



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



Executive Summary

May 2013
September 2013

California Department of Health Care Services
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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, physician supply, service utilization rates per 1,000 member months, and beneficiary help line feedback.

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

KEY FINDINGS

- Medi-Cal Beneficiaries' participating in the 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 third quarter of 2012. By September 2012, the largest segment of adult FFS Medi-Cal beneficiaries were those enrolled in Undocumented aid codes.
- The Medi-Cal physician supply grew modestly overall. Physician specialists such as primary care, OB/GYN, and pediatricians also recognized modest growth as well. Site-specific overall 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 continued to be utilized by fewer than 500 beneficiaries. Service utilization is continuing 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 8,500 calls were handled by the Office of the Ombudsman for beneficiaries enrolled in FFS, a 1.24% decrease from the previous study period. However, calls declined significantly in the last quarter of the study period. Smaller call volume during the current quarter is likely the result of fewer changes to Medi-Cal program benefits and services. In the earlier study periods, Medi-Cal transitioned the seniors and persons with disabilities (SPD) from FFS into managed care delivery systems throughout 14 counties.

Executive Summary

Background

This Medi-Cal access report is the fourth 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 third quarter of 2012, and presents data from the three previous quarters for comparison purposes. During this study 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
- Physician supply
- Service utilization rates per 1,000 member months
- Beneficiary help line feedback

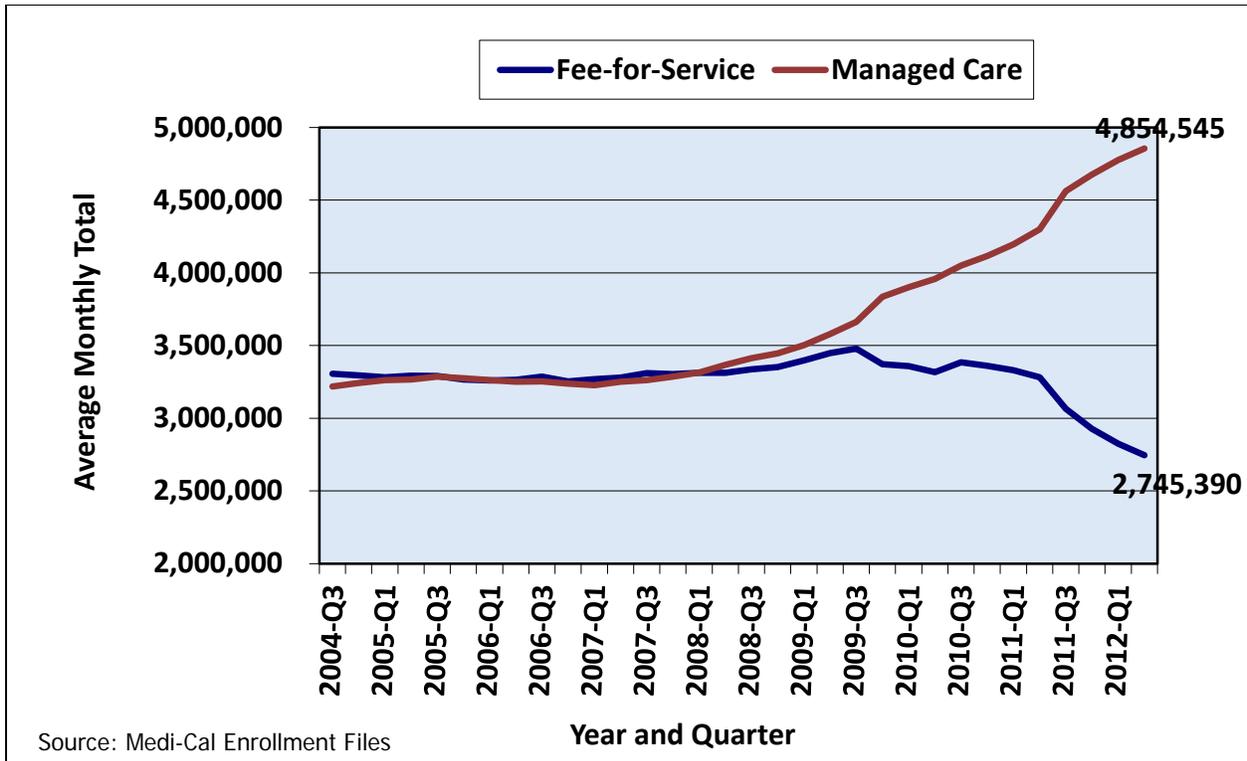
Recent changes to the Medi-Cal program have impacted benefits, health care delivery, and FFS population characteristics. All of these changes influenced the measures evaluated in Medi-Cal's quarterly access report. The DHCS systematic access monitoring system required the establishment of baseline statistics. 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 that were 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



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 third 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. As of September 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

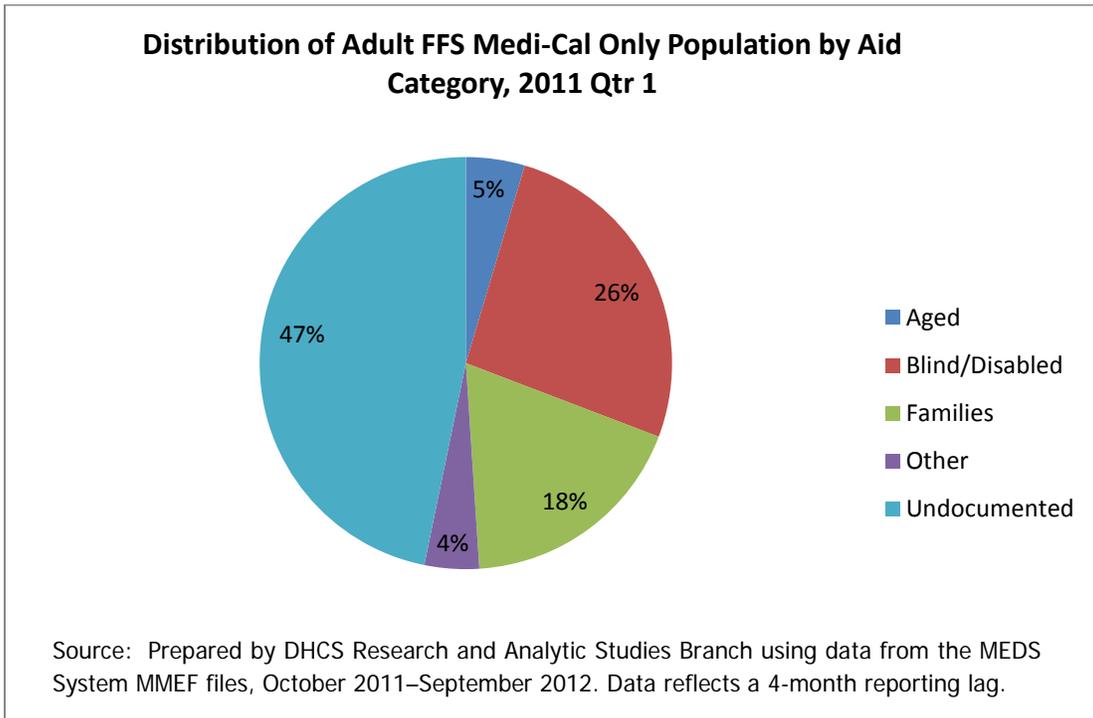
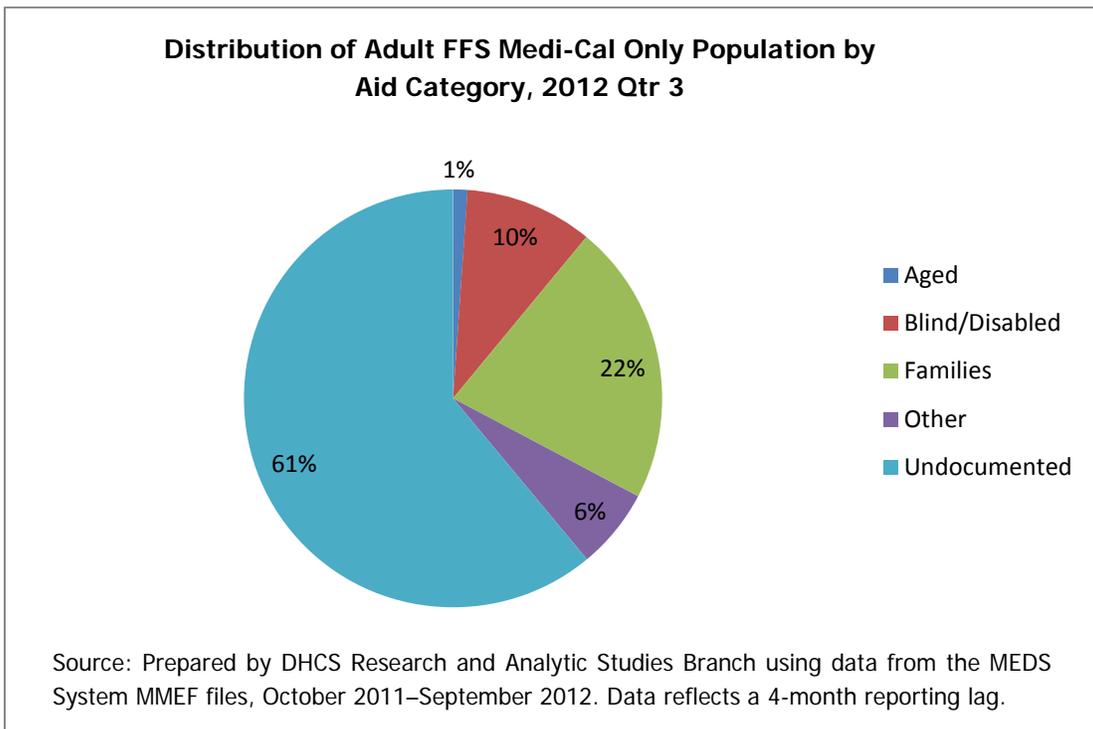


Figure ES-3 Distribution of Adult FFS Medi-Cal Only Population by Aid Category, 2012 Quarter 3



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 study period. For example, the SPD transition was phased in from June 2011–May 2012. This means that during most of the current study period of October 2011–September 2012, beneficiaries receiving health care services through the FFS system in the earlier quarters of the study period were now receiving care through managed care plans.

Shifting health care delivery systems materially influenced 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 service utilization rates per 1,000 member months. 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 represent high users.

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. [Figure ES-4](#) and [Figure 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.

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.

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

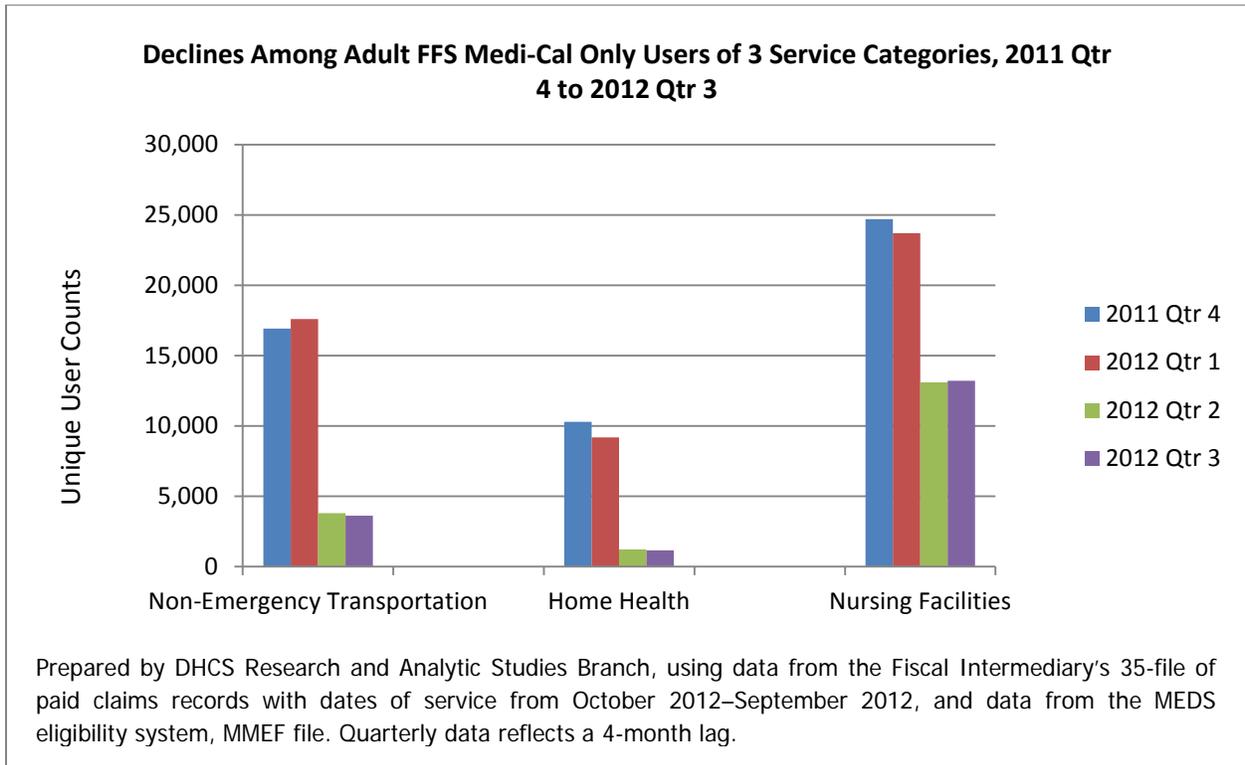
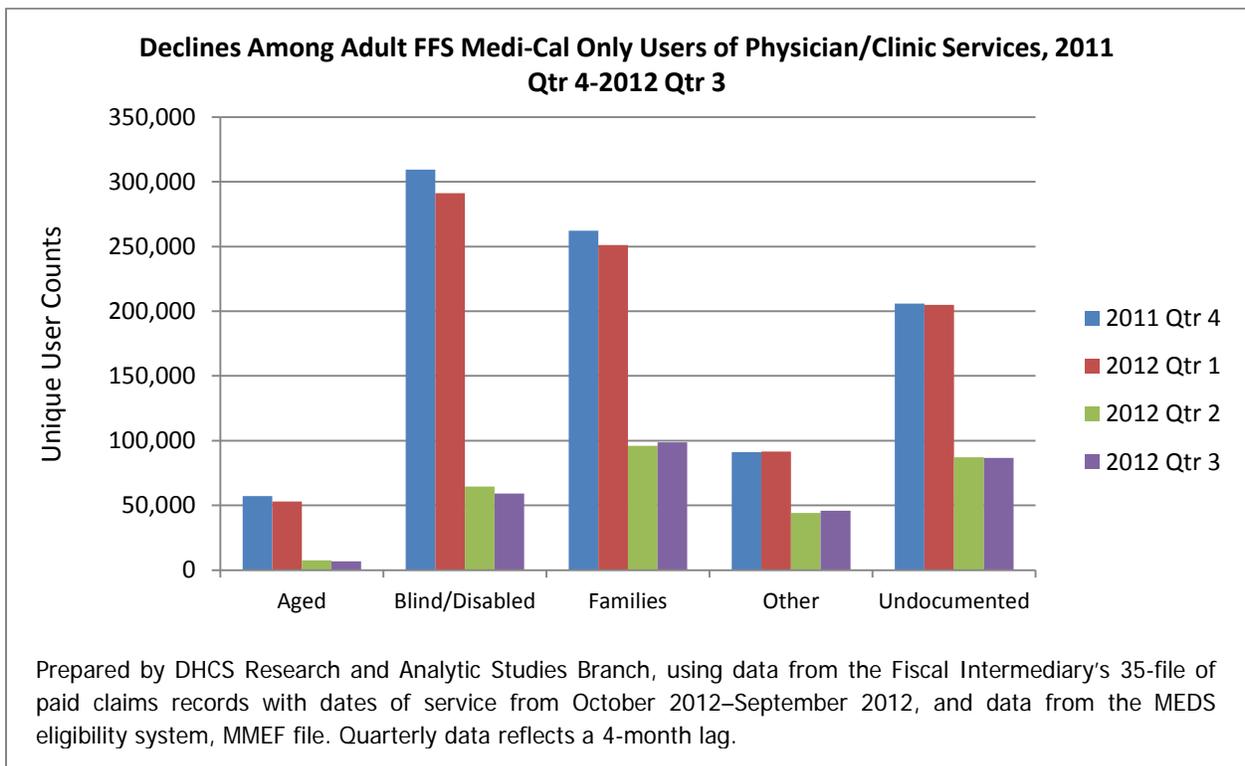


Figure ES-5 Declines in Adult FFS Medi-Cal Only Users of Physician/Clinic Services



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, utilization 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

The provider supply metric used in this quarterly access report has changed from beneficiary-to-provider ratios to site-specific physician counts. Site-specific physician counts are system wide metrics designed to alert Department management of changes in the number of providers and provider sites over time. Much like an internal control, this metric was designed to identify system-wide trends that may adversely impact access to health care services in the future. Continuously monitoring these trends provides useful early warning signs that adverse changes may be materializing (e.g., number of enrolled Medi-Cal physicians are declining) or that the supply of physicians has been stable over time. This has been the case for the last three quarters—enrolled physicians have been stable during the quarters examined (2011 Q4, 2012 Q1 and Q2) as well as for the current quarter. In these four access snapshots, modest increases in Medi-Cal physician enrollment have been reported.

The aggregate number of primary care physicians increased 1.7% from 39,068 to 39,722 during the four quarters studied.⁵

During the period under study, physician enrollment for each specialty area (primary care, OB/GYN, pediatrics) increased slightly.

This report's findings 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.

Change in Medi-Cal Participation

The number of beneficiaries eligible for Medi-Cal only, participating in FFS, and entitled to full scope benefits decreased 8.6% overall from the fourth quarter of 2011 to the third quarter of 2012, reflective of Medi-Cal's continued shift of beneficiaries to managed care.

The greatest decrease from the fourth quarter of 2011 to the third 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 (64.4%), with adults in Blind/Disabled aid category also significantly decreasing by 52.6%. The decrease in participation among the Aged and

⁵ For details on how "primary care physicians" were defined for this report, see the Physician Supply Section of the current report on the [DHCS-RASB Access Monitoring](#) website

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, 23 of 58 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 fourth quarter of 2011 to the third 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 (9.2%) in participation for the study 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.^{6,7}

Service Utilization Rates Per 1,000 Member Months for Adult Beneficiaries⁸

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 ten unique service categories:

1. Physician/Clinics;
2. Emergency Transportation;
3. Non-Emergency Transportation;

⁶Passel, 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/>

⁷Passel, 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/>

⁸ 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](#).

4. Home Health;
5. Hospital Inpatient;
6. Hospital Outpatient;
7. Nursing Facility;
8. Pharmacy;
9. Other; and
10. Radiology.

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 reports, adults in the Blind/Disabled aid category continued to place a greater demand on Emergency Transportation, Hospital Inpatient and Outpatient, as well as, Nursing Facility services. Despite experiencing a downward trend in Non-Emergency Transportation services utilization during the last two quarters of the study period, Blind/Disabled adults utilized these services at rates well above the expected baseline ranges. Additionally, after displaying a decline in utilization of Hospital Inpatient and Home Health services in the second quarter of 2012, adults in the Blind/Disabled aid category exhibited increased use of these particular services at the end of the study period.
- Adults in the Families aid category again displayed below average utilization of Emergency Transportation, Hospital Inpatient, Hospital Outpatient, and Physician/Clinic services throughout most of the study period. The utilization of these services among younger adults (age <65) in the Families aid category is most likely correlated with continued declines in the statewide birth rate.
- Adults in the Undocumented aid 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 supports the argument that these utilization patterns may be heavily influenced by the decline in overall births statewide and nationally,⁹ which is most noticeable among the immigrant population.¹⁰
- 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

⁹ Data from the National Vital Statistics System, found at <http://www.cdc.gov/nchs/data/databriefs/db60.pdf>

¹⁰ 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*.

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 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 study 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 study 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 Service Utilization 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 study 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	Radiology Services
Aged	Mostly below average and within expected range.	N/A	N/A.	N/A.	Upward trend Nov 2011–May 2012. Mostly above expected range.	Mostly above average and mostly within expected range. Upward trend (Nov-May).	Mostly above expected range. Upward trend (Oct-May).	Below average and mostly below expected range in last 3 quarters. Downward trend (Oct-Jul).	Below average and mostly below expected range.	Above average and mostly above expected range.
Blind/ Disabled	Mostly above average and within expected range.	Above expected range. Downward trend Mar 2012–Sep 2012.	Mostly above average with levels reaching above expected range in last 3 quarters.	Mostly above average and within expected range.	Mostly above average with several months above expected range in last 2 quarters.	Mostly above average with several months above expected range in last quarter. Upward trend (Dec–May).	Mostly above expected range. Upward trend (Oct-May).	Below average with non-consecutive months below the expected Range.	Mostly below average and within expected range.	Above average and mostly above 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 below expected range in last quarter.	Below average and mostly within expected range.	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.	Within expected range.	Below average with several non-consecutive months outside of the expected range. Decline in last quarter.	Within expected range.	Mostly below average and within expected range.	Within expected range.
Undocu- mented	Below average with several non-consecutive months below expected range.	N/A	Mostly below the expected range with levels reaching within range during last quarter.	N/A	Below the expected range.	Below average and mostly within expected range.	N/A	Mostly above average and within expected range.	Below the expected range.	Mostly below average and within expected range.

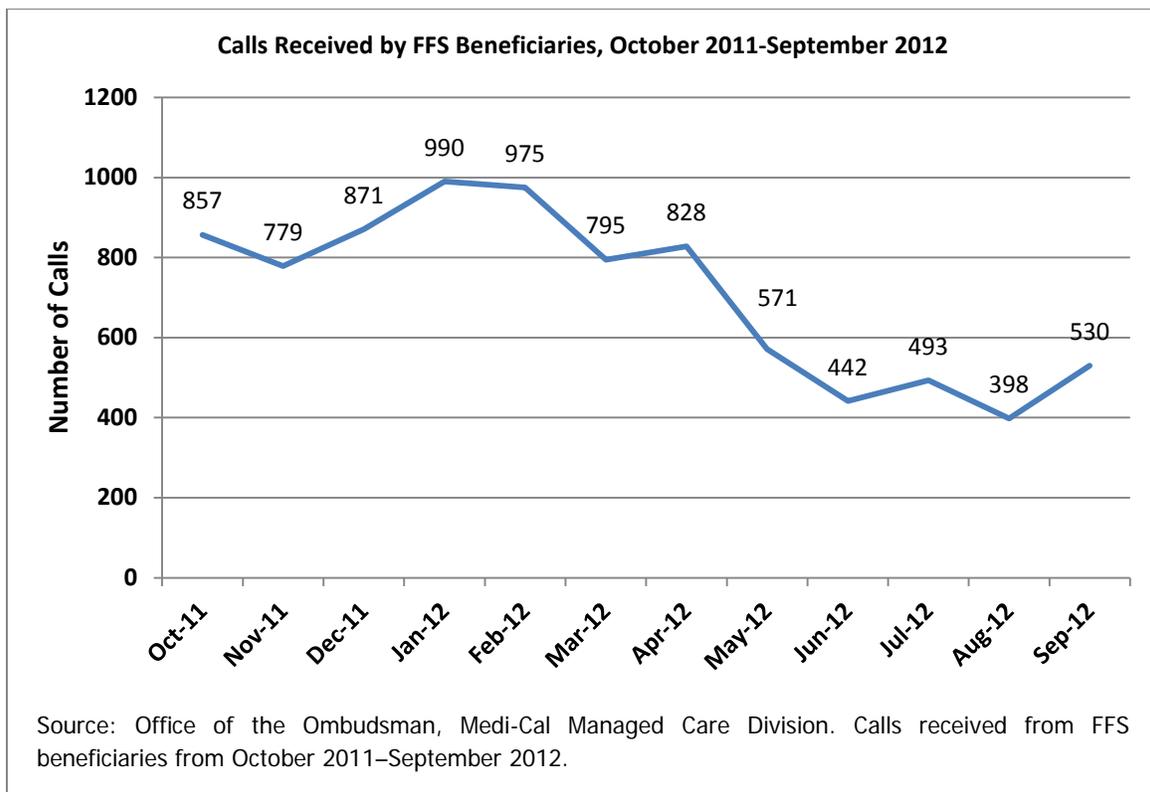
Beneficiary Help Line Feedback

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 fourth quarter of 2011 to the third quarter of 2012, the Office of the Ombudsman call center documented over 8,500 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 October 2011 to September 2012 by month. The most significant increase in call volume occurred between October 2011 and December 2011.

Figure ES-6 Calls Received from FFS Beneficiaries by Month, October 2011–September 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/Continuity of Care issues. Among Enrollment/Continuity of Care, the most common issues cited were requests for new enrollment, Foster Care/Adoption (Disenrollment Exemption Request) 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 program changes.



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Physician Supply

May 2013
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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.

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 Medi-Cal only and entitled to full scope health care services and participating in FFS continued to grow modestly.

Site-specific physician counts increased from 104,659 to 106,335, or 1.6%.

Site-specific primary care physician counts increased 1.7%, from 39,068 to 39,722.

Site-specific OB/GYN physician counts increased 0.7%, from 6,188 to 6,233.

Site-specific pediatrician counts increased 1.2%, from 10,708 to 10,841.

Consequently, physicians have 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.

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.

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.

In previous versions of the Access Quarterly Report, a beneficiary-to-provider ratio was calculated to reflect the number of beneficiaries enrolled under the FFS delivery of care model who have Medi-Cal only coverage for every provider. This metric has since been replaced with a simple calculation of the site-specific number of providers enrolled in the program. Site-specific physician counts are a system wide metric designed to alert Department management of changes in the number of providers and provider sites over time. Much like an internal control, this metric was designed to identify system wide trends that may adversely impact access to health care services in the future. Continuously monitoring these trends provides useful early warning signs that adverse changes may be materializing or that the supply of physicians has been stable over time.

Methods

Physician Enrollment Status

Physician supply metrics are based on those physicians who have gone through the Medi-Cal provider application and enrollment process¹ 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.^{2,3}

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.

¹ “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

² “Medi-Cal Provider Enrollment, Frequently Asked Questions,” URL: <http://www.dhcs.ca.gov/provgovpart/Pages/PEDFrequentlyAskedQuestions.aspx>

³ Medi-Cal Provider Agreement DHCS 6208 form; URL: <https://files.medi-cal.ca.gov/pubsdoco/forms.asp>

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 physician counts, 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 predates 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.

Results–Physician Supply

The following tables report the number of physicians, primary care physicians, and other physician specialists. The tables cover four consecutive quarters from the fourth quarter of 2011 to the third quarter of 2012 and indicate the magnitude of change over this period

You can view county-level details in tables PS-6 to PS-10 in the [Appendix](#).

Table PS-1 Summary and Description of Physician Supply Tables

Table	Description
Table PS-2	All Enrolled Physicians with an Active or Indirect status at a given location. Includes both Primary Care and Specialty physicians.
Table PS-3	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.
Table PS-4	All Physicians with an OB/GYN Specialty and an Active or Indirect status at a given location.
Table PS-5	All Physicians with a Pediatrics Specialty and an Active or Indirect status at a given location.

DHCS calculated site-specific physician counts 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.

Table PS-2 includes site-specific counts of all enrolled physicians identified in the Provider Master File. Table PS-3, Table PS-4, and Table PS-5 include only those physicians identified in the Provider Master File with a given specialty area. Due to a technical correction in the programming code used to count physicians, totals will be about three percent lower than previously reported.

Overall, the 28 primarily rural FFS counties have fewer physicians. This finding is consistent with other research and survey data that has reported that 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, September 2012

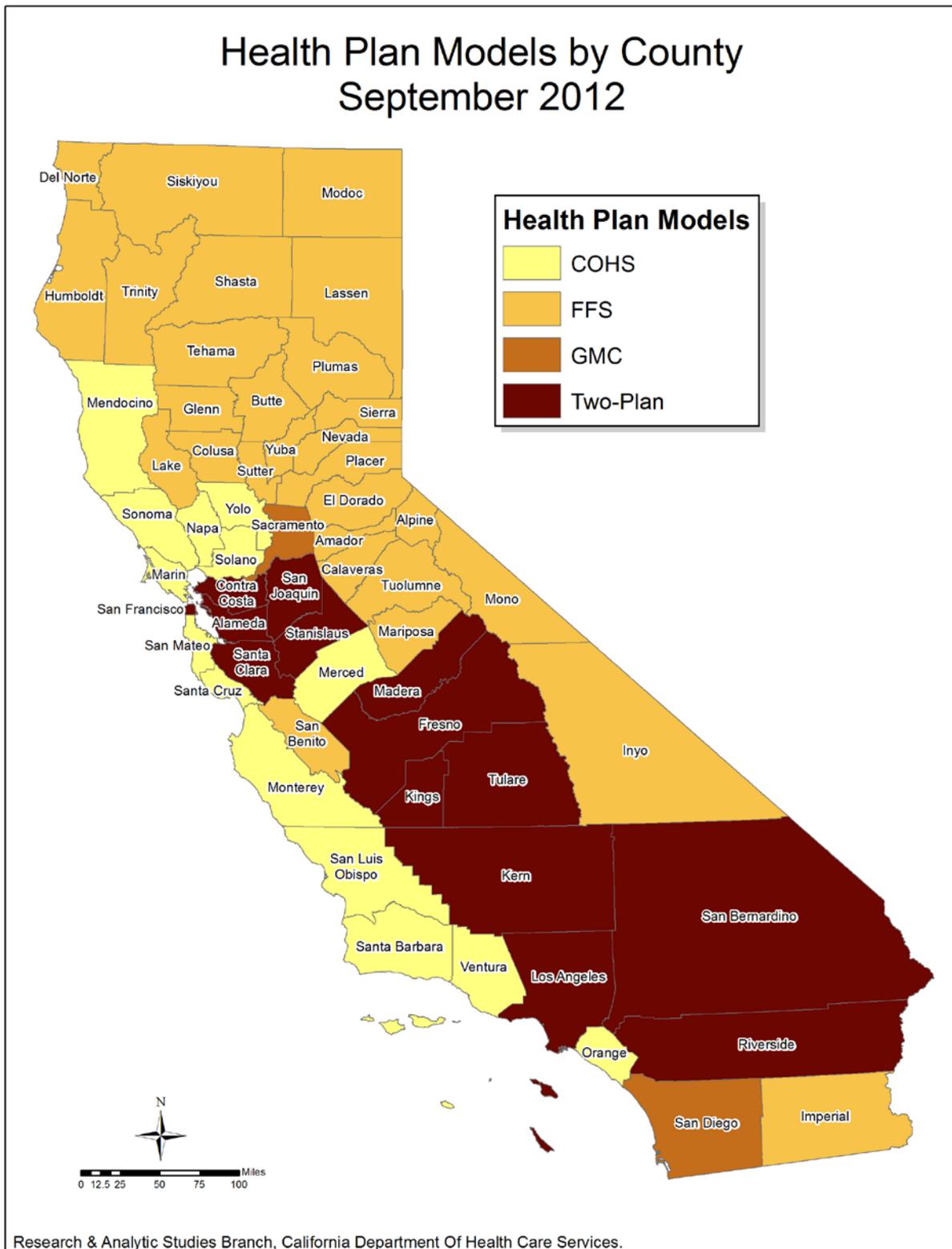
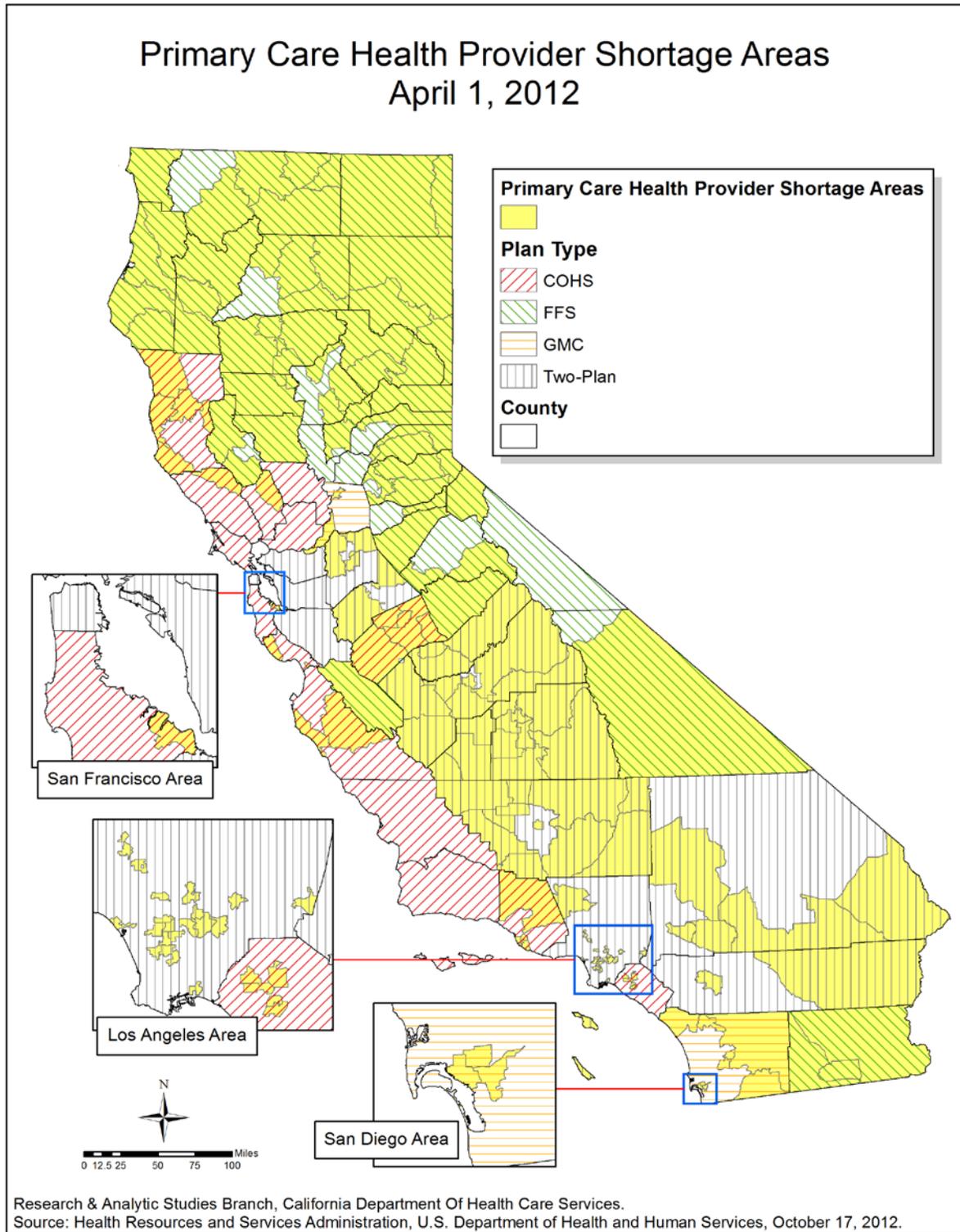


Figure PS-2 Primary Care Health Provider Shortage Areas, April 2012*



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

Number of Physicians

Table PS-2 presents site-specific counts of all enrolled physicians by county plan model type. Site-specific physician counts statewide increased from 104,659 to 106,335, or 1.6%.

Physician counts by Plan Type showed increases ranging from 0.5% for Fee-For-Service counties to 1.8% for Two-Plan counties. 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 29,192 in Los Angeles County (see Table PS-6 in the [Appendix](#) for county level detail). Figure PS-3 and Figure PS-4 show all enrolled physicians and the change in all enrolled physicians during the study period.

Site-specific physician counts statewide increased 1.6% from 104,659 to 106,335.

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

	Site-Specific Physician Counts				Percent Change In Number of Providers
	2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	
Statewide	104,659	105,608	106,373	106,335	1.6%
County Plan Model Type					
County Organized Health System (COHS)	19,598	19,742	19,885	19,854	1.3%
Fee-for-Service (FFS)	3,961	3,968	3,999	3,982	0.5%
Geographic Managed Care (GMC)	15,810	15,945	16,040	16,007	1.2%
Two-Plan (Commercial Plan and Local Initiative)	65,290	65,953	66,449	66,492	1.8%

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files October 2011–September 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 October 2011, January 2012, April 2012, and July 2012.

Figure PS-3 All Enrolled Physicians, by County, July 2012

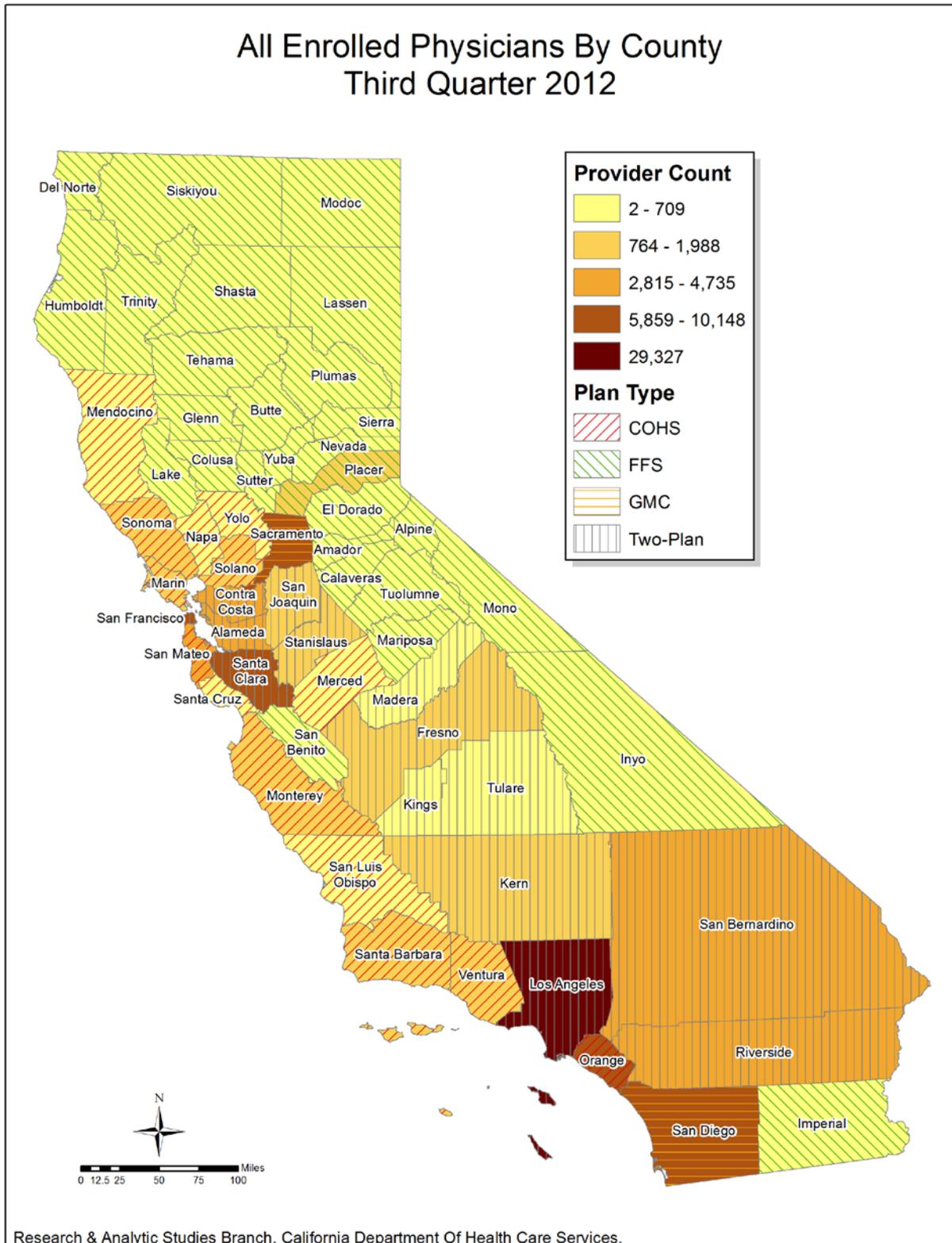
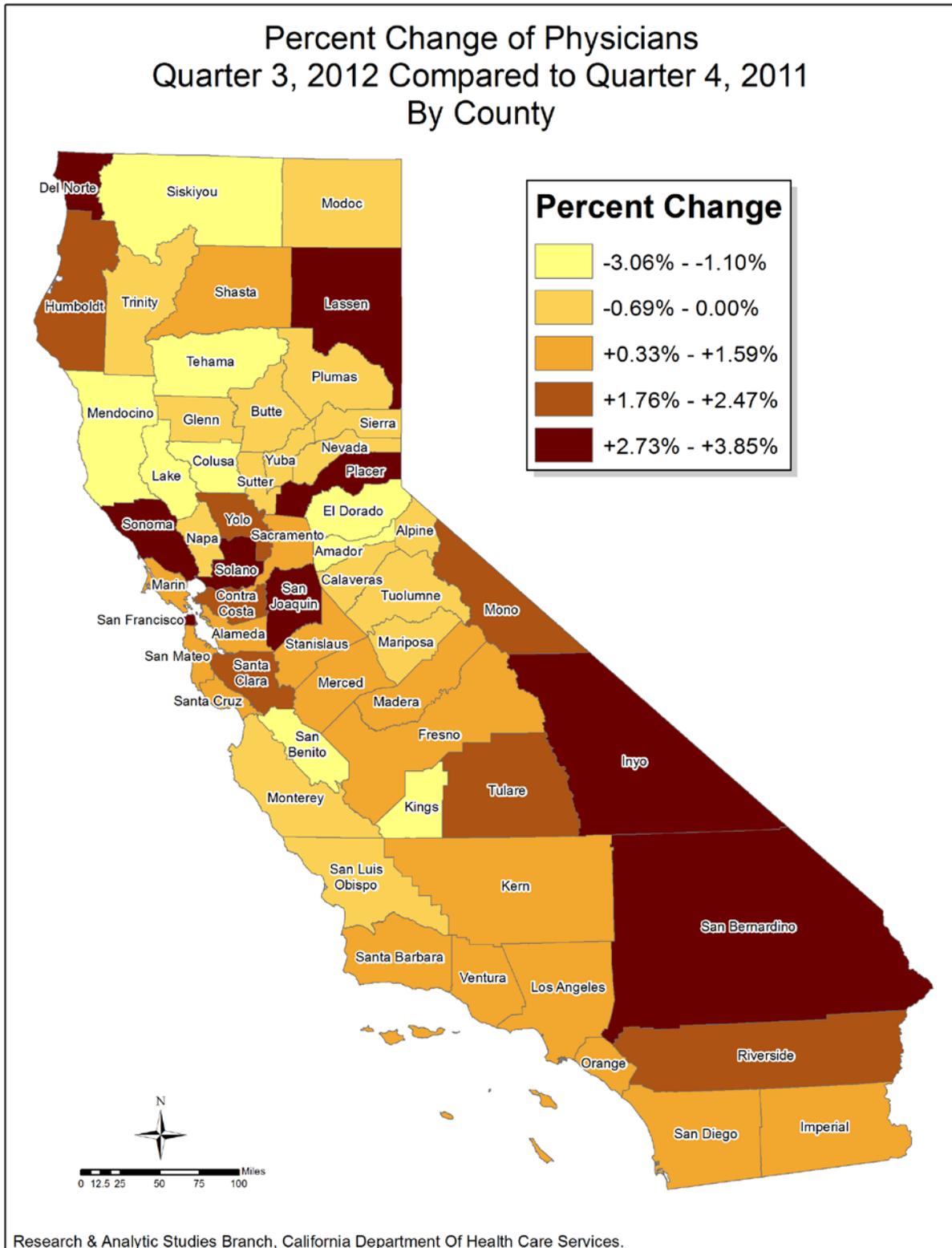


Figure PS-4 Change in All Enrolled Physicians, by County, Oct. 2011-Sept.2012



Primary Care Physicians

Table PS-3 includes site-specific counts of all enrolled primary care physicians by county and county plan model type. Statewide, primary care physician enrollment showed minor improvement from the fourth quarter of 2011 to the third quarter of 2012, increasing from 39,068 to 39,722, or 1.7%.

Physicians by Plan Type showed increases ranging from 0.8% for FFS counties to 1.9% for Two-Plan counties. Average counts ranged from one in Alpine County and fewer than 10 in Sierra, Trinity, and Glenn Counties (All such counties are primarily rural with small populations and offer only the FFS plan model) to 11,482.3 for Los Angeles County (see Table PS-7 in the [Appendix](#) for county level detail). It is important to note that, although there are counties with few 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-10 displays the total number of clinics by county available to serve Medi-Cal beneficiaries.

Statewide, site-specific primary care physician counts showed minor improvement from the fourth quarter of 2011 to the third quarter of 2012, increasing 1.7% from 39,068 to 39,722.

Table PS-3 Primary Care Physicians, All Enrolled Physician Sites, FFS, Full Scope, Medi-Cal Only

	Site-Specific Physician Counts				Percent Change In Number of Providers
	2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	
Statewide	39,068	39,426	39,747	39,722	1.7%
County Plan Model Type					
County Organized Health System (COHS)	7,369	7,425	7,503	7,488	1.6%
Fee-for-Service (FFS)	1,758	1,759	1,772	1,772	0.8%
Geographic Managed Care (GMC)	5,458	5,494	5,531	5,518	1.1%
Two-Plan (Commercial Plan and Local Initiative)	24,483	24,748	24,941	24,944	1.9%

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files October 2011–September 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 October 2011, January 2012, April 2012, and July 2012.

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

OB/GYN Physicians

Table PS-4 presents site-specific counts of all enrolled OB/GYN physicians. Statewide, OB/GYN physicians increased 0.7% from 6,188 to 6,233 during the study period.

Statewide, OB/GYN physician counts increased 0.7% from 6,188 to 6,233.

GMC counties showed no change over the four quarters. Other Plan Types showed increases from 0.7% for Two-Plan counties to 1.2% for COHS counties. Los Angeles County had an average of 1720 OB/GYNs enrolled in Medi-Cal (see Table PS-8 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. These counties have little or no OB/GYN physician presence according to California's Medical Board physician counts.

Low OB/GYN provider counts in some counties do not necessarily mean that beneficiaries have limited 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 these services to beneficiaries residing in communities where few OB/GYN specialists exist. Table PS-12 in the Appendix displays the total number of clinics by county available to serve Medi-Cal beneficiaries.

Table PS-4 Physician Supply, Physicians with an OB/GYN Specialty, FFS, Medi-Cal Only, Non-Elderly Adult Females

	Site-Specific Physician Counts				% Change In Number of Providers
	2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	
Statewide	6,188	6,244	6,281	6,233	0.7%
County Plan Model Type					
County Organized Health System (COHS)	1,244	1,258	1,265	1,259	1.2%
Fee-for-Service (FFS)	223	221	225	225	0.9%
Geographic Managed Care (GMC)	801	806	807	801	0.0%
Two-Plan (Commercial Plan and Local Initiative)	3,920	3,959	3,984	3,948	0.7%

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files October 2011–September 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 October 2011, January 2012, April 2012, and July 2012.

Pediatricians

Table PS-5 includes site-specific counts of all enrolled pediatric physicians by county plan model type. Enrollment increased statewide from 10,708 pediatricians in the fourth quarter of 2011 to 10,841 in the third quarter of 2012, for a 1.2% increase.

The number of pediatricians by Plan Type increased from 0.6% for GMC counties to 1.9% for FFS counties. Los Angeles County had the highest average number of pediatricians with 2,898 (see [Table PS-9](#) in the [Appendix](#) for county level detail). In 13 counties, there were fewer than ten 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 and other clinics, and general care physicians with a specialty other than pediatrics may render pediatric services in these communities. Table PS-10 in the [Appendix](#) displays the total number of clinics by county available to serve Medi-Cal beneficiaries.

Pediatrician counts increased 1.2% statewide from 10,708 to 10,841 pediatricians.

Table PS-5 Physician Supply, Physicians with a Pediatric Specialty, FFS, Full Scope, Medi-Cal Only Children

	Site-Specific Physician Counts				Percent Change In Number of Providers
	2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	
Statewide	10,708	10,779	10,862	10,841	1.2%
County Plan Model Type					
County Organized Health System (COHS)	1,877	1,883	1,897	1,899	1.2%
Fee-for-Service (FFS)	266	268	272	271	1.9%
Geographic Managed Care (GMC)	1,458	1,467	1,471	1,467	0.6%
Two-Plan (Commercial Plan and Local Initiative)	7,107	7,161	7,222	7,204	1.4%

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files October 2011–September 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 October 2011, January 2012, April 2012, and July 2012.

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 fourth quarter of 2011 to the third quarter of 2012. The findings indicate that the statewide supply of physicians potentially available to beneficiaries eligible for full scope Med-Cal only and participating in FFS continued to grow modestly.
2. Site-specific physician counts increased from 104,659 to 106,335, or 1.6%.
3. During the period under study, site-specific counts of physicians with a specialty (primary care, OB/GYN, pediatrics) grew modestly. Site-specific primary care physician counts increased 1.7%, from 39,068 to 39,722. Site-specific OB/GYN physician counts increased 0.7%, from 6,188 to 6,233. And, site-specific pediatrician counts increased 1.2%, from 10,708 to 10,841.

Appendix: Physician Supply by County

Table PS-6 Physician Supply, All Enrolled Physicians, by Plan Model Type and County

		Site-Specific Physician Counts					
		2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	Avg # of Physicians	Percent Change
Statewide		104,659	105,608	106,373	106,335	105,743.8	1.6%
County Plan Model Type							
County Organized Health System (COHS)		19,598	19,742	19,885	19,854	19,769.8	1.3%
Fee-for-Service (FFS)		3,961	3,968	3,999	3,982	3,977.5	0.5%
Geographic Managed Care (GMC)		15,810	15,945	16,040	16,007	15,950.5	1.2%
Two-Plan (Commercial Plan and Local Initiative)		65,290	65,953	66,449	66,492	66,046.0	1.8%
County							
Alameda	Two-Plan	4,661	4,695	4,730	4,735	4,705.3	1.6%
Alpine	FFS	2	2	2	2	2.0	0.0%
Amador	FFS	54	54	54	53	53.8	-1.9%
Butte	FFS	502	503	505	502	503.0	0.0%
Calaveras	FFS	48	48	47	48	47.8	0.0%
Colusa	FFS	40	39	39	39	39.3	-2.5%
Contra Costa	Two-Plan	2,831	2,864	2,892	2,901	2,872.0	2.5%
Del Norte	FFS	52	52	52	54	52.5	3.8%
El Dorado	FFS	273	273	274	265	271.3	-2.9%
Fresno	Two-Plan	1,965	1,982	1,999	1,988	1,983.5	1.2%
Glenn	FFS	21	21	21	21	21.0	0.0%
Humboldt	FFS	398	400	404	405	401.8	1.8%
Imperial	FFS	201	201	211	202	203.8	0.5%
Inyo	FFS	35	35	34	36	35.0	2.9%
Kern	Two-Plan	1,728	1,736	1,746	1,749	1,739.8	1.2%
Kings	Two-Plan	182	181	181	180	181.0	-1.1%
Lake	FFS	113	113	112	111	112.3	-1.8%
Lassen	FFS	28	30	29	29	29.0	3.6%
Los Angeles	Two-Plan	28,905	29,158	29,377	29,327	29,191.8	1.5%
Madera	Two-Plan	286	287	292	290	288.8	1.4%
Marin *	COHS	756	760	762	764	760.5	1.1%
Mariposa	FFS	19	19	18	19	18.8	0.0%
Mendocino *	COHS	198	197	197	194	196.5	-2.0%
Merced	COHS	364	364	367	368	365.8	1.1%
Modoc	FFS	14	14	14	14	14.0	0.0%

		Site-Specific Physician Counts					
		2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	Avg # of Physicians	Percent Change
Mono	FFS	41	41	41	42	41.3	2.4%
Monterey	COHS	872	875	877	866	872.5	-0.7%
Napa	COHS	361	359	360	361	360.3	0.0%
Nevada	FFS	187	187	189	187	187.5	0.0%
Orange	COHS	7,788	7,851	7,909	7,889	7,859.3	1.3%
Placer	FFS	747	752	765	768	758.0	2.8%
Plumas	FFS	33	33	33	33	33.0	0.0%
Riverside	Two-Plan	2,841	2,884	2,916	2,899	2,885.0	2.0%
Sacramento	GMC	5,795	5,839	5,875	5,859	5,842.0	1.1%
San Benito	FFS	62	61	61	61	61.3	-1.6%
San Bernardino	Two-Plan	4,498	4,596	4,619	4,631	4,586.0	3.0%
San Diego	GMC	10,015	10,106	10,165	10,148	10,108.5	1.3%
San Francisco	Two-Plan	6,442	6,503	6,547	6,622	6,528.5	2.8%
San Joaquin	Two-Plan	1,465	1,485	1,497	1,505	1,488.0	2.7%
San Luis Obispo	COHS	465	465	469	465	466.0	0.0%
San Mateo	COHS	2,774	2,788	2,813	2,815	2,797.5	1.5%
Santa Barbara	COHS	1,101	1,108	1,106	1,111	1,106.5	0.9%
Santa Clara	Two-Plan	7,522	7,597	7,651	7,668	7,609.5	1.9%
Santa Cruz	COHS	611	613	617	613	613.5	0.3%
Shasta	FFS	473	477	477	477	476.0	0.8%
Sierra	FFS	5	5	5	5	5.0	0.0%
Siskiyou	FFS	83	82	82	82	82.3	-1.2%
Solano	COHS	1,291	1,321	1,338	1,333	1,320.8	3.3%
Sonoma	COHS	1,135	1,145	1,157	1,166	1,150.8	2.7%
Stanislaus	Two-Plan	1,271	1,282	1,291	1,288	1,283.0	1.3%
Sutter	FFS	161	159	163	161	161.0	0.0%
Tehama	FFS	98	98	98	95	97.3	-3.1%
Trinity	FFS	12	12	12	12	12.0	0.0%
Tulare	Two-Plan	693	703	711	709	704.0	2.3%
Tuolumne	FFS	99	97	98	99	98.3	0.0%
Ventura *	COHS	1,421	1,426	1,441	1,438	1,431.5	1.2%
Yolo	COHS	461	470	472	471	468.5	2.2%
Yuba	FFS	160	160	159	160	159.8	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 October 2011, January 2012, April 2012, and July 2012.

Table PS-7 Primary Care Physician Supply, All Enrolled Physicians, by Plan Model Type and County

		Number of Providers					
		2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	Avg # of Providers	Percent Change
Statewide		39,068	39,426	39,747	39,722	39,490.8	1.7%
County Plan Model Type							
County Organized Health System (COHS)		7,369	7,425	7,503	7,488	7,446.3	1.6%
Fee-for-Service (FFS)		1,758	1,759	1,772	1,772	1,765.3	0.8%
Geographic Managed Care (GMC)		5,458	5,494	5,531	5,518	5,500.3	1.1%
Two-Plan (Commercial Plan and Local Initiative)		24,483	24,748	24,941	24,944	24,779.0	1.9%
County							
Alameda	Two-Plan	1,639	1,651	1,668	1,667	1,656.3	1.7%
Alpine	FFS	1	1	1	1	1.0	0.0%
Amador	FFS	33	33	32	31	32.3	-6.1%
Butte	FFS	190	190	193	191	191.0	0.5%
Calaveras	FFS	25	25	24	25	24.8	0.0%
Colusa	FFS	30	30	30	30	30.0	0.0%
Contra Costa	Two-Plan	1,100	1,109	1,125	1,132	1,116.5	2.9%
Del Norte	FFS	26	26	26	27	26.3	3.8%
El Dorado	FFS	103	103	103	104	103.3	1.0%
Fresno	Two-Plan	738	749	757	757	750.3	2.6%
Glenn	FFS	9	9	9	9	9.0	0.0%
Humboldt	FFS	184	184	185	185	184.5	0.5%
Imperial	FFS	63	65	70	68	66.5	7.9%
Inyo	FFS	18	18	18	18	18.0	0.0%
Kern	Two-Plan	701	704	709	709	705.8	1.1%
Kings	Two-Plan	83	82	82	81	82.0	-2.4%
Lake	FFS	48	48	48	48	48.0	0.0%
Lassen	FFS	14	15	15	15	14.8	7.1%
Los Angeles	Two-Plan	11,363	11,476	11,567	11,523	11,482.3	1.4%
Madera	Two-Plan	65	65	64	65	64.8	0.0%
Marin *	COHS	310	309	315	315	312.3	1.6%
Mariposa	FFS	12	12	11	12	11.8	0.0%
Mendocino *	COHS	71	71	71	71	71.0	0.0%
Merced	COHS	166	167	169	169	167.8	1.8%
Modoc	FFS	11	11	11	11	11.0	0.0%
Mono	FFS	19	19	19	19	19.0	0.0%
Monterey	COHS	339	339	343	343	341.0	1.2%
Napa	COHS	112	110	111	112	111.3	0.0%

		Number of Providers					
		2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	Avg # of Providers	Percent Change
Nevada	FFS	88	88	88	87	87.8	-1.1%
Orange	COHS	2,717	2,743	2,766	2,745	2,742.8	1.0%
Placer	FFS	352	353	359	359	355.8	2.0%
Plumas	FFS	25	25	25	25	25.0	0.0%
Riverside	Two-Plan	1,198	1,218	1,237	1,232	1,221.3	2.8%
Sacramento	GMC	1,975	1,986	1,997	1,991	1,987.3	0.8%
San Benito	FFS	24	23	23	24	23.5	0.0%
San Bernardino	Two-Plan	1,878	1,913	1,927	1,936	1,913.5	3.1%
San Diego	GMC	3,483	3,508	3,534	3,527	3,513.0	1.3%
San Francisco	Two-Plan	2,019	2,040	2,050	2,078	2,046.8	2.9%
San Joaquin	Two-Plan	556	562	563	567	562.0	2.0%
San Luis Obispo	COHS	165	165	167	165	165.5	0.0%
San Mateo	COHS	983	992	1,006	1,011	998.0	2.8%
Santa Barbara	COHS	356	356	356	357	356.3	0.3%
Santa Clara	Two-Plan	2,355	2,383	2,394	2,398	2,382.5	1.8%
Santa Cruz	COHS	242	243	246	247	244.5	2.1%
Shasta	FFS	205	205	206	205	205.3	0.0%
Sierra	FFS	5	5	5	5	5.0	0.0%
Siskiyou	FFS	39	38	39	39	38.8	0.0%
Solano	COHS	542	556	565	563	556.5	3.9%
Sonoma	COHS	498	499	502	505	501.0	1.4%
Stanislaus	Two-Plan	530	536	537	538	535.3	1.5%
Sutter	FFS	79	79	78	78	78.5	-1.3%
Tehama	FFS	48	48	48	48	48.0	0.0%
Trinity	FFS	5	5	5	5	5.0	0.0%
Tulare	Two-Plan	258	260	261	261	260.0	1.2%
Tuolumne	FFS	42	40	41	42	41.3	0.0%
Ventura *	COHS	649	650	660	658	654.3	1.4%
Yolo	COHS	219	225	226	227	224.3	3.7%
Yuba	FFS	60	61	60	61	60.5	1.7%

*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 October 2011–September 2012 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of October 2011, January 2012, April 2012, and July 2011

Table PS-8 Physician Supply, Physicians with an OB/GYN Specialty, by Plan Model Type and County

		Site-Specific Physician Counts					
		2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	Avg # of Providers	Percent Change
Statewide		6,188	6,244	6,281	6,233	6,236.5	0.7%
County Plan Model Type							
County Organized Health System (COHS)		1,244	1,258	1,265	1,259	1,256.5	1.2%
Fee-for-Service (FFS)		223	221	225	225	223.5	0.9%
Geographic Managed Care (GMC)		801	806	807	801	803.8	0.0%
Two-Plan (Commercial Plan and Local Initiative)		3,920	3,959	3,984	3,948	3,952.8	0.7%
County							
Alameda	Two-Plan	291	294	296	298	294.8	2.4%
Alpine	FFS	-	-	-	-	-	-
Amador	FFS	5	5	5	5	5.0	0.0%
Butte	FFS	32	32	34	35	33.3	9.4%
Calaveras	FFS	1	1	1	1	1.0	0.0%
Colusa	FFS	1	1	1	1	1.0	0.0%
Contra Costa	Two-Plan	147	150	151	151	149.8	2.7%
Del Norte	FFS	3	3	3	2	2.8	-33.3%
El Dorado	FFS	15	15	15	15	15.0	0.0%
Fresno	Two-Plan	126	125	127	122	125.0	-3.2%
Glenn	FFS	1	1	1	1	1.0	0.0%
Humboldt	FFS	18	18	18	18	18.0	0.0%
Imperial	FFS	17	17	17	16	16.8	-5.9%
Inyo	FFS	2	2	2	3	2.3	50.0%
Kern	Two-Plan	100	100	99	101	100.0	1.0%
Kings	Two-Plan	10	9	9	9	9.3	-10.0%
Lake	FFS	4	4	4	4	4.0	0.0%
Lassen	FFS	1	1	1	1	1.0	0.0%
Los Angeles	Two-Plan	1,715	1,727	1,733	1,703	1,719.5	-0.7%
Madera	Two-Plan	15	15	15	15	15.0	0.0%
Marin *	COHS	32	32	32	32	32.0	0.0%
Mariposa	FFS	-	-	-	-	-	-
Mendocino *	COHS	21	21	21	20	20.8	-4.8%
Merced	COHS	22	22	22	22	22.0	0.0%
Modoc	FFS	1	1	1	1	1.0	0.0%

		Site-Specific Physician Counts					
		2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	Avg # of Providers	Percent Change
Mono	FFS	1	1	1	1	1.0	0.0%
Monterey	COHS	71	71	71	71	71.0	0.0%
Napa	COHS	17	17	17	17	17.0	0.0%
Nevada	FFS	13	13	13	13	13.0	0.0%
Orange	COHS	558	564	570	564	564.0	1.1%
Placer	FFS	52	52	52	52	52.0	0.0%
Plumas	FFS	1	1	1	1	1.0	0.0%
Riverside	Two-Plan	190	194	195	191	192.5	0.5%
Sacramento	GMC	289	290	291	291	290.3	0.7%
San Benito	FFS	4	4	4	4	4.0	0.0%
San Bernardino	Two-Plan	239	247	250	248	246.0	3.8%
San Diego	GMC	512	516	516	510	513.5	-0.4%
San Francisco	Two-Plan	340	341	340	343	341.0	0.9%
San Joaquin	Two-Plan	113	116	117	117	115.8	3.5%
San Luis Obispo	COHS	29	30	30	29	29.5	0.0%
San Mateo	COHS	122	123	123	123	122.8	0.8%
Santa Barbara	COHS	72	72	73	73	72.5	1.4%
Santa Clara	Two-Plan	491	496	504	505	499.0	2.9%
Santa Cruz	COHS	40	41	40	41	40.5	2.5%
Shasta	FFS	17	17	17	17	17.0	0.0%
Sierra	FFS	-	-	-	-	-	-
Siskiyou	FFS	4	3	4	4	3.8	0.0%
Solano	COHS	77	80	79	78	78.5	1.3%
Sonoma	COHS	61	62	63	65	62.8	6.6%
Stanislaus	Two-Plan	69	70	73	70	70.5	1.4%
Sutter	FFS	14	13	14	14	13.8	0.0%
Tehama	FFS	5	5	5	5	5.0	0.0%
Trinity	FFS	-	-	-	-	-	-
Tulare	Two-Plan	74	75	75	75	74.8	1.4%
Tuolumne	FFS	7	7	7	7	7.0	0.0%
Ventura *	COHS	94	95	96	96	95.3	2.1%
Yolo	COHS	28	28	28	28	28.0	0.0%
Yuba	FFS	4	4	4	4	4.0	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 October 2011–September 2012 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of October 2011, January 2012, April 2012, and July 2012.

Table PS-9 Physician Supply, Physicians with a Pediatric Specialty, by Plan Model Type and County

		Number of Providers					
		2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	Avg # of Providers	Percent Change
Statewide		10,708	10,779	10,862	10,841	10,797.5	1.2%
County Plan Model Type							
County Organized Health System (COHS)		1,877	1,883	1,897	1,899	1,889.0	1.2%
Fee-for-Service (FFS)		266	268	272	271	269.3	1.9%
Geographic Managed Care (GMC)		1,458	1,467	1,471	1,467	1,465.8	0.6%
Two-Plan (Commercial Plan and Local Initiative)		7,107	7,161	7,222	7,204	7,173.5	1.4%
County							
Alameda	Two-Plan	722	730	733	736	730.3	1.9%
Alpine	FFS	-	-	-	-	-	-
Amador	FFS	2	2	2	2	2.0	0.0%
Butte	FFS	24	24	23	22	23.3	-8.3%
Calaveras	FFS	2	2	2	2	2.0	0.0%
Colusa	FFS	-	-	-	-	-	-
Contra Costa	Two-Plan	239	238	242	242	240.3	1.3%
Del Norte	FFS	5	5	5	5	5.0	0.0%
El Dorado	FFS	17	17	17	17	17.0	0.0%
Fresno	Two-Plan	178	178	180	177	178.3	-0.6%
Glenn	FFS	2	2	2	2	2.0	0.0%
Humboldt	FFS	17	17	17	17	17.0	0.0%
Imperial	FFS	19	19	20	19	19.3	0.0%
Inyo	FFS	5	5	5	5	5.0	0.0%
Kern	Two-Plan	143	141	141	140	141.3	-2.1%
Kings	Two-Plan	11	11	11	11	11.0	0.0%
Lake	FFS	5	5	5	5	5.0	0.0%
Lassen	FFS	2	2	2	2	2.0	0.0%
Los Angeles	Two-Plan	2,874	2,900	2,920	2,899	2,898.3	0.9%
Madera	Two-Plan	146	145	150	148	147.3	1.4%
Marin *	COHS	70	70	70	71	70.3	1.4%
Mariposa	FFS	-	-	-	-	-	-
Mendocino *	COHS	15	15	15	15	15.0	0.0%
Merced	COHS	24	24	24	24	24.0	0.0%
Modoc	FFS	-	-	-	-	-	-

		Number of Providers					
		2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	Avg # of Providers	Percent Change
Mono	FFS	5	5	5	6	5.3	20.0%
Monterey	COHS	85	85	86	86	85.5	1.2%
Napa	COHS	22	22	22	22	22.0	0.0%
Nevada	FFS	11	11	11	11	11.0	0.0%
Orange	COHS	867	868	872	874	870.3	0.8%
Placer	FFS	87	89	92	93	90.3	6.9%
Plumas	FFS	-	-	-	-	-	-
Riverside	Two-Plan	221	225	226	221	223.3	0.0%
Sacramento	GMC	524	527	525	522	524.5	-0.4%
San Benito	FFS	3	3	3	3	3.0	0.0%
San Bernardino	Two-Plan	508	514	516	516	513.5	1.6%
San Diego	GMC	934	940	946	945	941.3	1.2%
San Francisco	Two-Plan	682	687	694	703	691.5	3.1%
San Joaquin	Two-Plan	124	123	130	131	127.0	5.6%
San Luis Obispo	COHS	50	49	49	47	48.8	-6.0%
San Mateo	COHS	266	266	267	267	266.5	0.4%
Santa Barbara	COHS	94	94	94	94	94.0	0.0%
Santa Clara	Two-Plan	1,101	1,108	1,118	1,116	1,110.8	1.4%
Santa Cruz	COHS	45	46	47	46	46.0	2.2%
Shasta	FFS	19	19	19	19	19.0	0.0%
Sierra	FFS	-	-	-	-	-	-
Siskiyou	FFS	3	3	3	3	3.0	0.0%
Solano	COHS	119	119	121	122	120.3	2.5%
Sonoma	COHS	67	69	73	74	70.8	10.4%
Stanislaus	Two-Plan	82	83	83	85	83.3	3.7%
Sutter	FFS	11	11	12	12	11.5	9.1%
Tehama	FFS	10	10	10	9	9.8	-10.0%
Trinity	FFS	-	-	-	-	-	-
Tulare	Two-Plan	76	78	78	79	77.8	3.9%
Tuolumne	FFS	10	10	10	10	10.0	0.0%
Ventura *	COHS	114	116	116	117	115.8	2.6%
Yolo	COHS	39	40	41	40	40.0	2.6%
Yuba	FFS	7	7	7	7	7.0	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 October 2011, January 2012, April 2012, and July 2012.

Table PS-10 Outpatient Rural and FQHC Clinics

		Number of Rural/FQHC Clinics					
		2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	Avg # of Clinics	Percent Change
Statewide		959	957	983	960	964.8	0.1%
County Plan Model Type							
County Organized Health System (COHS)		186	187	195	184	188.0	-1.1%
Fee-for-Service (FFS)		196	197	201	196	197.5	0.0%
Geographic Managed Care (GMC)		80	80	83	79	80.5	-1.3%
Two-Plan (Commercial Plan and Local Initiative)		497	493	504	501	498.8	0.8%
County							
Alameda	Two-Plan	38	39	39	38	38.5	0.0%
Alpine	FFS	1	1	1	1	1.0	0.0%
Amador	FFS	4	4	4	5	4.3	25.0%
Butte	FFS	18	18	19	17	18.0	-5.6%
Calaveras	FFS	7	7	7	7	7.0	0.0%
Colusa	FFS	4	4	5	5	4.5	25.0%
Contra Costa	Two-Plan	16	16	16	16	16.0	0.0%
Del Norte	FFS	4	4	4	4	4.0	0.0%
El Dorado	FFS	6	6	6	6	6.0	0.0%
Fresno	Two-Plan	65	58	59	57	59.8	-12.3%
Glenn	FFS	12	12	13	12	12.3	0.0%
Humboldt	FFS	30	30	30	30	30.0	0.0%
Imperial	FFS	10	10	10	10	10.0	0.0%
Inyo	FFS	6	6	6	6	6.0	0.0%
Kern	Two-Plan	34	35	38	37	36.0	8.8%
Kings	Two-Plan	18	19	18	18	18.3	0.0%
Lake	FFS	10	10	11	10	10.3	0.0%
Lassen	FFS	6	5	5	5	5.3	-16.7%
Los Angeles	Two-Plan	146	147	148	153	148.5	4.8%
Madera	Two-Plan	12	12	12	12	12.0	0.0%
Marin *	COHS	5	5	8	8	6.5	60.0%
Mariposa	FFS	4	4	4	4	4.0	0.0%
Mendocino *	COHS	23	23	24	24	23.5	4.3%
Merced	COHS	26	26	27	22	25.3	-15.4%
Modoc	FFS	4	4	4	4	4.0	0.0%

		Number of Rural/FQHC Clinics					
		2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	Avg # of Clinics	Percent Change
Mono	FFS	1	1	1	1	1.0	0.0%
Monterey	COHS	21	21	21	21	21.0	0.0%
Napa	COHS	2	2	2	1	1.8	-50.0%
Nevada	FFS	2	2	2	2	2.0	0.0%
Orange	COHS	15	15	15	12	14.3	-20.0%
Placer	FFS	3	3	3	3	3.0	0.0%
Plumas	FFS	6	6	6	6	6.0	0.0%
Riverside	Two-Plan	23	23	23	23	23.0	0.0%
Sacramento	GMC	9	9	9	8	8.8	-11.1%
San Benito	FFS	3	3	3	3	3.0	0.0%
San Bernardino	Two-Plan	13	12	14	14	13.3	7.7%
San Diego	GMC	71	71	74	71	71.8	0.0%
San Francisco	Two-Plan	30	30	32	30	30.5	0.0%
San Joaquin	Two-Plan	8	8	8	8	8.0	0.0%
San Luis Obispo	COHS	12	12	12	12	12.0	0.0%
San Mateo	COHS	16	16	17	15	16.0	-6.3%
Santa Barbara	COHS	17	17	17	18	17.3	5.9%
Santa Clara	Two-Plan	22	22	24	23	22.8	4.5%
Santa Cruz	COHS	8	8	8	8	8.0	0.0%
Shasta	FFS	16	16	16	16	16.0	0.0%
Sierra	FFS	2	2	2	2	2.0	0.0%
Siskiyou	FFS	12	12	12	12	12.0	0.0%
Solano	COHS	8	8	8	8	8.0	0.0%
Sonoma	COHS	15	16	16	16	15.8	6.7%
Stanislaus	Two-Plan	26	26	26	25	25.8	-3.8%
Sutter	FFS	4	4	4	4	4.0	0.0%
Tehama	FFS	8	8	8	7	7.8	-12.5%
Trinity	FFS	2	3	3	3	2.8	50.0%
Tulare	Two-Plan	46	46	47	47	46.5	2.2%
Tuolumne	FFS	4	4	4	4	4.0	0.0%
Ventura *	COHS	12	12	14	13	12.8	8.3%
Yolo	COHS	6	6	6	6	6.0	0.0%
Yuba	FFS	7	8	8	7	7.5	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 October 2011–September 2012 (reflecting a 4-month reporting lag) and data from the Medi-Cal Provider Master File, for the months of October 2011, January 2012, April 2012, and July 2012.



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



BENEFICIARY PARTICIPATION

May 2013

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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 Supplemental Security Income (SSI) 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 coverage afforded. For example, approximately 80% of the

Highlights

FFS participation for full scope beneficiaries declined 8.6% from 1,251,960 to 1,143,773. This is primarily the result of Departmental policies that shifted several beneficiary subgroups into managed care plans.

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

Two largest increases in FFS participation occurred among children in Foster Care (12.7%) and Adults in the Other category (9.8%).

Spanish is primary language for 49.1% and 47.1% reported English.

Hispanics represent 62.8% of the total FFS Medi-Cal Only population.

beneficiaries participating in Medi-Cal's traditional FFS system and not eligible for Medicare are 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 exclude 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, regarding 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 beneficiaries receive 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 fourth quarter of 2011 to the third quarter of 2012. Additional comparisons were made between the current quarter being studied and 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

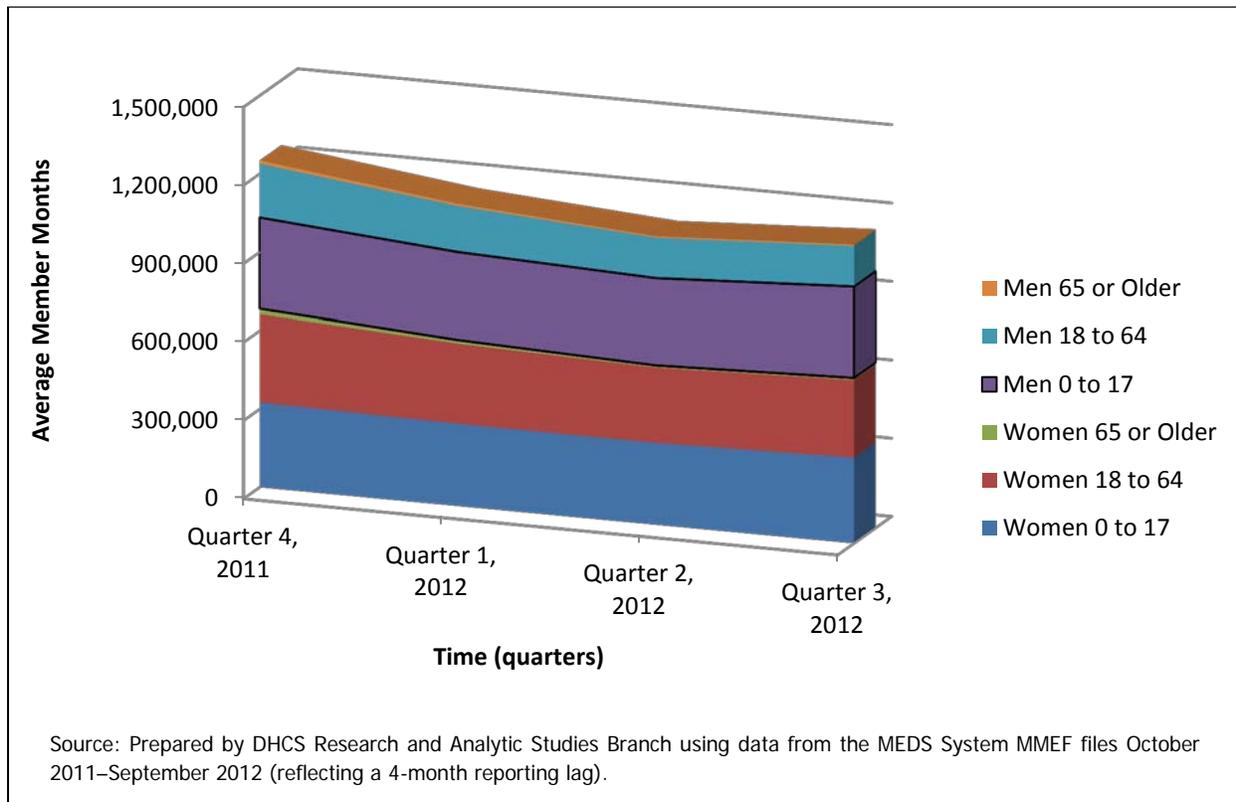
Medi-Cal Full Scope Beneficiaries by Gender and Age

Participation in the FFS health care delivery system for Medi-Cal beneficiaries who were eligible for full scope services decreased during the 12-month period, from 1,251,960 to 1,143,775, or 8.6% (see Table BP-5). However, children's participation remained relatively unchanged from the fourth quarter of 2011 to the third quarter of 2012.

Overall FFS participation for full scope beneficiaries declined 8.6% from October 2011–September 2012.

FFS program participation decreased steadily from the fourth quarter of 2011 to the third quarter of 2012. However, in the last quarter there was a small increase in FFS participation of 3.6% from the previous quarter. This increase in participation occurred among children and adults under age 65. For people age 65 and older, FFS participation continued to decrease during the last quarter, but at a much smaller rate (1.4%) than was observed when comparing the most distant quarters (61.0%) (see Table BP-5).

Figure BP-2 Quarterly Average Member Months for Full Scope FFS Beneficiaries, by Gender and Age Group, Quarter 4, 2011–Quarter 3, 2012

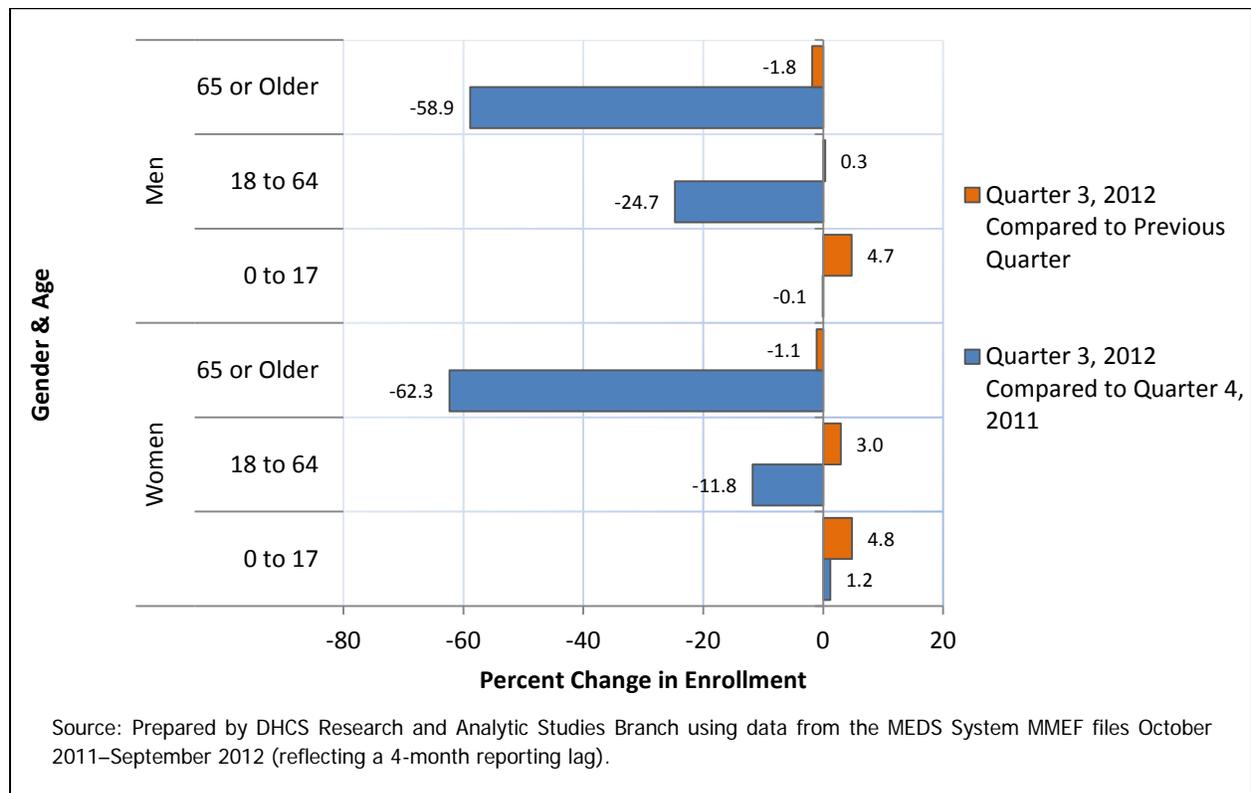


In Figure BP-3, the largest decrease in FFS participation from the fourth quarter of 2011 to the third quarter of 2012 was among females age 65 years and older (62.3%) and males age 65 and older (58.9%). Among young adults age 18–64, males experienced a larger decrease (24.7%) in FFS participation than women (11.8%) across this same 12-month study period.

Among adults age 18–64, FFS participation decreased more for males (24.7%) than females (11.8%).

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 only slight decreases in FFS participation during the 12-month study period (0.1% for males and 1.2% for females).

Figure BP-3 Change in FFS Participation among Full Scope Beneficiaries, by Gender and Age, Quarter 4, 2011–Quarter 3, 2012



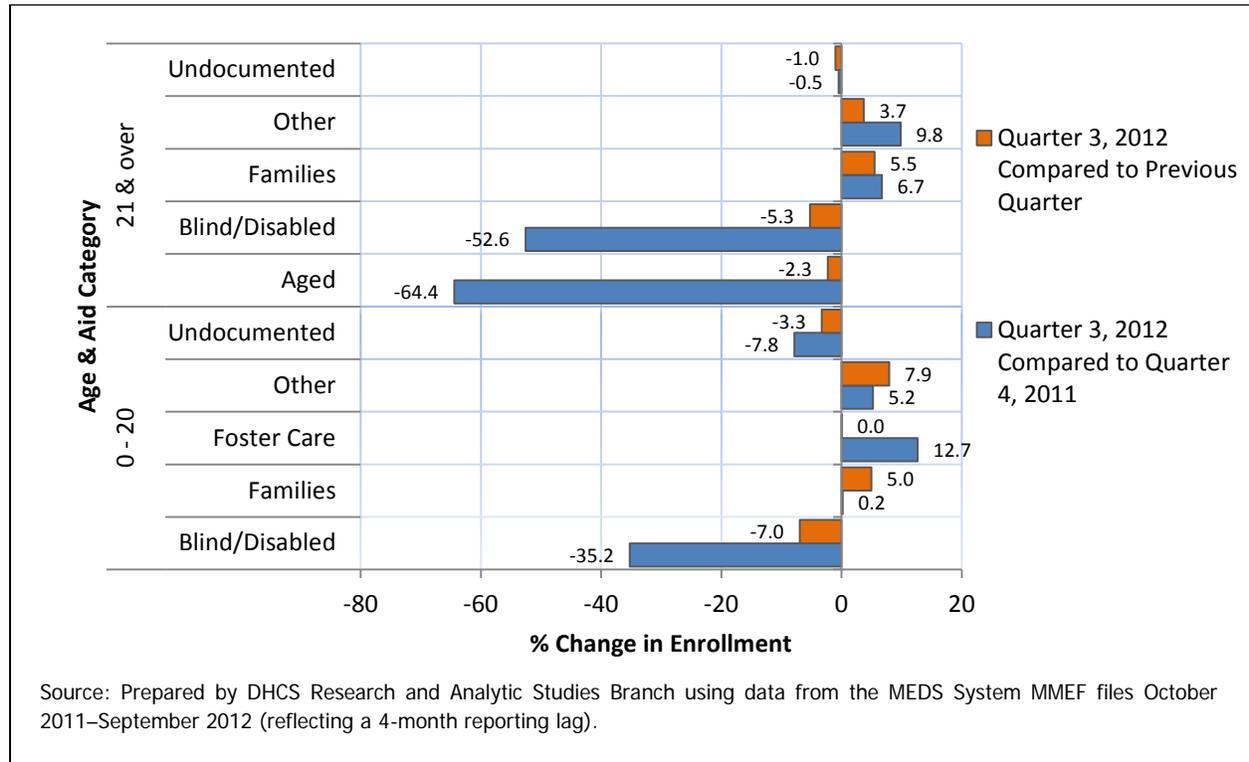
Aid Category and Age

Table BP-7 displays the change in FFS participation for beneficiaries eligible for Medi-Cal only by age and aid category. When comparing participation changes from the fourth quarter of 2011 to the third quarter of 2012 among adults, there was a decline in FFS participation in the Blind/Disabled and Aged aid categories, and for children declines in FFS participation were observed among the Blind/Disabled and Undocumented aid categories.

The largest declines in FFS participation in this reporting period occurred for beneficiaries in the Aged aid category (64.4%) and Blind/Disabled adults (52.6%). By contrast, FFS participation increased in the Foster Care, Other, and Families aid categories.

The largest declines in FFS participation occurred for adult beneficiaries in the Aged (64.4%) and Blind/Disabled (52.6%) aid categories.

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



Evaluating FFS participation across the last two quarters in the study period revealed a continuous but modest decline in the Blind/Disabled, Aged, and Undocumented aid categories. This decline ranged from 7.0% in Blind/Disabled children to 1.0% in Undocumented adults. During the last two quarters of the study period, FFS participation increased, regardless of age, in the Families and Other aid categories.

The drop in FFS participation among the Aged and Blind/Disabled populations reflects the implementation of the Bridge to Reform Waiver in 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, with only modest declines observed for during the most recent quarter studied.

FFS participation for beneficiaries in Foster Care aid codes increased 12.7% from October 2011–September 2012.

FFS participation for beneficiaries enrolled in Foster Care aid codes increased 12.7% from the fourth quarter of 2011 to the third 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 program conditions are met.

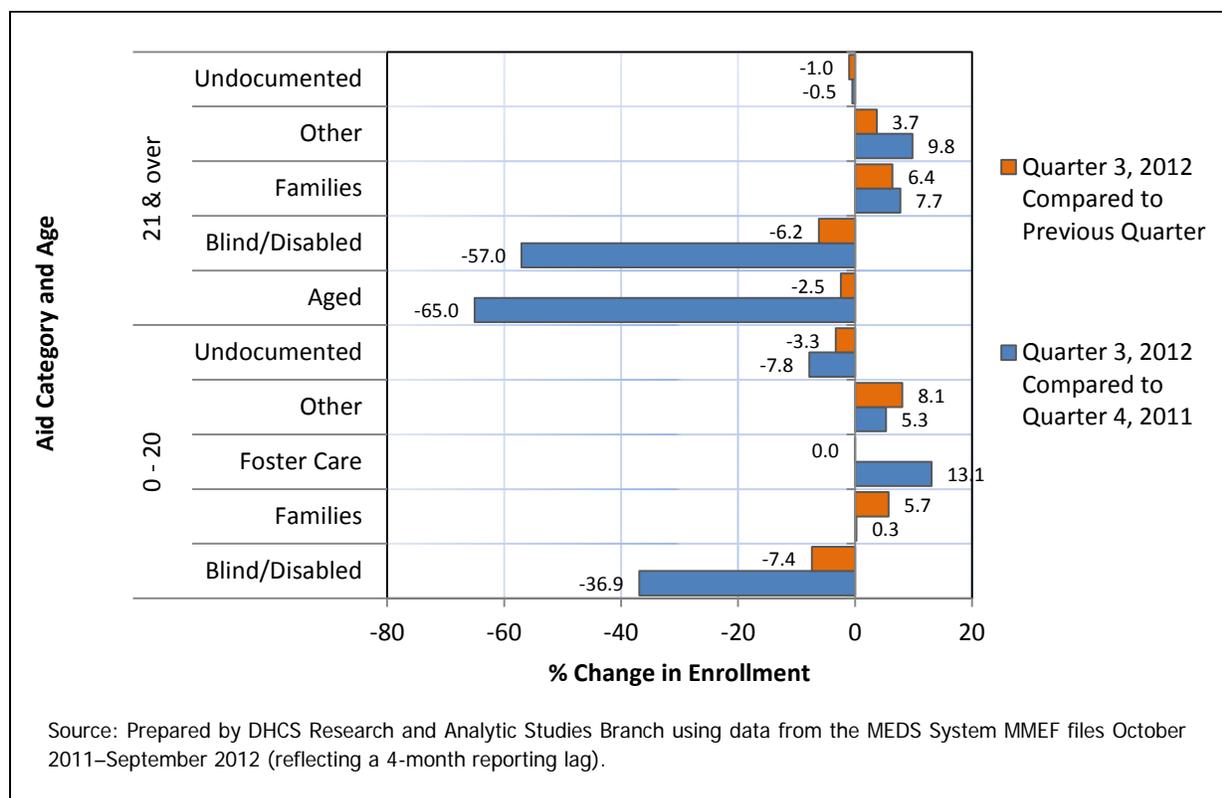
Participation by adults in FFS under the Other aid category rose by 9.8% during the reporting period. The Other aid category represents a variety of aid codes, including Refugee Assistance, Long-Term Care, and Breast and Cervical Cancer Treatment Program. DHCS hypothesizes that the increase in FFS participation 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 from the fourth quarter of 2011 to the third quarter of 2012 among beneficiaries residing in metropolitan counties (6.5%), remaining virtually unchanged in non-metropolitan counties (0.1%) (see [Table BP-8](#) and [Table BP-9](#) in [Appendix A](#)). However, FFS participation differed substantially among the different subpopulations evaluated in both metropolitan and non-metropolitan counties.

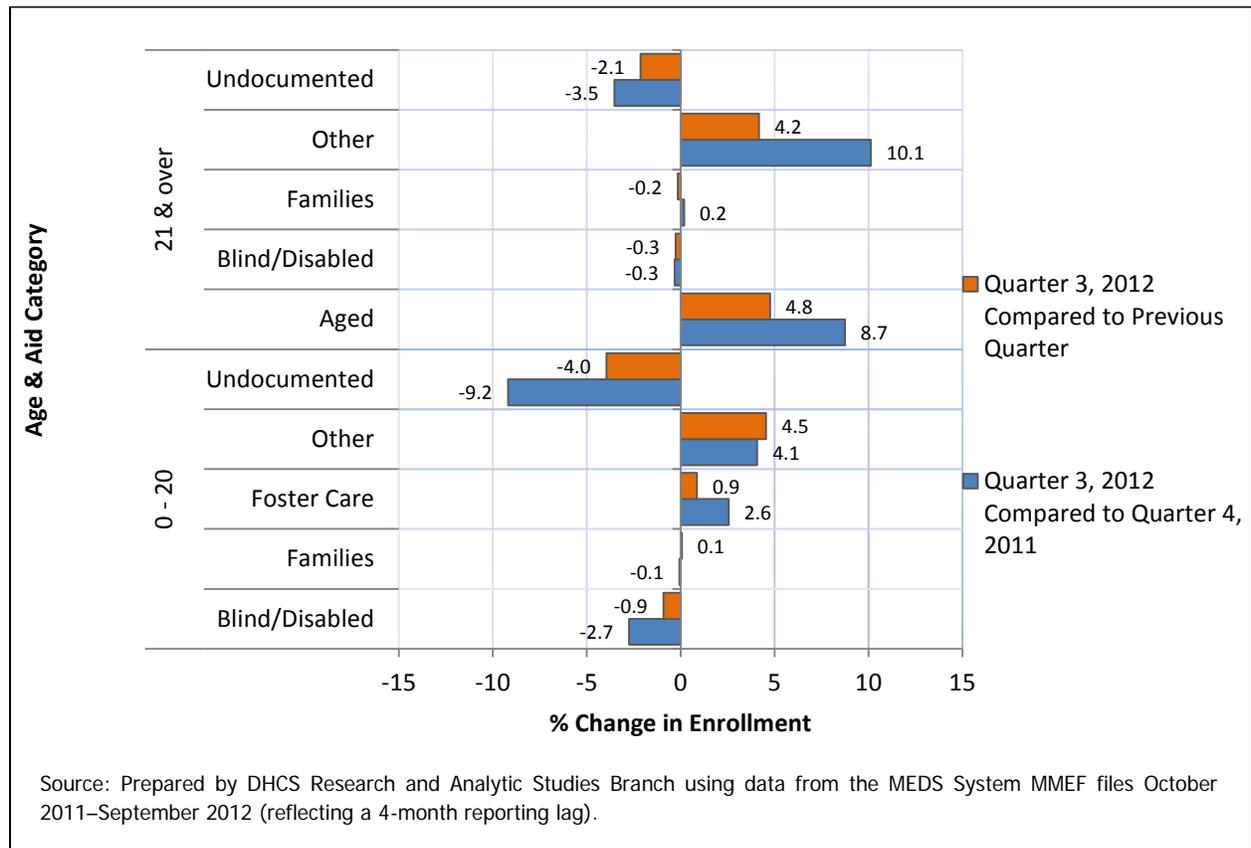
In Metropolitan areas, the largest decreases in FFS participation occurred among Aged adults (65.0%), and Blind/Disabled adults (57.0%) and children (36.9%).

Figure BP-4 Change in FFS Participation among Medi-Cal Beneficiaries, by Aid Category and Age, Metropolitan Counties, 2011 Quarter 4–2012 Quarter 3



For beneficiaries residing in metropolitan counties, participation across the four quarters studied followed a similar pattern as the one observed statewide. A substantial decrease occurred among Blind/Disabled adults (57.0%) and children (36.9%), and among Aged adults (65.0%), a modest decline was observed for children in the Undocumented aid category (7.8%), and a moderate increase was observed among adults in the Families (7.7%) and Other (9.8%) aid categories and among children in the Foster Care (13.1%) and Other (5.3%) aid categories (see [Figure BP-4](#)).

Figure BP-5 Change in FFS Participation among Medi-Cal Beneficiaries, by Age and Aid Category, Non-Metropolitan Counties, 2011 Quarter 4–2012 Quarter 3



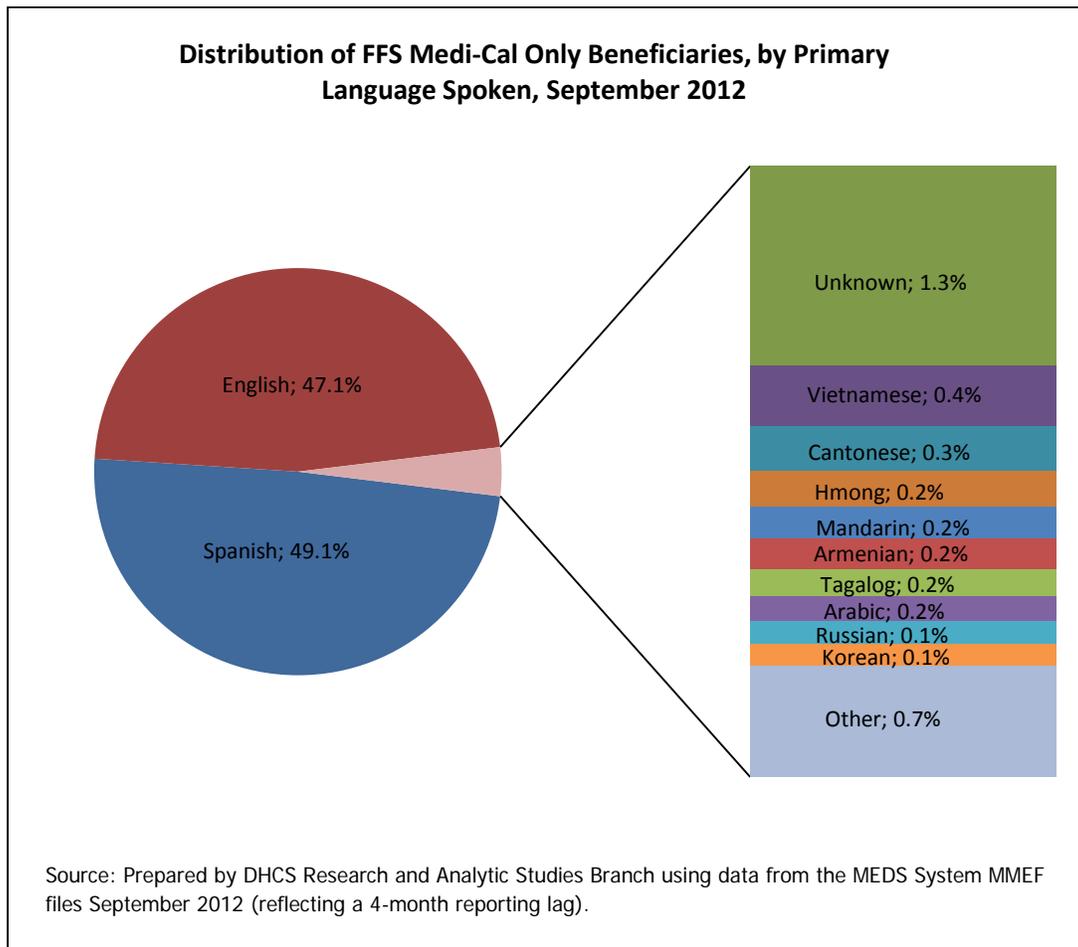
By contrast, FFS beneficiaries residing in non-metropolitan areas experienced smaller changes in FFS participation across the different subpopulations. For example, over the four quarters studied, changes in FFS participation varied from a 9.2% decline among Undocumented children, to a 10.1% increase among adults in the Other aid category (see Figure BP-5). Between the third quarter of 2012 and the previous quarter, small declines in participation were observed only among those in the Undocumented aid group (4.0% for children and 2.1% for adults), whereas participation increased slightly among adults and children in the Other aid category, and among adults in the Aged aid category (see Figure BP-5). Changes in FFS participation were negligible among Foster Care children, and both adults and children 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 9.2% decline among Undocumented children to a 10.1% increase among adults in the Other aid category.

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

As displayed in Figure BP-6, Spanish was self-reported as the primary language spoken by 49.1% of beneficiaries participating in FFS and eligible for Medi-Cal only for the third quarter of 2012. English was the primary language used by 47.1% of the beneficiaries participating in FFS and eligible for Medi-Cal only. The remaining 3.9% of beneficiaries spoke a variety of primary languages, including Vietnamese, Armenian, Hmong, Cantonese, Mandarin, Tagalog, and Russian.

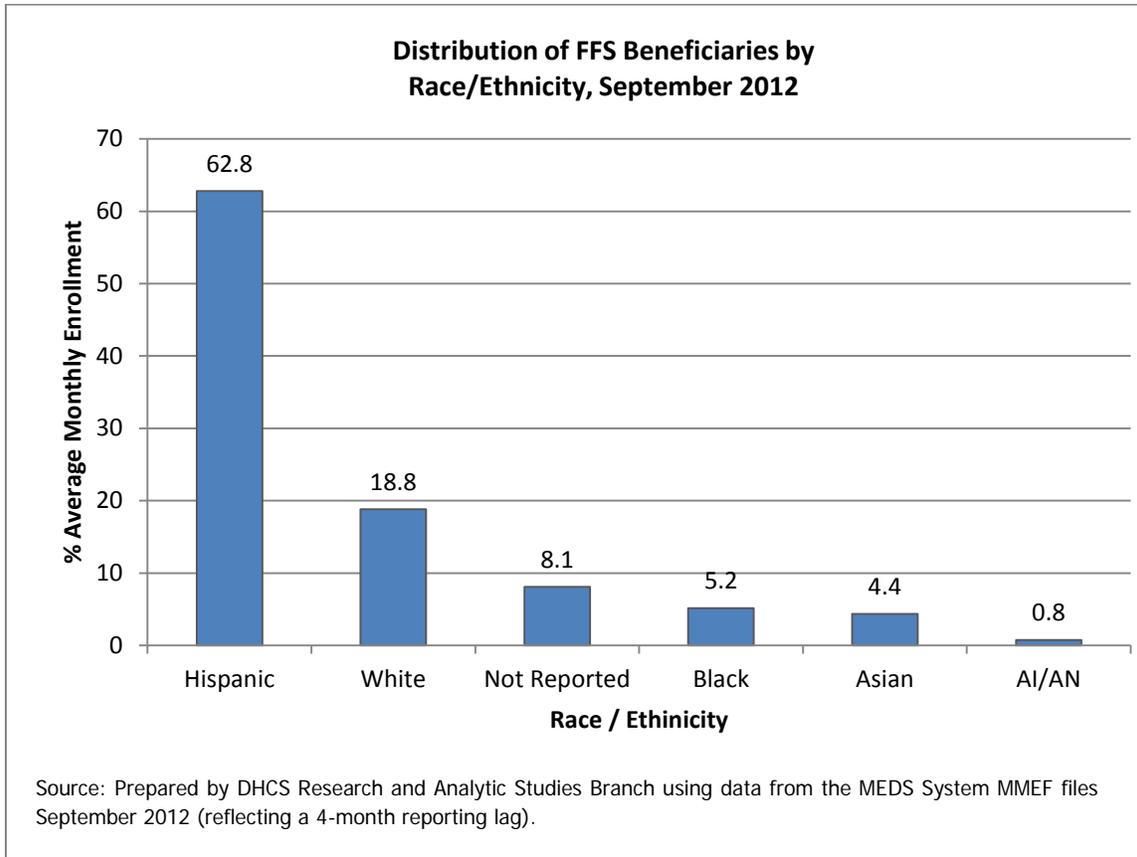
Figure BP-6 Distribution of FFS Medi-Cal Only Beneficiaries, by Primary Language Spoken, 2012 Quarter 3



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

In Figure BP-7, Hispanics represented 62.8% of the total population participating in FFS and eligible for Medi-Cal only for the third quarter of 2012. Whites accounted for 18.8% of all FFS Medi-Cal beneficiaries, while African American and Asian/Pacific Islander beneficiaries represented a much smaller portion of the overall population (5.2% and 4.4%, respectively). An additional 8.1% of the FFS Medi-Cal population reported no race/ethnic data.

Figure BP-7 Distribution of FFS Beneficiaries by Race/Ethnicity, 2012 Quarter 3



Distribution of Medi-Cal Only FFS Beneficiaries, by County

As shown in [Figure BP-8](#), when comparing participation changes for all FFS beneficiaries across the entire 12-month study period, large variations were observed by county. About 40% of the counties experienced a decline in participation, with San Francisco, Sacramento, and San Joaquin Counties recognizing the largest decrease (24.5%, 15.7%, and 14.1%, respectively). Approximately a third of counties saw an increase in FFS participation, with Solano, San Luis Obispo, and San Mateo Counties recognizing the greatest increases (49.6%, 35.5%, and 30.0%). The remaining counties had no significant changes in participation.

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

When evaluating participation for Full Scope beneficiaries, similar patterns were observed, although the degree of change was more pronounced, ranging from -36.9% for San Francisco County to 189.0% in Solano County over the year under study (see [Table BP-2](#)).

Figure BP-8 Comparison of FFS Participation by Medi-Cal Only Beneficiaries, 2012 Quarter 2-2011 Quarter 3

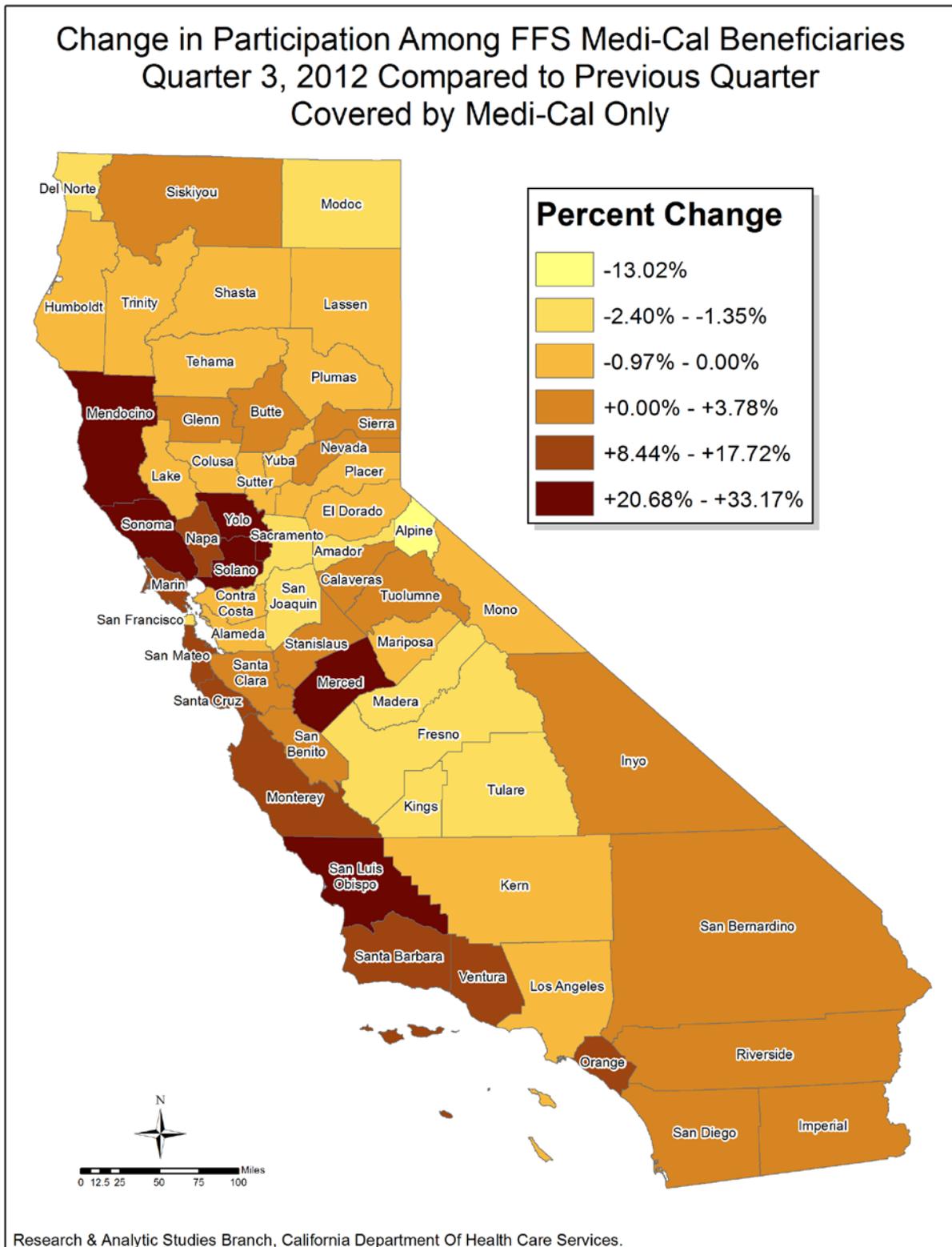
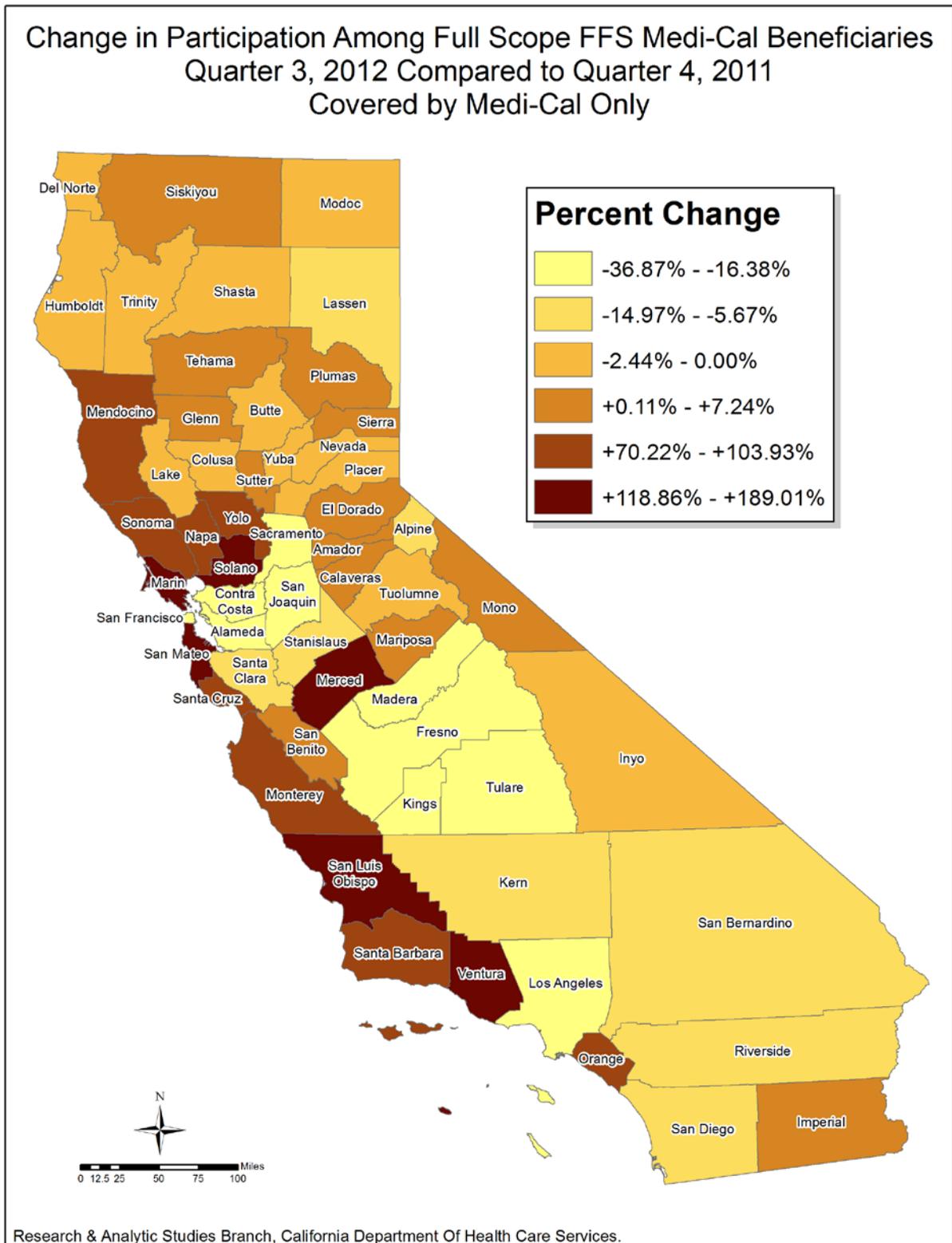


Figure BP-9 Comparison of FFS Participation by Medi-Cal Only Beneficiaries, 2012 Quarter 2 to Previous Quarter



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. Several Medi-Cal subpopulations participating in FFS were transitioned into managed care plans. During late 2010 and 2011, Kings, Madera, Ventura, Mendocino, and Marin Counties were transitioned from FFS to managed care delivery models. In addition, roughly 300,000 seniors and persons with disabilities were mandatorily enrolled in managed care health plans in the Two-Plan and GMC counties. These changes to Medi-Cal's health delivery system resulted in a decline in the number of beneficiaries participating in the FFS health care model.
3. Overall, the number of FFS beneficiaries eligible for Medi-Cal only and entitled to full scope benefits increased 3.6% between the second and the third quarter of 2012, but decreased by 8.6% when comparing FFS participation to earlier quarters of the study period.
4. Decreases in FFS participation among Medi-Cal only beneficiaries were observed in the Aged, Blind/Disabled, and Undocumented aid categories. The decrease in participation among the first two subpopulations was expected, given the DHCS initiative of transitioning SPDs into managed care plans.
5. Increase in FFS participation affected those enrolled in Families, Foster Care, and Other aid categories.
6. 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 mainly constant over the last four quarters studied.
7. In metropolitan counties, beneficiaries enrolled in the Aged and Blind/Disabled aid categories experienced the greatest decline in FFS participation across all quarters. In metropolitan counties, children in Foster Care had the highest expansion, followed by adults enrolled under Other aid category. In both cases, this expansion was due solely to an increase in participation from the last quarter of 2011 and the third quarter of 2012.
8. In non-metropolitan counties, participation increased for some aid groups (Other, Aged, and Foster Care) and decreased for others (Undocumented children and adults, 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.

9. Children in the Foster Care aid category experienced an increase in FFS participation from 2011 to 2012, most likely the result of legislation effective January 1, 2012, which optionally extends foster care benefits up to age 21. 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. Beneficiaries enrolled in managed care plans and needing LTC services beyond 30 days are shifted back into the FFS delivery system to obtain these services.
10. During the third quarter of 2012, the downwards trend in FFS participation that had been observed in all counties during 2011 were reversed for some counties (e.g., Solano, Santa Cruz, and San Mateo), and stabilized for about half of counties.

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	
	2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Qtr 3 Compared to 2011 Qtr 4	2012 Qtr 3 Compared to Previous Qtr
Alameda	60,254	54,958	52,161	52,121	-13.5	-0.1
Alpine	162	173	169	147	-9.3	-13.0
Amador	3,650	3,675	3,700	3,637	-0.4	-1.7
Butte	41,425	41,269	41,062	41,227	-0.5	0.4
Calaveras	5,530	5,542	5,574	5,596	1.2	0.4
Colusa	3,965	3,980	3,966	3,937	-0.7	-0.7
Contra Costa	37,882	35,443	33,420	33,106	-12.6	-0.9
Del Norte	6,725	6,730	6,676	6,567	-2.3	-1.6
El Dorado	15,603	15,588	15,633	15,573	-0.2	-0.4
Fresno	63,439	60,918	57,985	57,202	-9.8	-1.4
Glenn	5,999	6,066	6,106	6,113	1.9	0.1
Humboldt	21,777	21,678	21,710	21,610	-0.8	-0.5
Imperial	46,091	45,972	46,025	46,644	1.2	1.3
Inyo	2,899	2,916	2,900	2,901	0.1	0.0
Kern	62,891	60,974	58,648	58,530	-6.9	-0.2
Kings	8,776	8,332	7,766	7,653	-12.8	-1.5
Lake	13,923	13,945	13,824	13,759	-1.2	-0.5
Lassen	4,199	4,101	3,984	3,971	-5.4	-0.3
Los Angeles	639,689	594,787	569,835	566,940	-11.4	-0.5
Madera	12,891	12,440	11,856	11,585	-10.1	-2.3
Marin	5,118	5,126	5,226	5,682	11.0	8.7
Mariposa	2,198	2,205	2,262	2,240	1.9	-1.0
Mendocino	2,493	2,488	2,566	3,159	26.7	23.1
Merced	10,178	10,282	10,924	13,183	29.5	20.7
Modoc	1,589	1,587	1,595	1,557	-2.0	-2.4
Mono	1,210	1,253	1,291	1,288	6.4	-0.2
Monterey	19,951	20,691	21,323	23,122	15.9	8.4
Napa	2,621	2,591	2,754	3,008	14.8	9.2
Nevada	9,213	9,161	9,060	9,146	-0.7	0.9
Orange	72,060	70,628	73,052	85,233	18.3	16.7
Placer	24,872	24,906	24,957	24,868	0.0	-0.4
Plumas	2,434	2,427	2,448	2,439	0.2	-0.4
Riverside	102,091	95,248	91,519	92,524	-9.4	1.1
Sacramento	65,340	60,481	55,983	55,100	-15.7	-1.6
San Benito	8,796	8,908	8,860	8,866	0.8	0.1
San Bernardino	125,853	119,133	116,288	116,359	-7.5	0.1
San Diego	113,309	104,763	99,122	99,945	-11.8	0.8
San Francisco	28,143	24,448	21,603	21,249	-24.5	-1.6

County	Average Member Months				Percent Change	
	2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Qtr 3 Compared to 2011 Qtr 4	2012 Qtr 3 Compared to Previous Qtr
San Joaquin	40,627	38,061	35,770	34,912	-14.1	-2.4
San Luis Obispo	4,050	4,152	4,452	5,487	35.5	23.2
San Mateo	13,853	14,150	15,545	18,014	30.0	15.9
Santa Barbara	15,626	15,758	16,228	18,011	15.3	11.0
Santa Clara	69,287	66,585	63,005	63,773	-8.0	1.2
Santa Cruz	6,443	6,552	6,962	7,716	19.8	10.8
Shasta	32,745	32,557	32,548	32,482	-0.8	-0.2
Sierra	334	334	344	357	6.9	3.8
Siskiyou	8,277	8,350	8,393	8,416	1.7	0.3
Solano	6,714	6,640	7,540	10,041	49.6	33.2
Sonoma	8,841	8,670	9,310	11,284	27.6	21.2
Stanislaus	39,031	37,588	36,722	36,723	-5.9	0.0
Sutter	19,546	19,557	19,633	19,601	0.3	-0.2
Tehama	14,455	14,376	14,444	14,401	-0.4	-0.3
Trinity	2,217	2,204	2,196	2,188	-1.3	-0.4
Tulare	39,495	38,383	36,623	35,908	-9.1	-2.0
Tuolumne	6,378	6,391	6,320	6,349	-0.5	0.5
Ventura	19,606	19,453	20,617	24,271	23.8	17.7
Yolo	3,892	3,725	3,998	4,895	25.8	22.4
Yuba	17,559	17,352	17,264	17,238	-1.8	-0.2

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files, October 2011–September 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 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Qtr 3 Compared to 2011 Qtr 4	2012 Qtr 3 Compared to Previous Qtr
Alameda	39,254	33,910	31,099	31,233	-20.4	0.4
Alpine	162	173	169	147	-9.3	-13.0
Amador	3,537	3,568	3,610	3,541	0.1	-1.9
Butte	40,103	39,979	39,785	39,976	-0.3	0.5
Calaveras	5,370	5,380	5,420	5,445	1.4	0.5
Colusa	3,524	3,524	3,528	3,502	-0.6	-0.7
Contra Costa	23,575	21,320	19,279	19,073	-19.1	-1.1
Del Norte	6,540	6,558	6,519	6,408	-2.0	-1.7
El Dorado	14,506	14,507	14,555	14,543	0.3	-0.1
Fresno	34,230	31,524	28,468	28,298	-17.3	-0.6
Glenn	5,367	5,441	5,495	5,523	2.9	0.5
Humboldt	21,143	21,064	21,096	21,016	-0.6	-0.4
Imperial	45,029	44,952	45,056	45,708	1.5	1.4
Inyo	2,576	2,586	2,571	2,574	-0.1	0.1
Kern	39,547	37,492	35,032	35,344	-10.6	0.9
Kings	5,591	5,142	4,611	4,552	-18.6	-1.3
Lake	13,230	13,269	13,172	13,125	-0.8	-0.4
Lassen	4,074	3,984	3,865	3,843	-5.7	-0.6
Los Angeles	319,603	277,081	253,197	255,372	-20.1	0.9
Madera	5,645	5,195	4,650	4,664	-17.4	0.3
Marin	531	537	690	1,171	120.5	69.7
Mariposa	2,133	2,139	2,196	2,187	2.5	-0.4
Mendocino	740	712	783	1,457	96.9	86.1
Merced	2,179	2,310	2,935	5,257	141.3	79.1
Modoc	1,518	1,507	1,513	1,481	-2.4	-2.1
Mono	980	1,012	1,039	1,051	7.2	1.2
Monterey	2,802	2,779	3,293	5,714	103.9	73.5
Napa	636	609	809	1,168	83.6	44.4
Nevada	8,859	8,818	8,731	8,822	-0.4	1.0
Orange	15,423	14,130	16,704	29,164	89.1	74.6
Placer	23,746	23,747	23,805	23,708	-0.2	-0.4
Plumas	2,373	2,366	2,392	2,381	0.3	-0.5
Riverside	72,758	66,351	62,876	64,227	-11.7	2.1
Sacramento	50,891	46,002	41,570	40,894	-19.6	-1.6
San Benito	7,712	7,792	7,756	7,796	1.1	0.5
San Bernardino	92,566	86,416	83,464	83,818	-9.5	0.4

County	Average Member Months				Percent Change	
	2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Qtr 3 Compared to 2011 Qtr 4	2012 Qtr 3 Compared to Previous Qtr
San Diego	87,141	78,876	73,519	74,796	-14.2	1.7
San Francisco	18,845	15,086	12,272	11,897	-36.9	-3.1
San Joaquin	26,112	23,607	21,381	20,782	-20.4	-2.8
San Luis Obispo	1,233	1,279	1,613	2,722	120.8	68.8
San Mateo	2,875	2,903	4,026	6,357	121.1	57.9
Santa Barbara	3,253	3,178	3,565	5,611	72.5	57.4
Santa Clara	35,664	33,090	29,496	30,324	-15.0	2.8
Santa Cruz	1,552	1,564	2,055	2,978	91.9	44.9
Shasta	32,298	32,139	32,150	32,104	-0.6	-0.1
Sierra	331	330	338	351	6.0	3.8
Siskiyou	8,112	8,182	8,231	8,247	1.7	0.2
Solano	1,856	1,798	2,762	5,364	189.0	94.2
Sonoma	2,772	2,639	3,309	5,301	91.2	60.2
Stanislaus	28,363	27,103	26,373	26,518	-6.5	0.5
Sutter	17,953	17,968	18,008	18,028	0.4	0.1
Tehama	13,444	13,400	13,505	13,478	0.3	-0.2
Trinity	2,202	2,188	2,181	2,172	-1.4	-0.4
Tulare	20,415	19,186	17,362	17,072	-16.4	-1.7
Tuolumne	6,319	6,334	6,265	6,297	-0.3	0.5
Ventura	4,603	4,540	5,850	10,074	118.9	72.2
Yolo	1,699	1,606	1,921	2,892	70.2	50.5
Yuba	16,474	16,275	16,210	16,235	-1.5	0.2

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files October 2011–September 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 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Qtr 3 Compared to 2011 Qtr 4	2012 Qtr 3 Compared to Previous Qtr
Alameda	18,452	17,441	17,191	17,420	-5.6	1.3
Alpine	84	89	91	83	-1.2	-8.8
Amador	1,861	1,865	1,894	1,859	-0.1	-1.8
Butte	20,963	20,851	20,721	20,835	-0.6	0.6
Calaveras	2,802	2,790	2,826	2,853	1.8	1.0
Colusa	2,351	2,336	2,347	2,338	-0.6	-0.4
Contra Costa	11,649	11,388	11,000	10,914	-6.3	-0.8
Del Norte	3,334	3,363	3,329	3,292	-1.3	-1.1
El Dorado	8,083	8,084	8,165	8,125	0.5	-0.5
Fresno	17,956	17,561	16,736	16,812	-6.4	0.5
Glenn	3,380	3,398	3,427	3,444	1.9	0.5
Humboldt	11,002	10,926	10,990	10,967	-0.3	-0.2
Imperial	25,541	25,583	25,606	25,976	1.7	1.4
Inyo	1,518	1,507	1,496	1,514	-0.3	1.2
Kern	23,168	22,930	22,163	22,771	-1.7	2.7
Kings	3,290	3,164	2,937	2,985	-9.3	1.6
Lake	6,831	6,862	6,857	6,835	0.1	-0.3
Lassen	2,141	2,107	2,048	2,057	-3.9	0.4
Los Angeles	162,774	151,970	150,442	154,444	-5.1	2.7
Madera	3,386	3,173	2,916	3,031	-10.5	3.9
Marin	330	335	433	764	131.5	76.4
Mariposa	1,128	1,132	1,161	1,164	3.2	0.3
Mendocino	420	390	431	816	94.3	89.3
Merced	1,453	1,539	1,895	3,293	126.6	73.8
Modoc	817	804	808	799	-2.2	-1.1
Mono	673	681	698	711	5.6	1.9
Monterey	1,967	1,955	2,259	3,835	95.0	69.8
Napa	398	393	497	724	81.9	45.7
Nevada	4,657	4,632	4,605	4,674	0.4	1.5
Orange	10,850	9,665	11,024	19,025	75.3	72.6
Placer	13,802	13,871	13,887	13,870	0.5	-0.1
Plumas	1,280	1,248	1,254	1,271	-0.7	1.4
Riverside	43,674	41,362	40,405	41,495	-5.0	2.7
Sacramento	25,310	25,055	24,208	24,004	-5.2	-0.8
San Benito	4,904	4,950	4,939	4,968	1.3	0.6
San Bernardino	51,995	49,966	49,511	50,161	-3.5	1.3

County	Average Member Months				Percent Change	
	2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Qtr 3 Compared to 2011 Qtr 4	2012 Qtr 3 Compared to Previous Qtr
San Diego	49,085	46,992	45,702	46,685	-4.9	2.2
San Francisco	5,788	5,599	5,303	5,334	-7.8	0.6
San Joaquin	14,190	13,647	13,098	12,978	-8.5	-0.9
San Luis Obispo	778	800	955	1,588	104.1	66.3
San Mateo	1,851	1,845	2,531	4,032	117.8	59.3
Santa Barbara	2,433	2,379	2,441	3,709	52.4	51.9
Santa Clara	17,406	17,670	16,645	17,280	-0.7	3.8
Santa Cruz	1,020	988	1,177	1,698	66.5	44.3
Shasta	16,788	16,649	16,684	16,740	-0.3	0.3
Sierra	157	161	164	173	10.2	5.5
Siskiyou	4,206	4,210	4,243	4,270	1.5	0.6
Solano	1,217	1,121	1,691	3,160	159.7	86.9
Sonoma	1,872	1,749	2,046	3,292	75.9	60.9
Stanislaus	14,971	14,825	14,979	15,201	1.5	1.5
Sutter	10,629	10,693	10,749	10,798	1.6	0.5
Tehama	7,792	7,753	7,785	7,835	0.6	0.6
Trinity	1,076	1,073	1,071	1,066	-0.9	-0.5
Tulare	11,603	11,336	10,751	10,622	-8.5	-1.2
Tuolumne	3,216	3,225	3,227	3,251	1.1	0.7
Ventura	3,027	2,979	3,743	6,499	114.7	73.6
Yolo	1,227	1,145	1,288	1,869	52.3	45.1
Yuba	9,268	9,149	9,120	9,179	-1.0	0.6

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files October 2011–September 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 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Qtr 3 Compared to 2011 Qtr 4	2012 Qtr 3 Compared to Previous Qtr
Alameda	21,908	20,332	19,575	19,627	-10.4	0.3
Alpine	45	47	45	35	-22.2	-22.2
Amador	1,113	1,130	1,128	1,103	-0.9	-2.2
Butte	12,114	12,105	12,078	12,131	0.1	0.4
Calaveras	1,653	1,655	1,648	1,647	-0.4	-0.1
Colusa	1,005	1,020	1,007	1,001	-0.4	-0.6
Contra Costa	13,590	12,799	12,215	12,195	-10.3	-0.2
Del Norte	1,978	1,969	1,956	1,918	-3.0	-1.9
El Dorado	4,462	4,463	4,450	4,434	-0.6	-0.4
Fresno	23,970	23,016	22,130	21,887	-8.7	-1.1
Glenn	1,607	1,642	1,642	1,631	1.5	-0.7
Humboldt	6,432	6,441	6,415	6,368	-1.0	-0.7
Imperial	13,431	13,366	13,379	13,579	1.1	1.5
Inyo	815	826	823	814	-0.1	-1.1
Kern	21,350	20,672	20,000	19,793	-7.3	-1.0
Kings	2,993	2,790	2,605	2,543	-15.0	-2.4
Lake	4,141	4,127	4,077	4,050	-2.2	-0.7
Lassen	1,247	1,209	1,168	1,155	-7.4	-1.1
Los Angeles	254,311	240,781	231,500	229,000	-10.0	-1.1
Madera	4,894	4,818	4,713	4,555	-6.9	-3.4
Marin	2,591	2,624	2,618	2,704	4.4	3.3
Mariposa	655	647	659	635	-3.1	-3.6
Mendocino	1,061	1,072	1,097	1,245	17.3	13.5
Merced	4,543	4,598	4,786	5,319	17.1	11.1
Modoc	445	452	451	443	-0.4	-1.8
Mono	301	323	341	334	11.0	-2.1
Monterey	9,597	9,971	10,153	10,444	8.8	2.9
Napa	1,266	1,256	1,295	1,336	5.5	3.2
Nevada	2,799	2,775	2,725	2,742	-2.0	0.6
Orange	36,123	36,100	36,853	39,566	9.5	7.4
Placer	6,763	6,766	6,809	6,771	0.1	-0.6
Plumas	724	735	745	729	0.7	-2.1
Riverside	33,958	31,868	30,735	31,053	-8.6	1.0
Sacramento	22,157	19,933	18,269	18,087	-18.4	-1.0
San Benito	2,410	2,463	2,422	2,422	0.5	0.0
San Bernardino	42,675	40,500	39,656	39,604	-7.2	-0.1
San Diego	38,252	35,339	33,698	33,964	-11.2	0.8
San Francisco	10,605	9,437	8,647	8,537	-19.5	-1.3
San Joaquin	13,967	13,122	12,233	11,935	-14.5	-2.4
San Luis Obispo	1,798	1,845	1,948	2,236	24.4	14.8
San Mateo	6,537	6,679	6,993	7,549	15.5	8.0
Santa Barbara	7,541	7,645	7,899	8,317	10.3	5.3
Santa Clara	26,814	26,082	25,285	25,501	-4.9	0.9

County	Average Member Months				Percent Change	
	2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Qtr 3 Compared to 2011 Qtr 4	2012 Qtr 3 Compared to Previous Qtr
Santa Cruz	3,197	3,307	3,456	3,667	14.7	6.1
Shasta	9,695	9,654	9,655	9,564	-1.4	-0.9
Sierra	96	97	102	106	10.4	3.9
Siskiyou	2,442	2,485	2,480	2,479	1.5	0.0
Solano	2,944	2,981	3,220	3,932	33.6	22.1
Sonoma	4,137	4,096	4,334	4,867	17.6	12.3
Stanislaus	13,021	12,500	12,080	12,046	-7.5	-0.3
Sutter	5,190	5,165	5,186	5,155	-0.7	-0.6
Tehama	4,013	4,018	4,045	3,989	-0.6	-1.4
Trinity	687	674	664	665	-3.2	0.2
Tulare	14,410	14,064	13,587	13,377	-7.2	-1.5
Tuolumne	1,968	1,951	1,911	1,920	-2.4	0.5
Ventura	9,418	9,398	9,712	10,418	10.6	7.3
Yolo	1,495	1,474	1,559	1,766	18.1	13.3
Yuba	4,941	4,888	4,854	4,831	-2.2	-0.5

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

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

Gender	Age Category	Average Member Months				Percent Change	
		2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Qtr 3 Compared to 2011 Qtr 4	2012 Qtr 3 Compared to Previous Qtrr
Women	0 to 17	325,196	315,590	314,034	329,093	1.2	4.8
	18 to 64	337,321	307,470	289,087	297,636	-11.8	3.0
	65 or Older	21,639	13,530	8,241	8,153	-62.3	-1.1
Men	0 to 17	348,627	335,766	332,555	348,296	-0.1	4.7
	18 to 64	206,396	176,600	154,849	155,342	-24.7	0.3
	65 or Older	12,781	8,183	5,352	5,255	-58.9	-1.8
All	0 to 17	673,823	651,356	646,589	677,389	0.5	4.8
	18 to 64	543,717	484,070	443,936	452,978	-16.7	2.0
	65 or Older	34,420	21,713	13,593	13,408	-61.0	-1.4
Total		1,251,960	1,157,139	1,104,118	1,143,775	-8.6	3.6

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

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

Gender	Age Category	Average Member Months				Percent Change	
		2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	Qtr 3, 2012 Compared to Qtr 4, 2011	Qtr 3 2012 Compared to Previous Qtr
Women	0 to 17	64,082	62,164	60,417	58,306	-9.0	-3.5
	18 to 64	406,976	406,723	406,631	402,085	-1.2	-1.1
	65 or Older	10,902	11,015	11,072	11,078	1.6	0.1
Men	0 to 17	65,712	63,583	61,912	59,706	-9.1	-3.6
	18 to 64	219,124	220,472	221,993	219,313	0.1	-1.2
	65 or Older	5,438	5,555	5,591	5,573	2.5	-0.3
All	0 to 17	129,794	125,747	122,329	118,012	-9.1	-3.5
	18 to 64	626,100	627,195	628,624	621,398	-0.8	-1.1
	65 or Older	16,340	16,570	16,663	16,651	1.9	-0.1
Total		772,234	769,512	767,616	756,061	-2.1	-1.5

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files October 2011–September 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 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Qtr 3 Compared to 2011 Qtr 4	2012 Qtr 3 Compared to Previous Qtr
0 - 20	Blind/Disabled	61,535	53,567	42,841	39,860	-35.2	-7.0
	Families	411,342	392,609	392,707	412,216	0.2	5.0
	Foster Care	86,623	97,736	97,570	97,594	12.7	0.0
	Other	199,278	190,436	194,304	209,685	5.2	7.9
	Undocumented	167,425	163,190	159,533	154,284	-7.8	-3.3
21 & over	Aged	30,720	18,744	11,187	10,933	-64.4	-2.3
	Blind/Disabled	205,577	146,531	102,908	97,495	-52.6	-5.3
	Families	201,017	200,428	203,325	214,518	6.7	5.5
	Other	55,871	56,960	59,167	61,361	9.8	3.7
	Undocumented	604,809	606,310	608,084	601,777	-0.5	-1.0
Total		2,024,197	1,926,511	1,871,626	1,899,723	-6.1	1.5

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files October 2011–September 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 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Qtr 3 Compared to 2011 Qtr 4	2012 Qtr 3 Compared to Previous Qtr
0 - 20	Blind/Disabled	58,547	50,597	39,908	36,953	-36.9	-7.4
	Families	358,921	340,187	340,349	359,828	0.3	5.7
	Foster Care	83,218	94,314	94,108	94,102	13.1	0.0
	Other	190,410	181,767	185,477	200,457	5.3	8.1
	Undocumented	165,499	161,301	157,712	152,536	-7.8	-3.3
21 & over	Aged	30,457	18,477	10,915	10,647	-65.0	-2.5
	Blind/Disabled	189,458	130,405	86,798	81,429	-57.0	-6.2
	Families	174,066	173,365	176,285	187,519	7.7	6.4
	Other	54,350	55,371	57,560	59,685	9.8	3.7
	Undocumented	599,646	601,152	602,994	596,796	-0.5	-1.0
Total		1,904,572	1,806,936	1,752,106	1,779,952	-6.5	1.6

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

Age	Aid Category	Average Member Months				Percent Change	
		2011 Quarter 4	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Qtr 3 Compared to 2011 Qtr 4	2012 Qtr 3 Compared to Previous Qtr
0 - 20	Blind/Disabled	2,988	2,970	2,933	2,906	-2.7	-0.9
	Families	52,421	52,421	52,357	52,388	-0.1	0.1
	Foster Care	3,405	3,422	3,462	3,492	2.6	0.9
	Other	8,868	8,669	8,827	9,228	4.1	4.5
	Undocumented	1,926	1,889	1,821	1,749	-9.2	-4.0
21 & over	Aged	263	267	273	286	8.7	4.8
	Blind/Disabled	16,119	16,126	16,110	16,066	-0.3	-0.3
	Families	26,951	27,064	27,041	26,999	0.2	-0.2
	Other	1,521	1,590	1,608	1,675	10.1	4.2
	Undocumented	5,163	5,158	5,090	4,981	-3.5	-2.1
Total		119,625	119,576	119,522	119,770	0.1	0.2

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files October 2011–September 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	OL, OM, ON, OP, OR, OT, OU, OV, OW, OX, OY
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 #4 2012 Quarter 3



Service Utilization

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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 (<2,500 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 continues to shift 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 service categories such as Hospital Inpatient and Physician/Clinic services.

Methods

In this report, DHCS examines utilization trends for ten 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
10. Radiology

Service utilization was measured in various ways, depending upon the provider type. The unit of measure for Physician/Clinic, Home Health, Hospital Outpatient, and Radiology 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 October 2011–September 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 fourth quarter of 2011 to the third quarter of 2012.

The Physician/Clinic services utilization rates continued to be 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 predominantly below the expected baseline ranges observed in the baseline period of 2007–2009. Additionally, children in the Blind/Disabled aid category exhibited above average Physician/Clinic services utilization that reached levels above the expected baseline ranges during the first quarter of 2012. 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 205.3–1,359.5 visits per 1,000 member months from the fourth quarter of 2011 to the third 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 subgroups. The utilization trends among most adults, with exception to those in the Undocumented aid category, again fell within the expected ranges. Adults in the Blind/Disabled aid category exhibited above average Physician/Clinic services utilization during most of the first three quarters of 2012. In contrast, adults in the Families aid category displayed below average utilization throughout the study period. This lower utilization of Physician/Clinic Services among adults in the Families aid category coincides with the decline in the number of beneficiaries participating in the Medi-Cal FFS delivery system during the same time frame.

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 continued to exhibit below average and lower than expected use 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 through 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 subgroup. A definitive explanation for these service use patterns can only be reached by undertaking further analysis.

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, October 2011–September 2012

Figure SU-1 Physician/Clinic Utilization, Children (Age 0-20), Blind/Disabled, Oct. 2011–Sept. 2012

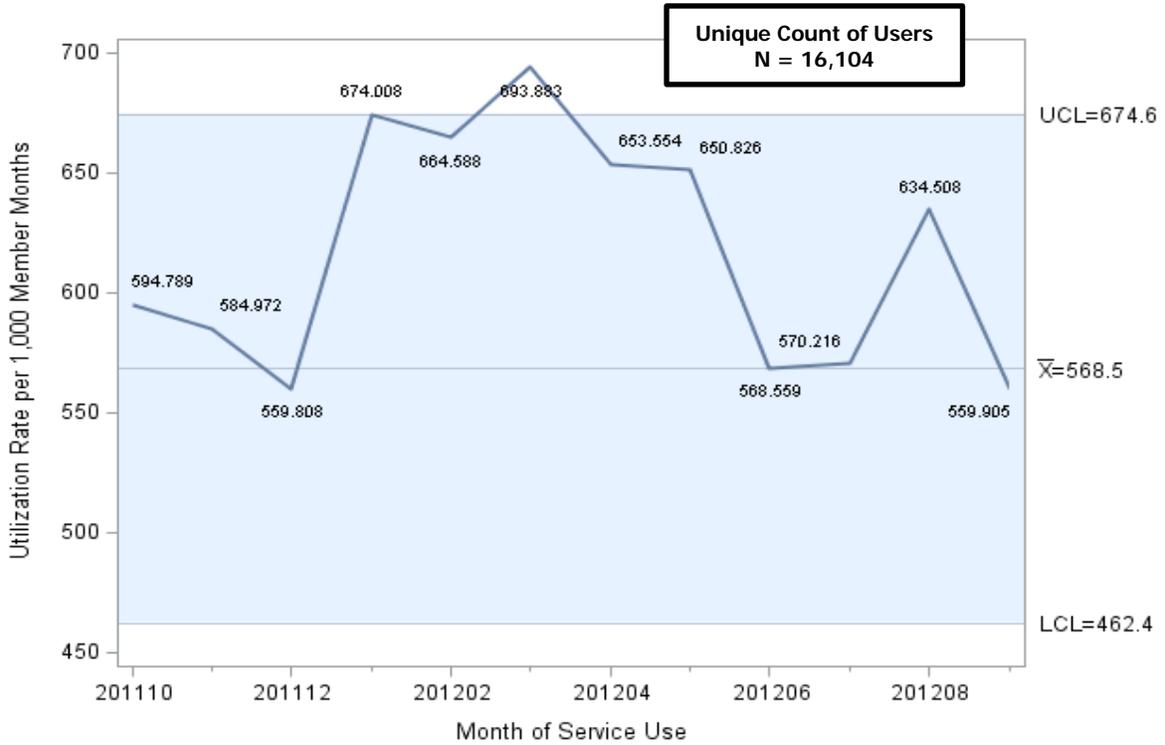


Figure SU-2 Physician/Clinic Utilization, Children (Age 0-20), Families, Oct. 2011–Sept. 2012

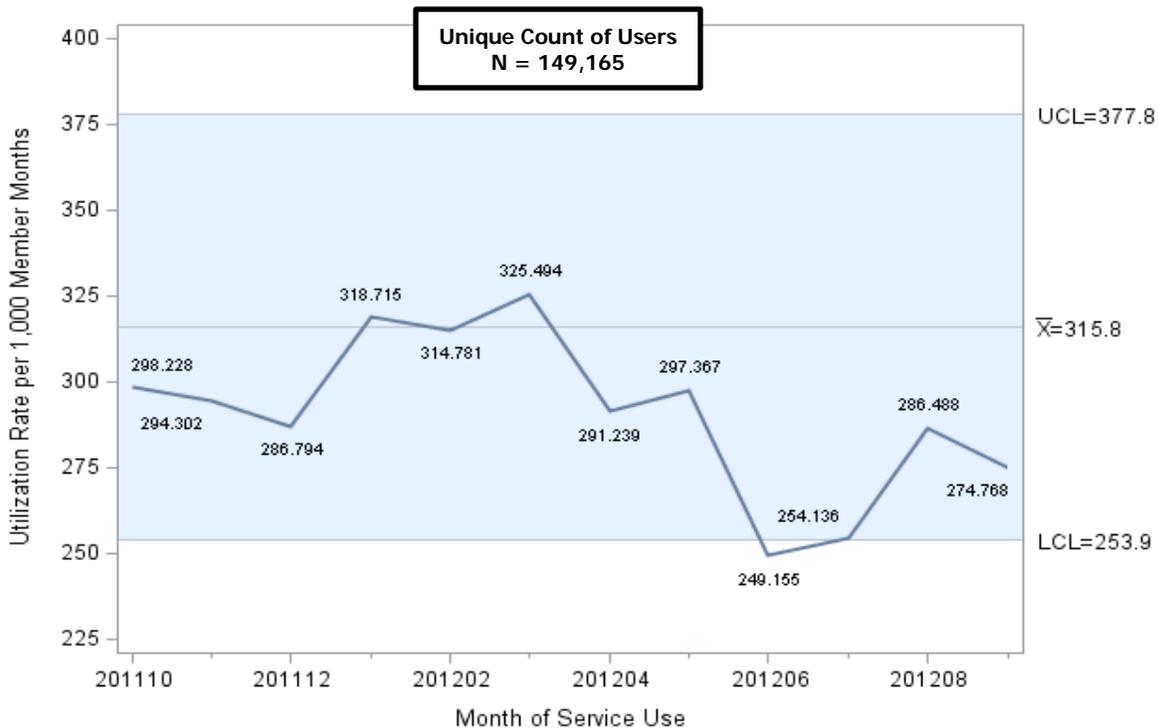


Figure SU-3 Physician/Clinic Utilization, Children (Age 0-20), Foster Care, Oct. 2011–Sept. 2012

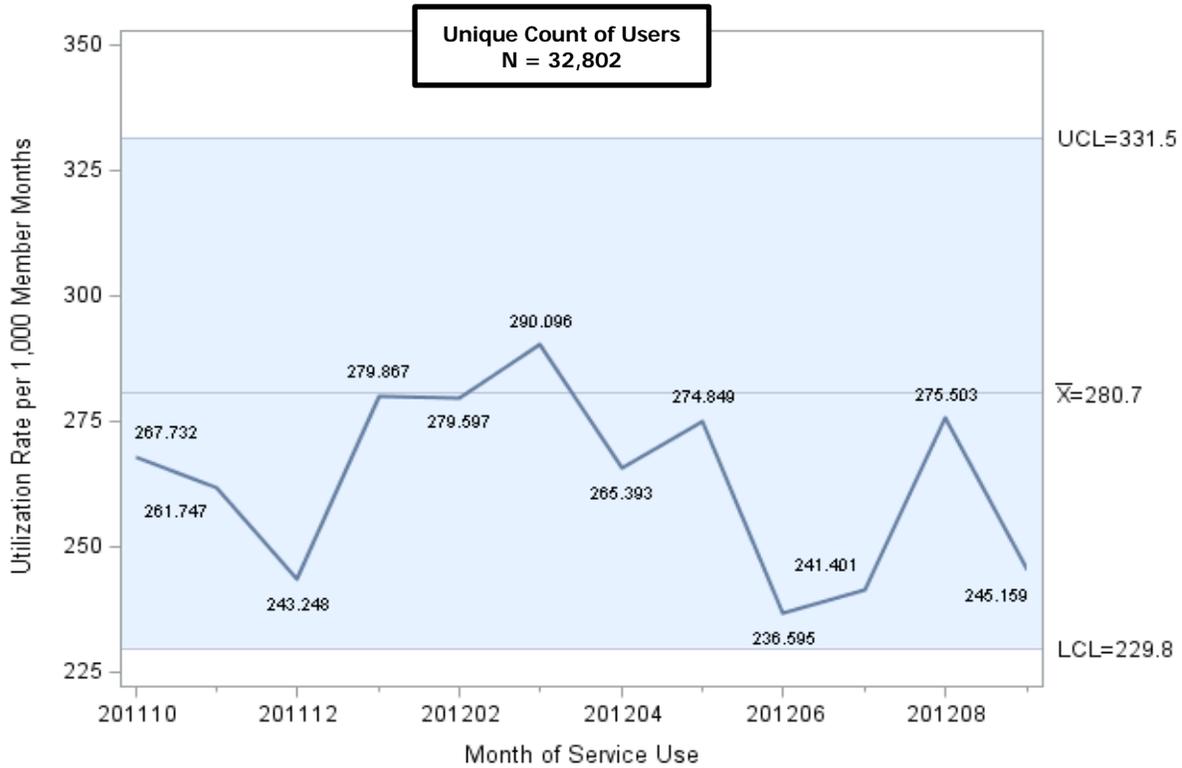


Figure SU-4 Physician/Clinic Utilization, Children (Age 0-20), Other, Oct. 2011–Sept. 2012

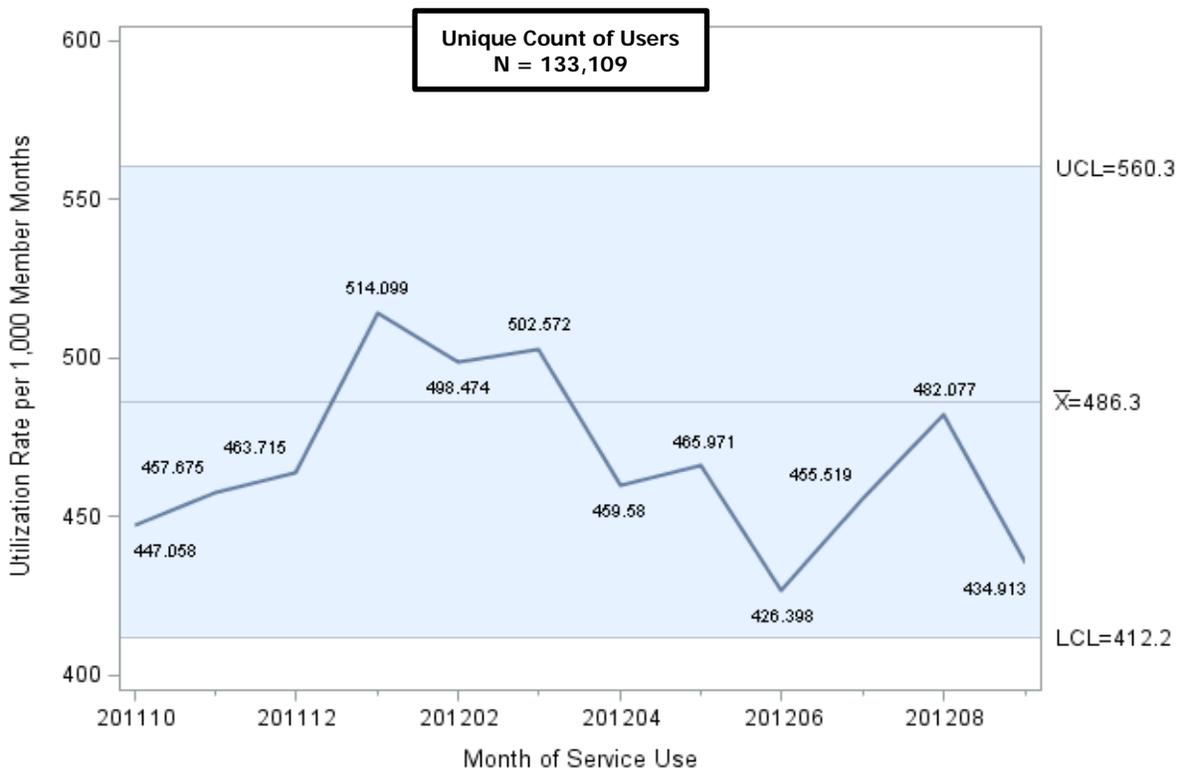
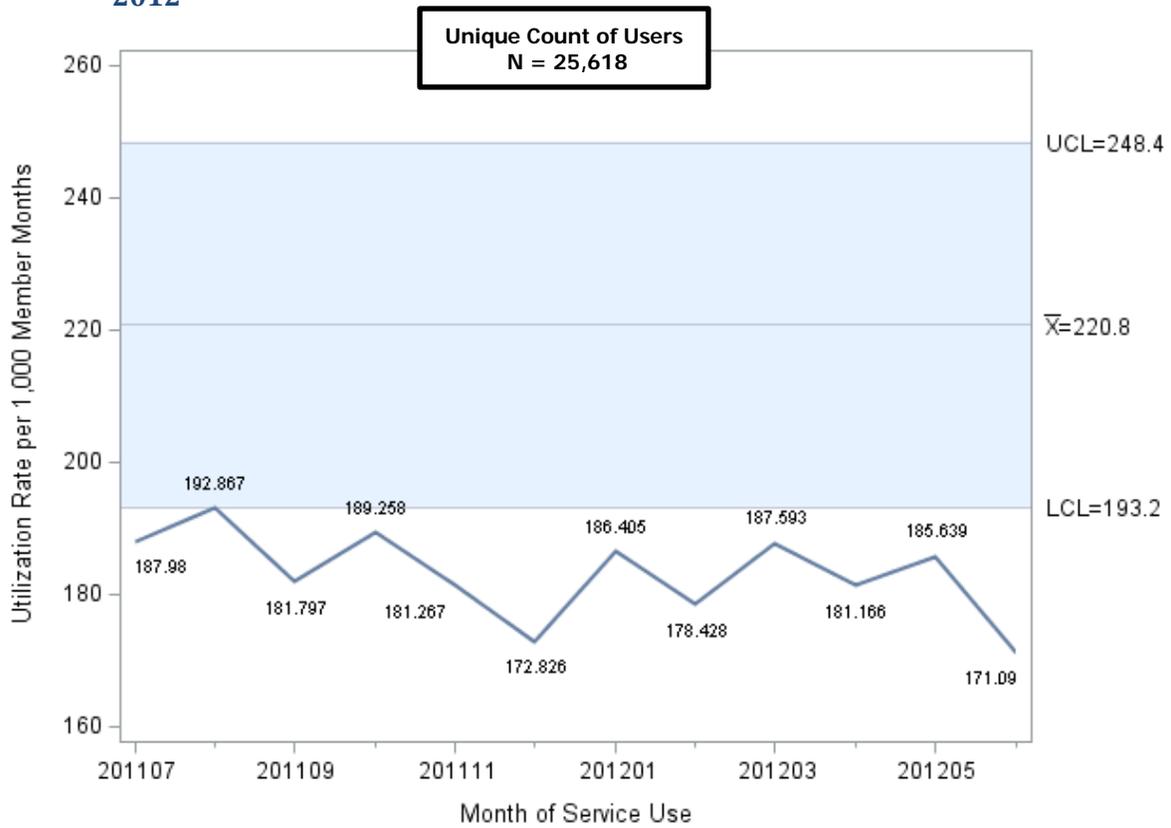


Figure SU-5 Physician/Clinic Utilization, Children (Age 0-20), Undocumented, Oct. 2011–Sept. 2012



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 October 2011–September 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, October 2011–September 2012

Figure SU-6 Physician/Clinic Utilization, Adults (Age 21+), Aged, Oct. 2011–Sept. 2012

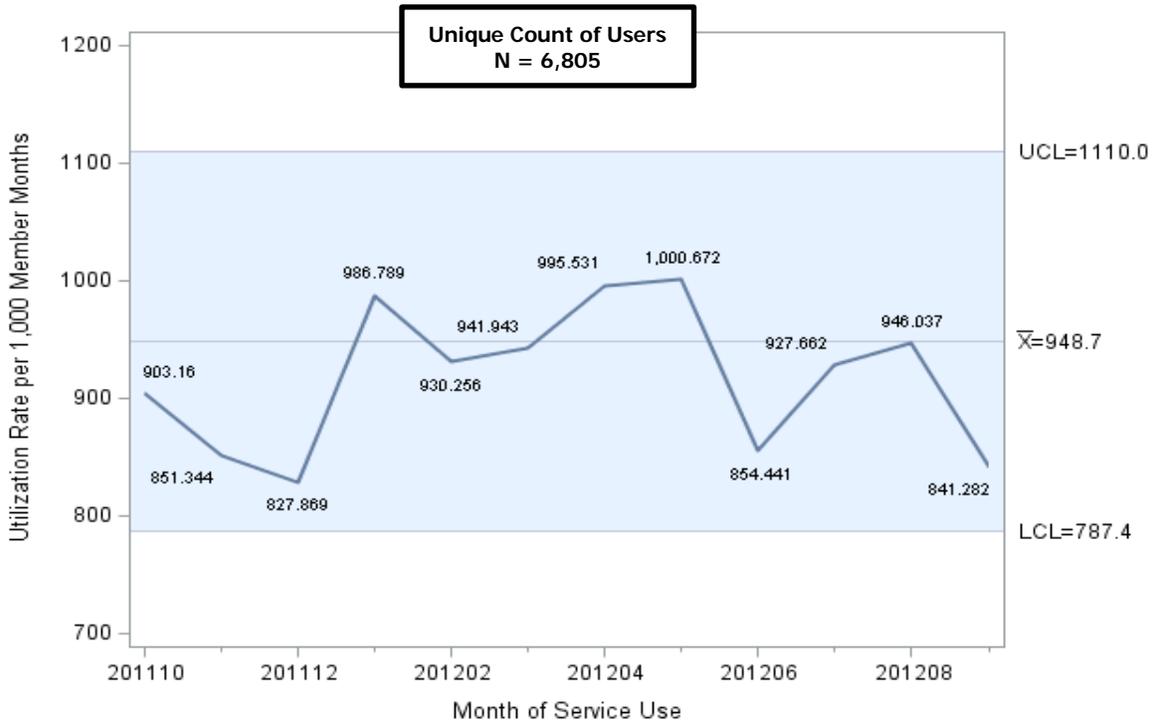


Figure SU-7 Physician/Clinic Utilization, Adults (Age 21+), Blind/Disabled, Oct. 2011–Sept. 2012

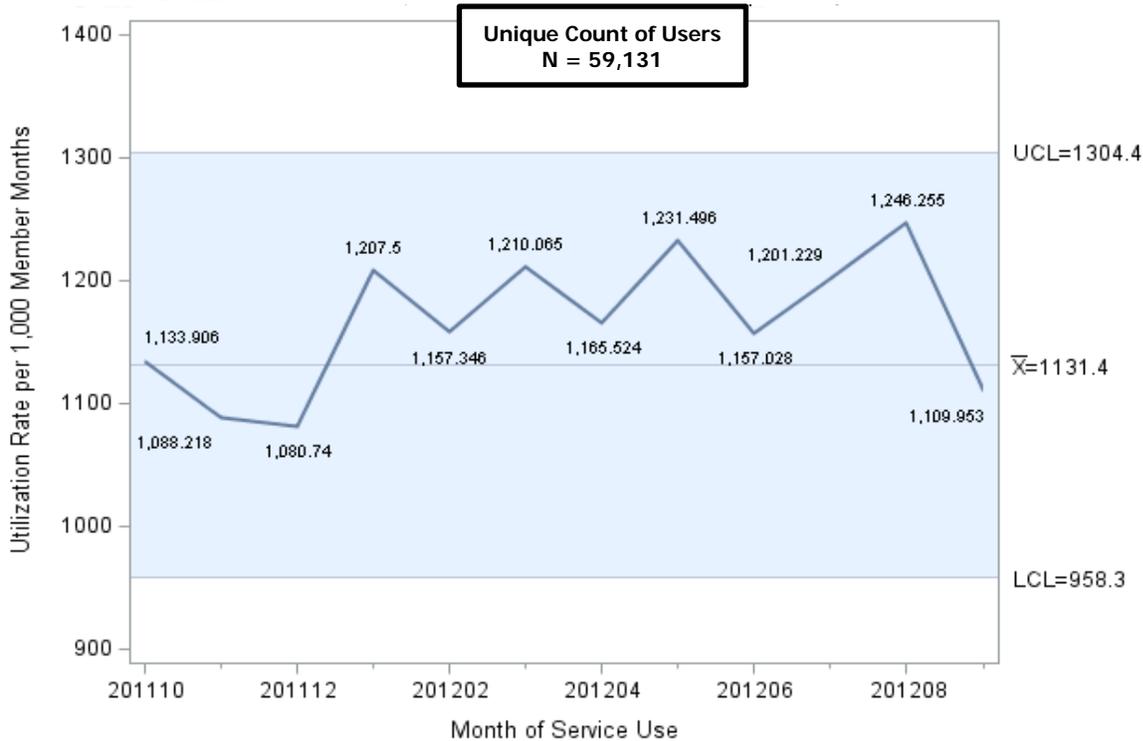


Figure SU-8 Physician/Clinic Utilization, Adults (Age 21+), Families, Oct. 2011–Sept. 2012

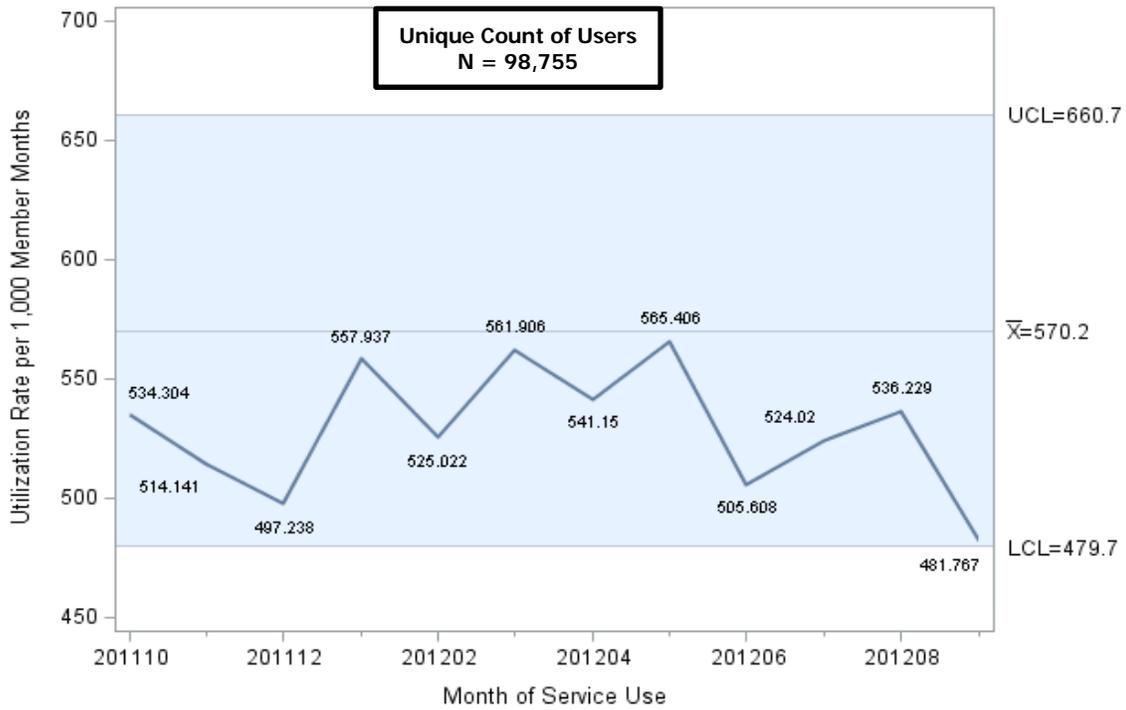


Figure SU-9 Physician/Clinic Utilization, Adults (Age 21+), Other, Oct. 2011–Sept. 2012

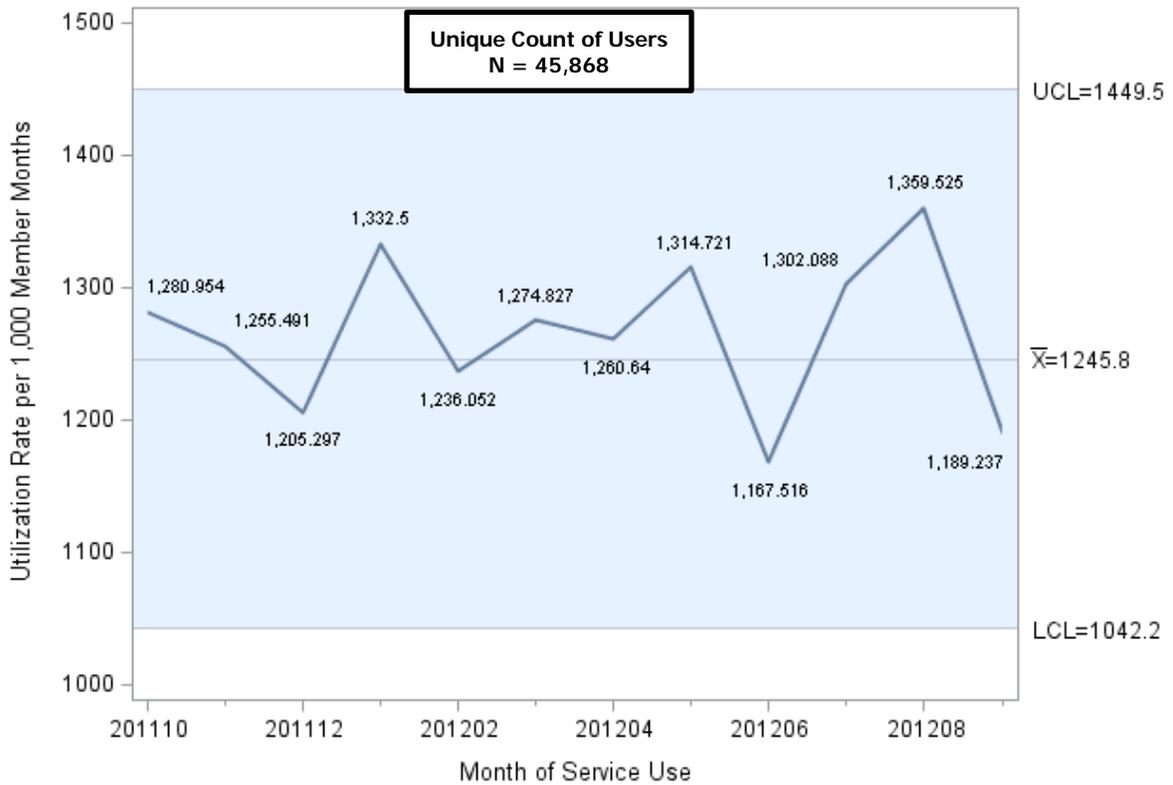
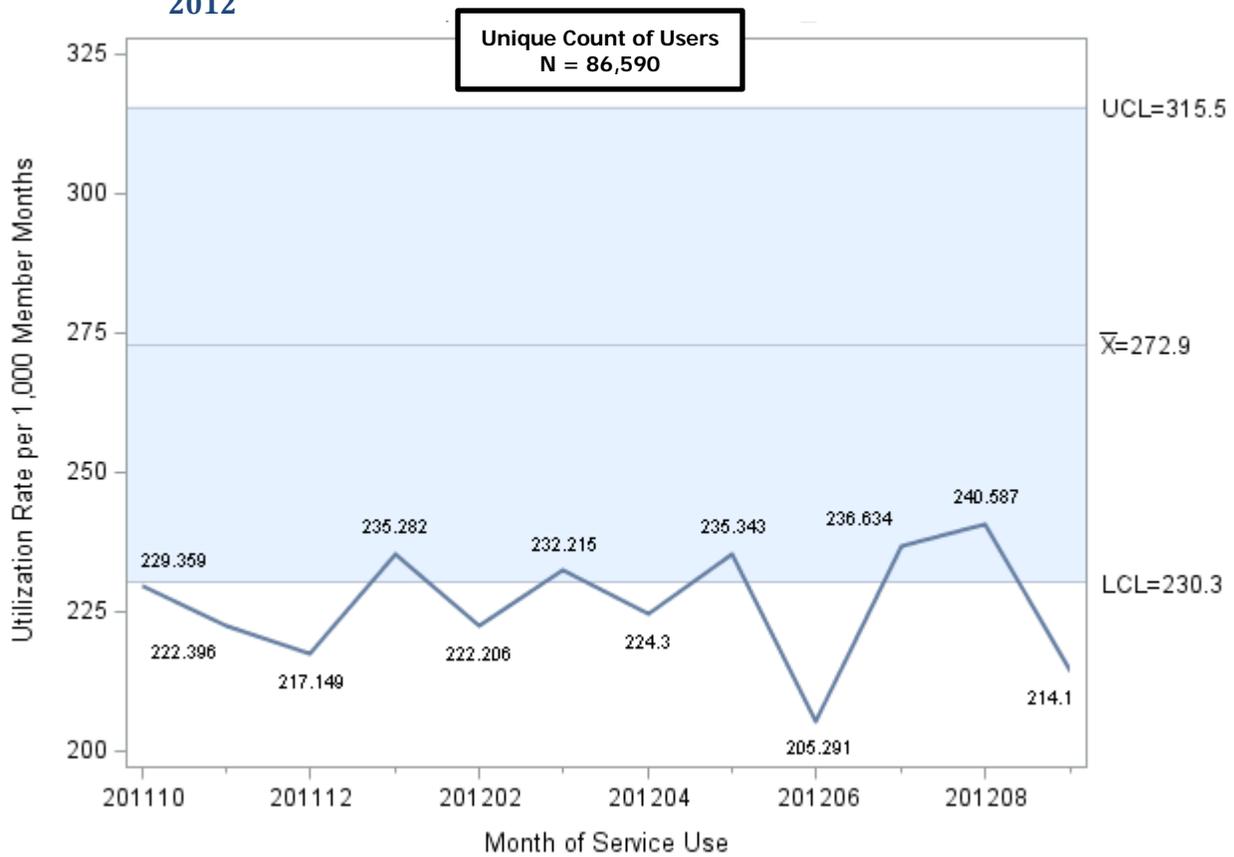


Figure SU-10 Physician/Clinic Utilization, Adults (Age 21+), Undocumented, Oct. 2011–Sept. 2012



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 October 2011–September 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.

Over 200,000 Medi-Cal beneficiaries 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 fourth quarter of 2011 to the third quarter of 2012.

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. Adults in the analyzed aid categories exhibited Non-Emergency Medical Transportation utilization rates above the expected baseline ranges throughout the study period. However, adults in the Blind/Disabled aid category displayed a noticeable downward trend in utilization over the last two quarters of the study period.

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 fourth quarter of 2011 to the third 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.

Trends—Monthly Non-Emergency Medical Transportation Services Utilization Rates by Adults, October 2011–September 2011

Figure SU-11 Non-Emergency Medical Transportation Utilization, Adults (Age 21+), Blind/Disabled, Oct. 2011–Sept. 2012

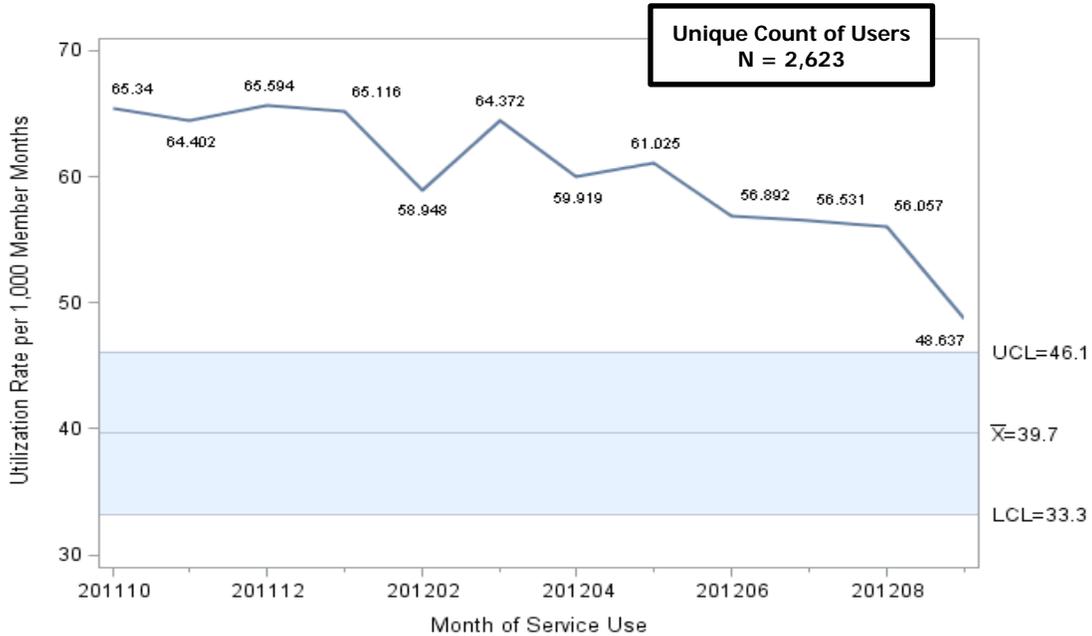
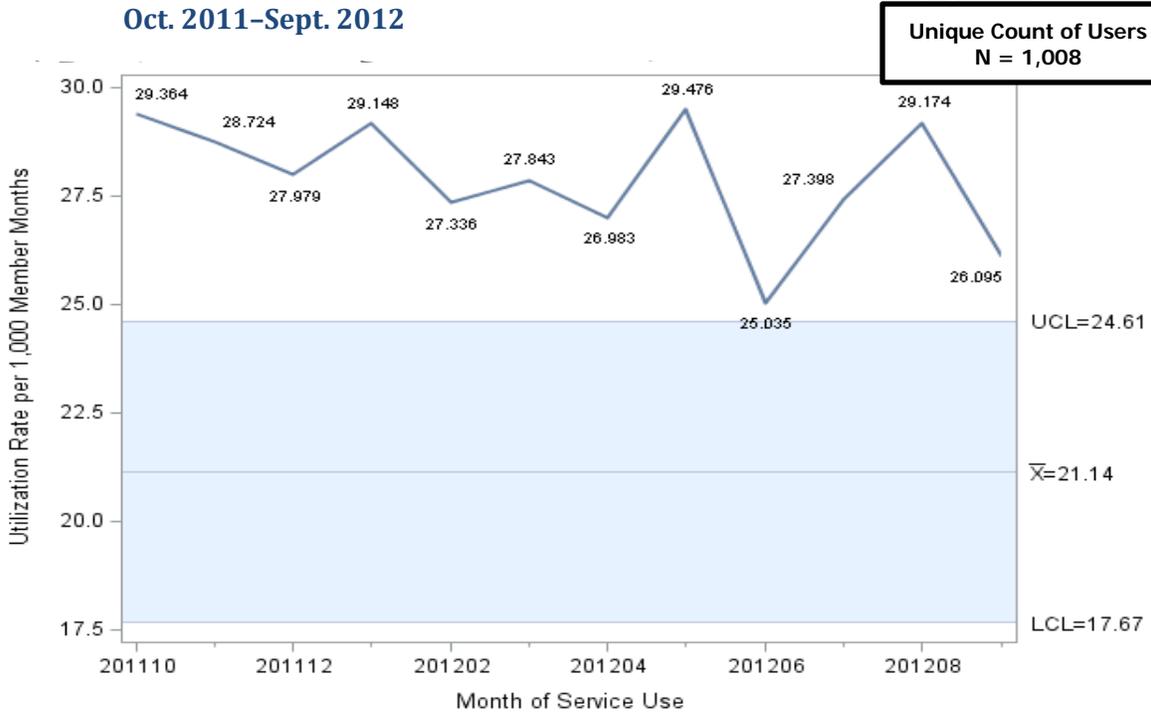


Figure SU-12 Non-Emergency Medical Transportation Utilization, Adults (Age 21+), Other, Oct. 2011–Sept. 2012



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 October 2011–September 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 fourth quarter of 2011 to the third quarter of 2012.

Patterns of service use 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 again 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, after previously exhibiting a downward trend in Emergency Medical Transportation services utilization, children in the Blind/Disabled aid category experienced an increase in utilization during the last quarter of the study period. Children in the Foster Care aid category had mostly above average utilization rates that at times reached levels above the expected ranges observed in the baseline period of 2007 to 2009. In contrast, 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 at the beginning of the study period, their utilization of Emergency Medical Transportation services fell within the baseline ranges during the first three quarters of 2012.

Medi-Cal children used Emergency Medical Transportation services at below average rates, except for those in Foster Care aid codes.

Adults

The monthly Emergency Medical Transportation services utilization rates for adults age 21 and older ranged from 1.7–44.9 visits per 1,000 member months from the fourth quarter of 2011 to the third 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 utilized these services. Adults in the Families aid category exhibited mostly below average Emergency Medical Transportation services utilization patterns that fell within the expected baseline ranges, whereas adults in the Blind/Disabled aid category primarily 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 expected baseline ranges during most of the study period.

Utilization among adults in Blind/Disabled aid codes were mostly above average and at times above expected ranges.

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 fourth quarter of 2011 to the third quarter of 2012.

Trends—Monthly Emergency Medical Transportation Services Utilization Rates by Children, October 2011–September 2011

Figure SU-13 Emergency Transportation Utilization, Children Age (0–20), Blind/Disabled, Oct. 2011–Sept. 2012

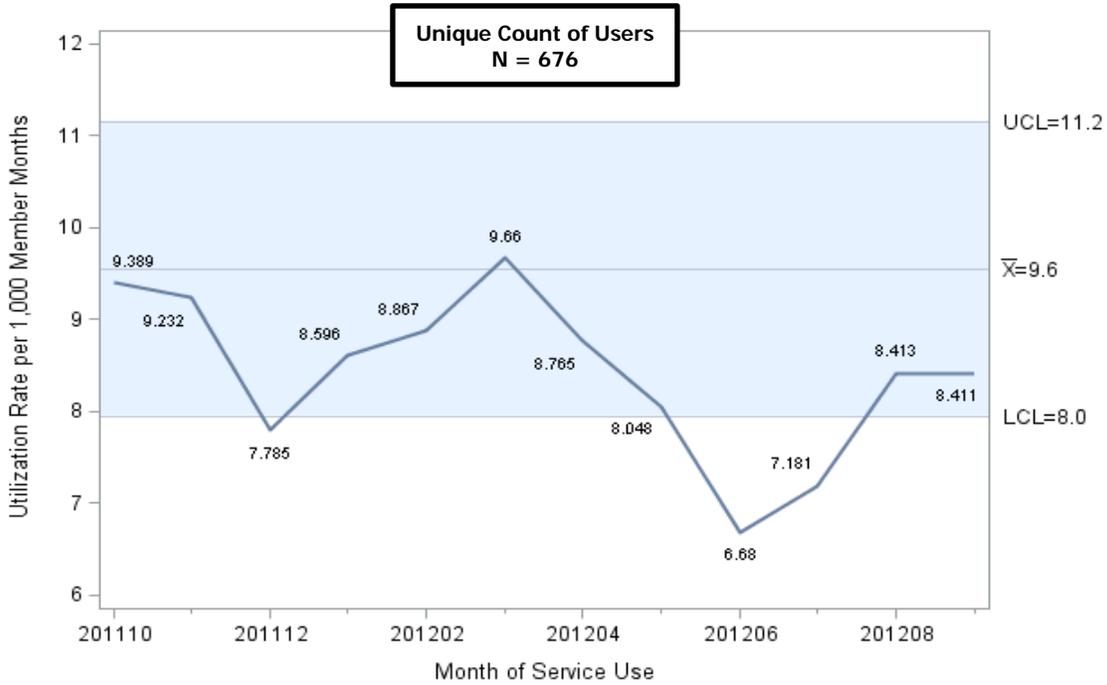


Figure SU-14 Emergency Transportation Utilization, Children (Age 0–20), Families, Oct. 2011–Sept. 2012

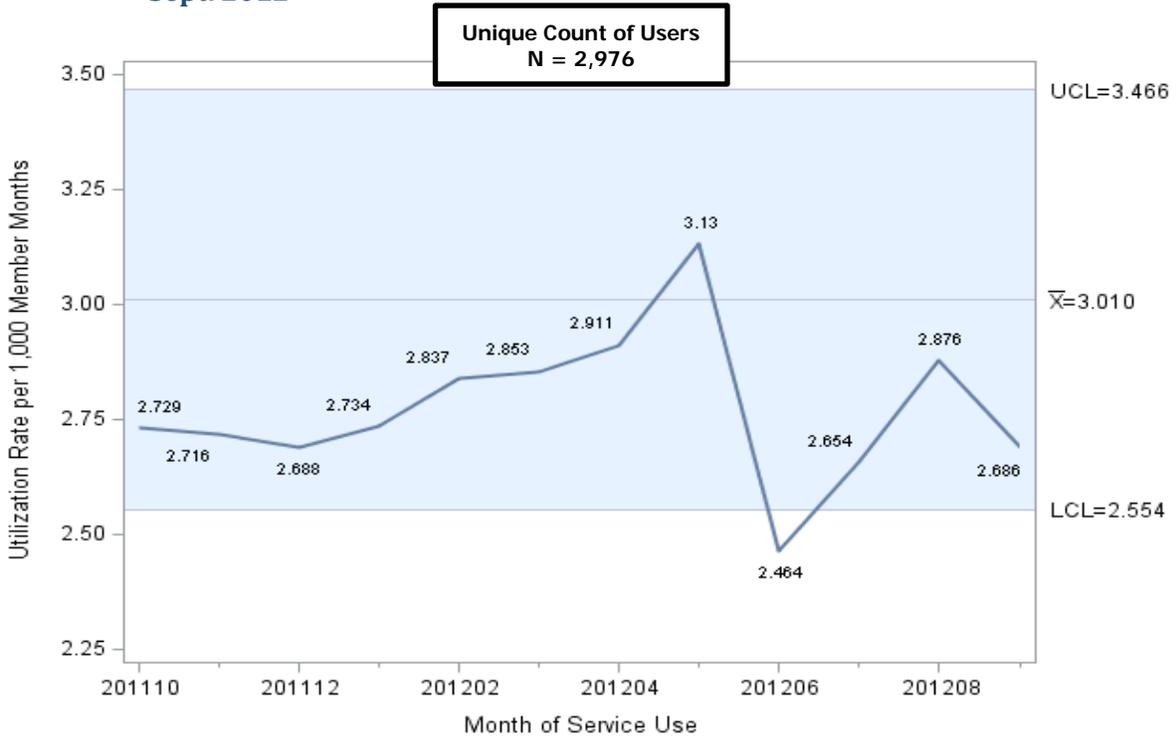


Figure SU-15 Emergency Transportation Utilization, Children (Age 0-20), Foster Care, Oct. 2011-Sept. 2012

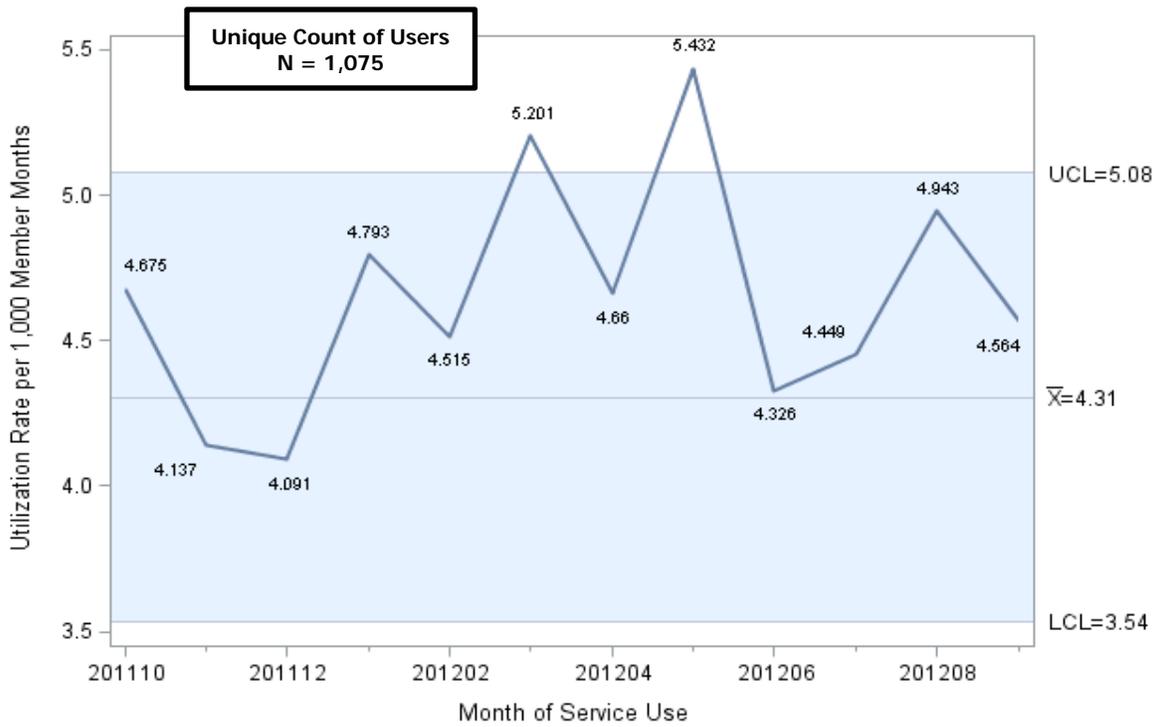


Figure SU-16 Emergency Transportation Utilization, Children (Age 0-20), Other, Oct. 2011-Sept. 2012

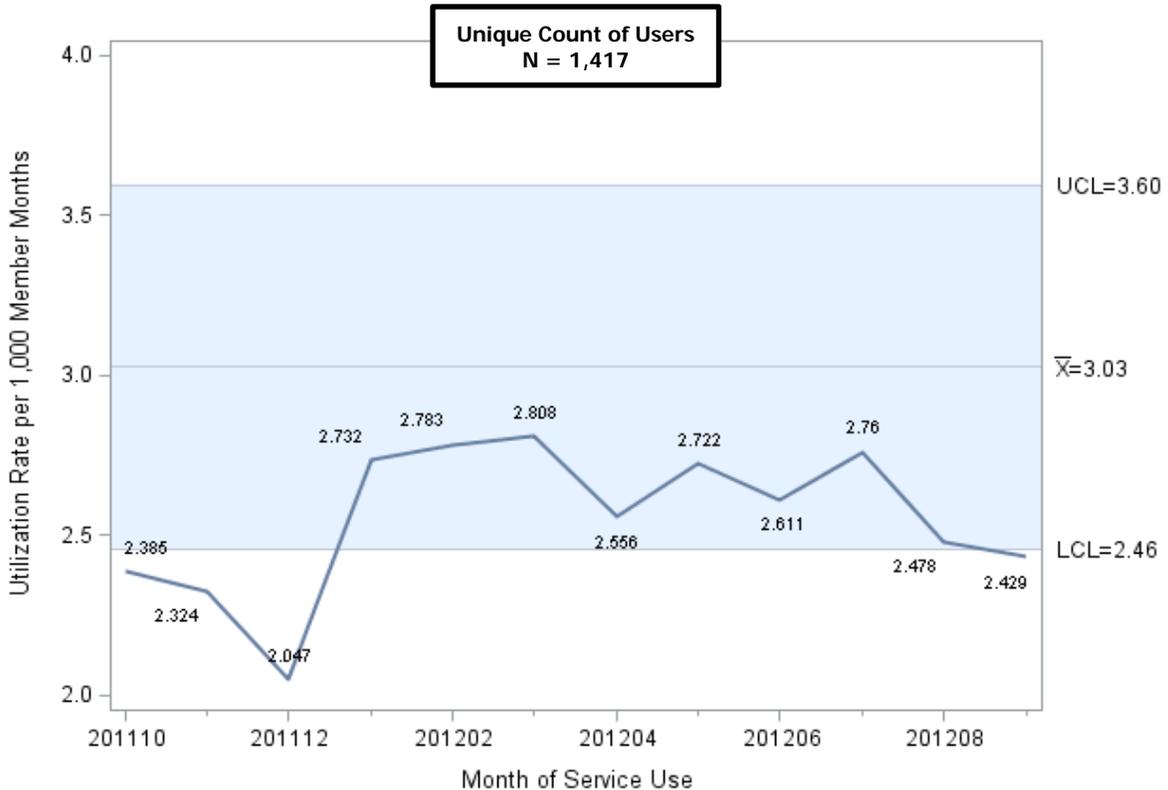
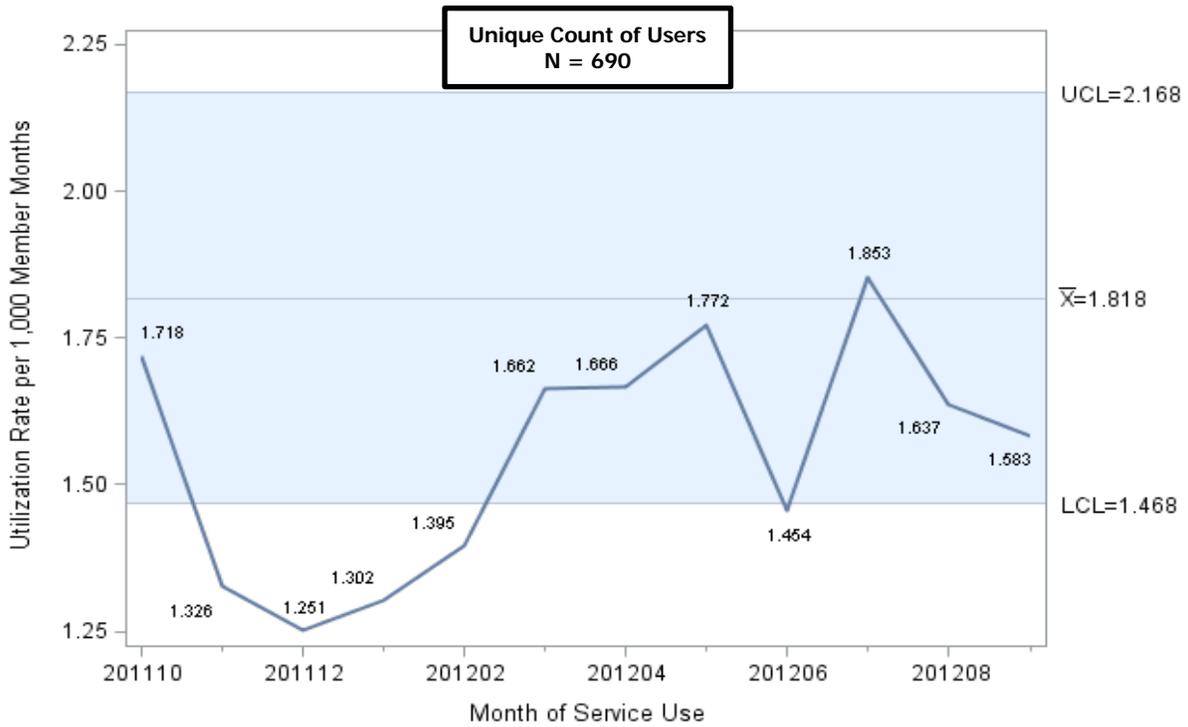


Figure SU-17 Emergency Transportation Utilization, Children (Age 0-20), Undocumented, Oct. 2011-Sept. 2012



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 October 2011–September 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, October 2011–September 2012

Figure SU-18 Emergency Medical Transportation Utilization, Adults (Age 21+), Blind/Disabled, Oct. 2011–Sept. 2012

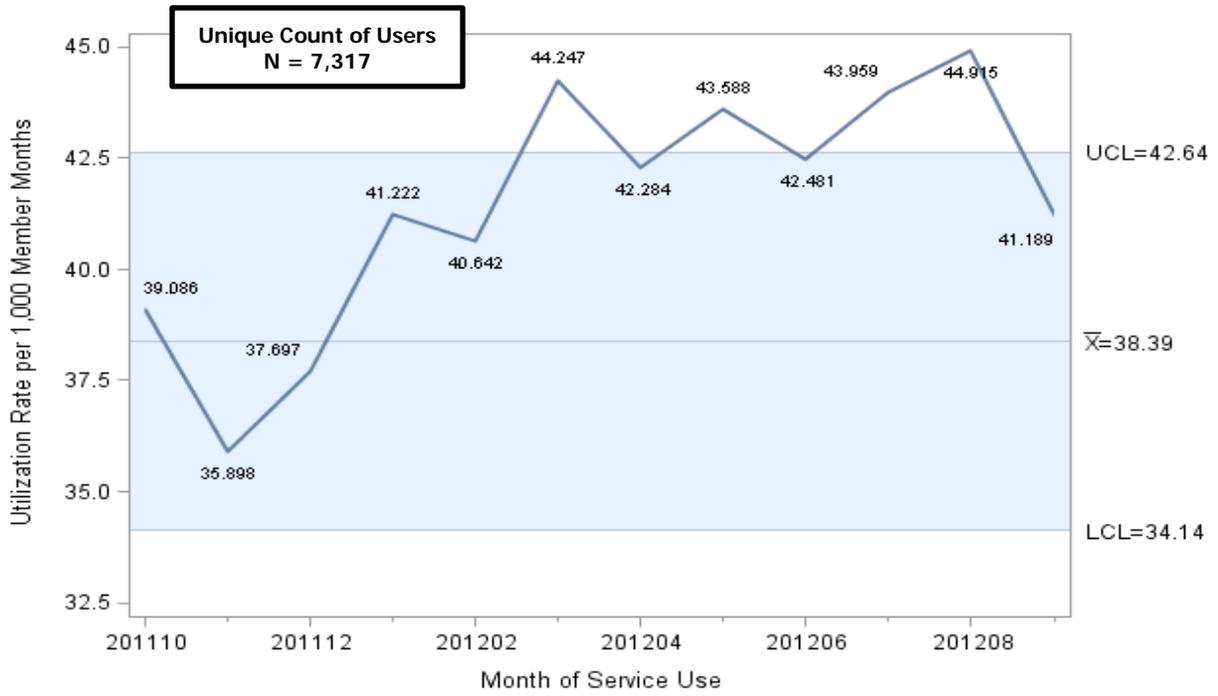


Figure SU-19 Emergency Medical Transportation Utilization, Adults (Age 21+), Families, Oct. 2011–Sept. 2012

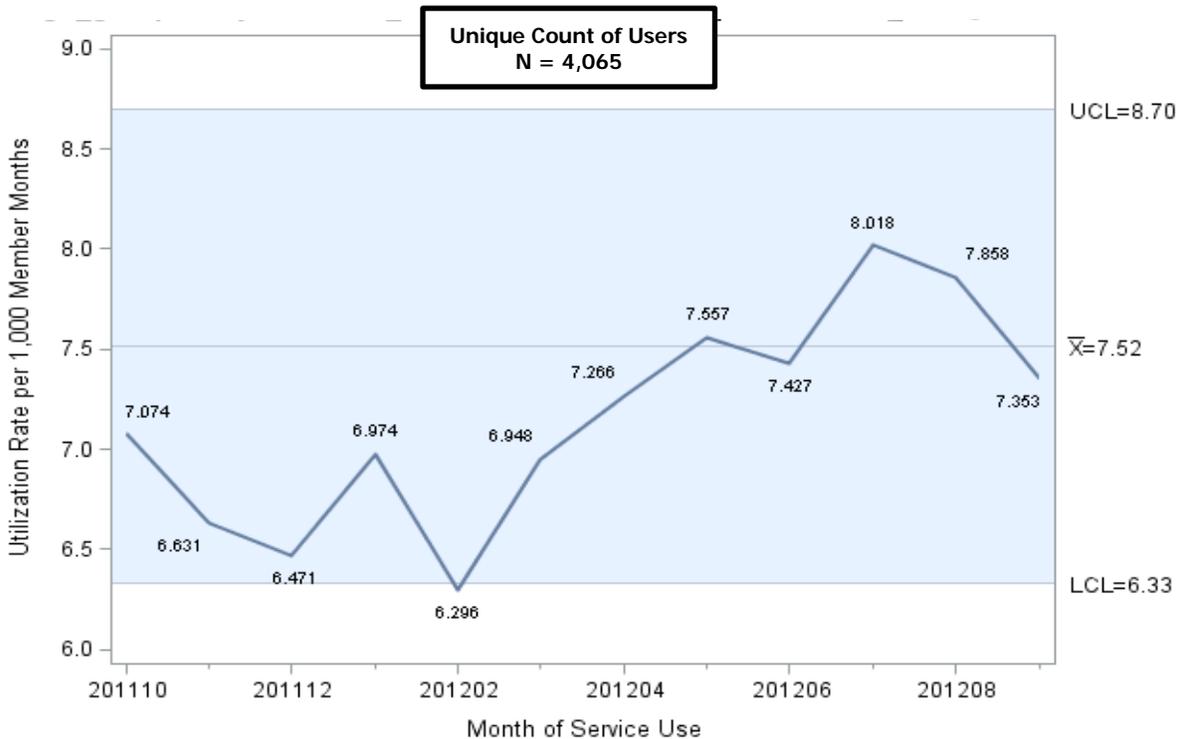


Figure SU-20 Emergency Medical Transportation Utilization, Adults (Age 21+), Other, Oct. 2011–Sept. 2012

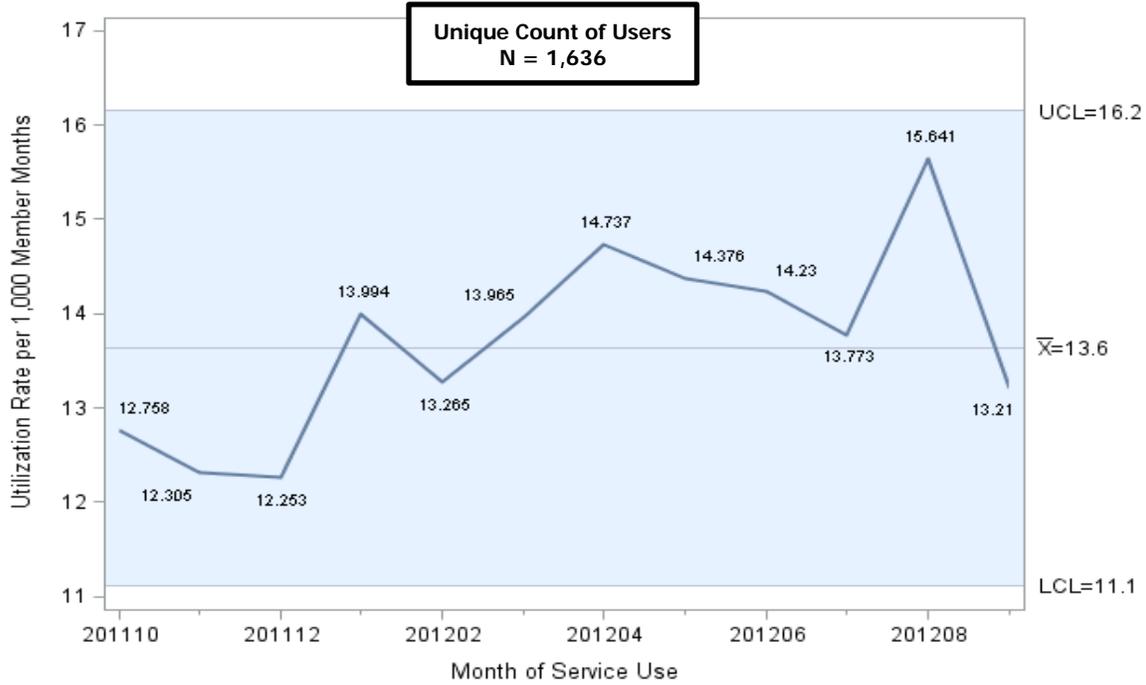
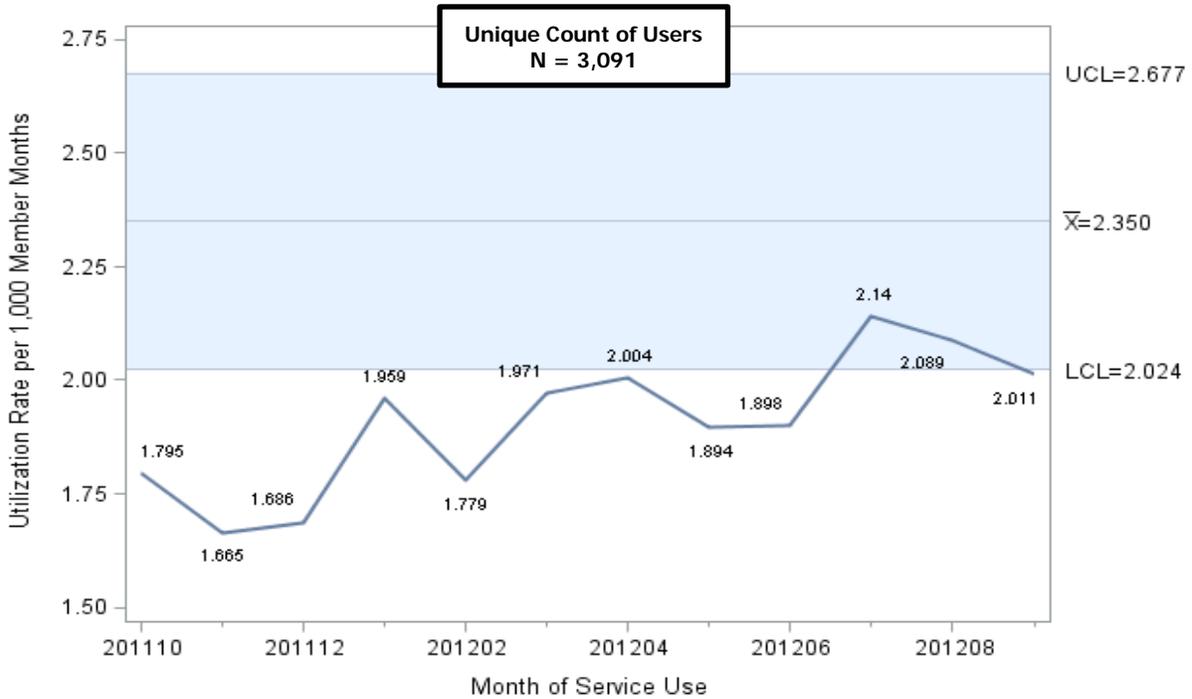


Figure SU-21 Emergency Medical Transportation Utilization, Adults (Age 21+), Undocumented, Oct. 2011–Sept. 2012



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 October 2011–September 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 0–20 participating in the FFS program and enrolled in the Blind/Disabled and Other aid categories. The monthly Home Health services utilization rates for children in these two aid categories ranged from 1.4–147.4 visits per 1,000 member months from the fourth quarter of 2011 to the third quarter of 2012.

Children in the Blind/Disabled aid category exhibited above average utilization of Home Health services, while children in the Other aid group rarely utilized these services. Children in the Blind/Disabled aid category again exhibited a gradual upward trend in service use. Additionally, children in the Blind/Disabled aid category exhibited Home Health services utilization above the thresholds established in the baseline period of 2007 to 2009 during the last two quarters of the study period. In contrast, children in the Other aid category displayed below average utilization that fell within the expected ranges throughout the study period.

Home Health service use is now concentrated among three user groups: children in the Other aid category and both children and adults in Blind/Disabled aid categories. The Blind/Disabled 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 10.5–14.3 visits per 1,000 member months from the fourth quarter of 2011 to the third quarter of 2012. Similar to the prior access quarterly reports, adults in the Blind/Disabled aid group exhibited much lower overall Home Health services utilization rates than children in the same aid category. Adults in this aid category mostly displayed above average utilization 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 and Foster Care aid categories were excluded because of their relatively small user counts (< 500).

The following figures SU-22 to SU-24 represent the control chart analysis for both children and adults from the fourth quarter of 2011 to the third quarter of 2012.

Trends—Monthly Home Health Services Utilization Rates by Children, October 2011–September 2012

Figure SU-22 Home Health Services Utilization, Children (Age 0–20), Blind/Disabled, Oct. 2011–Sept. 2012

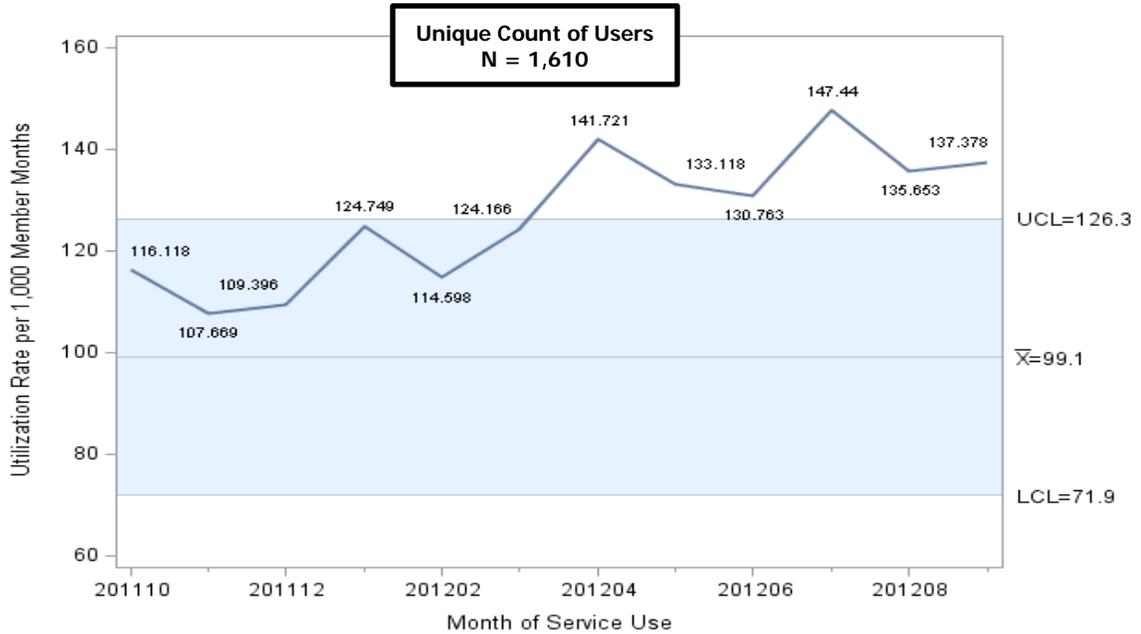
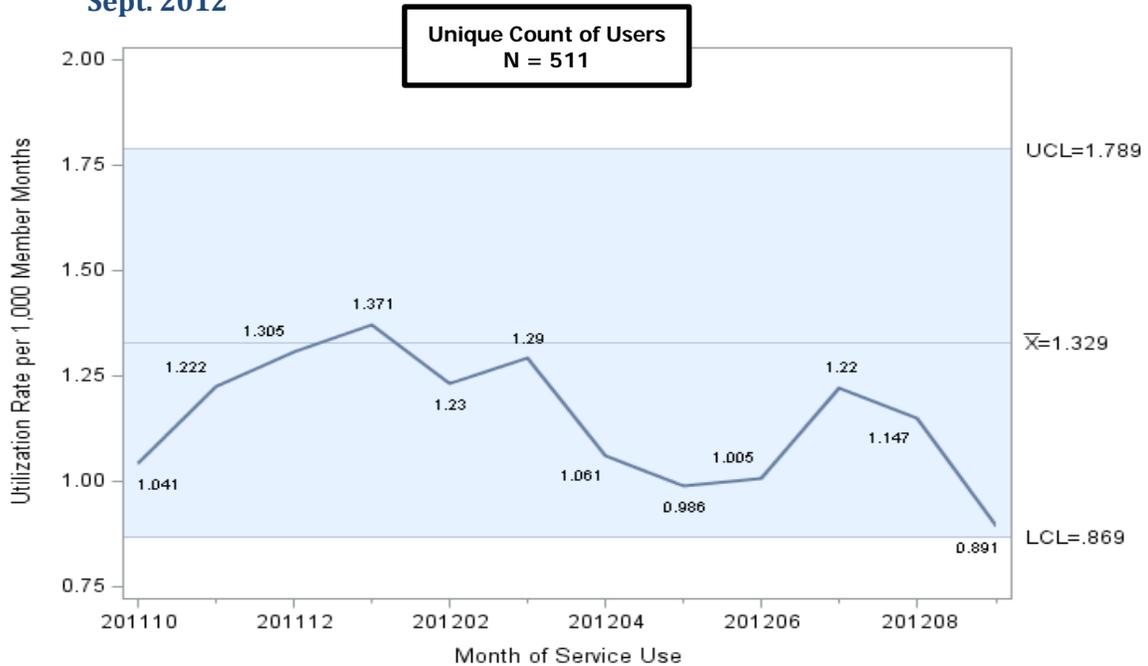


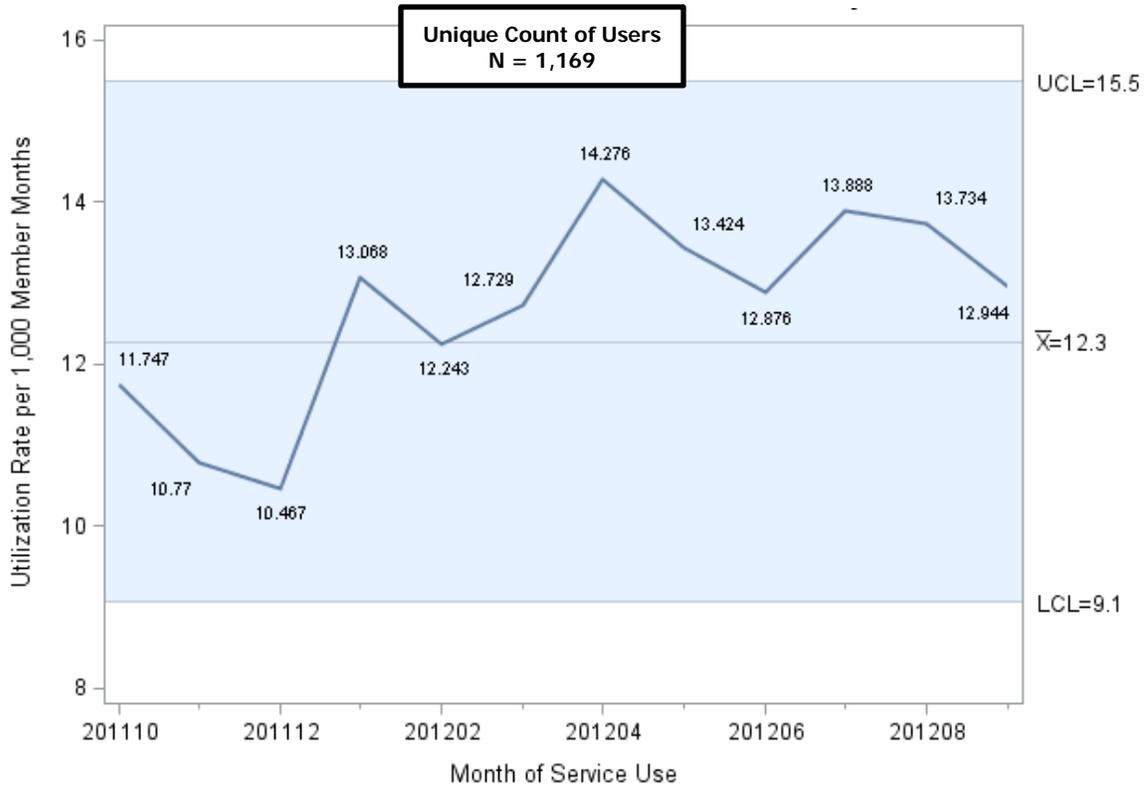
Figure SU-23 Home Health Services Utilization, Children (Age 0–20), Other, Oct. 2011–Sept. 2012



Source: Data for figures SU-22-23 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 October 2011–September 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Home Health Services Utilization by Adults, October 2011–September 2012

Figure 24 Home Health Utilization, Adults (Age 21+), Blind/Disabled, Oct. 2011–Sept. 2012



Source: Data for figure SU-24 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 October 2011–September 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 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 fourth quarter of 2011 to the third 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 about 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 utilization rates that at times fell below the expected baseline ranges.

Children in Blind/Disabled aid codes had Hospital Inpatient use rates that were 2-8 times higher than for children in the other aid categories.

Adults

Among adults 21 and older, monthly Hospital Inpatient services utilization rates ranged from 32.8–278.3 days per 1,000 member months from the fourth quarter of 2011 to the third quarter of 2012.

Hospital Inpatient services use 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 noticeably increased in 2012 to levels above the baseline thresholds. Of particular note, utilization rates for Adults in the Aged aid group dropped to within the expected ranges in June 2012 before returning above the baseline thresholds. 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 Hospital Inpatient services use among these subgroups may be influenced, in part, by the continued decline in statewide birth rates.⁵

Adults in both the Aged and Blind/Disabled aid categories experienced sharp increases in use in 2012, but with declines in the third quarter of 2012.

The following figures SU-25 to SU-34 represent the control chart analysis for both children and adults from the fourth quarter of 2011 to the third 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, October 2011–September 2012

Figure SU-25 Hospital Inpatient Utilization, Children (Age 0-20), Blind/Disabled, Oct. 2011–Sept. 2012

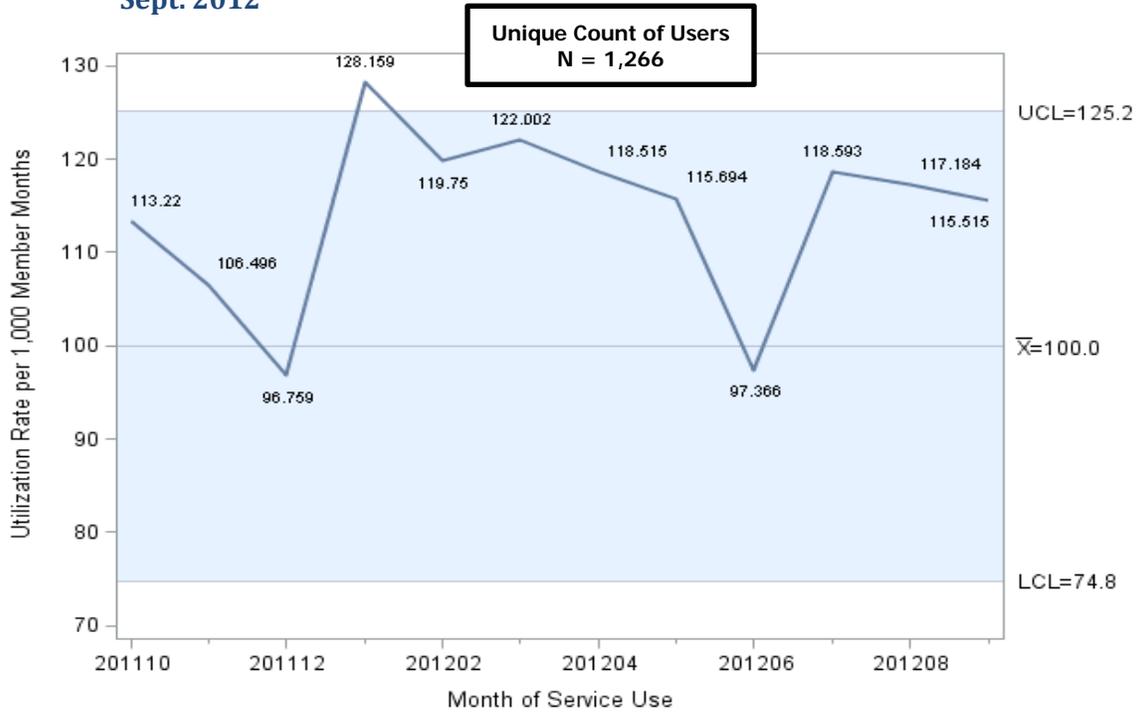


Figure SU-26 Hospital Inpatient Utilization, Children Age (0-20), Families, Oct. 2011–Sept. 2012

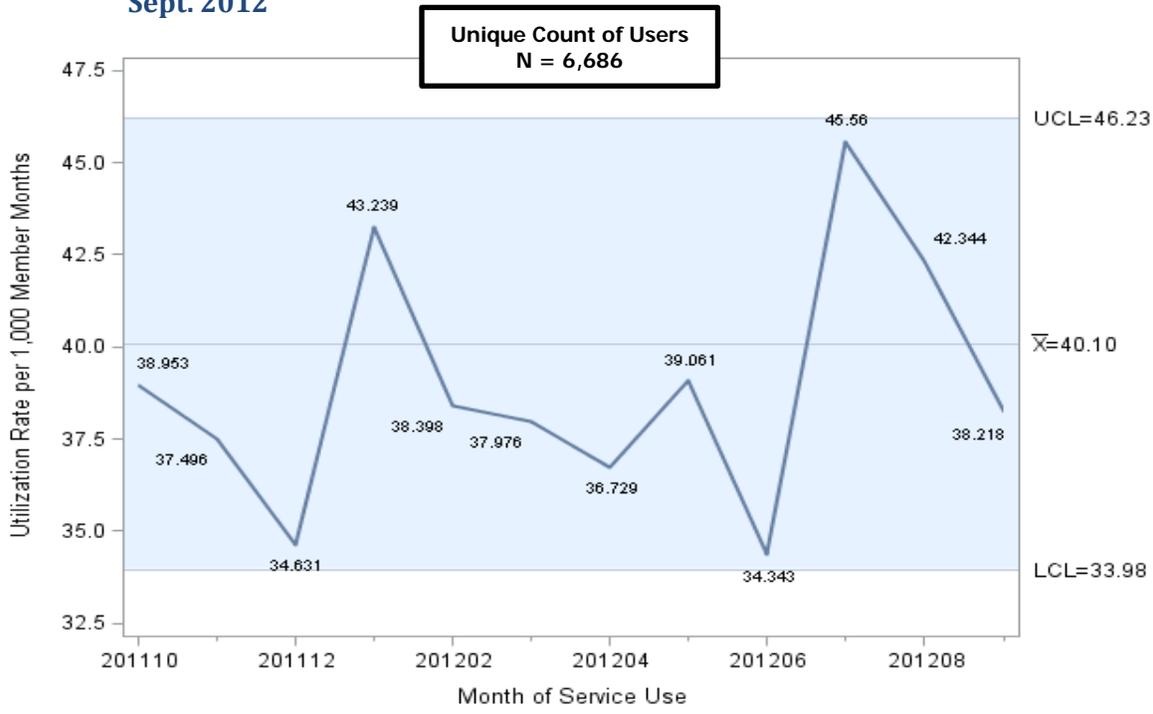


Figure SU-27 Hospital Inpatient Utilization, Children (Age 0-20), Foster Care, Oct. 2011-Sept. 2012

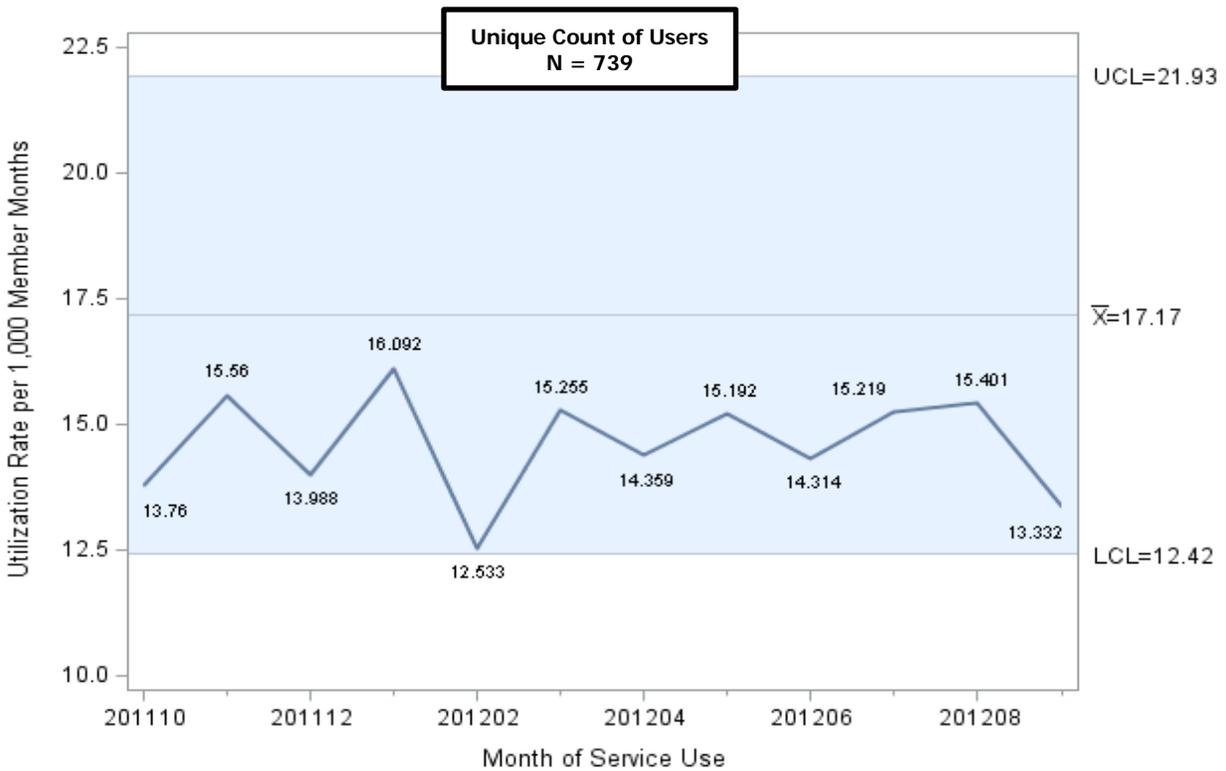


Figure SU-28 Hospital Inpatient Utilization, Children Age 0-20, Other, Oct 2011-Sept. 2012

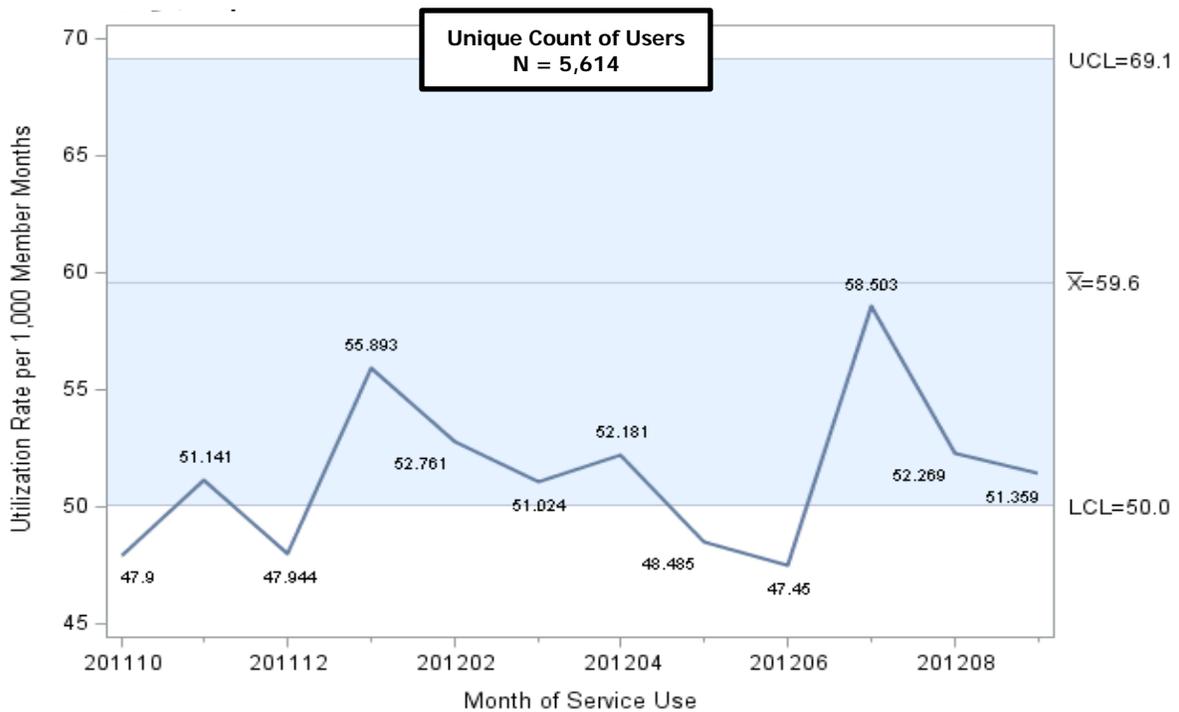
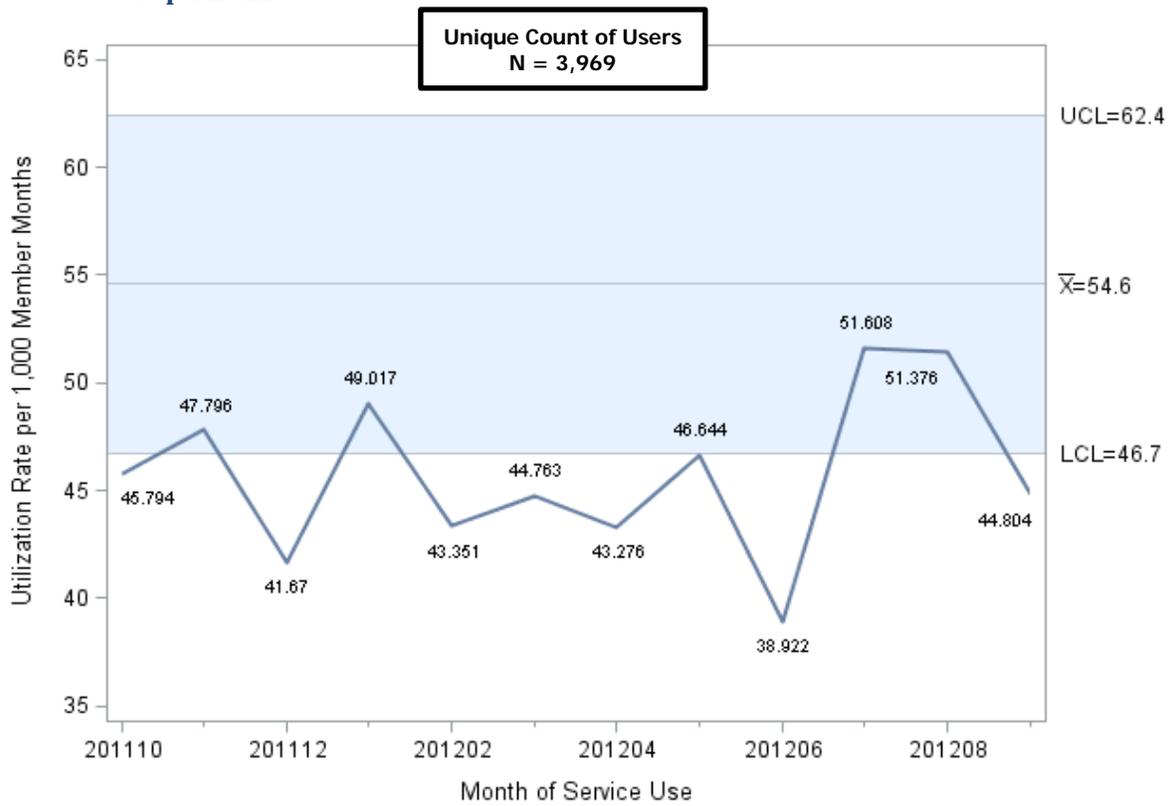


Figure SU-29 Hospital Inpatient Utilization, Children (Age 0-20), Undocumented, Oct. 2011–Sept. 2012



Source: Data for figures SU-25 to SU-29 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 October 2011–September 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends—Hospital Inpatient Services Utilization by Adults, October 2011–September 2012

Figure SU-30 Hospital Inpatient Utilization, Adults (Age 21+), Aged, Oct. 2011–Sept. 2012

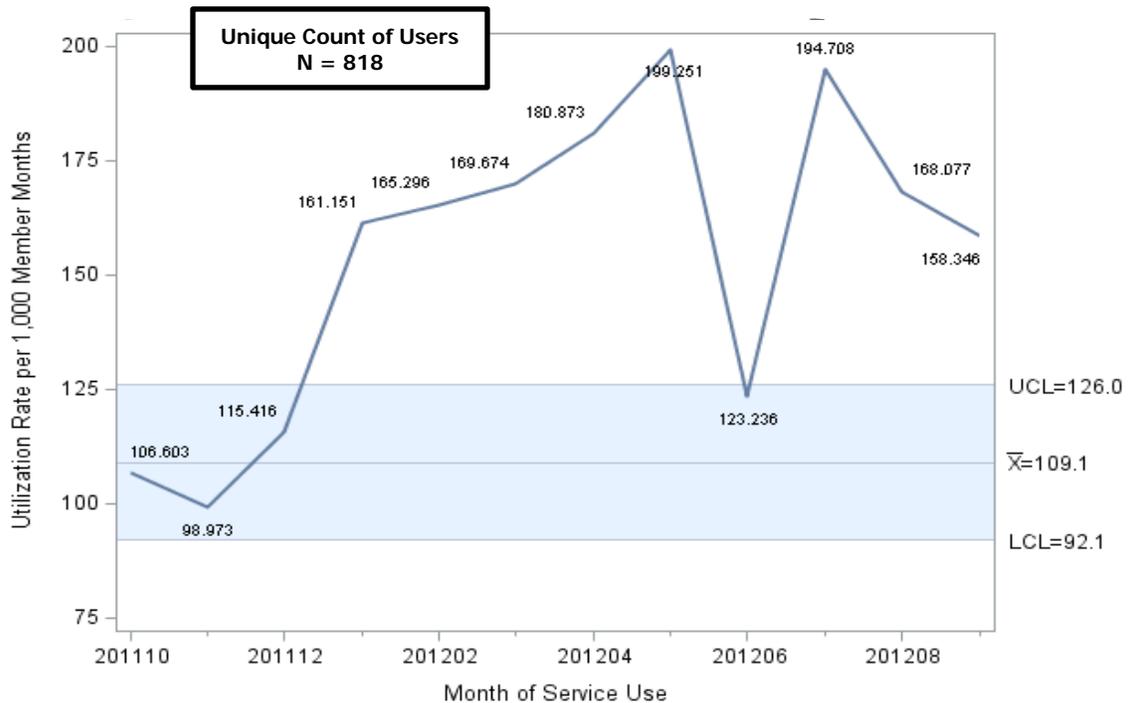


Figure SU-31 Hospital Inpatient Utilization, Adults (Age 21+), Blind/Disabled, Oct. 2011–Sept. 2012

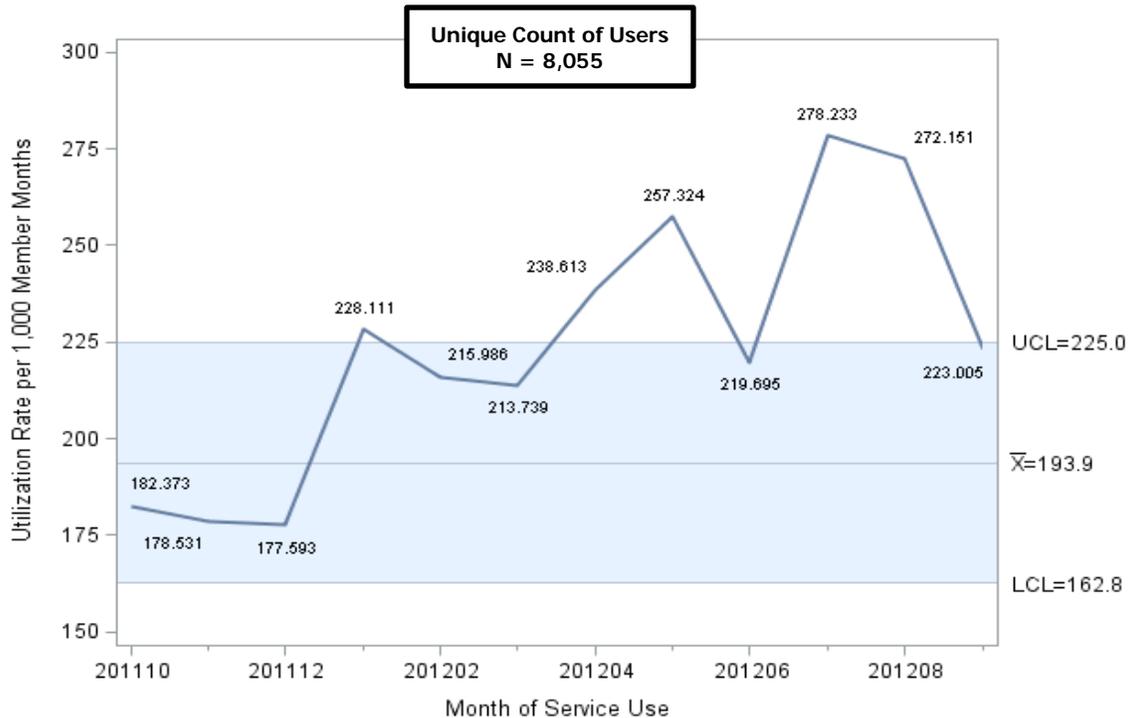


Figure SU-32 Hospital Inpatient Utilization Rates, Adults (Age 21+), Families, Oct. 2011–Sept. 2012

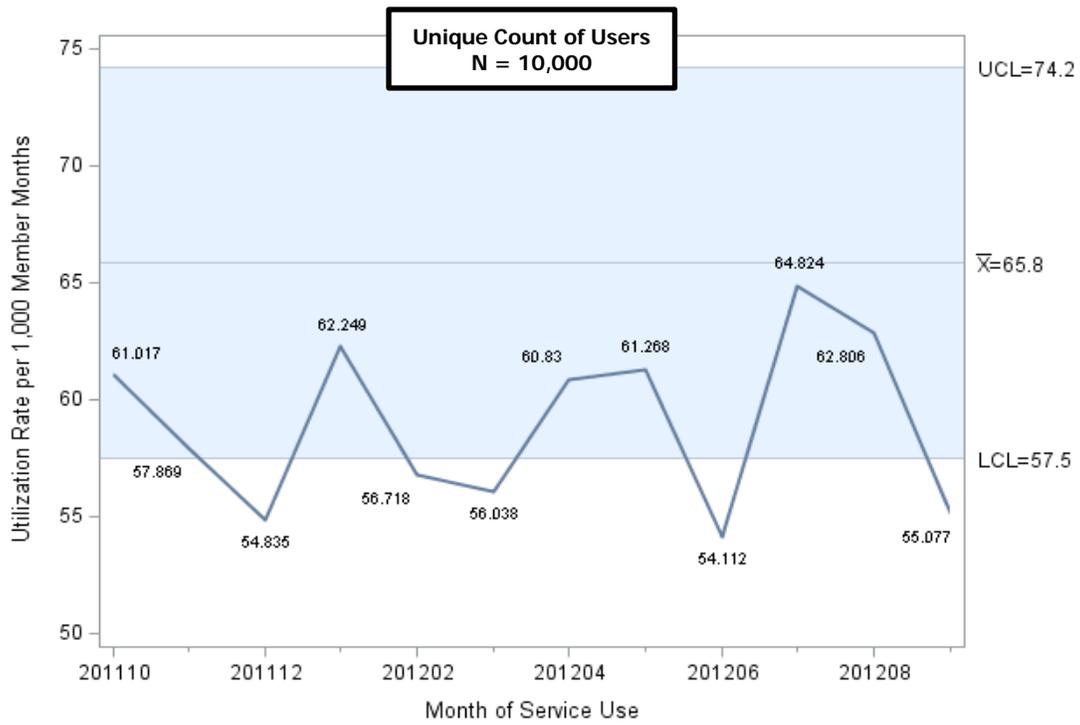


Figure SU-33 Hospital Inpatient Utilization, Adults (Age 21+), Other, Oct. 2011–Sept. 2012

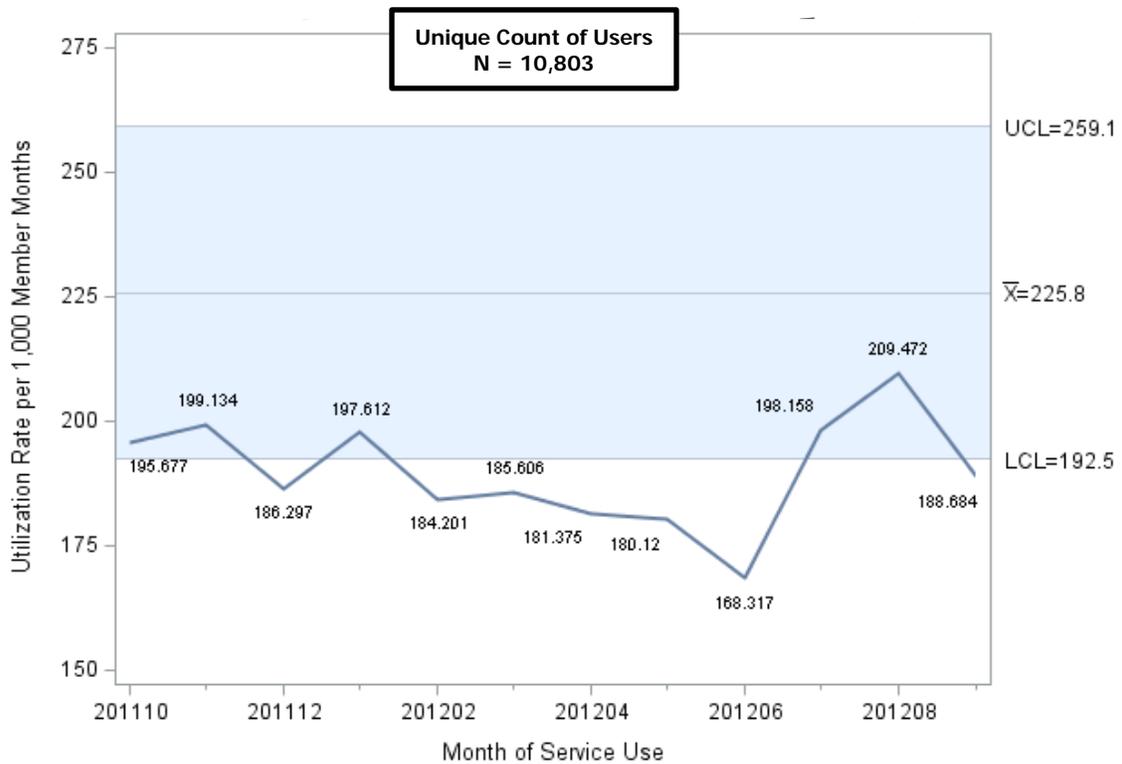
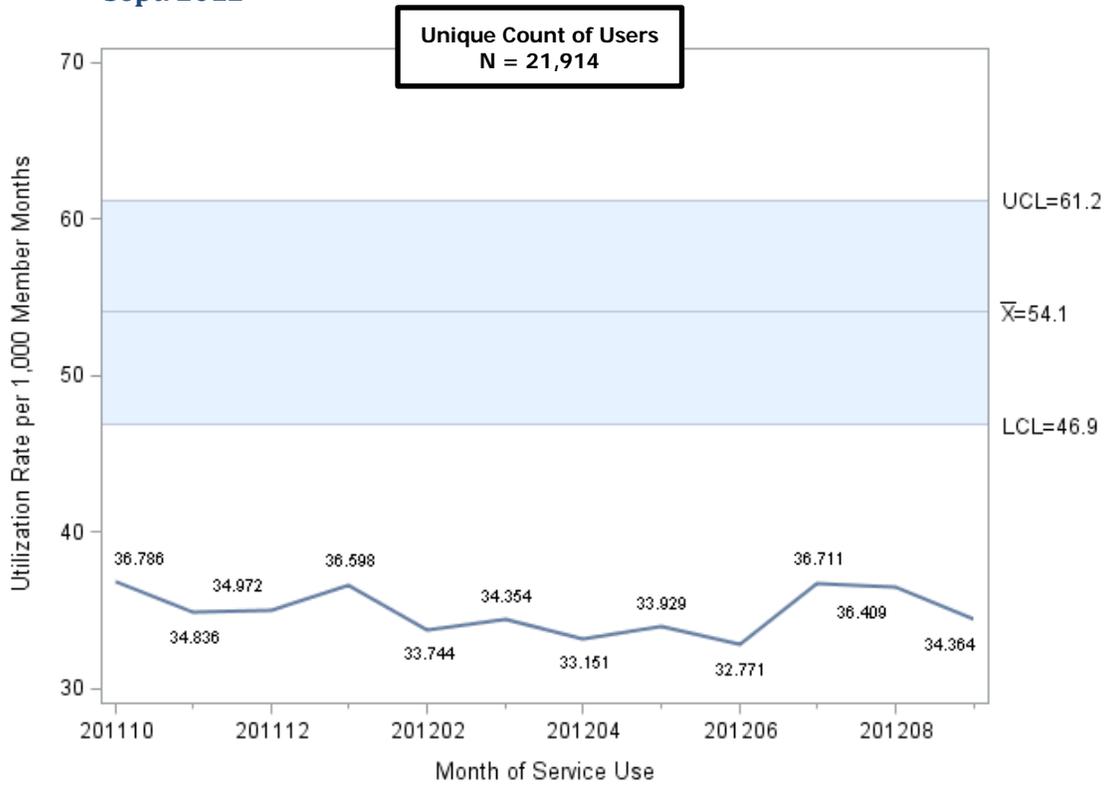


Figure SU-34 Hospital Inpatient Utilization, Adults (Age 21+), Undocumented, Oct. 2011–Sept. 2012



Source: Data for figures SU-30 to SU-34 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 October 2011–September 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 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 fourth quarter of 2011 to the third quarter of 2012.

Hospital Outpatient services use 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 use 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 most of the study period, while children in the Other aid group displayed six consecutive months of utilization below the expected ranges during the final two quarters. Children in the Blind/Disabled aid category exhibited an increase in Hospital Outpatient service use beginning in 2012 that reached above the expected ranges before dropping to average levels in May 2012.

Children in the Blind/Disabled aid category used Hospital Inpatient services at rates 2-3 times more than children in other aid categories.

Adults

The monthly Hospital Outpatient services utilization rates for adults age 21 and older ranged from 48.0–318.3 visits per 1,000 member months from the fourth quarter of 2011 to the third 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 Blind/Disabled aid category exhibited notable increases in Hospital Outpatient services use beginning in 2012 that reached levels above the expected ranges during the last two quarters of the study period. Of particular note, utilization for adults in the Aged aid group reached above the expected range in May 2012 before falling within the baseline thresholds. Adults in the Families, Other, and Undocumented aid categories all exhibited below average use of services that primarily remained within expected ranges.

Adult beneficiaries in the Blind/Disabled and Other aid categories exhibited higher utilization of Hospital Outpatient services.

The following figures SU-35 to SU-44 represent the control chart analysis for both children and adults from the fourth quarter of 2011 to the third quarter of 2012.

Trends—Monthly Hospital Outpatient Services Utilization Rates by Children, October 2011–September 2011

Figure SU-35 Hospital Outpatient Utilization, Children (Age 0-20), Blind/Disabled, Oct. 2011–Sept. 2012

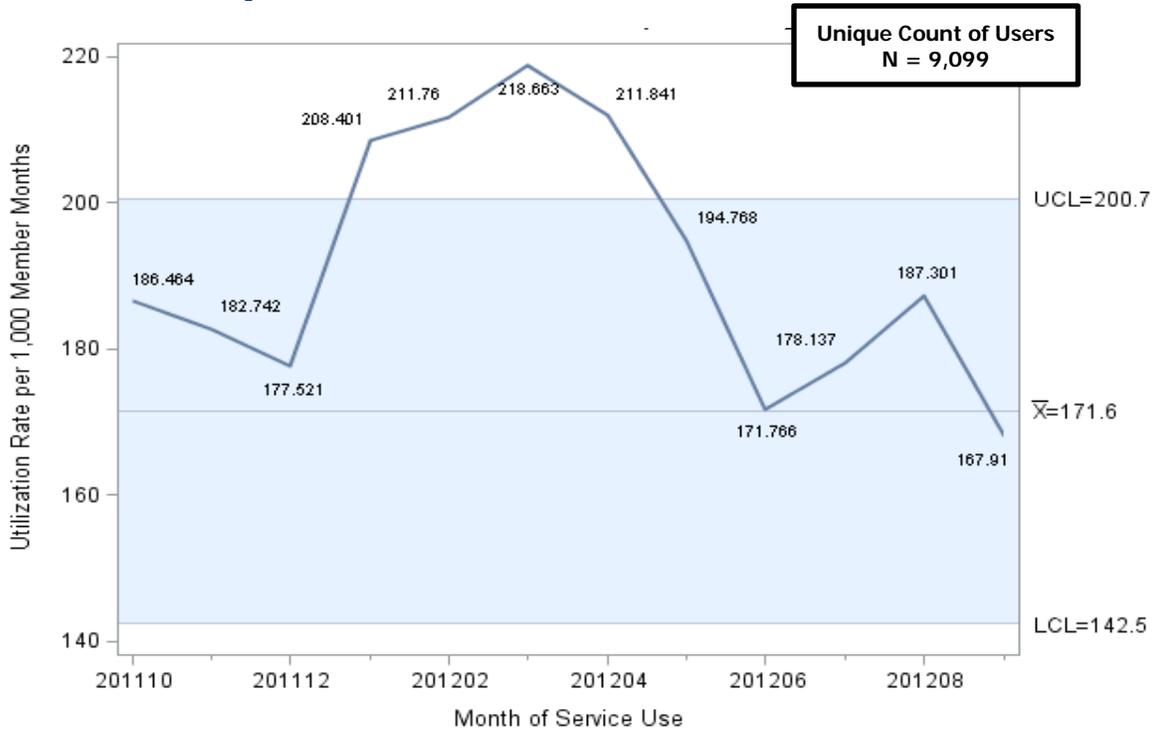


Figure SU-36 Hospital Outpatient Utilization, Children (Age 0-20), Families, Oct. 2011–Sept. 2012

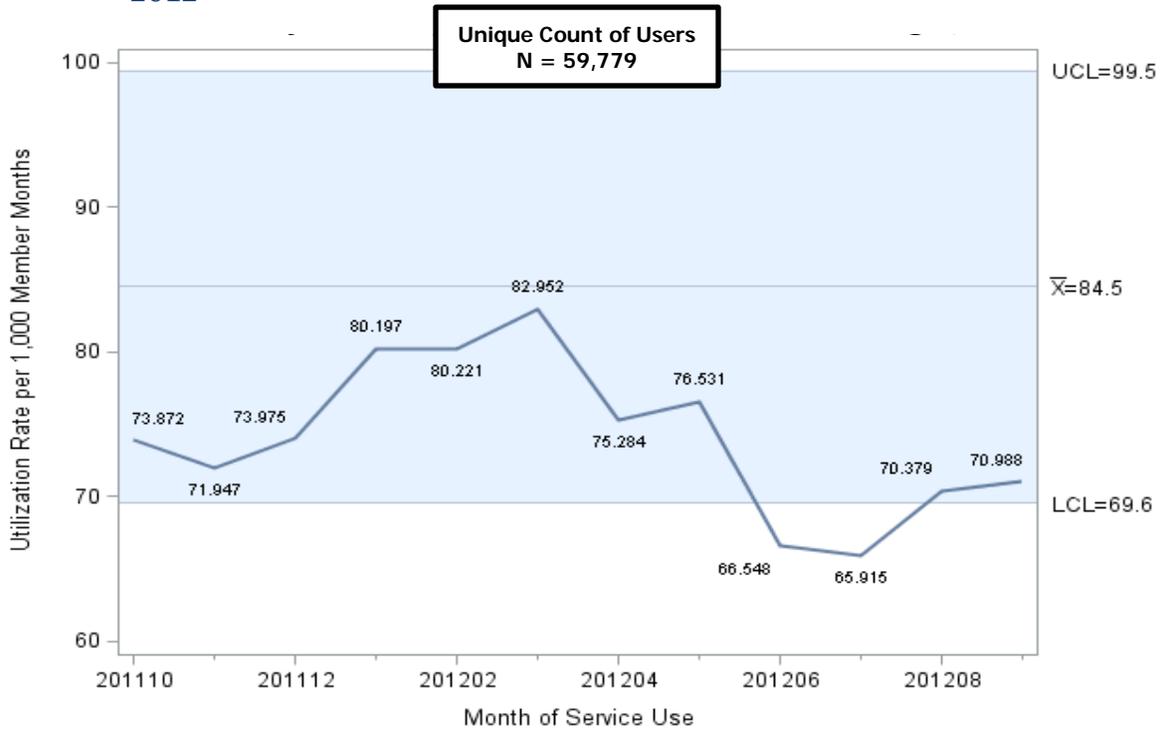


Figure SU-37 Hospital Outpatient Utilization, Children (Age 0-20), Foster Care, Oct. 2011–Sept. 2012

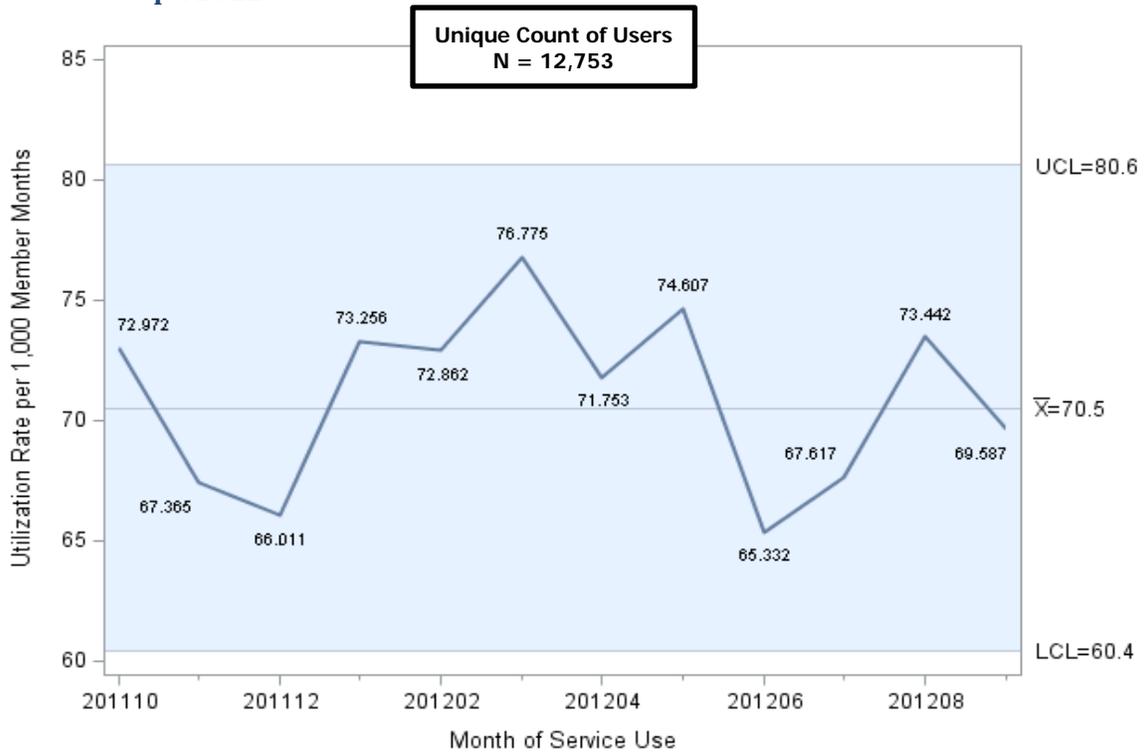


Figure SU-38 Hospital Outpatient Utilization, Children (Age 0-20), Other, Oct. 2011–Sept. 2012

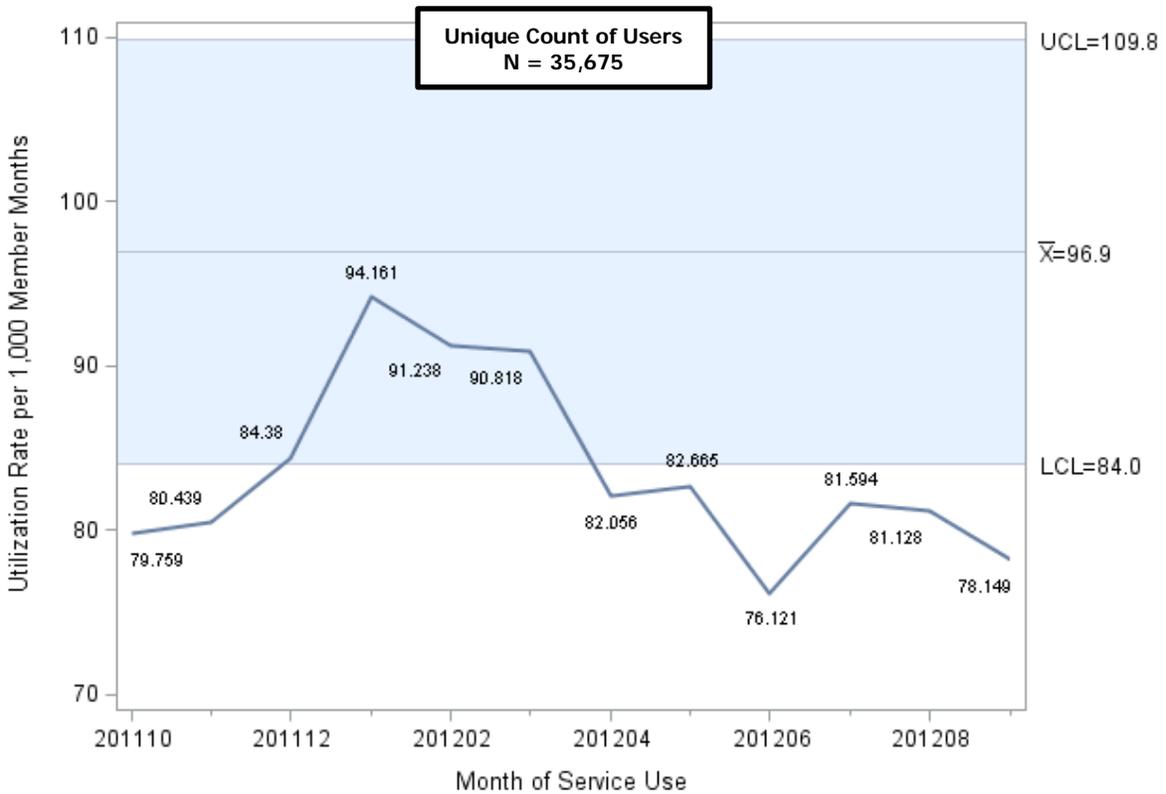
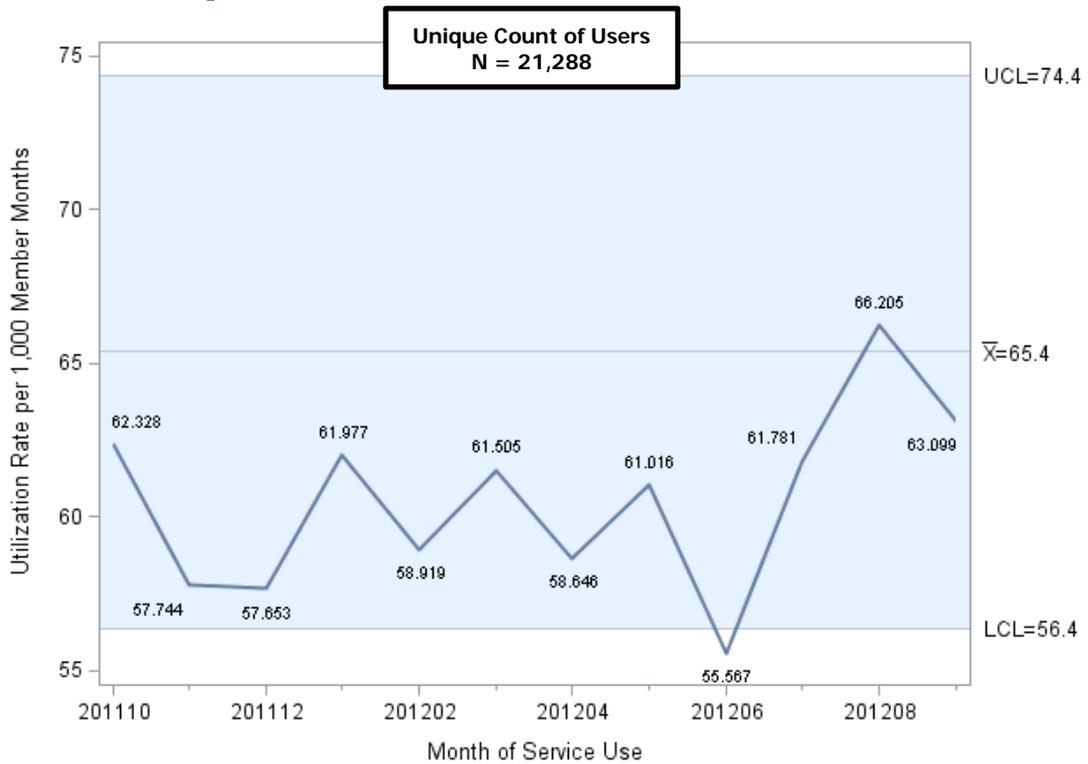


Figure SU-39 Hospital Outpatient Utilization, Children (Age 0-20), Undocumented, Oct. 2011–Sept. 2012



Source: Data for figures SU-35 to SU-39 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 October 2011–September 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, October 2011–September 2012

Figure SU-40 Hospital Outpatient Utilization, Adults (Age 21+), Aged, Oct. 2011–Sept. 2012

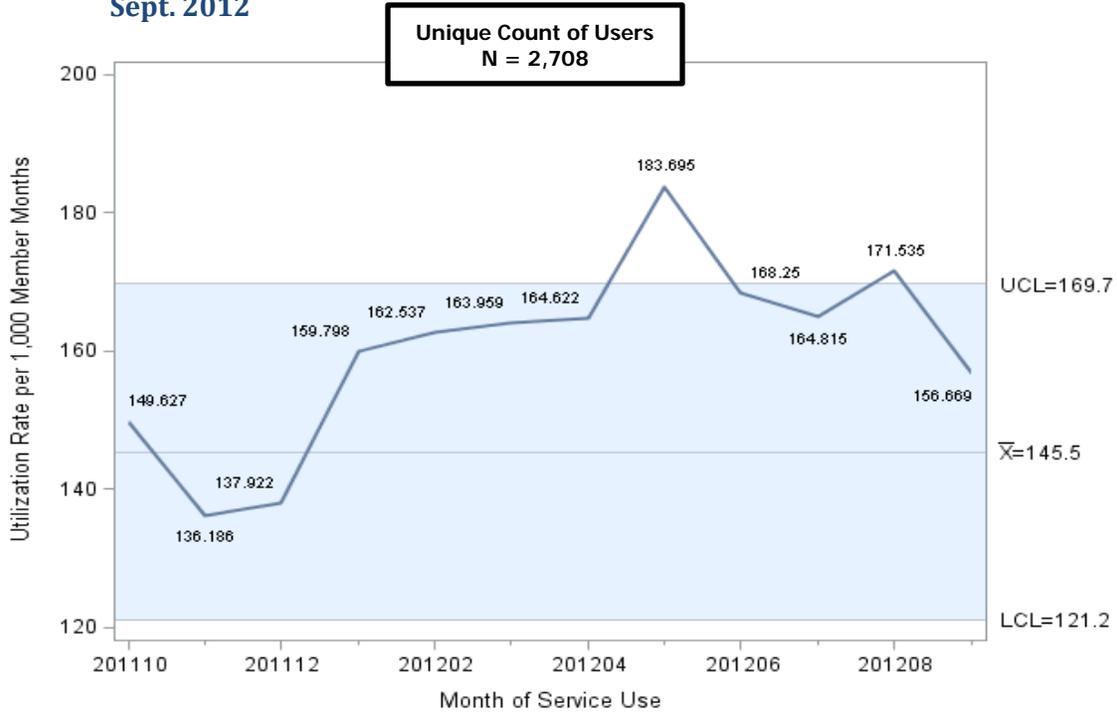


Figure SU-41 Hospital Outpatient Utilization, Adults (Age 21+), Blind/Disabled, Oct. 2011–Sept. 2012

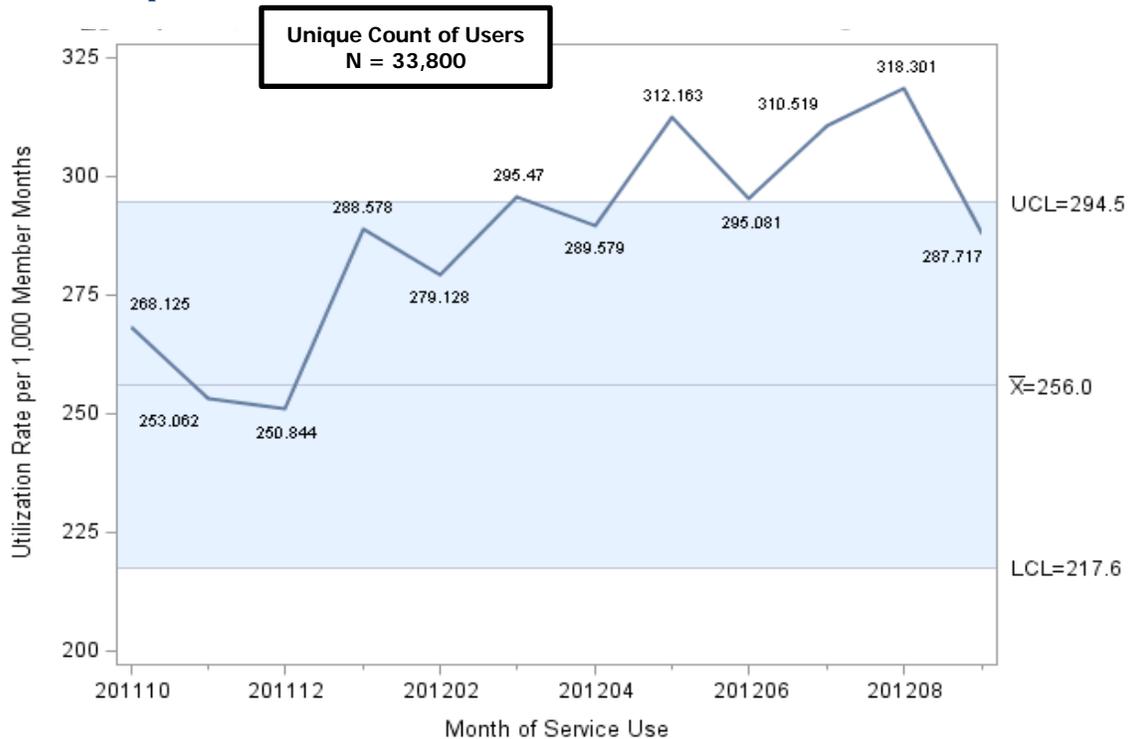


Figure SU-42 Hospital Outpatient Utilization, Adults (Age 21+), Families, Oct. 2011–Sept. 2012

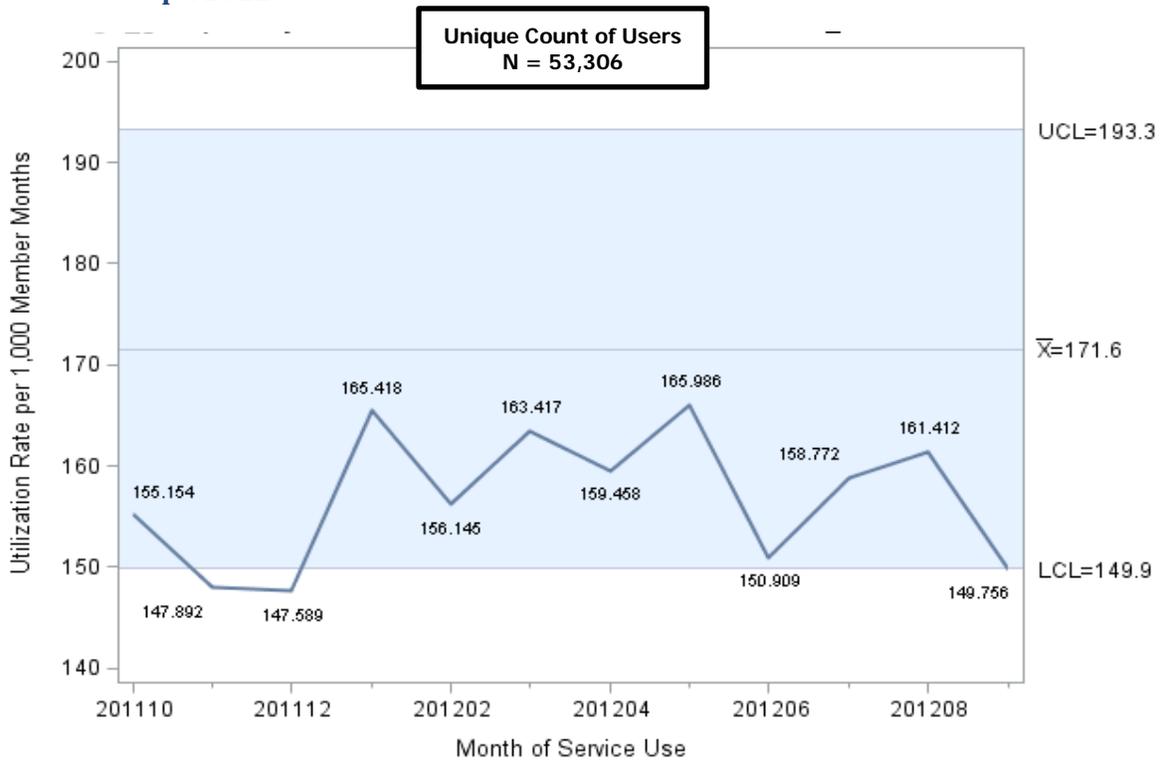


Figure SU-43 Hospital Outpatient Utilization, Adults (Age 21+), Other, Oct. 2011–Sept. 2012

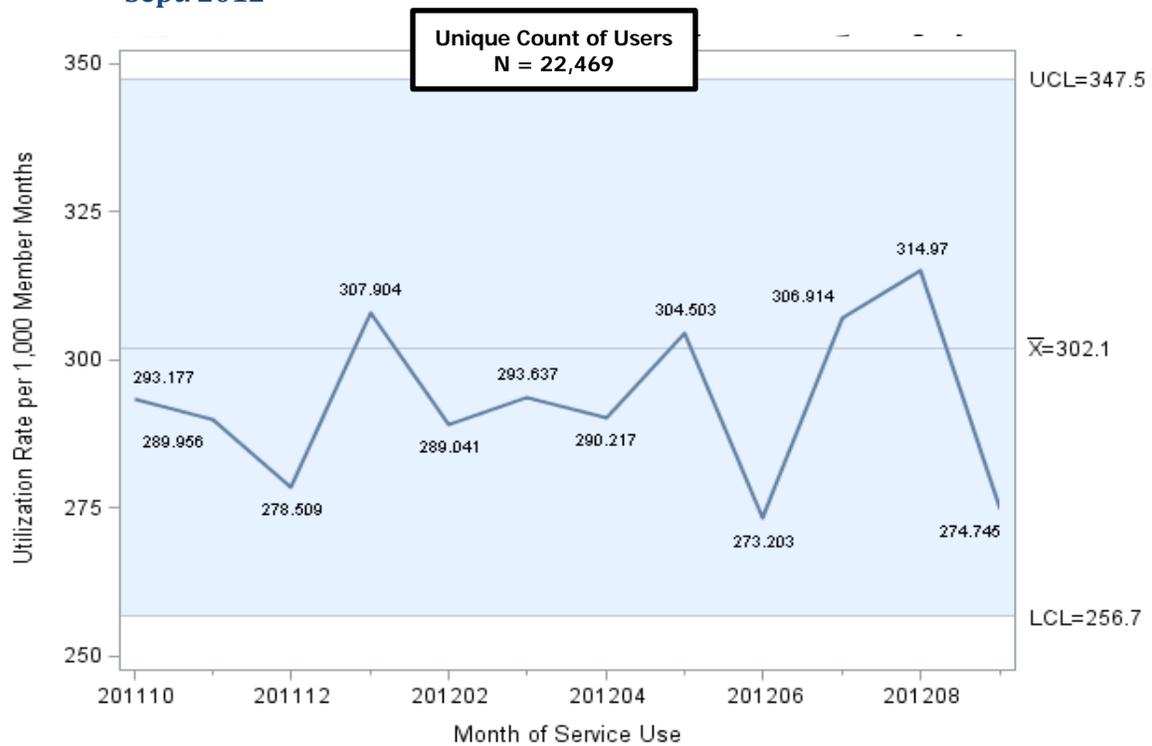
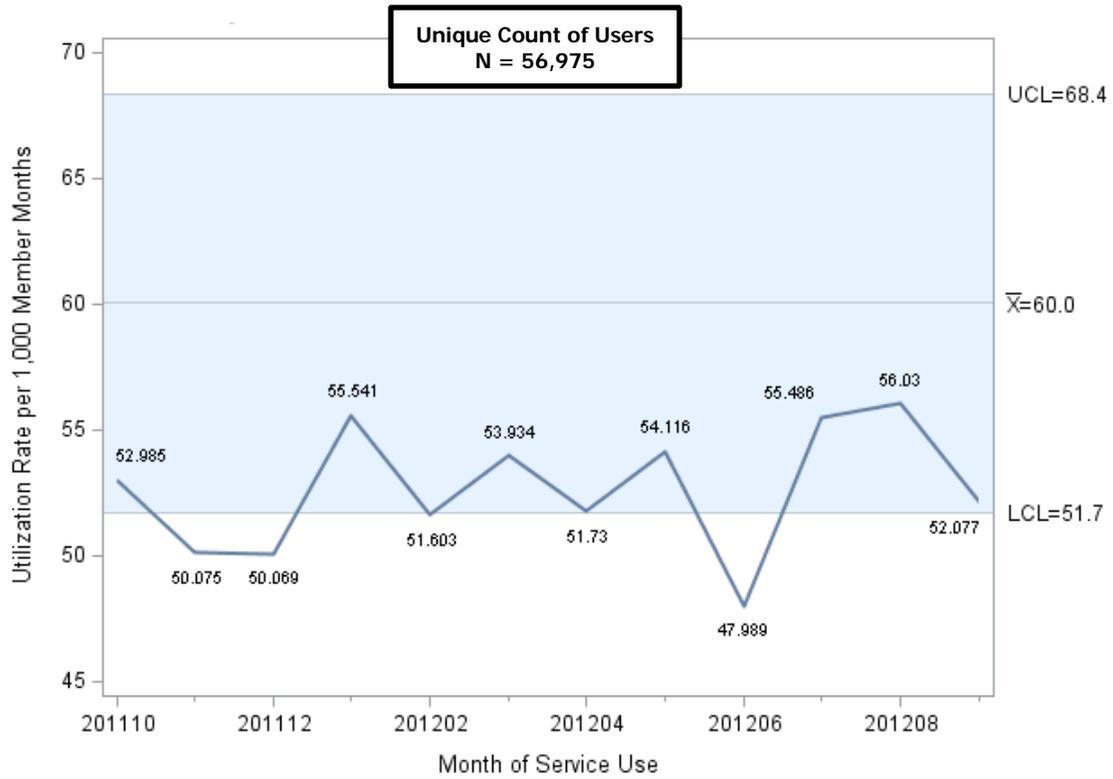


Figure SU-44 Hospital Outpatient Utilization, Adults (Age 21+), Undocumented, Oct. 2011–Sept. 2012



Source: Data for figures SU-40 to SU-44 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 October 2011–September 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 that 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 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 273.9–2,124.7 days per 1,000 member months from the fourth quarter of 2011 to the third 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 subgroup contains beneficiaries enrolled in long term care aid codes. Although displaying much higher use than most other beneficiary subgroups, adults in the Other aid category continued to exhibit below average Nursing Facility services utilization rates that at times fell below the ranges established during the baseline period. Adults in the Aged and Blind/Disabled aid categories continued to display upward trends in utilization of Nursing Facility services that reached levels well above the expected ranges during the first three quarters of the study period. Of particular note, Nursing Facility services use among adults in these two aid categories leveled off during the last quarter of the study period. Additionally, the utilization rates for adults in the Blind/Disabled and Aged aid categories approximately doubled over the course of the study period.

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 doubled during the study period, and tripled 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.

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

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

system can be characterized as those exhibiting health care needs that are much greater than the norm.

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-45 to SU-47 represent the control chart analysis for adults from the fourth quarter of 2011 to the third quarter of 2012.

Trends—Nursing Facility Services Utilization by Adults, October 2011–September 2012

Figure SU-45 Nursing Facility Utilization, Adults (Age 21+), Aged, Oct. 2011–Sept. 2012

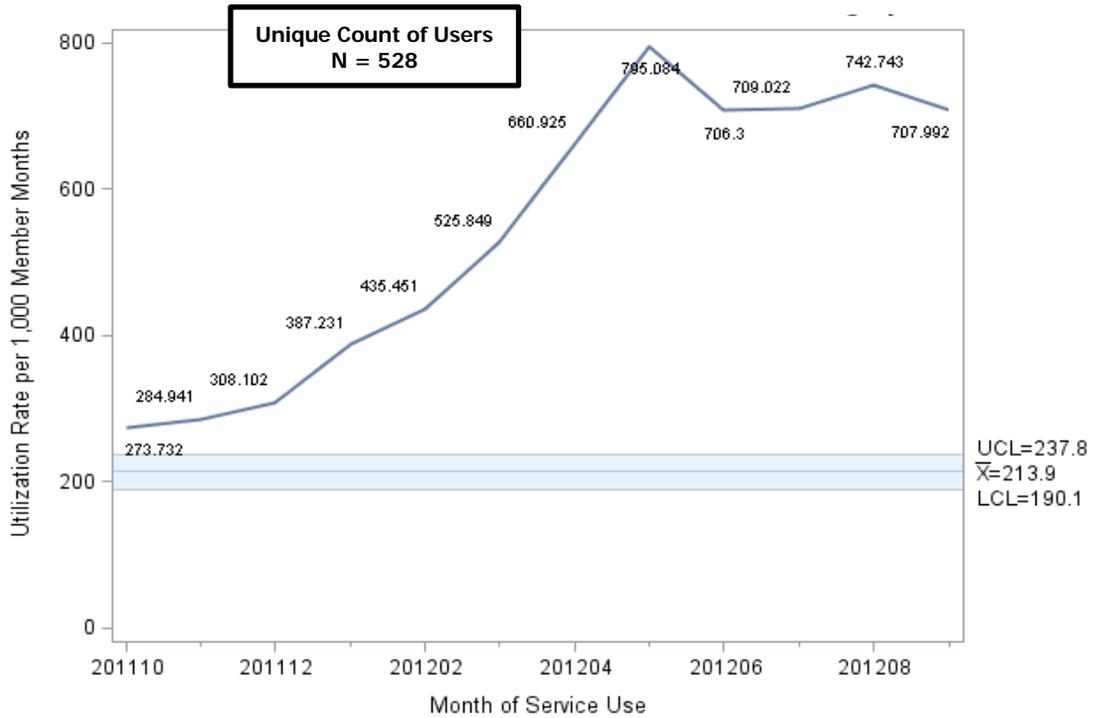


Figure SU-46 Nursing Facility Utilization, Adults (Age 21+), Blind/Disabled, Oct. 2011–Sept. 2012

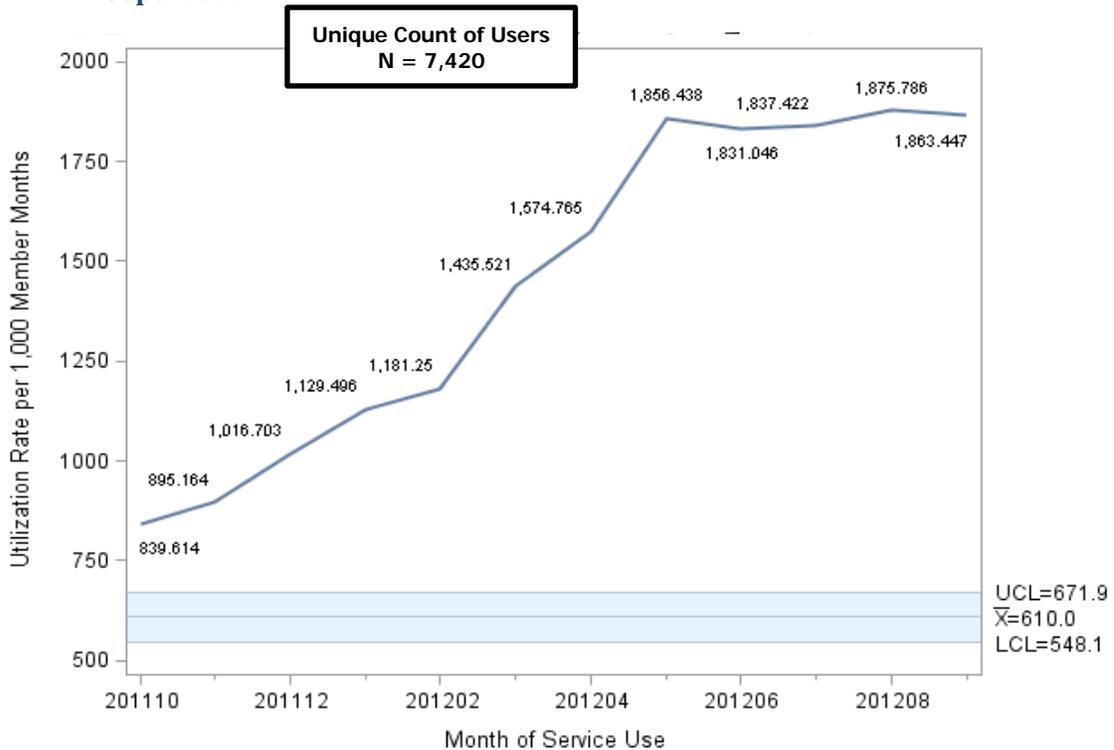
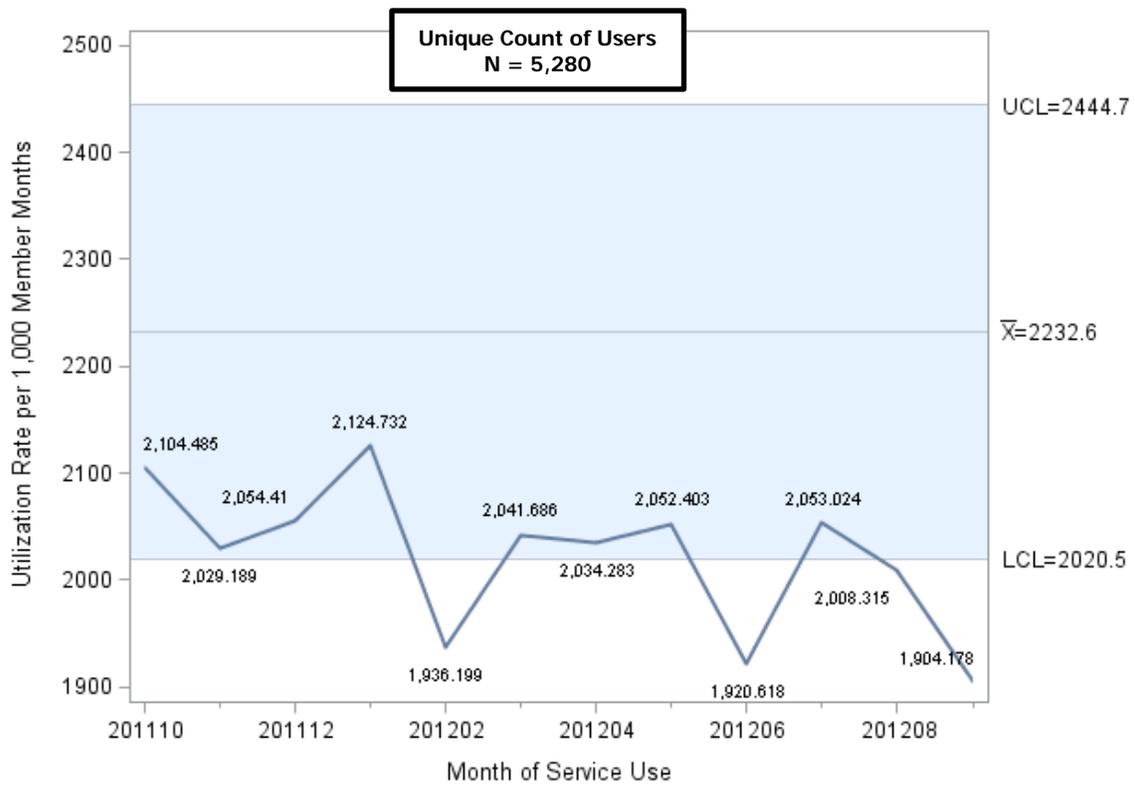


Figure SU-47 Nursing Facility Utilization, Adults (Age 21+), Other, Oct. 2011–Sept. 2012



Source: Data for figures SU-45 to SU-47 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 October 2011–September 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 65.8–1,521.9 prescriptions per 1,000 member months from the fourth quarter of 2011 to the third quarter of 2012.

Among children in the Blind/Disabled aid category, Pharmacy services use is 2-6 times higher than for other children in other aid categories.

Similar to the previous access quarterly reports, the utilization of Pharmacy services 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 the last quarter of the study period. Additionally, children in the Blind/Disabled aid category exhibited an upward trend in utilization over the initial two quarters of the study period that ultimately reached above the baseline ranges before declining back to normal levels in the last two analyzed quarters. 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 use.

Adults

Among adults 21 and older, monthly Pharmacy services utilization rates ranged from 183.3–3,300.8 prescriptions per 1,000 member months from the fourth quarter of 2011 to the third quarter of 2012.

Declining use of Pharmacy services since late-2011 among adults in the Aged, Blind/Disabled, and Families aid categories.

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 higher utilization rates of pharmacy services, while adults in the Undocumented aid category utilized these services at much lower rates. Adults in the Aged, Blind/Disabled, Families, and Other 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 throughout most of the study period that reached levels below the baseline ranges during 2012. Additionally, adults in the Blind/Disabled and Families aid categories displayed noticeably reduced utilization rates that at times fell below the expected ranges during the final two quarters of the study period. In contrast, Pharmacy services utilization rates for adults in the Other and Undocumented aid groups fell within the expected ranges.

The following figures SU-48 to SU-57 represent the control chart analysis for both children and adults from the fourth quarter of 2011 to the third quarter of 2012.

Trends—Pharmacy Services Utilization by Children, October 2011–September 2012

Figure SU-48 Pharmacy Utilization, Children (Age 0–20), Blind/Disabled, Oct. 2011–Sept. 2012

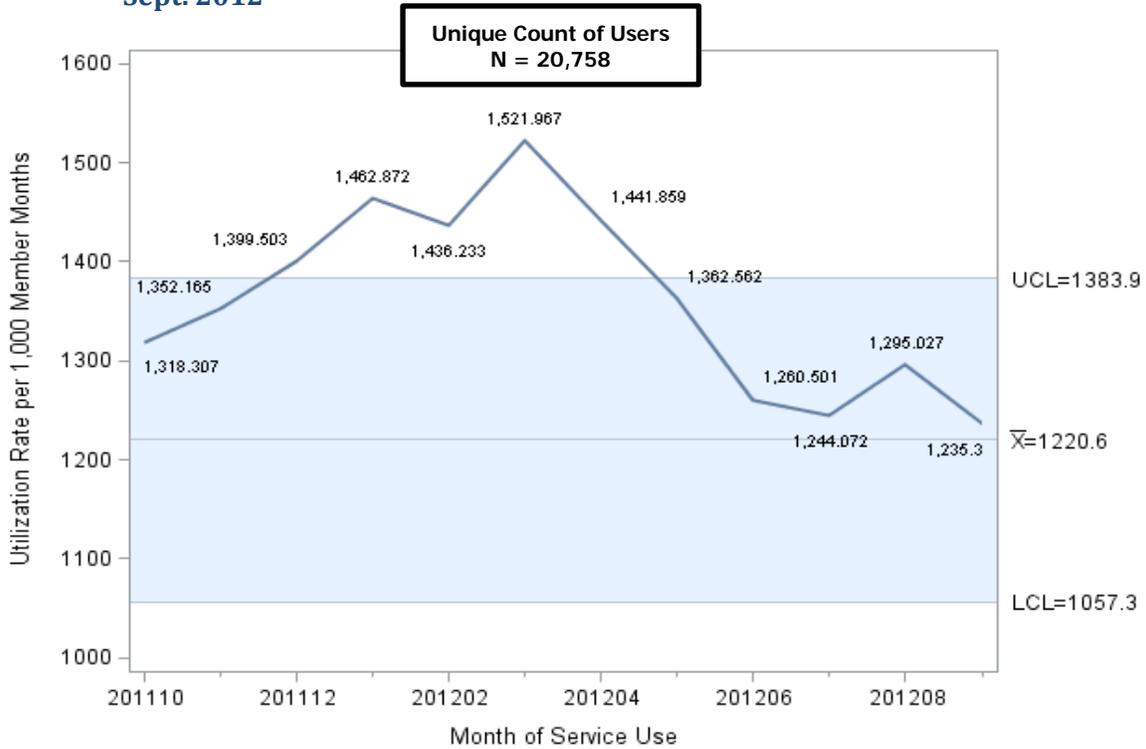


Figure SU-48 Pharmacy Utilization, Children (Age 0–20), Families, Oct. 2011–Sept. 2012

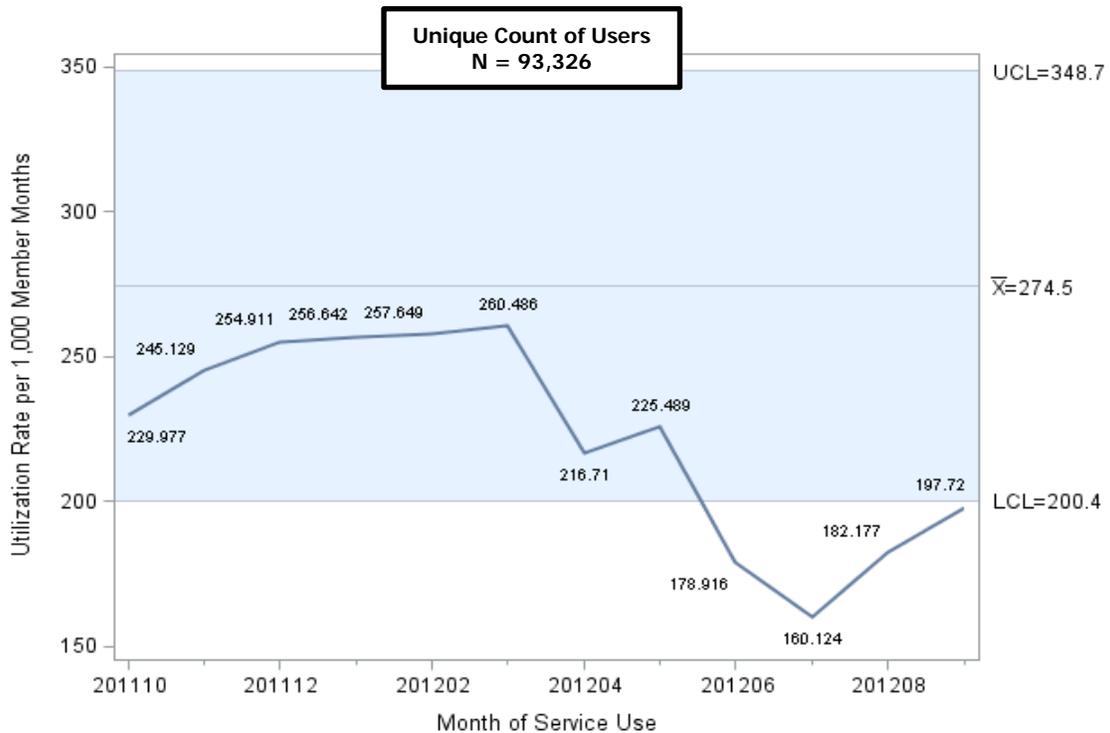


Figure SU-49 Pharmacy Utilization, Children (Age 0-20), Foster Care, Oct. 2011-Sept. 2012

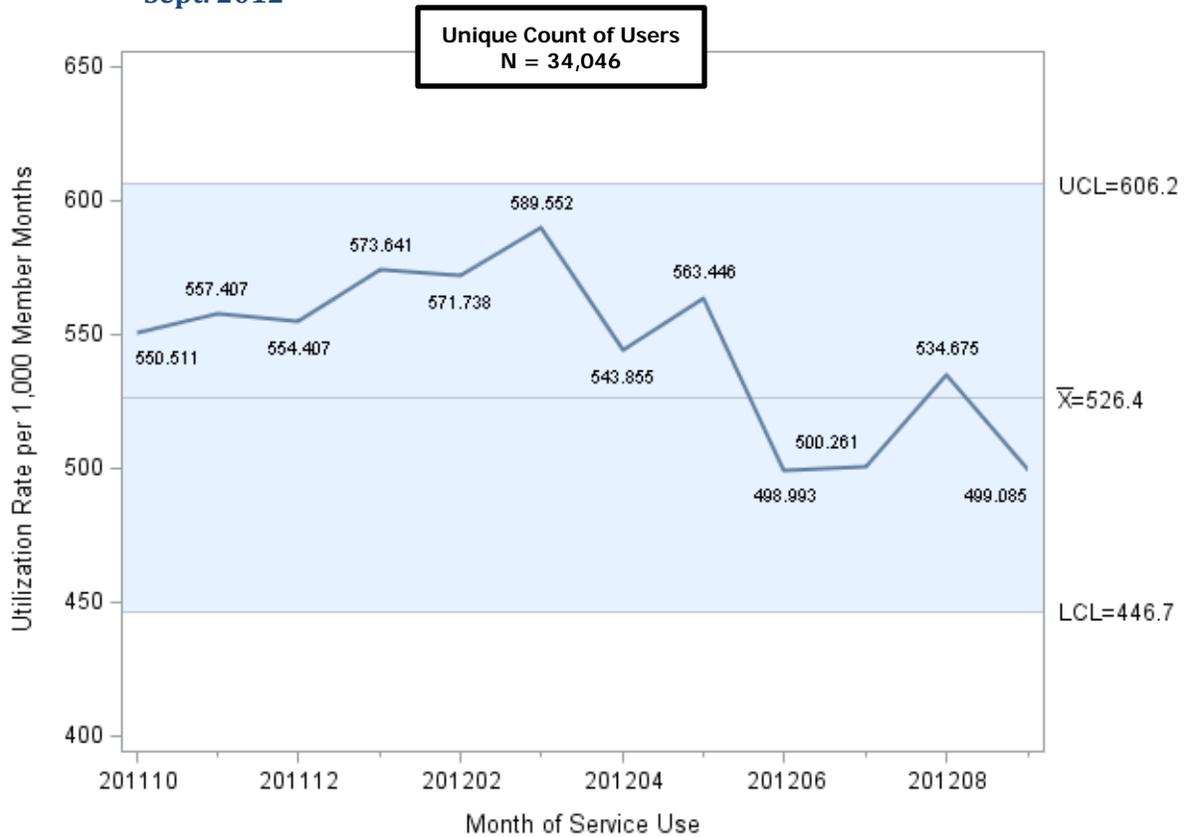


Figure SU-50 Pharmacy Utilization, Children (Age 0-20), Other, Oct. 2011-Sept. 2012

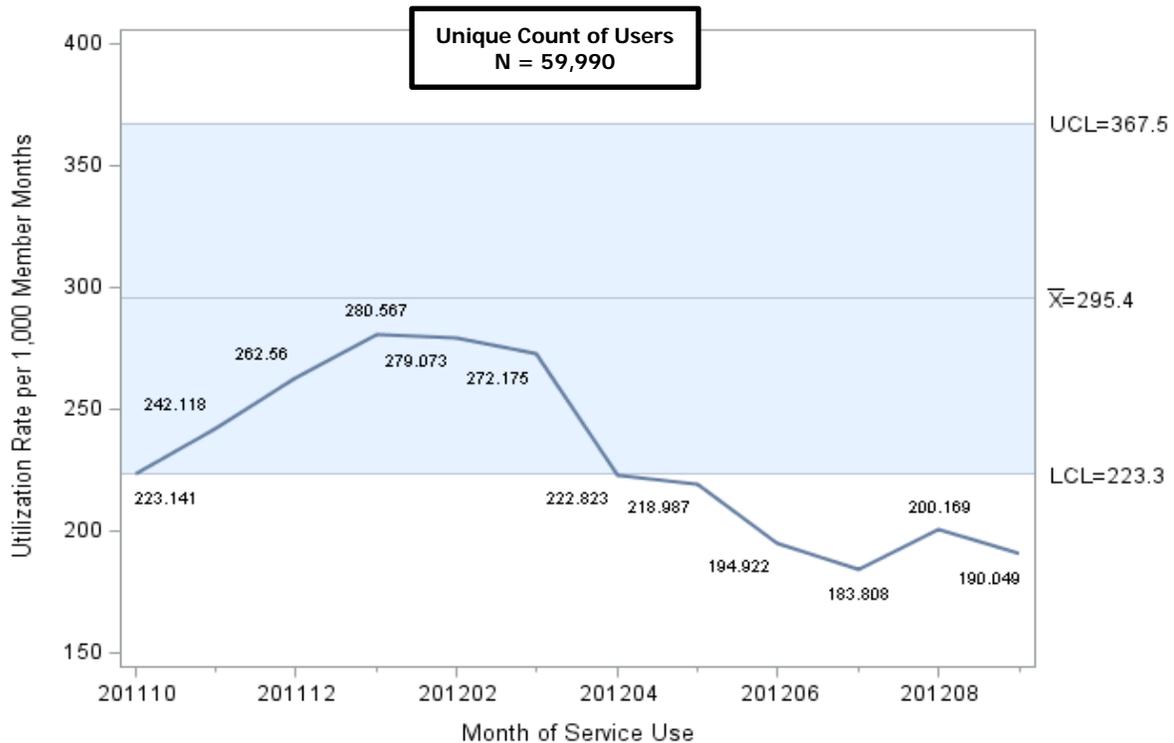
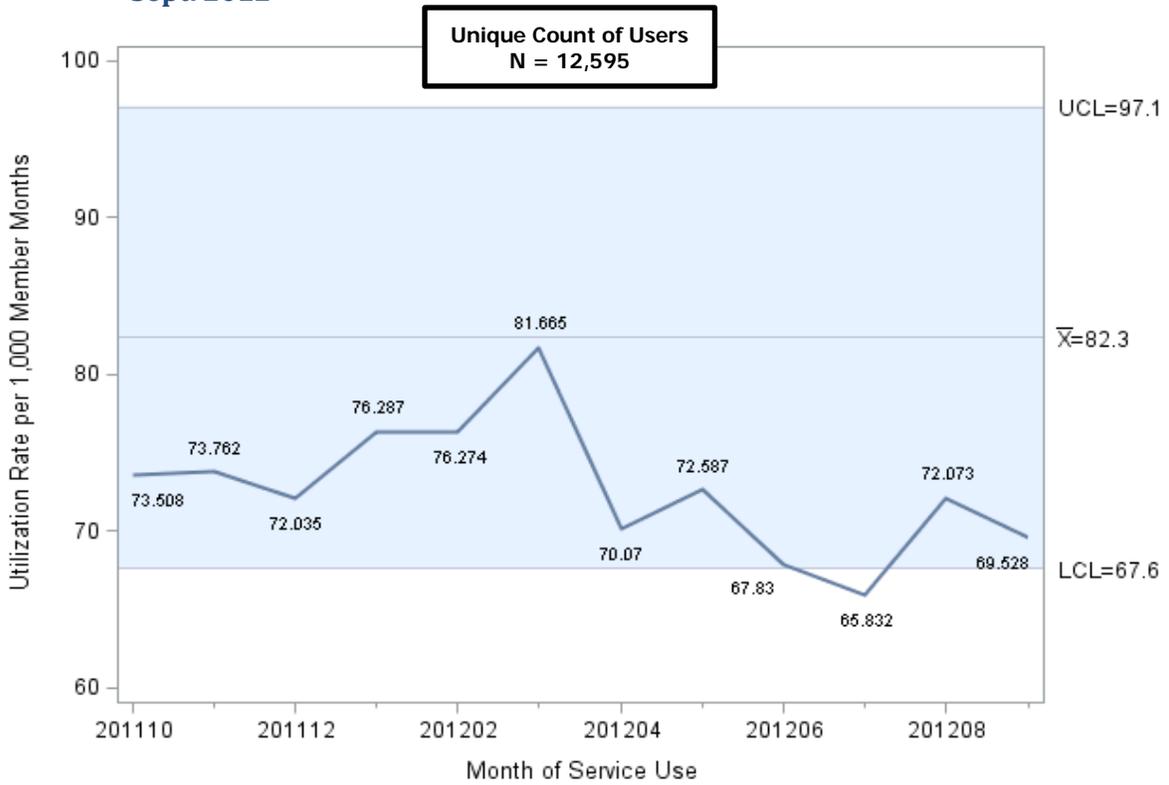


Figure SU-51 Pharmacy Utilization, Children (Age 0-20), Undocumented, Oct. 2011-Sept. 2012



Source: Data for figures SU-48 to SU-52 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 October 2011-September 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, October 2011–September 2012

Figure SU-52 Pharmacy Utilization, Adults (Age 21+), Aged, Oct. 2011–Sept. 2012

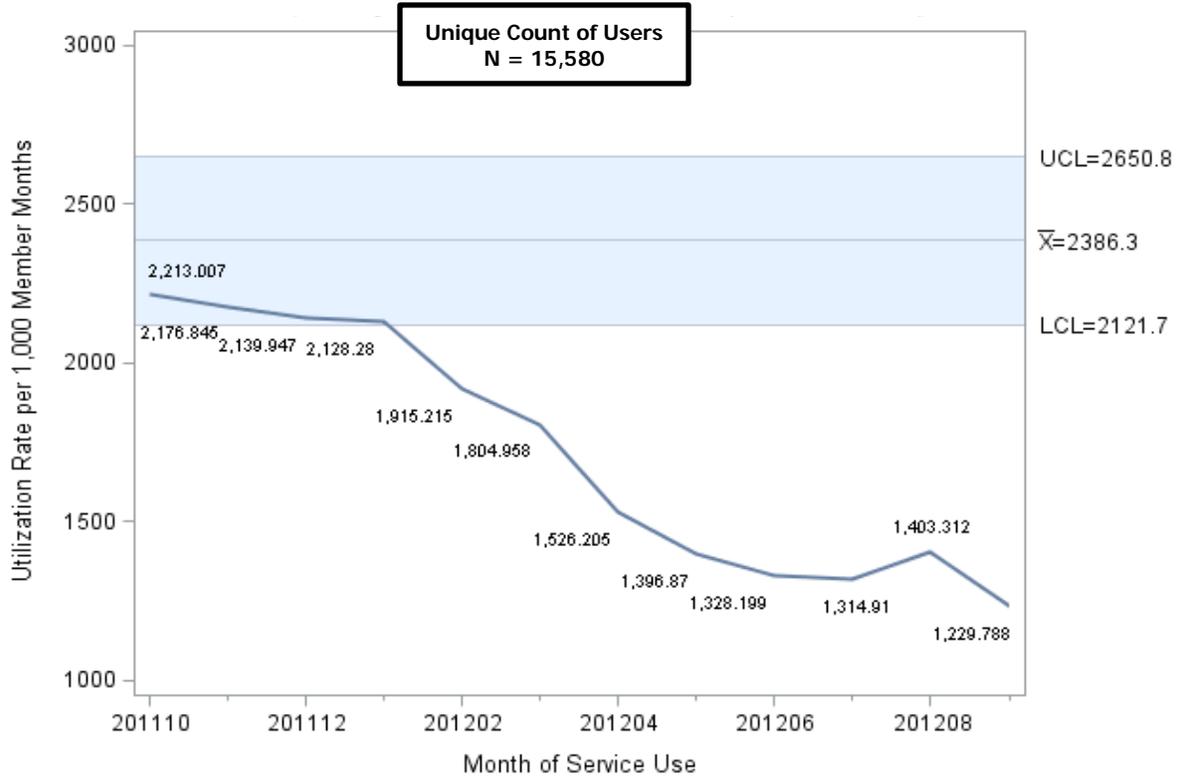


Figure SU-53 Pharmacy Utilization, Adults (Age 21+), Blind/Disabled, Oct. 2011–Sept. 2012

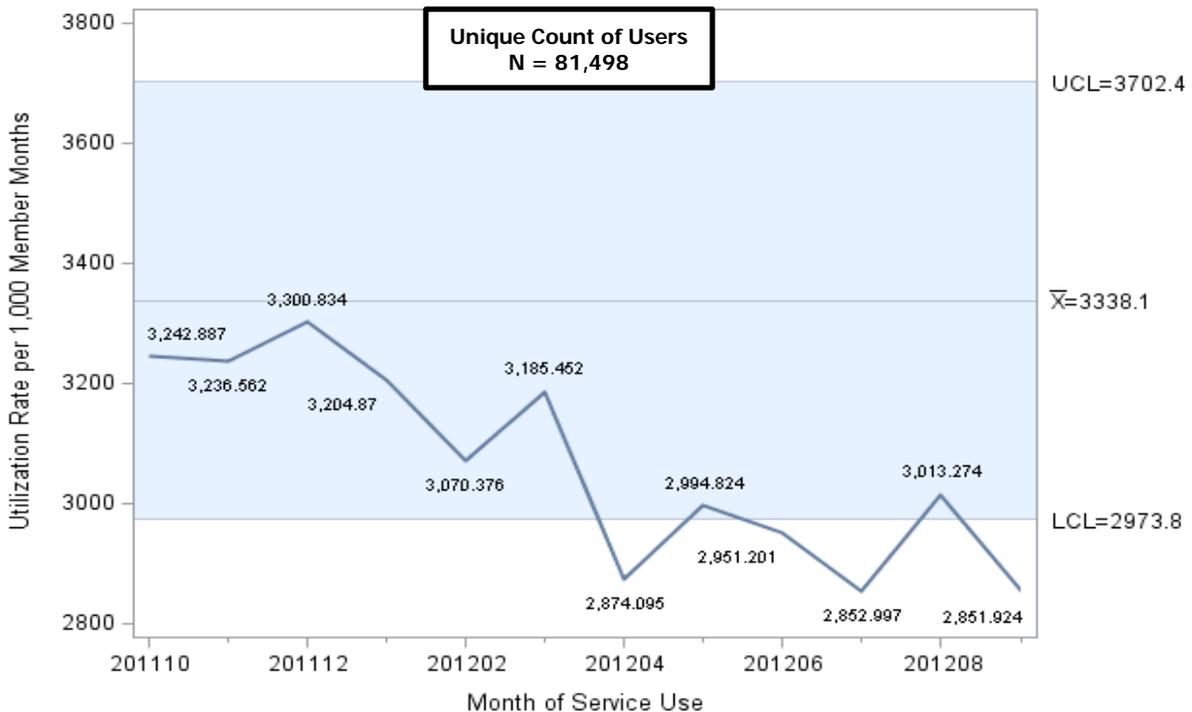


Figure SU-54 Pharmacy Utilization, Adults (Age 21+), Families, Oct. 2011–Sept. 2012

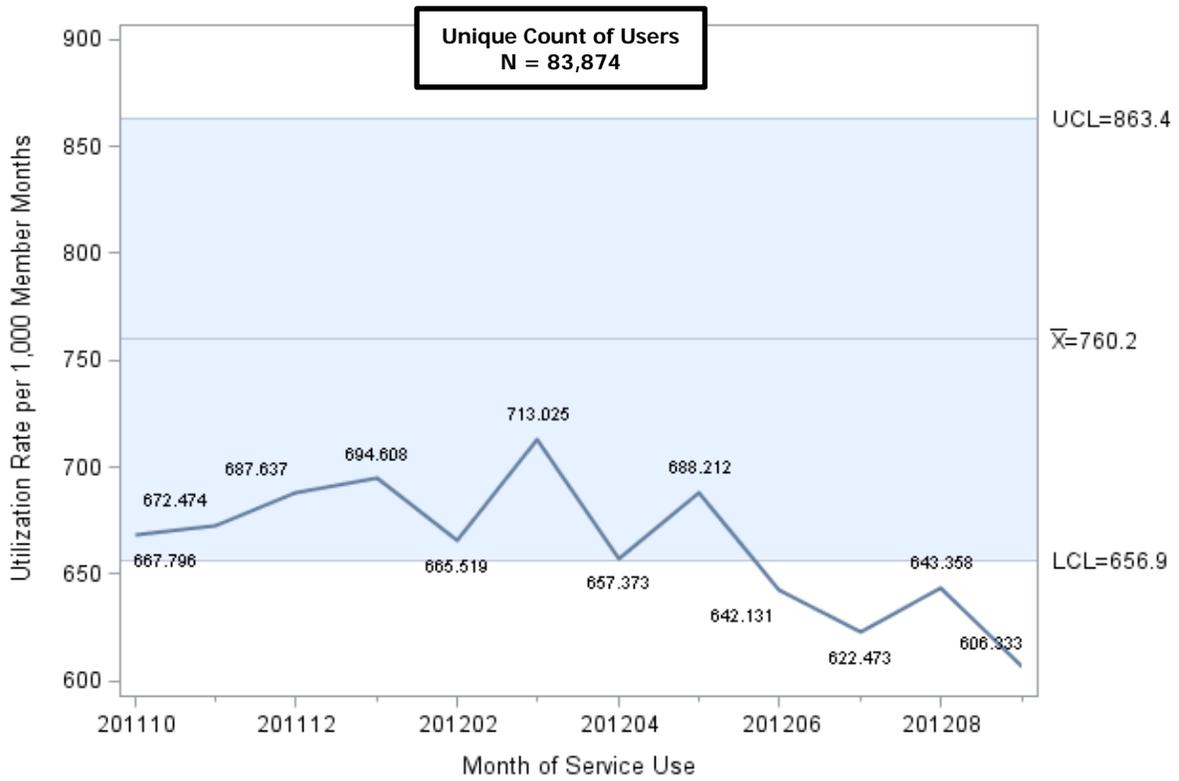


Figure SU-55 Pharmacy Utilization, Adults (Age 21+), Other, Oct. 2011–Sept. 2012

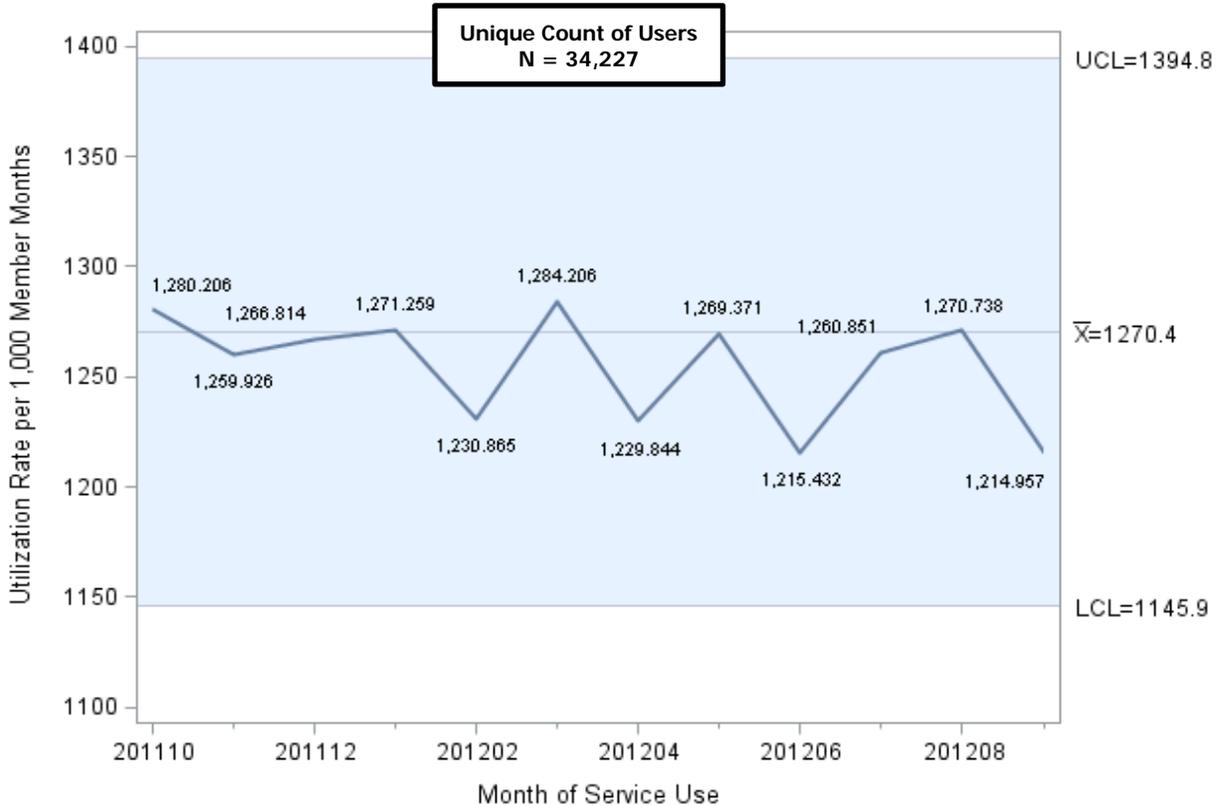
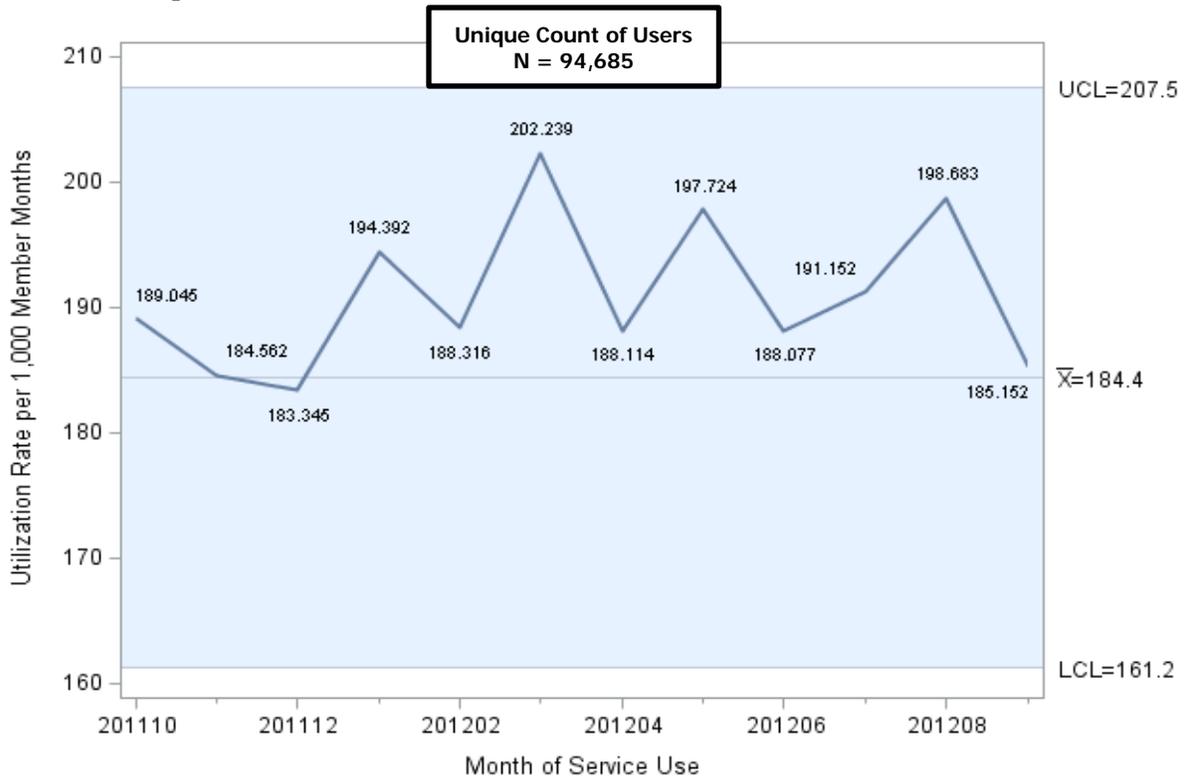


Figure SU-56 Pharmacy Utilization, Adults (Age 21+), Undocumented, Oct. 2011–Sept. 2012



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 October 2011–September 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 fourth quarter of 2011 to the third 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 utilization of Other services at rates within expected ranges. In contrast, children in the Undocumented aid category exhibited below average use and had several months of utilization below the expected ranges observed in the baseline period of 2007 to 2009. Of particular note, children in the Blind/Disabled, Families, and Foster Care aid groups exhibited a noticeable increase in Other services utilization during the last quarter of the study period.

Children in the Blind/Disabled, Families, and Foster Care aid categories exhibited a noticeable increase in Other services utilization during the last quarter of the study period.

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 fourth quarter of 2011 to the third 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 group. Adults in all of the analyzed aid categories exhibited mostly below average use of Other services during the study period. Additionally, adults in the Aged and Undocumented aid categories displayed utilization rates below the expected ranges throughout most of the study period.

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

Trends—Monthly Other Services Utilization Rates by Children, October 2011–September 2012

Figure SU-57 Other Services Utilization, Children (Age 0–20), Blind/Disabled, Oct. 2011–Sept. 2012

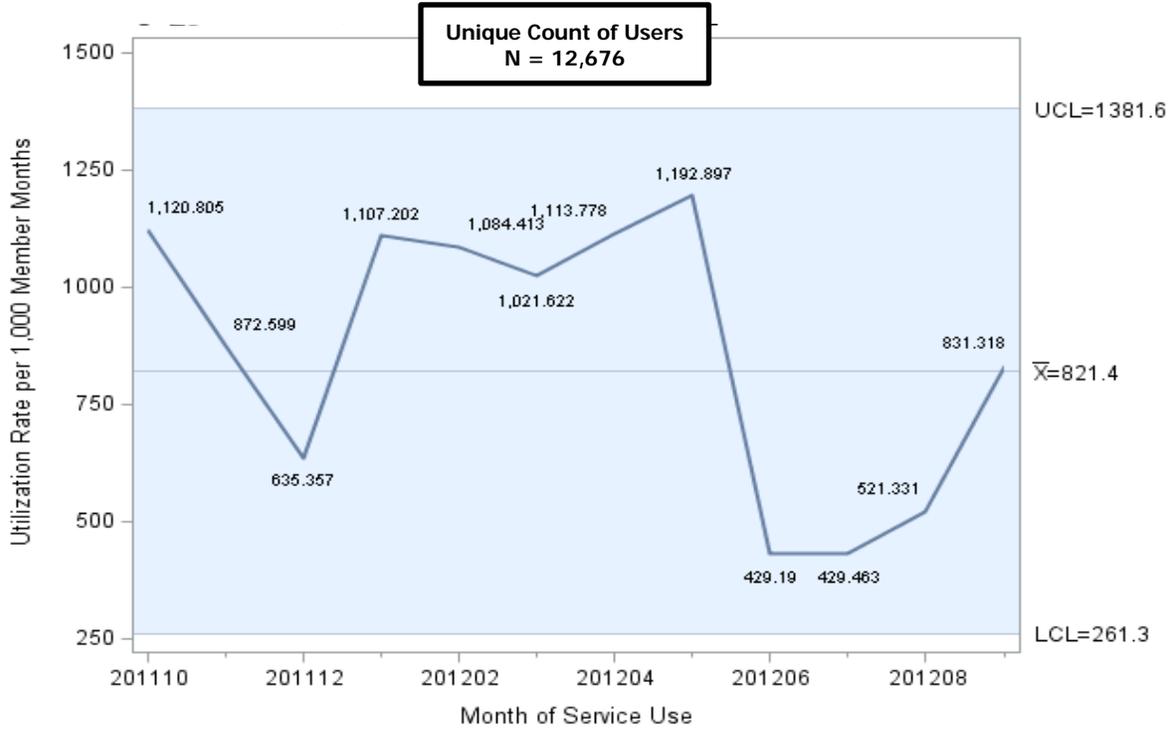


Figure SU-58 Other Services Utilization, Children (Age 0–20), Families, Oct. 2011–Sept. 2012

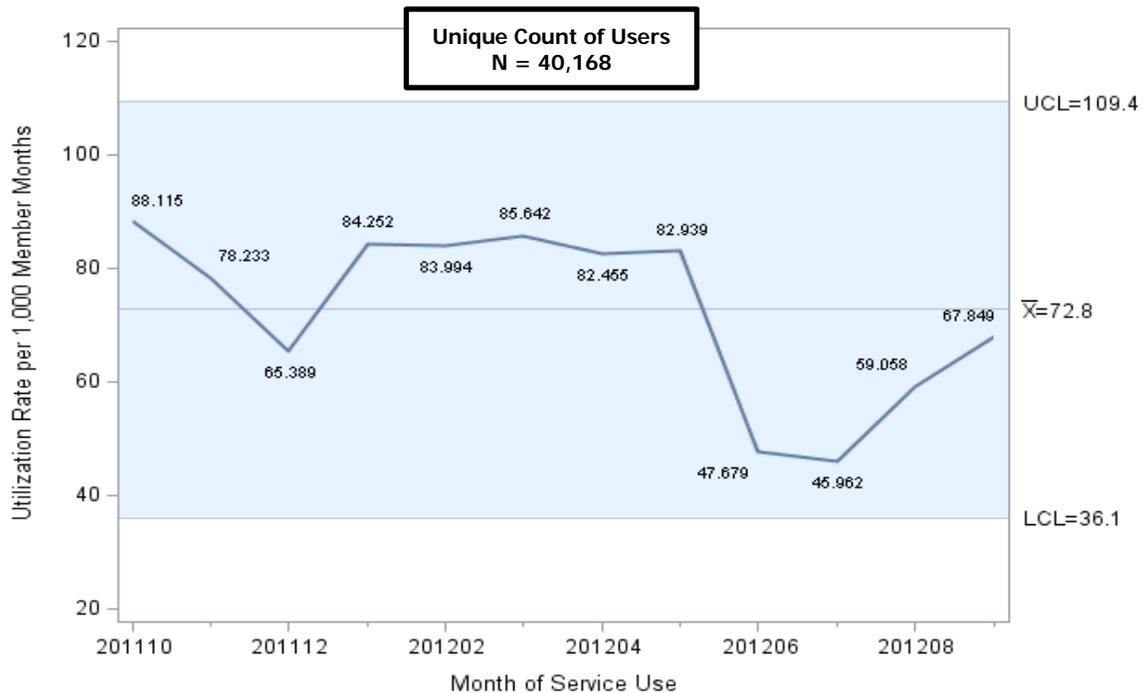


Figure SU-59 Other Services Utilization, Children (Age 0-20), Foster Care, Oct. 2011-Sept. 2012

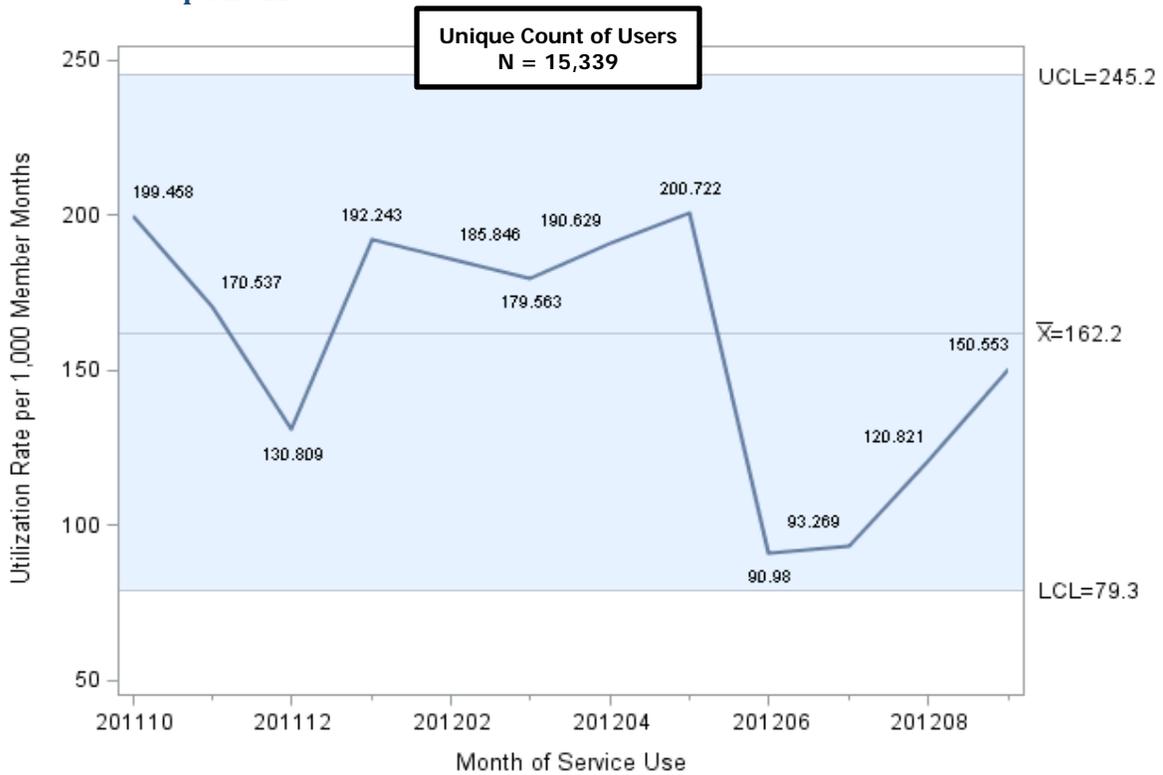


Figure SU-60 Other Services Utilization, Children (Age 0-20), Other, Oct. 2011-Sept. 2012

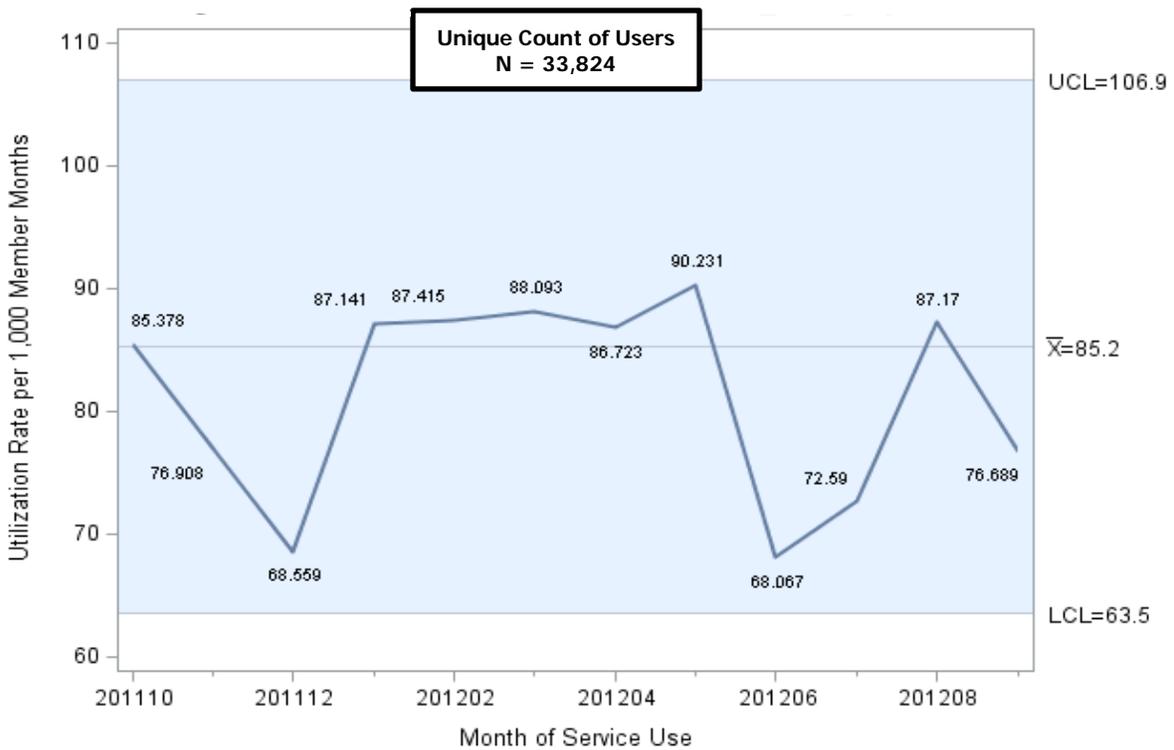
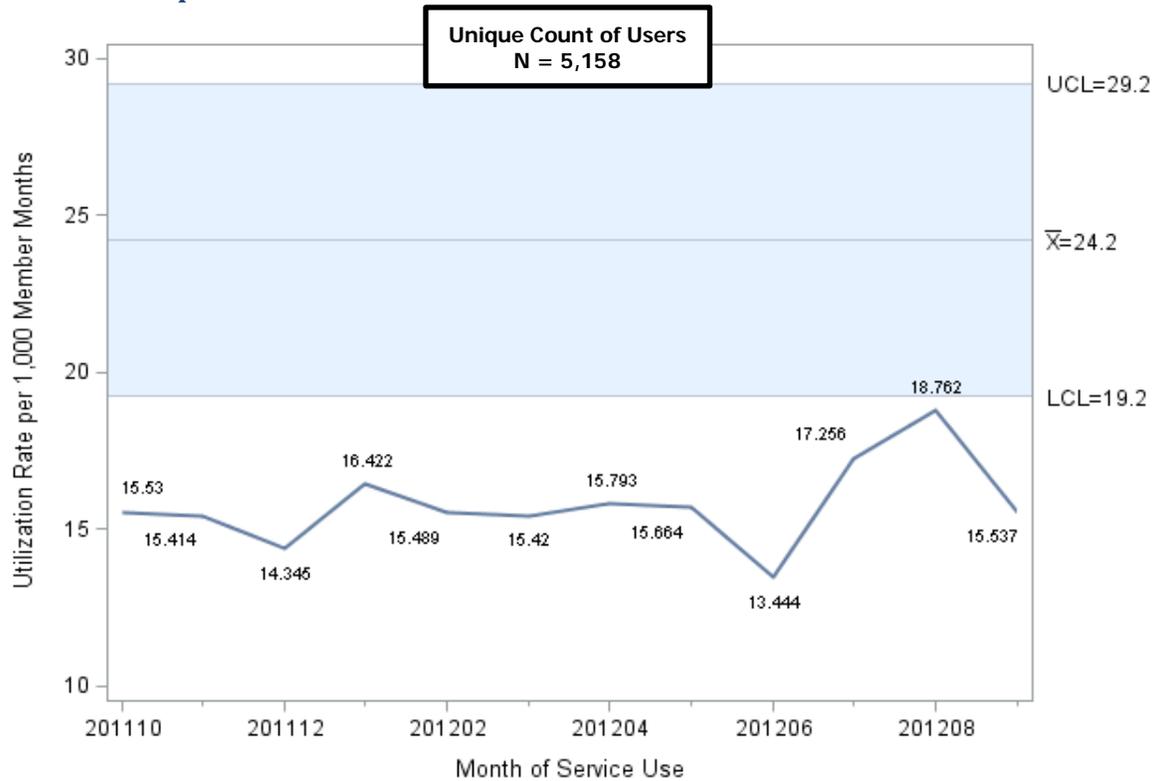


Figure SU-61 Other Services Utilization, Children (Age 0-20), Undocumented, Oct. 2011-Sept. 2012



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 October 2011–September 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, October 2011–September 2012

Figure SU-62 Other Services Utilization, Adults (Age 21+), Aged, Oct. 2011–Sept. 2012

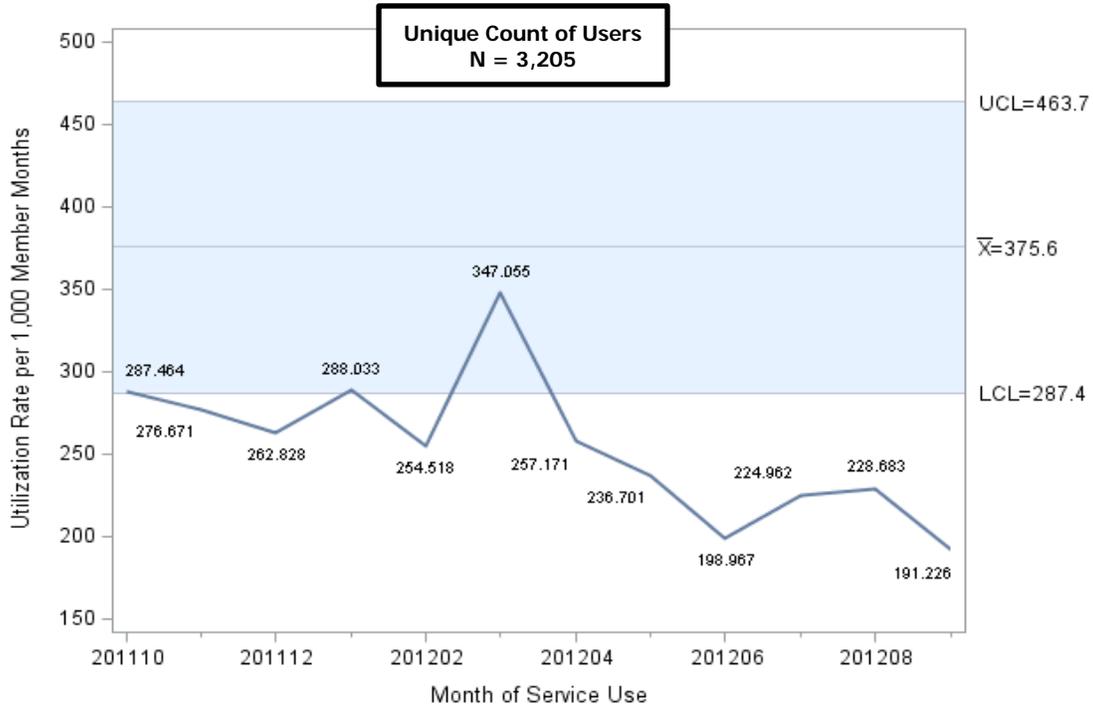


Figure SU-63 Other Services Utilization, Adults (Age 21+), Blind/Disabled, Oct. 2011–Sept. 2012

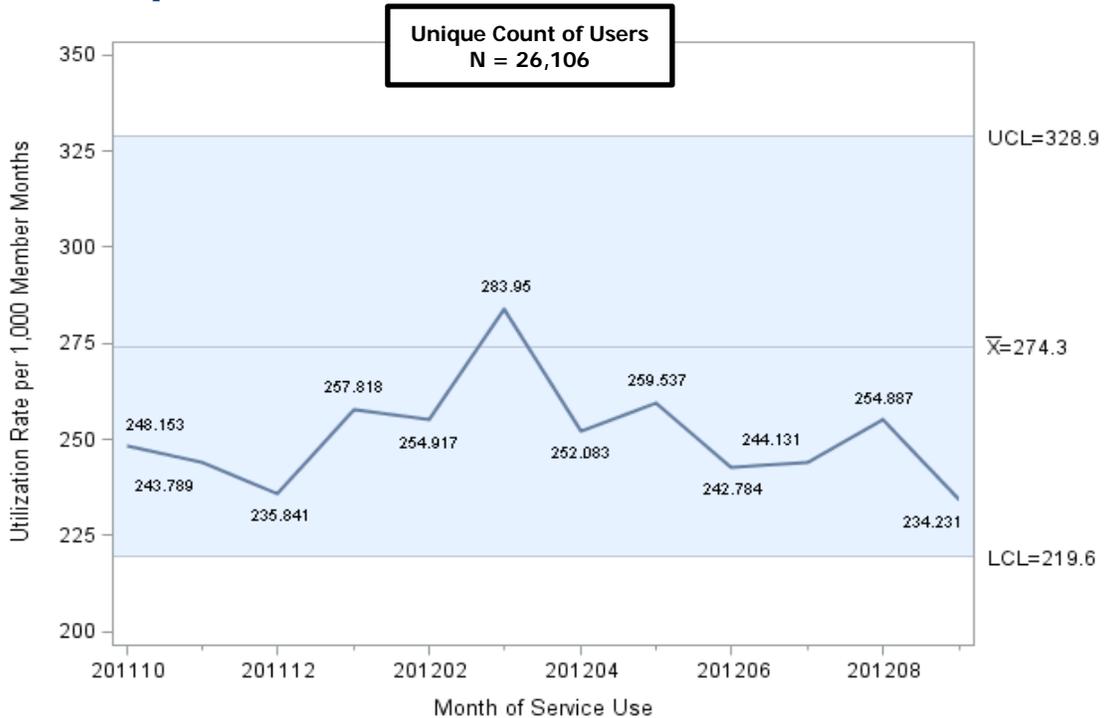


Figure SU-64 Other Services Utilization, Adults (Age 21+), Families, Oct. 2011–Sept. 2012

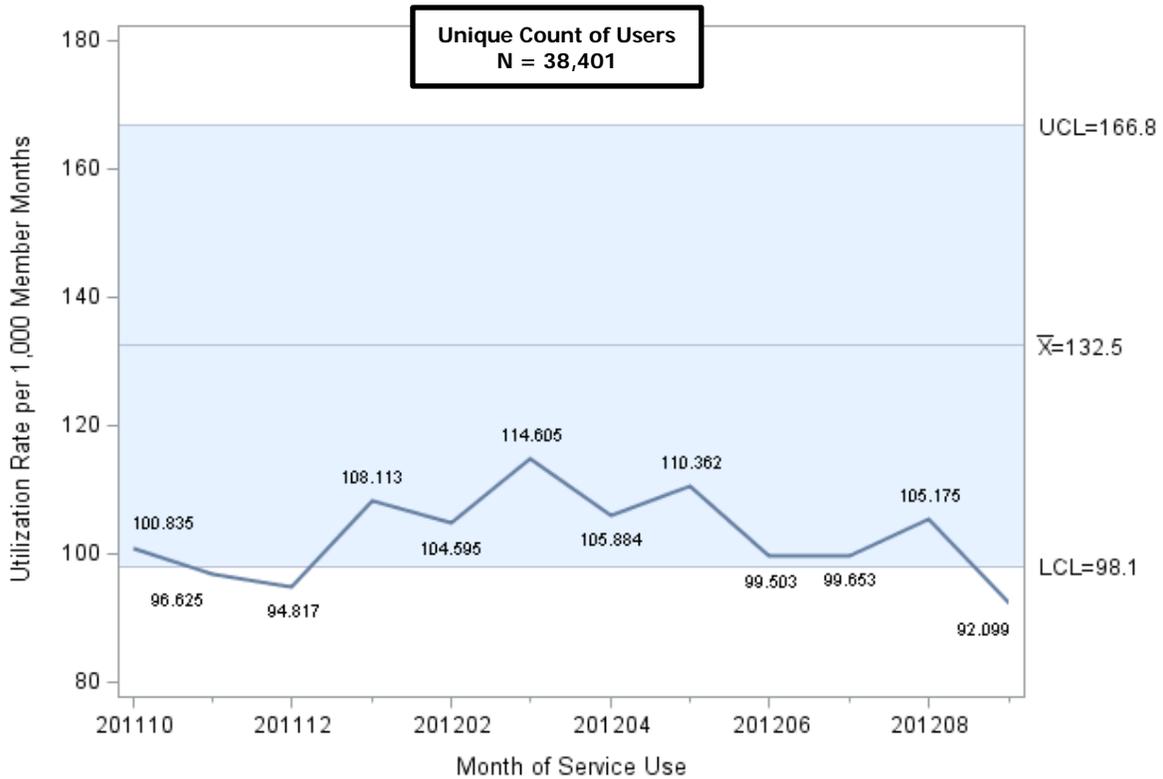


Figure SU-65 Other Services Utilization, Adults (Age 21+), Other, Oct. 2011–Sept. 2012

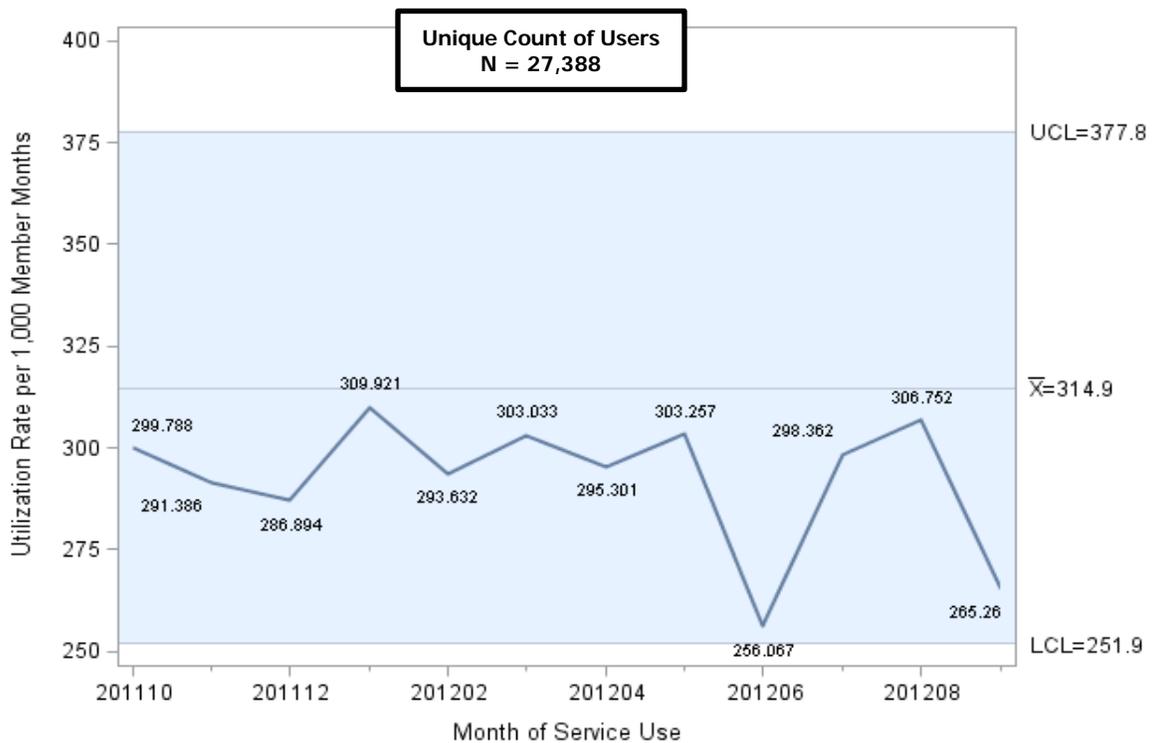
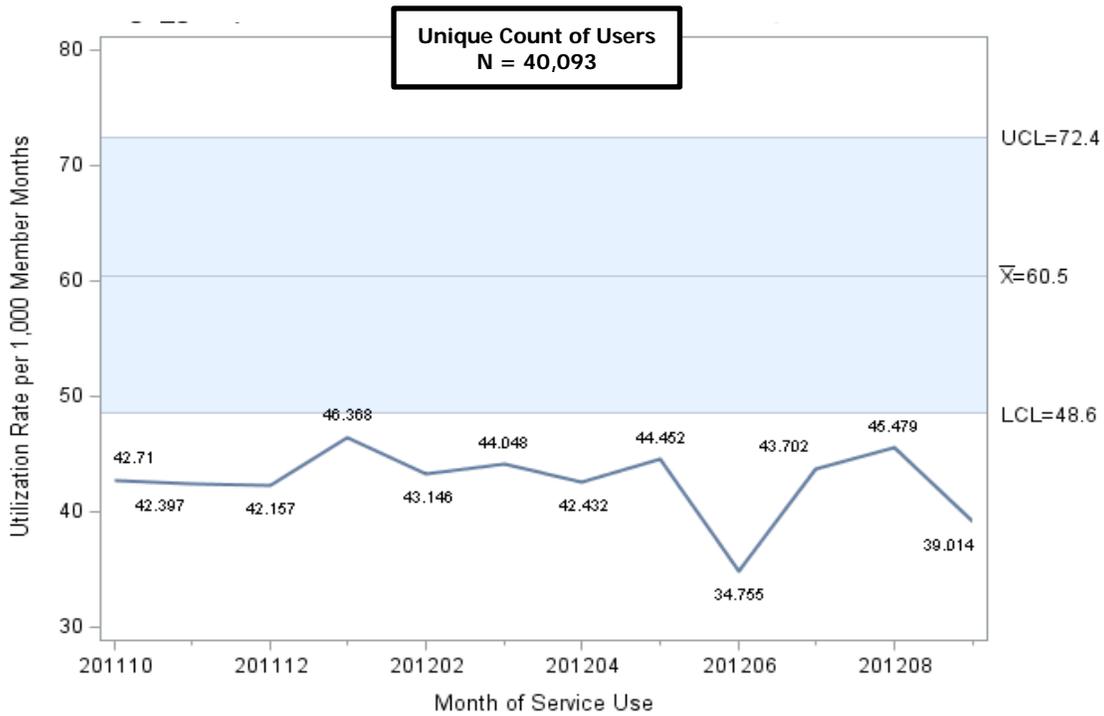


Figure SU-66 Other Services Utilization, Adults (Age 21+), Undocumented, Oct. 2011–Sept. 2012



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 October 2011–September 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Radiology

Background

Radiology services are used to diagnose, treat, or manage medical conditions. Radiology services covered by Medi-Cal's state plan include:

- Computed Tomography (CT) Scans
- Computed Tomography Angiography (CTA) Scans
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography
- Magnetic Resonance Cholangiopancreatography (MRCP)
- Fluoroscopy and Esophagus Studies
- Screening and Diagnostic Mammography
- Mammography with Xeroradiography
- Dual Energy X-Ray Absorptiometry (DXA)
- Angiography Services
- Single Photon Emission Computed Tomography (SPECT)
- Positron Emission Tomography (PET) Scans
- Radiation Oncology Procedures
- Other Nuclear Medicine Services
- Ultrasound Services
- X-Ray and Portable X-Ray Services

Radiology services are administered in several medical settings including Inpatient Hospitals, Outpatient Hospitals, Physician/Clinics, and independent clinical laboratories. The federal Clinical Laboratory Improvement Act (CLIA) mandates that all providers must be certified for the types of Radiology services that they administer.^{7,8}

Radiology services must be medically appropriate for health screening, preoperative evaluation, method surveillance, and complication management, and must be ordered by a Family PACT provider, Medi-Cal provider, or their associated practitioners.⁸

⁷ Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (<http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/downloads/HowObtainCLIACertificate.pdf>).

⁸ You can view additional information on radiology services at www.medi-cal.ca.gov under the Publications tab, go to Provider Manuals and select Clinics and Hospitals link.

URL:http://files.medical.ca.gov/pubsdoco/manual/man_query.asp?wSearch=%28%23filename+%2A%5F%2Ao00%2A%2Edoc+OR+%23filename+%2A%5F%2Ao00%2A%2Ezip+OR+%23filename+%2A%5F%2Ao03%2A%2Edoc+OR+%23filename+%2A%5F%2Ao03%2A%2Ezip+OR+%23filename+%2A%5F%2Az00%2A%2Edoc+OR+%23filename+%2A%5F%2Az00%2A%2Ezip+OR+%23filename+%2A%5F%2Az02%2A%2Edoc+OR+%23filename+%2A%5F%2Az02%2A%2Ezip%29&wFLogo=Part+2+%26%23150%3B+Clinics+and+Hospitals+%28CAH%29&wFLogoH=53&wFLogoW=564&wAlt=Part+2+%26%23150%3B+Clinics+and+Hospital s+%28CAH%29&wPath=N

Trend Analysis

DHCS began evaluating Radiology services in the third quarter of 2012. The analysis of Radiology services presented below contains data for the third quarter of 2012, with comparisons made to the baseline period of 2007–2009.

Children

Among children age 0–20 in the Medi-Cal FFS program, monthly Radiology services utilization rates ranged from 33.0–105.1 visits per 1,000 member months during the third quarter of 2012.

Radiology services utilization was 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. Children in the Foster Care aid category exhibited Radiology services utilization rates that followed closely with average rates calculated for the baseline period of 2007-2009, while those in all of the other aid groups primarily displayed service use rates that fell below baseline averages. Radiology utilization rates for children in the Other aid category reached levels below the expected ranges.

Utilization rates for children in the Blind/Disabled aid category were 2-3 times higher than for children in other aid categories.

Adults

Radiology services utilization rates for adults age 21 and older ranged from 56.0–329.3 visits per 1,000 member months in the third quarter of 2012.

Radiology services utilization rates were noticeably higher among adults in the Blind/Disabled and Other aid categories, while adults in the Undocumented aid category exhibited markedly lower utilization. Utilization rates for adults in the Aged and Blind/Disabled aid categories were above average and at times reached levels above the expected baseline ranges. Radiology utilization rates for adults in the other analyzed aid categories (Families, Other, and Undocumented) fell within the expected baseline ranges throughout the study period.

Utilization rates for adults in the Blind/Disabled and Other aid categories were above average and at times reached levels above the expected baseline ranges.

The ensuing charts represent the analysis of Radiology services utilization for both children and adults during the third quarter of 2012.

Trends—Monthly Radiology Services Utilization Rates by Children, October 2011–September 2012

Figure SU-67 Radiology Utilization, Children (Age 0-20), Blind/Disabled, July 2012–Sept. 2012

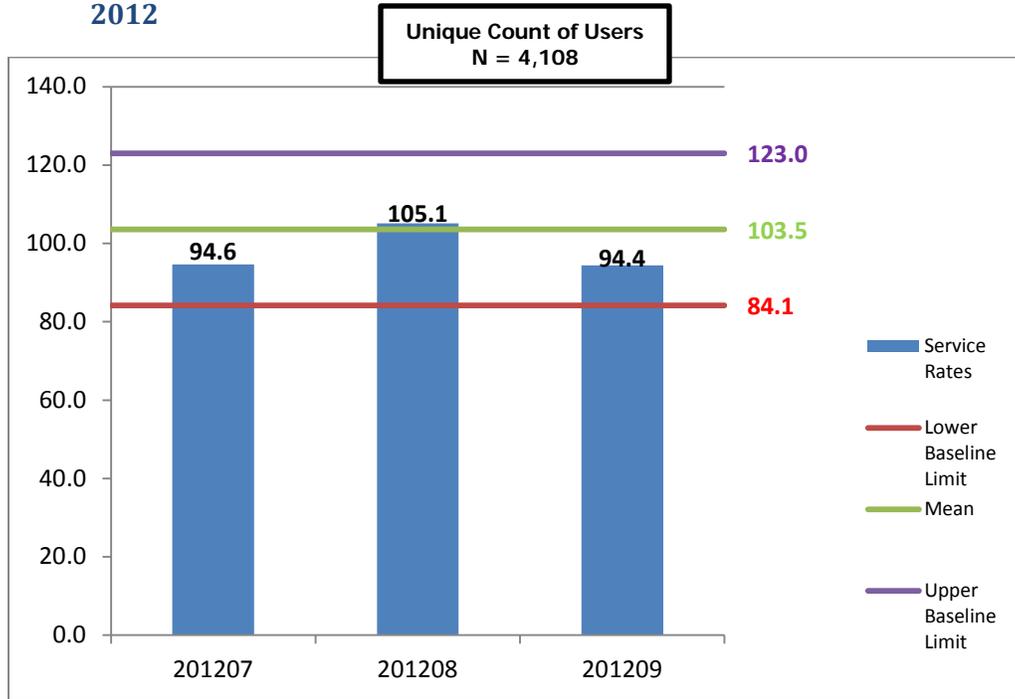


Figure SU-68 Radiology Utilization, Children (Age 0-20), Families, July 2012–Sept. 2012,

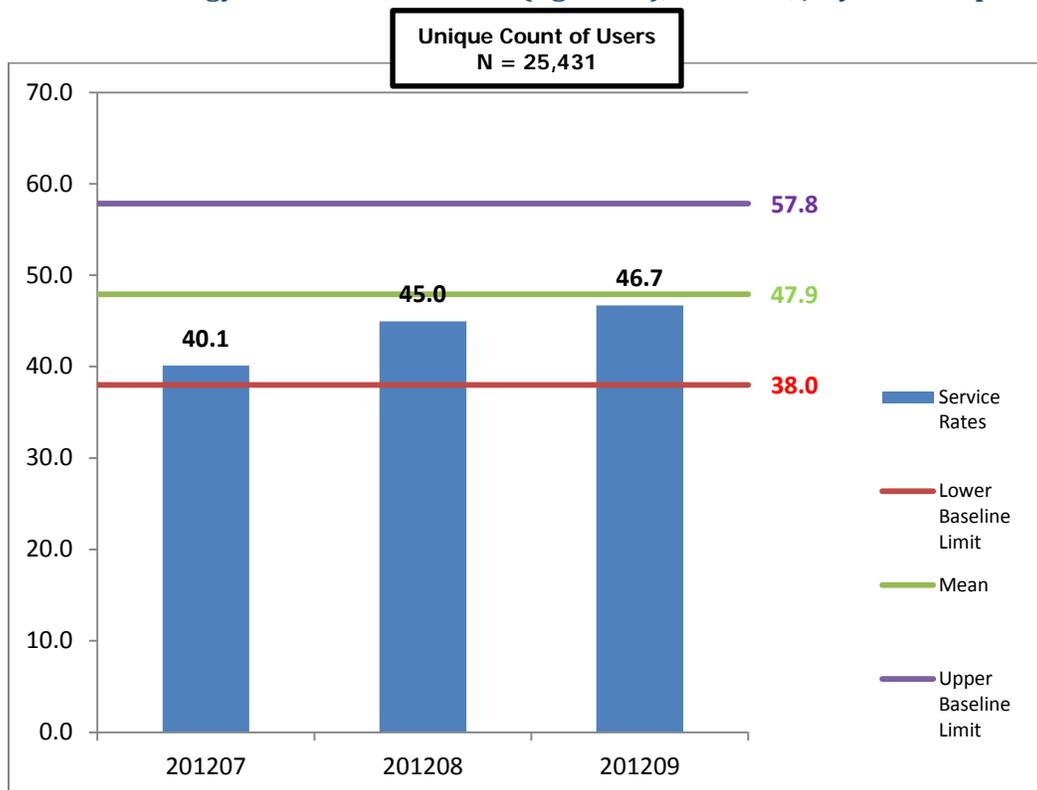


Figure SU-69 Radiology Utilization, Children (Age 0-20), Foster Care, July 2012–Sept. 2012,

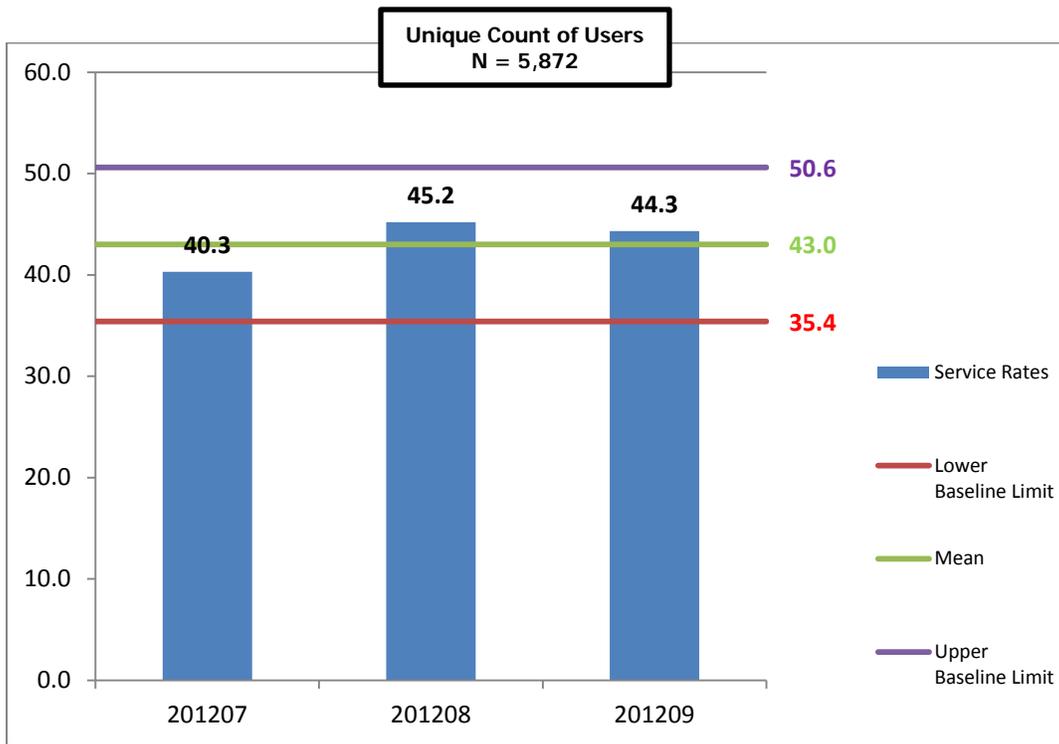


Figure SU-70 Radiology Utilization, Children (Age 0-20), Other Aid, July 2012– Sept 2012,

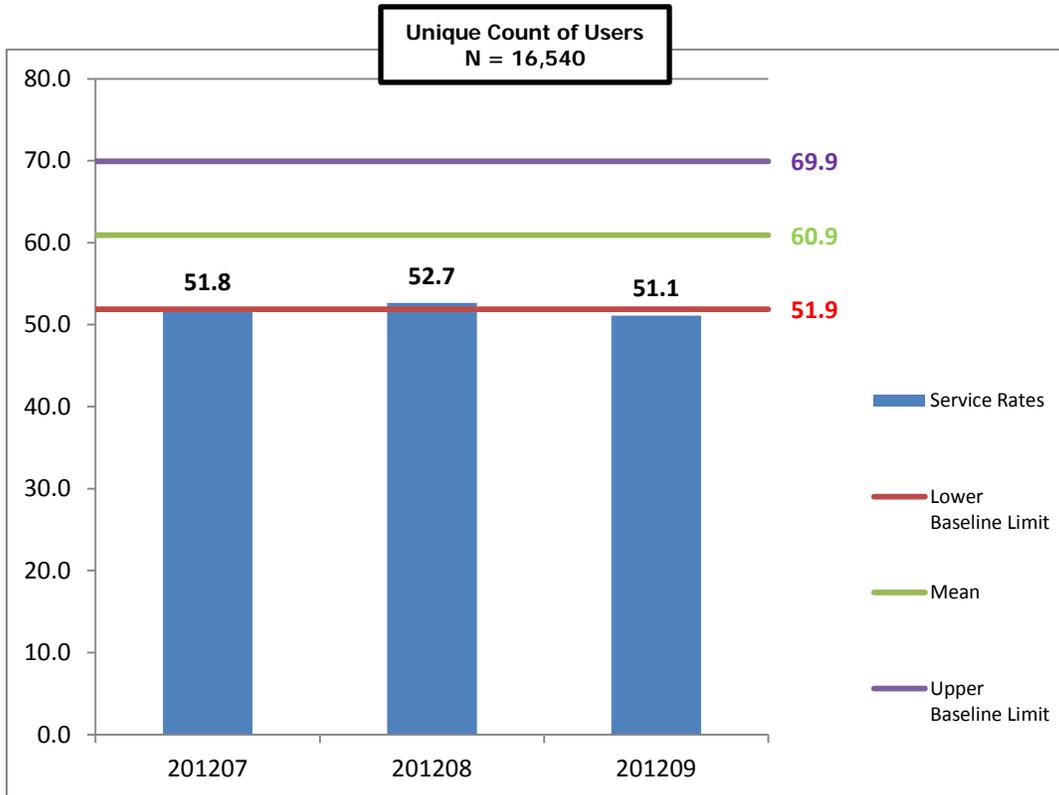
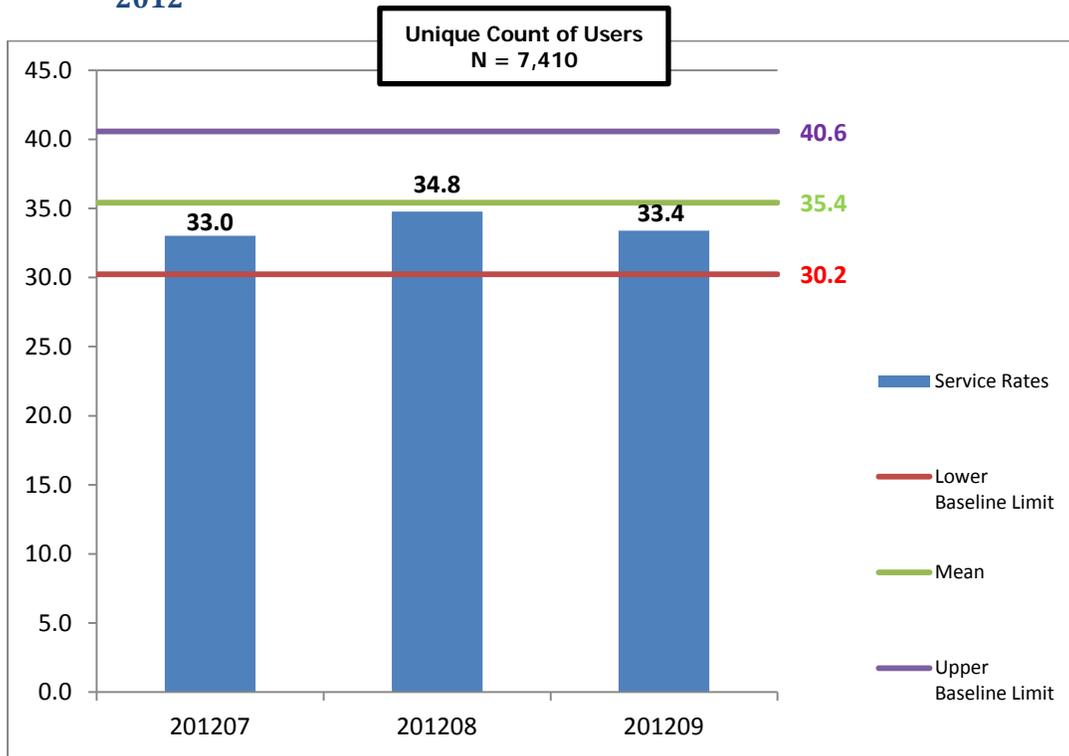


Figure SU-71 Radiology Utilization, Children (Age 0-20), Undocumented, July 2012–Sept. 2012



Source: Figures 65-69 were 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 2012–September 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Figure SU-72 Radiology Utilization, Adults (Age 21+), Aged, July 2012–Sept 2012

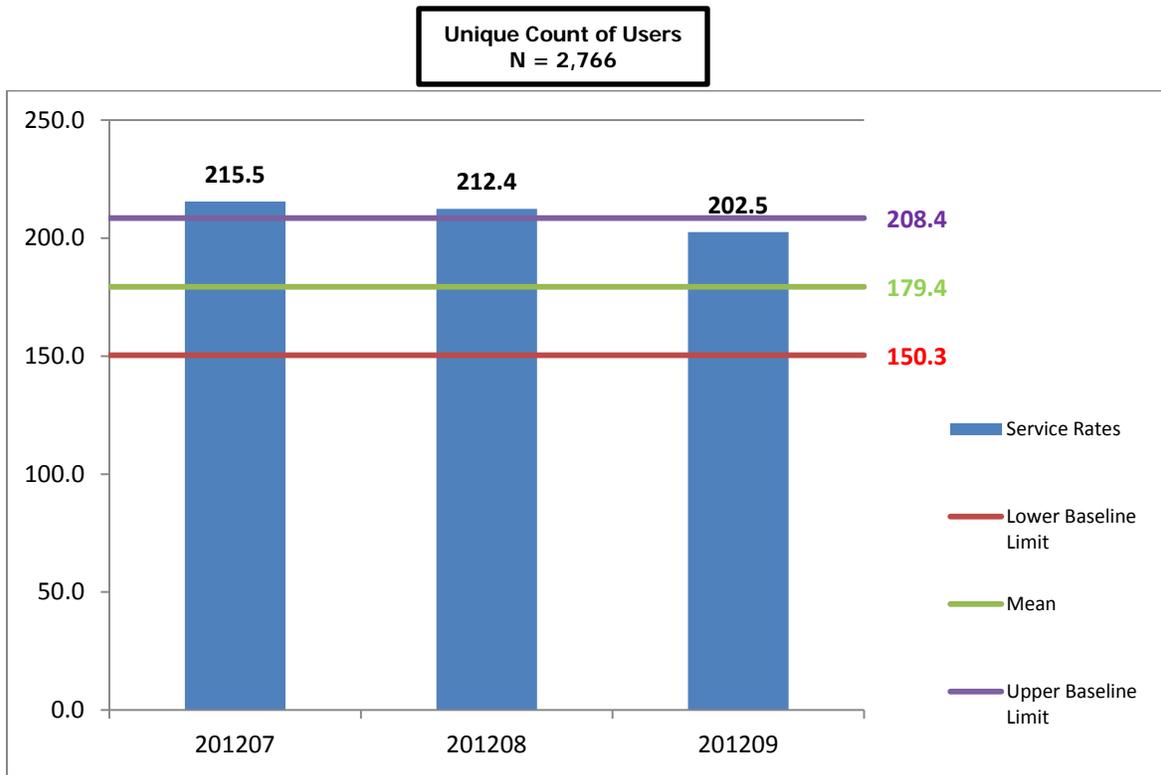


Figure SU-73 Radiology Utilization, Adults (Age 21+), Blind/Disabled, July 2012–Sept 2012

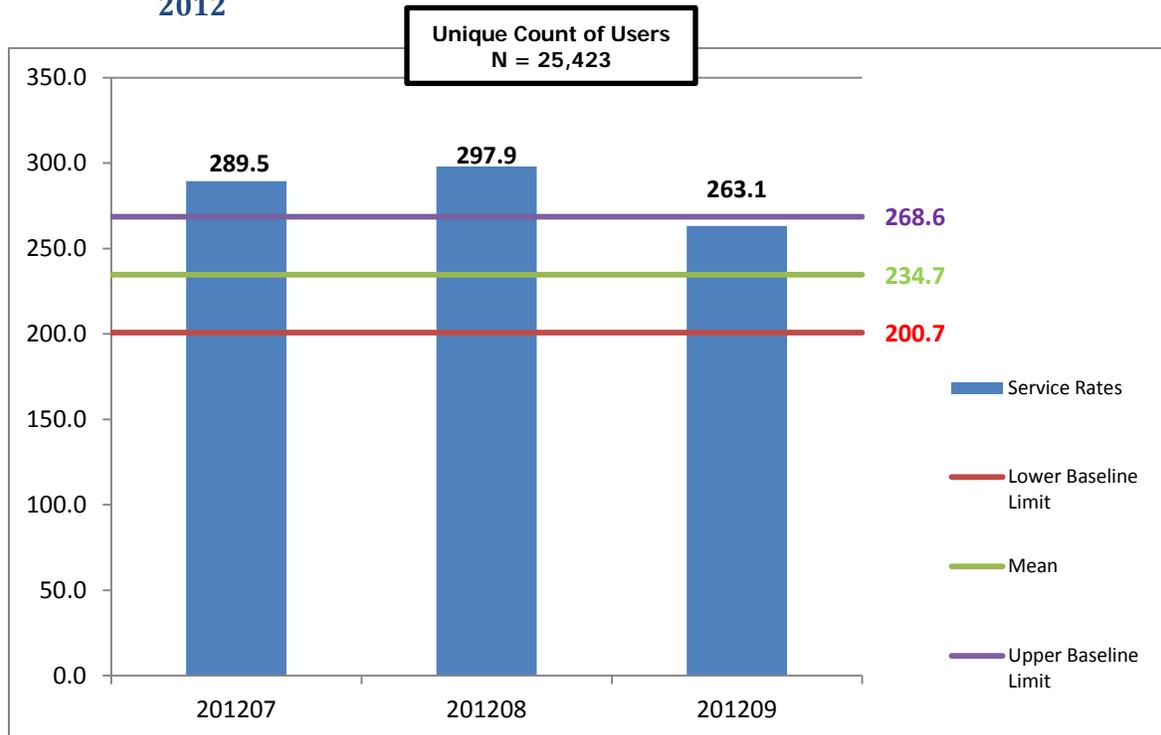


Figure SU-74 Radiology Utilization, Adults (Age 21+), Families, July 2012–Sept. 2012

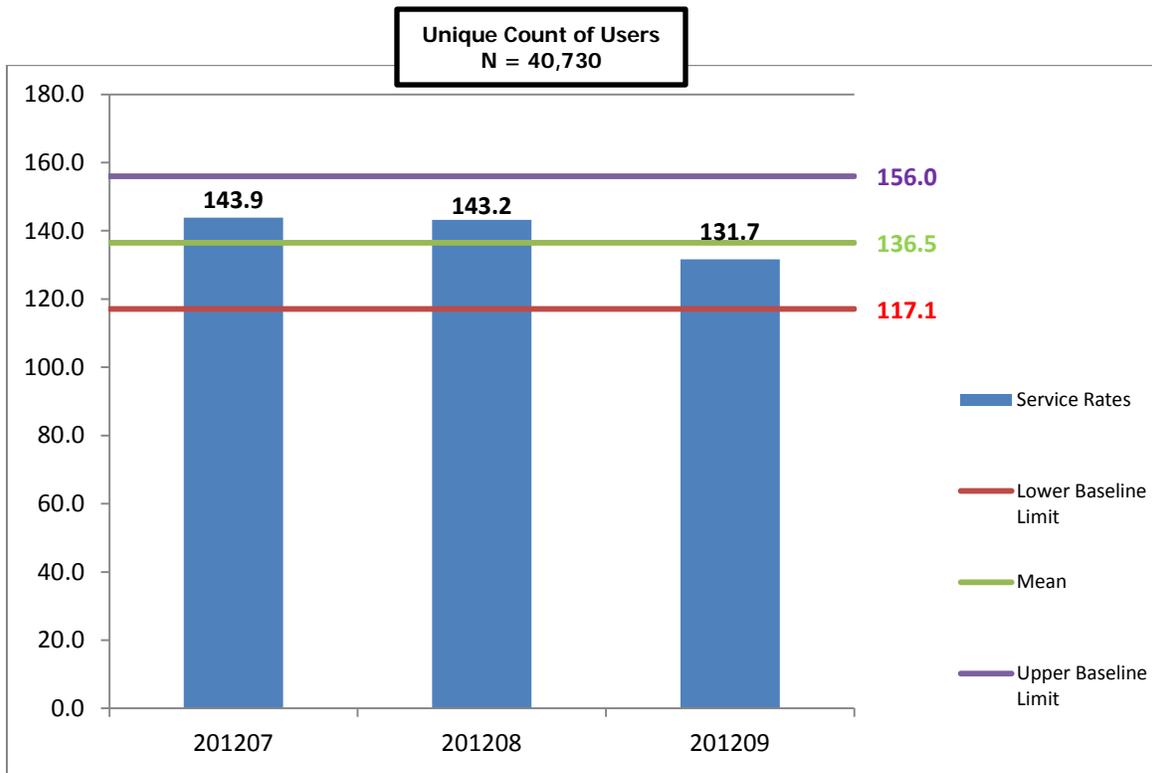


Figure SU-75 Radiology Utilization, Adults (Age 21+), Other, July 2012–Sept. 2012

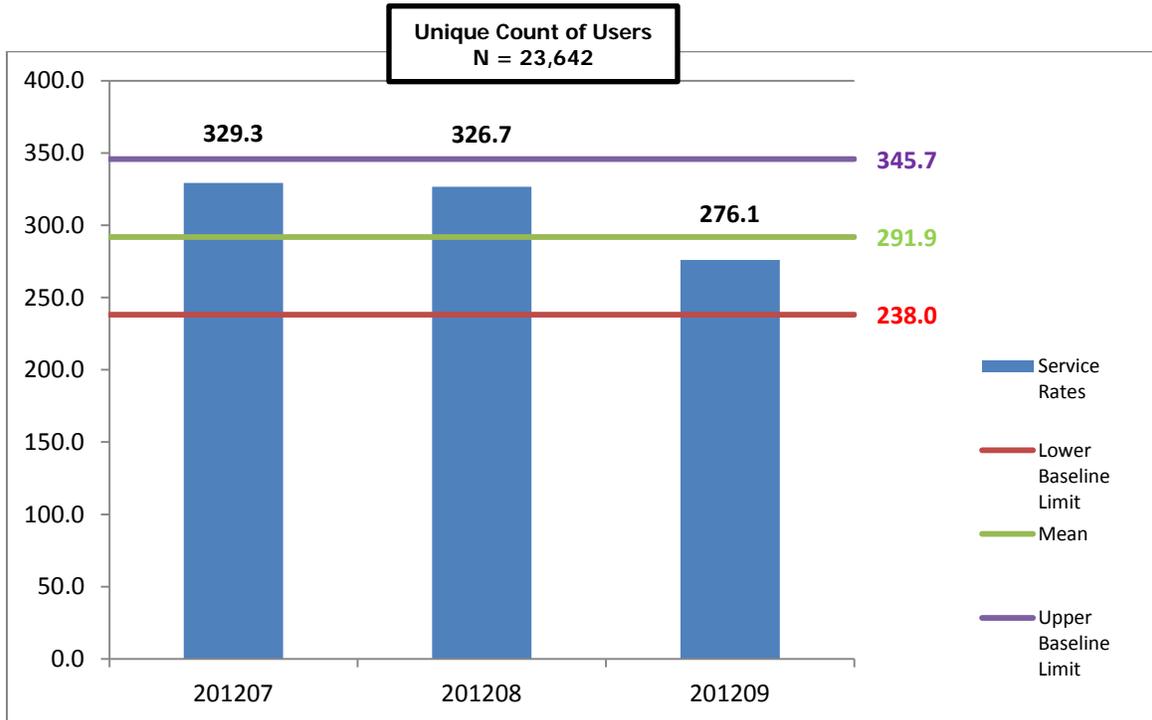
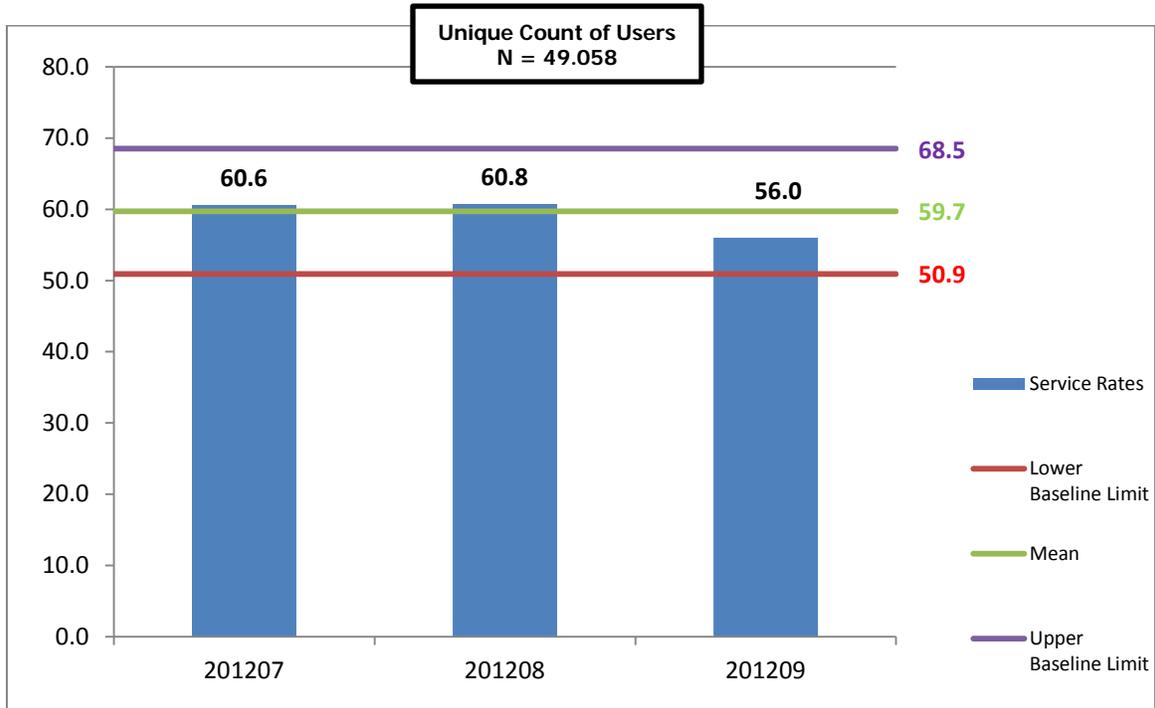


Figure SU-76 Radiology Utilization, Adults (Age 21+), Undocumented, July 2012–Sept. 2012



Source: Figures 70-74 were 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 2012–September 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	Emergency Medical Transportation	Home Health Services	Hospital Inpatient Services	Hospital Outpatient Services	Pharmacy Services	Other Services	Radiology Services
Blind/ Disabled	Mostly above average and within expected range.	Mostly below average and within expected range.	Upward trend and above expected range in Apr 2012 – Sep 2012.	Mostly above average and mostly within expected range.	Mostly above average with 4 consecutive months (Jan 2012– May 2012) above expected range.	Above average with 5 consecutive months above expected range. Downward trend Mar 2012–Sep 2012.	Within expected range.	Mostly below average and within expected range.
Families	Mostly below average and within expected range.	Mostly below average and within expected range.	N/A	Mostly below average and within expected range.	Below average and mostly within expected range.	Below average with 4 consecutive months below expected range Jun 2012–Sep 2012.	Within expected range.	Mostly below average and within expected range.
Foster Care	Mostly below average but within expected range.	Mostly above average and within expected range.	N/A	Below average and within expected range.	Within expected range.	Mostly above average and within expected range.	Within expected range.	Within expected range.
Other	Mostly below average but within expected range.	Below average with 3 consecutive months Below expected range (Oct 2011-Dec 2011). Within expected range Jan 2012-Sep 2012.	Below average and within expected range.	Below average and mostly within expected range Jan 2012-Apr 2012.	Below average with 6 consecutive months (Apr 2012– Sep 2012) below expected range.	Below average and below the expected range in Apr 2012–Sep 2012.	Within expected range.	Mostly below expected range.
Undocumented	Mostly below expected range. Reached levels within expected range during last quarter.	Mostly below average and below expected range (Nov 2011-Feb 2012) but within expected range during last two quarters.	N/A	Below average and mostly below expected range.	Mostly below average and within expected range.	Below average and mostly within expected Range.	Below average and mostly below expected range.	Mostly below average and within 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	Radiology Services
Aged	Mostly below average and within expected range.	N/A	N/A.	N/A.	Upward trend Nov 2011–May 2012. Mostly above expected range.	Mostly above average and mostly within expected range. Upward trend (Nov–May).	Mostly above expected range. Upward trend (Oct–May).	Below average and mostly below expected range in last 3 quarters. Downward trend (Oct–Jul).	Below average and mostly below expected range.	Above average and mostly above expected range.
Blind/ Disabled	Mostly above average and within expected range.	Above expected range. Downward trend Mar 2012–Sep 2012.	Mostly above average with levels reaching above expected range in last 3 quarters.	Mostly above average and within expected range.	Mostly above average with several months above expected range in last 2 quarters.	Mostly above average with several months above expected range in last quarter. Upward trend (Dec–May).	Mostly above expected range. Upward trend (Oct–May).	Below average with non-consecutive months below the expected Range.	Mostly below average and within expected range.	Above average and mostly above 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 below expected range in last quarter.	Below average and mostly within expected range.	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.	Within expected range.	Below average with several non-consecutive months outside of the expected range. Decline in last quarter.	Within expected range.	Mostly below average and within expected range.	Within expected range.
Undocu- mented	Below average with several non-consecutive months below expected range.	N/A	Mostly below the expected range with levels reaching within range during last quarter.	N/A	Below the expected range.	Below average and mostly within expected range.	N/A	Mostly above average and within expected range.	Below the expected range.	Mostly below average and within expected range.

Conclusions—Service Utilization, Children Participating in FFS

1. Overall, service utilization patterns for children in most aid code categories primarily followed the patterns identified in the previous access quarterly report. For example, Hospital Outpatient services use 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 were observed to be within the 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 use of Hospital Outpatient and Pharmacy services. After displaying noticeable declines in Hospital Inpatient and Emergency Medical Transportation services, as well as Physician/Clinic visits, during the second quarter of 2012, Blind/Disabled children exhibited increased utilization of these service categories at the end of the study period. This pattern may indicate a return to the normal service use observed in the baseline period. Overall, 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 who remained in the Medi-Cal FFS delivery system continue to place a disproportionate demand on services of all kinds, which is most likely due to their complex medical needs.
3. Physician/Clinic service use patterns among children in most of the evaluated aid categories fell below the average rates established during the baseline period. 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.⁹
4. The utilization of most services by children in the Other aid category again fell below either the average rates or the expected ranges established during the baseline period. After experiencing a noticeable decline in their utilization of Other services and Physician/Clinic visits in the second quarter of 2012, this population displayed increased utilization of these service categories at the end of the study period. This pattern may indicate a return to the normal service use that was observed in the baseline 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

⁹ Data from the National Vital Statistics System, found at <http://www.cdc.gov/nchs/data/databriefs/db60.pdf>

Nursing Facility Services) experienced a noticeable decline in user counts that made the data unsuitable for analysis.

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 Transportation, Hospital Inpatient and Outpatient, as well as, Nursing Facility services. Despite experiencing a downward trend in Non-Emergency Transportation services utilization during the last two quarters of the study period, Blind/Disabled adults utilized these services at rates well above the expected baseline ranges. Additionally, after displaying a decline in utilization of Hospital Inpatient and Home Health services in the second quarter of CY 2012, adults in the Blind/Disabled aid category exhibited increased use of these particular services at the end 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.¹⁰
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 use of Emergency Transportation, Physician/Clinic, and Hospital Inpatient services. This lower service use further supports the argument that these utilization patterns may be heavily influenced by the decline in overall births statewide and nationally,¹¹ which is most noticeable among the immigrant population.¹²
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 use of these service categories inconsequential to the current analysis. The beneficiary subgroups that continue to use 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.

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

¹¹ Data from the National Vital Statistics System, found at <http://www.cdc.gov/nchs/data/databriefs/db60.pdf>

¹² 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)

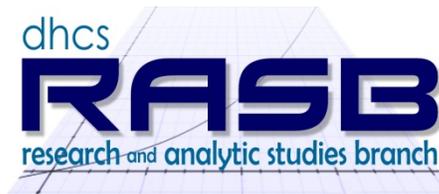
CCS/GHPP Non-Institutional Providers (PT 080)

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 #4 2012 Quarter 3



Beneficiary Feedback

May 2013

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

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Beneficiary Help Line Feedback

Introduction

In 2011, the Centers for Medicare and Medicaid Services strongly encouraged DHCS to implement a beneficiary help line as part of the DHCS' comprehensive health care access monitoring plan. Though DHCS has several administrative data sources that can be used to monitor health care access, there is no ongoing mechanism in place allowing beneficiaries to

provide feedback pertaining to their experiences, including difficulties finding a provider, receiving referrals to specialists, and their difficulties with enrollment. In addition, though data from claims provides DHCS with information regarding services that were utilized by its members, beneficiaries who encounter factors that impede their use of services cannot be accounted for using this data source. The DHCS help line will address this gap in the information for monitoring health care access, and provide needed assistance to FFS beneficiaries having difficulties navigating the health care system.

The Medi-Cal beneficiary help line was implemented in December 2011, and is similar to the Medi-Cal Managed Care Division's Office of the Ombudsman call center that addresses the needs of Medi-Cal managed care beneficiaries. The rate that Medi-Cal FFS beneficiaries contact the help line for information and complaints can offer one measure of how well the program is meeting the needs of its FFS beneficiaries and solving problems when they arise.

Highlights

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

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

The largest percentage (45%) of calls were regarding Enrollment/Continuity of Care.

Among Enrollment/Continuity of Care and Provider/Availability call categories, those in Families and Blind/Disabled aid categories were the top two groups of callers.

Methods

DHCS continues to rely on data obtained from the Office of the Ombudsman for the purpose of monitoring health care access until such time that data from the newly-implemented Call Center becomes available.

The Office of the Ombudsman call center documented 8,509 calls from FFS beneficiaries from the fourth quarter of 2011 to the third quarter of 2012. For each of these calls, the call center recorded the date and time of call, beneficiary aid category, county of residence, and reasons for the call. Data for these calls were summarized by month received, county, six aid category groupings (Families, Blind/Disabled, Aged, Foster Care, Undocumented, and Other), and reason for call.

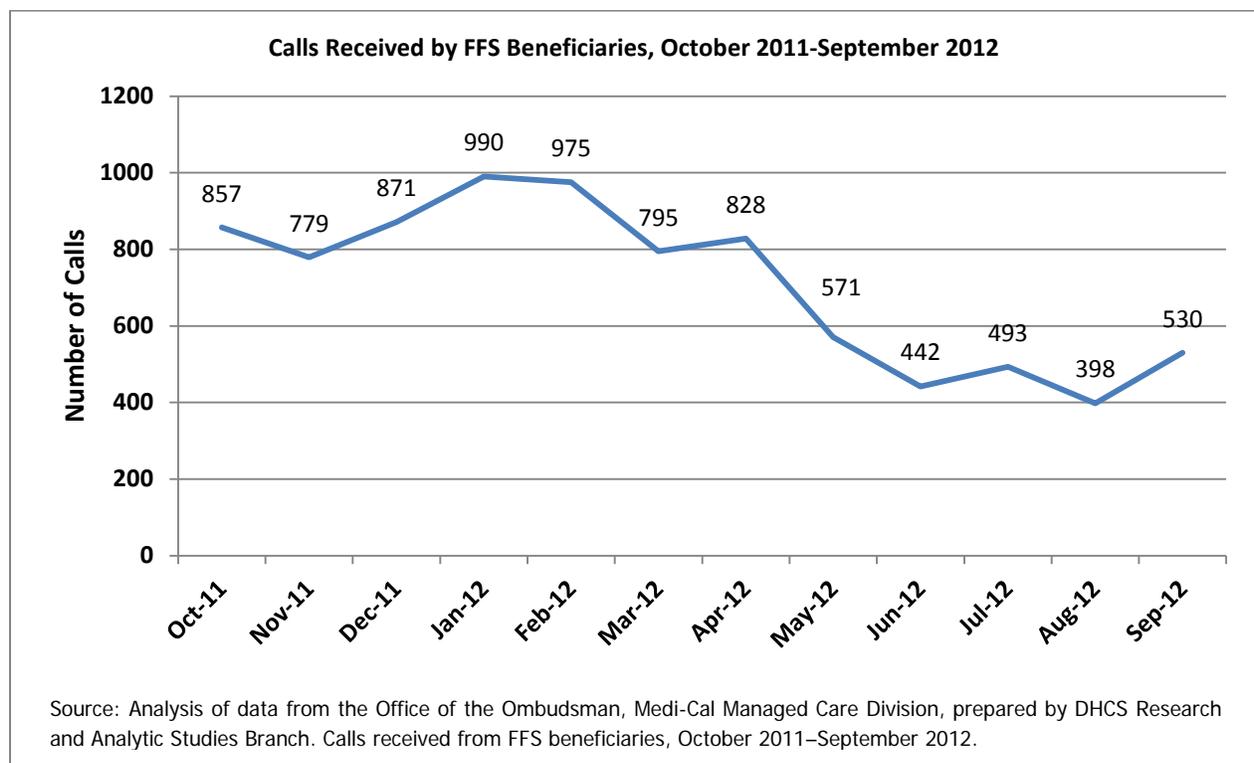
Results

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

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

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

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



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

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

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

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

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

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

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

Modified Call Categories

To help monitor whether managed care health plans are operating in line with their contractual obligation, the Ombudsman call center staff assigns codes to each call based on the reason for the call. The codes fall under certain categories such as “Enrollment/Continuity of Care” and “Quality of Care,” which enables the Ombudsman to identify potential problems among particular health plans or counties that may need investigating.

While the coding scheme used by the Ombudsman is helpful for overseeing health plans, call groupings are categorized differently for the purpose of this report to better identify whether beneficiaries are having problems accessing the care they need, including whether they are able to find a provider, continue with the same provider as their “usual source of care,” and access specialty services when needed.

Table BF-2 presents these groupings and a description of the codes that fall within each category. The first two categories, Enrollment/Continuity of Care and Provider/Availability Issues, are key elements in understanding whether beneficiaries are experiencing access-related problems.

Table BF-2 Modified Call Categories

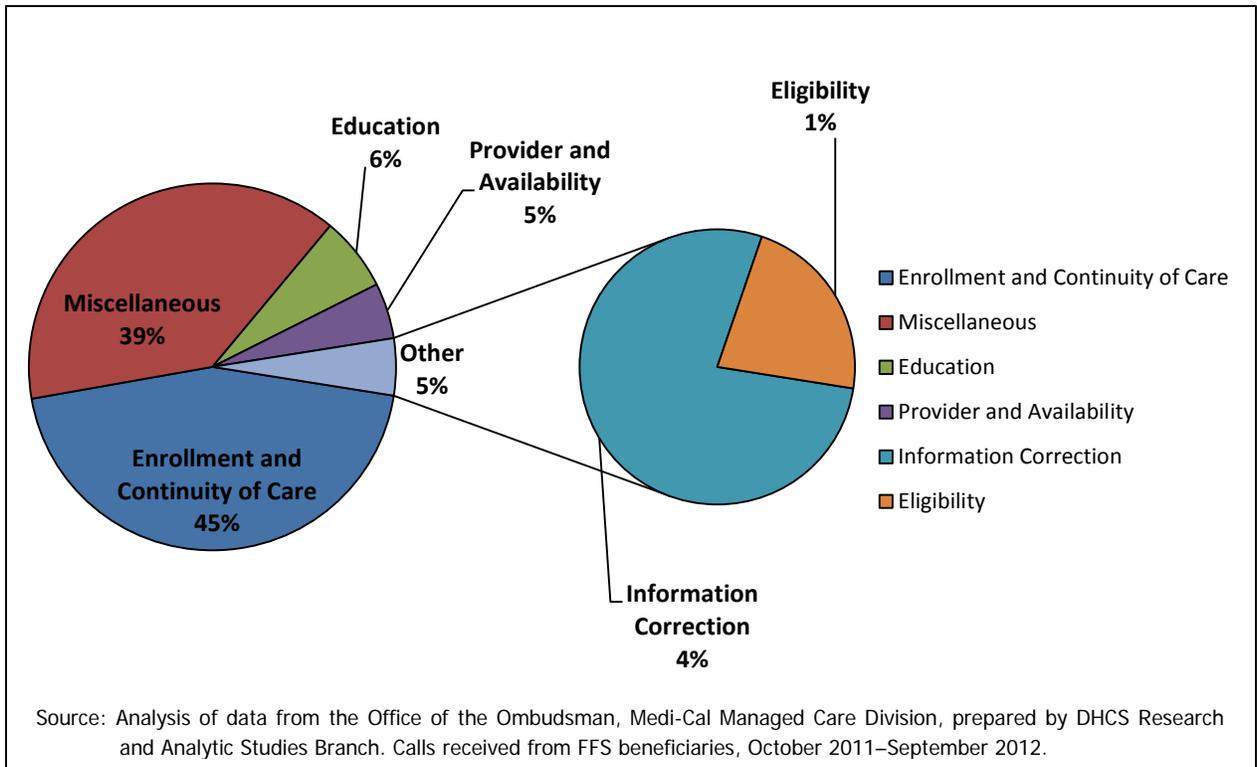
Call Category	Reason for Call
Enrollment and Continuity of Care	<ul style="list-style-type: none"> • Seeking information for new enrollment into plan • Wanting to change plans or disenroll from managed care • Seeking medical exemptions • Emergency plan disenrollment requests • Pregnancy or other qualifying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

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

Distribution of Calls by Call Category

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

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



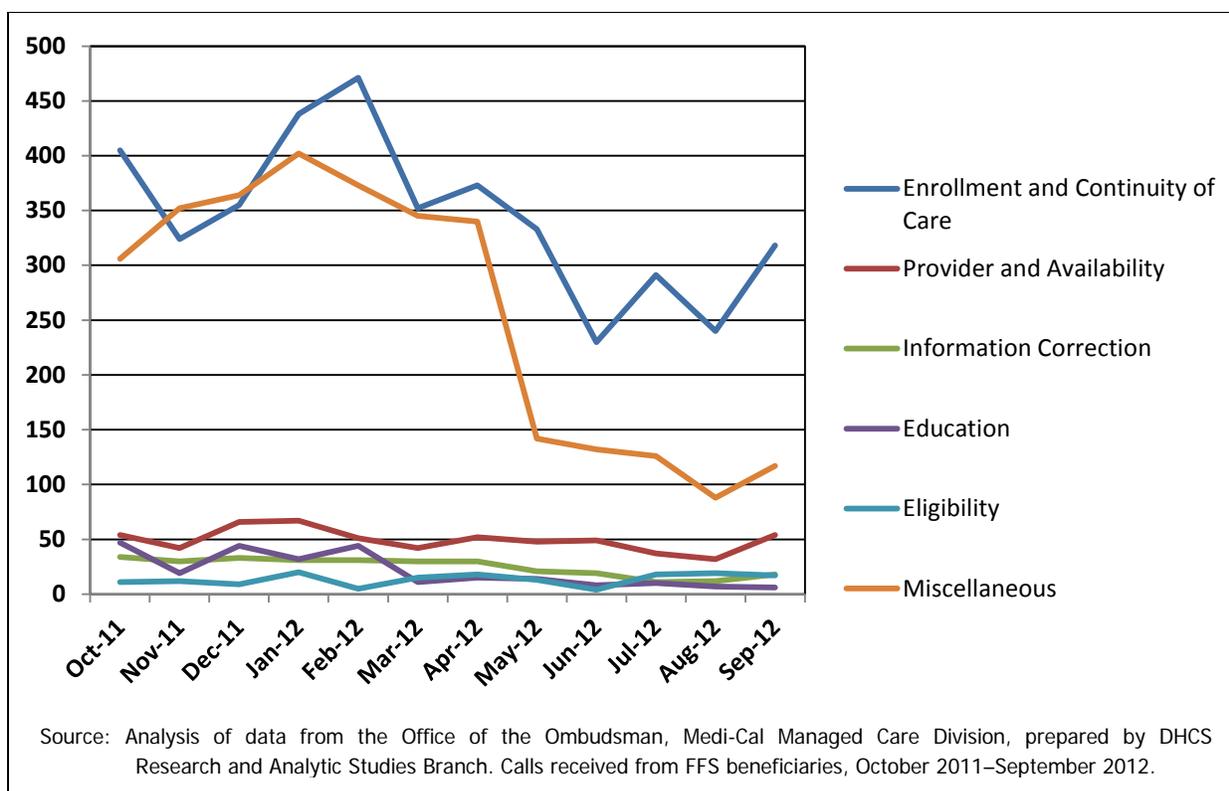
Distribution of Calls by Call Category and Month

As key elements in understanding whether beneficiaries are experiencing access-related problems, the remainder of this analysis will focus on two categories: Enrollment/Continuity of Care, and Provider/Availability issues. Of the total calls received, there were 4,130 calls categorized as Enrollment/Continuity of Care and 594 categorized as Provider/Availability issues.

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

Figure BF-3 presents the total calls received by call category and month. Throughout the reporting period, the majority of calls pertained to Enrollment/Continuity of Care. The next most frequently reported category was Miscellaneous. There were fluctuations in the number of calls related to Enrollment/Continuity of Care, with an average of nearly 350 calls per month. Although calls categorized as Miscellaneous comprised the next largest amount of calls (3,087 calls, or 39%), the descriptions of these calls are too ambiguous to interpret. Therefore, these calls will not be further analyzed.

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



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

Calls by Aid Code Category

The Medi-Cal aid codes reported by FFS beneficiary callers were collapsed into six aid code categories. Figure BF-3 presents the calls received by call category and aid category.

Table BF-3 Calls for Enrollment/Continuity of Care and Provider/Availability, by Aid Category, Oct. 2011–Sept. 2012

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

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

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

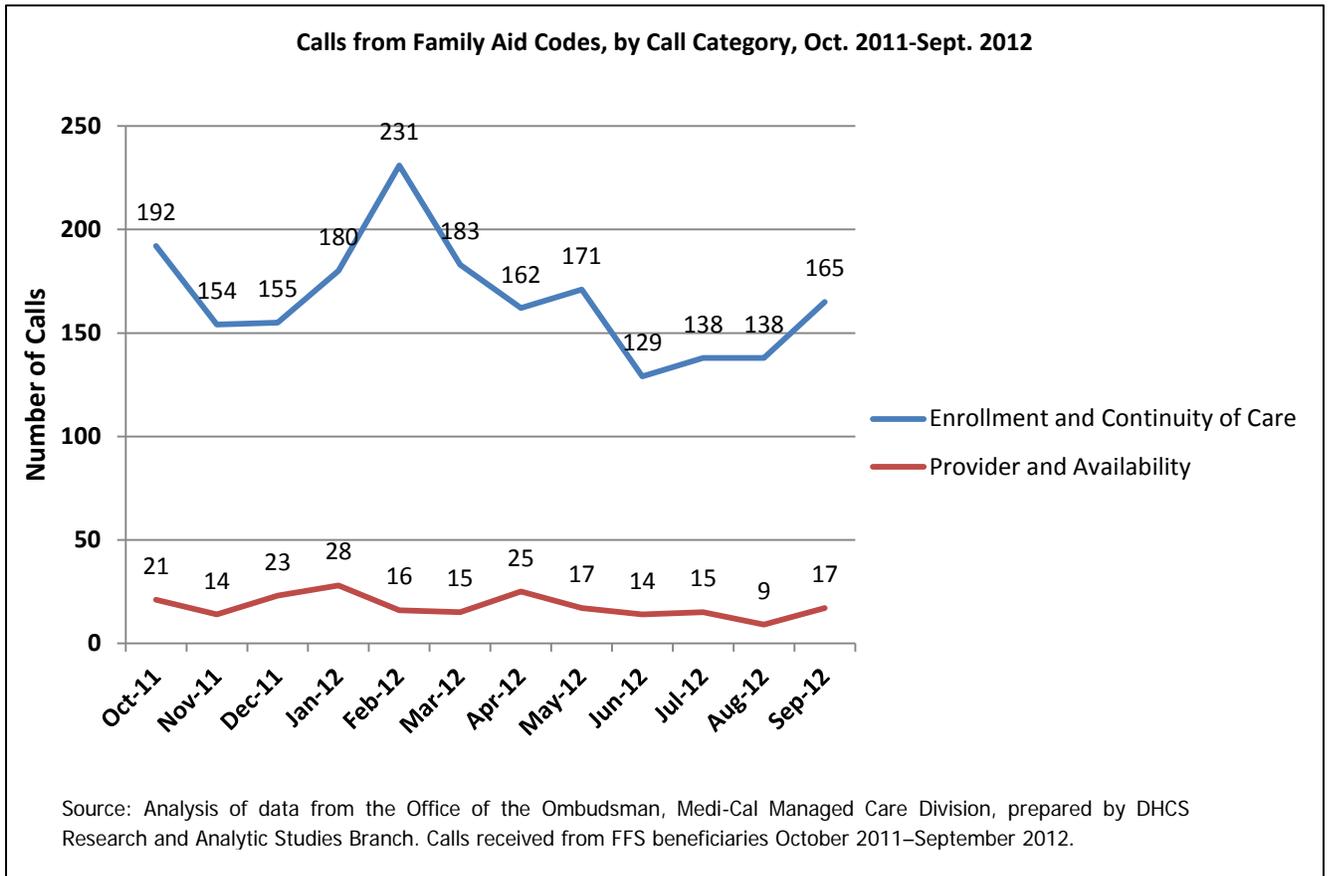
For Enrollment and Continuity of Care calls, there were more calls from beneficiaries in the Foster Care than Undocumented aid category; the reverse was observed for Provider and Availability calls, with more calls received from beneficiaries in Undocumented aid codes than Foster Care.

Distribution of Calls from Family Aid Codes by Call Category

Since the majority of calls for each call category were received from callers in Family and Blind/Disabled aid codes, these calls were analyzed by month and call category. Figure BF-4 presents the distribution of calls from Family aid codes by call category and month. Calls pertaining to Enrollment and Continuity of Care reached 231 calls in February 2012 before decreasing to 129 calls in June 2012.

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

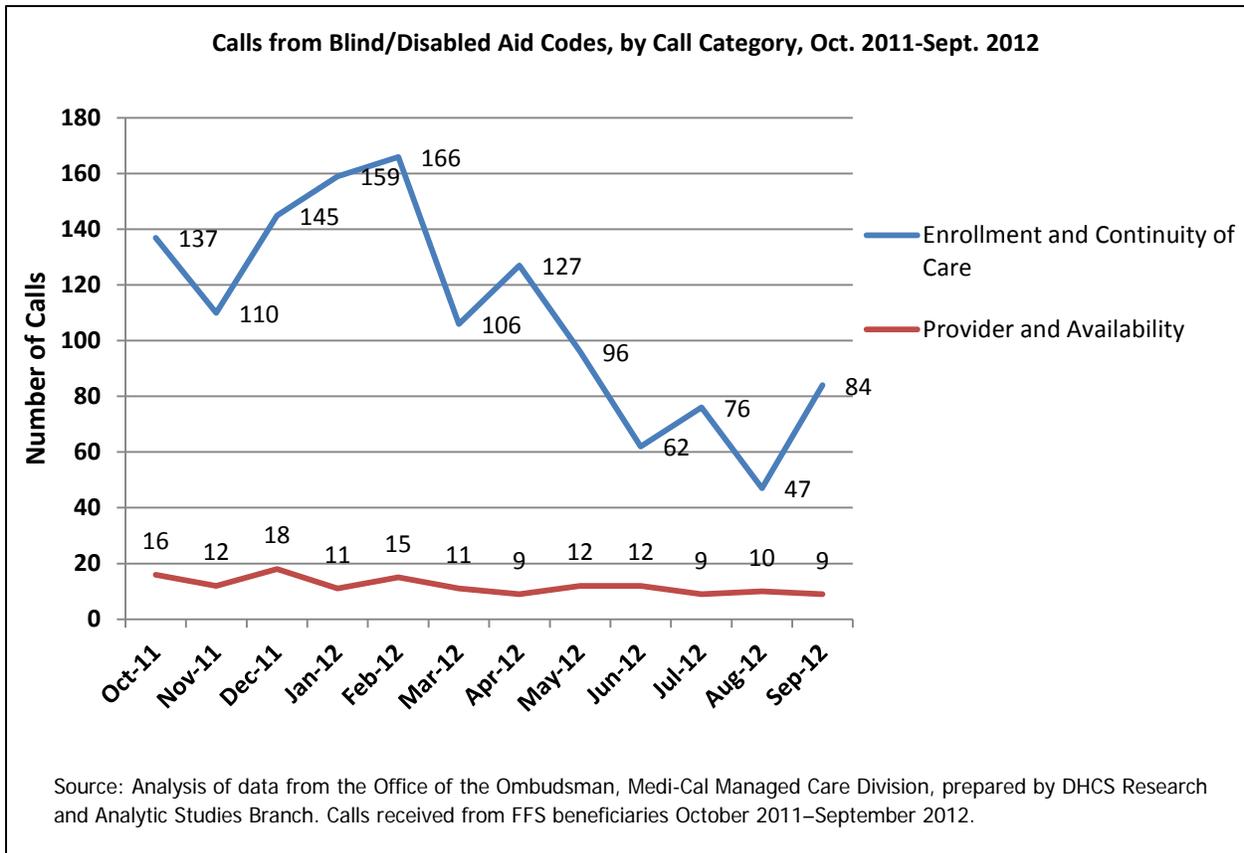
Figure BF-4 Calls from Family Aid Codes, Call Category by Month, Oct. 2011–Sept. 2012



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

Figure BF-5 presents the distribution of calls from beneficiaries in Blind/Disabled aid codes by call category and month. There were fluctuations in the number of calls pertaining to Enrollment/Continuity of Care throughout the reporting period, with call volume reaching 166 calls in February 2012, and then declining to 47 calls in August 2012.

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



Calls by County

The top 10 counties with the largest call volume are presented below for calls pertaining to Enrollment/Continuity of Care (see Table BF-4) and Provider/Availability (see Table BF-5). Eight counties made it to the top 10 list for both call categories. For each call category, Los Angeles was the top county, representing a quarter of calls for both categories.

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

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

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

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

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

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

Reason for Call

To further investigate calls received by FFS beneficiaries, the top reasons for calls under each call category were identified. Table BF-6 presents the top three reasons for calls among calls received from beneficiaries in the Family aid category. Nearly 80% of calls categorized as Enrollment and Continuity of Care pertained to requests for new enrollment. Another 6% of Enrollment and Continuity of Care calls were regarding Foster Care/Adoption issues, and 3% were disenrollment requests.

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

Among beneficiaries in Family aid codes, nearly 80% of calls regarding Enrollment/Continuity of Care were requests for new enrollment.

Table BF-6 Calls from Family Aid Codes, Top 3 Reasons for Calls, October 2011–September 2012

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

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

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

Table BF-7 presents the top three reasons for calls among calls received from beneficiaries in the Blind/Disabled aid category. Approximately 45% of the calls categorized as Enrollment/Continuity of Care involved callers requesting new enrollment. Another 22.1% concerned Medical Exemption Requests (MERs) or Emergency Disenrollment Exemption Requests (EDERs), and nearly 11% pertained to calls from beneficiaries in the Sention and Persons with Disabilities aid codes with concerns pertaining to denied medical exemptions and emergency disenrollment exemption requests.

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

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

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

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

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

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

Conclusions

1. Between October 2011 and September 2012, the Ombudsman call center staff documented 8,509 calls from FFS beneficiaries in the Medi-Cal program. The call total during this 12-month period decreased 1.24 percent from the July 2011–June 2012 reporting period.
2. About 45 percent of the calls pertained to Enrollment/Continuity of Care. Another 39 percent of calls were categorized under Miscellaneous. Due to the ambiguity of Miscellaneous calls, they were not further analyzed. The focus of the analyses were on calls related to Enrollment/Continuity of Care and Provider/Availability as these key elements help identify access-related issues experienced by beneficiaries.
3. Among calls categorized as Enrollment/Continuity of Care and Provider/Availability, the majority of calls were from Family and Blind/Disabled aid categories. Additionally, Los Angeles County was the most frequently reported county of residence, regardless of call category.
4. Callers in Family aid codes were primarily concerned with requesting new enrollment. Other important issues included foster care/adoption issues and disenrolling from or changing to an FFS plan. These callers also sought information regarding the termination of their Medi-Cal eligibility, as well as delayed or denied referrals to specialists, and refused medications.
5. Callers from Blind/Disabled aid codes were primarily concerned with requesting new enrollment. These callers also inquired about medical exemptions and emergency disenrollment exemption requests, as well as denied requests for exemptions. Other reasons for these calls included termination of Medi-Cal eligibility, provider not being a plan participant, and refused medications.