



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



Executive Summary

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Contents

| | |
|--------------------------------------------------------------------------------|----|
| List of Figures | 3 |
| Table..... | 4 |
| Executive Summary..... | 6 |
| Background..... | 6 |
| Findings..... | 13 |
| Physician Supply | 13 |
| Change in Medi-Cal Participation | 14 |
| Service Utilization Rates Per 1,000 Member Months for Adult Beneficiaries..... | 15 |
| Beneficiary Help Line Calls | 19 |

List of Figures

| | | |
|-------------|------------------------------------------------------------------------------------|----|
| Figure ES-1 | Trend in Quarterly FFS vs Managed Care Participation..... | 7 |
| Figure ES-2 | Distribution of Adult FFS Medi-Cal Only Population by Aid Category, 2011 Qtr 1.... | 8 |
| Figure ES-3 | Distribution of Adult FFS Medi-Cal Only Population by Aid Category, 2012 Qtr 2.... | 8 |
| Figure ES-4 | Declines in Adult FFS Medi-Cal Only Users of 3 Service Categories..... | 10 |
| Figure ES-5 | Declines in Adult FFS Medi-Cal Only Users of Physician/Clinic Services | 10 |
| Figure ES-6 | Calls Received from FFS Beneficiaries by Month, July 2011–June 2012..... | 20 |

Table

Table ES-1 Summary of Service Use Trends Among Adults by Aid Category and Service Category20

Abstract

The Department of Health Care Services' (DHCS) quarterly analysis includes an evaluation of four areas identified as providing a means of detecting the early signs of health care access disruptions. The areas evaluated include: changes in Medi-Cal participation, beneficiary-to-physician ratios, service use rates per 1,000 member months, and beneficiary help line calls.

Medi-Cal's assessment of health care access for the first quarter of 2012 disclosed that, for the most part, participation trends, provider supply, and service use rates were within expected ranges. When comparing the results of the current report to those reported for the first quarter of 2012, similar patterns were identified in all four areas under study. Key findings regarding these study areas are summarized below.

KEY FINDINGS

- Beneficiaries' participation in the Medi-Cal Fee-for-Service (FFS) delivery system continues to decline, particularly among adults in the Aged and Blind/Disabled aid categories. For some beneficiary subpopulations, such as those enrolled in a Foster Care and Other aid category, and in some geographic areas, FFS participation increased in the second quarter of 2012. By June 2012, the largest segment of adult FFS Medi-Cal beneficiaries were those enrolled in Undocumented aid codes.
- The Medi-Cal physician supply was determined to contain an adequate number of overall physicians as well as primary care physicians. Site-specific physician counts, or total physicians at distinct locations, increased statewide from 107,332 to 109,854, or 2.3%.
- Service utilization, or realized access, was generally within upper and lower expected bounds for most service categories and populations. For some FFS subpopulations, below average utilization of Physician/Clinic and Hospital Inpatient services may be attributed in part to declines in beneficiaries seeking pregnancy-related services, largely due to the national and statewide decline in birth rates. Due to the continuing shift from FFS to managed care, an increased number of service categories were utilized by fewer than 500 beneficiaries. Service utilization is beginning to concentrate among a smaller number of beneficiary subpopulations participating in FFS.
- A large number of beneficiaries participating in FFS continue to call into DHCS' Medi-Cal Managed Care Division's Office of the Ombudsman for assistance. Over 8,600 calls were handled by the Office of the Ombudsman for beneficiaries enrolled in FFS, a 7% increase from the previous reporting period. However, calls declined significantly in the last quarter of the reporting period. Smaller call volume during the current quarter is likely the result of fewer calls relating to the elimination of ADHC benefits and the completed transition of roughly 300,000 Seniors and Persons with Disabilities to managed care, two events preceding the current study period.

Executive Summary

Background

This Medi-Cal access report is the third in a series of reports concerning health care access among Medi-Cal's population. This report provides information for evaluating the early signs of potential health access problems related to beneficiaries eligible for Medi-Cal only¹ and participating in Medi-Cal's Fee-for-Service (FFS) system. This report covers the second quarter of 2012, and presents data from the three previous quarters for comparison purposes. During this reporting period, Medi-Cal's provider payment reduction proposed by Assembly Bill 97 (AB 97) was not in effect; applicable Medi-Cal providers were not subjected to the 10% payment reduction during the dates-of-service evaluated in this quarterly report.

DHCS' quarterly health care access monitoring report encompasses four specific *early warning* measures as follows:

- Change in Medi-Cal participation
- Beneficiaries-to-physician ratios
- Service utilization rates per 1,000 member months
- Beneficiary help line calls

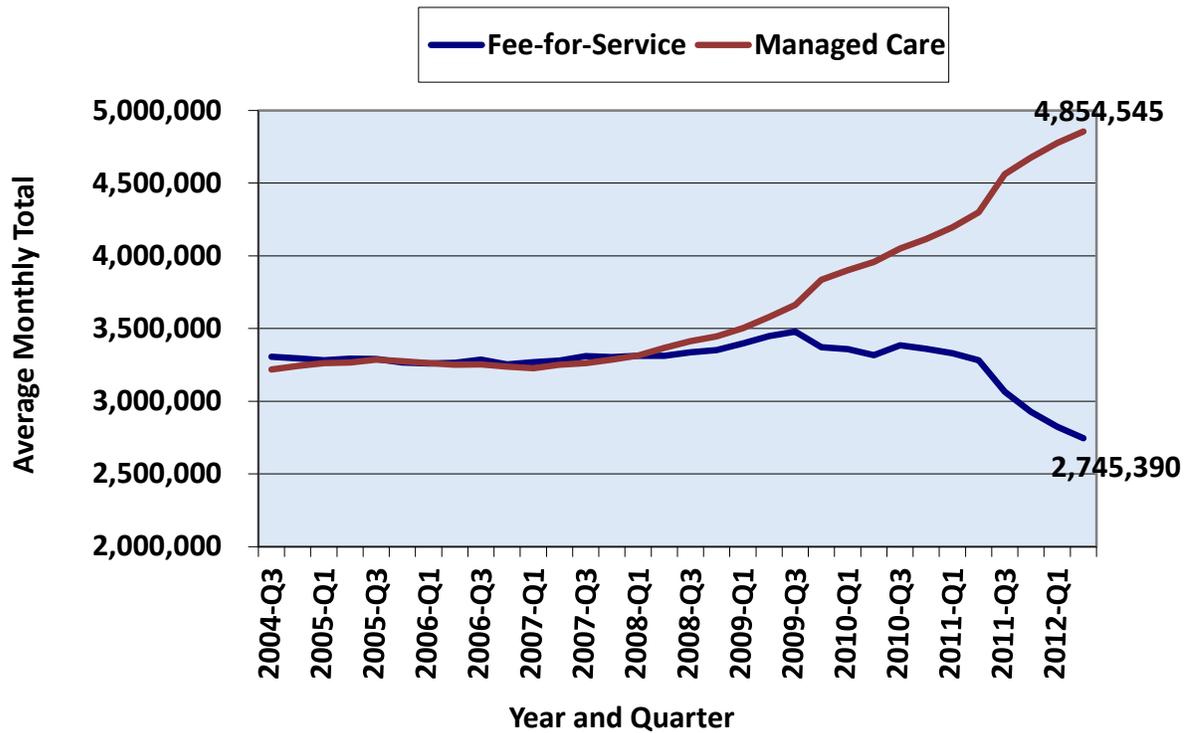
Recent changes to the Medi-Cal program have impacted benefits, health care delivery, and FFS population characteristics. All of these changes influenced the measures evaluated in Medi-Cal's quarterly access report. The DHCS systematic access monitoring system required the establishment of baseline statistics. These baseline statistics were established using data incorporating dates-of-service between 2007 and 2009.

Since 2007, Medi-Cal has undergone dramatic changes brought on by a deep economic recession and continual efforts to restructure its health care delivery system. In some cases, these changes dramatically affected Medi-Cal's FFS population, impacting how beneficiaries receive services. As a result, the present baseline metrics established during Medi-Cal's transformational period, may not always reflect the new reality. Therefore, the baseline statistics, or benchmarks, will be reconsidered in future reports.

Between 2008 and 2011, significant changes occurred within Medi-Cal that impacted participation distributions between Medi-Cal's traditional FFS system and managed care. These shifts in participation significantly impacted the number of beneficiaries this quarterly access monitoring effort focuses on (see Figure ES-1); access monitoring efforts focus on beneficiaries eligible for Medi-Cal only and participating in the FFS system.

¹ The term "Medi-Cal only" refers to individuals eligible for Medi-Cal but not Medicare.

Figure ES-1 Trend in Quarterly FFS vs Managed Care Participation

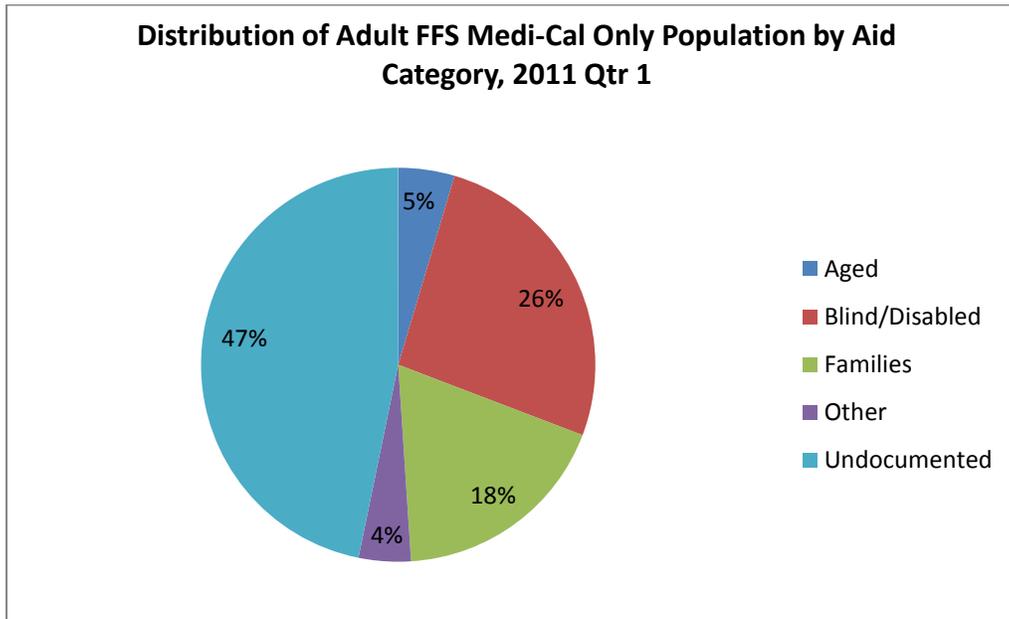


Source: Medi-Cal Enrollment Files

As beneficiaries are transitioned from FFS to managed care, the population evaluated in conjunction with this monitoring effort contracts, and in many cases the population mix is altered.

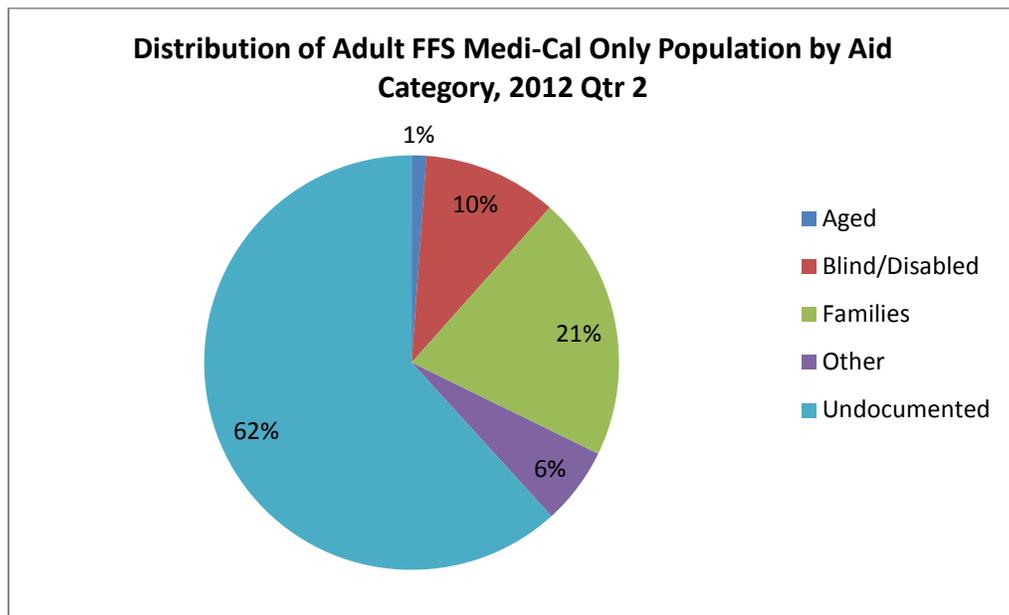
As the next two figures show, from the first quarter of 2011 to the second quarter of 2012, an increasing percentage of the overall Medi-Cal population is comprised of Undocumented beneficiaries, as subpopulations in the other aid categories shift from FFS to managed care. Since Undocumented beneficiaries are not eligible to enroll in managed care, and as the remaining population continues its shift over to managed care, the percentage of the Medi-Cal FFS population comprised of Undocumented beneficiaries will continue to increase. In June 2012, nearly two-thirds of the adult FFS Medi-Cal population were enrolled in Undocumented aid codes.

Figure ES-2 Distribution of Adult FFS Medi-Cal only Population by Aid Category, 2011 Quarter 1



Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files, July 2011–June 2012. Data reflects a 4-month reporting lag.

Figure ES-3 Distribution of Adult FFS Medi-Cal Only Population by Aid Category, 2012 Quarter 2



Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files, July 2011–June 2012. Data reflects a 4-month reporting lag.

From 2008–2011, San Luis Obispo, Sonoma, Merced, Kings, Madera, Ventura, Mendocino, and Marin Counties were transitioned from FFS to managed care delivery models. In these counties, roughly 306,000 beneficiaries formerly receiving health care services through Medi-Cal's FFS system were enrolled in managed care plans.²

In addition to the establishment of managed care models within former FFS counties, Medi-Cal also directed seniors and persons with disabilities (SPD), who were formerly receiving care through the FFS system, into Medi-Cal managed care plans in the Two-Plan and Geographic Managed Care (GMC) counties. Roughly 300,000 SPD beneficiaries were transitioned from FFS to managed care as a result of this policy. The SPD population represents one of Medi-Cal's most costly and medically complex groups, accounting for more than \$3.8 billion³ in annual health care spending.

All of these shifts from the FFS to managed care delivery models occurred at the end of the baseline period of 2007–2009 or during the present reporting period. For example, the SPD transition was phased in from June 2011–May 2012. This means that during the most of the current study period of July 2011–June 2012, beneficiaries receiving health care services through the FFS system in the earlier quarters of the reporting period were now receiving care through managed care plans.

Shifting health care delivery systems materially influenced FFS physician supply and service utilization measures. For example, in those counties that shifted from a FFS delivery system to a managed care model, the number of beneficiaries participating in Medi-Cal's FFS system declined significantly. The impact of these changes was recognized in measures such as the beneficiary-to-primary-care-physician ratio and service utilization rates per 1,000 member months.

Because Medi-Cal physician supply did not decline over this period, the ratio of beneficiary-to-physicians actually improved. Measuring the ratio of population to overall physician supply showed that the number of physicians increased slightly from the third quarter of 2011 to the second quarter of 2012. However, the most significant driver in the improvement of the beneficiary-to-provider ratio was the reduction in the numerator, or number of beneficiaries eligible for Medi-Cal only and participating in FFS.

Shifts in participation from FFS to managed care may also materially alter service utilization rates. When populations transition from FFS to managed care, the potential exists for case mix changes to occur. Beneficiaries who remain in FFS may exhibit very different health characteristics from the pre-shift population, resulting in changes to service utilization rates. In some cases, service utilization rates may rise, if for example, populations that remain in FFS may represent high users.

² Part of the 306,000 included "Working Disabled" individuals who were transitioned into managed care delivery systems (11,382).

³ This figure includes only DHCS-administered services. If services administered by other departments are included, the total rises to \$5.7 billion.

The change in FFS beneficiary case mix, and its result on service utilization, has become increasingly apparent in the analysis of realized access undertaken in the current quarter. As beneficiary subpopulations are moved into managed care plans, fewer adult beneficiaries that remain in the FFS delivery system have health conditions that require services such as Non-Emergency Transportation, Home Health, and Nursing Facility care. Figures ES-4 and ES-5 illustrate this point. For instance, adult FFS beneficiaries in the Aged and Families aid code who utilize services such as Non-Emergency Transportation and Home Health have declined to levels so small that their impact on these services has become inconsequential.

Figure ES-4 Declines in Adult FFS Medi-Cal Only Users of 3 Service Categories

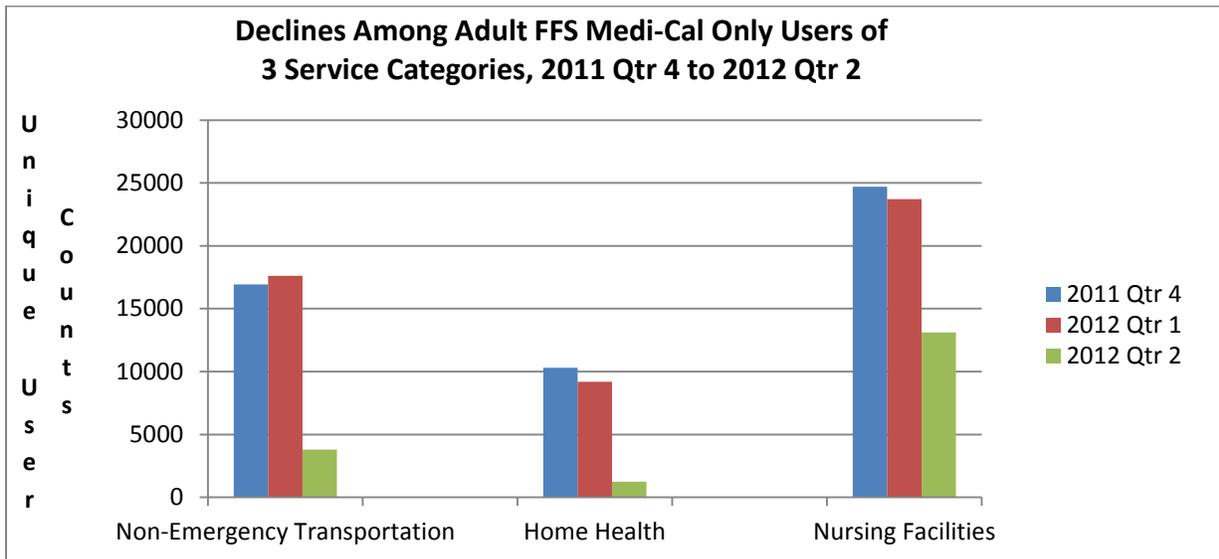
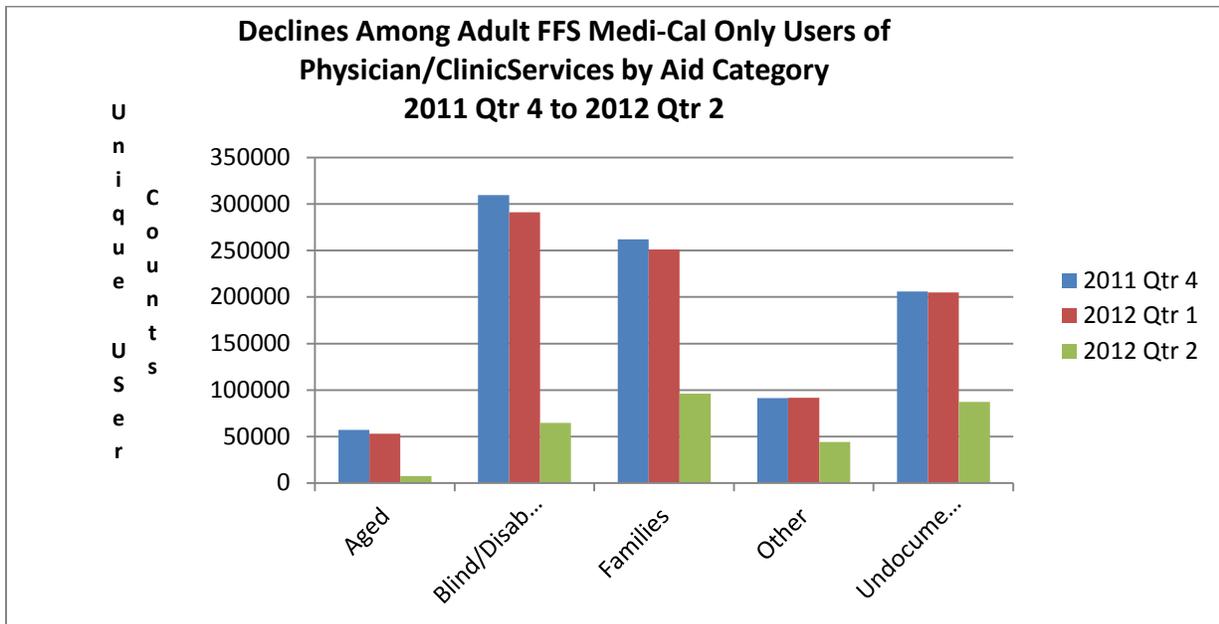


Figure ES-5 Declines in Adult FFS Medi-Cal Only Users of Physician/Clinic Services



As counties are transitioned to managed care delivery systems, the beneficiaries who remain in FFS and the service utilization associated with FFS member months tend to be either those exempted out of managed care participation, those initially eligible for Medi-Cal and not yet established in a plan, or the FFS member months may be associated with months of eligibility occurring during retroactive months of eligibility.⁴

Beneficiaries exempted from managed care participation through the medical exemption process generally exhibit health care needs greater than the norm. As a result, these individuals will generate higher than average service utilization rates. Similarly, beneficiaries new to the Medi-Cal program may use services during their first couple of months of participation at higher rates than the norm. Utilization of services occurring during retroactive months of participation tends to display significantly different patterns than services used during timely enrollment. Services used during the retroactive period are most likely associated with inpatient acute care services. If a particular county shifts from a FFS to managed care delivery system, service utilization associated with the remaining FFS population will exhibit patterns that, in many cases, deviate significantly from the pre-shift FFS population.

An additional consequence of the declining number of beneficiaries participating in the FFS delivery system is the impact it leaves on service utilization rates solely due to the reduction in the denominator. When the denominator, or counts of beneficiaries, declines significantly from one month to the next, service utilization rates may exhibit significant variation or wide swings above and below the "norm."

While participation in the FFS system declined for some beneficiary subpopulations, beneficiaries in other subpopulations increased in number during the second quarter of 2012. Policies affecting the eligibility of foster care youth may explain some of this increase. The California Fostering Connections to Success Act was signed into law September 30, 2010, through Assembly Bill 12. Effective January 1, 2012, the bill allows foster care eligible youth to extend foster care coverage they receive through Medi-Cal beyond age 18 and continue to receive services and supports up to age 21. Children in the Foster Care aid category were one of two populations to increase in FFS participation from the first quarter of 2012 to the second quarter of 2012.

In addition to shifts in participation, Medi-Cal also eliminated optional services that impacted service use rates. Assembly Bill X35 (Chapter 20, Statutes of 2009) added Section 14131.10 of the Welfare and Institutions Code (WIC) to exclude several optional benefit categories from coverage under the Medi-Cal program as of July 1, 2009, including: acupuncture, adult dental, audiology, chiropractic, incontinence creams and washes, optometric and optician services, podiatry, psychology, and speech therapy. These eliminated services were evaluated in this

⁴ Individuals applying for Medi-Cal in a given month may request retroactive coverage for unpaid medical expenses for three months prior to the month of application if the individual was otherwise eligible for Medi-Cal coverage during those three months. (22 CCR 50197 Retroactive Eligibility).

quarterly access report and compared to a baseline level constructed during the initial periods following the enactment of these benefit changes.

The baseline used to establish control limits included the effect of the benefit elimination. The benefits were eliminated in July 2009, while the baseline period included 2007–2009. Because the benefit elimination occurred late in the baseline period, use levels used to establish the baseline were higher than would be anticipated after the elimination. Baseline control limits established during major program changes may not truly reflect the new reality, and may require additional analysis in the future to adjust the mean and control limits.

The measures selected for monitoring health care service use and beneficiary interaction with Medi-Cal's delivery system have proven to be informative. The policy changes noted above all left some type of footprint in the selected measures evaluated.

Findings

Presented below are summary findings for the four measures evaluated in this quarterly access report.

Physician Supply

DHCS evaluated beneficiaries eligible for Medi-Cal only participating in the FFS system with respect to overall physician supply within all 58 counties. The findings indicate that the supply of physicians was adequate.

The beneficiary-to-provider ratios⁵ showed no deterioration in overall physician supply for beneficiaries eligible for Medi-Cal only participating in FFS over the four quarters studied, but did disclose differences among regions of the state. In general, the primarily rural counties using the FFS model reported the lowest physician supply relative to the target population. Counties utilizing the Two-Plan managed care model and having a more urbanized population reported greater physician supply compared to Two-Plan counties in more rural areas. In this respect, physician supply for Medi-Cal beneficiaries mirrored that of the entire state population.

The aggregate number of primary care physicians increased 2.4% from 38,833 to 39,747 during the four quarters studied. This modest expansion in the supply of program physicians occurred at the same time FFS participation among Medi-Cal beneficiaries declined, leading to a greater supply of physicians than was demonstrated in the last report. From the third quarter of 2011 to the second quarter of 2012, the beneficiary-to-primary-care-physician ratios declined from 35.2 to 27.8, or 21.0%. In no case did the beneficiary-to-primary-care-physician ratio exceed commonly referred to provider shortage benchmarks, such as those established by the Health Resources and Services Administration.

Based on the beneficiary population eligible for FFS Medi-Cal only and a panel size of 2,100 patients,⁶ the Medi-Cal program would need a primary care physician supply totaling about 523. With a current supply of Medi-Cal primary care providers at 39,747 and current level of full scope Medi-Cal FFS participation at 1,104,118 enrolled, primary care physicians need only dedicate 1.3% of their practice or each see an estimated 28 Medi-Cal patients to meet the current needs of the program. However, this does not consider specific geographic regions, patient mix, and the concentration of beneficiaries among providers. Nor does it take into consideration that these same providers may also participate in other health networks, including commercial plans. Although it does provide some context for the size of the Medi-Cal potential provider supply relative to population.

During the period under study, physician enrollment for each specialty area (primary care, OB/GYN, pediatrics) increased slightly, leading to favorable beneficiary-to-physician supply

⁵Physician supply was measured as a ratio of the count of beneficiaries to the count of individual physicians at distinct service locations providing specific categories of service. See the Methods section in the Physician Supply report on the [DHCS-RASB website](#).

⁶ Panel size is defined as the number of individual patients under care of a specific provider.

ratios. For example, for non-elderly adult women participating in the Medi-Cal FFS system and entitled to full scope services, the beneficiary-to-OB/GYN-provider ratio improved from 122.3 to 106.0, indicating an increased supply for this provider type. Likewise, the ratio of beneficiary-to-pediatric physicians improved from 64.3 to 57.9 for children eligible for full scope Medi-Cal benefits and participating in the FFS system.

Change in Medi-Cal Participation

The number of beneficiaries eligible for Medi-Cal only, participating in FFS, and entitled to full scope benefits decreased 19.1% overall from the third quarter of 2011 to the second quarter of 2012, reflective of Medi-Cal's continued shift of beneficiaries to managed care.

The greatest decrease from the third quarter of 2011 to the second quarter of 2012 in FFS participation was observed among beneficiaries eligible for full-scope Medi-Cal only benefits, and enrolled in the Aged aid category (74.7%), with adults in Blind/Disabled aid category also significantly decreasing by 62%. The decrease in participation among the Aged and Blind/Disabled subpopulation was expected due to DHCS' initiative aimed at transitioning SPDs into managed care plans.

Though overall participation in the FFS delivery system declined, these declines were not uniform across all regions of the state. In fact, when looking at full scope beneficiaries by county, almost half (23 of 52 counties) of counties experienced a decline in FFS participation of a magnitude 1% or more, while the remaining half either stayed about the same or increased.

Overall, participation in Medi-Cal FFS decreased in both metropolitan and non-metropolitan areas of the state from the third quarter of 2011 to the second quarter of 2012, with metropolitan areas experiencing larger decreases in FFS participation than non-metropolitan areas. However, the declines among FFS participants residing in metropolitan areas was greatest among Aged and Blind/Disabled aid categories, than among these same subpopulations residing in non-metropolitan counties.

Children in Undocumented aid codes residing in non-metropolitan counties also experienced significant declines (11.5%) in participation for the reporting period. Unlike the populations discussed previously, shifts in system participation from FFS to managed care were not responsible for the declines recognized in the undocumented population. Undocumented beneficiaries are generally not eligible to participate in Medi-Cal managed care plans. Rather, declines recognized in the undocumented population were the result of their declining enrollment in the Medi-Cal program overall, a trend that may be explained in part by changing immigration patterns nationwide, declines in birthrates among Mexican immigrants, and the residual effects of the recession.^{7,8}

⁷Passel, Jeffrey, Pew Hispanic Center, "Net Migration from Mexico Falls to Zero-and Perhaps Less," April 23, 2012, <http://www.pewhispanic.org/2012/04/23/net-migration-from-mexico-falls-to-zero-and-perhaps-less/>

⁸Passel, Jeffrey, Pew Hispanic Center, "Unauthorized Immigrants: 11.1 Million in 2011," December 6, 2012, <http://www.pewhispanic.org/2012/12/06/unauthorized-immigrants-11-1-million-in-2011/>

Service Utilization Rates Per 1,000 Member Months for Adult Beneficiaries⁹

Medi-Cal's quarterly access monitoring effort also incorporated measures of service utilization, or realized access. While evaluating physician supply and potential access trends is an integral part of evaluating access, considering what is actually occurring is vitally important in assessing the multifaceted phenomenon called access.

Evaluating FFS service utilization across all Medi-Cal provider types was an integral element of the quarterly monitoring effort. DHCS grouped all provider types into nine unique service categories:

1. Physician/Clinics;
2. Emergency Transportation;
3. Non-Emergency Transportation;
4. Home Health;
5. Hospital Inpatient;
6. Hospital Outpatient;
7. Nursing Facility;
8. Pharmacy; and
9. Other.

DHCS constructed control charts for each service category based on historical service utilization patterns and established the mean value as well as upper and lower bounds. The unit of measurement represents the service utilization rate per 1,000 beneficiaries. For example, Physician/Clinic services are measured in terms of visits per 1,000 beneficiaries, while Pharmacy services are measured in prescriptions per 1,000 beneficiaries. In general, service utilization rates found within the upper and lower bounds were considered within expected ranges.

- As noted in the previous access quarterly report, adults in the Aged and Blind/Disabled aid categories continued to place a greater demand on services such as Emergency and Non-Emergency Transportation, and Nursing Facility services. Although Hospital Inpatient and Home Health service utilization among adults in the Aged and Blind/Disabled aid categories fell below average in previous quarters, utilization rates for these services declined in the second quarter of 2012. Increases in the utilization of Hospital Outpatient and Physician/Clinic services were also reported during the first quarter of 2012, but remained within the expected ranges observed during the baseline period.
- Adults in the Families aid category again displayed below average utilization of Emergency Transportation, Hospital Inpatient, and Physician/Clinic services throughout most of the reporting period. The utilization of these services among younger adults (age <65) in the Families aid category is most likely correlated with continued declines

⁹ Service use for children has been excluded from the Executive Summary but is examined in detail within the Physician Supply report on the [DHCS-RASB website](#).

in the statewide birth rate, particularly for service categories such as Physician/Clinic, Emergency Transportation, and Hospital Inpatient.

- Adults in the Undocumented aid code category, who are only eligible for emergency and pregnancy-related services, also continued to exhibit below average and lower than expected utilization of Emergency Transportation, Physician/Clinic, Hospital Inpatient, and Hospital Outpatient services. This lower service utilization further emphasizes the argument that these utilization patterns may be heavily influenced by the decline in overall births statewide and nationally,¹⁰ which is most noticeable among the immigrant population.¹¹
- The continued decline in Medi-Cal's FFS population, which is a result of the transition of Medi-Cal beneficiaries into managed care plans, has directly reduced the pool of users for particular services. For instance, the number of adults in Aged and Families aid categories that utilize Non-Emergency Transportation and Home Health services have declined to levels (<500) that render their utilization of these service categories inconsequential to the current analysis. The beneficiary subpopulations that continue to utilize these service categories exhibited utilization patterns that are often times above the range of expected values. These shifts in utilization patterns provide further evidence of how markedly the Medi-Cal FFS population case mix has changed since the baseline period of 2007 to 2009.

The findings above were potentially impacted by several changes in Medi-Cal enrollment policies. For example, under the terms of California's Section 1115 "Bridge to Reform" waiver with the Federal government, SPDs were mandatorily enrolled in managed care plans. This means that SPD beneficiaries residing in Two-Plan and GMC counties are now required to enroll into managed care plans, unless a medical exemption is secured or a beneficiary is a member of a group that is exempted. This policy change resulted in a significant alteration in the case mix relative to Medi-Cal's traditional FFS system. Starting in June 2011, all newly eligible SPDs were required to enroll into a managed care plan.

After the initiation of the mandatory enrollment of SPD beneficiaries in Two-Plan and GMC counties, the beneficiaries who remained in Medi-Cal's FFS system were generally those who received a medical exemption or who were members of a group that was exempted from mandatory managed care participation. This influenced service utilization among those remaining in FFS. For example, the SPD beneficiaries remaining in FFS most likely represented beneficiaries who were medically compromised and suffering from severe chronic health conditions. In turn, they represented a group most likely to become long-term care (LTC) service users. In addition, current Medi-Cal managed care policy only places the plan at risk for

¹⁰ Data from the National Vital Statistics System, found at <http://www.cdc.gov/nchs/data/databriefs/db60.pdf>

¹¹ Livingston, G., & Cohn, D. (2012, November 29) U.S. Birth Rate Falls to a Record Low; Decline Is Greatest Among Immigrants. *Pew Research Center: Social & Demographic Trends*.

LTC services for the month of admission plus one additional month. After this timeframe, the beneficiary is enrolled into Medi-Cal's FFS system and LTC services are then reimbursed through the FFS system. During the reporting period, LTC use rates among the SPD or disabled actually increased.

The shift to managed care plans also impacted Home Health services. SPD beneficiaries newly eligible for Medi-Cal are mandatorily enrolled into managed care plans. In most cases, this occurs within 45 days of becoming eligible for Medi-Cal. Therefore, these newly eligible SPDs will most likely not utilize Home Health services during their initial two-month FFS participation. During the reporting period evaluated, the participation shifts from FFS to managed care plans resulted in significant changes in both the numerator (visits or days) and denominator (member months in 1,000s). The newly eligible SPDs added to the denominator, but did not add Home Health service utilization to the numerator. The SPD beneficiaries who remained in Medi-Cal's FFS system (e.g., those medically exempted) were shifting away from Home Health services and towards LTC services, resulting in a decrease in the numerator. These events most likely contributed to the service utilization changes presented (e.g., the increase in LTC service utilization rate and decrease in Home Health service utilization rate).

Table ES-1 presents the results of the analysis of the service utilization trends among adults by aid and service categories. Service utilization trends for children are examined in detail within the Physician Supply report on the [DHCS-RASB website](#), but are excluded from this Executive Summary. The table is color coded to identify those cases when a particular cell, which represents service utilization by aid and service category, generated a service utilization rate that was either lower or higher than the established confidence level. Cells highlighted in beige represent service utilization rates that were found to be within the expected confidence intervals, while those highlighted in green were found to be outside of the expected confidence level at some point during the reporting period. Cells highlighted in light green represent service utilization for specific subpopulations that were outside baseline thresholds at some point during the four quarters evaluated, but reached levels within expected ranges during the final quarter of analysis. In some cases, service utilization rates were found to be greater than expected. As noted above, there are a number of reasons why this might occur, such as changes in population mix.

Table ES-1 Summary of Service Utilization Trends Among Adults by Aid Category and Service Category

| Service Category Aid Category | Physician/ Clinic Visits | Non- Emergency Transportation | Emergency Medical Transportation | Home Health Services | Hospital Inpatient Services | Hospital Outpatient Services | Nursing Facility Services | Pharmacy Services | Other Services |
|----------------------------------|------------------------------------------------------|-------------------------------------|----------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------|
| Aged | Within expected range. | N/A | N/A. | N/A. | Upward trend with 5 consecutive months above expected range. Sharp decline returning to expected range in Jun. | Mostly within expected range. Upward trend (Nov-May). | Upward trend (Jul-May). mostly above expected range. | Downward trend (Aug-Jun). Below expected range in last 2 quarters. | Several non-consecutive months below expected range. |
| Blind / Disabled | Within expected range. | Above expected range. | Levels reaching above expected range in last 2 quarters. | Within expected range, slight upward trend noted. | Upward trend with 2 consecutive months above expected range. Within expected range last month of quarter. | Upward trend (Dec-May). Mostly within expected range. | Upward trend (Jul-May). Mostly above expected range. | Within expected range. | Within expected range. |
| Families | Within expected range. | N/A | Within expected range. | N/A | Several non-consecutive months below expected range. | Mostly within expected range. | N/A | Mostly within expected range. | Mostly within expected range. |
| Other | Within expected range. | Above expected range. | Within expected range. | N/A | 5 consecutive months below expected range. | Within expected range. | Several non-consecutive months below expected range. | Within expected range. | Within expected range. Sharp decline in Jun. |
| Undocu-mented | Several non-consecutive months below expected range. | N/A | Mostly below expected range. | N/A | Below expected range. | Mostly within expected range. | N/A | Within expected range. | Below expected range. |

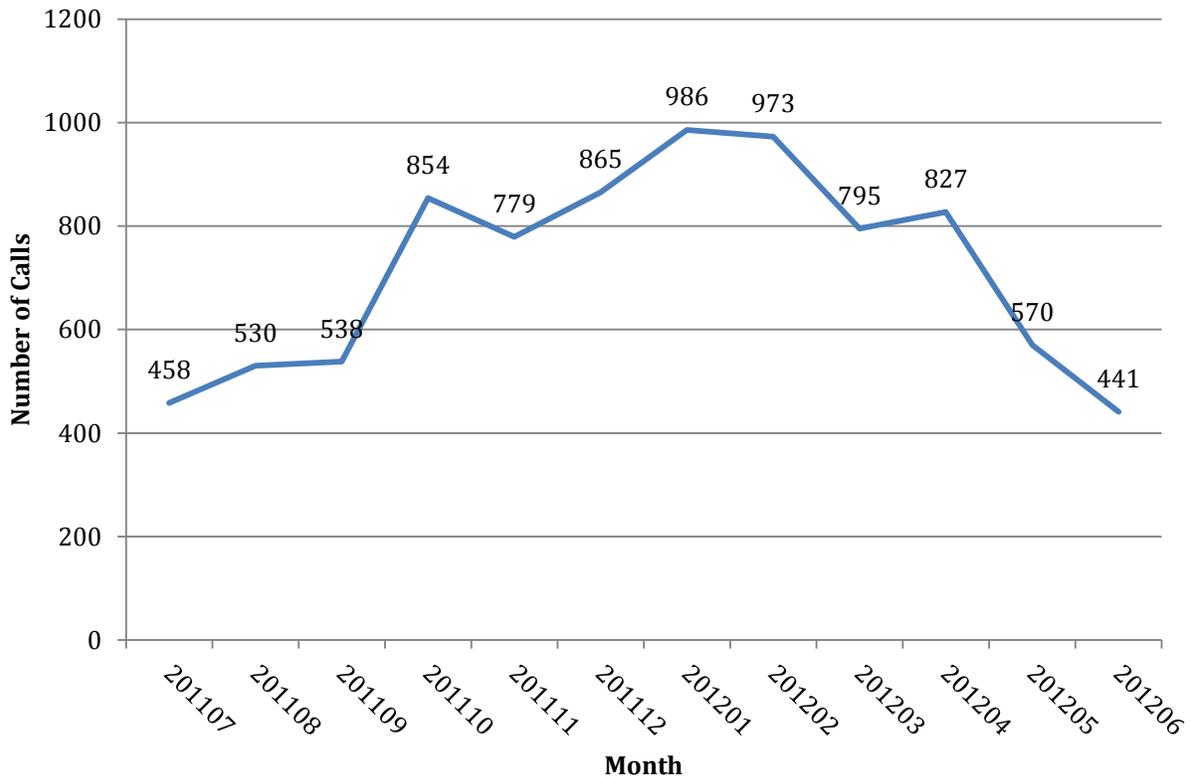
Beneficiary Help Line Calls

The Centers for Medicare and Medicaid Services (CMS) strongly encouraged DHCS to implement a beneficiary help line as part of a comprehensive health care access monitoring plan. The Medi-Cal beneficiary help line was implemented in December 2011 and is similar to the Medi-Cal Managed Care Division's (MMCD) Office of the Ombudsman call center, which 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 provides DHCS with one measure of how well the program is meeting the needs of its FFS beneficiaries and solving problems when they arise.

DHCS continues to rely on data obtained from the Office of the Ombudsman for the purpose of monitoring health care access. From the third quarter of 2011 to the second quarter of 2012, the Office of the Ombudsman call center documented over 8,600 calls from FFS beneficiaries seeking help with various aspects of their enrollment and care. 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.

Figure ES-6 presents the trend in calls made by FFS beneficiaries from July 2011 to June 2012 by month. The most significant increase in call volume occurred between September 2011 and October 2011, with a 59% increase, likely due to the elimination of ADHC services. Even though these benefits were scheduled to end in early 2012, beneficiaries received notices beginning in late August that the ADHC benefit would be eliminated. In Two-Plan and GMC counties, beneficiaries received an enrollment packet informing them they would be enrolled into managed care on October 1. Notices such as these contain the contact information of the Office of the Ombudsman for beneficiaries to obtain assistance and information. This factor most likely contributed to the significant increase in calls received by the Ombudsman call center beginning in October.

Figure ES-6 Calls Received from FFS Beneficiaries by Month, July 2011–June 2012



Source: Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received from FFS beneficiaries from July 2011–June 2012.

The Ombudsman’s Office received an increase in calls from FFS beneficiaries during the last quarter of 2011 and continuing through the first quarter of 2012. This increase in call volume was driven primarily by beneficiaries in the Blind/Disabled and Families aid categories. Some of this increase can be attributed to DHCS initiatives that transitioned the SPD population into managed care plans, while calls from beneficiaries in the Families aid category most often pertain to beneficiaries newly eligible for services and seeking assistance with enrolling into a health plan. In fact, a large proportion of calls received by the Ombudsman’s Office from beneficiaries in these two aid categories pertained to Enrollment/Disenrollment issues. Among Enrollment/Disenrollment, the most common issues cited were requests for new enrollment, medical exemptions, and requests to change plans or disenroll from managed care. Call volume decreased by half during the first two quarters of 2012 and returned to levels seen prior to the implementation of major Medi-Cal policy changes



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Physician Supply

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Table of Contents

Medi-Cal Physician Supply.....3

 Introduction..... 5

 Approaches for Measuring Physician Supply 7

 Relative Benchmarking 7

 Normative Benchmarking..... 7

 Methods 9

 Physician Enrollment Status 9

 Data Source 9

 How Are Physicians Counted?10

 Calculation of the Numerator10

Results–Physician Supply..... 11

 Physician Supply by County and Plan Model Types12

 Ratio of Beneficiaries to All Physicians15

 Ratio of Beneficiaries to Primary Care Physicians.....16

 Ratio of All Non-Elderly, Adult Female Beneficiaries to OB/GYN Physicians.....18

 Ratio of Children to Pediatricians20

 Conclusions—Physician Supply.....22

Appendix: Physician Supply by County.....23

List of Figures

| | |
|---------------------------------------------------------------------------------------|----|
| Figure PS-1 Health Plan Models by County, June 2012 | 13 |
| Figure PS-2 Primary Care Health Provider Shortage Areas, April 2012* | 14 |
| Figure PS-3 Ratios of Beneficiaries to All Physicians, by County, 2012 Quarter 2..... | 15 |

List of Tables

| | | |
|-------------|----------------------------------------------------------------------------------------------------------------|----|
| Table PS-1 | Summary and Description of Physician Supply Tables | 11 |
| Table PS-2 | Physician Supply, All Enrolled Physician Sites, FFS, Medi-Cal Only | 15 |
| Table PS-3 | Physician Supply, All Enrolled Physician Sites, All Medi-Cal Only Beneficiaries..... | 14 |
| Table PS-4 | Primary Care Physicians, All Enrolled Physician Sites, FFS, Full Scope, Medi-Cal Only | 16 |
| Table PS-5 | Physician Supply, Physicians with an OB/GYN Specialty, FFS, Medi-Cal Only, Non-Elderly Adult Females | 18 |
| Table PS-6 | Physician Supply, Physicians with a Pediatric Specialty, FFS, Full Scope, Medi-Cal Only Children..... | 20 |
| Table PS-7 | Physician Supply, All Enrolled Physicians, FFS Medi-Cal Only Beneficiaries | 23 |
| Table PS-8 | Physician Supply, All Enrolled Physicians, All Medi-Cal Only Beneficiaries | 26 |
| Table PS-9 | Primary Care Physician Supply, All Enrolled Physicians, FFS, Full Scope, Medi-Cal Only Beneficiaries | 29 |
| Table PS-10 | Physician Supply, Physicians with an OB/GYN Specialty, FFS, Medi-Cal Only, Non-Elderly, Adult Females | 32 |
| Table PS-11 | Physician Supply, Physicians with a Pediatric Specialty, FFS, Full Scope, Medi-Cal Only Children..... | 35 |
| Table PS-12 | Outpatient Clinics | 38 |

Medi-Cal Physician Supply

Introduction

Physician availability is an important first step in accessing health care, increasing the likelihood that patients receive preventive services and timely referrals to needed care. Studies have reported that a higher supply of primary care physicians is associated with lower mortality rates, longer life expectancy, and better birth outcomes. Physicians have consequently been described as the epicenter of health care delivery, providing patients with a gateway into the health system and affecting how 90% of all health care dollars are spent.

Physician supply provides a measure of the number of physicians who are “potential” care providers, but does not represent the number of providers who are actively rendering care. Evaluating physician supply is designed to provide decision makers with a sense of whether Medi-Cal’s network of physicians is decreasing, increasing, or remaining stable over time. In addition, a system’s provider supply can also be evaluated by geographic region, allowing those charged with maintaining an adequate network to assess differences throughout the state. Significant changes in the supply of physicians combined with other information may provide insight into various aspects of health care access. Long-term trends may help decision makers evaluate policies that may be inhibiting physician supply.

Readers should be aware that “physician supply” does not represent, in and of itself, a metric that can be used to assess the adequacy of health care access. Rather, it must be combined with an assessment of other access-related metrics to derive a holistic view of access.

The beneficiary-to-provider ratios report the number of beneficiaries enrolled under the FFS delivery of care model who have Medi-Cal only coverage for every provider. A low ratio indicates that there are a greater number of providers relative to the population, while a high ratio indicates that there are fewer providers relative to the population. Beneficiary-to-provider ratios are useful for identifying differences in physician supply from one geographic area to another, from one measurement period to another, or between the study population and another population or normative benchmark.

Highlights

Physician supply should not be used as the sole metric in assessing the adequacy of health care access; rather it must be combined with other access-related metrics to derive a holistic view of access.

Overall findings indicate that the statewide supply of physicians potentially available to beneficiaries eligible for full scope Med-Cal only and participating in FFS was more than adequate.

Site-specific physician counts increased from 107,332 to 109,854, or 2.3%.

Primary care physician enrollment increased 2.4%, from 38,833 to 39,747.

OB/GYN physician enrollment increased 2.2%, from 6,422 to 6,563.

Pediatrician enrollment increased 2.3%, from 10,921 to 11,168.

$$\text{Ratio} = \frac{\text{Beneficiaries (Numerator)}}{\text{Providers (Denominator)}}$$

The counts of physicians in this report represent **physician supply**, or the number of physicians **potentially** available to provide services to Medi-Cal beneficiaries. The term physician supply is not to be confused with the concept of **physician participation**. The concept of physician supply is *prospective*. It is a measure that reports the number of physicians who enrolled and were potentially available to provide services. The concept of physician participation is *retrospective*. It reports the number of physicians who actually provided or rendered services to Medi-Cal beneficiaries as measured from paid claims data.

Approaches for Measuring Physician Supply

There are three complementary methodologies available for evaluating the adequacy of physician supply. These include relative benchmarking, normative benchmarking, and economic analysis of the physician labor market.¹

Relative Benchmarking

Relative benchmarking compares the ratio of certain types of providers to the population in the geographic area of interest to other geographic areas.

Normative Benchmarking

Another approach towards evaluating adequacy of physician supply is normative benchmarking which compares a pre-determined desired ratio of beneficiaries to physician against the actual ratio measured. The Health Professional Shortage Areas (HPSA)² population-to-primary-care-physician ratio of 3,500:1 as a benchmark for “high need” is an example of a normative ratio. Of course, such ratios vary by provider type and demand for services by each specialty. For example, the number of visits to pediatricians or family practice physicians per thousand members is likely to be greater than the number of visits to dermatologists or ophthalmologists.

A variation of the normative benchmark is physician “panel” size. Panel size is simply defined as the number of individual patients under the care of a specific physician; in other words, panel size is the number of patients for which each physician can realistically be accountable. While the maximum panel size is typically defined as 2,000-2,500 patients per physician, there are limitations to using panel size as a normative benchmark. For example, some physicians may have other physicians or physician extenders (Physician Assistants and Nurse Practitioners) available at their location, giving them the potential to manage a larger panel size. Physicians may also contract with a commercial health plan, Medicare, and Medi-Cal. In these cases, Medi-Cal will only assess the panel size relative to the Medi-Cal patient load and cannot assess the patient load associated with the commercial health plan, Medicare, or any other potential buyer. Physicians who are at the location may not be full-time-equivalent (FTE) clinical providers, but may devote a portion of their time spent on non-appointment or nonclinical duties such as hospital rounds, operating room duties, procedures, management duties, and meeting time. Another consideration in determining panel size is the health status of patients seen by the physician. A panel of 2,000 elderly patients represents a much different workload than 2,000 patients in their 20s and 30s. Patients who suffer from complex health conditions and multiple comorbidities may garner greater resources.

¹ Janet Coffman, Brian Quinn, Timothy T. Brown, Richard Scheffler, “Is There a Doctor in the House? An Examination of the Physician Workforce in California over the Past 25 Years”, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare at the University of California, Berkeley 2004

² *As defined by the Public Health Service Act, Health professional(s) shortage area* means any of the following which the Secretary determines has a shortage of health professional(s): (1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility. For additional information concerning HPSAs please refer to the Health Resources and Services Administration website at <http://bhpr.hrsa.gov/shortage/>

Beneficiary-to-provider ratios evaluated strictly in terms of absolute numbers may also fail to take into account unique cultural characteristics of beneficiaries that may limit the actual number of suitable providers. For example, the communication between physicians and patients, which is essential for the effective delivery of treatment, may require that the physician or a member of his team be fluent in a foreign language, or be familiar with unique social dynamics or environmental issues that may impact health in a particular community.

Economic Analysis

The third approach towards evaluating physician supply adequacy is through analysis of the provider “market,” and the impact of reimbursement rates and compensation, as various health care organizations compete for the limited supply of physician services by offering higher payments. However, as our previous discussion on participation by different types of providers illustrates, not all share the same sensitivity, or elasticity, to price. Some physicians are able to accommodate a greater number of Medi-Cal beneficiaries as a percentage of their overall practice than others. As noted by Peter J. Cunningham and Len M. Nichols in *The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective*: “Although high fee levels increase the probability that individual physicians will accept Medicaid patients, high fee levels do not necessarily lead to high levels of physician Medicaid acceptance in an area. Numerous other physician practice, health system, and community characteristics also affect Medicaid acceptance. The effects of Medicaid fees on Medicaid acceptance are substantially lower in areas with high Medicaid managed care penetration and for physicians who practice in institutional settings. The results suggest that a broad range of factors need to be considered to increase access to physicians for Medicaid enrollees.”³

Many provider market analyses seek to build in estimates based on future events to determine whether physician shortages may occur in the years ahead. These analyses look at such variables as the number of medical school graduates choosing specialty medicine over primary care, the attractiveness of medicine as a profession and number of future physicians overall, the aging of the population that will need to access services, and the growth of the economy.⁴ The impact of the Affordable Care Act and the resulting expansion of the population with health care coverage is a recent addition to this list.

³ Peter J. Cunningham, Len M. Nichols, “The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective,” Center for Studying Health System Change, December 2005.

⁴ David Blumenthal, “New Steam from an Old Cauldron—The Physician-Supply Debate,” *New England Journal of Medicine*, April 22, 2004

Methods

Physician Enrollment Status

The numbers of physicians reported and reflected in the beneficiary-to-provider ratios are those physicians who have gone through the Medi-Cal provider application and enrollment process⁵ and who have a current “Active” (Billing) or “Indirect” (Rendering) enrollment status for the period reported. Physicians with an “Active” status directly bill Medi-Cal. Physicians with an “Indirect/Rendering” status render services on behalf of a medical group or clinic that bills for the services rendered.

Physicians who want to treat Medi-Cal beneficiaries must apply for a Medi-Cal provider number. Applications are reviewed and processed in accordance with Medi-Cal provider enrollment statutes. The review of a physician’s application package is a complex process that requires assessment of many elements of the application, including a review of the required supporting documentation, to determine eligibility for enrollment into the Medi-Cal program. DHCS may conduct a background check of an applicant for the purpose of verifying information. This background check may include an unannounced onsite inspection, a review of business records, and data searches to ensure that the applicant or provider meets enrollment criteria.^{6,7}

Data Source

The Medi-Cal Provider Master Enrollment File (PMF) was used as the primary data source for measuring physician supply. Physicians were identified in the PMF as providers with a provider type of “026” (physician). Primary care physicians were identified using the primary care indicator on the PMF and selecting from a narrow range of specialty areas: General Medicine, Family Practice, Gynecology, Obstetrics, Geriatrics, Internal Medicine, Pediatrics, and Clinics with mixed specialties.

Quarterly counts are presented in this report, based on the first month of each quarter. Only physicians enrolled and coded with a valid California county were included. The PMF presents providers in one of these enrollment statuses: 1-Active, 2-InActive, 3-Pending, 4-Deceased, 5-Rejected, 6-Suspended, 7-Indirect/Rendering, or 9-Temp Suspension. This report presents only counts of physicians that have a current “Active” (Billing) or “Indirect” (Rendering) enrollment status for the period reported.

⁵ “Provider Enrollment Regulations, California Code of Regulations, Title 22, Division 3; URL: https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/05enrollment_regulations.pdf

⁶ “Medi-Cal Provider Enrollment, Frequently Asked Questions,” URL: <http://www.dhcs.ca.gov/provgovpart/Pages/PEDFrequentlyAskedQuestions.aspx>

⁷ Medi-Cal Provider Agreement; URL: http://files.medi-cal.ca.gov/pubsdoco/provappsenroll/02enrollment_DHCS6208.pdf

How Are Physicians Counted?

There are various ways to count physicians, each of which produces different totals. Physicians can be counted as the:

- Number of distinct individual physicians or physician groups;
- Number of physicians at distinct service locations; and
- Number of physicians at distinct service locations providing specific categories of service.

Some physicians may practice at multiple sites or locations. For the purpose of evaluating beneficiary access to care using beneficiary-to-provider ratios, the last method is most appropriate, since geographic accessibility and appropriateness of care are two major elements of access. The reporting unit for physicians in this report is the unique combination of the physician provider ID, physician location identifier, and physician type. For individual physicians, the provider ID number is their license number as reported to the Medical Board of California. All other providers, including physician groups, are traced back to their original provider number, usually to one that pre-dates the onset of the National Provider ID (NPI).

This method is necessary in order to avoid double-counting physicians who have successfully applied for multiple NPI's, a common occurrence that has a cumulative effect over time.

However, counting distinct physicians in combination with their location may overstate physician supply in some cases. For example, if a physician practices in one office location two days per week, and another office location the remainder of the week, but both offices are located within Sacramento County, the physician will be represented as two full-time equivalent physicians in the tables presented in this report. This scenario only modestly inflates overall as well as county-specific Medi-Cal physician supply in this report by a magnitude of roughly 400 physicians per quarter, or <1% of total physician counts.

Calculation of the Numerator

The numerator for the beneficiary-to-provider ratios is the population of Medi-Cal beneficiaries eligible for Medi-Cal only and participating in Medi-Cal's FFS delivery of care model. Beneficiaries dually eligible for both Medicare and Medicaid benefits are excluded from the numerator for this analysis.

The reader should be aware that the population eligible for Medi-Cal only and participating in the FFS system is not static, and shifts of the population from FFS to managed care delivery systems may be responsible for differences or changes in beneficiary-to-provider ratios between different counties or different periods of measurement. For this reason, both the number of physicians and the ratios are displayed.

Results–Physician Supply

The following tables report the number of physicians, primary care physicians, and other physician specialists, as well as beneficiaries (population)-to-provider ratios. The tables cover four consecutive quarters from the third quarter of 2011 to the second quarter of 2012 and indicate the magnitude of change over this period

You can view county-level details in tables PS-7 to PS-11 in the [Appendix](#).

Table PS-1 Summary and Description of Physician Supply Tables

| | Denominator | Numerator |
|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| Table 2 | All Enrolled Physicians with an Active or Indirect status at a given location. Includes both Primary Care and Specialty physicians. | Beneficiaries entitled to full scope services, covered by Medi-Cal only, and participating in FFS. |
| Table 3 | All Enrolled Physicians with an Active or Indirect status at a given location. Includes both Primary Care and Specialty physicians. | Beneficiaries entitled to full scope services, covered by Medi-Cal only, and participating in either FFS or Managed Care. |
| Table 4 | All Enrolled Primary Care Physicians with an Active or Indirect status at a given location. Primary Care Physicians include those with specialties listed as General Medicine, Family Practice, Gynecology, Obstetrics, Geriatrics, Internal Medicine, Pediatrics, and Clinics with mixed specialties. | Beneficiaries entitled to full scope services, covered by Medi-Cal only, and participating in FFS. |
| Table 5 | All Physicians with an OB/GYN Specialty and an Active or Indirect status at a given location. | Non-elderly, adult women , covered by Medi-Cal only, and participating in FFS. |
| Table 6 | All Physicians with a Pediatrics Specialty and an Active or Indirect status at a given location. | Children entitled to full scope services, covered by Medi-Cal only, and participating in FFS. |

Physician Supply by County and Plan Model Types

DHCS calculated site-specific physician counts and beneficiary-to-provider ratios, both by county and by plan model type, in order to detect changes over the four quarters and to discern differences between counties and between plan model types. Plan model type is determined by county of enrollment. Figure PS-1 shows the distribution of plan model types by county.

As summarized above, these tables present beneficiary-to-provider ratios for those eligible for Medi-Cal only and participating in the FFS system. Tables PS-2 and PS-3 include site-specific counts of all enrolled physicians identified in the Provider Master File. Tables PS-4, PS-5, and PS-6 include only those physicians identified in the Provider Master File with a given specialty area.

DHCS also aggregates the count of physicians and ratios for each of the four county plan model types used by Medi-Cal. Differences in the ratios for the four models reflect differences in both beneficiaries and physicians. The COHS counties, where health plan enrollment is mandatory for all beneficiaries but the Undocumented, have the smallest FFS populations and therefore the lowest FFS-beneficiary-to-provider ratios. The Two Plan and GMC counties that include both managed care and FFS populations have higher ratios of FFS-beneficiaries-to-provider than the COHS counties, but significantly lower than the 28 primarily rural counties utilizing the FFS model that had the highest ratios of beneficiaries to provider. These trends remain unchanged from the previous report.

However, the higher beneficiaries-to-provider ratios in the 28 primarily rural FFS counties appeared to not only reflect a greater number of beneficiaries relative to physicians, but also fewer physicians overall. This finding is consistent with other research and survey data that has reported rural areas are also frequently health provider shortage areas. Figure PS-2 displays the location of areas designated as primary care health provider shortage areas.

Figure PS-1 Health Plan Models by County, June 2012

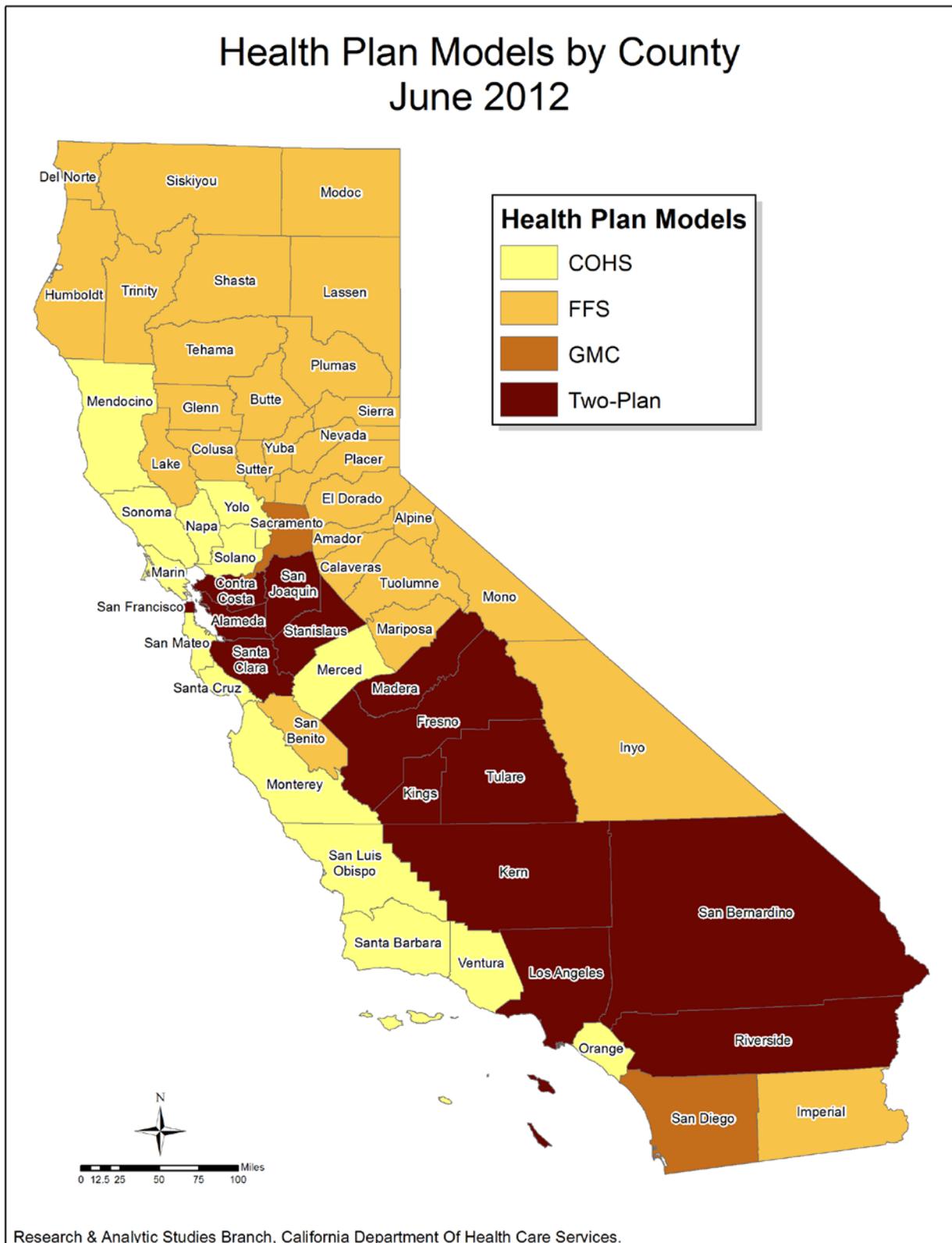
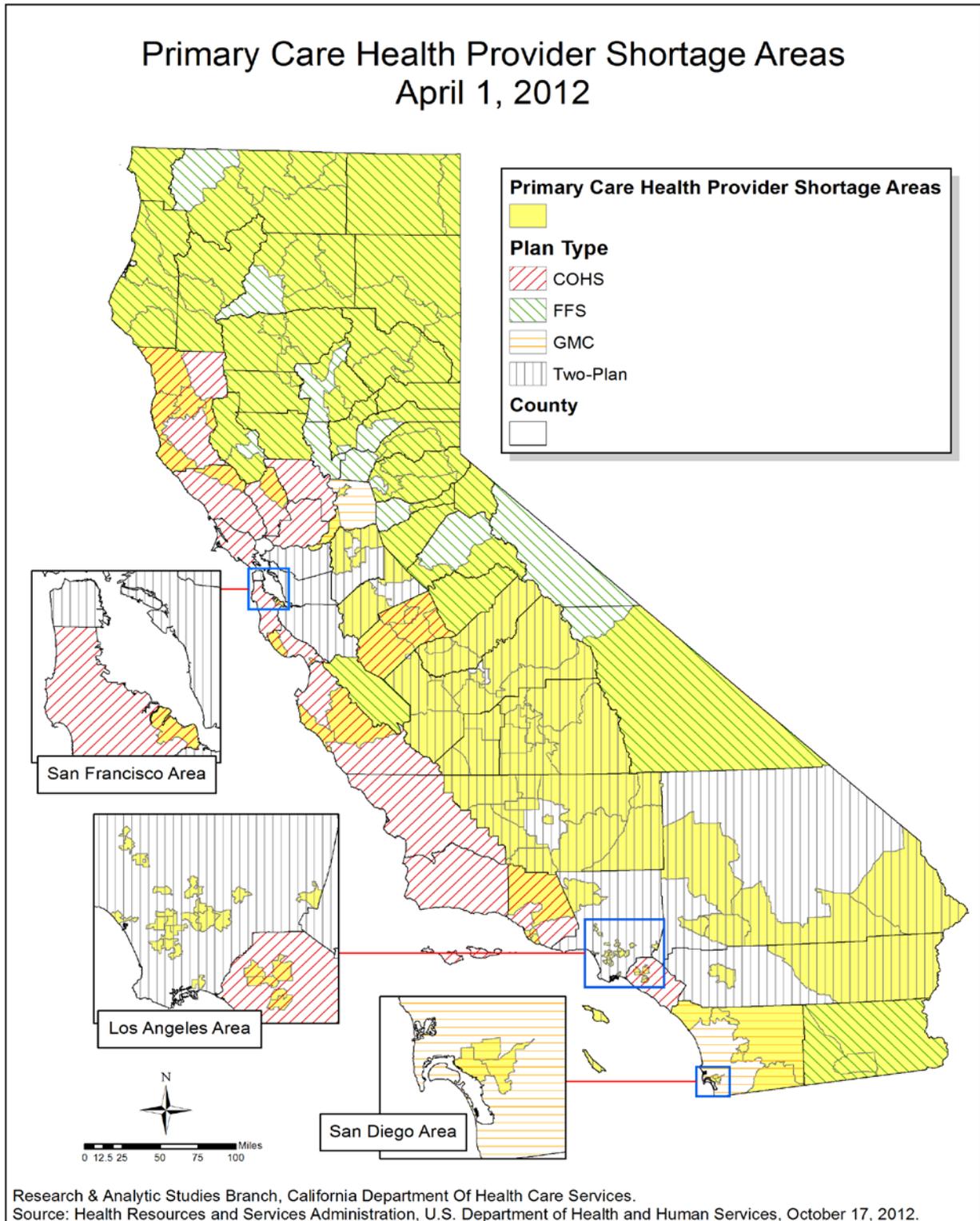


Figure PS-2 Primary Care Health Provider Shortage Areas, April 2012 *



*Data identifying health provider shortage areas are from the Health Resources and Services Administration as of April 2012.

Ratio of Beneficiaries to All Physicians

Table PS-2 presents site-specific counts of all enrolled physicians and the ratios of full scope FFS Medi-Cal only beneficiaries to all enrolled physicians by county plan model type. Site-specific physician counts statewide increased from 107,332 to 109,854, or 2.3%.

Average counts for counties over the four quarters ranged from as few as two in Alpine County and fewer than 20 in four other counties, to as high as 30,059 in Los Angeles County (see Table PS-7 in the [Appendix](#) for county level detail). Glenn County had the highest average ratio of beneficiaries to provider (247) and San Mateo County had the lowest ratio, averaging only 0.8. Imperial County was the only other county with over 201.2 beneficiaries per provider.

Statewide and plan type beneficiary-to-provider ratios improved for the study period. The statewide ratio improved by 20.5% and three of the plan type ratios improved, from 2.9% for FFS counties up to 28.1% for Two-Plan counties. However, the ratio for COHS counties increased by 4.3% (2.3 to 2.4).

Table PS-2 Physician Supply, All Enrolled Physician Sites, FFS, Medi-Cal Only

| | Site-Specific Physician Counts | | | | | Beneficiaries-to-Provider Ratio | | | | |
|-------------------------------------------------|--------------------------------|------------|------------|------------|--------------------------------|---------------------------------|------------|------------|------------|--------------------------------|
| | 2011 Qtr 3 | 2011 Qtr 4 | 2012 Qtr 1 | 2012 Qtr 2 | % Change 2011 Qtr 3–2012 Qtr 2 | 2011 Qtr 3 | 2011 Qtr 4 | 2012 Qtr 1 | 2012 Qtr 2 | % Change 2011 Qtr 3–2012 Qtr 2 |
| Statewide | 107,332 | 108,057 | 109,049 | 109,854 | 2.3% | 12.7 | 11.6 | 10.6 | 10.1 | -20.5% |
| County Plan Model Type | | | | | | | | | | |
| County Organized Health System (COHS) | 20,560 | 20,670 | 20,824 | 20,981 | 2.0% | 2.3 | 2.0 | 2.0 | 2.4 | 4.3% |
| Fee-for-Service (FFS) | 4,100 | 4,132 | 4,143 | 4,172 | 1.8% | 76.3 | 74.9 | 74.6 | 74.1 | -2.9% |
| Geographic Managed Care (GMC) | 15,976 | 16,108 | 16,252 | 16,353 | 2.4% | 9.4 | 8.6 | 7.7 | 7.0 | -25.5% |
| Two-Plan (Commercial Plan and Local Initiative) | 66,696 | 67,147 | 67,830 | 68,348 | 2.5% | 12.8 | 11.4 | 10.1 | 9.2 | -28.1% |

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag) and counts of physicians with Active and Indirect enrollment status from the Medi-Cal Provider Master File, for the months of August 2011, October 2011, January 2012, and April 2012.

Statewide and plan type beneficiary-to-provider ratios showed improvement for the study period. The statewide ratio decreased by 20.5% and three of the plan type ratios decreased, from 2.9% for FFS counties up to 28.1% for Two-Plan counties. The ratio for COHS counties increased by 4.3% (2.3 to 2.4).

Counties were more variable. In 39 counties, the beneficiary-to-provider ratios improved, from 0.1% for Trinity County to 45.7% for San Francisco County. Eighteen counties experienced some increase in their ratios ranging from 0.1% for Calaveras County to 33.3% for Solano County. Nine of these counties had a 10% or greater increase in their ratios. All but one were COHS counties. In absolute numbers, with the exception of Alpine County, whose ratio

increased from 76.0 to 84.5, the actual changes in the ratios from the beginning to the end of the study period range from 0.1 to 1.1. These eight counties have some of the lowest average beneficiary-to-provider ratios in the state, ranging from 0.8 for Marin County to 6.7 for Merced County. Santa Barbara County is the only county that did not change during the four quarters. Figure PS-3 illustrates the overall beneficiary-to-physician ratios by county.

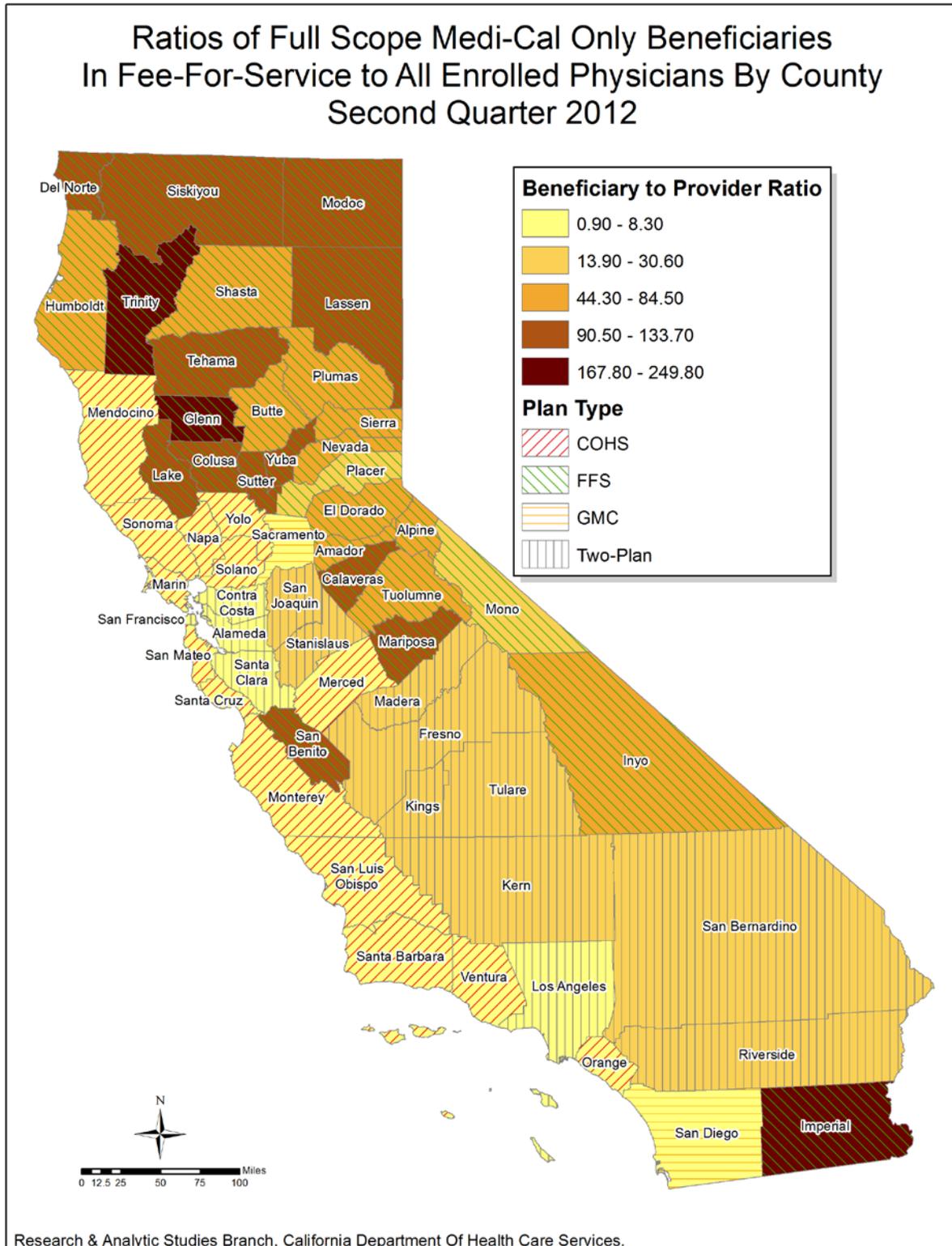
A version of Table PS-2 that includes full scope Managed Care beneficiaries is presented in Table PS-3 (See Table PS-8 in the [Appendix](#) for county level detail). This table is included for comparison purposes only, since network adequacy for beneficiaries enrolled in Managed Care health plans is governed by separate statutory and contractual requirements, and enforced and monitored by Medi-Cal's Managed Care Division.

Table PS-3 Physician Supply, All Enrolled Physician Sites, All Medi-Cal Only Beneficiaries

| | Site-Specific Physician Counts | | | | | Beneficiaries-to-Provider Ratio | | | | |
|-------------------------------------------------|--------------------------------|------------|------------|------------|--------------------------------|---------------------------------|------------|------------|------------|--------------------------------|
| | 2011 Qtr 3 | 2011 Qtr 4 | 2012 Qtr 1 | 2012 Qtr 2 | % Change 2011 Qtr 3–2012 Qtr 2 | 2011 Qtr 3 | 2011 Qtr 4 | 2012 Qtr 1 | 2012 Qtr 2 | % Change 2011 Qtr 3–2012 Qtr 2 |
| Statewide | 107,332 | 108,057 | 109,049 | 109,854 | 2.3% | 52.6 | 52.1 | 51.6 | 51.4 | -2.3% |
| County Plan Model Type | | | | | | | | | | |
| County Organized Health System (COHS) | 20,560 | 20,670 | 20,824 | 20,981 | 2.0% | 42.5 | 42.1 | 42.0 | 41.9 | -1.4% |
| Fee-for-Service (FFS) | 4,100 | 4,132 | 4,143 | 4,172 | 1.8% | 76.7 | 75.4 | 75.1 | 74.6 | -2.7% |
| Geographic Managed Care (GMC) | 15,976 | 16,108 | 16,252 | 16,353 | 2.4% | 37.3 | 37.1 | 36.7 | 36.6 | -1.9% |
| Two-Plan (Commercial Plan and Local Initiative) | 66,696 | 67,147 | 67,830 | 68,348 | 2.5% | 57.9 | 57.3 | 56.7 | 56.4 | -2.6% |

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag) and counts of physicians with Active and Indirect enrollment status from the Medi-Cal Provider Master File, for the months of August 2011, October 2011, January 2012, and April 2012.

Figure PS-3 Ratios of Beneficiaries to All Physicians, by County, 2012 Quarter 2



Ratio of Beneficiaries to Primary Care Physicians

Table PS-4 includes the counts of all enrolled primary care physicians, and the ratios of full scope Medi-Cal only beneficiaries to all enrolled primary care physicians by county and county plan model type.

Statewide, primary care physician enrollment showed some improvement from the third quarter of 2011 to the second quarter of 2012, increasing 2.4% from 38,833 to 39,747.

Average counts ranged from one in Alpine County to fewer than ten in Sierra, Trinity, and Glenn Counties (All such counties are primarily rural with small populations and offer only the FFS plan model), to Los Angeles County with 11,433.3 primary care providers (see Table PS-9 in [Appendix](#) for county level detail). It is important to note that although there are counties with few or no registered primary care physicians, Federally Qualified Health Clinics (FQHC), Rural Health Clinics (RHC), and other clinics are able to provide primary care services in these communities. Table PS-12 in the [Appendix](#) displays the total number of clinics by county available to serve Medi-Cal beneficiaries

The beneficiary-to-primary-care-physician ratio improved statewide by 21.0% during the study period, while the ratios for COHS counties increased by 4.7% (6.4 to 6.7).

Table PS-4 Primary Care Physicians, All Enrolled Physician Sites, FFS, Full Scope, Medi-Cal Only

| | Number of Providers | | | | | Population-to-Provider Ratio | | | | |
|-------------------------------------------------|---------------------|------------|------------|------------|----------------------------|------------------------------|------------|------------|------------|-------------------|
| | 2011 Qtr 3 | 2011 Qtr 4 | 2012 Qtr 1 | 2012 Qtr 2 | % Change In # of Providers | 2011 Qtr 3 | 2011 Qtr 4 | 2012 Qtr 1 | 2012 Qtr 2 | % Change in Ratio |
| Statewide | 38,833 | 39,068 | 39,426 | 39,747 | 2.4% | 35.2 | 32.1 | 29.4 | 27.8 | -21.0% |
| County Plan Model Type | | | | | | | | | | |
| County Organized Health System (COHS) | 7,315 | 7,369 | 7,425 | 7,503 | 2.6% | 6.4 | 5.7 | 5.5 | 6.7 | 4.7% |
| Fee-for-Service (FFS) | 1,744 | 1,758 | 1,759 | 1,772 | 1.6% | 179.3 | 176.1 | 175.8 | 174.5 | -2.7% |
| Geographic Managed Care (GMC) | 5,418 | 5,458 | 5,494 | 5,531 | 2.1% | 27.8 | 25.3 | 22.7 | 20.8 | -25.2% |
| Two-Plan (Commercial Plan and Local Initiative) | 24,356 | 24,483 | 24,748 | 24,941 | 2.4% | 35.1 | 31.1 | 27.6 | 25.2 | -28.2% |

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag) and counts of primary care physicians with Active and Indirect enrollment status from the Medi-Cal Provider Master File, for the months of August 2011, October 2011, January 2012, and April 2012.

Note: This table was updated using new methodology as outlined in the 2012 Quarter 4 report.

The beneficiary-to-primary-care-physician ratio experienced an overall improvement statewide by 21.0% during the study period. The ratios for COHS counties increased by 4.7% (6.4 to 6.7) and declined from 2.7% for FFS counties to 28.2% for Two-Plan counties.

The change in county level beneficiary-to-primary-care-physician ratios across the four quarters showed improvement for 38 counties, ranging from 0.3% for El Dorado County to 46.9% for

San Francisco County. Sixteen counties showed some increase in their ratios, ranging from 0.1% for Calaveras County to 32.4% for Solano County. Eight of these counties, seven COHS and one FFS, had increases greater than 10%. With the exception of Alpine County the actual changes in the ratios for these eight counties are relatively small, ranging from 0.3 for Marin County to 2.2 for Merced County. Alpine showed an increase of 17 patients per provider over the four quarters. As was seen with the beneficiary-to-physician ratios, the actual changes in the ratios for these eight counties are relatively small, ranging from 0.5 for Marin County to 6.1 for Merced County. These counties, with the exception of Alpine County, also have among the lowest ratios in the state. Alpine County has only one registered primary care provider.

Ratio of All Non-Elderly, Adult Female Beneficiaries to OB/GYN Physicians

Table PS-5 presents site-specific counts of all enrolled OB/GYN physicians and the ratios of all female full scope and limited scope beneficiaries between ages 18–64 to OB/GYN physicians.

Statewide, OB/GYN physicians increased 2.2%, from 6,422 to 6,563 during the study period.

Los Angeles County had an average of 1,802.5 OB/GYNs enrolled in Medi-Cal (see Table PS-10 in the [Appendix](#) for county level detail). However, 21 counties had ten or fewer and four counties had no physicians with an OB\GYN designation. All such counties are primarily rural with small populations and offer only the FFS plan model. Such low physician counts result in widely varying (and sometimes nonexistent) beneficiary-to-provider ratios by county. These counties have little or no OB/GYN physician presence according to California's Medical Board physician counts.

Beneficiary-to-OB/GYN-physician ratios improved statewide by 13.3%. Ratios for three of the plan types improved from 2.8% for FFS counties to 22.7% for GMC counties. COHS counties showed no change across the four quarters.

Table PS-5 Physician Supply, Physicians with an OB/GYN Specialty, FFS, Medi-Cal Only, Non-Elderly Adult Females

| | Site-Specific Physician Counts | | | | | Beneficiaries-to-Provider Ratio | | | | |
|-------------------------------------------------|--------------------------------|------------|------------|------------|--------------------------------|---------------------------------|------------|------------|------------|--------------------------------|
| | 2011 Qtr 3 | 2011 Qtr 4 | 2012 Qtr 1 | 2012 Qtr 2 | % Change 2011 Qtr 3–2012 Qtr 2 | 2011 Qtr 3 | 2011 Qtr 4 | 2012 Qtr 1 | 2012 Qtr 2 | % Change 2011 Qtr 3–2012 Qtr 2 |
| Statewide | 6,422 | 6,456 | 6,524 | 6,563 | 2.3% | 122.3 | 115.3 | 109.5 | 106.0 | -13.3% |
| County Plan Model Type | | | | | | | | | | |
| County Organized Health System (COHS) | 1,341 | 1,341 | 1,357 | 1,366 | 1.9% | 70.2 | 68.8 | 68.6 | 70.2 | -0.0% |
| Fee-for-Service (FFS) | 230 | 232 | 232 | 233 | 1.3% | 409.9 | 401.6 | 401.3 | 398.6 | -2.8% |
| Geographic Managed Care (GMC) | 810 | 817 | 822 | 825 | 1.9% | 81.5 | 73.9 | 67.2 | 63.0 | -22.7% |
| Two-Plan (Commercial Plan and Local Initiative) | 4,041 | 4,066 | 4,113 | 4,139 | 2.4% | 131.4 | 122.6 | 115.0 | 109.9 | -16.4% |

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag) and counts of OB/GYN physicians with Active and Indirect enrollment status from the Medi-Cal Provider Master File, for the months of August 2011, October 2011, January 2012, and April 2012.

The average beneficiary-to-OB/GYN-physician ratios for the study period ranged from 29.4 for San Francisco County to 1,656.0 for Calaveras County. Six counties had ratios over 1,000. The ratios of Alpine, Mariposa, Sierra, and Trinity Counties could not be calculated because there were no registered OB/GYN physicians. This does not necessarily mean that beneficiaries do not have access to gynecological health care services. Federally Qualified Health Clinics (FQHC), Rural Health Clinics (RHC), other clinics, and general care physicians with a specialty other than

OB/GYN may provide OB/GYN services to beneficiaries residing in these communities. Table PS-12 in the [Appendix](#) displays the total number of clinics by county available to serve Medi-Cal beneficiaries.

Beneficiary-to-OB/GYN-physician ratios improved statewide by 13.3%. Ratios for three of the plan types improved from 2.8% for FFS counties to 22.7% for GMC counties. COHS counties showed no change across the four quarters.

At the county level, 39 counties showed declines in their ratios, spanning from a low of 0.1% for Sutter County to a high of 26.8% for San Francisco County. Fifteen counties showed increases in their ratios, from 0.3% for Colusa County to 10.4% for Mono County. Alpine, Mariposa, Sierra, and Trinity Counties had no physicians registered in the OB/GYN specialty area.

Ratio of Children to Pediatricians

Table PS-6 includes site-specific counts of all enrolled pediatric physicians and the ratios of full scope children under age 18 and eligible for Medi-Cal only to all enrolled pediatric physicians by county plan model type.

Enrollment increased statewide from 10,921 pediatricians in the third quarter of 2011 to 11,168 in the second quarter of 2012, a 2.3% increase.

Los Angeles County had the highest average number of pediatricians with 2,986.8 (see Table PS-11 in the [Appendix](#) for county level detail). In 13 counties, there were fewer than 10 pediatricians and zero in seven other counties. The 20 counties with low counts or no count of pediatricians are all FFS plan counties and primarily rural. As with the OB/GYN specialty, FQHCs, RHCs, other clinics, and general care physicians with a specialty other than pediatrics may render pediatric services in these communities. Table PS-12 in the [Appendix](#) displays the total number of clinics by county available to serve Medi-Cal beneficiaries.

The child-to-pediatrician ratio improved statewide during the study period by 10.0% from 64.3 to 57.9. Ratios by plan type improved from 3.5% for FFS and COHS counties to 13.4% for Two-Plan counties.

Table PS-6 Physician Supply, Physicians with a Pediatric Specialty, FFS, Full Scope, Medi-Cal Only Children

| | Site-Specific Physician Counts | | | | | Beneficiaries-to-Provider Ratio | | | | |
|-------------------------------------------------|--------------------------------|------------|------------|------------|--------------------------------|---------------------------------|------------|------------|------------|--------------------------------|
| | 2011 Qtr 3 | 2011 Qtr 4 | 2012 Qtr 1 | 2012 Qtr 2 | % Change 2011 Qtr 3–2012 Qtr 2 | 2011 Qtr 3 | 2011 Qtr 4 | 2011 Qtr 1 | 2012 Qtr 2 | % Change 2011 Qtr 3–2012 Qtr 2 |
| Statewide | 10,921 | 11,007 | 11,089 | 11,168 | 2.3% | 64.3 | 61.2 | 58.7 | 57.9 | -10.0% |
| County Plan Model Type | | | | | | | | | | |
| County Organized Health System (COHS) | 1,944 | 1,948 | 1,959 | 1,977 | 1.7% | 17.0 | 14.8 | 13.9 | 16.4 | -3.5% |
| Fee-for-Service (FFS) | 274 | 275 | 277 | 281 | 2.6% | 627.5 | 619.2 | 613.7 | 605.7 | -3.5% |
| Geographic Managed Care (GMC) | 1,462 | 1,484 | 1,493 | 1,498 | 2.5% | 51.6 | 50.1 | 48.3 | 46.7 | -9.5% |
| Two-Plan (Commercial Plan and Local Initiative) | 7,241 | 7,300 | 7,360 | 7,412 | 2.4% | 58.3 | 54.8 | 51.9 | 50.5 | -13.4% |

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag) and counts of pediatricians with Active and Indirect enrollment status from the Medi-Cal Provider Master File, for the months of August 2011, October 2011, January 2012, and April 2012.

The average child-to-pediatrician ratio from the third quarter of 2011 to the second quarter of 2012 ranged from 5.2 for San Mateo County to 1,700.3 for Glenn County. Eight counties had ratios over 1,000. The ratios of seven counties could not be calculated because there were no pediatricians registered. As with the OB/GYNs, low pediatrician counts resulted in widely varying (and sometimes nonexistent) beneficiary-to-physician ratios by county.

The child-to-pediatrician ratio improved statewide during the study period by 10.0% from 64.3 to 57.9. Ratios by plan type improved from 3.5% for FFS and COHS counties to 13.4% for Two-Plan counties.

The ratios for 36 counties improved, from 0.2% for Del Norte County to 20.9% for Madera County (see Table PS-11 in the [Appendix](#)). Fifteen counties showed increases in their ratios, ranging from 0.2% for Siskiyou County to 30.2% for Santa Clara County. Five counties, all COHS counties, had increases of 10% or higher. As was seen with the beneficiary-to-physician ratios, the actual changes in the ratios for these five counties are relatively small, ranging from 0.7 for Marin County to 3.2 for San Luis Obispo and Solano Counties. These five counties also have some of the lowest ratios in the state. Seven counties had no physicians registered in the pediatric specialty area.

The distribution of child-to-pediatrician ratios by plan model type follows the same pattern as with the OB/GYNs. The lowest physician counts are all in rural, FFS plan counties and the highest child-to-pediatrician ratios are in FFS plan counties as a whole.

Conclusions—Physician Supply

1. DHCS evaluated all 58 counties and plan model types (i.e., Two-Plan, GMC, and FFS) with respect to physician supply from the third quarter of 2011 to the second quarter of 2012. The findings indicate that the statewide supply of physicians potentially available to beneficiaries eligible for full scope Medi-Cal only and participating in FFS was more than adequate.
2. The statewide beneficiary-to-provider ratios disclosed small increases in overall physician supply potentially available to Medi-Cal's FFS population (107,332 to 109,854, or 2.3%). However, there were significant differences in these ratios between regions of the state. In general, the primarily rural counties utilizing the FFS model reported lower site-specific physician numbers and significantly higher beneficiary-to-provider ratios than counties utilizing other health plan models. In general, counties utilizing the Two-Plan managed care model and having a more urbanized population reported lower beneficiary-to-provider ratios compared to Two-Plan counties in more rural areas.
3. The statewide number of primary care physicians increased 2.4%, from 38,833 to 39,747. The beneficiary-to-primary-care-physician ratio improved by 21.0%, from 35.2 in the third quarter of 2011 to 27.8 in the second quarter of 2012. This ratio indicates that statewide the supply of primary care physicians was more than adequate to meet demand. In no case did the beneficiary-to-provider ratio exceed commonly referred to health provider shortage benchmarks.
4. Based on the beneficiary population eligible for FFS Medi-Cal only and a panel size of 2,100 patients, the Medi-Cal program would need a primary care physician supply totaling about 523. With a current supply of Medi-Cal primary care physicians at 39,747 and current level of full scope Medi-Cal FFS participation at 1,104,125, an enrolled primary care physician need only dedicate 1.3% of his practice, or see an estimated 28 Medi-Cal patients, to meet the current needs of the program. However, this does not consider specific geographic regions, patient mix, and the concentration of beneficiaries among providers. Nor does it take into consideration that these same providers may also participate in other health networks, including commercial plans. Although, it does provide some context for the size of the Medi-Cal potential physician capacity.
5. During the period under study, physician enrollment for each specialty area investigated (primary care, OB/GYN, pediatrics) increased slightly, leading to favorable beneficiary-to-provider-supply ratios. For example, for non-elderly adult women participating in the Medi-Cal FFS system and entitled to full scope services, the beneficiary-to-OB/GYN-physician ratio declined from 122.3 to 106.0, indicating an increased supply for this physician specialty area. Likewise, the ratio of children to pediatricians improved from 64.3 to 57.9 for children eligible for full scope Medi-Cal benefits and participating in the FFS system.

Appendix: Physician Supply by County

Table PS-7 Physician Supply, All Enrolled Physicians, FFS Medi-Cal Only Beneficiaries

| | | Site-Specific Physician Counts | | | | | Beneficiaries-to-Provider Ratio | | | | | | |
|-------------------------------------------------|------------------|--------------------------------|----------------------|----------------------|----------------------|------------------------------------|--------------------------------------|----------------------|----------------------|----------------------|----------------------|--------------|------------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Physicians | % Change 2011 Q3-2012 Q2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Avg Ratio | Percent Change 2011 Qtr 3- 2012 Qtr 2 |
| Statewide | | 107,332 | 108,057 | 109,049 | 109,854 | 108,573.0 | 2.3% | 12.7 | 11.6 | 10.6 | 10.1 | 11.3 | -20.5% |
| County Plan Model Type | | | | | | | | | | | | | |
| County Organized Health System (COHS) | | 20,560 | 20,670 | 20,824 | 20,981 | 20,758.8 | 2.0% | 2.3 | 2.0 | 2.0 | 2.4 | 2.2 | 4.3% |
| Fee-for-Service (FFS) | | 4,100 | 4,132 | 4,143 | 4,172 | 4,136.8 | 1.8% | 76.3 | 74.9 | 74.6 | 74.1 | 75.0 | -2.9% |
| Geographic Managed Care (GMC) | | 15,976 | 16,108 | 16,252 | 16,353 | 16,172.3 | 2.4% | 9.4 | 8.6 | 7.7 | 7.0 | 8.2 | -25.5% |
| Two-Plan (Commercial Plan and Local Initiative) | | 66,696 | 67,147 | 67,830 | 68,348 | 67,505.3 | 2.5% | 12.8 | 11.4 | 10.1 | 9.2 | 10.9 | -28.1% |
| County | Plan Type | | | | | | | | | | | | |
| Alameda | Two-Plan | 4,724 | 4,755 | 4,786 | 4,820 | 4,771.3 | 2.0% | 9.5 | 8.3 | 7.1 | 6.5 | 7.9 | -31.6% |
| Alpine | FFS | 2 | 2 | 2 | 2 | 2.0 | 0.0% | 76.0 | 81.0 | 86.5 | 84.5 | 82.0 | 11.2% |
| Amador | FFS | 56 | 57 | 57 | 57 | 56.8 | 1.8% | 62.8 | 62.1 | 62.6 | 63.3 | 62.7 | 0.8% |
| Butte | FFS | 516 | 519 | 522 | 523 | 520.0 | 1.4% | 78.5 | 77.3 | 76.6 | 76.1 | 77.1 | -3.1% |
| Calaveras | FFS | 49 | 49 | 49 | 49 | 49.0 | 0.0% | 110.5 | 109.6 | 109.8 | 110.6 | 110.1 | 0.1% |
| Colusa | FFS | 40 | 40 | 39 | 39 | 39.5 | -2.5% | 88.9 | 88.1 | 90.4 | 90.5 | 89.5 | 1.8% |
| Contra Costa | Two-Plan | 2,863 | 2,872 | 2,905 | 2,933 | 2,893.3 | 2.4% | 9.1 | 8.2 | 7.3 | 6.6 | 7.8 | -27.5% |
| Del Norte | FFS | 53 | 54 | 54 | 54 | 53.8 | 1.9% | 123.9 | 121.1 | 121.4 | 120.7 | 121.8 | -2.6% |
| El Dorado | FFS | 280 | 283 | 283 | 284 | 282.5 | 1.4% | 52.1 | 51.3 | 51.3 | 51.3 | 51.5 | -1.5% |
| Fresno | Two-Plan | 2,002 | 2,014 | 2,031 | 2,046 | 2,023.3 | 2.2% | 19.1 | 17.0 | 15.5 | 13.9 | 16.4 | -27.2% |
| Glenn | FFS | 22 | 22 | 22 | 22 | 22.0 | 0.0% | 246.8 | 244.0 | 247.3 | 249.8 | 247.0 | 1.2% |
| Humboldt | FFS | 409 | 411 | 413 | 416 | 412.3 | 1.7% | 52.0 | 51.4 | 51.0 | 50.7 | 51.3 | -2.5% |
| Imperial | FFS | 216 | 225 | 225 | 231 | 224.3 | 6.9% | 209.7 | 200.1 | 199.8 | 195.1 | 201.2 | -7.0% |

| | | Site-Specific Physician Counts | | | | | | Beneficiaries-to-Provider Ratio | | | | | |
|----------------|----------|--------------------------------|----------------------|----------------------|----------------------|------------------------------------|--------------------------------------|---------------------------------|----------------------|----------------------|----------------------|--------------|------------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Physicians | % Change 2011 Q3-2012 Q2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Avg Ratio | Percent Change 2011 Qtr 3- 2012 Qtr 2 |
| Inyo | FFS | 39 | 39 | 38 | 38 | 38.5 | -2.6% | 66.9 | 66.1 | 68.1 | 67.7 | 67.2 | 1.2% |
| Kern | Two-Plan | 1,789 | 1,793 | 1,802 | 1,810 | 1,798.5 | 1.2% | 24.5 | 22.1 | 20.8 | 19.4 | 21.7 | -20.8% |
| Kings | Two-Plan | 189 | 194 | 195 | 194 | 193.0 | 2.6% | 32.4 | 28.8 | 26.4 | 23.8 | 27.9 | -26.5% |
| Lake | FFS | 120 | 121 | 121 | 120 | 120.5 | 0.0% | 111.6 | 109.3 | 109.7 | 109.8 | 110.1 | -1.6% |
| Lassen | FFS | 31 | 31 | 32 | 32 | 31.5 | 3.2% | 132.6 | 131.4 | 124.5 | 120.8 | 127.3 | -8.9% |
| Los Angeles | Two-Plan | 29,737 | 29,910 | 30,182 | 30,410 | 30,059.8 | 2.3% | 12.4 | 10.7 | 9.2 | 8.3 | 10.2 | -33.1% |
| Madera | Two-Plan | 288 | 294 | 295 | 300 | 294.3 | 4.2% | 21.9 | 19.2 | 17.6 | 15.5 | 18.6 | -29.2% |
| Marin * | COHS | 770 | 773 | 777 | 782 | 775.5 | 1.6% | 0.8 | 0.7 | 0.7 | 0.9 | 0.8 | 12.5% |
| Mariposa | FFS | 19 | 19 | 19 | 19 | 19.0 | 0.0% | 116.0 | 112.3 | 112.6 | 115.6 | 114.1 | -0.3% |
| Mendocino * | COHS | 206 | 206 | 206 | 206 | 206.0 | 0.0% | 3.9 | 3.6 | 3.5 | 3.8 | 3.7 | -2.6% |
| Merced | COHS | 366 | 371 | 373 | 376 | 371.5 | 2.7% | 6.7 | 5.9 | 6.2 | 7.8 | 6.7 | 16.4% |
| Modoc | FFS | 14 | 14 | 14 | 14 | 14.0 | 0.0% | 110.6 | 108.4 | 107.6 | 108.1 | 108.7 | -2.3% |
| Mono | FFS | 45 | 45 | 45 | 45 | 45.0 | 0.0% | 21.7 | 21.8 | 22.5 | 23.1 | 22.3 | 6.5% |
| Monterey | COHS | 911 | 916 | 919 | 923 | 917.3 | 1.3% | 3.7 | 3.1 | 3.0 | 3.6 | 3.4 | -2.7% |
| Napa | COHS | 379 | 379 | 379 | 382 | 379.8 | 0.8% | 1.9 | 1.7 | 1.6 | 2.1 | 1.8 | 10.5% |
| Nevada | FFS | 194 | 195 | 196 | 197 | 195.5 | 1.5% | 45.6 | 45.4 | 45.0 | 44.3 | 45.1 | -2.9% |
| Orange | COHS | 8,350 | 8,400 | 8,462 | 8,527 | 8,434.8 | 2.1% | 2.2 | 1.8 | 1.7 | 2.0 | 1.9 | -9.1% |
| Placer | FFS | 753 | 760 | 765 | 777 | 763.8 | 3.2% | 31.6 | 31.2 | 31.0 | 30.6 | 31.1 | -3.2% |
| Plumas | FFS | 35 | 35 | 35 | 35 | 35.0 | 0.0% | 67.3 | 67.8 | 67.6 | 68.3 | 67.8 | 1.5% |
| Riverside | Two-Plan | 2,957 | 2,978 | 3,023 | 3,055 | 3,003.3 | 3.3% | 27.0 | 24.4 | 22.0 | 20.6 | 23.5 | -23.7% |
| Sacramento | GMC | 5,851 | 5,889 | 5,933 | 5,971 | 5,911.0 | 2.1% | 9.6 | 8.6 | 7.8 | 7.0 | 8.3 | -27.1% |
| San Benito | FFS | 67 | 67 | 67 | 67 | 67.0 | 0.0% | 116.5 | 115.1 | 116.3 | 115.8 | 115.9 | -0.6% |
| San Bernardino | Two-Plan | 4,578 | 4,625 | 4,722 | 4,751 | 4,669.0 | 3.8% | 22.0 | 20.0 | 18.3 | 17.6 | 19.5 | -20.0% |
| San Diego | GMC | 10,125 | 10,219 | 10,319 | 10,382 | 10,261.3 | 2.5% | 9.4 | 8.5 | 7.6 | 7.1 | 8.2 | -24.5% |
| San Francisco | Two-Plan | 6,485 | 6,525 | 6,584 | 6,629 | 6,555.8 | 2.2% | 3.5 | 2.9 | 2.3 | 1.9 | 2.7 | -45.7% |

| | | Site-Specific Physician Counts | | | | | | Beneficiaries-to-Provider Ratio | | | | | |
|-----------------|----------|--------------------------------|----------------------|----------------------|----------------------|------------------------------------|--------------------------------------|---------------------------------|----------------------|----------------------|----------------------|--------------|------------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Physicians | % Change 2011 Q3-2012 Q2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Avg Ratio | Percent Change 2011 Qtr 3- 2012 Qtr 2 |
| San Joaquin | Two-Plan | 1,488 | 1,496 | 1,516 | 1,531 | 1,507.8 | 2.9% | 19.8 | 17.5 | 15.6 | 14.0 | 16.7 | -29.3% |
| San Luis Obispo | COHS | 483 | 485 | 486 | 488 | 485.5 | 1.0% | 2.6 | 2.5 | 2.6 | 3.3 | 2.8 | 26.9% |
| San Mateo | COHS | 2,876 | 2,888 | 2,906 | 2,928 | 2,899.5 | 1.8% | 1.1 | 1.0 | 1.0 | 1.4 | 1.1 | 27.3% |
| Santa Barbara | COHS | 1,159 | 1,163 | 1,168 | 1,173 | 1,165.8 | 1.2% | 3.0 | 2.8 | 2.7 | 3.0 | 2.9 | 0.0% |
| Santa Clara | Two-Plan | 7,560 | 7,627 | 7,702 | 7,764 | 7,663.3 | 2.7% | 5.0 | 4.7 | 4.3 | 3.8 | 4.5 | -24.0% |
| Santa Cruz | COHS | 635 | 636 | 639 | 644 | 638.5 | 1.4% | 2.5 | 2.4 | 2.5 | 3.2 | 2.7 | 28.0% |
| Shasta | FFS | 491 | 493 | 496 | 497 | 494.3 | 1.2% | 67.1 | 65.5 | 64.8 | 64.7 | 65.5 | -3.6% |
| Sierra | FFS | 5 | 5 | 5 | 5 | 5.0 | 0.0% | 68.0 | 66.2 | 66.0 | 67.6 | 67.0 | -0.6% |
| Siskiyou | FFS | 88 | 89 | 89 | 89 | 88.8 | 1.1% | 93.2 | 91.2 | 91.9 | 92.5 | 92.2 | -0.8% |
| Solano | COHS | 1,313 | 1,322 | 1,351 | 1,369 | 1,338.8 | 4.3% | 1.5 | 1.4 | 1.3 | 2.0 | 1.6 | 33.3% |
| Sonoma | COHS | 1,157 | 1,161 | 1,174 | 1,183 | 1,168.8 | 2.2% | 2.6 | 2.4 | 2.3 | 2.8 | 2.5 | 7.7% |
| Stanislaus | Two-Plan | 1,300 | 1,323 | 1,335 | 1,346 | 1,326.0 | 3.5% | 23.4 | 21.4 | 20.3 | 19.6 | 21.2 | -16.2% |
| Sutter | FFS | 168 | 169 | 168 | 172 | 169.3 | 2.4% | 107.0 | 106.2 | 107.0 | 104.7 | 106.2 | -2.1% |
| Tehama | FFS | 101 | 101 | 101 | 101 | 101.0 | 0.0% | 138.0 | 133.1 | 132.7 | 133.7 | 134.4 | -3.1% |
| Trinity | FFS | 13 | 13 | 13 | 13 | 13.0 | 0.0% | 167.9 | 169.4 | 168.3 | 167.8 | 168.4 | -0.1% |
| Tulare | Two-Plan | 736 | 741 | 752 | 759 | 747.0 | 3.1% | 29.6 | 27.6 | 25.5 | 22.9 | 26.4 | -22.6% |
| Tuolumne | FFS | 107 | 106 | 105 | 105 | 105.8 | -1.9% | 60.1 | 59.6 | 60.3 | 59.7 | 59.9 | -0.7% |
| Ventura * | COHS | 1,485 | 1,497 | 1,506 | 1,520 | 1,502.0 | 2.4% | 3.3 | 3.1 | 3.0 | 3.9 | 3.3 | 18.2% |
| Yolo | COHS | 470 | 473 | 478 | 480 | 475.3 | 2.1% | 3.8 | 3.6 | 3.4 | 4.0 | 3.7 | 5.3% |
| Yuba | FFS | 167 | 168 | 168 | 169 | 168.0 | 1.2% | 100.6 | 98.1 | 96.9 | 95.9 | 97.9 | -4.7% |

*Shifted from FFS to COHS Model on July 1, 2011

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of August 2011, October 2011, January 2012, and April 2012.

Table PS-8 Physician Supply, All Enrolled Physicians, All Medi-Cal Only Beneficiaries

| | | Site-Specific Physician Counts | | | | | Beneficiaries-to-Providers Ratio | | | | | | |
|-------------------------------------------------|------------------|--------------------------------|----------------------|----------------------|----------------------|------------------------------------|------------------------------------------------|----------------------|----------------------|----------------------|----------------------|--------------|------------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Physicians | Percent Change 2011 Qtr 3- 2012 Qtr 2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Avg Ratio | Percent Change 2011 Qtr 3- 2012 Qtr 2 |
| Statewide | | 107,332 | 108,057 | 109,049 | 109,854 | 108,573.0 | 2.3% | 52.6 | 52.1 | 51.6 | 51.4 | 51.9 | -2.3% |
| County Plan Model Type | | | | | | | | | | | | | |
| County Organized Health System (COHS) | | 20,560 | 20,670 | 20,824 | 20,981 | 20,758.8 | 2.0% | 42.5 | 42.1 | 42.0 | 41.9 | 42.1 | -1.4% |
| Fee-for-Service (FFS) | | 4,100 | 4,132 | 4,143 | 4,172 | 4,136.8 | 1.8% | 76.7 | 75.4 | 75.1 | 74.6 | 75.5 | -2.7% |
| Geographic Managed Care (GMC) | | 15,976 | 16,108 | 16,252 | 16,353 | 16,172.3 | 2.4% | 37.3 | 37.1 | 36.7 | 36.6 | 36.9 | -1.9% |
| Two-Plan (Commercial Plan and Local Initiative) | | 66,696 | 67,147 | 67,830 | 68,348 | 67,505.3 | 2.5% | 57.9 | 57.3 | 56.7 | 56.4 | 57.1 | -2.6% |
| County | Plan Type | | | | | | | | | | | | |
| Alameda | Two-Plan | 4,724 | 4,755 | 4,786 | 4,820 | 4,771.3 | 2.0% | 38.3 | 38.2 | 38.0 | 37.9 | 38.1 | -1.0% |
| Alpine | FFS | 2 | 2 | 2 | 2 | 2.0 | 0.0% | 76.5 | 81.5 | 86.5 | 85.0 | 82.4 | 11.1% |
| Amador | FFS | 56 | 57 | 57 | 57 | 56.8 | 1.8% | 63.1 | 62.5 | 63.0 | 63.6 | 63.1 | 0.8% |
| Butte | FFS | 516 | 519 | 522 | 523 | 520.0 | 1.4% | 78.9 | 77.7 | 77.0 | 76.4 | 77.5 | -3.2% |
| Calaveras | FFS | 49 | 49 | 49 | 49 | 49.0 | 0.0% | 111.4 | 110.5 | 110.7 | 111.8 | 111.1 | 0.4% |
| Colusa | FFS | 40 | 40 | 39 | 39 | 39.5 | -2.5% | 89.3 | 88.4 | 90.7 | 90.8 | 89.8 | 1.7% |
| Contra Costa | Two-Plan | 2,863 | 2,872 | 2,905 | 2,933 | 2,893.3 | 2.4% | 36.0 | 36.2 | 36.0 | 35.9 | 36.0 | -0.3% |
| Del Norte | FFS | 53 | 54 | 54 | 54 | 53.8 | 1.9% | 124.1 | 121.4 | 121.7 | 121.0 | 122.1 | -2.5% |
| El Dorado | FFS | 280 | 283 | 283 | 284 | 282.5 | 1.4% | 52.5 | 51.6 | 51.7 | 51.6 | 51.9 | -1.7% |
| Fresno | Two-Plan | 2,002 | 2,014 | 2,031 | 2,046 | 2,023.3 | 2.2% | 125.8 | 124.9 | 124.3 | 124.1 | 124.8 | -1.4% |
| Glenn | FFS | 22 | 22 | 22 | 22 | 22.0 | 0.0% | 247.5 | 244.7 | 248.4 | 251.0 | 247.9 | 1.4% |
| Humboldt | FFS | 409 | 411 | 413 | 416 | 412.3 | 1.7% | 52.2 | 51.7 | 51.3 | 50.9 | 51.5 | -2.5% |
| Imperial | FFS | 216 | 225 | 225 | 231 | 224.3 | 6.9% | 211.3 | 201.6 | 201.4 | 196.7 | 202.8 | -6.9% |
| Inyo | FFS | 39 | 39 | 38 | 38 | 38.5 | -2.6% | 67.0 | 66.2 | 68.2 | 67.8 | 67.3 | 1.2% |
| Kern | Two-Plan | 1,789 | 1,793 | 1,802 | 1,810 | 1,798.5 | 1.2% | 106.4 | 105.2 | 105.3 | 105.0 | 105.5 | -1.3% |

| | | Site-Specific Physician Counts | | | | | | Beneficiaries-to-Providers Ratio | | | | | |
|-----------------|----------|--------------------------------|----------------------|----------------------|----------------------|------------------------------------|------------------------------------------------|----------------------------------|----------------------|----------------------|----------------------|--------------|------------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Physicians | Percent Change 2011 Qtr 3- 2012 Qtr 2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Avg Ratio | Percent Change 2011 Qtr 3- 2012 Qtr 2 |
| Kings | Two-Plan | 189 | 194 | 195 | 194 | 193.0 | 2.6% | 153.4 | 148.5 | 147.9 | 148.8 | 149.7 | -3.0% |
| Lake | FFS | 120 | 121 | 121 | 120 | 120.5 | 0.0% | 112.8 | 110.6 | 111.0 | 110.8 | 111.3 | -1.8% |
| Lassen | FFS | 31 | 31 | 32 | 32 | 31.5 | 3.2% | 133.1 | 132.1 | 125.1 | 121.3 | 127.9 | -8.9% |
| Los Angeles | Two-Plan | 29,737 | 29,910 | 30,182 | 30,410 | 30,059.8 | 2.3% | 57.6 | 57.0 | 56.3 | 55.9 | 56.7 | -3.0% |
| Madera | Two-Plan | 288 | 294 | 295 | 300 | 294.3 | 4.2% | 118.0 | 115.3 | 115.8 | 115.0 | 116.0 | -2.5% |
| Marin * | COHS | 770 | 773 | 777 | 782 | 775.5 | 1.6% | 17.7 | 17.4 | 17.4 | 17.2 | 17.4 | -2.8% |
| Mariposa | FFS | 19 | 19 | 19 | 19 | 19.0 | 0.0% | 118.0 | 115.0 | 114.2 | 117.1 | 116.1 | -0.8% |
| Mendocino * | COHS | 206 | 206 | 206 | 206 | 206.0 | 0.0% | 84.4 | 84.7 | 85.6 | 86.2 | 85.2 | 2.1% |
| Merced | COHS | 366 | 371 | 373 | 376 | 371.5 | 2.7% | 183.3 | 180.0 | 180.2 | 179.9 | 180.9 | -1.9% |
| Modoc | FFS | 14 | 14 | 14 | 14 | 14.0 | 0.0% | 110.6 | 108.6 | 108.1 | 108.2 | 108.9 | -2.2% |
| Mono | FFS | 45 | 45 | 45 | 45 | 45.0 | 0.0% | 21.8 | 21.8 | 22.6 | 23.2 | 22.4 | 6.4% |
| Monterey | COHS | 911 | 916 | 919 | 923 | 917.3 | 1.3% | 73.5 | 72.5 | 73.7 | 74.1 | 73.5 | 0.8% |
| Napa | COHS | 379 | 379 | 379 | 382 | 379.8 | 0.8% | 31.5 | 31.4 | 31.5 | 31.4 | 31.5 | -0.3% |
| Nevada | FFS | 194 | 195 | 196 | 197 | 195.5 | 1.5% | 45.8 | 45.6 | 45.2 | 44.5 | 45.3 | -2.8% |
| Orange | COHS | 8,350 | 8,400 | 8,462 | 8,527 | 8,434.8 | 2.1% | 38.7 | 38.4 | 38.1 | 38.1 | 38.3 | -1.6% |
| Placer | FFS | 753 | 760 | 765 | 777 | 763.8 | 3.2% | 31.9 | 31.6 | 31.5 | 31.0 | 31.5 | -2.8% |
| Plumas | FFS | 35 | 35 | 35 | 35 | 35.0 | 0.0% | 67.6 | 68.1 | 67.8 | 68.6 | 68.0 | 1.5% |
| Riverside | Two-Plan | 2,957 | 2,978 | 3,023 | 3,055 | 3,003.3 | 3.3% | 111.0 | 109.9 | 107.7 | 107.0 | 108.9 | -3.6% |
| Sacramento | GMC | 5,851 | 5,889 | 5,933 | 5,971 | 5,911.0 | 2.1% | 44.3 | 44.1 | 43.8 | 43.8 | 44.0 | -1.1% |
| San Benito | FFS | 67 | 67 | 67 | 67 | 67.0 | 0.0% | 118.9 | 117.5 | 118.3 | 118.0 | 118.2 | -0.8% |
| San Bernardino | Two-Plan | 4,578 | 4,625 | 4,722 | 4,751 | 4,669.0 | 3.8% | 85.5 | 84.3 | 82.7 | 83.0 | 83.9 | -2.9% |
| San Diego | GMC | 10,125 | 10,219 | 10,319 | 10,382 | 10,261.3 | 2.5% | 33.3 | 33.0 | 32.6 | 32.5 | 32.9 | -2.4% |
| San Francisco | Two-Plan | 6,485 | 6,525 | 6,584 | 6,629 | 6,555.8 | 2.2% | 12.3 | 12.1 | 12.0 | 12.0 | 12.1 | -2.4% |
| San Joaquin | Two-Plan | 1,488 | 1,496 | 1,516 | 1,531 | 1,507.8 | 2.9% | 96.7 | 95.9 | 95.0 | 94.6 | 95.6 | -2.2% |
| San Luis Obispo | COHS | 483 | 485 | 486 | 488 | 485.5 | 1.0% | 50.7 | 50.2 | 50.4 | 50.2 | 50.4 | -1.0% |

| | | Site-Specific Physician Counts | | | | | | Beneficiaries-to-Providers Ratio | | | | | |
|---------------|----------|--------------------------------|----------------------|----------------------|----------------------|------------------------------------|------------------------------------------------|----------------------------------|----------------------|----------------------|----------------------|--------------|------------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Physicians | Percent Change 2011 Qtr 3- 2012 Qtr 2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Avg Ratio | Percent Change 2011 Qtr 3- 2012 Qtr 2 |
| San Mateo | COHS | 2,876 | 2,888 | 2,906 | 2,928 | 2,899.5 | 1.8% | 16.7 | 16.9 | 16.9 | 17.0 | 16.9 | 1.8% |
| Santa Barbara | COHS | 1,159 | 1,163 | 1,168 | 1,173 | 1,165.8 | 1.2% | 50.2 | 49.7 | 49.6 | 49.5 | 49.8 | -1.4% |
| Santa Clara | Two-Plan | 7,560 | 7,627 | 7,702 | 7,764 | 7,663.3 | 2.7% | 23.1 | 22.9 | 22.7 | 22.5 | 22.8 | -2.6% |
| Santa Cruz | COHS | 635 | 636 | 639 | 644 | 638.5 | 1.4% | 48.4 | 48.1 | 48.2 | 48.2 | 48.2 | -0.4% |
| Shasta | FFS | 491 | 493 | 496 | 497 | 494.3 | 1.2% | 67.3 | 65.7 | 65.0 | 64.9 | 65.7 | -3.6% |
| Sierra | FFS | 5 | 5 | 5 | 5 | 5.0 | 0.0% | 70.2 | 68.4 | 68.6 | 69.8 | 69.3 | -0.6% |
| Siskiyou | FFS | 88 | 89 | 89 | 89 | 88.8 | 1.1% | 93.5 | 91.4 | 92.2 | 92.7 | 92.5 | -0.9% |
| Solano | COHS | 1,313 | 1,322 | 1,351 | 1,369 | 1,338.8 | 4.3% | 40.1 | 39.7 | 38.7 | 38.3 | 39.2 | -4.5% |
| Sonoma | COHS | 1,157 | 1,161 | 1,174 | 1,183 | 1,168.8 | 2.2% | 38.9 | 38.8 | 38.4 | 38.5 | 38.7 | -1.0% |
| Stanislaus | Two-Plan | 1,300 | 1,323 | 1,335 | 1,346 | 1,326.0 | 3.5% | 82.6 | 81.1 | 80.2 | 80.2 | 81.0 | -2.9% |
| Sutter | FFS | 168 | 169 | 168 | 172 | 169.3 | 2.4% | 107.5 | 106.7 | 107.5 | 105.2 | 106.7 | -2.1% |
| Tehama | FFS | 101 | 101 | 101 | 101 | 101.0 | 0.0% | 138.5 | 133.5 | 133.0 | 134.1 | 134.8 | -3.2% |
| Trinity | FFS | 13 | 13 | 13 | 13 | 13.0 | 0.0% | 168.3 | 170.0 | 168.8 | 168.3 | 168.9 | 0.0% |
| Tulare | Two-Plan | 736 | 741 | 752 | 759 | 747.0 | 3.1% | 180.6 | 179.1 | 177.4 | 176.5 | 178.4 | -2.3% |
| Tuolumne | FFS | 107 | 106 | 105 | 105 | 105.8 | -1.9% | 60.6 | 60.3 | 61.1 | 60.5 | 60.6 | -0.2% |
| Ventura * | COHS | 1,485 | 1,497 | 1,506 | 1,520 | 1,502.0 | 2.4% | 61.5 | 60.3 | 59.9 | 59.4 | 60.3 | -3.4% |
| Yolo | COHS | 470 | 473 | 478 | 480 | 475.3 | 2.1% | 49.8 | 49.3 | 48.8 | 49.0 | 49.2 | -1.6% |
| Yuba | FFS | 167 | 168 | 168 | 169 | 168.0 | 1.2% | 101.1 | 98.5 | 97.3 | 96.3 | 98.3 | -4.7% |

* Shifted from FFS to COHS Model on July 1, 2011

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of August 2011, October 2011, January 2012, and April 2012.

Table PS-9 Primary Care Physician Supply, All Enrolled Physicians, FFS, Full Scope, Medi-Cal Only Beneficiaries

| | | Site-Specific Physician Counts | | | | | Beneficiaries-to-Providers Ratio | | | | | | |
|-------------------------------------------------|------------------|--------------------------------|----------------------|----------------------|----------------------|--------------------------------|----------------------------------|----------------------|----------------------|----------------------|----------------------|--------------|-------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Avg Number of Physicians | % Change In # of Providers | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Avg Ratio | Percent Change in Ratio |
| Statewide | | 38,833 | 39,068 | 39,426 | 39,747 | 39,268.5 | 2.4% | 35.2 | 32.1 | 29.4 | 27.8 | 31.1 | -21.0% |
| County Plan Model Type | | | | | | | | | | | | | |
| County Organized Health System (COHS) | | 7,315 | 7,369 | 7,425 | 7,503 | 7,403.0 | 2.6% | 6.4 | 5.7 | 5.5 | 6.7 | 6.1 | 4.7% |
| Fee-for-Service (FFS) | | 1,744 | 1,758 | 1,759 | 1,772 | 1,758.3 | 1.6% | 179.3 | 176.1 | 175.8 | 174.5 | 176.4 | -2.7% |
| Geographic Managed Care (GMC) | | 5,418 | 5,458 | 5,494 | 5,531 | 5,475.3 | 2.1% | 27.8 | 25.3 | 22.7 | 20.8 | 24.2 | -25.2% |
| Two-Plan (Commercial Plan and Local Initiative) | | 24,356 | 24,483 | 24,748 | 24,941 | 24,632.0 | 2.4% | 35.1 | 31.1 | 27.6 | 25.2 | 29.8 | -28.2% |
| County | Plan Type | | | | | | | | | | | | |
| Alameda | Two-Plan | 1,634 | 1,639 | 1,651 | 1,668 | 1,648.0 | 2.1% | 27.5 | 24.0 | 20.5 | 18.6 | 22.7 | -32.4% |
| Alpine | FFS | 1 | 1 | 1 | 1 | 1.0 | 0.0% | 152.0 | 162.0 | 173.0 | 169.0 | 164.0 | 11.2% |
| Amador | FFS | 33 | 33 | 33 | 32 | 32.8 | -3.0% | 106.6 | 107.2 | 108.1 | 112.8 | 108.7 | 5.8% |
| Butte | FFS | 192 | 190 | 190 | 193 | 191.3 | 0.5% | 211.0 | 211.1 | 210.4 | 206.1 | 209.7 | -2.3% |
| Calaveras | FFS | 24 | 25 | 25 | 24 | 24.5 | 0.0% | 225.5 | 214.8 | 215.2 | 225.8 | 220.3 | 0.1% |
| Colusa | FFS | 30 | 30 | 30 | 30 | 30.0 | 0.0% | 118.6 | 117.5 | 117.5 | 117.6 | 117.8 | -0.8% |
| Contra Costa | Two-Plan | 1,096 | 1,100 | 1,109 | 1,125 | 1,107.5 | 2.6% | 23.7 | 21.4 | 19.2 | 17.1 | 20.4 | -27.8% |
| Del Norte | FFS | 25 | 26 | 26 | 26 | 25.8 | 4.0% | 262.6 | 251.5 | 252.2 | 250.7 | 254.3 | -4.5% |
| El Dorado | FFS | 103 | 103 | 103 | 103 | 103.0 | 0.0% | 141.7 | 140.8 | 140.8 | 141.3 | 141.2 | -0.3% |
| Fresno | Two-Plan | 733 | 738 | 749 | 757 | 744.3 | 3.3% | 52.1 | 46.4 | 42.1 | 37.6 | 44.6 | -27.8% |
| Glenn | FFS | 9 | 9 | 9 | 9 | 9.0 | 0.0% | 603.2 | 596.3 | 604.6 | 610.6 | 603.7 | 1.2% |
| Humboldt | FFS | 183 | 184 | 184 | 185 | 184.0 | 1.1% | 116.2 | 114.9 | 114.5 | 114.0 | 114.9 | -1.9% |
| Imperial | FFS | 57 | 63 | 65 | 70 | 63.8 | 22.8% | 794.6 | 714.8 | 691.6 | 643.7 | 711.2 | -19.0% |
| Inyo | FFS | 18 | 18 | 18 | 18 | 18.0 | 0.0% | 145.0 | 143.1 | 143.7 | 142.8 | 143.7 | -1.5% |
| Kern | Two-Plan | 703 | 701 | 704 | 709 | 704.3 | 0.9% | 62.4 | 56.4 | 53.3 | 49.4 | 55.4 | -20.8% |

| | | Site-Specific Physician Counts | | | | | | Beneficiaries-to-Providers Ratio | | | | | |
|-----------------|----------|--------------------------------|----------------------|----------------------|----------------------|--------------------------------|----------------------------------|----------------------------------|----------------------|----------------------|----------------------|--------------|-------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Avg Number of Physicians | % Change In # of Providers | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Avg Ratio | Percent Change in Ratio |
| Kings | Two-Plan | 79 | 83 | 82 | 82 | 81.5 | 3.8% | 77.6 | 67.4 | 62.7 | 56.2 | 66.0 | -27.6% |
| Lake | FFS | 47 | 48 | 48 | 48 | 47.8 | 2.1% | 284.8 | 275.6 | 276.4 | 274.4 | 277.8 | -3.7% |
| Lassen | FFS | 14 | 14 | 15 | 15 | 14.5 | 7.1% | 293.6 | 291.0 | 265.6 | 257.7 | 277.0 | -12.2% |
| Los Angeles | Two-Plan | 11,327 | 11,363 | 11,476 | 11,567 | 11,433.3 | 2.1% | 32.4 | 28.1 | 24.1 | 21.9 | 26.6 | -32.4% |
| Madera | Two-Plan | 64 | 65 | 65 | 64 | 64.5 | 0.0% | 98.5 | 86.9 | 79.9 | 72.7 | 84.5 | -26.2% |
| Marin * | COHS | 309 | 310 | 309 | 315 | 310.8 | 1.9% | 1.9 | 1.7 | 1.7 | 2.2 | 1.9 | 15.8% |
| Mariposa | FFS | 12 | 12 | 12 | 11 | 11.8 | -8.3% | 183.6 | 177.8 | 178.3 | 199.6 | 184.8 | 8.7% |
| Mendocino * | COHS | 71 | 71 | 71 | 71 | 71.0 | 0.0% | 11.3 | 10.4 | 10.0 | 11.0 | 10.7 | -2.7% |
| Merced | COHS | 162 | 166 | 167 | 169 | 166.0 | 4.3% | 15.2 | 13.1 | 13.8 | 17.4 | 14.9 | 14.5% |
| Modoc | FFS | 11 | 11 | 11 | 11 | 11.0 | 0.0% | 140.7 | 138.0 | 137.0 | 137.6 | 138.3 | -2.2% |
| Mono | FFS | 19 | 19 | 19 | 19 | 19.0 | 0.0% | 51.3 | 51.6 | 53.3 | 54.7 | 52.7 | 6.6% |
| Monterey | COHS | 336 | 339 | 339 | 343 | 339.3 | 2.1% | 10.0 | 8.3 | 8.2 | 9.6 | 9.0 | -4.0% |
| Napa | COHS | 112 | 112 | 110 | 111 | 111.3 | -0.9% | 6.3 | 5.7 | 5.5 | 7.3 | 6.2 | 15.9% |
| Nevada | FFS | 88 | 88 | 88 | 88 | 88.0 | 0.0% | 100.6 | 100.7 | 100.2 | 99.2 | 100.2 | -1.4% |
| Orange | COHS | 2,699 | 2,717 | 2,743 | 2,766 | 2,731.3 | 2.5% | 6.7 | 5.7 | 5.2 | 6.0 | 5.9 | -10.4% |
| Placer | FFS | 348 | 352 | 353 | 359 | 353.0 | 3.2% | 68.4 | 67.5 | 67.3 | 66.3 | 67.4 | -3.1% |
| Plumas | FFS | 25 | 25 | 25 | 25 | 25.0 | 0.0% | 94.3 | 94.9 | 94.6 | 95.7 | 94.9 | 1.5% |
| Riverside | Two-Plan | 1,192 | 1,198 | 1,218 | 1,237 | 1,211.3 | 3.8% | 67.0 | 60.7 | 54.5 | 50.8 | 58.3 | -24.2% |
| Sacramento | GMC | 1,970 | 1,975 | 1,986 | 1,997 | 1,982.0 | 1.4% | 28.4 | 25.8 | 23.2 | 20.8 | 24.6 | -26.8% |
| San Benito | FFS | 23 | 24 | 23 | 23 | 23.3 | 0.0% | 339.3 | 321.3 | 338.8 | 337.2 | 334.2 | -0.6% |
| San Bernardino | Two-Plan | 1,860 | 1,878 | 1,913 | 1,927 | 1,894.5 | 3.6% | 54.2 | 49.3 | 45.2 | 43.3 | 48.0 | -20.1% |
| San Diego | GMC | 3,448 | 3,483 | 3,508 | 3,534 | 3,493.3 | 2.5% | 27.4 | 25.0 | 22.5 | 20.8 | 23.9 | -24.1% |
| San Francisco | Two-Plan | 2,005 | 2,019 | 2,040 | 2,050 | 2,028.5 | 2.2% | 11.3 | 9.3 | 7.4 | 6.0 | 8.5 | -46.9% |
| San Joaquin | Two-Plan | 553 | 556 | 562 | 563 | 558.5 | 1.8% | 53.4 | 47.0 | 42.0 | 38.0 | 45.1 | -28.8% |
| San Luis Obispo | COHS | 164 | 165 | 165 | 167 | 165.3 | 1.8% | 7.8 | 7.5 | 7.8 | 9.7 | 8.2 | 24.4% |
| San Mateo | COHS | 976 | 983 | 992 | 1,006 | 989.3 | 3.1% | 3.2 | 2.9 | 2.9 | 4.0 | 3.3 | 25.0% |
| Santa Barbara | COHS | 354 | 356 | 356 | 356 | 355.5 | 0.6% | 9.7 | 9.1 | 8.9 | 10.0 | 9.4 | 3.1% |

| | | Site-Specific Physician Counts | | | | | | Beneficiaries-to-Providers Ratio | | | | | |
|-------------|----------|--------------------------------|----------------------|----------------------|----------------------|--------------------------------|----------------------------------|----------------------------------|----------------------|----------------------|----------------------|--------------|-------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Avg Number of Physicians | % Change In # of Providers | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Avg Ratio | Percent Change in Ratio |
| Santa Clara | Two-Plan | 2,330 | 2,355 | 2,383 | 2,394 | 2,365.5 | 2.7% | 16.2 | 15.1 | 13.9 | 12.3 | 14.4 | -24.1% |
| Santa Cruz | COHS | 242 | 242 | 243 | 246 | 243.3 | 1.7% | 6.5 | 6.4 | 6.4 | 8.4 | 6.9 | 29.2% |
| Shasta | FFS | 205 | 205 | 205 | 206 | 205.3 | 0.5% | 160.8 | 157.6 | 156.8 | 156.1 | 157.8 | -2.9% |
| Sierra | FFS | 5 | 5 | 5 | 5 | 5.0 | 0.0% | 68.0 | 66.2 | 66.0 | 67.6 | 67.0 | -0.6% |
| Siskiyou | FFS | 38 | 39 | 38 | 39 | 38.5 | 2.6% | 215.8 | 208.0 | 215.3 | 211.1 | 212.6 | -2.2% |
| Solano | COHS | 537 | 542 | 556 | 565 | 550.0 | 5.2% | 3.7 | 3.4 | 3.2 | 4.9 | 3.8 | 32.4% |
| Sonoma | COHS | 494 | 498 | 499 | 502 | 498.3 | 1.6% | 6.0 | 5.6 | 5.3 | 6.6 | 5.9 | 10.0% |
| Stanislaus | Two-Plan | 520 | 530 | 536 | 537 | 530.8 | 3.3% | 58.6 | 53.5 | 50.6 | 49.1 | 53.0 | -16.2% |
| Sutter | FFS | 77 | 79 | 79 | 78 | 78.3 | 1.3% | 233.5 | 227.3 | 227.4 | 230.9 | 229.8 | -1.1% |
| Tehama | FFS | 48 | 48 | 48 | 48 | 48.0 | 0.0% | 290.5 | 280.1 | 279.2 | 281.4 | 282.8 | -3.1% |
| Trinity | FFS | 5 | 5 | 5 | 5 | 5.0 | 0.0% | 436.4 | 440.4 | 437.6 | 436.2 | 437.7 | 0.0% |
| Tulare | Two-Plan | 260 | 258 | 260 | 261 | 259.8 | 0.4% | 83.7 | 79.1 | 73.8 | 66.5 | 75.8 | -20.5% |
| Tuolumne | FFS | 44 | 42 | 40 | 41 | 41.8 | -6.8% | 146.0 | 150.5 | 158.4 | 152.8 | 151.9 | 4.7% |
| Ventura * | COHS | 642 | 649 | 650 | 660 | 650.3 | 2.8% | 7.7 | 7.1 | 7.0 | 8.9 | 7.7 | 15.6% |
| Yolo | COHS | 217 | 219 | 225 | 226 | 221.8 | 4.1% | 8.3 | 7.8 | 7.1 | 8.5 | 7.9 | 2.4% |
| Yuba | FFS | 60 | 60 | 61 | 60 | 60.3 | 0.0% | 280.1 | 274.6 | 266.8 | 270.2 | 272.9 | -3.5% |

*Shifted from FFS to COHS Model on July 1, 2011

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of August 2011, October 2011, January 2012, and April 2012.

Table PS-10 Physician Supply, Physicians with an OB/GYN Specialty, FFS, Medi-Cal Only, Non-Elderly, Adult Females

| | | Site-Specific Physician Counts | | | | | Beneficiaries-to-Provider Ratio | | | | | | |
|-------------------------------------------------|------------------|--------------------------------|----------------|----------------|----------------|-----------------------------|--------------------------------------|----------------|----------------|----------------|----------------|---------------|--------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Providers | Percent Change 2011 Qtr 3-2012 Qtr 2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Ratio | Percent Change 2011 Qtr 3-2012 Qtr 2 |
| Statewide | | 6,422 | 6,456 | 6,524 | 6,563 | 6,491.3 | 2.2% | 122.3 | 115.3 | 109.5 | 106.0 | 113.3 | -13.3% |
| County Plan Model Type | | | | | | | | | | | | | |
| County Organized Health System (COHS) | | 1,341 | 1,341 | 1,357 | 1,366 | 1,351.3 | 1.9% | 70.2 | 68.8 | 68.6 | 70.2 | 69.5 | 0.0% |
| Fee-for-Service (FFS) | | 230 | 232 | 232 | 233 | 231.8 | 1.3% | 409.9 | 401.6 | 401.3 | 398.6 | 402.9 | -2.8% |
| Geographic Managed Care (GMC) | | 810 | 817 | 822 | 825 | 818.5 | 1.9% | 81.5 | 73.9 | 67.2 | 63.0 | 71.4 | -22.7% |
| Two-Plan (Commercial Plan and Local Initiative) | | 4,041 | 4,066 | 4,113 | 4,139 | 4,089.8 | 2.4% | 131.4 | 122.6 | 115.0 | 109.9 | 119.7 | -16.4% |
| County | Plan Type | | | | | | | | | | | | |
| Alameda | Two-Plan | 294 | 298 | 303 | 305 | 300.0 | 3.7% | 80.7 | 73.5 | 67.1 | 64.2 | 71.4 | -20.4% |
| Alpine | FFS | - | - | - | - | - | - | - | - | - | - | - | - |
| Amador | FFS | 5 | 5 | 5 | 5 | 5.0 | 0.0% | 221.0 | 222.6 | 226.0 | 225.6 | 223.8 | 2.1% |
| Butte | FFS | 31 | 32 | 32 | 34 | 32.3 | 9.7% | 395.7 | 378.6 | 378.3 | 355.2 | 377.0 | -10.2% |
| Calaveras | FFS | 1 | 1 | 1 | 1 | 1.0 | 0.0% | 1,668.0 | 1,653.0 | 1,655.0 | 1,648.0 | 1,656.0 | -1.2% |
| Colusa | FFS | 1 | 1 | 1 | 1 | 1.0 | 0.0% | 1,004.0 | 1,005.0 | 1,020.0 | 1,007.0 | 1,009.0 | 0.3% |
| Contra Costa | Two-Plan | 146 | 147 | 150 | 151 | 148.5 | 3.4% | 99.6 | 92.5 | 85.3 | 80.9 | 89.6 | -18.8% |
| Del Norte | FFS | 3 | 3 | 3 | 3 | 3.0 | 0.0% | 664.0 | 659.3 | 656.3 | 652.0 | 657.9 | -1.8% |
| El Dorado | FFS | 15 | 15 | 15 | 15 | 15.0 | 0.0% | 299.6 | 297.5 | 297.5 | 296.7 | 297.8 | -1.0% |
| Fresno | Two-Plan | 129 | 131 | 132 | 133 | 131.3 | 3.1% | 196.3 | 183.0 | 174.4 | 166.4 | 180.0 | -15.2% |
| Glenn | FFS | 1 | 1 | 1 | 1 | 1.0 | 0.0% | 1,645.0 | 1,607.0 | 1,642.0 | 1,642.0 | 1,634.0 | -0.2% |
| Humboldt | FFS | 19 | 19 | 19 | 19 | 19.0 | 0.0% | 341.8 | 338.5 | 339.0 | 337.6 | 339.2 | -1.2% |
| Imperial | FFS | 19 | 19 | 19 | 18 | 18.8 | -5.3% | 707.6 | 706.9 | 703.5 | 743.3 | 715.3 | 5.0% |
| Inyo | FFS | 3 | 3 | 3 | 3 | 3.0 | 0.0% | 277.0 | 271.7 | 275.3 | 274.3 | 274.6 | -1.0% |
| Kern | Two-Plan | 106 | 106 | 106 | 107 | 106.3 | 0.9% | 215.9 | 201.4 | 195.0 | 186.9 | 199.8 | -13.4% |
| Kings | Two-Plan | 11 | 11 | 11 | 10 | 10.8 | -9.1% | 292.3 | 272.1 | 253.6 | 260.5 | 269.6 | -10.9% |
| Lake | FFS | 4 | 4 | 4 | 4 | 4.0 | 0.0% | 1,045.0 | 1,035.3 | 1,031.8 | 1,019.3 | 1,032.9 | -2.5% |

| | | Site-Specific Physician Counts | | | | | | Beneficiaries-to-Provider Ratio | | | | | |
|-----------------|----------|--------------------------------|----------------------|----------------------|----------------------|--------------------------------------|------------------------------------------------|---------------------------------|----------------------|----------------------|----------------------|------------------|------------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Providers | Percent Change 2011 Qtr 3- 2012 Qtr 2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Ratio | Percent Change 2011 Qtr 3- 2012 Qtr 2 |
| Lassen | FFS | 1 | 1 | 1 | 1 | 1.0 | 0.0% | 1,269.0 | 1,247.0 | 1,209.0 | 1,168.0 | 1,223.3 | -8.0% |
| Los Angeles | Two-Plan | 1,787 | 1,794 | 1,812 | 1,817 | 1,802.5 | 1.7% | 151.8 | 141.8 | 132.9 | 127.4 | 138.5 | -16.1% |
| Madera | Two-Plan | 15 | 15 | 15 | 15 | 15.0 | 0.0% | 345.9 | 326.3 | 321.2 | 314.2 | 326.9 | -9.2% |
| Marin * | COHS | 33 | 33 | 33 | 33 | 33.0 | 0.0% | 81.4 | 78.5 | 79.5 | 79.3 | 79.7 | -2.6% |
| Mariposa | FFS | - | - | - | - | - | - | - | - | - | - | - | - |
| Mendocino * | COHS | 22 | 22 | 22 | 22 | 22.0 | 0.0% | 48.9 | 48.2 | 48.7 | 49.9 | 48.9 | 2.0% |
| Merced | COHS | 22 | 22 | 22 | 22 | 22.0 | 0.0% | 208.1 | 206.5 | 209.0 | 217.6 | 210.3 | 4.6% |
| Modoc | FFS | 1 | 1 | 1 | 1 | 1.0 | 0.0% | 470.0 | 445.0 | 452.0 | 451.0 | 454.5 | -4.0% |
| Mono | FFS | 1 | 1 | 1 | 1 | 1.0 | 0.0% | 309.0 | 301.0 | 323.0 | 341.0 | 318.5 | 10.4% |
| Monterey | COHS | 75 | 75 | 75 | 75 | 75.0 | 0.0% | 131.5 | 128.0 | 133.0 | 135.4 | 132.0 | 3.0% |
| Napa | COHS | 16 | 16 | 16 | 16 | 16.0 | 0.0% | 81.1 | 79.1 | 78.5 | 80.9 | 79.9 | -0.2% |
| Nevada | FFS | 14 | 14 | 14 | 14 | 14.0 | 0.0% | 199.7 | 199.9 | 198.2 | 194.6 | 198.1 | -2.6% |
| Orange | COHS | 613 | 613 | 624 | 629 | 619.8 | 2.6% | 60.0 | 58.9 | 57.9 | 58.6 | 58.9 | -2.3% |
| Placer | FFS | 52 | 53 | 53 | 53 | 52.8 | 1.9% | 131.3 | 127.6 | 127.7 | 128.5 | 128.8 | -2.1% |
| Plumas | FFS | 1 | 1 | 1 | 1 | 1.0 | 0.0% | 728.0 | 724.0 | 735.0 | 745.0 | 733.0 | 2.3% |
| Riverside | Two-Plan | 197 | 199 | 204 | 206 | 201.5 | 4.6% | 182.7 | 170.6 | 156.2 | 149.2 | 164.7 | -18.3% |
| Sacramento | GMC | 295 | 295 | 296 | 297 | 295.8 | 0.7% | 83.8 | 75.1 | 67.3 | 61.5 | 71.9 | -26.6% |
| San Benito | FFS | 4 | 4 | 4 | 4 | 4.0 | 0.0% | 607.5 | 602.5 | 615.8 | 605.5 | 607.8 | -0.3% |
| San Bernardino | Two-Plan | 247 | 247 | 252 | 255 | 250.3 | 3.2% | 183.3 | 172.8 | 160.7 | 155.5 | 168.1 | -15.2% |
| San Diego | GMC | 515 | 522 | 526 | 528 | 522.8 | 2.5% | 80.2 | 73.3 | 67.2 | 63.8 | 71.1 | -20.4% |
| San Francisco | Two-Plan | 344 | 344 | 345 | 345 | 344.5 | 0.3% | 34.3 | 30.8 | 27.4 | 25.1 | 29.4 | -26.8% |
| San Joaquin | Two-Plan | 112 | 113 | 115 | 117 | 114.3 | 4.5% | 135.5 | 123.6 | 114.1 | 104.6 | 119.5 | -22.8% |
| San Luis Obispo | COHS | 33 | 33 | 33 | 33 | 33.0 | 0.0% | 55.9 | 54.5 | 55.9 | 59.0 | 56.3 | 5.5% |
| San Mateo | COHS | 136 | 137 | 137 | 139 | 137.3 | 2.2% | 47.5 | 47.7 | 48.8 | 50.3 | 48.6 | 5.9% |
| Santa Barbara | COHS | 79 | 79 | 79 | 80 | 79.3 | 1.3% | 97.4 | 95.5 | 96.8 | 98.7 | 97.1 | 1.3% |
| Santa Clara | Two-Plan | 501 | 505 | 510 | 517 | 508.3 | 3.2% | 55.1 | 53.1 | 51.1 | 48.9 | 52.1 | -11.3% |
| Santa Cruz | COHS | 40 | 40 | 41 | 41 | 40.5 | 2.5% | 81.8 | 79.9 | 80.7 | 84.3 | 81.7 | 3.1% |

| | | Site-Specific Physician Counts | | | | | | Beneficiaries-to-Provider Ratio | | | | | |
|------------|----------|--------------------------------|----------------------|----------------------|----------------------|--------------------------------------|------------------------------------------------|---------------------------------|----------------------|----------------------|----------------------|------------------|------------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Providers | Percent Change 2011 Qtr 3- 2012 Qtr 2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Ratio | Percent Change 2011 Qtr 3- 2012 Qtr 2 |
| Shasta | FFS | 19 | 19 | 19 | 19 | 19.0 | 0.0% | 522.4 | 510.3 | 508.1 | 508.2 | 512.3 | -2.7% |
| Sierra | FFS | - | - | - | - | - | - | - | - | - | - | - | - |
| Siskiyou | FFS | 4 | 4 | 4 | 4 | 4.0 | 0.0% | 616.8 | 610.5 | 621.3 | 620.0 | 617.2 | 0.5% |
| Solano | COHS | 77 | 77 | 79 | 78 | 77.8 | 1.3% | 39.5 | 38.2 | 37.7 | 41.3 | 39.2 | 4.6% |
| Sonoma | COHS | 63 | 63 | 64 | 65 | 63.8 | 3.2% | 67.5 | 65.7 | 64.0 | 66.7 | 66.0 | -1.2% |
| Stanislaus | Two-Plan | 74 | 75 | 76 | 79 | 76.0 | 6.8% | 189.4 | 173.6 | 164.5 | 152.9 | 170.1 | -19.3% |
| Sutter | FFS | 14 | 14 | 14 | 14 | 14.0 | 0.0% | 370.6 | 370.7 | 368.9 | 370.4 | 370.2 | -0.1% |
| Tehama | FFS | 5 | 5 | 5 | 5 | 5.0 | 0.0% | 834.4 | 802.6 | 803.6 | 809.0 | 812.4 | -3.0% |
| Trinity | FFS | - | - | - | - | - | - | - | - | - | - | - | - |
| Tulare | Two-Plan | 78 | 81 | 82 | 82 | 80.8 | 5.1% | 192.5 | 177.9 | 171.5 | 165.7 | 176.9 | -13.9% |
| Tuolumne | FFS | 8 | 8 | 8 | 8 | 8.0 | 0.0% | 249.9 | 246.0 | 243.9 | 238.9 | 244.7 | -4.4% |
| Ventura * | COHS | 104 | 103 | 104 | 105 | 104.0 | 1.0% | 93.6 | 91.4 | 90.4 | 92.5 | 92.0 | -1.2% |
| Yolo | COHS | 28 | 28 | 28 | 28 | 28.0 | 0.0% | 54.5 | 53.4 | 52.6 | 55.7 | 54.1 | 2.2% |
| Yuba | FFS | 4 | 4 | 4 | 4 | 4.0 | 0.0% | 1,268.5 | 1,235.3 | 1,222.0 | 1,213.5 | 1,234.8 | -4.3% |

*Shifted from FFS to COHS Model on July 1, 2011

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of August 2011, October 2011, January 2012, and April 2012.

Table PS-11 Physician Supply, Physicians with a Pediatric Specialty, FFS, Full Scope, Medi-Cal Only Children

| | Number of Physicians | | | | | | Beneficiaries-to-Provider Ratio | | | | | | |
|-------------------------------------------------|----------------------|----------------------|----------------------|----------------------|------------------------------------------|-----------------------------------------------|---------------------------------|----------------------|----------------------|----------------------|------------------|-----------------------------------------------|--------|
| | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Provider s | Percent Change 2011 Qtr 3–2012 Qtr 2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Ratio | Percent Change 2011 Qtr 3–2012 Qtr 2 | |
| Statewide | 10,921 | 11,007 | 11,089 | 11,168 | 11,046.3 | 2.3% | 64.3 | 61.2 | 58.7 | 57.9 | 60.5 | -10.0% | |
| County Plan Model Type | | | | | | | | | | | | | |
| County Organized Health System (COHS) | 1,944 | 1,948 | 1,959 | 1,977 | 1,957.0 | 1.7% | 17.0 | 14.8 | 13.9 | 16.4 | 15.5 | -3.5% | |
| Fee-for-Service (FFS) | 274 | 275 | 277 | 281 | 276.8 | 2.6% | 627.5 | 619.2 | 613.7 | 605.7 | 616.5 | -3.5% | |
| Geographic Managed Care (GMC) | 1,462 | 1,484 | 1,493 | 1,498 | 1,484.3 | 2.5% | 51.6 | 50.1 | 48.3 | 46.7 | 49.2 | -9.5% | |
| Two-Plan (Commercial Plan and Local Initiative) | 7,241 | 7,300 | 7,360 | 7,412 | 7,328.3 | 2.4% | 58.3 | 54.8 | 51.9 | 50.5 | 53.9 | -13.4% | |
| County Plan Type | | | | | | | | | | | | | |
| Alameda | Two-Plan | 735 | 741 | 747 | 750 | 743.3 | 2.0% | 25.9 | 24.9 | 23.4 | 22.9 | 24.3 | -11.6% |
| Alpine | FFS | - | - | - | - | - | - | - | - | - | - | - | - |
| Amador | FFS | 2 | 2 | 2 | 2 | 2.0 | 0.0% | 933.0 | 930.5 | 932.5 | 947.0 | 935.8 | 1.5% |
| Butte | FFS | 25 | 25 | 25 | 24 | 24.8 | -4.0% | 847.5 | 838.5 | 834.0 | 863.4 | 845.9 | 1.9% |
| Calaveras | FFS | 2 | 2 | 2 | 2 | 2.0 | 0.0% | 1,402.0 | 1,401.0 | 1,395.0 | 1,413.0 | 1,402.8 | 0.8% |
| Colusa | FFS | - | - | - | - | - | - | - | - | - | - | - | - |
| Contra Costa | Two-Plan | 241 | 241 | 242 | 246 | 242.5 | 2.1% | 48.1 | 48.3 | 47.1 | 44.7 | 47.1 | -7.1% |
| Del Norte | FFS | 5 | 5 | 5 | 5 | 5.0 | 0.0% | 667.2 | 666.8 | 672.6 | 665.8 | 668.1 | -0.2% |
| El Dorado | FFS | 17 | 17 | 17 | 17 | 17.0 | 0.0% | 477.1 | 475.5 | 475.5 | 480.3 | 477.1 | 0.7% |
| Fresno | Two-Plan | 184 | 186 | 187 | 189 | 186.5 | 2.7% | 102.7 | 96.5 | 93.9 | 88.6 | 95.4 | -13.7% |
| Glenn | FFS | 2 | 2 | 2 | 2 | 2.0 | 0.0% | 1,698.5 | 1,690.0 | 1,699.0 | 1,713.5 | 1,700.3 | 0.9% |
| Humboldt | FFS | 16 | 17 | 17 | 17 | 16.8 | 6.3% | 689.8 | 647.2 | 642.7 | 646.5 | 656.6 | -6.3% |
| Imperial | FFS | 20 | 20 | 20 | 21 | 20.3 | 5.0% | 1,284.8 | 1,277.1 | 1,279.2 | 1,219.3 | 1,265.1 | -5.1% |
| Inyo | FFS | 5 | 5 | 5 | 5 | 5.0 | 0.0% | 305.6 | 303.6 | 301.4 | 299.2 | 302.5 | -2.1% |

| | | Number of Physicians | | | | | | Beneficiaries-to-Provider Ratio | | | | | |
|----------------|----------|----------------------|----------------------|----------------------|----------------------|------------------------------------------|-----------------------------------------------|---------------------------------|----------------------|----------------------|----------------------|------------------|-----------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Provider s | Percent Change 2011 Qtr 3-2012 Qtr 2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Ratio | Percent Change 2011 Qtr 3-2012 Qtr 2 |
| Kern | Two-Plan | 143 | 144 | 142 | 142 | 142.8 | -0.7% | 173.5 | 160.9 | 161.5 | 156.1 | 163.0 | -10.0% |
| Kings | Two-Plan | 12 | 12 | 12 | 12 | 12.0 | 0.0% | 288.5 | 274.2 | 263.7 | 244.8 | 267.8 | -15.1% |
| Lake | FFS | 6 | 6 | 6 | 6 | 6.0 | 0.0% | 1,158.2 | 1,138.5 | 1,143.7 | 1,142.8 | 1,145.8 | -1.3% |
| Lassen | FFS | 2 | 2 | 2 | 2 | 2.0 | 0.0% | 1,077.5 | 1,070.5 | 1,053.5 | 1,024.0 | 1,056.4 | -5.0% |
| Los Angeles | Two-Plan | 2,949 | 2,973 | 3,004 | 3,021 | 2,986.8 | 2.4% | 59.0 | 54.8 | 50.6 | 49.8 | 53.6 | -15.6% |
| Madera | Two-Plan | 140 | 142 | 141 | 145 | 142.0 | 3.6% | 25.4 | 23.9 | 22.5 | 20.1 | 23.0 | -20.9% |
| Marin * | COHS | 71 | 71 | 72 | 72 | 71.5 | 1.4% | 5.3 | 4.7 | 4.7 | 6.0 | 5.2 | 13.2% |
| Mariposa | FFS | - | - | - | - | - | - | - | - | - | - | - | - |
| Mendocino * | COHS | 14 | 14 | 14 | 14 | 14.0 | 0.0% | 33.9 | 30.0 | 27.9 | 30.8 | 30.7 | -9.1% |
| Merced | COHS | 23 | 24 | 24 | 25 | 24.0 | 8.7% | 74.7 | 60.5 | 64.1 | 75.8 | 68.8 | 1.5% |
| Modoc | FFS | - | - | - | - | - | - | - | - | - | - | - | - |
| Mono | FFS | 5 | 5 | 5 | 5 | 5.0 | 0.0% | 134.8 | 134.6 | 136.2 | 139.6 | 136.3 | 3.6% |
| Monterey | COHS | 88 | 87 | 88 | 88 | 87.8 | 0.0% | 28.3 | 22.6 | 22.2 | 25.7 | 24.7 | -9.2% |
| Napa | COHS | 23 | 23 | 23 | 23 | 23.0 | 0.0% | 20.3 | 17.3 | 17.1 | 21.6 | 19.1 | 6.4% |
| Nevada | FFS | 11 | 11 | 11 | 11 | 11.0 | 0.0% | 422.9 | 423.4 | 421.1 | 418.6 | 421.5 | -1.0% |
| Orange | COHS | 902 | 906 | 910 | 916 | 908.5 | 1.6% | 14.6 | 12.0 | 10.6 | 12.0 | 12.3 | -17.8% |
| Placer | FFS | 88 | 88 | 90 | 93 | 89.8 | 5.7% | 157.2 | 156.8 | 154.1 | 149.3 | 154.4 | -5.0% |
| Plumas | FFS | - | - | - | - | - | - | - | - | - | - | - | - |
| Riverside | Two-Plan | 239 | 240 | 243 | 243 | 241.3 | 1.7% | 194.9 | 182.0 | 170.2 | 166.3 | 178.4 | -14.7% |
| Sacramento | GMC | 525 | 534 | 536 | 536 | 532.8 | 2.1% | 48.1 | 47.4 | 46.7 | 45.2 | 46.9 | -6.0% |
| San Benito | FFS | 4 | 4 | 4 | 4 | 4.0 | 0.0% | 1,244.0 | 1,226.0 | 1,237.5 | 1,234.8 | 1,235.6 | -0.7% |
| San Bernardino | Two-Plan | 517 | 521 | 528 | 530 | 524.0 | 2.5% | 106.7 | 99.8 | 94.6 | 93.4 | 98.6 | -12.5% |
| San Diego | GMC | 937 | 950 | 957 | 962 | 951.5 | 2.7% | 53.5 | 51.7 | 49.1 | 47.5 | 50.5 | -11.2% |
| San Francisco | Two-Plan | 682 | 689 | 693 | 698 | 690.5 | 2.3% | 8.8 | 8.4 | 8.1 | 7.6 | 8.2 | -13.6% |

| | | Number of Physicians | | | | | | Beneficiaries-to-Provider Ratio | | | | | |
|-----------------|----------|----------------------|----------------------|----------------------|----------------------|------------------------------------------|-----------------------------------------------|---------------------------------|----------------------|----------------------|----------------------|------------------|-----------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Provider s | Percent Change 2011 Qtr 3-2012 Qtr 2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Ratio | Percent Change 2011 Qtr 3-2012 Qtr 2 |
| San Joaquin | Two-Plan | 123 | 125 | 126 | 130 | 126.0 | 5.7% | 123.2 | 113.5 | 108.3 | 100.8 | 111.5 | -18.2% |
| San Luis Obispo | COHS | 51 | 51 | 51 | 51 | 51.0 | 0.0% | 15.5 | 15.3 | 15.7 | 18.7 | 16.3 | 20.6% |
| San Mateo | COHS | 275 | 275 | 275 | 277 | 275.5 | 0.7% | 7.4 | 6.7 | 6.7 | 9.1 | 7.5 | 23.0% |
| Santa Barbara | COHS | 97 | 97 | 97 | 98 | 97.3 | 1.0% | 26.8 | 25.1 | 24.5 | 24.9 | 25.3 | -7.1% |
| Santa Clara | Two-Plan | 1,110 | 1,118 | 1,125 | 1,137 | 1,122.5 | 2.4% | 14.8 | 15.6 | 15.7 | 14.6 | 15.2 | -1.4% |
| Santa Cruz | COHS | 44 | 44 | 45 | 46 | 44.8 | 4.5% | 23.3 | 23.2 | 22.0 | 25.6 | 23.5 | 9.9% |
| Shasta | FFS | 22 | 22 | 22 | 22 | 22.0 | 0.0% | 777.1 | 763.1 | 756.8 | 758.4 | 763.9 | -2.4% |
| Sierra | FFS | - | - | - | - | - | - | - | - | - | - | - | - |
| Siskiyou | FFS | 3 | 3 | 3 | 3 | 3.0 | 0.0% | 1,411.7 | 1,402.0 | 1,403.3 | 1,414.3 | 1,407.8 | 0.2% |
| Solano | COHS | 121 | 121 | 121 | 123 | 121.5 | 1.7% | 10.6 | 10.1 | 9.3 | 13.8 | 11.0 | 30.2% |
| Sonoma | COHS | 67 | 67 | 69 | 73 | 69.0 | 9.0% | 30.0 | 27.9 | 25.4 | 28.0 | 27.8 | -6.7% |
| Stanislaus | Two-Plan | 83 | 84 | 84 | 83 | 83.5 | 0.0% | 186.1 | 178.2 | 176.5 | 180.5 | 180.3 | -3.0% |
| Sutter | FFS | 12 | 12 | 12 | 13 | 12.3 | 8.3% | 891.4 | 885.8 | 891.1 | 826.9 | 873.8 | -7.2% |
| Tehama | FFS | 10 | 10 | 10 | 10 | 10.0 | 0.0% | 806.1 | 779.2 | 775.3 | 778.5 | 784.8 | -3.4% |
| Trinity | FFS | - | - | - | - | - | - | - | - | - | - | - | - |
| Tulare | Two-Plan | 83 | 84 | 86 | 86 | 84.8 | 3.6% | 143.4 | 138.1 | 131.8 | 125.0 | 134.6 | -12.8% |
| Tuolumne | FFS | 10 | 10 | 10 | 10 | 10.0 | 0.0% | 327.7 | 321.6 | 322.5 | 322.7 | 323.6 | -1.5% |
| Ventura * | COHS | 123 | 123 | 124 | 125 | 123.8 | 1.6% | 27.1 | 24.6 | 24.0 | 29.9 | 26.4 | 10.3% |
| Yolo | COHS | 45 | 45 | 46 | 46 | 45.5 | 2.2% | 29.0 | 27.3 | 24.9 | 28.0 | 27.3 | -3.4% |
| Yuba | FFS | 7 | 7 | 7 | 7 | 7.0 | 0.0% | 1,345.4 | 1,324.0 | 1,307.0 | 1,302.9 | 1,319.8 | -3.2% |

*Shifted from FFS to COHS Model on July 1, 2011

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of August 2011, October 2011, January 2012, and April 2012.

Table PS-12 Outpatient Clinics

| | | Number of Rural/FQHC Clinics | | | | | | Number of Other Clinics | | | | | |
|-------------------------------------------------|------------------|------------------------------|----------------------|----------------------|----------------------|------------------------------------|-----------------------------------------------|-------------------------|----------------------|----------------------|----------------------|------------------------------------|-----------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Clinics | Percent Change 2011 Qtr 3–2012 Qtr 2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Clinics | Percent Change 2011 Qtr 3–2012 Qtr 2 |
| Statewide | | 961 | 959 | 957 | 983 | 965.0 | 2.3% | 1,624 | 1,638 | 1,656 | 1,682 | 1,650.0 | 3.6% |
| County Plan Model Type | | | | | | | | | | | | | |
| County Organized Health System (COHS) | | 189 | 186 | 187 | 195 | 189.3 | 3.2% | 410 | 419 | 423 | 425 | 419.3 | 3.7% |
| Fee-for-Service (FFS) | | 195 | 196 | 197 | 200 | 197.0 | 2.6% | 215 | 216 | 218 | 221 | 217.5 | 2.8% |
| Geographic Managed Care (GMC) | | 80 | 80 | 79 | 84 | 80.8 | 5.0% | 191 | 192 | 195 | 195 | 193.3 | 2.1% |
| Two-Plan (Commercial Plan and Local Initiative) | | 497 | 497 | 494 | 504 | 498.0 | 1.4% | 808 | 811 | 820 | 841 | 820.0 | 4.1% |
| County | Plan Type | | | | | | | | | | | | |
| Alameda | Two-Plan | 39 | 38 | 39 | 39 | 38.8 | 0.0% | 54 | 54 | 55 | 57 | 55.0 | 5.6% |
| Alpine | FFS | 1 | 1 | 1 | 1 | 1.0 | 0.0% | 1 | 1 | 1 | 1 | 1.0 | 0.0% |
| Amador | FFS | 4 | 4 | 4 | 4 | 4.0 | 0.0% | 6 | 6 | 6 | 6 | 6.0 | 0.0% |
| Butte | FFS | 19 | 19 | 19 | 20 | 19.3 | 5.3% | 26 | 26 | 26 | 27 | 26.3 | 3.8% |
| Calaveras | FFS | 7 | 7 | 7 | 7 | 7.0 | 0.0% | 3 | 3 | 3 | 3 | 3.0 | 0.0% |
| Colusa | FFS | 4 | 4 | 4 | 4 | 4.0 | 0.0% | 4 | 3 | 3 | 3 | 3.3 | -25.0% |
| Contra Costa | Two-Plan | 16 | 16 | 16 | 16 | 16.0 | 0.0% | 30 | 30 | 30 | 30 | 30.0 | 0.0% |
| Del Norte | FFS | 4 | 4 | 4 | 4 | 4.0 | 0.0% | 3 | 3 | 3 | 3 | 3.0 | 0.0% |
| El Dorado | FFS | 6 | 6 | 6 | 6 | 6.0 | 0.0% | 8 | 8 | 8 | 10 | 8.5 | 25.0% |
| Fresno | Two-Plan | 64 | 65 | 58 | 59 | 61.5 | -7.8% | 40 | 40 | 40 | 41 | 40.3 | 2.5% |
| Glenn | FFS | 11 | 12 | 12 | 13 | 12.0 | 18.2% | 2 | 2 | 2 | 2 | 2.0 | 0.0% |
| Humboldt | FFS | 30 | 30 | 30 | 30 | 30.0 | 0.0% | 14 | 14 | 14 | 14 | 14.0 | 0.0% |
| Imperial | FFS | 10 | 10 | 10 | 10 | 10.0 | 0.0% | 6 | 6 | 6 | 7 | 6.3 | 16.7% |
| Inyo | FFS | 6 | 6 | 6 | 6 | 6.0 | 0.0% | 5 | 5 | 5 | 5 | 5.0 | 0.0% |
| Kern | Two-Plan | 34 | 34 | 35 | 38 | 35.3 | 11.8% | 40 | 41 | 41 | 42 | 41.0 | 5.0% |

| | | Number of Rural/FQHC Clinics | | | | | | Number of Other Clinics | | | | | |
|-----------------|----------|------------------------------|----------------------|----------------------|----------------------|------------------------------------|-----------------------------------------------|-------------------------|----------------------|----------------------|----------------------|------------------------------------|-----------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Clinics | Percent Change 2011 Qtr 3-2012 Qtr 2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Clinics | Percent Change 2011 Qtr 3-2012 Qtr 2 |
| Kings | Two-Plan | 18 | 18 | 19 | 18 | 18.3 | 0.0% | 13 | 13 | 13 | 13 | 13.0 | 0.0% |
| Lake | FFS | 10 | 10 | 10 | 11 | 10.3 | 10.0% | 10 | 11 | 11 | 11 | 10.8 | 10.0% |
| Lassen | FFS | 5 | 6 | 5 | 5 | 5.3 | 0.0% | 2 | 2 | 2 | 2 | 2.0 | 0.0% |
| Los Angeles | Two-Plan | 146 | 146 | 147 | 148 | 146.8 | 1.4% | 338 | 339 | 345 | 357 | 344.8 | 5.6% |
| Madera | Two-Plan | 12 | 12 | 12 | 12 | 12.0 | 0.0% | 7 | 7 | 7 | 8 | 7.3 | 14.3% |
| Marin * | COHS | 5 | 5 | 5 | 8 | 5.8 | 60.0% | 25 | 25 | 25 | 23 | 24.5 | -8.0% |
| Mariposa | FFS | 4 | 4 | 4 | 4 | 4.0 | 0.0% | 2 | 2 | 2 | 2 | 2.0 | 0.0% |
| Mendocino * | COHS | 23 | 23 | 23 | 24 | 23.3 | 4.3% | 8 | 8 | 9 | 9 | 8.5 | 12.5% |
| Merced | COHS | 29 | 26 | 26 | 27 | 27.0 | -6.9% | 11 | 11 | 11 | 11 | 11.0 | 0.0% |
| Modoc | FFS | 4 | 4 | 4 | 4 | 4.0 | 0.0% | 3 | 3 | 3 | 3 | 3.0 | 0.0% |
| Mono | FFS | 1 | 1 | 1 | 1 | 1.0 | 0.0% | 2 | 2 | 2 | 2 | 2.0 | 0.0% |
| Monterey | COHS | 21 | 21 | 21 | 21 | 21.0 | 0.0% | 23 | 23 | 23 | 23 | 23.0 | 0.0% |
| Napa | COHS | 2 | 2 | 2 | 2 | 2.0 | 0.0% | 18 | 22 | 22 | 22 | 21.0 | 22.2% |
| Nevada | FFS | 2 | 2 | 2 | 2 | 2.0 | 0.0% | 19 | 19 | 19 | 19 | 19.0 | 0.0% |
| Orange | COHS | 15 | 15 | 15 | 15 | 15.0 | 0.0% | 133 | 134 | 135 | 136 | 134.5 | 2.3% |
| Placer | FFS | 3 | 3 | 3 | 3 | 3.0 | 0.0% | 14 | 14 | 15 | 15 | 14.5 | 7.1% |
| Plumas | FFS | 6 | 6 | 6 | 6 | 6.0 | 0.0% | 5 | 5 | 5 | 5 | 5.0 | 0.0% |
| Riverside | Two-Plan | 23 | 23 | 23 | 23 | 23.0 | 0.0% | 48 | 48 | 49 | 50 | 48.8 | 4.2% |
| Sacramento | GMC | 9 | 9 | 8 | 10 | 9.0 | 11.1% | 87 | 88 | 89 | 89 | 88.3 | 2.3% |
| San Benito | FFS | 3 | 3 | 3 | 3 | 3.0 | 0.0% | 3 | 3 | 3 | 3 | 3.0 | 0.0% |
| San Bernardino | Two-Plan | 13 | 13 | 13 | 14 | 13.3 | 7.7% | 60 | 62 | 62 | 63 | 61.8 | 5.0% |
| San Diego | GMC | 71 | 71 | 71 | 74 | 71.8 | 4.2% | 104 | 104 | 106 | 106 | 105.0 | 1.9% |
| San Francisco | Two-Plan | 30 | 30 | 30 | 32 | 30.5 | 6.7% | 50 | 51 | 51 | 52 | 51.0 | 4.0% |
| San Joaquin | Two-Plan | 7 | 8 | 8 | 8 | 7.8 | 14.3% | 35 | 34 | 34 | 34 | 34.3 | -2.9% |
| San Luis Obispo | COHS | 12 | 12 | 12 | 12 | 12.0 | 0.0% | 20 | 19 | 19 | 19 | 19.3 | -5.0% |

| | | Number of Rural/FQHC Clinics | | | | | | Number of Other Clinics | | | | | |
|---------------|----------|------------------------------|----------------------|----------------------|----------------------|------------------------------------|-----------------------------------------------|-------------------------|----------------------|----------------------|----------------------|------------------------------------|-----------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Clinics | Percent Change 2011 Qtr 3-2012 Qtr 2 | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | Average Number of Clinics | Percent Change 2011 Qtr 3-2012 Qtr 2 |
| San Mateo | COHS | 16 | 16 | 16 | 17 | 16.3 | 6.3% | 33 | 33 | 33 | 33 | 33.0 | 0.0% |
| Santa Barbara | COHS | 17 | 17 | 17 | 17 | 17.0 | 0.0% | 30 | 30 | 30 | 31 | 30.3 | 3.3% |
| Santa Clara | Two-Plan | 22 | 22 | 22 | 24 | 22.5 | 9.1% | 51 | 51 | 51 | 51 | 51.0 | 0.0% |
| Santa Cruz | COHS | 8 | 8 | 8 | 8 | 8.0 | 0.0% | 17 | 17 | 17 | 18 | 17.3 | 5.9% |
| Shasta | FFS | 16 | 16 | 16 | 16 | 16.0 | 0.0% | 28 | 28 | 28 | 28 | 28.0 | 0.0% |
| Sierra | FFS | 2 | 2 | 2 | 2 | 2.0 | 0.0% | 2 | 2 | 2 | 2 | 2.0 | 0.0% |
| Siskiyou | FFS | 12 | 12 | 12 | 12 | 12.0 | 0.0% | 8 | 8 | 8 | 7 | 7.8 | -12.5% |
| Solano | COHS | 8 | 8 | 8 | 8 | 8.0 | 0.0% | 20 | 20 | 22 | 23 | 21.3 | 15.0% |
| Sonoma | COHS | 15 | 15 | 16 | 16 | 15.5 | 6.7% | 33 | 35 | 35 | 35 | 34.5 | 6.1% |
| Stanislaus | Two-Plan | 26 | 26 | 26 | 26 | 26.0 | 0.0% | 26 | 25 | 25 | 26 | 25.5 | 0.0% |
| Sutter | FFS | 4 | 4 | 4 | 4 | 4.0 | 0.0% | 13 | 14 | 15 | 14 | 14.0 | 7.7% |
| Tehama | FFS | 8 | 8 | 8 | 8 | 8.0 | 0.0% | 6 | 6 | 6 | 7 | 6.3 | 16.7% |
| Trinity | FFS | 2 | 2 | 3 | 3 | 2.5 | 50.0% | 2 | 2 | 2 | 2 | 2.0 | 0.0% |
| Tulare | Two-Plan | 47 | 46 | 46 | 47 | 46.5 | 0.0% | 16 | 16 | 17 | 17 | 16.5 | 6.3% |
| Tuolumne | FFS | 4 | 4 | 4 | 4 | 4.0 | 0.0% | 15 | 15 | 15 | 15 | 15.0 | 0.0% |
| Ventura * | COHS | 12 | 12 | 12 | 14 | 12.5 | 16.7% | 31 | 32 | 32 | 32 | 31.8 | 3.2% |
| Yolo | COHS | 6 | 6 | 6 | 6 | 6.0 | 0.0% | 8 | 10 | 10 | 10 | 9.5 | 25.0% |
| Yuba | FFS | 7 | 6 | 7 | 7 | 6.8 | 0.0% | 3 | 3 | 3 | 3 | 3.0 | 0.0% |

*Shifted from FFS to COHS Model on July 1, 2011

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011-June 2012 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of August 2011, October 2011, January 2012, and April 2012.



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



BENEFICIARY PARTICIPATION

January 2013

California Department of Health Care Services
Research and Analytic Studies Branch
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Contents

| | |
|-----------------------------------------------------------------------------------|----|
| Medi-Cal FFS Beneficiary Participation Trends | 3 |
| Introduction | 5 |
| Methods | 5 |
| Results | 6 |
| Medi-Cal Full Scope Beneficiaries by Gender and Age | 6 |
| Aid Category and Age | 8 |
| Participation in Metropolitan vs. Non-Metropolitan Counties | 10 |
| Distribution of Medi-Cal Only FFS Beneficiaries, by Primary Language Spoken | 12 |
| Distribution of Medi-Cal Only FFS Beneficiaries, by Race/Ethnicity | 13 |
| Distribution of Medi-Cal Only FFS Beneficiaries, by County | 14 |
| Conclusions—Beneficiary Participation | 17 |
| Appendix A—County Level Tables | 18 |
| Appendix B—Medi-Cal Aid Codes | 29 |

List of Figures

| | | |
|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----|
| Figure BP-1 | Top Reasons Medi-Cal FFS Beneficiaries Seek Care, by Age and Aid Category | 4 |
| Figure BP-2 | Quarterly Average Member Months for Full Scope FFS Beneficiaries, by Gender and Age Group, 2011 Quarter 3–2012 Quarter 2 | 6 |
| Figure BP-3 | Change in FFS Participation among Full Scope Beneficiaries, by Gender and Age, 2011 Quarter 3–2012 Quarter 2 | 7 |
| Figure BP-4 | Change in FFS Participation among All Beneficiaries, by Aid Category and Age, 2011 Quarter 3–2012 Quarter 2 | 8 |
| Figure BP-5 | Change in FFS Participation among Medi-Cal Beneficiaries, by Aid Category and Age, Metropolitan Counties, 2011 Quarter 3–2012 Quarter 2 | 10 |
| Figure BP-6 | Change in FFS Participation among Medi-Cal Beneficiaries, by Age and Aid Category, Non-Metropolitan Counties, 2011 Quarter 3–2012 Quarter 2..... | 11 |
| Figure BP-7 | Distribution of FFS Beneficiaries in Medi-Cal Only Population, by Primary Language Spoken, 2012 Quarter 2 | 12 |
| Figure BP-8 | Distribution of FFS Beneficiaries by Race/Ethnicity, 2012 Quarter 2 | 13 |
| Figure BP-9 | Comparison of FFS Participation by Medi-Cal Only Beneficiaries, 2012 Quarter 2–2011 Quarter 3 | 15 |
| Figure BP-10 | Comparison of FFS Participation by Medi-Cal Only Beneficiaries, 2012 Quarter 2–Previous Quarter | 16 |

List of Tables

| | | |
|------------|-----------------------------------------------------------------------------------------|----|
| Table BP-1 | FFS Beneficiaries, Medi-Cal Only, Average Member Months per Quarter, by County | 18 |
| Table BP-2 | FFS Full Scope Beneficiaries, Medi-Cal only Average Member Months, by County . | 20 |
| Table BP-3 | FFS Full Scope Children Age 0–17, Medi-Cal only, Average Member Months, by County | 22 |
| Table BP-4 | FFS Women Age 18–64, Medi-Cal Only, Average Member Months, by County | 24 |
| Table BP-5 | FFS Full Scope, Average Member Months, by Gender and Age..... | 26 |
| Table BP-6 | FFS Restricted Scope, Average Member Months, by Gender and Age | 26 |
| Table BP-7 | FFS Beneficiaries, Average Member Months, by Age and Aid Category | 27 |
| Table BP-8 | FFS Average Member Months, by Age and Aid Category, Metropolitan Counties... | 27 |
| Table BP-9 | FFS Average Member Months by Age and Aid Category, Non-Metropolitan Counties | 28 |

Medi-Cal FFS Beneficiary Participation Trends

Introduction

Compared to those covered by private insurance, the Medi-Cal program provides health care coverage to a fairly heterogeneous and disadvantaged population. The Medi-Cal population is comprised of individuals with unique demographic characteristics, clinical needs, and benefit packages, which are reflective of complex eligibility and administrative rules.

Historically, Medi-Cal eligibility was subject to categorical restrictions that limited enrolled coverage to the elderly, persons with disabilities, members of families with dependent children, pregnant women and children, certain women with breast or cervical cancer, and uninsured individuals with tuberculosis. To qualify, an individual's income and resources had to meet specific thresholds. While many of Medi-Cal's initial eligibility pathways were tied to receipt of cash assistance under programs such as Aid to Families with Dependent Children, or the SSI program, program changes in recent years have shifted eligibility determination to an income-based approach.

The range of benefits offered by the Medi-Cal program also varies among groups. For example, some groups may gain access to Medi-Cal services only after experiencing an acute care hospital admission, in which case individuals are not eligible for Medi-Cal at the time of admission but gain it retroactively. Other groups, such as undocumented immigrants, are only entitled to a limited scope of health care services.

Understanding the unique complexities of the Medi-Cal subpopulations is crucial for administrators to develop suitable policies and processes that will ensure appropriate access to care for all beneficiaries. Population characteristics such as age and health care needs must be carefully evaluated when considering health system capacity and service use, since each subpopulation will present different clinical needs and thus require specific services and provider types. In addition, how the population is distributed throughout the state geographically relative to providers is also vitally important. Figure BP-1 shows the most prevalent clinical conditions affecting various Medi-Cal subpopulations.

The degree of responsibility for ensuring access to care may vary depending on the subpopulation and type of service. For example, approximately 80% of the beneficiaries participating in Medi-Cal's traditional FFS system and not eligible for Medicare are

Highlights

FFS participation decreased for all age and gender groups.

FFS participation declined 19.1% from 1,365,590 to 1,104,118.

Largest decrease by age and gender group occurred among individuals age 65 and older.

Two aid category groups increased in FFS participation, children in Foster Care and Adults in the Other category.

Spanish is primary language for 49.9% and 46.1% reported English.

Hispanics represent 63.2% of total FFS Medi-Cal only population.

undocumented aliens who are entitled only to pregnancy-related care and emergency services. For these beneficiaries, DHCS is responsible for ensuring access to prenatal care, obstetrical, and emergency department services only. The remaining beneficiaries participating in Medi-Cal's FFS system who are not eligible for Medicare qualify for full-scope services. Roughly one-third of this population is enrolled in Family aid categories, and less than 10% is enrolled in Blind/Disabled aid categories.

The distribution of beneficiaries enrolled in FFS and managed care was approximately fifty-fifty between 2004–2007. Since 2007, managed care has become the predominant health care delivery model, accounting for 62.8% of all Medi-Cal beneficiaries as of January 1, 2012.

Between January 2011–January 2012 there was a net shift of 575,695 beneficiaries, or 7.2%, of the Medi-Cal population from FFS to the managed care delivery model. Two developments are responsible for the shift in participation between the two health care delivery models:

1. Under the terms of California's Section 1115 "Bridge to Reform" waiver, beneficiaries enrolled in "Seniors and Persons with Disabilities" (SPDs) aid categories were required to enroll in managed care programs. From May 1, 2011–January 1, 2012, the number of SPD beneficiaries participating in Medi-Cal's FFS system decreased from 394,582 to 158,771.
2. An expansion in the number of counties that transitioned from the FFS to the managed care model. Between January 2011–January 2012, Ventura, Mendocino, and Marin Counties shifted a total of 140,944 Medi-Cal beneficiaries from the FFS to the managed care model.

Figure BP-1 Top Reasons Medi-Cal FFS Beneficiaries Seek Care, by Age and Aid Category

| Aid Category | Adults (21+ years) | Aid Category | Children (0–21 years) |
|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Aged (65+ years) | Essential hypertension Diabetes mellitus with and without complication Disorders of lipid metabolism Lower respiratory diseases Chest pain Deficiency and other Anemia Cardiac Dysrhythmias | Blind/Disabled | Rehabilitative care; fitting of prostheses Developmental disorders Paralysis Upper respiratory infections Other congenital anomalies Nutrition, endocrine, and other metabolic disorders Epilepsy |
| Blind/Disabled | Essential hypertension Spondylosis; intervertebral disc disorders; other back problems Diabetes mellitus without complications Lower respiratory diseases Non traumatic joint disease Abdominal pain | Foster Care | Upper respiratory infections Blindness and vision defects Attention-deficit conduct and disruptive behavior Medical exams and evaluations Asthma Developmental disorders |
| Families | Pregnancy-related conditions Medical exams, evaluations, and screening for suspected conditions Abdominal pain Spondylosis; intervertebral disc disorders; other back problems Contraceptive and procreative management Upper respiratory diseases | Families | Upper and lower respiratory infections Otitis media and related conditions Acute bronchitis Blindness and vision defects Liveborn infant care Disorders of the teeth and jaw |
| Other | Pregnancy-related conditions Medical exams, evaluations, and screening for suspected conditions Breast cancer Contraception and procreative management Diabetes Essential hypertension | Other | Upper and lower respiratory infections Liveborn infant care Hemolytic and perinatal jaundice Other perinatal conditions Otitis media and related conditions Normal pregnancy and delivery Nutritional, endocrine, and metabolic disorders |
| Undocumented | Pregnancy-related conditions Medical exams, evaluations and screening for suspected conditions Abdominal pain Injuries and conditions due to external causes Contraceptive and procreative management Chest Pain | Undocumented | Liveborn infant care Normal pregnancy and delivery Hemolytic and perinatal jaundice Other perinatal conditions Complications of pregnancy and birth Abdominal pain |

Methods

The access monitoring activities that DHCS has undertaken and described here are directed at beneficiaries participating in Medi-Cal's FFS delivery system only and excludes beneficiaries eligible for both Medicare and Medi-Cal. In addition, only those beneficiaries who become "certified" by meeting their monthly share of cost are included in the analysis.

Beneficiary participation summaries were derived from the Medi-Cal Eligibility System Monthly Extract File (MMEF). This data source provides information on a monthly basis on a beneficiaries' length of participation, aid category under which they are eligible for services, and demographic data, including age, gender, race/ethnicity, and primary language spoken. In addition, the MMEF file contains geographic variables, which allow examination of the data by county, metropolitan designation, or Medical Service Study Area (MSSA).

In this report, Medi-Cal participation in the FFS health care delivery system was measured as 'Member Months,' representing the number of months a beneficiary has been in the Medi-Cal FFS delivery system during the reporting period. Average quarterly member months were calculated for all Medi-Cal beneficiaries included in the selection criteria. To reveal potential differences in participation based on specific health care needs, beneficiaries participating in Medi-Cal's FFS system and not eligible for Medicare were grouped into homogeneous subpopulations based on one of six eligibility categories: Blind/Disabled, Families, Aged, Foster Care, Undocumented, and Other. See [Appendix B](#) for more detailed information on aid categories and codes.

Additional criteria include whether beneficiary receives full or restricted scope of Medi-Cal services, and their age group (0–17, 18–65, 65+ years old). Statistics reflecting the gender, race/ethnicity, and primary language spoken among beneficiaries are also presented since these factors have been known to influence health service use. Furthermore, geographic variations in Medi-Cal enrollees were explored stratifying beneficiaries by county and metropolitan designation.¹

Change in participation in the FFS health care delivery system was evaluated by calculating the difference in the number of Medi-Cal beneficiaries (average member months) across quarters, as a percentage of total beneficiaries participating from the third quarter of 2011 to the second quarter of 2012. Additional comparisons were made between the current quarter being studied to the previous quarter.

¹ Metropolitan designations were identified using ERS Rural-Urban Continuum Codes. The Rural-Urban Continuum Codes are calculated by examining the size of a county and its proximity to a metropolitan area. Rural-Urban Continuum Codes form a classification scheme that distinguishes metropolitan (metro) counties by the population size of their metro area, and nonmetropolitan (nonmetro) counties by degree of urbanization and adjacency to a metro area or areas.

Results

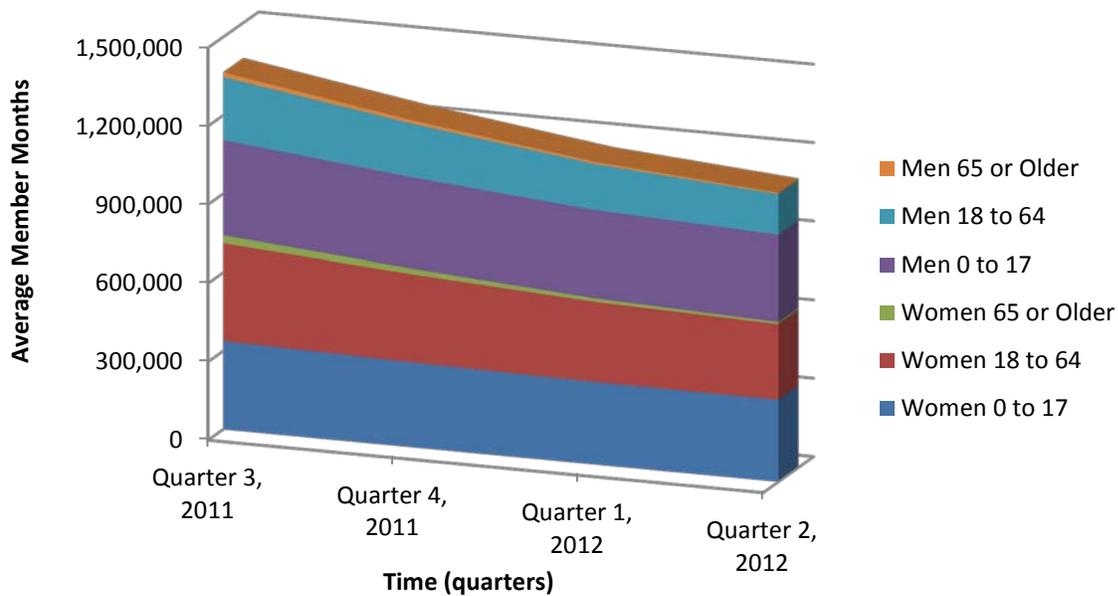
Medi-Cal Full Scope Beneficiaries by Gender and Age

Participation in the FFS health care delivery system for Medi-Cal beneficiaries who were eligible for full scope services decreased for all age and gender groups from the third quarter of 2011 to the second quarter of 2012 (see Figure BP-2).

FFS participation declined 19.1% from July 2011–June 2012.

Overall, FFS participation declined 19.1% during the 12-month period, from 1,365,590 to 1,104,118. The highest rate of reduction in FFS participation (8.3%) occurred between the third and fourth quarters of 2011. Declines in FFS program participation decreased steadily, changing at a rate of 4.6% between the first and second quarters of 2012.

Figure BP-2 Quarterly Average Member Months for Full Scope FFS Beneficiaries, by Gender and Age Group, 2011 Quarter 3–2012 Quarter 2

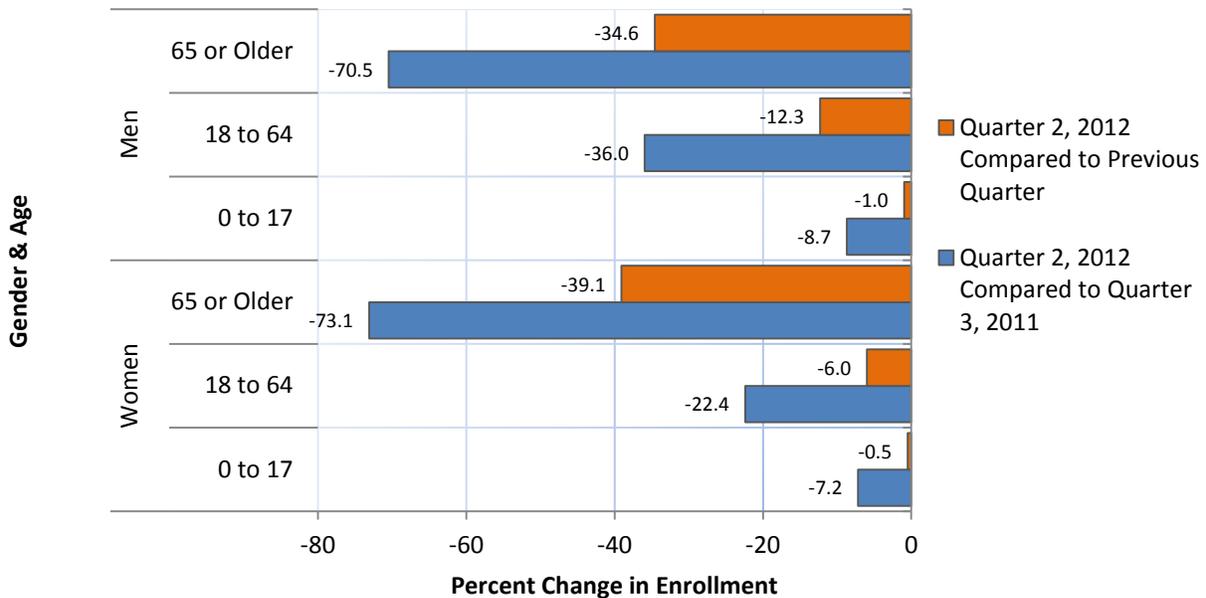


Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag).

In Figure BP-3, the largest decrease in FFS participation from the third quarter of 2011 to the second quarter of 2012 was among individuals 65 years and older (72.1%) (see Table BP-5 in [Appendix A](#)). This reduction affected both gender groups equally. Among young adults age 18–64, males experienced a larger decrease (36%) in FFS participation than women (22.4%) across this same 12-month study period. A large number of beneficiaries participating in the FFS health care delivery system with full scope benefits are age 0-17, but this same group experienced the lowest declines in FFS participation (8%).

Among adults age 18–64, FFS participation decreased more for males (36.0%) than females (22.4%).

Figure BP-3 Change in FFS Participation among Full Scope Beneficiaries, by Gender and Age, 2011 Quarter 3–2012 Quarter 2



Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag).

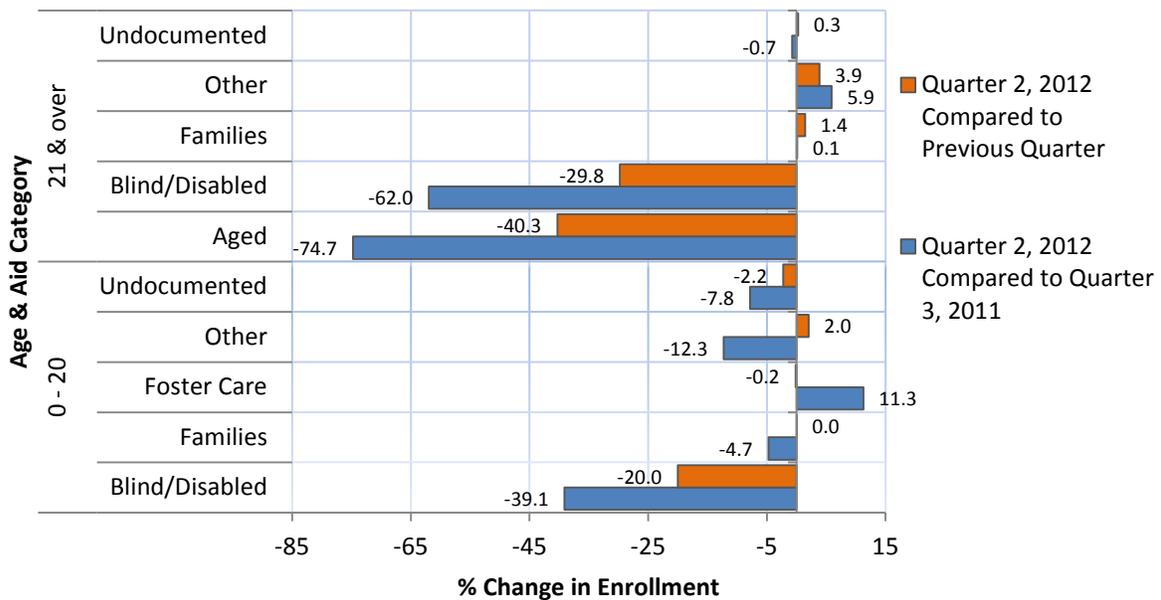
Aid Category and Age

Table BP-4 displays the change in FFS participation for beneficiaries with Medi-Cal only by age and aid category for the third quarter of 2011 to the second quarter of 2012. Across this 12-month period, FFS participation declined gradually for all aid categories and age groups, with the exception of children enrolled in Foster Care aid codes and adults in the Other aid category.

The largest declines in FFS participation occurred for beneficiaries in the Aged aid category.

The largest declines in FFS participation occurred for beneficiaries in the Aged aid category (74.7%) when comparing participation changes from the third quarter of 2011 to the second quarter of 2012, and 40.3% when comparing changes from the first to second quarter of 2012. The next largest declines in FFS participation were observed among adult beneficiaries in the Blind/Disabled aid category, with a 62% decline from the third quarter of 2011 to the second quarter of 2012, and a 29.8% decline from the first to second quarter of 2012.

Figure BP-4 Change in FFS Participation among All Beneficiaries, by Aid Category and Age, 2011 Quarter 3–2012 Quarter 2



Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag).

Among children, the largest decrease in FFS participation was in the Blind/Disabled group, with a 39.1% decline from the third quarter of 2011 to the second quarter of 2012, and a 20% decline from the second quarter of 2012 to the previous quarter. The drop in FFS participation among the Aged and Blind/Disabled populations reflects the implementation of the Bridge to Reform Waiver by which seniors and persons with disabilities (SPDs) were mandatorily shifted

from the traditional FFS to the managed care delivery model. These large shifts in beneficiary participation from FFS to managed care occurred predominantly in 2011 and have since diminished in size during the most recent quarter studied.

FFS participation for beneficiaries enrolled in Foster Care aid codes remained constant during the first two quarters of 2012 but increased 11.3% from the third quarter of 2011 to the second quarter of 2012. This trend can be explained by Assembly Bill 12 (AB 12) California Fostering Connections to Success, effective January 1, 2012, which optionally extends foster care benefits up to age 21 if specific age and program conditions are met.

FFS participation for beneficiaries in Foster Care aid codes increased 11.3% from July 2011–June 2012.

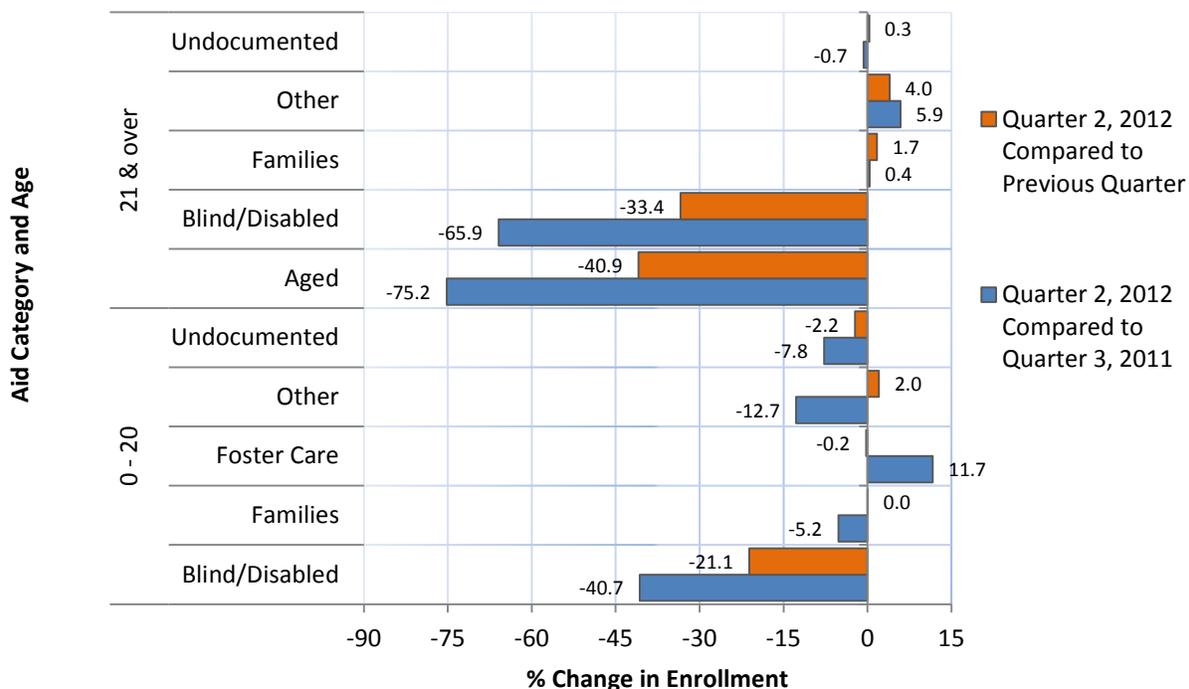
Participation in FFS for adults over age 21 who are eligible for Medi-Cal under the Other aid category rose by 3.9% over the first two quarters of 2012, and by 5.9% during the entire reporting period. The Other aid category represents a variety of aid codes, including Refugee Assistance, Long-Term Care, and Breast and Cervical Cancer Treatment Program. DHCS hypothesizes that the increase in FFS participation for adults eligible under Other aid category might have been driven by beneficiaries in long-term care assistance programs who had been previously shifted from FFS to the managed care delivery system after implementation of the Bridge to Reform, and who later were “carved out” from managed care back into FFS in order to access long-term care benefits. Further evaluation will be needed in order to confirm this hypothesis.

Participation in Metropolitan vs. Non-Metropolitan Counties

Overall, FFS participation decreased slightly (3%) from the third quarter of 2011 to the second quarter of 2012 among beneficiaries residing in metropolitan counties (see Figure BP-5), remaining virtually unchanged in non-metropolitan counties (-0.3%) (see Figure BP-6, and see Table BP-8 and Table BP-9 in [Appendix A](#) for county-level detail). However, FFS participation differed substantially among the different subpopulations evaluated in both metropolitan and non-metropolitan counties.

In Metropolitan areas, the largest decreases in FFS participation occurred among Aged adults (75.2%), and Blind/Disabled children (40.7%).

Figure BP-5 Change in FFS Participation among Medi-Cal Beneficiaries, by Aid Category and Age, Metropolitan Counties, 2011 Quarter 3–2012 Quarter 2



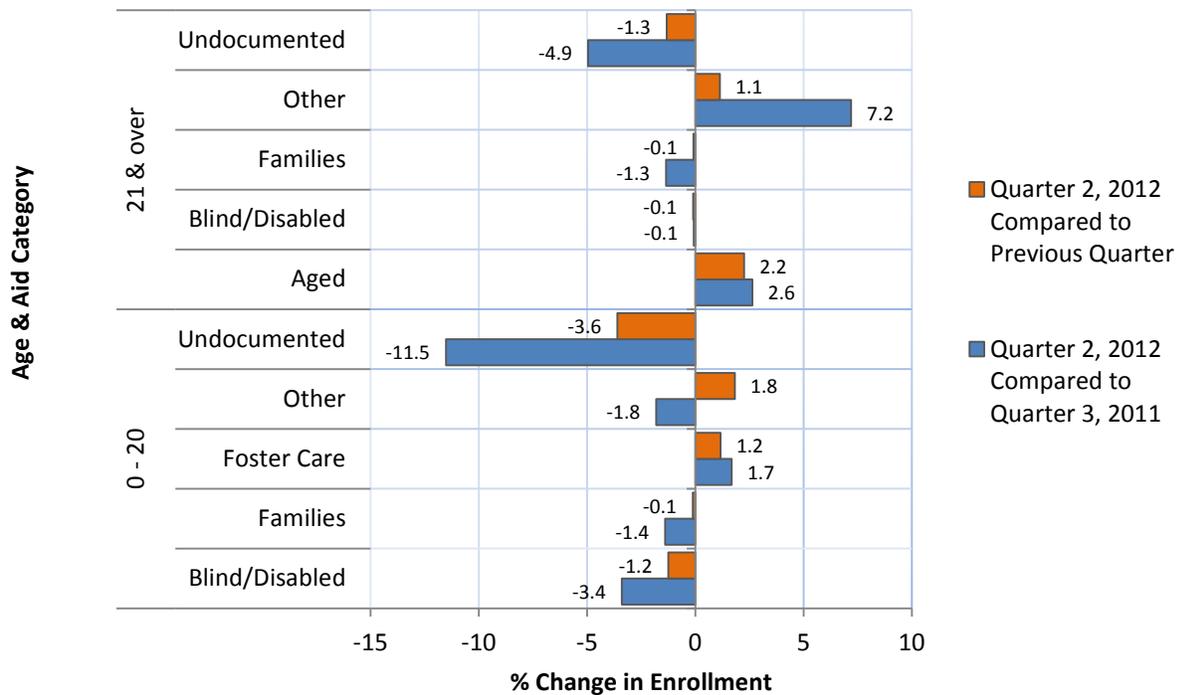
Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag).

For beneficiaries residing in metropolitan counties, participation across the four quarters varied greatly, from an increase of 11.7% in Foster Care children to a decrease of 75.2% in the Aged group. A significant decrease in participation was also observed among the Blind/Disabled population in both adults and children (65.9% and 40.7%, respectively). This trend of decreased participation persisted during the last two quarters among the Aged group and the Blind/Disabled adult and children populations (40.9%, 33.4%, and 21.1%, respectively). No significant changes in participation were observed among Undocumented and Families age 21 and over groups.

By contrast, FFS beneficiaries residing in non-metropolitan areas experienced smaller changes in FFS participation across the different subpopulations. For example, during the entire study period, participation changes varied from an 11.5% decline among Undocumented children, to a 7.2% increase among adults under the Other aid category (see Figure BP-6). Between the second quarter of 2012 and the previous quarter, small declines in participation were observed only among those in the Undocumented aid group (3.6% in children and 1.3% in adults) and Blind/Disabled children (1.2%), whereas participation increased slightly among those in the Other, Aged, and Foster Care aid categories. Changes in FFS participation were almost negligible for adults in the Families and Blind/Disabled aid categories.

In non-metropolitan areas, FFS participation changes were smaller than those in metropolitan areas, ranging from a 11.5% decline among Undocumented children to a 7.2% increase among adults in the Other aid category.

Figure BP-6 Change in FFS Participation among Medi-Cal Beneficiaries, by Age and Aid Category, Non-Metropolitan Counties, 2011 Quarter 3–2012 Quarter 2

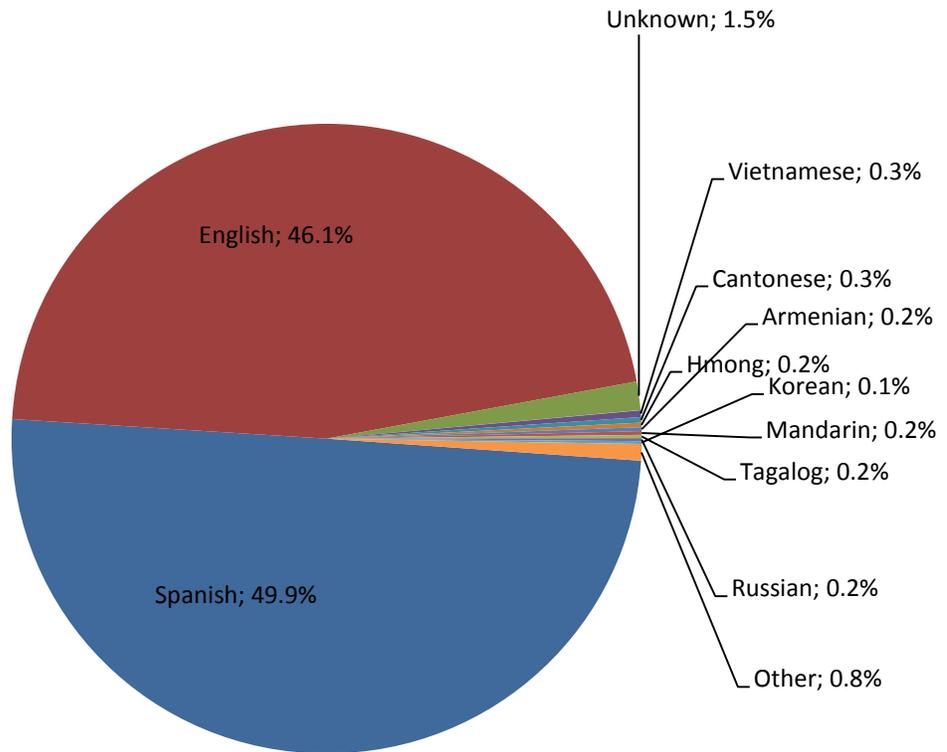


Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag).

Distribution of Medi-Cal Only FFS Beneficiaries, by Primary Language Spoken

As displayed in Figure BP-7, Spanish was self-reported as the primary language spoken by 49.9% of FFS Medi-Cal only beneficiaries for the second quarter of 2012. English was the primary language used by 46.1% of FFS Medi-Cal beneficiaries. The remaining 4% beneficiaries spoke a variety of primary languages, including Vietnamese, Armenian, Hmong, Cantonese, Mandarin, Tagalog, and Russian.

Figure BP-7 Distribution of FFS Beneficiaries in Medi-Cal Only Population, by Primary Language Spoken, 2012 Quarter 2

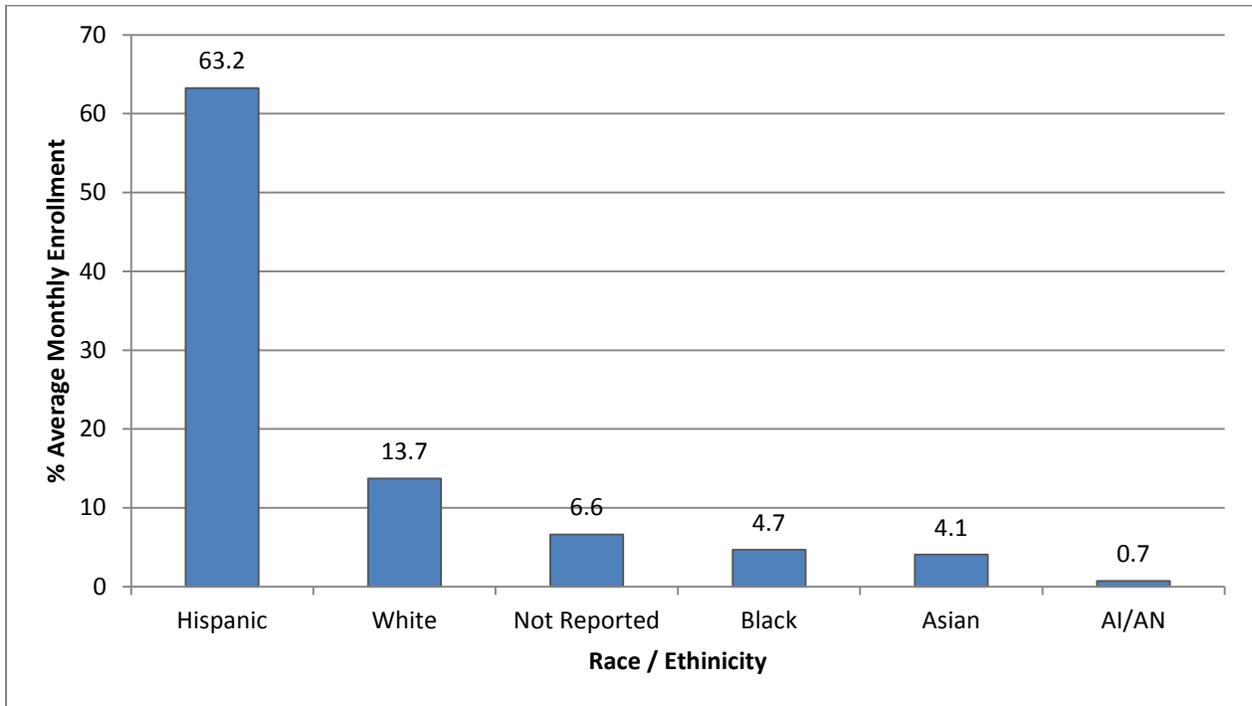


Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag).

Distribution of Medi-Cal Only FFS Beneficiaries, by Race/Ethnicity

Hispanics represented 63.2% of the total FFS Medi-Cal only population for the second quarter of 2012 (see Figure BP-8). Whites accounted for 13.7% of all FFS Medi-Cal beneficiaries, while African American and Asian/Pacific Islander beneficiaries represented a much smaller portion of the overall population (4.7% and 4.1%, respectively). An additional 6.6% of the FFS Medi-Cal population had no race/ethnic data.

Figure BP-8 Distribution of FFS Beneficiaries by Race/Ethnicity, 2012 Quarter 2



Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012 (reflecting a 4-month reporting lag).

Distribution of Medi-Cal Only FFS Beneficiaries, by County

As shown in Figure BP-9 on the next page, when comparing participation across the whole study period, the majority of counties experienced a decrease in FFS participation for all beneficiaries. The steepest decline in FFS participation occurred in the counties of San Francisco (32.3%), Sacramento (20.9%), and Alameda (20.9%). A handful of counties experienced a small increase in participation, most notably San Mateo and Alpine Counties (12.2% and 11.2%, respectively).

When evaluating participation for Full Scope beneficiaries, similar patterns were observed, although the degree of change was more pronounced, ranging from -45.8% for San Francisco County to 39.6% in Solano County for the study period (see Figure BP-10).

San Francisco, Sacramento, and Alameda Counties had the largest decreases in FFS participation.

Figure BP-9 Comparison of FFS Participation by Medi-Cal Only Beneficiaries, 2012 Quarter 2-2011 Quarter 3

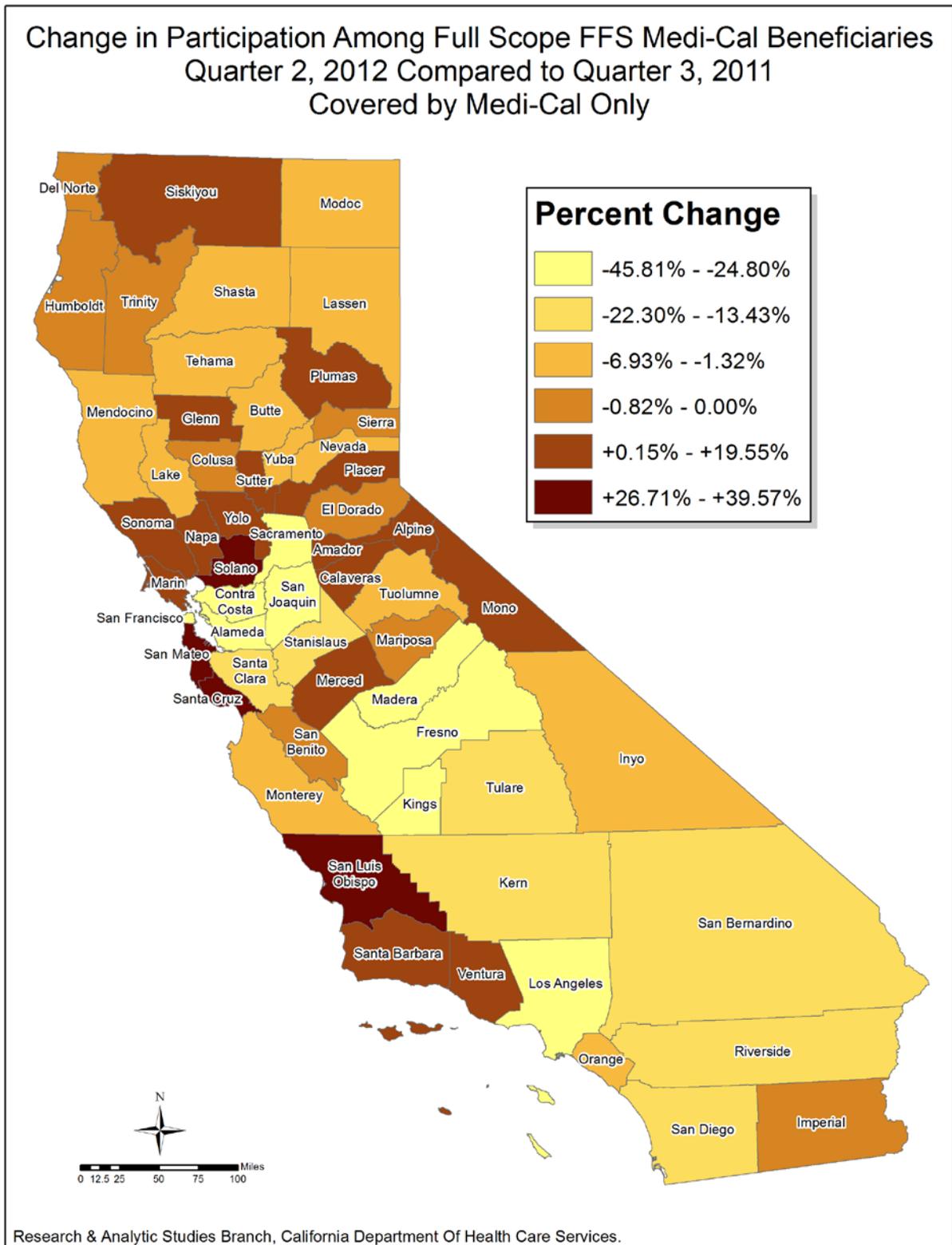
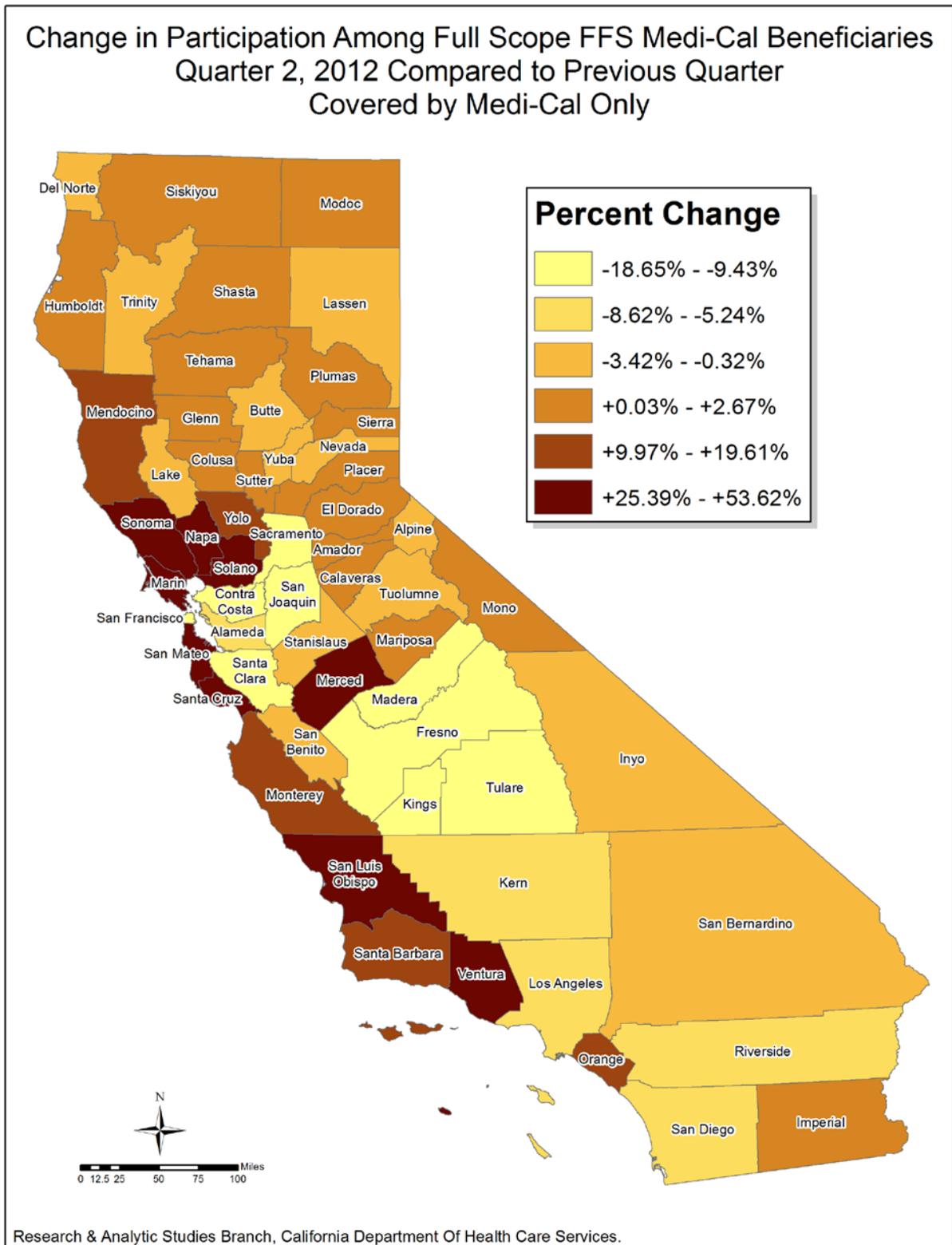


Figure BP-10 Comparison of FFS Participation by Medi-Cal Only Beneficiaries, 2012 Quarter 2 to Previous Quarter



Conclusions—Beneficiary Participation

1. Beneficiaries eligible for Medi-Cal only and participating in the FFS system are a culturally and ethnically diverse population. The majority describe themselves as Hispanic. About half speak Spanish as their primary language.
2. The number of FFS beneficiaries eligible for Medi-Cal only and entitled to full scope FFS benefits decreased 4.6% between the second and the first quarter of 2012 and 19.1% when comparing participation for the third quarter of 2011 to the second quarter of 2012, reflective of Medi-Cal's shift of beneficiaries into managed care plans.
3. The greatest decrease in FFS participation among Medi-Cal only beneficiaries with full scope benefits was observed in those enrolled in Aged and Blind/Disabled aid categories. The decrease in participation among these subpopulations was expected, given DHCS' initiative aimed at transitioning SPDs into managed care plans.
4. Overall, participation trends for Medi-Cal's FFS population were different in metropolitan and non-metropolitan counties. In metropolitan areas, participation decreased steadily throughout all quarters under study, whereas in non-metropolitan areas, participation remained virtually constant over the last three quarters evaluated.
5. In metropolitan counties, beneficiaries enrolled in the Aged and Blind/Disabled aid categories experienced the greatest decline in FFS participation across all quarters. In those counties, children in Foster Care had the highest expansion, followed by adults enrolled under the Other aid category. In both cases, this expansion was due solely to an increase in participation from the last quarter of 2011 and the first quarter of 2012.
6. In non-metropolitan counties, participation increased for some aid groups (Other, Aged, and Foster Care) and decreased for others (Undocumented children and adult, and Blind/Disabled children). Shifts in system participation (i.e., from FFS to managed care) were not responsible for the declines recognized in the undocumented population since they are not eligible for Medi-Cal managed care participation. These declines are most likely the result of declining participation in the Medi-Cal program.
7. During the second quarter of 2012, the downwards trend in FFS participation that had been observed in all counties during 2011 was reversed for a few counties (e.g., Solano, Santa Cruz, and San Mateo), or stabilized for about half of counties.
8. Children in the Foster Care aid category experienced an increase in FFS participation in the second quarter of 2012, reflective of legislation effective January 1, 2012, which optionally extends foster care benefits up to age 21. Similarly, FFS participation of adults in the Other aid category also increased, possibly as a result of the need for long-term care services which are only paid by managed care plans for the first 30 days.

Appendix A—County Level Tables

Table BP-1 FFS Beneficiaries, Medi-Cal Only, Average Member Months per Quarter, by County

| County | Average Member Months | | | | Percent Change | |
|----------------|-----------------------|----------------|----------------|----------------|-----------------------------------|-------------------------------------|
| | Quarter 3 2011 | Quarter 4 2011 | Quarter 1 2012 | Quarter 2 2012 | 2012 Qtr 2 Compared to 2011 Qtr 3 | 2012 Qtr 2 Compared to Previous Qtr |
| Alameda | 65,975 | 60,254 | 54,958 | 52,161 | -20.9 | -5.1 |
| Alpine | 152 | 162 | 173 | 169 | 11.2 | -2.3 |
| Amador | 3,651 | 3,650 | 3,675 | 3,700 | 1.3 | 0.7 |
| Butte | 41,917 | 41,425 | 41,269 | 41,062 | -2.0 | -0.5 |
| Calaveras | 5,577 | 5,530 | 5,542 | 5,574 | -0.1 | 0.6 |
| Colusa | 4,012 | 3,965 | 3,980 | 3,966 | -1.1 | -0.4 |
| Contra Costa | 40,453 | 37,882 | 35,443 | 33,420 | -17.4 | -5.7 |
| Del Norte | 6,757 | 6,725 | 6,730 | 6,676 | -1.2 | -0.8 |
| El Dorado | 15,757 | 15,603 | 15,588 | 15,633 | -0.8 | 0.3 |
| Fresno | 67,728 | 63,439 | 60,918 | 57,985 | -14.4 | -4.8 |
| Glenn | 6,084 | 5,999 | 6,066 | 6,106 | 0.4 | 0.7 |
| Humboldt | 21,923 | 21,777 | 21,678 | 21,710 | -1.0 | 0.1 |
| Imperial | 46,416 | 46,091 | 45,972 | 46,025 | -0.8 | 0.1 |
| Inyo | 2,935 | 2,899 | 2,916 | 2,900 | -1.2 | -0.5 |
| Kern | 67,869 | 62,891 | 60,974 | 58,648 | -13.6 | -3.8 |
| Kings | 9,431 | 8,776 | 8,332 | 7,766 | -17.7 | -6.8 |
| Lake | 14,115 | 13,923 | 13,945 | 13,824 | -2.1 | -0.9 |
| Lassen | 4,252 | 4,199 | 4,101 | 3,984 | -6.3 | -2.9 |
| Los Angeles | 692,151 | 639,689 | 594,787 | 569,835 | -17.7 | -4.2 |
| Madera | 13,625 | 12,891 | 12,440 | 11,856 | -13.0 | -4.7 |
| Marin | 5,356 | 5,118 | 5,126 | 5,226 | -2.4 | 2.0 |
| Mariposa | 2,273 | 2,198 | 2,205 | 2,262 | -0.5 | 2.6 |
| Mendocino | 2,582 | 2,493 | 2,488 | 2,566 | -0.6 | 3.1 |
| Merced | 10,594 | 10,178 | 10,282 | 10,924 | 3.1 | 6.2 |
| Modoc | 1,625 | 1,589 | 1,587 | 1,595 | -1.8 | 0.5 |
| Mono | 1,233 | 1,210 | 1,253 | 1,291 | 4.7 | 3.0 |
| Monterey | 21,104 | 19,951 | 20,691 | 21,323 | 1.0 | 3.1 |
| Napa | 2,754 | 2,621 | 2,591 | 2,754 | 0.0 | 6.3 |
| Nevada | 9,213 | 9,213 | 9,161 | 9,060 | -1.7 | -1.1 |
| Orange | 75,536 | 72,060 | 70,628 | 73,052 | -3.3 | 3.4 |
| Placer | 24,978 | 24,872 | 24,906 | 24,957 | -0.1 | 0.2 |
| Plumas | 2,419 | 2,434 | 2,427 | 2,448 | 1.2 | 0.9 |
| Riverside | 109,459 | 102,091 | 95,248 | 91,519 | -16.4 | -3.9 |
| Sacramento | 70,796 | 65,340 | 60,481 | 55,983 | -20.9 | -7.4 |
| San Benito | 8,924 | 8,796 | 8,908 | 8,860 | -0.7 | -0.5 |
| San Bernardino | 134,580 | 125,853 | 119,133 | 116,288 | -13.6 | -2.4 |
| San Diego | 121,431 | 113,309 | 104,763 | 99,122 | -18.4 | -5.4 |
| San Francisco | 31,915 | 28,143 | 24,448 | 21,603 | -32.3 | -11.6 |

| County | Average Member Months | | | | Percent Change | |
|-----------------|-----------------------|-------------------|-------------------|-------------------|-----------------------------------------|-------------------------------------------|
| | Quarter 3 2011 | Quarter 4 2011 | Quarter 1 2012 | Quarter 2 2012 | 2012 Qtr 2 Compared to 2011 Qtr 3 | 2012 Qtr 2 Compared to Previous Qtr |
| San Joaquin | 44,403 | 40,627 | 38,061 | 35,770 | -19.4 | -6.0 |
| San Luis Obispo | 4,198 | 4,050 | 4,152 | 4,452 | 6.1 | 7.2 |
| San Mateo | 13,854 | 13,853 | 14,150 | 15,545 | 12.2 | 9.9 |
| Santa Barbara | 16,122 | 15,626 | 15,758 | 16,228 | 0.7 | 3.0 |
| Santa Clara | 71,686 | 69,287 | 66,585 | 63,005 | -12.1 | -5.4 |
| Santa Cruz | 6,578 | 6,443 | 6,552 | 6,962 | 5.8 | 6.3 |
| Shasta | 33,444 | 32,745 | 32,557 | 32,548 | -2.7 | 0.0 |
| Sierra | 343 | 334 | 334 | 344 | 0.3 | 3.0 |
| Siskiyou | 8,371 | 8,277 | 8,350 | 8,393 | 0.3 | 0.5 |
| Solano | 6,951 | 6,714 | 6,640 | 7,540 | 8.5 | 13.6 |
| Sonoma | 9,153 | 8,841 | 8,670 | 9,310 | 1.7 | 7.4 |
| Stanislaus | 41,442 | 39,031 | 37,588 | 36,722 | -11.4 | -2.3 |
| Sutter | 19,606 | 19,546 | 19,557 | 19,633 | 0.1 | 0.4 |
| Tehama | 15,025 | 14,455 | 14,376 | 14,444 | -3.9 | 0.5 |
| Trinity | 2,199 | 2,217 | 2,204 | 2,196 | -0.1 | -0.4 |
| Tulare | 41,187 | 39,495 | 38,383 | 36,623 | -11.1 | -4.6 |
| Tuolumne | 6,495 | 6,378 | 6,391 | 6,320 | -2.7 | -1.1 |
| Ventura | 20,583 | 19,606 | 19,453 | 20,617 | 0.2 | 6.0 |
| Yolo | 4,050 | 3,892 | 3,725 | 3,998 | -1.3 | 7.3 |
| Yuba | 17,921 | 17,559 | 17,352 | 17,264 | -3.7 | -0.5 |

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files, July 2011–June 2012. Data reflects a 4-month reporting lag.

Table BP-2 FFS Full Scope Beneficiaries, Medi-Cal only Average Member Months, by County

| County | Average Member Months | | | | Percent Change | |
|----------------|-----------------------|----------------|----------------|----------------|-----------------------------------|-------------------------------------|
| | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | 2012 Qtr 2 Compared to 2011 Qtr 3 | 2012 Qtr 2 Compared to Previous Qtr |
| Alameda | 44,954 | 39,254 | 33,910 | 31,099 | -30.8 | -8.3 |
| Alpine | 152 | 162 | 173 | 169 | 11.2 | -2.3 |
| Amador | 3,517 | 3,537 | 3,568 | 3,610 | 2.6 | 1.2 |
| Butte | 40,507 | 40,103 | 39,979 | 39,785 | -1.8 | -0.5 |
| Calaveras | 5,412 | 5,370 | 5,380 | 5,420 | 0.1 | 0.7 |
| Colusa | 3,557 | 3,524 | 3,524 | 3,528 | -0.8 | 0.1 |
| Contra Costa | 25,929 | 23,575 | 21,320 | 19,279 | -25.6 | -9.6 |
| Del Norte | 6,564 | 6,540 | 6,558 | 6,519 | -0.7 | -0.6 |
| El Dorado | 14,597 | 14,506 | 14,507 | 14,555 | -0.3 | 0.3 |
| Fresno | 38,207 | 34,230 | 31,524 | 28,468 | -25.5 | -9.7 |
| Glenn | 5,429 | 5,367 | 5,441 | 5,495 | 1.2 | 1.0 |
| Humboldt | 21,260 | 21,143 | 21,064 | 21,096 | -0.8 | 0.2 |
| Imperial | 45,294 | 45,029 | 44,952 | 45,056 | -0.5 | 0.2 |
| Inyo | 2,610 | 2,576 | 2,586 | 2,571 | -1.5 | -0.6 |
| Kern | 43,841 | 39,547 | 37,492 | 35,032 | -20.1 | -6.6 |
| Kings | 6,132 | 5,591 | 5,142 | 4,611 | -24.8 | -10.3 |
| Lake | 13,387 | 13,230 | 13,269 | 13,172 | -1.6 | -0.7 |
| Lassen | 4,110 | 4,074 | 3,984 | 3,865 | -6.0 | -3.0 |
| Los Angeles | 367,363 | 319,603 | 277,081 | 253,197 | -31.1 | -8.6 |
| Madera | 6,303 | 5,645 | 5,195 | 4,650 | -26.2 | -10.5 |
| Marin | 582 | 531 | 537 | 690 | 18.6 | 28.5 |
| Mariposa | 2,203 | 2,133 | 2,139 | 2,196 | -0.3 | 2.7 |
| Mendocino | 804 | 740 | 712 | 783 | -2.6 | 10.0 |
| Merced | 2,455 | 2,179 | 2,310 | 2,935 | 19.6 | 27.1 |
| Modoc | 1,548 | 1,518 | 1,507 | 1,513 | -2.3 | 0.4 |
| Mono | 975 | 980 | 1,012 | 1,039 | 6.6 | 2.7 |
| Monterey | 3,368 | 2,802 | 2,779 | 3,293 | -2.2 | 18.5 |
| Napa | 706 | 636 | 609 | 809 | 14.6 | 32.8 |
| Nevada | 8,848 | 8,859 | 8,818 | 8,731 | -1.3 | -1.0 |
| Orange | 17,948 | 15,423 | 14,130 | 16,704 | -6.9 | 18.2 |
| Placer | 23,804 | 23,746 | 23,747 | 23,805 | 0.0 | 0.2 |
| Plumas | 2,357 | 2,373 | 2,366 | 2,392 | 1.5 | 1.1 |
| Riverside | 79,802 | 72,758 | 66,351 | 62,876 | -21.2 | -5.2 |
| Sacramento | 56,012 | 50,891 | 46,002 | 41,570 | -25.8 | -9.6 |
| San Benito | 7,803 | 7,712 | 7,792 | 7,756 | -0.6 | -0.5 |
| San Bernardino | 100,730 | 92,566 | 86,416 | 83,464 | -17.1 | -3.4 |
| San Diego | 94,624 | 87,141 | 78,876 | 73,519 | -22.3 | -6.8 |

| County | Average Member Months | | | | Percent Change | |
|-----------------|-----------------------|-------------------|-------------------|-------------------|-----------------------------------------|-------------------------------------------|
| | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | 2012 Qtr 2 Compared to 2011 Qtr 3 | 2012 Qtr 2 Compared to Previous Qtr |
| San Francisco | 22,648 | 18,845 | 15,086 | 12,272 | -45.8 | -18.7 |
| San Joaquin | 29,510 | 26,112 | 23,607 | 21,381 | -27.5 | -9.4 |
| San Luis Obispo | 1,273 | 1,233 | 1,279 | 1,613 | 26.7 | 26.1 |
| San Mateo | 3,077 | 2,875 | 2,903 | 4,026 | 30.8 | 38.7 |
| Santa Barbara | 3,422 | 3,253 | 3,178 | 3,565 | 4.2 | 12.2 |
| Santa Clara | 37,650 | 35,664 | 33,090 | 29,496 | -21.7 | -10.9 |
| Santa Cruz | 1,564 | 1,552 | 1,564 | 2,055 | 31.4 | 31.4 |
| Shasta | 32,958 | 32,298 | 32,139 | 32,150 | -2.5 | 0.0 |
| Sierra | 340 | 331 | 330 | 338 | -0.6 | 2.4 |
| Siskiyou | 8,201 | 8,112 | 8,182 | 8,231 | 0.4 | 0.6 |
| Solano | 1,979 | 1,856 | 1,798 | 2,762 | 39.6 | 53.6 |
| Sonoma | 2,947 | 2,772 | 2,639 | 3,309 | 12.3 | 25.4 |
| Stanislaus | 30,464 | 28,363 | 27,103 | 26,373 | -13.4 | -2.7 |
| Sutter | 17,980 | 17,953 | 17,968 | 18,008 | 0.2 | 0.2 |
| Tehama | 13,942 | 13,444 | 13,400 | 13,505 | -3.1 | 0.8 |
| Trinity | 2,182 | 2,202 | 2,188 | 2,181 | 0.0 | -0.3 |
| Tulare | 21,763 | 20,415 | 19,186 | 17,362 | -20.2 | -9.5 |
| Tuolumne | 6,425 | 6,319 | 6,334 | 6,265 | -2.5 | -1.1 |
| Ventura | 4,962 | 4,603 | 4,540 | 5,850 | 17.9 | 28.9 |
| Yolo | 1,790 | 1,699 | 1,606 | 1,921 | 7.3 | 19.6 |
| Yuba | 16,803 | 16,474 | 16,275 | 16,210 | -3.5 | -0.4 |

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012. Data reflects a 4-month reporting lag.

Table BP-3 FFS Full Scope Children Age 0-17, Medi-Cal only, Average Member Months, by County

| County | Average Member Months | | | | Percent Change | |
|----------------|-----------------------|----------------|----------------|----------------|-----------------------------------|-------------------------------------|
| | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | 2012 Qtr 2 Compared to 2011 Qtr 3 | 2012 Qtr 2 Compared to Previous Qtr |
| Alameda | 19,028 | 18,452 | 17,441 | 17,191 | -9.7 | -1.4 |
| Alpine | 81 | 84 | 89 | 91 | 12.3 | 2.2 |
| Amador | 1,866 | 1,861 | 1,865 | 1,894 | 1.5 | 1.6 |
| Butte | 21,187 | 20,963 | 20,851 | 20,721 | -2.2 | -0.6 |
| Calaveras | 2,804 | 2,802 | 2,790 | 2,826 | 0.8 | 1.3 |
| Colusa | 2,391 | 2,351 | 2,336 | 2,347 | -1.8 | 0.5 |
| Contra Costa | 11,590 | 11,649 | 11,388 | 11,000 | -5.1 | -3.4 |
| Del Norte | 3,336 | 3,334 | 3,363 | 3,329 | -0.2 | -1.0 |
| El Dorado | 8,111 | 8,083 | 8,084 | 8,165 | 0.7 | 1.0 |
| Fresno | 18,903 | 17,956 | 17,561 | 16,736 | -11.5 | -4.7 |
| Glenn | 3,397 | 3,380 | 3,398 | 3,427 | 0.9 | 0.9 |
| Humboldt | 11,037 | 11,002 | 10,926 | 10,990 | -0.4 | 0.6 |
| Imperial | 25,695 | 25,541 | 25,583 | 25,606 | -0.3 | 0.1 |
| Inyo | 1,528 | 1,518 | 1,507 | 1,496 | -2.1 | -0.7 |
| Kern | 24,812 | 23,168 | 22,930 | 22,163 | -10.7 | -3.3 |
| Kings | 3,462 | 3,290 | 3,164 | 2,937 | -15.2 | -7.2 |
| Lake | 6,949 | 6,831 | 6,862 | 6,857 | -1.3 | -0.1 |
| Lassen | 2,155 | 2,141 | 2,107 | 2,048 | -5.0 | -2.8 |
| Los Angeles | 174,068 | 162,774 | 151,970 | 150,442 | -13.6 | -1.0 |
| Madera | 3,554 | 3,386 | 3,173 | 2,916 | -18.0 | -8.1 |
| Marin | 374 | 330 | 335 | 433 | 15.8 | 29.3 |
| Mariposa | 1,170 | 1,128 | 1,132 | 1,161 | -0.8 | 2.6 |
| Mendocino | 475 | 420 | 390 | 431 | -9.3 | 10.5 |
| Merced | 1,718 | 1,453 | 1,539 | 1,895 | 10.3 | 23.1 |
| Modoc | 830 | 817 | 804 | 808 | -2.7 | 0.5 |
| Mono | 674 | 673 | 681 | 698 | 3.6 | 2.5 |
| Monterey | 2,488 | 1,967 | 1,955 | 2,259 | -9.2 | 15.5 |
| Napa | 467 | 398 | 393 | 497 | 6.4 | 26.5 |
| Nevada | 4,652 | 4,657 | 4,632 | 4,605 | -1.0 | -0.6 |
| Orange | 13,175 | 10,850 | 9,665 | 11,024 | -16.3 | 14.1 |
| Placer | 13,835 | 13,802 | 13,871 | 13,887 | 0.4 | 0.1 |
| Plumas | 1,250 | 1,280 | 1,248 | 1,254 | 0.3 | 0.5 |
| Riverside | 46,574 | 43,674 | 41,362 | 40,405 | -13.2 | -2.3 |
| Sacramento | 25,269 | 25,310 | 25,055 | 24,208 | -4.2 | -3.4 |
| San Benito | 4,976 | 4,904 | 4,950 | 4,939 | -0.7 | -0.2 |
| San Bernardino | 55,158 | 51,995 | 49,966 | 49,511 | -10.2 | -0.9 |

| County | Average Member Months | | | | Percent Change | |
|-----------------|-----------------------|-------------------|-------------------|-------------------|-----------------------------------------|-------------------------------------------|
| | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | 2012 Qtr 2 Compared to 2011 Qtr 3 | 2012 Qtr 2 Compared to Previous Qtr |
| San Diego | 50,130 | 49,085 | 46,992 | 45,702 | -8.8 | -2.7 |
| San Francisco | 5,982 | 5,788 | 5,599 | 5,303 | -11.4 | -5.3 |
| San Joaquin | 15,157 | 14,190 | 13,647 | 13,098 | -13.6 | -4.0 |
| San Luis Obispo | 791 | 778 | 800 | 955 | 20.7 | 19.4 |
| San Mateo | 2,038 | 1,851 | 1,845 | 2,531 | 24.2 | 37.2 |
| Santa Barbara | 2,599 | 2,433 | 2,379 | 2,441 | -6.1 | 2.6 |
| Santa Clara | 16,477 | 17,406 | 17,670 | 16,645 | 1.0 | -5.8 |
| Santa Cruz | 1,027 | 1,020 | 988 | 1,177 | 14.6 | 19.1 |
| Shasta | 17,097 | 16,788 | 16,649 | 16,684 | -2.4 | 0.2 |
| Sierra | 167 | 1,57 | 161 | 164 | -1.8 | 1.9 |
| Siskiyou | 4,235 | 4,206 | 4,210 | 4,243 | 0.2 | 0.8 |
| Solano | 1,276 | 1,217 | 1,121 | 1,691 | 32.5 | 50.8 |
| Sonoma | 2,009 | 1,872 | 1,749 | 2,046 | 1.8 | 17.0 |
| Stanislaus | 15,443 | 14,971 | 14,825 | 14,979 | -3.0 | 1.0 |
| Sutter | 10,697 | 10,629 | 10,693 | 10,749 | 0.5 | 0.5 |
| Tehama | 8,061 | 7,792 | 7,753 | 7,785 | -3.4 | 0.4 |
| Trinity | 1,054 | 1,076 | 1,073 | 1,071 | 1.6 | -0.2 |
| Tulare | 11,899 | 11,603 | 11,336 | 10,751 | -9.6 | -5.2 |
| Tuolumne | 3,277 | 3,216 | 3,225 | 3,227 | -1.5 | 0.1 |
| Ventura | 3,333 | 3,027 | 2,979 | 3,743 | 12.3 | 25.6 |
| Yolo | 1,305 | 1,227 | 1,145 | 1,288 | -1.3 | 12.5 |
| Yuba | 9,418 | 9,268 | 9,149 | 9,120 | -3.2 | -0.3 |

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012. Data reflects a 4-month reporting lag.

Table BP-4 FFS Women Age 18–64, Medi-Cal Only, Average Member Months, by County

| County | Average Member Months | | | | Percent Change | |
|-----------------|-----------------------|-------------------|-------------------|-------------------|-----------------------------------------|-------------------------------------------|
| | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | 2012 Qtr 2 Compared to 2011 Qtr 3 | 2012 Qtr 2 Compared to Previous Qtr |
| Alameda | 23,714 | 21,908 | 20,332 | 19,575 | -17.5 | -3.7 |
| Alpine | 39 | 45 | 47 | 45 | 15.4 | -4.3 |
| Amador | 1,105 | 1,113 | 1,130 | 1,128 | 2.1 | -0.2 |
| Butte | 12,267 | 12,114 | 12,105 | 12,078 | -1.5 | -0.2 |
| Calaveras | 1,668 | 1,653 | 1,655 | 1,648 | -1.2 | -0.4 |
| Colusa | 1,004 | 1,005 | 1,020 | 1,007 | 0.3 | -1.3 |
| Contra Costa | 14,535 | 13,590 | 12,799 | 12,215 | -16.0 | -4.6 |
| Del Norte | 1,992 | 1,978 | 1,969 | 1,956 | -1.8 | -0.7 |
| El Dorado | 4,494 | 4,462 | 4,463 | 4,450 | -1.0 | -0.3 |
| Fresno | 25,325 | 23,970 | 23,016 | 22,130 | -12.6 | -3.8 |
| Glenn | 1,645 | 1,607 | 1,642 | 1,642 | -0.2 | 0.0 |
| Humboldt | 6,495 | 6,432 | 6,441 | 6,415 | -1.2 | -0.4 |
| Imperial | 13,444 | 13,431 | 13,366 | 13,379 | -0.5 | 0.1 |
| Inyo | 831 | 815 | 826 | 823 | -1.0 | -0.4 |
| Kern | 22,885 | 21,350 | 20,672 | 20,000 | -12.6 | -3.3 |
| Kings | 3,215 | 2,993 | 2,790 | 2,605 | -19.0 | -6.6 |
| Lake | 4,180 | 4,141 | 4,127 | 4,077 | -2.5 | -1.2 |
| Lassen | 1,269 | 1,247 | 1,209 | 1,168 | -8.0 | -3.4 |
| Los Angeles | 271,222 | 254,311 | 240,781 | 231,500 | -14.6 | -3.9 |
| Madera | 5,188 | 4,894 | 4,818 | 4,713 | -9.2 | -2.2 |
| Marin | 2,687 | 2,591 | 2,624 | 2,618 | -2.6 | -0.2 |
| Mariposa | 664 | 655 | 647 | 659 | -0.8 | 1.9 |
| Mendocino | 1,075 | 1,061 | 1,072 | 1,097 | 2.0 | 2.3 |
| Merced | 4,577 | 4,543 | 4,598 | 4,786 | 4.6 | 4.1 |
| Modoc | 470 | 445 | 452 | 451 | -4.0 | -0.2 |
| Mono | 309 | 301 | 323 | 341 | 10.4 | 5.6 |
| Monterey | 9,862 | 9,597 | 9,971 | 10,153 | 3.0 | 1.8 |
| Napa | 1,297 | 1,266 | 1,256 | 1,295 | -0.2 | 3.1 |
| Nevada | 2,796 | 2,799 | 2,775 | 2,725 | -2.5 | -1.8 |
| Orange | 36,780 | 36,123 | 36,100 | 36,853 | 0.2 | 2.1 |
| Placer | 6,829 | 6,763 | 6,766 | 6,809 | -0.3 | 0.6 |
| Plumas | 728 | 724 | 735 | 745 | 2.3 | 1.4 |
| Riverside | 35,992 | 33,958 | 31,868 | 30,735 | -14.6 | -3.6 |
| Sacramento | 24,715 | 22,157 | 19,933 | 18,269 | -26.1 | -8.3 |
| San Benito | 2,430 | 2,410 | 2,463 | 2,422 | -0.3 | -1.7 |
| San Bernardino | 45,279 | 42,675 | 40,500 | 39,656 | -12.4 | -2.1 |
| San Diego | 41,300 | 38,252 | 35,339 | 33,698 | -18.4 | -4.6 |
| San Francisco | 11,814 | 10,605 | 9,437 | 8,647 | -26.8 | -8.4 |
| San Joaquin | 15,181 | 13,967 | 13,122 | 12,233 | -19.4 | -6.8 |
| San Luis Obispo | 1,846 | 1,798 | 1,845 | 1,948 | 5.5 | 5.6 |
| San Mateo | 6,462 | 6,537 | 6,679 | 6,993 | 8.2 | 4.7 |
| Santa Barbara | 7,697 | 7,541 | 7,645 | 7,899 | 2.6 | 3.3 |
| Santa Clara | 27,591 | 26,814 | 26,082 | 25,285 | -8.4 | -3.1 |

| County | Average Member Months | | | | Percent Change | |
|------------|-----------------------|-------------------|-------------------|-------------------|-----------------------------------------|-------------------------------------------|
| | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | 2012 Qtr 2 Compared to 2011 Qtr 3 | 2012 Qtr 2 Compared to Previous Qtr |
| Santa Cruz | 3,270 | 3,197 | 3,307 | 3,456 | 5.7 | 4.5 |
| Shasta | 9,926 | 9,695 | 9,654 | 9,655 | -2.7 | 0.0 |
| Sierra | 97 | 96 | 97 | 102 | 5.2 | 5.2 |
| Siskiyou | 2,467 | 2,442 | 2,485 | 2,480 | 0.5 | -0.2 |
| Solano | 3,041 | 2,944 | 2,981 | 3,220 | 5.9 | 8.0 |
| Sonoma | 4,250 | 4,137 | 4,096 | 4,334 | 2.0 | 5.8 |
| Stanislaus | 14,013 | 13,021 | 12,500 | 12,080 | -13.8 | -3.4 |
| Sutter | 5,188 | 5,190 | 5,165 | 5,186 | 0.0 | 0.4 |
| Tehama | 4,172 | 4,013 | 4,018 | 4,045 | -3.0 | 0.7 |
| Trinity | 696 | 687 | 674 | 664 | -4.6 | -1.5 |
| Tulare | 15,012 | 14,410 | 14,064 | 13,587 | -9.5 | -3.4 |
| Tuolumne | 1,999 | 1,968 | 1,951 | 1,911 | -4.4 | -2.1 |
| Ventura | 9,731 | 9,418 | 9,398 | 9,712 | -0.2 | 3.3 |
| Yolo | 1,526 | 1,495 | 1,474 | 1,559 | 2.2 | 5.8 |
| Yuba | 5,074 | 4,941 | 4,888 | 4,854 | -4.3 | -0.7 |

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012. Data reflects a 4-month reporting lag.

Table BP-5 FFS Full Scope, Average Member Months, by Gender and Age

| Gender | Age | Average Member Months | | | | Percent Change | |
|--------------|-------------|-----------------------|----------------|----------------|----------------|-----------------------------------|-------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | 2012 Qtr 2 Compared to 2011 Qtr 3 | 2012 Qtr 2 Compared to Previous Qtr |
| Women | 0 to 17 | 338,311 | 325,196 | 315,590 | 314,034 | -7.2 | -0.5 |
| | 18 to 64 | 372,547 | 337,321 | 307,470 | 289,087 | -22.4 | -6.0 |
| | 65 or Older | 30,650 | 21,625 | 13,530 | 8,241 | -73.1 | -39.1 |
| Men | 0 to 17 | 364,202 | 348,627 | 335,766 | 332,555 | -8.7 | -1.0 |
| | 18 to 64 | 241,765 | 206,396 | 176,600 | 154,849 | -36.0 | -12.3 |
| | 65 or Older | 18,115 | 12,821 | 8,183 | 5,352 | -70.5 | -34.6 |
| All | 0 to 17 | 702,513 | 673,823 | 651,356 | 646,589 | -8.0 | -0.7 |
| | 18 to 64 | 614,312 | 543,717 | 484,070 | 443,936 | -27.7 | -8.3 |
| | 65 or Older | 48,765 | 34,446 | 21,713 | 13,593 | -72.1 | -37.4 |
| Total | | 1,365,590 | 1,251,986 | 1,157,139 | 1,104,118 | -19.1 | -4.6 |

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012. Data reflects a 4-month reporting lag.

Table BP-6 FFS Restricted Scope, Average Member Months, by Gender and Age

| Gender | Age | Average Member Months | | | | Percent Change | |
|--------------|-------------|-----------------------|----------------|----------------|----------------|-----------------------------------|-------------------------------------|
| | | Quarter 3 2011 | Quarter 4 2011 | Quarter 1 2012 | Quarter 2 2012 | 2012 Qtr 2 Compared to 2011 Qtr 3 | 2012 Qtr 2 Compared to Previous Qtr |
| Women | 0 to 17 | 66,456 | 64,082 | 62,164 | 60,417 | -9.1 | -2.8 |
| | 18 to 64 | 412,814 | 406,976 | 406,723 | 406,631 | -1.5 | 0.0 |
| | 65 or Older | 10,861 | 10,863 | 11,015 | 11,072 | 1.9 | 0.5 |
| Men | 0 to 17 | 68,054 | 65,712 | 63,583 | 61,912 | -9.0 | -2.6 |
| | 18 to 64 | 222,727 | 219,832 | 221,180 | 221,993 | -0.3 | 0.4 |
| | 65 or Older | 5,380 | 5,451 | 5,555 | 5,591 | 3.9 | 0.6 |
| All | 0 to 17 | 134,510 | 129,794 | 125,747 | 122,329 | -9.1 | -2.7 |
| | 18 to 64 | 635,541 | 626,808 | 627,903 | 628,624 | -1.1 | 0.1 |
| | 65 or Older | 16,241 | 16,314 | 16,570 | 16,663 | 2.6 | 0.6 |
| Total | | 786,292 | 772,916 | 770,220 | 767,616 | -2.4 | -0.3 |

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012. Data reflects a 4-month reporting lag.

Table BP-7 FFS Beneficiaries, Average Member Months, by Age and Aid Category

| Age | Aid Category | Average Member Months | | | | Percent Change | |
|--------------|----------------|-----------------------|-------------------|-------------------|-------------------|-----------------------------------------|-------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | 2012 Qtr 2 Compared to 2011 Qtr 3 | 2012 Qtr 2 Compared to Previous Qtr |
| 0 - 20 | Blind/Disabled | 70,342 | 61,535 | 53,567 | 42,841 | -39.1 | -20.0 |
| | Families | 412,180 | 411,342 | 392,609 | 392,707 | -4.7 | 0.0 |
| | Foster Care | 87,688 | 86,623 | 97,736 | 97,570 | 11.3 | -0.2 |
| | Other | 221,541 | 199,278 | 190,436 | 194,304 | -12.3 | 2.0 |
| | Undocumented | 173,069 | 167,425 | 163,190 | 159,533 | -7.8 | -2.2 |
| 21 & over | Aged | 44,294 | 30,720 | 18,744 | 11,187 | -74.7 | -40.3 |
| | Blind/Disabled | 270,616 | 205,577 | 146,531 | 102,908 | -62.0 | -29.8 |
| | Families | 203,053 | 201,017 | 200,428 | 203,325 | 0.1 | 1.4 |
| | Other | 55,853 | 55,871 | 56,960 | 59,167 | 5.9 | 3.9 |
| | Undocumented | 612,510 | 604,809 | 606,310 | 608,084 | -0.7 | 0.3 |
| Total | | 2,151,164 | 2,024,217 | 1,926,524 | 1,871,640 | -13.0 | -2.8 |

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012. Data reflects a 4-month reporting lag.

Table BP-8 FFS Average Member Months, by Age and Aid Category, Metropolitan Counties

| Age | Aid Category | Average Member Months | | | | Percent Change | |
|--------------|----------------|-----------------------|-------------------|-------------------|-------------------|-----------------------------------------|-------------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | 2012 Qtr 2 Compared to 2011 Qtr 3 | 2012 Qtr 2 Compared to Previous Qtr |
| 0 - 20 | Blind/Disabled | 67,306 | 58,547 | 50,597 | 39,908 | -40.7 | -21.1 |
| | Families | 359,085 | 358,921 | 340,187 | 340,349 | -5.2 | 0.0 |
| | Foster Care | 84,283 | 83,218 | 94,314 | 94,108 | 11.7 | -0.2 |
| | Other | 212,552 | 190,410 | 181,767 | 185,477 | -12.7 | 2.0 |
| | Undocumented | 171,011 | 165,499 | 161,301 | 157,712 | -7.8 | -2.2 |
| 21 & over | Aged | 44,027 | 30,457 | 18,477 | 10,915 | -75.2 | -40.9 |
| | Blind/Disabled | 254,494 | 189,458 | 130,405 | 86,798 | -65.9 | -33.4 |
| | Families | 175,641 | 174,066 | 173,365 | 176,285 | 0.4 | 1.7 |
| | Other | 54,353 | 54,350 | 55,371 | 57,560 | 5.9 | 4.0 |
| | Undocumented | 607,155 | 599,646 | 601,152 | 602,994 | -0.7 | 0.3 |
| Total | | 2,029,928 | 1,904,591 | 1,806,949 | 1,752,118 | -13.7 | -3.0 |

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012. Data reflects a 4-month reporting lag.

Table BP-9 FFS Average Member Months by Age and Aid Category, Non-Metropolitan Counties

| Age | Aid Category | Average Member Months | | | | Percent Change | |
|--------------|----------------|-----------------------|----------------|----------------|----------------|-----------------------------------|-------------------------------------|
| | | 2011 Quarter 3 | 2011 Quarter 4 | 2012 Quarter 1 | 2012 Quarter 2 | 2012 Qtr 2 Compared to 2011 Qtr 3 | 2012 Qtr 2 Compared to Previous Qtr |
| 0 - 20 | Blind/Disabled | 3,036 | 2,988 | 2,970 | 2,933 | -3.4 | -1.2 |
| | Families | 53,095 | 52,421 | 52,421 | 52,357 | -1.4 | -0.1 |
| | Foster Care | 3,405 | 3,405 | 3,422 | 3,462 | 1.7 | 1.2 |
| | Other | 8,989 | 8,868 | 8,669 | 8,827 | -1.8 | 1.8 |
| | Undocumented | 2,058 | 1,926 | 1,889 | 1,821 | -11.5 | -3.6 |
| 21 & over | Aged | 266 | 263 | 267 | 273 | 2.6 | 2.2 |
| | Blind/Disabled | 16,121 | 16,119 | 16,126 | 16,110 | -0.1 | -0.1 |
| | Families | 27,411 | 26,951 | 27,064 | 27,041 | -1.3 | -0.1 |
| | Other | 1,500 | 1,521 | 1,590 | 1,608 | 7.2 | 1.1 |
| | Undocumented | 5,355 | 5,163 | 5,158 | 5,090 | -4.9 | -1.3 |
| Total | | 121,236 | 119,626 | 119,575 | 119,522 | -1.4 | 0.0 |

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files July 2011–June 2012. Data reflects a 4-month reporting lag.

Appendix B—Medi-Cal Aid Codes

Aid codes are assigned to each Medi-Cal beneficiary based on how they become eligible for Medi-Cal services. Factors such as age, income, or disability status are some of the criteria used to assess an individual's eligibility for program services. There are over 170 different aid codes that enable DHCS to gain an understanding of how beneficiaries might use Medi-Cal program services.

The aid code categories used for this analysis were intended to group beneficiaries with similar ages, disability status, and benefit scope into groups that might place similar demands on program services. However, some aid categories represent a heterogeneous population that might use Medi-Cal services in quite different ways.

For example, beneficiaries in the Families aid category are mostly comprised of no- or low-income young adults with children who have routine health care needs. However, this aid category also includes families who earn incomes above the Medi-Cal limit, but have a "Medically Needy" individual with one or more serious conditions requiring medical treatment exceeding the family's income. This subpopulation would place stronger demands on program services than others in the Families aid category. Likewise, the Other aid category is comprised of a diverse population, such as individuals in the Breast and Cancer Cervical Treatment Program who have access to a restricted scope of benefits, long-term care recipients, and the medically indigent, among other populations. See table below.

A more detailed breakdown of aid codes within each category can be found at http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/aidcodes_z01c00.doc

| Detail Aid Category | Rolled up Aid Category | Aid Codes |
|-------------------------------------|-------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| BCCTP | Other | 0L, 0M, 0N, 0P, 0R, 0T, 0U, 0V, 0W, 0X, 0Y |
| Inmates | Other | F1, F2, F3, F4, G1, G2, G3, G4 |
| Hurricane Katrina Evacuees | Other | 65 |
| MI - Adoption or Foster Care | Foster Care | 03, 04, 06, 45, 46, 4A, 4K, 4M, 5K |
| MI – Adult | Other | 81, 86, 87 |
| MI - Child | Other | 82, 83, 5E, 7T, 8U, 8V, 8W |
| MI - LTC | Other | 53 |
| MN - Aged | Aged | 14, 17, 1D, 1H, 1X, 1Y |
| MN - Blind | Blind/Disabled | 24, 27, 2D, 2H |
| MN - Disabled | Blind/Disabled | 64, 67, 6D, 6H, 6S, 6V, 6W, 6X, 6Y, 8G |
| MN - Families | Families | 34, 37, 39, 54, 59, 3D, 3N, 5X, 6J, 6R, 7J |
| MN - LTC | Other | 13, 23, 63 |
| Other | Other | 01, 02, 08, 44, 47, 51, 52, 56, 57, 71, 72, 73, 76, 79, 80, 0A, 2A, 2V, 4V, 5V, 6G, 7A, 7F, 7G, 7H, 7M, 7N, 7P, 7R, 7V, 8E, 8P, 8R |
| PA - Adoption or Foster Care | Foster Care | 40, 42, 43, 77, 78, 4C, 4F, 4G, 4H, 4L, 4T |
| PA - Aged | Aged | 10, 16, 18, 1E |
| PA - Blind | Blind/Disabled | 20, 26, 28, 2E, 6A |
| PA - Disabled | Blind/Disabled | 36, 60, 66, 68, 6C, 6E, 6N, 6P |
| PA - Families | Families | 30, 32, 33, 35, 38, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3P, 3R, 3U, 3W |
| Undocumented | Undocumented | 07, 48, 49, 55, 58, 69, 70, 74, 75, 1U, 3T, 3V, 5F, 5G, 5J, 5N, 5R, 5T, 5W, 6U, 7C, 7K, 8N, 8T, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, 5H, 5M, 5Y |

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



Service Utilization

January 2013

Contents

| | |
|--------------------------------------------------------------------------------------------------------------------|----|
| List of Figures | 5 |
| List of Tables | 8 |
| Utilization of Select Services by Medi-Cal FFS Beneficiaries..... | 9 |
| Introduction | 9 |
| Methods | 10 |
| Physician/Clinic..... | 12 |
| Background | 12 |
| Trend Analysis..... | 13 |
| Children | 13 |
| Adults | 13 |
| Trends—Physician/Clinic Services Utilization Rates, Children, July 2011–June 2012 | 15 |
| Trends—Monthly Physician/Clinic Services Utilization Rates by Adults, July 2011–June 2012 | 18 |
| Non-Emergency Medical Transportation..... | 21 |
| Background | 21 |
| Trend Analysis..... | 22 |
| Children | 22 |
| Adults | 22 |
| Trends—Monthly Non-Emergency Medical Transportation Services Utilization Rates by Adults, July 2011–June 2012..... | 23 |
| Emergency Medical Transportation..... | 24 |
| Background | 24 |
| Trend Analysis..... | 25 |
| Children | 25 |
| Adults | 25 |
| Trends—Monthly Emergency Medical Transportation Services Utilization Rates by Children, July 2011–June 2012..... | 27 |
| Trends—Monthly Emergency Medical Transportation Services Utilization by Adults, July 2011–June 2012..... | 30 |
| Home Health Services | 32 |
| Background | 32 |
| Trend Analysis..... | 33 |

| | |
|---------------------------------------------------------------------------------------------------|----|
| Children | 33 |
| Adults | 33 |
| Trends—Monthly Home Health Services Utilization Rates by Children, July 2011–June 2012 | 34 |
| Trends—Home Health Services Utilization by Adults, July 2011–June 2012 | 35 |
| Hospital Inpatient Services | 36 |
| Background | 36 |
| Trend Analysis..... | 37 |
| Children | 37 |
| Adults | 37 |
| Trends—Monthly Hospital Inpatient Services Utilization Rates, Children, July 2011–June 2012 | 38 |
| Trends—Hospital Inpatient Services Utilization by Adults, July 2011–June 2012 | 41 |
| Hospital Outpatient Services | 44 |
| Background | 44 |
| Trend Analysis..... | 45 |
| Children | 45 |
| Adults | 45 |
| Trends—Monthly Hospital Outpatient Services Utilization Rates by Children, Jul 2011–Jun 2012..... | 46 |
| Trends—Monthly Hospital Outpatient Services Utilization Rates by Adults, Jul 2011–Jun 2012 | 49 |
| Nursing Facility Services..... | 52 |
| Background | 52 |
| Trend Analysis..... | 54 |
| Children | 54 |
| Adults | 54 |
| Trends—Nursing Facility Services Utilization by Adults, July 2011–June 2012 | 56 |
| Pharmacy Services..... | 58 |
| Background | 58 |
| Trend Analysis..... | 59 |
| Children | 59 |
| Adults | 59 |
| Trends—Pharmacy Services Utilization by Children, July 2011–June 2012 | 60 |
| Trends—Monthly Pharmacy Services Utilization Rates by Adults, July 2011–June 2012 | 63 |
| Other Services..... | 66 |

Background66

Trend Analysis.....67

 Children67

 Adults67

Trends—Monthly Other Services Utilization Rates by Children, July 2011–June 201268

Trends—Monthly Other Services Utilization Rates by Adults, July 2011–June 201271

Summary Tables.....74

Conclusions—Service Utilization, Children Participating in FFS.....77

Conclusions—Service Utilization, Adults Participating in FFS.....78

Appendix—Detailed List of Other Providers79

List of Figures

| | | |
|--------------|----------------------------------------------------------------------------------------------------------------|----|
| Figure SU-1 | Physician/Clinic Utilization, Children Age 0-20, Blind/Disabled, July 2011– June 2012 | 15 |
| Figure SU-2 | Physician/Clinic Utilization, Children Age 0-20, Families, July 2011–June 2012 | 15 |
| Figure SU-3 | Physician/Clinic Utilization, Children Age 0-20, Foster Care, July 2011–June 2012 | 16 |
| Figure SU-4 | Physician/Clinic Utilization, Children Age 0–20, Other, July 2011–June 2012 | 16 |
| Figure SU-5 | Physician/Clinic Utilization, Children Age 0-20, Undocumented, July 2011– June 2012 | 17 |
| Figure SU-6 | Physician/Clinic Utilization, Adults Age 21+, Aged, July 2011–June 2012 | 18 |
| Figure SU-7 | Physician/Clinic Utilization, Adults Age 21+, Blind/Disabled, Jul 2011–Jun 2012 ... | 18 |
| Figure SU-8 | Physician/Clinic Utilization, Adults Age 21+, Families, July 2011–June 2012..... | 19 |
| Figure SU-9 | Physician/Clinic Utilization, Adults age 21+, Other, July 2011–June 2012 | 19 |
| Figure SU-10 | Physician/Clinic Utilization, Adults Age 21+, Undocumented, July 2011– June 2012 | 20 |
| Figure SU-11 | Non-Emergency Medical Transportation Utilization, Adults Age 21+, Blind/Disabled, July 2011–June 2012 | 23 |
| Figure SU-12 | Non-Emergency Medical Transportation Utilization, Adults Age 21+, Other, July 2011–June 2012 | 23 |
| Figure SU-13 | Emergency Transportation Utilization, Children Age 0–20, Blind/Disabled, July 2011–June 2012 | 27 |
| Figure SU-14 | Emergency Transportation Utilization, Children Age 0–20, Families, July 2011– June 2012 | 27 |
| Figure SU-15 | Emergency Transportation Utilization, Children Age 0–20, Foster Care, July 2011– June 2012 | 28 |
| Figure SU-16 | Emergency Transportation Utilization, Children Age 0–20, Other, July 2011– June 2012 | 28 |
| Figure SU-17 | Emergency Transportation Utilization, Children Age 0–20, Undocumented, July ...2011–June2012..... | 29 |
| Figure SU-18 | Emergency Medical Transportation Utilization, Adults Age 21+, Blind/Disabled, July 2011–June2012 | 30 |
| Figure SU-19 | Emergency Medical Transportation Utilization, Adults age 21+, Families, July 2011– June 2012 | 30 |
| Figure SU-20 | Emergency Medical Transportation Utilization, Adults Age 21+, Other, July 2011– June 2012 | 31 |
| Figure SU-21 | Emergency Medical Transportation Utilization, Adults Age 21+, Undocumented, July 2011–June 2012 | 31 |
| Figure SU-22 | Home Health Services Utilization, Children Age 0–20, Blind/Disabled, July 2011– June 2012 | 34 |
| Figure SU-23 | Home Health Utilization, Adults Age 21+, Blind/Disabled, July 2011–June 2012 ... | 35 |
| Figure SU-24 | Hospital Inpatient Utilization, Children Age 0–20, Blind/Disabled, July 2011– June 2012 | 38 |
| Figure SU-25 | Hospital Inpatient Utilization, Children Age 0–20, Families, July 2011–June 2012 | 38 |

| | | |
|--------------|---------------------------------------------------------------------------------------------------|----|
| Figure SU-26 | Hospital Inpatient Utilization, Children Age 0–20, Foster Care, July 2011– June 2012 | 39 |
| Figure SU-27 | Hospital Inpatient Utilization, Children Age 0–20, Other, July 2011–June 2012 | 39 |
| Figure SU-28 | Hospital Inpatient Utilization, Children Age 0–20, Undocumented, July 2011– June 2012 | 40 |
| Figure SU-29 | Hospital Inpatient Utilization, Adults Age 21+, Aged, July 2011–June 2012 | 41 |
| Figure SU-30 | Hospital Inpatient Utilization, Adults Age 21+, Blind/Disabled, July 2011– June 2012 | 41 |
| Figure SU-31 | Hospital Inpatient Utilization Rates, Adults Age 21+, Families, July 2011– June 2012 | 42 |
| Figure SU-32 | Hospital Inpatient Utilization, Adults Age 21+, Other, July 2011–June 2012 | 42 |
| Figure SU-33 | Hospital Inpatient Utilization, Adults Age 21+, Undocumented, July 2011– June 2012 | 43 |
| Figure SU-34 | Hospital Outpatient Utilization, Children Age 0-20, Blind/Disabled, July 2011– June 2012 | 46 |
| Figure SU-35 | Hospital Outpatient Utilization, Children Age 0-20, Families, Jul 2011–Jun 2012... | 46 |
| Figure SU-36 | Hospital Outpatient Utilization, Children Age 0-20, Foster Care, July 2011– June 2012 | 47 |
| Figure SU-37 | Hospital Outpatient Utilization, Children Age 0-20, Other, July 2011–June 2012... | 47 |
| Figure SU-38 | Hospital Outpatient Utilization, Children Age 0-20, Undocumented, July 2011– June 2012 | 48 |
| Figure SU-39 | Hospital Outpatient Utilization, Adults, Age 21+, Aged, July 2011–June 2012 | 49 |
| Figure SU-40 | Hospital Outpatient Utilization, Adults, Age 21+, Blind/Disabled, July 2011– June 2012 | 49 |
| Figure SU-41 | Hospital Outpatient Utilization, Adults, Age 21+, Families, July 2011–June 2012.. | 50 |
| Figure SU-42 | Hospital Outpatient Utilization, Adults Age 21+, Other, April 2011–March 2012 ... | 50 |
| Figure SU-43 | Hospital Outpatient Utilization, Adults Age 21+, Undocumented, July 2011– June 2012 | 51 |
| Figure SU-44 | Nursing Facility Utilization, Adults Age 21+, Aged, July 2011–June 2012 | 56 |
| Figure SU-45 | Nursing Facility Utilization, Adults Age 21+, Blind/Disabled, Jul 2011–Jun 2012 ... | 56 |
| Figure SU-46 | Nursing Facility Utilization, Adults Age 21+, Other, July 2011–June 2012 | 57 |
| Figure SU-47 | Pharmacy Utilization, Children Age 0–20, Blind/Disabled, July 2011–June 2012 ... | 60 |
| Figure SU-48 | Pharmacy Utilization, Children Age 0–20, Families, July 2011–June 2012 | 60 |
| Figure SU-49 | Pharmacy Utilization, Children Age 0–20, Foster Care, July 2011–June 2012 | 61 |
| Figure SU-50 | Pharmacy Utilization, Children Age 0–20, Other, July 2011–June 2012 | 61 |
| Figure SU-51 | Pharmacy Utilization, Children Age 0–20, Undocumented, July 2011–June 2012 .. | 62 |
| Figure SU-52 | Pharmacy Utilization, Adults Age 21+, Aged, July 2011–June 2012 | 63 |
| Figure SU-53 | Pharmacy Utilization, Adults Age 21+, Blind/Disabled, July 2011–June 2012..... | 63 |
| Figure SU-54 | Pharmacy Utilization, Adults Age 21+, Families, July 2011–June 2012..... | 64 |
| Figure SU-55 | Pharmacy Utilization, Adults Age 21+, Other, July 2011–June 2012 | 64 |
| Figure SU-56 | Pharmacy Utilization, Adults Age 21+, Undocumented, July 2011–June 2012 | 65 |
| Figure SU-57 | Other Services Utilization, Children Age 0–20, Blind/Disabled, July 2011– June 2012 | 68 |

| | | |
|--------------|--------------------------------------------------------------------------------------------|----|
| Figure SU-58 | Other Services Utilization, Children Age 0–20, Families, July 2011–June 2012..... | 68 |
| Figure SU-59 | Other Services Utilization, Children Age 0–20, Foster Care, July 2011–June 2012..... | 69 |
| Figure SU-60 | Other Services Utilization, Children Age 0–20, Other, July 2011–June 2012..... | 69 |
| Figure SU-61 | Other Services Utilization, Children Age 0–20, Undocumented, July 2011– June 2012 | 70 |
| Figure SU-62 | Other Services Utilization, Adults Age 21+, Aged, July 2011–June 2012 | 71 |
| Figure SU-63 | Other Services Utilization, Adults Age 21+, Blind/Disabled, Jul 2011–Jun 2012 | 71 |
| Figure SU-64 | Other Services Utilization, Adults Age 21+, Families, July 2011–June 2012..... | 72 |
| Figure SU-65 | Other Services Utilization, Adults Age 21+, Other, July 2011–June 2012 | 72 |
| Figure SU-66 | Other Services Utilization, Adults Age 21+, Undocumented, Jul 2011–Jun 2012... | 73 |

List of Tables

Table SU-1 Summary of Service Utilization Trends Among Children by Aid Category and Service Category.....75

Table SU-2 Summary of Service Utilization Trends Among Adults by Aid Category and Service Category76

Utilization of Select Services by Medi-Cal FFS Beneficiaries

Introduction

Studying trends in service utilization provides DHCS with information regarding Medi-Cal beneficiaries' receipt of services, whether those services or service settings were appropriate, and may help identify areas where health care access gaps exist.

Many factors affect health care utilization and the type of health care used by a given population. One of those factors is adequate access to care. Limitations on the scope of benefits provided under a health plan, cost-sharing requirements, and gaps in health plan coverage may all contribute to underutilization of health care services. Other factors that influence health care utilization include the prevalence of chronic disease in the population, provider practice patterns, recommended medical practice guidelines for specific subpopulations (e.g., cancer screenings for women, immunization schedules, and developmental assessments for children), and cultural acceptance of medical practices among the population.

Age is also associated with health care utilization patterns. For example, advanced age increases functional limitations and the prevalence of chronic conditions. The elderly have higher utilization rates for inpatient and long-term care services, many medical procedures, and are prescribed more medications, such as glucose-lowering or antihypertensive drugs. In general, children have lower health care utilization rates than the elderly. However, infants born at low birth weight (<2500 grams, or 5.5 lbs), and children with chronic health conditions and disabilities have both higher rates of health care utilization and use more costly services than their counterparts. Children in foster care are particularly vulnerable to physical, emotional, or developmental problems stemming from abuse or neglect, substance abuse by their mothers during pregnancy, or their own substance abuse issues. A majority of these children have at least one physical or emotional health problem, and as many as 25% suffer from three or more chronic health conditions. Consequently, examining health care utilization patterns should be undertaken with specific thought given to the characteristics of a population.

Highlights

Although many children in the Blind/Disabled aid code category transitioned into managed care during 2011, those that remained in the Medi-Cal FFS delivery system continue to place a disproportionate demand on services of all kinds most likely due to their complex medical needs.

As beneficiary participation shifted away from the FFS delivery system and into managed care, many service categories experienced a noticeable decline in user counts that made the data unsuitable for analysis.

Ongoing declines in statewide birthrates are reflected in lower service utilization of certain categories of service such as Hospital Inpatient and Physician/Clinic services.

Methods

In this report, DHCS examines utilization trends for nine different provider types:

1. Physician/Clinics
2. Non-Emergency Transportation
3. Emergency Transportation
4. Home Health
5. Hospital Inpatient
6. Hospital Outpatient
7. Nursing Facility
8. Pharmacy services
9. Other

Service utilization was measured in various ways, depending upon the provider type. The unit of measure for Physician/Clinic, Home Health, and Hospital Outpatient services was the number of unique visits or patient encounters. The unit of measure for Pharmacy services was the unit counts of prescriptions. Individual encounters were used as the measure for both Emergency and Non-Emergency Transportation services, while the length of stay as measured in days was the unit of measure for Hospital Inpatient and Nursing Facility service utilization. Service rates were calculated per 1,000 member months for each of these service types and for beneficiaries eligible for Medi-Cal only and participating in FFS. Beneficiaries were classified into broad age groupings (children age 0–20 vs. adults age 21+) and aid categories as a proxy for health and disability status, factors which are known to influence utilization patterns.

DHCS plotted monthly service utilization rates per 1,000 member months for the study period of July 2011–June 2012. DHCS used Shewhart control charts to identify whether health care service utilization rates changed over this time period and compared to low and high utilization thresholds calculated from the baseline period January 1, 2007–December 31, 2009.¹ These thresholds or control limits have been set at three standard deviations from the mean, and define the natural range of variability expected from the plotted measures. Upper and lower threshold levels are represented in each control chart, with UCL representing upper control limits, LCL representing Lower control limits, and \bar{x} representing the mean. Comparing the plotted measures to the mean and upper and lower control limits can lead to inferences regarding whether the data are within an expected or predictable range, or whether there are marked changes in the data over time. Potential marked changes include:

- Eight or more consecutive points all either above or below the mean line indicate a shift in utilization patterns.
- Six or more consecutive points all going in the same direction (either up or down) indicate a trend.

¹ See various health care service utilization baseline analysis on the DHCS website at www.dhcs.ca.gov/pages/RateReductionInformation.aspx

- Two or more consecutive points plotted outside of these established limits will provide a signal indicating that health care utilization has deviated markedly from the expected range.

Changes in enrollment and provider capacity are important factors influencing health care utilization trends. When evaluating utilization trends, some basic paradigms should be considered. Under the first paradigm, if enrollment increases within a subpopulation and the network of health care providers cannot absorb the increased demand, beneficiaries may experience difficulties accessing health care services.² In that case, one would expect to detect a decline in service utilization rates as beneficiaries forego health care services.

Under the second paradigm, if participation increases and the network of providers is able to absorb additional demand, then one would expect service utilization rates to remain constant, increase, or to experience no significant decreases.³

Under the third paradigm, if participation decreases within a subpopulation and those that remain in the health care system have a significantly different case mix than the initial population, one would expect marked changes in health care utilization. For example, if the subpopulation that remains in the health care system has significantly greater medical needs than the initial population, one would expect service utilization rates to increase. However, if the subpopulation that remains is healthier, one would expect service utilization rates to decrease. Certain shifts in populations from one health care system to another, such as FFS to managed care, might result in a significant change in the mix of patients. This in turn may result in significant changes in utilization trends.

The sections that follow present health care utilization trends for each of the nine service categories studied. Each section is introduced with a discussion that presents background material related to each unique service category. This background provides the reader with some introductory information regarding the types of services associated with the category, historical use, and types of providers, where applicable, contained within the service category. The reader should note that the background sections present service utilization information that relates to 2010 and includes all FFS utilization, regardless of health care system participation in FFS or managed care. In addition, utilization statistics associated with the background sections includes utilization associated with dual eligibles. Following the background information, utilization trends for each service category is presented. The utilization trends display statistics associated with beneficiaries eligible for Medi-Cal only and participating in Medi-Cal's FFS system.

² Assumes populations who enroll exhibit similar health needs as those who were enrolled prior. If the newly enrolled individuals are a much healthier population with low health service utilization, utilization rates may actually decline. This decline may be driven more by the health characteristics than access difficulties.

³ Assumes populations who enroll exhibit similar health needs as those who were enrolled prior.

Physician/Clinic

Background

It is important for any health care delivery system to monitor trends in physician service utilization among its patients, because physicians are the first point of contact for most health care needs. Once contact is made in a physician's office, numerous other services may be accessed, such as prescription drugs, lab services, and referrals to specialty care. Receiving regular ambulatory health care visits has been widely recognized as a fundamental measure of successful health care access.

In the Medi-Cal program, beneficiaries may see a physician in solo practice, physicians affiliated with a physician group, or those affiliated with a Federally Qualified Health Clinic (FQHC), Rural Health Clinic (RHC), or some other clinical setting. A large proportion of Medi-Cal beneficiaries with paid claims in the FFS system (> 5 million) receive at least one physician or clinic visit throughout the year.

FQHCs are nonprofit, community-based organizations or public entities that offer primary and preventive health care and related social services to the medically underserved and uninsured population, regardless of their ability to pay. FQHCs receive funding under the Public Health Service Act, Section 330, which is determined by the U.S. Department of Health and Human Services.

RHCs are organized outpatient clinics or hospital outpatient departments located in rural shortage areas as designated by the U.S. Department of Health and Human Services. To qualify as an RHC, a clinic must be located in a non-urbanized area or area currently designated by the Health Resources and Services Agency (HRSA) as a federally designated or certified shortage area.

Indian Health Services Clinics are those authorized by the U.S. Secretary of Health, Education and Welfare, to contract services to tribal organizations. Services available under the IHS provider type are more extensive than under the FQHC or RHC provider type, and include the following services: physician and physician assistant, nurse practitioner and nurse midwife, visiting nurse, clinical psychology and social work, comprehensive perinatal care, Early Periodic Screening, Diagnosis and Treatment (EPSDT), ambulatory, and optometry.

Other clinics in the Medi-Cal program include: Free Clinics, Community Clinics, Surgical Clinics, Clinics Exempt from Licensure, Rehabilitation Clinics, County Clinics not associated with a hospital, and Alternative Birthing Centers. All of these various clinics are included in this analysis.

Many users of Physician/Clinic services are either being seen in physician group practices (2,413,502, or 46%) or in an FQHC or RHC (2,040,980, or 38.8%). Nearly half of all Physician/Clinic services are provided to children under age 20, and many are eligible for benefits under the Families aid category. Most users of these services (75%) have on average one to five visits annually.

Trend Analysis

Children

Among children age 0–20 in the Medi-Cal FFS program, monthly Physician/Clinic services utilization rates ranged from 171.1–693.9 visits per 1,000 member months from the third quarter of 2011 to the second quarter of 2012.

The Physician/Clinic services utilization rates continued to be notably higher among children in the Blind/Disabled aid category, most likely due to their inherent complex medical needs. The utilization rates for children in the Undocumented aid category again fell well below the anticipated baseline ranges observed in the baseline period of 2007 to 2009. Additionally, children in the Blind/Disabled aid category exhibited above average utilization of Physician/Clinic services that at times reached levels above the expected baseline ranges. In contrast, children in the Families, Foster Care, and Other aid categories continued to display predominantly lower than average utilization rates during the study period. These lower utilization rates coincide with the decrease in participation in the Medi-Cal FFS delivery system among beneficiaries in this age group over the same time period.

Both children and adult beneficiaries in the Blind/Disabled aid category place a greater demand on Physician/Clinic services than any other beneficiary subgroup.

Adults

The monthly Physician/Clinic services utilization rates for adults age 21 and older ranged from 205.3–1,359.0 visits per 1,000 member months from the third quarter of 2011 to the second quarter of 2012.

Similar to the Physician/Clinic services utilization trends identified in the previous quarterly access reports, adults in the Blind/Disabled and Other aid categories again exhibited noticeably higher utilization rates than adult beneficiaries in other aid subpopulations. The utilization trends among most adults, with exception to those in the Undocumented aid category, again fell within the expected ranges. Adults in the Aged and Families aid categories displayed below average utilization during the final two quarters of 2011. These lower utilization rates for adults in the Aged and Families aid categories also coincide with the decline in the number of beneficiaries participating in the Medi-Cal FFS delivery system during the same time frame. Adults in the Aged and Blind/Disabled aid categories exhibited a noticeable increase in Physician/Clinic services utilization in the first two quarters of 2012. However, Physician/Clinic services utilization rates for adults in the Aged aid category declined back below the average at the end of the study period.

Adults enrolled in the Families and Undocumented aid categories had lower than average use of physician/clinic services, a trend that is most likely due to continued declines in the state birth rates.

Adults in the Families and Undocumented aid categories exhibited below average and lower than expected utilization of Physician/Clinic services throughout the study period, which may be explained in part by the continued declines in national and state birth rates. For instance, national

birth rates experienced its sharpest decline in over thirty years from 2007 to 2010,⁴ while preliminary National Vital Statistics' data indicates a continued decline in the birth rate for 2011 and into 2012. Given that many beneficiaries in the Undocumented aid category become eligible for services because they are pregnant, it can be hypothesized that the demand for Physician/Clinic services, particularly as it pertains to prenatal care and delivery, has decreased due to the decline in birth rates among this subpopulation. A definitive explanation for these service utilization patterns can only be reached by undertaking further analysis.

The following figures SU-1 to SU-10 represent the control chart analysis for both children and adults from the third quarter of 2011 to the second quarter of 2012.

⁴ Data from the National Vital Statistics System, found at <http://www.cdc.gov/nchs/data/databriefs/db60.pdf>

Trends—Physician/Clinic Services Utilization Rates, Children, July 2011–June 2012

Figure SU-1 Physician/Clinic Utilization, Children Age 0-20, Blind/Disabled, July 2011–June 2012

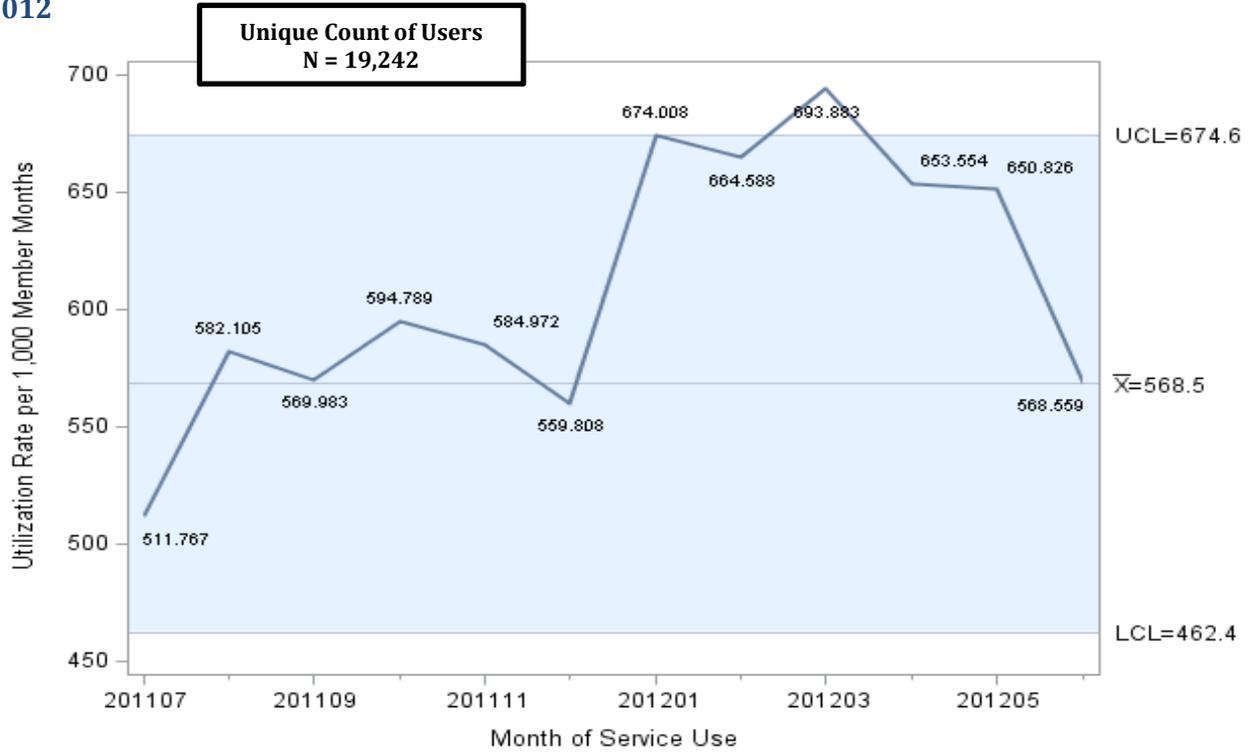


Figure SU-2 Physician/Clinic Utilization, Children Age 0-20, Families, July 2011–June 2012

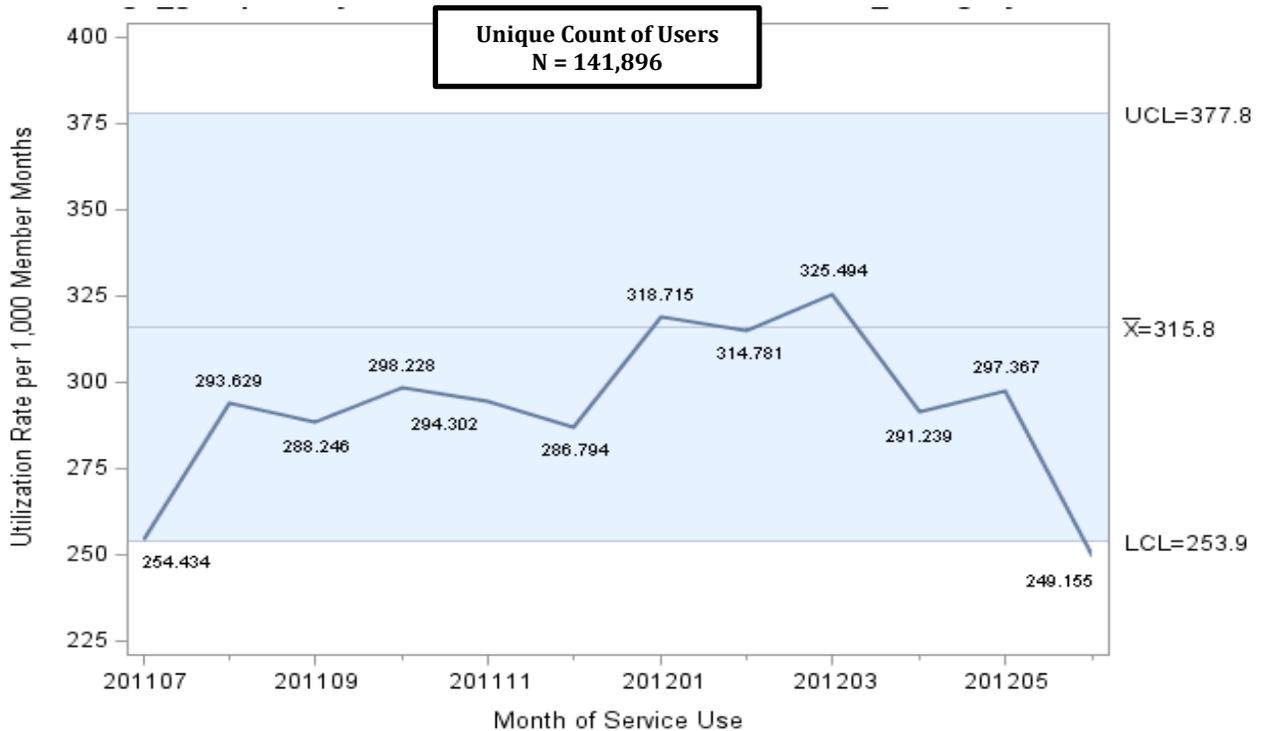


Figure SU-3 Physician/Clinic Utilization, Children Age 0-20, Foster Care, July 2011–June 2012

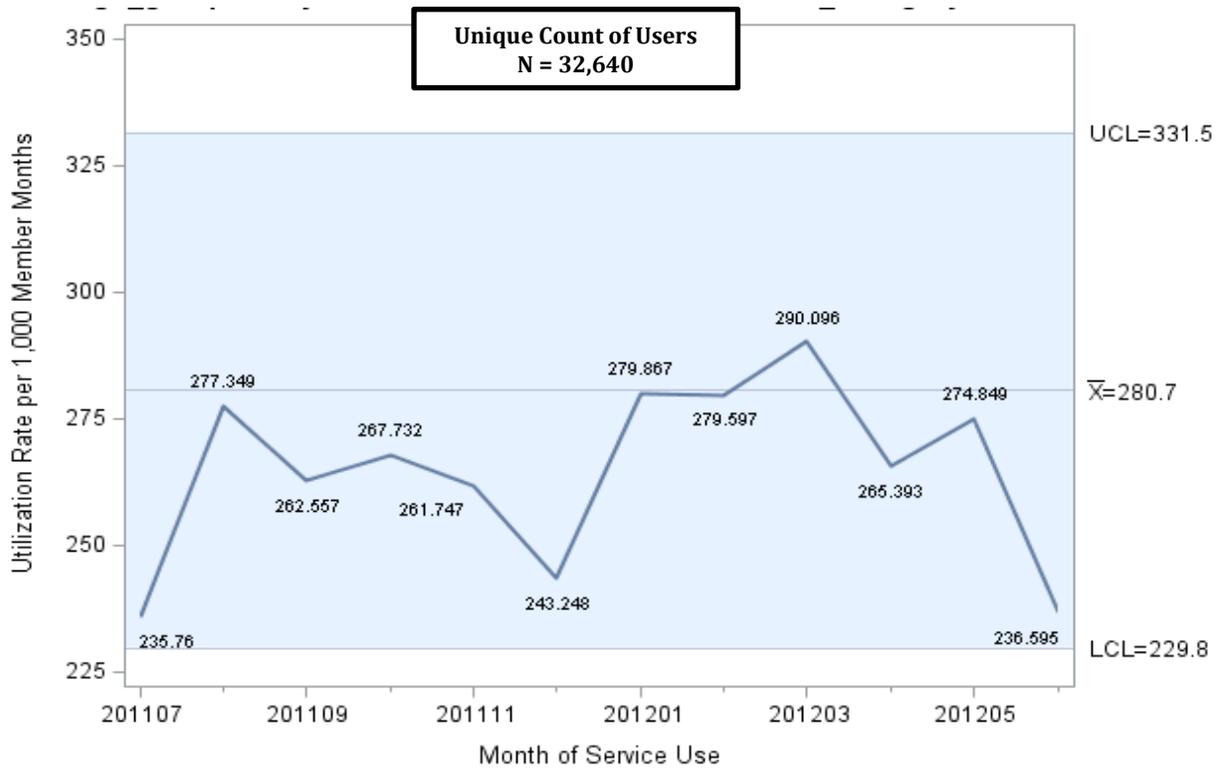


Figure SU-4 Physician/Clinic Utilization, Children Age 0-20, Other, July 2011–June 2012

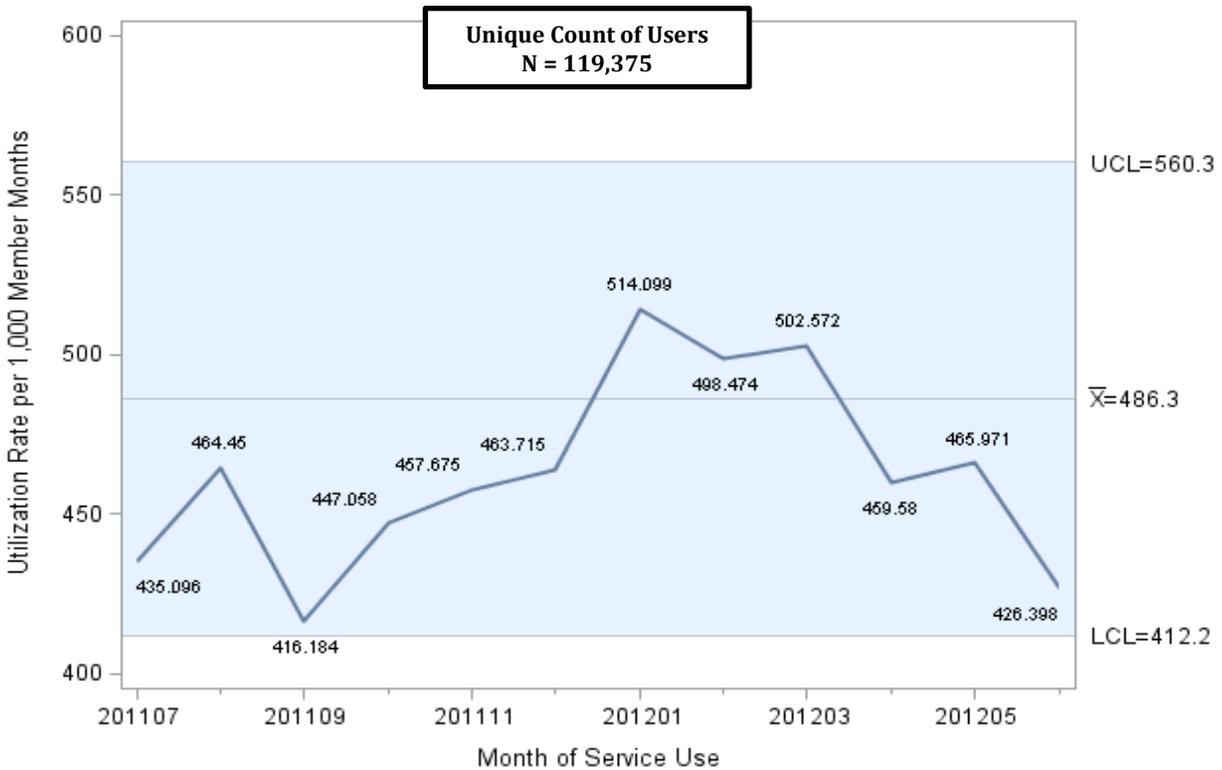
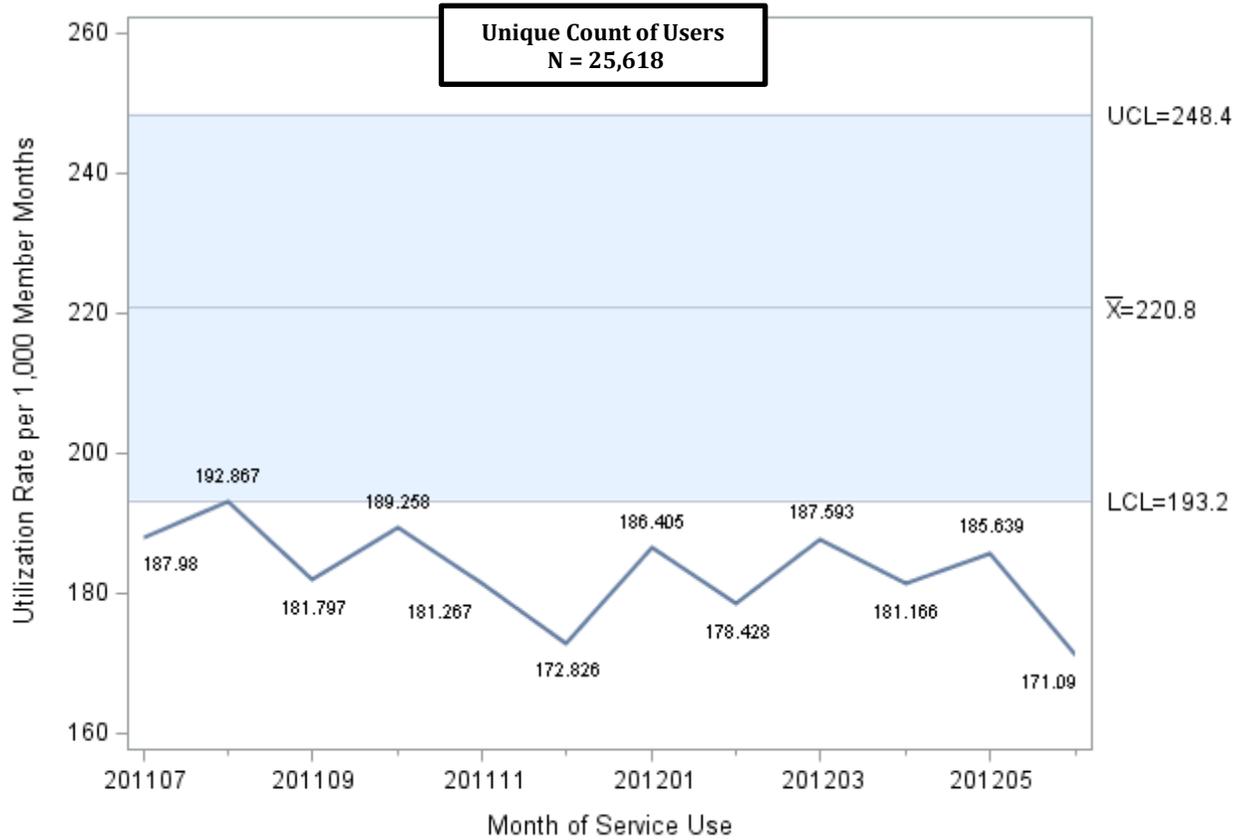


Figure SU-5 Physician/Clinic Utilization, Children Age 0-20, Undocumented, July 2011–June 2012



Source: Data for figures SU-1 to SU-5 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2011–June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Monthly Physician/Clinic Services Utilization Rates by Adults, July 2011–June 2012

Figure SU-6 Physician/Clinic Utilization, Adults Age 21+, Aged, July 2011–June 2012

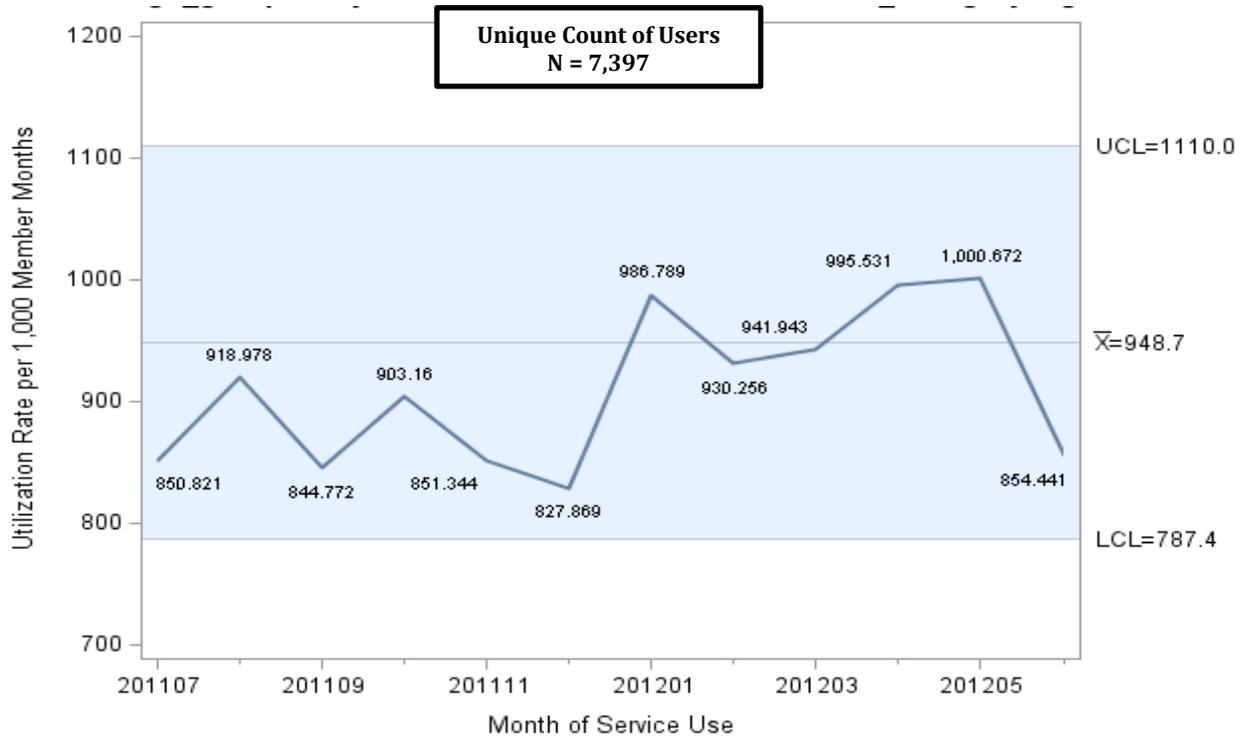


Figure SU-7 Physician/Clinic Utilization, Adults Age 21+, Blind/Disabled, July 2011–June 2012

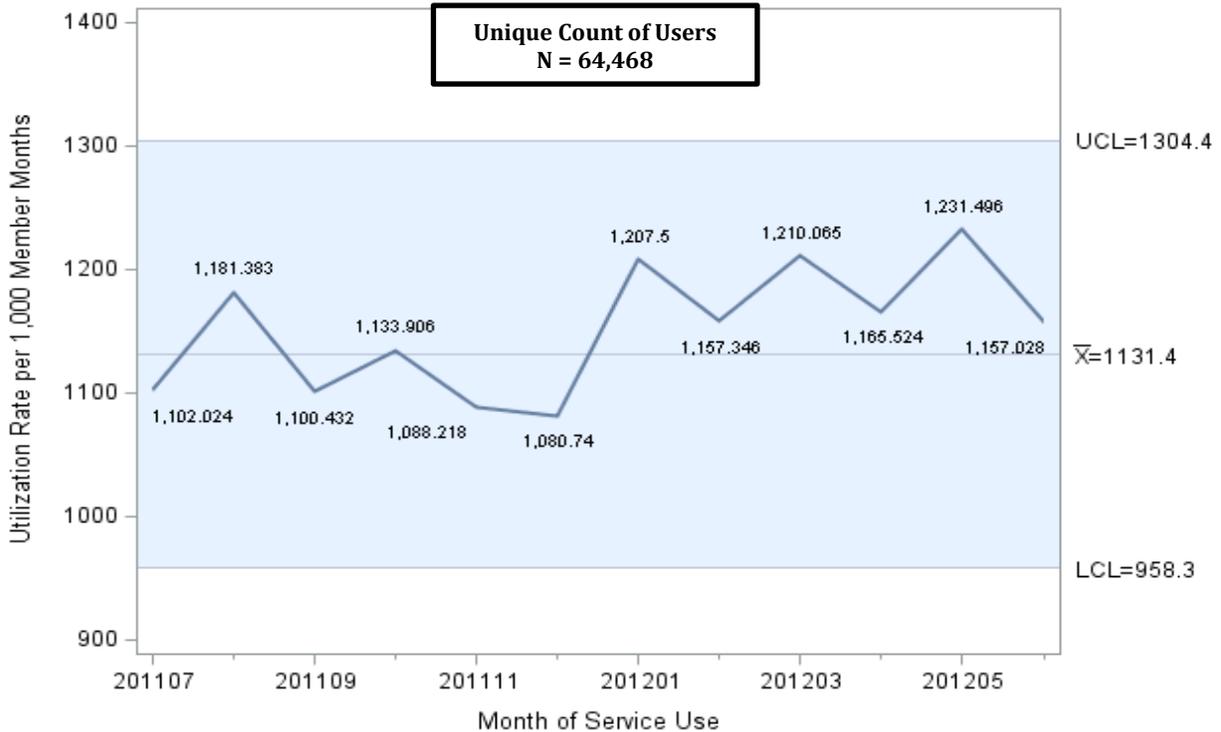


Figure SU-8 Physician/Clinic Utilization, Adults Age 21+, Families, July 2011–June 2012

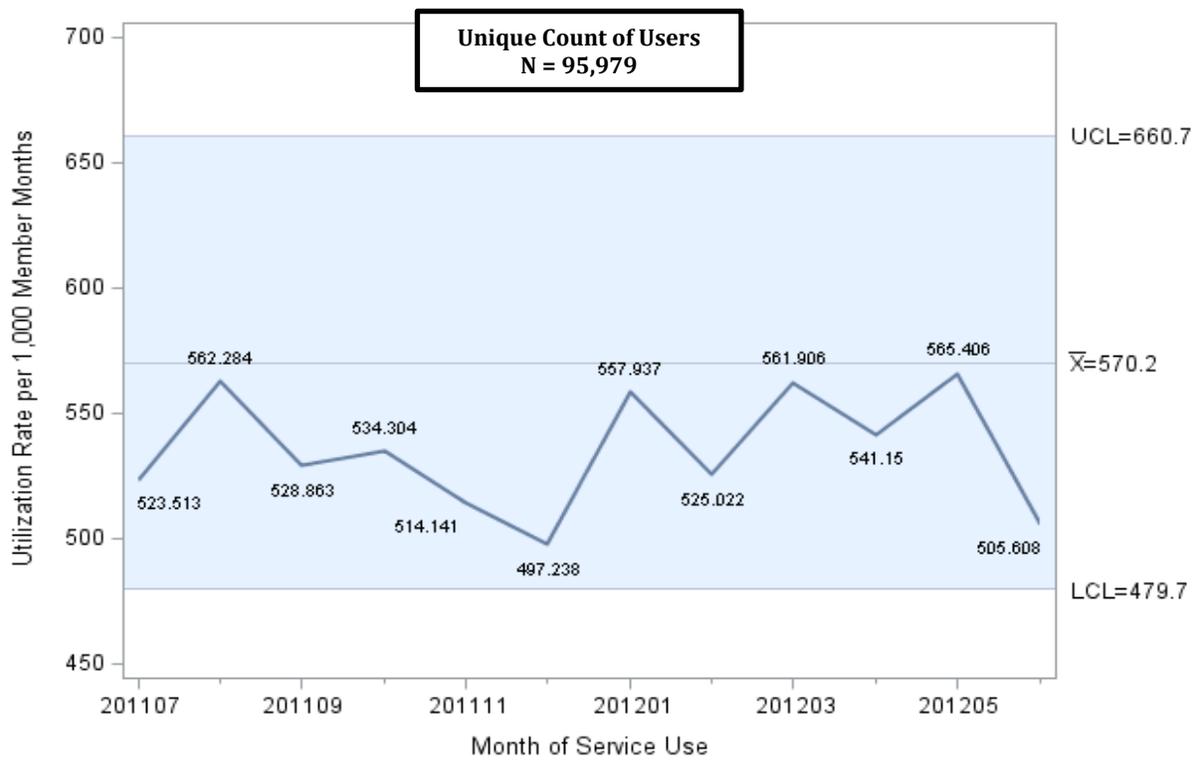


Figure SU-9 Physician/Clinic Utilization, Adults age 21+, Other, July 2011–June 2012

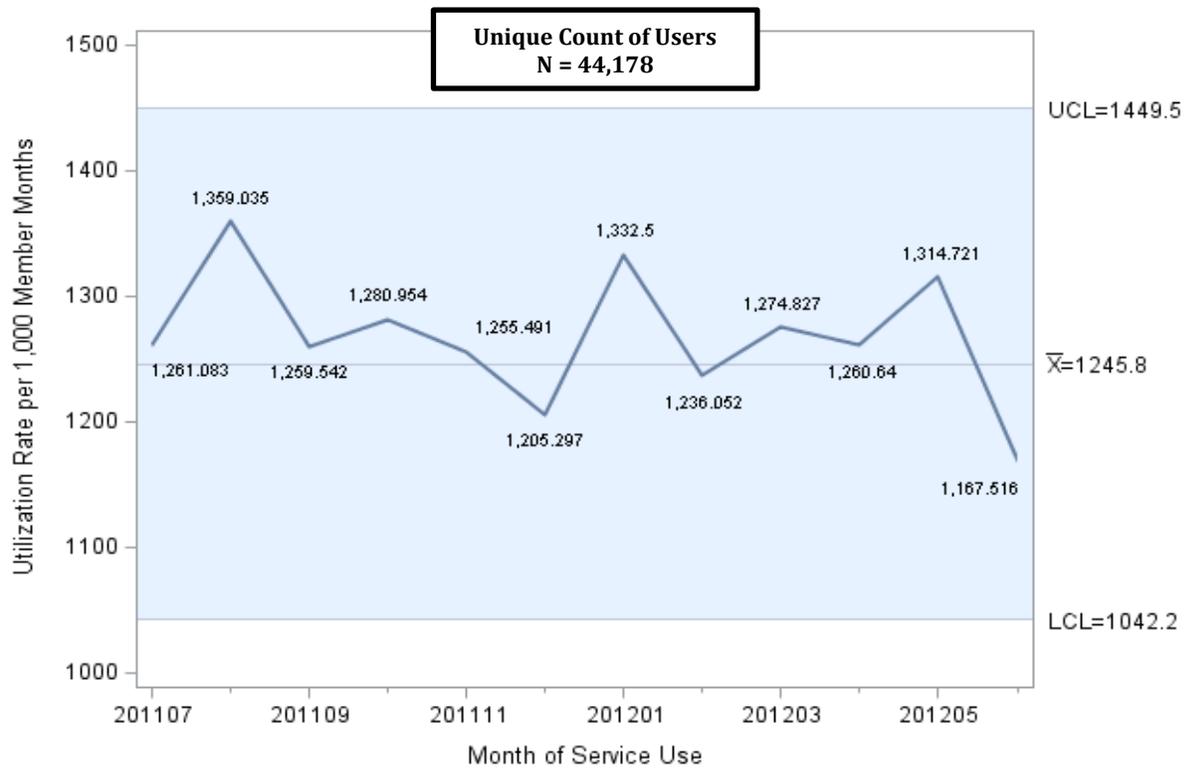
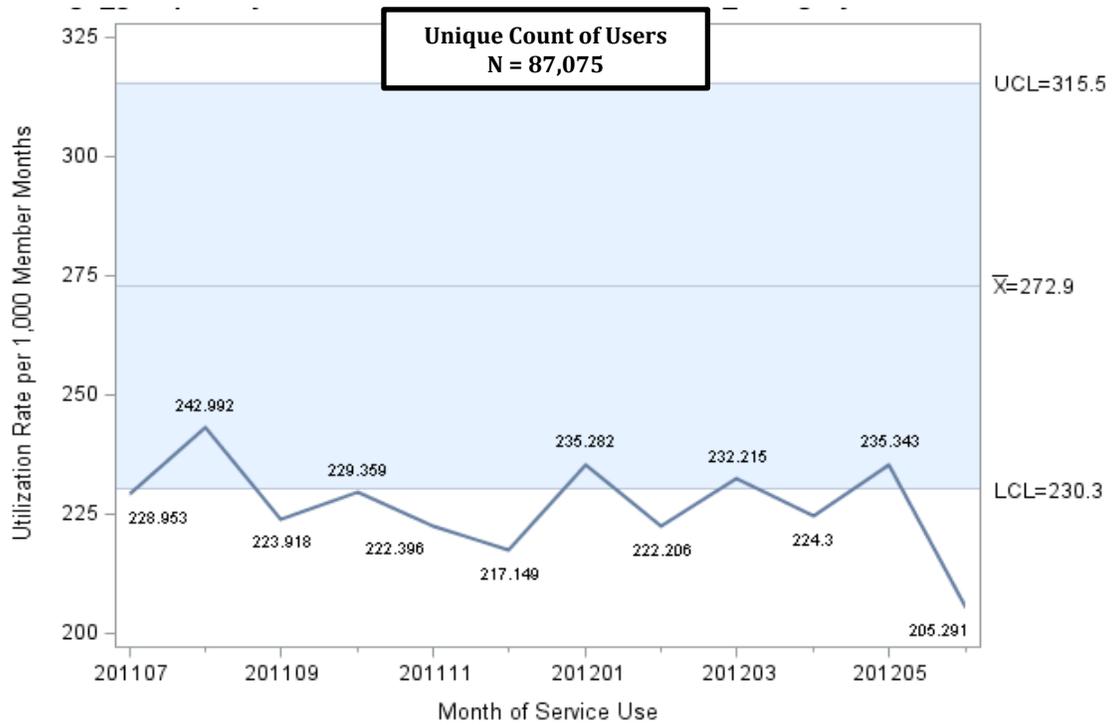


Figure SU-10 Physician/Clinic Utilization, Adults Age 21+, Undocumented, July 2011–June 2012



Source: Data for figures SU-6 to SU-10 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2011–June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Non-Emergency Medical Transportation

Background

Non-emergency transportation is the transportation of the sick, injured, invalid, convalescent, infirmed, or otherwise incapacitated persons when access to medical treatment is needed, but when the condition is not immediately life-threatening. An example of non-emergency transportation would be transport by litter van or wheelchair van to a doctor or clinic. Transportation services are also provided through air ambulance services. For non-emergencies, medical transportation by air is only covered when the medical condition of the patient or practical considerations make ground transportation impractical.

The Medi-Cal program covers medical transportation when a beneficiary cannot obtain medical services using ordinary means of transportation. Non-emergency transportation requires previous authorization and is covered only in limited situations. While most insurance plans apart from Medi-Cal provide their members with emergency medical transportation, non-emergency transportation is only covered by other plans in a limited form. For example, private insurance companies may cover non-emergency transportation when transferring a patient being discharged from the hospital, or when plan members seek specific treatment such as organ transplantation services.

There are over 200,000 Medi-Cal beneficiaries that access some form of medical transportation service paid through the Medi-Cal FFS claiming system annually. Fewer than 40% of medical transportation service recipients are users of non-emergency medical transportation. Approximately 70% of beneficiaries using non-emergency medical transportation services have between one and five service encounters annually and are predominantly age 65+ (58%). Many beneficiaries who utilize these services are covered under Disabled (45%), Aged (30%), and Long-Term Care (18%) aid categories, and are seen for conditions such as renal failure, brain damage, congestive heart failure, and other serious illnesses. Beneficiaries who utilize non-emergency medical transportation services six or more times annually represent a small segment of users (16%), a majority of whom have been diagnosed with renal failure (55%).

Trend Analysis

Children

Children in all of the aid categories are excluded from this analysis because of their relatively small user counts (< 500).

Adults

This analysis only focuses on Non-Emergency Medical Transportation services utilization among Medi-Cal adults age 21 and older participating in the FFS program and enrolled in the Blind/Disabled and Other aid categories. Among adults in these two aid categories, monthly Non-Emergency Medical Transportation services utilization rates ranged from 25.0–65.6 visits per 1,000 member months from the third quarter of 2011 to the second quarter of 2012.

Users of Non-Emergency Medical Transportation are now comprised of only two beneficiary subpopulations, adults in the Blind/Disabled and Other aid categories. Service use rates for these two populations were above expected ranges for the entire study period.

The Non-Emergency Medical Transportation services utilization rates among adults across the analyzed aid categories were similar to the previous quarterly access reports. For instance, adults in the Blind/Disabled aid category exhibited noticeably higher utilization with rates about two times higher than for adults in the Other aid category. Additionally, adults in the analyzed aid categories exhibited Non-Emergency Medical Transportation utilization rates above the expected baseline ranges throughout the study period. This trend is most likely due to the change in case mix that resulted when large groups of beneficiaries transitioned from the FFS delivery system into managed care plans. As these beneficiaries transitioned to managed care delivery systems, those that remain in FFS are either beneficiaries who have successfully obtained a medical exemption or that that return to the FFS delivery system because of their need for long-term care services. Beneficiaries exempted from managed care enrollment through the medical exemption process and those requiring long-term care services generally exhibit health care needs that are greater than the norm. As a result, these individuals will generate higher than average utilization rates.

Medi-Cal FFS beneficiaries in the Undocumented aid category are not entitled to Non-Emergency Medical Transportation services and were subsequently excluded from this analysis. Additionally, adults in the Aged and Families aid categories were excluded due to their relatively small user counts (< 500).

The following figures SU-11 to SU-12 represent the control chart analysis for adults from the third quarter of 2011 to the second quarter of 2012.

Trends—Monthly Non-Emergency Medical Transportation Services Utilization Rates by Adults, July 2011–June 2012

Figure SU-11 Non-Emergency Medical Transportation Utilization, Adults Age 21+, Blind/Disabled, July 2011–June 2012

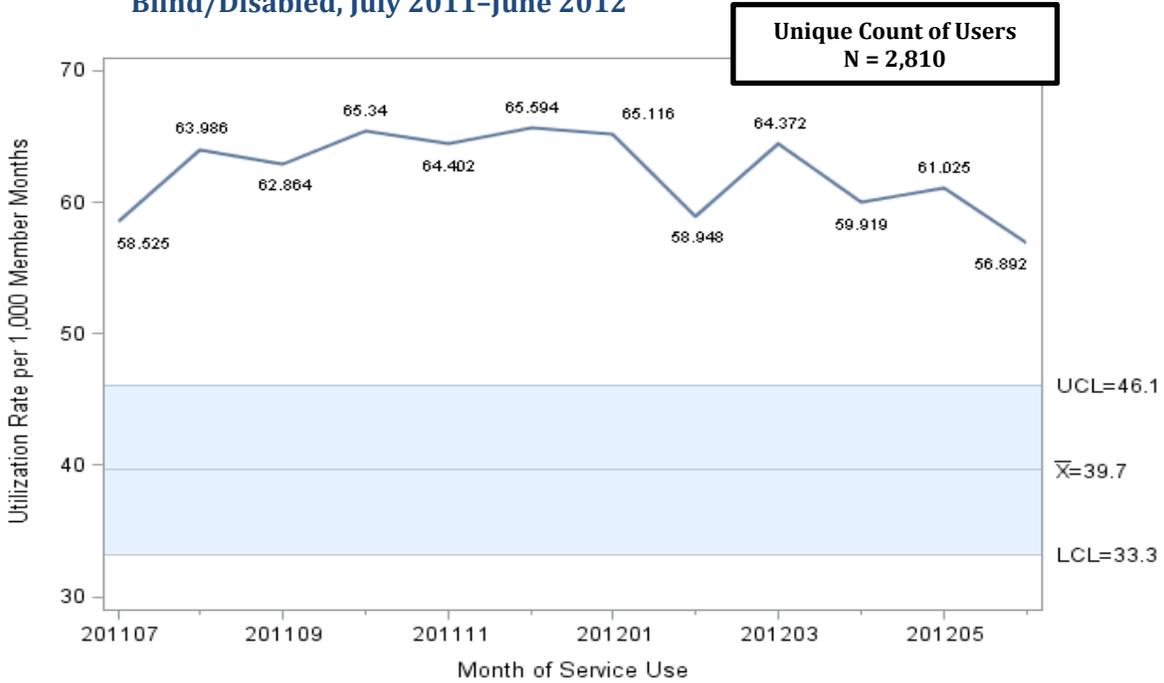
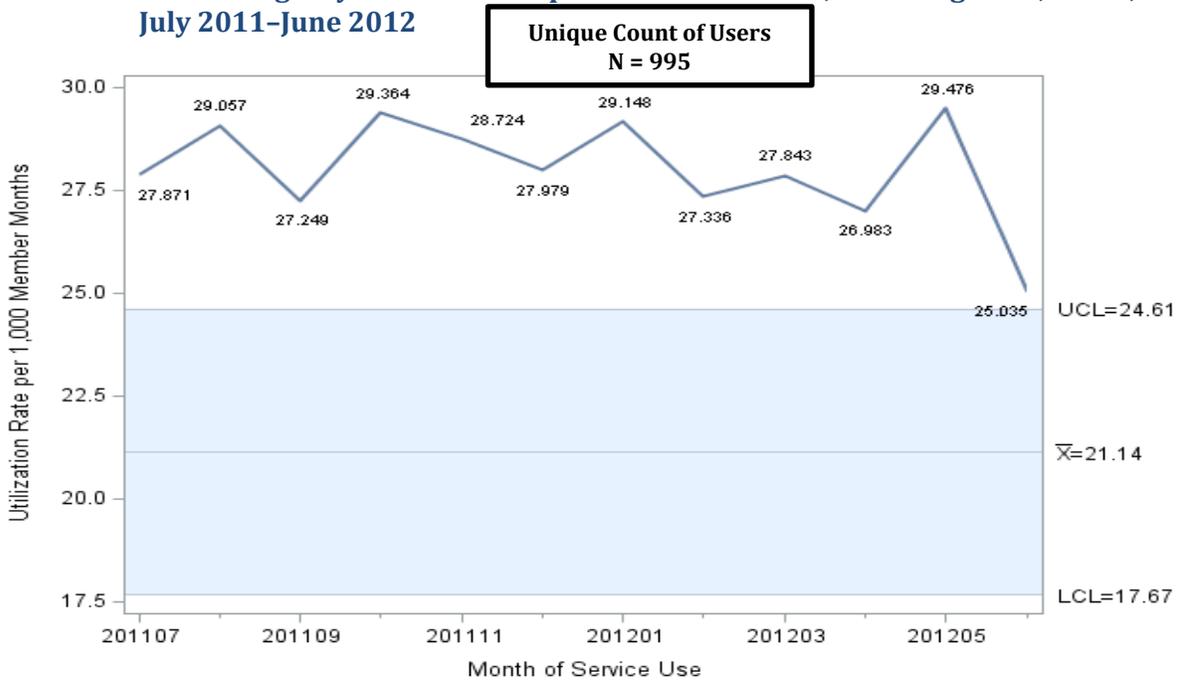


Figure SU-12 Non-Emergency Medical Transportation Utilization, Adults Age 21+, Other, July 2011–June 2012



Source: Data for figures SU-11 to SU-12 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2011–June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Emergency Medical Transportation

Background

Emergency transportation is the transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated persons for medical treatment needed in life-threatening situations. Similar to non-emergency transportation, emergency transportation services are provided through air ambulance services and ground medical transportation providers. Transportation by air is covered for emergencies if the medical condition of the patient contraindicates using other means of transportation, or if either the patient, or the nearest hospital capable of attending to the patient's medical needs, is inaccessible by ground transportation. Approximately 2.5% of all emergency transportation services are provided by air ambulance.

Emergency transportation is covered by Medi-Cal. Although this type of transportation does not require prior authorization, each claim must include a justification for the emergency transportation.

Of the 213,796 Medi-Cal beneficiaries that accessed medical transportation services in 2010, 69% utilized emergency transportation at a cost of \$56,777,111, or 32.3%, of the total medical transportation expenditures. A large proportion of users of emergency medical transportation services utilize services just once annually (69%), while a small proportion (5%) have six or more emergency medical transportation service encounters annually. The predominant user groups of emergency transportation services are adults between age 21–64 (66%), in Disabled aid categories (50%), and being treated for abdominal and chest pain, injuries, epilepsy or convulsions, spondylosis and other back problems, and schizophrenia or other psychotic disorders.

Trend Analysis

Children

Among children age 0–20 in the Medi-Cal FFS program, monthly Emergency Medical Transportation services utilization rates ranged from 1.3–9.7 visits per 1,000 member months from the third quarter of 2011 to the second quarter of 2012.

Patterns of service utilization among children in all of the analyzed aid categories mostly followed those identified in the previous quarterly access reports. For instance, Emergency Medical Transportation services utilization was noticeably higher among children in the Blind/Disabled aid category with rates ranging from 6.7–9.7 visits per 1,000 member months. In contrast, utilization rates for children in the Families and Other aid categories ranged from 2.0–3.1 visits per 1,000 member months.

Children in the Blind/Disabled, Families, Other, and Undocumented aid categories continued to exhibit below average utilization rates. Also, of particular note, children in the Blind/Disabled aid category experienced a downward trend in utilization during the last quarter of the study period. Children in the Foster Care aid category had mostly above average utilization rates that, in the last quarter of the study period, reached levels above the expected ranges observed in the baseline period of 2007 to 2009. Children in the Undocumented aid category had two or more consecutive months of Emergency Medical Transportation services utilization below the baseline ranges that returned to levels within the expected ranges beginning in March 2012. While children in the Other aid category displayed utilization rates below the expected ranges, their utilization of Emergency Medical Transportation services fell within the baseline ranges during the last two quarters of the study period.

Medi-Cal children used Emergency Medical Transportation services at below average rates, except for those in Foster Care aid codes. Use among adults in Blind/Disabled aid codes were mostly above average and at times above expected ranges.

Adults

The monthly Emergency Medical Transportation services utilization rates for adults age 21 and older ranged from 1.6–44.2 visits per 1,000 member months from the third quarter of 2011 to the second quarter of 2012.

Similar to the prior access quarterly reports, the utilization rates were noticeably higher for adults in the Blind/Disabled aid category, while adults in the Undocumented aid category rarely used these services. Adults in the Blind/Disabled aid category exhibited a noticeable upward trend in utilization beginning in December 2011. Adults in the Families aid category exhibited below average Emergency Medical Transportation services utilization patterns that fell within the expected baseline ranges, whereas adults in the Blind/Disabled aid category mostly displayed above average utilization rates that were, at times, above the baseline ranges. The utilization rates for adults in the Undocumented aid category again fell below the anticipated baseline ranges during the entirety of the study period.

Adults in the Aged aid category were excluded due to their relatively small user counts (< 500).

The following figures SU-13 to SU-21 represent the control chart analysis for both children and adults from the third quarter of 2011 to the second quarter of 2012.

Trends—Monthly Emergency Medical Transportation Services Utilization Rates by Children, July 2011–June 2012

Figure SU-13 Emergency Transportation Utilization, Children Age 0–20, Blind/Disabled, July 2011–June 2012

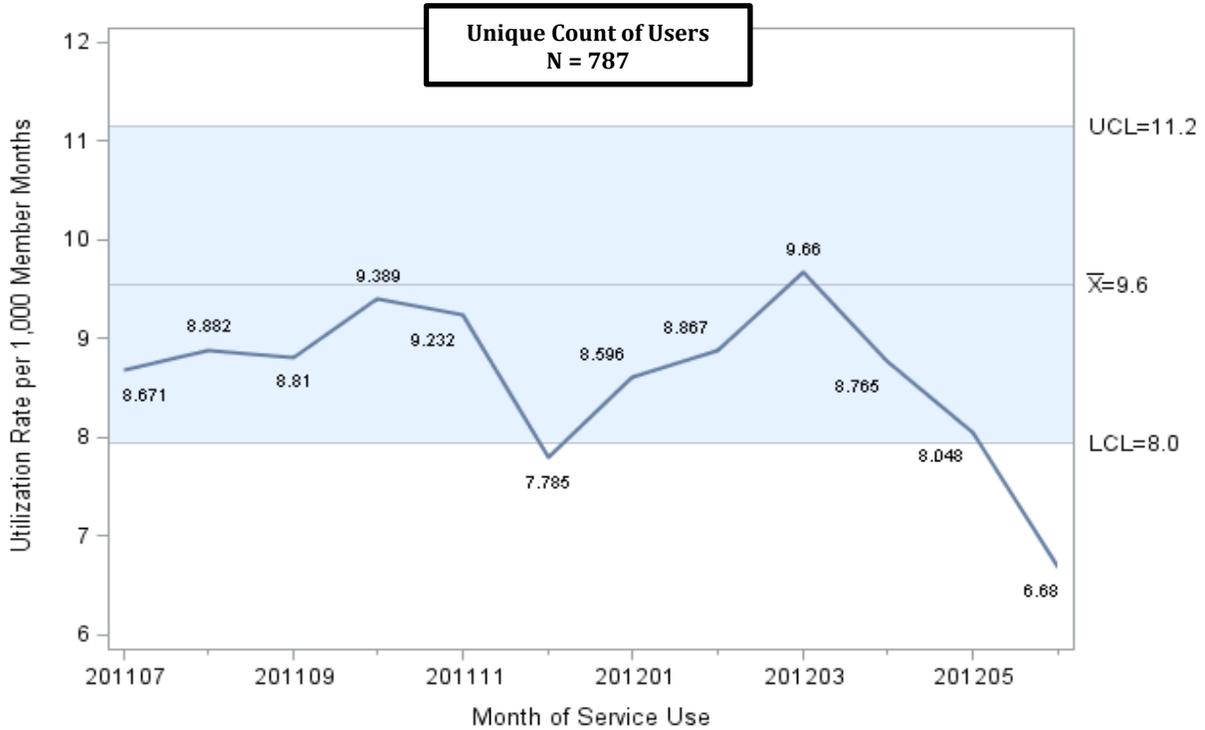


Figure SU-14 Emergency Transportation Utilization, Children Age 0–20, Families, July 2011–June 2012

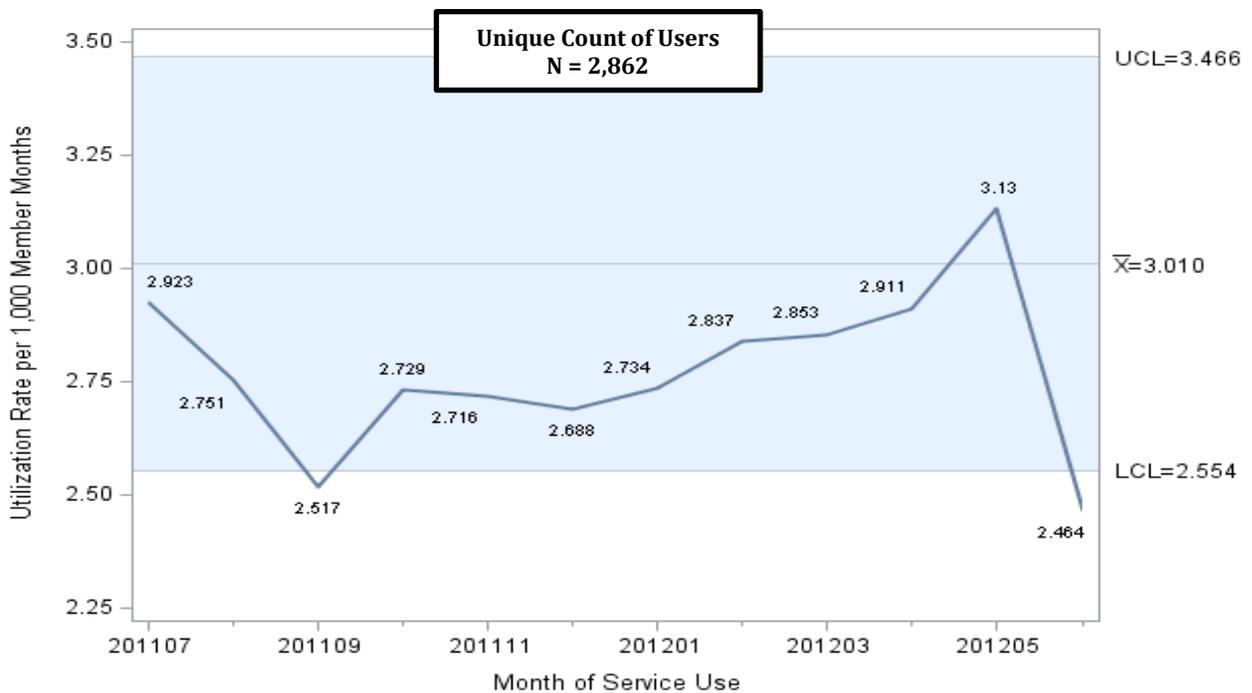


Figure SU-15 Emergency Transportation Utilization, Children Age 0-20, Foster Care, July 2011-June 2012

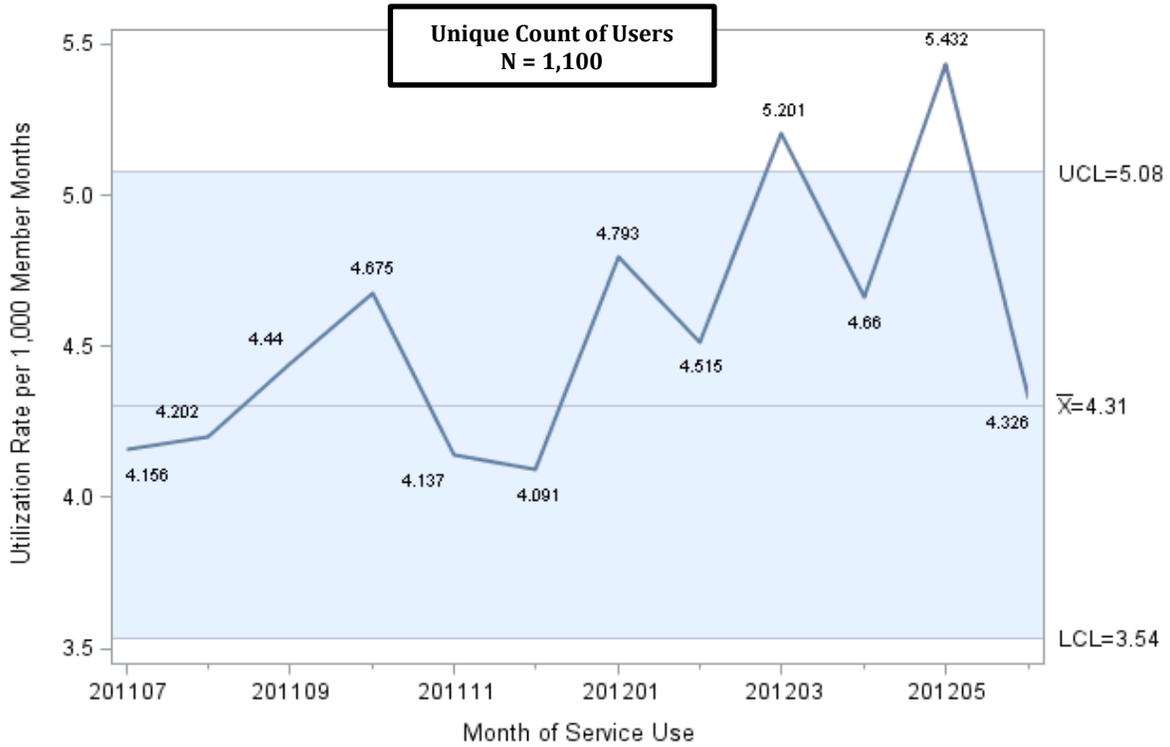


Figure SU-16 Emergency Transportation Utilization, Children Age 0-20, Other, July 2011-June 2012

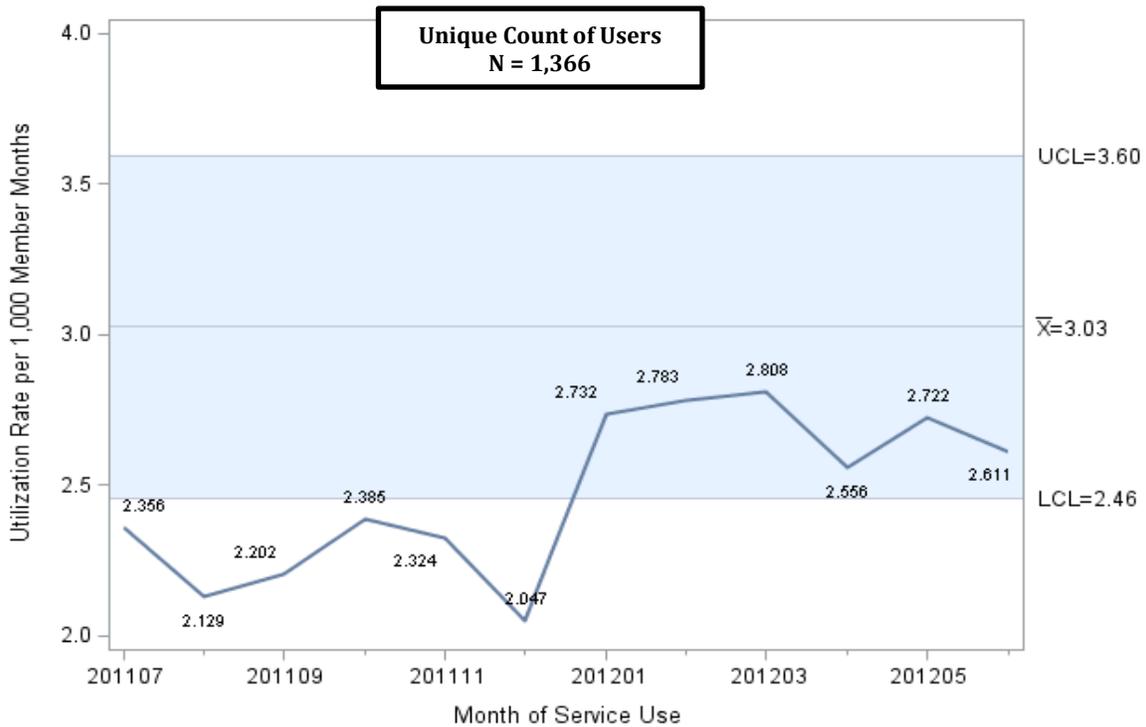
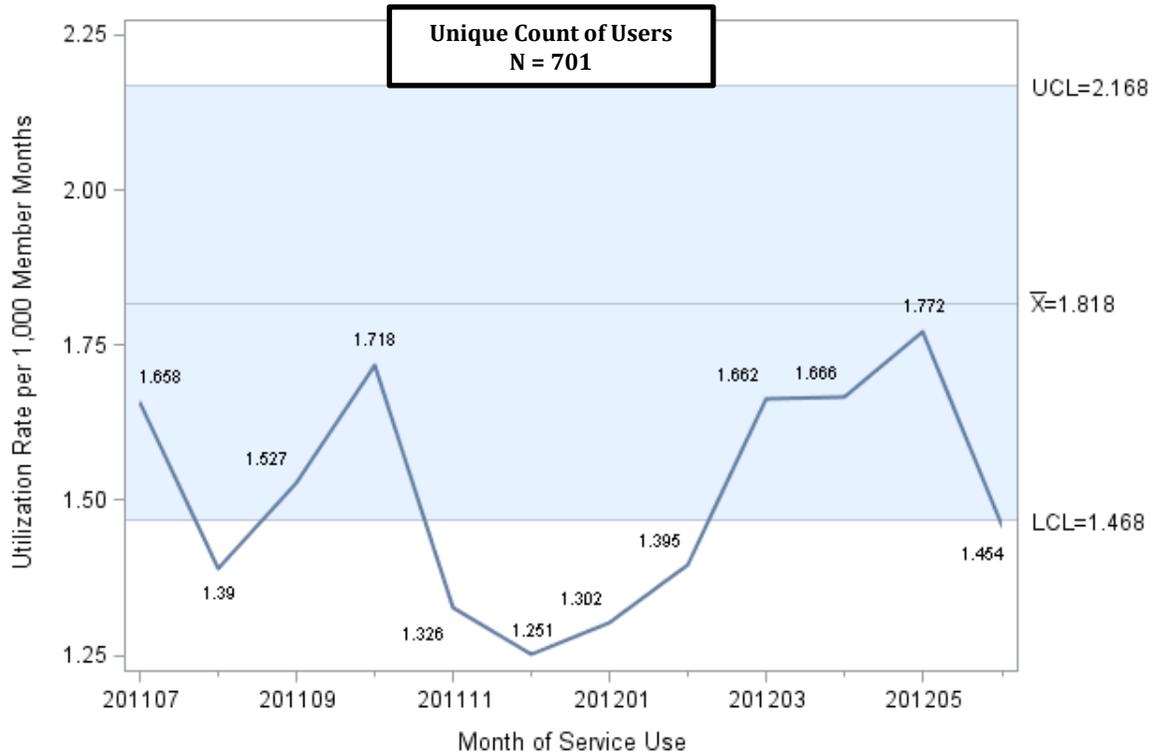


Figure SU-17 Emergency Transportation Utilization, Children Age 0-20, Undocumented, July 2011-June 2012



Source: Data for figures SU-13 to SU-17 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2011-June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Monthly Emergency Medical Transportation Services Utilization by Adults, July 2011–June 2012

Figure SU-18 Emergency Medical Transportation Utilization, Adults Age 21+, Blind/Disabled, July 2011–June 2012

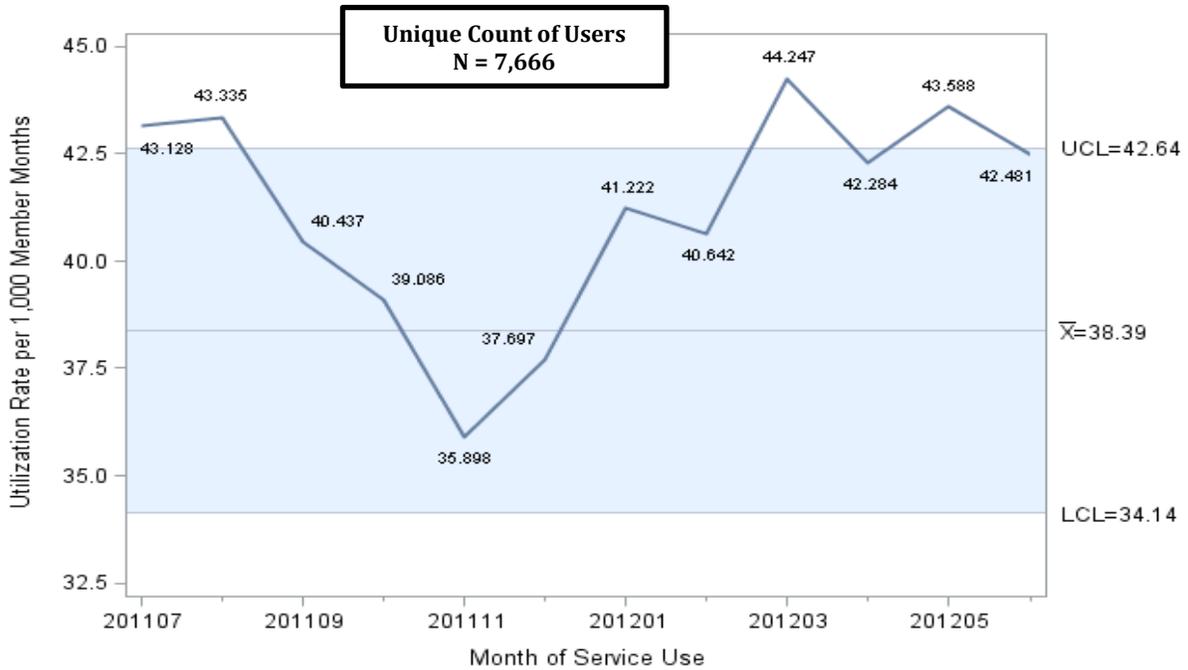


Figure SU-19 Emergency Medical Transportation Utilization, Adults age 21+, Families, July 2011–June 2012

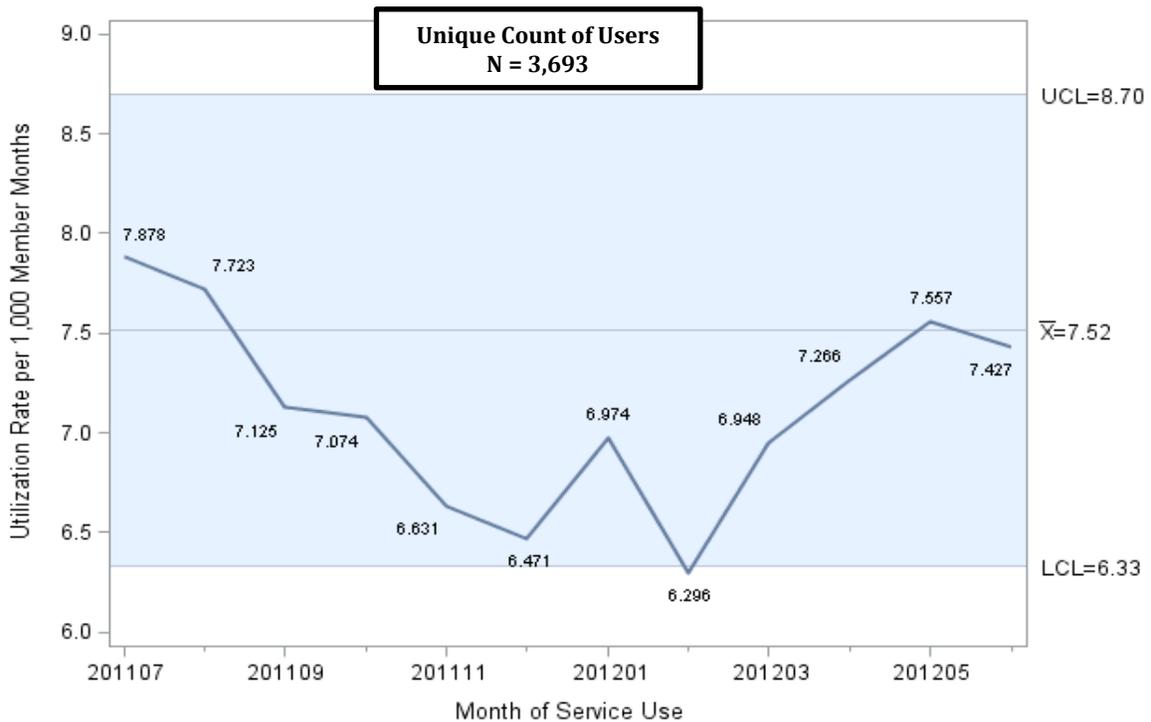


Figure SU-20 Emergency Medical Transportation Utilization, Adults Age 21+, Other, July 2011–June 2012

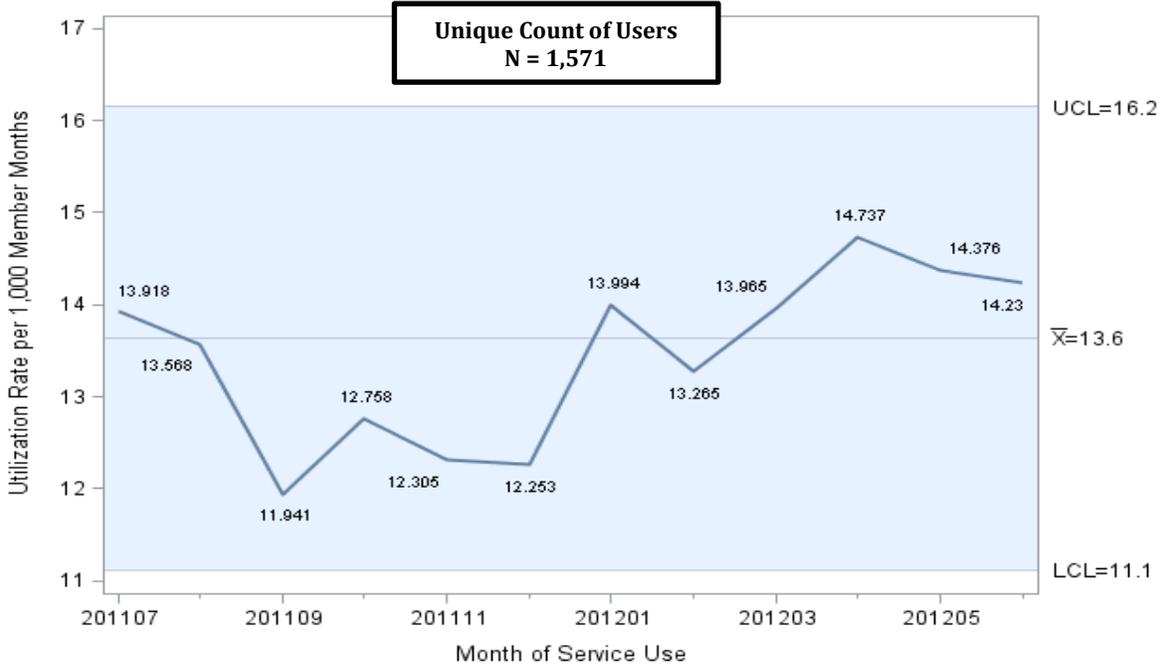
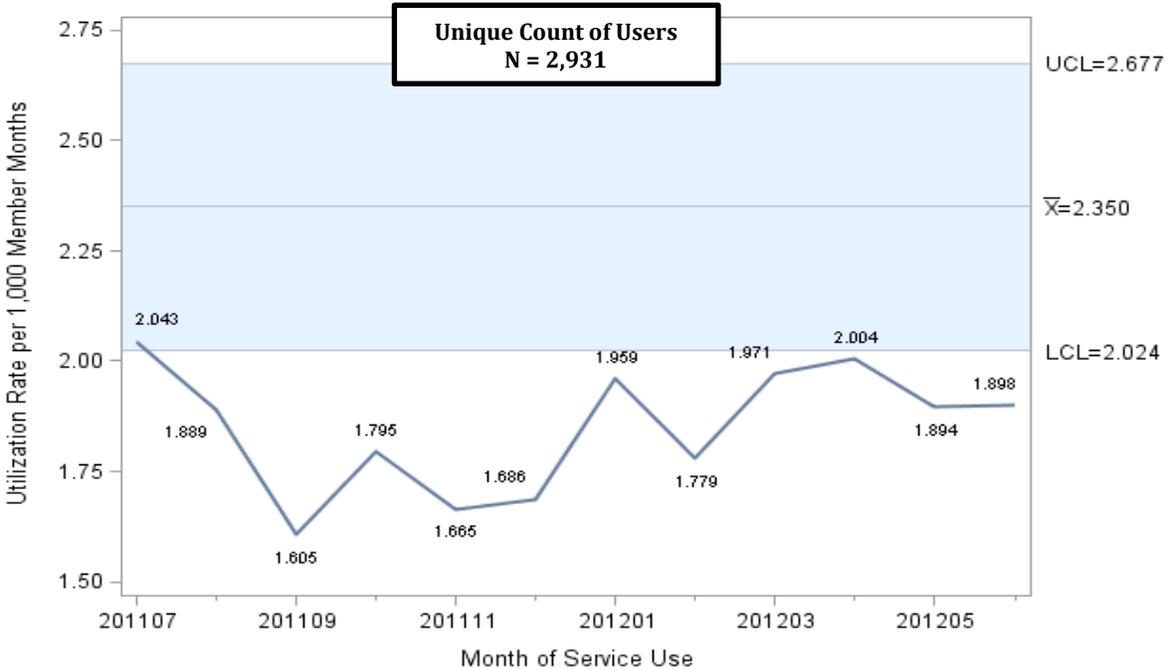


Figure SU-21 Emergency Medical Transportation Utilization, Adults Age 21+, Undocumented, July 2011–June 2012



Source: Data for figures SU-18 to SU-21 prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2011–June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Home Health Services

Background

Home Health services provide outpatient care to Medi-Cal beneficiaries on an intermittent or part-time basis. Services include:

- Part-time or intermittent skilled nursing by licensed nursing personnel;
- In-home medical care;
- Physical, occupational, or speech therapy;
- Home health aide;
- Provision of medical supplies, excluding drugs and biological;
- Medical social services; and
- Use of medical appliances.

These services must be prescribed by a physician under a written plan renewed every 60 days, and be provided at the recipient's place of residence. Most services require prior authorization, except for services related to case evaluations and early discharge follow-up visits.

Home Health services paid through FFS Medi-Cal comprise any claim paid under provider type "014"—Home Health Agency, which covers a variety of services, including services provided by home health agencies, home- and community-based services, residential care and home health under the assisted living waiver, and pediatric palliative care waiver services.

In any given year, there are approximately 26,000 unique users of Home Health agency services paid through FFS Medi-Cal. Most Home Health services users are adults age 21 and older (69%), while the remaining 31% are children. Though children represent a small proportion of home health users, their expenditures are significant, accounting for 73% of total Home Health service costs. Most of these expenditures are attributable to EPSDT private duty nursing that provides care for children with paralysis, nervous system disorders, epilepsy, and other congenital anomalies and hereditary conditions.

Private duty nursing and home- and community-based waiver populations receive long-term Home Health services averaging 9.3 months. Most individuals receiving long-term services have more chronic conditions, are under age 21, and covered under Disabled aid categories. Intermittent Home Health services users received an average of 1.76 months of visits for such things as rehabilitative care, mother-baby checks, and other aftercare treatment.

Nearly 50% of all Home Health services users are in Disabled aid categories, and approximately 25% are in medically needy Families and Undocumented aid categories and most likely receive services for postpartum follow-up care.

Trend Analysis

Children

This analysis focuses only on Home Health services utilization rates among Medi-Cal children age 0 to 20 participating in the FFS program and enrolled in the Blind/Disabled aid category. The monthly Home Health services utilization rates for children in this aid category ranged from 90.5–141.7 visits per 1,000 member months from the third quarter of 2011 to the second quarter of 2012.

Children in the Blind/Disabled aid category again exhibited an upward trend in service utilization. Although mostly exhibiting utilization within the boundaries observed in the baseline period of 2007 to 2009, the Home Health utilization rates for children in this group reached levels above the expected ranges starting in April 2012.

Home Health service use is now concentrated among two user groups: children and adults in Blind/Disabled aid codes. Both of these user groups exhibited upward trends during the study period.

Adults

Among adults 21 and older, this analysis only focuses on Home Health services utilization among beneficiaries enrolled in the Blind/Disabled aid category. The monthly Home Health services utilization rates for adults in this aid category ranged from 9.1–14.3 visits per 1,000 member months from the third quarter of 2011 to the second quarter of 2012.

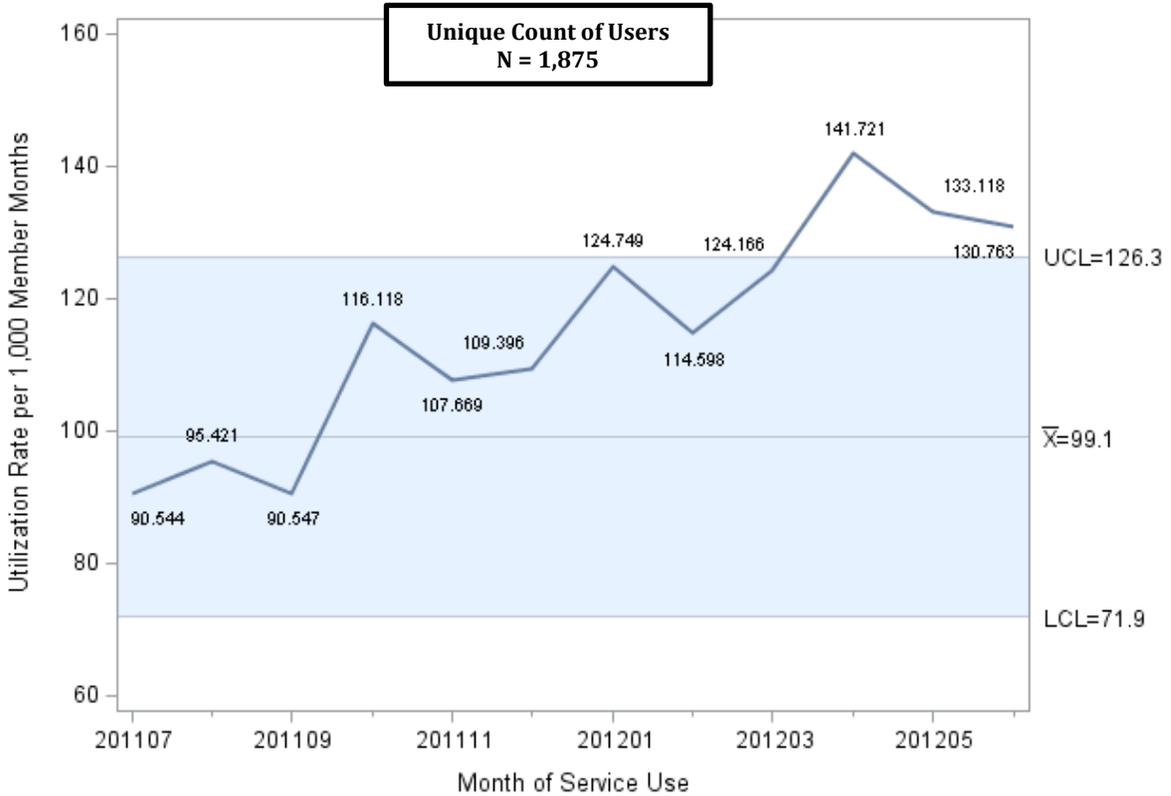
Similar to the prior access quarterly reports, adults exhibited much lower overall Home Health services utilization rates than children. Adults in the Blind/Disabled aid category continued to exhibit noticeable upward trends in utilization rates that also remained within the expected baseline ranges.

Medi-Cal FFS beneficiaries in the Undocumented aid category are not entitled to Home Health services and were subsequently excluded from this analysis. Additionally, adults in the Aged, Families, and Other aid categories, as well as, children in the Families, Foster Care, and Other aid categories were excluded because of their relatively small user counts (< 500).

The following figures SU-22 to SU-23 represent the control chart analysis for both children and adults from the third quarter of 2011 to the second quarter of 2012.

Trends—Monthly Home Health Services Utilization Rates by Children, July 2011–June 2012

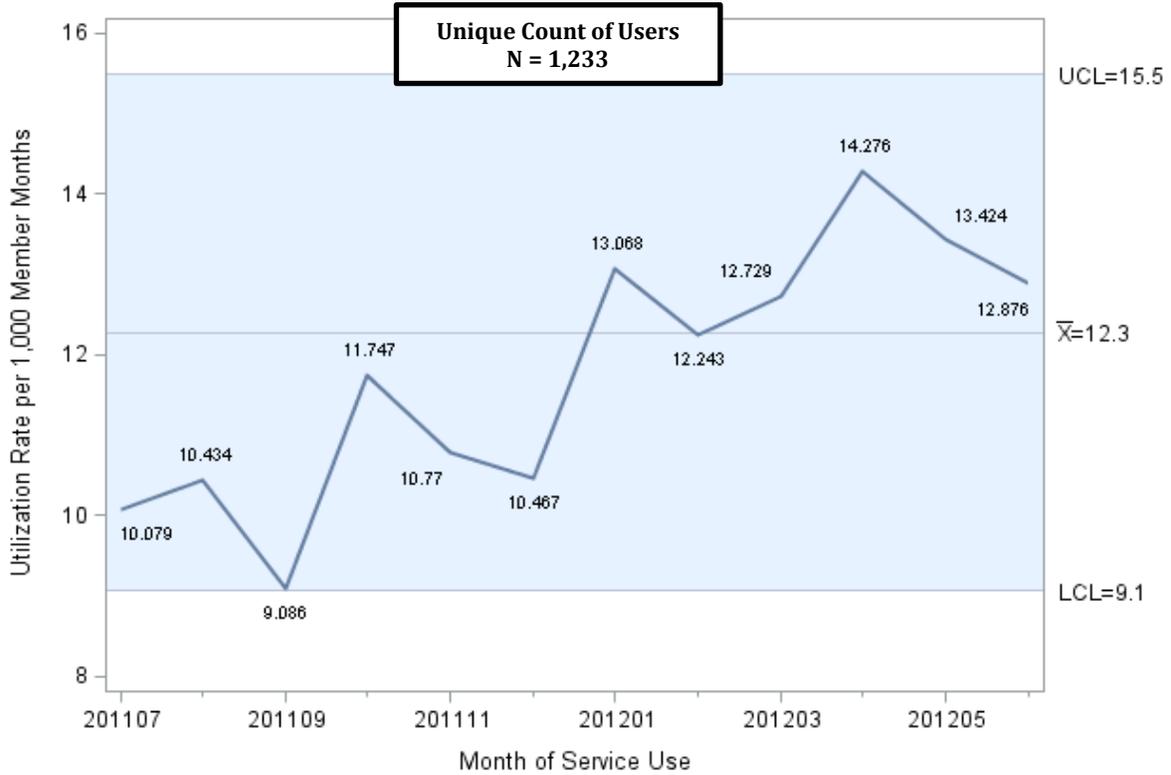
Figure SU-22 Home Health Services Utilization, Children Age 0–20, Blind/Disabled, July 2011–June 2012



Source: Data for figure SU-22 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from July 2011–June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Home Health Services Utilization by Adults, July 2011–June 2012

Figure SU-23 Home Health Utilization, Adults Age 21+, Blind/Disabled, July 2011–June 2012



Source: Data for figure SU-23 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2011–June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Hospital Inpatient Services

Background

Hospital Inpatient services are those services provided by a physician to patients admitted to the hospital at least overnight or who are transferred to another facility in the same day. Hospital Inpatient services do not include skilled nursing and intermediate care services furnished by a hospital with a swing-bed approval.

The general public is ensured access to emergency medical services, regardless of their ability to pay, under the Emergency Medical Treatment and Active Labor Act (EMTALA). Under this act, individuals who present to hospitals having emergency rooms must be appropriately screened and examined to determine whether or not an emergency medical condition exists, and must receive stabilizing treatment when medically needed. Emergency medical conditions include women in active labor. This provision is equally applicable to Medi-Cal beneficiaries seeking emergency and pregnancy-related services, including beneficiaries who are in restricted scope aid categories with limited benefits.

There are over 700,000 hospital admissions in the Medi-Cal FFS program annually, with nearly one-third of these admissions originating in a hospital emergency room. The most common reason for Hospital Inpatient admissions among the Medi-Cal FFS population is for childbirth and pregnancy-related services.

A large proportion of hospital admissions are to Medi-Cal FFS beneficiaries between age 21–64 (52%), and those in the Undocumented and Families aid categories (33%). An additional 33% of hospital inpatient service users are beneficiaries in Disabled and Aged aid categories. Over 90% of beneficiaries admitted to the hospital during the year have only one hospital inpatient stay, while a small proportion (7%) are admitted three or more times.

Beneficiaries who are hospitalized multiple times during the year are predominantly in the Aged and Disabled aid categories (>70%), and are hospitalized for reasons such as septicemia, pneumonia, congestive heart failure, complications of devices or implants, chronic obstructive pulmonary disease, and diabetes with complications.

Trend Analysis

Children

The monthly Hospital Inpatient services utilization rates for children age 0-20 in the Medi-Cal FFS program ranged from 12.5–128.2 days per 1,000 member months from the third quarter of 2011 to the second quarter of 2012.

Hospital Inpatient services utilization continued to be higher among children in the Blind/Disabled aid category with rates two to three times higher than for children in the Families, Other, and Undocumented aid categories and eight times higher than for children in the Foster Care aid category. Children in the Blind/Disabled aid category exhibited mostly above average Hospital Inpatient services utilization rates that fell within expected baseline ranges. Children in the other analyzed aid categories mostly exhibited below average utilization of Hospital Inpatient services throughout the study period. For instance, children in the Families and Foster Care aid categories exhibited below average utilization rates for most of the study period, while those within the Undocumented and Other aid categories displayed four or more consecutive months of utilization below the expected baseline ranges.

Children in Blind/Disabled aid codes had Hospital Inpatient use rates that were 2-3 times higher than for other children. Adults in both the Aged and Blind/Disabled aid categories experienced sharp increases in use in 2012.

Adults

Among adults 21 and older, monthly Hospital Inpatient services utilization rates ranged from 32.8–257.3 days per 1,000 member months from the third quarter of 2011 to the second quarter of 2012.

Hospital Inpatient services utilization was again noticeably higher for adults in the Aged, Blind/Disabled, and Other aid categories. The utilization of Hospital Inpatient services among adults in the Aged and Blind/Disabled aid categories sharply increased in 2012 to levels above the baseline thresholds before declining back within the expected range in June. Additionally, adults in the Family, Other, and Undocumented aid categories exhibited below average Hospital Inpatient services utilization rates that often fell below the expected ranges. This low utilization of Hospital Inpatient services among these subpopulations may be influenced, in part, by the continued decline in statewide birth rates.⁵

The following figures SU-24 to SU-33 represent the control chart analysis for both children and adults from the third quarter of 2011 to the second quarter of 2012.

⁵Data from the National Vital Statistics System, found at <http://www.cdc.gov/nchs/data/databriefs/db60.pdf>

Trends—Monthly Hospital Inpatient Services Utilization Rates, Children, July 2011–June 2012

Figure SU-24 Hospital Inpatient Utilization, Children Age 0-20, Blind/Disabled, July 2011–June 2012

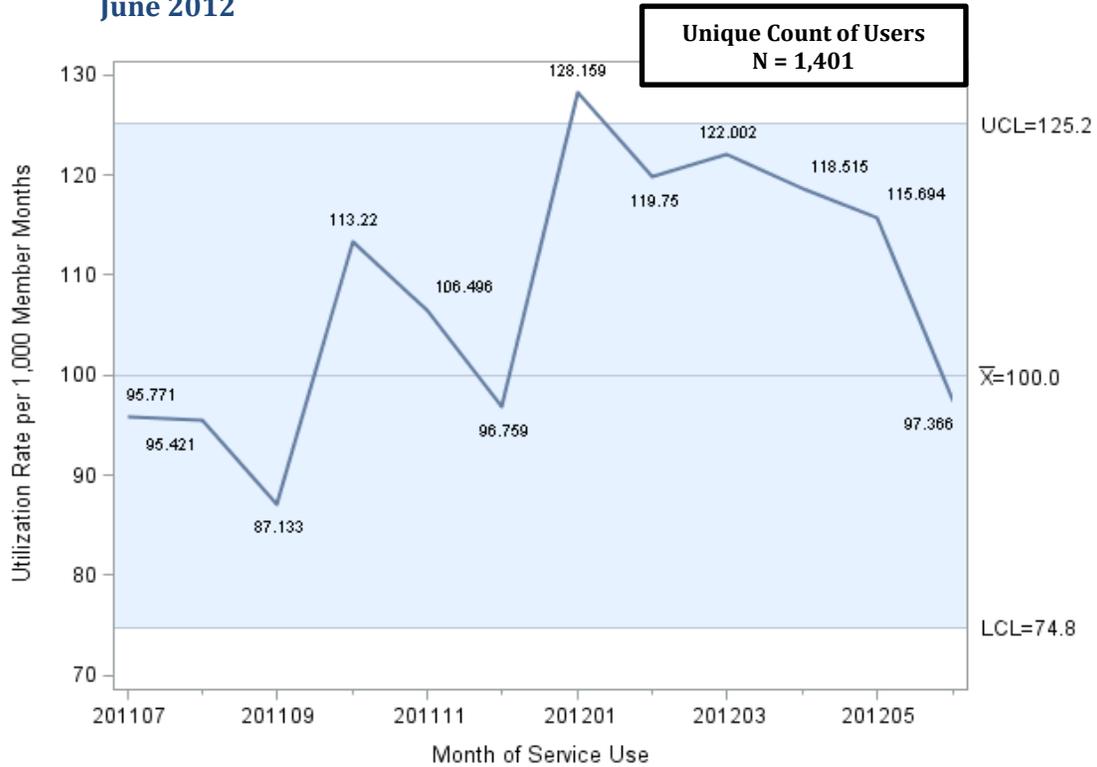


Figure SU-25 Hospital Inpatient Utilization, Children Age 0-20, Families, July 2011–June 2012

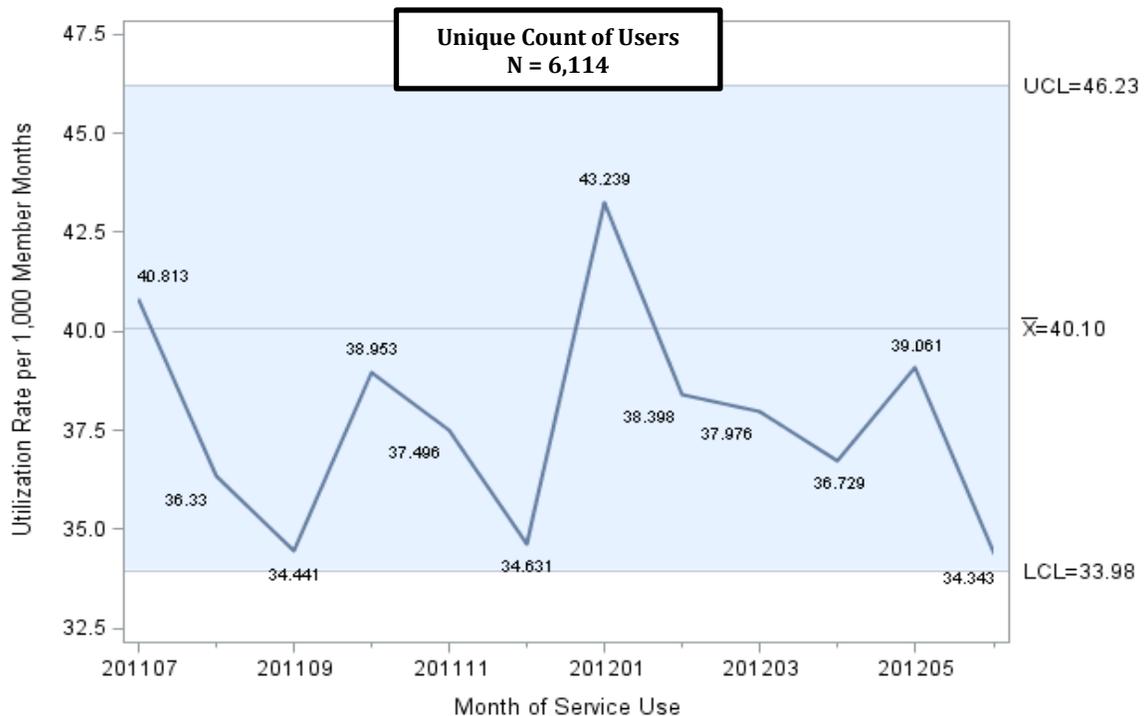


Figure SU-26 Hospital Inpatient Utilization, Children Age 0-20, Foster Care, July 2011-June 2012

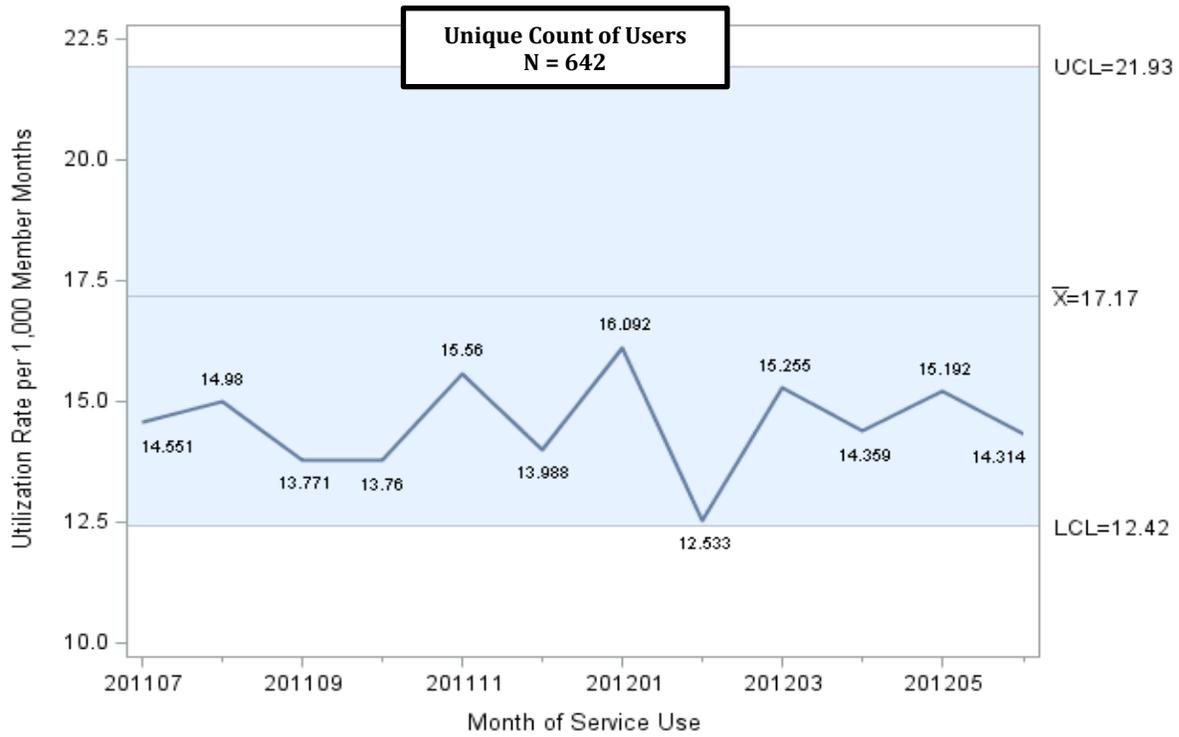


Figure SU-27 Hospital Inpatient Utilization, Children Age 0-20, Other, July 2011-June 2012

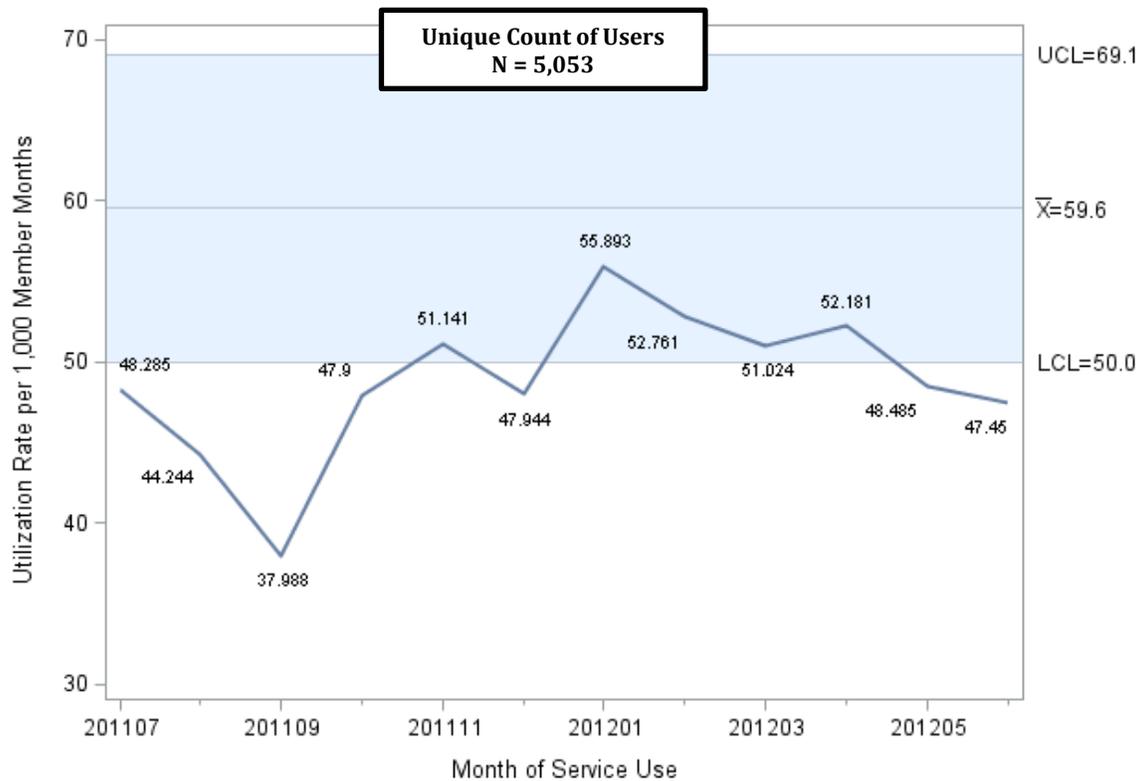
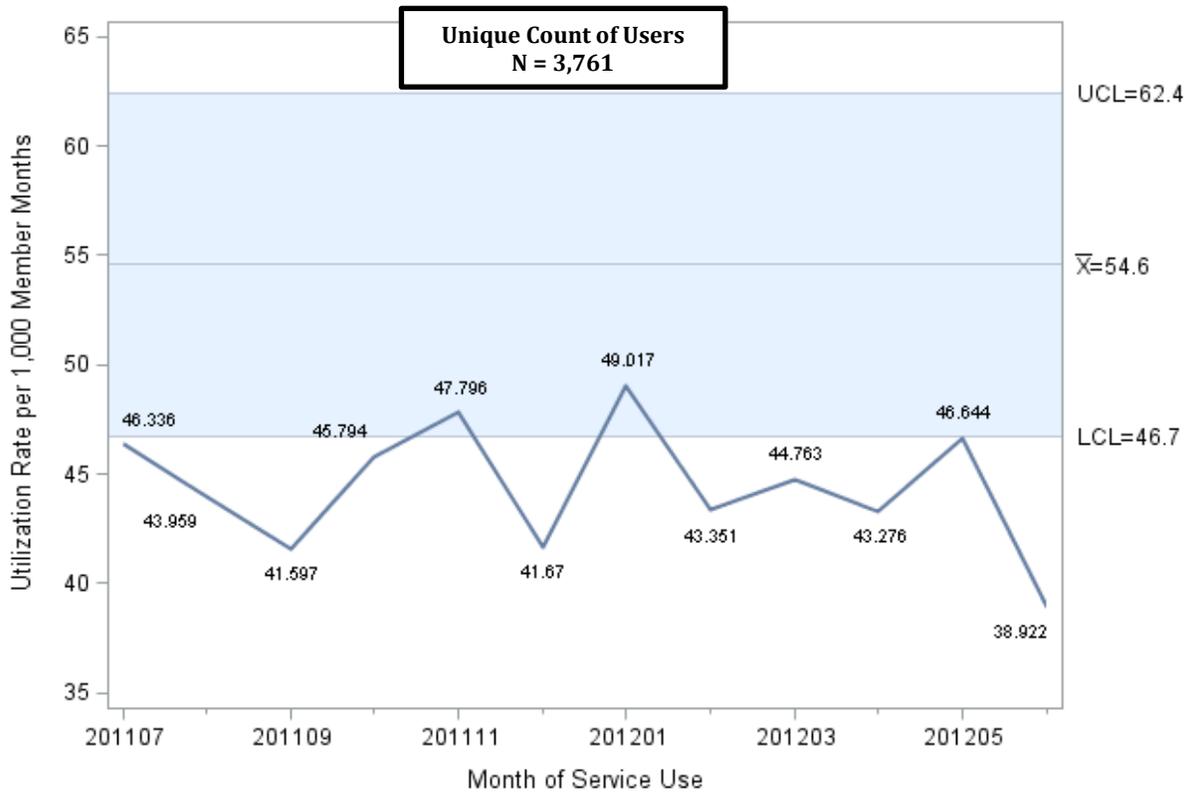


Figure SU-28 Hospital Inpatient Utilization, Children Age 0-20, Undocumented, July 2011-June 2012



Source: Data for figures SU-24 to SU-28 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2011-June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Hospital Inpatient Services Utilization by Adults, July 2011–June 2012

Figure SU-29 Hospital Inpatient Utilization, Adults Age 21+, Aged, July 2011–June 2012

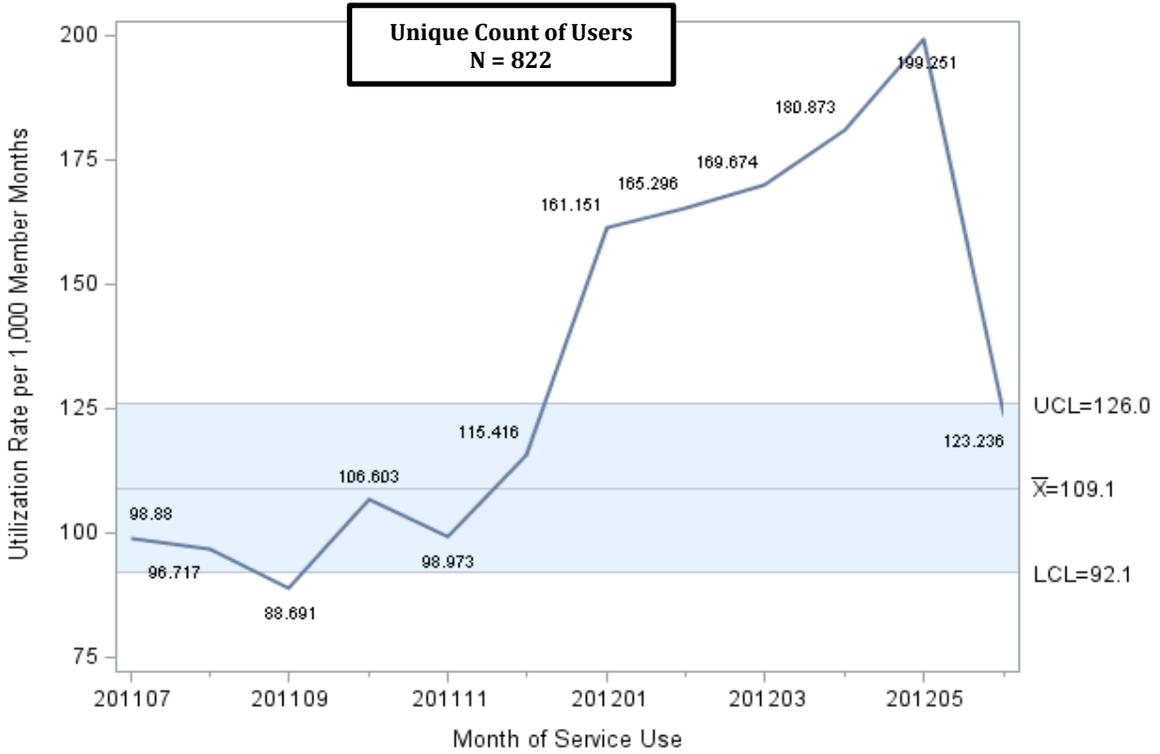


Figure SU-30 Hospital Inpatient Utilization, Adults Age 21+, Blind/Disabled, July 2011–June 2012

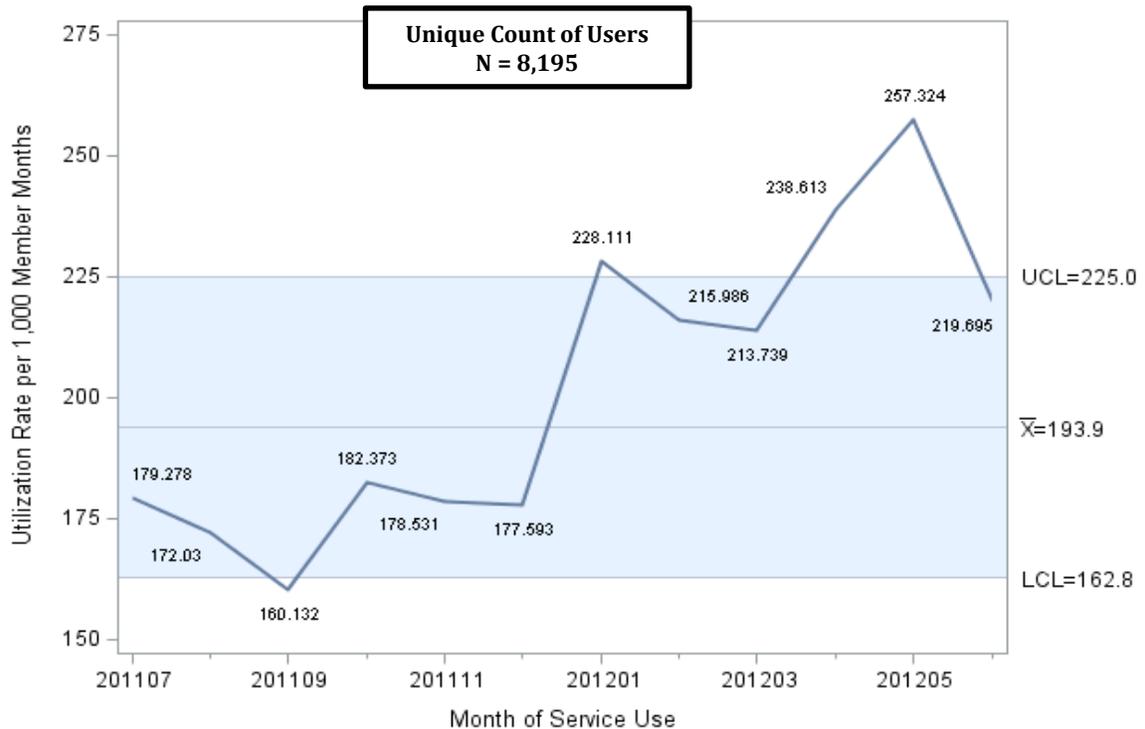


Figure SU-31 Hospital Inpatient Utilization Rates, Adults Age 21+, Families, July 2011–June 2012

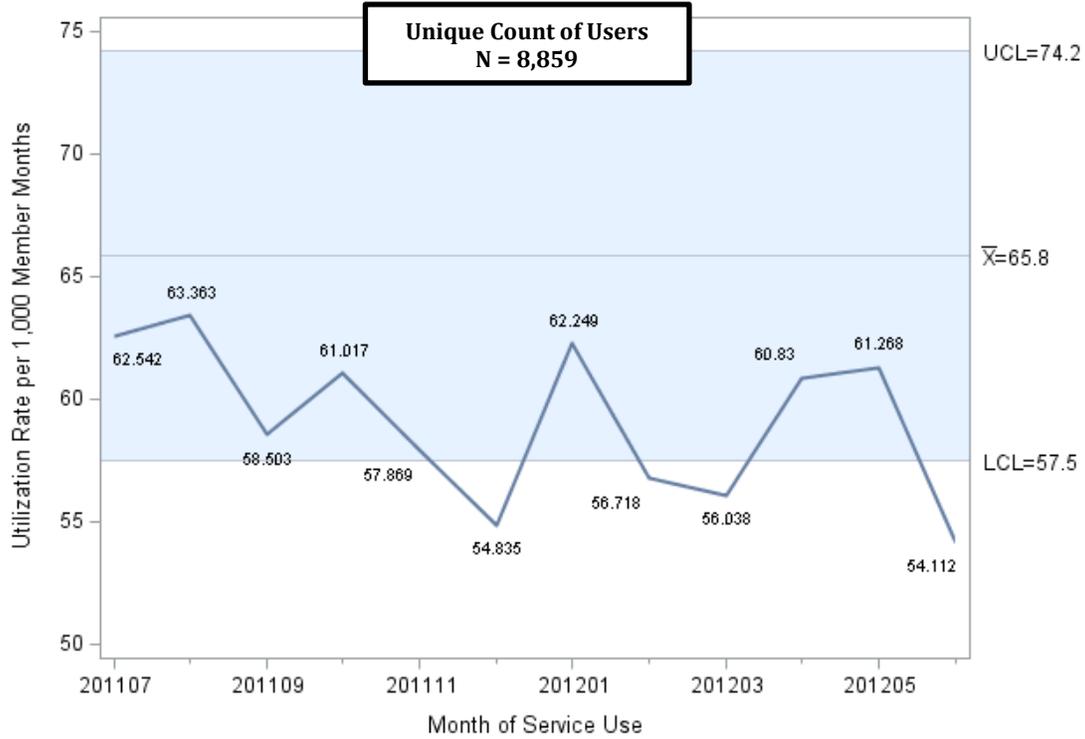


Figure SU-32 Hospital Inpatient Utilization, Adults Age 21+, Other, July 2011–June 2012

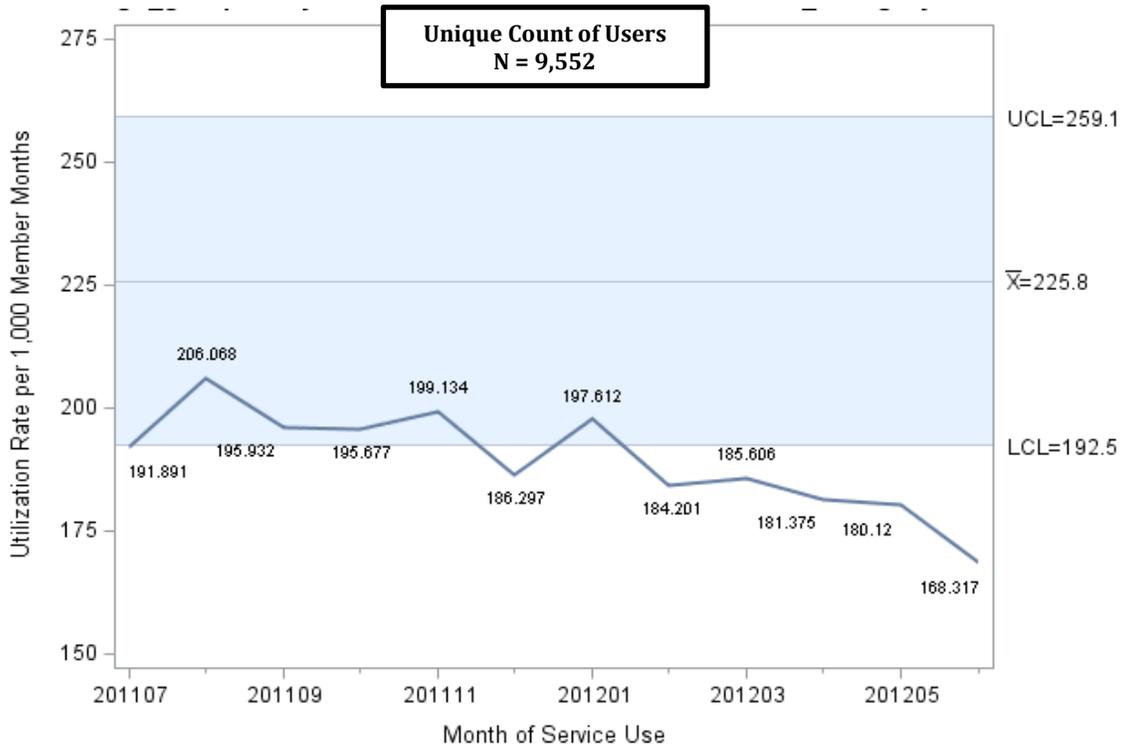
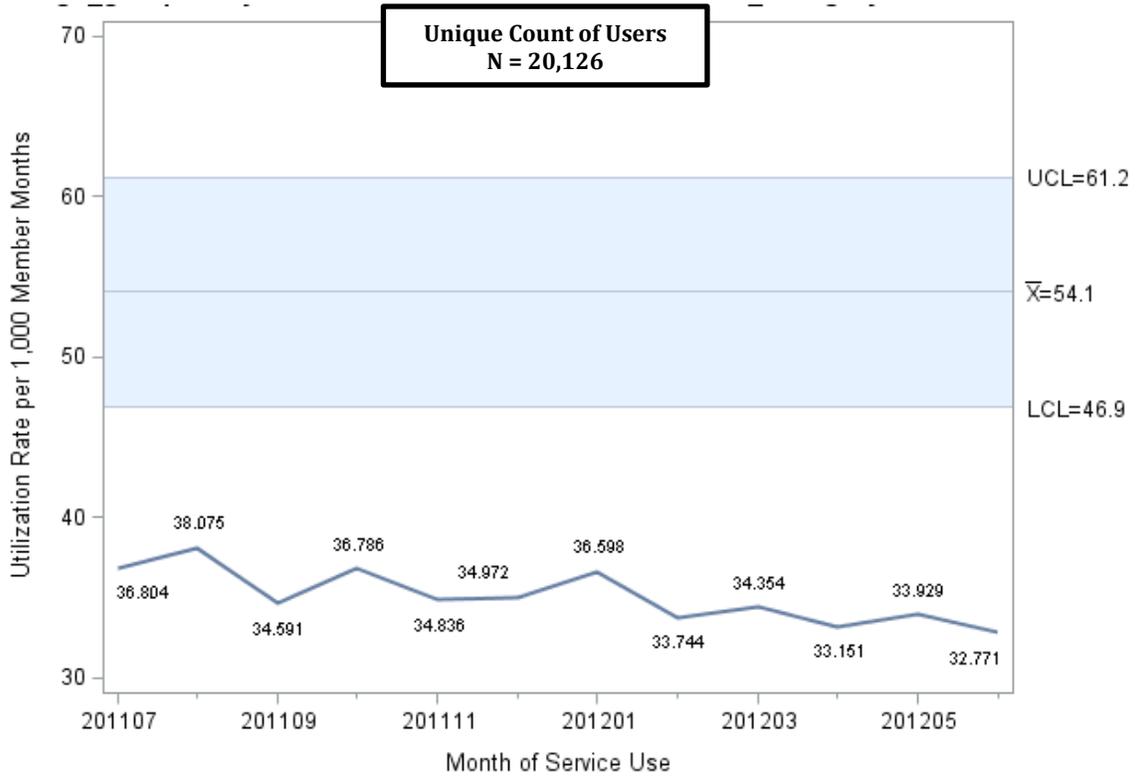


Figure SU-33 Hospital Inpatient Utilization, Adults Age 21+, Undocumented, July 2011–June 2012



Source: Data for figures SU-29 to SU-33 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2011–June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Hospital Outpatient Services

Background

Hospital Outpatient services are diagnostic, preventative, or therapeutic services furnished on an outpatient basis on the premises of a hospital. These services are rendered on the expectation that a patient will not require services beyond a 24-hour period. Hospital Outpatient services may include visits to an emergency room, as well as scheduled procedures that do not require overnight hospitalization.

The general public is ensured access to emergency medical services under EMTALA, regardless of their ability to pay. Under this act, individuals who present to hospitals having emergency rooms must be appropriately screened and examined to determine if an emergency medical condition exists, and must receive stabilizing treatment when medically needed. Emergency medical conditions include women in active labor. This provision is equally applicable to Medi-Cal beneficiaries seeking emergency and pregnancy-related services, including beneficiaries who are in restricted scope aid categories with limited benefits.

There are over 1,600,000 beneficiaries in the Medi-Cal program that utilize Hospital Outpatient services at any given time during the year, only 16% of whom utilize emergency services. A large proportion of beneficiaries who utilize Hospital Outpatient services use these services only once during the year (44%), while more than half are repeat users of these services (56%).

Nearly 40% of non-emergency Hospital Outpatient service users are age 20 and younger, another 40% are age 21–64, and an additional 20% are elderly beneficiaries age 65 and over. Many users of non-emergency hospital services are enrolled in Families and Undocumented (40%), or in Aged and Disabled aid categories (34%). Beneficiaries who utilize emergency Hospital Outpatient services are predominantly adults between age 21–64 (60%), and in Undocumented aid categories (45%).

Trend Analysis

Children

Among children age 0–20 in the Medi-Cal FFS program, monthly Hospital Outpatient services utilization rates ranged from 55.6–218.7 visits per 1,000 member months from the third quarter of 2011 to the second quarter of 2012. Hospital Outpatient services utilization continued to be higher among children in the Blind/Disabled aid category with rates ranging from two to three times higher than for children in any other aid category. Children in the Foster Care aid category exhibited normal patterns of Hospital Outpatient services utilization that remained within the expected ranges throughout the study period. In contrast, children in the Families and Undocumented aid categories exhibited below average utilization throughout the study period, while utilization rates for those in the Other aid category reached levels below the anticipated ranges. Children in the Blind/Disabled aid category exhibited a noticeable increase in Hospital Outpatient service utilization beginning in 2012 that reached above the expected ranges before declining back to average levels in June.

Beneficiaries in the Aged and Blind/Disabled aid categories exhibited notable increases in Hospital Outpatient services use beginning in 2012.

Adults

The monthly Hospital Outpatient services utilization rates for adults age 21 and older ranged from 48.0–312.2 visits per 1,000 member months from the third quarter of 2011 to the second quarter of 2012. As noted in the prior access quarterly reports, Hospital Outpatient services utilization rates were noticeably higher for adults in the Blind/Disabled and Other aid categories. Adults in the Aged and Blind/Disabled aid categories exhibited notable increases in Hospital Outpatient services utilization beginning in 2012 that reached levels above the expected ranges during the last quarter of the study period. Adults in the Families, Other, and Undocumented aid categories all exhibited mostly below average utilization of services that, however, primarily remained within expected ranges.

The following figures SU-34 to SU-43 represent the control chart analysis for both children and adults from the third quarter of 2011 to the second quarter of 2012.

Trends—Monthly Hospital Outpatient Services Utilization Rates by Children, July 2011–June 2012

Figure SU-34 Hospital Outpatient Utilization, Children Age 0-20, Blind/Disabled, July 2011–June 2012

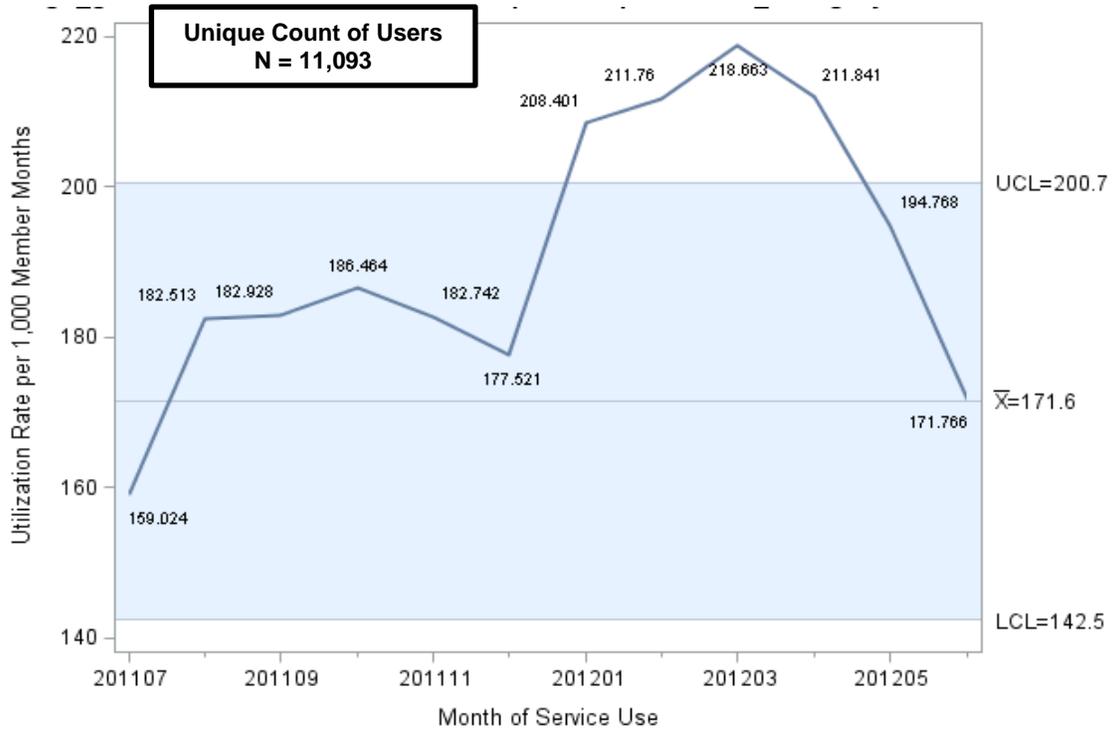


Figure SU-35 Hospital Outpatient Utilization, Children Age 0-20, Families, July 2011–June 2012

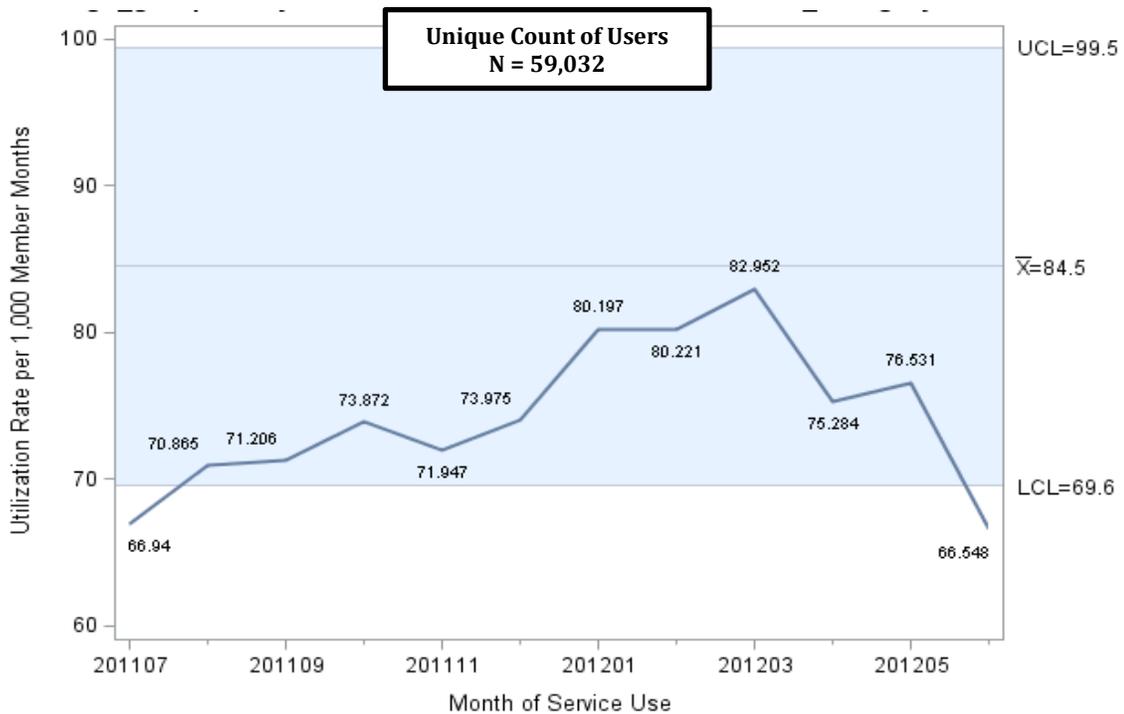


Figure SU-36 Hospital Outpatient Utilization, Children Age 0-20, Foster Care, July 2011–June 2012

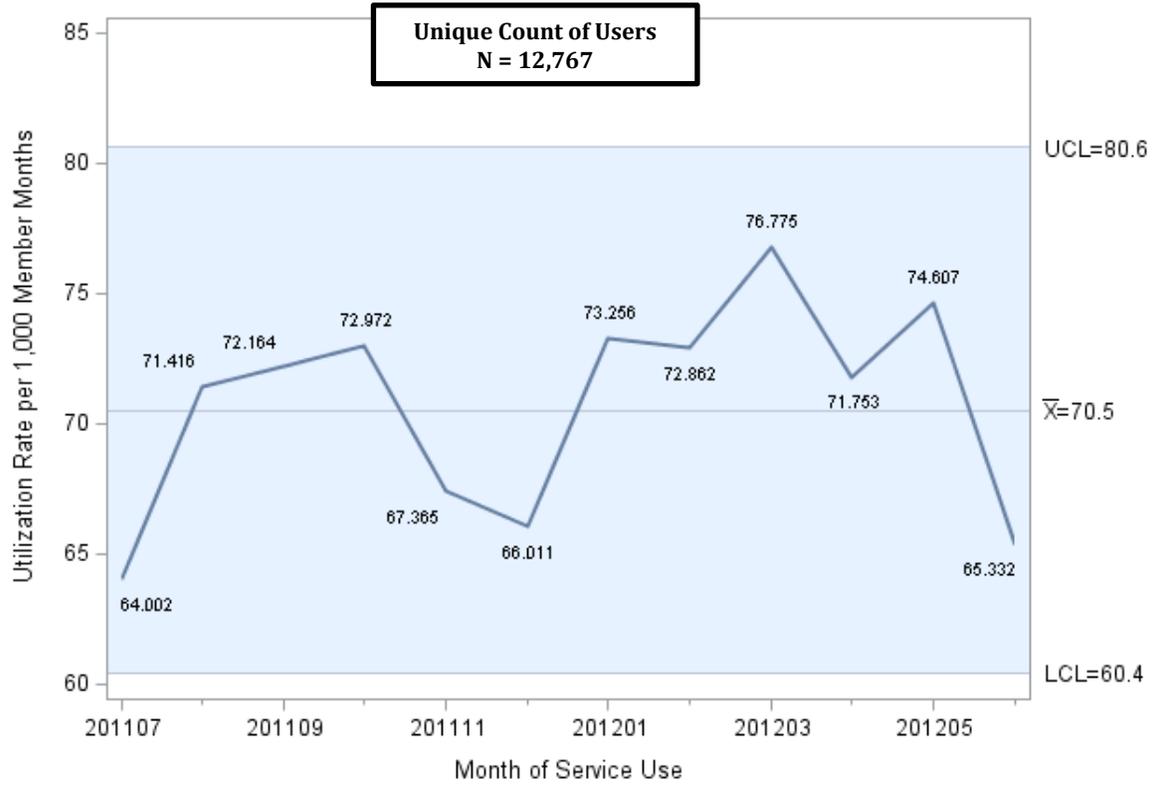


Figure SU-37 Hospital Outpatient Utilization, Children Age 0-20, Other, July 2011–June 2012

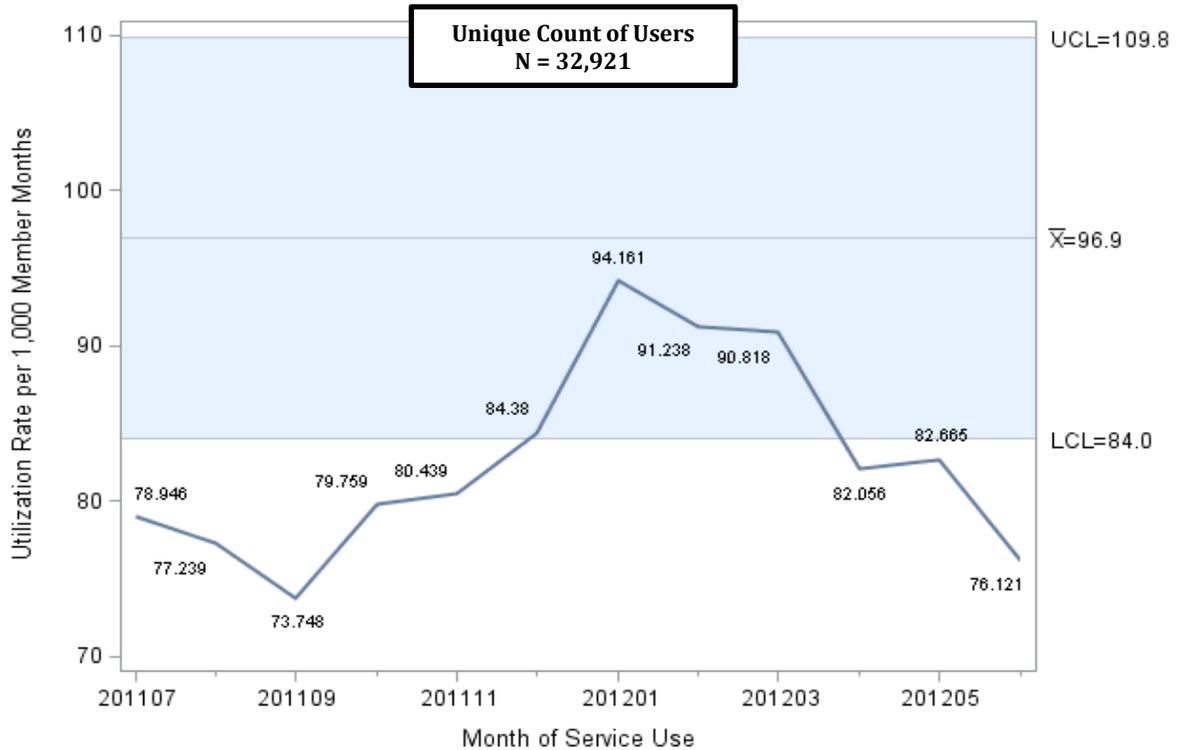
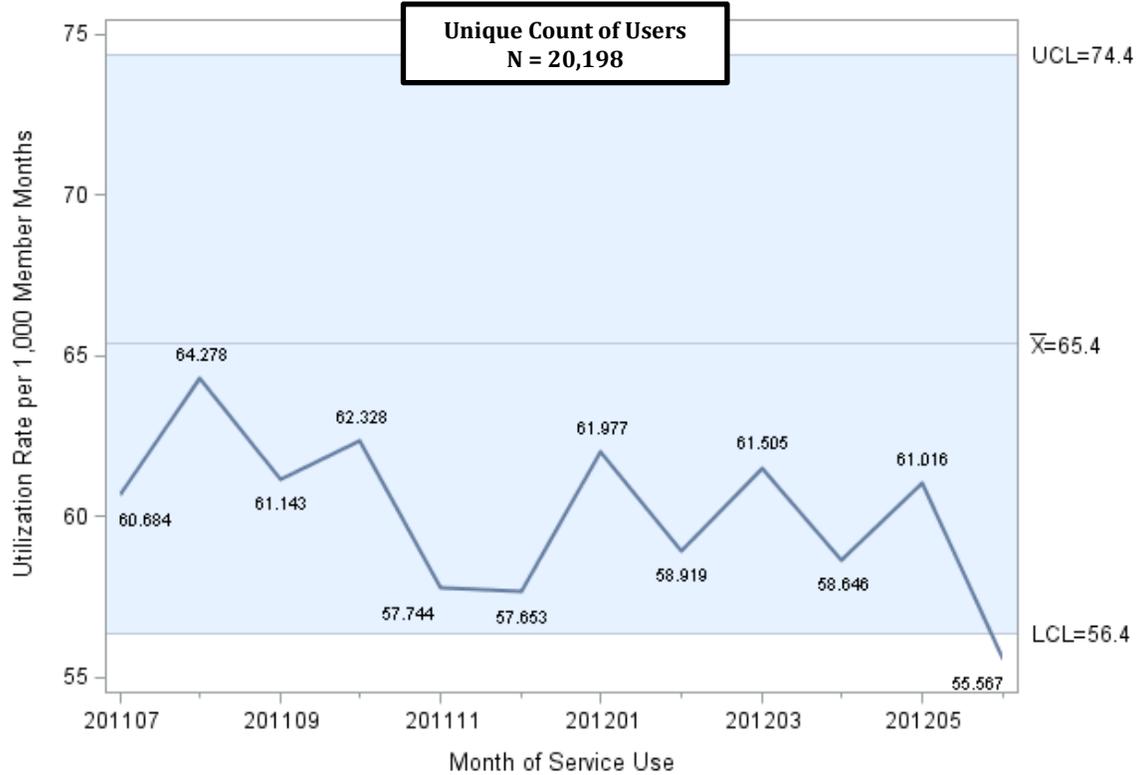


Figure SU-38 Hospital Outpatient Utilization, Children Age 0-20, Undocumented, July 2011–June 2012



Source: Data for figures SU-34 to SU-38 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2011–June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Monthly Hospital Outpatient Services Utilization Rates by Adults, July 2011–June 2012

Figure SU-39 Hospital Outpatient Utilization, Adults, Age 21+, Aged, July 2011–June 2012

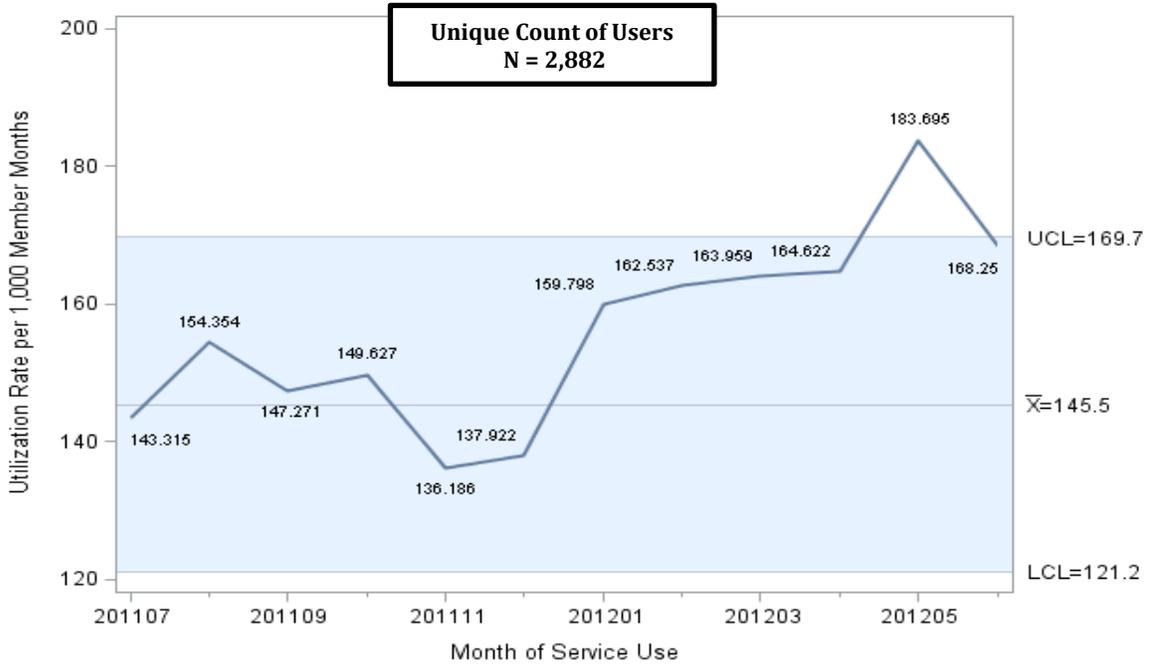


Figure SU-40 Hospital Outpatient Utilization, Adults, Age 21+, Blind/Disabled, July 2011–June 2012

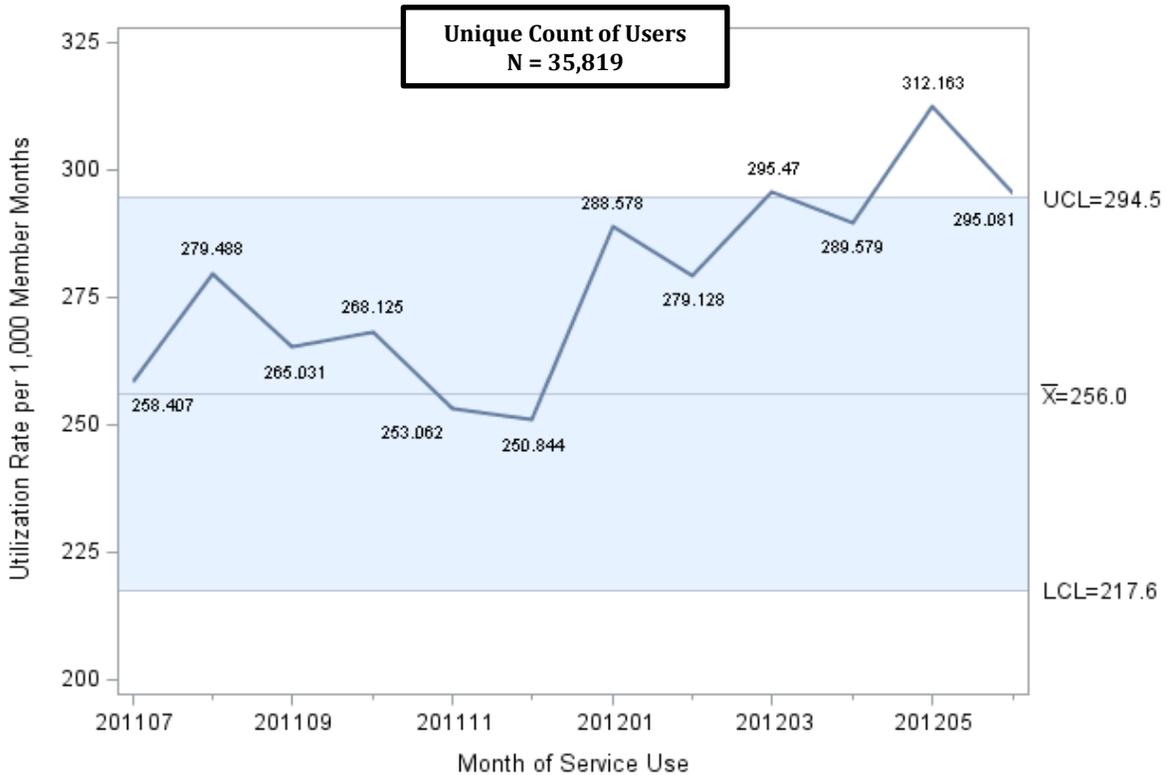


Figure SU-41 Hospital Outpatient Utilization, Adults, Age 21+, Families, July 2011–June 2012

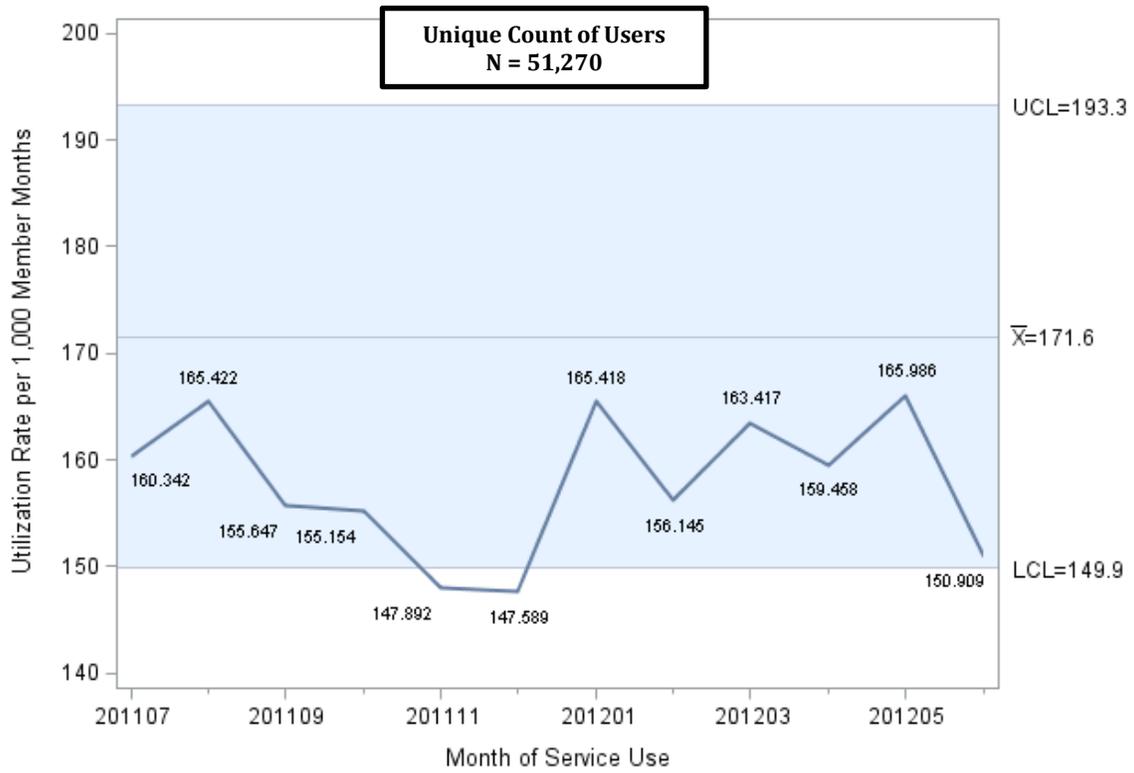


Figure SU-42 Hospital Outpatient Utilization, Adults Age 21+, Other, July 2011–June 2012

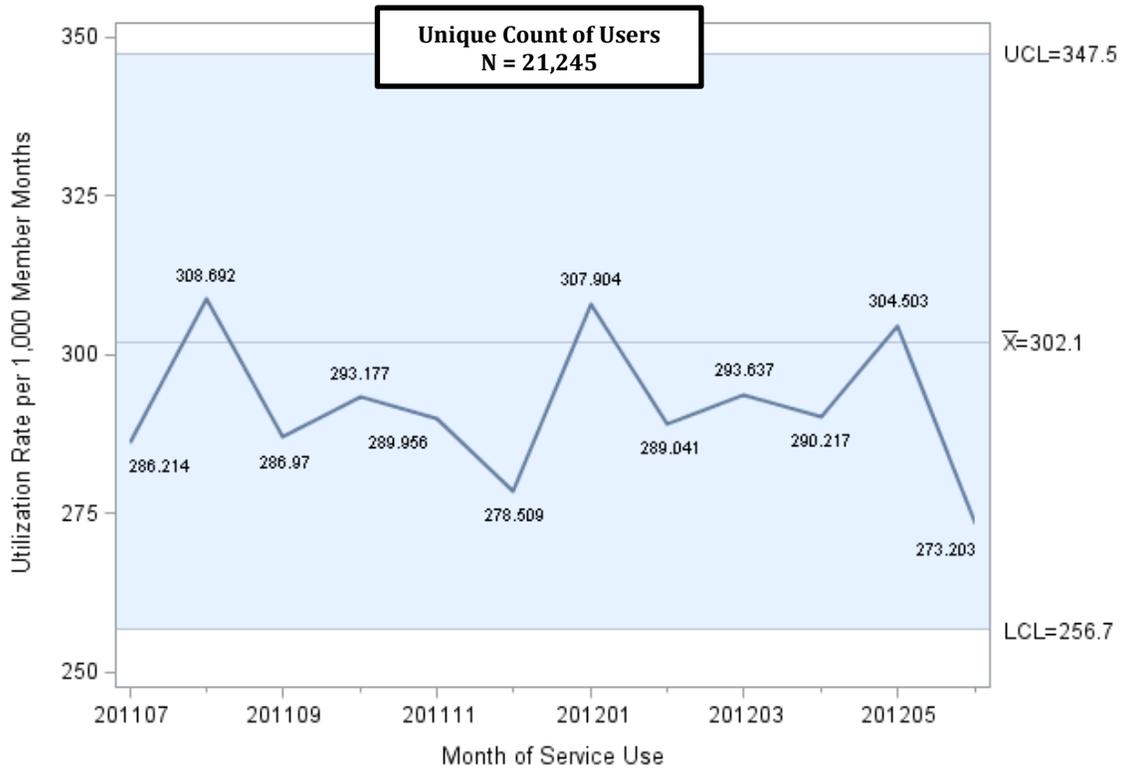
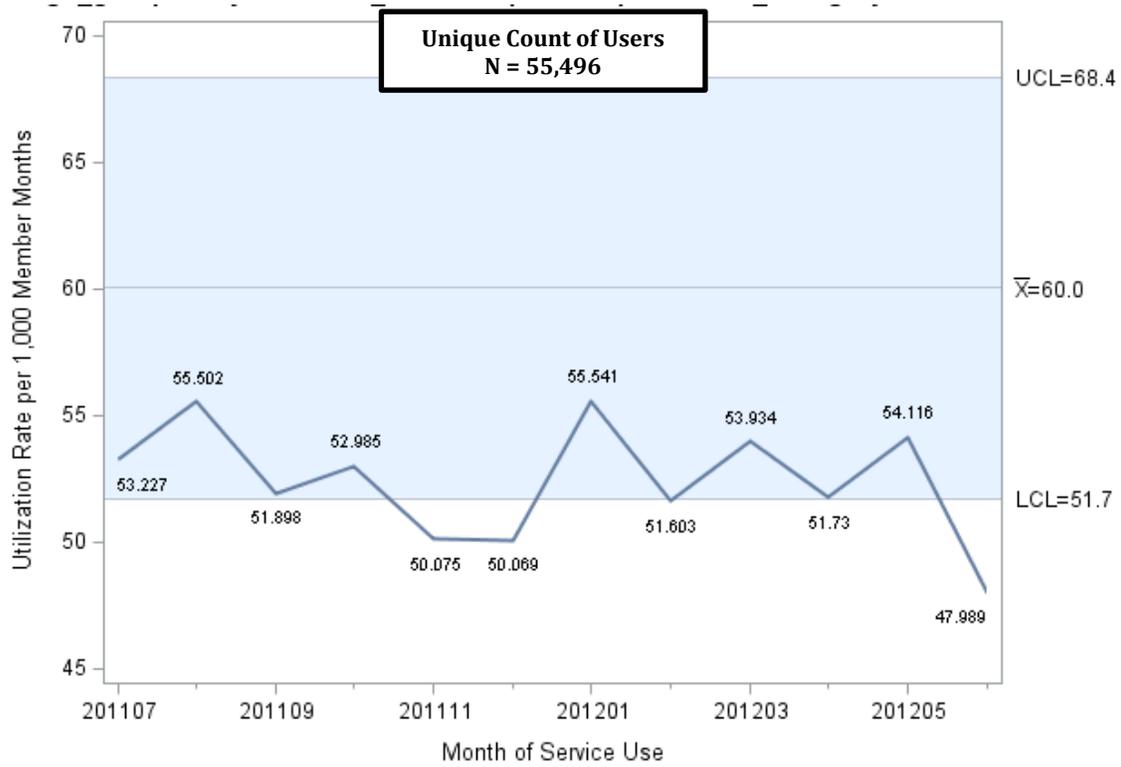


Figure SU-43 Hospital Outpatient Utilization, Adults Age 21+, Undocumented, July 2011–June 2012



Source: Data for figures SU-39 to SU-43 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2011–June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Nursing Facility Services

Background

Nursing Facility services offered under the Medi-Cal program encompass a variety of provider types, including intermediate care facilities for the developmentally disabled (ICF/DD), nursing facility Level A and B care, and certified hospice services.

ICF/DD facilities provide 24-hour personal, habilitation, developmental, and supportive health care to clients who need developmental services and who have a recurring but intermittent need for skilled nursing services. There are three types of ICF/DD facilities, which are distinguished by the different levels of developmental and skilled nursing services they provide. ICF/DD facilities primarily provide developmental services for individuals who may have a recurring, intermittent need for skilled nursing. ICF/DD–Habilitative facilities provide developmental services to 15 or fewer clients who do not require the availability of continuous skilled nursing care. ICF/DD–Nursing facilities offer the same services as those found in an ICF/DD–Habilitative facility, but focus their services on medically-frail persons requiring a greater level of skilled nursing care.

There are approximately 6,500 unique users of ICF/DD services, representing 4.5% of all nursing facility service recipients. Many of these recipients are adults age 21–64 (82%), and enrolled in long-term care (54.4%) and Disabled (41.6%) aid categories.

Nursing Facility Level A (NF-A) provides intermediate care for non-developmentally disabled clients. These facilities provide inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision, need supportive care, but who do not require the availability of continuous skilled nursing care. Approximately 3% of all nursing facility recipients use NF-A services annually.

Skilled Nursing Facility Level B (SNF-B) provides skilled nursing and supportive care to patients whose primary need is for continuous care on an extended basis, such as those with physical and/or mental limitations and those requiring subacute care. Recipients of SNF-B services are the predominant user group of Nursing Facility services, representing about 80% of all users in this service category.

A large proportion of Medi-Cal beneficiaries who use NF-A or SNF-B services are covered under Long-Term Care (51.2%), Aged (25.4%), and Disabled (18.6%) aid categories, and are primarily adults age 65 and older (76.1%).

Certified hospice services are designed to meet the unique needs of terminally ill individuals who opt to receive palliative care versus care to treat their illness. The following providers may render hospice services to program beneficiaries: hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, and licensed Medi-Cal health providers who are certified by *Medicare* to provide hospice services. Hospice services may include: nursing and physician services, medical social and counseling services, home health aide and homemaker services, bereavement counseling, and any additional item that may otherwise be paid under the Medi-Cal program. There are approximately 15,000 users of hospice care, representing just over 10% of

recipients of Nursing Facility services. Most hospice recipients are elderly beneficiaries over age 65 (71.3%) and covered under Long-Term Care (39.3%), Aged (27.5%), and Disabled (20.9%) aid categories.

Trend Analysis

Children

Children in all of the aid categories are excluded from this analysis because of their relatively small user counts (< 500).

Adults

This analysis only focuses on Nursing Facility services utilization among Medi-Cal adults age 21 and older participating in the FFS program and enrolled in the Aged, Blind/Disabled, and Other aid categories. Among adults in these aid categories, the monthly Nursing Facility services utilization rates ranged from 208.9–2,153.3 days per 1,000 member months from the third quarter of 2011 to the second quarter of 2012.

The Nursing Facility services utilization rates were again noticeably higher for adults in the Other aid category, which is understandable given that this subpopulation contains beneficiaries enrolled in long term care aid codes. Although adults in the Other aid category used Nursing Facility services at rates much higher than most other beneficiary subpopulations, their utilization of these services continued to be below the average rates established during the baseline period. Adults in the Aged and Blind/Disabled aid categories continued to display upward trends in utilization rates of Nursing Facility services that reached levels well above those established during the baseline period. Of particular note, the utilization rates for adults in the Blind/Disabled aid category tripled over the course of the study period and quadrupled for beneficiaries in the Aged aid category.

These trends highlight how markedly the case mix of the FFS beneficiary population has changed since the baseline utilization rates were established in 2007-2009. As DHCS transitioned beneficiaries enrolled in the Seniors and Persons with Disabilities (SPDs) aid codes into managed care plans beginning in 2011, the SPDs who remained in Medi-Cal's FFS system were generally those who receive a medical exemption or incurred an LTC stay or residing in an LTC facility. SPD beneficiaries remaining in FFS most likely represent beneficiaries who are medically compromised and suffering from severe chronic health conditions. In turn, they represent a group most likely to become LTC service utilizers. For those beneficiaries completing their transition into managed care plans and needing LTC services, an additional enrollment shift may be made back into Medi-Cal's FFS system where LTC services are then reimbursed.⁶ This is due to the current Medi-Cal managed care policy that only places the plan at risk for LTC services for the month of admission plus one additional month. Consequently, the case mix of adult beneficiaries who remain in the FFS delivery system can be characterized as those exhibiting health care needs that are much greater than the norm.

Nursing Facility use is now concentrated among three beneficiary subpopulations: adults in the Aged, Blind/Disabled, and Other aid categories. Use rates for adults in the Blind/Disabled aid category tripled during the study period, and quadrupled for those in the Aged aid category.

These trends highlight how markedly the case mix of the adult FFS beneficiary population has changed since the baseline utilization rates were established.

⁶ This policy applies to managed care plans operating in Two-Plan and GMC counties.

Medi-Cal FFS beneficiaries in the Undocumented aid category are not eligible for Nursing Facility services and were subsequently excluded from this analysis. Additionally, adults in the Families aid category were excluded due to their relatively small user counts (< 100).

The following figures SU-44 to SU-46 represent the control chart analysis for adults from the third quarter of 2011 to the second quarter of 2012.

Trends—Nursing Facility Services Utilization by Adults, July 2011–June 2012

Figure SU-44 Nursing Facility Utilization, Adults Age 21+, Aged, July 2011–June 2012

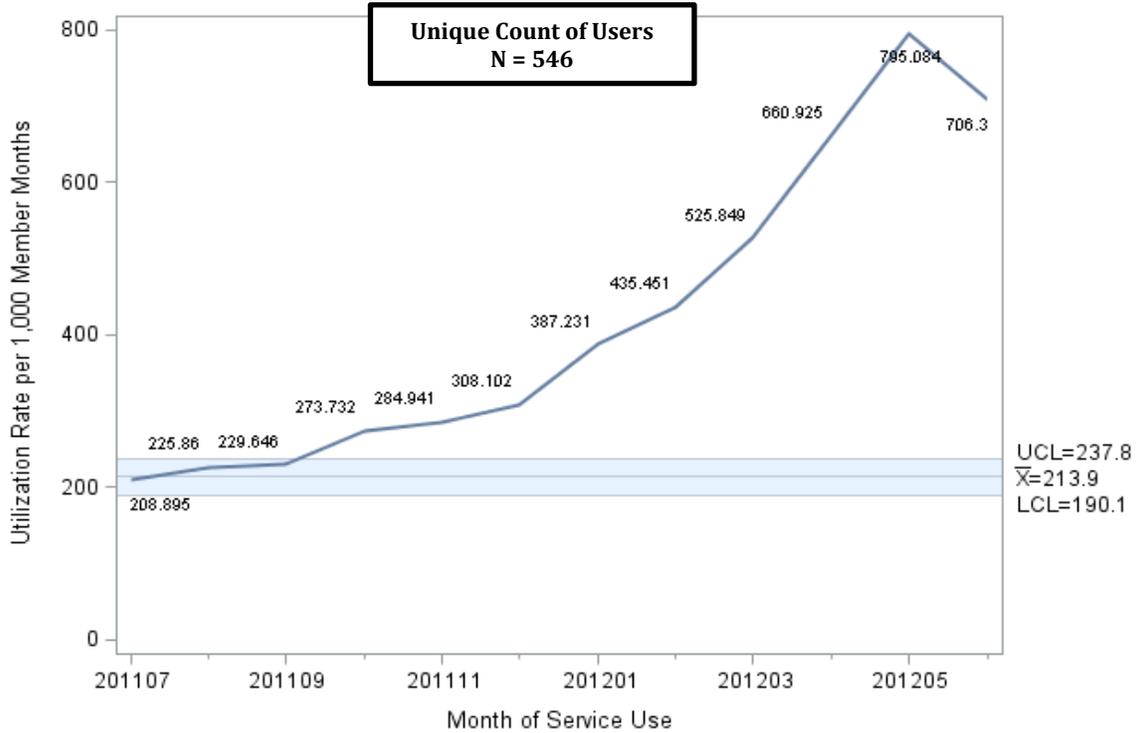


Figure SU-45 Nursing Facility Utilization, Adults Age 21+, Blind/Disabled, July 2011–June 2012

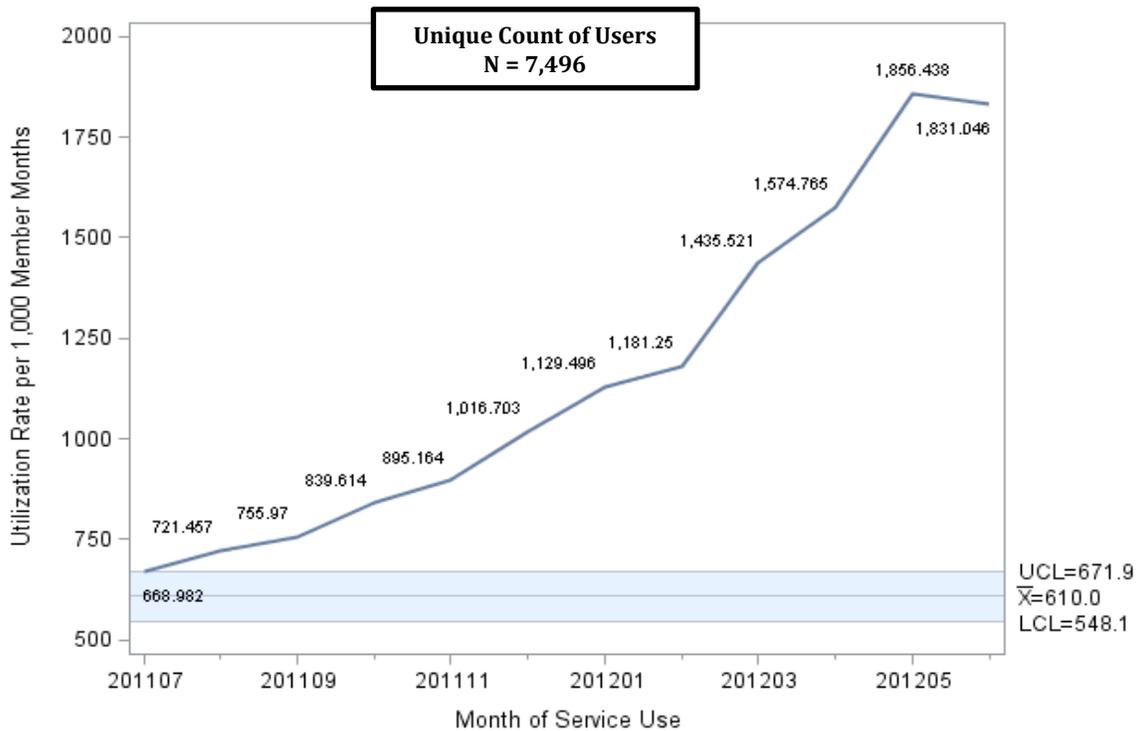
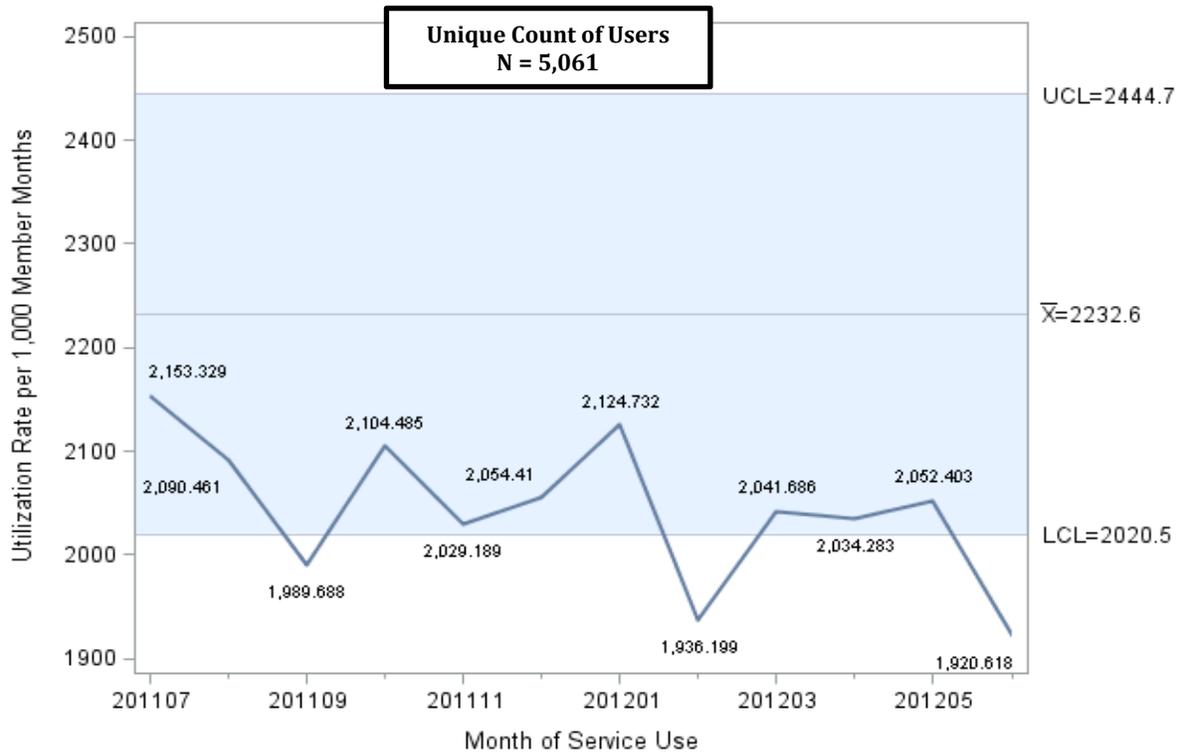


Figure SU-46 Nursing Facility Utilization, Adults Age 21+, Other, July 2011–June 2012



Source: Data for figures SU-44 to SU-46 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2011–June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Pharmacy Services

Background

Pharmacy services are the most frequently used Medi-Cal benefit and the fastest growing portion of the Medi-Cal budget. Pharmacy coverage is a significant proportion of the benefits received by the elderly and for beneficiaries with a disability, mental illness, or chronic condition.

Pharmacy providers not only dispense prescription drugs, they also bill for over-the-counter drugs, enteral formula, medical supplies, incontinent supplies, and durable medical equipment. Most outpatient prescription drug claims are billed by pharmacy providers. Physicians and clinics may also bill for drugs administered in their office and prenatal care vitamins that are distributed through Comprehensive Perinatal Services Program providers.

Pharmacy services for beneficiaries eligible for FFS Medi-Cal only are restricted to six prescriptions per month per beneficiary for most drugs. Previous authorization is needed to obtain coverage beyond the six-prescription cap. A copayment of \$1 per prescription is required for most beneficiaries, although beneficiaries cannot be denied coverage if they can't afford the copayment. Federal law prohibits states from imposing cost sharing on children, pregnant women, and institutionalized beneficiaries, and for family planning services, hospice services, emergencies, and Native Americans served by an Indian health care provider.

Assembly Bill 97 enacted mandatory copayments of \$3 per prescription for preferred drugs, and \$5 per prescription for non-preferred drugs. DHCS has proposed changing the copayment requirement to \$3.10 for non-preferred drugs. This copayment requirement is pending approval by CMS, with a proposed implementation date of January 1, 2013.

In 2010, there were over 3 million beneficiaries who received at least one Pharmacy service through the Medi-Cal FFS program. The majority of Pharmacy service users (99%) accessed prescription drugs. Young beneficiaries under age 20 represent 35% of Pharmacy service users, while adults age 21–64 represent 43%, and an additional 22% are Pharmacy service users over age 65. Beneficiaries who utilize Pharmacy services are predominantly found in the Families (27.6%), Disabled (24.5%), Aged (10%), and Undocumented (10%) aid categories. The most frequently dispensed pharmacy products are non-steroidal anti-inflammatory drugs (NSAIDs), penicillin, and analgesics.

Trend Analysis

Children

The monthly Pharmacy services utilization rates for children age 0–20 in the Medi-Cal FFS program ranged from 67.8–1,522.0 prescriptions per 1,000 member months from the third quarter of 2011 to the second quarter of 2012.

Similar to the previous access quarterly reports, the utilization of Pharmacy services again was noticeably higher among children in the Blind/Disabled aid category with rates two to three times higher than Children in the Foster Care aid category and five to six times higher than Children in the Families and Other aid categories. Children in the Families and Other aid categories displayed below average Pharmacy services utilization that reached levels below the expected baseline ranges in both the first and last quarter of the study period. Additionally, children in the Blind/Disabled aid category exhibited an upward trend in utilization over the initial three quarters of the study period that ultimately reached above the anticipated baseline ranges before declining back to normal levels in the last analyzed quarter. While children in the Families, Other, and Undocumented aid categories mostly displayed below average utilization throughout the study period, children in the Foster Care aid category primarily exhibited above average service utilization.

Among children in the Blind/Disabled aid category, Pharmacy services use is 2-6 times higher than for other children. Among adults in the Aged and Blind/Disabled aid categories, downward use of Pharmacy services have been seen since mid-2011.

Adults

Among adults 21 and older, monthly Pharmacy services utilization rates ranged from 181.0–3,428.3 prescriptions per 1,000 member months from the third quarter of 2011 to the second quarter of 2012.

Similar to the trends identified in the prior access quarterly reports, Pharmacy services utilization was again noticeably higher among adults in the Blind/Disabled aid category. Additionally, adults in the Aged and Other aid categories exhibited significant utilization rates of pharmacy services, while adults in the Undocumented aid category used these services at much lower rates. Adults in both the Aged and Blind/Disabled aid categories mostly displayed below average Pharmacy services utilization, while adults in the Undocumented aid category primarily displayed above average utilization. Adults in the Aged aid category exhibited a downward trend in utilization starting in August 2011 that reached levels below the baseline ranges during 2012. This may be explained, in part, by the fact that a large proportion of adults in the Aged aid categories who remain in FFS are receiving care in inpatient setting where pharmacy services are included, Pharmacy services utilization rates for most other adults fell within the anticipated ranges.

The following figures SU-47 to SU-56 represent the control chart analysis for both children and adults from the third quarter of 2011 to the second quarter of 2012.

Trends—Pharmacy Services Utilization by Children, July 2011–June 2012

Figure SU-47 Pharmacy Utilization, Children Age 0–20, Blind/Disabled, July 2011–June 2012

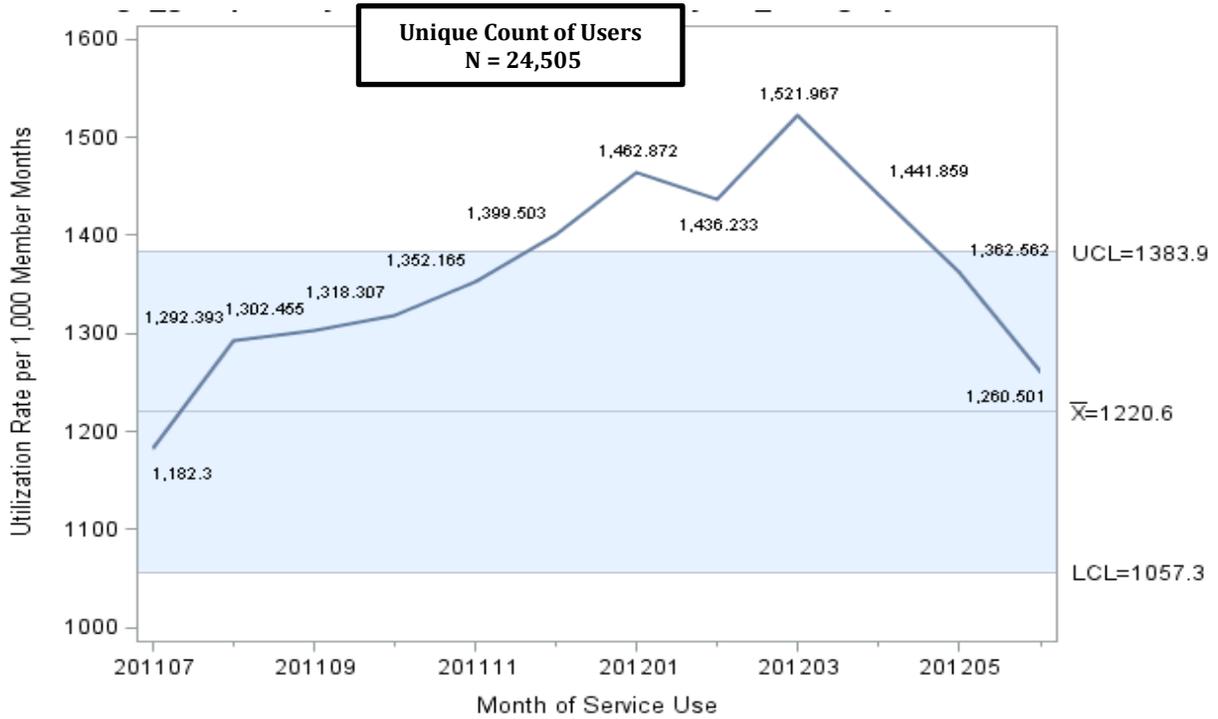


Figure SU-48 Pharmacy Utilization, Children Age 0–20, Families, July 2011–June 2012

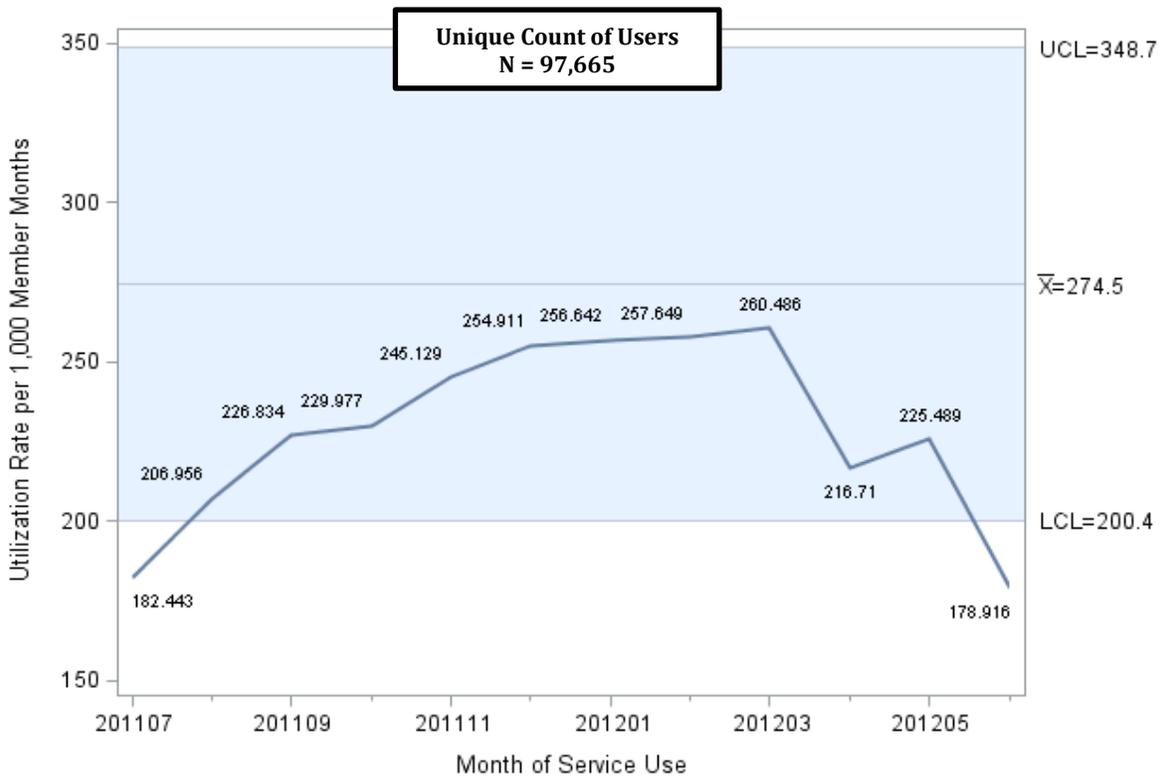


Figure SU-49 Pharmacy Utilization, Children Age 0–20, Foster Care, July 2011–June 2012

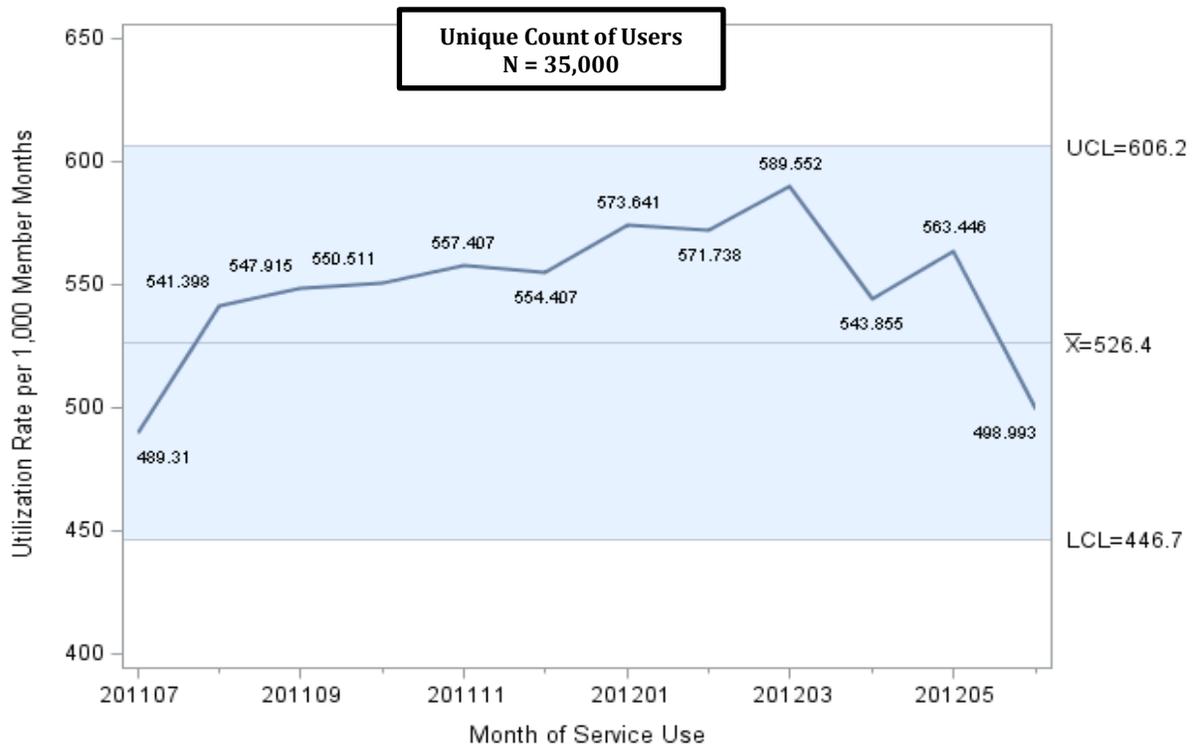


Figure SU-50 Pharmacy Utilization, Children Age 0–20, Other, July 2011–June 2012

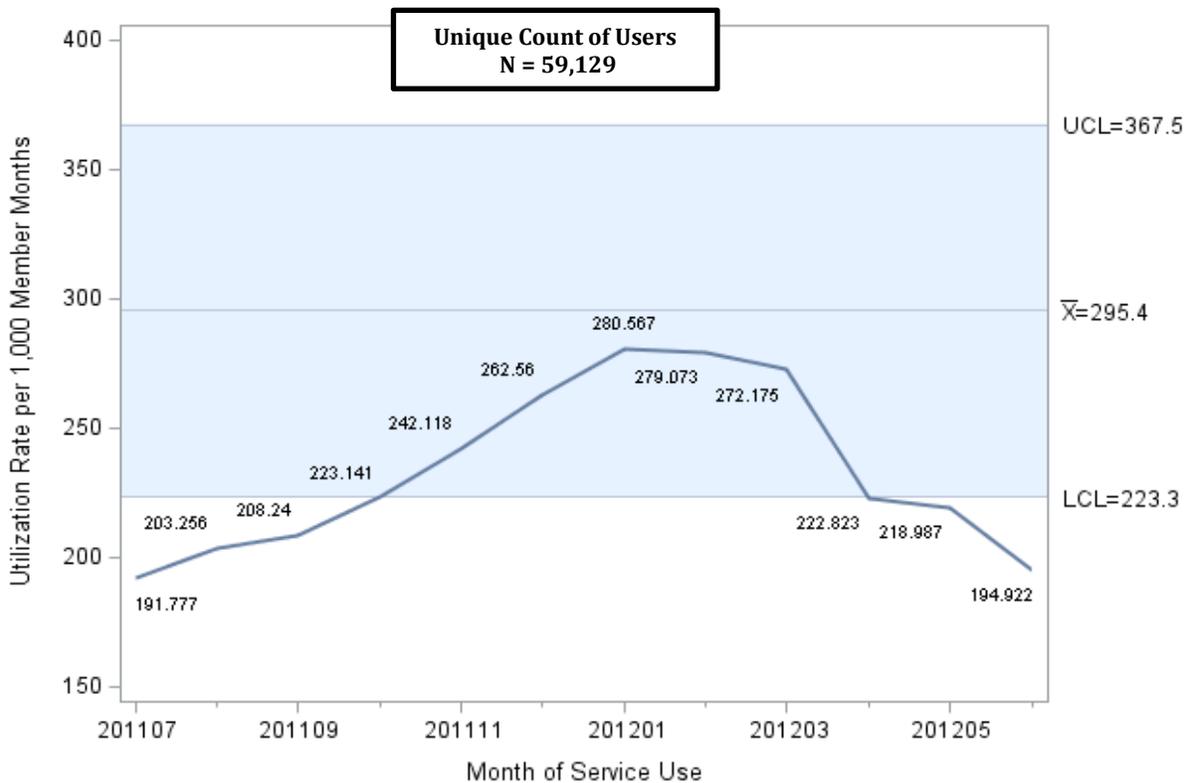
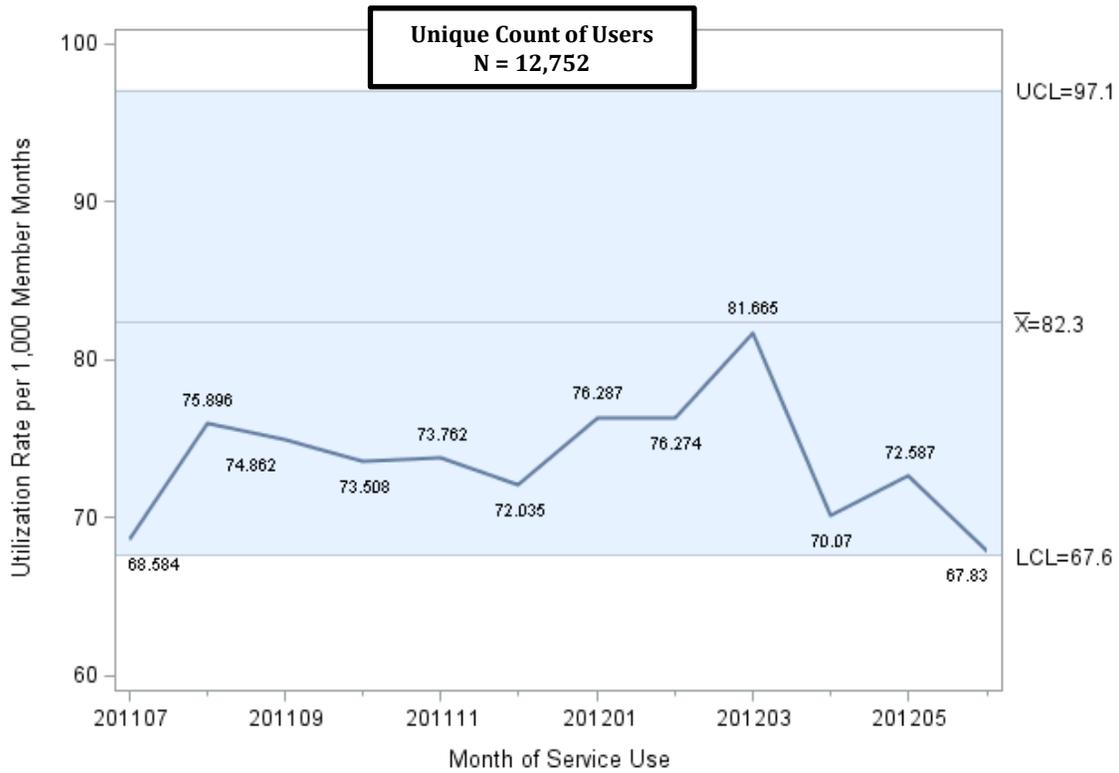


Figure SU-51 Pharmacy Utilization, Children Age 0–20, Undocumented, July 2011–June 2012



Source: Data for figures SU-47 to SU-51 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from July 2011–June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Monthly Pharmacy Services Utilization Rates by Adults, July 2011–June 2012

Figure SU-52 Pharmacy Utilization, Adults Age 21+, Aged, July 2011–June 2012

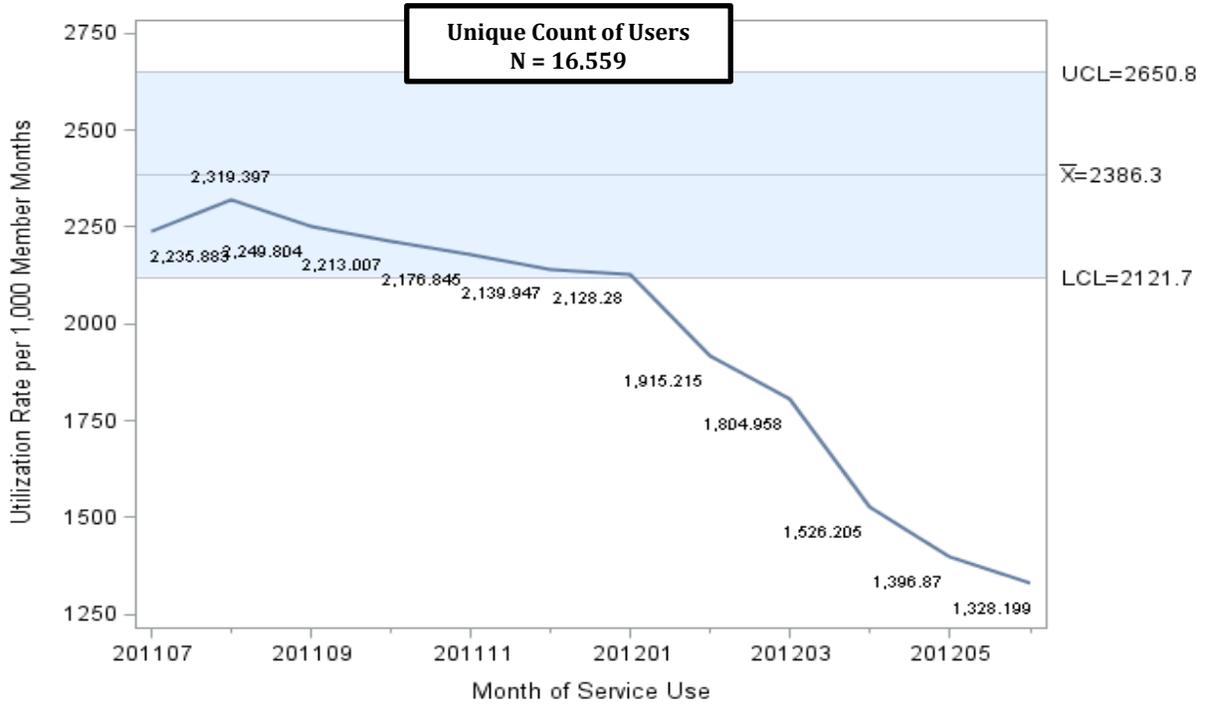


Figure SU-53 Pharmacy Utilization, Adults Age 21+, Blind/Disabled, July 2011–June 2012

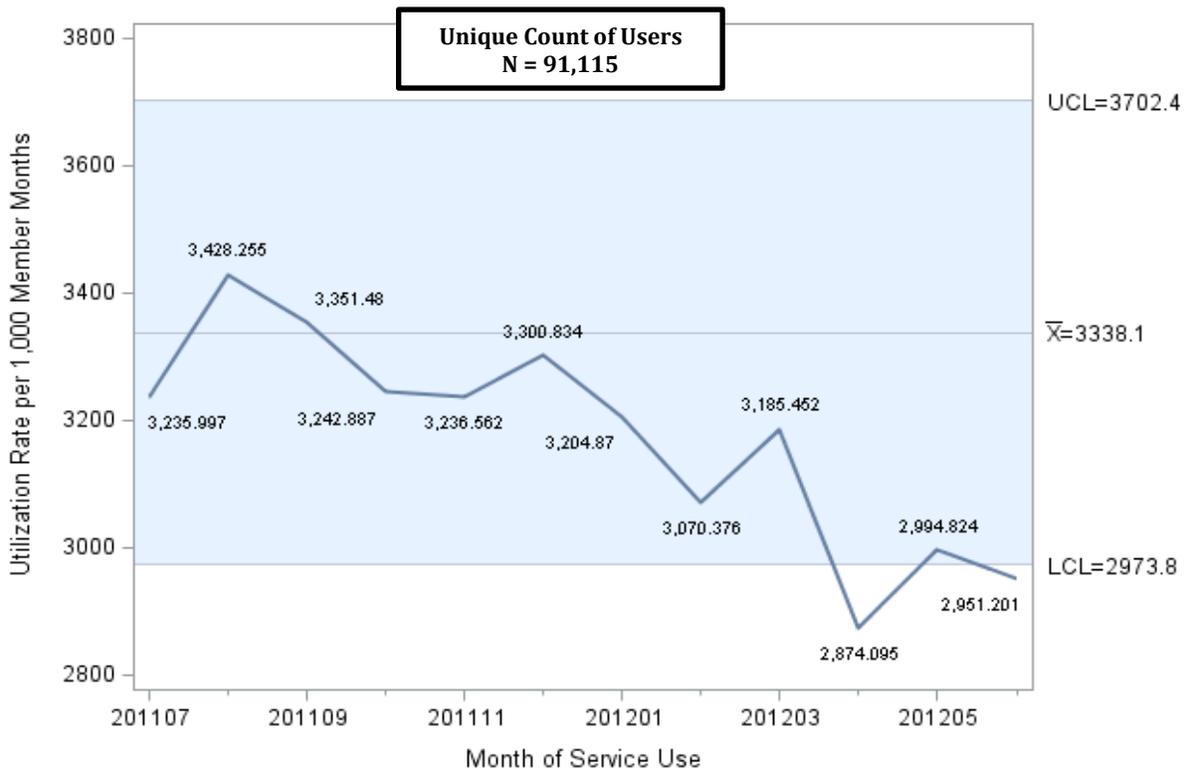


Figure SU-54 Pharmacy Utilization, Adults Age 21+, Families, July 2011–June 2012

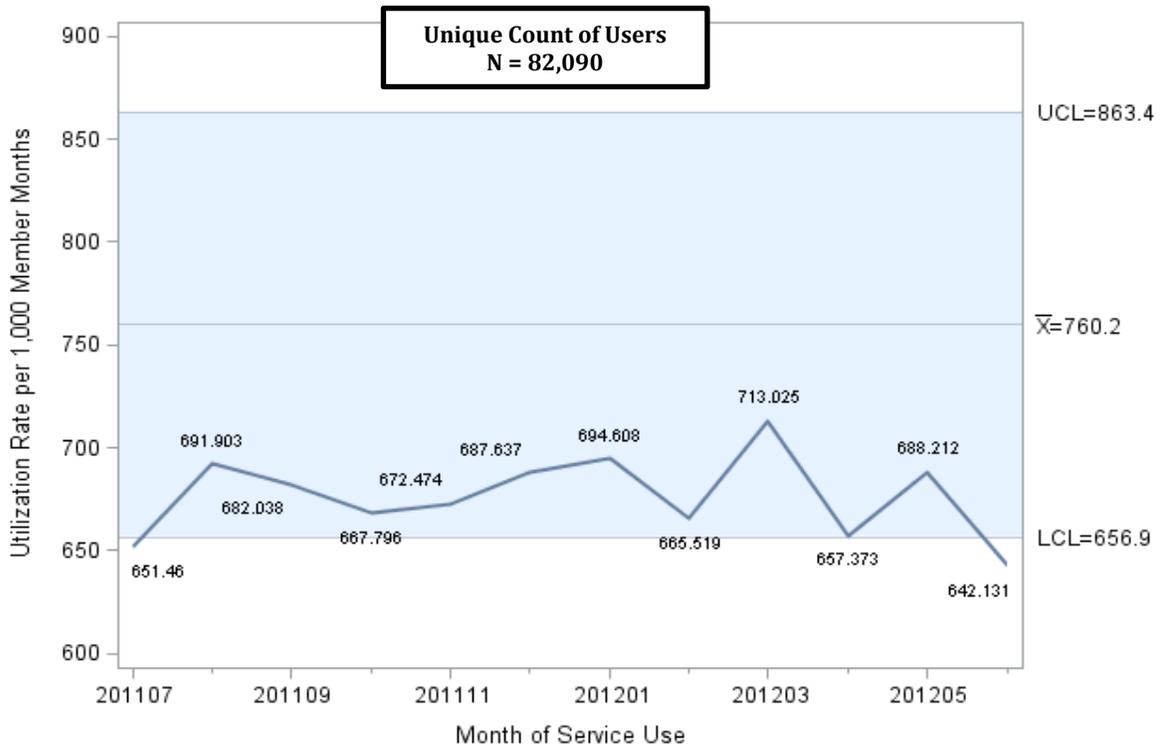


Figure SU-55 Pharmacy Utilization, Adults Age 21+, Other, July 2011–June 2012

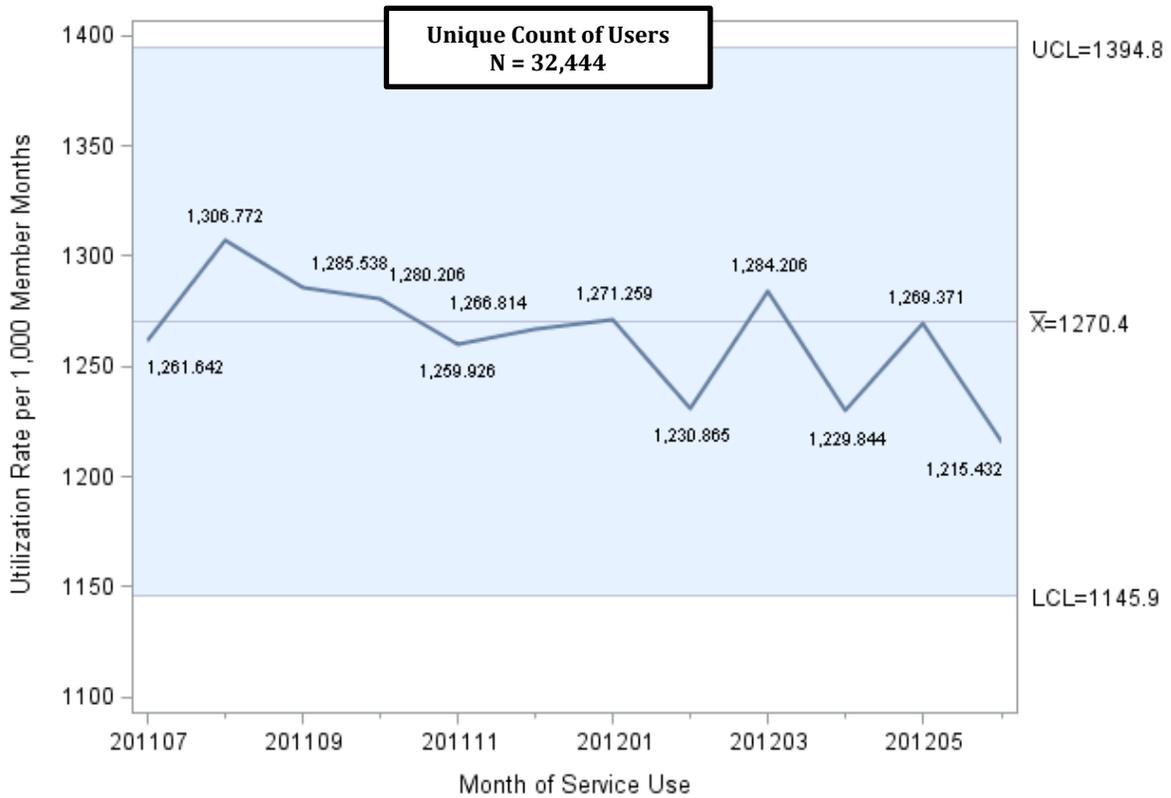
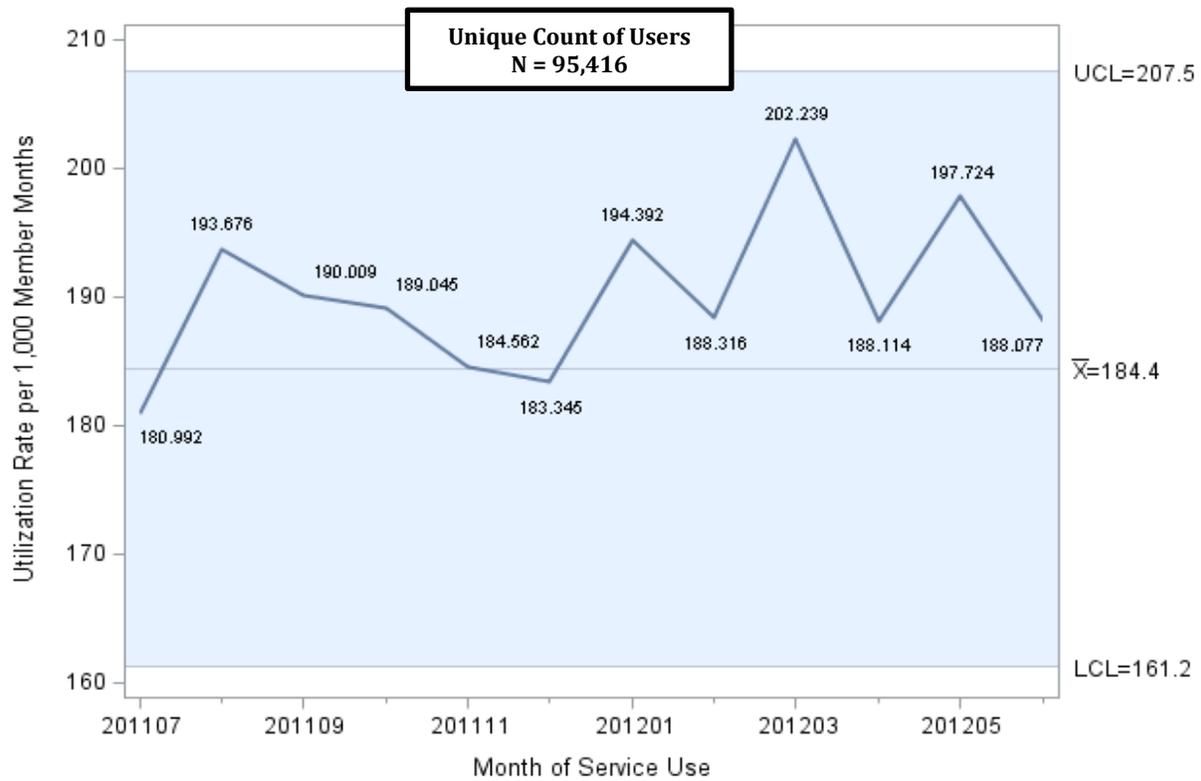


Figure SU-56 Pharmacy Utilization, Adults Age 21+, Undocumented, July 2011–June 2012



Source: Data for figures SU-52 to SU-56 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2011–June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Other Services

Background

Service providers covered under the “Other” aid category include the following partial list:

- Community-Based Adult Services Program (formerly called Adult Day Health Care)
- Assistive Device and Sick Room Supply Dealers
- Audiologists and Hearing Aid Dispensers
- Certified Nurse Practitioners, Pediatric Nurse Practitioners
- Physical, Occupational and Speech Therapists
- Orthotists and Prosthetists
- Podiatrists
- Psychologists
- Genetic Disease Testing
- Local Education Agency (LEA)
- Respiratory Care Practitioners
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services Providers
- Health Access Program (HAP)

For a full list of provider types, see the [Appendix](#).

It is important to note that beginning in July 2009, several optional benefits were excluded from the Medi-Cal program. These benefits comprise the following list and impact most beneficiaries except those eligible for EPSDT services, beneficiaries in skilled nursing facilities or residing in intermediate care facilities for the developmentally disabled (ICF/DD), and beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly (PACE):

- Acupuncture
- Adult Dental Services
- Audiology Services
- Chiropractic Services
- Incontinence Creams and Washes
- Dispensing Optician Services
- Fabricating Optical Laboratory Services
- Podiatric Services
- Psychology Services
- Speech Therapy

Trend Analysis

Children

Among children age 0–20 in the Medi-Cal FFS program, monthly utilization rates for Other services ranged from 13.4–1,192.9 visits per 1,000 member months from the third quarter of 2011 to the second quarter of 2012.

Similar to the prior reporting period, the utilization of Other services was again noticeably higher among children in the Blind/Disabled aid category with rates nearly six times higher than for children in the Foster Care aid category and 12 to 13 times higher than for children in the Families and Other aid categories. Children in the Blind/Disabled, Families, Foster Care, and Other aid categories exhibited mostly normal utilization of Other services. In contrast, children in the Undocumented aid category exhibited below average utilization and had several months of utilization below the expected ranges observed in the baseline period of 2007 to 2009.

Children in Blind/Disabled aid codes utilize Other services at rates six times that of other children.

Both children and adult beneficiaries in Undocumented aid codes are low users of these services.

Adults

The monthly utilization rates for Other services among adults age 21 and older ranged from 34.8–347.1 visits per 1,000 member months from the third quarter of 2011 to the second quarter of 2012.

Consistent with the trends identified in the previous access quarterly reports, Other services utilization rates were noticeably higher for adults in the Aged, Blind/Disabled, and Other aid categories and lowest among adults in the Undocumented aid category. Adults in all of the analyzed aid categories exhibited mostly below average utilization of Other services during the study period, whereas utilization rates for those in the Aged, Families, and Undocumented aid categories at times reached levels below the expected ranges. Additionally, after exhibiting an increase in utilization at the beginning of 2012, adults in the Aged aid category experienced a noticeable decline in utilization during the final quarter of the study period.

The following figures SU-57 to SU-66 represent the control chart analysis for both children and adults from the third quarter of 2011 to the second quarter of 2012.

Trends—Monthly Other Services Utilization Rates by Children, July 2011–June 2012

Figure SU-57 Other Services Utilization, Children Age 0–20, Blind/Disabled, July 2011–June 2012

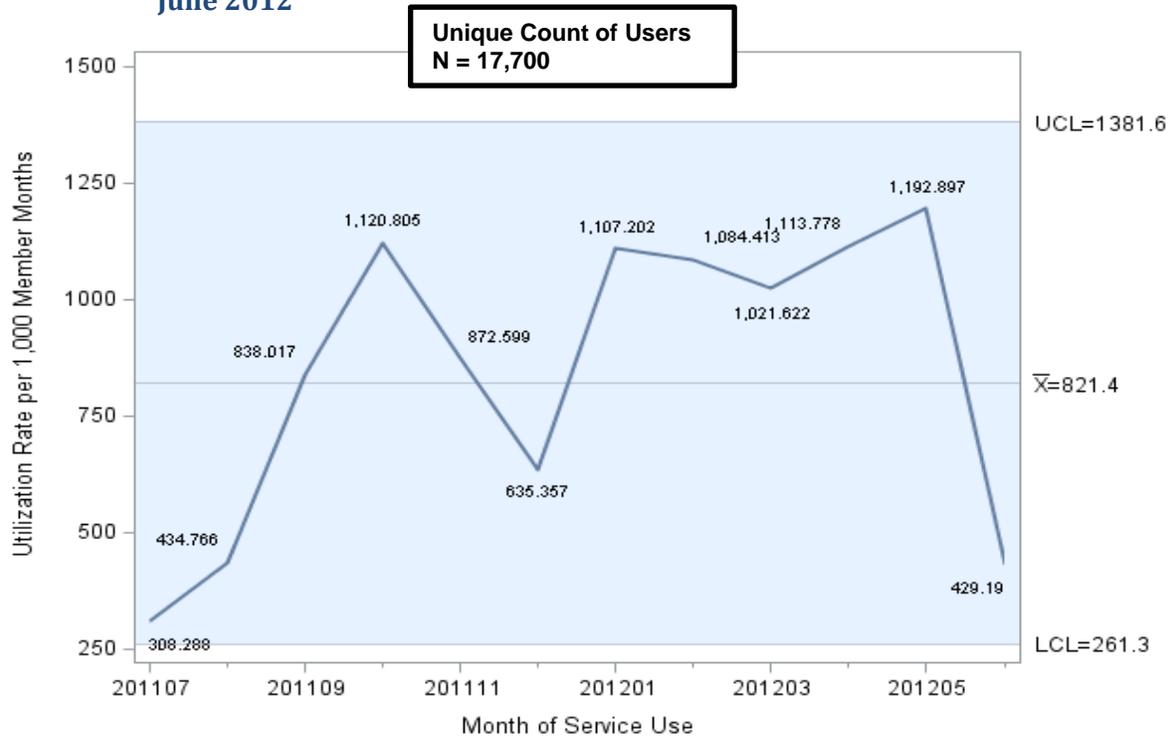


Figure SU-58 Other Services Utilization, Children Age 0–20, Families, July 2011–June 2012

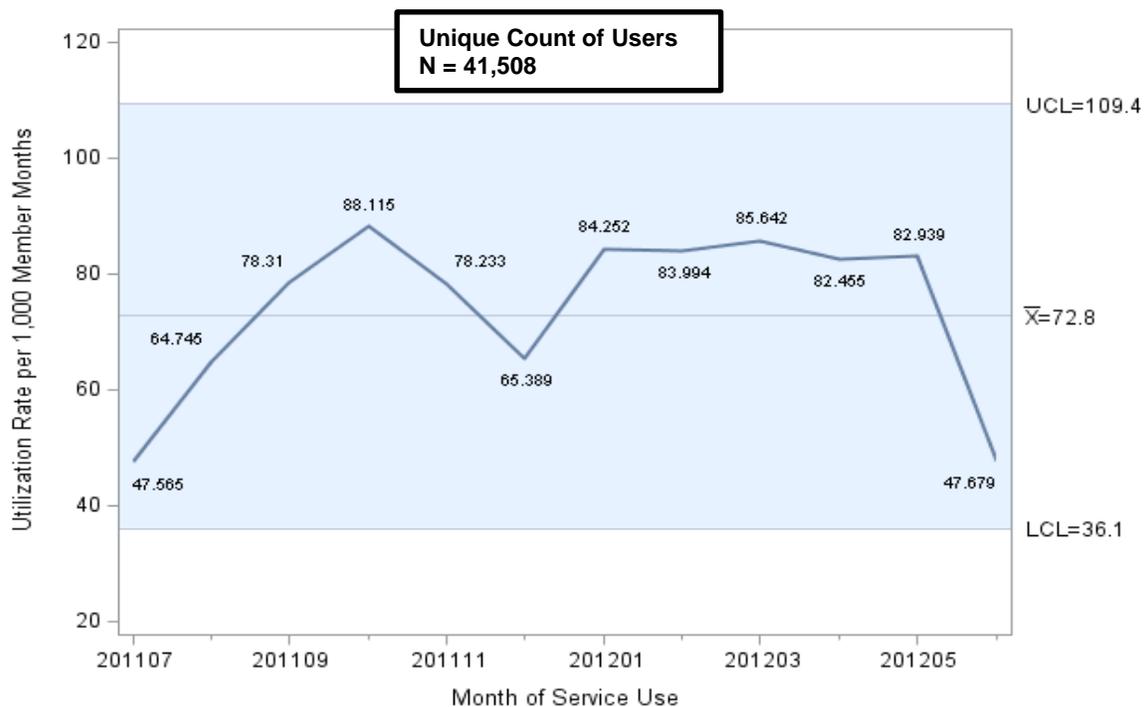


Figure SU-59 Other Services Utilization, Children Age 0-20, Foster Care, July 2011- June 2012

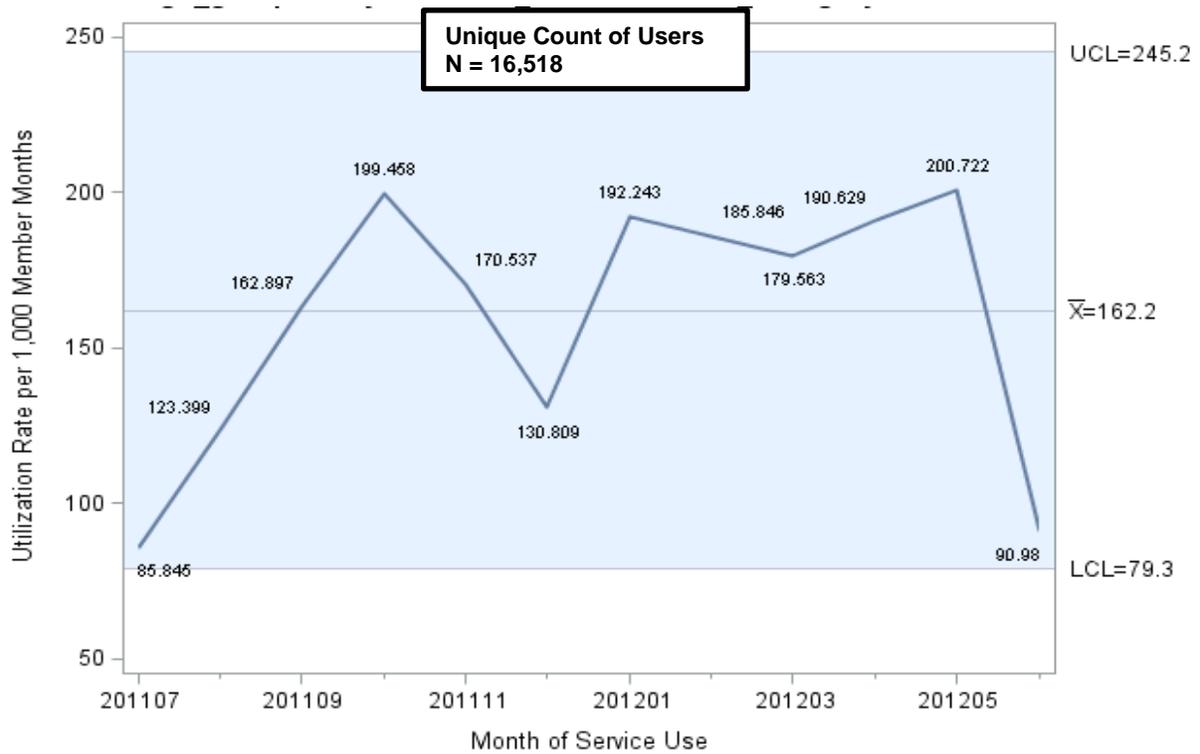


Figure SU-60 Other Services Utilization, Children Age 0-20, Other, July 2011-June 2012

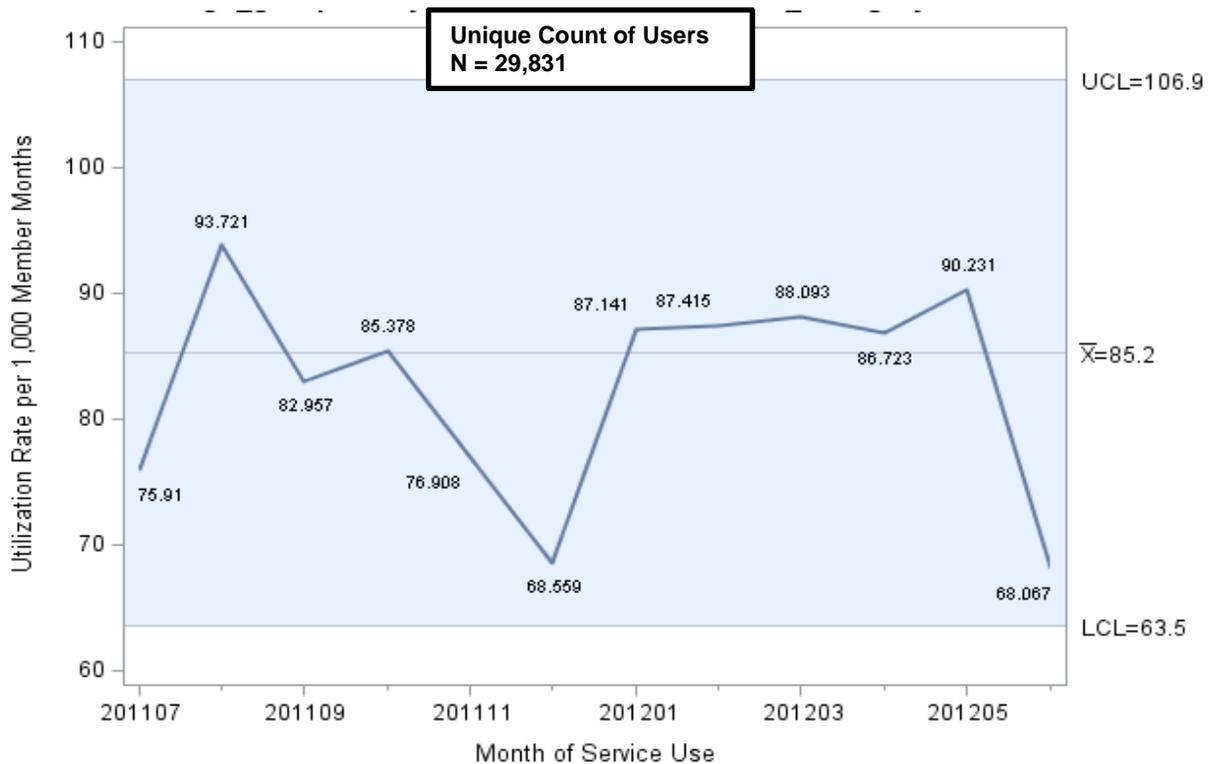
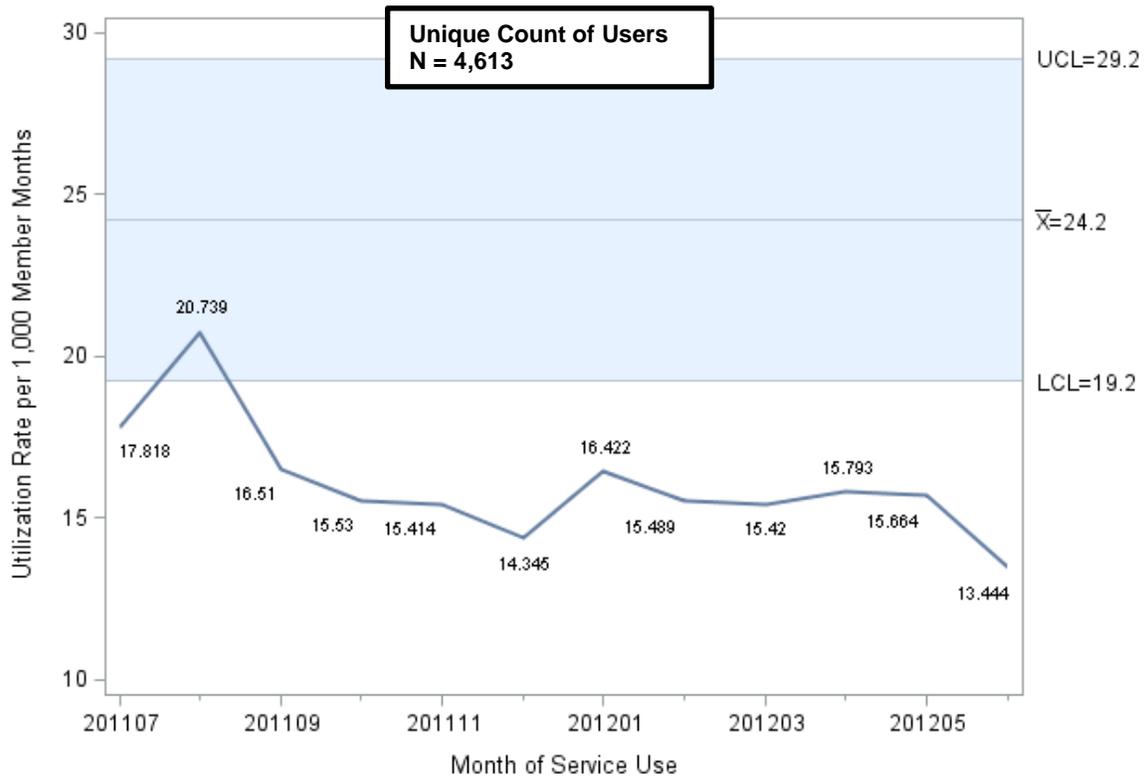


Figure SU-61 Other Services Utilization, Children Age 0-20, Undocumented, July 2011- June 2012



Source: Data for figures SU-57 to SU-61 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2011-June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Monthly Other Services Utilization Rates by Adults, July 2011–June 2012

Figure SU-62 Other Services Utilization, Adults Age 21+, Aged, July 2011–June 2012

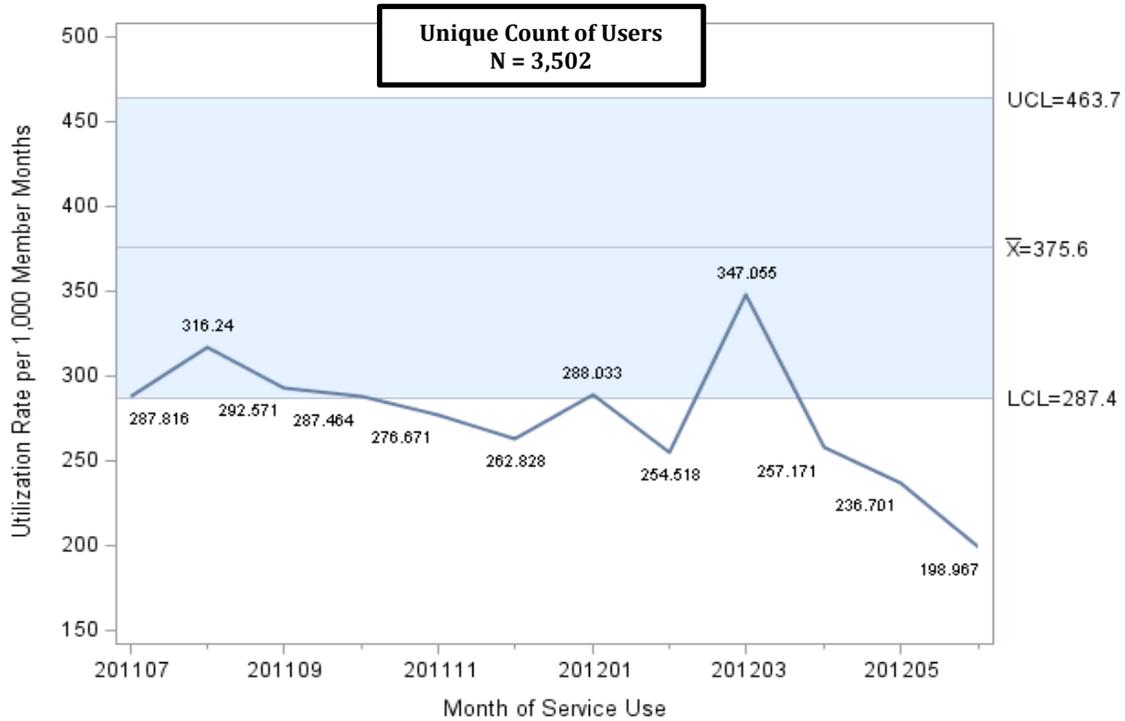


Figure SU-63 Other Services Utilization, Adults Age 21+, Blind/Disabled, July 2011–June 2012

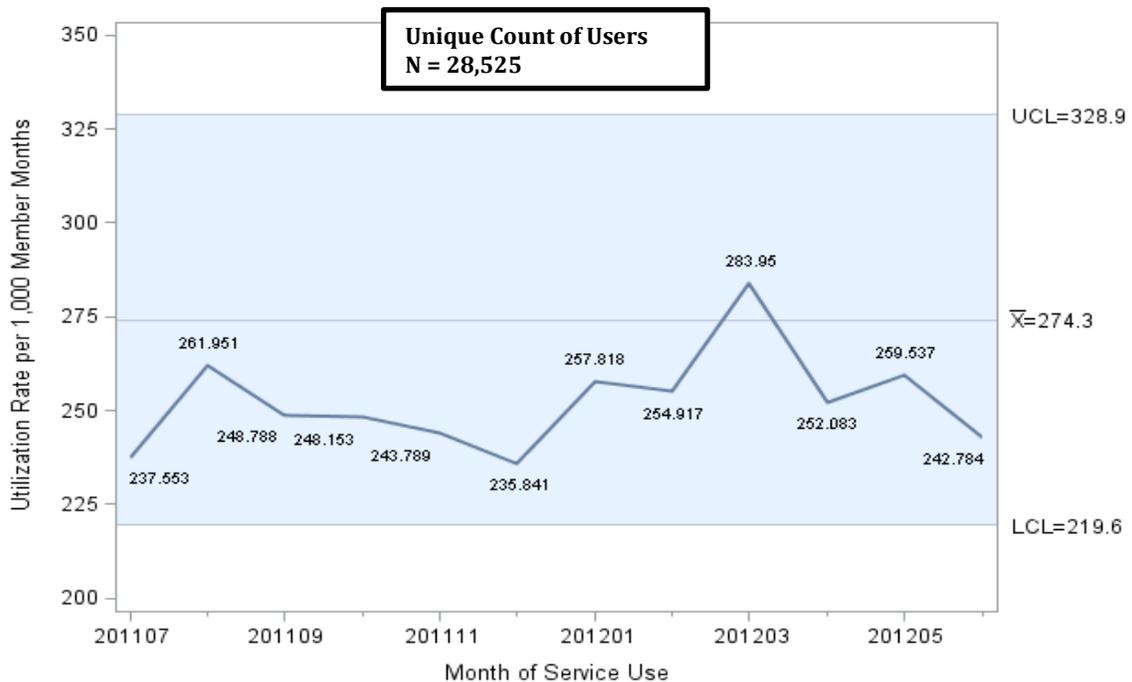


Figure SU-64 Other Services Utilization, Adults Age 21+, Families, July 2011–June 2012

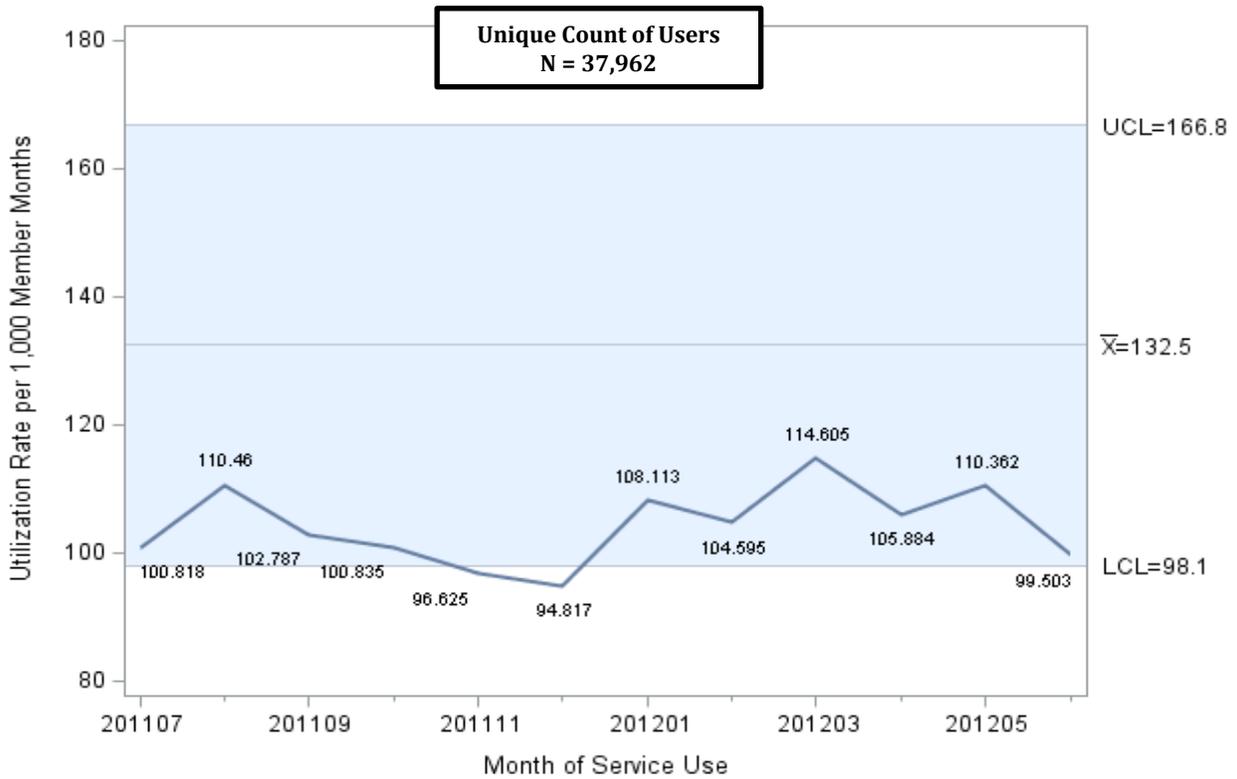


Figure SU-65 Other Services Utilization, Adults Age 21+, Other, July 2011–June 2012

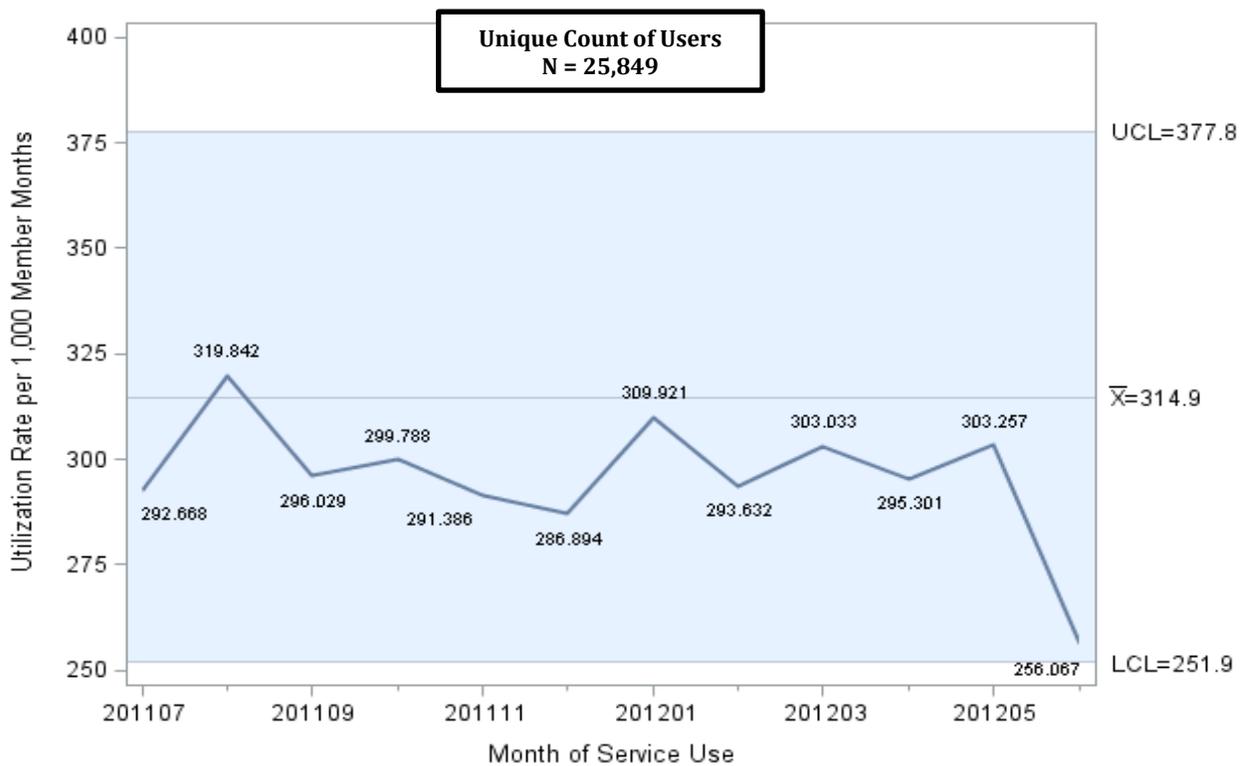
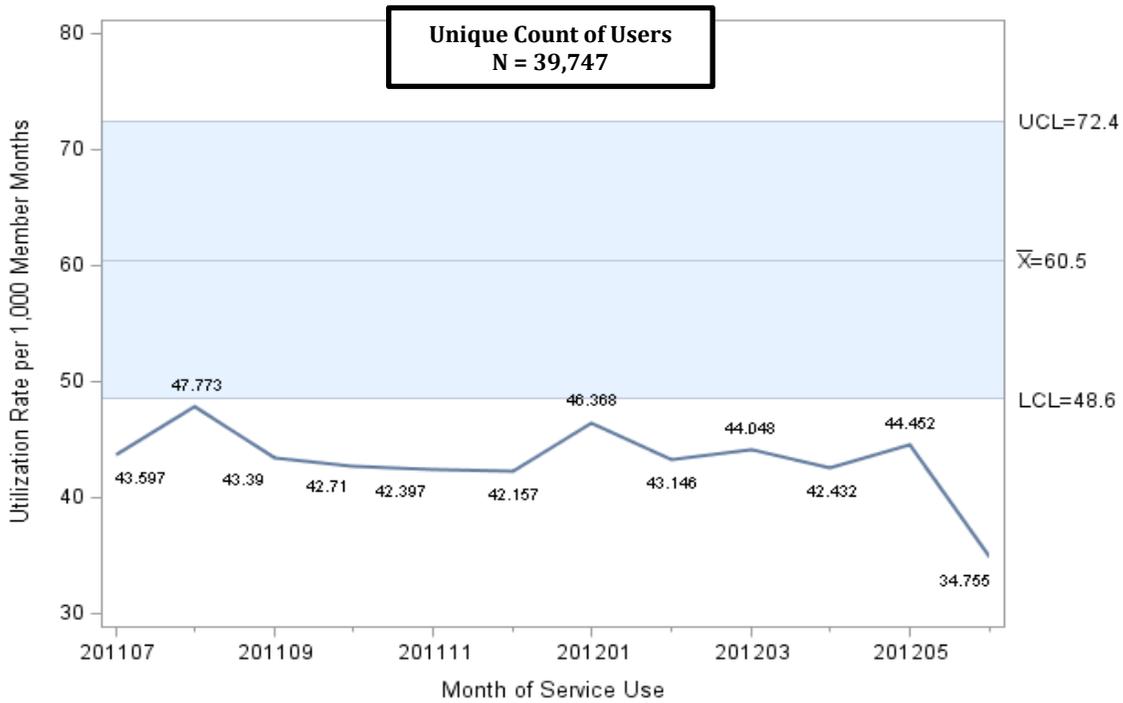


Figure SU-66 Other Services Utilization, Adults Age 21+, Undocumented, July 2011–June 2012



Source: Data for figures SU-62 to SU-66 was prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2011–June 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Summary Tables

Table SU-1 and Table SU-2 present the results of DHCS' analysis of the utilization trends among children and adults, respectively, by aid and service categories. The tables are color coded to identify those cases when a particular cell, which presents utilization by aid and service categories, generated a utilization rate that was either lower or higher than the established confidence level.

- Beige–Represents utilization rates found to be within the expected confidence intervals.
- Light Green–Represents utilization rates found to be outside of expected ranges earlier in the study period, but returning to rates within baseline ranges for the current quarter.
- Green–Represents utilization rates found to be outside of the expected confidence level.

In some cases, the utilization rate was found to be greater than expected. As noted above, there are a number of reasons why this might occur, such as changes in population mix.

Table SU-1 Summary of Service Utilization Trends Among Children by Aid Category and Service Category

| Aid Category / Service Category | Physician/Clinic Visits | Non-Emergency Transportation | Emergency Medical Transportation | Home Health Services | Hospital Inpatient Services | Hospital Outpatient Services | Nursing Facility Services | Pharmacy Services | Other Services |
|---------------------------------|--------------------------------------------------------------------------|------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| Blind/ Disabled | Mostly above average and within expected range, Decline in last quarter. | N/A | Mostly below average and Within expected range, Decline in last quarter. | Upward trend and above expected range in last quarter. | Mostly within expected range, Decline in last quarter. | Mostly above average with 4 consecutive months above expected range. Decline in last quarter. | N/A | Upward trend (Jul 2011 - Mar 2012) with 5 consecutive months above expected range. Decline in last quarter. | Within expected range. |
| Families | Mostly below average but within expected range, Decline in last quarter. | N/A | Mostly below average and within expected range, Sharp decline in June. | N/A | Mostly below average and within expected range. | Upward trend (Jul 2011-Mar 2012). Below average and mostly within expected range. | N/A | Upward trend (Jul 2011-Mar 2012). Mostly below average and mostly within expected range. Decline in last quarter. | Within expected range. Decline in last quarter. |
| Foster Care | Mostly below average but within expected range, Decline in last quarter. | N/A | Mostly above average and within expected range. | N/A | Below average and within expected range. | Within expected range. | N/A | Mostly above average and within expected range. | Within expected range. Decline in last quarter. |
| Other | Mostly below average but within range, Decline in last quarter. | N/A | Below average with 6 consecutive months below expected range. Within expected range Jan-June. | N/A | Mostly below average and below expected range. Within expected range Jan-Apr. | Upward trend (Sep 2011 -Jan 2012). Below average and mostly below expected range. | N/A | Below average and below the expected range in first and third quarters. | Within expected range. Decline in last quarter. |
| Undocumented | Below expected range. | N/A | Below average with 4 consecutive months below expected range. Within expected range in last quarter. | N/A | Below average and mostly below expected range. | Below average and within expected range. | N/A | Below average and within expected range. | Downward trend. Mostly below expected range. |

Table SU-2 Summary of Service Utilization Trends Among Adults by Aid Category and Service Category

| Service Category Aid Category | Physician/ Clinic Visits | Non-Emergency Transportation | Emergency Medical Transportation | Home Health Services | Hospital Inpatient Services | Hospital Outpatient Services | Nursing Facility Services | Pharmacy Services | Other Services |
|------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| Aged | Mostly below average and within expected range. | N/A | N/A. | N/A. | Upward trend with 5 consecutive months above expected range. Sharp decline returning to expected range in Jun. | Mostly within expected range. Upward trend (Nov-May). | Upward Trend (Jul-May). Mostly above expected range. | Downward trend (Aug-Jun). Below average and below expected range in last 2 quarters. | Below average with several non-consecutive months below expected range. |
| Blind / Disabled | Within expected range. | Above expected range. | Mostly above average with levels reaching above expected range in last 2 quarters. | Within expected range. Slight upward trend noted. | Upward trend and mostly within expected range. | Upward trend (Dec – May). Mostly above average and Mostly within expected range. | Upward trend (Jul-May). Mostly above expected range. | Mostly below average and within expected range. | Mostly below average and within expected range. |
| Families | Below average and within expected range. | N/A | Mostly below average and within expected range. | N/A | Below average with several non-consecutive months below expected range. | Mostly below average and mostly within expected range. | N/A | Below average and mostly within expected range. | Below average and mostly within expected range. |
| Other | Mostly above average and within expected range. | Above expected range. | Within expected range. | N/A | Below average with 5 consecutive months below expected range. | Mostly below average and within expected range. | Below average and mostly within expected range. | Within expected range. | Mostly below average and within expected range. Sharp decline in Jun. |
| Undocumented | Below average with several non-consecutive months below expected range. | N/A | Mostly below expected range. | N/A | Below expected range. | Below average and mostly within expected range. | N/A | Mostly above average and within expected range. | Below expected range. |

Conclusions—Service Utilization, Children Participating in FFS

1. Overall, service utilization patterns for children in most aid code categories followed the patterns identified in the previous access quarterly report. For example, Hospital Outpatient services utilization was again noticeably higher among children in the Blind/Disabled aid category with rates ranging from two to three times higher than for children in any other aid category. Other services utilization among children in the majority of the analyzed aid categories again fell within expected ranges. Additionally, service utilization rates for Emergency Transportation were again predominantly below average for children in most aid code categories and, in some cases, fell below rates established during the baseline study period.
2. Children in the Blind/Disabled aid category continued to exhibit upward trends in Home Health utilization in addition to above average utilization of Hospital Outpatient and Pharmacy services. However, this population displayed noticeable declines in their utilization of Hospital Inpatient and Emergency Medical Transportation services, as well as Physician/Clinic visits during the last quarter of the study period. These declines in utilization directly coincide with a noticeable decrease in the overall size of this population during the same time period. Despite these declines in utilization, this population continues to place a great demand on all the evaluated service types compared to children in the other analyzed aid categories. Although many children in the Blind/Disabled aid code category transitioned into managed care during 2011, those that remained in the Medi-Cal FFS delivery system continue to place a disproportionate demand on services of all kinds most likely due to their complex medical needs.
3. Physician/Clinic service utilization patterns among children in most of the evaluated aid categories fell below the average rates established during the baseline period but were found to be within the expected ranges. The lower utilization rates among children in the Families, Foster Care, Other, and Undocumented aid categories may be influenced, in part, by the declines in national and statewide teen birth rates over the same time period.⁷
4. The utilization of most services by children in the Other aid category again fell below either the expected average rates or the anticipated ranges established during the baseline period. Additionally, this population experienced a noticeable decline in their utilization of Other services and Physician/Clinic visits in the last quarter of the study period.
5. As beneficiary participation shifted away from the FFS delivery system and into managed care, many service categories (e.g.; Non-Emergency Transportation, Home Health, and Nursing Facility Services) experienced a noticeable decline in user counts that made the data unsuitable for analysis.

⁷ Data from the National Vital Statistics System, found at <http://www.cdc.gov/nchs/data/databriefs/db60.pdf>

Conclusions—Service Utilization, Adults Participating in FFS

1. As noted in the previous access quarterly reports, adults in the Blind/Disabled aid category continued to place a greater demand on Emergency and Non-Emergency Transportation, as well as Nursing Facility services. Adults in these this aid category also exhibited mostly above average utilization of Hospital Outpatient services. In contrast, adults in the Blind/Disabled aid category experienced a noticeable decline in their utilization of Hospital Inpatient and Home Health services in the last quarter of the study period.
2. Adults in the Families aid code category again displayed below average utilization of Emergency Transportation, Hospital Inpatient and Physician/Clinic services throughout most of the study period. The lower utilization of these services among younger adults (age < 65) in the Families aid category is most likely correlated with continued declines in the birth rate.
3. Adults in the Undocumented aid code category, who are only eligible for emergency and pregnancy-related services, also continued to exhibit below average and lower than expected utilization of Emergency Transportation, Physician/Clinic, Hospital Inpatient, and Hospital Outpatient services. This lower service utilization further emphasizes the argument that these utilization patterns may be heavily influenced by the decline in overall births statewide and nationally,⁸ which is most noticeable among the immigrant population.⁹
4. The continued decline in Medi-Cal's FFS population, which is a result of the transition of Medi-Cal beneficiaries into managed care plans, has directly reduced the pool of users for particular services. For instance, the number of adults in Aged and Families aid categories that utilize Non-Emergency Transportation and Home Health services have declined to levels (<500) that render their utilization of these service categories inconsequential to the current analysis. The beneficiary subpopulations that continue to utilize these service categories exhibited utilization patterns that are often times above the range of expected values. These shifts in utilization patterns provide further evidence of how markedly the Medi-Cal FFS population case mix has changed since the baseline period of 2007 to 2009.

⁸ Data from the National Vital Statistics System, found at <http://www.cdc.gov/nchs/data/databriefs/db60.pdf>

⁹ Livingston, G., & Cohn, D. (2012, November 29) U.S. Birth Rate Falls to a Record Low; Decline Is Greatest Among Immigrants. *Pew Research Center: Social & Demographic Trends*.

Appendix—Detailed List of Other Providers

Community-Based Adult Services Program (formerly called Adult Day Health Care) (PT 001)

Assistive Device and Sick Room Supply Dealers (PT 002)

Audiology Services—Audiologists (PT 003), Hearing Aid Dispensers (PT 013)

Blood Banks (PT 004)

Certified Nurse Midwife (PT 005)

Chiropractors (PT 006)

Certified Nurse Practitioner (PT 007), Group Certified Family/Pediatric Nurse Practitioners (PT 010)

Christian Science Practitioner (PT 008)

Fabricating Optical Lab (PT 011), Dispensing Opticians (PT 012), Optometrists (PT 020), and Optometric Groups (PT 023)

Nurse Anesthetists (PT 018)

Physical Therapist (PT 025), Occupational Therapist (PT 019), Speech Therapist (PT 037)

Orthotists (PT 021), Prosthetists (PT 029)

Podiatrists (PT 027)

Portable X-Ray (PT 028)

Psychologists (PT 031)

Certified Acupuncturist (PT 032)

Genetic Disease Testing (PT 033)

Medicare Crossover Provider Only (PT 034)

Outpatient Heroin Detoxification Center (PT 051)

Local Education Agency (LEA) (PT 055)

Respiratory Care Practitioner (056) and Respiratory Care Practitioner Group (PT 062)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services Provider (PT 057)

Health Access Program (HAP)(PT 058)

Home and Community-Based Services (HCBS) Waiver Programs (Multiple Provider Types):

HCBS Nursing Facility (Congregate Living Health Facilities with Type A licensure) (PT 059)

HCBS Licensed Building Contractors (PT 063)

HCBS Employment Agency (PT 064)

HCBS Personal Care Agency (PT 066)

HCBS Benefit Provider (Licensed Clinical Social Worker, Licensed Psychologist, or Marriage and Family Therapist) (PT 068)

HCBS Professional Corporation (PT 069)

AIDS Waiver (PT 073)

Multipurpose Senior Services Program Waiver (PT 074)

Assisted Living Waiver-Facility (PT 092)

Assisted Living Waiver-Care Coordinator (PT 093)

HCBS Private Non-Profit (PT 095)

Pediatric Subacute Care/LTC (PT 065)

RVNS Individual Nurse Providers (PT 067)

CCS/GHPP Non-Institutional Providers (PT 080)

CCS/GHPP Institutional Providers (PT 081)

Independent Diagnostic Testing Facility Crossover (PT 084)

Clinical Nurse Specialist Crossover Provider (PT 085)

Out of State Providers (PT 090)



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



Beneficiary Feedback

January 2013

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

Contents

Beneficiary Feedback..... 3

 Introduction..... 5

 Methods 5

 Results 6

 Modified Call Categories 8

 Distribution of Calls by Call Category10

 Distribution of Calls by Call Category and Month.....11

 Calls by Aid Code Category13

 Distribution of Calls from Family Aid Codes by Call Category14

 Distribution of Calls from Blind/Disabled Aid Codes by Call Category.....15

 Calls by County.....16

 Reason for Call17

Conclusions.....19

List of Figures

| | | |
|-------------|-----------------------------------------------------------------------------------|----|
| Figure BF-1 | Calls Received by FFS Beneficiaries by Month, July 2011–June 2012 | 6 |
| Figure BF-2 | Calls Received by FFS Beneficiaries by Call Category, July 2011–June 2012 | 10 |
| Figure BF-3 | Calls by Call Category and Month FFS Beneficiaries, July 2011–June 2012 | 11 |
| Figure BF-4 | Calls from Family Aid Codes, Call Category by Month, July 2011–June 2012 | 14 |
| Figure BF-5 | Calls from Blind/Disabled Aid Codes, Call Category by Month, Jul 2011–Jun 2012 .. | 15 |

List of Tables

| | | |
|------------|------------------------------------------------------------------------------------------------------------------|----|
| Table BF-1 | Quarterly Average Number of Calls Received from FFS Beneficiaries, July 2011– June 2012 | 7 |
| Table BF-2 | Modified Call Categories..... | 9 |
| Table BF-3 | Calls for Enrollment/Continuity of Care and Provider/Availability, by Aid Category, July 2011–June 2012 | 13 |
| Table BF-4 | Calls for Enrollment and Continuity of Care by County, Top 10 Counties, July 2011–June 2012 | 16 |
| Table BF-5 | Calls for Provider/Availability Issues by County, Top 10 Counties, July 2011–June 2012 | 16 |
| Table BF-6 | Calls from Family Aid Codes, Top 3 Reasons for Calls, July 2011–June 2012 | 17 |
| Table BF-7 | Calls from Blind/Disabled Aid Codes, Top 3 Reasons for Calls, July 2011–June 2012 | 18 |

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.

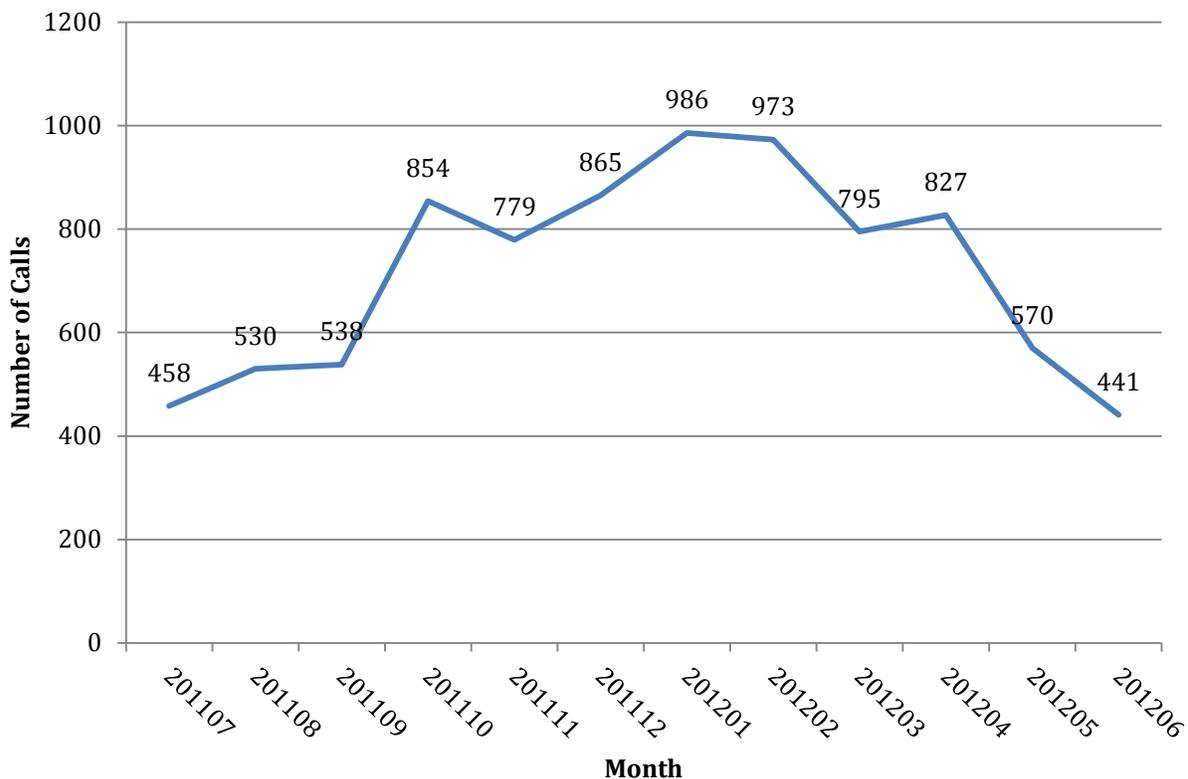
Results

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.

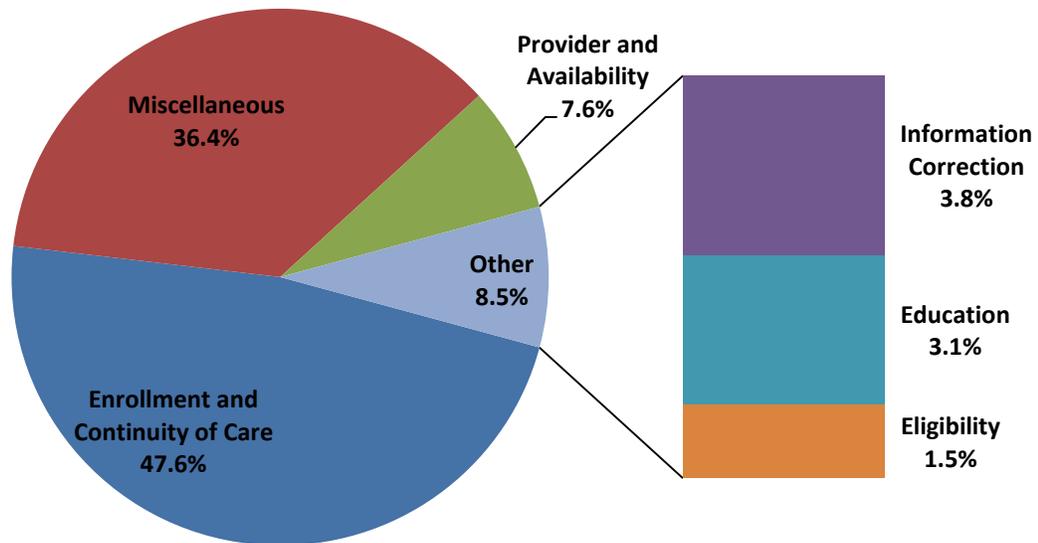
Table BF-2 Modified Call Categories

| Call Category | Reason for Call |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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), 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 |

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.

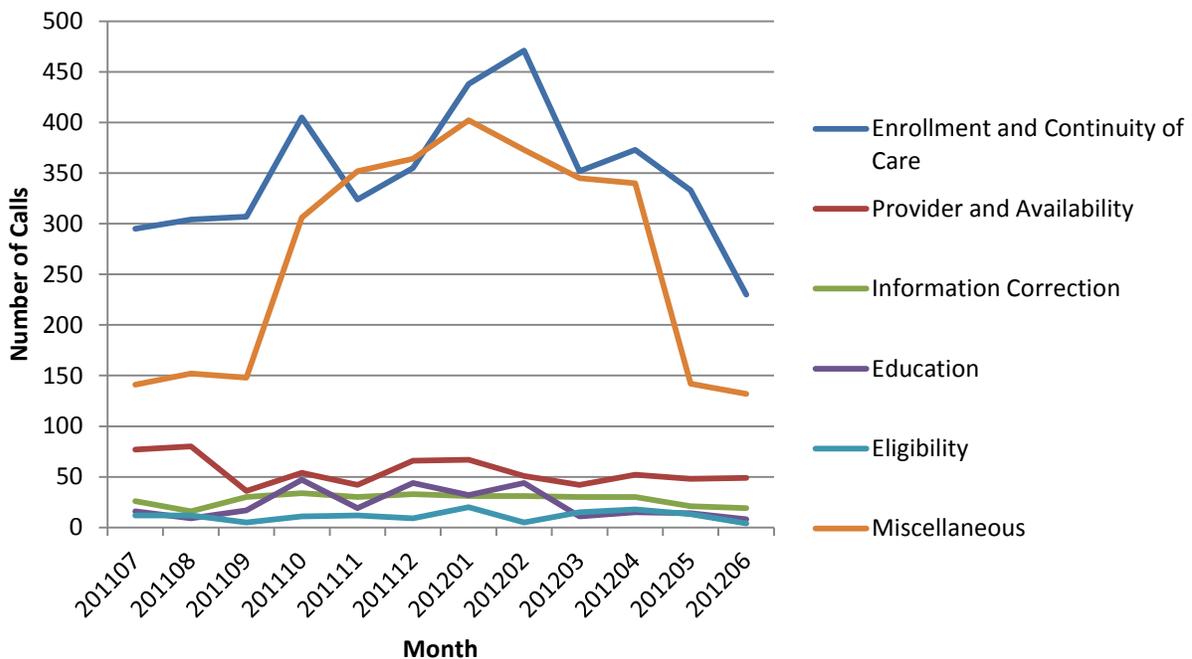
Distribution of Calls by Call Category and Month

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.

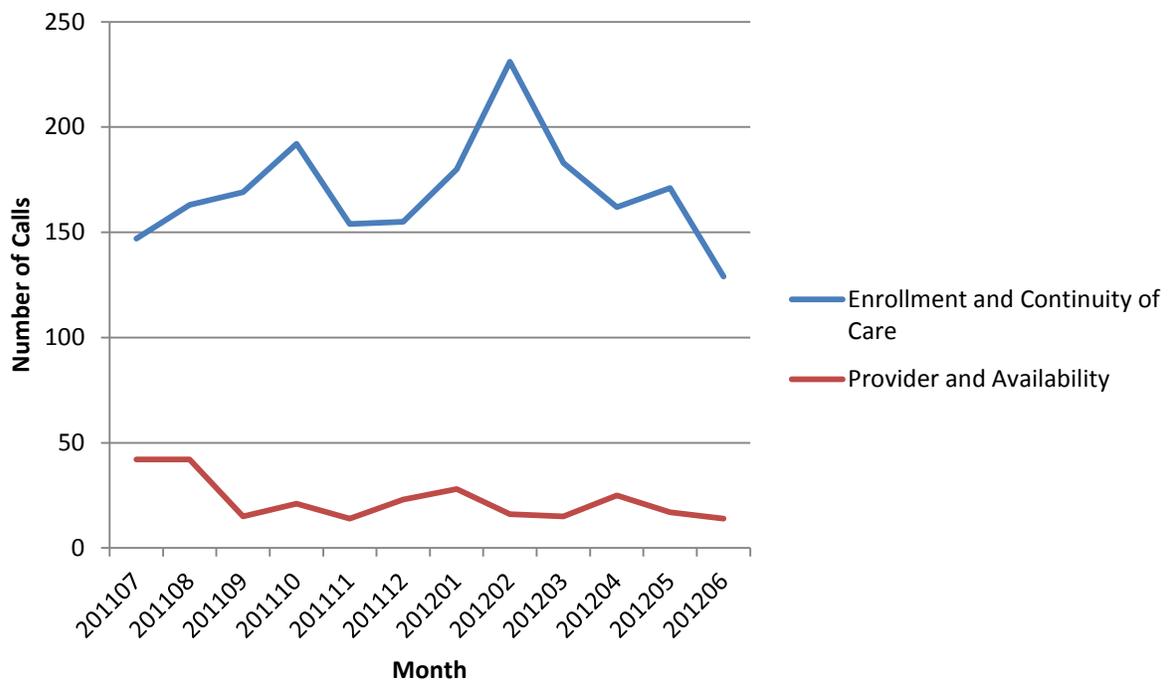
Distribution of Calls from Family Aid Codes by Call Category

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



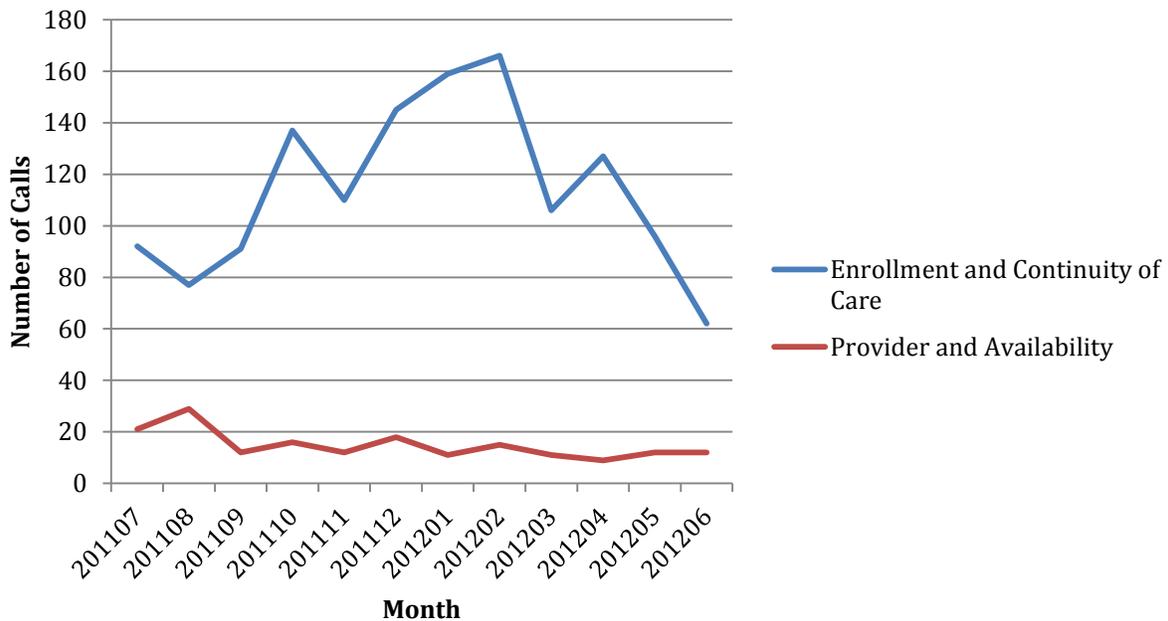
Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Branch. Calls received from FFS beneficiaries July 2011–June 2012.

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* |
|--------------------------------------------------------|------------|-----------------|
| Enrollment and Continuity of Care (n=2,036) | | |
| 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% |
| Provider and Availability (n=272) | | |
| 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* |
|--------------------------------------------------------|------------|-----------------|
| Enrollment and Continuity of Care (n=1,368) | | |
| 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% |
| Provider and Availability (n=178) | | |
| 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.