



Medi-Cal Access to Care Quarterly Monitoring Report #5 2012 Quarter 4



Executive Summary

September 2013

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

List of Figures.....	2
Table.....	3
Abstract	4
Executive Summary.....	5
Background.....	5
Findings.....	12
Physician Supply	12
Change in Medi-Cal Participation	12
Service Utilization Rates Per 1,000 Member Months for Adult Beneficiaries.....	13
Beneficiary Help Line Feedback	18

List of Figures

Figure ES-1. Trend in Biannual FFS vs Managed Care Participation	6
Figure ES-2. Distribution of Adult FFS Medi-Cal Only Population by Aid Category as of Quarter 1, 2011	7
Figure ES-3. Distribution of Adult FFS Medi-Cal Only Population by Aid Category as of Quarter 4, 2012	7
Figure ES-4. Declines in Adult FFS Medi-Cal Only Users of Three Service Categories for Quarter 1, 2012–Quarter 4, 2012.....	9
Figure ES-5. Declines in Adult FFS Medi-Cal Only Users of Physician/Clinic Services from Quarter 1, 2012–Quarter 4, 2012.....	9
Figure ES-6. Calls Received from FFS Beneficiaries by Month for January 2012–December 2012	19

Table

Table ES-1. Summary of Service Utilization Trends Among Adults by Aid Category and Service Category for Quarter 1, 2012–Quarter 4, 2012.....17

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 fourth 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 third quarter of 2012, similar patterns were identified in all four areas under study. Key findings regarding these study areas are summarized below.

KEY FINDINGS

- The number of 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 beneficiaries enrolled in the Other aid category, and in some geographic areas, FFS participation increased in the fourth quarter of 2012. By December 2012, the largest segment of adults participating in Medi-Cal's FFS system 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 supply, or total physicians at distinct locations, increased statewide from 105,608 to 107,896, or 2.2%.
- 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 call volume that was similar to the previous study period. Although call volume declined significantly in the first half of 2012, the number of calls received by the Ombudsman's Office increased during the last quarter of the study period.

Executive Summary

Background

This Medi-Cal access report is the fifth in a series of reports concerning health care access among Medi-Cal beneficiaries. 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 fourth 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:

- Physician Supply
- Change in Medi-Cal participation
- Service utilization rates per 1,000 member months
- Beneficiary help line feedback

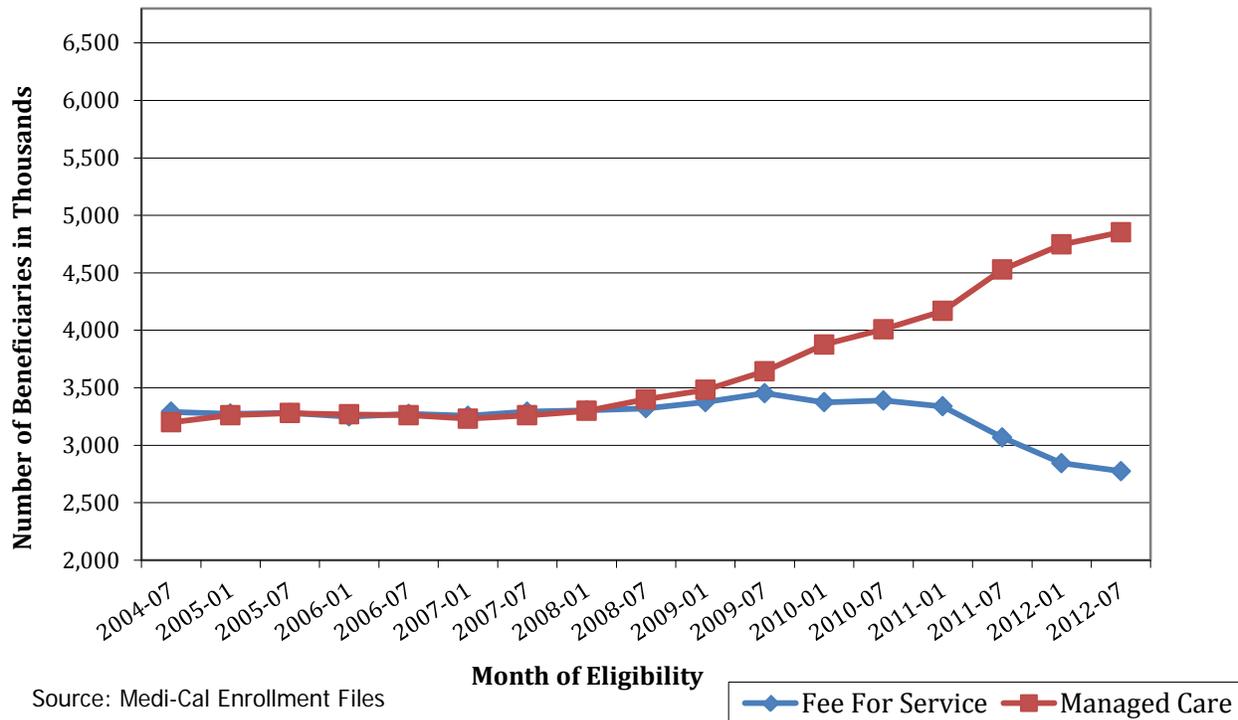
Recent changes to the Medi-Cal program have impacted benefits, health care delivery, and FFS population characteristics. All of these changes influenced the measures evaluated in Medi-Cal's quarterly access report. The DHCS systematic access monitoring system required the establishment of baseline statistics.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

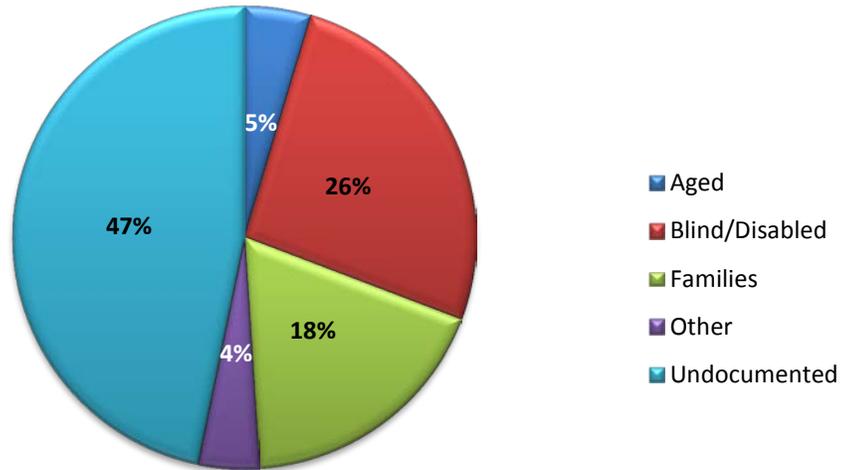
Figure ES-1. Trend in Biannual FFS vs Managed Care Participation



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.

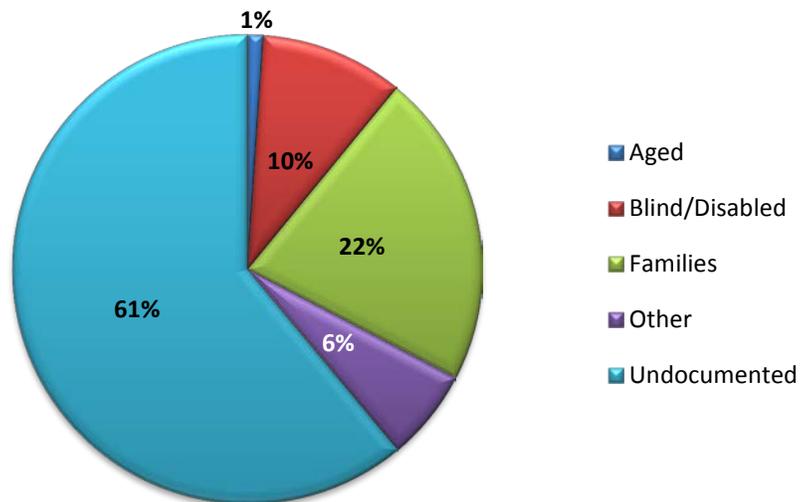
As the next two figures show, from the first quarter of 2011 to the fourth quarter of 2012, an increasing percentage of the overall Medi-Cal population is comprised of Undocumented beneficiaries, as subpopulations in the other aid categories shift from FFS to managed care. Since Undocumented beneficiaries 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 December 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 as of Quarter 1, 2011



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

Figure ES-3. Distribution of Adult FFS Medi-Cal Only Population by Aid Category as of Quarter 4, 2012



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

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

In addition to the establishment of managed care models within former FFS counties, Medi-Cal also directed seniors and persons with disabilities (SPD), who were formerly receiving care through the FFS system, into Medi-Cal managed care plans in the Two-Plan and Geographic Managed Care (GMC) counties. Roughly 300,000 SPD beneficiaries were transitioned from FFS to managed care as a result of this policy from June 2011–May 2012. 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 for nearly half of the current study period of January 2012–May 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.

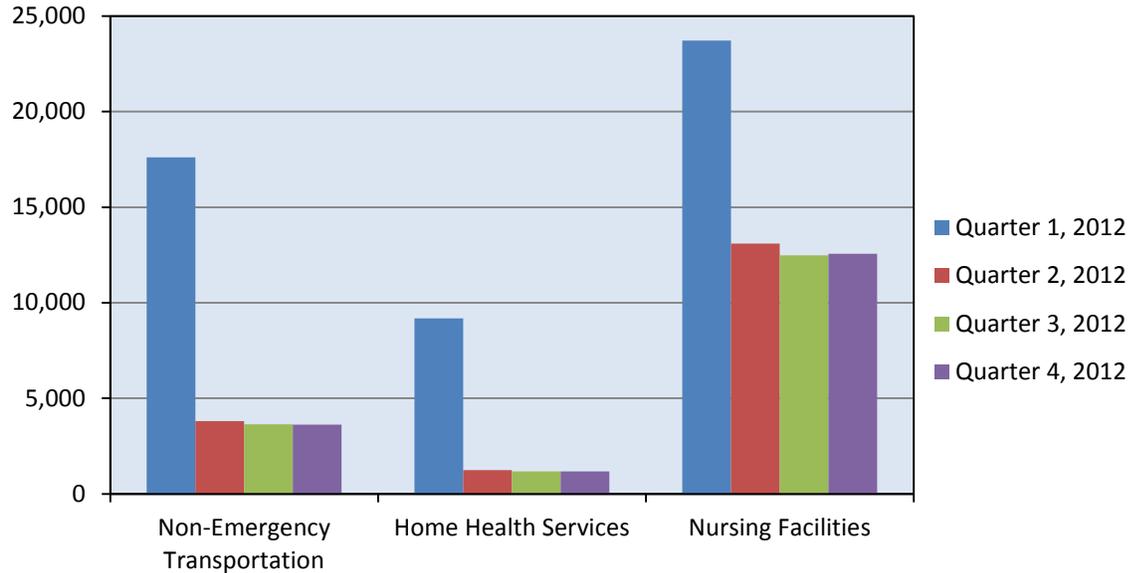
Shifting health care delivery systems materially influenced service utilization measures. For example, in those counties that shifted from a FFS delivery system to a managed care model, the number of beneficiaries participating in Medi-Cal's FFS system declined significantly. The impact of these changes 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 categories who utilize Non-Emergency Transportation and Home Health services 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).

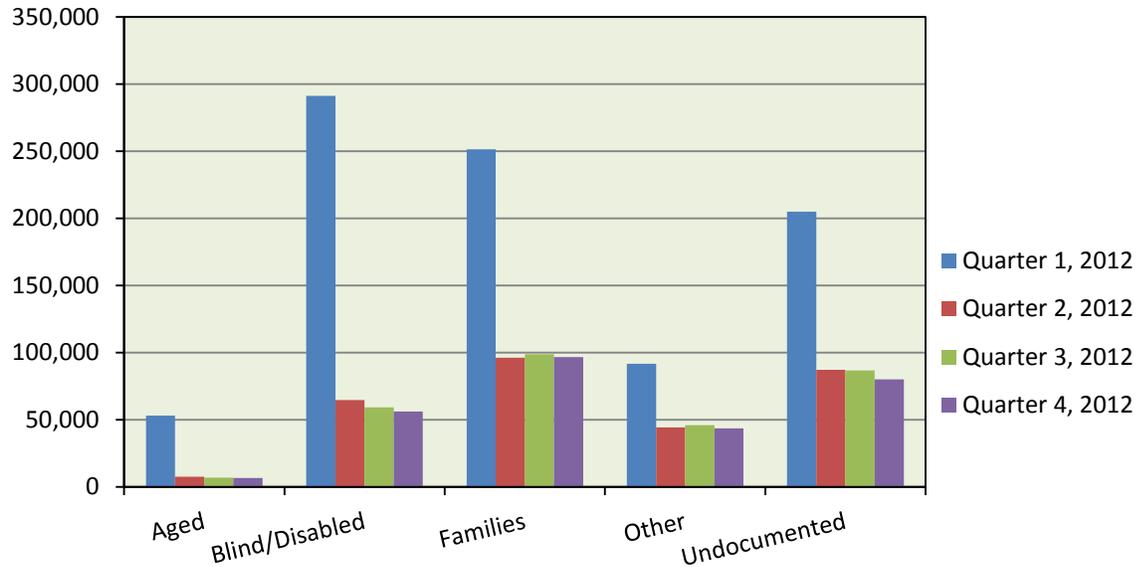
³ This figure includes only DHCS-administered services. If services administered by other departments are included, the total rises to \$5.7 billion.

Figure ES-4. Declines in Adult FFS Medi-Cal Only Users of Three Service Categories for Quarter 1, 2012–Quarter 4, 2012



Source: 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 January 2012–December 2012. Quarterly data reflects a 4-month lag.

Figure ES-5. Declines in Adult FFS Medi-Cal Only Users of Physician/Clinic Services from Quarter 1, 2012–Quarter 4, 2012



Source: 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 January 2012–December 2012. Quarterly data reflects a 4-month lag.

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."

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 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.

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).

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 four quarters—enrolled physicians have been stable during the quarters examined (quarters one, two, three and four of 2012). In these four access snapshots, modest increases in Medi-Cal physician enrollment have been reported.

The aggregate number of primary care physicians increased 2.0 % from 39,426 to 40,220 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 2.6% overall from the first quarter of 2012 to the fourth quarter of 2012, reflective of Medi-Cal's continued shift of beneficiaries to managed care.

The greatest decrease from the first quarter of 2012 to the fourth 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 (44.0%), with adults in the Blind/Disabled aid category

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. This method was modified with the 2012 Quarter 4 report. Prior reports have been updated to allow trending.

also significantly decreasing by 34.7%. The decrease in participation among the Aged and Blind/Disabled subpopulation was expected due to DHCS' initiative aimed at transitioning SPDs into managed care plans from June 2011–May 2012.

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, 25 of 58 counties experienced a decline in FFS participation of a magnitude 1% or more, while the remaining counties either stayed about the same or increased.

Overall, patterns in Medi-Cal FFS participation varied depending on whether beneficiaries resided in metropolitan or non-metropolitan areas of the state. Among adults in the Aged aid category, FFS participation grew by 8.5% in non-metropolitan counties, while FFS participation declined by 44.8% in metropolitan areas for this same beneficiary subgroup. In general, the declines among FFS participants residing in metropolitan areas were 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 experienced significant declines (12.8%) in participation for the study period, while participation for those residing in metropolitan areas were observed to decline at a much smaller magnitude (8.5%). 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 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

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/>

⁸Service use for children has been excluded from the Executive Summary but is examined in detail within the Service Utilization report on the [DHCS-RASB website](#).

2. Emergency Transportation
3. Non-Emergency Transportation
4. Home Health
5. Hospital Inpatient
6. Hospital Outpatient
7. Nursing Facility
8. Pharmacy
9. Other
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 Nursing Facility services. Despite experiencing a downward trend in Non-Emergency Transportation services utilization over the four quarters of the study period, Blind/Disabled adults utilized these services at rates well above the expected baseline ranges.
- Adults in the Families aid category again displayed below average utilization of Physician/Clinic, Emergency Transportation, Hospital Inpatient, and Hospital Outpatient services. 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 Physician/Clinic, Emergency Transportation, 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 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

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*.

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 were required to enroll into managed care plans, unless a medical exemption was 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 and through May 2012, 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 Medi-Cal FFS Adults by Aid Category and Service Category for Quarter 1, 2012–Quarter 4, 2012

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. Decline in Dec 2012.	N/A	N/A	N/A	Mostly Above Expected Range. Upward Trend Jan 2012–May 2012	Mostly Above Average and Mostly Within Expected Range. Decline in Last Quarter.	N/A	Below Average and Mostly Below Expected Range. Downward Trend Jan 2012 – Dec 2012.	Below Average and Mostly Below Expected Range.	Above Average and Mostly Above Expected Range.
Blind/ Disabled	Mostly Above Average and Within Expected Range. Downward Trend Aug 2012–Dec 2012.	Above Expected Range. Slight Downward Trend Mar 2012–Dec 2012.	Mostly Above Average with Levels Reaching Above Expected Range in 2 nd and 3 rd Quarters.	Mostly Above Average and Within Expected Range.	Mostly Above Average with Several Months Above Expected Range.	Mostly Above Average with 4 Consecutive (May 2012–Aug 2012) Months Above Expected Range. Downward Trend (Aug 2012–Dec 2012).	Mostly Above Expected Range. Upward Trend (Jan 2012–May 2012).	Below Average with Several 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 Mostly Within Expected Range. Downward Trend Aug 2012 – Dec 2012. Below Range During Last Quarter.	N/A	Within Expected Range. Downward Trend Jul 2012 – Dec 2012.	N/A	Below Average with Several Non-Consecutive Months Below Expected Range.	Below Average and Mostly Within Expected Range. Downward Trend Aug 2012 – Dec 2012. Below Range During Last Quarter.	N/A	Below Average with 4 Consecutive Months (June 2012 – Sep 2012) Below Expected Range	Below Average and Mostly Within Expected Range. Decline in Dec 2012.	Within Expected Range.
Other	Mostly Within Expected Range. Downward Trend Aug 2012 – Dec 2012.	Above Expected Range	Within Expected Range.	N/A	Below Average with 5 Consecutive Months (Feb 2012 – June 2012) Below Expected Range.	Mostly Within Expected Range. Downward Trend Aug 2012 – Dec 2012.	Below Average with 5 Consecutive Months (Aug 2012 – Dec 2012) Below the Expected Range.	Within Expected Range.	Mostly Below Average and Within Expected Range.	Within Expected Range.
Undocu- mented	Below Average and Mostly Below Expected Range. Downward Trend Aug 2012 – Dec 2012.	N/A	Mostly Below the Expected Range with Levels Reaching Within Range During 3 rd Quarter.	N/A	Below the Expected Range.	Below Average and Mostly Within Expected Range. Downward Trend Aug 2012 – Dec 2012. Below Range During Last Quarter.	N/A	Mostly Above Average and Within Expected Range.	Below the Expected Range.	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 first quarter of 2012 to the fourth 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, 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 during the study period by month.

Figure ES-6. Calls Received from FFS Beneficiaries by Month for January 2012–December 2012¹¹



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

The Ombudsman’s Office received an increase in calls from FFS beneficiaries during the last quarter of 2012 after a general decline for the first three quarters of 2012. This increase in call volume was driven primarily by calls categorized as pertaining to “miscellaneous” issues. The increase in call volume beginning in September may be the result of announced changes to the Healthy Families program that shifted previously covered children into Medi-Cal. Further exploration into the rise in call volume is necessary in order to arrive at a definitive reason for this noted increase.

¹¹ A different data extraction method was used by the Office of the Ombudsman to identify calls made by FFS beneficiaries using data obtained by this new method. Call counts are slightly higher (3% to 6%) than noted in previous access quarterly reports.



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Physician Supply

September 2013

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Table of Contents

List of Figures	2
List of Tables	3
Medi-Cal Physician Supply.....	4
Introduction.....	4
Methods	6
Physician Enrollment Status	6
Data Source	6
How Are Physicians Counted?	7
Results—Physician Supply	8
Number of Physicians	11
Primary Care Physicians	14
OB/GYN Physicians	15
Pediatricians	16
Conclusions—Physician Supply.....	17
Appendix: Physician Supply by County	18

List of Figures

Figure PS-1. Health Plan Models by County, September 2012	9
Figure PS-2. Primary Care Health Provider Shortage Areas, April 2012*	10
Figure PS-3. All Enrolled Physicians by County for Fourth Quarter 2012	12
Figure PS-4. Change in All Enrolled Physicians by County for January 2012-December 2012	13

List of Tables

Table PS-1. Summary and Description of Physician Supply Tables	8
Table PS-2. Physician Supply, All Enrolled Physician Sites	11
Table PS-3. Primary Care Physicians, All Enrolled Physician Sites	14
Table PS-4. Physician Supply, Physicians with an OB/GYN Specialty.....	15
Table PS-5. Physician Supply, Physicians with a Pediatric Specialty.....	16
Table PS-6. Physician Supply, All Enrolled Physicians, by Plan Model Type and County.....	18
Table PS-7. Primary Care Physician Supply, All Enrolled Physicians, by Plan Model Type and County	20
Table PS-8. Physician Supply, Physicians with an OB/GYN Specialty, by Plan Model Type and County	22
Table PS-9. Physician Supply, Physicians with a Pediatric Specialty, by Plan Model Type and County	24
Table PS-10. Outpatient Rural and FQHC Clinics.....	26

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 2.2% from 105,608 to 107,896.

Site-specific primary care physician counts increased 2.0% from 39,426 to 40,220.

Site-specific OB/GYN physician counts remained relatively flat at 6,292.

Site-specific pediatrician counts increased 2.1%, from 10,779 to 11,001.

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 decisionmakers 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 systemwide metric designed to alert DHCS management of changes in the number of providers and provider sites over time. Much like an internal control, this metric was designed to identify systemwide 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 first quarter of 2012 to the fourth 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 within a given specialty area.

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 in California.

Figure PS-1. Health Plan Models by County, September 2012

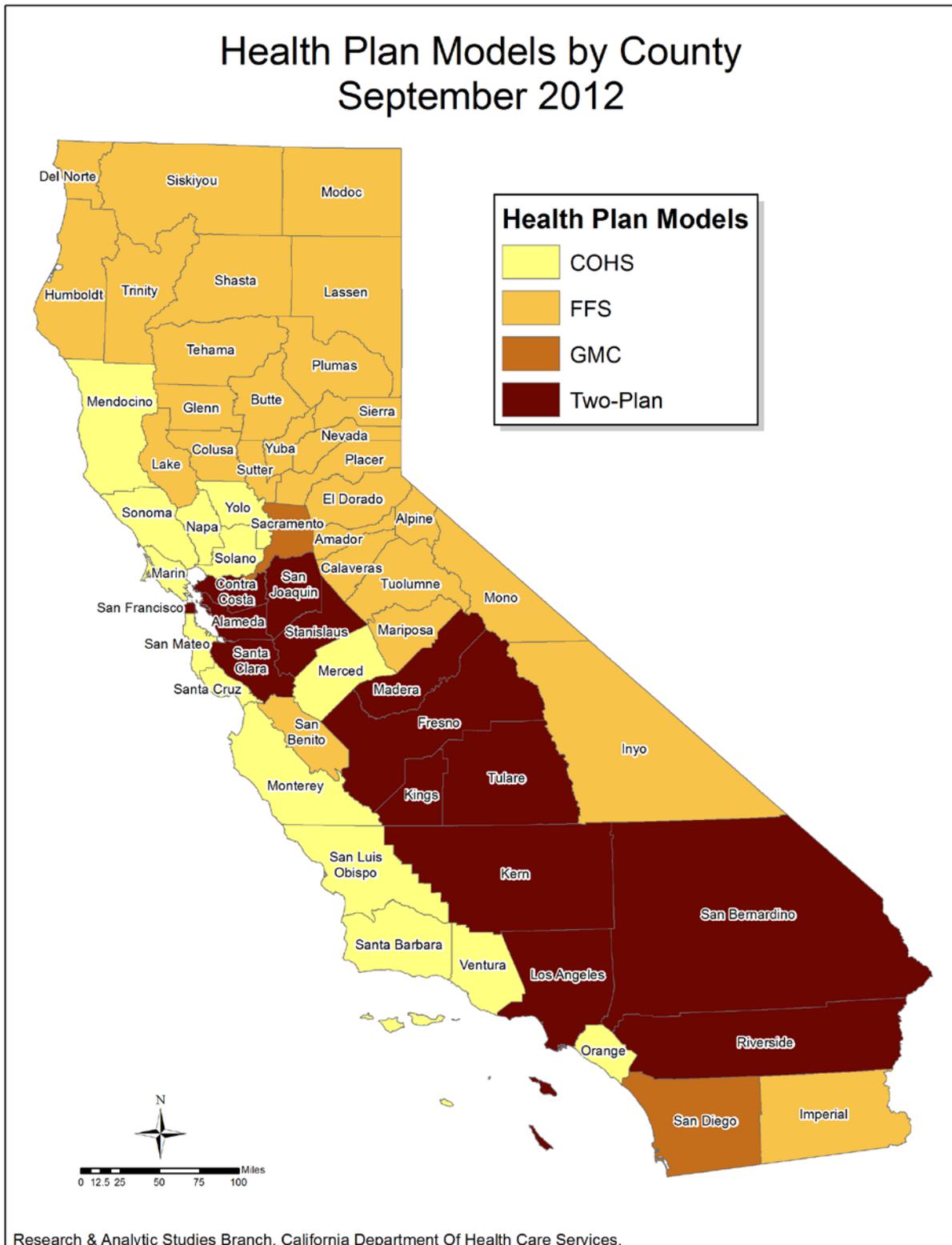
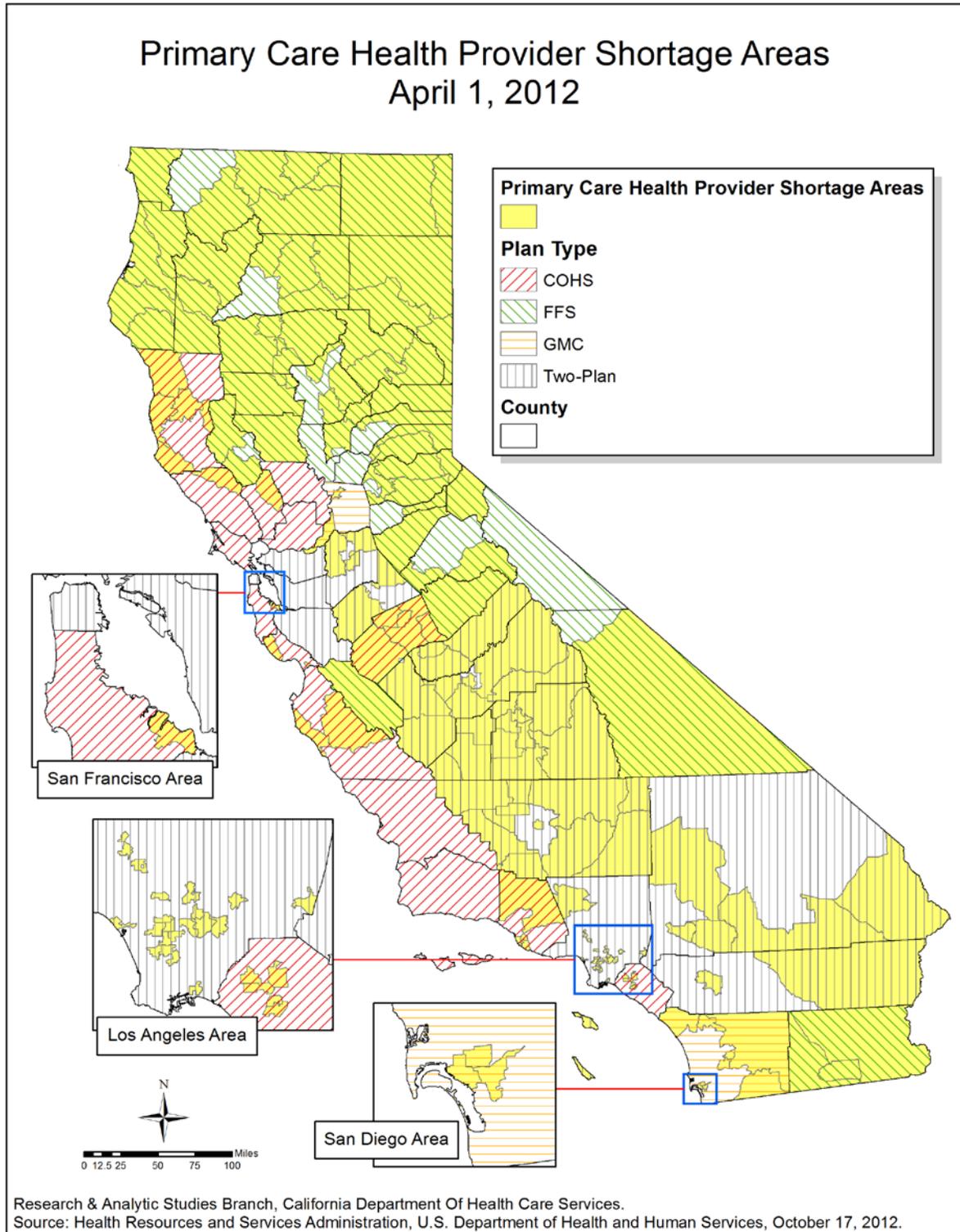


Figure PS-2. Primary Care Health Provider Shortage Areas, April 2012*



*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 105,608 to 107,896, or 2.2%.

Physician counts by Plan Type showed increases ranging from 1.6% for County Organized Health System (COHS) counties to 2.4% for Geographic Managed Care (GMC) 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 29,390 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 2.2% from 105,608 to 107,896.

Table PS-2. Physician Supply, All Enrolled Physician Sites

	Site-Specific Physician Counts				
	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Percent Change In Number of Providers
Statewide	105,608	106,373	106,335	107,896	2.2%
County Plan Model Type					
County Organized Health System (COHS)	19,742	19,885	19,854	20,053	1.6%
Fee-for-Service (FFS)	3,968	3,999	3,982	4,050	2.1%
Geographic Managed Care (GMC)	15,945	16,040	16,007	16,320	2.4%
Two-Plan (Commercial Plan and Local Initiative)	65,953	66,449	66,492	67,473	2.3%

Source: Prepared by DHCS Research and Analytic Studies Branch. Counts of physicians with Active and Indirect enrollment status we obtained from the Medi-Cal Provider Master File for the months of January 2012, April 2012, July 2012, and October 2012.

Figure PS-3. All Enrolled Physicians by County for Fourth Quarter 2012

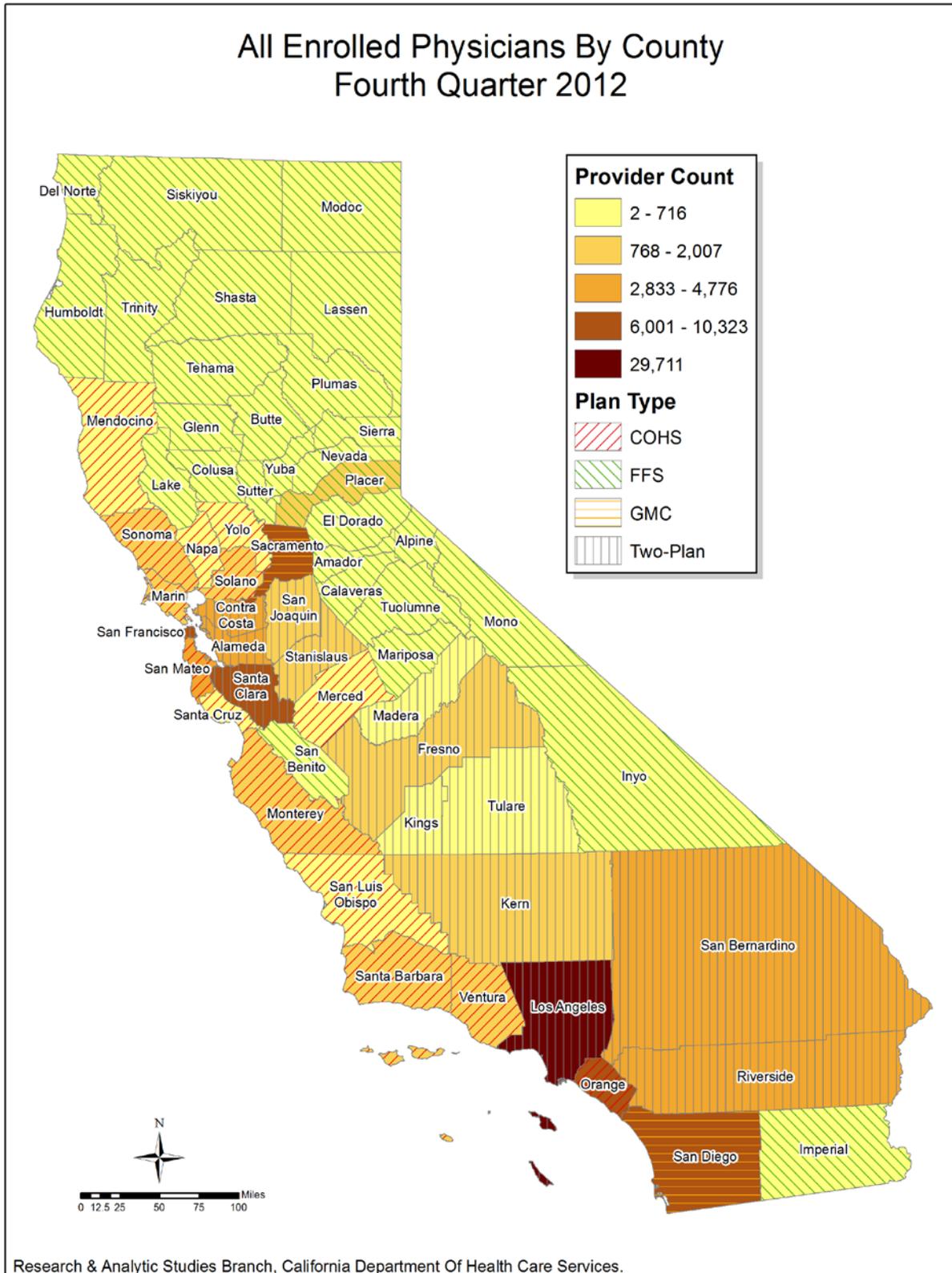
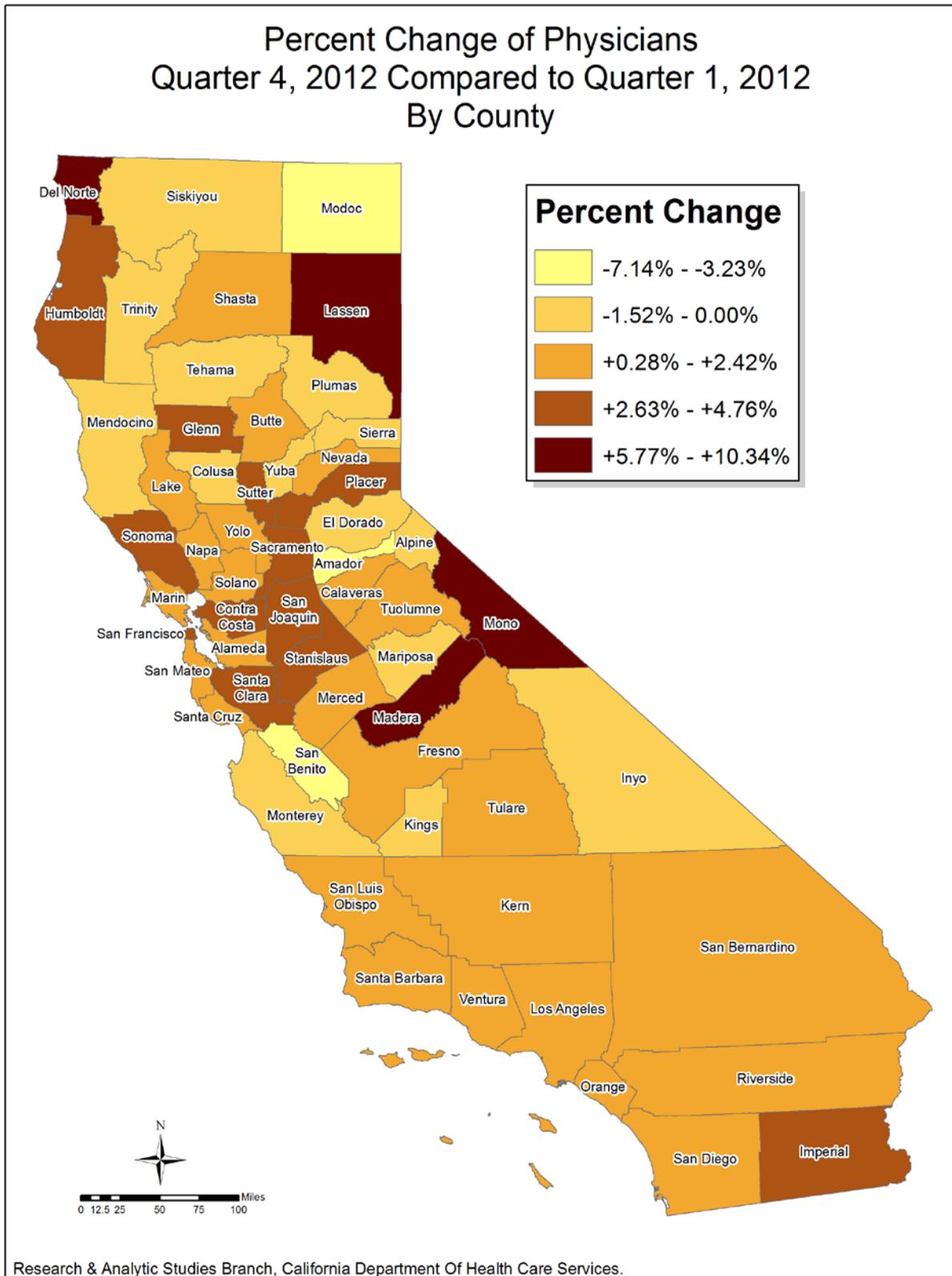


Figure PS-4. Change in All Enrolled Physicians by County for January 2012-December 2012



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 first quarter of 2012 to the fourth quarter of 2012, increasing from 39,426 to 40,220, or 2.0%.

Physicians by Plan Type showed increases ranging from 1.7% for COHS counties to 2.2% for Fee-for-Service (FFS) counties. Average counts ranged from one to fewer than 10 in four counties, to 11,555 in Los Angeles County (see Table PS-7 in the [Appendix](#) for county level detail). The counties with low primary care physician counts are primarily rural with small populations and offer only the FFS plan model. It is important to note that, although there are counties with few to no registered primary care physicians, Federally Qualified Health Clinics (FQHC), Rural Health Clinics (RHC), and other clinics are able to provide primary care services in these communities. Table PS-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 first quarter of 2012 to the fourth quarter of 2012, increasing 2.0% from 39,426 to 40,220.

Table PS-3. Primary Care Physicians, All Enrolled Physician Sites

	Number of Providers				Percent Change In Number of Providers
	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	
Statewide	39,426	39,747	39,722	40,220	2.0%
County Plan Model Type					
County Organized Health System (COHS)	7,425	7,503	7,488	7,551	1.7%
Fee-for-Service (FFS)	1,759	1,772	1,772	1,798	2.2%
Geographic Managed Care (GMC)	5,494	5,531	5,518	5,606	2.0%
Two-Plan (Commercial Plan and Local Initiative)	24,748	24,941	24,944	25,265	2.1%

Source: Prepared by DHCS Research and Analytic Studies Branch. Counts of primary care physicians with Active and Indirect enrollment status were obtained from the Medi-Cal Provider Master File for the months of January 2012, April 2012, July 2012, and October 2012.

OB/GYN Physicians

Table PS-4 presents site-specific counts of all enrolled OB/GYN physicians. Statewide, OB/GYN physicians remained relatively unchanged at 6,292.

Physicians by Plan Types showed little change for Two-Plan counties, and modest increases of 1.4% for FFS and GMC counties. Los Angeles County had an average of 1,719 OB/GYNs enrolled in Medi-Cal (see Table PS-8 in the [Appendix](#) for county level detail). Twenty-one counties had ten or fewer physicians, and four of those counties, Alpine, Mariposa, Sierra and Trinity, 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.

Statewide, OB/GYN physician counts remained stable at 6,292.

Table PS-4. Physician Supply, Physicians with an OB/GYN Specialty

	Site-Specific Physician Counts				
	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Percent Change In Number of Providers
Statewide	6,244	6,281	6,233	6,292	0.8%
County Plan Model Type					
County Organized Health System (COHS)	1,258	1,265	1,259	1,273	1.2%
Fee-for-Service (FFS)	221	225	225	224	1.4%
Geographic Managed Care (GMC)	806	807	801	817	1.4%
Two-Plan (Commercial Plan and Local Initiative)	3,959	3,984	3,948	3,978	0.5%

Source: Prepared by DHCS Research and Analytic Studies Branch. Counts of OB/GYN physicians with Active and Indirect enrollment status were obtained from the Medi-Cal Provider Master File for the months of January 2012, April 2012, July 2012, and October 2012.

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-10 in the Appendix displays the total number of clinics by county available to serve Medi-Cal beneficiaries.

Pediatricians

Table PS-5 includes site-specific counts of all enrolled pediatric physicians by county plan model type. Enrollment increased 2.1% statewide, from 10,779 pediatricians in the first quarter of 2012 to 11,001 in the fourth quarter of 2012.

The number of pediatricians by Plan Type increased from 1.6% for GMC counties to 3.4% for FFS counties. Los Angeles County had the highest average number of pediatricians with 2,918 (see Table PS-9 in the [Appendix](#) for county level detail). In 11 counties, there were fewer than ten pediatricians and zero in seven other counties. The 18 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 2.1% statewide from 10,779 to 11,001 pediatricians.

Table PS-5. Physician Supply, Physicians with a Pediatric Specialty

	Site-Specific Physician Counts				Percent Change In Number of Providers
	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	
Statewide	10,779	10,862	10,841	11,001	2.1%
County Plan Model Type					
County Organized Health System (COHS)	1,883	1,897	1,899	1,918	1.9%
Fee-for-Service (FFS)	268	272	271	277	3.4%
Geographic Managed Care (GMC)	1,467	1,471	1,467	1,490	1.6%
Two-Plan (Commercial Plan and Local Initiative)	7,161	7,222	7,204	7,316	2.2%

Source: Prepared by DHCS Research and Analytic Studies Branch. Counts of pediatric physicians with Active and Indirect enrollment status were obtained from the Medi-Cal Provider Master File for the months of January 2012, April 2012, July 2012, and October 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 first quarter of 2012 to the fourth 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 105,608 to 107,896, or 2.2%.
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 2.0%, from 39,426 to 40,220. Site-specific OB/GYN physician counts remained relatively unchanged at 6,292. Site-specific pediatrician counts increased 2.1%, from 10,779 to 11,001.

Appendix: Physician Supply by County

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

		Site-Specific Physician Counts					
		2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Average Number of Providers	Percent Change In Number of Providers
Statewide		105,608	106,373	106,335	107,896	106,553	2.2%
County Plan Model Type							
County Organized Health System (COHS)		19,742	19,885	19,854	20,053	19,884	1.6%
Fee-for-Service (FFS)		3,968	3,999	3,982	4,050	4,000	2.1%
Geographic Managed Care (GMC)		15,945	16,040	16,007	16,320	16,078	2.4%
Two-Plan (Commercial Plan and Local Initiative)		65,953	66,449	66,492	67,473	66,592	2.3%
County							
Alameda	Two-Plan	4,695	4,730	4,735	4,777	4,734	1.7%
Alpine	FFS	2	2	2	2	2	0.0%
Amador	FFS	54	54	53	53	54	-1.9%
Butte	FFS	503	505	502	510	505	1.4%
Calaveras	FFS	48	47	48	47	48	-2.1%
Colusa	FFS	39	39	39	39	39	0.0%
Contra Costa	Two-Plan	2,864	2,892	2,901	2,940	2,899	2.7%
Del Norte	FFS	52	52	54	55	53	5.8%
El Dorado	FFS	273	274	265	274	272	0.4%
Fresno	Two-Plan	1,982	1,999	1,988	2,006	1,994	1.2%
Glenn	FFS	21	21	21	22	21	4.8%
Humboldt	FFS	400	404	405	413	406	3.3%
Imperial	FFS	201	211	202	212	207	5.5%
Inyo	FFS	35	34	36	35	35	0.0%
Kern	Two-Plan	1,736	1,746	1,749	1,772	1,751	2.1%
Kings	Two-Plan	181	181	180	181	181	0.0%
Lake	FFS	113	112	111	113	112	0.0%
Lassen	FFS	30	29	29	32	30	6.7%
Los Angeles	Two-Plan	29,158	29,377	29,327	29,696	29,390	1.8%
Madera	Two-Plan	287	292	290	308	294	7.3%
Marin *	COHS	760	762	764	765	763	0.7%
Mariposa	FFS	19	18	19	19	19	0.0%
Mendocino *	COHS	197	197	194	195	196	-1.0%
Merced	COHS	364	367	368	371	368	1.9%
Modoc	FFS	14	14	14	13	14	-7.1%
Mono	FFS	41	41	42	44	42	7.3%

		Site-Specific Physician Counts					
		2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Average Number of Providers	Percent Change In Number of Providers
Monterey	COHS	875	877	866	879	874	0.5%
Napa	COHS	359	360	361	360	360	0.3%
Nevada	FFS	187	189	187	190	188	1.6%
Orange	COHS	7,851	7,909	7,889	7,987	7,909	1.7%
Placer	FFS	752	765	768	778	766	3.5%
Plumas	FFS	33	33	33	33	33	0.0%
Riverside	Two-Plan	2,884	2,916	2,899	2,948	2,912	2.2%
Sacramento	GMC	5,839	5,875	5,859	6,003	5,894	2.8%
San Benito	FFS	61	61	61	60	61	-1.6%
San Bernardino	Two-Plan	4,596	4,619	4,631	4,705	4,638	2.4%
San Diego	GMC	10,106	10,165	10,148	10,317	10,184	2.1%
San Francisco	Two-Plan	6,503	6,547	6,622	6,766	6,610	4.0%
San Joaquin	Two-Plan	1,485	1,497	1,505	1,524	1,503	2.6%
San Luis Obispo	COHS	465	469	465	471	468	1.3%
San Mateo	COHS	2,788	2,813	2,815	2,831	2,812	1.5%
Santa Barbara	COHS	1,108	1,106	1,111	1,125	1,113	1.5%
Santa Clara	Two-Plan	7,597	7,651	7,668	7,813	7,682	2.8%
Santa Cruz	COHS	613	617	613	621	616	1.3%
Shasta	FFS	477	477	477	486	479	1.9%
Sierra	FFS	5	5	5	5	5	0.0%
Siskiyou	FFS	82	82	82	82	82	0.0%
Solano	COHS	1,321	1,338	1,333	1,338	1,333	1.3%
Sonoma	COHS	1,145	1,157	1,166	1,182	1,163	3.2%
Stanislaus	Two-Plan	1,282	1,291	1,288	1,322	1,296	3.1%
Sutter	FFS	159	163	161	166	162	4.4%
Tehama	FFS	98	98	95	97	97	-1.0%
Trinity	FFS	12	12	12	12	12	0.0%
Tulare	Two-Plan	703	711	709	715	710	1.7%
Tuolumne	FFS	97	98	99	99	98	2.1%
Ventura *	COHS	1,426	1,441	1,438	1,456	1,440	2.1%
Yolo	COHS	470	472	471	472	471	0.4%
Yuba	FFS	160	159	160	159	160	-0.6%

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

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the Medi-Cal Provider Master File for the months of January 2012, April 2012, July 2012, and October 2012.

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

		Site-Specific Physician Counts					
		2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Average Number of Providers	Percent Change In Number of Providers
Statewide		39,426	39,747	39,722	40,220	39,779	2.0%
County Plan Model Type							
County Organized Health System (COHS)		7,425	7,503	7,488	7,551	7,492	1.7%
Fee-for-Service (FFS)		1,759	1,772	1,772	1,798	1,775	2.2%
Geographic Managed Care (GMC)		5,494	5,531	5,518	5,606	5,537	2.0%
Two-Plan (Commercial Plan and Local Initiative)		24,748	24,941	24,944	25,265	24,975	2.1%
County	Plan Type						
Alameda	Two-Plan	1,651	1,668	1,667	1,677	1,666	1.6%
Alpine	FFS	1	1	1	1	1	0.0%
Amador	FFS	33	32	31	31	32	-6.1%
Butte	FFS	190	193	191	190	191	0.0%
Calaveras	FFS	25	24	25	24	25	-4.0%
Colusa	FFS	30	30	30	30	30	0.0%
Contra Costa	Two-Plan	1,109	1,125	1,132	1,148	1,129	3.5%
Del Norte	FFS	26	26	27	28	27	7.7%
El Dorado	FFS	103	103	104	108	105	4.9%
Fresno	Two-Plan	749	757	757	764	757	2.0%
Glenn	FFS	9	9	9	9	9	0.0%
Humboldt	FFS	184	185	185	189	186	2.7%
Imperial	FFS	65	70	68	74	69	13.8%
Inyo	FFS	18	18	18	18	18	0.0%
Kern	Two-Plan	704	709	709	710	708	0.9%
Kings	Two-Plan	82	82	81	83	82	1.2%
Lake	FFS	48	48	48	48	48	0.0%
Lassen	FFS	15	15	15	18	16	20.0%
Los Angeles	Two-Plan	11,476	11,567	11,523	11,655	11,555	1.6%
Madera	Two-Plan	65	64	65	67	65	3.1%
Marin *	COHS	309	315	315	315	314	1.9%
Mariposa	FFS	12	11	12	12	12	0.0%
Mendocino *	COHS	71	71	71	71	71	0.0%
Merced	COHS	167	169	169	170	169	1.8%
Modoc	FFS	11	11	11	10	11	-9.1%
Mono	FFS	19	19	19	21	20	10.5%

Monterey	COHS	339	343	343	350	344	3.2%
Napa	COHS	110	111	112	111	111	0.9%
Nevada	FFS	88	88	87	88	88	0.0%
Orange	COHS	2,743	2,766	2,745	2,778	2,758	1.3%
Placer	FFS	353	359	359	363	359	2.8%
Plumas	FFS	25	25	25	25	25	0.0%
Riverside	Two-Plan	1,218	1,237	1,232	1,249	1,234	2.5%
Sacramento	GMC	1,986	1,997	1,991	2,025	2,000	2.0%
San Benito	FFS	23	23	24	23	23	0.0%
San Bernardino	Two-Plan	1,913	1,927	1,936	1,965	1,935	2.7%
San Diego	GMC	3,508	3,534	3,527	3,581	3,538	2.1%
San Francisco	Two-Plan	2,040	2,050	2,078	2,125	2,073	4.2%
San Joaquin	Two-Plan	562	563	567	580	568	3.2%
San Luis Obispo	COHS	165	167	165	166	166	0.6%
San Mateo	COHS	992	1,006	1,011	1,019	1,007	2.7%
Santa Barbara	COHS	356	356	357	362	358	1.7%
Santa Clara	Two-Plan	2,383	2,394	2,398	2,427	2,401	1.8%
Santa Cruz	COHS	243	246	247	249	246	2.5%
Shasta	FFS	205	206	205	209	206	2.0%
Sierra	FFS	5	5	5	5	5	0.0%
Siskiyou	FFS	38	39	39	39	39	2.6%
Solano	COHS	556	565	563	561	561	0.9%
Sonoma	COHS	499	502	505	508	504	1.8%
Stanislaus	Two-Plan	536	537	538	551	541	2.8%
Sutter	FFS	79	78	78	80	79	1.3%
Tehama	FFS	48	48	48	49	48	2.1%
Trinity	FFS	5	5	5	5	5	0.0%
Tulare	Two-Plan	260	261	261	264	262	1.5%
Tuolumne	FFS	40	41	42	42	41	5.0%
Ventura *	COHS	650	660	658	665	658	2.3%
Yolo	COHS	225	226	227	226	226	0.4%
Yuba	FFS	61	60	61	59	60	-3.3%

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

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the Medi-Cal Provider Master File for the months of January 2012, April 2012, July 2012, and October 2012

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

		Site-Specific Physician Counts					
		2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Average Number of Providers	Percent Change In Number of Providers
Statewide		6,244	6,281	6,233	6,292	6,263	0.8%
County Plan Model Type							
County Organized Health System (COHS)		1,258	1,265	1,259	1,273	1,264	1.2%
Fee-for-Service (FFS)		221	225	225	224	224	1.4%
Geographic Managed Care (GMC)		806	807	801	817	808	1.4%
Two-Plan (Commercial Plan and Local Initiative)		3,959	3,984	3,948	3,978	3,967	0.5%
County	Plan Type						
Alameda	Two-Plan	294	296	298	301	297	2.4%
Alpine	FFS	-	-	-	-	-	-
Amador	FFS	5	5	5	5	5	0.0%
Butte	FFS	32	34	35	35	34	9.4%
Calaveras	FFS	1	1	1	1	1	0.0%
Colusa	FFS	1	1	1	1	1	0.0%
Contra Costa	Two-Plan	150	151	151	151	151	0.7%
Del Norte	FFS	3	3	2	2	3	-33.3%
El Dorado	FFS	15	15	15	15	15	0.0%
Fresno	Two-Plan	125	127	122	123	124	-1.6%
Glenn	FFS	1	1	1	1	1	0.0%
Humboldt	FFS	18	18	18	18	18	0.0%
Imperial	FFS	17	17	16	16	17	-5.9%
Inyo	FFS	2	2	3	3	3	50.0%
Kern	Two-Plan	100	99	101	102	101	2.0%
Kings	Two-Plan	9	9	9	10	9	11.1%
Lake	FFS	4	4	4	4	4	0.0%
Lassen	FFS	1	1	1	1	1	0.0%
Los Angeles	Two-Plan	1,727	1,733	1,703	1,714	1,719	-0.8%
Madera	Two-Plan	15	15	15	15	15	0.0%
Marin *	COHS	32	32	32	32	32	0.0%
Mariposa	FFS	-	-	-	-	-	-
Mendocino *	COHS	21	21	20	20	21	-4.8%
Merced	COHS	22	22	22	22	22	0.0%
Modoc	FFS	1	1	1	1	1	0.0%

		Site-Specific Physician Counts					
		2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Average Number of Providers	Percent Change In Number of Providers
Mono	FFS	1	1	1	1	1	0.0%
Monterey	COHS	71	71	71	72	71	1.4%
Napa	COHS	17	17	17	16	17	-5.9%
Nevada	FFS	13	13	13	13	13	0.0%
Orange	COHS	564	570	564	574	568	1.8%
Placer	FFS	52	52	52	52	52	0.0%
Plumas	FFS	1	1	1	1	1	0.0%
Riverside	Two-Plan	194	195	191	192	193	-1.0%
Sacramento	GMC	290	291	291	299	293	3.1%
San Benito	FFS	4	4	4	4	4	0.0%
San Bernardino	Two-Plan	247	250	248	248	248	0.4%
San Diego	GMC	516	516	510	518	515	0.4%
San Francisco	Two-Plan	341	340	343	348	343	2.1%
San Joaquin	Two-Plan	116	117	117	117	117	0.9%
San Luis Obispo	COHS	30	30	29	30	30	0.0%
San Mateo	COHS	123	123	123	123	123	0.0%
Santa Barbara	COHS	72	73	73	73	73	1.4%
Santa Clara	Two-Plan	496	504	505	511	504	3.0%
Santa Cruz	COHS	41	40	41	41	41	0.0%
Shasta	FFS	17	17	17	17	17	0.0%
Sierra	FFS	-	-	-	-	-	-
Siskiyou	FFS	3	4	4	3	4	0.0%
Solano	COHS	80	79	78	80	79	0.0%
Sonoma	COHS	62	63	65	65	64	4.8%
Stanislaus	Two-Plan	70	73	70	71	71	1.4%
Sutter	FFS	13	14	14	14	14	7.7%
Tehama	FFS	5	5	5	5	5	0.0%
Trinity	FFS	-	-	-	-	-	-
Tulare	Two-Plan	75	75	75	75	75	0.0%
Tuolumne	FFS	7	7	7	7	7	0.0%
Ventura *	COHS	95	96	96	97	96	2.1%
Yolo	COHS	28	28	28	28	28	0.0%
Yuba	FFS	4	4	4	4	4	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 Medi-Cal Provider Master File for the months of January 2012, April 2012, July 2012, and October 2012.

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

		Site-Specific Physician Counts					
		2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Average Number of Providers	Percent Change In Number of Providers
Statewide		10,779	10,862	10,841	11,001	10,871	2.1%
County Plan Model Type							
County Organized Health System (COHS)		1,883	1,897	1,899	1,918	1,899	1.9%
Fee-for-Service (FFS)		268	272	271	277	272	3.4%
Geographic Managed Care (GMC)		1,467	1,471	1,467	1,490	1,474	1.6%
Two-Plan (Commercial Plan and Local Initiative)		7,161	7,222	7,204	7,316	7,226	2.2%
County	Plan Type						
Alameda	Two-Plan	730	733	736	743	736	1.8%
Alpine	FFS	-	-	-	-	-	-
Amador	FFS	2	2	2	2	2	0.0%
Butte	FFS	24	23	22	22	23	-8.3%
Calaveras	FFS	2	2	2	2	2	0.0%
Colusa	FFS	-	-	-	-	-	-
Contra Costa	Two-Plan	238	242	242	243	241	2.1%
Del Norte	FFS	5	5	5	5	5	0.0%
El Dorado	FFS	17	17	17	17	17	0.0%
Fresno	Two-Plan	178	180	177	179	179	0.6%
Glenn	FFS	2	2	2	2	2	0.0%
Humboldt	FFS	17	17	17	17	17	0.0%
Imperial	FFS	19	20	19	19	19	0.0%
Inyo	FFS	5	5	5	5	5	0.0%
Kern	Two-Plan	141	141	140	141	141	0.0%
Kings	Two-Plan	11	11	11	11	11	0.0%
Lake	FFS	5	5	5	5	5	0.0%
Lassen	FFS	2	2	2	2	2	0.0%
Los Angeles	Two-Plan	2,900	2,920	2,899	2,952	2,918	1.8%
Madera	Two-Plan	145	150	148	161	151	11.0%
Marin *	COHS	70	70	71	71	71	1.4%
Mariposa	FFS	-	-	-	-	-	-
Mendocino *	COHS	15	15	15	16	15	6.7%
Merced	COHS	24	24	24	24	24	0.0%
Modoc	FFS	-	-	-	-	-	-

		Site-Specific Physician Counts					
		2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Average Number of Providers	Percent Change In Number of Providers
Mono	FFS	5	5	6	6	6	20.0%
Monterey	COHS	85	86	86	86	86	1.2%
Napa	COHS	22	22	22	22	22	0.0%
Nevada	FFS	11	11	11	11	11	0.0%
Orange	COHS	868	872	874	887	875	2.2%
Placer	FFS	89	92	93	97	93	9.0%
Plumas	FFS	-	-	-	-	-	-
Riverside	Two-Plan	225	226	221	223	224	-0.9%
Sacramento	GMC	527	525	522	534	527	1.3%
San Benito	FFS	3	3	3	3	3	0.0%
San Bernardino	Two-Plan	514	516	516	525	518	2.1%
San Diego	GMC	940	946	945	956	947	1.7%
San Francisco	Two-Plan	687	694	703	709	698	3.2%
San Joaquin	Two-Plan	123	130	131	131	129	6.5%
San Luis Obispo	COHS	49	49	47	48	48	-2.0%
San Mateo	COHS	266	267	267	270	268	1.5%
Santa Barbara	COHS	94	94	94	95	94	1.1%
Santa Clara	Two-Plan	1,108	1,118	1,116	1,134	1,119	2.3%
Santa Cruz	COHS	46	47	46	46	46	0.0%
Shasta	FFS	19	19	19	19	19	0.0%
Sierra	FFS	-	-	-	-	-	-
Siskiyou	FFS	3	3	3	3	3	0.0%
Solano	COHS	119	121	122	123	121	3.4%
Sonoma	COHS	69	73	74	74	73	7.2%
Stanislaus	Two-Plan	83	83	85	83	84	0.0%
Sutter	FFS	11	12	12	12	12	9.1%
Tehama	FFS	10	10	9	11	10	10.0%
Trinity	FFS	-	-	-	-	-	-
Tulare	Two-Plan	78	78	79	81	79	3.8%
Tuolumne	FFS	10	10	10	10	10	0.0%
Ventura *	COHS	116	116	117	116	116	0.0%
Yolo	COHS	40	41	40	40	40	0.0%
Yuba	FFS	7	7	7	7	7	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 Medi-Cal Provider Master File for the months of January 2012, April 2012, July 2012, and October 2012

Table PS-10. Outpatient Rural and FQHC Clinics

		Number of Rural/FQHC Clinics					
		2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Average Number of Clinics	Percent Change In Number of Clinics
Statewide		957	983	960	968	967	1.1%
County Plan Model Type							
County Organized Health System (COHS)		187	195	184	188	189	0.5%
Fee-for-Service (FFS)		197	201	196	196	198	-0.5%
Geographic Managed Care (GMC)		80	83	79	79	80	-1.3%
Two-Plan (Commercial Plan and Local Initiative)		493	504	501	505	501	2.4%
County	Plan Type						
Alameda	Two-Plan	39	39	38	39	39	0.0%
Alpine	FFS	1	1	1	1	1	0.0%
Amador	FFS	4	4	5	5	5	25.0%
Butte	FFS	18	19	17	17	18	-5.6%
Calaveras	FFS	7	7	7	7	7	0.0%
Colusa	FFS	4	5	5	5	5	25.0%
Contra Costa	Two-Plan	16	16	16	16	16	0.0%
Del Norte	FFS	4	4	4	4	4	0.0%
El Dorado	FFS	6	6	6	6	6	0.0%
Fresno	Two-Plan	58	59	57	57	58	-1.7%
Glenn	FFS	12	13	12	12	12	0.0%
Humboldt	FFS	30	30	30	30	30	0.0%
Imperial	FFS	10	10	10	10	10	0.0%
Inyo	FFS	6	6	6	6	6	0.0%
Kern	Two-Plan	35	38	37	37	37	5.7%
Kings	Two-Plan	19	18	18	18	18	-5.3%
Lake	FFS	10	11	10	10	10	0.0%
Lassen	FFS	5	5	5	5	5	0.0%
Los Angeles	Two-Plan	147	148	153	154	151	4.8%
Madera	Two-Plan	12	12	12	12	12	0.0%
Marin *	COHS	5	8	8	7	7	40.0%
Mariposa	FFS	4	4	4	4	4	0.0%
Mendocino *	COHS	23	24	24	24	24	4.3%
Merced	COHS	26	27	22	21	24	-19.2%
Modoc	FFS	4	4	4	4	4	0.0%

		Number of Rural/FQHC Clinics					
		2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Average Number of Clinics	Percent Change In Number of Clinics
Mono	FFS	1	1	1	1	1	0.0%
Monterey	COHS	21	21	21	21	21	0.0%
Napa	COHS	2	2	1	1	2	-50.0%
Nevada	FFS	2	2	2	2	2	0.0%
Orange	COHS	15	15	12	14	14	-6.7%
Placer	FFS	3	3	3	3	3	0.0%
Plumas	FFS	6	6	6	6	6	0.0%
Riverside	Two-Plan	23	23	23	23	23	0.0%
Sacramento	GMC	9	9	8	8	9	-11.1%
San Benito	FFS	3	3	3	4	3	33.3%
San Bernardino	Two-Plan	12	14	14	13	13	8.3%
San Diego	GMC	71	74	71	71	72	0.0%
San Francisco	Two-Plan	30	32	30	30	31	0.0%
San Joaquin	Two-Plan	8	8	8	8	8	0.0%
San Luis Obispo	COHS	12	12	12	11	12	-8.3%
San Mateo	COHS	16	17	15	15	16	-6.3%
Santa Barbara	COHS	17	17	18	19	18	11.8%
Santa Clara	Two-Plan	22	24	23	25	24	13.6%
Santa Cruz	COHS	8	8	8	8	8	0.0%
Shasta	FFS	16	16	16	16	16	0.0%
Sierra	FFS	2	2	2	2	2	0.0%
Siskiyou	FFS	12	12	12	11	12	-8.3%
Solano	COHS	8	8	8	9	8	12.5%
Sonoma	COHS	16	16	16	16	16	0.0%
Stanislaus	Two-Plan	26	26	25	25	26	-3.8%
Sutter	FFS	4	4	4	4	4	0.0%
Tehama	FFS	8	8	7	7	8	-12.5%
Trinity	FFS	3	3	3	3	3	0.0%
Tulare	Two-Plan	46	47	47	48	47	4.3%
Tuolumne	FFS	4	4	4	4	4	0.0%
Ventura *	COHS	12	14	13	16	14	33.3%
Yolo	COHS	6	6	6	6	6	0.0%
Yuba	FFS	8	8	7	7	8	-12.5%

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

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the Medi-Cal Provider Master File for the months of January 2012, April 2012, July 2012, and October 2012.



Medi-Cal Access to Care Quarterly Monitoring Report #5 2012 Quarter 4



BENEFICIARY PARTICIPATION

September 2013

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Contents

List of Figures	2
List of Tables	3
Medi-Cal FFS Beneficiary Participation Trends	4
Introduction	4
Methods	7
Results	8
Medi-Cal Full Scope Beneficiaries by Gender and Age	8
Medi-Cal Beneficiaries by Aid Category and Age	10
Medi-Cal Beneficiary Participation in Metropolitan vs. Non-Metropolitan Counties	11
Distribution of Medi-Cal Only FFS Beneficiaries by Primary Language Spoken	13
Distribution of Medi-Cal Only FFS Beneficiaries by Race/Ethnicity	14
Distribution of Medi-Cal Only FFS Beneficiaries by County	15
Conclusions—Beneficiary Participation	18
Appendix A—County and Statewide Tables	19
Appendix B—Medi-Cal Aid Codes	30

List of Figures

Figure BP-1. Top Reasons Medi-Cal FFS Beneficiaries Seek Care by Age and Aid Category.....	5
Figure BP-2. Quarterly Average Member Months for Full Scope FFS Beneficiaries by Gender and Age Group for Quarter 1, 2012–Quarter 4, 2012	8
Figure BP-3. Change in FFS Participation among Full Scope Beneficiaries by Gender and Age for Quarter 1, 2012–Quarter 4, 2012.....	9
Figure BP-4. Change in FFS Participation among All Beneficiaries by Aid Category and Age for Quarter 1, 2012–Quarter 4, 2012.....	10
Figure BP-5. Change in FFS Participation among Medi-Cal Beneficiaries in Metropolitan Counties by Aid Category and Age for Quarter 1, 2012–Quarter 4, 2012.....	11
Figure BP-6. Change in FFS Participation among Medi-Cal Beneficiaries in Non-Metropolitan Counties by Age and Aid Category for Quarter 1, 2012–Quarter 4, 2012	12
Figure BP-7. Distribution of FFS Medi-Cal Only Beneficiaries by Primary Language Spoken as of December 2012.....	13
Figure BP-8. Distribution of FFS Beneficiaries by Race/Ethnicity as of December 2012.....	14
Figure BP-9. Comparison of FFS Participation by All Medi-Cal Only Beneficiaries for Quarter 1, 2012– Quarter 4, 2012.....	16
Figure BP-10. Comparison of FFS Participation by Full-Scope Medi-Cal Only Beneficiaries for Quarter 1, 2012–Quarter 4, 2012.....	17

List of Tables

Table BP-1. Average Member Months Per Quarter for All FFS Medi-Cal Only Beneficiaries by County	19
Table BP-2. Average Member Months for FFS Full Scope Medi-Cal Only Beneficiaries by County	21
Table BP-3. Average Member Months of FFS Full Scope Medi-Cal Only Children Age 0–17 by County	23
Table BP-4. Average Member Months of FFS Medi-Cal Only Women Age 18–64 by County	25
Table BP-5. Average Member Months of FFS Full Scope Beneficiaries by Gender and Age.....	27
Table BP-6. Average Member Months of FFS Restricted Scope Beneficiaries by Gender and Age	27
Table BP-7. Average Member Months of FFS Beneficiaries by Age and Aid Category	28
Table BP-8. Average Member Months of FFS Beneficiaries in Metropolitan Counties by Age and Aid Category	28
Table BP-9. Average Member Months of FFS Beneficiaries in Non-Metropolitan Counties by Age and Aid Category.....	29

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 enrollment 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.

Highlights

FFS participation for full scope beneficiaries declined 2.6% from 1,157,140 to 1,127,039. 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 the Other aid category (6.1%) and Adults in the Other category (7.6%).

Spanish is primary language for 48.9% and 47.2% reported English.

Hispanics represent 62.9% of the total FFS Medi-Cal Only population.

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

The degree of responsibility for ensuring access to care may vary depending on the subpopulation and type of coverage afforded. For example, approximately 40% of the 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 primarily 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. Approximately 300,000 SPDs were shifted into managed care plans from June 2011–May 2012.
2. An expansion in the number of counties that transitioned from the FFS to the managed care model occurred 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.

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 first quarter of 2012 to the fourth 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

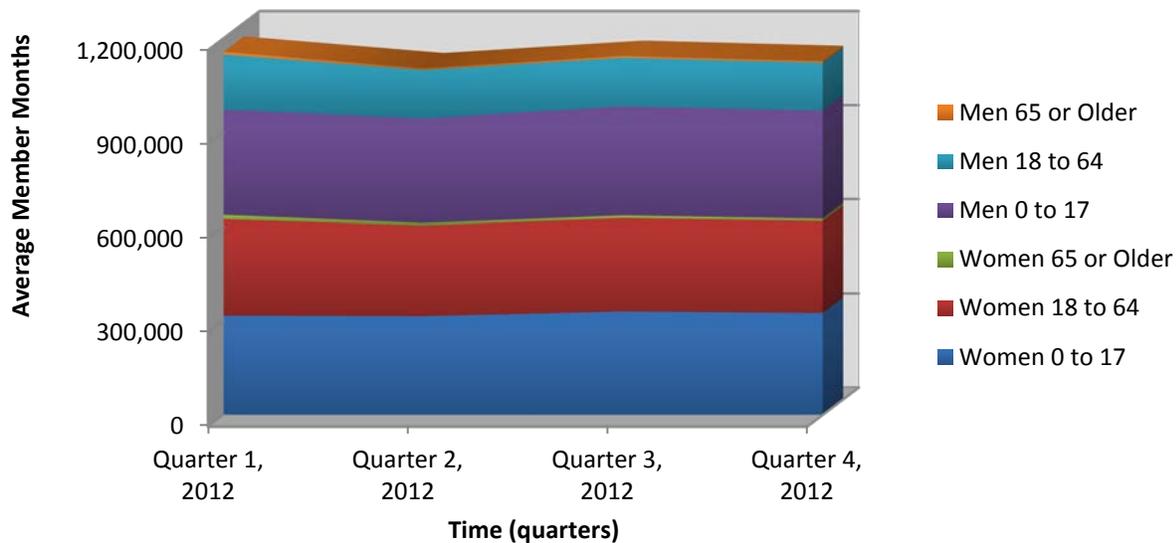
Medi-Cal Full Scope Beneficiaries by Gender and Age

Participation in the FFS health care delivery system for Medi-Cal beneficiaries who were eligible for full scope services decreased from the first quarter of 2012 to the fourth quarter of 2012, from 1,157,140 to 1,127,039, or 2.6% (see Table BP-5). However, children’s participation was the only group to experience an increase in participation, with a 2.6% increase from the first quarter of 2012 to the fourth quarter of 2012.

Overall FFS participation for full scope beneficiaries declined 2.6% from January 2012–December 2012.

FFS program participation decreased modestly by 1.5% between quarter four and the previous quarter. All age and gender groups experienced decreases between 1.3% to 2.9% in the last two quarters of the study period. For people age 65 and older, FFS participation continued to decrease during the last quarter, but at a much smaller rate (-2.7%) than was observed when comparing the most distant quarters (-39.9%) (see Table BP-5).

Figure BP-2. Quarterly Average Member Months for Full Scope FFS Beneficiaries by Gender and Age Group for Quarter 1, 2012–Quarter 4, 2012



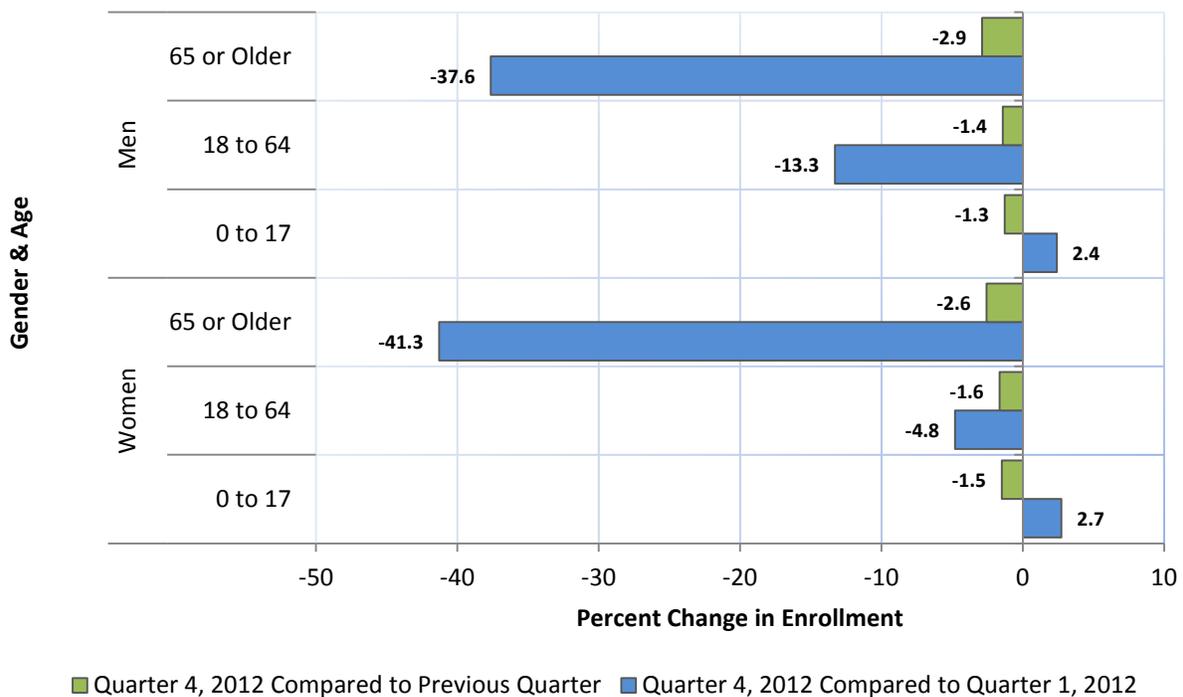
Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files January 2012–December 2012. Data reflects a 4-month reporting lag.

In Figure BP-3, the largest decrease in FFS participation from the first quarter of 2012 to the fourth quarter of 2012 was among females age 65 years and older (-41.3%) and males age 65 and older (-37.6%). Among young adults age 18–64, males experienced a larger decrease (-13.3%) in FFS participation than women (-4.8%) across this same 12-month study period.

Among adults age 65 or older, there were large declines for both women (41.3%) and men (37.6%).

A large number of full scope beneficiaries participating in the FFS health care delivery system are age 0-17, comprising 56% of the population in the first quarter and 59% in the fourth quarter. This same group experienced increases in FFS participation across all four quarters of 2012 (2.4% for males and 2.7% for females).

Figure BP-3. Change in FFS Participation among Full Scope Beneficiaries by Gender and Age for Quarter 1, 2012–Quarter 4, 2012



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

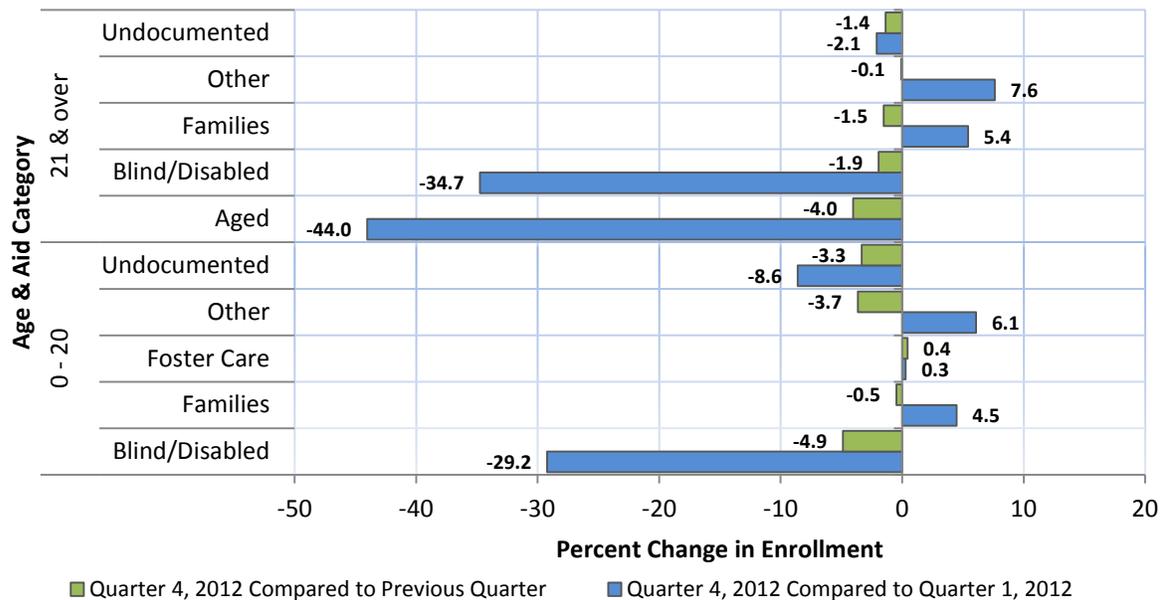
Medi-Cal Beneficiaries by Aid Category and Age

When comparing participation changes from the first quarter of 2012 to the fourth quarter of 2012 among adults, the largest decline in FFS participation were among the Blind/Disabled and Aged aid categories, and for children the largest declines in FFS participation were observed among the Blind/Disabled and Undocumented aid categories.

The largest declines in FFS participation occurred for adult beneficiaries in the Aged (-44.0%) and Blind/Disabled (-34.7%) aid categories.

The largest declines in FFS participation in this reporting period occurred for beneficiaries in the Aged aid category (-44.0%) and among Blind/Disabled adults (-34.7%) and children (-29.2%). By contrast, FFS participation increased in the Other and Families aid categories.

Figure BP-4. Change in FFS Participation among All Beneficiaries by Aid Category and Age for Quarter 1, 2012–Quarter 4, 2012



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

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 4.9% for children in the Blind/Disabled aid category to 1.4% of adults in the Undocumented aid category.

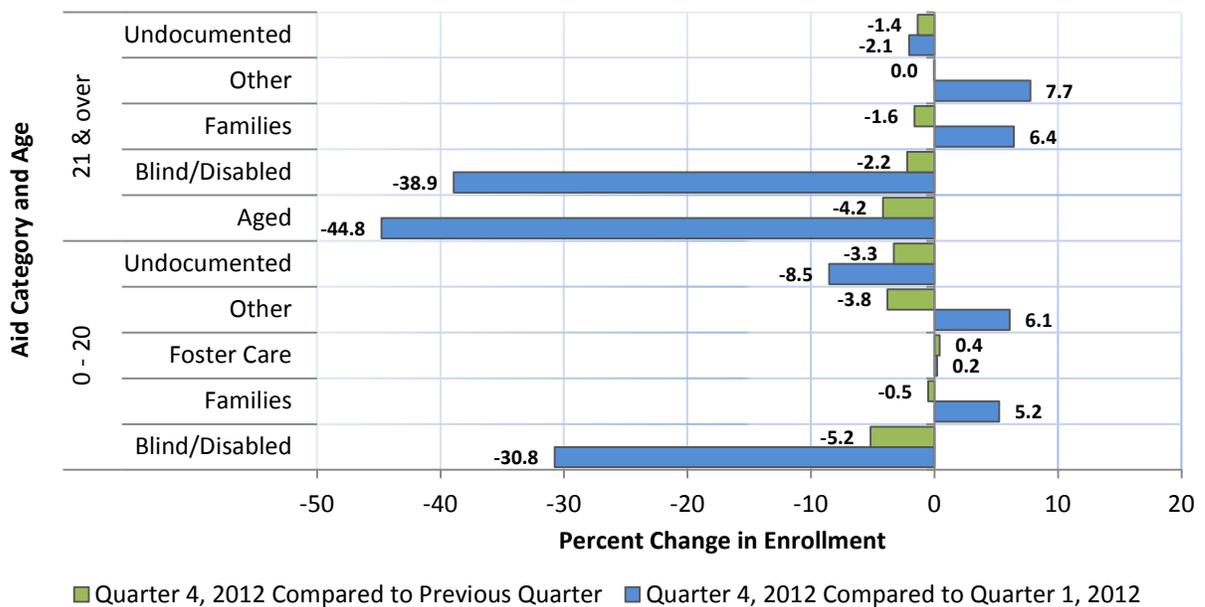
The drop in FFS participation among the Aged and Blind/Disabled populations reflects the implementation of the Bridge to Reform Waiver in which seniors and persons with disabilities (SPDs) were mandatorily shifted from the traditional FFS to the managed care delivery model from June 2011 to May 2012.

Medi-Cal Beneficiary Participation in Metropolitan vs. Non-Metropolitan Counties

Overall, FFS participation decreased slightly from the first quarter of 2012 to the fourth quarter of 2012 among beneficiaries residing in metropolitan counties (-3.1%), remaining virtually unchanged in non-metropolitan counties (-0.4%) (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 (44.8%), and among Blind/Disabled adults (38.9%) and children (30.8%).

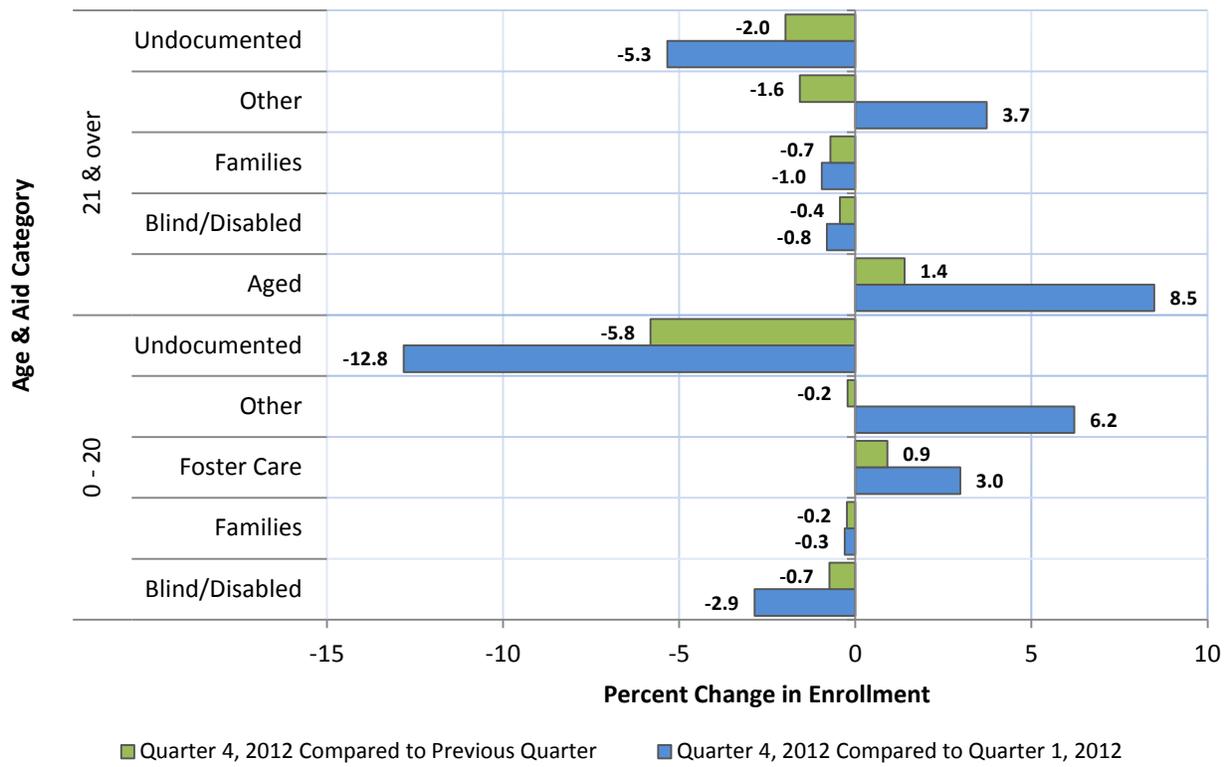
Figure BP-5. Change in FFS Participation among Medi-Cal Beneficiaries in Metropolitan Counties by Aid Category and Age for Quarter 1, 2012–Quarter 4, 2012



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

For beneficiaries residing in metropolitan counties, participation across the four quarters followed a similar pattern as the pattern observed statewide. A substantial decrease occurred among Aged adults (-44.8%), and among Blind/Disabled adults (-38.9%) and children (-30.8%), with a modest decline observed for children in the Undocumented aid category (-8.5%). A moderate increase was observed among adults in the Families (6.4%) and Other (7.7%) aid categories and among children in the Other (6.1%) aid categories (see Figure BP-4).

Figure BP-6. Change in FFS Participation among Medi-Cal Beneficiaries in Non-Metropolitan Counties by Age and Aid Category for Quarter 1, 2012–Quarter 4, 2012



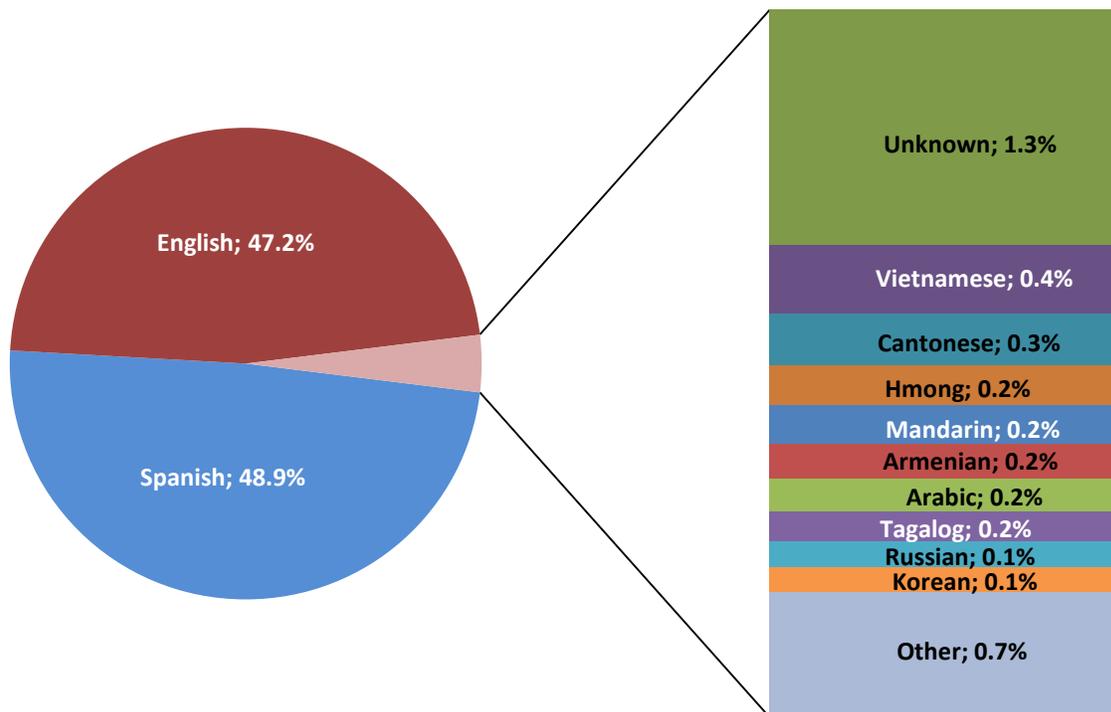
Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files January 2012–December 2012. Data reflects a 4-month reporting lag).

FFS beneficiaries residing in non-metropolitan areas experienced different changes in FFS participation patterns than was observed for beneficiaries in metropolitan areas. For example, FFS participation for children enrolled in the Undocumented aid codes and residing in non-metropolitan areas of the state declined by 12.8%, while FFS participation for those residing in metropolitan areas declined at a much smaller rate (-8.5%). Among adults in the Aged aid category, FFS participation grew by 8.5% in non-metropolitan areas, while FFS participation declined by 44.8% in metropolitan areas for the same beneficiary subgroup. FFS participation declined at much higher rates among Undocumented immigrants residing in non-metropolitan vs. metropolitan counties, while declines in FFS participation among Blind/Disabled beneficiaries were smaller for those residing in non-metropolitan vs. metropolitan areas.

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

As displayed in Figure BP-7, Spanish was self-reported as the primary language spoken by 48.9% of beneficiaries participating in FFS and eligible for Medi-Cal only for the fourth quarter of 2012. English was the primary language used by 47.2% 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, Arabic, Hmong, Cantonese, Mandarin, Tagalog, and Russian.

Figure BP-7. Distribution of FFS Medi-Cal Only Beneficiaries by Primary Language Spoken as of December 2012

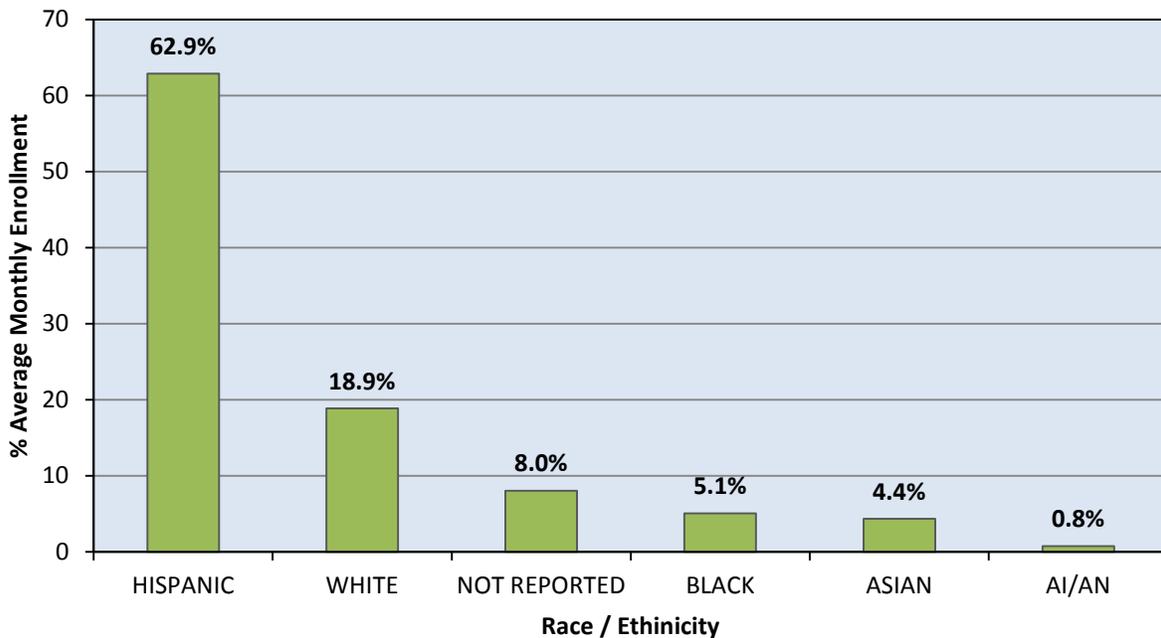


Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF, December 2012 file. Data reflects a 4-month reporting lag.

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

As displayed in Figure BP-8, Hispanics represented 62.9% of the total population participating in FFS and eligible for Medi-Cal only for the fourth quarter of 2012. Whites accounted for 18.9% of all FFS Medi-Cal beneficiaries, while African American and Asian/Pacific Islander beneficiaries represented a much smaller portion of the overall population (5.1% and 4.4%, respectively). An additional 8.0% of the FFS Medi-Cal population reported no race/ethnic data.

Figure BP-8. Distribution of FFS Beneficiaries by Race/Ethnicity as of December 2012



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

Distribution of Medi-Cal Only FFS Beneficiaries by County

As shown in Figure BP-9, when comparing participation changes for all FFS beneficiaries across the entire 12-month study period, large variations were observed by county. About half of the counties experienced a decline in participation, with San Francisco (-14.3%), Alpine (-10.0%), Sacramento (-8.9%), Tulare (-8.4%), and Kings (-8.1%) Counties experiencing the largest decreases. Approximately a quarter of counties saw an increase in FFS participation, with Solano, San Luis Obispo, and Yolo Counties recognizing the greatest increases (47.5%, 30.4%, and 29.3%). The remaining eleven counties had no significant changes in participation.

When evaluating participation for Full Scope beneficiaries in Figure BP-10, similar patterns were observed, although the degree of change was more pronounced, ranging from -22.4% for San Francisco County to 184.5% in Solano County over the year under study (see Table BP-2).

Nearly half of all counties continued to experience declines in FFS participation while a quarter of counties experienced increases in FFS participation.

Figure BP-9. Comparison of FFS Participation by All Medi-Cal Only Beneficiaries for Quarter 1, 2012–Quarter 4, 2012

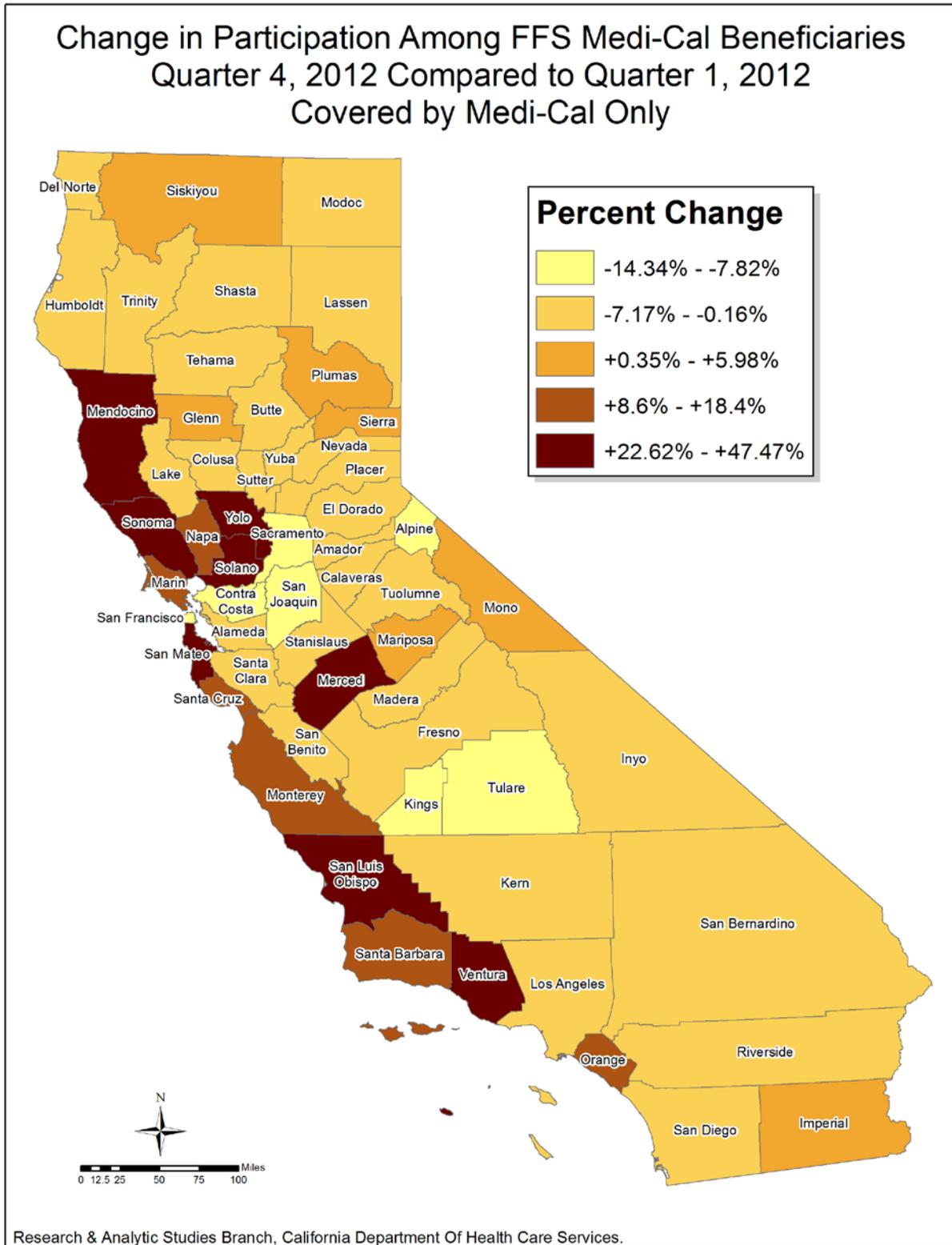
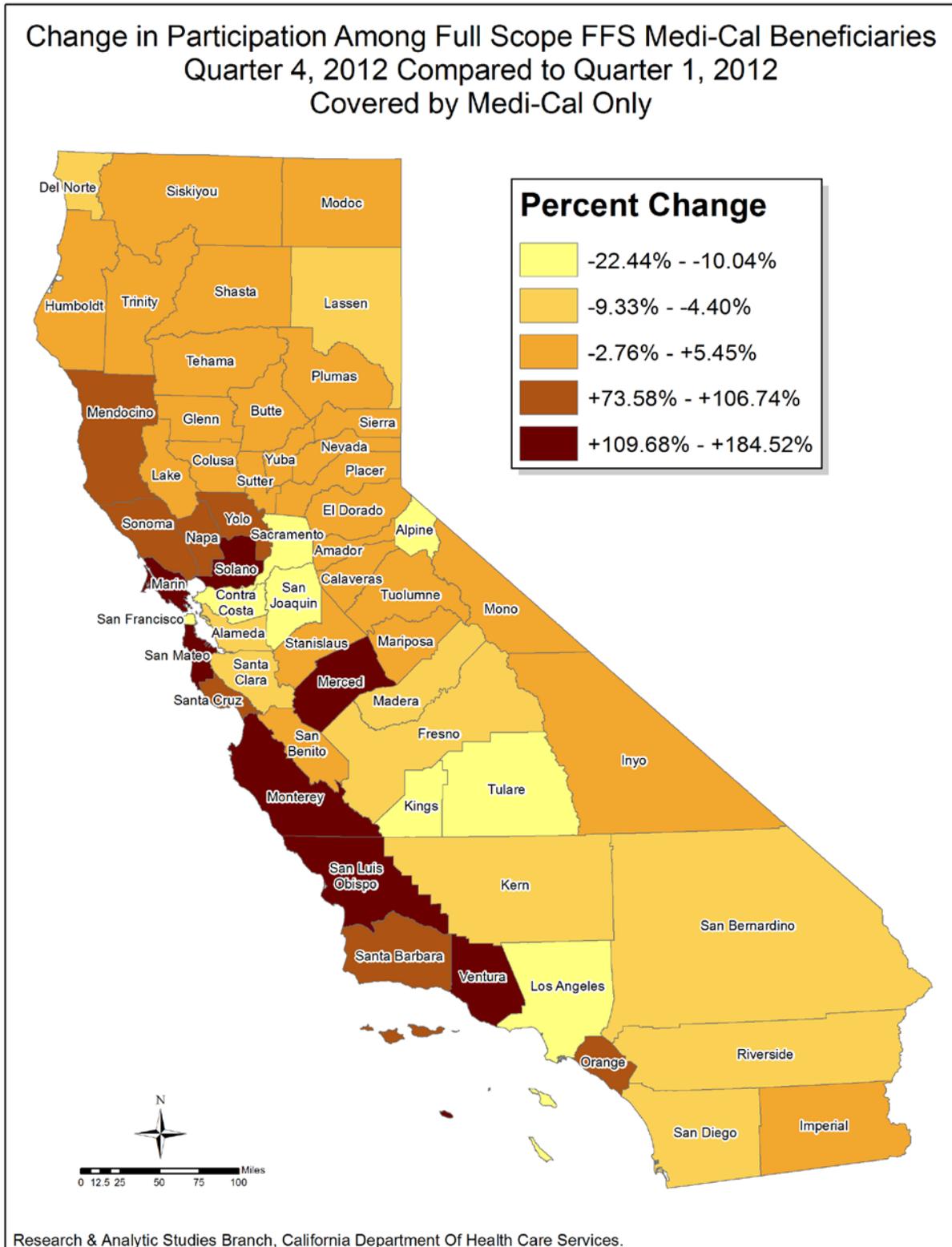


Figure BP-10. Comparison of FFS Participation by Full-Scope Medi-Cal Only Beneficiaries for Quarter 1, 2012–Quarter 4, 2012



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. Overall, the number of FFS beneficiaries eligible for Medi-Cal only and entitled to full scope benefits decreased modestly by 1.5% between the third and fourth quarter of 2012, but decreased 2.6% when comparing FFS participation from the first to the fourth quarter of 2012.
3. 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, which began in June 2011 and continued through May 2012.
4. Increases in FFS participation affected those enrolled in Families and Other aid categories.
5. Overall, participation trends for Medi-Cal's FFS population were different in metropolitan and non-metropolitan counties. Among beneficiaries enrolled in Undocumented aid codes, FFS participation declined more sharply in non-metropolitan areas of the state, while declining at a smaller rate in metropolitan counties. FFS participation declined markedly for Blind/Disabled beneficiaries residing in metropolitan areas, while declining only modestly for this beneficiary subgroup in non-metropolitan areas. Adults enrolled in the Aged aid codes experienced FFS participation declines in metropolitan counties, while expanding in non-metropolitan areas of the state.
6. During 2012, FFS participation stabilized for 31% of counties (i.e., counties experiencing <2% change from the first to the fourth quarter), but expanded by double digits for 22% of counties. The greatest increases in FFS participation occurred in Solano (47.5%), San Luis Obispo (30.4%), and Yolo (29.3%) Counties.

Appendix A—County and Statewide Tables

Table BP-1. Average Member Months Per Quarter for All FFS Medi-Cal Only Beneficiaries by County

County	Average Member Months				Percent Change	
	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Qtr 4, 2012, Compared to Qtr 1, 2012	Qtr 4, 2012, Compared to Previous Qtr
Alameda	54,958	52,161	52,121	51,457	-6.4	-1.3
Alpine	173	169	147	155	-10.0	5.4
Amador	3,675	3,700	3,637	3,586	-2.4	-1.4
Butte	41,269	41,062	41,227	40,902	-0.9	-0.8
Calaveras	5,542	5,574	5,596	5,517	-0.5	-1.4
Colusa	3,980	3,966	3,937	3,879	-2.5	-1.5
Contra Costa	35,443	33,420	33,106	32,658	-7.9	-1.4
Del Norte	6,730	6,676	6,567	6,420	-4.6	-2.2
El Dorado	15,588	15,633	15,573	15,476	-0.7	-0.6
Fresno	60,918	57,985	57,202	57,243	-6.0	0.1
Glenn	6,066	6,106	6,113	6,087	0.4	-0.4
Humboldt	21,678	21,710	21,610	21,539	-0.6	-0.3
Imperial	45,972	46,025	46,644	46,762	1.7	0.3
Inyo	2,916	2,900	2,901	2,872	-1.5	-1.0
Kern	60,974	58,648	58,530	57,619	-5.5	-1.6
Kings	8,332	7,766	7,653	7,657	-8.1	0.1
Lake	13,945	13,824	13,759	13,811	-1.0	0.4
Lassen	4,101	3,984	3,971	3,938	-4.0	-0.8
Los Angeles	594,779	569,826	566,931	552,108	-7.2	-2.6
Madera	12,440	11,856	11,585	11,617	-6.6	0.3
Marin	5,126	5,226	5,682	5,567	8.6	-2.0
Mariposa	2,205	2,262	2,240	2,253	2.2	0.6
Mendocino	2,488	2,566	3,159	3,146	26.5	-0.4
Merced	10,282	10,924	13,183	12,859	25.1	-2.5
Modoc	1,587	1,595	1,557	1,565	-1.4	0.5
Mono	1,253	1,291	1,288	1,276	1.9	-1.0
Monterey	20,691	21,323	23,122	23,066	11.5	-0.2
Napa	2,591	2,754	3,008	2,994	15.6	-0.5
Nevada	9,161	9,060	9,146	9,145	-0.2	0.0
Orange	70,627	73,051	85,231	83,623	18.4	-1.9
Placer	24,906	24,957	24,868	24,803	-0.4	-0.3
Plumas	2,427	2,448	2,439	2,477	2.1	1.6
Riverside	95,246	91,517	92,523	89,970	-5.5	-2.8
Sacramento	60,481	55,983	55,099	55,072	-8.9	0.0
San Benito	8,908	8,860	8,866	8,871	-0.4	0.1
San Bernardino	119,133	116,288	116,359	113,295	-4.9	-2.6
San Diego	104,763	99,122	99,945	98,456	-6.0	-1.5
San Francisco	24,448	21,603	21,249	20,941	-14.3	-1.4

County	Average Member Months				Percent Change	
	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Qtr 4, 2012, Compared to Qtr 1, 2012	Qtr 4, 2012, Compared to Previous Qtr
San Joaquin	38,061	35,770	34,912	35,084	-7.8	0.5
San Luis Obispo	4,151	4,451	5,486	5,413	30.4	-1.3
San Mateo	14,150	15,545	18,013	17,902	26.5	-0.6
Santa Barbara	15,758	16,228	18,011	17,660	12.1	-2.0
Santa Clara	66,585	63,005	63,773	64,013	-3.9	0.4
Santa Cruz	6,552	6,962	7,716	7,736	18.1	0.3
Shasta	32,557	32,548	32,482	31,898	-2.0	-1.8
Sierra	334	344	357	354	6.0	-0.7
Siskiyou	8,350	8,393	8,416	8,446	1.1	0.4
Solano	6,640	7,540	10,041	9,792	47.5	-2.5
Sonoma	8,670	9,310	11,284	10,952	26.3	-2.9
Stanislaus	37,586	36,721	36,722	36,871	-1.9	0.4
Sutter	19,557	19,633	19,601	19,470	-0.4	-0.7
Tehama	14,376	14,444	14,401	14,206	-1.2	-1.4
Trinity	2,204	2,196	2,188	2,141	-2.9	-2.1
Tulare	38,383	36,623	35,908	35,164	-8.4	-2.1
Tuolumne	6,391	6,320	6,349	6,341	-0.8	-0.1
Ventura	19,453	20,617	24,271	23,853	22.6	-1.7
Yolo	3,725	3,998	4,895	4,817	29.3	-1.6
Yuba	17,352	17,264	17,238	16,986	-2.1	-1.5

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

Table BP-2. Average Member Months for FFS Full Scope Medi-Cal Only Beneficiaries by County

County	Average Member Months				Percent Change	
	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Qtr 4, 2012 Compared to Qtr 1, 2012	Qtr 4, 2012 Compared to Previous Qtr
Alameda	33,910	31,099	31,233	30,934	-8.8	-1.0
Alpine	173	169	147	155	-10.0	5.4
Amador	3,568	3,610	3,541	3,499	-1.9	-1.2
Butte	39,979	39,785	39,976	39,697	-0.7	-0.7
Calaveras	5,380	5,420	5,445	5,369	-0.2	-1.4
Colusa	3,524	3,528	3,502	3,471	-1.5	-0.9
Contra Costa	21,320	19,279	19,073	18,865	-11.5	-1.1
Del Norte	6,558	6,519	6,408	6,269	-4.4	-2.2
El Dorado	14,507	14,555	14,543	14,482	-0.2	-0.4
Fresno	31,524	28,468	28,298	28,583	-9.3	1.0
Glenn	5,441	5,495	5,523	5,508	1.2	-0.3
Humboldt	21,064	21,096	21,016	20,955	-0.5	-0.3
Imperial	44,952	45,056	45,708	45,849	2.0	0.3
Inyo	2,586	2,571	2,574	2,560	-1.0	-0.6
Kern	37,492	35,032	35,344	34,815	-7.1	-1.5
Kings	5,142	4,611	4,552	4,593	-10.7	0.9
Lake	13,269	13,172	13,125	13,182	-0.7	0.4
Lassen	3,984	3,865	3,843	3,806	-4.5	-1.0
Los Angeles	277,078	253,194	255,369	248,425	-10.3	-2.7
Madera	5,195	4,650	4,664	4,812	-7.4	3.2
Marin	537	690	1,171	1,127	109.7	-3.8
Mariposa	2,139	2,196	2,187	2,212	3.4	1.1
Mendocino	712	783	1,457	1,472	106.7	1.1
Merced	2,310	2,935	5,257	5,067	119.4	-3.6
Modoc	1,507	1,513	1,481	1,494	-0.9	0.8
Mono	1,012	1,039	1,051	1,060	4.7	0.8
Monterey	2,779	3,293	5,714	6,052	117.8	5.9
Napa	609	809	1,168	1,211	98.7	3.7
Nevada	8,818	8,731	8,822	8,853	0.4	0.3
Orange	14,130	16,704	29,163	27,992	98.1	-4.0
Placer	23,747	23,805	23,708	23,648	-0.4	-0.3
Plumas	2,366	2,392	2,381	2,420	2.3	1.6
Riverside	66,349	62,875	64,226	61,958	-6.6	-3.5
Sacramento	46,002	41,570	40,893	40,983	-10.9	0.2
San Benito	7,792	7,756	7,796	7,828	0.5	0.4

County	Average Member Months				Percent Change	
	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Qtr 4, 2012 Compared to Qtr 1, 2012	Qtr 4, 2012 Compared to Previous Qtr
San Bernardino	86,416	83,464	83,818	81,186	-6.1	-3.1
San Diego	78,876	73,519	74,796	73,797	-6.4	-1.3
San Francisco	15,086	12,272	11,897	11,701	-22.4	-1.6
San Joaquin	23,607	21,381	20,782	21,157	-10.4	1.8
San Luis Obispo	1,279	1,612	2,721	2,698	111.0	-0.9
San Mateo	2,903	4,026	6,357	6,190	113.2	-2.6
Santa Barbara	3,178	3,565	5,611	5,516	73.6	-1.7
Santa Clara	33,090	29,496	30,324	30,563	-7.6	0.8
Santa Cruz	1,564	2,055	2,978	3,076	96.6	3.3
Shasta	32,139	32,150	32,104	31,510	-2.0	-1.9
Sierra	330	338	351	348	5.5	-0.9
Siskiyou	8,182	8,231	8,247	8,282	1.2	0.4
Solano	1,798	2,762	5,364	5,115	184.5	-4.6
Sonoma	2,639	3,309	5,301	5,057	91.6	-4.6
Stanislaus	27,103	26,373	26,518	26,676	-1.6	0.6
Sutter	17,968	18,008	18,028	17,966	0.0	-0.3
Tehama	13,400	13,505	13,478	13,302	-0.7	-1.3
Trinity	2,188	2,181	2,172	2,127	-2.8	-2.0
Tulare	19,186	17,362	17,072	16,531	-13.8	-3.2
Tuolumne	6,334	6,265	6,297	6,281	-0.8	-0.3
Ventura	4,540	5,850	10,074	9,916	118.4	-1.6
Yolo	1,606	1,921	2,892	2,835	76.5	-2.0
Yuba	16,275	16,210	16,235	16,006	-1.7	-1.4

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

Table BP-3. Average Member Months of FFS Full Scope Medi-Cal Only Children Age 0–17 by County

County	Average Member Months				Percent Change	
	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Qtr 4, 2012 Compared to Qtr 1, 2012	Qtr 4, 2012 Compared to Previous Qtr
Alameda	17,441	17,191	17,420	17,304	-0.8	-0.7
Alpine	89	91	83	84	-5.2	1.2
Amador	1,865	1,894	1,859	1,867	0.1	0.4
Butte	20,851	20,721	20,835	20,692	-0.8	-0.7
Calaveras	2,790	2,826	2,853	2,800	0.4	-1.8
Colusa	2,336	2,347	2,338	2,309	-1.2	-1.2
Contra Costa	11,388	11,000	10,914	10,947	-3.9	0.3
Del Norte	3,363	3,329	3,292	3,223	-4.2	-2.1
El Dorado	8,084	8,165	8,125	8,099	0.2	-0.3
Fresno	17,561	16,736	16,812	17,080	-2.7	1.6
Glenn	3,398	3,427	3,444	3,448	1.5	0.1
Humboldt	10,926	10,990	10,967	11,007	0.7	0.4
Imperial	25,583	25,606	25,976	26,144	2.2	0.6
Inyo	1,507	1,496	1,514	1,525	1.2	0.7
Kern	22,930	22,163	22,771	22,527	-1.8	-1.1
Kings	3,164	2,937	2,985	3,047	-3.7	2.1
Lake	6,862	6,857	6,835	6,877	0.2	0.6
Lassen	2,107	2,048	2,057	2,038	-3.3	-1.0
Los Angeles	151,970	150,442	154,444	150,110	-1.2	-2.8
Madera	3,173	2,916	3,031	3,149	-0.7	3.9
Marin	335	433	764	740	120.8	-3.2
Mariposa	1,132	1,161	1,164	1,170	3.3	0.5
Mendocino	390	431	816	855	119.0	4.7
Merced	1,539	1,895	3,293	3,145	104.4	-4.5
Modoc	804	808	799	799	-0.6	0.0
Mono	681	698	711	728	6.8	2.4
Monterey	1,955	2,259	3,835	3,958	102.4	3.2
Napa	393	497	724	740	88.3	2.2
Nevada	4,632	4,605	4,674	4,702	1.5	0.6
Orange	9,665	11,024	19,025	17,854	84.7	-6.2
Placer	13,871	13,887	13,870	13,898	0.2	0.2
Plumas	1,248	1,254	1,271	1,302	4.3	2.5
Riverside	41,362	40,405	41,495	40,171	-2.9	-3.2
Sacramento	25,055	24,208	24,004	24,280	-3.1	1.1
San Benito	4,950	4,939	4,968	5,016	1.3	1.0

Medi-Cal Access to Care Report Quarter 4, 2012

County	Average Member Months				Percent Change	
	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Qtr 4, 2012 Compared to Qtr 1, 2012	Qtr 4, 2012 Compared to Previous Qtr
San Bernardino	49,966	49,511	50,161	48,555	-2.8	-3.2
San Diego	46,992	45,702	46,685	46,266	-1.5	-0.9
San Francisco	5,599	5,303	5,334	5,364	-4.2	0.5
San Joaquin	13,647	13,098	12,978	13,190	-3.3	1.6
San Luis Obispo	800	955	1,588	1,557	94.6	-2.0
San Mateo	1,845	2,531	4,032	4,002	117.0	-0.7
Santa Barbara	2,379	2,441	3,709	3,581	50.5	-3.5
Santa Clara	17,670	16,645	17,280	17,594	-0.4	1.8
Santa Cruz	988	1,177	1,698	1,810	83.1	6.6
Shasta	16,649	16,684	16,740	16,430	-1.3	-1.8
Sierra	161	164	130	164	1.9	26.1
Siskiyou	4,210	4,243	4,270	4,305	2.2	0.8
Solano	1,121	1,691	3,160	3,005	168.2	-4.9
Sonoma	1,749	2,046	3,292	3,142	79.7	-4.5
Stanislaus	14,825	14,979	15,201	15,292	3.2	0.6
Sutter	10,693	10,749	10,798	10,739	0.4	-0.5
Tehama	7,753	7,785	7,835	7,782	0.4	-0.7
Trinity	1,073	1,071	1,066	1,050	-2.1	-1.5
Tulare	11,336	10,751	10,622	10,172	-10.3	-4.2
Tuolumne	3,225	3,227	3,251	3,250	0.8	0.0
Ventura	2,979	3,743	6,499	6,320	112.2	-2.8
Yolo	1,145	1,288	1,869	1,812	58.2	-3.0
Yuba	9,149	9,120	9,179	9,061	-1.0	-1.3

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

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

County	Average Member Months				Percent Change	
	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Qtr 4, 2012 Compared to Qtr 1, 2012	Qtr 4, 2012 Compared to Previous Qtr
Alameda	20,332	19,575	19,627	19,339	-4.9	-1.5
Alpine	47	45	35	37	-21.8	5.7
Amador	1,130	1,128	1,103	1,075	-4.8	-2.6
Butte	12,105	12,078	12,131	12,066	-0.3	-0.5
Calaveras	1,655	1,648	1,647	1,619	-2.2	-1.7
Colusa	1,020	1,007	1,001	986	-3.3	-1.5
Contra Costa	12,799	12,215	12,195	12,045	-5.9	-1.2
Del Norte	1,969	1,956	1,918	1,870	-5.0	-2.5
El Dorado	4,463	4,450	4,434	4,363	-2.2	-1.6
Fresno	34,525	33,195	21,887	21,792	-36.9	-0.4
Glenn	1,642	1,642	1,631	1,616	-1.6	-0.9
Humboldt	6,441	6,415	6,368	6,321	-1.9	-0.7
Imperial	13,366	13,379	13,579	13,526	1.2	-0.4
Inyo	826	823	814	790	-4.4	-3.0
Kern	20,672	20,000	19,793	19,436	-6.0	-1.8
Kings	2,790	2,605	2,543	2,504	-10.2	-1.5
Lake	4,127	4,077	4,050	4,066	-1.5	0.4
Lassen	1,209	1,168	1,155	1,141	-5.7	-1.2
Los Angeles	240,781	231,500	229,000	223,457	-7.2	-2.4
Madera	4,818	4,713	4,555	4,533	-5.9	-0.5
Marin	2,624	2,618	2,704	2,658	1.3	-1.7
Mariposa	647	282	635	640	-1.1	0.8
Mendocino	1,072	1,097	1,245	1,205	12.5	-3.2
Merced	4,598	4,786	5,319	5,195	13.0	-2.3
Modoc	452	451	443	451	-0.3	1.7
Mono	323	341	334	317	-1.7	-5.0
Monterey	9,971	10,153	10,444	10,467	5.0	0.2
Napa	1,256	1,295	1,336	1,308	4.2	-2.0
Nevada	2,775	2,725	2,742	2,736	-1.4	-0.2
Orange	36,100	36,853	39,566	39,343	9.0	-0.6
Placer	6,766	6,809	6,771	6,682	-1.2	-1.3
Plumas	735	745	729	731	-0.5	0.2
Riverside	31,868	30,735	31,053	30,296	-4.9	-2.4
Sacramento	19,933	18,269	18,087	17,941	-10.0	-0.8
San Benito	2,463	2,422	2,422	2,404	-2.4	-0.8
San Bernardino	40,500	39,656	39,604	38,677	-4.5	-2.3
San Diego	35,339	33,698	33,964	33,257	-5.9	-2.1
San Francisco	9,437	8,647	8,537	8,363	-11.4	-2.0
San Joaquin	13,122	12,233	11,935	12,000	-8.6	0.5
San Luis Obispo	1,845	1,948	2,236	2,225	20.6	-0.5
San Mateo	6,679	6,993	7,549	7,476	11.9	-1.0

County	Average Member Months				Percent Change	
	2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Qtr 4, 2012 Compared to Qtr 1, 2012	Qtr 4, 2012 Compared to Previous Qtr
Santa Barbara	7,645	7,899	8,317	8,283	8.3	-0.4
Santa Clara	26,082	25,285	25,501	25,463	-2.4	-0.1
Santa Cruz	3,307	3,456	3,667	3,613	9.3	-1.5
Shasta	9,654	9,655	9,564	9,388	-2.8	-1.8
Sierra	97	102	106	113	16.1	6.6
Siskiyou	2,485	2,480	2,479	2,476	-0.4	-0.1
Solano	2,981	3,220	3,932	3,885	30.3	-1.2
Sonoma	4,096	4,334	4,867	4,769	16.4	-2.0
Stanislaus	12,500	12,080	12,046	12,093	-3.3	0.4
Sutter	5,165	5,186	5,155	5,085	-1.5	-1.4
Tehama	4,018	4,045	3,989	3,887	-3.3	-2.6
Trinity	674	664	665	647	-3.9	-2.6
Tulare	14,064	13,587	13,377	13,227	-6.0	-1.1
Tuolumne	1,951	1,911	1,920	1,905	-2.4	-0.8
Ventura	9,398	9,712	10,418	10,299	9.6	-1.1
Yolo	1,474	1,559	1,766	1,763	19.6	-0.2
Yuba	4,888	4,854	4,831	4,743	-3.0	-1.8

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

Table BP-5. Average Member Months of FFS Full Scope Beneficiaries by Gender and Age

Gender	Age Category	Average Member Months				Percent Change	
		2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Qtr 4, 2012 Compared to Qtr 1, 2012	Qtr 4, 2012 Compared to Previous Qtr
Women	0 to 17	315,590	314,034	329,094	324,236	2.7	-1.5
	18 to 64	307,470	289,087	297,636	292,764	-4.8	-1.6
	65 or Older	13,531	8,241	8,153	7,944	-41.3	-2.6
Men	0 to 17	335,766	332,555	348,295	343,844	2.4	-1.3
	18 to 64	176,600	154,848	155,342	153,147	-13.3	-1.4
	65 or Older	8,183	5,352	5,255	5,104	-37.6	-2.9
All	0 to 17	651,356	646,589	677,389	668,080	2.6	-1.4
	18 to 64	484,070	443,935	452,978	445,911	-7.9	-1.6
	65 or Older	21,714	13,593	13,408	13,048	-39.9	-2.7
Total		1,157,140	1,104,117	1,143,775	1,127,039	-2.6	-1.5

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

Table BP-6. Average Member Months of FFS Restricted Scope Beneficiaries by Gender and Age

Gender	Age Category	Average Member Months				Percent Change	
		2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Qtr 4, 2012 Compared to Qtr 1, 2012	Qtr 4, 2012 Compared to Previous Quarter
Women	0 to 17	62,164	60,417	58,306	56,090	-9.8	-3.8
	18 to 64	406,723	406,631	402,085	395,832	-2.7	-1.6
	65 or Older	11,015	11,073	11,078	11,069	0.5	-0.1
Men	0 to 17	63,583	61,912	59,706	57,659	-9.3	-3.4
	18 to 64	220,472	221,993	219,313	216,485	-1.8	-1.3
	65 or Older	5,543	5,591	5,573	5,608	1.2	0.6
All	0 to 17	125,747	122,329	118,012	113,749	-9.5	-3.6
	18 to 64	627,195	628,624	621,398	612,317	-2.4	-1.5
	65 or Older	16,558	16,664	16,651	16,677	0.7	0.2
Total		769,500	767,617	756,062	742,743	-3.5	-1.8

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

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

Age	Aid Category	Average Member Months				Percent Change	
		2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Quarter 4, 2012 Compared to Quarter 1, 2012	Quarter 4, 2012 Compared to Previous Quarter
0 - 20	Blind/Disabled	53,567	42,841	39,860	37,920	-29.2	-4.9
	Families	392,609	392,707	412,216	410,240	4.5	-0.5
	Foster Care	97,736	97,570	97,594	98,025	0.3	0.4
	Other	190,436	194,304	209,685	202,023	6.1	-3.7
	Undocumented	163,190	159,533	154,284	149,168	-8.6	-3.3
21 & over	Aged	18,744	11,187	10,933	10,492	-44.0	-4.0
	Blind/Disabled	146,531	102,908	97,495	95,617	-34.7	-1.9
	Families	200,428	203,325	214,518	211,287	5.4	-1.5
	Other	56,960	59,167	61,361	61,310	7.6	-0.1
	Undocumented	606,310	608,084	601,777	593,576	-2.1	-1.4
Total		1,926,511	1,871,626	1,899,723	1,869,658	-3.0	-1.6

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

Table BP-8. Average Member Months of FFS Beneficiaries in Metropolitan Counties by Age and Aid Category

Age	Aid Category	Average Member Months				Percent Change	
		2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Quarter 4, 2012 Compared to Quarter 1, 2012	Quarter 4, 2012 Compared to Previous Quarter
0 - 20	Blind/Disabled	50,597	39,908	36,953	35,035	-30.8	-5.2
	Families	340,187	340,349	359,828	357,976	5.2	-0.5
	Foster Care	94,314	94,108	94,102	94,501	0.2	0.4
	Other	181,767	185,477	200,457	192,816	6.1	-3.8
	Undocumented	161,301	157,712	152,536	147,521	-8.5	-3.3
21 & over	Aged	18,477	10,915	10,647	10,202	-44.8	-4.2
	Blind/Disabled	130,405	86,798	81,429	79,621	-38.9	-2.2
	Families	173,365	176,285	187,519	184,480	6.4	-1.6
	Other	55,371	57,560	59,685	59,661	7.7	0.0
	Undocumented	601,152	602,994	596,796	588,693	-2.1	-1.4
Total		1,806,936	1,752,106	1,779,952	1,750,506	-3.1	-1.7

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

Table BP-9. Average Member Months of FFS Beneficiaries in Non-Metropolitan Counties by Age and Aid Category

Age	Aid Category	Average Member Months				Percent Change	
		2012 Quarter 1	2012 Quarter 2	2012 Quarter 3	2012 Quarter 4	Quarter 4, 2012 Compared to Quarter 1, 2012	Quarter 4, 2012 Compared to Previous Quarter
0 - 20	Blind/Disabled	2,970	2,933	2,906	2,885	-2.9	-0.7
	Families	52,421	52,357	52,388	52,265	-0.3	-0.2
	Foster Care	3,422	3,462	3,492	3,524	3.0	0.9
	Other	8,669	8,827	9,228	9,208	6.2	-0.2
	Undocumented	1,889	1,821	1,749	1,647	-12.8	-5.8
21 & over	Aged	267	273	286	290	8.5	1.4
	Blind/Disabled	16,126	16,110	16,066	15,996	-0.8	-0.4
	Families	27,064	27,041	26,999	26,806	-1.0	-0.7
	Other	1,590	1,608	1,675	1,649	3.7	-1.6
	Undocumented	5,158	5,090	4,981	4,882	-5.3	-2.0
Total		119,575	119,522	119,771	119,152	-0.4	-0.5

Source: Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files January 2012–December 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	03,07, 40, 42, 43, 49, 77, 78, 4C, 4F, 4G, 4H, 4L, 4N, 4S, 4T, 4W
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 #5 2012 Quarter 4



Service Utilization

September 2013

Contents

List of Figures.....	4
List of Tables	8
Utilization of Select Services by Medi-Cal FFS Beneficiaries	9
Introduction.....	9
Methods	10
Physician/Clinic Services	12
Background	12
Trend Analysis.....	13
Children	13
Adults	13
Trends of Monthly Physician/Clinic Services Utilization Rates by Children for January 2012– December 2012	15
Trends of Monthly Physician/Clinic Services Utilization Rates by Adults for January 2012– December 2012	18
Non-Emergency Medical Transportation	21
Background	21
Trend Analysis.....	22
Children	22
Adults	22
Trends of Monthly Non-Emergency Medical Transportation Services Utilization Rates by Adults for January 2012–December 2012.....	23
Emergency Medical Transportation	24
Background	24
Trend Analysis.....	25
Children	25
Adults	25
Trends of Monthly Emergency Medical Transportation Services Utilization Rates by Children for January 2012–December 2012.....	26
Trends of Monthly Emergency Transportation Services Utilization Rates by Adults for January 2012–December 2012	29
Home Health Services	31

Background	31
Trend Analysis.....	32
Children	32
Adults	32
Trends of Monthly Home Health Services Utilization Rates by Children for January 2012– December 2012	33
Trends of Monthly Home Health Services Utilization Rates by Adults for January 2012–December 2012.....	35
Hospital Inpatient Services	36
Background	36
Trend Analysis.....	37
Children	37
Adults	37
Trends of Monthly Hospital Inpatient Services Utilization Rates by Children for January 2012– December 2012	38
Trends of Monthly Hospital Inpatient Services Utilization Rates by Adults for January 2012– December 2012	41
Hospital Outpatient Services	44
Background	44
Trend Analysis.....	45
Children	45
Adults	45
Trends of Monthly Hospital Outpatient Services Utilization Rates by Children for January 2012– December 2012	46
Trends of Monthly Hospital Outpatient Services Utilization Rates by Adults for January 2012– December 2012	49
Nursing Facility Services	52
Background	52
Trend Analysis.....	54
Children	54
Adults	54
Trends of Monthly Nursing Facility Services Utilization by Adults for January 2012–December 2012.....	56
Pharmacy Services	57

Background	57
Trend Analysis.....	58
Children	58
Adults	58
Trends of Monthly Pharmacy Services Utilization Rates by Children for January 2012–December 2012.....	59
Trends of Monthly Pharmacy Services Utilization Rates by Adults for January 2012–December 2012.....	62
Other Services.....	65
Background	65
Trend Analysis.....	66
Children	66
Adults	66
Trends of Monthly Other Services Utilization Rates by Children for January 2012–December 2012	67
Trends of Monthly Other Services Utilization Rates by Adults for January 2012–December 2012	70
Radiology Services.....	73
Background.....	73
Trend Analysis.....	74
Children	74
Adults	74
Trends of Monthly Radiology Services Utilization Rates by Children for July 2012–December 2012	75
Trends of Monthly Radiology Services Utilization Rates by Adults for July 2012–December 2012	78
Summary Tables.....	81
Conclusions—Service Utilization of Children Participating in FFS.....	84
Conclusions—Service Utilization of Adults Participating in FFS.....	85
Appendix—Detailed List of Other Providers	86

List of Figures

Figure SU-1. Physician/Clinic Utilization by Children (Age 0-20) in the Blind/Disabled Aid Category for January 2012–December 2012.....	15
Figure SU-2. Physician/Clinic Utilization by Children (Age 0-20) in the Families Aid Category for January 2012–December 2012.....	15
Figure SU-3. Physician/Clinic Utilization by Children (Age 0-20) in the Foster Care Aid Category for January 2012–December 2012.....	16
Figure SU-4. Physician/Clinic Utilization by Children (Age 0–20) in the Other Aid Category for January 2012–December 2012.....	16
Figure SU-5. Physician/Clinic Utilization by Children (Age 0-20) in the Undocumented Aid Category for January 2012–December 2012.....	17
Figure SU-6. Physician/Clinic Utilization by Adults (Age 21+) in the Aged Aid Category for January 2012–December 2012.....	18
Figure SU-7. Physician/Clinic Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012.....	18
Figure SU-8. Physician/Clinic Utilization by Adults (Age 21+) in Families Aid Category, January 2012–December 2012.....	19
Figure SU-9. Physician/Clinic Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012.....	19
Figure SU-10. Physician/Clinic Utilization by Adults (Age 21+) in the Undocumented Aid Category for January 2012–December 2012.....	20
Figure SU-11. Non-Emergency Transportation Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012.....	23
Figure SU-12. Non-Emergency Transportation Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012.....	23
Figure SU-13. Emergency Transportation Utilization by Children Age (0–20) in the Blind/Disabled Aid Category for January 2012–December 2012.....	26
Figure SU-14. Emergency Transportation Utilization by Children (Age 0–20) in the Families Aid Category for January 2012–December 2012.....	26
Figure SU-15. Emergency Transportation Utilization by Children (Age 0–20) in the Foster Care Aid Category for January 2012–December 2012.....	27
Figure SU-16. Emergency Transportation Utilization by Children (Age 0–20) in the Other Aid Category for January 2012–December 2012.....	27
Figure SU-17. Emergency Transportation Utilization by Children (Age 0–20) in the Undocumented Aid Category January 2012–December 2012.....	28
Figure SU-18. Emergency Transportation Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category, January 2012–December 2012.....	29
Figure SU-19. Emergency Transportation Utilization by Adults (Age 21+) in the Families Aid Category for January 2012–December 2012.....	29
Figure SU-20. Emergency Transportation Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012.....	30

Figure SU-21. Emergency Transportation Utilization by Adults (Age 21+) in the Undocumented Aid Category for January 2012–December 2012..... 30

Figure SU-22. Home Health Services Utilization by Children (Age 0–20) in the Blind/Disabled Aid Category for January 2012–December 2012..... 33

Figure SU-23. Home Health Services Utilization by Children (Age 0–20) in the Families Aid Category for January 2012–December 2012..... 33

Figure SU-24. Home Health Services Utilization by Children (Age 0–20) in the Other Aid Category for January 2012–December 2012..... 34

Figure SU-25. Home Health Services Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012..... 35

Figure SU-26. Hospital Inpatient Utilization by Children (Age 0–20) in the Blind/Disabled Aid Category for January 2012–December 2012..... 38

Figure SU-27. Hospital Inpatient Utilization by Children (Age 0–20) in the Families Aid Category for January 2012–December 2012..... 38

Figure SU-28. Hospital Inpatient Utilization by Children (Age 0–20) in the Foster Care Aid Category for January 2012–December 2012 39

Figure SU-29. Hospital Inpatient Utilization by Children (Age 0–20) in the Other Aid Category for January 2012–December 2012..... 39

Figure SU-30. Hospital Inpatient Utilization by Children (Age 0–20), in the Undocumented Aid Category for January 2012–December 2012..... 40

Figure SU-31. Hospital Inpatient Utilization by Adults (Age 21+) in the Aged Aid Category for January 2012–December 2012..... 41

Figure SU-32. Hospital Inpatient Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012..... 41

Figure SU-33. Hospital Inpatient Utilization Rates by Adults (Age 21+) in the Families Aid Category for January 2012–December 2012..... 42

Figure SU-34. Hospital Inpatient Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012..... 42

Figure SU-35. Hospital Inpatient Utilization by Adults (Age 21+) in the Undocumented Aid Category for January 2012–December 2012..... 43

Figure SU-36. Hospital Outpatient Utilization by Children (Age 0-20) in the Blind/Disabled Aid Category for January 2012–December 2012..... 46

Figure SU-37. Hospital Outpatient Utilization by Children (Age 0-20) in the Families Aid Category for January 2012–December 2012..... 46

Figure SU-38. Hospital Outpatient Utilization by Children (Age 0-20) in the Foster Care Aid Category for January 2012–December 2012..... 47

Figure SU-39. Hospital Outpatient Utilization by Children (Age 0-20) in the Other Aid Category for January 2012–December 2012..... 47

Figure SU-40. Hospital Outpatient Utilization by Children (Age 0-20) in the Undocumented Aid Category for January 2012–December 2012..... 48

Figure SU-41. Hospital Outpatient Utilization by Adults (Age 21+) in the Aged Aid Category for January 2012–December 2012..... 49

Figure SU-42. Hospital Outpatient Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012..... 49

Figure SU-43. Hospital Outpatient Utilization by Adults (Age 21+) in the Families Aid Category for January 2012–December 2012..... 50

Figure SU-44. Hospital Outpatient Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012..... 50

Figure SU-45. Hospital Outpatient Utilization by Adults (Age 21+) in the Undocumented Aid Category for January 2012–December 2012 51

Figure SU-46. Nursing Facility Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012..... 56

Figure SU-47. Nursing Facility Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012..... 56

Figure SU-48. Pharmacy Utilization by Children (Age 0–20) in the Blind/Disabled Aid Category for January 2012–December 2012..... 59

Figure SU-49. Pharmacy Utilization by Children (Age 0–20) in the Families Aid Category for January 2012–December 2012..... 59

Figure SU-50. Pharmacy Utilization by Children (Age 0–20) in the Foster Care Aid Category for January 2012–December 2012..... 60

Figure SU-51. Pharmacy Utilization by Children (Age 0–20) in the Other Aid Category for January 2012–December 2012..... 60

Figure SU-52. Pharmacy Utilization by Children (Age 0–20) in the Undocumented Aid Category for January 2012–December 2012..... 61

Figure SU-53. Pharmacy Utilization by Adults (Age 21+) in the Aged Aid Category for January 2012–December 2012..... 62

Figure SU-54. Pharmacy Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012..... 62

Figure SU-55. Pharmacy Utilization by Adults (Age 21+) in the Families Aid Category for January 2012–December 2012..... 63

Figure SU-56. Pharmacy Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012..... 63

Figure SU-57. Pharmacy Utilization by Adults (Age 21+) in the Undocumented Aid Category for January 2012–December 2012..... 64

Figure SU-58. Other Services Utilization by Children (Age 0–20) in the Blind/Disabled Aid Category for January 2012–December 2012..... 67

Figure SU-59. Other Services Utilization by Children (Age 0–20) in the Families Aid Category for January 2012–December 2012..... 67

Figure SU-60. Other Services Utilization by Children (Age 0–20) in the Foster Care Aid Category for January 2012–December 2012..... 68

Figure SU-61. Other Services Utilization by Children (Age 0–20) in the Other Aid Category for January 2012–December 2012..... 68

Figure SU-62. Other Services Utilization by Children (Age 0–20) in the Undocumented Aid Category for January 2012–December 2012..... 69

Figure SU-63. Other Services Utilization by Adults (Age 21+) in the Aged Aid Category for January 2012–December 2012 70

Figure SU-64. Other Services Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012..... 70

Figure SU-65. Other Services Utilization by Adults (Age 21+) in the Families Aid Category for January 2012–December 2012..... 71

Figure SU-66. Other Services Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012 71

Figure SU-67. Other Services Utilization by Adults (Age 21+) in the Undocumented Aid Category for January 2012–December 2012..... 72

Figure SU-68. Radiology Utilization by Children (Age 0-20) in the Blind/Disabled Aid Category for July 2012–December 2012 75

Figure SU-69. Radiology Utilization by Children (Age 0-20) in the Families Aid Category for July 2012–December 2012 75

Figure SU-70. Radiology Utilization by Children (Age 0-20) in the Foster Care Aid Category for July 2012–December 2012 76

Figure SU-71. Radiology Utilization by Children (Age 0-20) in the Other Aid Category for July 2012–December 2012 76

Figure SU-72. Radiology Utilization by Children (Age 0-20) in the Undocumented Aid Category for July 2012–December 2012 77

Figure SU-73. Radiology Utilization by Adults (Age 21+) in the Aged Aid Category for July 2012–December 2012 78

Figure SU-74. Radiology Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for July 2012–December 2012 78

Figure SU-75. Radiology Utilization by Adults (Age 21+) in the Families Aid Category for July 2012–December 2012 79

Figure SU-76. Radiology Utilization by Adults (Age 21+) in the Other Aid Category July 2012–December 2012 79

Figure SU-77. Radiology Utilization by Adults (Age 21+) in the Undocumented Aid Category for July 2012–December 2012 80

List of Tables

Table SU-1. Summary of Service Utilization Trends Among Medi-Cal FFS Children by Aid Category and Service Category	82
Table SU-2. Summary of Service Utilization Trends Among Medi-Cal FFS Adults by Aid Category and Service Category	83

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 January 2012–December 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 ten 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 Services

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 162.7 to 693.9 visits per 1,000 member months from the first quarter of 2012 to the fourth 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. Children in the Families, Foster Care, and Other aid categories continued to display predominantly lower than average utilization rates during the study period. Additionally, while displaying above average Physician/Clinic services utilization in the first three quarters on 2012, children in the Blind/Disabled aid category experienced a decline in utilization during the last quarter of 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 most other beneficiary subgroups.

Adults

The monthly Physician/Clinic services utilization rates for adults age 21 and older ranged from 171.8 to 1,359.5 visits per 1,000 member months from the first quarter of 2012 to the fourth 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 Families and Undocumented aid categories, primarily fell within the expected ranges. Adults in all of the analyzed aid categories experienced a noticeable downward trend in Physician/Clinic services utilization during the last two quarters of 2012. This lower utilization of Physician/Clinic Services among some adult subpopulations 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, while preliminary National Vital Statistics' data indicates a continued decline in the birth rate for 2011 and 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.

Trends of Monthly Physician/Clinic Services Utilization Rates by Children for January 2012–December 2012

Figure SU-1. Physician/Clinic Utilization by Children (Age 0-20) in the Blind/Disabled Aid Category for January 2012–December 2012

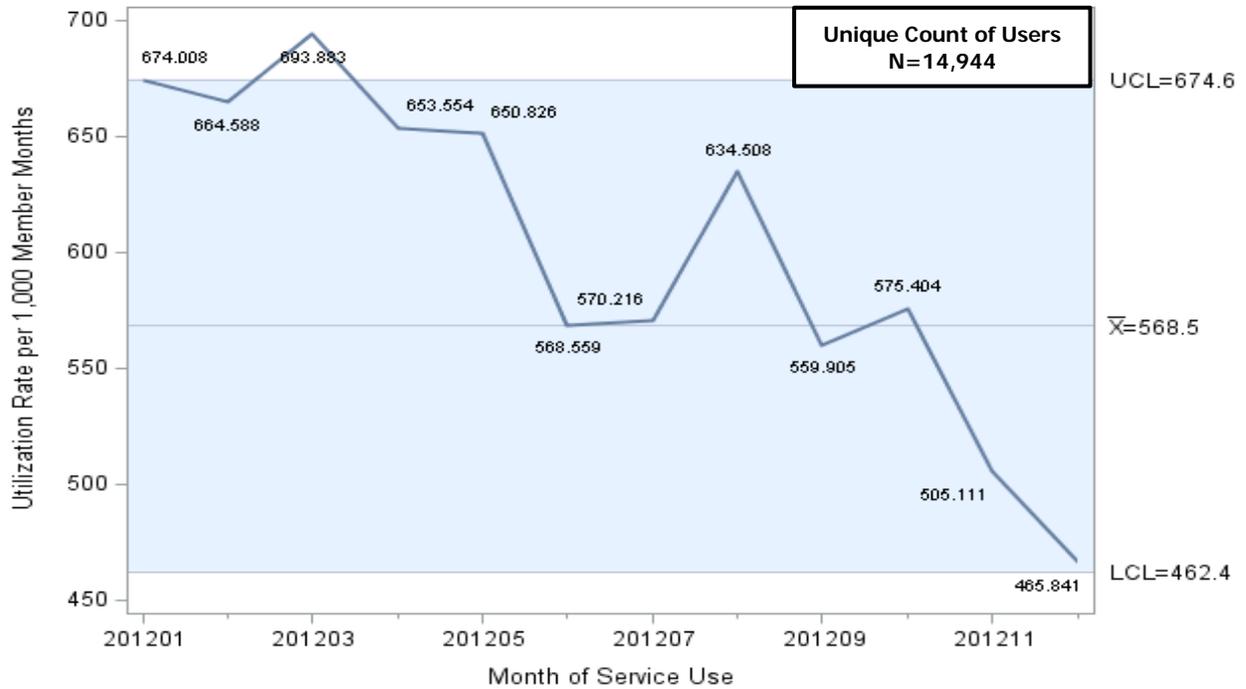


Figure SU-2. Physician/Clinic Utilization by Children (Age 0-20) in the Families Aid Category for January 2012–December 2012

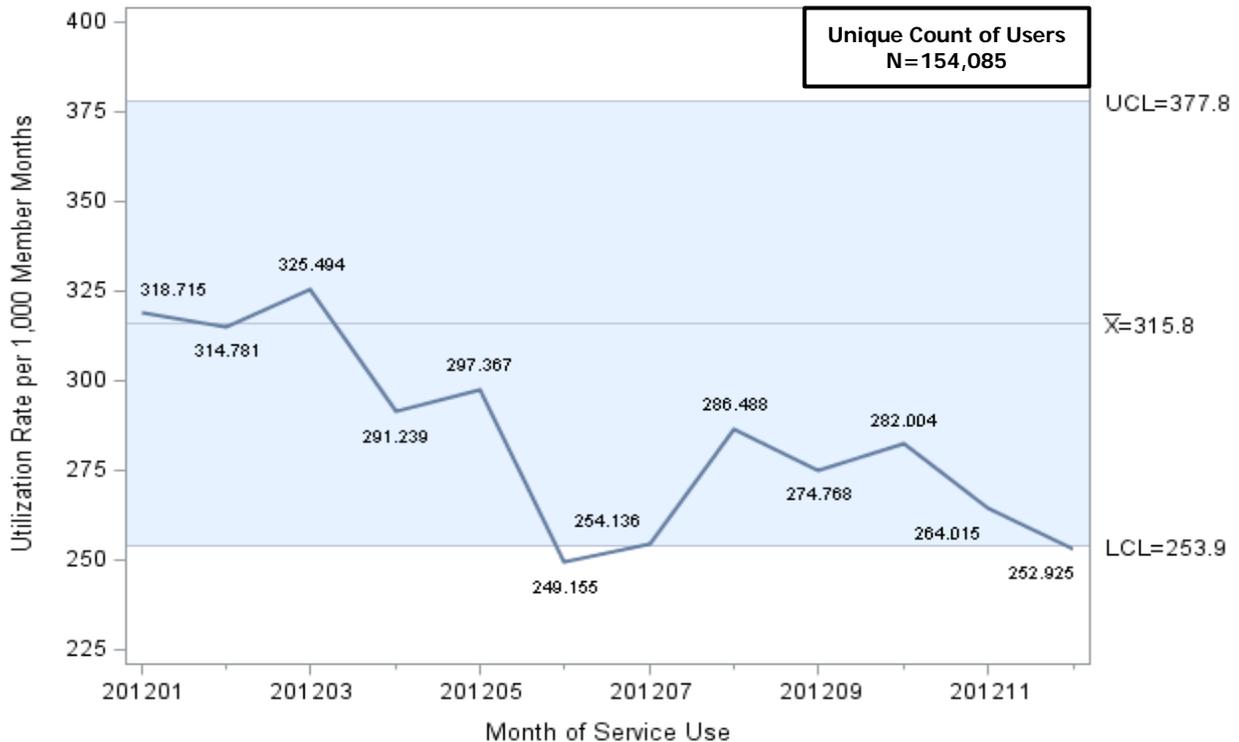


Figure SU-3. Physician/Clinic Utilization by Children (Age 0-20) in the Foster Care Aid Category for January 2012–December 2012

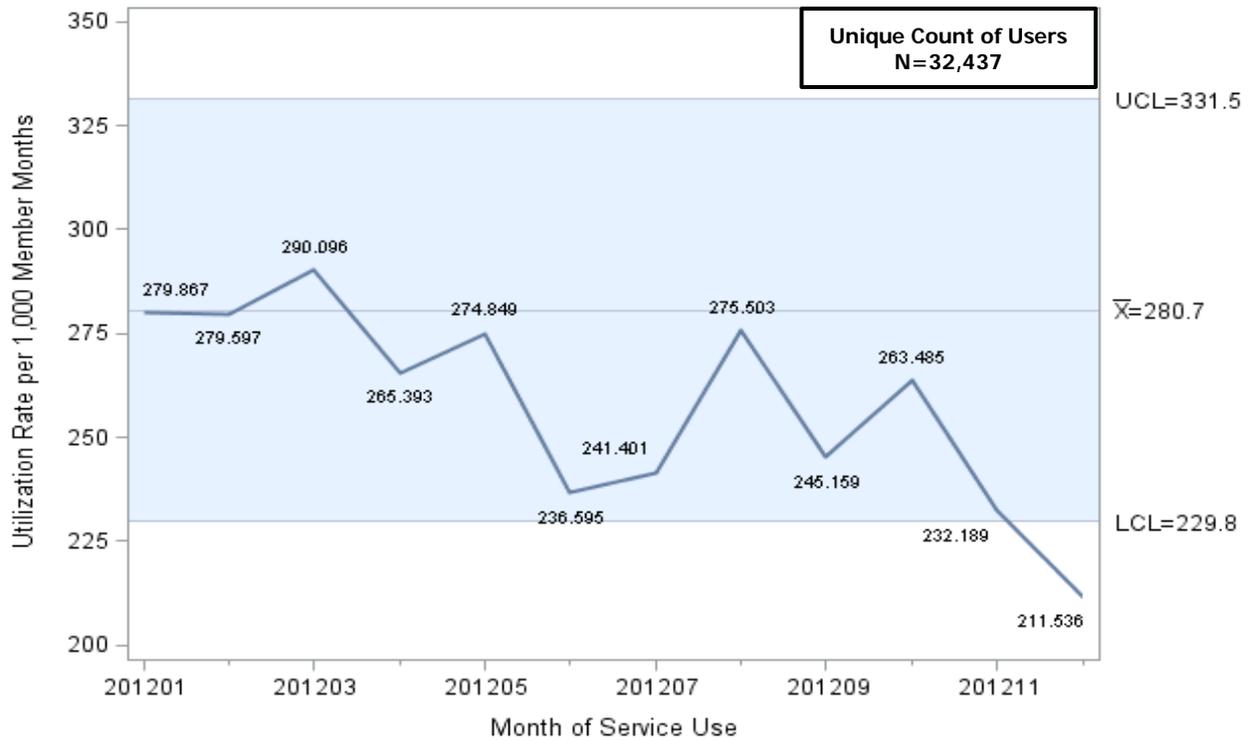


Figure SU-4. Physician/Clinic Utilization by Children (Age 0-20) in the Other Aid Category for January 2012–December 2012

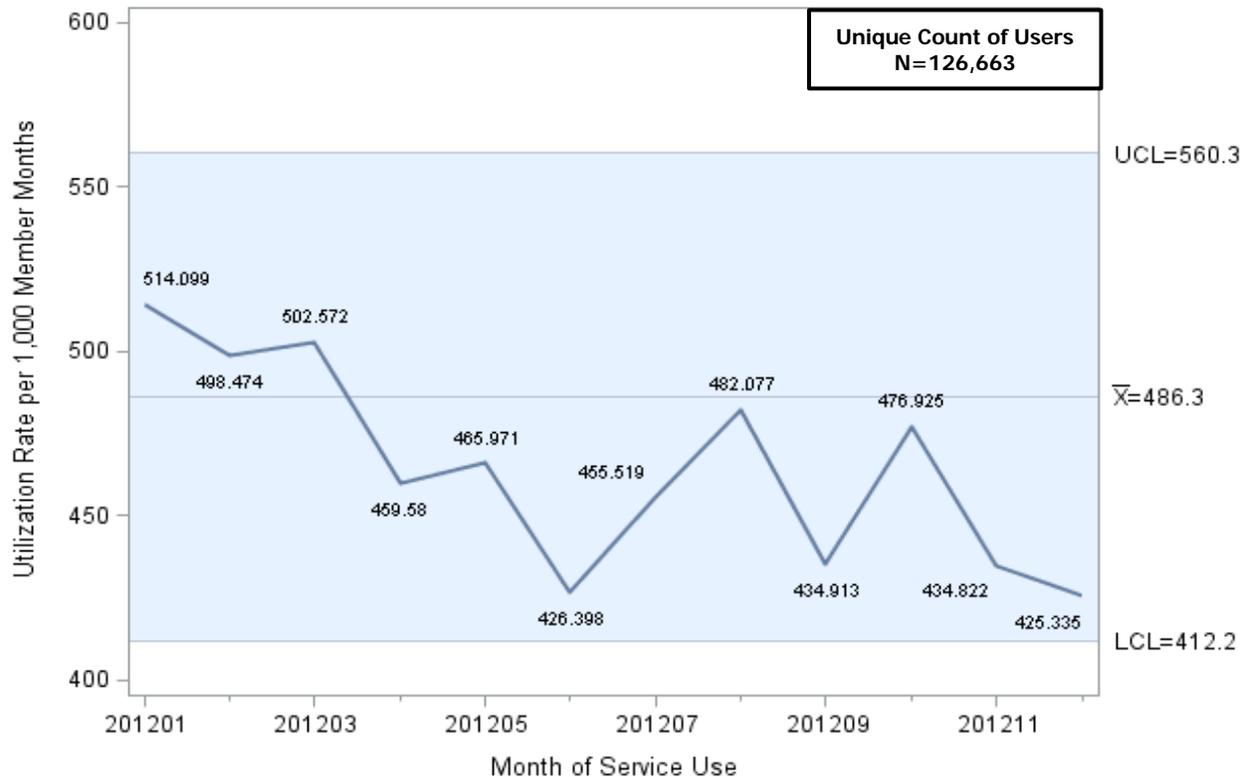
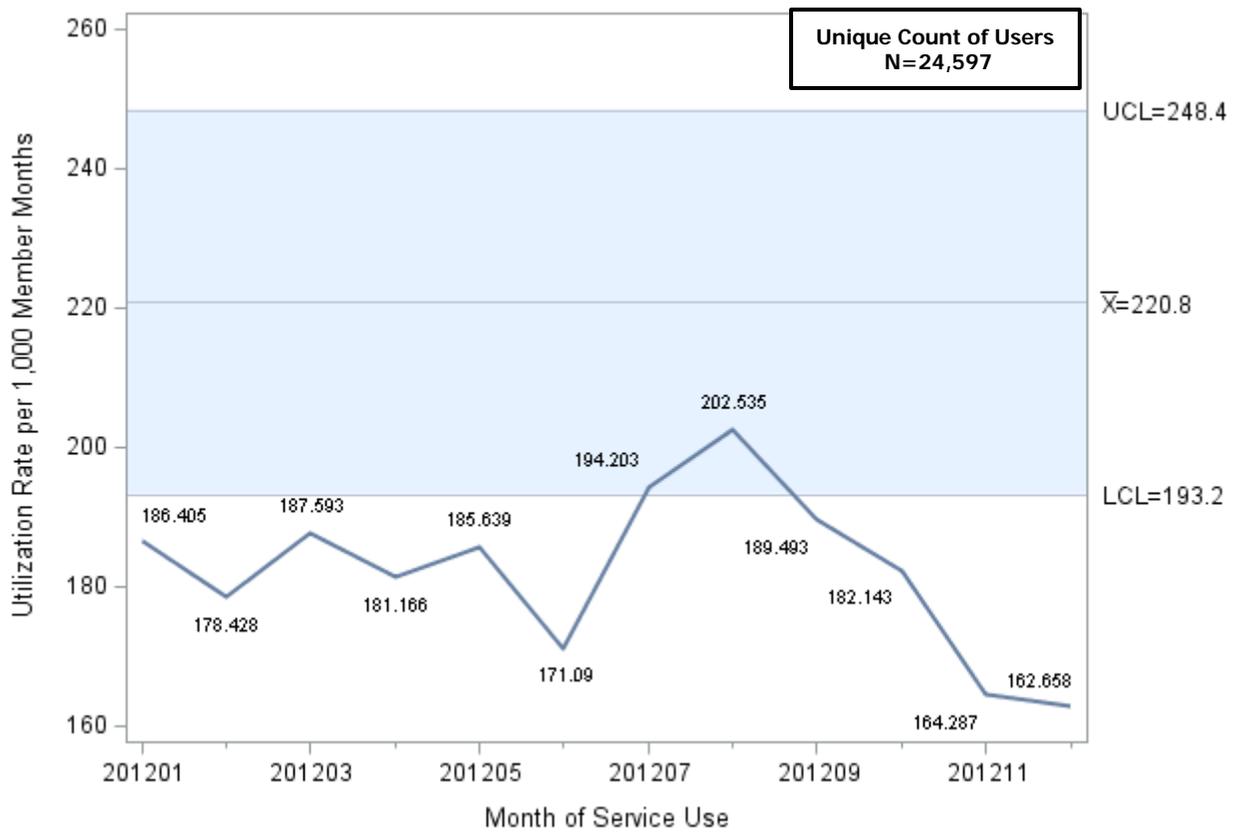


Figure SU-5. Physician/Clinic Utilization by Children (Age 0-20) in the Undocumented Aid Category for January 2012–December 2012



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

Trends of Monthly Physician/Clinic Services Utilization Rates by Adults for January 2012–December 2012

Figure SU-6. Physician/Clinic Utilization by Adults (Age 21+) in the Aged Aid Category for January 2012–December 2012

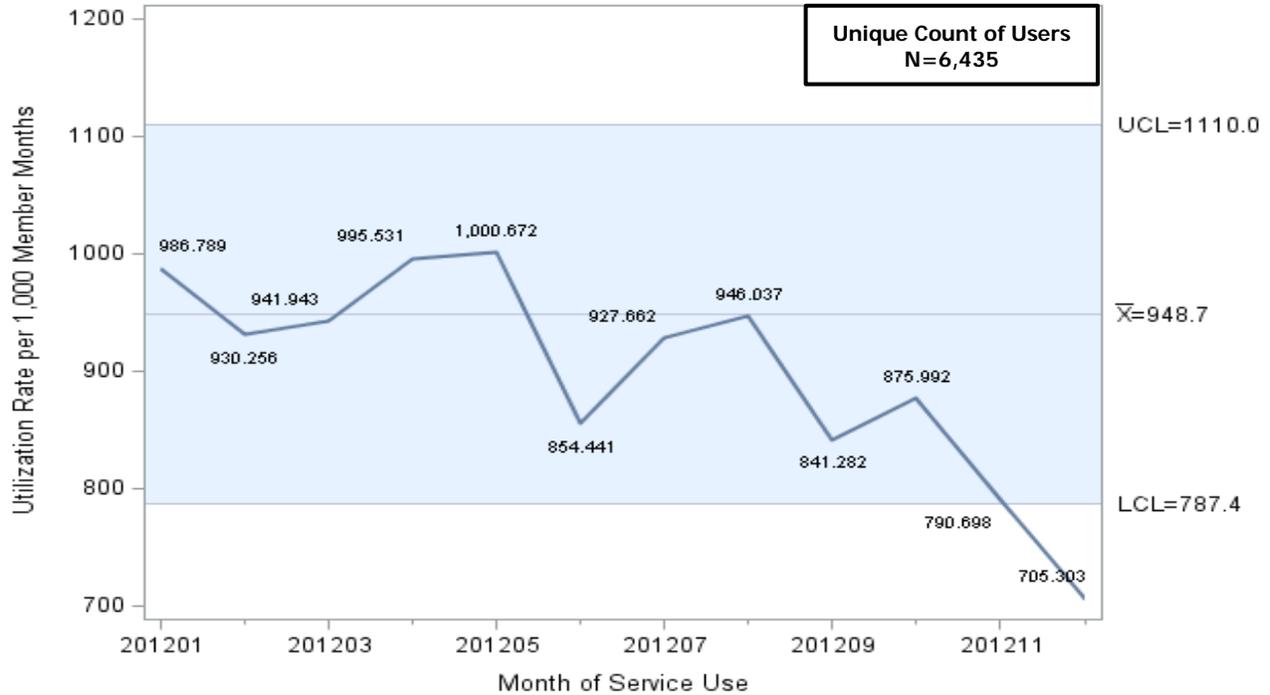


Figure SU-7. Physician/Clinic Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012

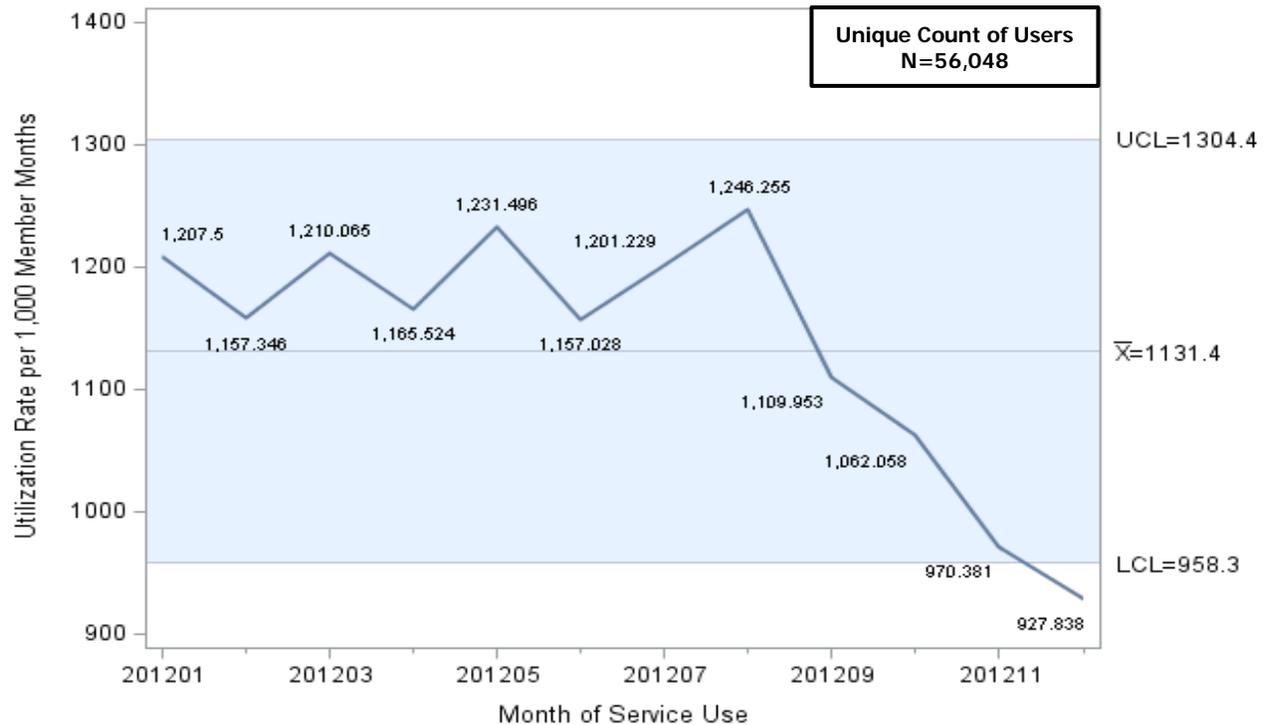


Figure SU-8. Physician/Clinic Utilization by Adults (Age 21+) in Families Aid Category, January 2012–December 2012

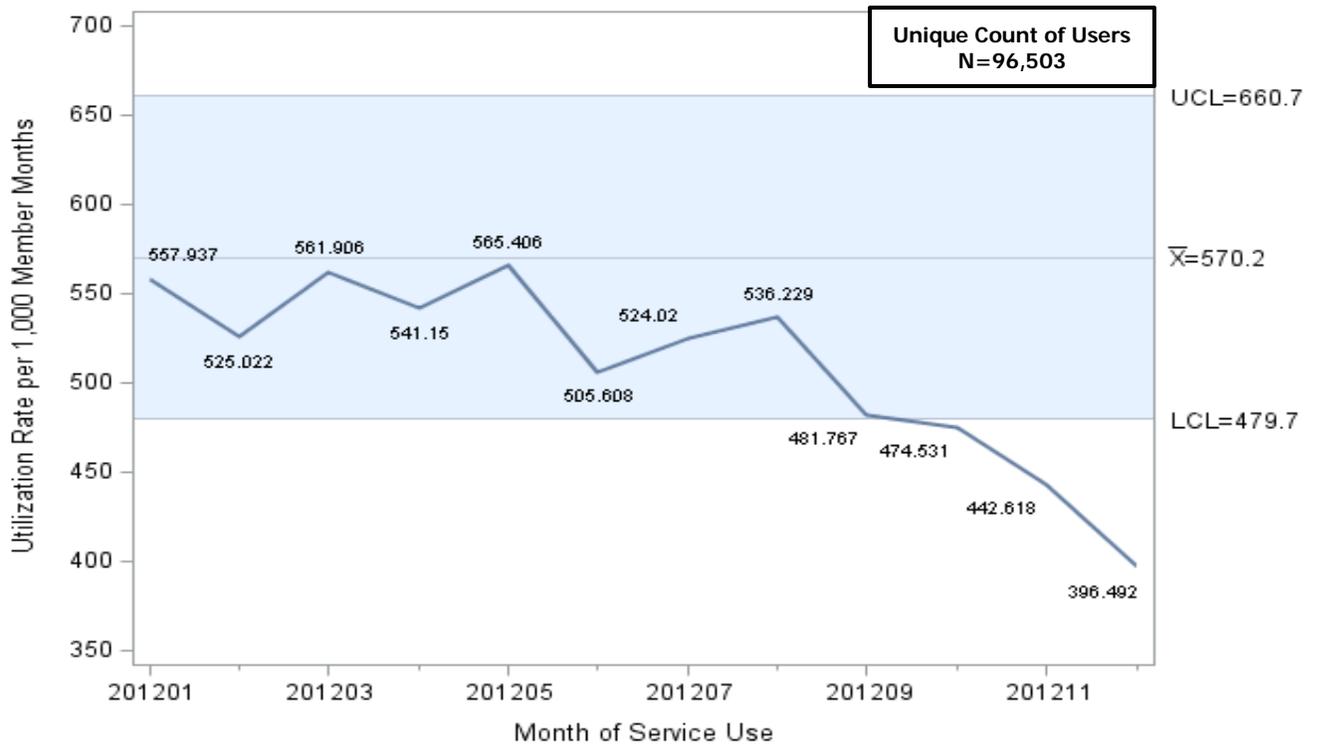


Figure SU-9. Physician/Clinic Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012

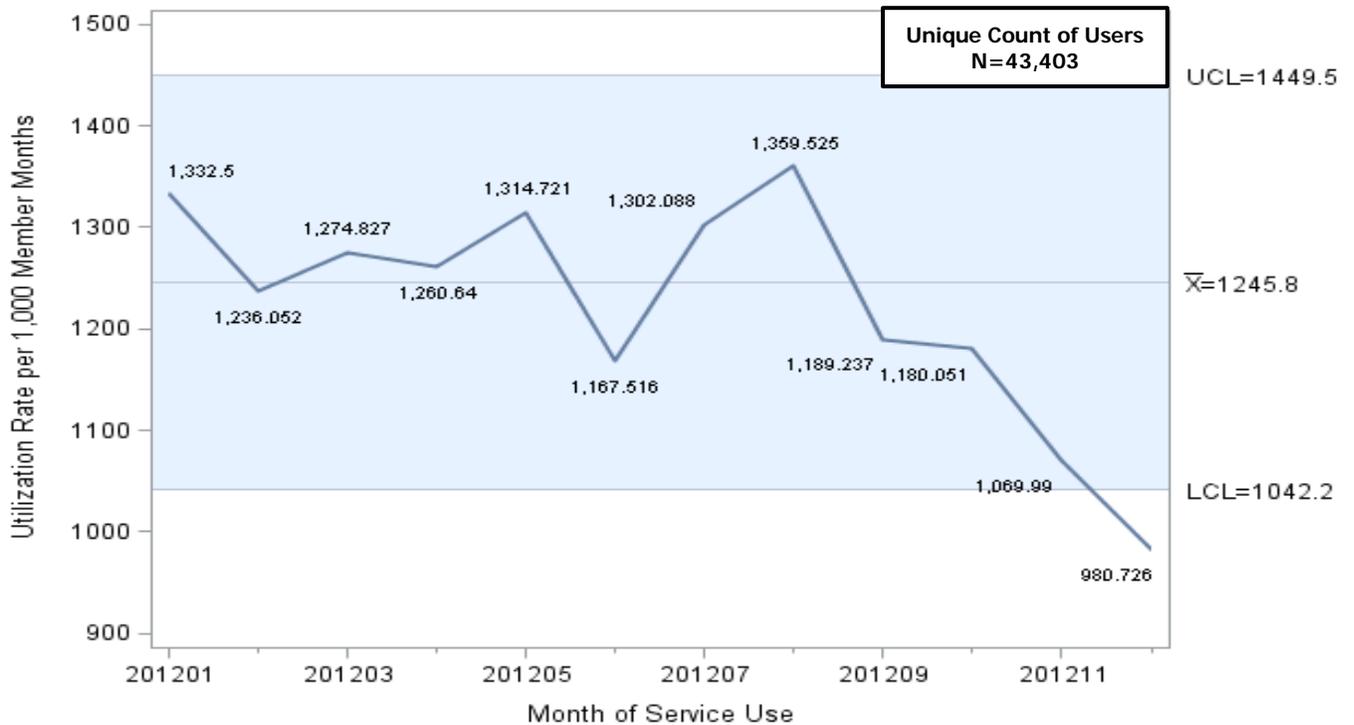
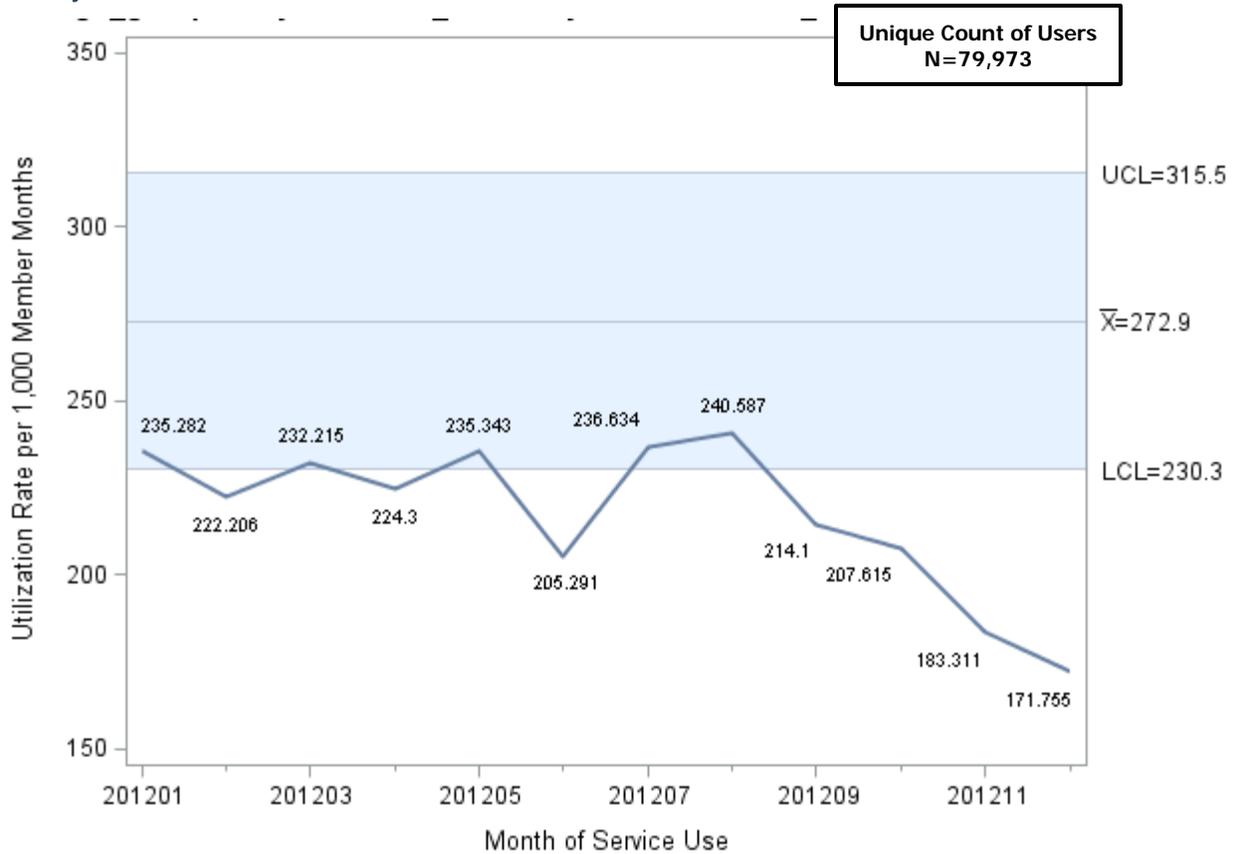


Figure SU-10. Physician/Clinic Utilization by Adults (Age 21+) in the Undocumented Aid Category for January 2012–December 2012



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 January 2012–December 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 to 65.1 visits per 1,000 member months from the first quarter of 2012 to the fourth 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 first quarter of 2012 to the fourth 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 of Monthly Non-Emergency Medical Transportation Services Utilization Rates by Adults for January 2012–December 2012

Figure SU-11. Non-Emergency Transportation Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012

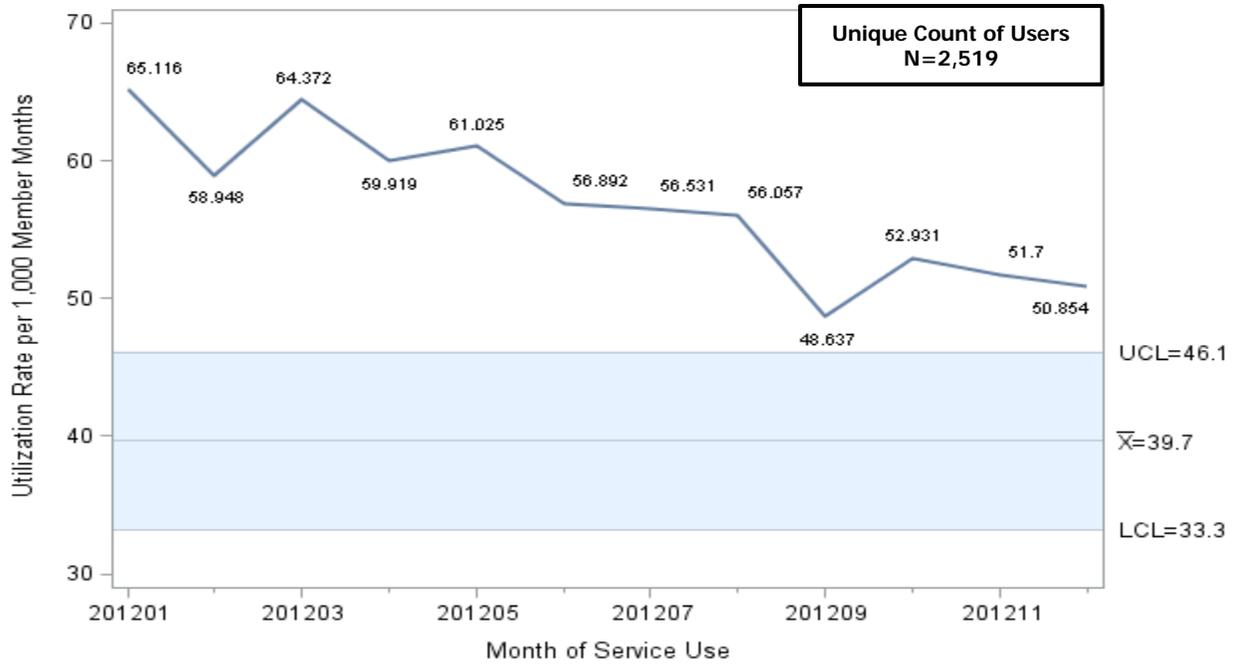
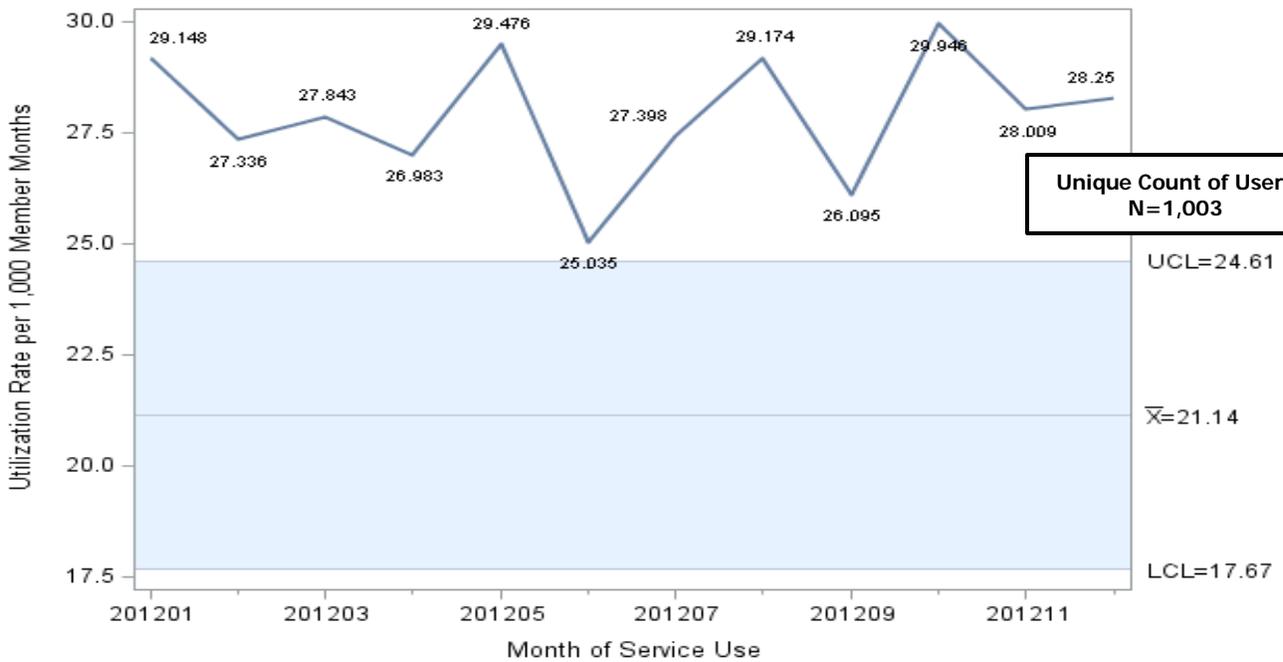


Figure SU-12. Non-Emergency Transportation Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012



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 January 2012–December 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 to 9.7 visits per 1,000 member months from the first quarter of 2012 to the fourth 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 to 9.7 visits per 1,000 member months.

In contrast, utilization rates for children in the Families and Other aid categories ranged from 2.4 to 3.1 visits per 1,000 member months. Additionally, children in the Blind/Disabled, Families, Other, and Undocumented aid categories continued to exhibit below average utilization rates. 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 2007–2009. In contrast, children in the Undocumented aid category exhibited Emergency Medical Transportation services utilization below the baseline ranges during the first quarter of the study period.

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 1.8 to 44.9 visits per 1,000 member months from the first quarter of 2012 to the fourth 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 primarily fell below the expected baseline ranges.

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 first quarter of 2011 to the fourth quarter of 2012.

Trends of Monthly Emergency Medical Transportation Services Utilization Rates by Children for January 2012–December 2012

Figure SU-13. Emergency Transportation Utilization by Children Age (0-20) in the Blind/Disabled Aid Category for January 2012–December 2012

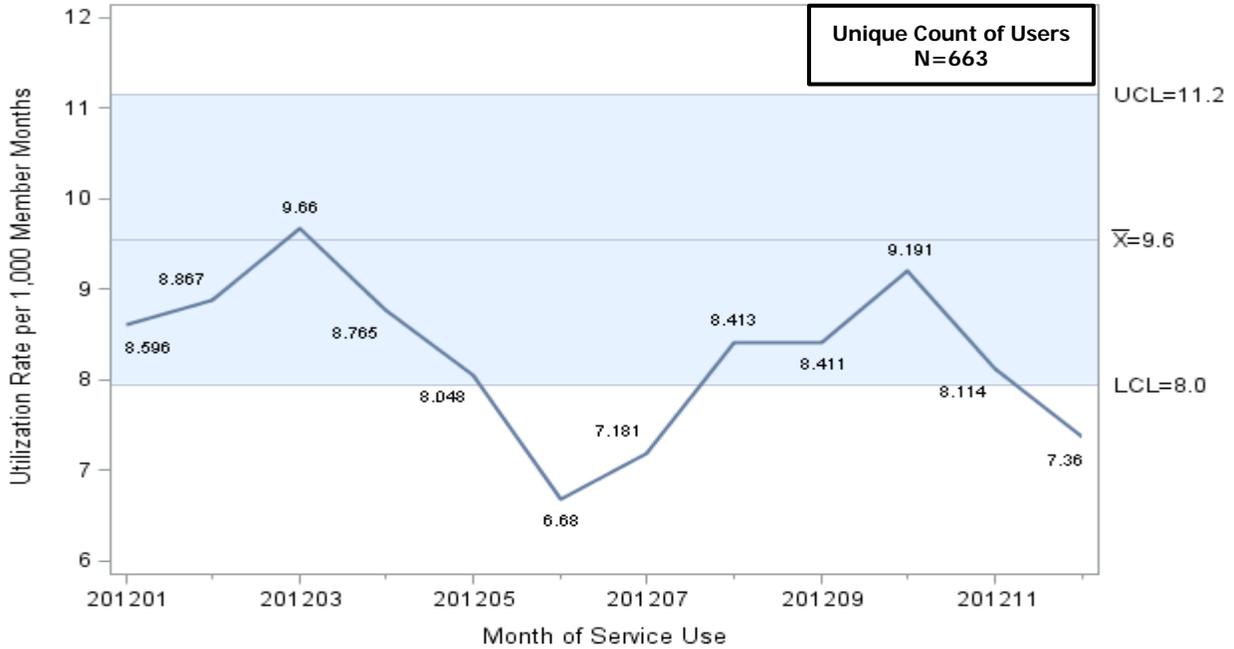


Figure SU-14. Emergency Transportation Utilization by Children (Age 0-20) in the Families Aid Category for January 2012–December 2012

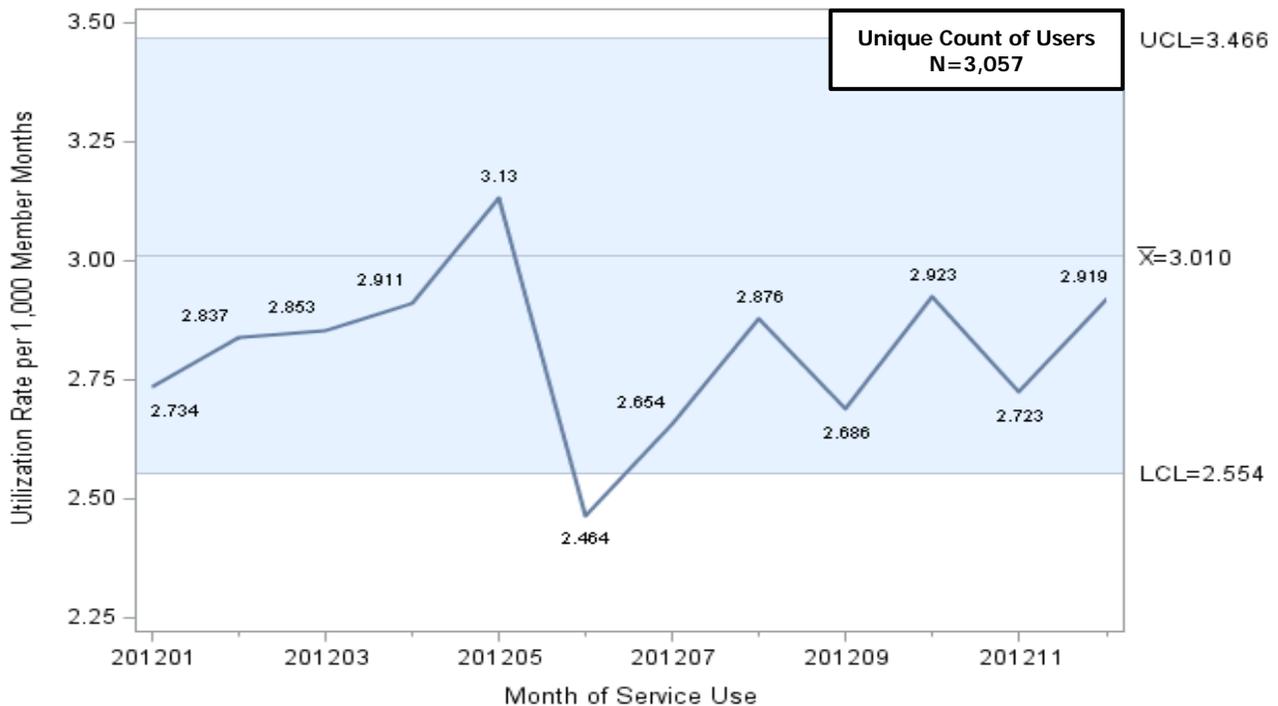


Figure SU-15. Emergency Transportation Utilization by Children (Age 0-20) in the Foster Care Aid Category for January 2012–December 2012

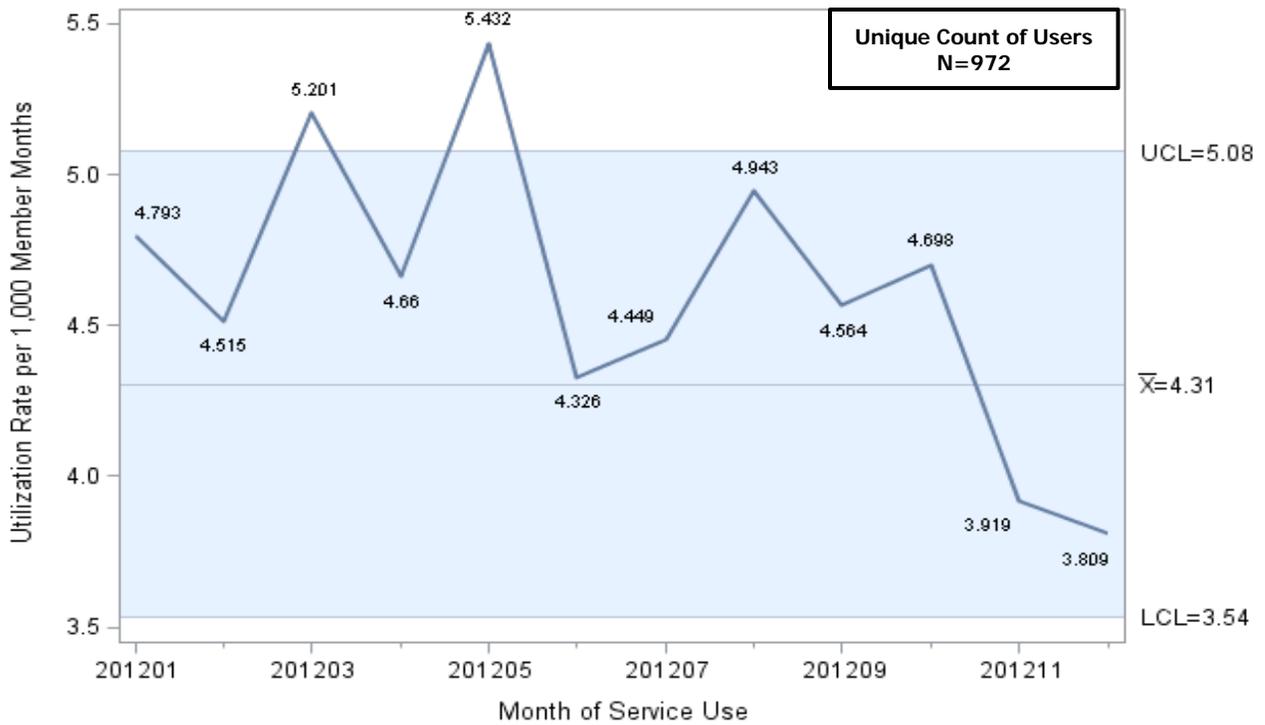


Figure SU-16. Emergency Transportation Utilization by Children (Age 0-20) in the Other Aid Category for January 2012–December 2012

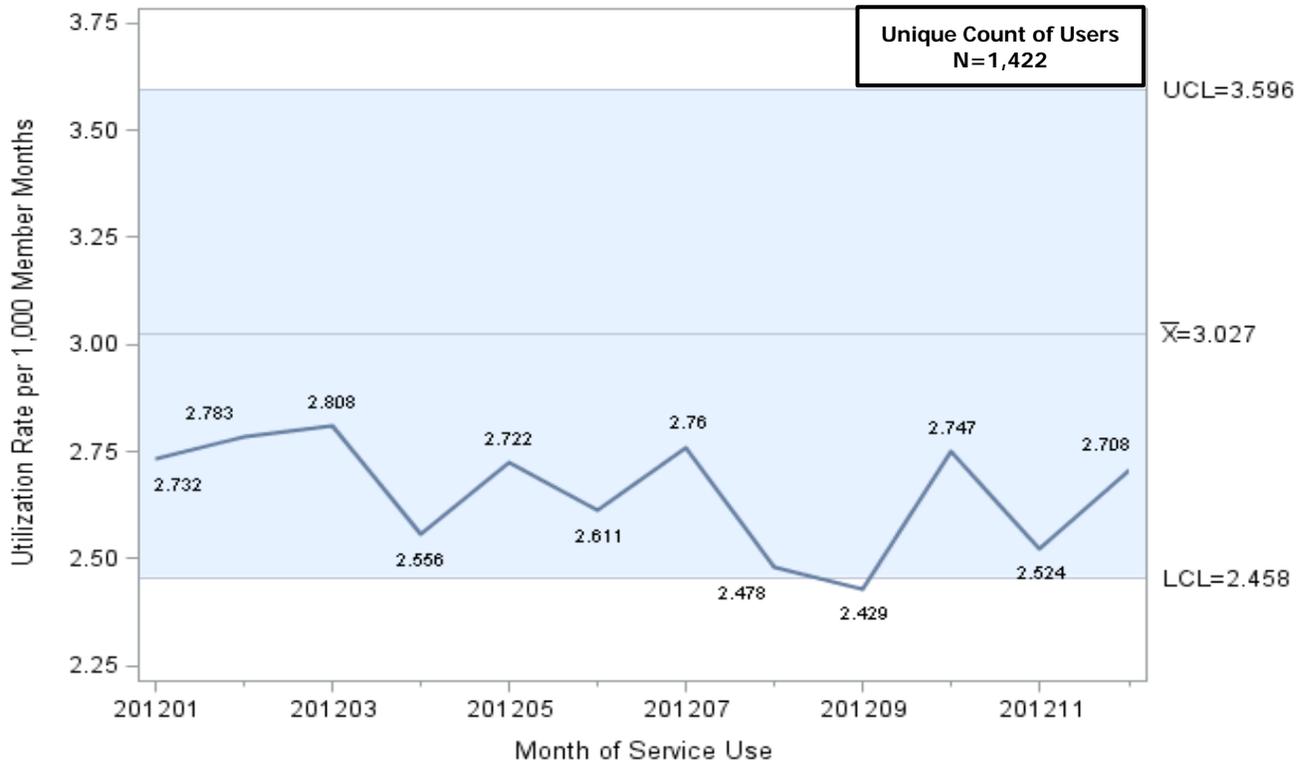
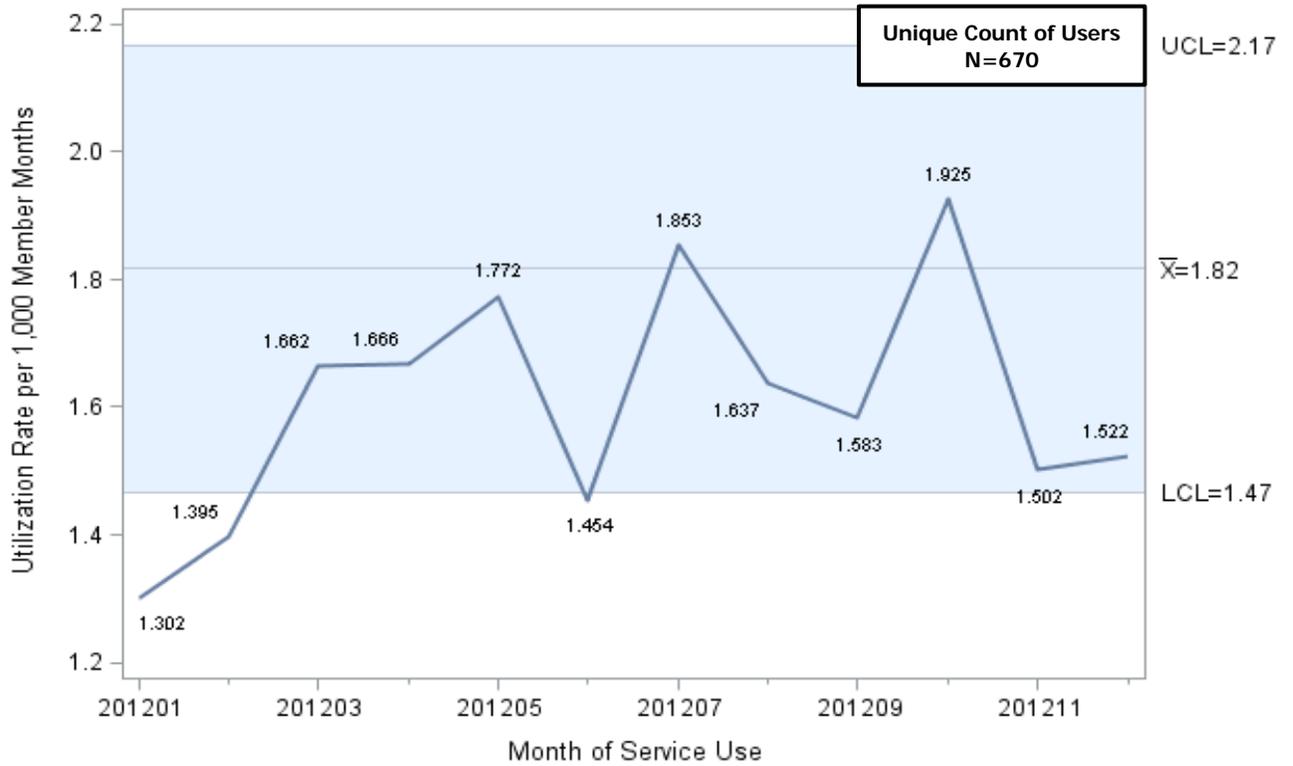


Figure SU-17. Emergency Transportation Utilization by Children (Age 0-20) in the Undocumented Aid Category January 2012–December 2012



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

Trends of Monthly Emergency Transportation Services Utilization Rates by Adults for January 2012–December 2012

Figure SU-18. Emergency Transportation Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category, January 2012–December 2012

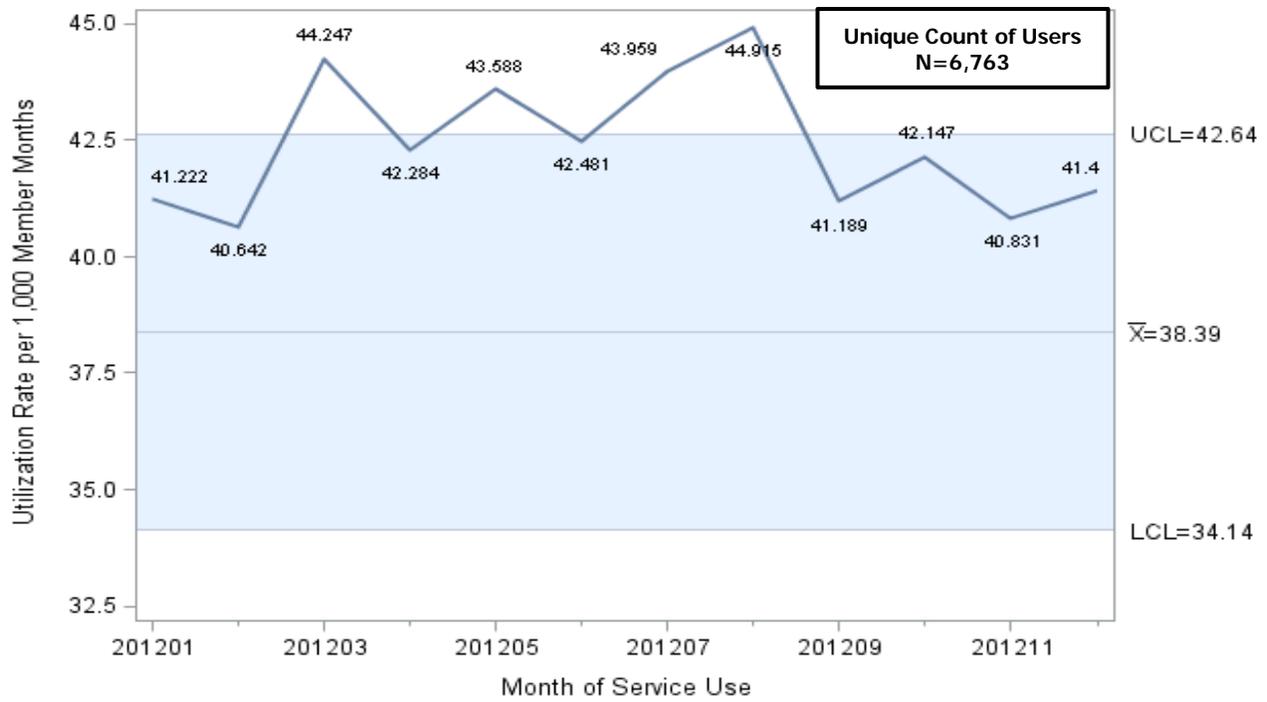


Figure SU-19. Emergency Transportation Utilization by Adults (Age 21+) in the Families Aid Category for January 2012–December 2012

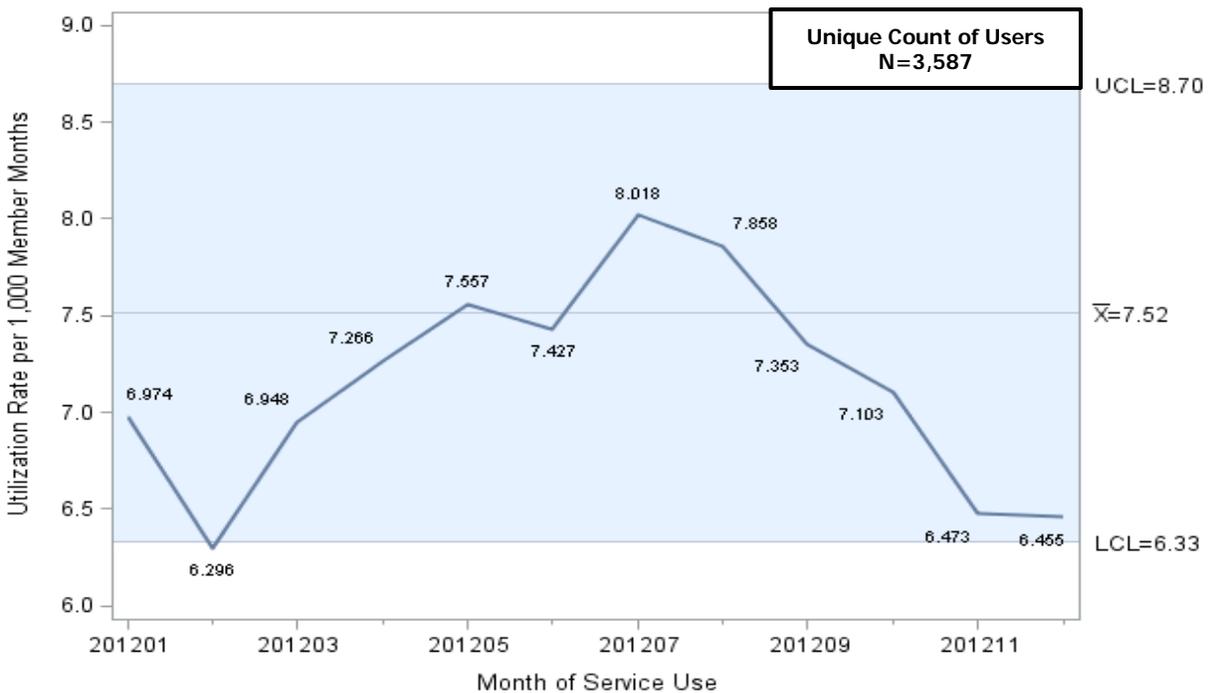


Figure SU-20. Emergency Transportation Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012

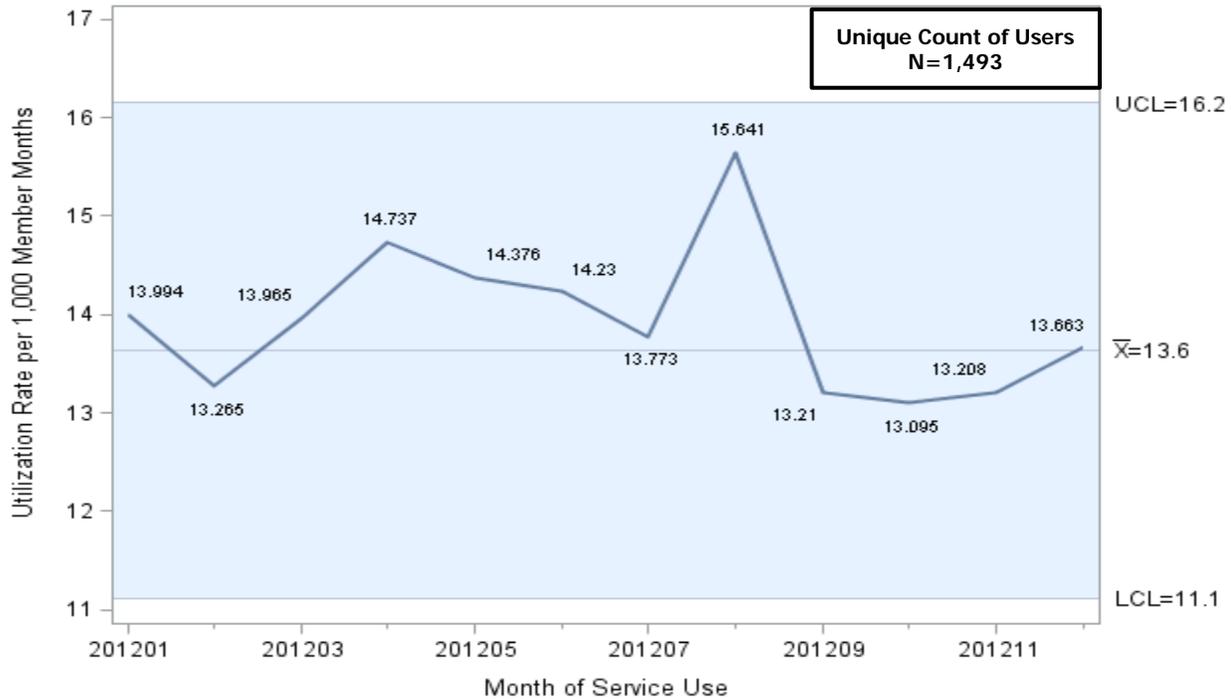
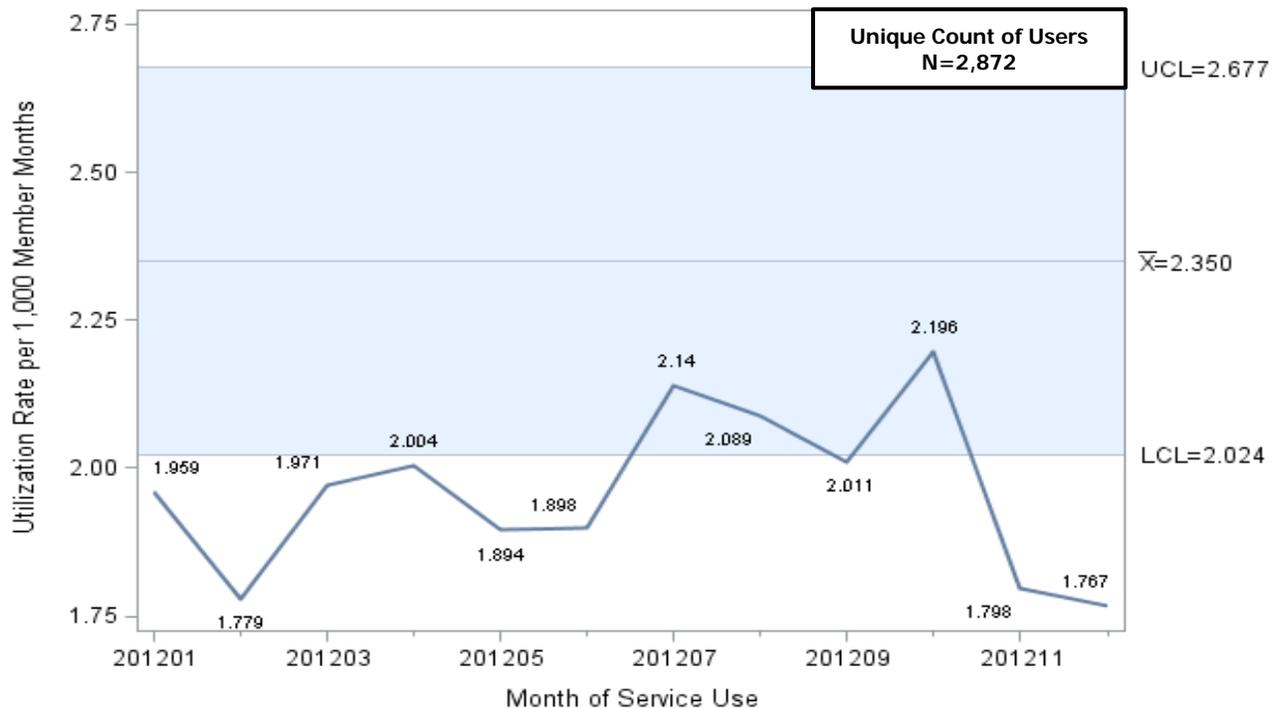


Figure SU-21. Emergency Transportation Utilization by Adults (Age 21+) in the Undocumented Aid Category for January 2012–December 2012



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 January 2012–December 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, Families, and Other aid categories. The monthly Home Health services utilization rates for children in these three aid categories ranged from 0.6 to 155.4 visits per 1,000 member months from the first quarter of 2012 to the fourth quarter of 2012.

Children in the Blind/Disabled aid category exhibited above average utilization of Home Health services, while children in the Families and Other aid groups 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 2007–2009 during the last three quarters of the study period. In contrast, children in the Families and Other aid categories displayed below average utilization that fell within the expected ranges throughout 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 12.2 to 15.1 visits per 1,000 member months from the first quarter of 2012 to the fourth 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 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 Foster Care aid category, 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 first quarter of 2012 to the fourth quarter of 2012.

Use of Home Health services among children is now concentrated among three user groups: Blind/Disabled, Families and Other aid categories. For adults, only those in the Blind/Disabled aid category had sufficient data for analysis. Children in the Blind/Disabled aid category continue to exhibit upward trends in Home Health Services use, while Blind/Disabled adults exhibited stable but above average use during the study period.

Trends of Monthly Home Health Services Utilization Rates by Children for January 2012–December 2012

Figure SU-22. Home Health Services Utilization by Children (Age 0-20) in the Blind/Disabled Aid Category for January 2012–December 2012

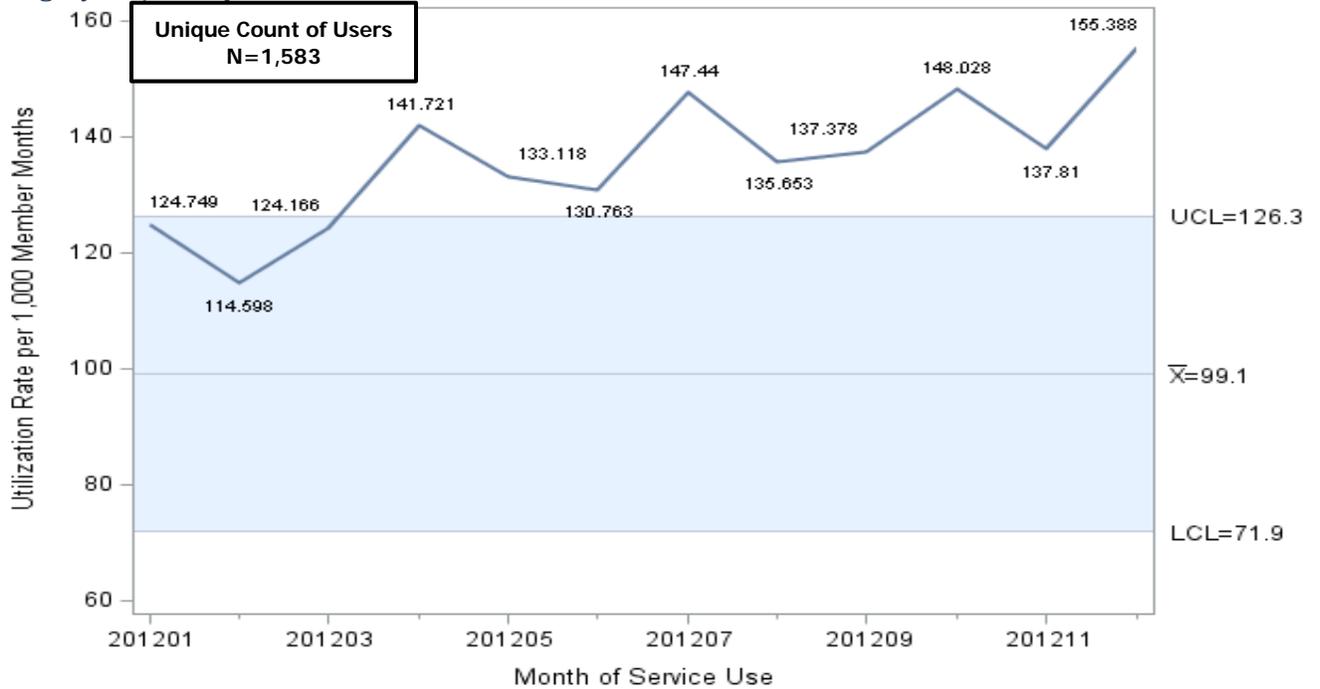


Figure SU-23. Home Health Services Utilization by Children (Age 0-20) in the Families Aid Category for January 2012–December 2012

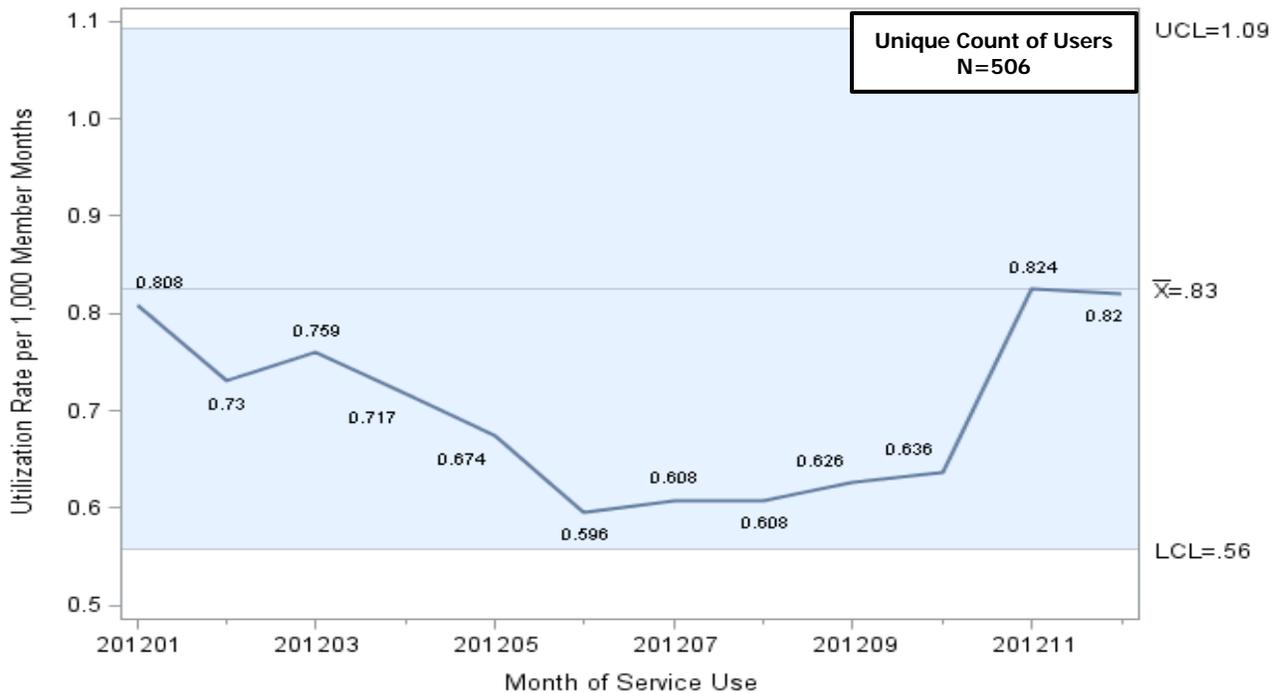
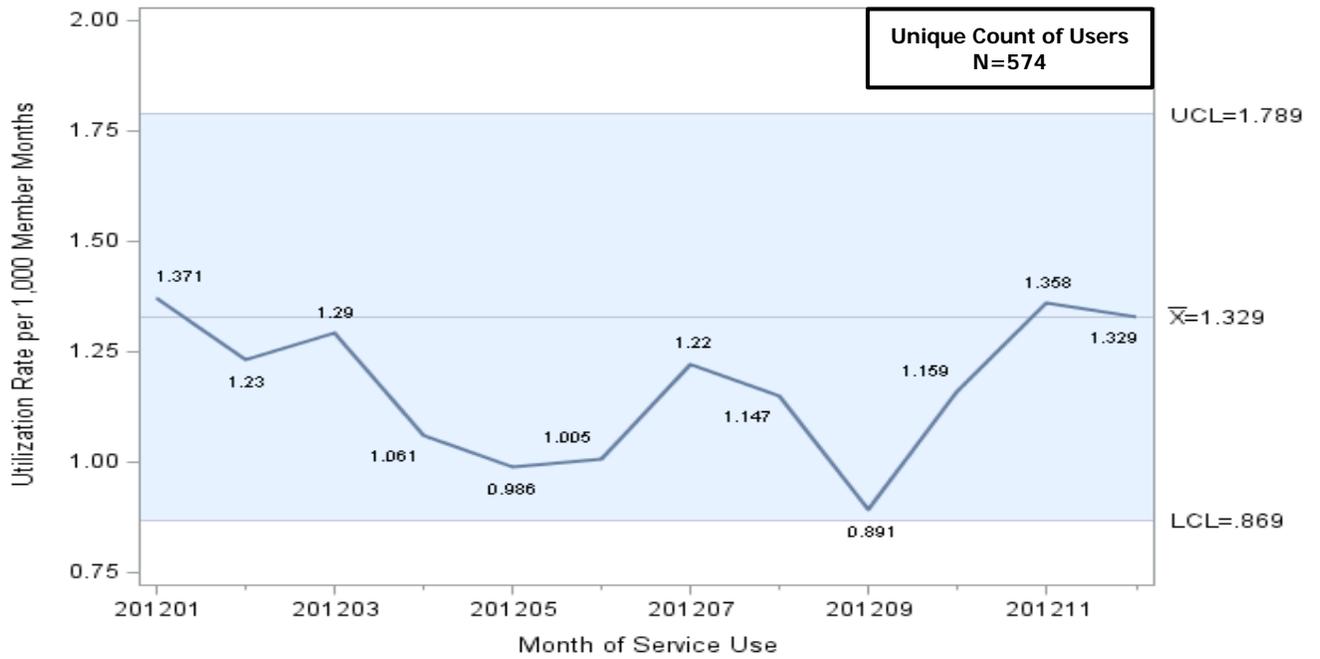


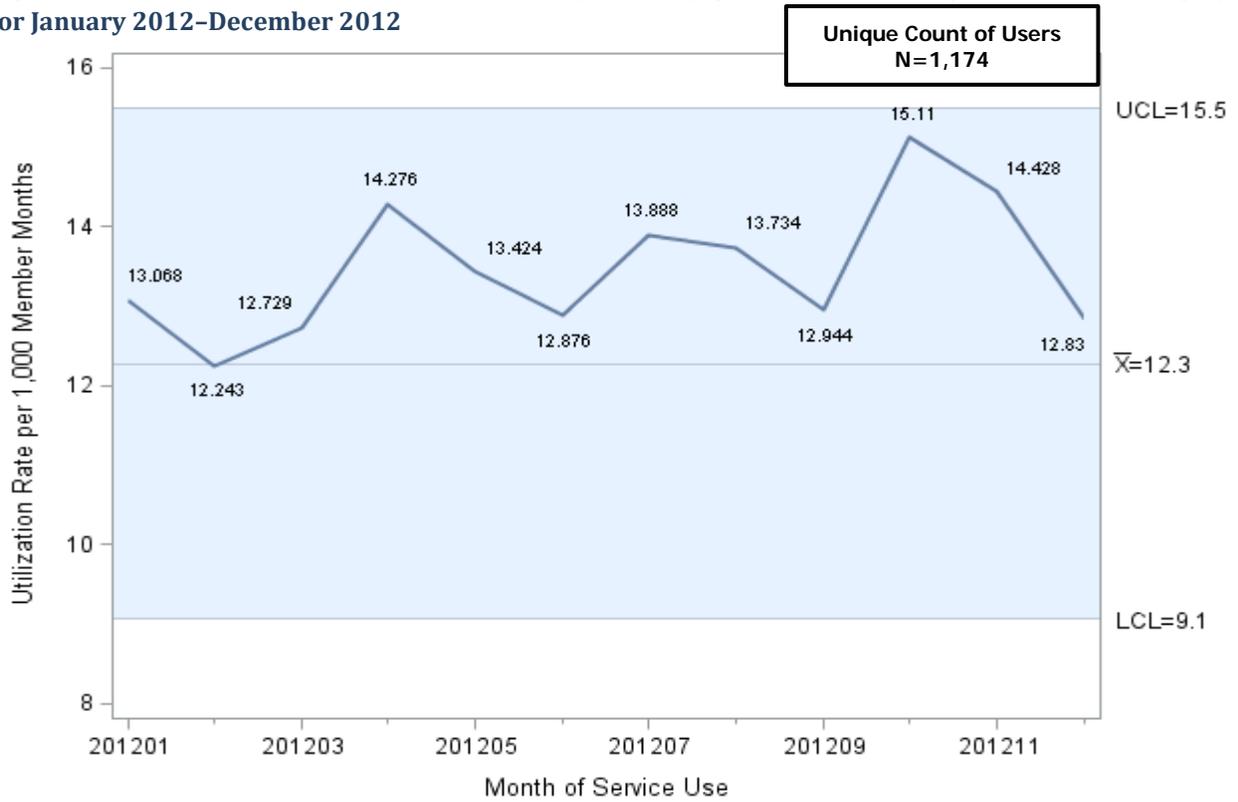
Figure SU-24. Home Health Services Utilization by Children (Age 0-20) in the Other Aid Category for January 2012–December 2012



Source: Data for figures SU-22-24 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 January 2012–December 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends of Monthly Home Health Services Utilization Rates by Adults for January 2012–December 2012

Figure SU-25. Home Health Services Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012



Source: Data for figure SU-25 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 January 2012–December 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 to 134.6 days per 1,000 member months from the first quarter of 2012 to the fourth 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 primarily fell within expected baseline ranges. In contrast, children in the Foster Care, Other, and Undocumented aid categories again exhibited below average utilization of Hospital Inpatient services throughout the study period.

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 to 278.3 days per 1,000 member months from the first quarter of 2012 to the fourth quarter of 2012.

Hospital Inpatient services use was again noticeably higher for adults in the Aged, Blind/Disabled, and Other aid categories. Adults in the Aged and Blind/Disabled aid categories exhibited above average utilization that reached 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.

Adults in the Aged and Blind/Disabled aid categories had Hospital Inpatient service use rates that were well above baseline levels, while service use for adults in the Families, Other, and Undocumented aid categories were mostly below average.

The following figures SU-25 to SU-34 represent the control chart analysis for both children and adults from the first quarter of 2012 to the fourth quarter of 2012.

Trends of Monthly Hospital Inpatient Services Utilization Rates by Children for January 2012–December 2012

Figure SU-26. Hospital Inpatient Utilization by Children (Age 0–20) in the Blind/Disabled Aid Category for January 2012–December 2012

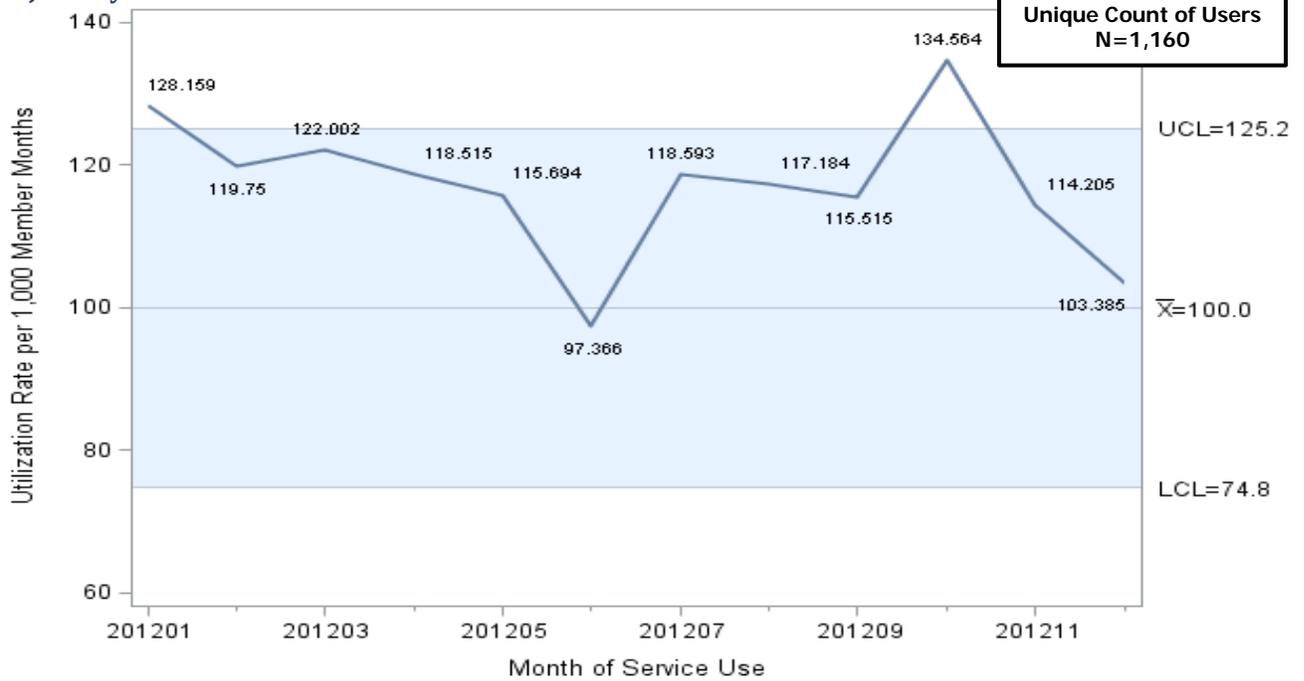


Figure SU-27. Hospital Inpatient Utilization by Children (Age 0–20) in the Families Aid Category for January 2012–December 2012

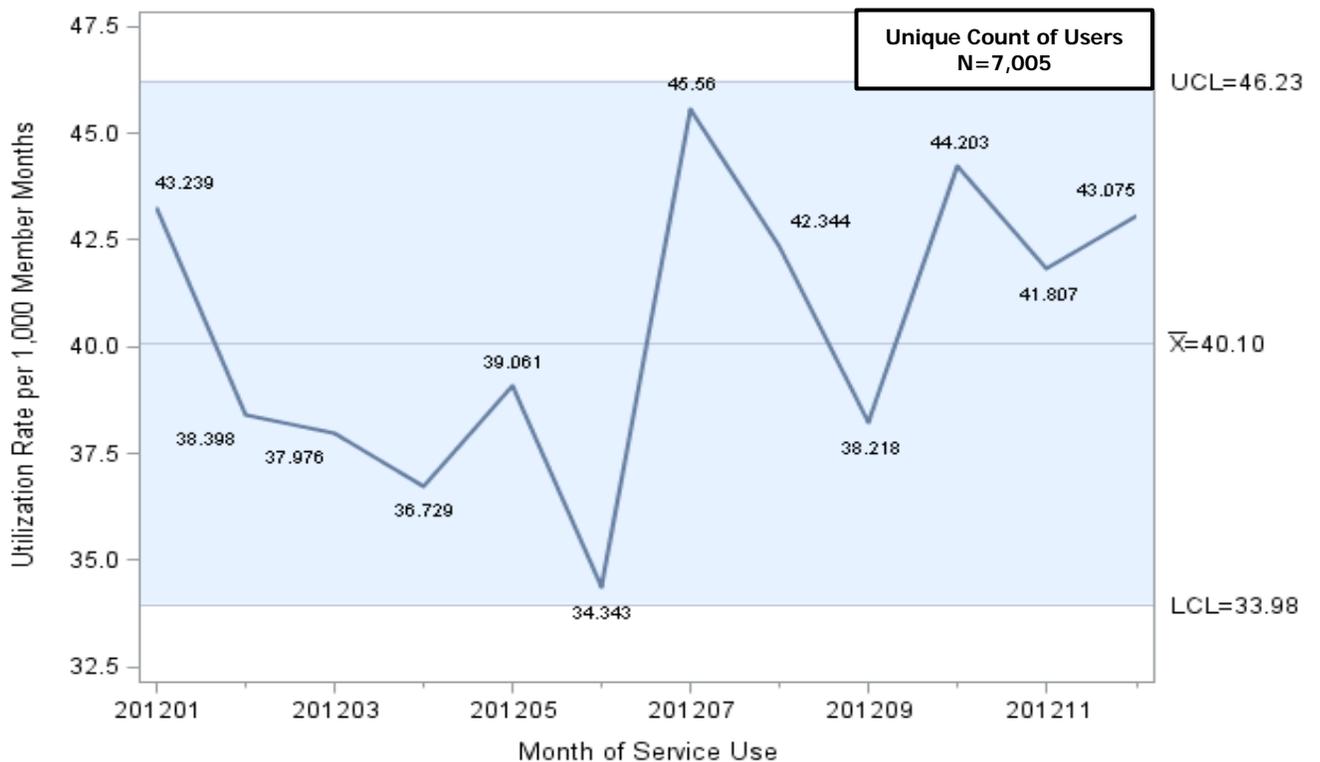


Figure SU-28. Hospital Inpatient Utilization by Children (Age 0-20) in the Foster Care Aid Category for January 2012–December 2012

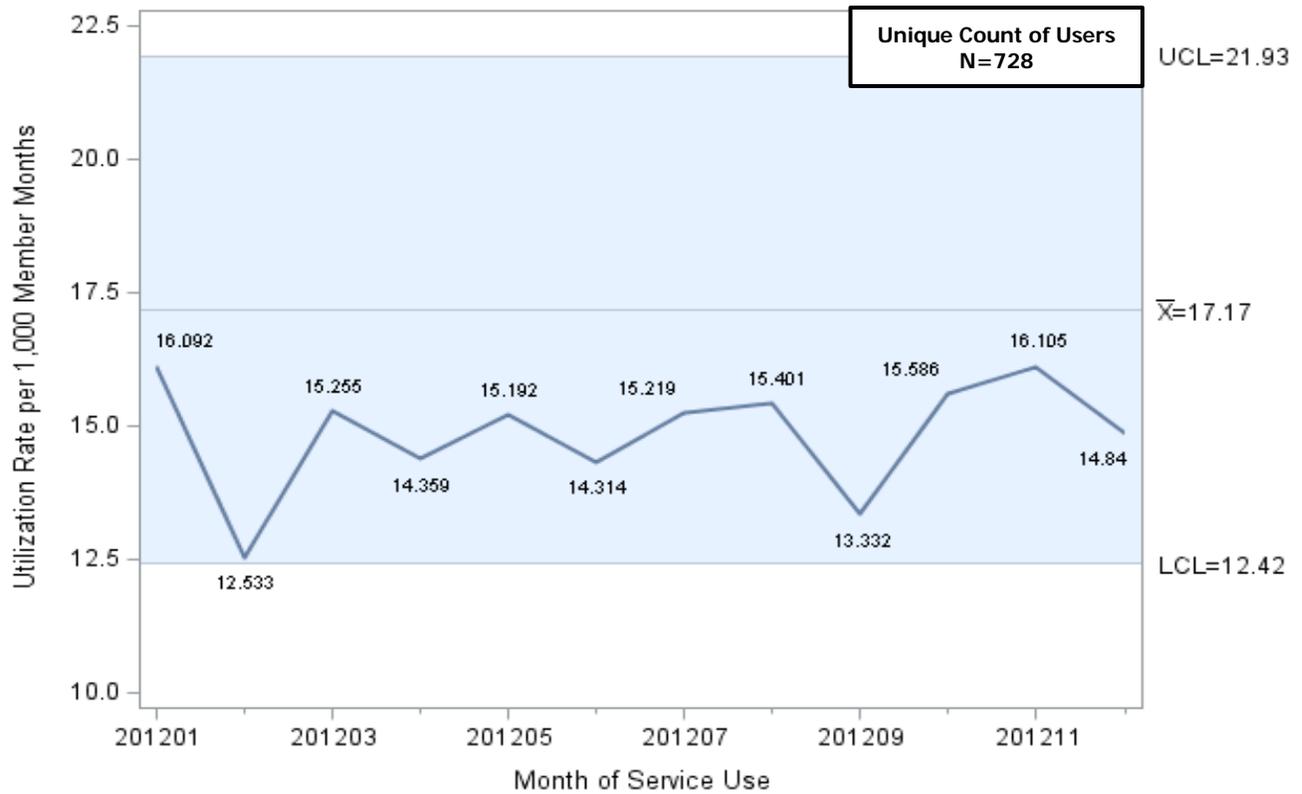


Figure SU-29. Hospital Inpatient Utilization by Children (Age 0-20) in the Other Aid Category for January 2012–December 2012

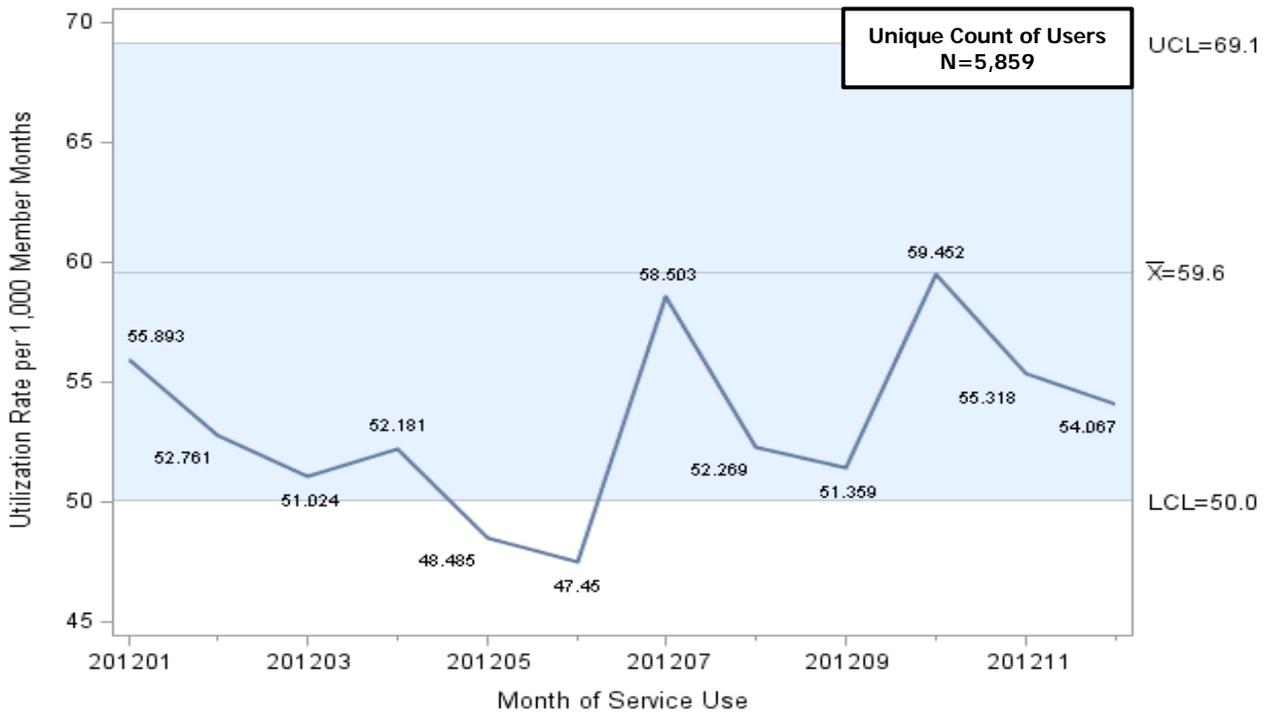
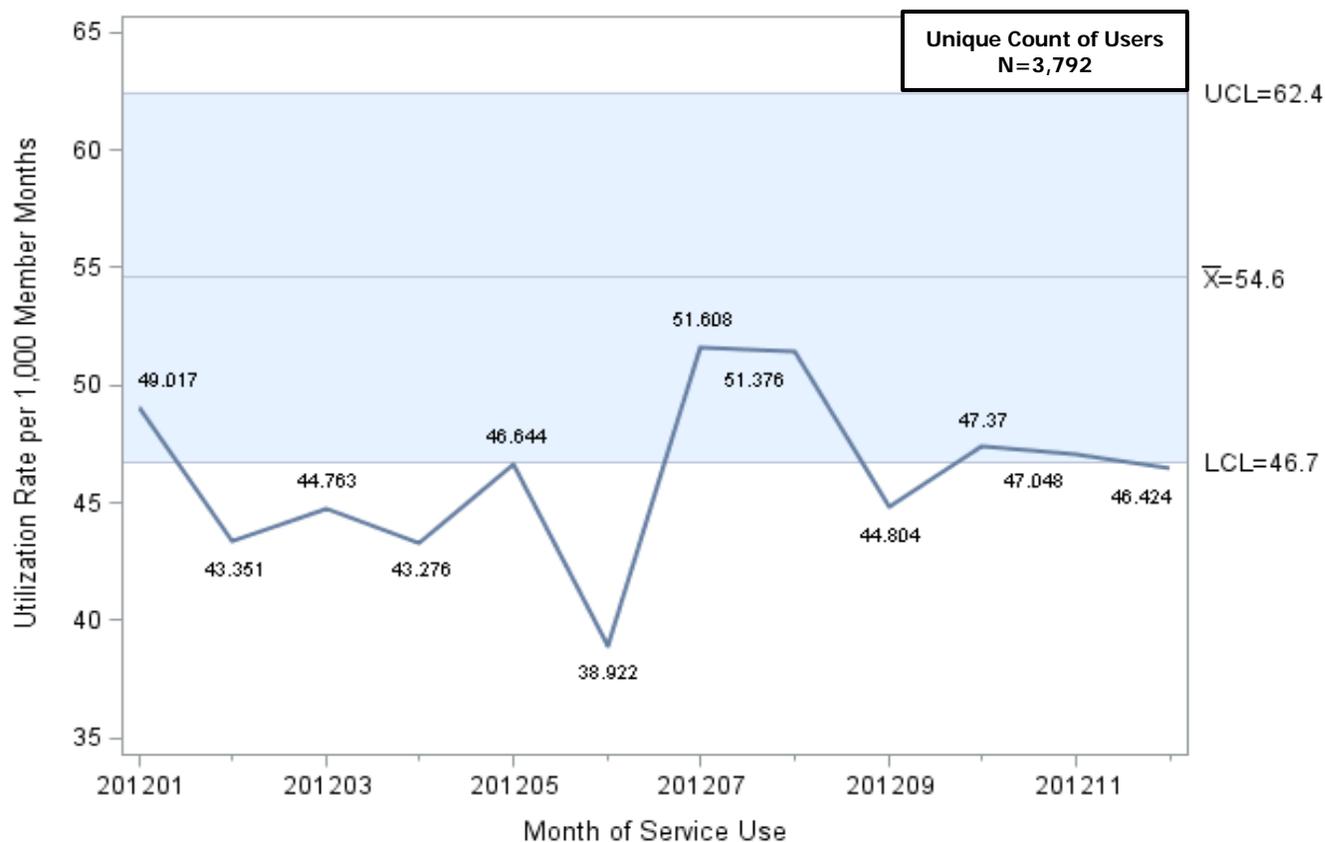


Figure SU-30. Hospital Inpatient Utilization by Children (Age 0-20), in the Undocumented Aid Category for January 2012–December 2012



Source: Data for figures SU-26 to SU-30 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 January 2012–December 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends of Monthly Hospital Inpatient Services Utilization Rates by Adults for January 2012–December 2012

Figure SU-31. Hospital Inpatient Utilization by Adults (Age 21+) in the Aged Aid Category for January 2012–December 2012

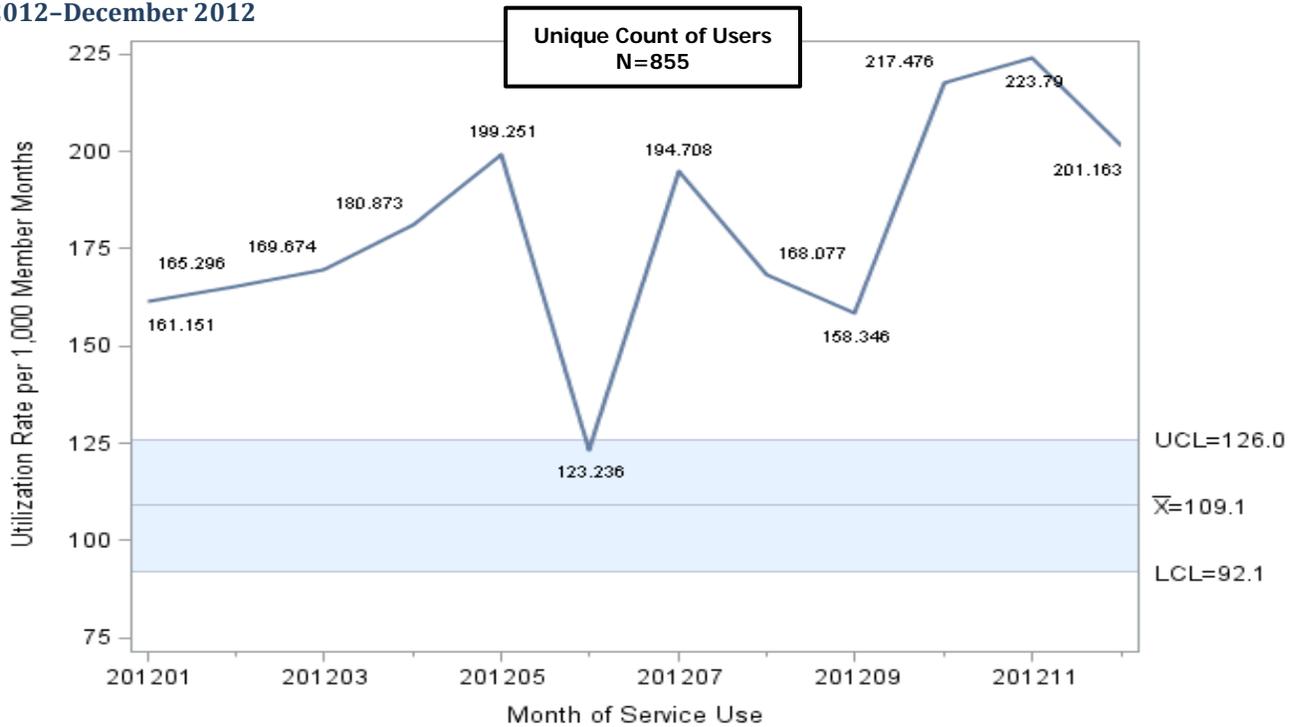


Figure SU-32. Hospital Inpatient Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012

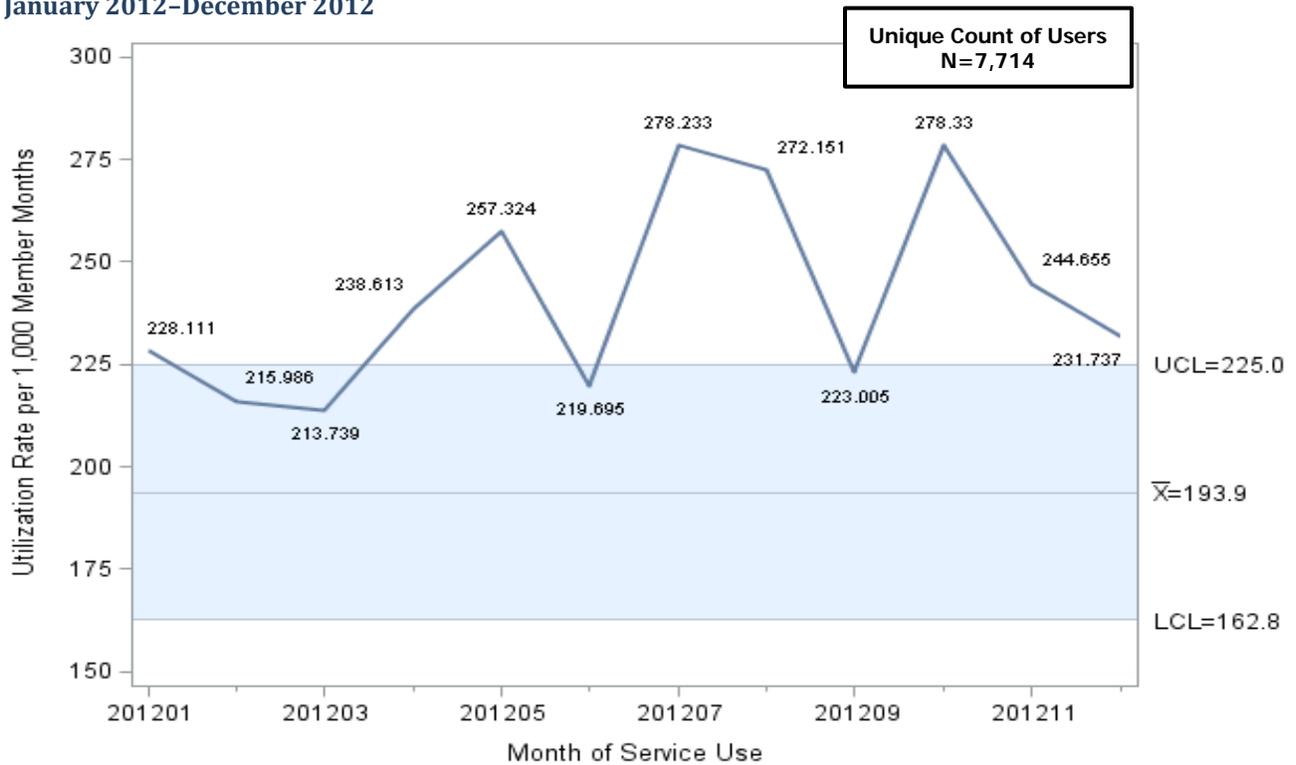


Figure SU-33. Hospital Inpatient Utilization Rates by Adults (Age 21+) in the Families Aid Category for January 2012–December 2012

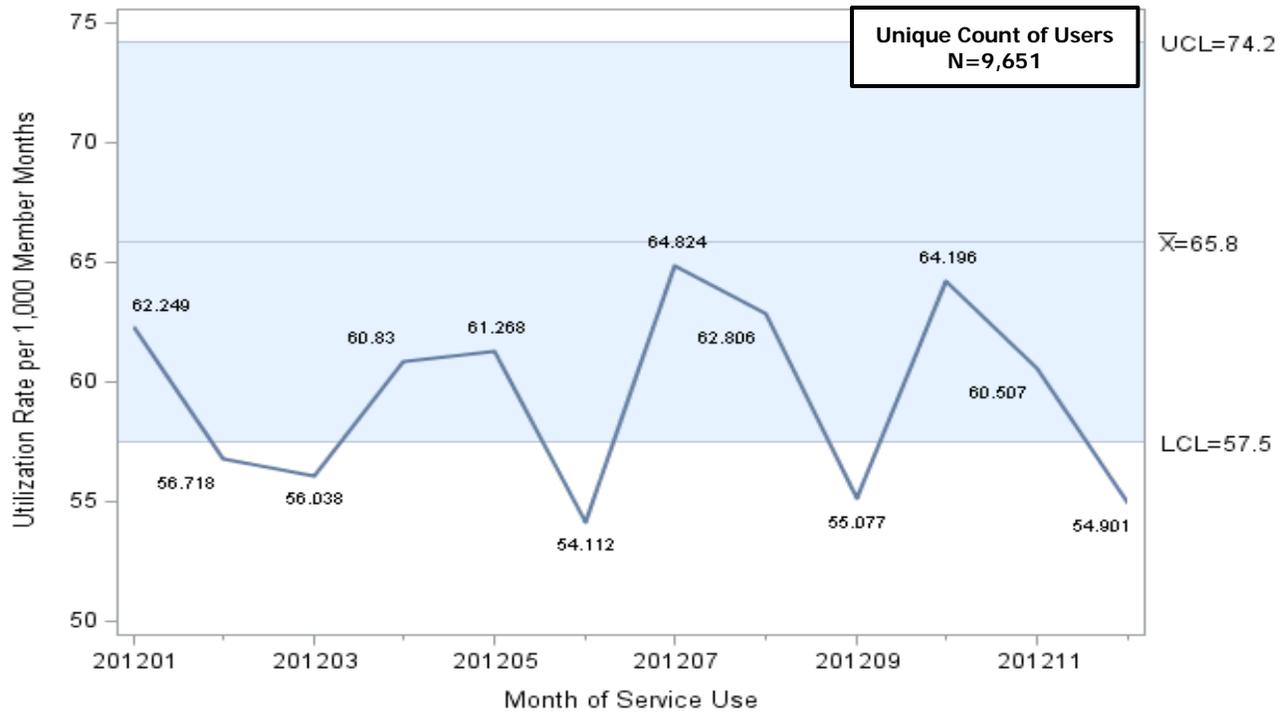


Figure SU-34. Hospital Inpatient Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012

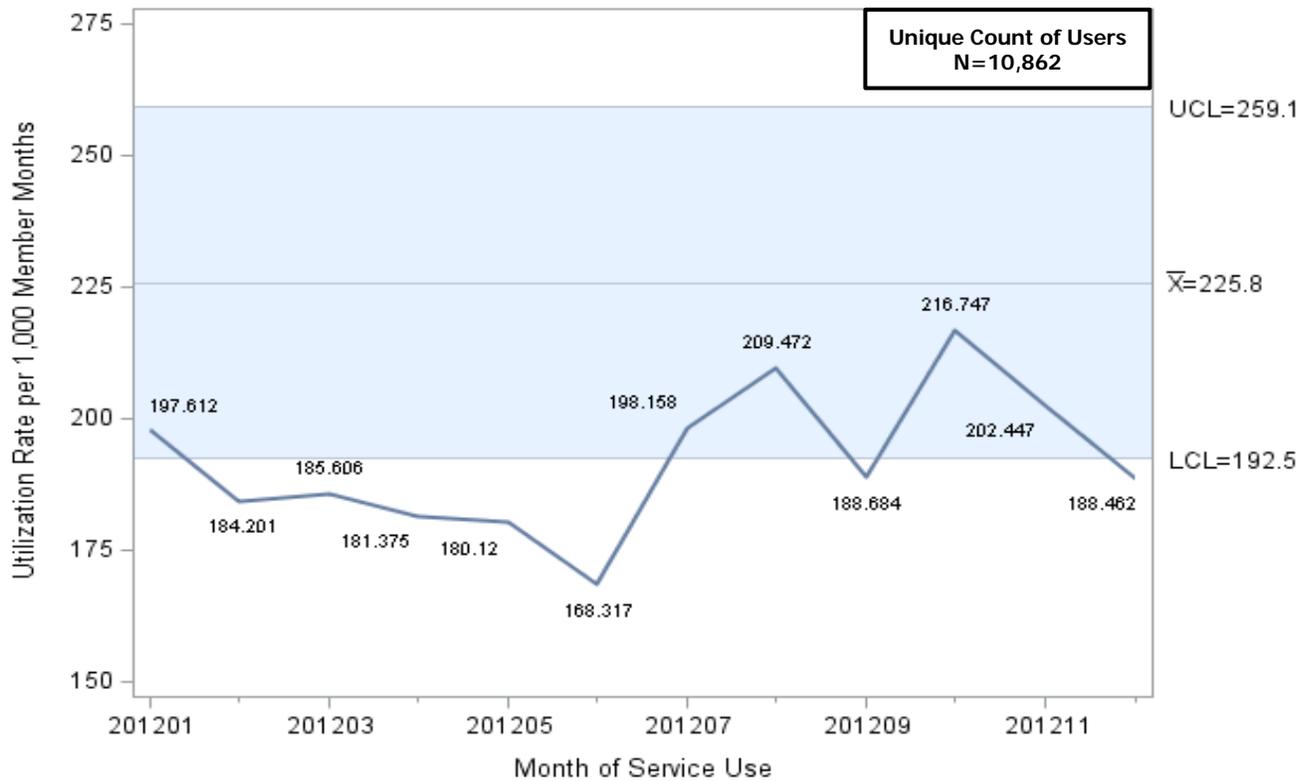
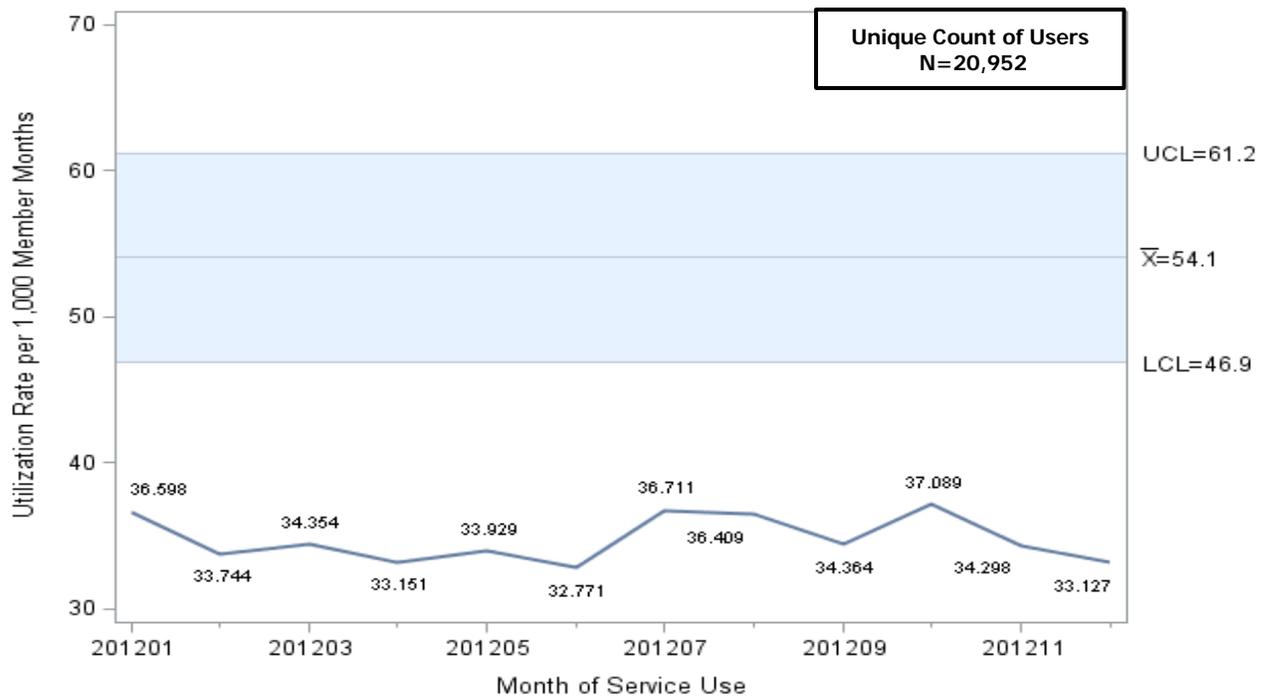


Figure SU-35. Hospital Inpatient Utilization by Adults (Age 21+) in the Undocumented Aid Category for January 2012–December 2012



Source: Data for figures SU-31 to SU-35 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 January 2012–December 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 to 218.7 visits per 1,000 member months from the first quarter of 2012 to the fourth 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 Families and Undocumented aid categories exhibited below average utilization throughout most of the study period, while children in the Other aid group displayed nine consecutive months of utilization below the expected ranges over the final three quarters. Of particular note, children in the Foster Care aid category displayed a downward trend in Hospital Outpatient services utilization during the last two quarters of 2012. Additionally, children in the Blind/Disabled aid category displayed Hospital Outpatient service use above the expected ranges in the first quarter of 2012 before exhibiting a noticeable downward trend in utilization that reached below average levels by the end of the study period.

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

Adults

The monthly Hospital Outpatient services utilization rates for adults age 21 and older ranged from 44.1 to 318.3 visits per 1,000 member months from the first quarter of 2012 to the fourth quarter of 2012.

As noted in the prior access quarterly reports, Hospital Outpatient services utilization rates were noticeably higher for adults in the Blind/Disabled and Other aid categories. Adults in the Aged and Blind/Disabled aid categories primarily exhibited above average utilization that at times reached levels above the expected ranges. In contrast, adults in the Families, Other, and Undocumented aid categories all mostly exhibited below average utilization that fell below the expected ranges during the last quarter of the study period. Of particular note, adults in the Blind/Disabled, Families, Other, and Undocumented aid categories exhibited a noticeable downward trend in Hospital Outpatient services utilization starting in August 2012, while those in the Aged aid group displayed a decline in utilization during the last quarter of the study period.

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 first quarter of 2012 to the fourth quarter of 2012.

Trends of Monthly Hospital Outpatient Services Utilization Rates by Children for January 2012–December 2012

Figure SU-36. Hospital Outpatient Utilization by Children (Age 0-20) in the Blind/Disabled Aid Category for January 2012–December 2012

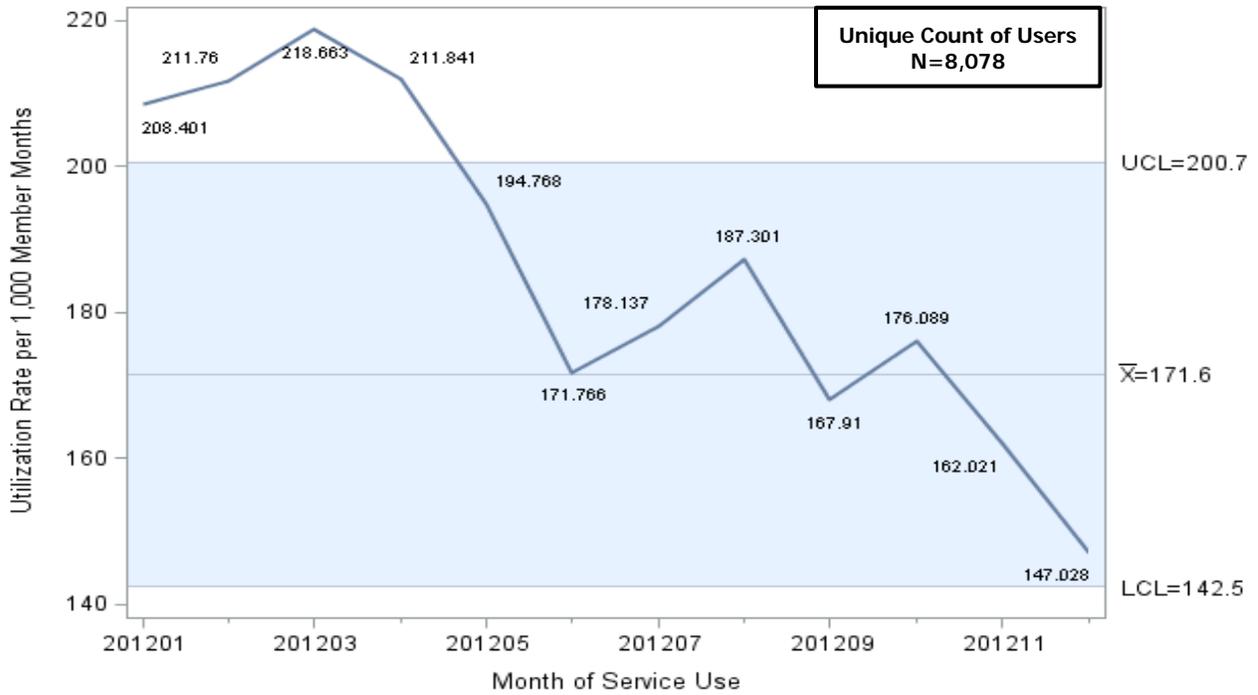


Figure SU-37. Hospital Outpatient Utilization by Children (Age 0-20) in the Families Aid Category for January 2012–December 2012

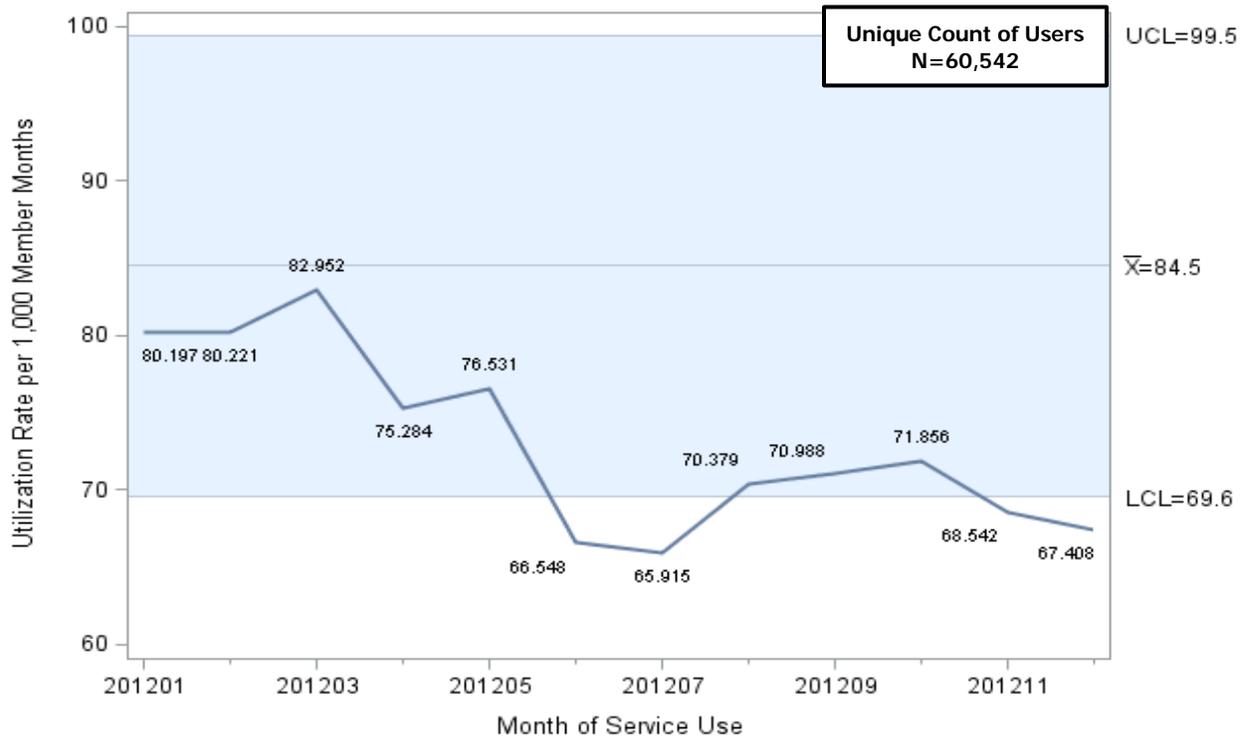


Figure SU-38. Hospital Outpatient Utilization by Children (Age 0-20) in the Foster Care Aid Category for January 2012–December 2012

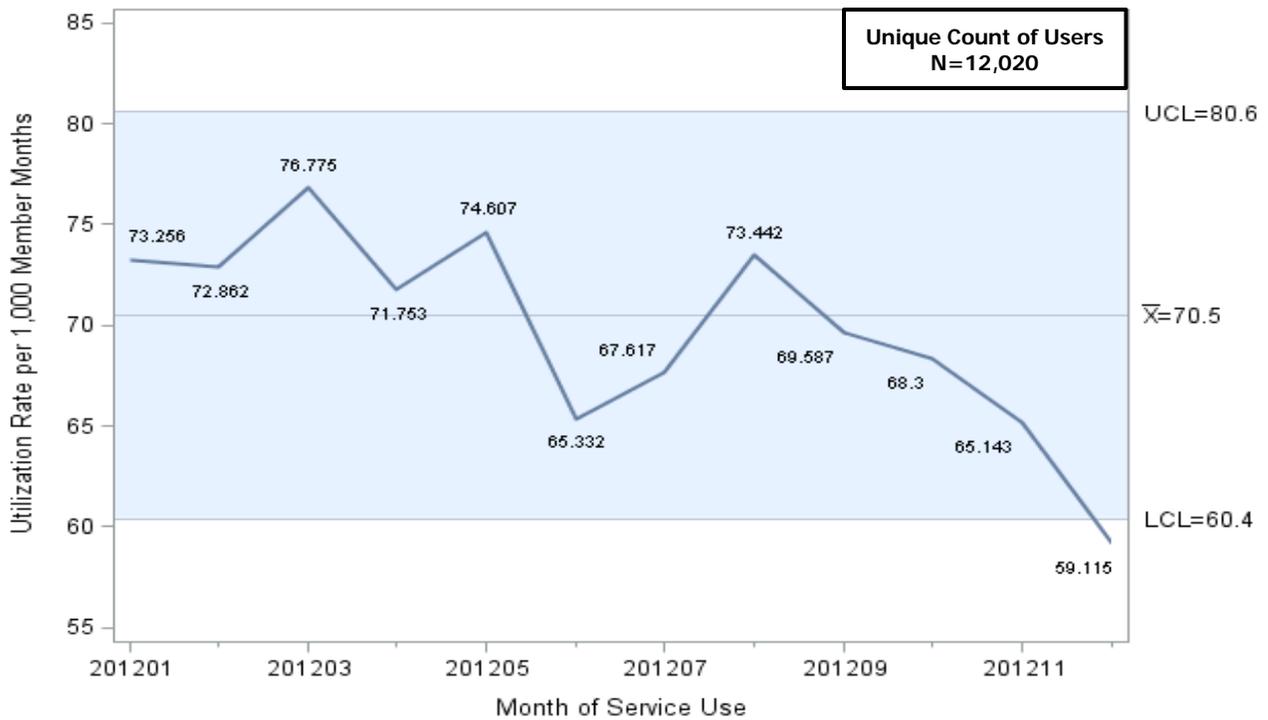


Figure SU-39. Hospital Outpatient Utilization by Children (Age 0-20) in the Other Aid Category for January 2012–December 2012

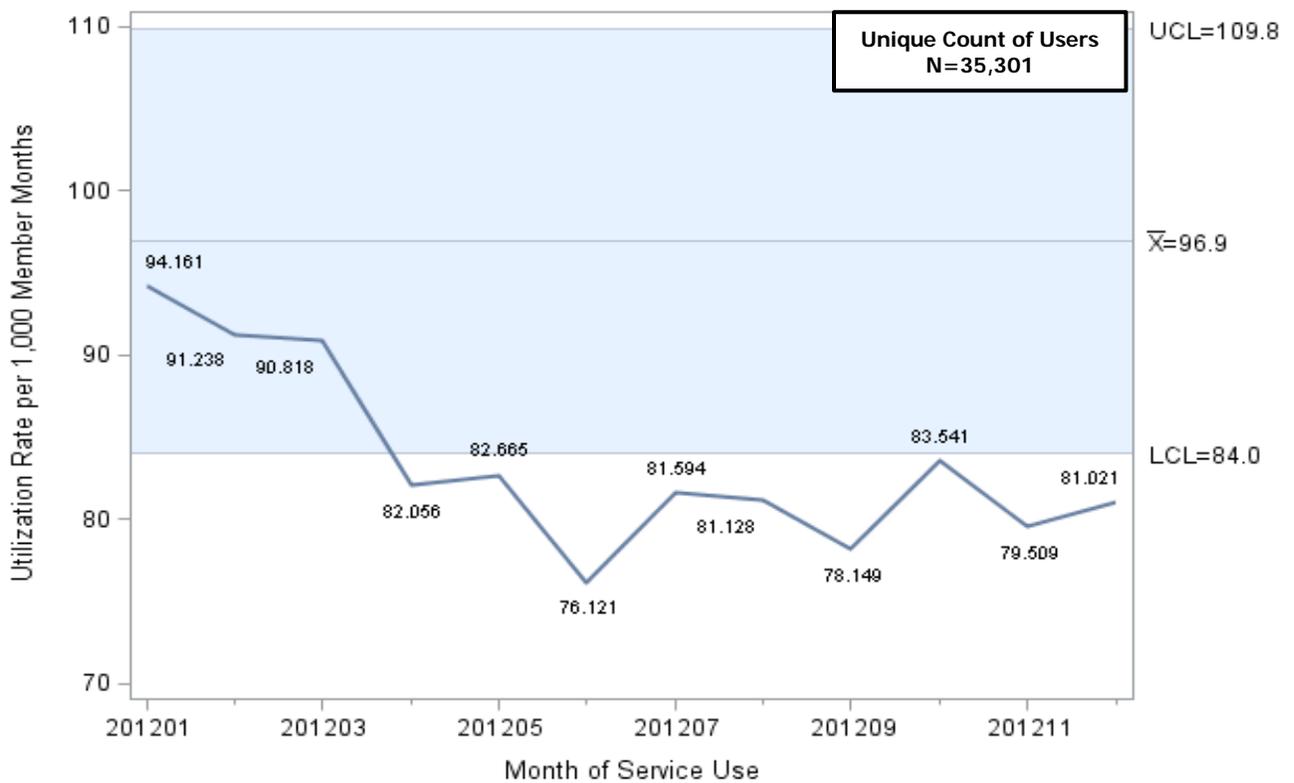
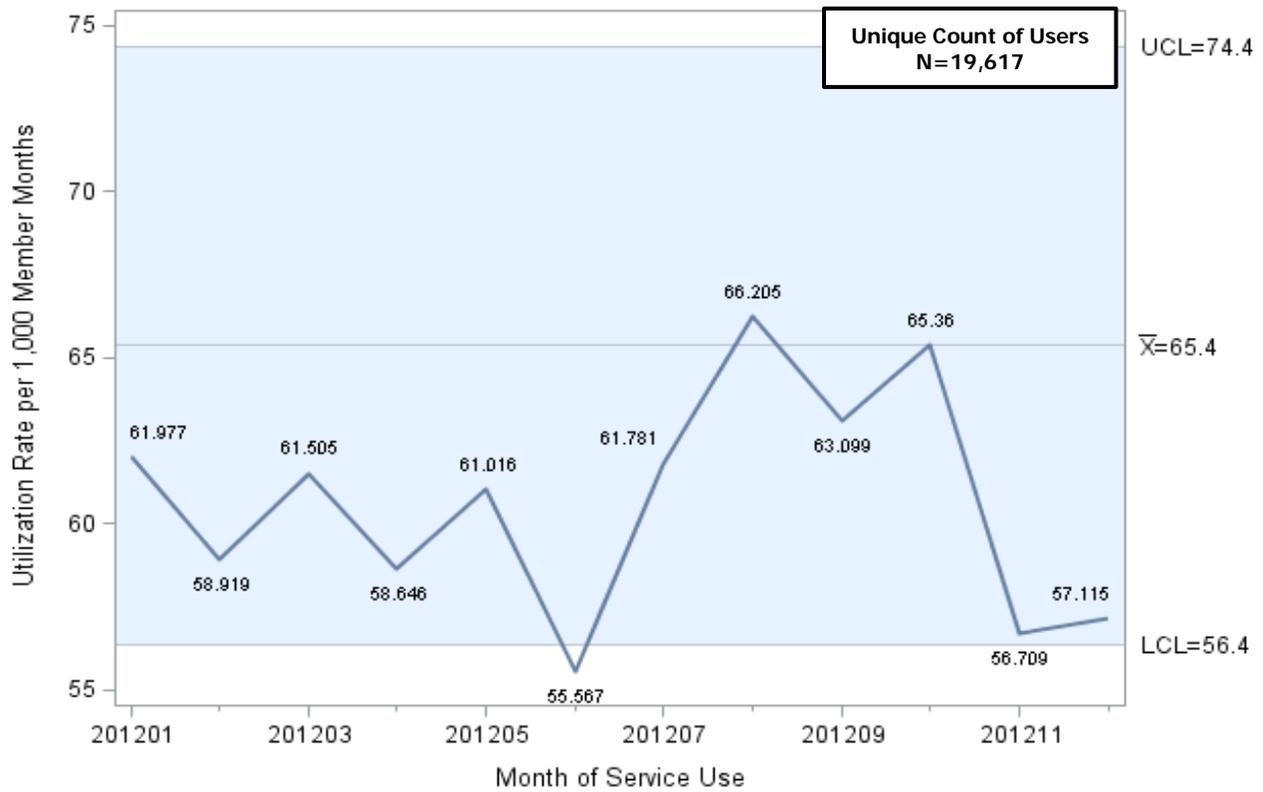


Figure SU-40. Hospital Outpatient Utilization by Children (Age 0-20) in the Undocumented Aid Category for January 2012–December 2012



Source: Data for figures SU-36 to SU-40 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 January 2012–December 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends of Monthly Hospital Outpatient Services Utilization Rates by Adults for January 2012–December 2012

Figure SU-41. Hospital Outpatient Utilization by Adults (Age 21+) in the Aged Aid Category for January 2012–December 2012

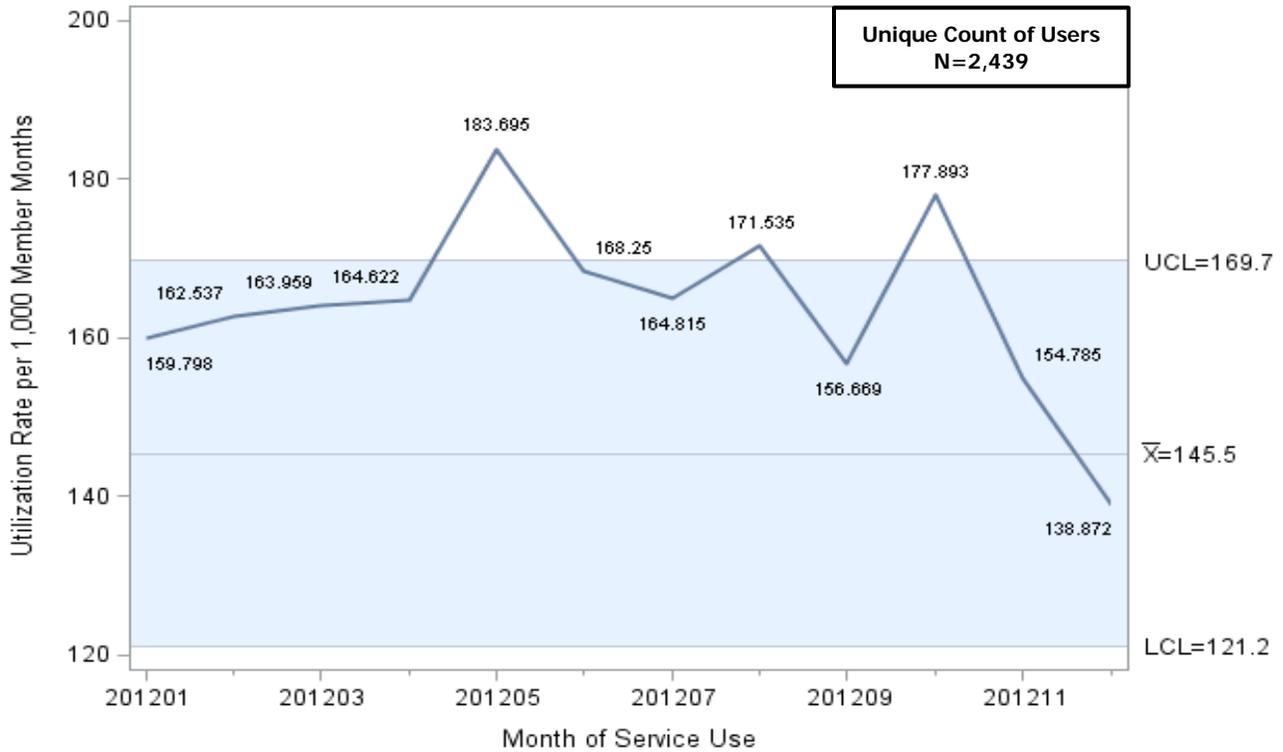


Figure SU-42. Hospital Outpatient Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012

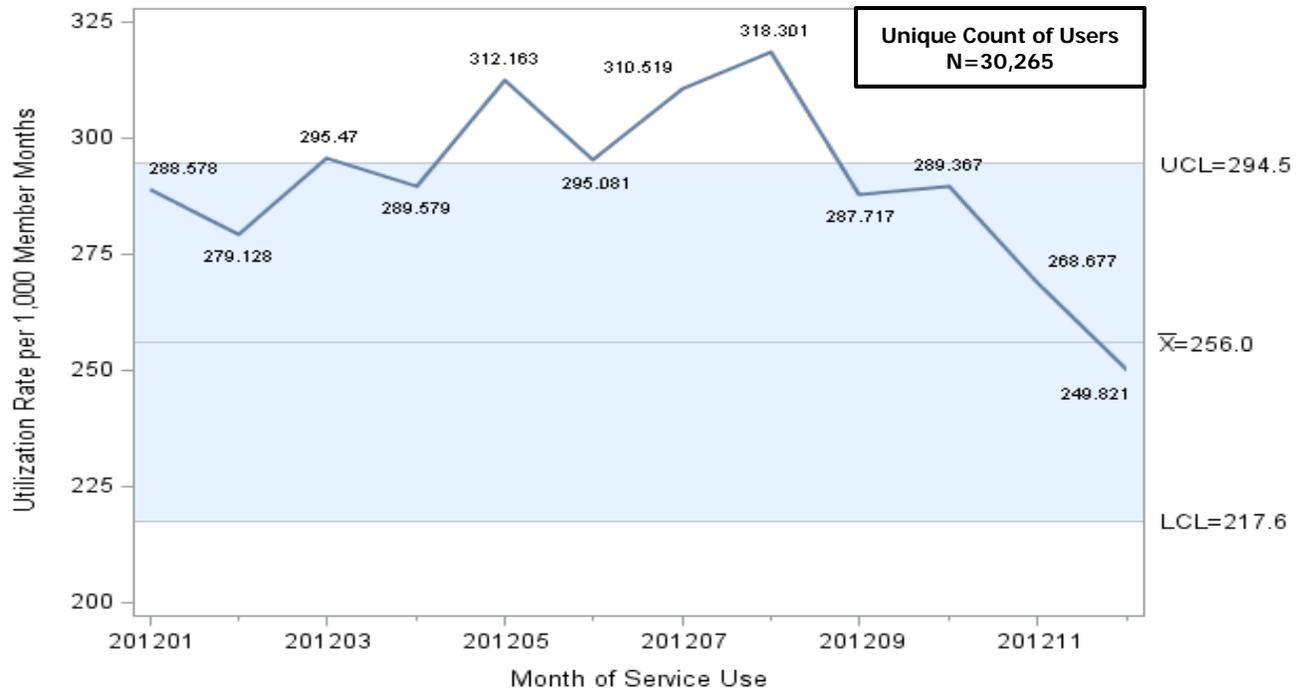


Figure SU-43. Hospital Outpatient Utilization by Adults (Age 21+) in the Families Aid Category for January 2012–December 2012

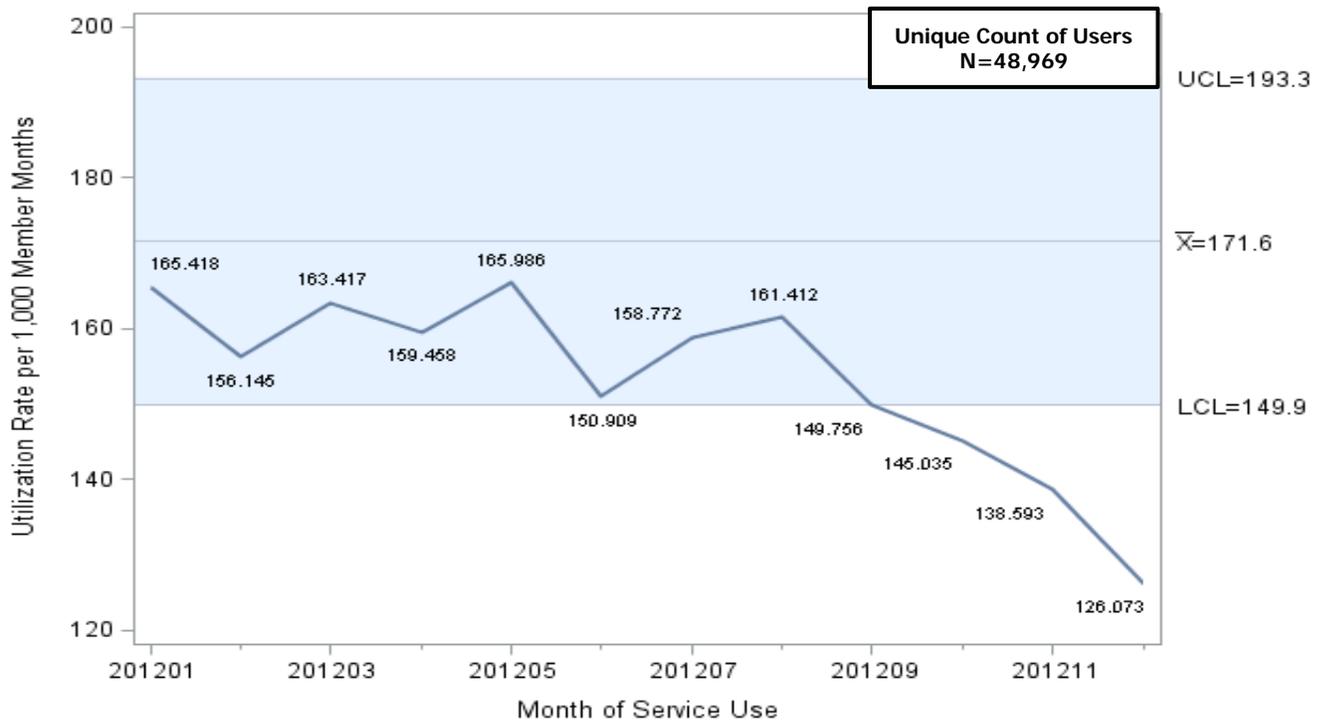


Figure SU-44. Hospital Outpatient Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012

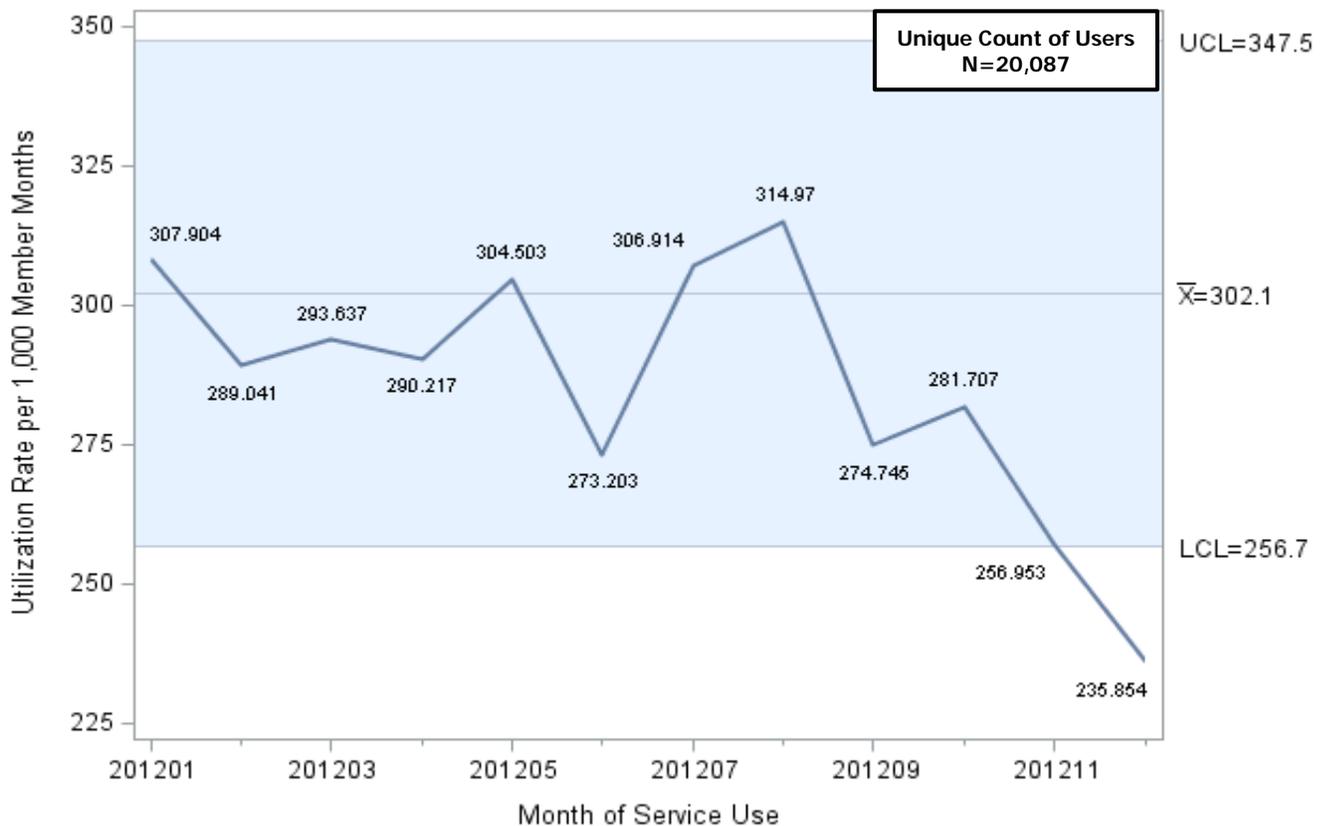
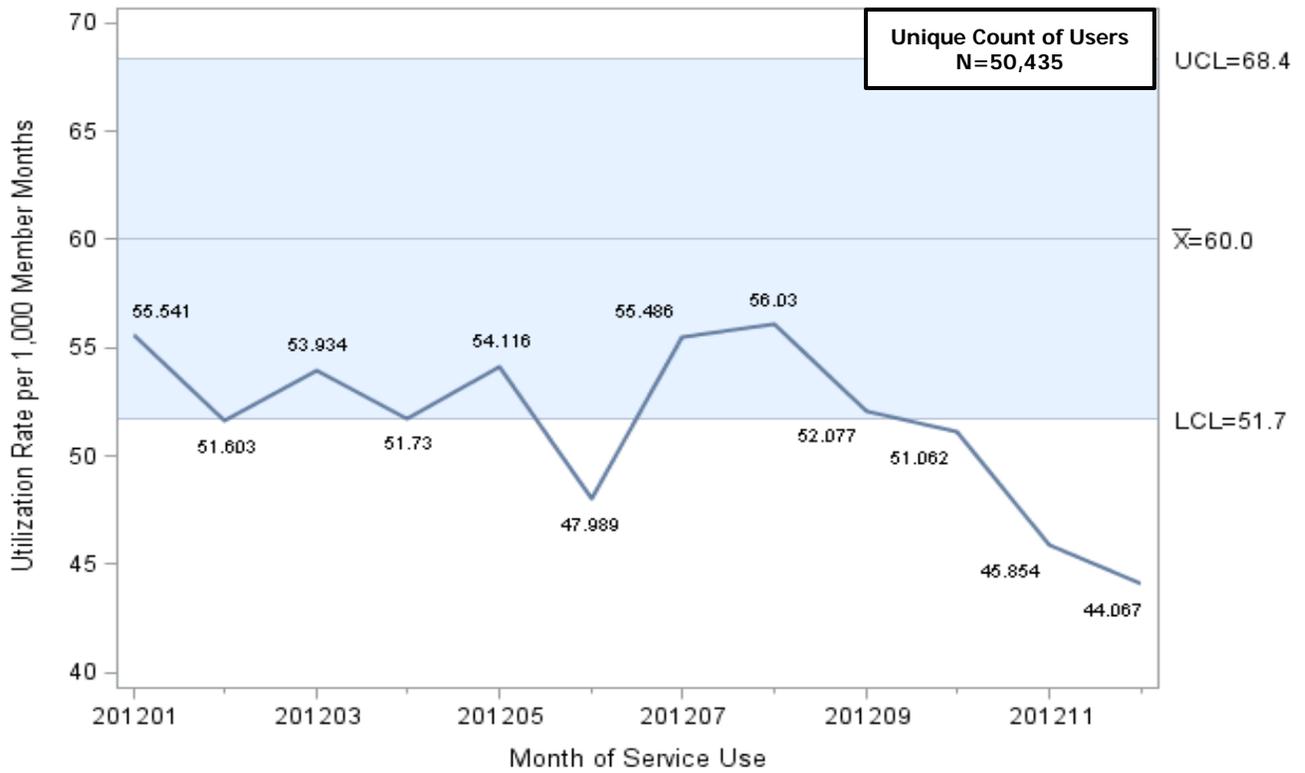


Figure SU-45. Hospital Outpatient Utilization by Adults (Age 21+) in the Undocumented Aid Category for January 2012–December 2012



Source: Data for figures SU-41 to SU-45 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 January 2012–December 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 Blind/Disabled and Other aid categories. Among adults in these aid categories, the monthly Nursing Facility services utilization rates ranged from 1,129.5 to 2,124.7 days per 1,000 member months from the first quarter of 2012 to the fourth quarter of 2012.

The Nursing Facility services utilization rates were again higher for adults in the Other aid category, which is understandable given that this subgroup includes beneficiaries enrolled in long term care aid codes. Although displaying high use, 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 Blind/Disabled aid category continued to display upward trends in utilization of Nursing Facility services that reached levels well above the expected ranges throughout the study period.

These trends highlight how markedly the case mix of the FFS beneficiary population has changed since the baseline utilization rates were established during 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.⁴ This is due to the current Medi-Cal managed care policy that only places the plan at risk for LTC services for the month of admission plus one additional month. Consequently, the case mix of adult beneficiaries who remain in the FFS delivery system can be characterized as those exhibiting health care needs that are much greater than the norm.

Nursing Facility use is now concentrated among two beneficiary subpopulations: adults in the Blind/Disabled and Other aid categories. Use rates for adults in the Blind/Disabled aid category nearly doubled during the study period.

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

⁴ This policy applies to managed care plans operating in Two-Plan and GMC counties.

Medi-Cal FFS beneficiaries in the Undocumented aid category are not eligible for Nursing Facility services and were subsequently excluded from this analysis. Additionally, adults in the Aged and Families aid categories 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 first quarter of 2012 to the fourth quarter of 2012.

Trends of Monthly Nursing Facility Services Utilization by Adults for January 2012–December 2012

Figure SU-46. Nursing Facility Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012

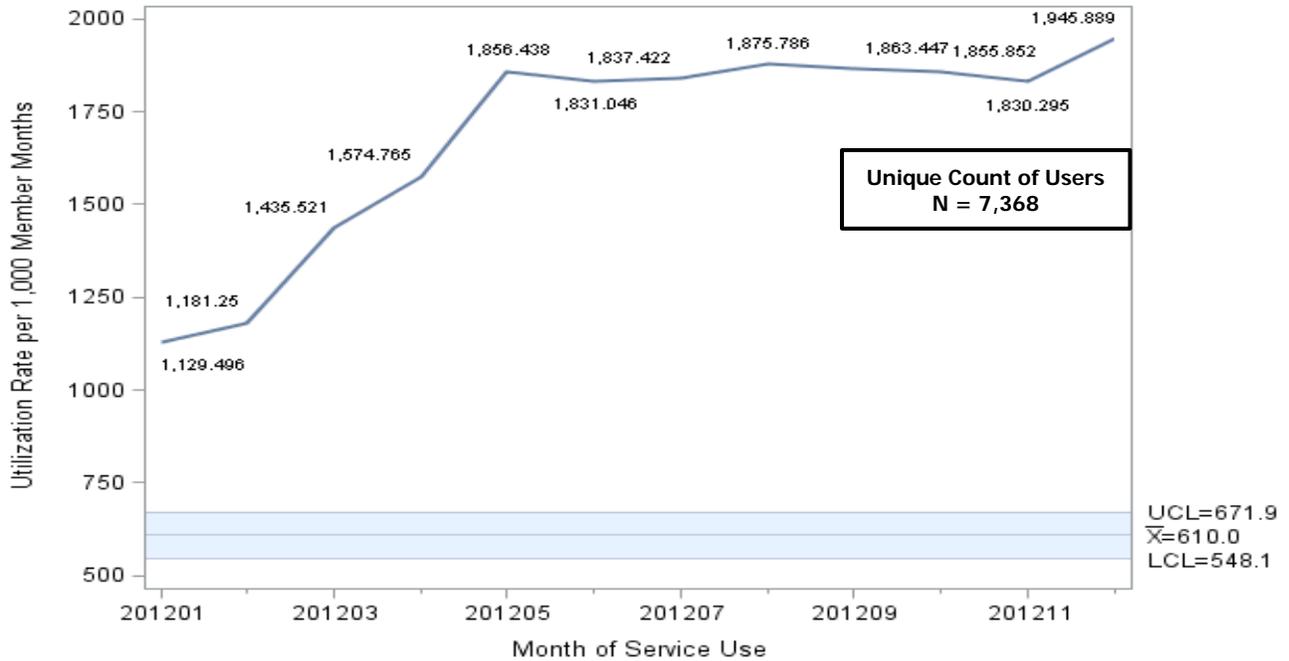
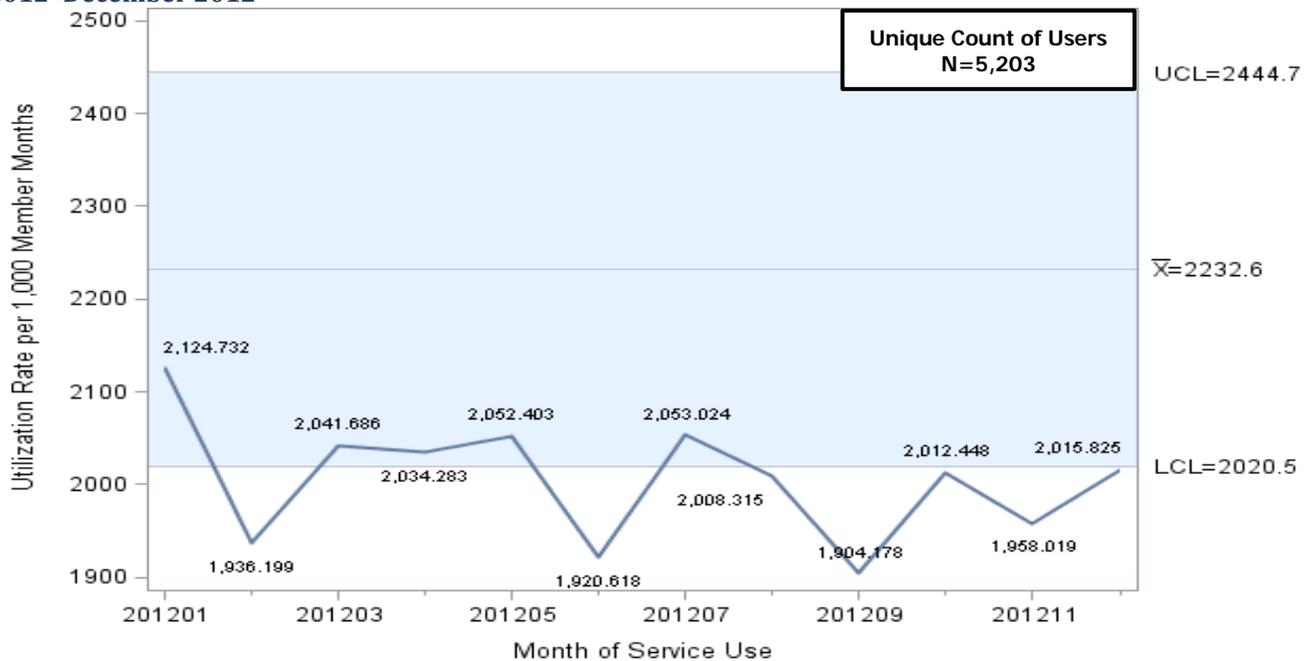


Figure SU-47. Nursing Facility Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012



Source: Data for figures SU-46 and 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 January 2012–December 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.

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 64.7 to 1,521.9 prescriptions per 1,000 member months from the first quarter of 2012 to the fourth quarter of 2012.

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.

Among children in the Blind/Disabled aid category, Pharmacy services use is 2-6 times higher than for children in 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 during the third quarter of the study period. Additionally, children in the Blind/Disabled aid category exhibited above average utilization that ultimately reached above the baseline ranges during the initial quarter of the study period before declining back to normal levels in the last three 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 exhibited normal use patterns.

Adults

Among adults 21 and older, monthly Pharmacy services utilization rates ranged from 172.9 to 3,204.9 prescriptions per 1,000 member months from the first quarter of 2012 to the fourth quarter of 2012.

Similar to the trends identified in the prior access quarterly reports, Pharmacy services utilization was again noticeably higher among adults in the Blind/Disabled aid category. Additionally, adults in the Aged and Other aid categories exhibited significant utilization rates of pharmacy services, while adults in the Undocumented aid category utilized these services at much lower rates. Adults in the Aged, Blind/Disabled, and Families 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 that fell below the baseline throughout most of the study period. Additionally, adults in the Blind/Disabled and Families aid categories displayed downward trends in utilization rates that at times fell below the expected ranges. In contrast, Pharmacy services utilization rates for adults in the Other and Undocumented aid groups again fell within the expected ranges.

In 2012, Pharmacy services use declined among adults in the Aged, Blind/Disabled, and Families aid categories.

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

Trends of Monthly Pharmacy Services Utilization Rates by Children for January 2012–December 2012

Figure SU-48. Pharmacy Utilization by Children (Age 0-20) in the Blind/Disabled Aid Category for January 2012–December 2012

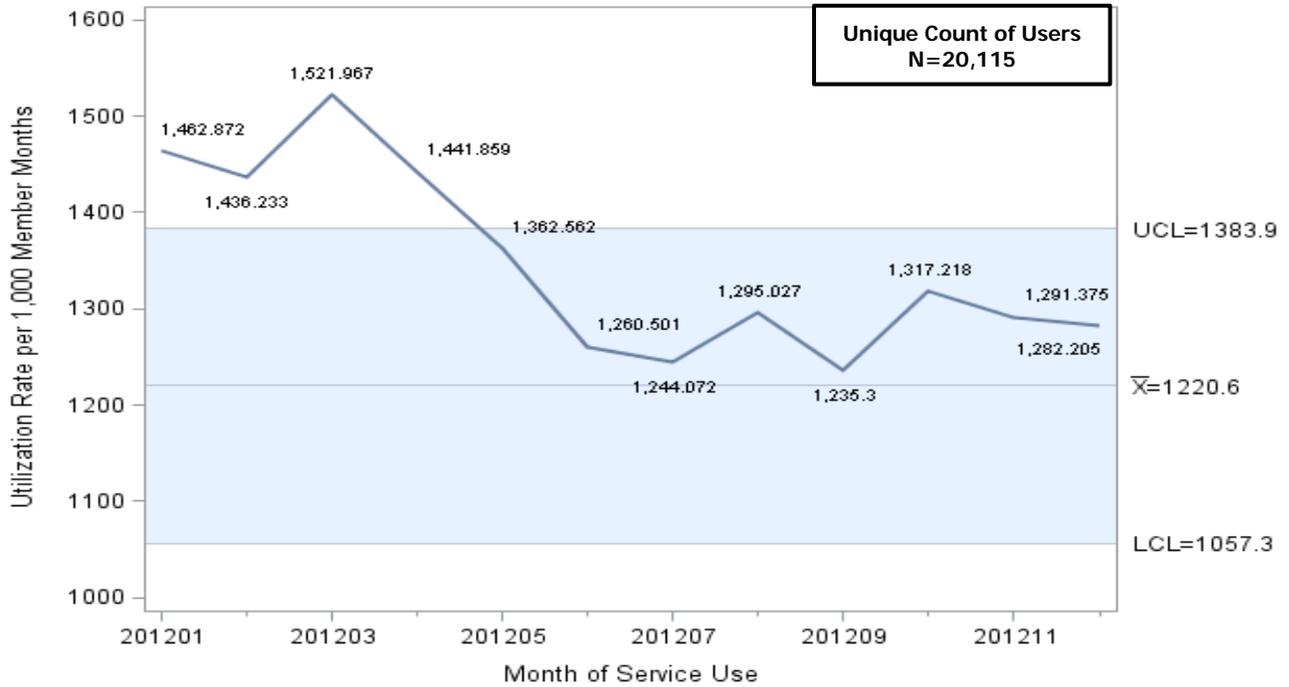


Figure SU-49. Pharmacy Utilization by Children (Age 0-20) in the Families Aid Category for January 2012–December 2012

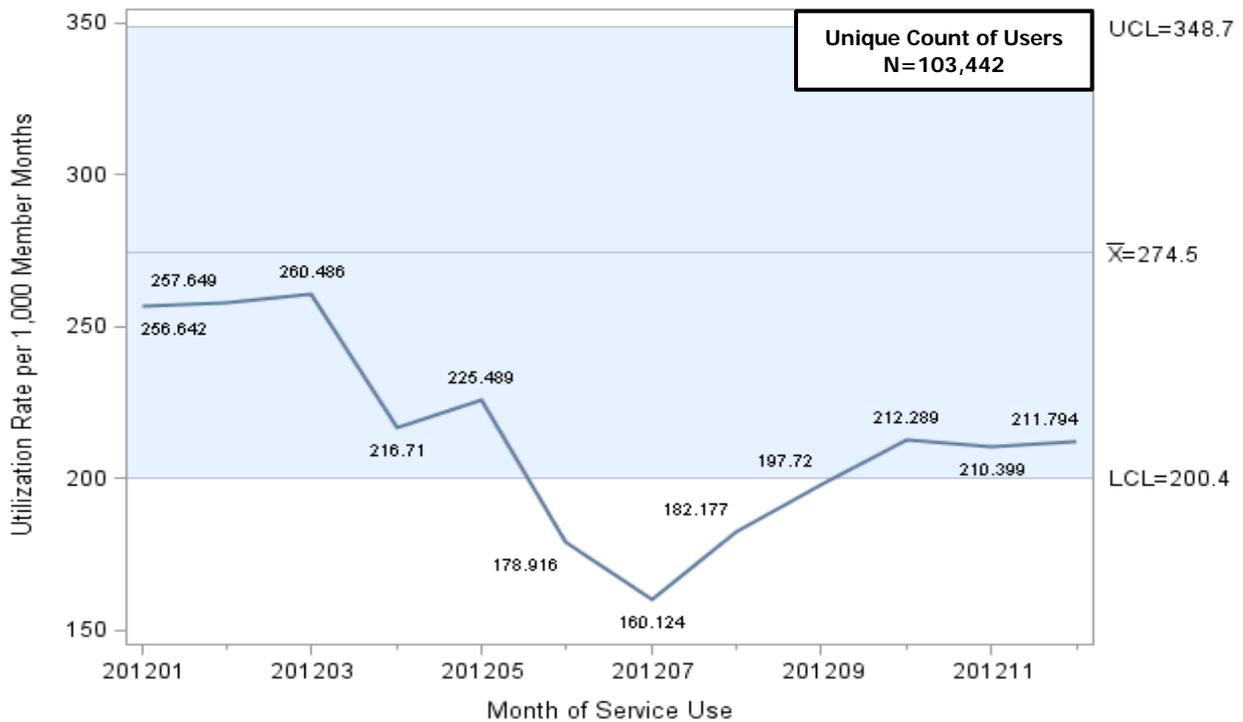


Figure SU-50. Pharmacy Utilization by Children (Age 0-20) in the Foster Care Aid Category for January 2012–December 2012

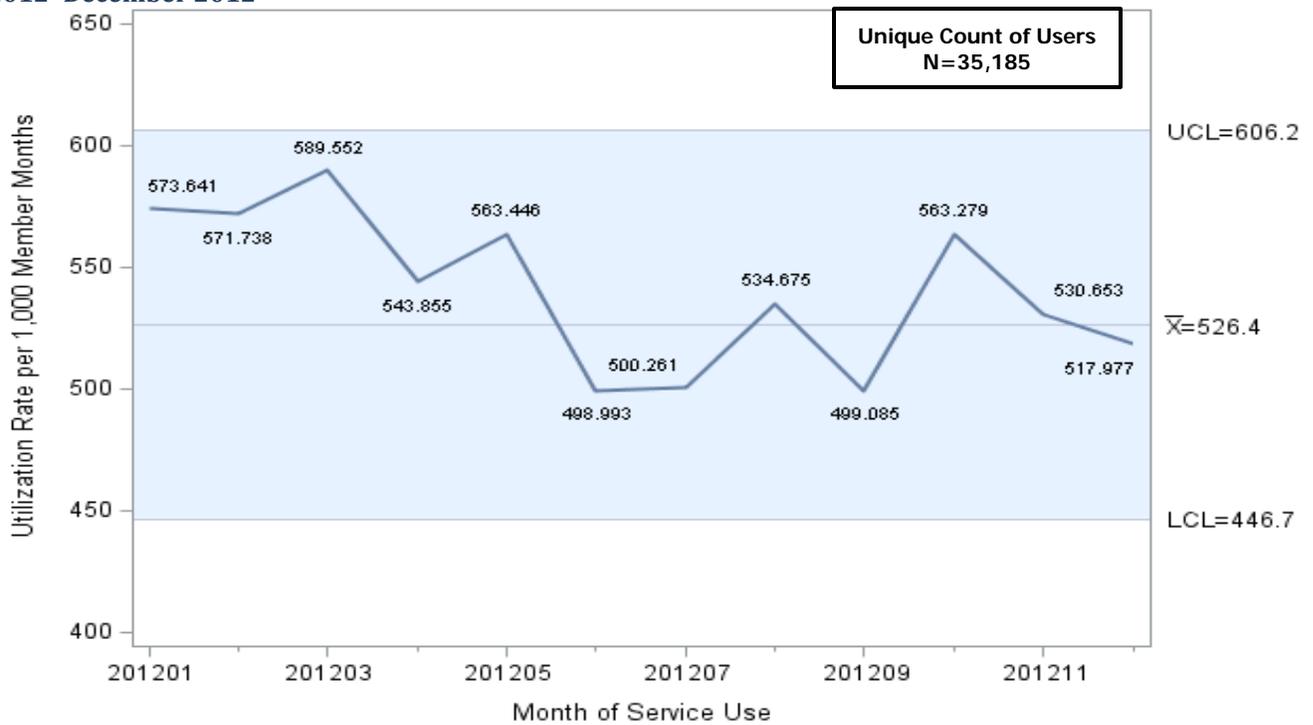


Figure SU-51. Pharmacy Utilization by Children (Age 0-20) in the Other Aid Category for January 2012–December 2012

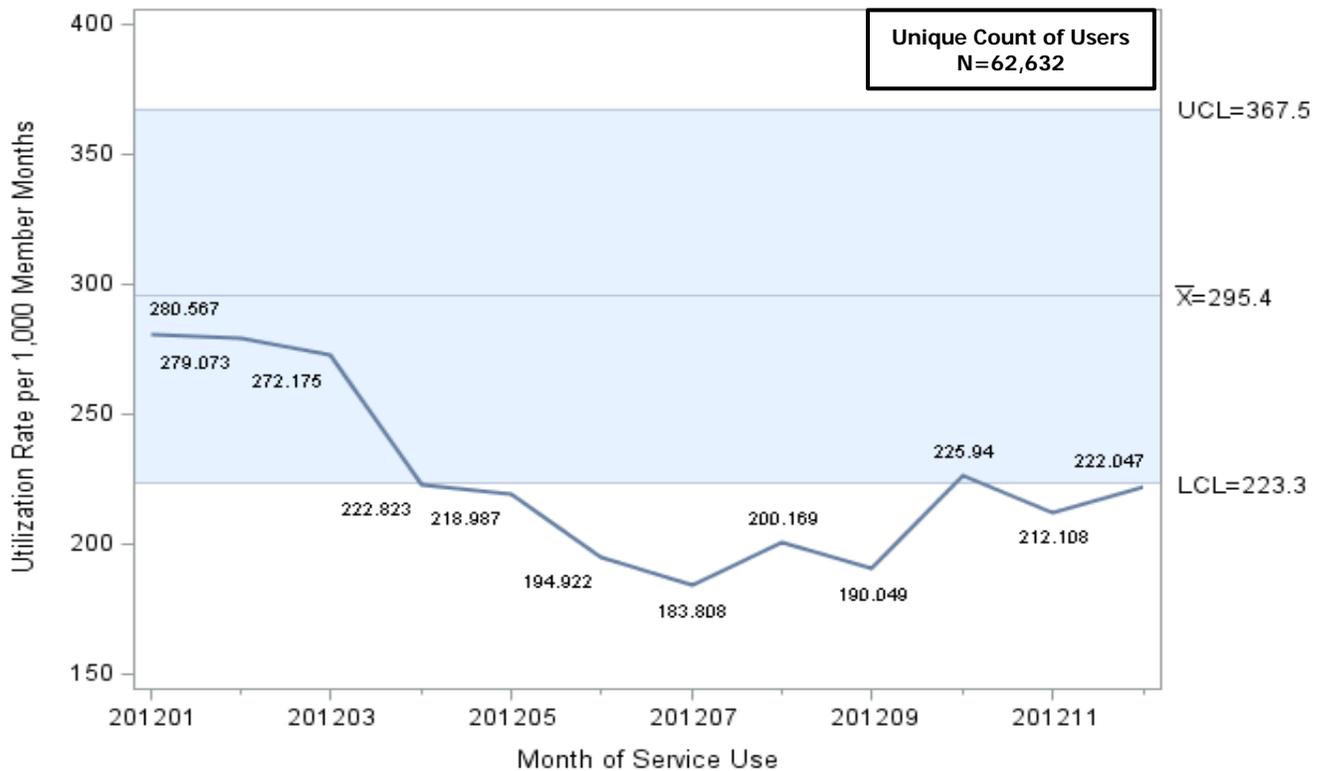
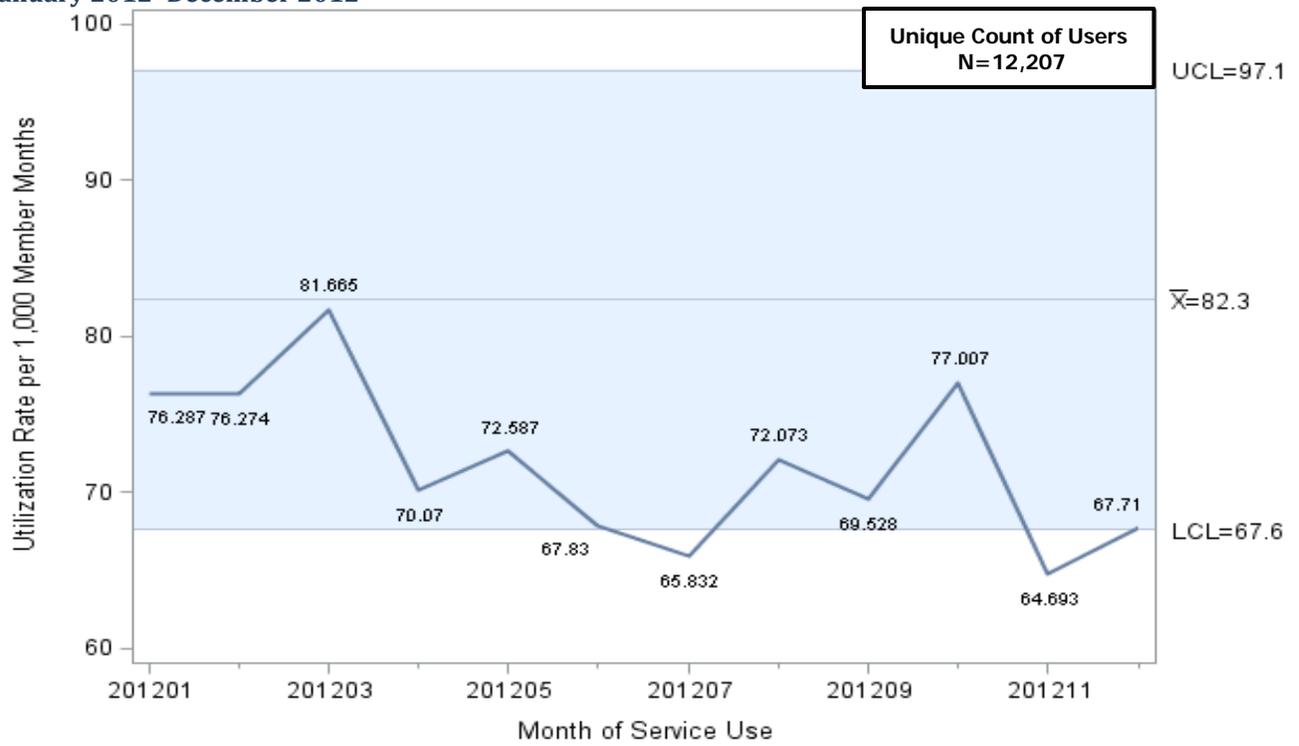


Figure SU-52. Pharmacy Utilization by Children (Age 0-20) in the Undocumented Aid Category for January 2012–December 2012



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

Trends of Monthly Pharmacy Services Utilization Rates by Adults for January 2012–December 2012

Figure SU-53. Pharmacy Utilization by Adults (Age 21+) in the Aged Aid Category for January 2012–December 2012

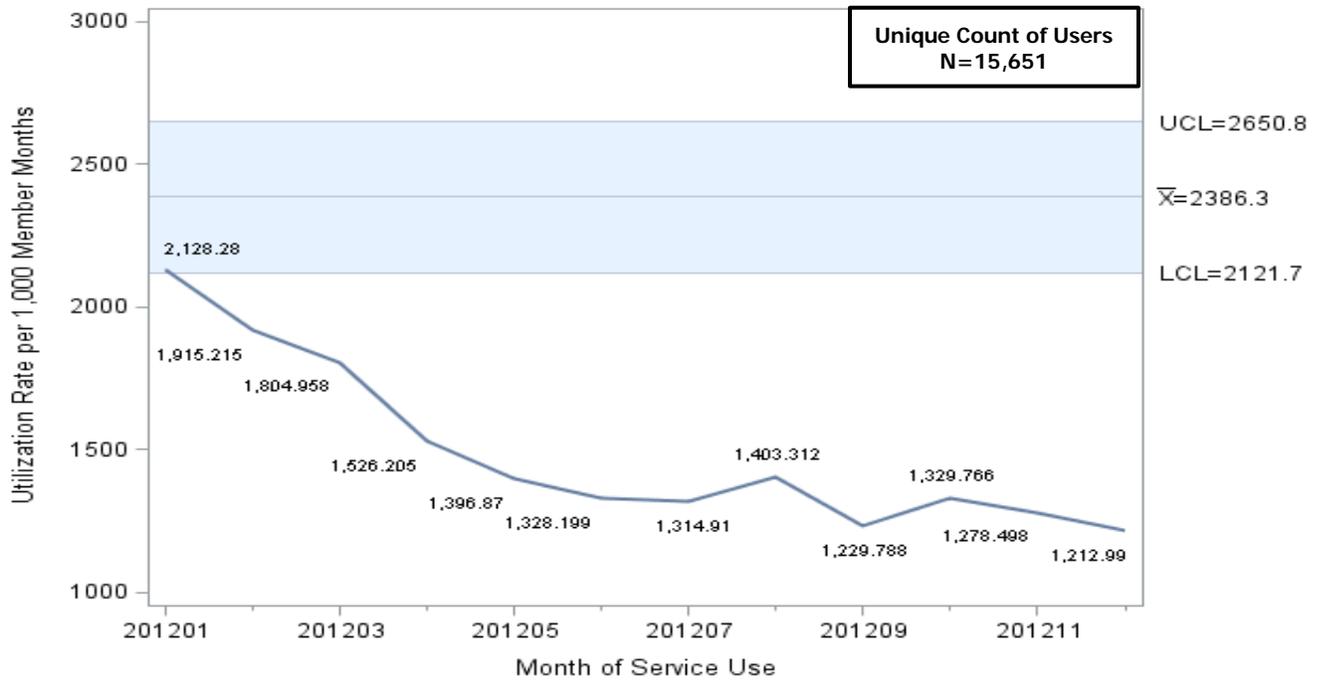


Figure SU-54. Pharmacy Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012

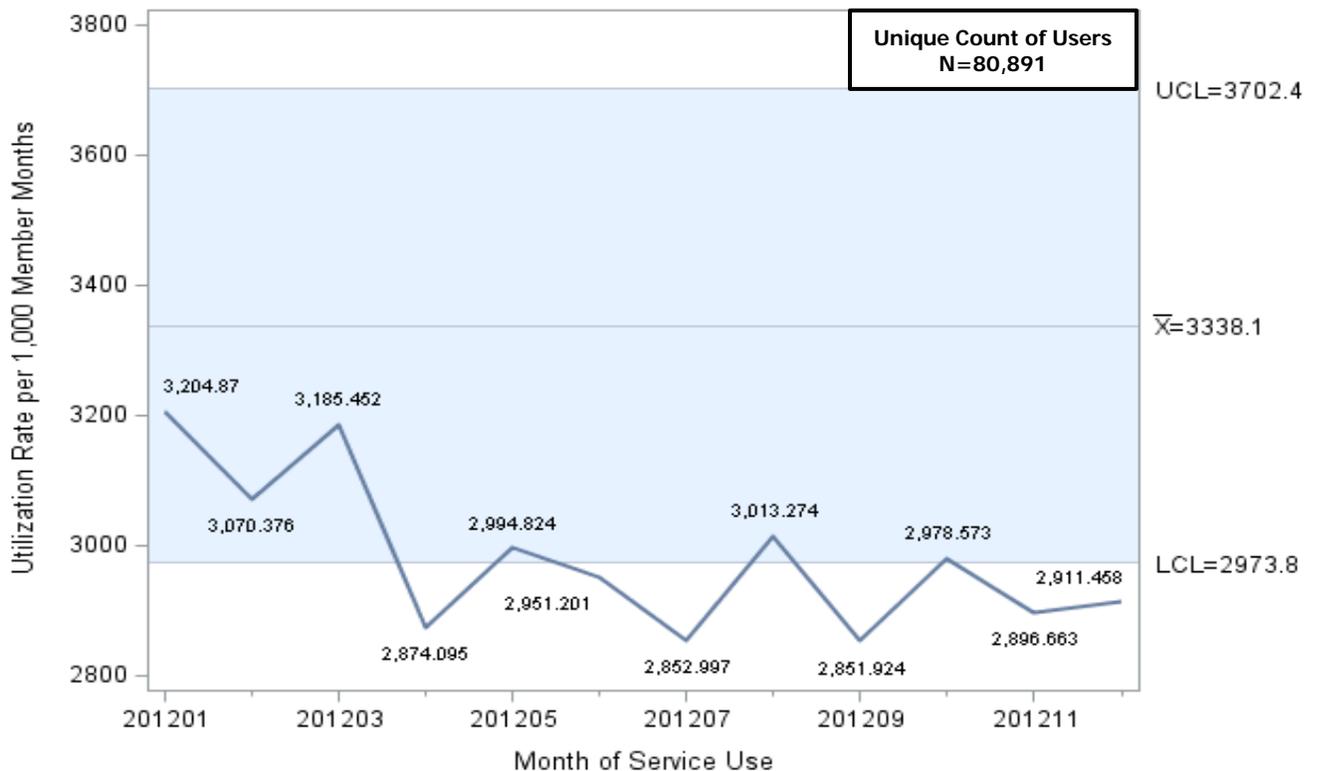


Figure SU-55. Pharmacy Utilization by Adults (Age 21+) in the Families Aid Category for January 2012–December 2012

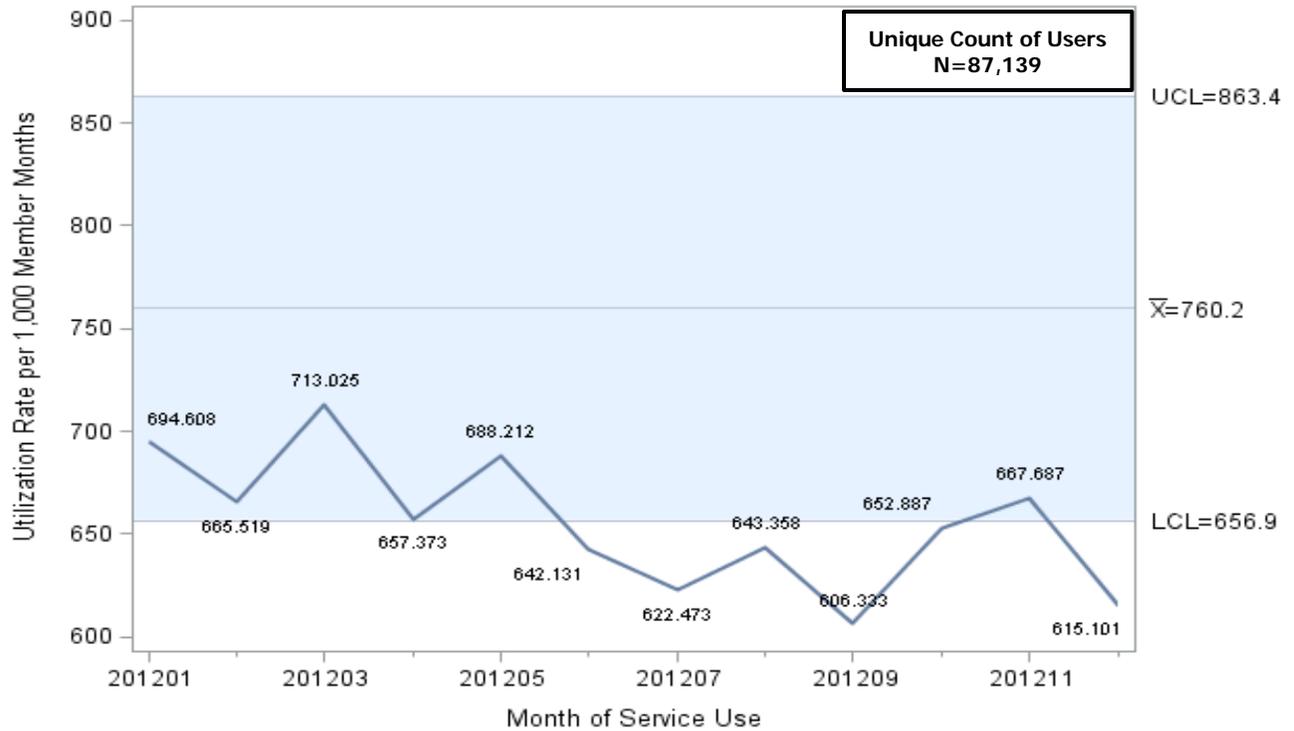


Figure SU-56. Pharmacy Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012

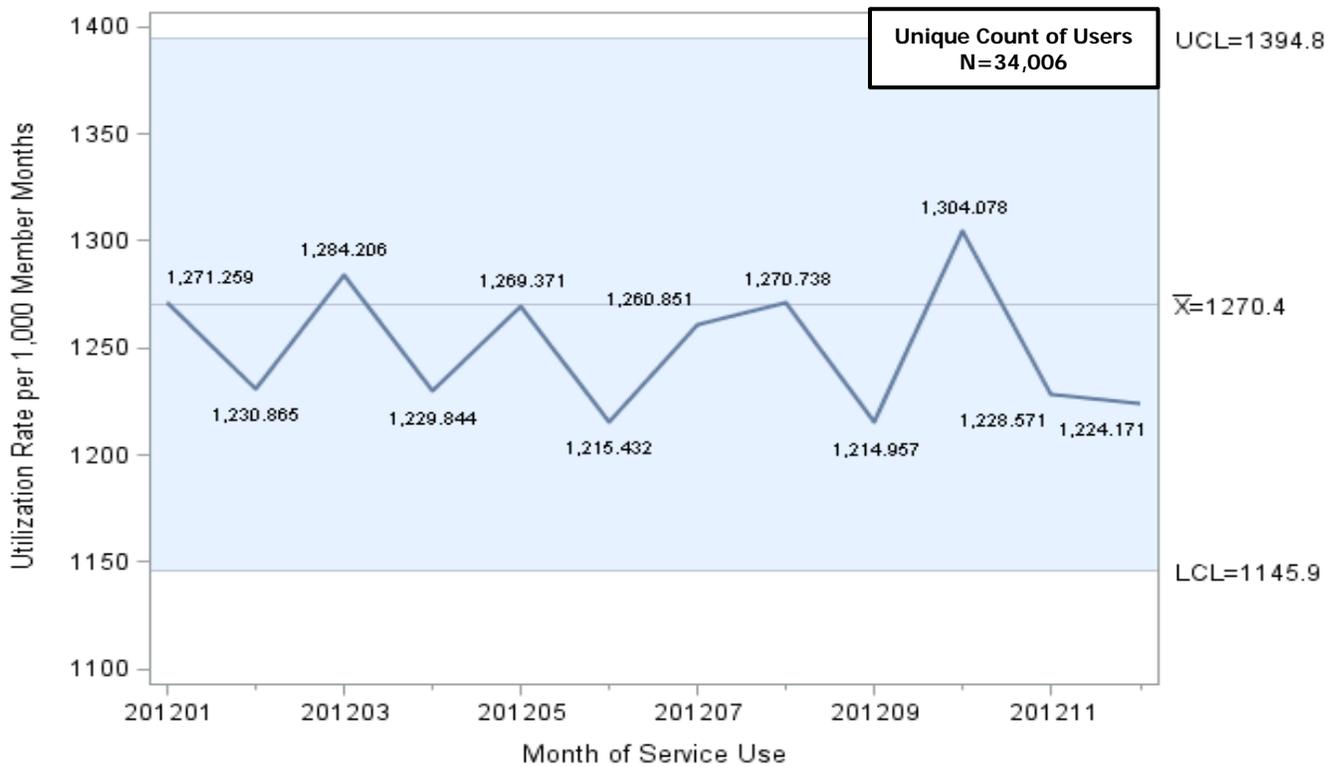
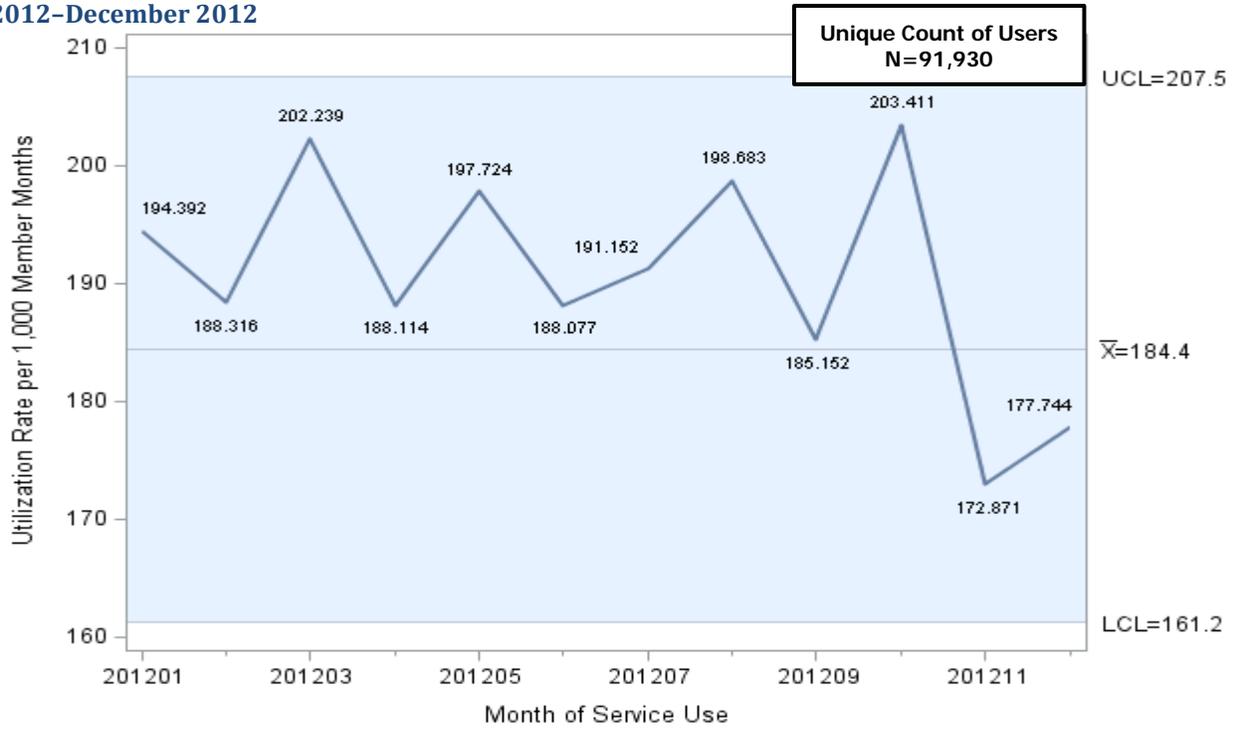


Figure SU-57. Pharmacy Utilization by Adults (Age 21+) in the Undocumented Aid Category for January 2012–December 2012



Source: Data for figures SU-53 to SU-57 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 January 2012 –December 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 to 1,305.1 visits per 1,000 member months from the first quarter of 2012 to the fourth quarter of 2012.

Children in most aid categories exhibited use of Other services at rates within the expected range, while those in the Undocumented aid category used Other services at rates below baseline levels.

Similar to the prior reporting period, the utilization of Other services was again noticeably higher among children in the Blind/Disabled aid category. Children in the Blind/Disabled, Families, Foster Care, and Other aid categories exhibited utilization of Other services within the expected ranges. In contrast, children in the Undocumented aid category exhibited below average utilization that fell below the expected ranges observed in the baseline period of 2007–2009.

Adults

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

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

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

Trends of Monthly Other Services Utilization Rates by Children for January 2012–December 2012

Figure SU-58. Other Services Utilization by Children (Age 0–20) in the Blind/Disabled Aid Category for January 2012–December 2012

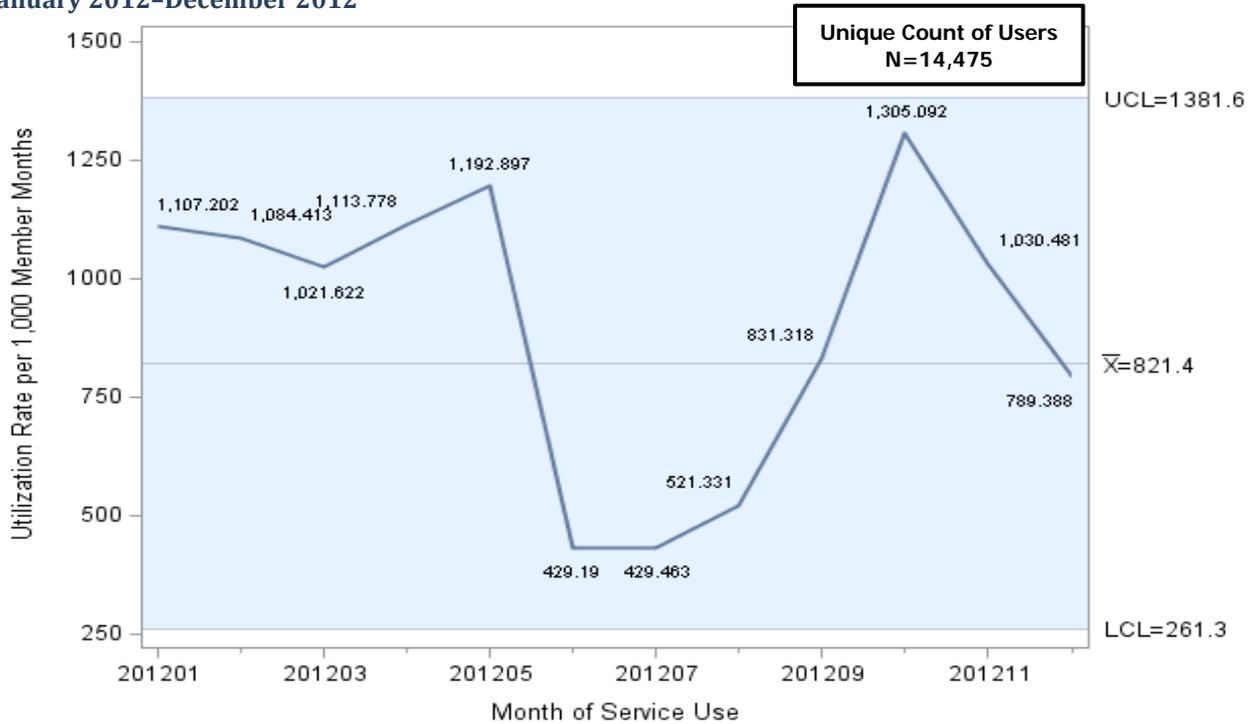


Figure SU-59. Other Services Utilization by Children (Age 0–20) in the Families Aid Category for January 2012–December 2012

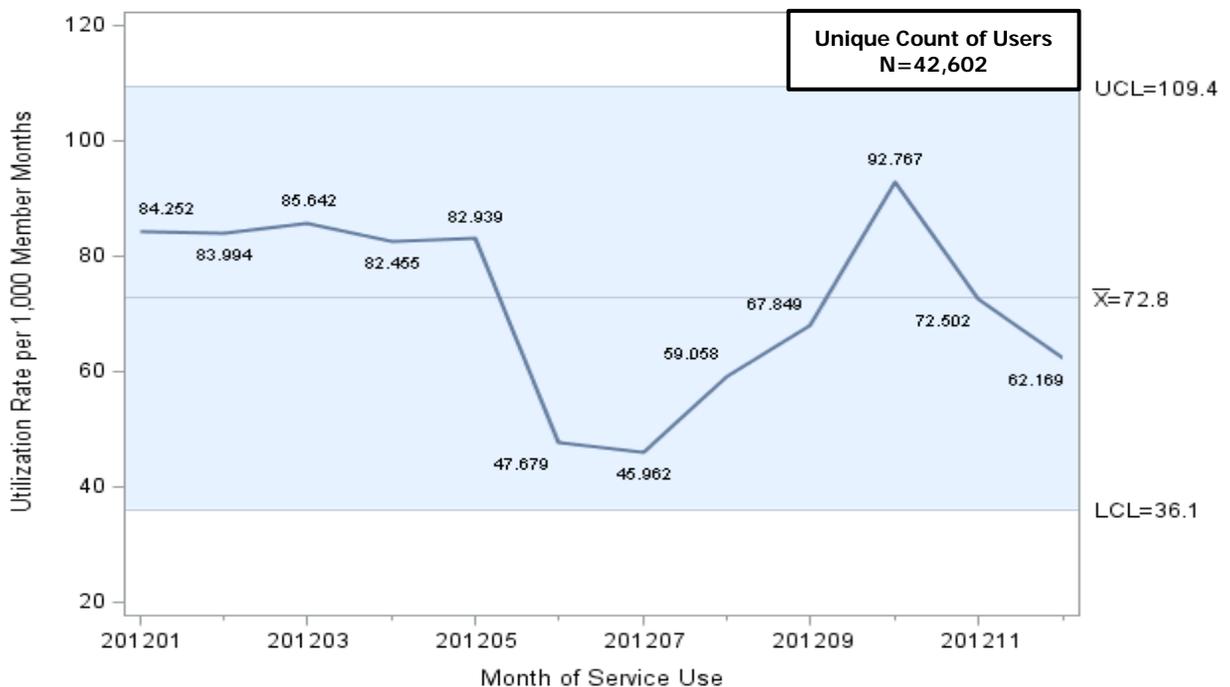


Figure SU-60. Other Services Utilization by Children (Age 0-20) in the Foster Care Aid Category for January 2012–December 2012

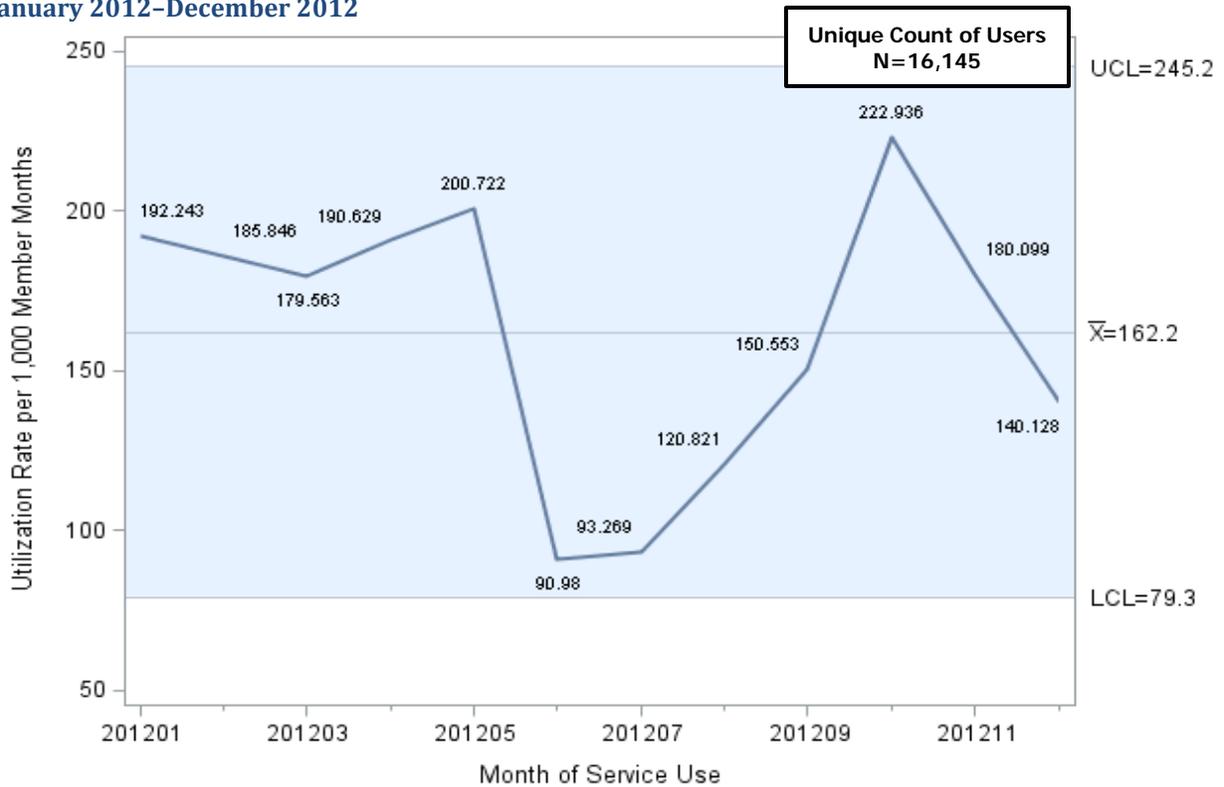


Figure SU-61. Other Services Utilization by Children (Age 0-20) in the Other Aid Category for January 2012–December 2012

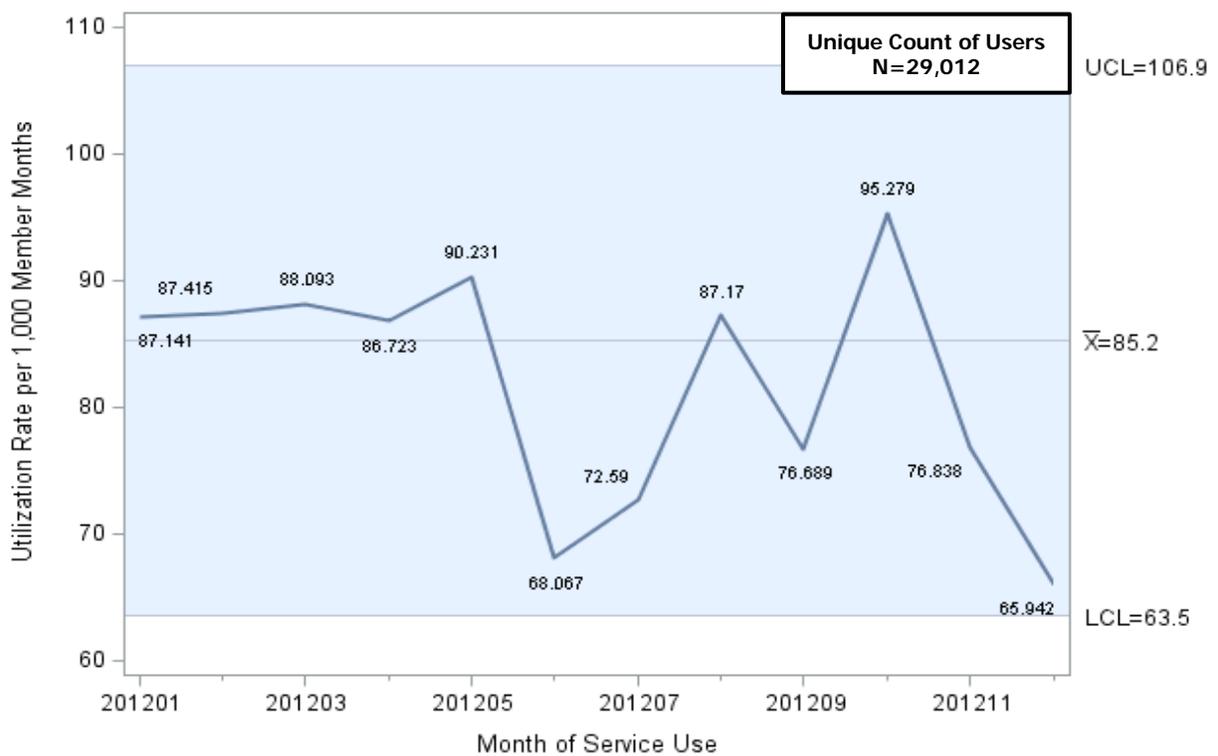
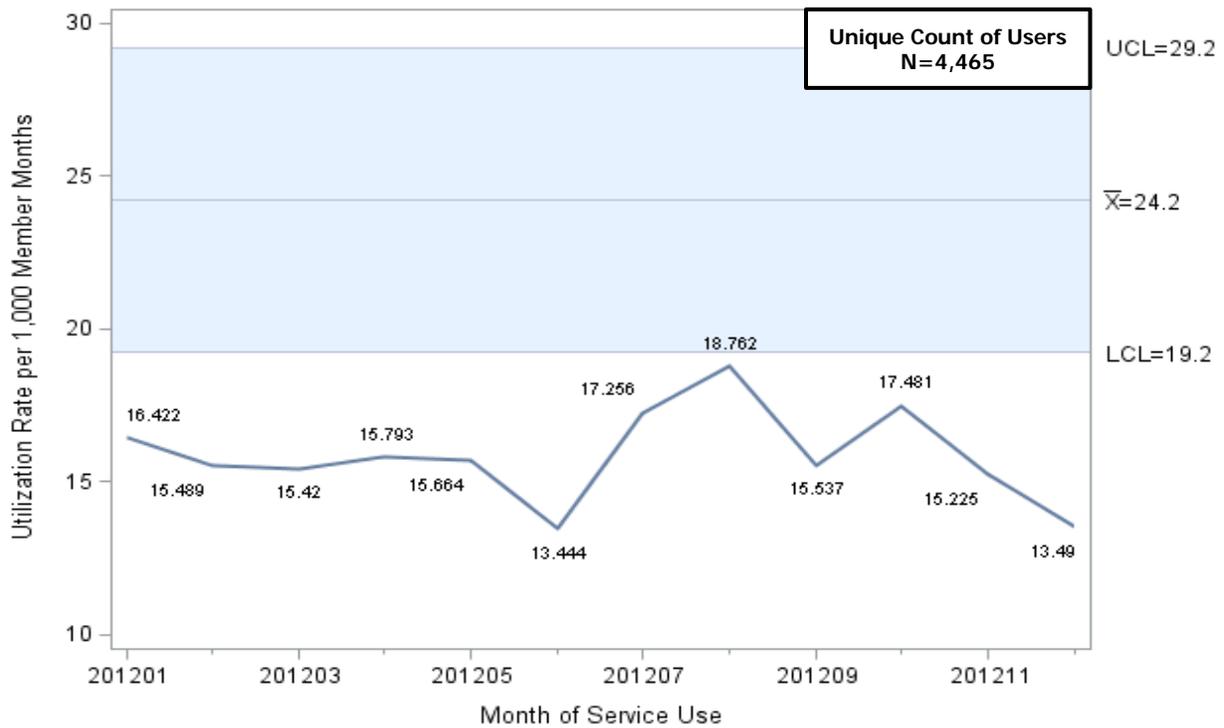


Figure SU-62. Other Services Utilization by Children (Age 0–20) in the Undocumented Aid Category for January 2012–December 2012



Source: Data for figures SU-58 to SU-62 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 January 2012–December 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends of Monthly Other Services Utilization Rates by Adults for January 2012–December 2012

Figure SU-63. Other Services Utilization by Adults (Age 21+) in the Aged Aid Category for January 2012–December 2012

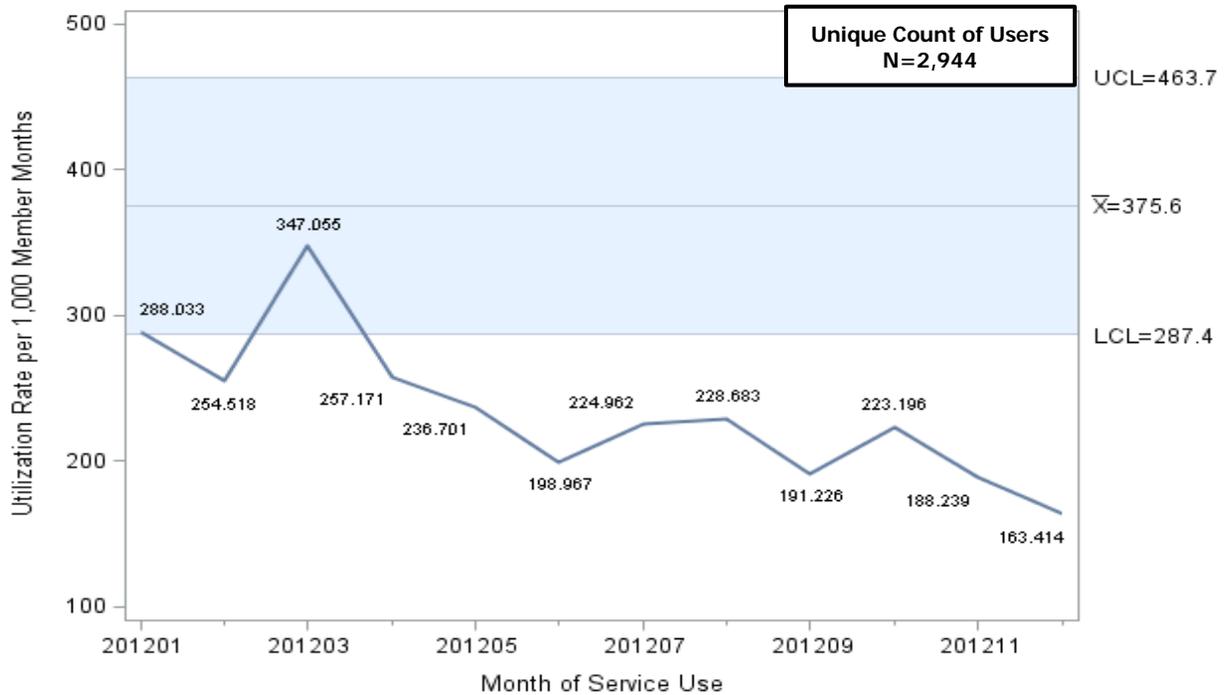


Figure SU-64. Other Services Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for January 2012–December 2012

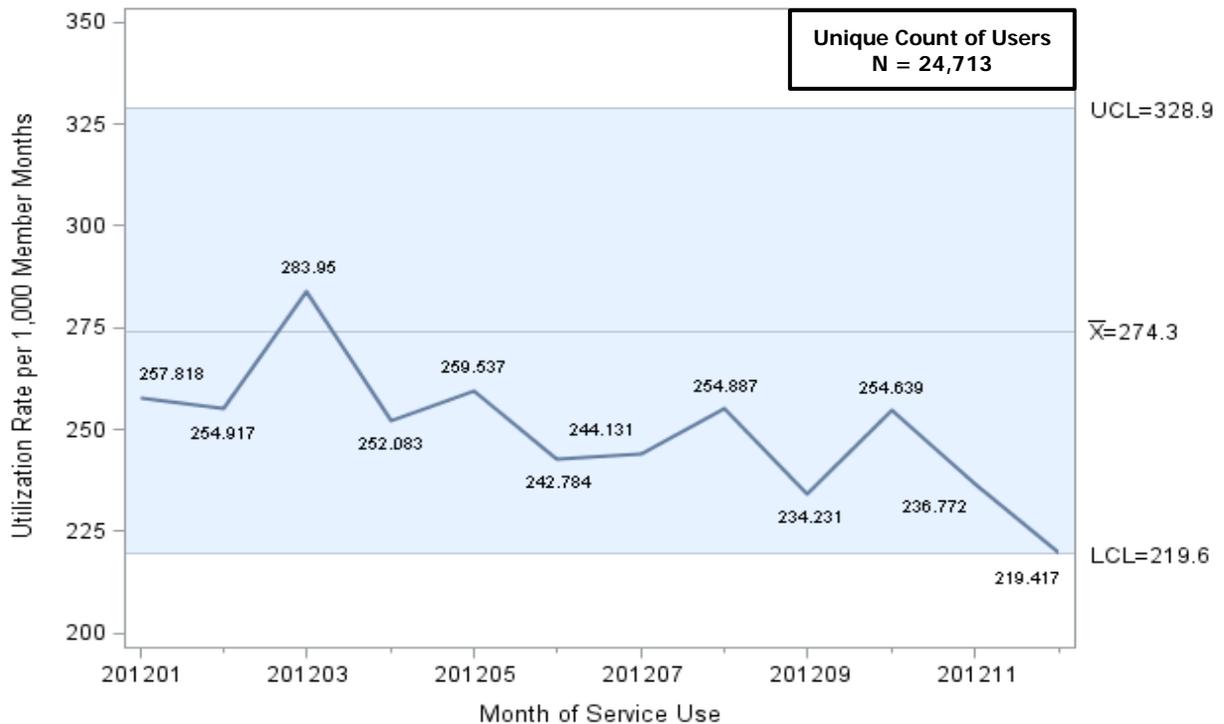


Figure SU-65. Other Services Utilization by Adults (Age 21+) in the Families Aid Category for January 2012–December 2012

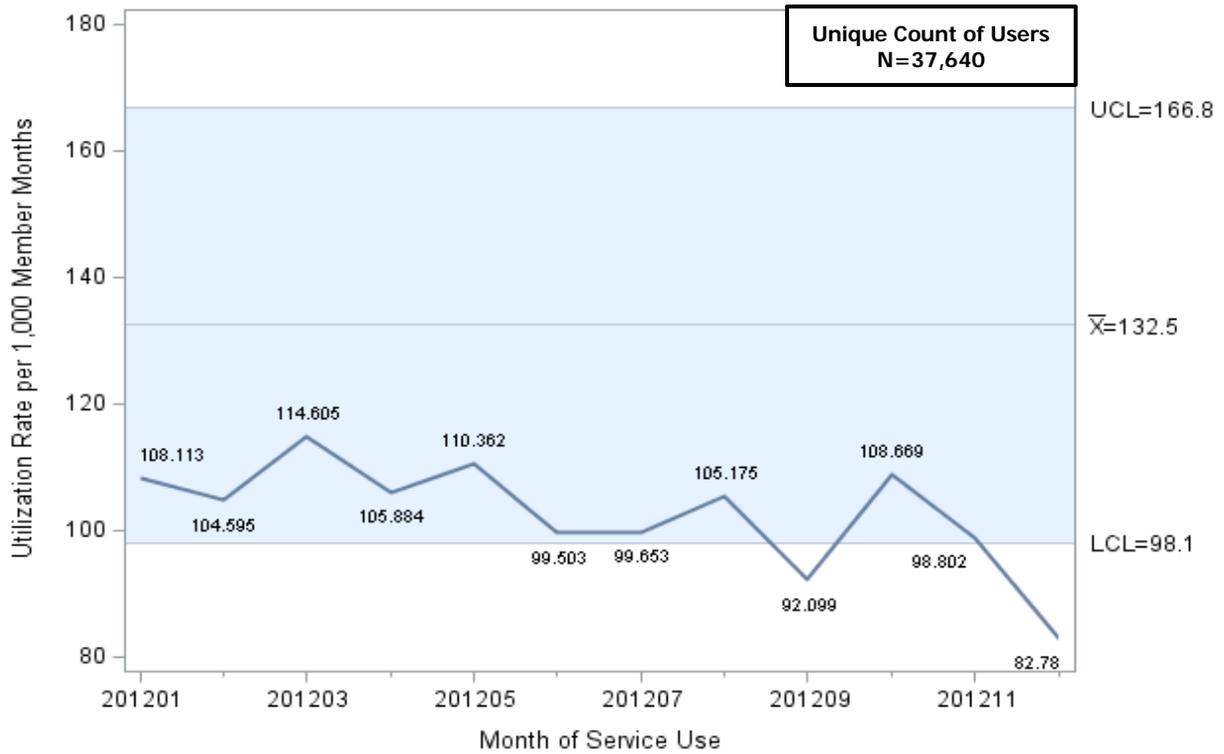


Figure SU-66. Other Services Utilization by Adults (Age 21+) in the Other Aid Category for January 2012–December 2012

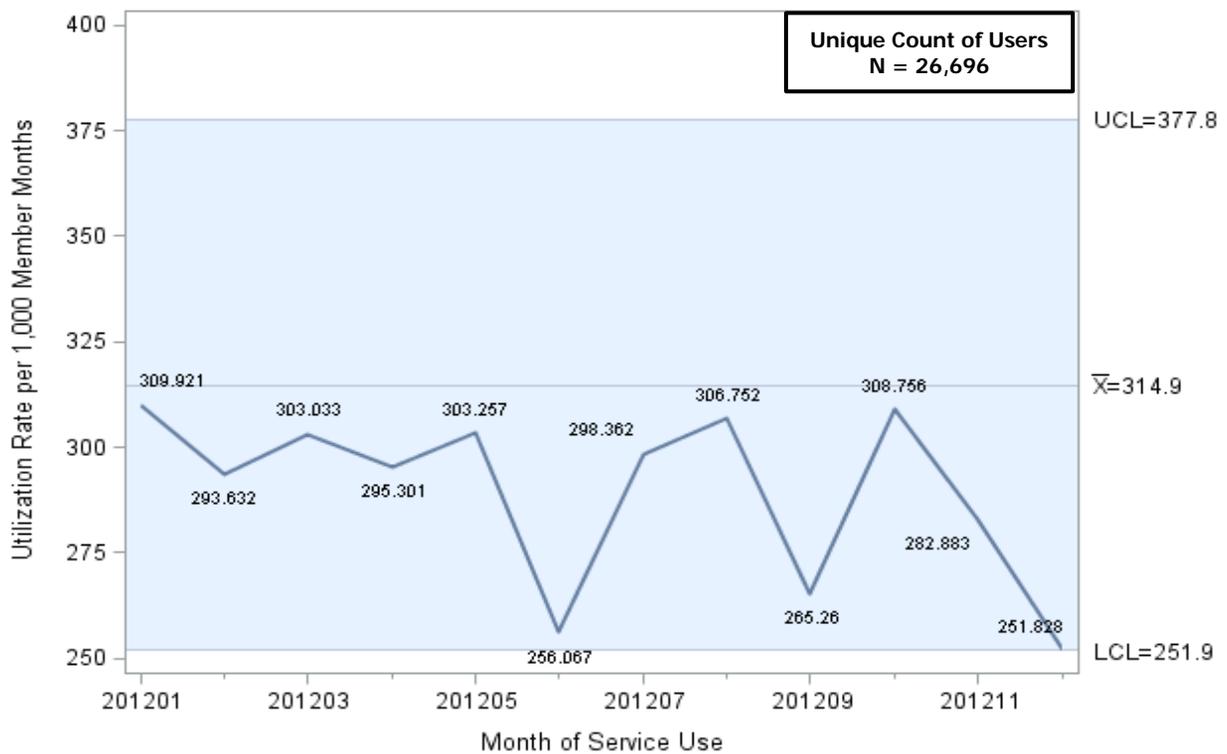
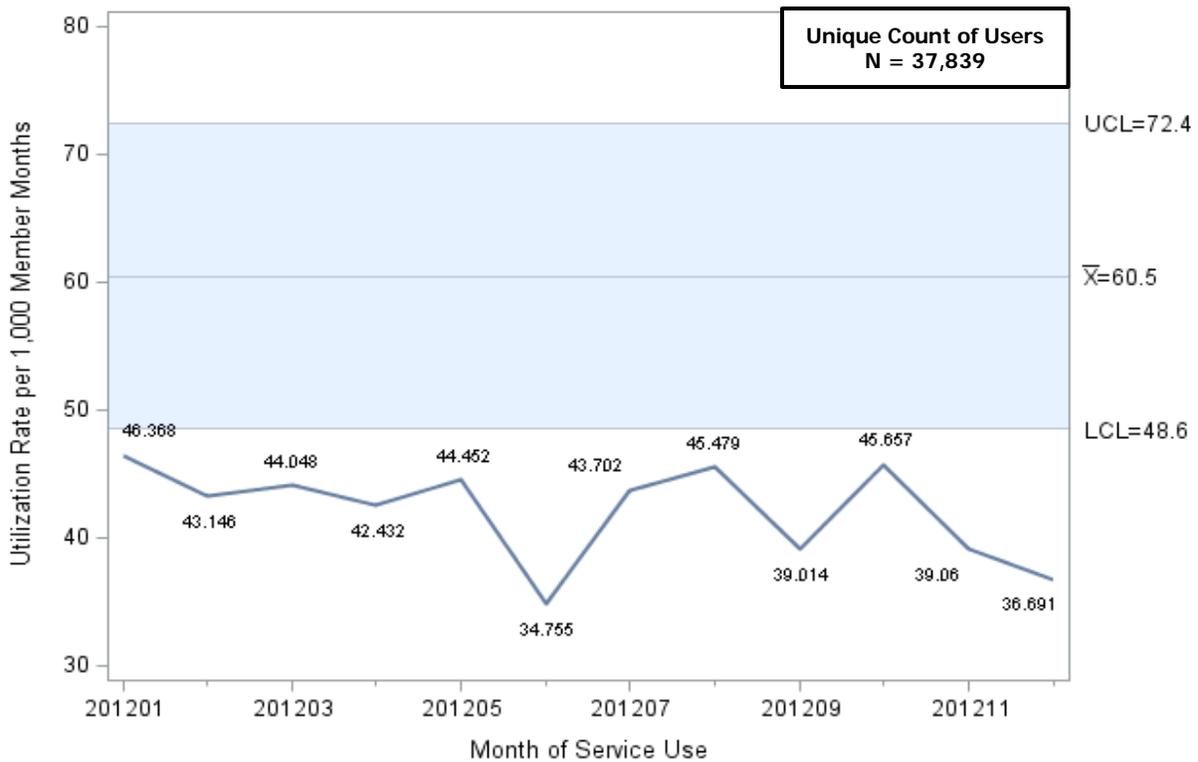


Figure SU-67. Other Services Utilization by Adults (Age 21+) in the Undocumented Aid Category for January 2012–December 2012



Source: Data for figures SU-63 to SU-67 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 January 2012–December 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Radiology Services

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.^{5,6}

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

⁵ Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (<http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/downloads/HowObtainCLIACertificate.pdf>).

⁶ You can view additional information on radiology services at www.medi-cal.ca.gov under the Publications tab, go to Provider Manuals and select the [Clinics and Hospitals link](#).

Trend Analysis

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

Children

Among children age 0–20 in the Medi-Cal FFS program, monthly Radiology services utilization rates ranged from 31.1–105.1 visits per 1,000 member months during the third and fourth quarters of 2012. Radiology services utilization was again noticeably higher among children in the Blind/Disabled aid category with rates ranging from two to three times higher than for children in any other aid category. The Radiology services utilization rates exhibited by children in the Foster Care aid category continued to closely follow the average rates observed in the baseline period of 2007–2009. Children in the Blind/Disabled, Families, Foster Care, and Undocumented aid categories displayed service use rates that fell within the baseline ranges, while rates for those 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 51.4 to 329.3 visits per 1,000 member months during the third and fourth quarters of 2012. Services utilization rates were again 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 continued to be 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 Aged and Blind/Disabled aid categories were above average and at times reached levels above the expected baseline ranges.

Charts SU-68 to SU-77 represent the analysis of Radiology services utilization for both children and adults during the third and fourth quarters of 2012.

Trends of Monthly Radiology Services Utilization Rates by Children for July 2012–December 2012

Figure SU-68. Radiology Utilization by Children (Age 0-20) in the Blind/Disabled Aid Category for July 2012–December 2012

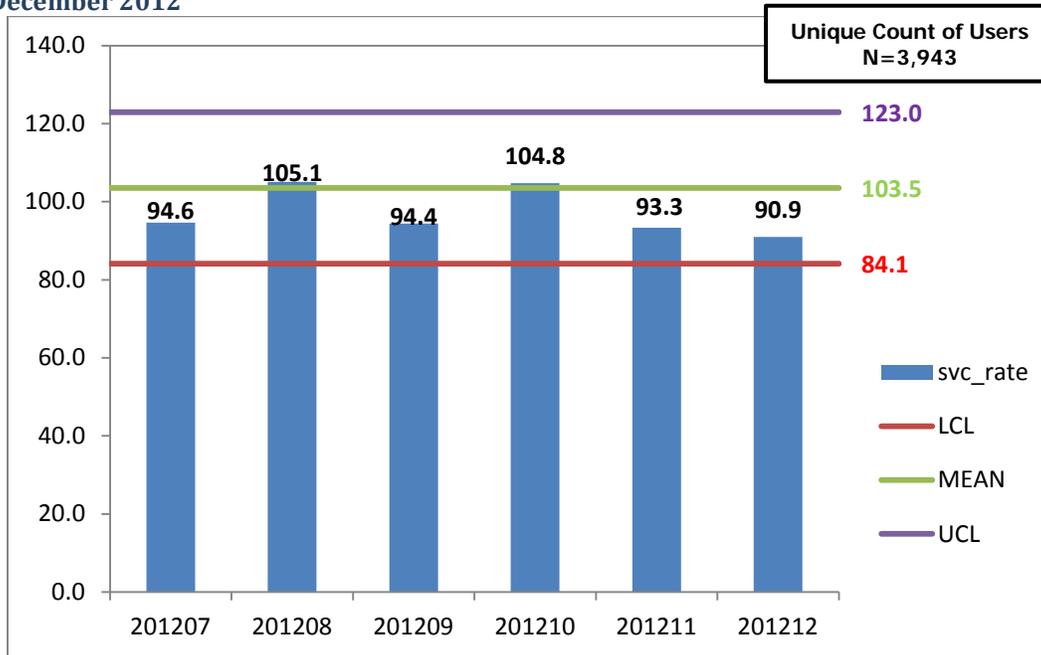


Figure SU-69. Radiology Utilization by Children (Age 0-20) in the Families Aid Category for July 2012–December 2012

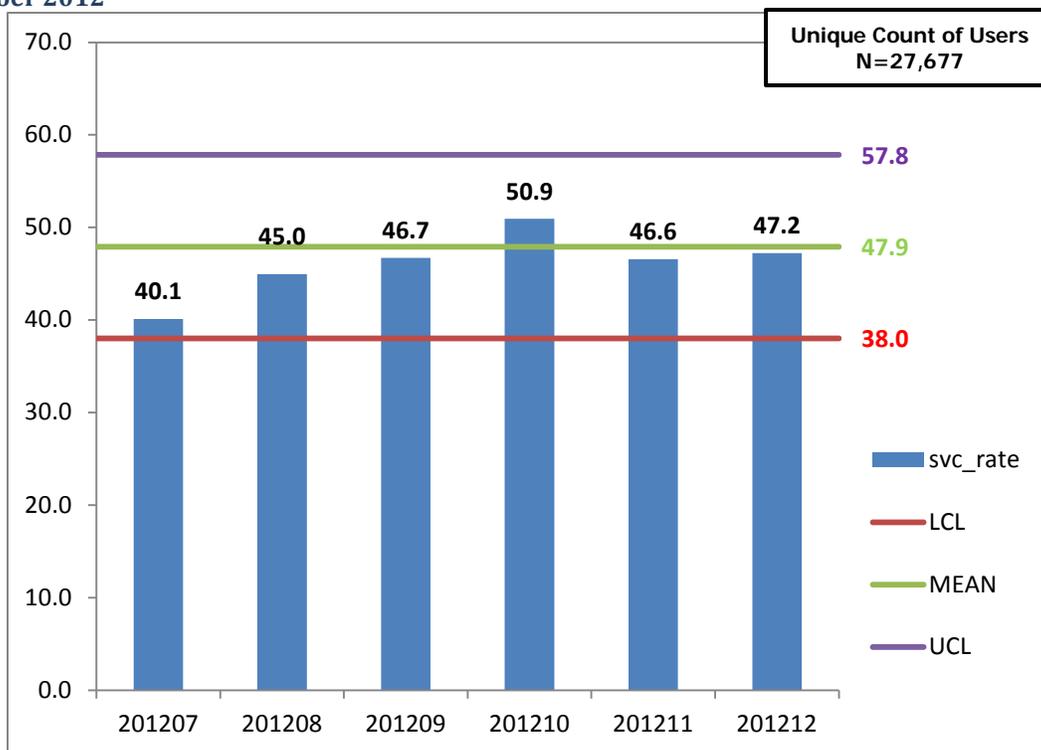


Figure SU-70. Radiology Utilization by Children (Age 0-20) in the Foster Care Aid Category for July 2012–December 2012

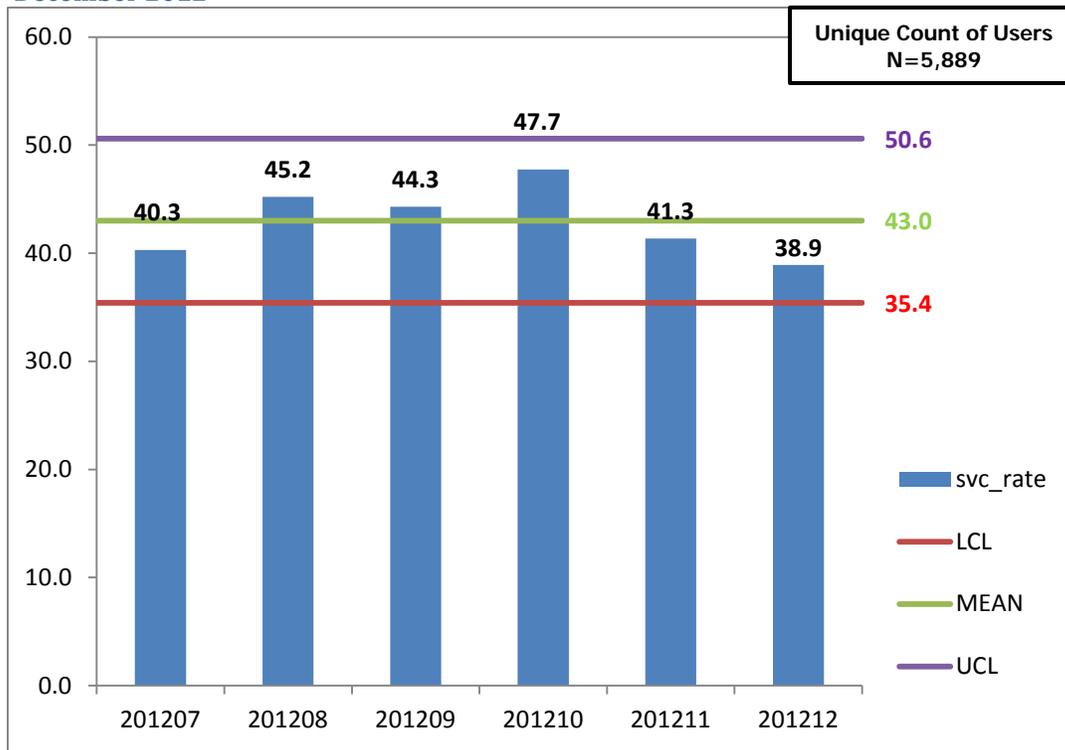


Figure SU-71. Radiology Utilization by Children (Age 0-20) in the Other Aid Category for July 2012–December 2012

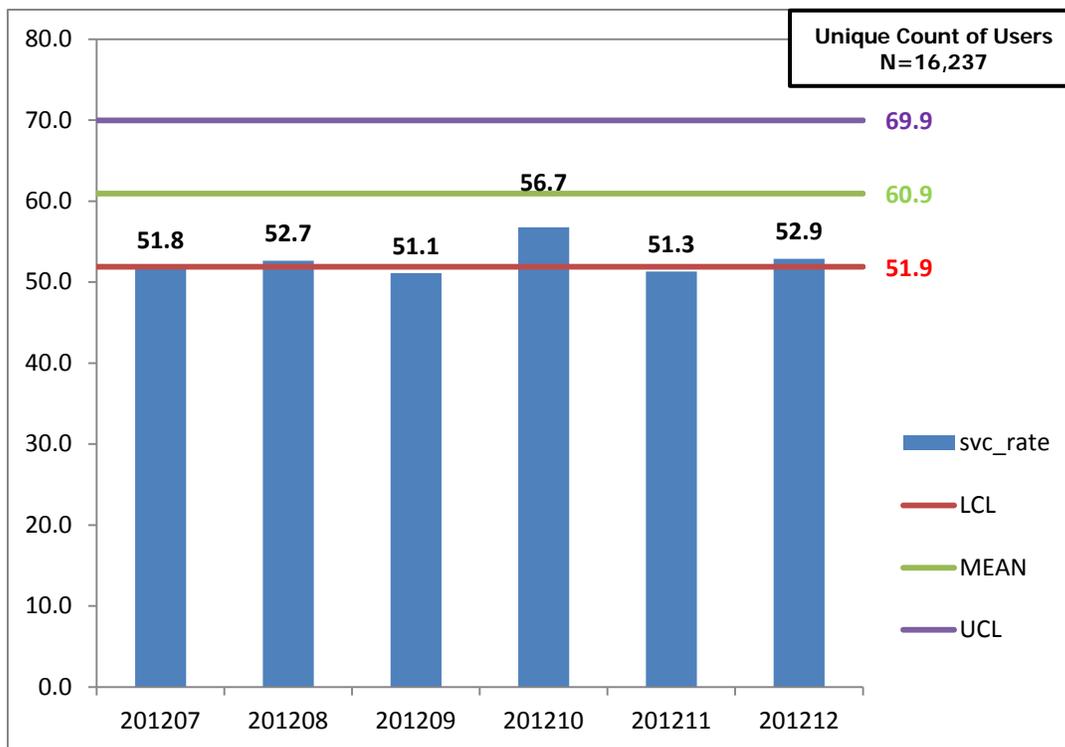
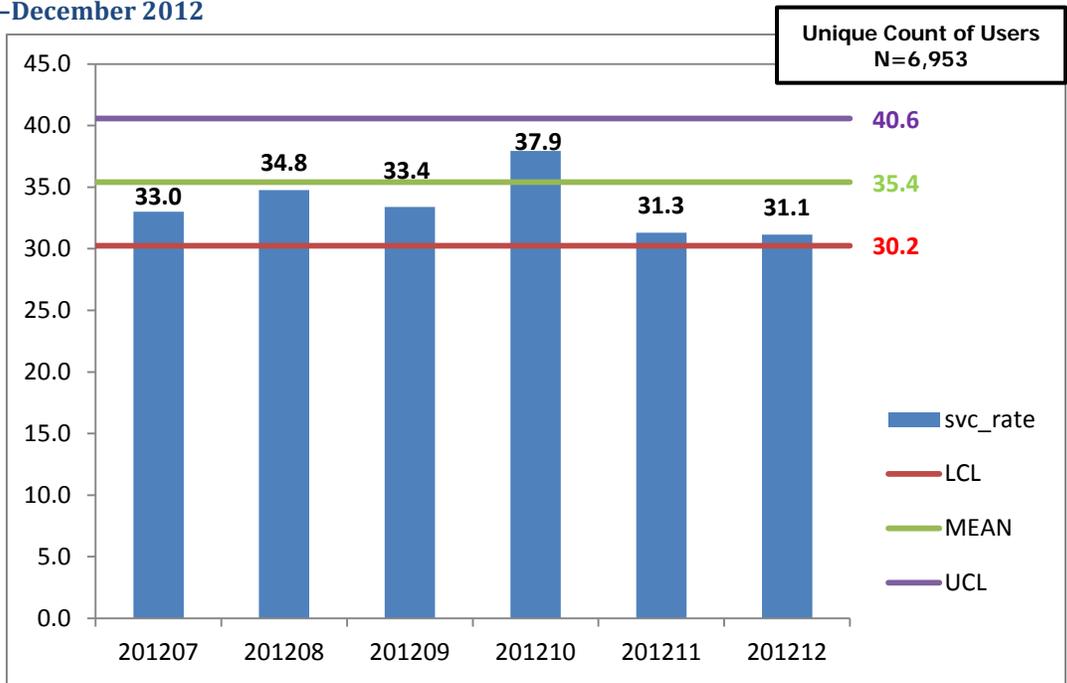


Figure SU-72. Radiology Utilization by Children (Age 0-20) in the Undocumented Aid Category for July 2012–December 2012



Source: Figures SU-68 to SU-72 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–December 2012, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends of Monthly Radiology Services Utilization Rates by Adults for July 2012–December 2012

Figure SU-73. Radiology Utilization by Adults (Age 21+) in the Aged Aid Category for July 2012–December 2012

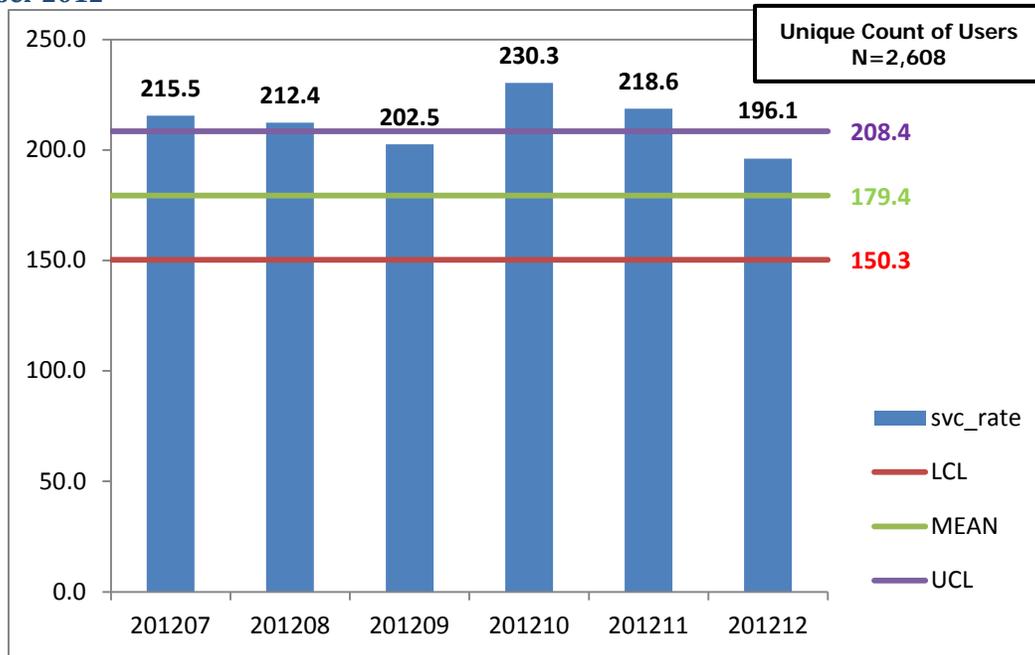


Figure SU-74. Radiology Utilization by Adults (Age 21+) in the Blind/Disabled Aid Category for July 2012–December 2012

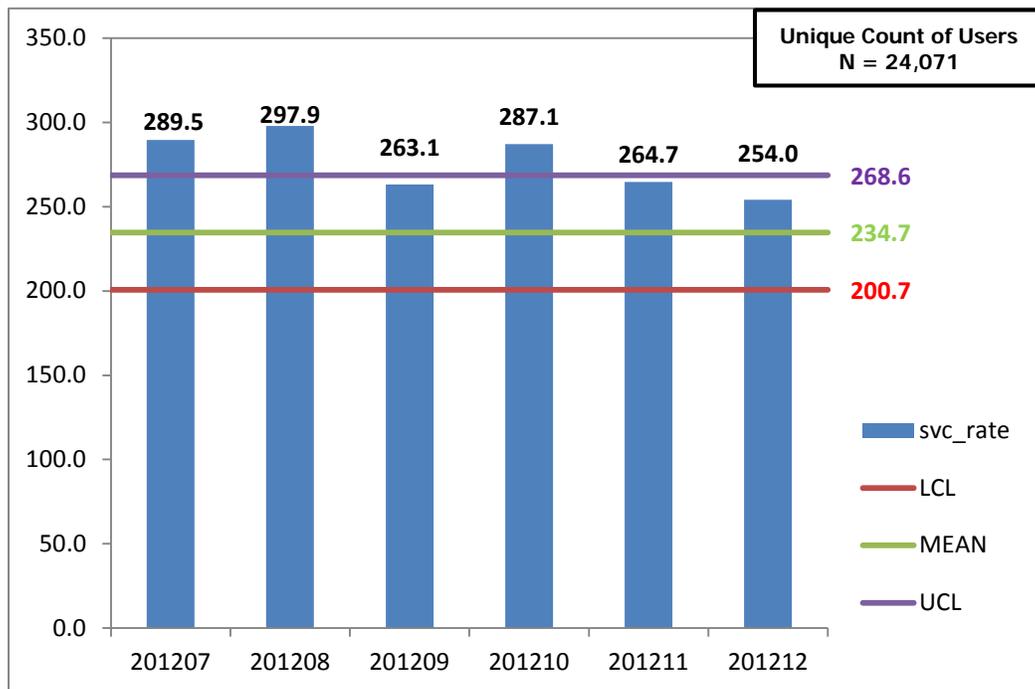


Figure SU-75. Radiology Utilization by Adults (Age 21+) in the Families Aid Category for July 2012-December 2012

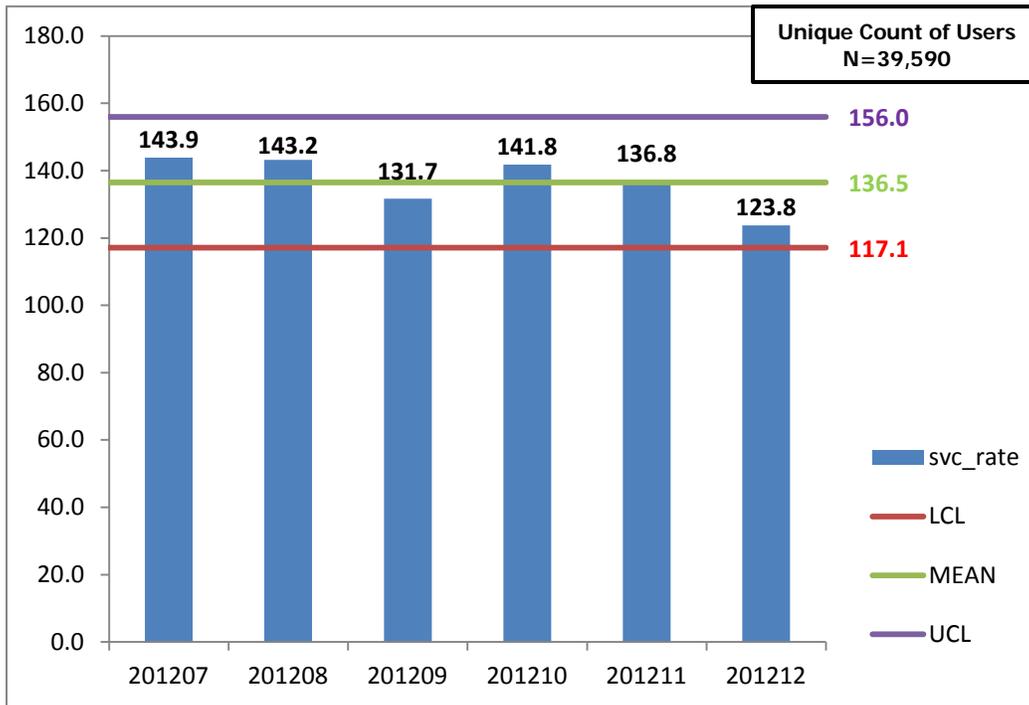


Figure SU-76. Radiology Utilization by Adults (Age 21+) in the Other Aid Category July 2012-December 2012

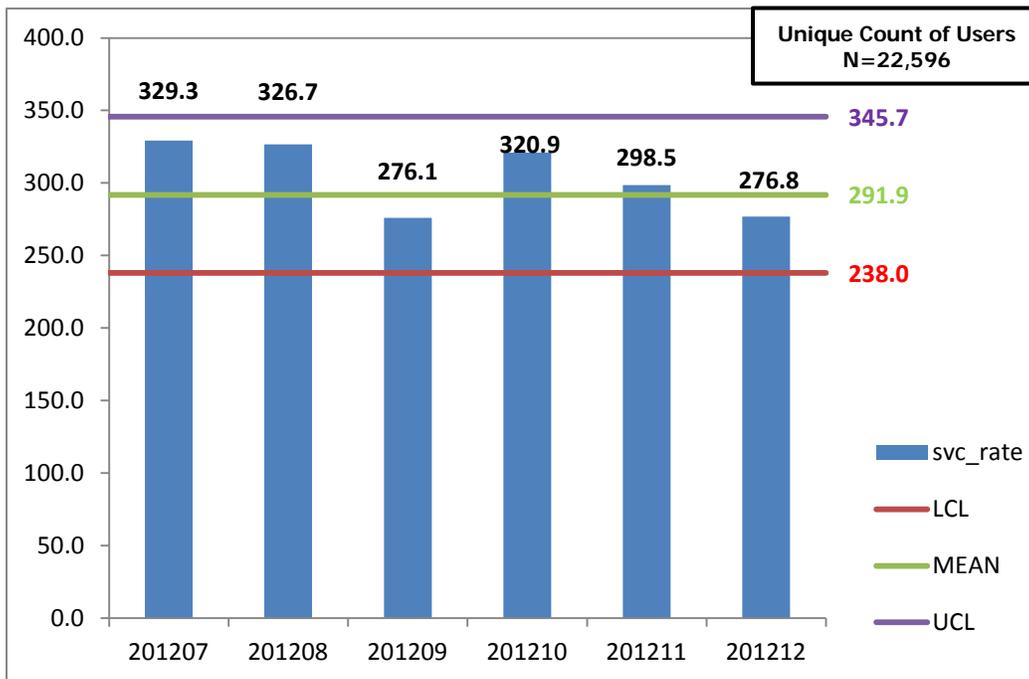
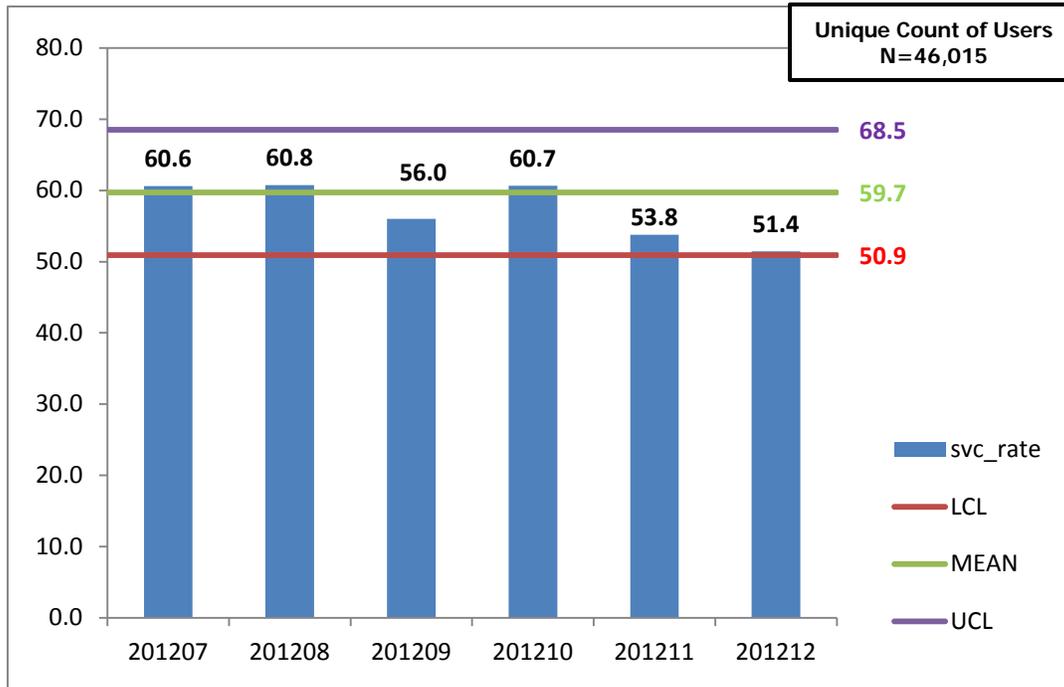


Figure SU-77. Radiology Utilization by Adults (Age 21+) in the Undocumented Aid Category for July 2012–December 2012



Source: Figures SU-73 to SU-77 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–December 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 Medi-Cal FFS Children by Aid Category and Service Category

Service Category Aid 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. Decline Below Average in Last Quarter.	Mostly Below Average and Within Expected Range. 3 Non-Consecutive Months Below Expected Range.	Upward Trend and Above Expected Range in Apr 2012 – Dec 2012.	Mostly Above Average and Mostly Within Expected Range.	Mostly Above Average with 4 Consecutive Months (Jan 2012–April 2012) Above Expected Range. Within Expected Range May 2012 –Dec 2012.	Above Average with 4 Consecutive Months (Jan 2012 – April 2012) Above Expected Range. Within Expected Range May 2012 – Dec 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.	Below Average and Within Expected Range	Within Expected Range.	Below Average and Mostly Within Expected Range.	Below Average with 4 Consecutive Months (Jun 2012 – Sep 2012) Below Expected Range. Within Expected Range Last Quarter.	Within Expected Range.	Mostly Below Average and Within Expected Range.
Foster Care	Mostly Below Average and Mostly Within Expected Range. Decline in Dec 2012.	Mostly Above Average and Within Expected Range. Decline Below Average in Last Quarter	N/A	Below Average and Within Expected Range.	Mostly Within Expected Range. Downward Trend Aug 2012 – Dec 2012.	Mostly Above Average and Within Expected Range	Within Expected Range.	Within Expected Range.
Other	Mostly Below Average and Within Expected Range.	Below Average and Within Expected Range.	Below Average and Within Expected Range.	Below Average and Mostly Within Expected Range.	Below Average with 9 Consecutive Months (Apr 2012 – Dec 2012) Below Expected Range.	Below Average and Below the Expected Range in Apr 2012 – Dec 2012.	Within Expected Range.	Mostly Below Average with 2 Non-Consecutive Months Below Expected Range
Undocumented	Mostly Below Expected Range. Reached Levels Within Expected Range During Third Quarter.	Mostly Below Average and Mostly Within Expected Range	N/A	Below Average and Mostly Below Expected Range.	Mostly Below Average and Mostly 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 Medi-Cal FFS Adults by Aid Category and Service Category

Service Category Aid Category	Physician/ Clinic Visits	Non-Emergency Medical 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. Decline in Dec 2012.	N/A	N/A.	N/A.	Mostly Above Expected Range. Upward Trend Jan 2012–May 2012	Mostly Above Average and Mostly Within Expected Range. Decline in Last Quarter.	N/A	Below Average and Mostly Below Expected Range. Downward Trend Jan 2012 – Dec 2012.	Below Average and Mostly Below Expected Range.	Above Average and Mostly Above Expected Range.
Blind/ Disabled	Mostly Above Average and Within Expected Range. Downward Trend Aug 2012–Dec 2012.	Above Expected Range. Slight Downward Trend Mar 2012–Dec 2012.	Mostly Above Average with Levels Reaching Above Expected Range in 2 nd and 3 rd Quarters.	Mostly Above Average and Within Expected Range.	Mostly Above Average with Several Months Above Expected Range.	Mostly Above Average with 4 Consecutive (May 2012–Aug 2012) Months Above Expected Range. Downward Trend (Aug 2012–Dec 2012).	Mostly Above Expected Range. Upward Trend (Jan 2012–May 2012).	Below Average with Several 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 Mostly Within Expected Range. Downward Trend Aug 2012 – Dec 2012. Below Range During Last Quarter.	N/A	Within Expected Range. Downward Trend Jul 2012 – Dec 2012.	N/A	Below Average with Several Non-Consecutive Months Below Expected Range.	Below Average and Mostly Within Expected Range. Downward Trend Aug 2012 – Dec 2012. Below Range During Last Quarter.	N/A	Below Average with 4 Consecutive Months (June 2012 – Sep 2012) Below Expected Range	Below Average and Mostly Within Expected Range. Decline in Dec 2012.	Within Expected Range.
Other	Mostly Within Expected Range. Downward Trend Aug 2012 – Dec 2012.	Above Expected Range	Within Expected Range.	N/A	Below Average with 5 Consecutive Months (Feb 2012 – June 2012) Below Expected Range.	Mostly Within Expected Range. Downward Trend Aug 2012 – Dec 2012.	Below Average with 5 Consecutive Months (Aug 2012 – Dec 2012) Below the Expected Range.	Within Expected Range.	Mostly Below Average and Within Expected Range.	Within Expected Range.
Undocu- mented	Below Average and Mostly Below Expected Range. Downward Trend Aug 2012 – Dec 2012.	N/A	Mostly Below the Expected Range with Levels Reaching Within Range During 3 rd Quarter.	N/A	Below the Expected Range.	Below Average and Mostly Within Expected Range. Downward Trend Aug 2012 – Dec 2012. Below Range During Last Quarter.	N/A	Mostly Above Average and Within Expected Range.	Below the Expected Range.	Within Expected Range.

Conclusions—Service Utilization of 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.
2. Children in the Blind/Disabled aid category continued to exhibit upward trends in Home Health utilization, in addition to, above average use of Pharmacy services. After displaying increased utilization in Hospital Inpatient, Hospital Outpatient and Emergency Medical Transportation services, as well as, Physician/Clinic visits during the third quarter of 2012, Blind/Disabled children exhibited noticeable decreases in utilization of these service categories at the end of the study period. These shifts in utilization may indicate the development of newly established 'normal' service use patterns which manifested after the transition of the SPD beneficiary population into managed care plans. 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 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 again 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.
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 increased utilization of Other services and Physician/Clinic visits in the third quarter of 2012, this population exhibited a decline in utilization of these service categories at the end of the study period. These shifts in utilization may indicate the development of new 'normal' service use patterns that manifested after the transition of various beneficiary subgroups into managed care plans.
5. As beneficiary participation shifted away from the FFS delivery system and into managed care, many service categories (e.g.; Non-Emergency Transportation, Home Health, and Nursing Facility Services) again experienced a noticeable decline in user counts that made the data unsuitable for analysis.

Conclusions—Service Utilization of Adults Participating in FFS

1. As noted in the previous access quarterly reports, adults in the Blind/Disabled aid category continued to place a great 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 three quarters of the study period, Blind/Disabled adults utilized these services at rates well above the expected baseline ranges. Of particular note, Blind/Disabled adults exhibited a noticeable downward trend in Physician/Clinic visits over the last two quarters of 2012.
2. Adults in all of the analyzed aid categories displayed noticeable downward trends in Physician/Clinic visits over the last two quarters of the study period. These utilization patterns may be explained for some beneficiary subgroups (Aged and Blind/Disabled) by the decline in Medi-Cal FFS participation over the same time period.
3. Adults in the Families aid code category again displayed below average utilization of Emergency Transportation and Hospital Inpatient services, as well as, Physician/Clinic visits throughout most of the study period. The lower utilization of these services among younger adults (age < 65) in the Families aid category may be explained in part by the continued declines in the birth rate.²
4. 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 and Hospital Inpatient services, as well as, Physician/Clinic visits. 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,⁷ which is most noticeable among the immigrant population.⁸
5. 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.

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

⁸ 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 #5 2012 Quarter 4



Beneficiary Feedback

September 2013

California Department of Health Care Services
Research and Analytic Studies Branch
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Sacramento, CA 95899-7413

Contents

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

List of Figures

Figure BF-1. Calls Received by FFS Beneficiaries by Month for January 2012-December 2012 ...	6
Figure BF-2. Calls Received by FFS Beneficiaries by Call Category for January 2012–December 2012	10
Figure BF-3. Monthly Call Volumes from Family Aid Codes by Call Category for January 2012–December 2012.....	12
Figure BF-4. Monthly Calls from Blind/Disabled Beneficiaries by Call Category for January 2012–December 2012.....	13

List of Tables

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

Beneficiary Help Line Feedback

Introduction

In 2011, the Centers for Medicare and Medicaid Services strongly encouraged DHCS to implement a beneficiary help line as part of 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 information for monitoring health care access, and provide needed assistance to FFS beneficiaries having difficulties navigating the health care system.

Highlights

Calls increased by the end of the reporting period, with nearly 400 calls in August 2012 compared with over 800 calls in November 2012.

The largest percentage (51%) of calls were regarding Enrollment/Continuity of Care.

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

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.

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 8,532¹ calls from FFS beneficiaries from the first quarter of 2012 to the fourth 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, six aid category groupings (Families, Blind/Disabled, Aged, Foster Care, Undocumented, and Other), and reason for call.

¹ A different data extraction method was used by the Office of the Ombudsman to identify calls made by FFS beneficiaries. Using data obtained by this new method, call counts are slightly higher (3%–6%) than noted in previous access quarterly reports.

Results

Between January 2012 and December 2012, the Office of the Ombudsman documented a total of 8,532 calls received from Medi-Cal FFS beneficiaries.

The total number of calls remained relatively the same as the previous reporting period (8,509 calls for October 2011-September 2012). Figure BF-1 provides a graph of the total calls received during the current reporting period by month. A general downward trend in call volume was observed during the first half of the year, with call volume returning to higher levels during the last quarter of 2012.

Call volume experienced a downward trend during the first half of the year, but returned to higher levels during the last quarter of 2012.

Figure BF-1. Calls Received by FFS Beneficiaries by Month for January 2012-December 2012



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

Beginning in September 2012, call volume notably increased, particularly for calls pertaining to miscellaneous reasons (data not shown). This increase in call volume may be attributed, in part, to the Department’s transitioning of children served by the Healthy Families Program into Medi-Cal beginning in January 2013. A definitive explanation of this rise in call volume can only be reached upon further investigation.

Call Volume by Quarter

Table BF-1 presents the number of calls received for each quarter of the current reporting period. Call volume for the second and third quarters of 2012 decreased significantly from the first quarter (34% and 23%, respectively). Call volume increased 49% in the fourth quarter to 2,208 calls.

Call volume nearly doubled between the months of August and November 2012.

Table BF-1. Number of Calls Received from FFS Beneficiaries by Quarter for January 2012–December 2012

Quarter	Calls per Quarter	% Change from Previous Quarter
Jan–Mar 2012	2,912	
Apr–Jun 2012	1,931	-34%
Jul–Sep 2012	1,481	-23%
Oct–Dec 2012	2,208	49%

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, January 2012–December 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

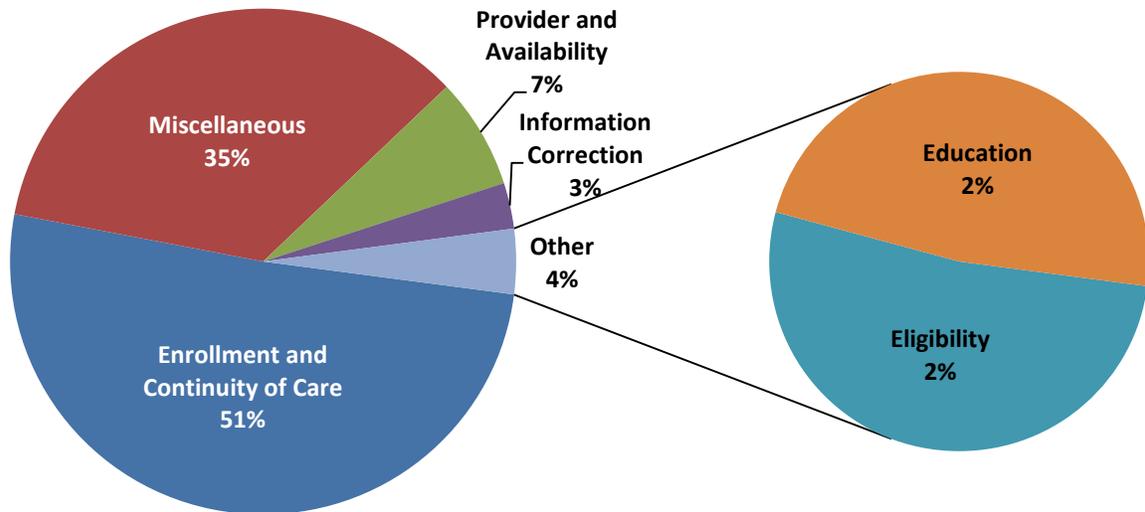
Call Category	Reason for Call
Enrollment and Continuity of Care	<ul style="list-style-type: none"> • Seeking information for new enrollment into plan • Wanting to change plans or disenroll from managed care • Seeking medical exemptions • Emergency plan disenrollment requests • Pregnancy or other qualifying 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 51% of calls, while another 35% of calls were categorized as Miscellaneous. The remaining 14% of calls pertained to Provider and Availability, Information Correction, Education, and Eligibility issues.

Figure BF-2. Calls Received by FFS Beneficiaries by Call Category for January 2012–December 2012



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

As key elements in understanding whether beneficiaries are experiencing access-related problems, the remainder of this analysis will focus on two call categories: Enrollment/Continuity of Care and Provider/Availability issues. Of the total calls received, there were 4,343 calls categorized as Enrollment/Continuity of Care and 606 calls categorized as Provider/Availability.

Calls by Aid Code Category

The Medi-Cal aid codes reported by FFS beneficiary callers were collapsed into six aid code categories. Table BF-3 presents the calls received by FFS beneficiaries based on the primary access issue (Enrollment/Continuity of Care and Provider/Availability) and aid code in which the beneficiary was enrolled.

Table BF-3. Calls for Enrollment/Continuity of Care and Provider/Availability Issues by Aid Category for January 2012–December 2012

Aid Category	Call Category			
	Enrollment and Continuity of Care		Provider and Availability	
	# of Calls	% of Calls	# of Calls	% of Calls
Families	2,122	49%	215	35%
Blind/Disabled	1,224	28%	139	23%
Other	443	10%	161	27%
Aged	315	7%	58	10%
Foster Care	225	5%	8	1%
Undocumented	14	0.3%	25	4%
Total	4,343	100%	606	100%

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 January 2012–December 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.

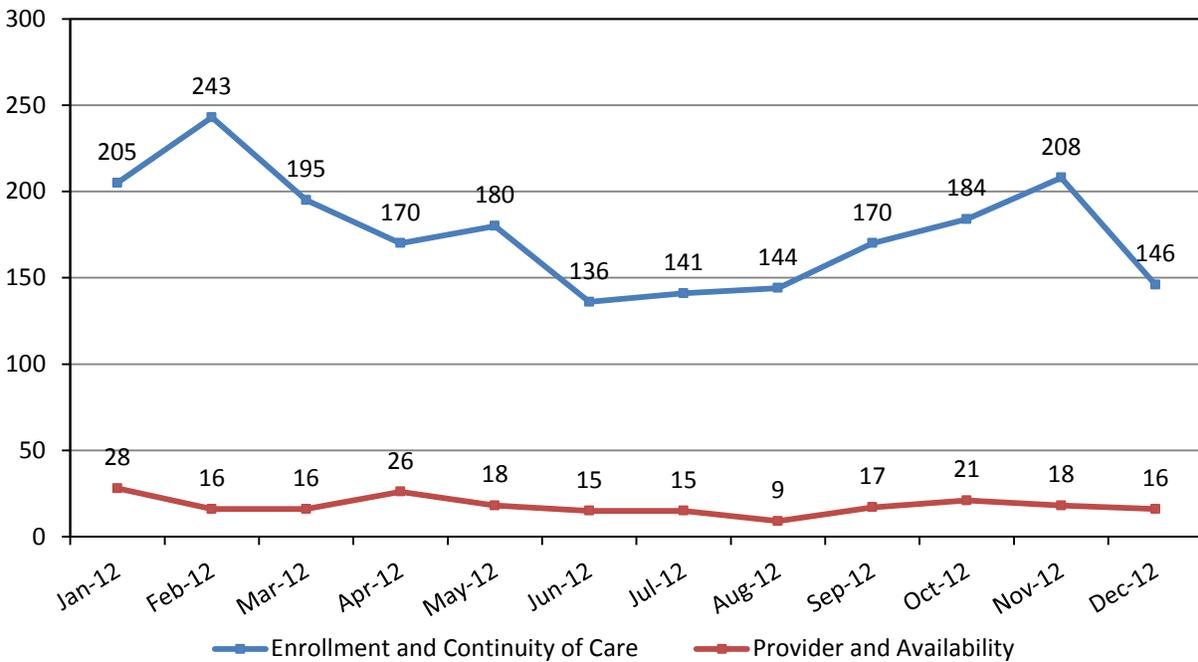
In general, a large proportion of calls received by the Ombudsman’s Office pertained to Enrollment/Continuity of Care issues as compared with Provider/Availability issues. However, among beneficiaries enrolled in Undocumented aid codes, a larger volume of calls pertained to Provider/Availability issues.

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

Distribution of Calls from Family Aid Codes by Call Category

Since the majority of calls were received from callers in Family and Blind/Disabled aid codes, the following sections of the report will focus on calls received by beneficiaries in these two aid categories, analyzed by month and call category. Figure BF-3 represents calls made by FFS beneficiaries enrolled in the Families aid category. As with overall call volume, calls made by beneficiaries in the Families aid category and pertaining to Enrollment/Continuity of Care issues, experienced a downward trend during the first half of 2012, but increased in the months of September, October, and November. Calls pertaining to Provider/Availability issues from beneficiaries in the Families aid category were less frequent but stable during the period under study.

Figure BF-3. Monthly Call Volumes from Family Aid Codes by Call Category for January 2012–December 2012

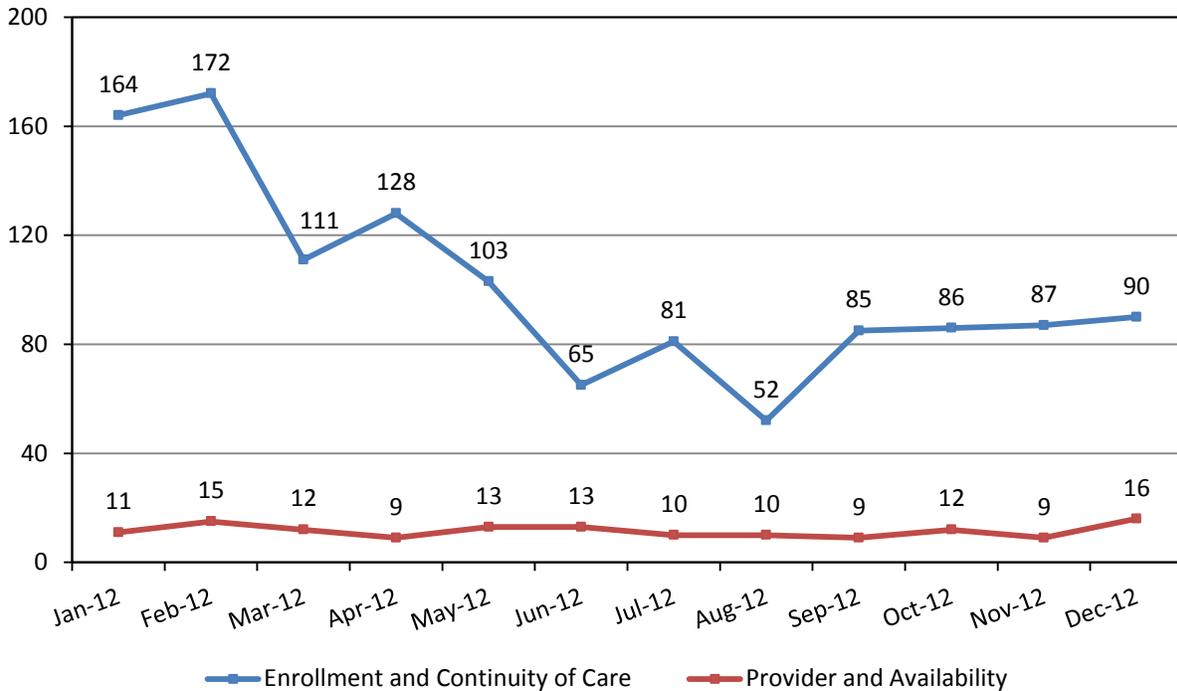


Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Branch. Calls received from FFS beneficiaries January 2012–December 2012.

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

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

Figure BF-4. Monthly Calls from Blind/Disabled Beneficiaries by Call Category for January 2012–December 2012



Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Branch. Calls received from FFS beneficiaries January 2012–December 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-4 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 7% of Enrollment and Continuity of Care calls were regarding Foster Care/Adoption issues, and 3% were requests to disenroll from managed care.

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

Of the calls categorized under Provider and Availability, nearly 85% were addressing the termination of Medi-Cal eligibility. Another 6.5% were related to beneficiaries being billed for services, and 3.3% concerned refusal of medications.

Table BF-4. Top 3 Reasons for Calls from Family Aid Codes for January 2012–December 2012

Reason for Call	# of Calls	% of All Calls*
Enrollment and Continuity of Care (n=2,122)		
Requesting New Enrollment into Plan	1,692	80%
Foster Care/Adoption (Disenrollment Exemption Request)	142	7%
Wants to Disenroll from Plan to Become FFS	60	3%
Provider and Availability (n=215)		
Medi-Cal Eligibility Terminated	182	8%
Beneficiary Being Billed	14	7%
Refusal of Medications	7	3%

Source: Analysis of data from the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Branch. Calls received from FFS beneficiaries, January 2012–December 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-5 presents the top three reasons for calls among calls received from beneficiaries in the Blind/Disabled aid category. Approximately 46% of the calls categorized as Enrollment/Continuity of Care involved callers requesting new enrollment. Nearly 20% concerned Medical Exemption Requests (MERs) or Emergency Disenrollment Exemption Requests (EDERs), and nearly 11% pertained to calls from beneficiaries in the Seniors 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, nearly 45% of those categorized as Provider and Availability issues called about termination of Medi-Cal eligibility.

Of the calls categorized under Provider/Availability, nearly 45% of calls involved termination of Medi-Cal eligibility. Two issues, a provider not being part of the beneficiaries' plan and the refusal of medications, both received nearly 17% of calls for the reporting period.

Table BF-5. Top 3 Reasons for Calls from Blind/Disabled Aid Codes for January 2012–December 2012

Reason for Call	# of Calls	% of All Calls*
Enrollment and Continuity of Care (n=1,224)		
Requesting New Enrollment into Plan	564	46%
Status Checks on MERs/EDERs	242	20%
Denial of SPD MERs/EDERs	129	11%
Provider and Availability (n=139)		
Medi-Cal Eligibility Terminated	62	45%
Provider Not a Plan Partner	23	17%
Refusal of Medications	23	17%

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, January 2012–December 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 January 2012 and December 2012, the Ombudsman call center staff documented 8,532 calls from FFS beneficiaries in the Medi-Cal program. The call total during this 12-month period remained similar to the October 2011–September 2012 reporting period.
2. About 51 percent of the calls pertained to Enrollment/Continuity of Care. Another 35 percent of calls were categorized under Miscellaneous. Due to the ambiguity of Miscellaneous calls, they were not further analyzed. The focus of the analyses were on calls related to Enrollment/Continuity of Care and Provider/Availability as these key elements help identify access-related issues experienced by beneficiaries.
3. Among calls categorized as Enrollment/Continuity of Care and Provider/Availability, the majority of calls were from FFS beneficiaries enrolled in Family, Blind/Disabled, and Other aid categories.
4. Callers in Family aid codes were primarily concerned with requesting new enrollment. Other important issues included foster care/adoption issues and disenrolling from or changing to a FFS delivery system. These callers also sought information regarding the termination of their Medi-Cal eligibility, as well as being billed for services and refusal of medications.
5. Callers from Blind/Disabled aid codes were primarily concerned with requesting new enrollment. These callers also requested medical exemptions and emergency disenrollment exemption requests, as well as following up on denied requests for exemptions. Other reasons for these calls included termination of Medi-Cal eligibility, provider not being a plan participant, and refused medications.