (Table BF-4).

Calls by Aid Code Category

The Medi-Cal aid codes reported by FFS beneficiary callers were collapsed into six aid code categories. The following table presents the calls received from FFS beneficiaries based on the primary access issue (Enrollment/Continuity of Care and Provider/Availability) and aid category in which the beneficiary was enrolled (Table BF-4).

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 Family aid category, followed by beneficiaries in the Blind/Disabled, Other, and Aged aid categories (Table BF-4).

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 higher volume of calls pertained to Provider/Availability issues (Table BF-4).

Table BF-4: Calls for Enrollment/Continuity of Care and Provider/Availability Issues from October 2012 to September 2013, by Aid Category

Aid Category	Call Category			
	Enrollment/Continuity of Care		Provider/Availability	
	Calls	% of Calls	Calls	% of Calls
Families	2,685	49.2%	232	33.1%
Blind/Disabled	1,219	22.3%	130	18.5%
Other	833	15.3%	237	33.8%
Aged	431	7.9%	59	8.4%
Foster Care	269	4.9%	8	1.1%
Undocumented	19	0.4%	36	5.1%
Total	5,456	100%	702	100%

Source: DHCS' RASD's analysis of FFS calls received October 2012–September 2013 by the Office of the Ombudsman, Medi-Cal Managed Care Division.

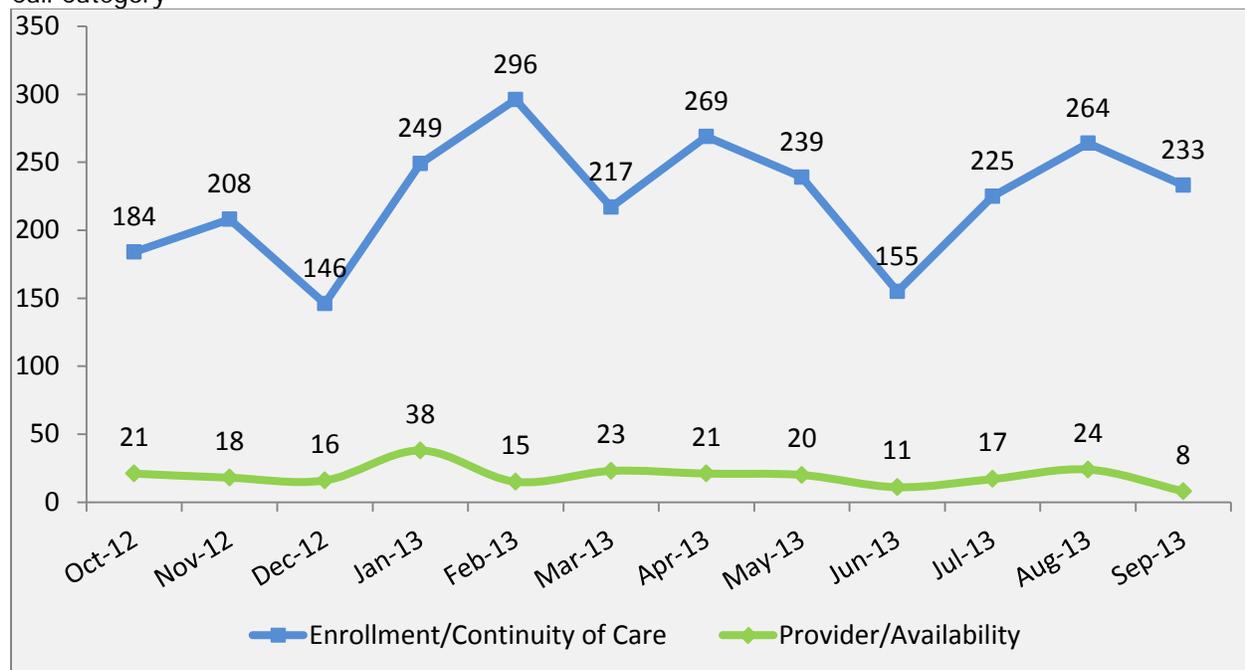
As the majority of calls were received from beneficiaries in Families and Blind/Disabled aid codes, the following sections will focus on calls received from beneficiaries in these two aid categories.

Distribution of Calls from Family Aid Codes by Call Category

Among beneficiaries in Family aid codes, there were numerous fluctuations in the number of calls pertaining to Enrollment/Continuity of Care issues throughout the reporting period. During the third quarter of 2013, call volume increased 9% compared with the second quarter of 2013, even as the volume of calls declined in September 2013 (Figure BF-3).

Additionally, calls pertaining to Provider/Availability issues were less frequent but stable until September 2013, when calls declined 67%, the lowest number reported during the study period (Figure BF-3).

Figure BF-3: Monthly Call Volume from Family Aid Codes from Quarter 4, 2012 to Quarter 3, 2013, by Call Category



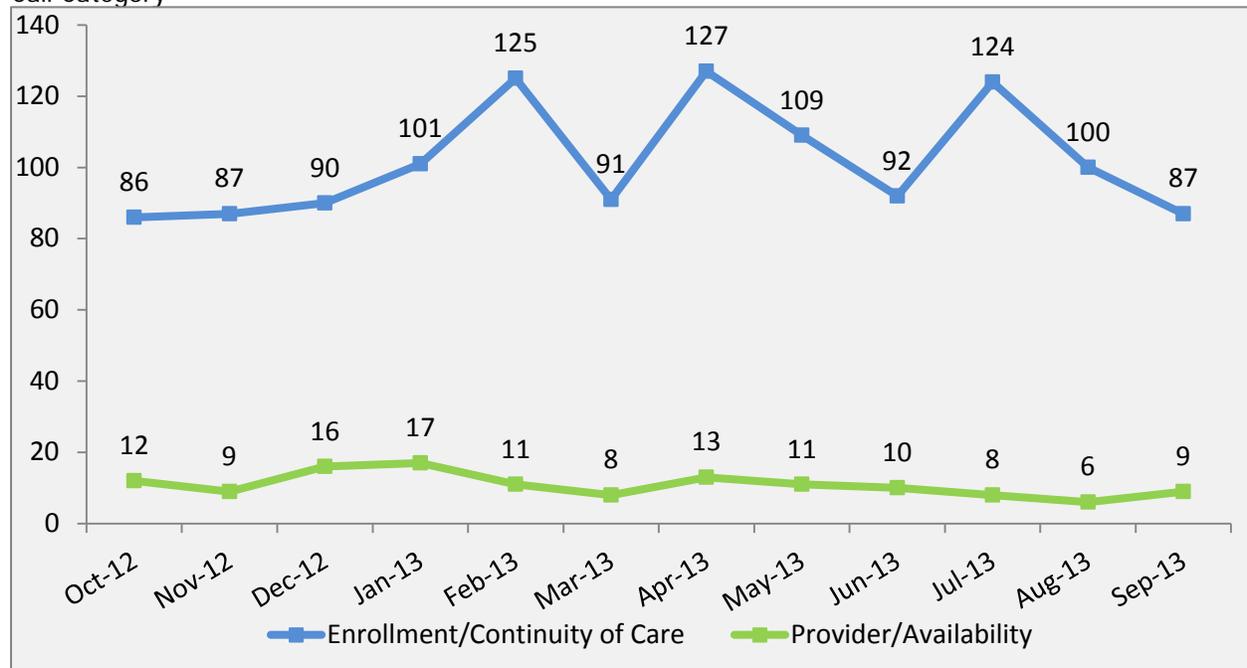
Source: DHCS' RASD's analysis of FFS calls received October 2012-September 2013 by the Office of the Ombudsman, Medi-Cal Managed Care Division.

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

Among beneficiaries in Blind/Disabled aid codes, there were fluctuations in the number of calls pertaining to Enrollment/Continuity of Care issues throughout the reporting period before decreasing 19% in August and 13% in September 2013 (Figure BF-4).

Additionally, calls pertaining to Provider/Availability issues were infrequent but stable for most of the study period before decreasing 32% in the third quarter of 2013 (Figure BF-4).

Figure BF-4: Monthly Calls from Blind/Disabled Beneficiaries from Quarter 4, 2012 to Quarter 3, 2013, by Call Category



Source: DHCS' RASD's analysis of FFS calls received October 2012–September 2013 by the Office of the Ombudsman, Medical Managed Care Division.

Reason for Call

To further investigate calls received from FFS beneficiaries, the top reasons for calls under each call category were identified. Among beneficiaries in Family aid codes, about 88% of calls categorized as Enrollment/Continuity of Care pertained to requests for new enrollment. Another 3% of Enrollment/Continuity of Care calls were regarding Foster Care disenrollment exemption requests, 2% pertained to requests to disenroll from managed care, and just over 1% pertained to holds on health plans (Table BF-5).

Additionally, of the calls categorized under Provider/Availability, nearly 85% were addressing the termination of Medi-Cal eligibility. Approximately 8% 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-5).

Table BF-5: Top Four Reasons for Calls from Family Aid Codes from Quarter 4, 2012 to Quarter 3, 2013

Reason for Call	# of Calls	% of All Calls*
Enrollment/Continuity of Care (n=2,685)		
Requesting New Enrollment into Plan	2,370	88.3%
Foster Care/Adoption Disenrollment Exemption Request	87	3.2%
Wants to Disenroll from Plan to Become FFS	59	2.2%
Hold on Plan	39	1.5%
Provider/Availability (n=232)		
Medi-Cal Eligibility Terminated	196	84.5%
Beneficiary Being Billed	19	8.2%
Refusal of Medications	6	2.6%
Delay/Denial of Referrals or Appointments	3	1.3%

Source: DHCS' RASD's analysis of FFS calls received October 2012–September 2013 by the Office of the Ombudsman, Medi-Cal Managed Care Division.

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

Among beneficiaries in Blind/Disabled aid codes, about 60% of the calls categorized as Enrollment/Continuity of Care involved callers requesting new enrollment. Approximately 13% concerned medical exemption requests or emergency disenrollment exemption requests, just over 10% pertained to calls from beneficiaries wanting to disenroll from managed care to become a FFS participant, and 2% of calls were pertaining to long-term care disenrollment emergency requests (Table BF-6).

Additionally, of the calls categorized under Provider/Availability, 60% of calls involved termination of Medi-Cal eligibility, 15% pertained to refusal of medication, nearly 11% were from beneficiaries who were erroneously billed for services, and just over 5% were calls about denials of Durable Medical Equipment (Table BF-6).

Table BF-6: Top Four Reasons for Calls from Blind/Disabled Aid Codes from Quarter 4, 2012 to Quarter 3, 2013, by Call Category

Reason for Call	# of	% of All
Enrollment/Continuity of Care (n=1,219)		
Requesting New Enrollment into Plan	735	60.3%
Status Checks on Medical Exemptions and Emergency Disenrollments	164	13.5%
Wants to Disenroll from Plan to become FFS	126	10.3%
Long-Term Care Issues—Disenrollment Emergency Request	28	2.3%
Provider/Availability (n=130)		
Medi-Cal Eligibility Terminated	78	60.0%
Refusal of Medication	20	15.4%
Beneficiary Being Billed	14	10.8%
Denial of Durable Medical Equipment	7	5.4%

Source: DHCS' RASD's analysis of FFS calls received October 2012–September 2013 by the Office of the Ombudsman, Medi-Cal Managed Care Division.

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

Conclusions

- Between October 2012 and September 2013, the Ombudsman call center staff documented 10,633 calls from FFS beneficiaries in the Medi-Cal program. Call volume during this 12-month period was 15% higher than July 2012 to June 2013.
- About 51% of the calls received by the Office of the Ombudsman pertained to Enrollment/Continuity of Care. Another 37% of the calls were categorized under Miscellaneous. Due to the ambiguity of Miscellaneous calls, they were not further analyzed. The focus of the analyses was on calls related to Enrollment/Continuity of Care and Provider/Availability, as these key elements help identify access-related issues experienced by beneficiaries.
- 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.
- 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, being erroneously billed for services, and refusal of medications.
- Callers from Blind/Disabled aid codes were primarily concerned with requesting new enrollment. These callers also requested medical exemptions and emergency disenrollment exemption requests, disenrollment from managed care, and emergency disenrollment from plan due to long-term care issues. Other reasons for these calls included termination of Medi-Cal eligibility, refused medications, being billed erroneously for services, and denial of Durable Medical Equipment.