



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



Executive Summary

February 2014

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Abstract

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

Medi-Cal's assessment of health care access for the second quarter of 2013 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 first quarter of 2013, similar patterns were identified in all four areas under study. Key findings regarding these study areas are summarized below.

KEY FINDINGS

- 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 4.6% statewide, from 75,093 to 78,534.
- The number of Medi-Cal beneficiaries participating in the Fee-for-Service (FFS) delivery system increased by 4.4% throughout the year.¹ However, the largest segment of adults remaining in Medi-Cal's FFS system were those enrolled in Undocumented aid codes.
- 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 birthrates. 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.
- Beneficiaries participating in FFS continue to call into DHCS' Medi-Cal Managed Care Division's Office of the Ombudsman for assistance. Over 9,200 (this represents the total number for all four quarters) calls were handled by the Office of the Ombudsman for beneficiaries enrolled in FFS, an increase in call volume from the previous study period. The number of calls received by the Ombudsman's Office generally increased over the first three quarters before declining in the second quarter of 2013.

¹ A multi-phase transition of children from the Healthy Families program into Medi-Cal occurred throughout 2013. Some of these children temporarily entered FFS, but were subsequently required to enroll in managed care health plans in accordance with program policy.

Executive Summary

Background

This Medi-Cal access report is the seventh in a series of quarterly reports concerning health care access among Medi-Cal beneficiaries. This report provides information for evaluating the early signs of potential health access problems among beneficiaries eligible for Medi-Cal only² and participating in Medi-Cal's Fee-for-Service (FFS) system. This report covers the second quarter of 2013, 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.

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

- Physician Supply
- Medi-Cal Beneficiary Participation
- Service Utilization
- Beneficiary Feedback

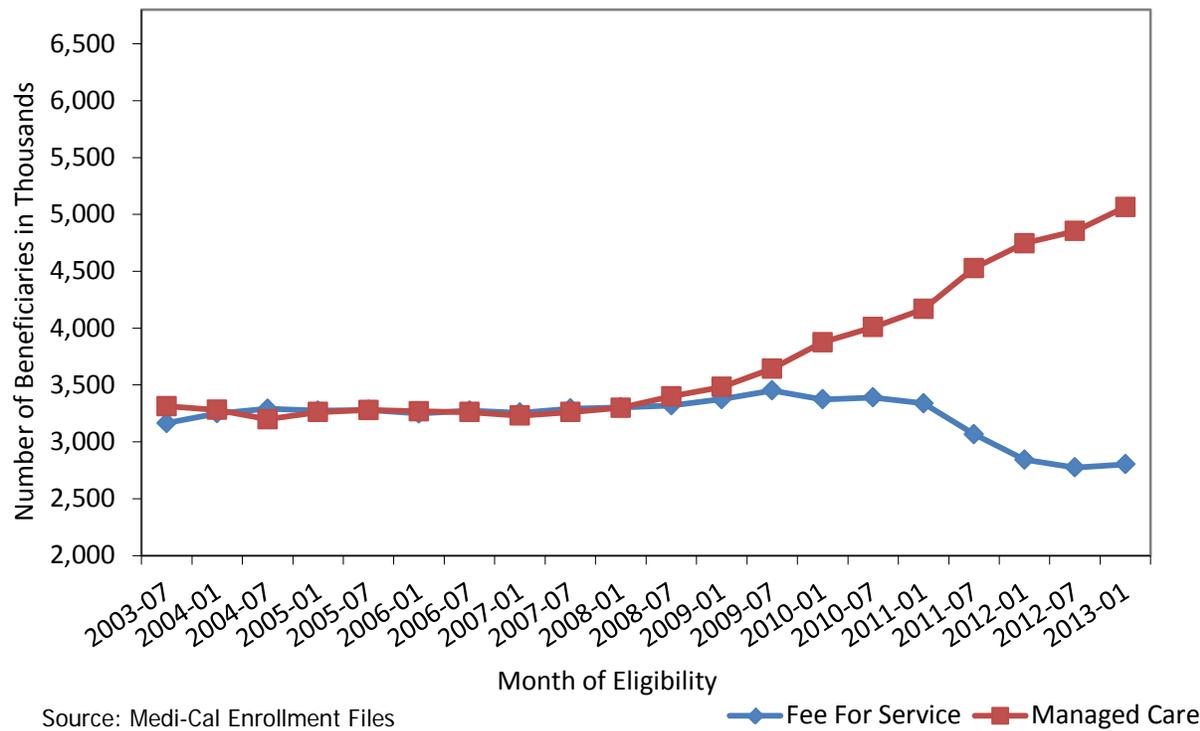
Recent changes to the Medi-Cal program have impacted benefits, health care delivery, and FFS population characteristics. All of these changes influenced the measures evaluated in Medi-Cal's quarterly access report. The DHCS systematic access monitoring system required the establishment of baseline statistics. 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, thus 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 recalculated for use in the Medi-Cal Access to Care Quarterly Monitoring Report, 2013 Quarter 4.

Significant changes have also occurred within Medi-Cal since 2008 that impacted participation distributions between Medi-Cal's traditional FFS system and managed care. These shifts in participation impacted the number of FFS beneficiaries eligible for Medi-Cal only that this quarterly access monitoring effort focuses on (see Figure ES-1).

² The term "Medi-Cal only" refers to individuals eligible for Medi-Cal but not Medicare.

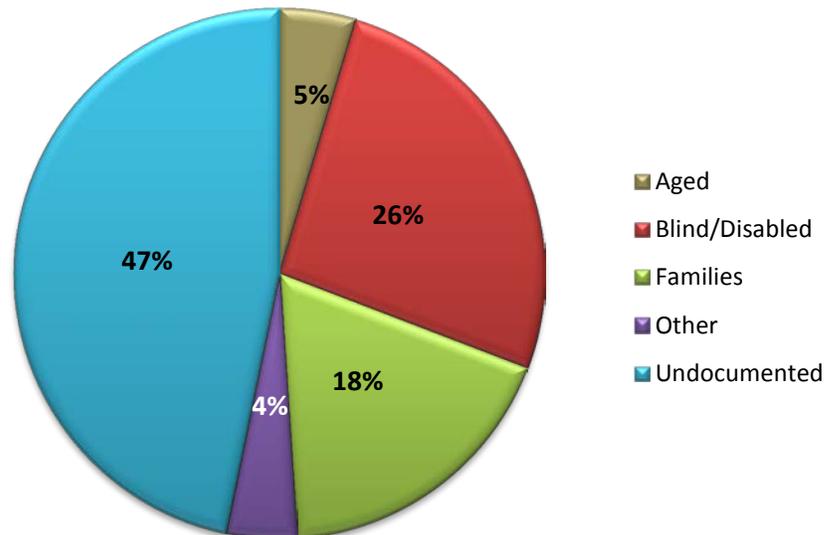
Figure ES-1. Trend in Biannual FFS vs Managed Care Participation, 2004–2013



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

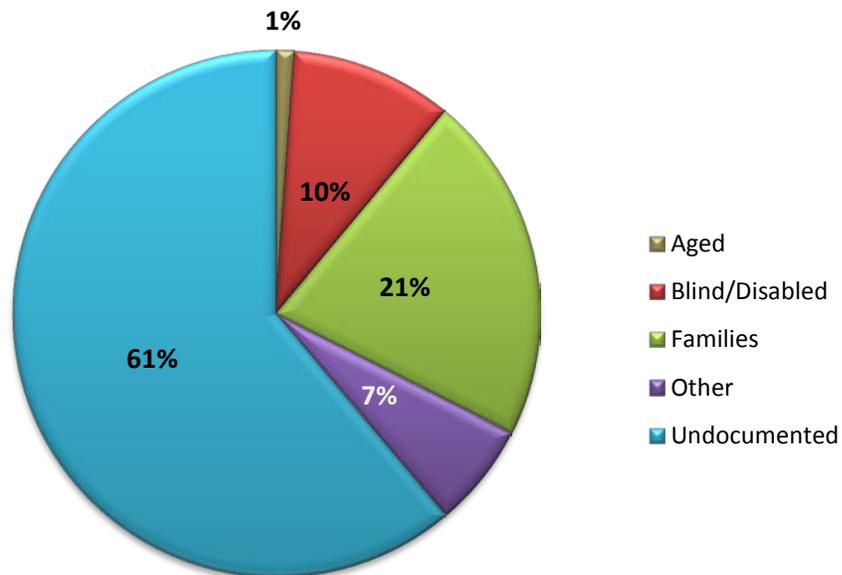
As the next two figures show, from the first quarter of 2011 to the second quarter of 2013, an increasing percentage of the overall Medi-Cal population is comprised of Undocumented beneficiaries, as subpopulations in the other aid categories shift from FFS to managed care. Since Undocumented beneficiaries are not eligible to enroll in managed care, and as the remaining population continues its shift to managed care, the percentage of the Medi-Cal FFS population comprised of Undocumented beneficiaries will continue to increase. At the start of 2011, less than half of the FFS population was comprised of beneficiaries in Undocumented aid codes. As of June 2013, nearly two-thirds of the adult FFS Medi-Cal population was enrolled in Undocumented aid codes.

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



Source: Prepared by DHCS Research and Analytic Studies Division 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, Quarter 2, 2013



Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files, April-June 2013. 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.³

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. From June 2011 to May 2012, roughly 300,000 SPD beneficiaries were transitioned from FFS to managed care as a result of this policy. The SPD population represents one of Medi-Cal's most costly and medically complex groups, accounting for more than \$3.8 billion⁴ in annual health care spending.

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.

As counties transition 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.⁵

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 an FFS to managed care delivery system, service

³ Part of the 306,000 included "Working Disabled" individuals who were transitioned into managed care delivery systems (11,382).

⁴ This figure includes only DHCS-administered services. If services administered by other departments are included, the total rises to \$5.7 billion.

⁵ 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)

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. Therefore, the baseline statistics, or benchmarks, will be recalculated for use in the Medi-Cal Access to Care Quarterly Monitoring Report, 2013 Quarter 4.

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

Findings

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

Physician Supply

DHCS used site-specific physician counts as the primary provider supply metric in this quarterly access report. In addition, DHCS calculated the ratio of beneficiaries to physicians statewide, as well as within each of the four county plan model types and by county.

Site-specific physician counts are systemwide 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 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 (e.g., number of enrolled Medi-Cal physicians is declining) or that the supply of physicians has been stable over time. This has been the case for the last four quarters, as the number of enrolled physicians has remained stable during the current study period. In these four access snapshots, modest increases in Medi-Cal physician enrollment have been reported.

Beneficiary-to-provider ratios measure the number of beneficiaries relative to providers. A low ratio indicates that there are a greater number of providers relative to the population, while a high ratio indicates that there are fewer providers relative to the population. Beneficiary-to-provider ratios are useful for identifying differences in physician supply from one geographic area to another, from one measurement period to another, or between the study population and another population or normative benchmark.

The total number of physicians increased 4.6% overall, from 75,093 to 78,534 physicians. The aggregate number of primary care physicians increased 4.2%, from 28,178 to 29,359 physicians.⁶ 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.

⁶ For details on how "primary care physicians" were defined for this report, see the Physician Supply Section of the current report on the [DHCS-RASD Access Monitoring](#) website. This method was modified with the 2012 Quarter 4 report. Prior reports have been updated to allow trending.

Change in Medi-Cal Participation

The number of beneficiaries eligible for Medi-Cal only, participating in FFS, and entitled to full scope benefits increased 4.4% from the third quarter of 2012 to the second quarter of 2013, largely due to the transition of children from the Healthy Families Program into Medi-Cal.⁷

In contrast with prior access reports, most counties experienced increases in FFS participation for the four quarters of the study period. When looking at FFS full-scope participation, 47 of 58 counties experienced increases of 1.0% or more, while only five counties experienced decreases of 1.0% or more. Six counties did not experience significant changes in FFS participation.

The greatest increase in FFS participation from the third quarter of 2012 to the second quarter of 2013 occurred for children enrolled in the Other aid category (49.4%), after increasing 47.6% in the last study period. These sharp increases are due to the transition of children from the Healthy Families program into Medi-Cal. The largest increase for adults occurred for those enrolled in the Aged aid category (7.2%).

The greatest decrease in FFS participation from the third quarter of 2012 to the second quarter of 2013 was observed among children eligible for full-scope Medi-Cal only benefits and enrolled in the Families aid category (-11.0%), while also decreasing for children enrolled in the Blind/Disabled aid category (-9.3%). The largest decline in participation among Adults occurred for those in the Families aid category (-2.5%). Declines among adults enrolled in the Aged and Blind/Disabled aid category were less than 1% for the current study period, compared with declines of -8.9% and -6.5% in the previous study period, respectively. This may be due to the transition of SPDs into managed care plans that was completed in May 2012.

Overall, patterns in Medi-Cal FFS participation were similar for beneficiaries residing in metropolitan and non-metropolitan areas of the state, with 3.7% and 1.4% increases in FFS participation over the four quarters studied, respectively. For example, the largest increase in FFS participation occurred among children in the Other aid category, with a 48.5% increase in metropolitan areas and a 28.9% increase in non-metropolitan areas. These increases among children in FFS are largely due to children covered by Healthy Families transitioning to Medi-Cal. However, there were some differences among certain subpopulations. Among adults in the Aged aid category, FFS participation increased 7.0% in non-metropolitan counties, while declining 9.3% in metropolitan areas for this same beneficiary subgroup.

Children in Undocumented aid codes residing in non-metropolitan counties experienced significant declines (-13.2%) in participation for the study period, while participation for those residing in metropolitan areas was observed to decline at a smaller magnitude (-8.7%). Unlike the populations discussed previously, shifts in system participation from FFS to managed care were not responsible for the reductions recognized in the undocumented population.

⁷ A multi-phase transition of children from the Healthy Families program into Medi-Cal occurred throughout 2013. Some of these children temporarily entered FFS, but were subsequently required to enroll in managed care health plans in accordance with program policy.

Undocumented beneficiaries are not eligible to participate in Medi-Cal managed care plans. Rather, the downward trend recognized in the undocumented population was 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.^{8,9}

⁸Passel, 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/>

⁹Passel, Jeffrey, Pew Hispanic Center, "Unauthorized Immigrants: 11.1 Million in 2011," December 6, 2012, <http://www.pewhispanic.org/2012/12/06/unauthorized-immigrants-11-1-million-in-2011/>

Service Utilization Rates per 1,000 Member Months for Adult Beneficiaries¹⁰

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
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.

- Adults in the Blind/Disabled aid category continued to place a great demand on Emergency Transportation, Hospital Inpatient, Hospital Outpatient, Nursing Facility, and Radiology services. Additionally, despite experiencing a downward trend in Non-Emergency Transportation services utilization during the first two quarters of the study period, Blind/Disabled adults again utilized these services at rates well above the expected baseline ranges.
- Adults in the Families aid code category again displayed below average utilization of Emergency Transportation, Hospital Inpatient services, and 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 birthrate.¹¹

¹⁰ Service use for children has been excluded from the Executive Summary but is examined in detail within the Service Utilization report on the [DHCS-RASD Access web page](#).

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

- 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, Hospital Inpatient services, and 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, which is most noticeable among the immigrant population.¹²
- 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 has 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 at above average rates that often rise above the expected ranges. 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 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

¹² Livingston, G., & Cohn, D. (2012, November 29) U.S. Birth Rate Falls to a Record Low; Decline Is Greatest Among Immigrants. *Pew Research Center: Social & Demographic Trends*.

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-RASD 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. 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, Quarter 3, 2012–Quarter 2, 2013

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	Below Average and Mostly Within Expected Range. Decline in Last Quarter.	N/A	N/A	N/A	Above Expected Range.	Mostly Above Average and Mostly Within Expected Range. Decline in Last Quarter.	Above Expected Range.	Below Expected Range.	Below Expected Range.	Above Average and Mostly Above Expected Range. Decline in Last Quarter.
Blind/ Disabled	Mostly Below Average and Mostly Within Expected Range. Downward Trend Aug 2012–Dec 2012. Decline in Jun 2013.	Above Expected Range.	Above Average with Several Months Above Expected Range.	Mostly Above Average and Within Expected Range.	Mostly Above Expected Range.	Mostly Above Average and Mostly Within Expected Range.	Above Expected Range.	Mostly Below Expected Range.	Mostly Below Average and Within Expected Range.	Above Average and Mostly Above Expected Range.
Families	Mostly Below Expected Range. Downward Trend (Aug 2012–Dec 2012).	N/A	Mostly Below Average and Within Expected Range. Downward Trend Jul 2012–Dec 2012.	N/A	Mostly Below Average with Several Months Below Expected Range.	Mostly Below Expected Range. Downward Trend Aug 2012–Dec 2012.	N/A	Mostly Below Expected Range.	Below Average with Several Non-Consecutive Months Below Expected Range.	Within Expected Range.
Other	Mostly Below Average and Mostly Within Expected Range. Downward Trend Aug 2012–Dec 2012.	Above Expected Range.	Within Expected Range.	N/A	Below Average with 5 Consecutive Months Below Expected Range Feb 2013–Jun 2013.	Mostly Below Average and Mostly Within Expected Range. 3 Non-Consecutive Months Below Expected Range.	Mostly Below Expected Range.	Mostly Below Average and Within Expected Range.	Below Average and Within Expected Range.	Mostly Above Average and Within Expected Range.
Undocu- mented	Mostly Below Range. Downward Trend Aug 2012–Dec 2012.	N/A	Below Average with Several Months Below Expected Range.	N/A	Below Expected Range.	Mostly Below Expected Range. Downward Trend Aug 2012–Dec 2012.	N/A	Mostly Above Average and Within the Expected Range.	Below Expected Range.	Within Expected Range.

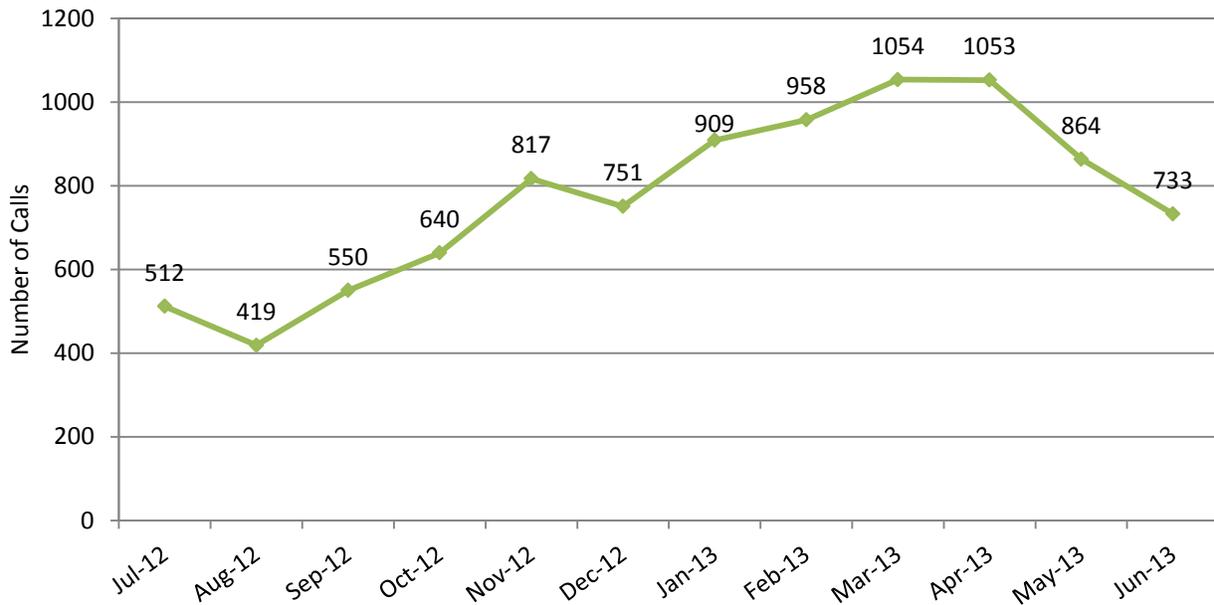
Beneficiary Help Line Feedback

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 third quarter of 2012 to the second quarter of 2013, the Office of the Ombudsman call center documented over 9,200 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-4 presents the trend in calls made by FFS beneficiaries during the study period by month. The Ombudsman's Office received a decrease in calls from FFS beneficiaries during the second quarter of 2013 after a general increase since September 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.

Figure ES-4. Calls Received from FFS Beneficiaries by Month, July 2012–June 2013¹³



Source: Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received from FFS beneficiaries, July 2012–June 2013.

¹³ 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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BENEFICIARY PARTICIPATION

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Medi-Cal FFS Beneficiary Participation Trends

Introduction

Compared with 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.

Highlights

FFS participation for full scope beneficiaries increased 4.4% from the third quarter of 2012 to the second quarter of 2013, from 1,143,775 to 1,193,735 average monthly eligibles.

The largest increase in FFS participation occurred among children transitioned from the Healthy Families program (49.4%).*

English is the primary language for 48.4% of beneficiaries; 47.9% of beneficiaries reported Spanish as their primary language.

Hispanics represent 62.4% of the total FFS Medi-Cal Only population.

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.

*A multi-phase transition of children from the Healthy Families program into Medi-Cal occurred throughout 2013. Some of these children temporarily entered FFS, but were subsequently required to enroll in managed care health plans in accordance with program policy.

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 38% 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 and 2007. Since 2008, managed care has become the predominant health care delivery model, accounting for 63.6% of all Medi-Cal beneficiaries as of July 1, 2012.

Between January 2011–January 2012, there was a net shift of over one-half million beneficiaries 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 nearly 150,000 Medi-Cal beneficiaries from the FFS to the managed care model.

Healthy Families Transition

On January 1, 2013, DHCS began the first of four phases in 2013 to transition approximately 860,000 children from the Healthy Families Program into Medi-Cal. To ensure minimal disruption to coverage, DHCS assigned certain children presumptive eligibility for Medi-Cal benefits under the FFS program until the date of their annual eligibility review for Medi-Cal. These children with presumptive eligibility under the FFS program are classified under the Other aid category in this report, which was a significant factor in the overall increase in FFS participation in the second quarter of 2013.

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 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 third quarter of 2012 to the second quarter of 2013. 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

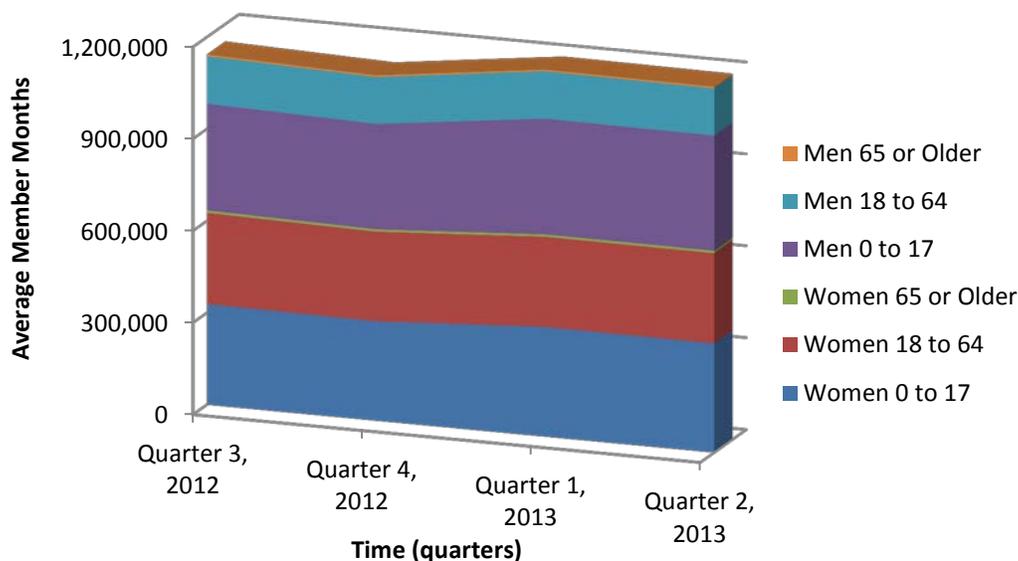
Medi-Cal Full Scope Beneficiaries by Gender and Age

Participation in the FFS health care delivery system for Medi-Cal beneficiaries who were eligible for full scope services increased 4.4% from the third quarter of 2012 to the second quarter of 2013, from 1,143,775 to 1,193,735 average monthly eligibles (see Table BP-5). Children’s increased participation was primarily responsible for the overall increase, with an 8.0% increase from the third quarter of 2012 to the second quarter of 2013. This increase is due to the transition of children from the Healthy Families program into Medi-Cal that began January 1, 2013.

Overall FFS participation for full scope beneficiaries increased 4.4% from the third quarter of 2012 to the second quarter of 2013.

FFS program participation decreased slightly (-0.3%) between the most recent quarter of the study period and the previous quarter. For people age 65 and older, FFS participation increased during the last quarter (5.9%), a significant development when compared with the change over the entire study period (0.9%) (see Table BP-5).

Figure BP-2. Average Monthly Eligibles, Full Scope FFS Beneficiaries, by Gender and Age Group, Quarter 3, 2012–Quarter 2, 2013



Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files July 2012–June 2013. Data reflects a 4-month reporting lag.

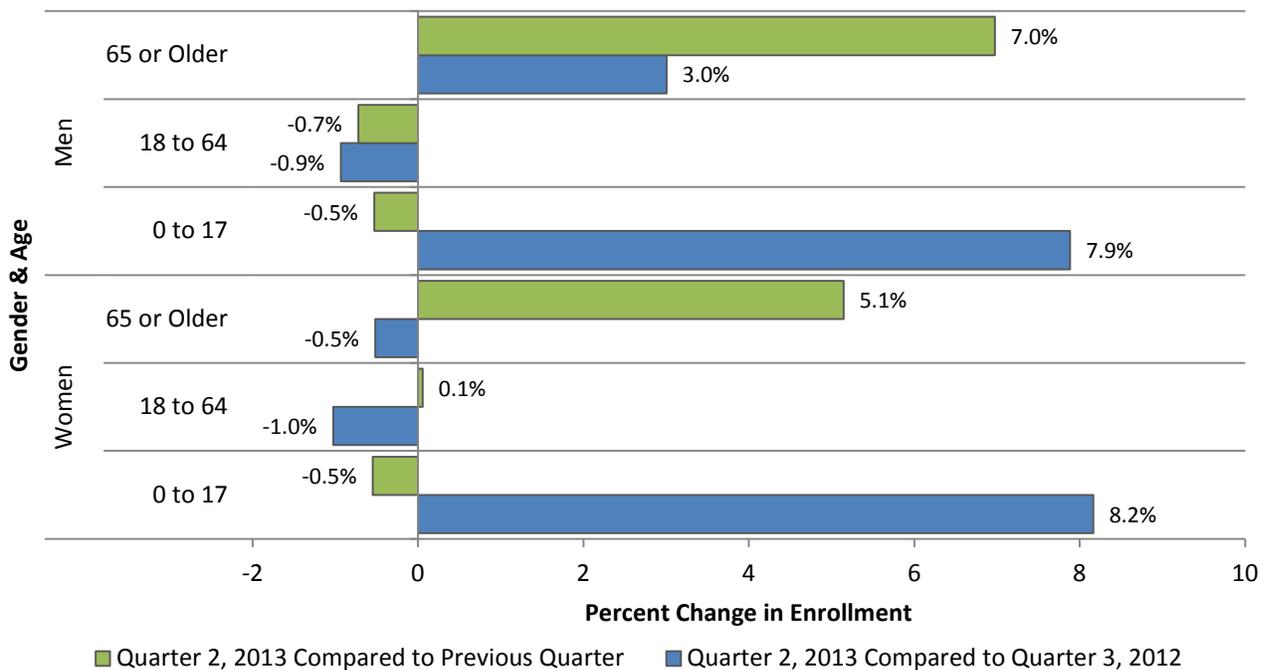
In Figure BP-3, the largest increase in FFS participation from the third quarter of 2012 to the second quarter of 2013 was among females age 0-17 (8.2%) and males age 0-17 (7.9%). Among young adults age 18–64, females experienced a larger decrease (-1.0%) in FFS participation than males (-0.9%) across this same 12-month study period.

Among adults age 65 or older, there were significant increases in participation among both women (5.1%) and men (7.0%) from the previous quarter to the second quarter of 2013.

A large number of full scope beneficiaries participating in the FFS health care delivery system are age 0-17, comprising 59% of the population in the third quarter of 2012 and 61% in the second quarter of 2013.

Increased FFS participation was observed among both males (7.0%) and females (5.1%) over the age of 65 when comparing the second quarter of 2013 with the previous quarter. When examining the 12-month study period, FFS participation declined among women over the age of 65 (-0.5%) and increased among men of that age group (3.0%).

Figure BP-3. Change in FFS Participation among Full Scope Beneficiaries, by Gender and Age, Quarter 3, 2012–Quarter 2, 2013



Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files July 2012–June 2013. Data reflects a 4-month reporting lag.

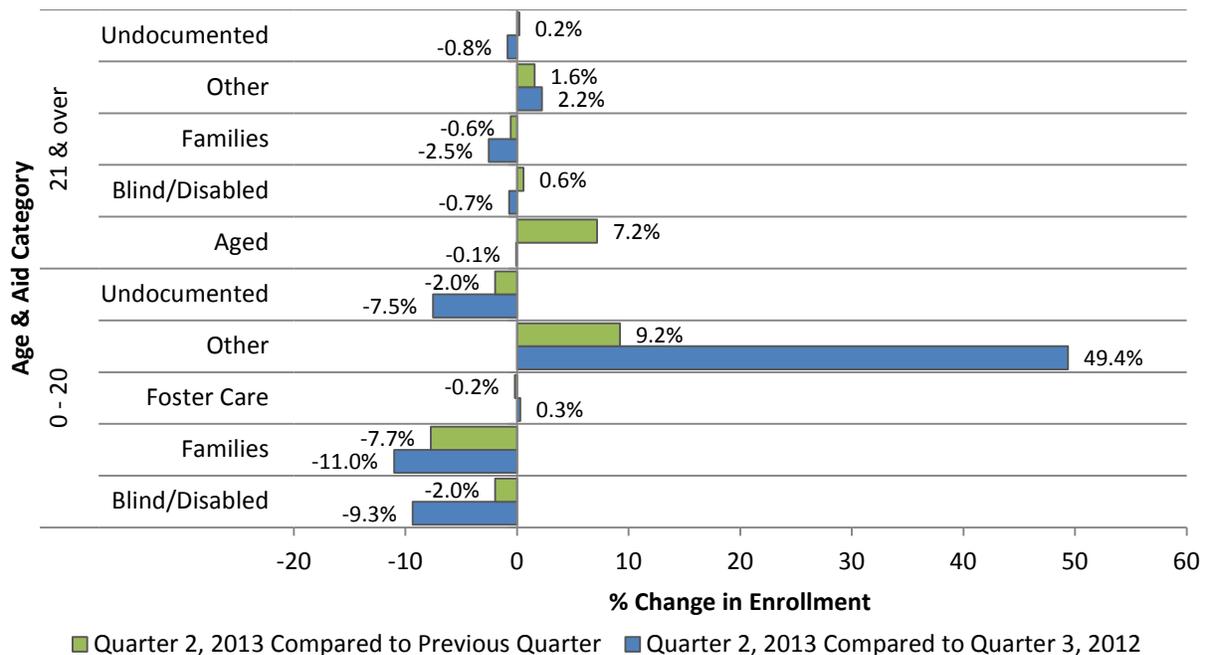
Medi-Cal Beneficiaries by Age and Aid Category

When comparing participation changes from the third quarter of 2012 to the second quarter of 2013, increases in FFS participation were observed among both adults and children in the Other aid category. A sharp increase in FFS participation was observed among children in the Other aid category (49.4%), primarily due to the transition of children from the Healthy Families program into Medi-Cal starting January 1, 2013.

The largest increase in FFS participation occurred among children age 0-20 in the Other aid category (49.4%).

The largest decline in FFS participation in this reporting period occurred for children in the Families (-11.0%) aid category, with smaller declines observed for children in the Blind/Disabled (-9.3%) and Undocumented (-7.5%) aid categories, and adult beneficiaries in the Families (-2.5%) aid category.

Figure BP-4. Change in FFS Participation among All Beneficiaries, by Age and Aid Category, Quarter 3, 2012–Quarter 2, 2013



Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files July 2012–June 2013. Data reflects a 4-month reporting lag.

Evaluating FFS participation across the last two quarters in the study period revealed significant declines for children in the Families (-7.7%) aid category and modest declines for children in the Blind/Disabled (-2.0%), and Undocumented (-2.0%) aid categories. Changes for adults were negligible except for a 7.2% increase in the Aged aid category.

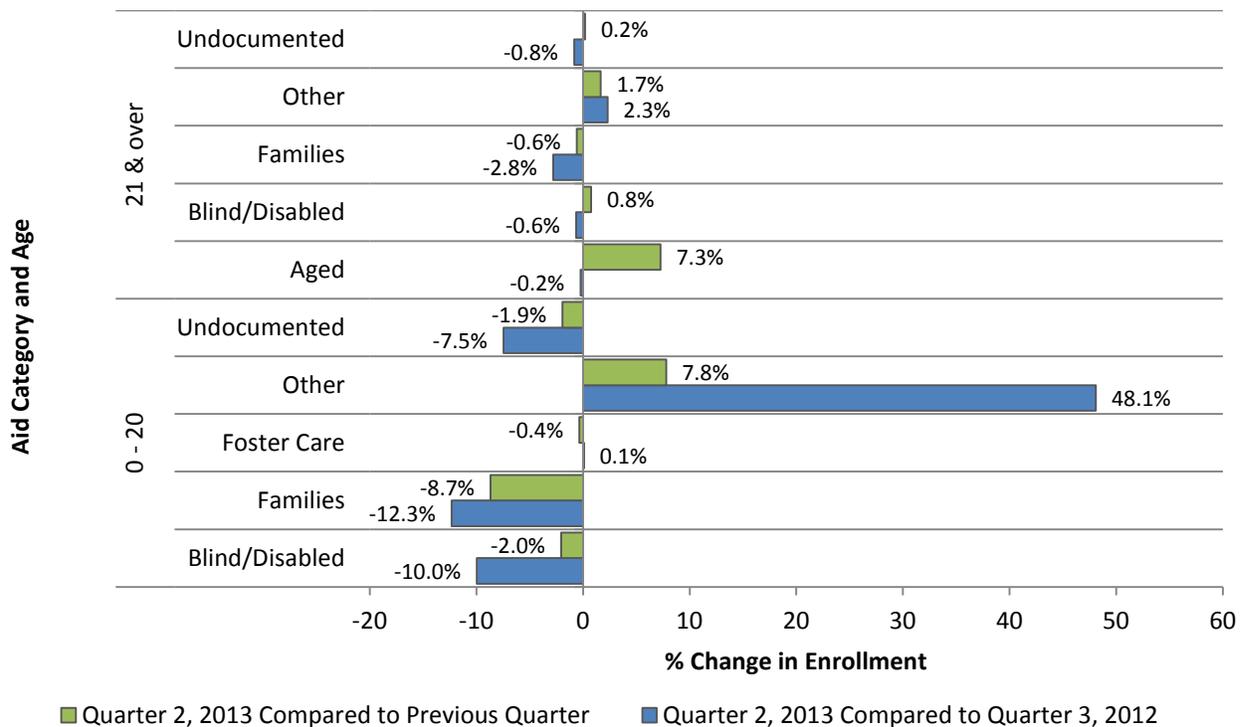
Medi-Cal Beneficiary Participation in Metropolitan and Non-Metropolitan Counties

Overall, FFS participation increased 1.6% from the third quarter of 2012 to the second quarter of 2013 among beneficiaries residing in metropolitan counties and increased 4.6% in non-metropolitan counties (see Table BP-8 and Table BP-9 in [Appendix A](#)). However, FFS participation differed among some of the different subpopulations evaluated in both metropolitan and non-metropolitan counties.

In metropolitan areas, a large increase in FFS participation was observed among children in the Other aid category (48.1%).

For beneficiaries residing in metropolitan counties, decreases in participation occurred among adults in the Aged (-0.2%), Blind/Disabled (-0.6%), Undocumented (-0.8%), and Families (-2.8%) aid categories. More significant decreases occurred among metropolitan children in the Families (-12.3%), Blind/Disabled (-10.0%), and Undocumented (-7.5%) aid categories. A sharp increase was observed for children in the Other (48.1%) aid category, with modest increases among adults in the Other (2.3%) aid category.

Figure BP-5. Change in FFS Participation among Medi-Cal Beneficiaries in Metropolitan Counties, by Age and Aid Category, Quarter 3, 2012–Quarter 2, 2013

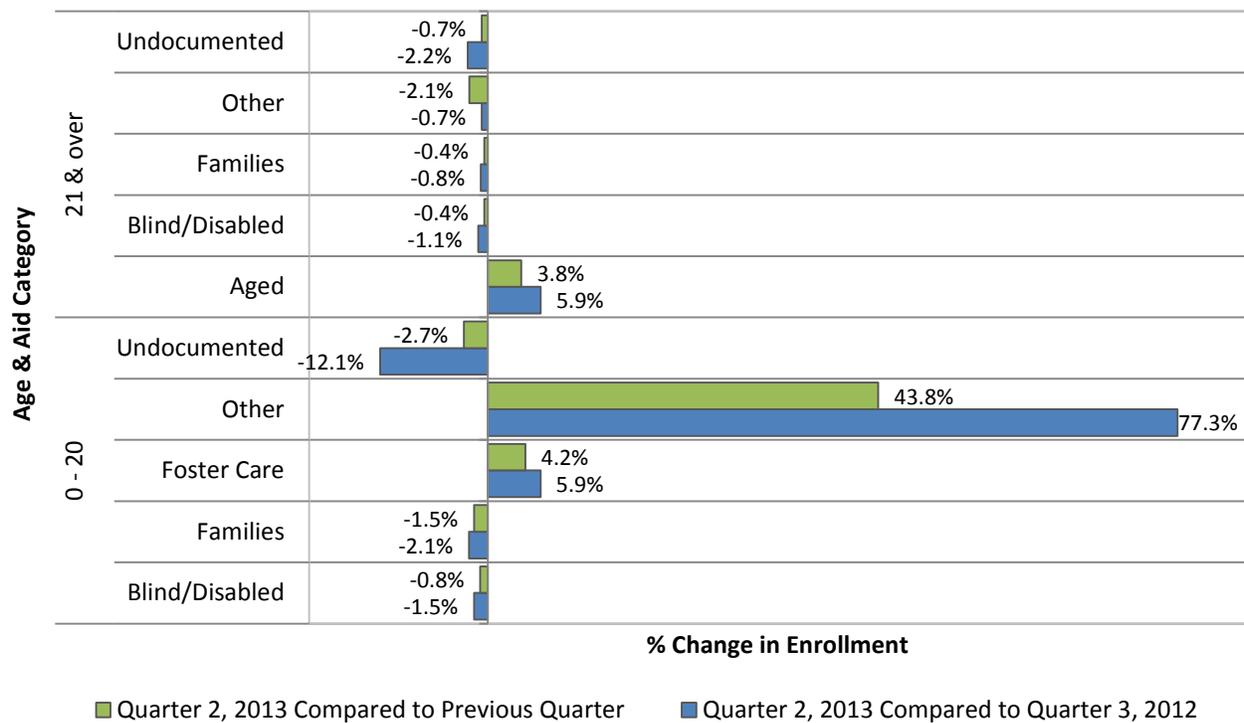


Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files July 2012–June 2013. Data reflects a 4-month reporting lag.

FFS beneficiaries in non-metropolitan counties generally experienced similar patterns in FFS participation as metropolitan areas. For example, FFS participation for children enrolled in Undocumented aid codes and residing in non-metropolitan areas of the state declined 12.1%, while FFS participation for those residing in metropolitan areas declined 7.5%. Meanwhile, the largest increase in non-metropolitan areas occurred among children in the Other aid category, with a 77.3% increase over the 12-month study period and a 43.8% increase between the second quarter of 2013 and the previous quarter.

The most significant difference between metropolitan and non-metropolitan counties was the pattern of overall decline in FFS participation for non-metropolitan adults, with the exception of an increase of adults enrolled in the Aged aid category (5.9%). Declines in FFS participation for children were more moderate in non-metropolitan areas, especially among those enrolled in the Families (-2.1%) and Blind/Disabled (-1.5%) aid categories. Finally, increases in participation among children enrolled in the Foster Care aid category were more significant for non-metropolitan areas (5.9%) compared with metropolitan areas (0.1%).

Figure BP-6. Change in FFS Participation among Medi-Cal Beneficiaries in Non-Metropolitan Counties, by Age and Aid Category, Quarter 3, 2012–Quarter 2, 2013

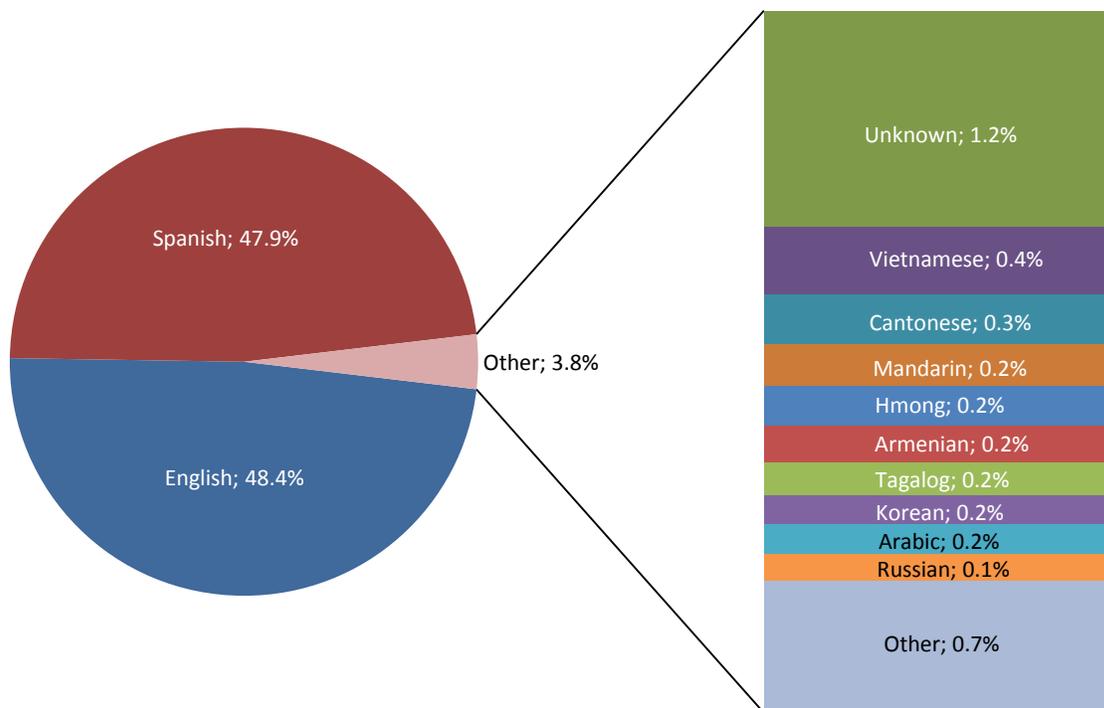


Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files July 2012–June 2013. Data reflects a 4-month reporting lag.

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

As displayed in Figure BP-7, English was self-reported as the primary language spoken by 48.4% of beneficiaries participating in FFS and eligible for Medi-Cal only for the second quarter of 2013. Spanish was the primary language used by 47.9% of the beneficiaries participating in FFS and eligible for Medi-Cal only. The remaining 3.8% of beneficiaries spoke a variety of primary languages, including Vietnamese, Cantonese, Mandarin, Hmong, Armenian, Tagalog, Korean, Arabic, and Russian.

Figure BP-7. Distribution of FFS Medi-Cal Only Beneficiaries, by Primary Language Spoken, June 2013

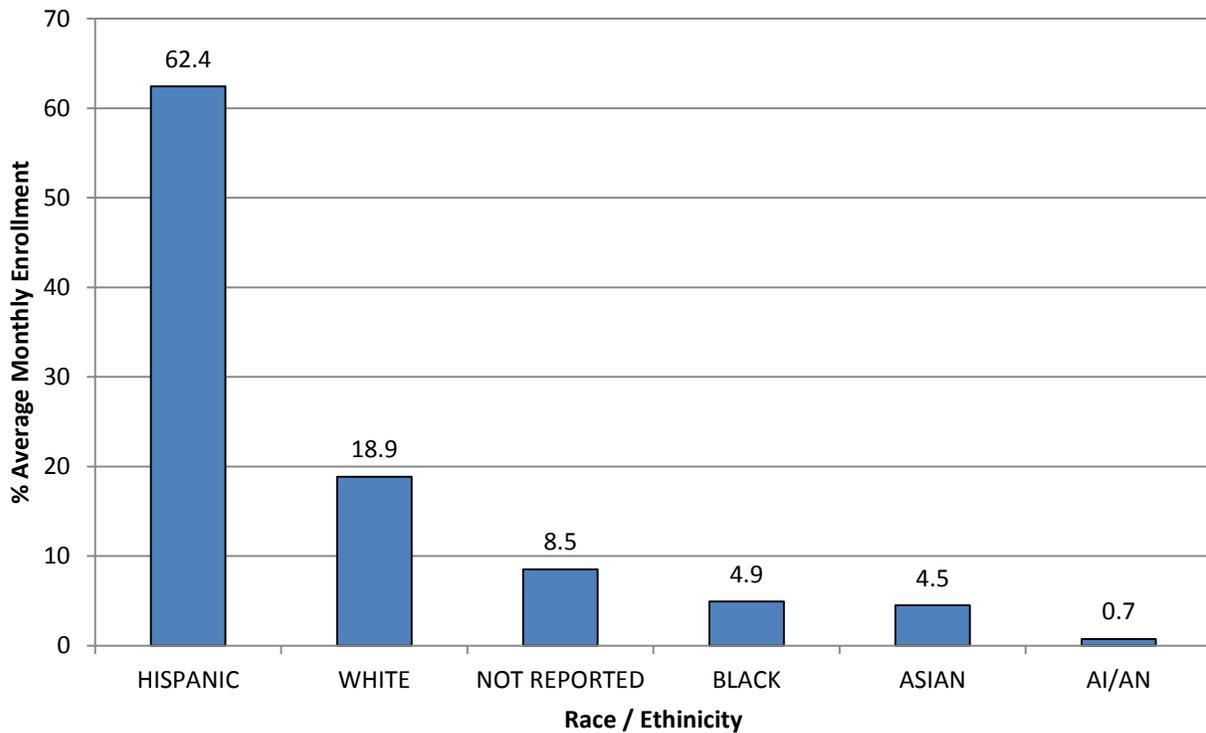


Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF, June 2013 file (reflecting a 4-month reporting lag).

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

As displayed in Figure BP-8, Hispanics represented 62.4% of the total population participating in FFS and eligible for Medi-Cal only for the second quarter of 2013. Whites accounted for 18.9% of all FFS Medi-Cal beneficiaries, while African American and Asian beneficiaries represented a much smaller portion of the overall population (4.9% and 4.5%, respectively). An additional 8.5% of the FFS Medi-Cal population reported no race/ethnic data.

Figure BP-8. Distribution of FFS Beneficiaries, by Race/Ethnicity, June 2013



Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF, June 2013 file. Data reflects a 4-month reporting lag.

Distribution of Medi-Cal Only FFS Beneficiaries by County

As shown in Figure BP-9 and Figure BP-10, when comparing participation changes for all FFS beneficiaries across the entire 12-month study period, large variations were observed by county. A majority of counties (50 out of 58 total counties) saw an increase in FFS participation, with the counties of San Mateo (28.3%), and Mendocino (16.3%) representing the greatest increases. Only eight counties experienced a decline in participation, with Solano County experiencing the largest decrease (-3.2%). Six counties experienced less than one percent point change in either direction.

Only eight counties in California experienced decreases in FFS participation.

Some differences were noted when evaluating participation for full-scope beneficiaries. Similar patterns were observed in Figure BP-10, although the degree of change was more pronounced, with a 68.8% increase in San Mateo County over the four quarters under study (see Table BP-2). The change in participation is most likely due to the transition of children from the Healthy Families program into Medi-Cal that started in January 2013. The data include children as they temporarily enter FFS, but are subsequently enrolled in managed care according to program policy. Participation rates are expected to stabilize by the end of 2013.

Figure BP-9. Comparison of FFS Participation by All Medi-Cal Only Beneficiaries, Quarter 3, 2012–Quarter 2, 2013

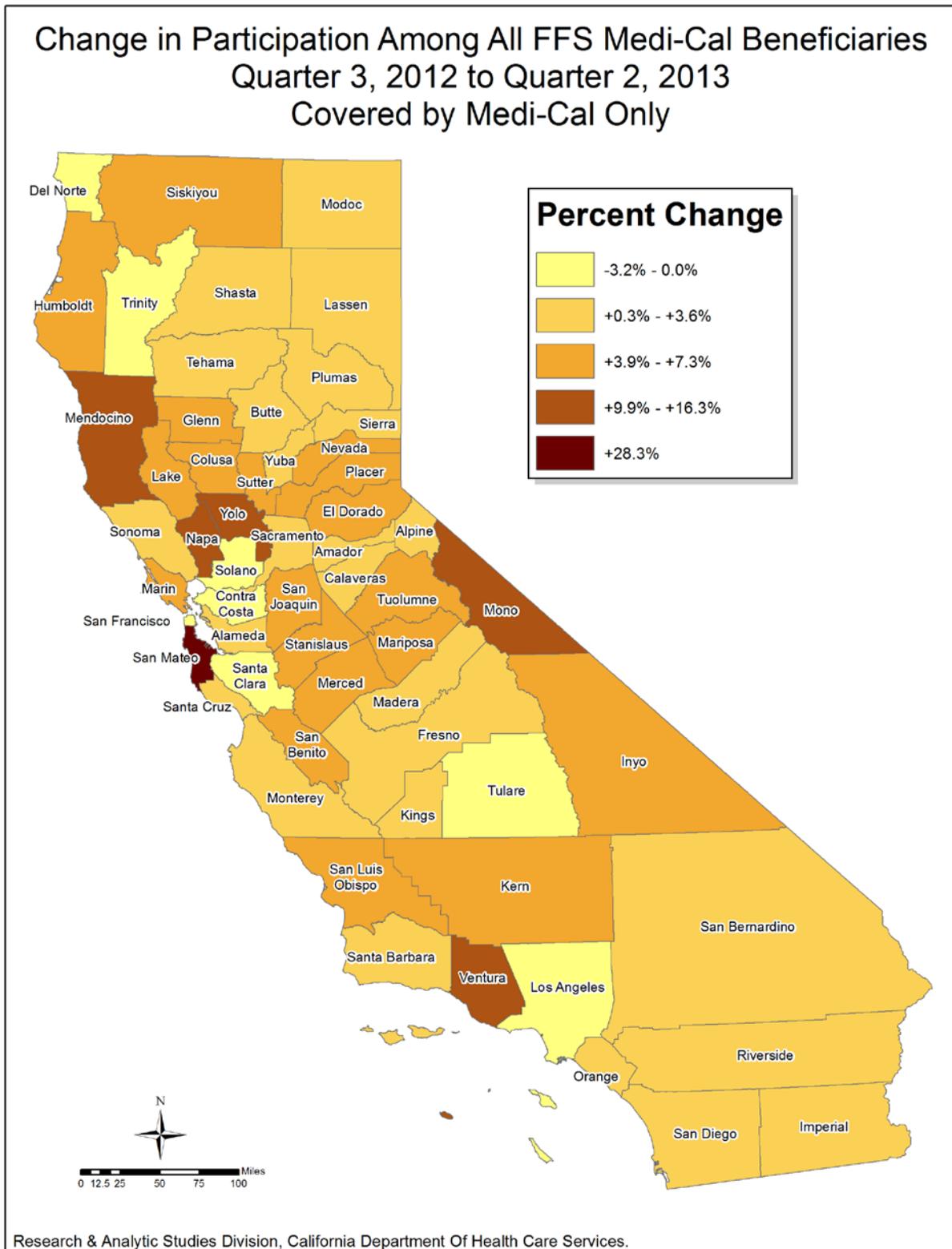
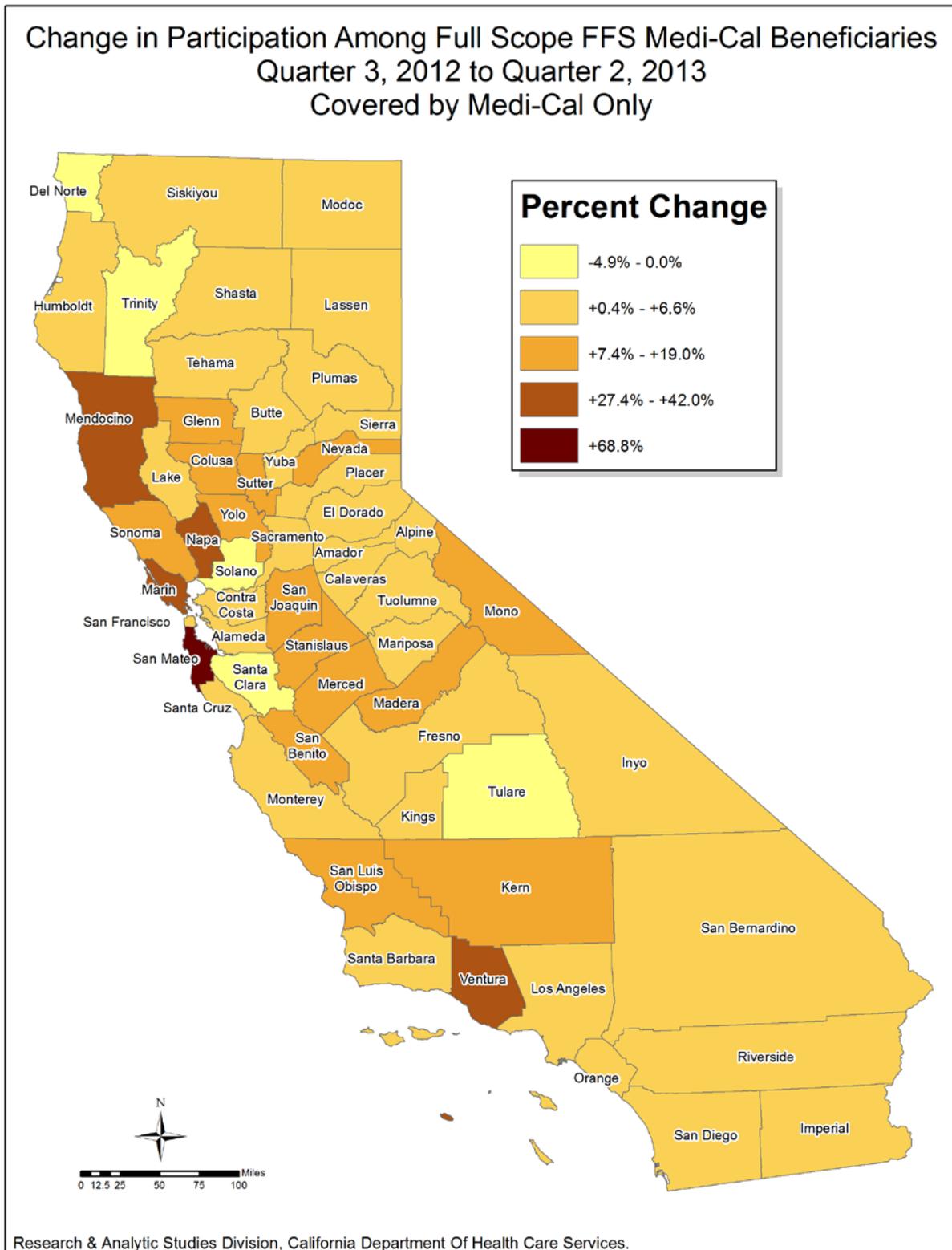


Figure BP-10. Comparison of FFS Participation by Full-Scope Medi-Cal Only Beneficiaries, Quarter 3, 2012–Quarter 2, 2013



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 declined 0.3% between the first quarter of 2013 and the second quarter of 2013, and increased 4.4% when comparing FFS participation from the third quarter of 2012 to the second quarter of 2013.
3. Decreases in FFS participation among Medi-Cal only beneficiaries were observed in the Aged, Blind/Disabled, Families, and Undocumented aid categories.
4. Increases in FFS participation mainly affected those enrolled in the Other aid categories. The sharp increase among children age 0-20 in the Other aid category was due to the transition of children from the Healthy Families program into Medi-Cal that started in January 2013. The data include children as they temporarily enter FFS, but are subsequently enrolled in managed care according to program policy. Participation rates are expected to stabilize by the end of 2013.
5. Participation trends for Medi-Cal's FFS population were somewhat different in metropolitan and non-metropolitan counties. The most significant difference was the pattern of overall decline in FFS participation for non-metropolitan adults, with the exception of increases in the Aged aid category. Declines in FFS participation for children were more moderate in non-metropolitan areas, especially among those enrolled in the Families and Blind/Disabled aid categories.
6. A majority of counties saw an increase in FFS participation, with San Mateo County representing the greatest increase. Only eight counties experienced a decline in FFS participation. Six counties experienced less than one percent point change in either direction over the 12-month study period.

Appendix A—County and Statewide Tables

Table BP-1. Average Monthly FFS Eligibles , All FFS Medi-Cal Only by County, Quarter 3, 2012–Quarter 2, 2013

County	Average Member Months				Percent Change	
	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Quarter 2, 2013 Compared to Quarter 3, 2012	Quarter 2, 2013 Compared to Previous Quarter
Alameda	52,121	51,457	51,843	52,779	1.3	1.8
Alpine	147	155	153	152	3.4	-0.7
Amador	3,637	3,586	3,623	3,693	1.5	1.9
Butte	41,227	40,902	41,210	42,143	2.2	2.3
Calaveras	5,596	5,517	5,624	5,747	2.7	2.2
Colusa	3,937	3,879	4,045	4,226	7.3	4.5
Contra Costa	33,106	32,658	33,843	33,057	-0.1	-2.3
Del Norte	6,567	6,420	6,426	6,469	-1.5	0.7
El Dorado	15,573	15,476	15,768	16,186	3.9	2.7
Fresno	57,202	57,243	58,251	58,446	2.2	0.3
Glenn	6,113	6,087	6,362	6,559	7.3	3.1
Humboldt	21,610	21,539	21,780	22,651	4.8	4.0
Imperial	46,644	46,762	46,905	47,674	2.2	1.6
Inyo	2,901	2,872	2,862	3,027	4.3	5.8
Kern	58,530	57,619	59,189	60,851	4.0	2.8
Kings	7,653	7,657	7,827	7,814	2.1	-0.2
Lake	13,759	13,811	13,964	14,376	4.5	3.0
Lassen	3,971	3,938	3,988	4,084	2.8	2.4
Los Angeles	566,931	552,108	583,243	564,586	-0.4	-3.2
Madera	11,585	11,617	12,217	11,861	2.4	-2.9
Marin	5,682	5,567	5,812	6,000	5.6	3.2
Mariposa	2,240	2,253	2,286	2,341	4.5	2.4
Mendocino	3,159	3,146	3,308	3,675	16.3	11.1
Merced	13,183	12,859	13,730	13,800	4.7	0.5
Modoc	1,557	1,565	1,543	1,598	2.6	3.6
Mono	1,288	1,276	1,329	1,443	12.0	8.6
Monterey	23,122	23,066	24,834	23,518	1.7	-5.3
Napa	3,008	2,994	3,209	3,345	11.2	4.2
Nevada	9,146	9,145	9,332	9,767	6.8	4.7
Orange	85,231	83,623	86,604	85,523	0.3	-1.2
Placer	24,868	24,803	25,297	26,172	5.2	3.5
Plumas	2,439	2,477	2,493	2,528	3.6	1.4
Riverside	92,523	89,970	92,676	95,419	3.1	3.0
Sacramento	55,099	55,072	55,446	55,653	1.0	0.4
San Benito	8,866	8,871	9,130	9,471	6.8	3.7
San Bernardino	116,359	113,295	115,013	117,159	0.7	1.9

County	Average Member Months				Percent Change	
	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Quarter 2, 2013 Compared to Quarter 3, 2012	Quarter 2, 2013 Compared to Previous Quarter
San Diego	99,945	98,456	98,988	102,241	2.3	3.3
San Francisco	21,249	20,941	21,213	21,110	-0.7	-0.5
San Joaquin	34,912	35,084	38,313	36,346	4.1	-5.1
San Luis Obispo	5,486	5,413	5,844	5,739	4.6	-1.8
San Mateo	18,013	17,902	18,664	23,117	28.3	23.9
Santa Barbara	18,011	17,660	19,230	18,108	0.5	-5.8
Santa Clara	63,773	64,013	63,641	62,632	-1.8	-1.6
Santa Cruz	7,716	7,736	8,301	7,855	1.8	-5.4
Shasta	32,482	31,898	32,132	32,997	1.6	2.7
Sierra	357	354	376	370	3.6	-1.6
Siskiyou	8,416	8,446	8,709	8,924	6.0	2.5
Solano	10,041	9,792	10,409	9,724	-3.2	-6.6
Sonoma	11,284	10,952	11,823	11,533	2.2	-2.5
Stanislaus	36,722	36,871	42,406	39,063	6.4	-7.9
Sutter	19,601	19,470	19,961	20,891	6.6	4.7
Tehama	14,401	14,206	14,406	14,786	2.7	2.6
Trinity	2,188	2,141	2,124	2,156	-1.5	1.5
Tulare	35,908	35,164	35,976	35,029	-2.4	-2.6
Tuolumne	6,349	6,341	6,501	6,722	5.9	3.4
Ventura	24,271	23,853	26,117	26,929	11.0	3.1
Yolo	4,895	4,817	5,356	5,381	9.9	0.5
Yuba	17,238	16,986	17,304	17,676	2.5	2.1

Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files, July 2012–June 2013. Data reflects a 4-month reporting lag.

Table BP-2. Average Monthly FFS Eligibles, Full Scope Medi-Cal Only by County, Quarter 3, 2012–Quarter 2, 2013

County	Average Member Months				Percent Change	
	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Quarter 2, 2013 Compared to Quarter 3, 2012	Quarter 2, 2013 Compared to Previous Quarter
Alameda	31,233	30,934	31,528	32,753	4.9	3.9
Alpine	147	155	153	151	2.7	-1.3
Amador	3,541	3,499	3,534	3,605	1.8	2.0
Butte	39,976	39,697	40,021	40,954	2.4	2.3
Calaveras	5,445	5,369	5,477	5,612	3.1	2.5
Colusa	3,502	3,471	3,644	3,841	9.7	5.4
Contra Costa	19,073	18,865	20,213	19,615	2.8	-3.0
Del Norte	6,408	6,269	6,279	6,320	-1.4	0.7
El Dorado	14,543	14,482	14,765	15,180	4.4	2.8
Fresno	28,298	28,583	29,537	30,176	6.6	2.2
Glenn	5,523	5,508	5,777	5,978	8.2	3.5
Humboldt	21,016	20,955	21,209	22,078	5.1	4.1
Imperial	45,708	45,849	46,009	46,805	2.4	1.7
Inyo	2,574	2,560	2,553	2,719	5.6	6.5
Kern	35,344	34,815	36,310	38,003	7.5	4.7
Kings	4,552	4,593	4,718	4,729	3.9	0.2
Lake	13,125	13,182	13,324	13,739	4.7	3.1
Lassen	3,843	3,806	3,867	3,966	3.2	2.6
Los Angeles	255,369	248,425	281,539	261,514	2.4	-7.1
Madera	4,664	4,812	5,368	5,086	9.0	-5.3
Marin	1,171	1,127	1,368	1,553	32.6	13.5
Mariposa	2,187	2,212	2,234	2,282	4.3	2.1
Mendocino	1,457	1,472	1,654	2,018	38.5	22.0
Merced	5,257	5,067	5,863	5,946	13.1	1.4
Modoc	1,481	1,494	1,471	1,531	3.4	4.1
Mono	1,051	1,060	1,116	1,231	17.1	10.3
Monterey	5,714	6,052	7,009	5,734	0.4	-18.2
Napa	1,168	1,211	1,475	1,658	42.0	12.4
Nevada	8,822	8,853	9,039	9,486	7.5	4.9
Orange	29,163	27,992	31,252	30,400	4.2	-2.7
Placer	23,708	23,648	24,152	25,042	5.6	3.7
Plumas	2,381	2,420	2,436	2,473	3.9	1.5
Riverside	64,226	61,958	65,011	67,758	5.5	4.2
Sacramento	40,893	40,983	41,433	41,823	2.3	0.9
San Benito	7,796	7,828	8,053	8,383	7.5	4.1

County	Average Member Months				Percent Change	
	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Quarter 2, 2013 Compared to Quarter 3, 2012	Quarter 2, 2013 Compared to Previous Quarter
San Bernardino	83,818	81,186	83,051	85,419	1.9	2.9
San Diego	74,796	73,797	74,505	78,168	4.5	4.9
San Francisco	11,897	11,701	12,053	12,047	1.3	0.0
San Joaquin	20,782	21,157	24,405	22,615	8.8	-7.3
San Luis Obispo	2,721	2,698	3,106	3,055	12.3	-1.6
San Mateo	6,357	6,190	6,936	10,733	68.8	54.7
Santa Barbara	5,611	5,516	6,900	5,786	3.1	-16.1
Santa Clara	30,324	30,563	30,221	29,614	-2.3	-2.0
Santa Cruz	2,978	3,076	3,554	3,167	6.3	-10.9
Shasta	32,104	31,510	31,732	32,608	1.6	2.8
Sierra	351	348	369	364	3.7	-1.4
Siskiyou	8,247	8,282	8,546	8,766	6.3	2.6
Solano	5,364	5,115	5,722	5,102	-4.9	-10.8
Sonoma	5,301	5,057	5,900	5,729	8.1	-2.9
Stanislaus	26,518	26,676	32,193	28,967	9.2	-10.0
Sutter	18,028	17,966	18,434	19,361	7.4	5.0
Tehama	13,478	13,302	13,520	13,922	3.3	3.0
Trinity	2,172	2,127	2,109	2,142	-1.4	1.6
Tulare	17,072	16,531	17,237	16,349	-4.2	-5.2
Tuolumne	6,297	6,281	6,443	6,661	5.8	3.4
Ventura	10,074	9,916	11,868	12,831	27.4	8.1
Yolo	2,892	2,835	3,363	3,441	19.0	2.3
Yuba	16,235	16,006	16,324	16,742	3.1	2.6

Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files July 2012–June 2013. Data reflects a 4-month reporting lag.

Table BP-3. Average Monthly FFS Eligibles, Full Scope Medi-Cal Only Children Age 0–17 by County, Quarter 3, 2012–Quarter 2, 2013

County	Average Member Months				Percent Change	
	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Quarter 2, 2013 Compared to Quarter 3, 2012	Quarter 2, 2013 Compared to Previous Quarter
Alameda	17,420	17,304	18,053	18,845	8.2	4.4
Alpine	83	84	84	83	0.0	-1.2
Amador	1,859	1,867	1,918	2,016	8.4	5.1
Butte	20,835	20,692	21,013	21,943	5.3	4.4
Calaveras	2,853	2,800	2,870	3,037	6.4	5.8
Colusa	2,338	2,309	2,462	2,698	15.4	9.6
Contra Costa	10,914	10,947	12,428	11,832	8.4	-4.8
Del Norte	3,292	3,223	3,238	3,338	1.4	3.1
El Dorado	8,125	8,099	8,386	8,921	9.8	6.4
Fresno	16,812	17,080	17,992	18,840	12.1	4.7
Glenn	3,444	3,448	3,687	3,880	12.7	5.2
Humboldt	10,967	11,007	11,317	12,170	11.0	7.5
Imperial	25,976	26,144	26,431	27,361	5.3	3.5
Inyo	1,514	1,525	1,528	1,671	10.4	9.4
Kern	22,771	22,527	23,942	25,358	11.4	5.9
Kings	2,985	3,047	3,158	3,199	7.2	1.3
Lake	6,835	6,877	7,015	7,388	8.1	5.3
Lassen	2,057	2,038	2,072	2,176	5.8	5.0
Los Angeles	154,444	150,110	181,313	160,876	4.2	-11.3
Madera	3,031	3,149	3,599	3,404	12.3	-5.4
Marin	764	740	929	1,115	45.9	20.0
Mariposa	1,164	1,170	1,187	1,252	7.6	5.5
Mendocino	816	855	1,006	1,366	67.4	35.8
Merced	3,293	3,145	3,864	4,081	23.9	5.6
Modoc	799	799	779	843	5.5	8.2
Mono	711	728	771	878	23.5	13.9
Monterey	3,835	3,958	4,729	3,728	-2.8	-21.2
Napa	724	740	955	1,143	57.9	19.7
Nevada	4,674	4,702	4,890	5,316	13.7	8.7
Orange	19,025	17,854	20,757	20,061	5.4	-3.4
Placer	13,870	13,898	14,418	15,209	9.7	5.5
Plumas	1,271	1,302	1,307	1,361	7.1	4.1
Riverside	41,495	40,171	43,277	45,431	9.5	5.0
Sacramento	24,004	24,280	25,019	25,174	4.9	0.6
San Benito	4,968	5,016	5,194	5,546	11.6	6.8

County	Average Member Months				Percent Change	
	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Quarter 2, 2013 Compared to Quarter 3, 2012	Quarter 2, 2013 Compared to Previous Quarter
San Bernardino	50,161	48,555	51,032	52,916	5.5	3.7
San Diego	46,685	46,266	48,021	51,364	10.0	7.0
San Francisco	5,334	5,364	5,775	5,673	6.4	-1.8
San Joaquin	12,978	13,190	15,620	14,605	12.5	-6.5
San Luis Obispo	1,588	1,557	1,918	1,937	22.0	1.0
San Mateo	4,032	4,002	4,641	7,469	85.2	60.9
Santa Barbara	3,709	3,581	4,771	3,760	1.4	-21.2
Santa Clara	17,280	17,594	18,238	17,752	2.7	-2.7
Santa Cruz	1,698	1,810	2,180	1,873	10.3	-14.1
Shasta	16,740	16,430	16,714	17,672	5.6	5.7
Sierra	173	164	179	185	6.9	3.4
Siskiyou	4,270	4,305	4,484	4,677	9.5	4.3
Solano	3,160	3,005	3,594	2,991	-5.3	-16.8
Sonoma	3,292	3,142	3,868	3,784	14.9	-2.2
Stanislaus	15,201	15,292	19,178	17,397	14.4	-9.3
Sutter	10,798	10,739	11,117	11,919	10.4	7.2
Tehama	7,835	7,782	8,001	8,354	6.6	4.4
Trinity	1,066	1,050	1,064	1,095	2.7	2.9
Tulare	10,622	10,172	10,683	9,990	-5.9	-6.5
Tuolumne	3,251	3,250	3,353	3,565	9.7	6.3
Ventura	6,499	6,320	8,134	9,183	41.3	12.9
Yolo	1,869	1,812	2,224	2,340	25.2	5.2
Yuba	9,179	9,061	9,302	9,690	5.6	4.2

Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files July 2012–June 2013. Data reflects a 4-month reporting lag.

Table BP-4. Average Monthly FFS Eligibles, Medi-Cal Only Women Age 18–64 by County, Quarter 3, 2012–Quarter 2, 2013

County	Average Member Months				Percent Change	
	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Quarter 2, 2013 Compared to Quarter 3, 2012	Quarter 2, 2013 Compared to Previous Quarter
Alameda	19,627	19,339	19,325	19,475	-0.8	0.8
Alpine	35	37	38	37	5.7	-2.6
Amador	1,103	1,075	1,067	1,052	-4.6	-1.4
Butte	12,131	12,066	12,045	12,062	-0.6	0.1
Calaveras	1,647	1,619	1,637	1,614	-2.0	-1.4
Colusa	1,001	986	995	961	-4.0	-3.4
Contra Costa	12,195	12,045	11,894	11,810	-3.2	-0.7
Del Norte	1,918	1,870	1,870	1,840	-4.1	-1.6
El Dorado	4,434	4,363	4,341	4,263	-3.9	-1.8
Fresno	21,887	21,792	21,773	21,500	-1.8	-1.3
Glenn	1,631	1,616	1,642	1,643	0.7	0.1
Humboldt	6,368	6,321	6,289	6,268	-1.6	-0.3
Imperial	13,579	13,526	13,455	13,385	-1.4	-0.5
Inyo	814	790	786	799	-1.8	1.7
Kern	19,793	19,436	19,503	19,696	-0.5	1.0
Kings	2,543	2,504	2,520	2,508	-1.4	-0.5
Lake	4,050	4,066	4,077	4,095	1.1	0.4
Lassen	1,155	1,141	1,153	1,144	-1.0	-0.8
Los Angeles	229,000	223,457	223,841	225,425	-1.6	0.7
Madera	4,555	4,533	4,602	4,519	-0.8	-1.8
Marin	2,704	2,658	2,682	2,678	-1.0	-0.1
Mariposa	635	640	654	653	2.8	-0.2
Mendocino	1,245	1,205	1,227	1,241	-0.3	1.1
Merced	5,319	5,195	5,274	5,224	-1.8	-0.9
Modoc	443	451	452	443	0.0	-2.0
Mono	334	317	328	334	0.0	1.8
Monterey	10,444	10,467	10,947	10,739	2.8	-1.9
Napa	1,336	1,308	1,334	1,281	-4.1	-4.0
Nevada	2,742	2,736	2,741	2,752	0.4	0.4
Orange	39,566	39,343	39,451	39,306	-0.7	-0.4
Placer	6,771	6,682	6,637	6,679	-1.4	0.6
Plumas	729	731	731	714	-2.1	-2.3
Riverside	31,053	30,296	30,070	30,455	-1.9	1.3
Sacramento	18,087	17,941	17,745	17,817	-1.5	0.4
San Benito	2,422	2,404	2,465	2,456	1.4	-0.4
San Bernardino	39,604	38,677	38,171	38,401	-3.0	0.6
San Diego	33,964	33,257	32,376	32,289	-4.9	-0.3
San Francisco	8,537	8,363	8,331	8,235	-3.5	-1.2
San Joaquin	11,935	12,000	12,432	11,893	-0.4	-4.3

County	Average Member Months				Percent Change	
	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Quarter 2, 2013 Compared to Quarter 3, 2012	Quarter 2, 2013 Compared to Previous Quarter
San Luis Obispo	2,236	2,225	2,261	2,201	-1.6	-2.7
San Mateo	7,549	7,476	7,549	8,401	11.3	11.3
Santa Barbara	8,317	8,283	8,503	8,492	2.1	-0.1
Santa Clara	25,501	25,463	25,023	24,759	-2.9	-1.1
Santa Cruz	3,667	3,613	3,713	3,622	-1.2	-2.5
Shasta	9,564	9,388	9,348	9,318	-2.6	-0.3
Sierra	106	113	116	110	3.8	-5.2
Siskiyou	2,479	2,476	2,521	2,544	2.6	0.9
Solano	3,932	3,885	3,915	3,891	-1.0	-0.6
Sonoma	4,867	4,769	4,849	4,722	-3.0	-2.6
Stanislaus	12,046	12,093	13,210	12,263	1.8	-7.2
Sutter	5,155	5,085	5,133	5,209	1.0	1.5
Tehama	3,989	3,887	3,862	3,901	-2.2	1.0
Trinity	665	647	624	625	-6.0	0.2
Tulare	13,377	13,227	13,449	13,418	0.3	-0.2
Tuolumne	1,920	1,905	1,952	1,962	2.2	0.5
Ventura	10,418	10,299	10,551	10,461	0.4	-0.9
Yolo	1,766	1,763	1,853	1,791	1.4	-3.3
Yuba	4,831	4,743	4,776	4,777	-1.1	0.0

Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files July 2012–June 2013. Data reflects a 4-month reporting lag.

Table BP-5. Average Monthly FFS Eligibles with Full Scope by Gender and Age, Quarter 3, 2012–Quarter 2, 2013

Gender	Age Category	Average Member Months				Percent Change	
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Quarter 2, 2013 Compared to Quarter 3, 2012	Quarter 2, 2013 Compared to Previous Quarter
Women	0 to 17	329,094	324,236	357,924	355,970	8.2	-0.5
	18 to 64	297,636	292,764	294,413	294,586	-1.0	0.1
	65 or Older	8,153	7,944	7,714	8,111	-0.5	5.1
Men	0 to 17	348,295	343,844	377,757	375,762	7.9	-0.5
	18 to 64	155,342	153,147	155,013	153,893	-0.9	-0.7
	65 or Older	5,255	5,104	5,060	5,413	3.0	7.0
All	0 to 17	677,389	668,080	735,681	731,732	8.0	-0.5
	18 to 64	452,978	445,911	449,426	448,479	-1.0	-0.2
	65 or Older	13,408	13,048	12,774	13,524	0.9	5.9
Total		1,143,775	1,127,039	1,197,881	1,193,735	4.4	-0.3

Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files July 2012–June 2013. Data reflects a 4-month reporting lag.

Table BP-6. Average Monthly FFS Eligibles with Restricted Scope by Gender and Age, Quarter 3, 2012–Quarter 2, 2013

Gender	Age Category	Average Member Months				Percent Change	
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Quarter 2, 2013 Compared to Quarter 3, 2012	Quarter 2, 2013 Compared to Previous Quarter
Women	0 to 17	58,306	56,090	54,350	52,999	-9.1	-2.5
	18 to 64	402,085	395,832	395,698	395,569	-1.6	0.0
	65 or Older	11,078	11,069	11,091	11,163	0.8	0.6
Men	0 to 17	59,706	57,659	56,118	54,868	-8.1	-2.2
	18 to 64	219,313	216,485	218,174	219,068	-0.1	0.4
	65 or Older	5,573	5,608	5,645	5,718	2.6	1.3
All	0 to 17	118,012	113,749	110,468	107,867	-8.6	-2.4
	18 to 64	621,398	612,317	613,872	614,637	-1.1	0.1
	65 or Older	16,651	16,677	16,736	16,881	1.4	0.9
Total		756,061	742,743	741,076	739,385	-2.2	-0.2

Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files July 2012–June 2013. Data reflects a 4-month reporting lag.

Table BP-7. Average Monthly All FFS Eligibles by Age and Aid Category, Quarter 3, 2012–Quarter 2, 2013

Age	Aid Category	Average Member Months				Percent Change	
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Quarter 2, 2013 Compared to Quarter 3, 2012	Quarter 2, 2013 Compared to Previous Quarter
0 - 20	Blind/Disabled	39,860	37,920	36,855	36,136	-9.3	-2.0
	Families	412,216	410,240	397,567	366,813	-11.0	-7.7
	Foster Care	97,594	98,025	98,073	97,892	0.3	-0.2
	Other	209,685	202,023	286,775	313,222	49.4	9.2
	Undocumented	154,284	149,168	145,527	142,688	-7.5	-2.0
21 & over	Aged	10,933	10,492	10,194	10,925	-0.1	7.2
	Blind/Disabled	97,495	95,617	96,249	96,799	-0.7	0.6
	Families	214,518	211,287	210,256	209,062	-2.5	-0.6
	Other	61,361	61,310	61,764	62,729	2.2	1.6
	Undocumented	601,777	593,576	595,550	596,696	-0.8	0.2
Total		1,899,723	1,869,658	1,938,810	1,932,962	1.7	-0.3

Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files July 2012–June 2013. Data reflects a 4-month reporting lag.

Table BP-8. Average Monthly FFS Eligibles in Metropolitan Counties by Age and Aid Category, Quarter 3, 2012–Quarter 2, 2013

Age	Aid Category	Average Member Months				Percent Change	
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Quarter 2, 2013 Compared to Quarter 3, 2012	Quarter 2, 2013 Compared to Previous Quarter
0 - 20	Blind/Disabled	36,953	35,035	33,969	33,274	-10.0	-2.0
	Families	359,828	357,976	345,476	315,517	-12.3	-8.7
	Foster Care	94,102	94,501	94,524	94,193	0.1	-0.4
	Other	200,457	192,816	275,394	296,858	48.1	7.8
	Undocumented	152,536	147,521	143,947	141,150	-7.5	-1.9
21 & over	Aged	10,647	10,202	9,902	10,622	-0.2	7.3
	Blind/Disabled	81,429	79,621	80,293	80,904	-0.6	0.8
	Families	187,519	184,480	183,360	182,267	-2.8	-0.6
	Other	59,685	59,661	60,065	61,065	2.3	1.7
	Undocumented	596,796	588,693	590,649	591,827	-0.8	0.2
Total		1,779,952	1,750,506	1,817,579	1,807,677	1.6	-0.5

Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files July 2012–June 2013. Data reflects a 4-month reporting lag.

Table BP-9. Average Monthly FFS Eligibles in Non-Metropolitan Counties by Age and Aid Category, Quarter 3, 2012–Quarter 2, 2013

Age	Aid Category	Average Member Months				Percent Change	
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Quarter 2, 2013 Compared to Quarter 3, 2012	Quarter 2, 2013 Compared to Previous Quarter
0 - 20	Blind/Disabled	2,906	2,885	2,886	2,862	-1.5	-0.8
	Families	52,388	52,265	52,091	51,296	-2.1	-1.5
	Foster Care	3,492	3,524	3,549	3,699	5.9	4.2
	Other	9,228	9,208	11,380	16,364	77.3	43.8
	Undocumented	1,749	1,647	1,580	1,538	-12.1	-2.7
21 & over	Aged	286	290	292	303	5.9	3.8
	Blind/Disabled	16,066	15,996	15,955	15,896	-1.1	-0.4
	Families	26,999	26,806	26,895	26,795	-0.8	-0.4
	Other	1,675	1,649	1,699	1,664	-0.7	-2.1
	Undocumented	4,981	4,882	4,901	4,869	-2.2	-0.7
Total		119,770	119,152	121,228	125,286	4.6	3.3

Source: Prepared by DHCS Research and Analytic Studies Division using data from the MEDS System MMEF files July 2012–June 2013. 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 the Medi-Cal website:

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 #7 2013 Quarter 2



Physician Supply

February 2014

May 2014

California Department of Health Care Services
Research and Analytic Studies Division
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Errata

5/2/2014

This section has been updated to more clearly describe the statistics presented for Primary Care Physicians. The previous description indicated that Clinics and all physician specialty types (General Medicine, Family Practice, Internal Medicine, Pediatrics, Obstetrics, Gynecology) were included in the total counts of Primary Care Physicians (Table PS-3). The descriptions have been updated to clarify that the counts of Primary Care Physicians only include the physician specialties General Medicine, Family Practice, and Internal Medicine. It has been further clarified that while Clinics and the other physician specialties (Pediatrics, Obstetrics, and Gynecology) are also considered Primary Care Physicians, they are each counted and represented in separate tables within the section. As a result, there have been no changes in the aggregate counts or trend analyses of Primary Care Physicians, but rather an expansion of the description of how the data are presented.

Updated Elements:

- Table PS-1, Page 9, update to the description of Table PS-3 for Primary Care Physicians.
- First paragraph, Page 16, update to the description of Primary Care Physicians.

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Medi-Cal Physician Supply

Introduction

Physician availability is an important first step in accessing health care, increasing the likelihood that patients receive preventive services and timely referrals to needed care. Studies have reported that a higher supply of primary care physicians is associated with lower mortality rates, longer life expectancy, and better birth outcomes.

Highlights

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

Overall findings indicate that the statewide supply of physicians potentially available to beneficiaries eligible for Medi-Cal only and entitled to full scope health care services and participating in FFS continued to grow modestly.

Site-specific physician counts increased 4.6%, from 75,093 to 78,534.

Site-specific primary care physician counts increased 4.2%, from 28,178 to 29,359.

Site-specific OB/GYN physician counts increased 4.1%, from 4,442 to 4,625.

Site-specific pediatrician counts increased 4.4%, from 7,846 to 8,192.

Consequently, physicians have been described as the epicenter of health care delivery, providing patients with a gateway into the health system and affecting how 90% of all health care dollars are spent.

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

The counts of physicians in this report represent physician supply, or the number of physicians potentially available to provide services to Medi-Cal beneficiaries. The term physician supply is not to be confused with the concept of physician participation. The concept of physician supply is prospective. It is a measure that reports the number of physicians who enrolled and were potentially available to provide services.

The concept of physician participation is retrospective. It reports the number of physicians who actually provided or rendered services to Medi-Cal beneficiaries as measured from paid claims data.

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

The beneficiary-to-provider ratios measure the number of beneficiaries relative to providers. A low ratio indicates that there are a greater number of providers relative to the population, while a high ratio indicates that there are fewer providers relative to the population. Beneficiary-to-provider ratios are useful for identifying differences in physician supply from one geographic area to another, from one measurement period to another, or between the study population and another population or normative benchmark.

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 the following 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.

The Department of Health Care Services evaluates its listing of providers from time to time to ensure that it maintains the most complete and accurate list of Medi-Cal providers. As part of this process, the number of providers denoted as active participants may change from period to period as the dataset is revised for any additions, deletions, or changes. This quarterly access report has incorporated modifications to the Department’s Provider Master File that occurred during the first quarter of 2013.

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 by the:

- Number of distinct individual physicians or physician groups.
- Number of physicians at distinct service locations.
- 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 the overall count and county-specific count for Medi-Cal physician supply in this report by a magnitude of roughly 400 physicians per quarter, or <1% of total physician counts.

Calculation of the Numerator

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

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

Results–Physician Supply

The following tables report the number of physicians, primary care physicians, and other physician specialists. The tables cover four consecutive quarters from the third quarter of 2012 to the second quarter of 2013 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 and beneficiary-to-provider ratios. 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 with specialties in General Medicine, Family Practice, or Internal Medicine. Although Clinics and physicians with specialties in Pediatrics, Obstetrics, or Gynecology are also considered Primary Care Physicians, they are presented separately in this report.
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 Pediatric Specialty and an Active or Indirect status at a given location.

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

Table PS-2 includes site-specific counts of all enrolled physicians identified in the Provider Master File. Table PS-3, Table PS-4, and Table PS-5 include only those physicians identified in the Provider Master File with a given specialty area.

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, June 2013

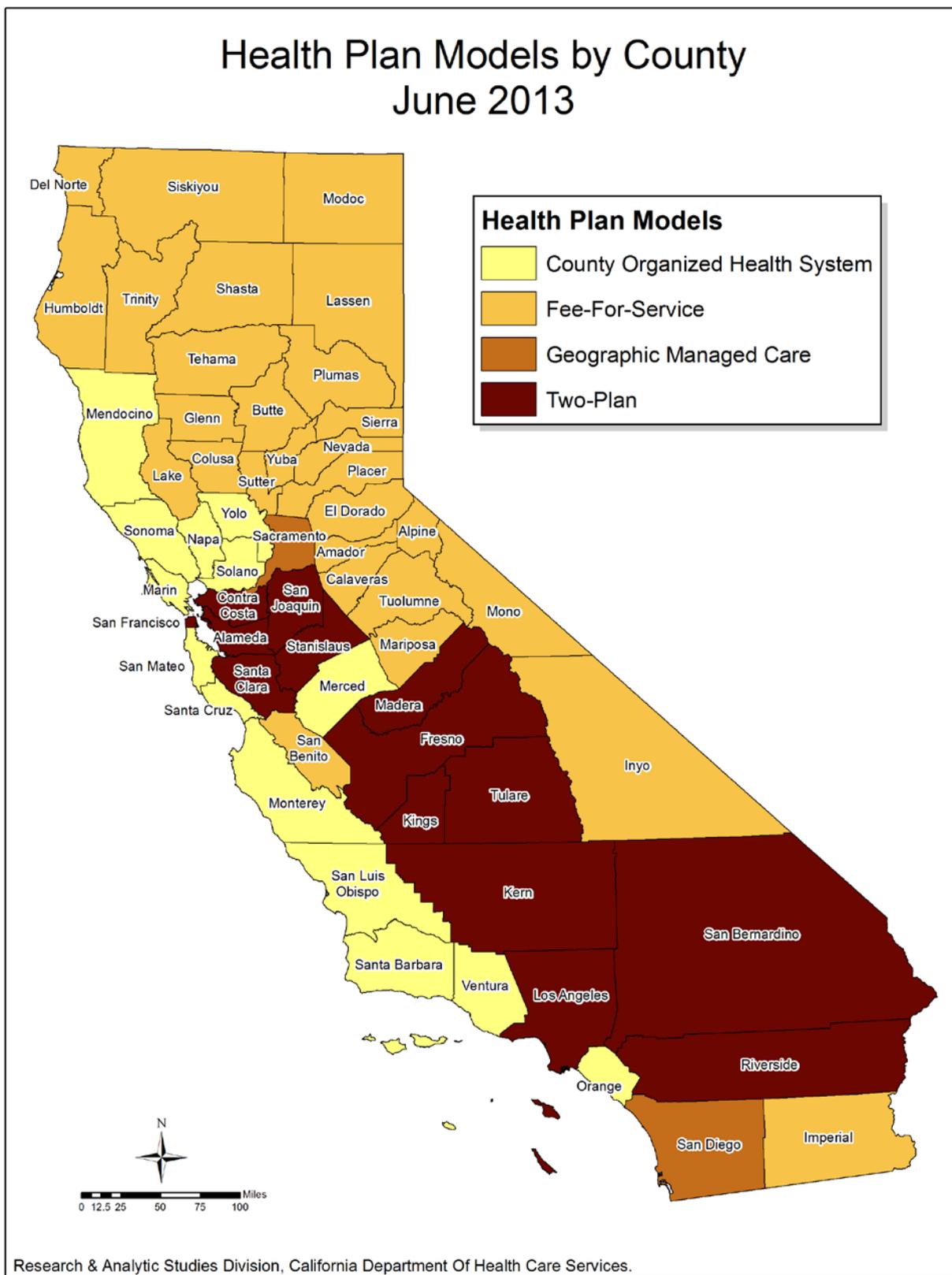
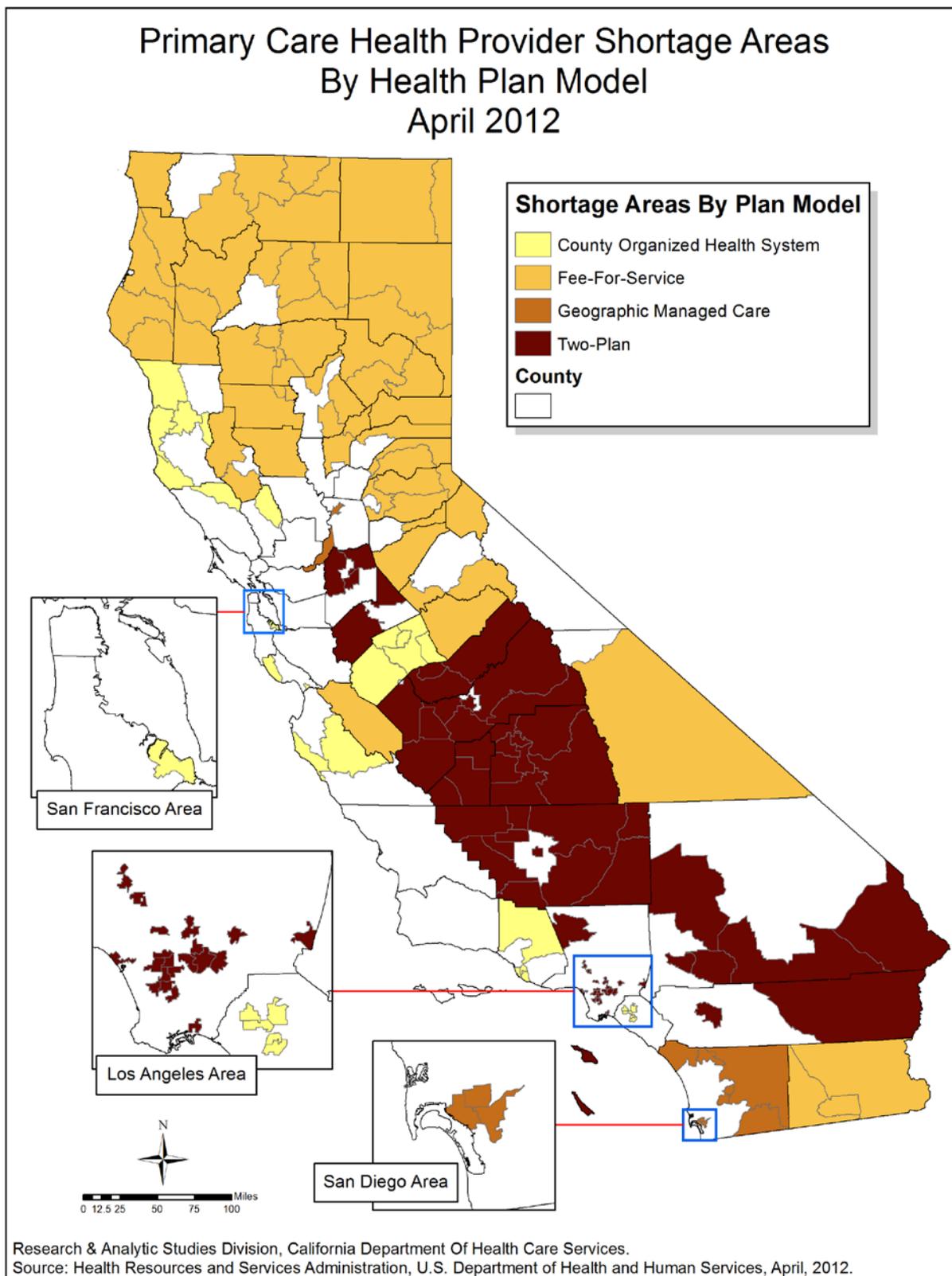


Figure PS-2. Primary Care Health Provider Shortage Areas, by Health Plan Model, April 2012*



*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 75,093 to 78,534, or 4.6%.

Physician counts by plan type showed increases ranging from 3.8% for County Organized Health System (COHS) counties to 5.2% for Geographic Managed Care (GMC) and Fee-For-Service (FFS) counties. Average counts for counties over the four quarters ranged from as few as one in Sierra County and fewer than 10 in four other counties, to as high as 20,699 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 increased Statewide 4.6% from 75,093 to 78,534.

Statewide beneficiary-to-provider ratios for full scope FFS Medi-Cal only beneficiaries showed no change during the study period. Beneficiary-to-provider ratios by plan type increased 9.5% for COHS counties. All other plans had decreases ranging from 0.7% to 1.9%.

Table PS-2. Physician Supply, All Enrolled Physician Sites, FFS, Full Scope, Medi-Cal Only, Quarter 3, 2012–Quarter 2, 2013

	Site-Specific Physician Counts					Beneficiaries-to-Provider Ratio				
	2012 Qtr 3	2012 Qtr 4	2013 Qtr 1	2013 Qtr 2	% Change 2012 Qtr 3–2013 Qtr 2	2012 Qtr 3	2012 Qtr 4	2013 Qtr 1	2013 Qtr 2	% Change 2012 Qtr 3–2013 Qtr 2
Statewide	75,093	76,766	77,787	78,534	4.6%	15.2	14.7	15.4	15.2	0.0%
County Plan Model Type										
County Organized Health System (COHS)	13,626	13,845	14,018	14,143	3.8%	6.3	6.0	6.9	6.9	9.5%
Fee-for-Service (FFS)	3,035	3,102	3,163	3,194	5.2%	102.0	99.3	98.8	100.8	-1.2%
Geographic Managed Care (GMC)	11,251	11,576	11,730	11,831	5.2%	10.3	9.9	9.9	10.1	-1.9%
Two-Plan (Commercial Plan and Local Initiative)	47,181	48,243	48,876	49,366	4.6%	13.4	12.9	13.8	13.3	-0.7%

Source: Prepared by DHCS Research and Analytic Studies Division. Counts of physicians with Active and Indirect enrollment status for April 2103 were obtained from the Medi-Cal Provider Master File and estimated from the Medi-Cal Provider Master File for July 2012, October 2012, and January 2013.

Figure PS-3. All Enrolled Physicians, by County, Quarter 2, 2013

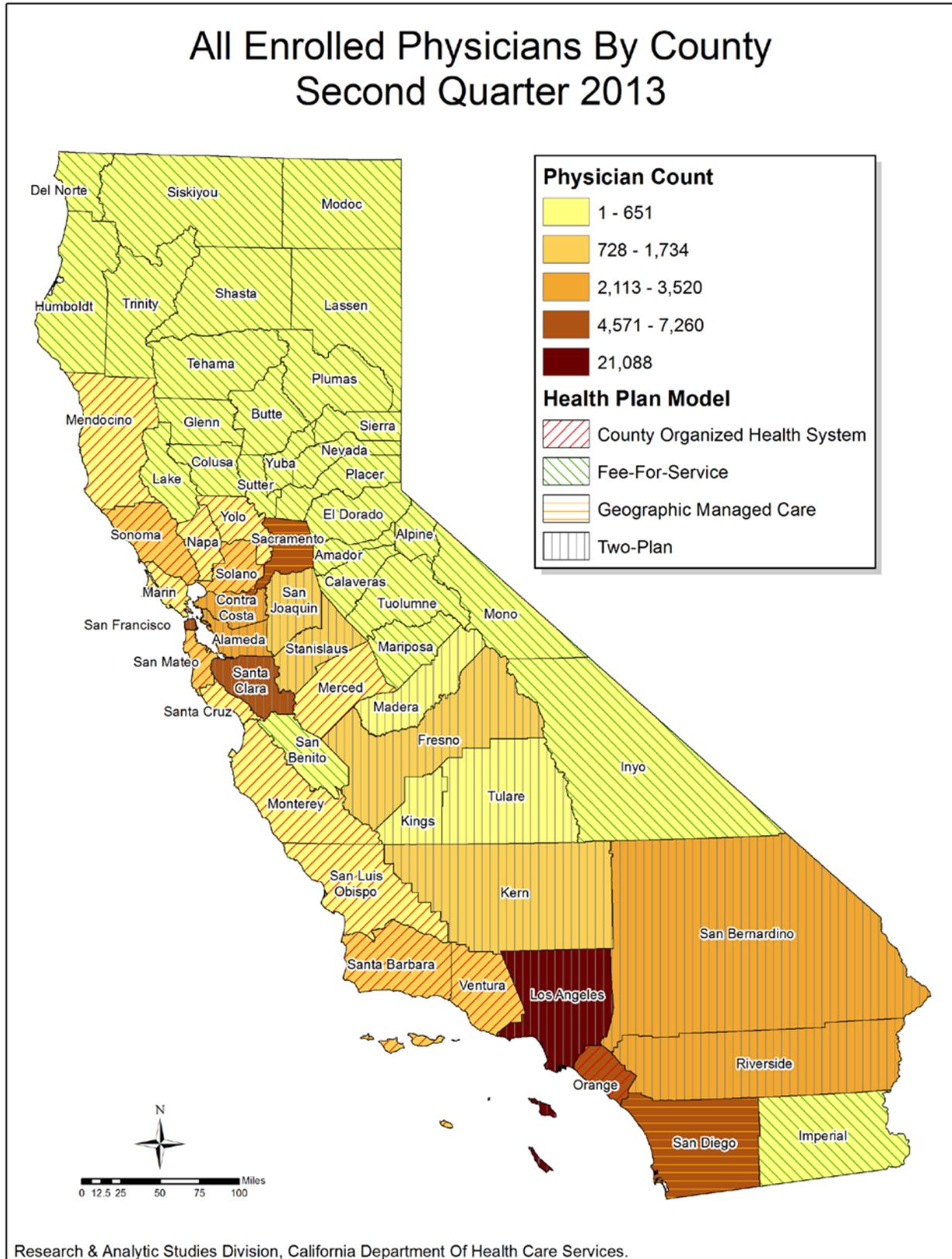


Figure PS-4. Change in All Enrolled Physicians, by County, Quarter 3, 2012 to Quarter 2, 2013

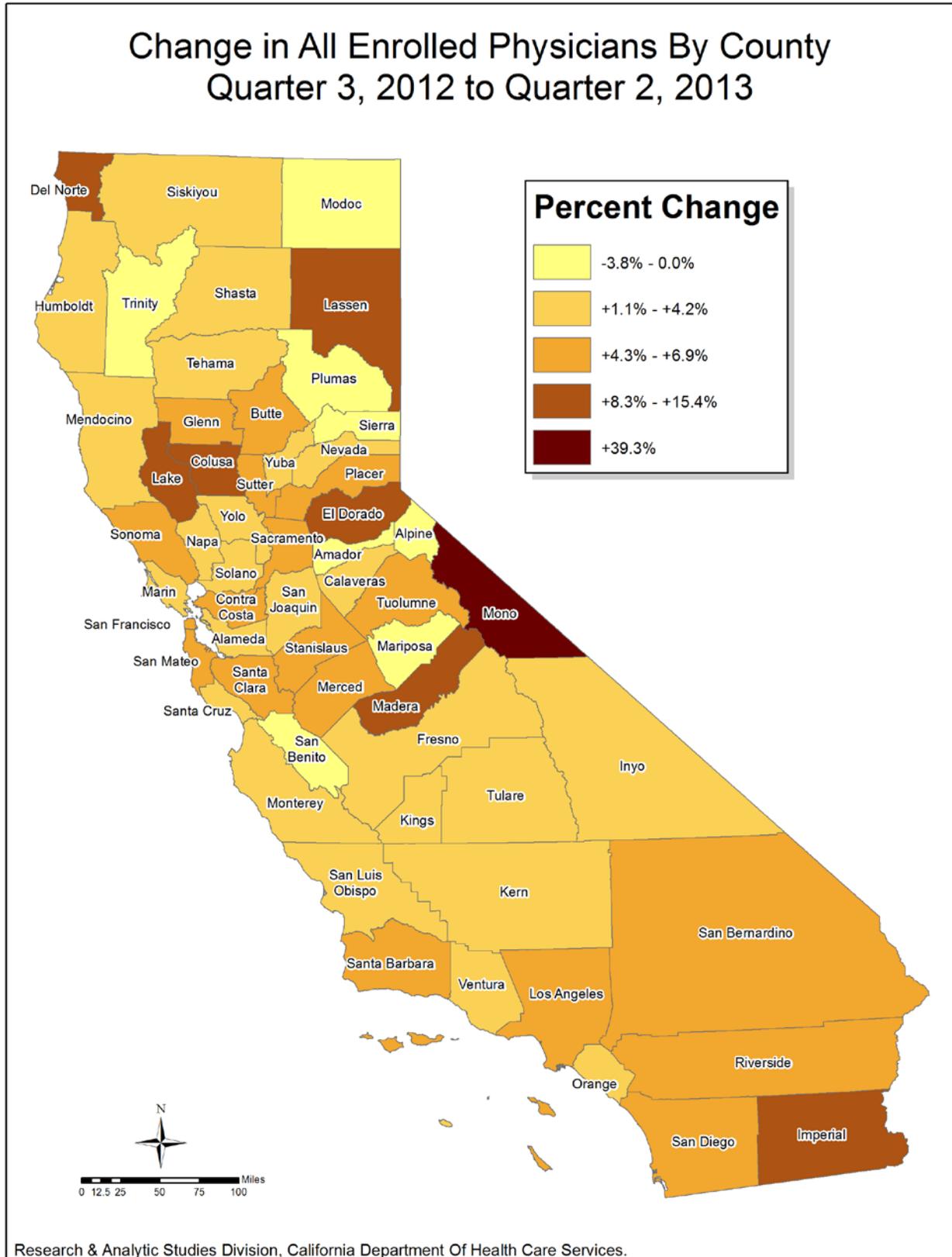
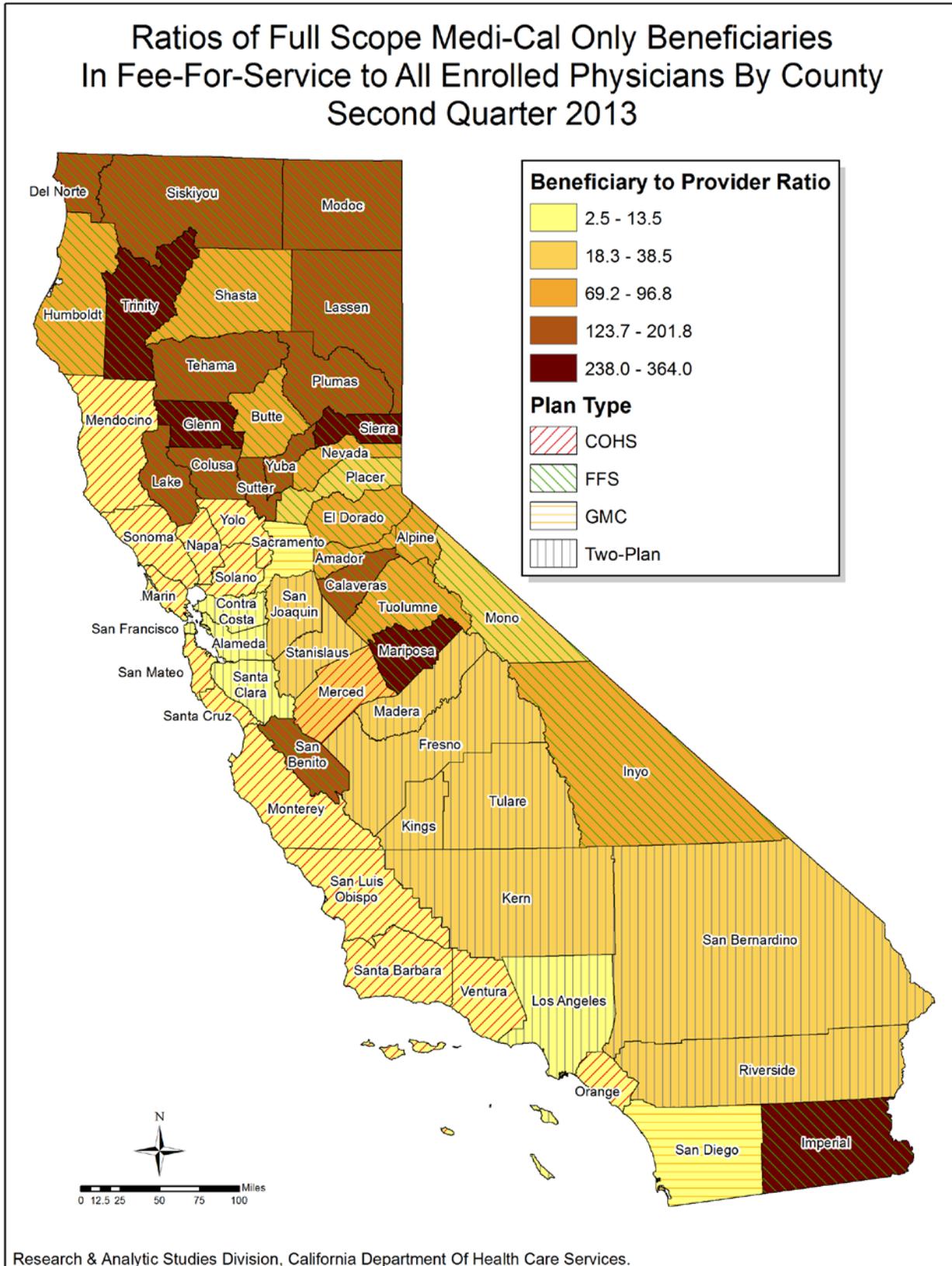


Figure PS-5. Ratios of Beneficiaries to All Physicians, by County, 2013 Quarter 2



Primary Care Physicians

Table PS-3 reflects all enrolled Primary Care Physicians with an Active or Indirect status at a given location with specialties in General Medicine, Family Practice, or Internal Medicine. Although Clinics and physicians with specialties in Pediatrics, Obstetrics, or Gynecology are also considered Primary Care Physicians, they are presented separately in this report.

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 improvement from the third quarter of 2012 to the second quarter of 2013, increasing from 28,178 to 29,359, or 4.2%.

Statewide, site-specific primary care physician counts showed improvement from the third quarter of 2012 to the second quarter of 2013, increasing 4.2% from 28,178 to 29,359.

Primary care physicians by plan type showed increases ranging from 3.6% for COHS counties to 4.9% for FFS counties. Average counts ranged from one in Alpine and Sierra Counties and fewer than 10 in five other counties, to 8,038 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 (FOHC), Rural Health Clinics (RHC), and other clinics are able to provide primary care services in these communities. Table PS-10 and Table PS-11 display the total number of clinics by county available to serve Medi-Cal beneficiaries.

Table PS-3. Primary Care Physicians, All Enrolled Physician Sites, FFS, Medi-Cal Only, Quarter 3, 2012–Quarter 2, 2013

	Site-Specific Physician Counts				Percent Change In Number of Providers
	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	
Statewide	28,178	28,707	29,082	29,359	4.2%
County Plan Model Type					
County Organized Health System (COHS)	5,187	5,261	5,320	5,373	3.6%
Fee-for-Service (FFS)	1,294	1,322	1,341	1,357	4.9%
Geographic Managed Care (GMC)	3,848	3,944	3,997	4,029	4.7%
Two-Plan (Commercial Plan and Local Initiative)	17,849	18,180	18,424	18,600	4.2%

Source: Prepared by DHCS Research and Analytic Studies Division. Counts of physicians with Active and Indirect enrollment status for April 2013 were obtained from the Medi-Cal Provider Master File and estimated from the Medi-Cal Provider Master File for July 2012, October 2012, and January 2013.

OB/GYN Physicians

Table PS-4 presents site-specific counts of all enrolled OB/GYN physicians. Statewide, OB/GYN physicians showed a minor increase of 4.1%, from 4,442 to 4,625, during the four quarters.

OB/GYN physicians by plan type showed increases from 3.6% for COHS counties up to 4.9% for FFS counties. Los Angeles County had the highest average of OB/GYNs enrolled in Medi-Cal with 1,147 (see Table PS-8 in the [Appendix](#) for county level detail). Twenty counties had fewer than 10 physicians, and five of those counties, Alpine, Colusa, 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, site-specific OB/GYN physician counts increased 4.1% from 4,442 to 4,625.

Table PS-4. Physician Supply, Physicians with an OB/GYN Specialty, FFS, Medi-Cal Only, Quarter 3, 2012–Quarter 2, 2013

	Site-Specific Physician Counts				Percent Change In Number of Providers
	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	
Statewide	4,442	4,512	4,581	4,625	4.1%
County Plan Model Type					
County Organized Health System (COHS)	883	896	904	915	3.6%
Fee-for-Service (FFS)	184	184	192	193	4.9%
Geographic Managed Care (GMC)	602	617	624	627	4.2%
Two-Plan (Commercial Plan and Local Initiative)	2,773	2,815	2,861	2,890	4.2%

Source: Prepared by DHCS Research and Analytic Studies Division. Counts of physicians with Active and Indirect enrollment status for April 2013 were obtained from the Medi-Cal Provider Master File and estimated from the Medi-Cal Provider Master File for July 2012, October 2012, and January 2013.

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 and Table PS-11 in the Appendix display 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 4.4% statewide, from 7,846 pediatricians in the third quarter of 2012 to 8,192 in the second quarter of 2013.

The number of pediatricians by plan type increased from 3.5% for COHS counties to 6.0% for FFS counties. Los Angeles County had the highest average number of pediatricians with 2,099 (see Table PS-9 in the [Appendix](#) for county level detail). In 21 counties, there were fewer than ten pediatricians with zero pediatricians in seven of those counties. Of the 21 counties with low counts or no count of pediatricians, 20 are FFS plan counties and primarily rural. As with the OB/GYN specialty, FQHCs, RHCs, other clinics, and general care physicians with a specialty other than pediatrics may render pediatric services in these communities. Table PS-10 and Table PS-11 in the [Appendix](#) display the total number of clinics by county available to serve Medi-Cal beneficiaries.

Site specific pediatrician counts increased 4.4% statewide from 7,846 to 8,192 pediatricians.

Table PS-5. Physician Supply, Physicians with a Pediatric Specialty, FFS, Medi-Cal Only, Quarter 3, 2012–Quarter 2, 2013

	Site-Specific Physician Counts				Percent Change In Number of Providers
	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	
Statewide	7,846	8,023	8,109	8,192	4.4%
County Plan Model Type					
County Organized Health System (COHS)	1,315	1,333	1,347	1,361	3.5%
Fee-for-Service (FFS)	217	223	231	230	6.0%
Geographic Managed Care (GMC)	1,098	1,125	1,135	1,150	4.7%
Two-Plan (Commercial Plan and Local Initiative)	5,216	5,342	5,396	5,451	4.5%

Source: Prepared by DHCS Research and Analytic Studies Division. Counts of physicians with Active and Indirect enrollment status for April 2013 were obtained from the Medi-Cal Provider Master File and estimated from the Medi-Cal Provider Master File for July 2012, October 2012, and January 2013.

Conclusions—Physician Supply

1. DHCS evaluated all 58 counties and plan model types (i.e., Two-Plan, GMC, and FFS) with respect to physician supply from the third quarter of 2012 to the second quarter of 2013. 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.
2. Overall site-specific physician counts increased 4.6%, from 75,093 to 78,534.
3. During the period under study, site-specific counts of physicians with a specialty (primary care, OB/GYN, and pediatrics) continued to grow. Site-specific primary care physician counts increased 4.2%, from 28,178 to 29,359. Site-specific OB/GYN physician counts increased 4.1%, from 4,442 to 4,625, and site-specific pediatrician counts increased 4.4%, from 7,846 to 8,192.

Appendix: Physician Supply by County

Table PS-6. Physician Supply, All Enrolled Physician Sites, FFS, Medi-Cal Only, Quarter 3, 2012–Quarter 2, 2013

	Site-Specific Physician Counts						Beneficiaries-to-Provider Ratio					
	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Average Number of Providers	Percent Change In Number of Providers	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Percent Change in Ratio	
Statewide	75,093	76,766	77,787	78,534	77,045.0	4.6%	15.2	14.7	15.4	15.2	0.0%	
County Plan Model Type												
County Organized Health System (COHS)	13,626	13,845	14,018	14,143	13,908.0	3.8%	6.3	6.0	6.9	6.9	9.5%	
Fee-for-Service (FFS)	3,035	3,102	3,163	3,194	3,123.5	5.2%	102.0	99.3	98.8	100.8	-1.2%	
Geographic Managed Care (GMC)	11,251	11,576	11,730	11,831	11,597.0	5.2%	10.3	9.9	9.9	10.1	-1.9%	
Two-Plan (Commercial Plan and Local Initiative)	47,181	48,243	48,876	49,366	48,416.5	4.6%	13.4	12.9	13.8	13.3	-0.7%	
County Plan Type												
Alameda	Two-Plan	3,383	3,424	3,481	3,520	3,452.0	4.0%	9	9	9	9	1.1%
Alpine	FFS	2	2	2	2	2.0	0.0%	74	78	77	76	2.7%
Amador	FFS	46	46	45	46	45.8	0.0%	77	76	79	78	1.8%
Butte	FFS	405	410	419	423	414.3	4.4%	99	97	96	97	-1.9%
Calaveras	FFS	34	34	36	35	34.8	2.9%	160	158	152	160	0.1%
Colusa	FFS	24	24	26	26	25.0	8.3%	146	145	140	148	1.2%
Contra Costa	Two-Plan	2,015	2,054	2,084	2,113	2,066.5	4.9%	10	9	10	9	-2.1%
Del Norte	FFS	35	36	38	39	37.0	11.4%	183	174	165	162	-11.5%
El Dorado	FFS	180	188	192	196	189.0	8.9%	81	77	77	78	-4.1%
Fresno	Two-Plan	1,466	1,488	1,506	1,516	1,494.0	3.4%	19	19	20	20	3.1%
Glenn	FFS	18	19	19	19	18.8	5.6%	307	290	304	315	2.5%
Humboldt	FFS	302	310	314	313	309.8	3.6%	70	68	68	71	1.3%
Imperial	FFS	164	171	176	178	172.3	8.5%	279	268	261	263	-5.6%

		Site-Specific Physician Counts						Beneficiaries-to-Provider Ratio				
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Average Number of Providers	Percent Change In Number of Providers	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Percent Change in Ratio
Inyo	FFS	31	31	31	32	31.3	3.2%	83	83	82	85	2.4%
Kern	Two-Plan	1,403	1,437	1,453	1,457	1,437.5	3.8%	25	24	25	26	3.6%
Kings	Two-Plan	138	137	138	142	138.8	2.9%	33	34	34	33	0.9%
Lake	FFS	87	89	93	97	91.5	11.5%	151	148	143	142	-6.2%
Lassen	FFS	26	30	30	30	29.0	15.4%	148	127	129	132	-10.6%
Los Angeles	Two-Plan	20,204	20,618	20,886	21,088	20,699.0	4.4%	13	12	14	12	-1.6%
Madera	Two-Plan	229	246	253	254	245.5	10.9%	20	20	21	20	-2.0%
Marin	COHS	512	514	524	531	520.3	3.7%	2	2	3	3	26.1%
Mariposa	FFS	8	8	8	8	8.0	0.0%	273	277	279	285	4.4%
Mendocino	COHS	144	146	150	150	147.5	4.2%	10	10	11	14	33.7%
Merced	COHS	281	286	287	294	287.0	4.6%	19	18	20	20	8.0%
Modoc	FFS	9	9	9	9	9.0	0.0%	165	166	163	170	3.3%
Mono	FFS	28	30	38	39	33.8	39.3%	38	35	29	32	-15.7%
Monterey	COHS	582	594	593	602	592.8	3.4%	10	10	12	10	-3.1%
Napa	COHS	228	231	231	235	231.3	3.1%	5	5	6	7	39.2%
Nevada	FFS	134	137	136	137	136.0	2.2%	66	65	67	69	5.2%
Orange	COHS	5,402	5,500	5,558	5,591	5,512.8	3.5%	5	5	6	5	0.0%
Placer	FFS	612	626	642	651	632.8	6.4%	39	38	38	39	-0.5%
Plumas	FFS	20	20	20	20	20.0	0.0%	119	121	122	124	3.9%
Riverside	Two-Plan	2,236	2,284	2,303	2,335	2,289.5	4.4%	29	27	28	29	1.0%
Sacramento	GMC	4,335	4,482	4,543	4,571	4,482.8	5.4%	9	9	9	9	-2.1%
San Benito	FFS	53	51	50	51	51.3	-3.8%	147	154	161	164	11.8%
San Bernardino	Two-Plan	3,346	3,422	3,466	3,508	3,435.5	4.8%	25	24	24	24	-2.8%
San Diego	GMC	6,916	7,094	7,187	7,260	7,114.3	5.0%	11	10	10	11	0.0%
San Francisco	Two-Plan	4,617	4,767	4,812	4,845	4,760.3	4.9%	3	3	3	3	-3.8%
San Joaquin	Two-Plan	1,195	1,212	1,222	1,238	1,216.8	3.6%	17	18	20	18	5.2%

		Site-Specific Physician Counts						Beneficiaries-to-Provider Ratio				
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Average Number of Providers	Percent Change In Number of Providers	2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Percent Change in Ratio
San Luis Obispo	COHS	333	336	338	342	337.3	2.7%	8	8	9	9	8.5%
San Mateo	COHS	1,662	1,684	1,714	1,734	1,698.5	4.3%	4	4	4	6	63.2%
Santa Barbara	COHS	695	706	719	728	712.0	4.7%	8	8	10	8	-1.2%
Santa Clara	Two-Plan	5,398	5,554	5,654	5,707	5,578.3	5.7%	6	6	5	5	-7.1%
Santa Cruz	COHS	441	451	453	453	449.5	2.7%	7	7	8	7	2.9%
Shasta	FFS	372	380	382	383	379.3	3.0%	86	83	83	85	-1.4%
Sierra	FFS	1	1	1	1	1.0	0.0%	351	348	369	364	3.7%
Siskiyou	FFS	69	69	69	70	69.3	1.4%	120	120	124	125	4.8%
Solano	COHS	941	951	968	978	959.5	3.9%	6	5	6	5	-8.8%
Sonoma	COHS	958	975	988	1000	980.3	4.4%	6	5	6	6	3.6%
Stanislaus	Two-Plan	1,054	1,094	1,106	1,127	1,095.3	6.9%	25	24	29	26	2.0%
Sutter	FFS	130	133	138	138	134.8	6.2%	139	135	134	140	1.2%
Tehama	FFS	68	69	69	69	68.8	1.5%	198	193	196	202	1.8%
Trinity	FFS	9	9	9	9	9.0	0.0%	241	236	234	238	-1.4%
Tulare	Two-Plan	497	506	512	516	507.8	3.8%	34	33	34	32	-7.8%
Tuolumne	FFS	79	80	81	83	80.8	5.1%	80	79	80	80	0.8%
Ventura	COHS	1,117	1,138	1,154	1,162	1,142.8	4.0%	9	9	10	11	22.2%
Yolo	COHS	330	333	341	343	336.8	3.9%	9	9	10	10	13.6%
Yuba	FFS	89	90	90	90	89.8	1.1%	182	178	181	186	2.0%

Source: Prepared by DHCS Research and Analytic Studies Division using data from the Medi-Cal Provider Master File for July 2012, October 2012, January 2013, and April 2013.

Table PS-7. Primary Care Physician Supply, All Enrolled Physicians, by Plan Model Type and County, Quarter 3, 2012–Quarter 2, 2013

		Site-Specific Physician Counts					
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Average Number of Providers	Percent Change In Number of Providers
Statewide		28,178	28,707	29,082	29,359	28,831.5	4.2%
County Plan Model Type							
County Organized Health System (COHS)		5,187	5,261	5,320	5,373	5,285.3	3.6%
Fee-for-Service (FFS)		1,294	1,322	1,341	1,357	1,328.5	4.9%
Geographic Managed Care (GMC)		3,848	3,944	3,997	4,029	3,954.5	4.7%
Two-Plan (Commercial Plan and Local Initiative)		17,849	18,180	18,424	18,600	18,263.3	4.2%
County	Plan Type						
Alameda	Two-Plan	1,209	1,221	1,236	1,251	1,229.3	3.5%
Alpine	FFS	1	1	1	1	1.0	0.0%
Amador	FFS	29	29	29	29	29.0	0.0%
Butte	FFS	139	138	140	140	139.3	0.7%
Calaveras	FFS	18	18	19	19	18.5	5.6%
Colusa	FFS	16	16	18	18	17.0	12.5%
Contra Costa	Two-Plan	837	853	864	874	857.0	4.4%
Del Norte	FFS	12	13	13	13	12.8	8.3%
El Dorado	FFS	70	73	74	75	73.0	7.1%
Fresno	Two-Plan	559	568	574	576	569.3	3.0%
Glenn	FFS	8	8	8	8	8.0	0.0%
Humboldt	FFS	132	136	138	138	136.0	4.5%
Imperial	FFS	61	64	64	65	63.5	6.6%
Inyo	FFS	16	16	16	16	16.0	0.0%
Kern	Two-Plan	579	587	592	594	588.0	2.6%
Kings	Two-Plan	64	64	65	64	64.3	0.0%
Lake	FFS	34	34	36	38	35.5	11.8%
Lassen	FFS	13	17	17	17	16.0	30.8%
Los Angeles	Two-Plan	7,869	8,003	8,103	8,176	8,037.8	3.9%
Madera	Two-Plan	46	48	48	48	47.5	4.3%
Marin	COHS	209	210	211	216	211.5	3.3%
Mariposa	FFS	5	5	5	5	5.0	0.0%
Mendocino	COHS	49	49	49	49	49.0	0.0%
Merced	COHS	133	135	136	139	135.8	4.5%
Modoc	FFS	7	7	7	7	7.0	0.0%
Mono	FFS	6	8	10	11	8.8	83.3%

		Site-Specific Physician Counts					
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Average Number of Providers	Percent Change In Number of Providers
Monterey	COHS	209	215	214	219	214.3	4.8%
Napa	COHS	74	74	75	76	74.8	2.7%
Nevada	FFS	57	58	57	58	57.5	1.8%
Orange	COHS	1,897	1,929	1,945	1,956	1,931.8	3.1%
Placer	FFS	281	285	290	296	288.0	5.3%
Plumas	FFS	15	15	15	15	15.0	0.0%
Riverside	Two-Plan	965	980	990	1,010	986.3	4.7%
Sacramento	GMC	1,491	1,530	1,550	1,560	1,532.8	4.6%
San Benito	FFS	21	21	20	21	20.8	0.0%
San Bernardino	Two-Plan	1,460	1,487	1,505	1,524	1,494.0	4.4%
San Diego	GMC	2,357	2,414	2,447	2,469	2,421.8	4.8%
San Francisco	Two-Plan	1,448	1,497	1,516	1,525	1,496.5	5.3%
San Joaquin	Two-Plan	461	472	476	480	472.3	4.1%
San Luis Obispo	COHS	103	104	103	105	103.8	1.9%
San Mateo	COHS	631	645	656	665	649.3	5.4%
Santa Barbara	COHS	209	212	214	214	212.3	2.4%
Santa Clara	Two-Plan	1,726	1,757	1,802	1,816	1,775.3	5.2%
Santa Cruz	COHS	166	169	169	169	168.3	1.8%
Shasta	FFS	156	160	160	160	159.0	2.6%
Sierra	FFS	1	1	1	1	1.0	0.0%
Siskiyou	FFS	35	35	35	36	35.3	2.9%
Solano	COHS	411	412	421	425	417.3	3.4%
Sonoma	COHS	413	417	426	433	422.3	4.8%
Stanislaus	Two-Plan	437	450	455	463	451.3	5.9%
Sutter	FFS	59	60	62	63	61.0	6.8%
Tehama	FFS	34	35	35	35	34.8	2.9%
Trinity	FFS	4	4	4	4	4.0	0.0%
Tulare	Two-Plan	189	193	198	199	194.8	5.3%
Tuolumne	FFS	32	33	34	35	33.5	9.4%
Ventura	COHS	519	526	533	537	528.8	3.5%
Yolo	COHS	164	164	168	170	166.5	3.7%
Yuba	FFS	32	32	33	33	32.5	3.1%

Source: Prepared by DHCS Research and Analytic Studies Division using data from the Medi-Cal Provider Master File for July 2012, October 2012, January 2013, and April 2013.

Table PS-8. Physician Supply, Physicians with an OB/GYN Specialty, by Plan Model Type and County, Quarter 3, 2012–Quarter 2, 2013

		Site-Specific Physician Counts					
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Average Number of Providers	Percent Change In Number of Providers
Statewide		4,442	4,512	4,581	4,625	4,540.0	4.1%
County Plan Model Type							
County Organized Health System (COHS)		883	896	904	915	899.5	3.6%
Fee-for-Service (FFS)		184	184	192	193	188.3	4.9%
Geographic Managed Care (GMC)		602	617	624	627	617.5	4.2%
Two-Plan (Commercial Plan and Local Initiative)		2,773	2,815	2,861	2,890	2,834.8	4.2%
County	Plan Type						
Alameda	Two-Plan	219	221	229	230	224.8	5.0%
Alpine	FFS	0	0	0	0	0	0.0%
Amador	FFS	4	4	4	4	4.0	0.0%
Butte	FFS	28	28	29	29	28.5	3.6%
Calaveras	FFS	1	1	1	1	1.0	0.0%
Colusa	FFS	0	0	0	0	0	0.0%
Contra Costa	Two-Plan	98	99	103	106	101.5	8.2%
Del Norte	FFS	2	2	2	2	2.0	0.0%
El Dorado	FFS	11	11	11	12	11.3	9.1%
Fresno	Two-Plan	93	95	94	96	94.5	3.2%
Glenn	FFS	1	1	1	1	1.0	0.0%
Humboldt	FFS	13	13	13	13	13.0	0.0%
Imperial	FFS	14	14	16	16	15.0	14.3%
Inyo	FFS	3	4	3	3	3.3	0.0%
Kern	Two-Plan	89	90	93	90	90.5	1.1%
Kings	Two-Plan	10	10	10	10	10.0	0.0%
Lake	FFS	3	3	3	3	3.0	0.0%
Lassen	FFS	1	1	1	1	1.0	0.0%
Los Angeles	Two-Plan	1,125	1,142	1,157	1,163	1,146.8	3.4%
Madera	Two-Plan	12	13	14	14	13.3	16.7%
Marin	COHS	24	24	25	25	24.5	4.2%
Mariposa	FFS	0	0	0	0	0	0.0%
Mendocino	COHS	15	15	16	16	15.5	6.7%
Merced	COHS	18	18	18	18	18.0	0.0%
Modoc	FFS	1	1	1	1	1.0	0.0%
Mono	FFS	1	1	3	3	2.0	200.0%

		Site-Specific Physician Counts					
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Average Number of Providers	Percent Change In Number of Providers
Monterey	COHS	56	57	56	58	56.8	3.6%
Napa	COHS	16	16	16	17	16.3	6.3%
Nevada	FFS	10	10	10	10	10.0	0.0%
Orange	COHS	360	364	368	371	365.8	3.1%
Placer	FFS	44	44	46	46	45.0	4.5%
Plumas	FFS	1	1	1	1	1.0	0.0%
Riverside	Two-Plan	146	147	147	150	147.5	2.7%
Sacramento	GMC	236	243	244	245	242.0	3.8%
San Benito	FFS	4	4	4	4	4.0	0.0%
San Bernardino	Two-Plan	184	186	190	193	188.3	4.9%
San Diego	GMC	366	374	380	382	375.5	4.4%
San Francisco	Two-Plan	224	232	234	237	231.8	5.8%
San Joaquin	Two-Plan	96	96	97	99	97.0	3.1%
San Luis Obispo	COHS	22	22	22	22	22.0	0.0%
San Mateo	COHS	86	86	88	88	87.0	2.3%
Santa Barbara	COHS	50	51	51	52	51.0	4.0%
Santa Clara	Two-Plan	358	364	372	375	367.3	4.7%
Santa Cruz	COHS	29	30	29	30	29.5	3.4%
Shasta	FFS	13	13	14	14	13.5	7.7%
Sierra	FFS	0	0	0	0	0	0.0%
Siskiyou	FFS	4	4	4	4	4.0	0.0%
Solano	COHS	59	61	63	63	61.5	6.8%
Sonoma	COHS	54	55	55	56	55.0	3.7%
Stanislaus	Two-Plan	63	64	65	67	64.8	6.3%
Sutter	FFS	11	11	11	11	11.0	0.0%
Tehama	FFS	4	4	4	4	4.0	0.0%
Trinity	FFS	0	0	0	0	0	0.0%
Tulare	Two-Plan	56	56	56	60	57.0	7.1%
Tuolumne	FFS	7	6	7	7	6.8	0.0%
Ventura	COHS	75	78	78	80	77.8	6.7%
Yolo	COHS	19	19	19	19	19.0	0.0%
Yuba	FFS	3	3	3	3	3.0	0.0%

Source: Prepared by DHCS Research and Analytic Studies Division using data from the Medi-Cal Provider Master File for July 2012, October 2012, January 2013, and April 2013.

Table PS-9. Physician Supply, Physicians with a Pediatric Specialty, by Plan Model Type and County, Quarter 3, 2012–Quarter 2, 2013

		Site-Specific Physician Counts					
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Average Number of Providers	Percent Change In Number of Providers
Statewide		7,846	8,023	8,109	8,192	8,042.5	4.4%
County Plan Model Type							
County Organized Health System (COHS)		1,315	1,333	1,347	1,361	1,339.0	3.5%
Fee-for-Service (FFS)		217	223	231	230	225.3	6.0%
Geographic Managed Care (GMC)		1,098	1,125	1,135	1,150	1,127.0	4.7%
Two-Plan (Commercial Plan and Local Initiative)		5,216	5,342	5,396	5,451	5,351.3	4.5%
County	Plan Type						
Alameda	Two-Plan	538	546	554	560	549.5	4.1%
Alpine	FFS	0	0	0	0	0	0.0%
Amador	FFS	1	1	1	1	1.0	0.0%
Butte	FFS	17	17	17	17	17.0	0.0%
Calaveras	FFS	1	1	1	1	1.0	0.0%
Colusa	FFS	0	0	0	0	0	0.0%
Contra Costa	Two-Plan	158	160	160	160	159.5	1.3%
Del Norte	FFS	5	5	5	5	5.0	0.0%
El Dorado	FFS	12	12	13	13	12.5	8.3%
Fresno	Two-Plan	139	140	143	143	141.3	2.9%
Glenn	FFS	2	2	2	2	2.0	0.0%
Humboldt	FFS	12	13	13	12	12.5	0.0%
Imperial	FFS	12	12	12	12	12.0	0.0%
Inyo	FFS	3	3	3	4	3.3	33.3%
Kern	Two-Plan	121	125	124	126	124.0	4.1%
Kings	Two-Plan	9	9	9	10	9.3	11.1%
Lake	FFS	4	4	4	4	4.0	0.0%
Lassen	FFS	2	2	2	2	2.0	0.0%
Los Angeles	Two-Plan	2,040	2,096	2,117	2,141	2,098.5	5.0%
Madera	Two-Plan	124	136	141	142	135.8	14.5%
Marin	COHS	44	44	44	44	44.0	0.0%
Mariposa	FFS	0	0	0	0	0	0.0%
Mendocino	COHS	9	10	11	11	10.3	22.2%
Merced	COHS	18	18	18	19	18.3	5.6%
Modoc	FFS	0	0	0	0	0	0.0%
Mono	FFS	3	3	5	5	4.0	66.7%

		Site-Specific Physician Counts					
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Average Number of Providers	Percent Change In Number of Providers
Monterey	COHS	65	65	65	65	65.0	0.0%
Napa	COHS	18	18	18	18	18.0	0.0%
Nevada	FFS	10	10	10	10	10.0	0.0%
Orange	COHS	630	642	648	656	644.0	4.1%
Placer	FFS	82	86	91	91	87.5	11.0%
Plumas	FFS	0	0	0	0	0	0.0%
Riverside	Two-Plan	182	183	183	182	182.5	0.0%
Sacramento	GMC	397	409	413	417	409.0	5.0%
San Benito	FFS	3	3	3	3	3.0	0.0%
San Bernardino	Two-Plan	374	386	386	391	384.3	4.5%
San Diego	GMC	701	716	722	733	718.0	4.6%
San Francisco	Two-Plan	491	500	505	509	501.3	3.7%
San Joaquin	Two-Plan	108	107	109	109	108.3	0.9%
San Luis Obispo	COHS	31	31	31	31	31.0	0.0%
San Mateo	COHS	147	148	153	156	151.0	6.1%
Santa Barbara	COHS	65	66	68	68	66.8	4.6%
Santa Clara	Two-Plan	799	818	828	838	820.8	4.9%
Santa Cruz	COHS	34	34	34	34	34.0	0.0%
Shasta	FFS	18	18	18	18	18.0	0.0%
Sierra	FFS	0	0	0	0	0	0.0%
Siskiyou	FFS	2	2	2	1	1.8	-50.0%
Solano	COHS	81	81	81	81	81.0	0.0%
Sonoma	COHS	60	61	61	63	61.3	5.0%
Stanislaus	Two-Plan	68	69	69	72	69.5	5.9%
Sutter	FFS	12	12	12	12	12.0	0.0%
Tehama	FFS	7	8	8	8	7.8	14.3%
Trinity	FFS	0	0	0	0	0	0.0%
Tulare	Two-Plan	65	67	68	68	67.0	4.6%
Tuolumne	FFS	6	6	6	6	6.0	0.0%
Ventura	COHS	82	84	83	83	83.0	1.2%
Yolo	COHS	31	31	32	32	31.5	3.2%
Yuba	FFS	3	3	3	3	3.0	0.0%

Source: Prepared by DHCS Research and Analytic Studies Division using data from the Medi-Cal Provider Master File for July 2012, October 2012, January 2013, and April 2013.

Table PS-10. Rural/FQHC Clinics, Quarter 3, 2012–Quarter 2, 2013

		Number of Rural/FQHC Clinics					
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Average Number of Clinics	Percent Change In Number of Clinics
Statewide		418	412	406	410	411.5	-1.9%
County Plan Model Type							
County Organized Health System (COHS)		85	88	84	85	85.5	0.0%
Fee-for-Service (FFS)		81	81	82	82	81.5	1.2%
Geographic Managed Care (GMC)		19	18	16	17	17.5	-10.5%
Two-Plan (Commercial Plan and Local Initiative)		233	225	224	226	227.0	-3.0%
County	Plan Type						
Alameda	Two-Plan	20	20	20	19	19.8	-5.0%
Alpine	FFS	0	0	0	0	0	0.0%
Amador	FFS	2	2	2	2	2.0	0.0%
Butte	FFS	10	10	11	11	10.5	10.0%
Calaveras	FFS	4	4	4	4	4.0	0.0%
Colusa	FFS	4	4	4	4	4.0	0.0%
Contra Costa	Two-Plan	14	12	13	12	12.8	-14.3%
Del Norte	FFS	2	2	2	2	2.0	0.0%
El Dorado	FFS	2	2	2	2	2.0	0.0%
Fresno	Two-Plan	35	28	29	29	30.3	-17.1%
Glenn	FFS	7	7	7	7	7.0	0.0%
Humboldt	FFS	12	12	12	12	12.0	0.0%
Imperial	FFS	5	5	5	5	5.0	0.0%
Inyo	FFS	2	2	2	2	2.0	0.0%
Kern	Two-Plan	10	9	10	9	9.5	-10.0%
Kings	Two-Plan	5	5	5	6	5.3	20.0%
Lake	FFS	1	1	1	1	1.0	0.0%
Lassen	FFS	0	0	0	0	0	0.0%
Los Angeles	Two-Plan	59	60	58	59	59.0	0.0%
Madera	Two-Plan	5	5	5	6	5.3	20.0%
Marin	COHS	3	2	1	1	1.8	-66.7%
Mariposa	FFS	4	4	4	4	4.0	0.0%
Mendocino	COHS	9	9	9	8	8.8	-11.1%
Merced	COHS	14	13	13	13	13.3	-7.1%
Modoc	FFS	1	1	1	1	1.0	0.0%
Mono	FFS	1	1	1	1	1.0	0.0%
Monterey	COHS	9	8	9	9	8.8	0.0%

		Number of Rural/FQHC Clinics					
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Average Number of Clinics	Percent Change In Number of Clinics
Napa	COHS	0	0	0	0	0	0.0%
Nevada	FFS	0	0	0	0	0	0.0%
Orange	COHS	3	5	4	4	4.0	33.3%
Placer	FFS	2	2	2	2	2.0	0.0%
Plumas	FFS	3	3	3	3	3.0	0.0%
Riverside	Two-Plan	7	7	7	10	7.8	42.9%
Sacramento	GMC	6	5	4	4	4.8	-33.3%
San Benito	FFS	0	1	1	0	0.5	0.0%
San Bernardino	Two-Plan	9	9	9	8	8.8	-11.1%
San Diego	GMC	13	13	12	13	12.8	0.0%
San Francisco	Two-Plan	22	22	22	22	22.0	0.0%
San Joaquin	Two-Plan	5	5	4	5	4.8	0.0%
San Luis Obispo	COHS	2	1	1	2	1.5	0.0%
San Mateo	COHS	11	11	11	11	11.0	0.0%
Santa Barbara	COHS	9	10	10	10	9.8	11.1%
Santa Clara	Two-Plan	11	13	12	12	12.0	9.1%
Santa Cruz	COHS	3	3	3	3	3.0	0.0%
Shasta	FFS	5	5	5	5	5.0	0.0%
Sierra	FFS	1	1	1	1	1.0	0.0%
Siskiyou	FFS	4	3	3	3	3.3	-25.0%
Solano	COHS	5	6	5	6	5.5	20.0%
Sonoma	COHS	10	10	8	8	9.0	-20.0%
Stanislaus	Two-Plan	14	14	14	14	14.0	0.0%
Sutter	FFS	1	1	1	1	1.0	0.0%
Tehama	FFS	2	2	2	2	2.0	0.0%
Trinity	FFS	1	1	1	1	1.0	0.0%
Tulare	Two-Plan	17	16	16	15	16.0	-11.8%
Tuolumne	FFS	2	2	2	3	2.3	50.0%
Ventura	COHS	3	6	6	6	5.3	100.0%
Yolo	COHS	4	4	4	4	4.0	0.0%
Yuba	FFS	3	3	3	3	3.0	0.0%

Source: Prepared by DHCS Research and Analytic Studies Division using data from the Medi-Cal Provider Master File for July 2012, October 2012, January 2013, and April 2013.

Table PS-11. Other Clinics, Quarter 3, 2012–Quarter 2, 2013

		Number of Other Clinics					
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Average Number of Clinics	Percent Change In Number of Clinics
Statewide		972	1,009	1,037	1,052	1,017.5	8.2%
County Plan Model Type							
County Organized Health System (COHS)		238	249	256	254	249.3	6.7%
Fee-for-Service (FFS)		112	116	121	122	117.8	8.9%
Geographic Managed Care (GMC)		120	124	125	130	124.8	8.3%
Two-Plan (Commercial Plan and Local Initiative)		502	520	535	546	525.8	8.8%
County Plan Type							
Alameda	Two-Plan	36	37	38	40	37.8	11.1%
Alpine	FFS	1	1	1	1	1.0	0.0%
Amador	FFS	3	3	3	3	3.0	0.0%
Butte	FFS	13	13	14	14	13.5	7.7%
Calaveras	FFS	2	3	3	3	2.8	50.0%
Colusa	FFS	1	1	1	1	1.0	0.0%
Contra Costa	Two-Plan	19	19	19	19	19.0	0.0%
Del Norte	FFS	2	2	2	2	2.0	0.0%
El Dorado	FFS	3	3	3	3	3.0	0.0%
Fresno	Two-Plan	26	27	26	27	26.5	3.8%
Glenn	FFS	2	2	2	2	2.0	0.0%
Humboldt	FFS	10	10	10	10	10.0	0.0%
Imperial	FFS	5	5	6	6	5.5	20.0%
Inyo	FFS	1	1	1	1	1.0	0.0%
Kern	Two-Plan	26	26	29	31	28.0	19.2%
Kings	Two-Plan	11	11	10	10	10.5	-9.1%
Lake	FFS	6	6	6	6	6.0	0.0%
Lassen	FFS	1	2	2	2	1.8	100.0%
Los Angeles	Two-Plan	215	225	233	239	228.0	11.2%
Madera	Two-Plan	8	10	10	9	9.3	12.5%
Marin	COHS	14	14	14	14	14.0	0.0%
Mariposa	FFS	1	1	2	2	1.5	100.0%
Mendocino	COHS	4	4	5	5	4.5	25.0%
Merced	COHS	7	8	9	9	8.3	28.6%
Modoc	FFS	1	2	2	2	1.8	100.0%
Mono	FFS	0	0	0	0	0	0.0%
Monterey	COHS	17	19	18	18	18.0	5.9%
Napa	COHS	12	12	13	13	12.5	8.3%
Nevada	FFS	6	6	6	6	6.0	0.0%

		Number of Other Clinics					
		2012 Quarter 3	2012 Quarter 4	2013 Quarter 1	2013 Quarter 2	Average Number of Clinics	Percent Change In Number of Clinics
Orange	COHS	70	74	78	79	75.3	12.9%
Placer	FFS	10	11	11	12	11.0	20.0%
Plumas	FFS	3	3	3	3	3.0	0.0%
Riverside	Two-Plan	28	30	31	28	29.3	0.0%
Sacramento	GMC	56	59	59	59	58.3	5.4%
San Benito	FFS	2	2	2	2	2.0	0.0%
San Bernardino	Two-Plan	30	30	30	31	30.3	3.3%
San Diego	GMC	64	65	66	71	66.5	10.9%
San Francisco	Two-Plan	30	29	31	33	30.8	10.0%
San Joaquin	Two-Plan	21	21	22	22	21.5	4.8%
San Luis Obispo	COHS	13	14	14	14	13.8	7.7%
San Mateo	COHS	18	18	18	18	18.0	0.0%
Santa Barbara	COHS	17	21	22	22	20.5	29.4%
Santa Clara	Two-Plan	30	32	32	32	31.5	6.7%
Santa Cruz	COHS	11	11	11	10	10.8	-9.1%
Shasta	FFS	13	13	13	13	13.0	0.0%
Sierra	FFS	2	2	2	2	2.0	0.0%
Siskiyou	FFS	3	3	3	3	3.0	0.0%
Solano	COHS	12	12	12	11	11.8	-8.3%
Sonoma	COHS	19	19	19	19	19.0	0.0%
Stanislaus	Two-Plan	11	11	11	12	11.3	9.1%
Sutter	FFS	9	9	9	9	9.0	0.0%
Tehama	FFS	4	4	5	5	4.5	25.0%
Trinity	FFS	0	0	0	0	0	0.0%
Tulare	Two-Plan	11	12	13	13	12.3	18.2%
Tuolumne	FFS	6	6	7	7	6.5	16.7%
Ventura	COHS	22	20	20	19	20.3	-13.6%
Yolo	COHS	2	3	3	3	2.8	50.0%
Yuba	FFS	2	2	2	2	2.0	0.0%

Source: Prepared by DHCS Research and Analytic Studies Division using data from the Medi-Cal Provider Master File for July 2012, October 2012, January 2013, and April 2013.



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



Service Utilization

February 2014

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Utilization of Select Services by Medi-Cal FFS Beneficiaries

Introduction

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

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

Age is also associated with health care utilization patterns. For example, advanced age increases functional limitations and the prevalence of chronic conditions. The elderly have higher utilization rates for inpatient and long-term care services, many medical procedures, and are prescribed more medications, such as glucose-lowering or antihypertensive drugs. In general, children have lower health care utilization rates than the elderly. However, infants born at low birthweight (<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 July 2012–June 2013. 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.

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

- Six or more consecutive points all going in the same direction (either up or down) indicate a trend.
- 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 include utilization associated with dual eligibles. Following the background information, utilization trends for each service category are 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 (IHS) 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.

In 2010, many users of Physician/Clinic services were either 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 to 20 in the Medi-Cal FFS program, monthly Physician/Clinic services utilization rates ranged from 155.3 to 634.5 visits per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

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 Other and Undocumented aid categories mostly fell below the expected baseline ranges observed in the baseline period of 2007 to 2009. Children in all of the analyzed aid categories continued to display predominantly lower than average utilization rates during the study period. These lower utilization rates coincide with the decrease in participation in the Medi-Cal FFS delivery system among beneficiaries in this age group over the same time period.

Both children and adult beneficiaries in the Blind/Disabled aid category place a greater demand on Physician/Clinic services than 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 third quarter of 2012 to the second quarter of 2013.

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. Additionally, while experiencing increased utilization in the first quarter of 2013, adults in every aid category continued to exhibit below average utilization during this time period. 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 timeframe.

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 birthrates. For instance, national birthrates experienced its sharpest decline in over 30 years from 2007 through 2010, while preliminary National Vital Statistics' data indicates a continued decline in the birthrate 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 birthrates among this subgroup. A definitive explanation for these service use patterns can only be reached by undertaking further analysis.

The following figures SU-1 to SU-10 represent the control chart analysis for physician/clinic visits by children and adults from the third quarter of 2012 to the second quarter of 2013.

Trends of Monthly Physician/Clinic Services Utilization Rates among Children, July 2012–June 2013

Figure SU-1. Physician/Clinic Utilization Rates among Children (Age 0-20) in the Blind/Disabled Aid Category, July 2012–June 2013

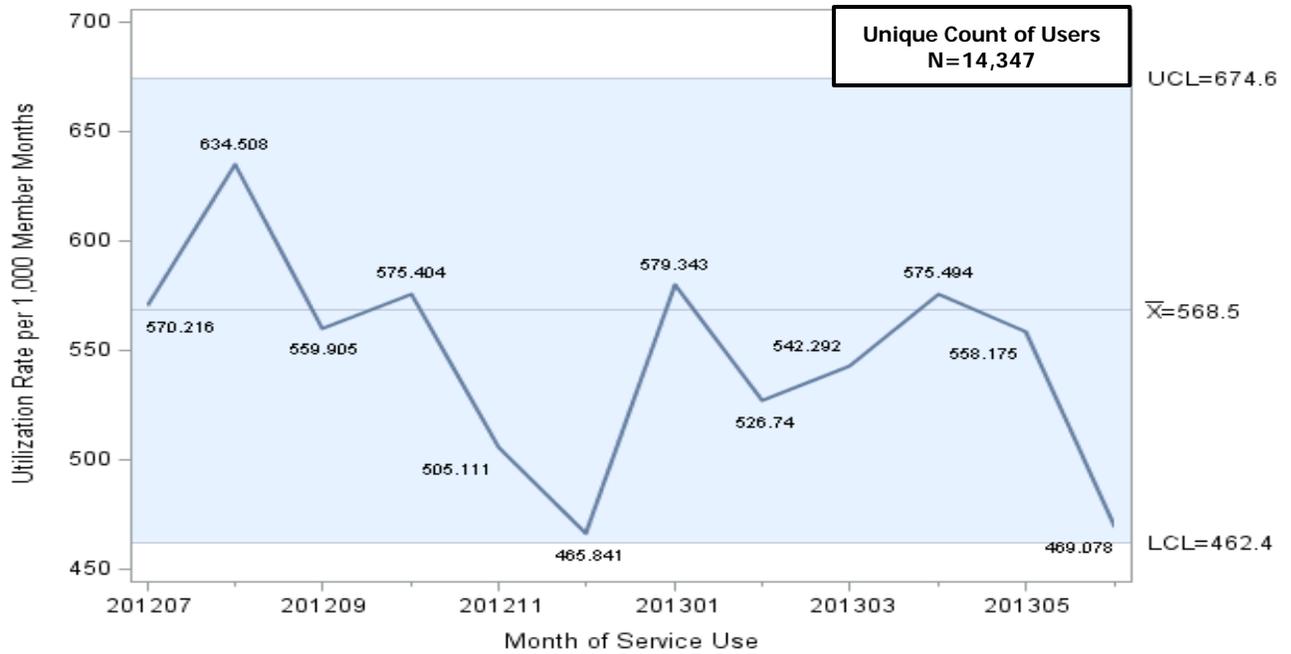


Figure SU-2. Physician/Clinic Utilization Rates among Children (Age 0-20) in the Families Aid Category, July 2012–June 2013

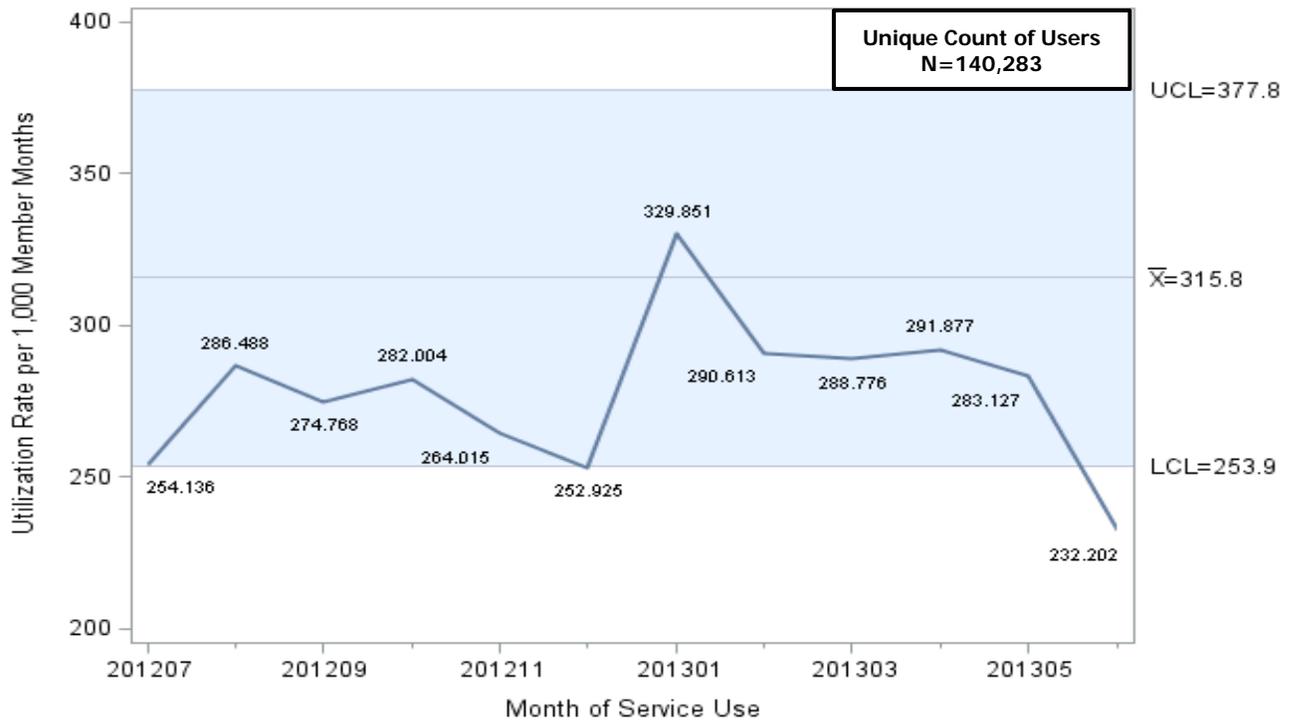


Figure SU-3. Physician/Clinic Utilization Rates among Children (Age 0-20) in the Foster Care Aid Category, July 2012–June 2013

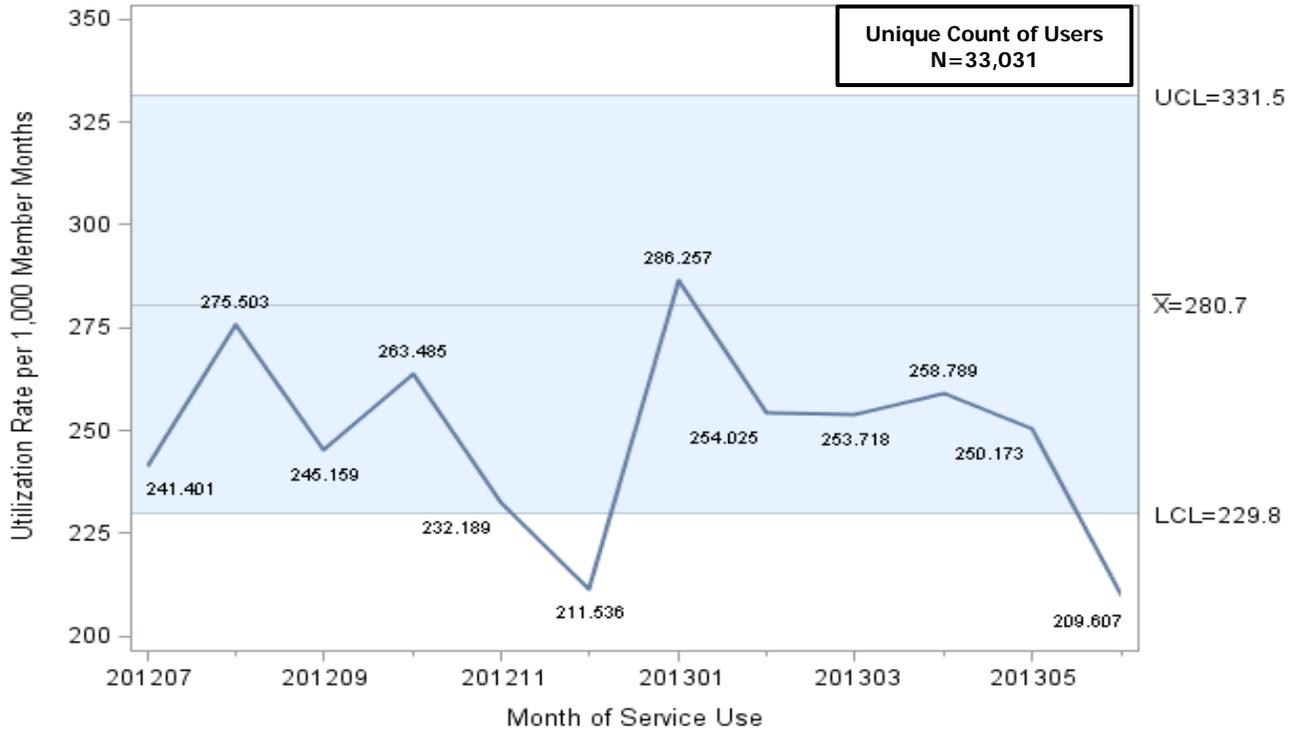


Figure SU-4. Physician/Clinic Utilization Rates among Children (Age 0-20) in the Other Aid Category, July 2012–June 2013

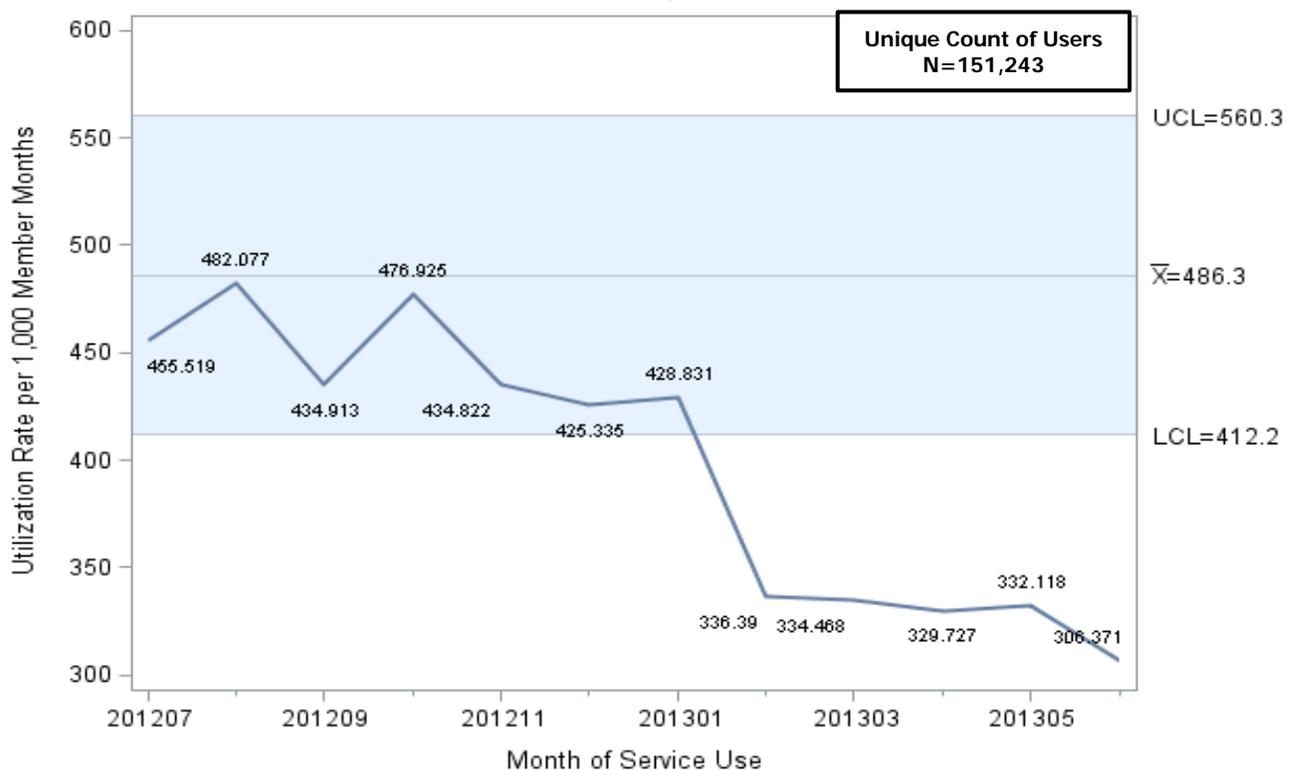
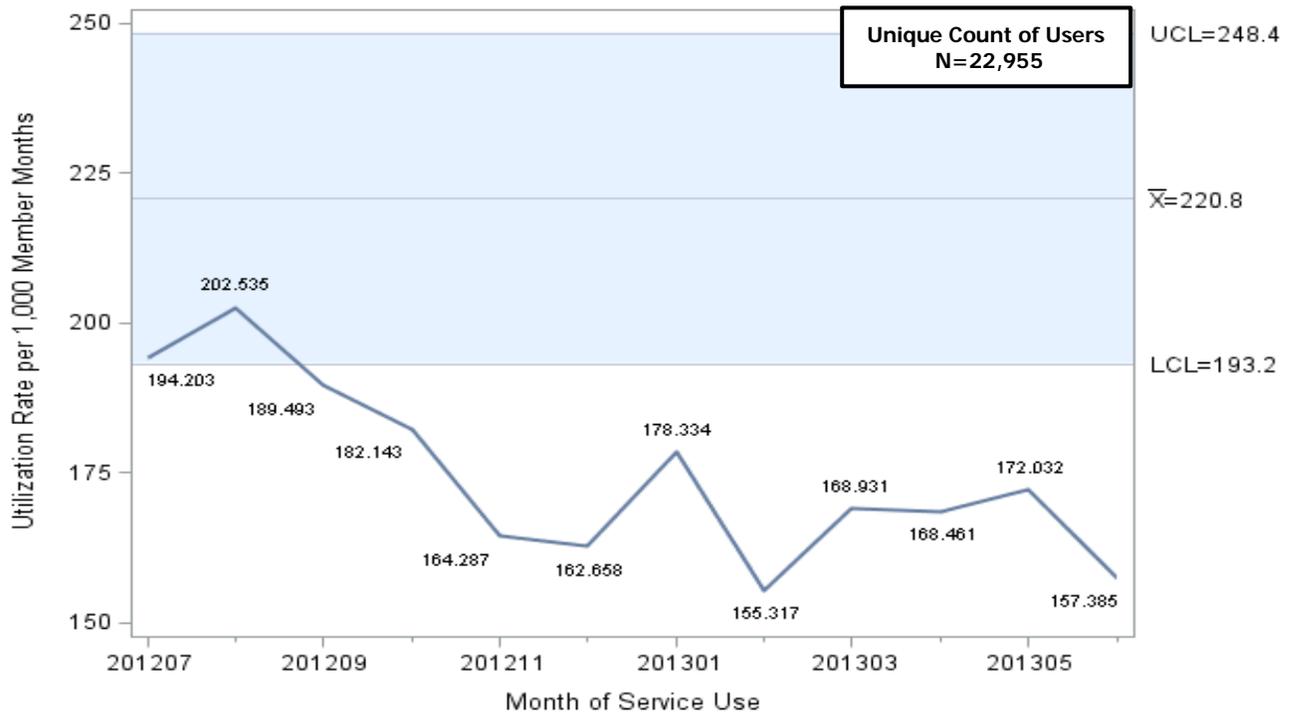


Figure SU-5. Physician/Clinic Utilization Rates among Children (Age 0-20) in the Undocumented Aid Category, July 2012–June 2013



Source: Data for figures SU-1 to SU-5 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends of Monthly Physician/Clinic Services Utilization Rates among Adults, July 2012–June 2013

Figure SU-6. Physician/Clinic Utilization Rates among Adults (Age 21+) in the Aged Aid Category, July 2012–June 2013

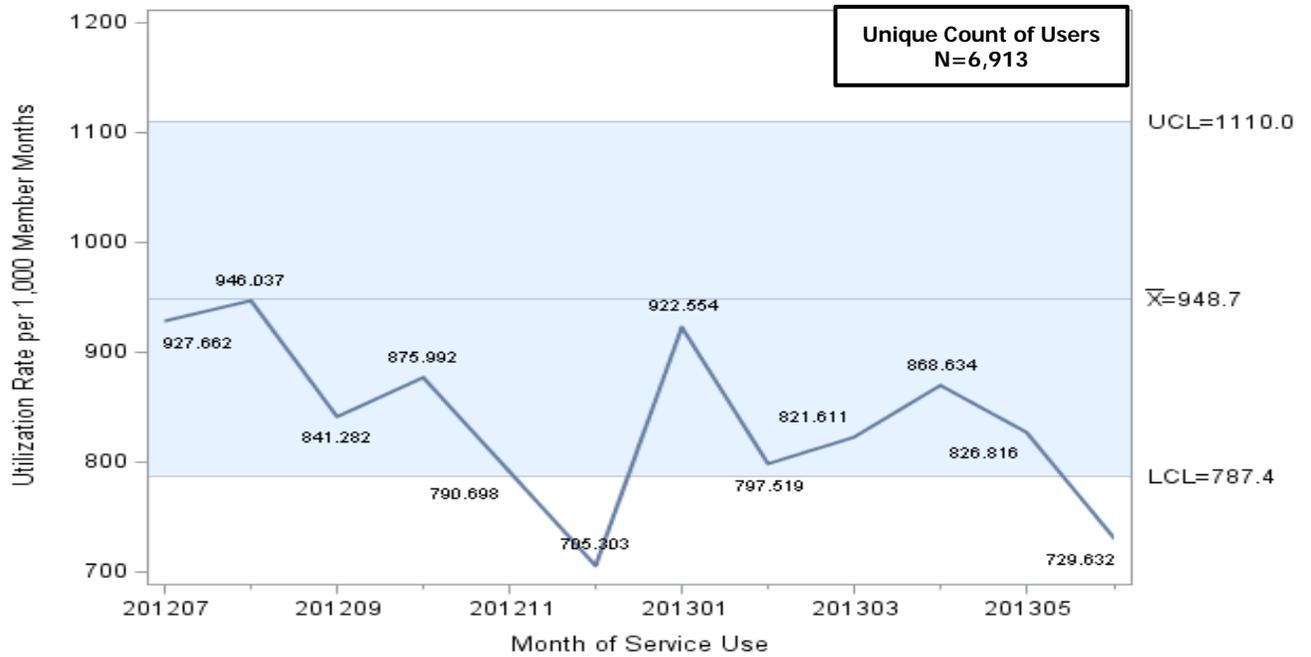


Figure SU-7. Physician/Clinic Utilization Rates among Adults (Age 21+) in the Blind/Disabled Aid Category, July 2012–June 2013

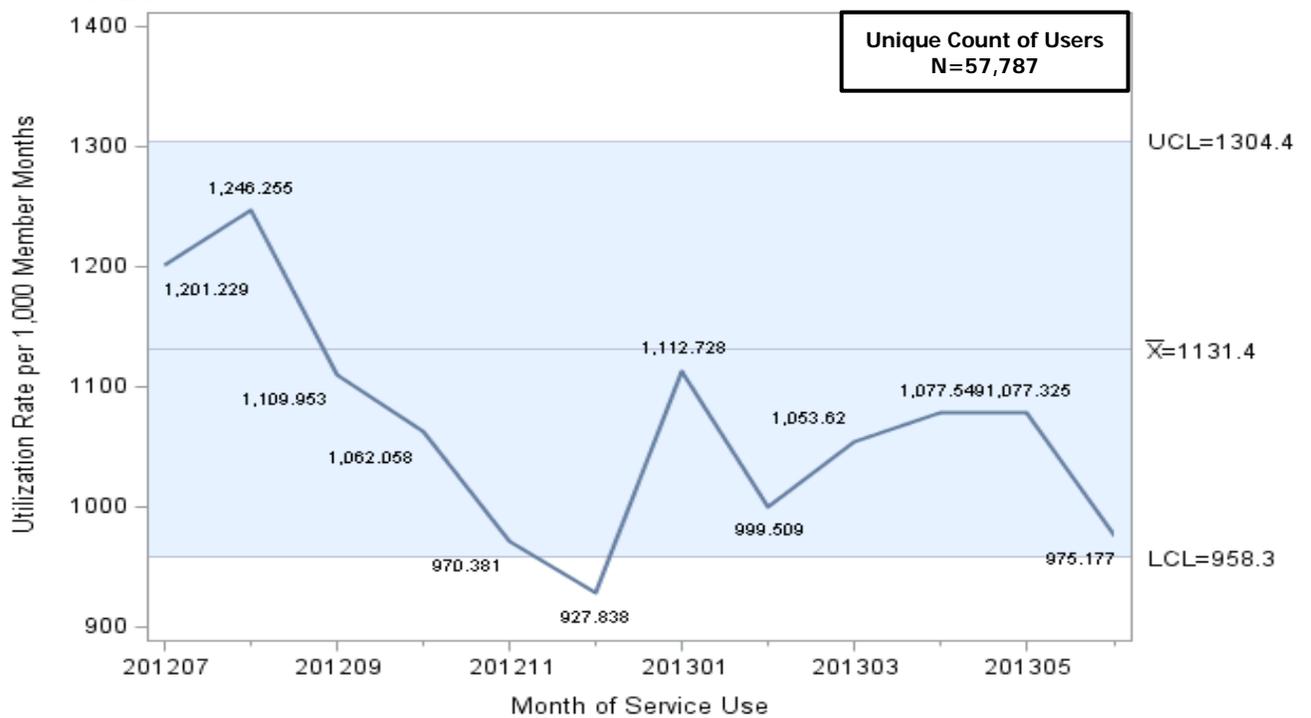


Figure SU-8. Physician/Clinic Utilization Rates among Adults (Age 21+) in Families Aid Category, July 2012–June 2013

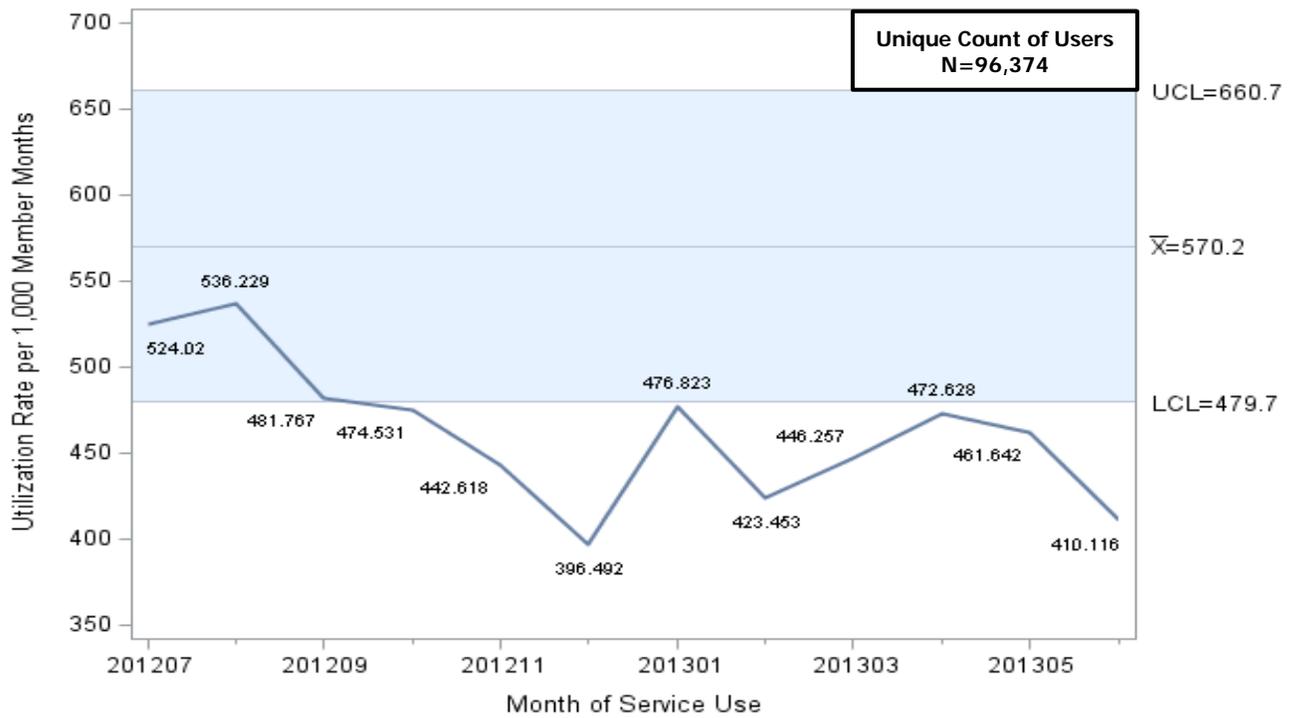


Figure SU-9. Physician/Clinic Utilization Rates among Adults (Age 21+) in the Other Aid Category, July 2012–June 2013

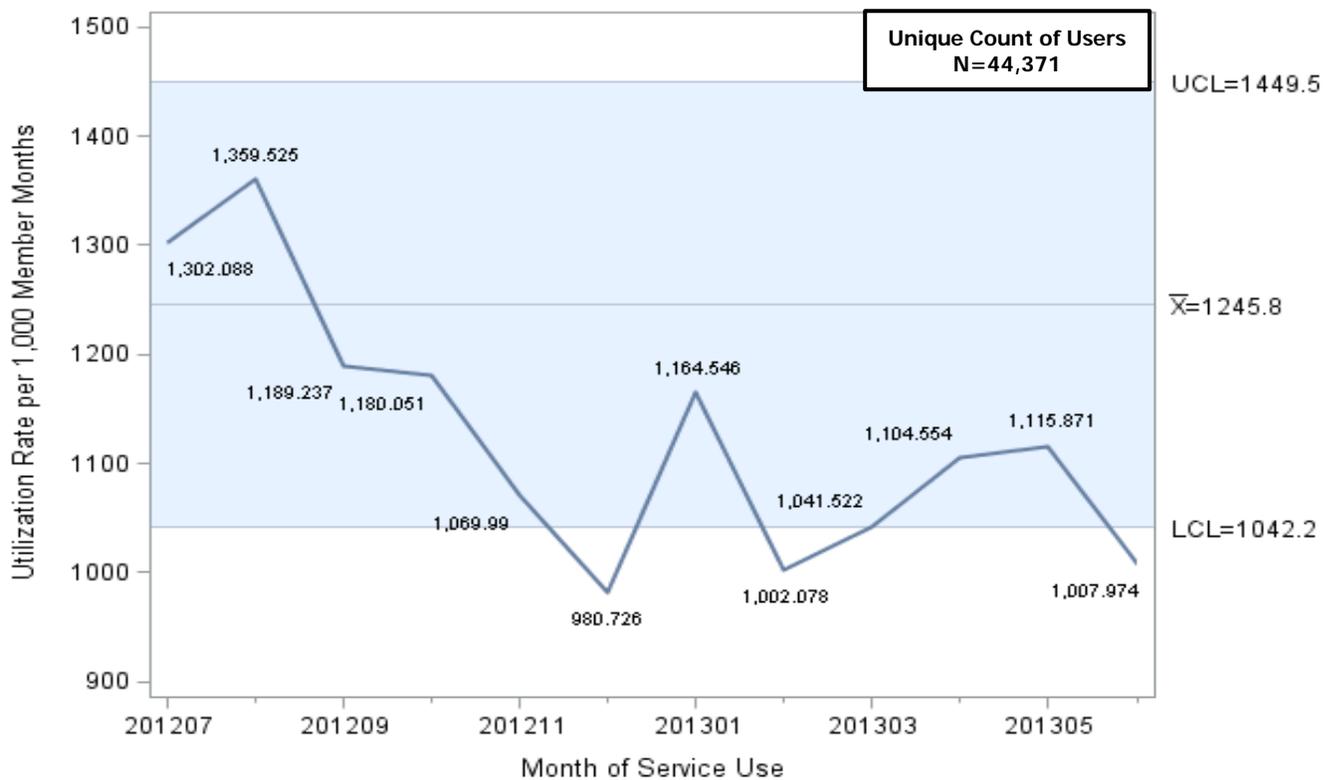
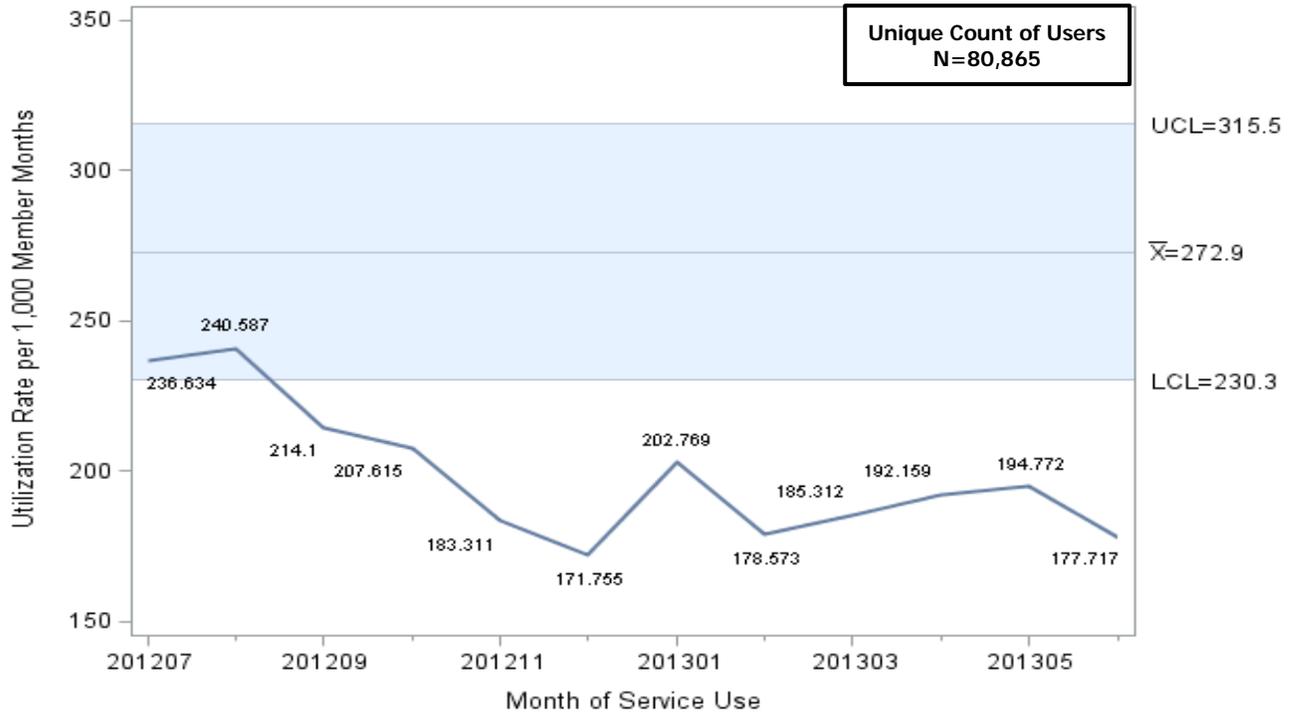


Figure SU-10. Physician/Clinic Utilization Rates among Adults (Age 21+) in the Undocumented Aid Category, July 2012–June 2013



Source: Data for figures SU-6 to SU-10 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, 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 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 26.1 to 61.4 visits per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

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 1.5 to two times higher than for adults in the Other aid category. Adults in the analyzed aid categories again exhibited Non-Emergency Medical Transportation utilization rates above the expected baseline ranges throughout 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 and SU-12 represent the control chart analysis for adults from the third quarter of 2012 to the second quarter of 2013.

Due to low user counts for most subpopulations, utilization rates of Non-Emergency Medical Transportation services are only reported for 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 among Adults, July 2012–June 2013

Figure SU-11. Non-Emergency Transportation Utilization Rates among Adults (Age 21+) in the Blind/Disabled Aid Category, July 2012–June 2013

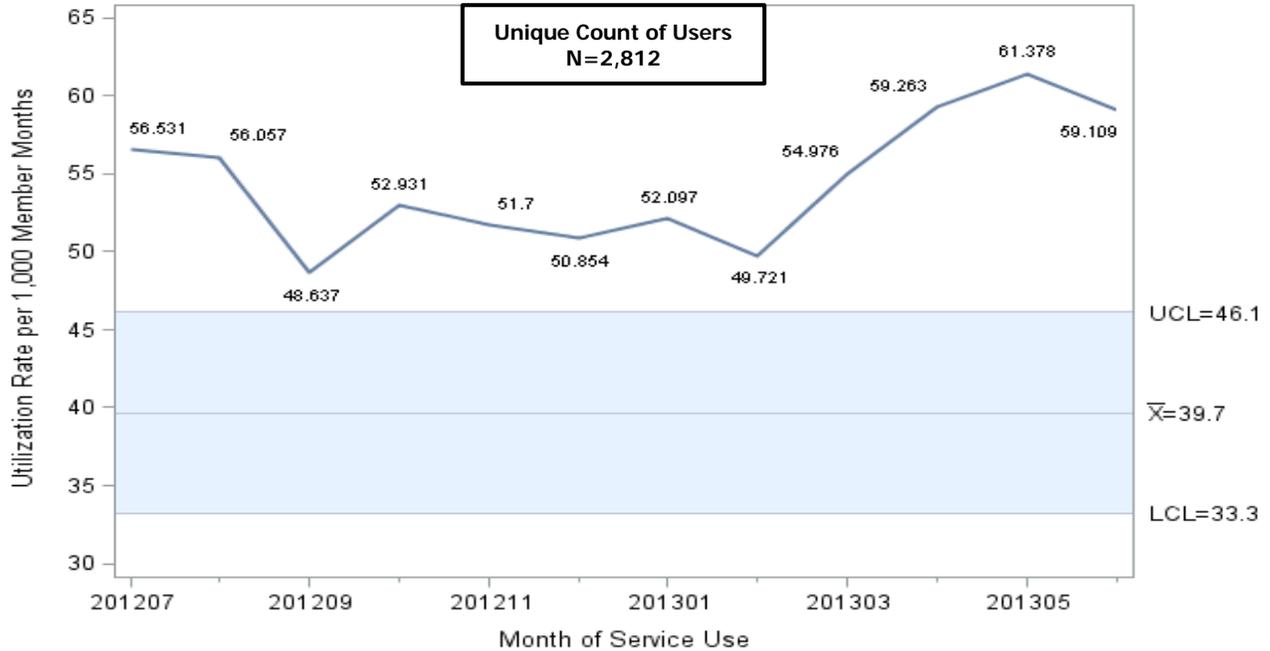
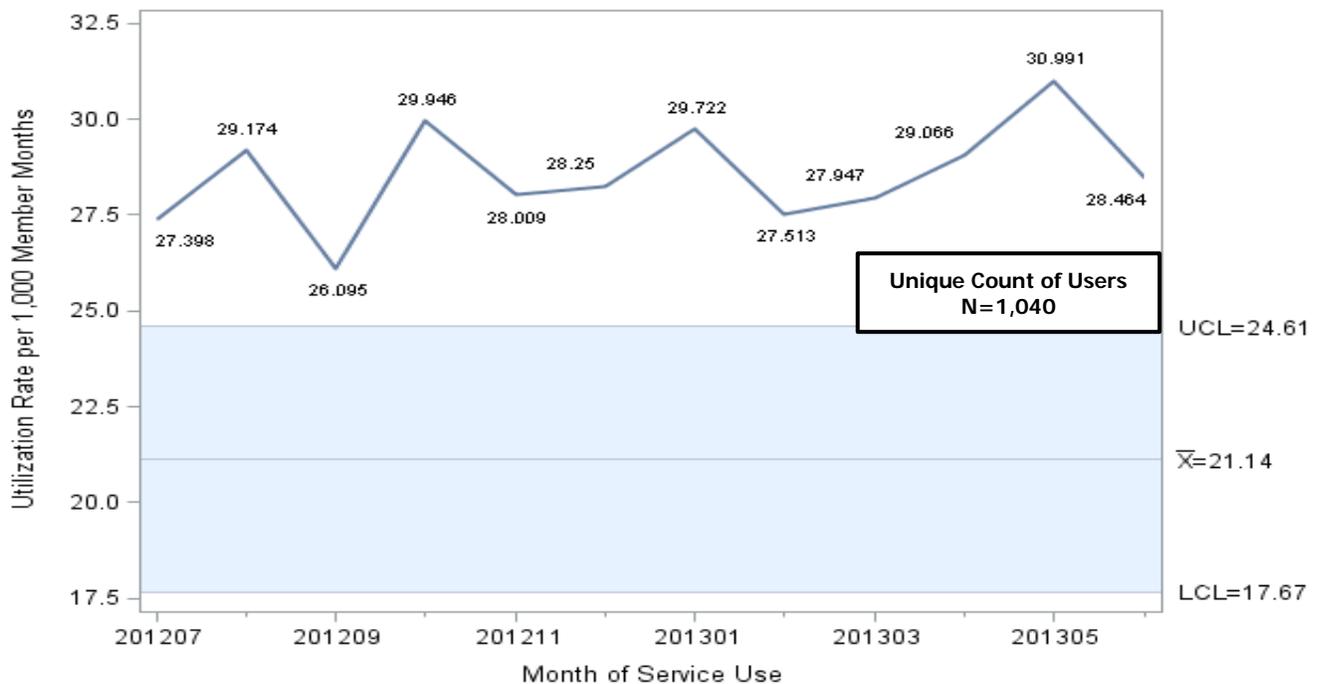


Figure SU-12. Non-Emergency Transportation Utilization Rates among Adults (Age 21+) in the Other Aid Category, July 2012–June 2013



Source: Data for figures SU-11 and SU-12 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, 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 to 20 in the Medi-Cal FFS program, monthly Emergency Medical Transportation services utilization rates ranged from 1.5 to 9.2 visits per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

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 7.0 to 9.2 visits per 1,000 member months. In contrast, utilization rates for children in the Families and Other aid categories ranged from 1.9 to 6.0 visits per 1,000 member months. Children in the Blind/Disabled, Other, and Undocumented aid categories continued to mostly exhibit below average utilization, while those in the Foster Care aid category again primarily displayed above average utilization rates. Additionally, the Emergency Medical Transportation utilization rates for children in the Other aid category fell below the expected baseline ranges during the first two quarters of 2013.

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

Adults

The monthly Emergency Medical Transportation services utilization rates for adults age 21 and older ranged from 6.5 to 45.3 visits per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

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 was 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 third quarter of 2012 to the second quarter of 2013.

Trends of Monthly Emergency Medical Transportation Services Utilization Rates among Children, July 2012–June 2013

Figure SU-13. Emergency Transportation Utilization Rates among Children Age (0–20) in the Blind/Disabled Aid Category, July 2012–June 2013

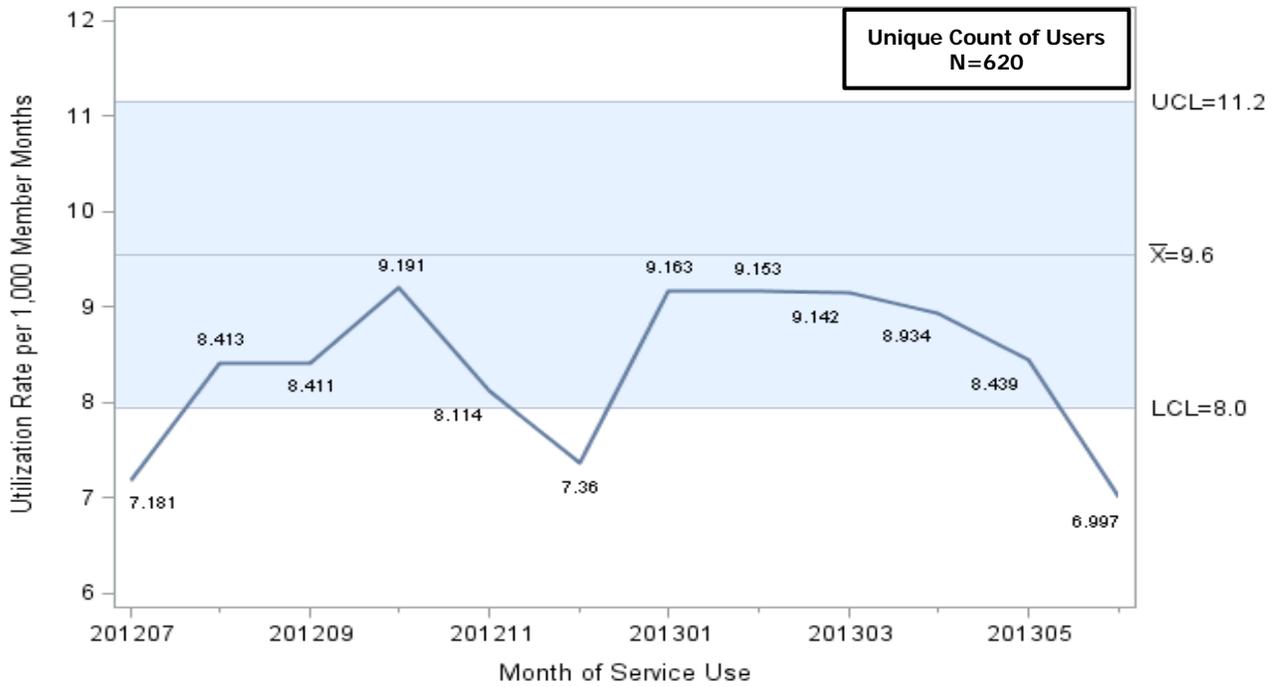


Figure SU-14. Emergency Transportation Utilization Rates among Children (Age 0–20) in the Families Aid Category, July 2012–June 2013

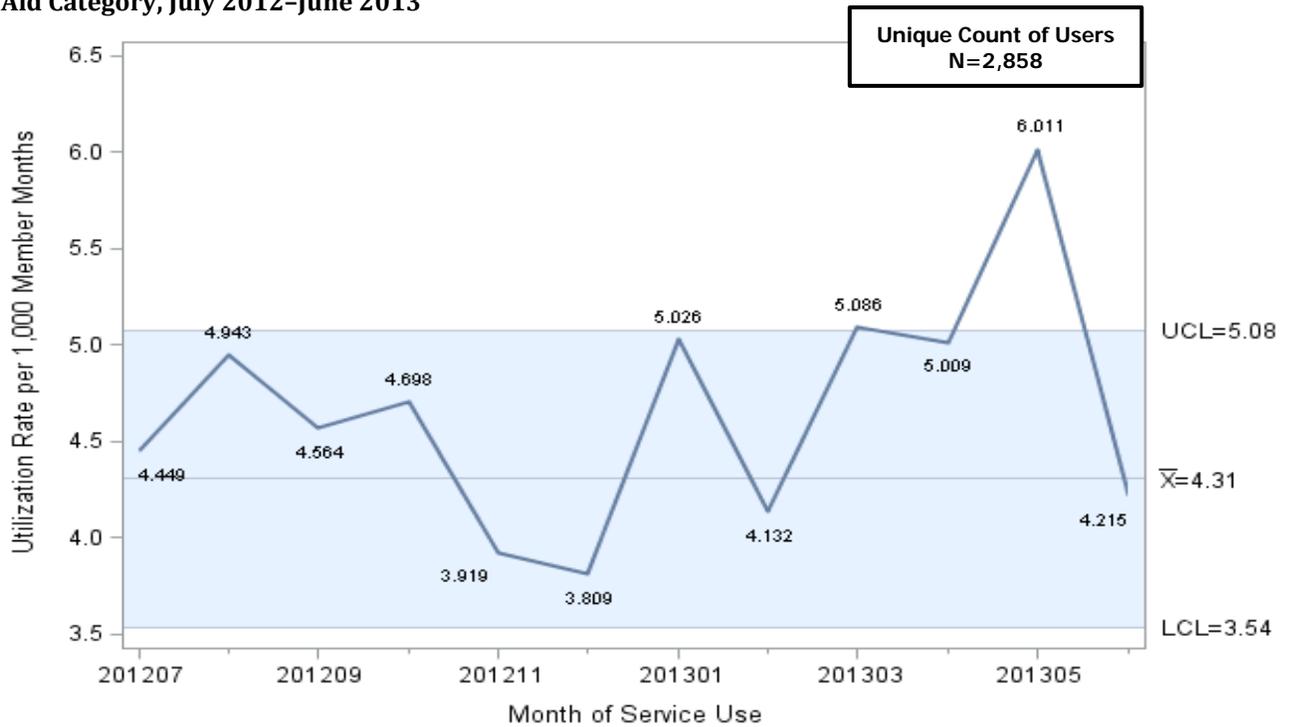


Figure SU-15. Emergency Transportation Utilization Rates among Children (Age 0-20) in the Foster Care Aid Category, July 2012-June 2013

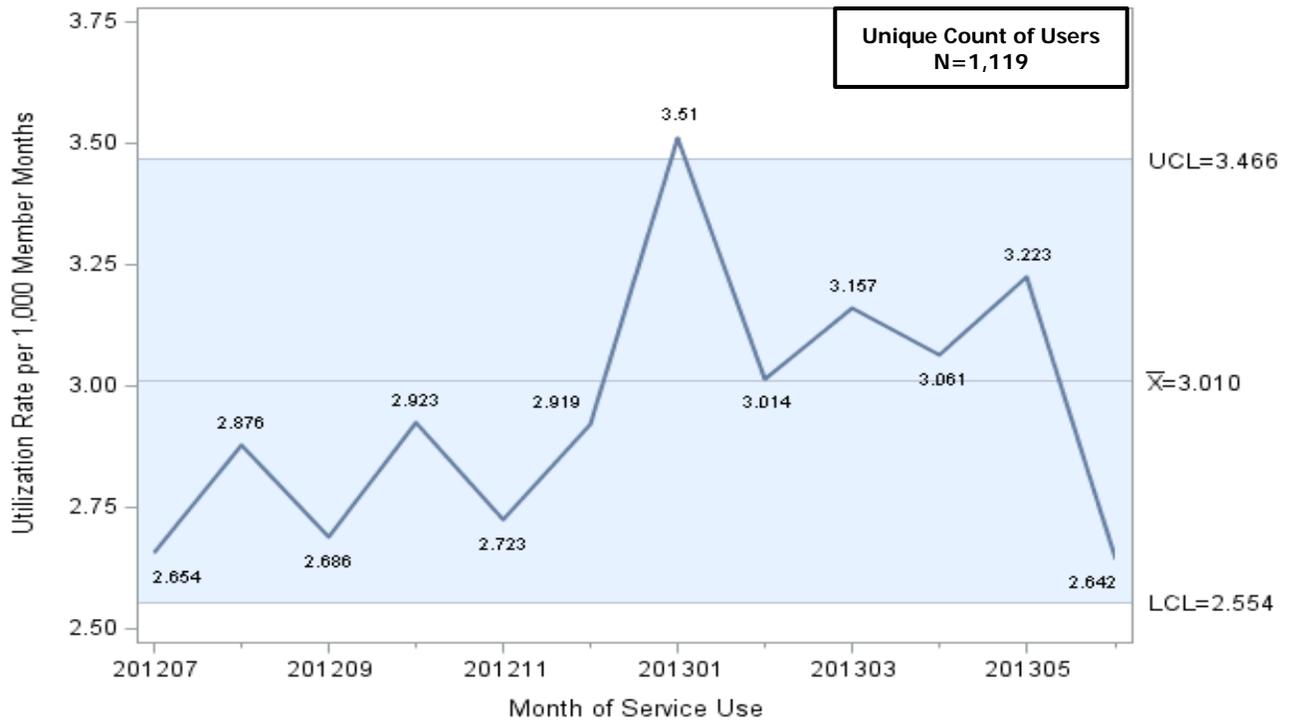


Figure SU-16. Emergency Transportation Utilization Rates among Children (Age 0-20) in the Other Aid Category, July 2012-June 2013

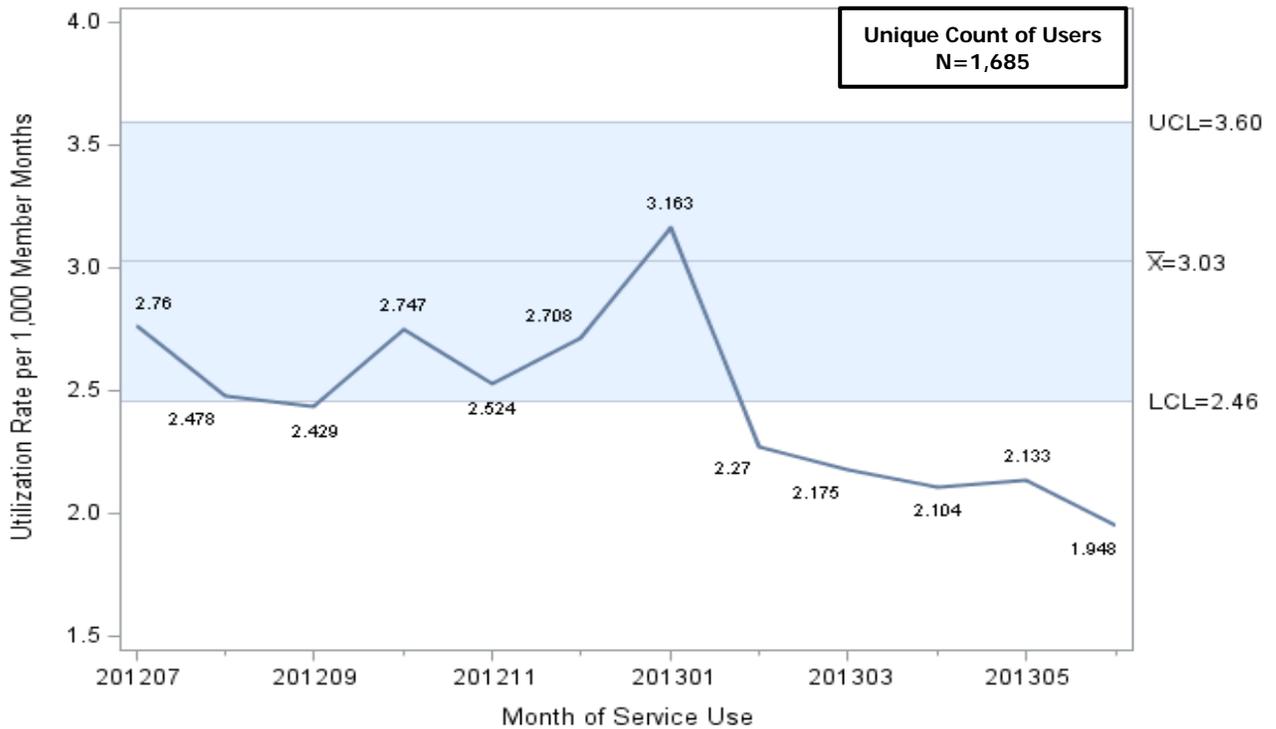
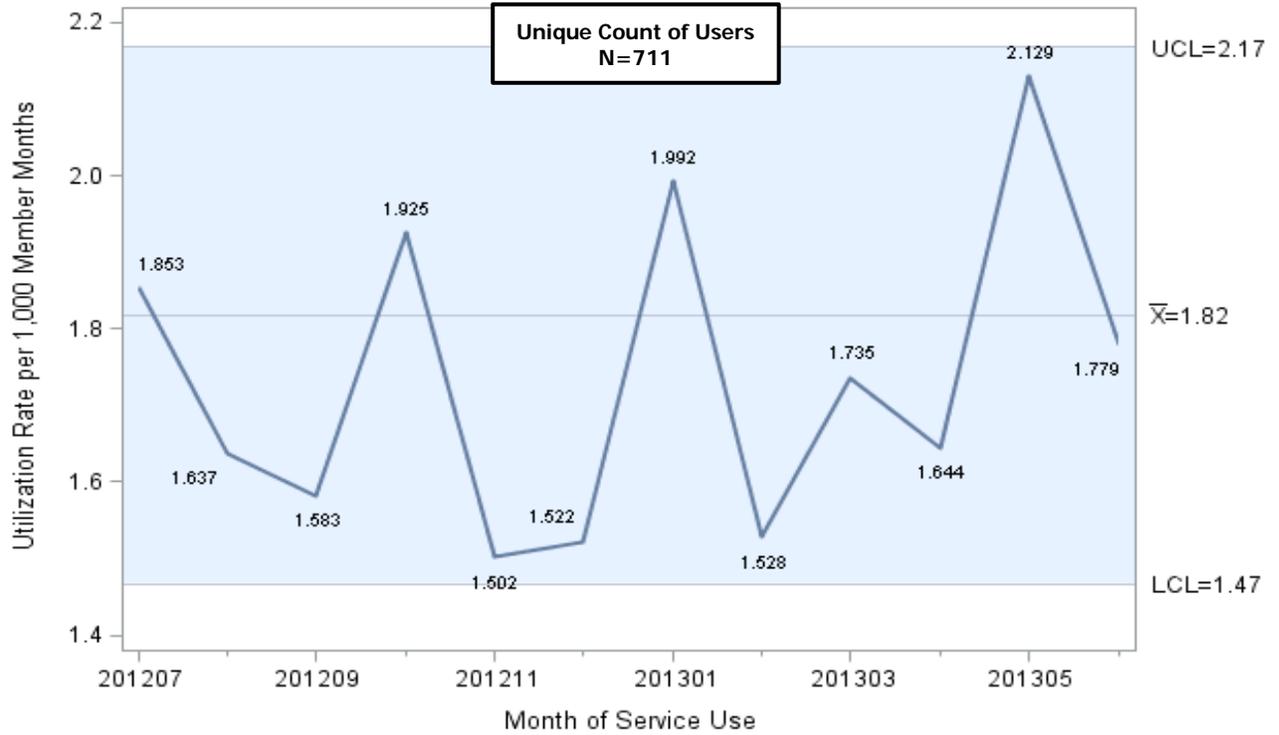


Figure SU-17. Emergency Transportation Utilization Rates among Children (Age 0-20) in the Undocumented Aid Category, July 2012-June 2013



Source: Data for figures SU-13 to SU-17 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012-June 2013, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends of Monthly Emergency Transportation Services Utilization Rates among Adults, July 2012–June 2013

Figure SU-18. Emergency Transportation Utilization Rates among Adults (Age 21+) in the Blind/Disabled Aid Category, July 2012–June 2013

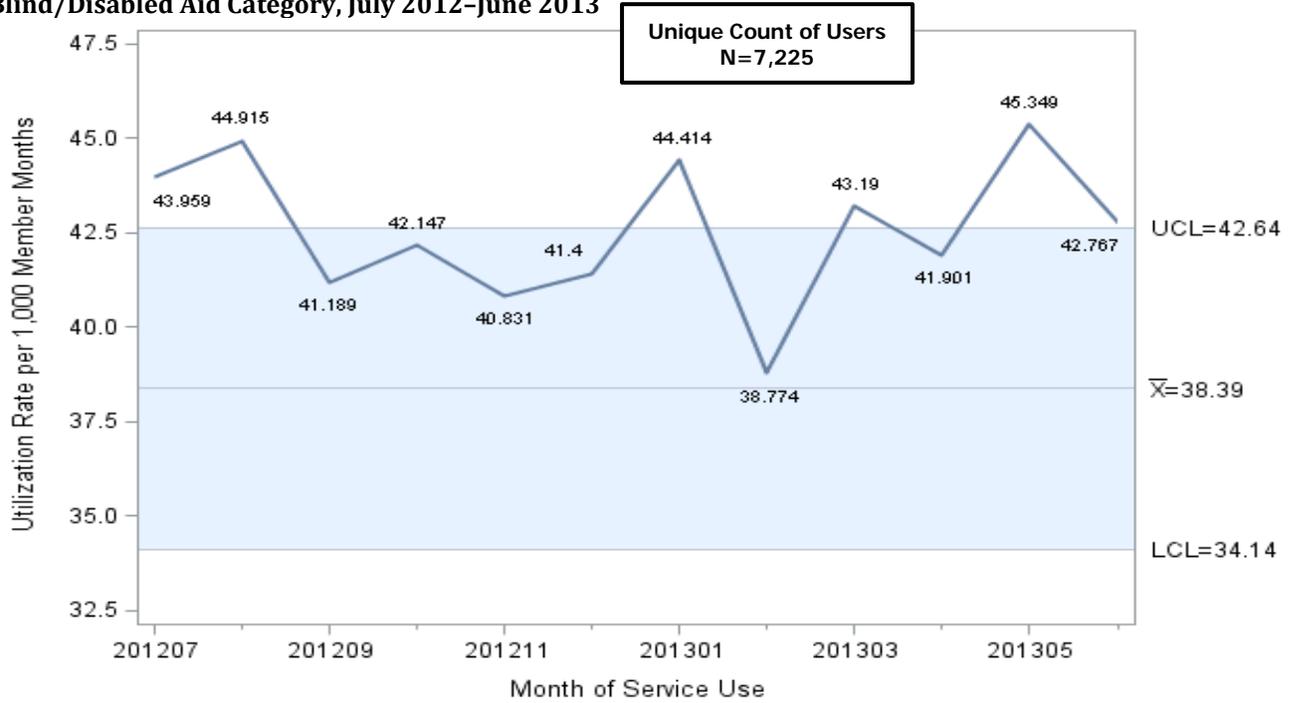


Figure SU-19. Emergency Transportation Utilization Rates among Adults (Age 21+) in the Families Aid Category, July 2012–June 2013

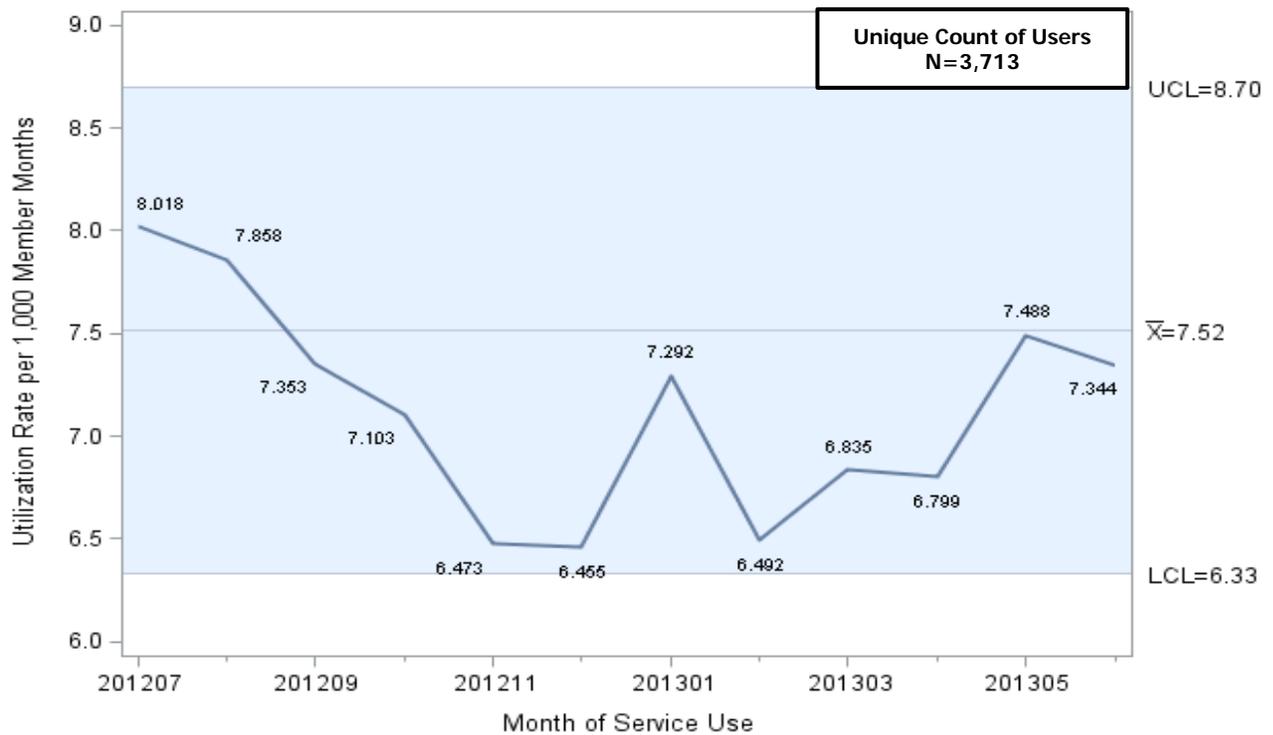


Figure SU-20. Emergency Transportation Utilization Rates among Adults (Age 21+) in the Other Aid Category, July 2012–June 2013

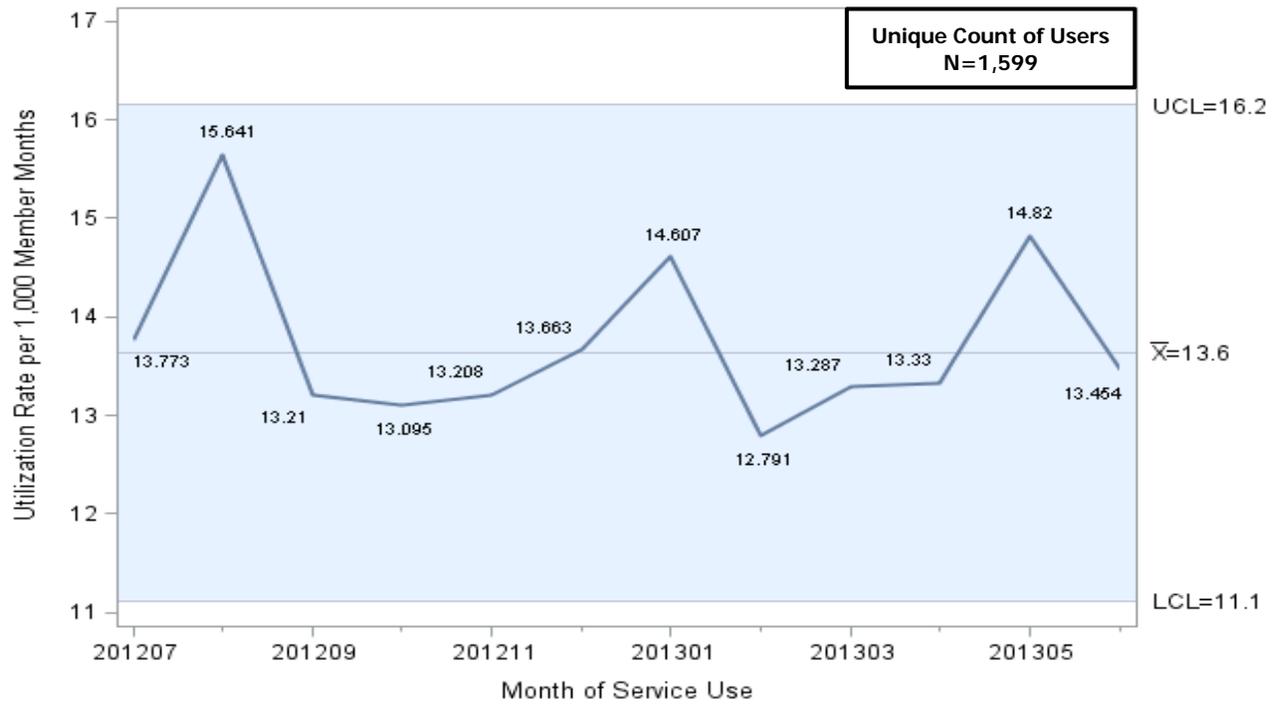
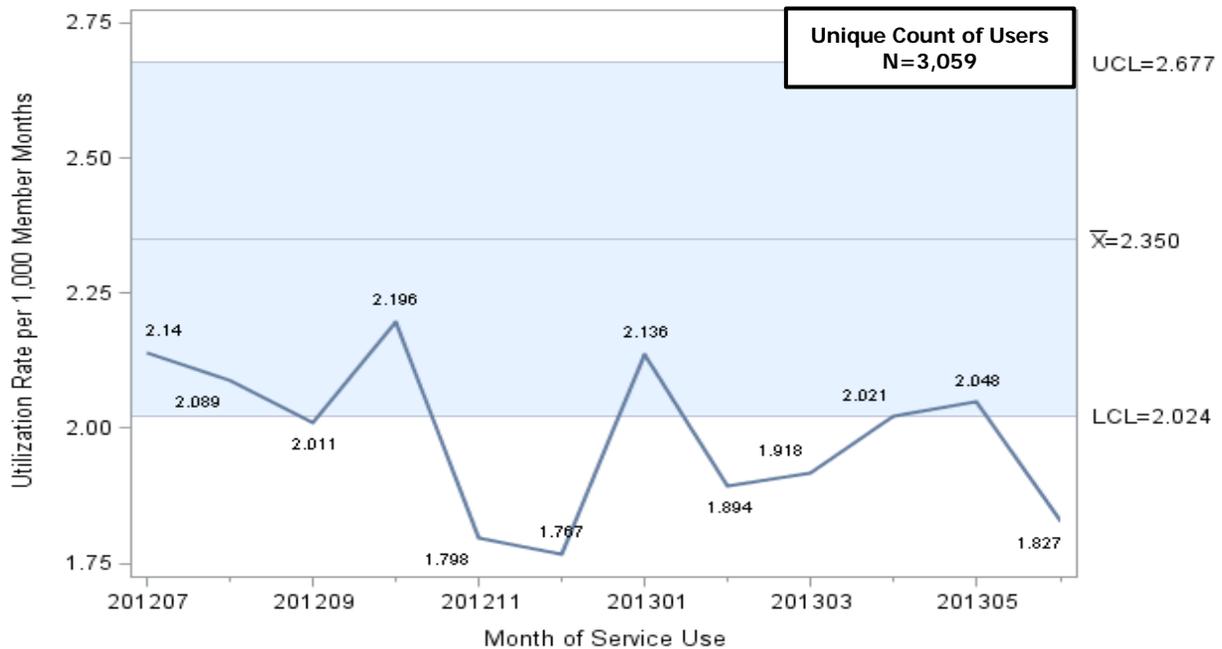


Figure SU-21. Emergency Transportation Rates among Adults (Age 21+) in the Undocumented Aid Category, July 2012–June 2013



Source: Data for figures SU-18 to SU-21 prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, 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
- 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 services costs. Most of these expenditures are attributable to EPSDT private duty nursing that provides care for children with paralysis, nervous system disorders, epilepsy, and other congenital anomalies and hereditary conditions.

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

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

Trend Analysis

Children

This analysis focuses only on Home Health services utilization rates among Medi-Cal children age 0 to 20 participating in the FFS program and enrolled in the Blind/Disabled aid category. The monthly Home Health services utilization rates for children in this aid category ranged from 135.4 to 157.0 visits per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

Children in the Blind/Disabled aid category again exhibited utilization rates above the thresholds established in the baseline period of 2007 to 2009 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 11.8 to 15.1 visits per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

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 primarily displayed above average utilization that also remained within the expected baseline ranges.

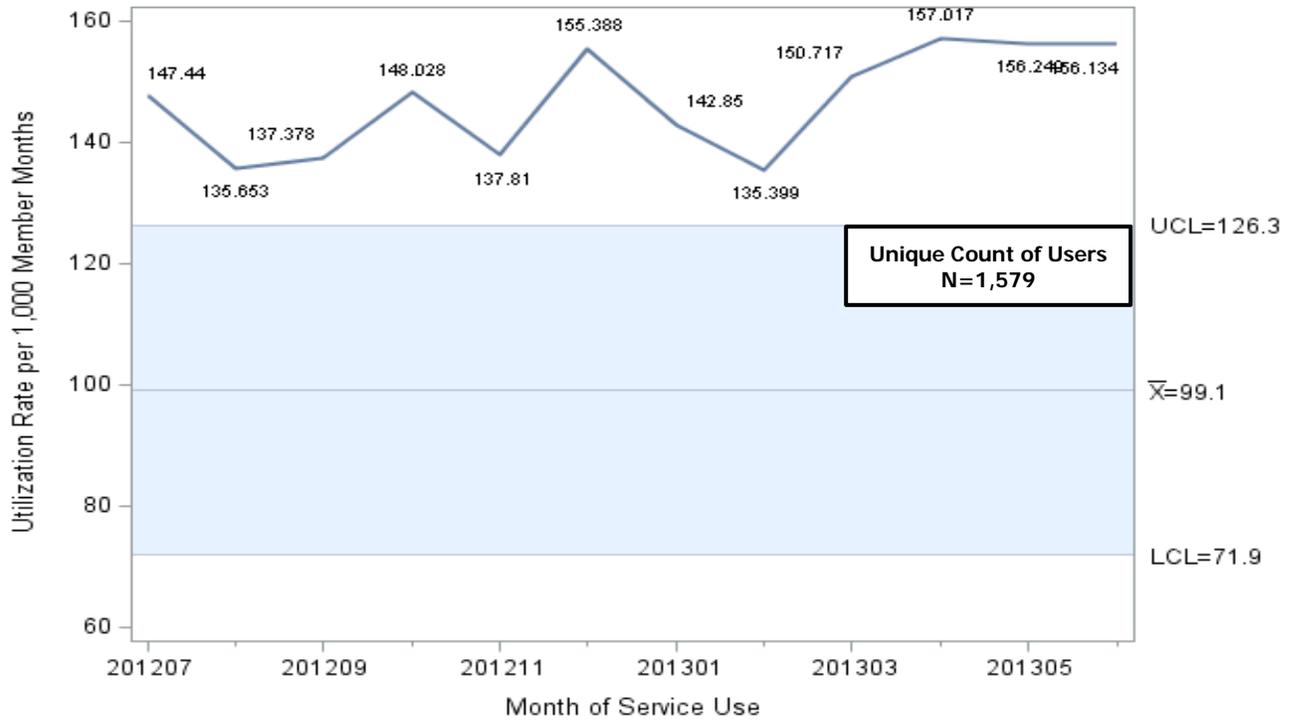
Medi-Cal FFS beneficiaries in the Undocumented aid category are not entitled to Home Health services and were subsequently excluded from this analysis. Additionally, adults in the Aged, Families, and Other aid categories, as well as children in the Families, Foster Care, and Other aid categories were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

The following figures for SU-22 and SU-23 represent the control chart analysis for both children and adults from the third quarter of 2012 to the second quarter of 2013.

Use of Home Health services among children is now concentrated among children and adults in the Blind/Disabled aid category.

Trends of Monthly Home Health Services Utilization Rates among Children, July 2012–June 2013

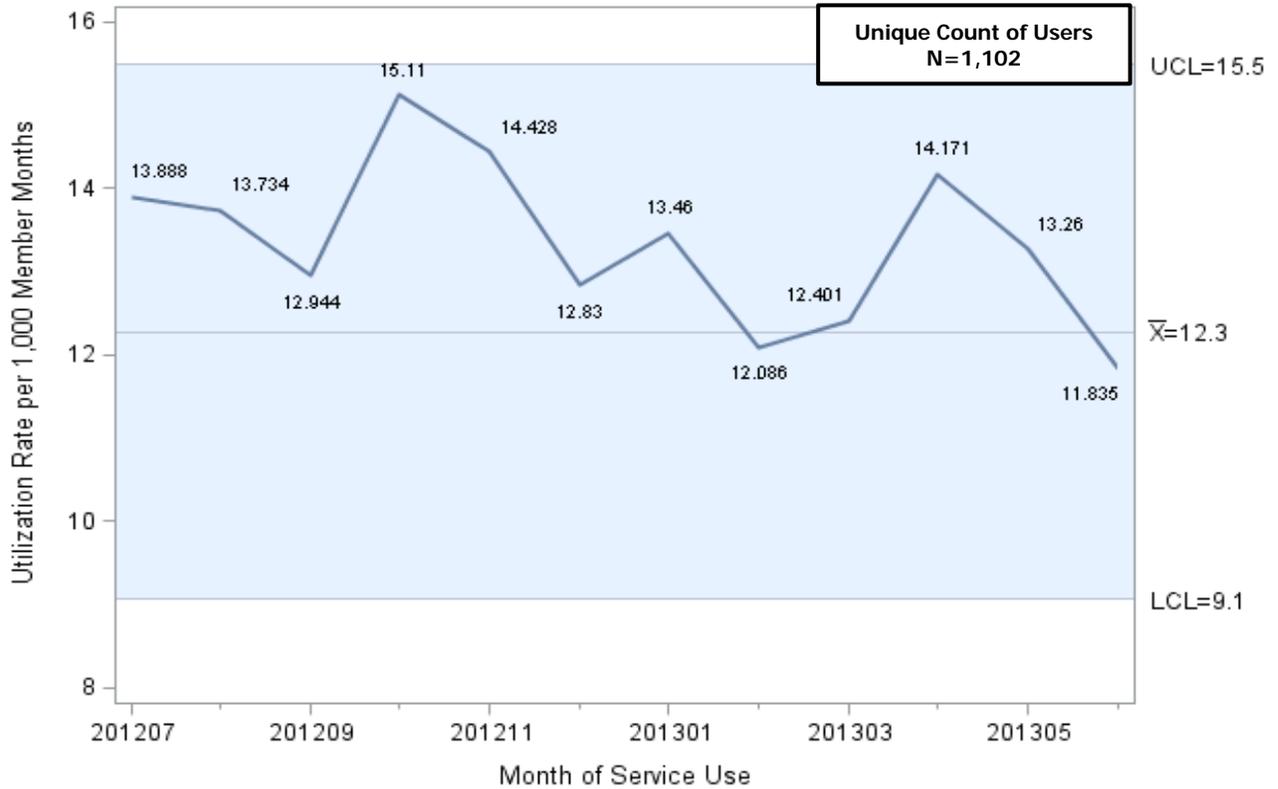
Figure SU-22. Home Health Services Utilization Rates among Children (Age 0–20) in the Blind/Disabled Aid Category, July 2012–June 2013



Source: Data for figure SU-22 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends of Monthly Home Health Services Utilization Rates among Adults, July 2012–June 2013

Figure SU-23. Home Health Services Utilization Rates among Adults (Age 21+) in the Blind/Disabled Aid Category, July 2012–June 2013



Source: Data for figure SU-23 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, 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 13.3 to 141.6 days per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

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 seven to eight times higher than for children in the Foster Care aid category. Children in the Blind/Disabled and Families aid categories 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 mostly exhibited below average utilization of Hospital Inpatient services throughout the study period. Of particular note, utilization among children in the Other and Undocumented aid categories declined to levels below the expected ranges during the last two quarters of the study period.

Children in the Blind/Disabled aid category 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 29.4 to 302.3 days per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

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. In contrast, adults in the Families, Other, and Undocumented aid categories exhibited below average Hospital Inpatient services utilization rates that often fell below the expected ranges. This continued low Hospital Inpatient services use among these subgroups may be influenced in part by the continued decline in statewide birthrates.

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-24 to SU-33 represent the control chart analysis for both children and adults from the third quarter of 2012 to the second quarter of 2013.

Trends of Monthly Hospital Inpatient Services Utilization Rates among Children, July 2012–June 2013

Figure SU-24. Hospital Inpatient Utilization Rates among Children (Age 0-20) in the Blind/Disabled Aid Category, July 2012–June 2013

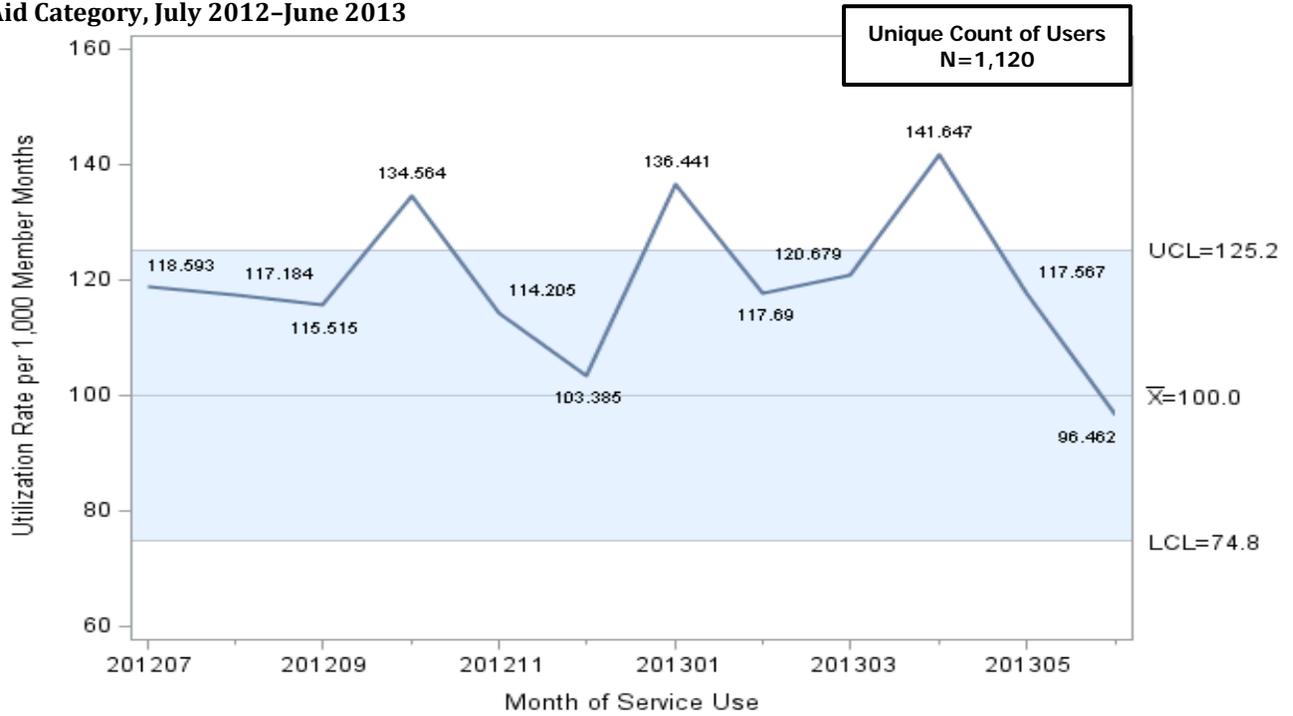


Figure SU-25. Hospital Inpatient Utilization Rates among Children (Age 0-20) in the Families Aid Category, July 2012–June 2013

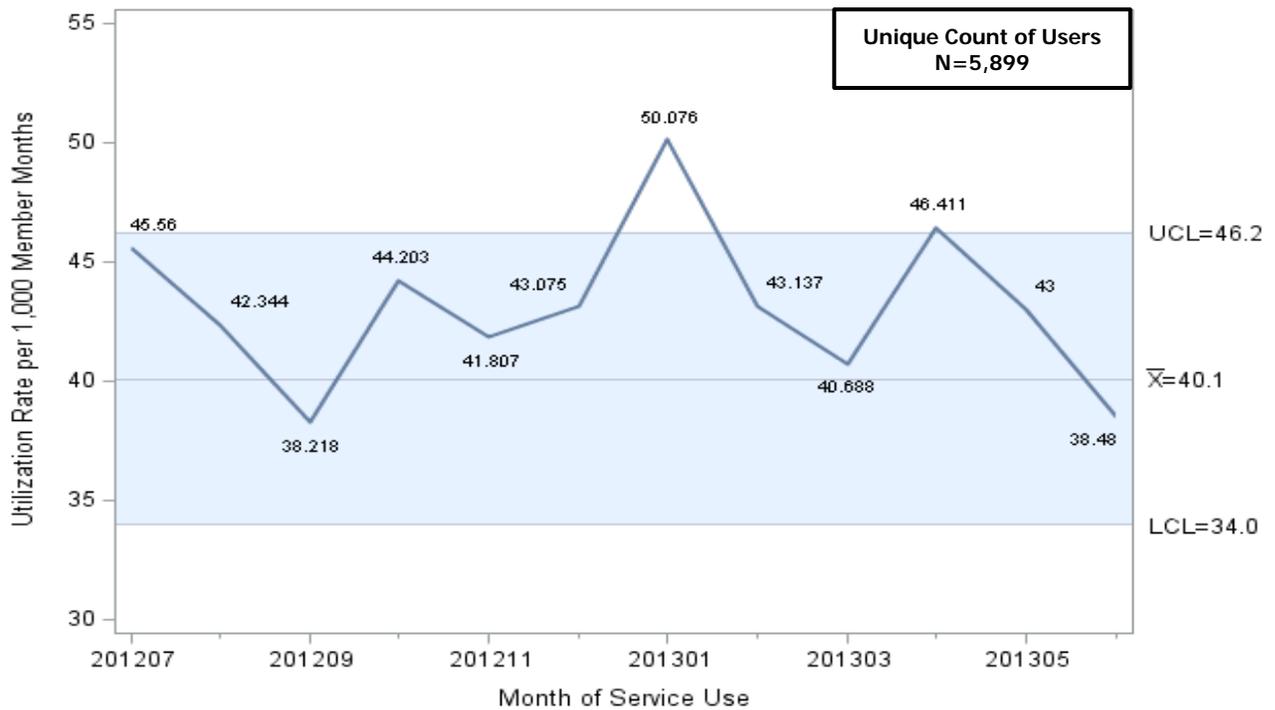


Figure SU-26. Hospital Inpatient Utilization Rates among Children (Age 0-20) in the Foster Care Aid Category, July 2012-June 2013

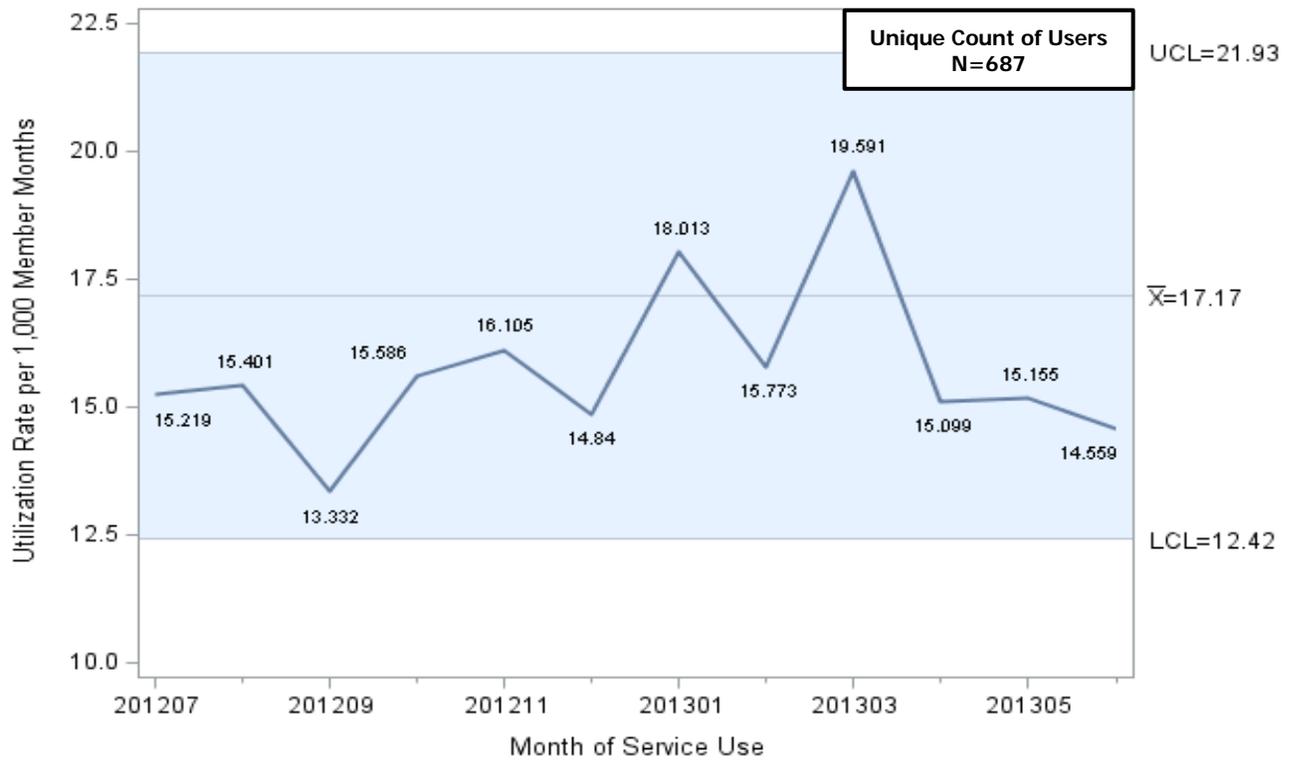


Figure SU-27. Hospital Inpatient Utilization Rates among Children (Age 0-20) in the Other Aid Category, July 2012-June 2013

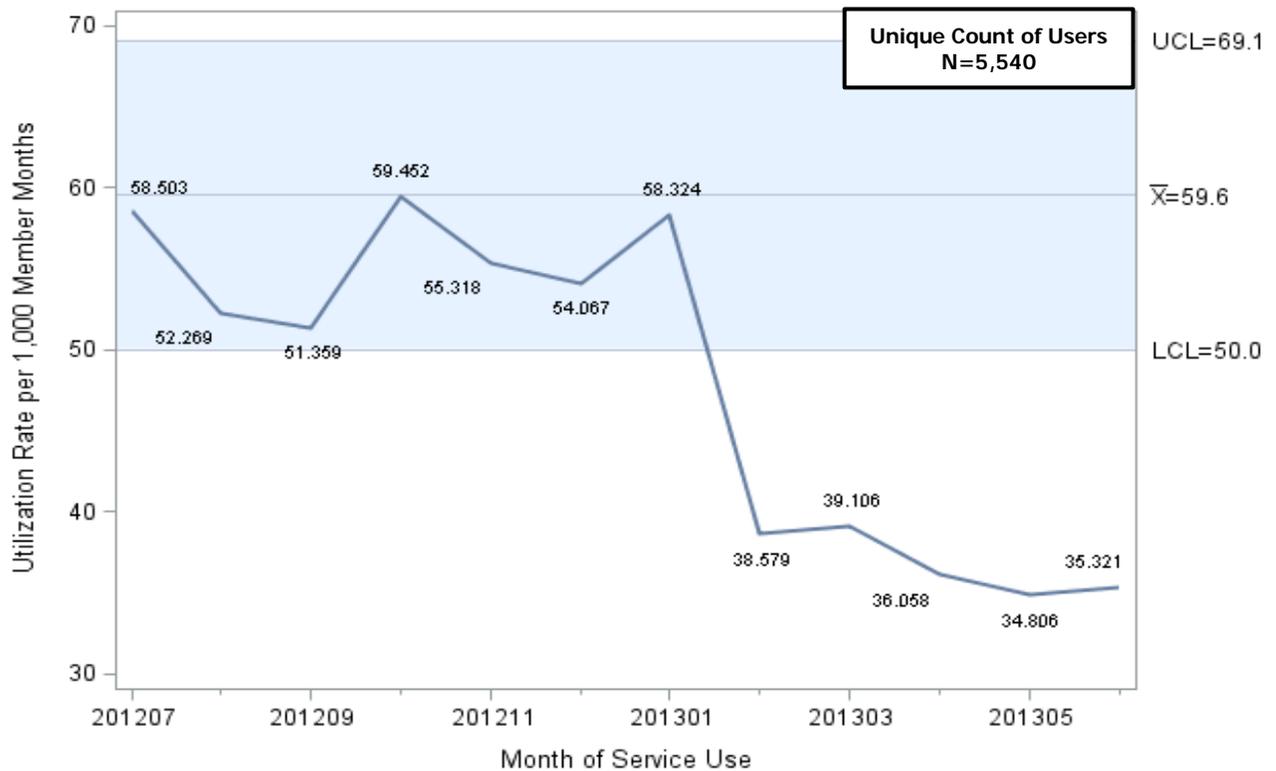
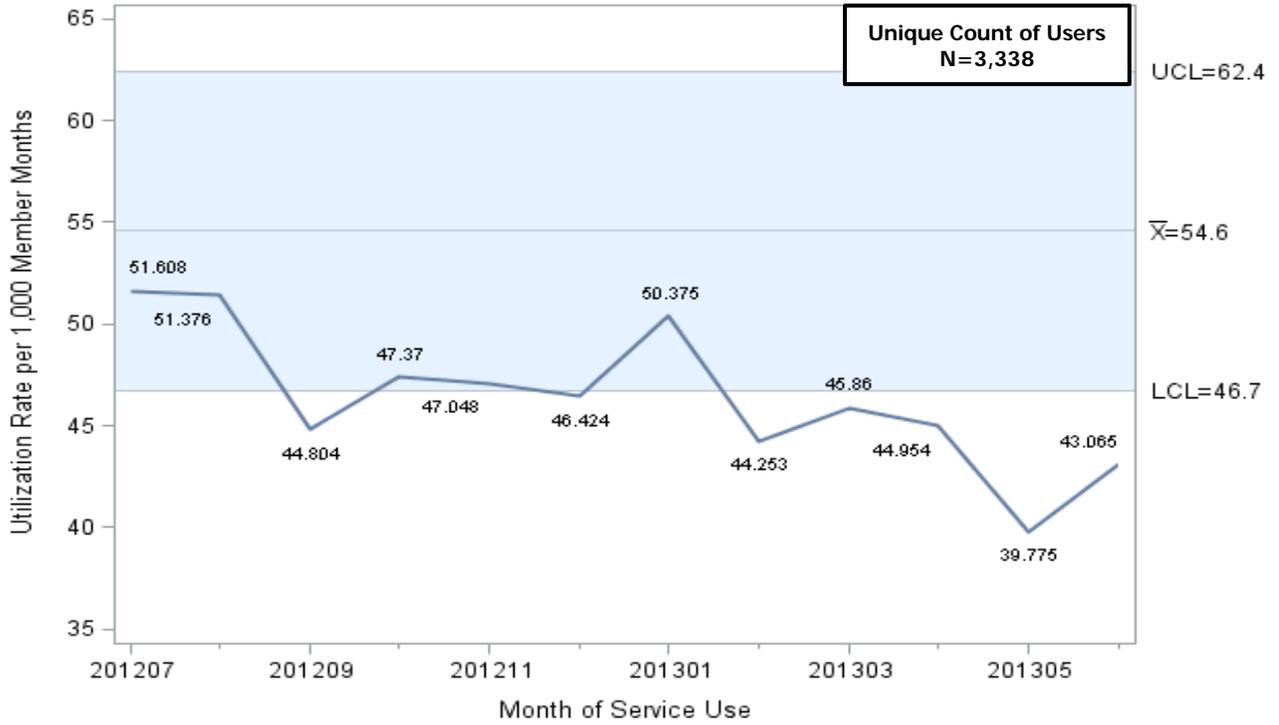


Figure SU-28. Hospital Inpatient Utilization Rates among Children (Age 0-20) in the Undocumented Aid Category, July 2012–June 2013



Source: Data for figures SU-24 to SU-28 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends of Monthly Hospital Inpatient Services Utilization Rates among Adults, July 2012–June 2013

Figure SU-29. Hospital Inpatient Utilization Rates among Adults (Age 21+) in the Aged Aid Category, July 2012–June 2013

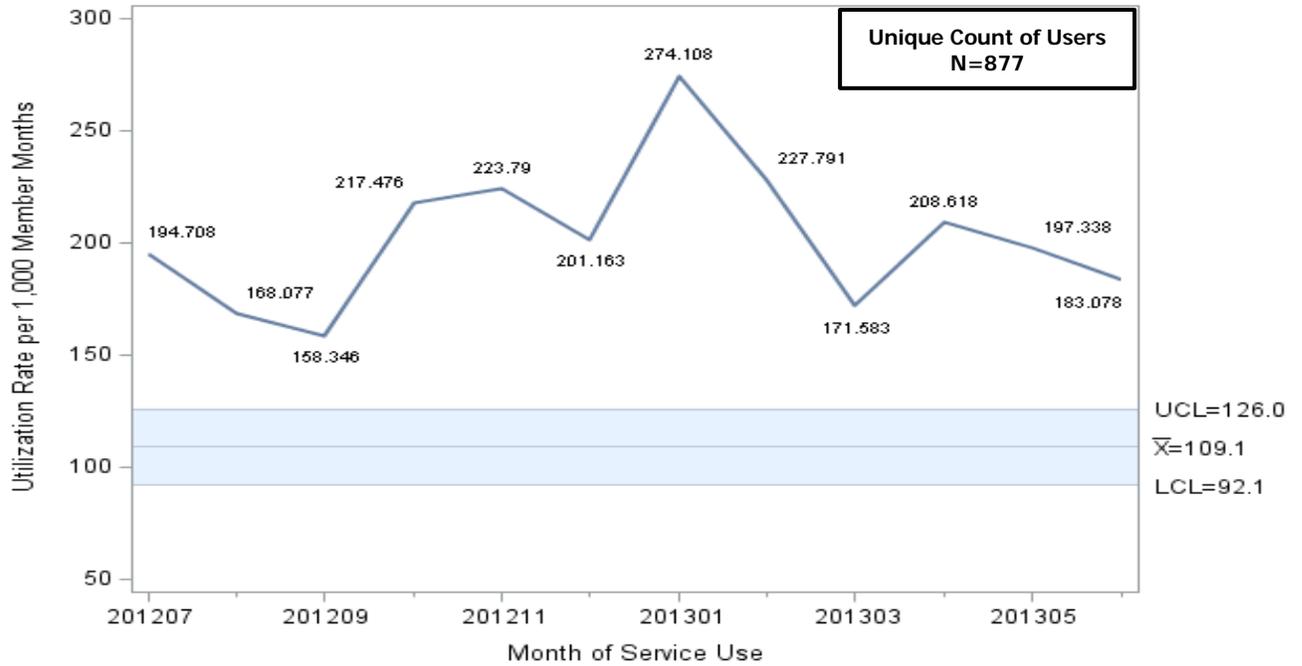


Figure SU-30. Hospital Inpatient Utilization Rates among Adults (Age 21+) in the Blind/Disabled Aid Category, July 2012–June 2013

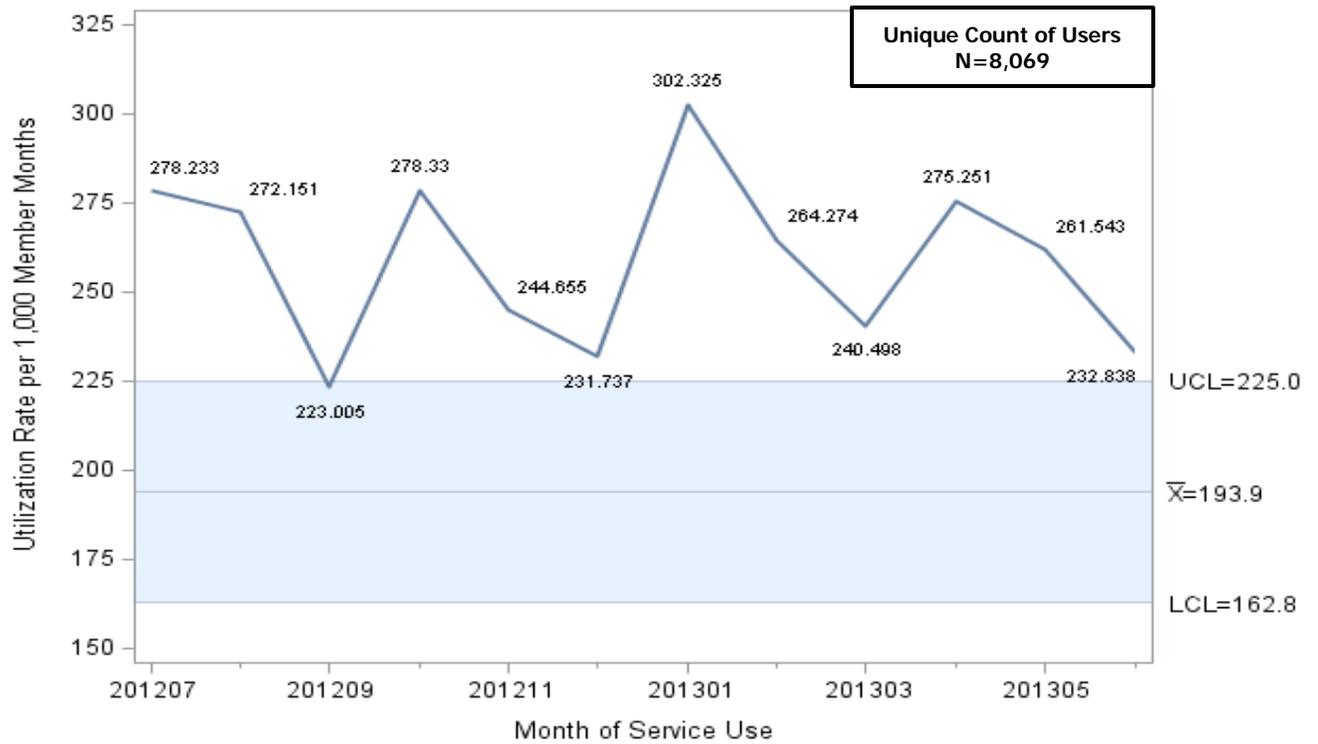


Figure SU-31. Hospital Inpatient Utilization Rates among Adults (Age 21+) in the Families Aid Category, July 2012–June 2013

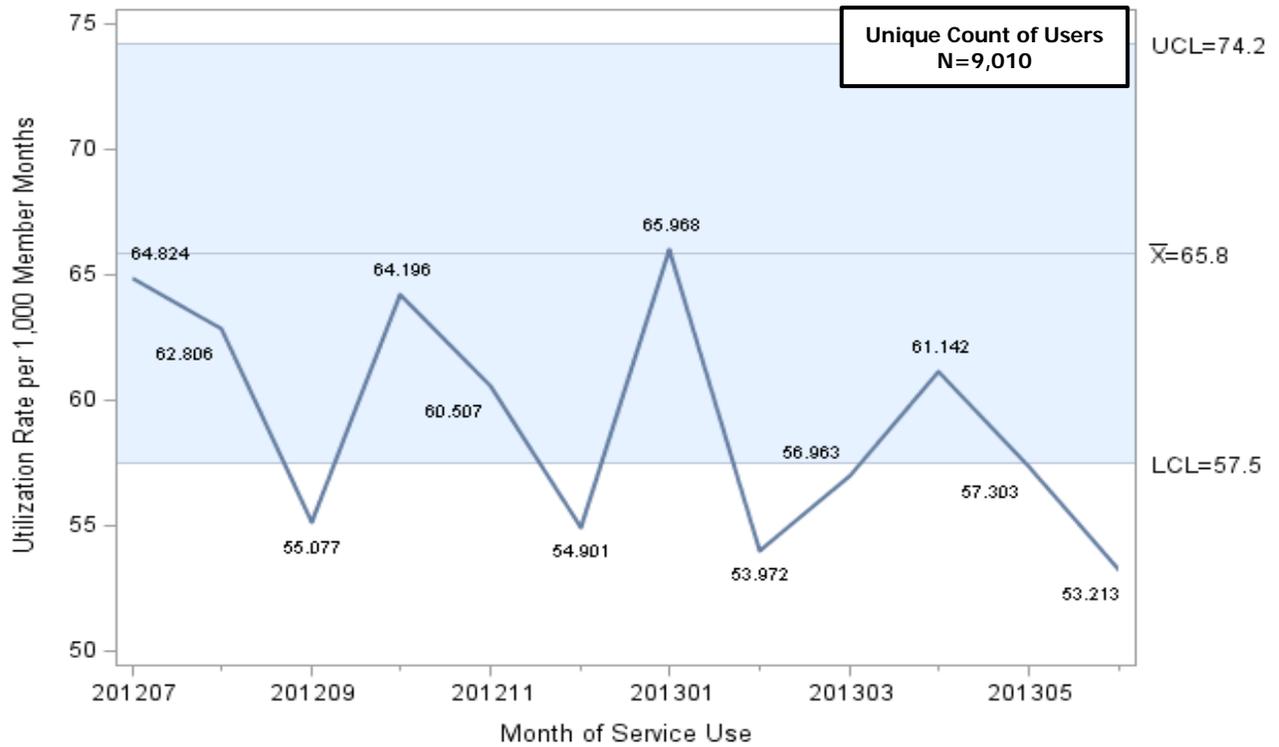


Figure SU-32. Hospital Inpatient Utilization Rates among Adults (Age 21+) in the Other Aid Category, July 2012–June 2013

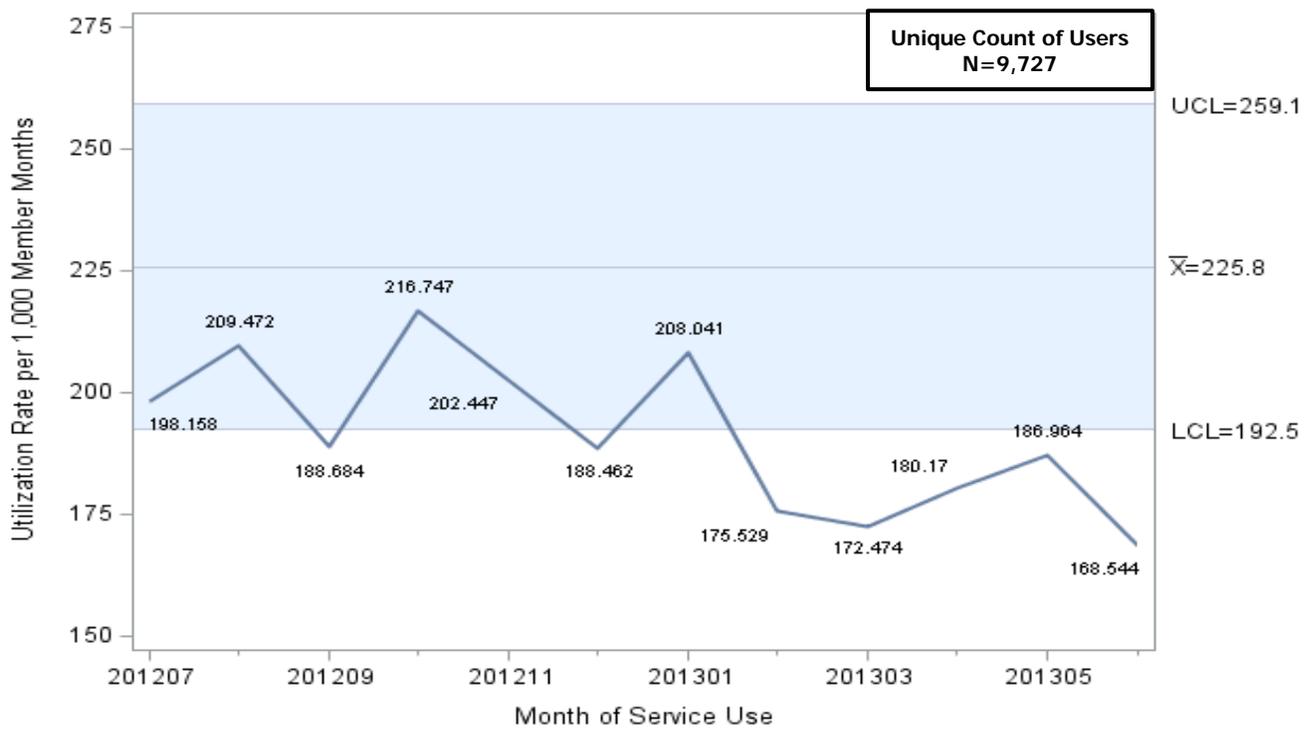
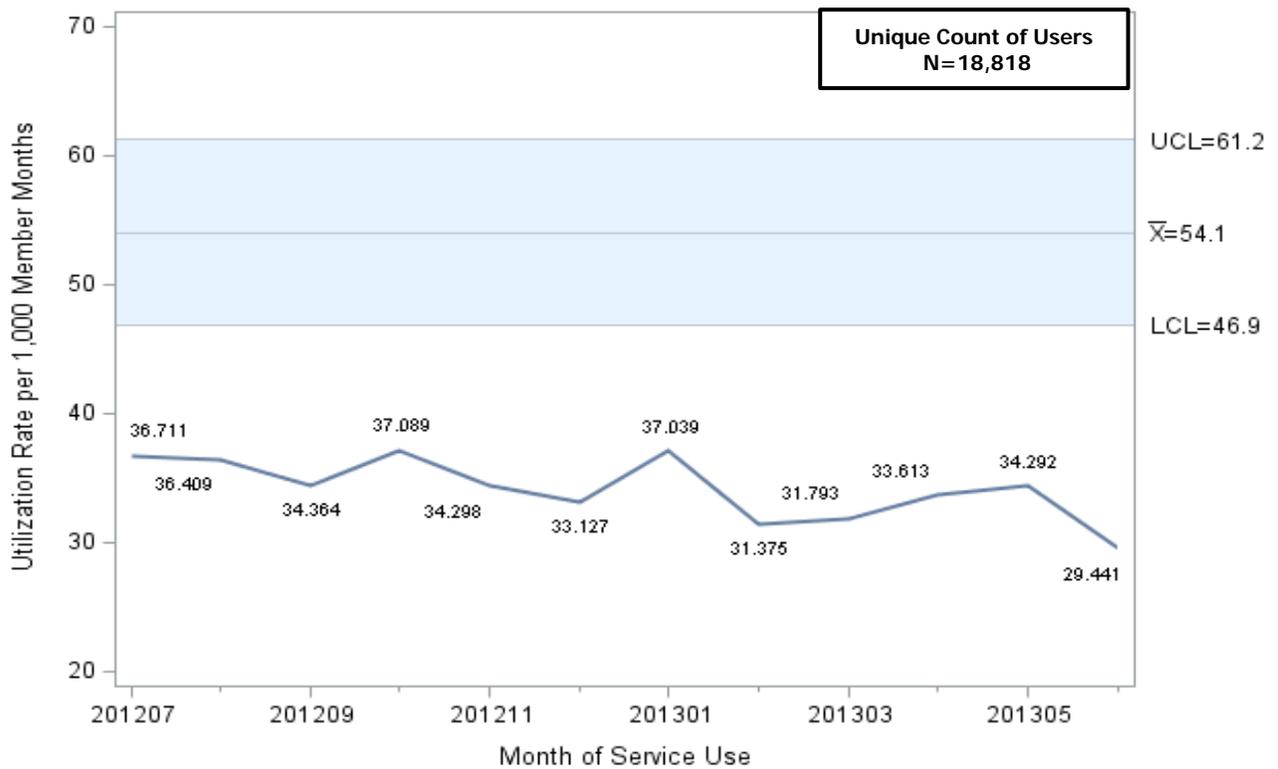


Figure SU-33. Hospital Inpatient Utilization Rates among Adults (Age 21+) in the Undocumented Aid Category, July 2012–June 2013



Source: Data for figures SU-29 to SU-33 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, 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%) aid categories, 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 to 20 in the Medi-Cal FFS program, monthly Hospital Outpatient services utilization rates ranged from 54.8 to 187.3 visits per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

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 Blind/Disabled aid category primarily displayed above average utilization, while those in the Families and Undocumented aid categories mostly exhibited below average utilization. Additionally, children in the Other aid group displayed Hospital Outpatient services utilization below the expected ranges throughout the study period. Of particular note, children in the Families and Other aid categories displayed a downward trend in Hospital Outpatient services utilization between January 2013 and June 2013. Children in the Blind/Disabled, Foster Care, and Undocumented aid categories displayed a decrease in Hospital Outpatient utilization in June 2013.

Children in the Blind/Disabled aid category used Hospital Outpatient services at rates two to three 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 third quarter of 2012 to the second quarter of 2013.

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 again 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 mostly exhibited below average utilization that reached levels below the expected ranges during the last three quarters 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 between August 2012 and December 2012.

Adults in Blind/Disabled and Other aid categories experienced higher utilization rates for Hospital Outpatient services.

The following figures SU-34 to SU-43 represent the control chart analysis for both children and adults from the third quarter of 2012 to the second quarter of 2013.

Trends of Monthly Hospital Outpatient Services Utilization Rates among Children, July 2012–June 2013

Figure SU-34. Hospital Outpatient Utilization Rates among Children (Age 0-20) in the Blind/Disabled Aid Category, July 2012–June 2013

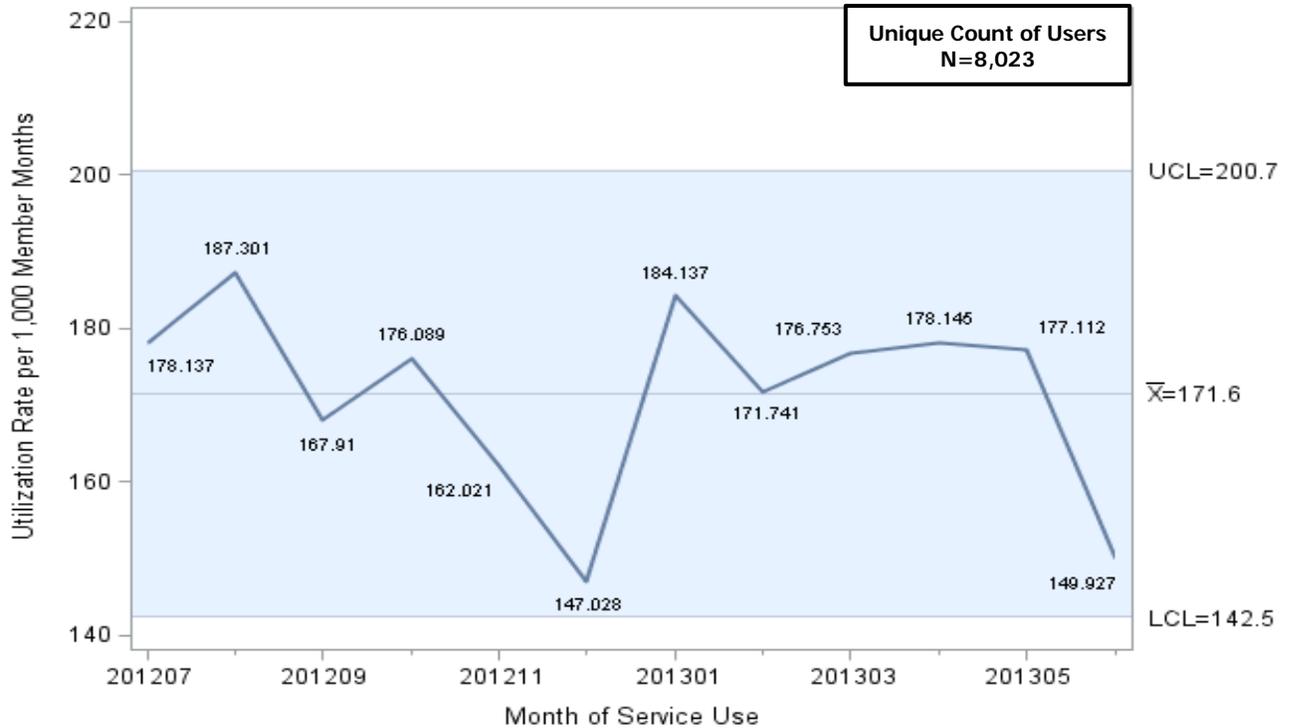


Figure SU-35. Hospital Outpatient Utilization Rates among Children (Age 0-20) in the Families Aid Category, July 2012–June 2013

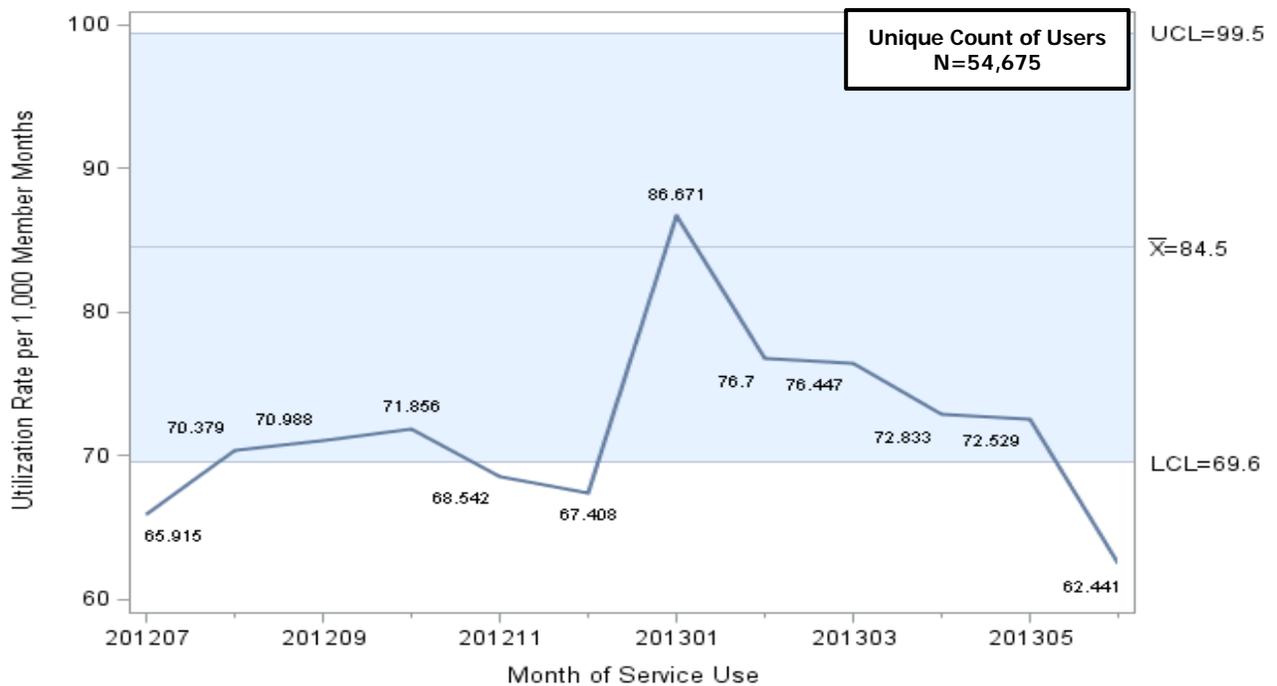


Figure SU-36. Hospital Outpatient Utilization Rates among Children (Age 0-20) in the Foster Care Aid Category, July 2012–June 2013

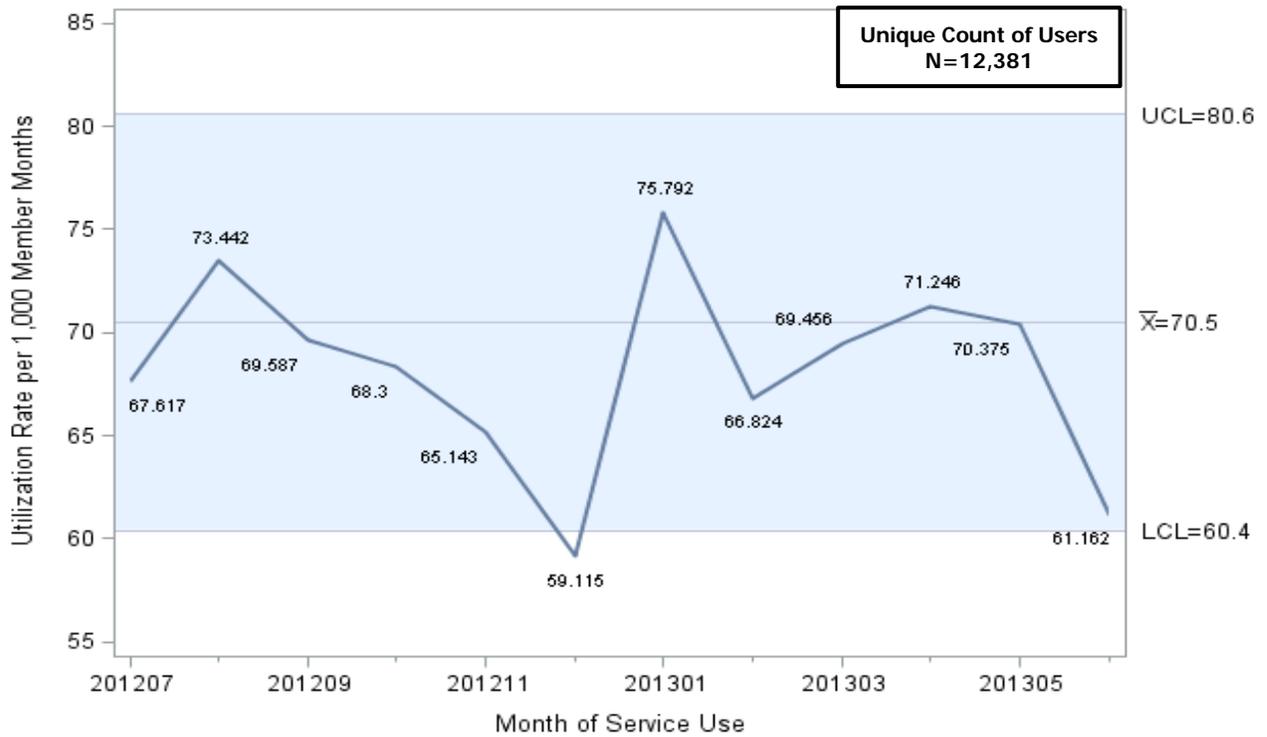


Figure SU-37. Hospital Outpatient Utilization Rates among Children (Age 0-20) in the Other Aid Category, July 2012–June 2013

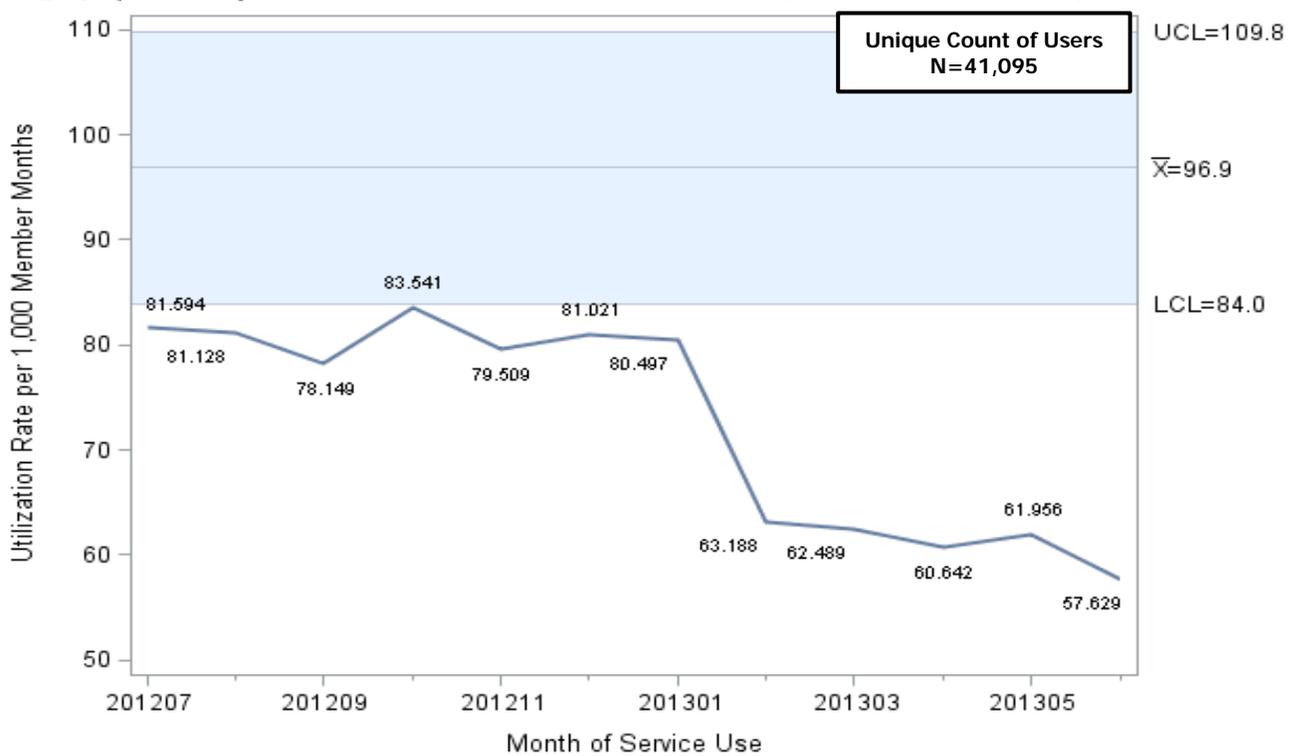
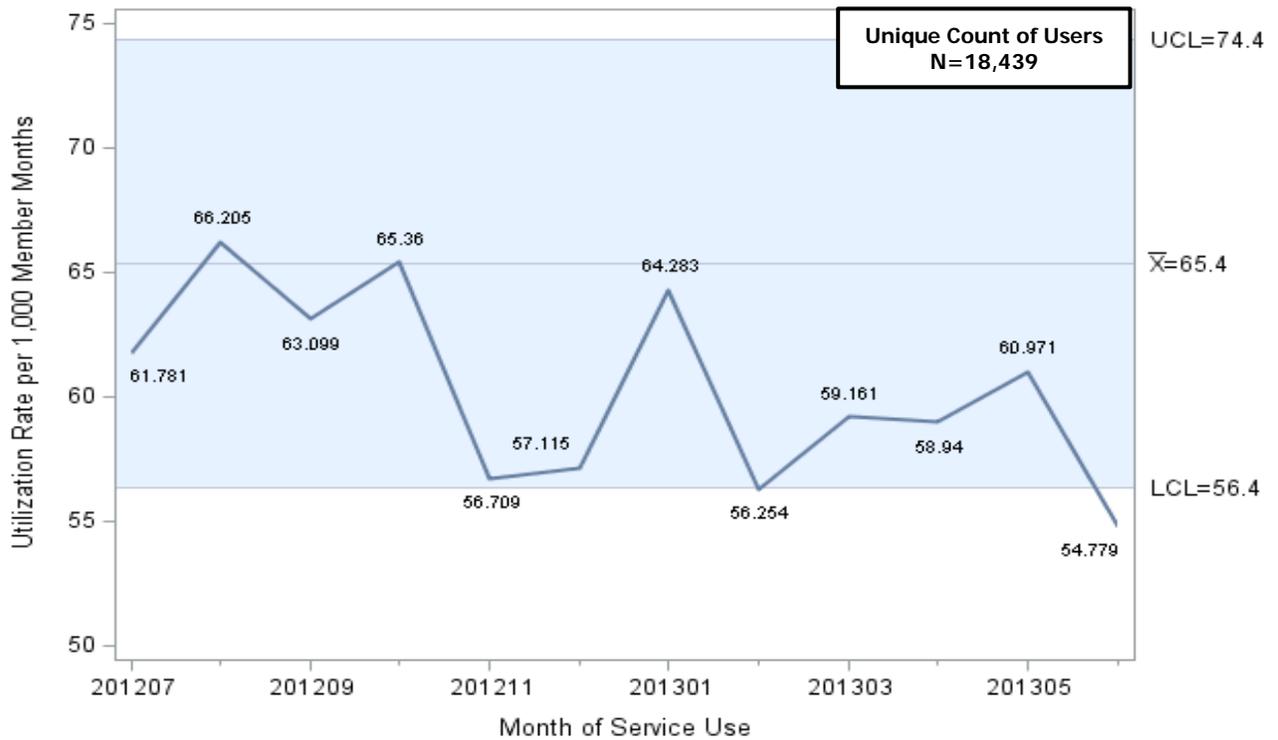


Figure SU-38. Hospital Outpatient Utilization Rates among Children (Age 0-20) in the Undocumented Aid Category, July 2012–June 2013



Source: Data for figures SU-34 to SU-38 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends of Monthly Hospital Outpatient Services Utilization Rates among Adults, July 2012–June 2013

Figure SU-39. Hospital Outpatient Utilization Rates among Adults (Age 21+) in the Aged Aid Category, July 2012–June 2013

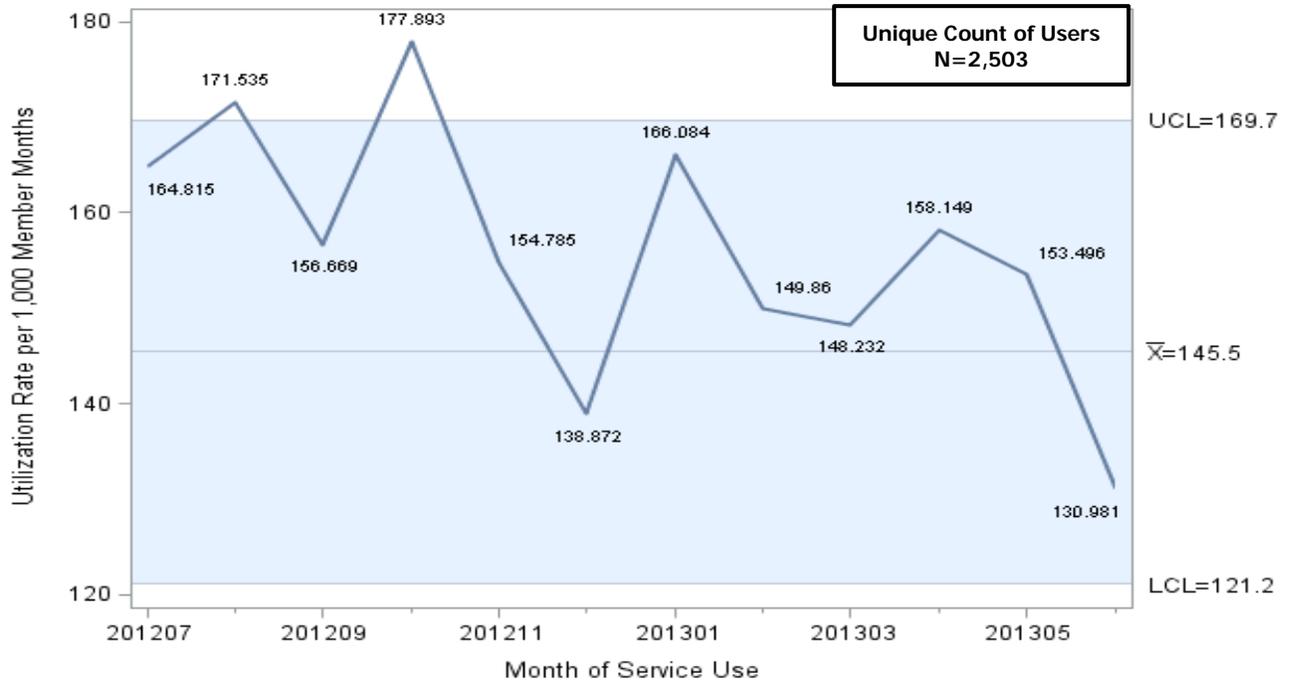


Figure SU-40. Hospital Outpatient Utilization Rates among Adults (Age 21+) in the Blind/Disabled Aid Category, July 2012–June 2013

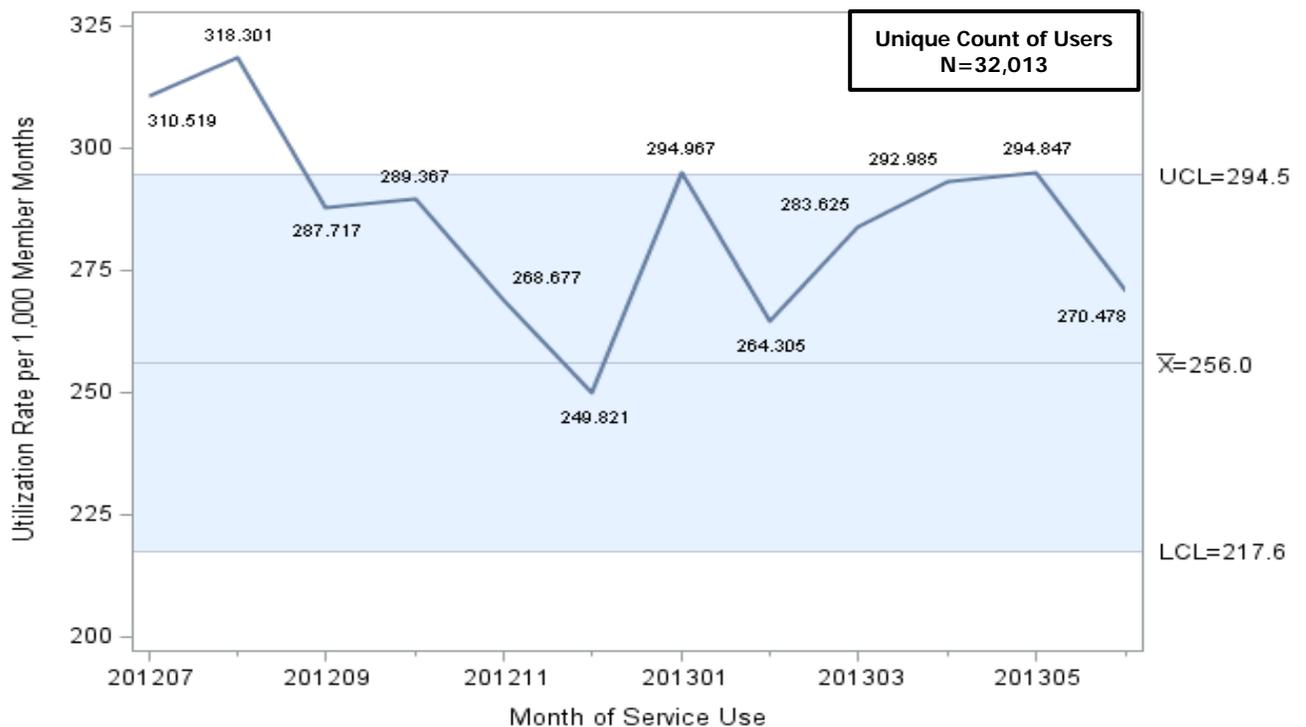


Figure SU-41. Hospital Outpatient Utilization Rates among Adults (Age 21+) in the Families Aid Category, July 2012–June 2013

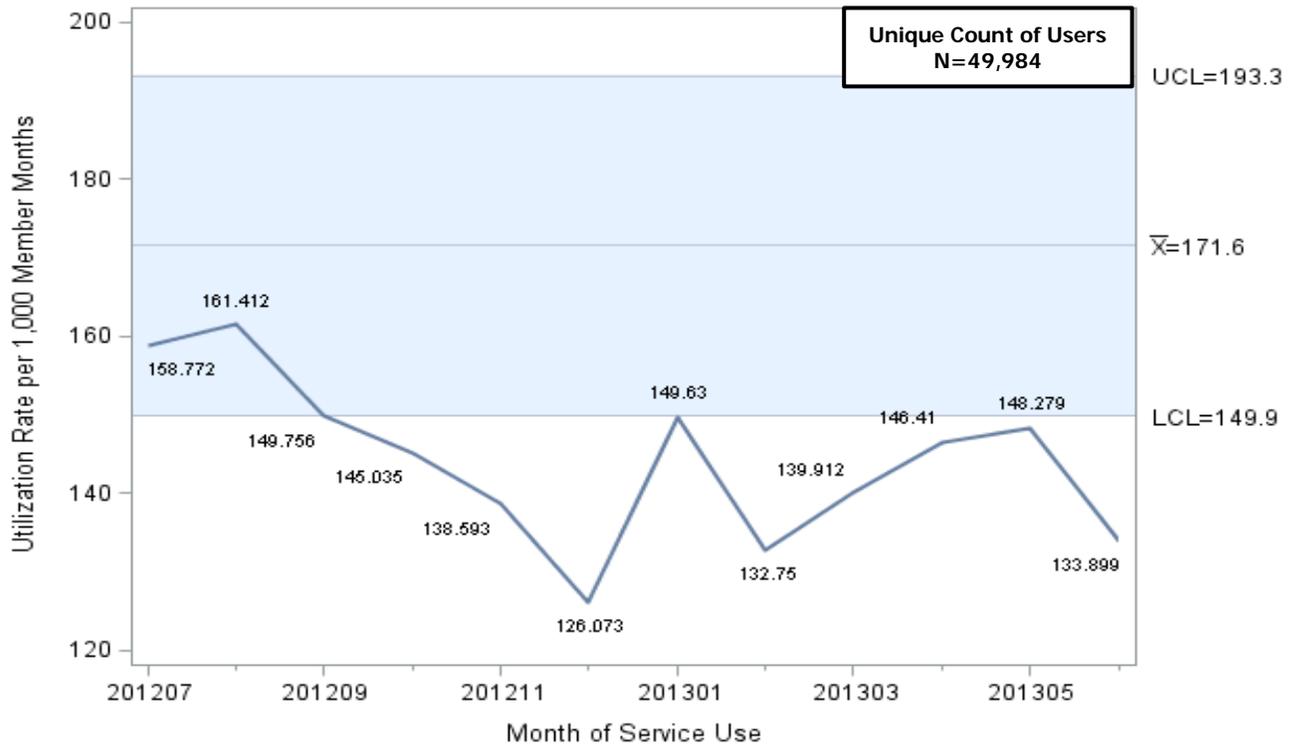


Figure SU-42. Hospital Outpatient Utilization Rates among Adults (Age 21+) in the Other Aid Category, July 2012–June 2013

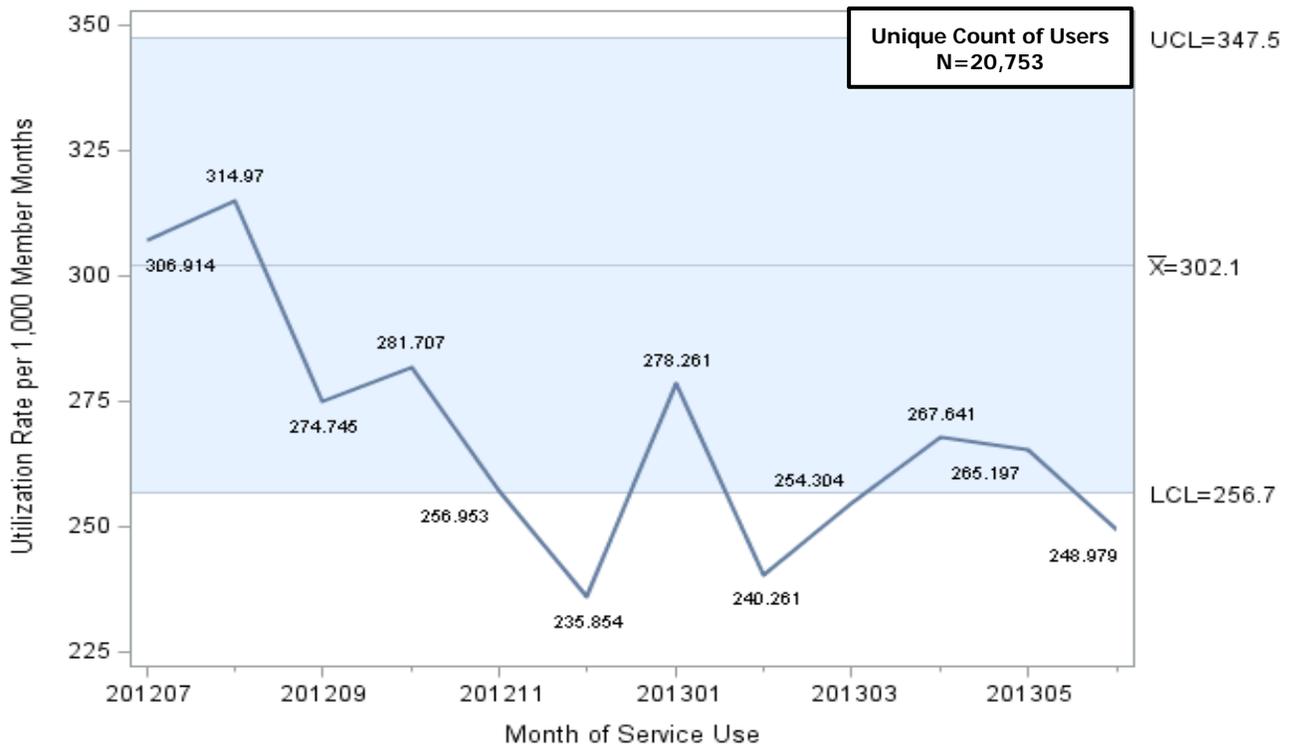
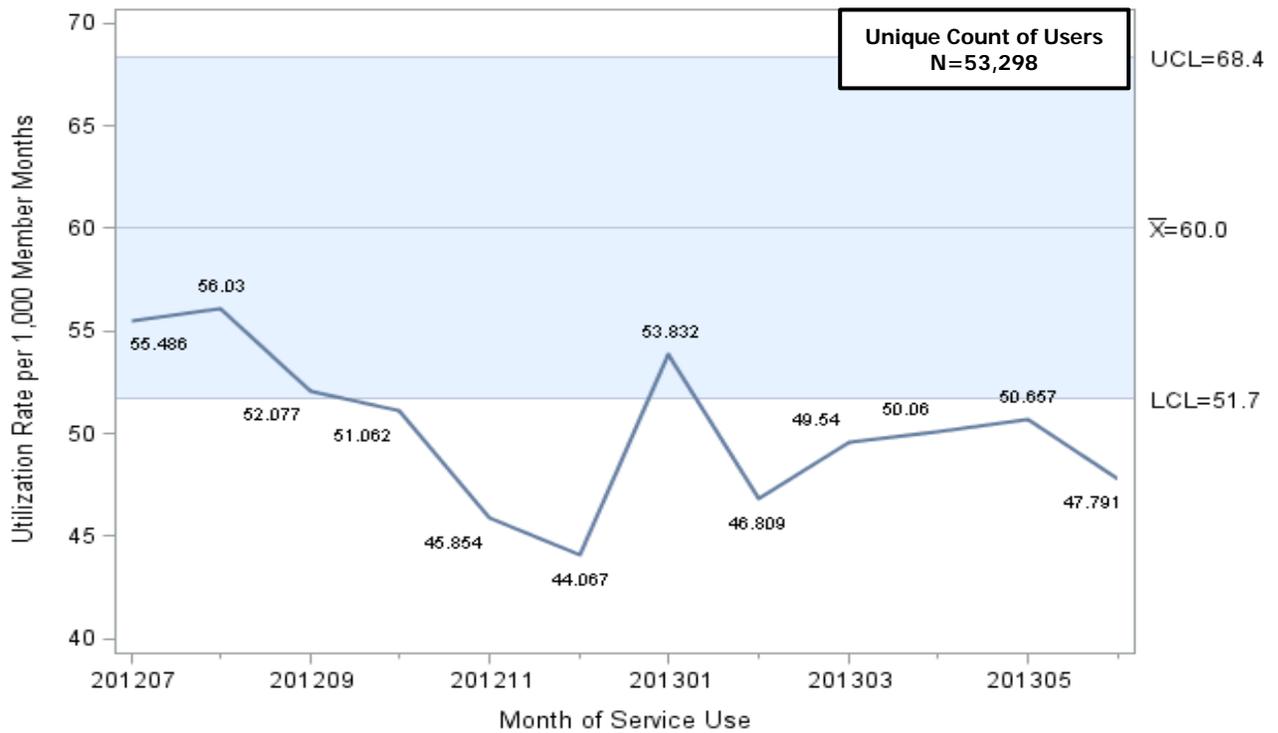


Figure SU-43. Hospital Outpatient Utilization Rates among Adults (Age 21+) in the Undocumented Aid Category, July 2012–June 2013



Source: Data for figures SU-39 to SU-43 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, 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 age 21 and older participating in the FFS program and enrolled in the Aged, Blind/Disabled and Other aid categories.

Among adults in these aid categories, the monthly Nursing Facility services utilization rates ranged from 675.8 to 2,053.0 days per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

The Nursing Facility services utilization rates were again highest among adults in the Other aid category, which is understandable given that this subgroup contains beneficiaries enrolled in Long-Term Care aid codes. Additionally, adults in the Blind/Disabled aid category exhibited high utilization of Nursing Facility services, most likely due to their inherent complex medical needs. Although displaying high use, adults in the Other aid category continued to exhibit below average Nursing Facility services utilization that predominantly fell below the ranges established during the baseline period. In contrast, adults in the Aged and Blind/Disabled aid categories displayed above average 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 resided 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

Nursing Facility use is now concentrated among three beneficiary subpopulations: adults in the Blind/Disabled, Aged, and Other aid categories.

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.

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.

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

The following figures SU-44 to SU-46 represent the control chart analysis for adults from the third quarter of 2012 to the second quarter of 2013.

Trends of Monthly Nursing Facility Services Utilization Rates among Adults, July 2012–June 2013

Figure SU-44. Nursing Facility Utilization Rates among Adults (Age 21+) in the Aged Aid Category, July 2012–June 2013

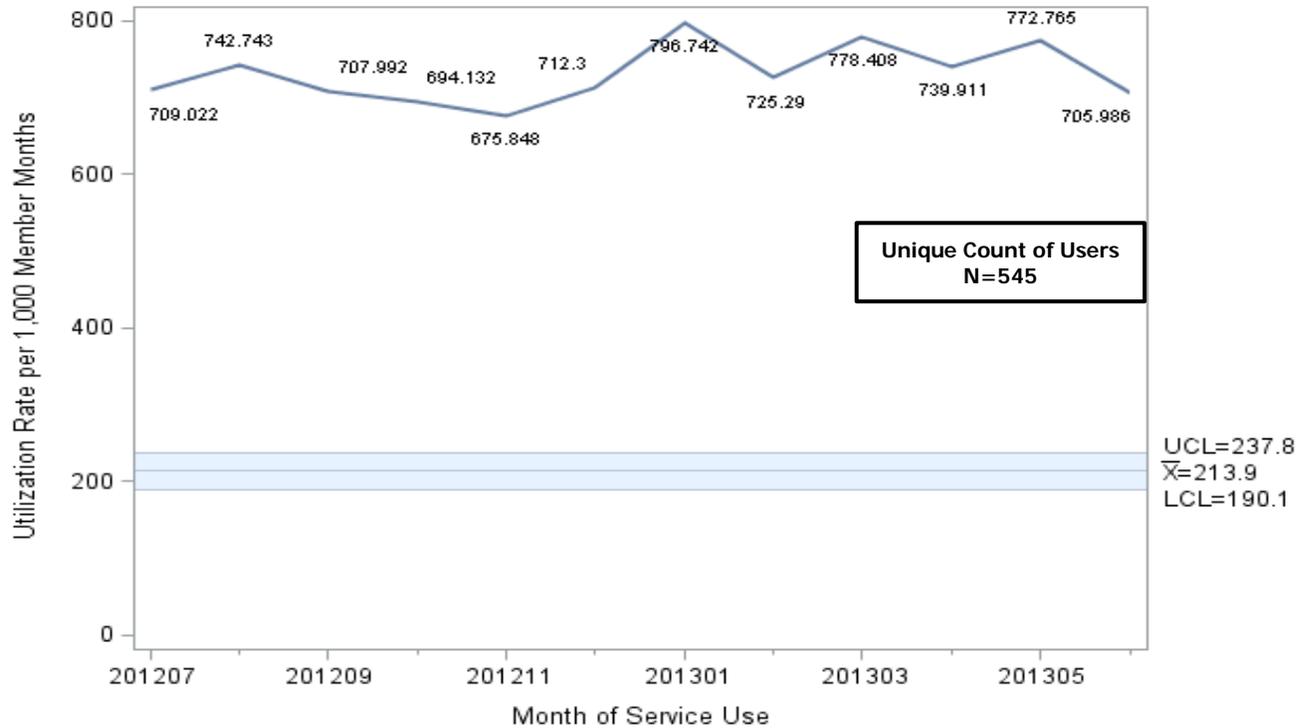


Figure SU-45. Nursing Facility Utilization Rates among Adults (Age 21+) in the Blind/Disabled Aid Category, July 2012–June 2013

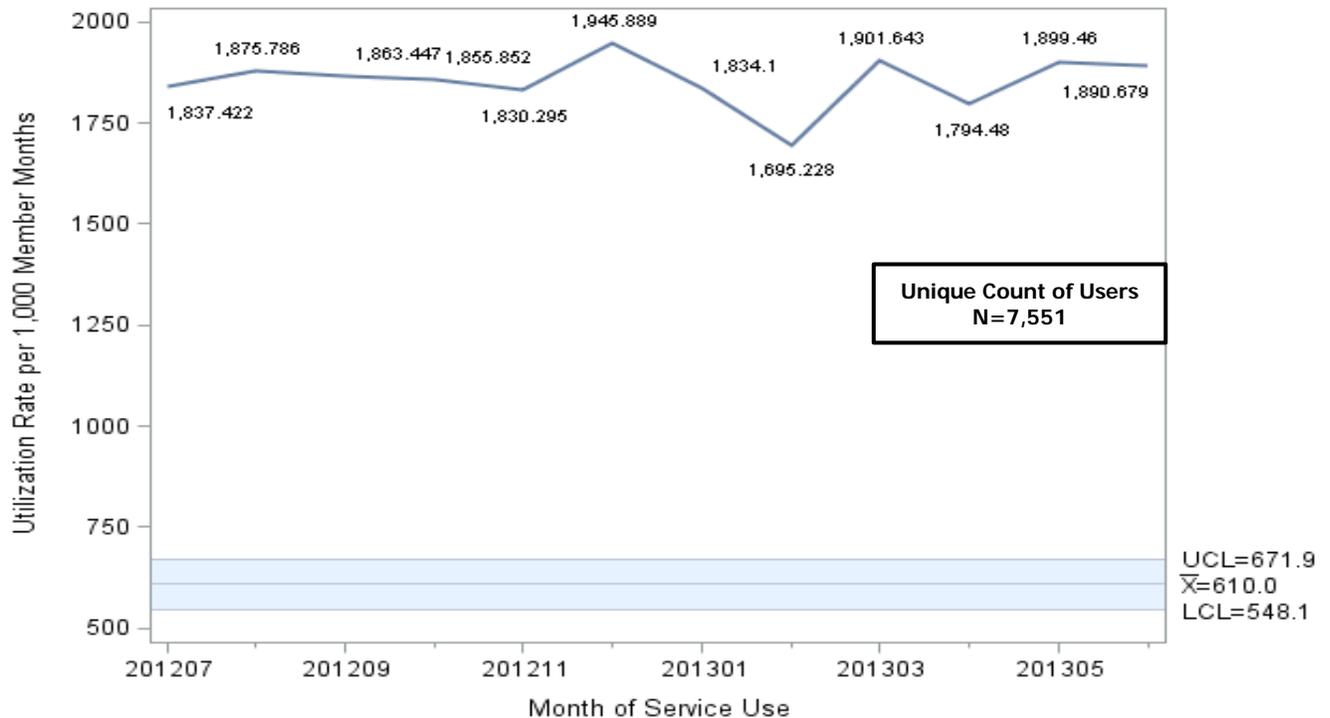
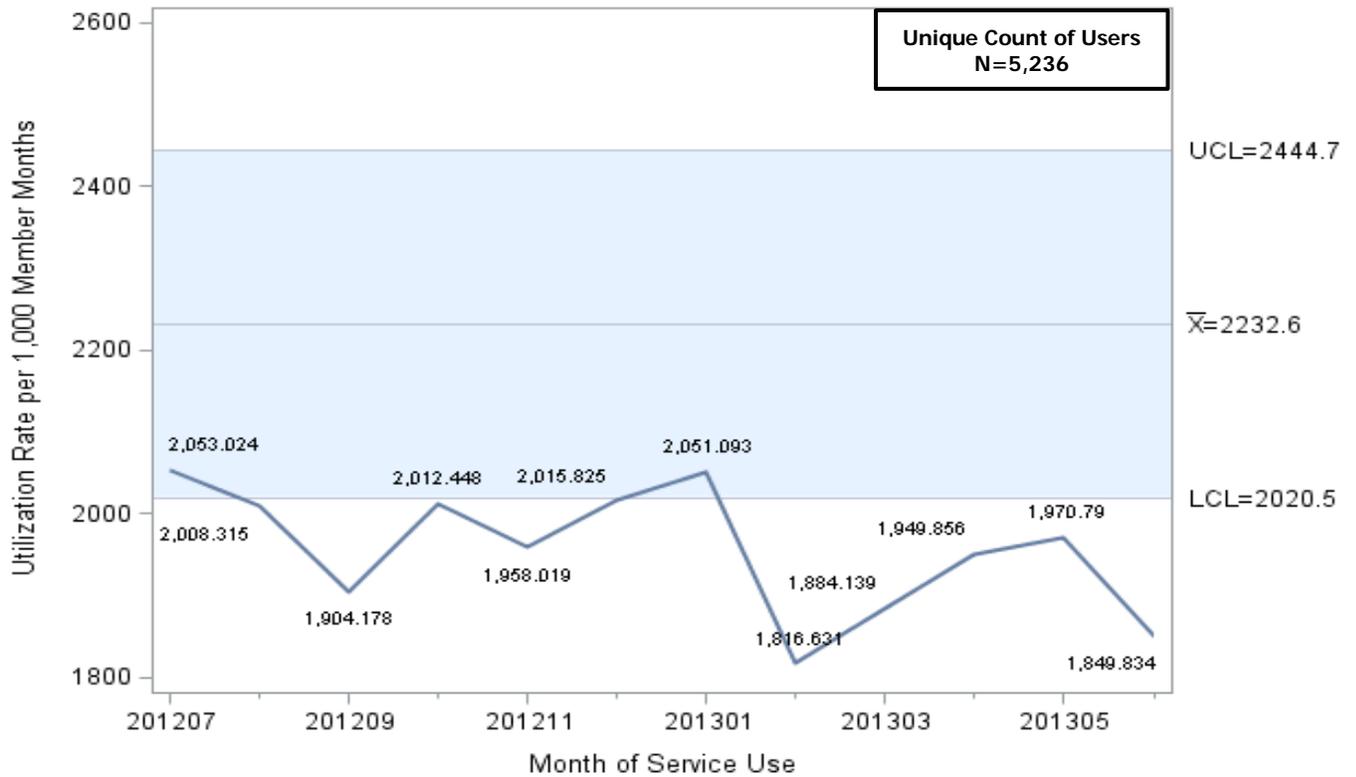


Figure SU-46. Nursing Facility Utilization Rates among Adults (Age 21+) in the Other Aid Category, July 2012–June 2013



Source: Data for figures SU-44 to SU-46 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, 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 to 20 in the Medi-Cal FFS program ranged from 64.7 to 1,372.8 prescriptions per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

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 about two times higher than children in the Foster Care aid category and five to six times higher than children in the Families and Other aid categories. Children in the Families, Other, and Undocumented aid categories again primarily displayed below average Pharmacy services utilization that at times reached levels below the expected baseline ranges. In contrast, children in the Blind/Disabled aid category exhibited above average utilization that remained within the baseline ranges, while children in the Foster Care aid category continued to exhibit normal use patterns. Additionally, children in the Families, Other, and Undocumented aid categories displayed a downward trend in utilization over the first two quarters of 2013.

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

Adults

Among adults 21 and older, monthly Pharmacy services utilization rates ranged from 172.9 to 3,047.4 prescriptions per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

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, Families, and Other aid categories mostly displayed below average Pharmacy services utilization, while adults in the Undocumented aid category mostly displayed above average utilization. The Pharmacy services utilization rates for adults in the Aged, Blind/Disabled, and Families aid categories primarily 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.

Use of Pharmacy services was highest among adults in the Blind/Disabled aid category.

The following figures SU-47 to SU-56 represent the control chart analysis for both children and adults from the third quarter of 2012 to the second quarter of 2013.

Trends of Monthly Pharmacy Services Utilization Rates among Children, July 2012–June 2013

Figure SU-47. Pharmacy Utilization Rates among Children (Age 0–20) in the Blind/Disabled Aid Category, July 2012–June 2013

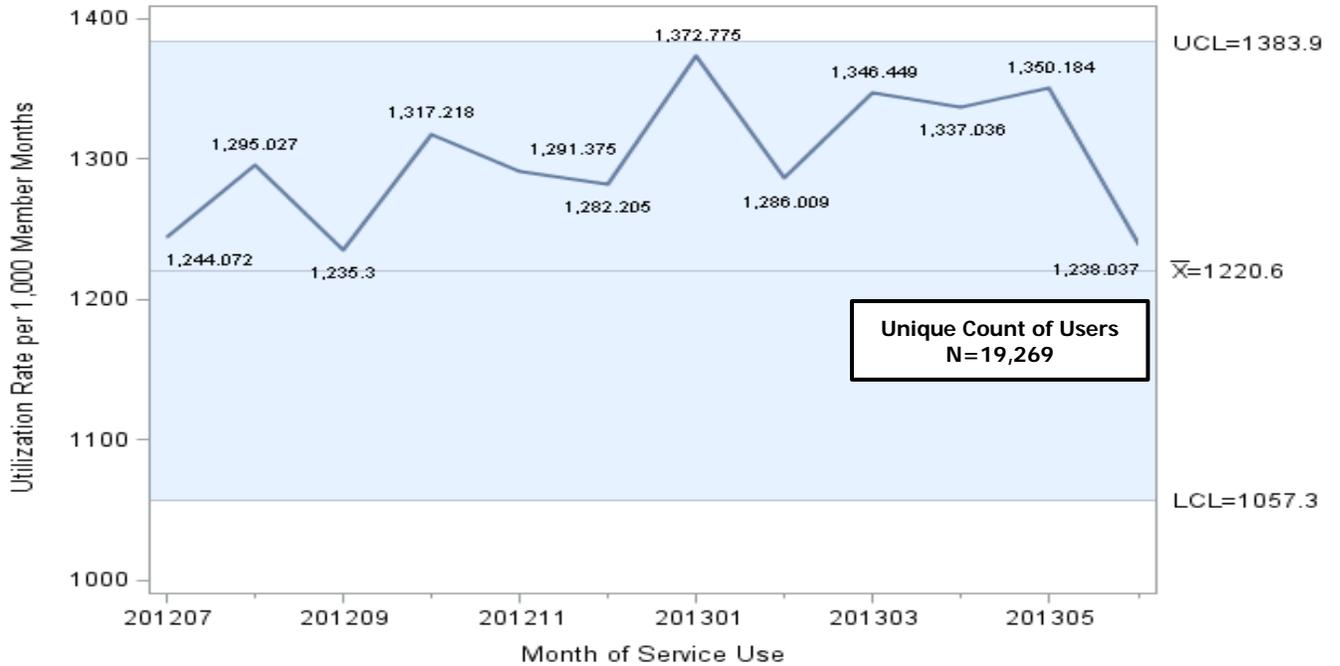


Figure SU-48. Pharmacy Utilization Rates among Children (Age 0–20) in the Families Aid Category, July 2012–June 2013

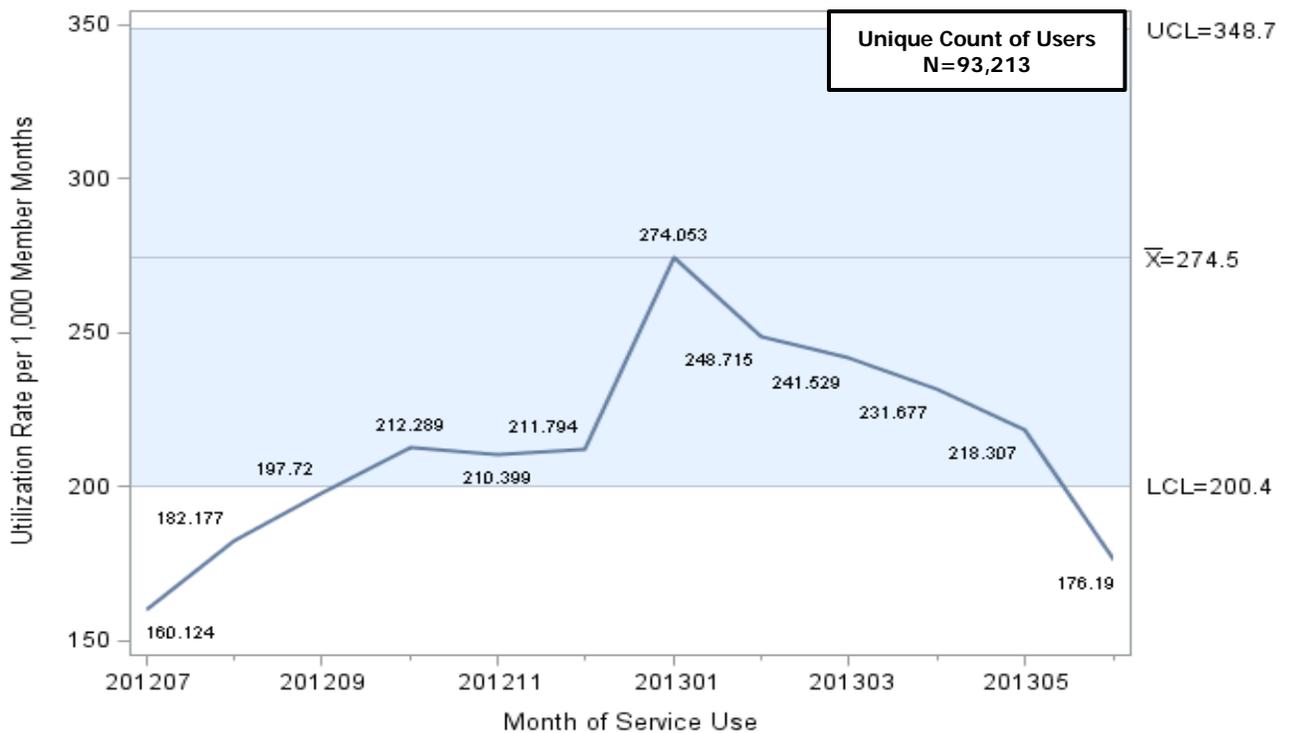


Figure SU-49. Pharmacy Utilization Rates among Children (Age 0-20) in the Foster Care Aid Category, July 2012-June 2013

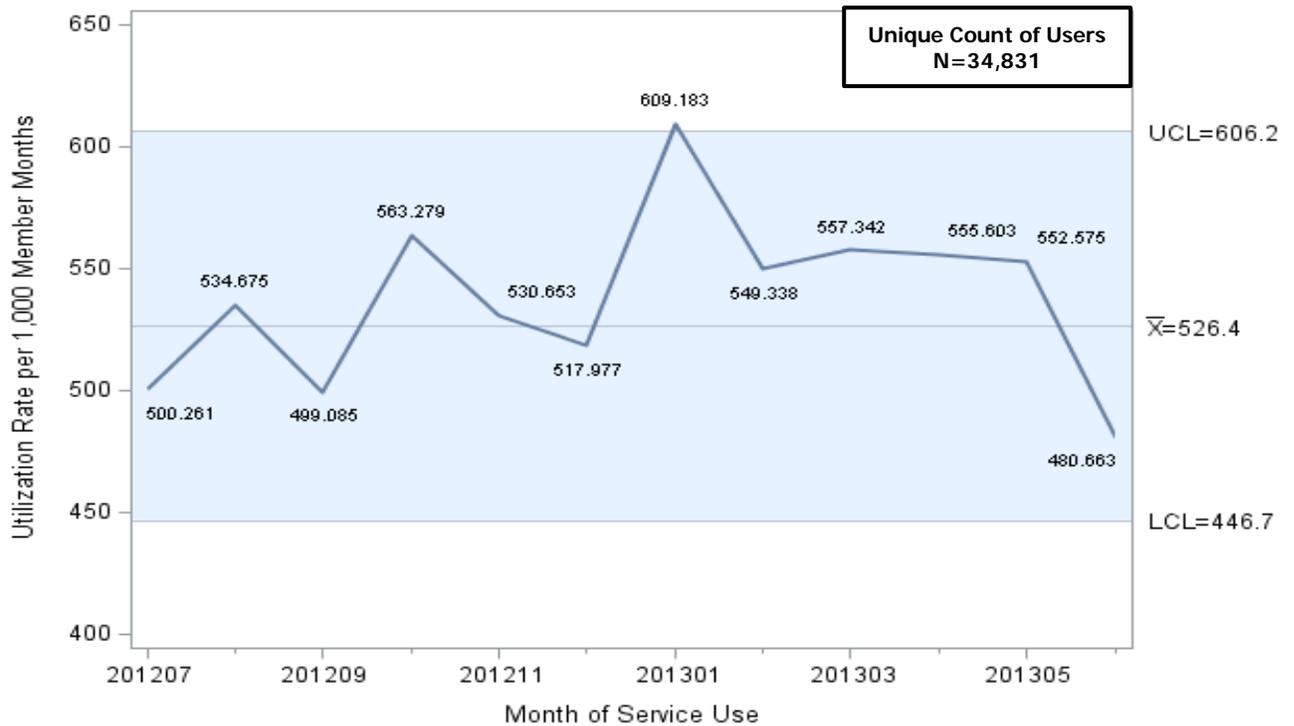


Figure SU-50. Pharmacy Utilization Rates among Children (Age 0-20) in the Other Aid Category, July 2012-June 2013

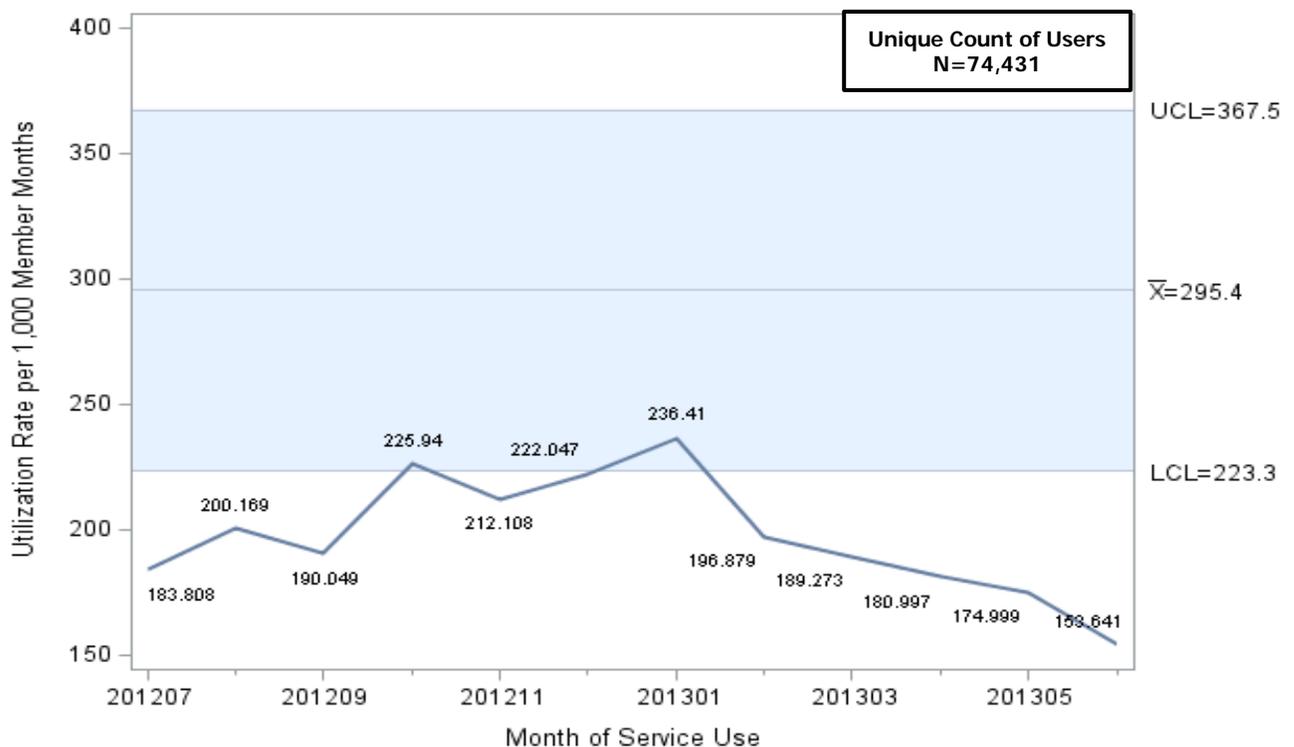
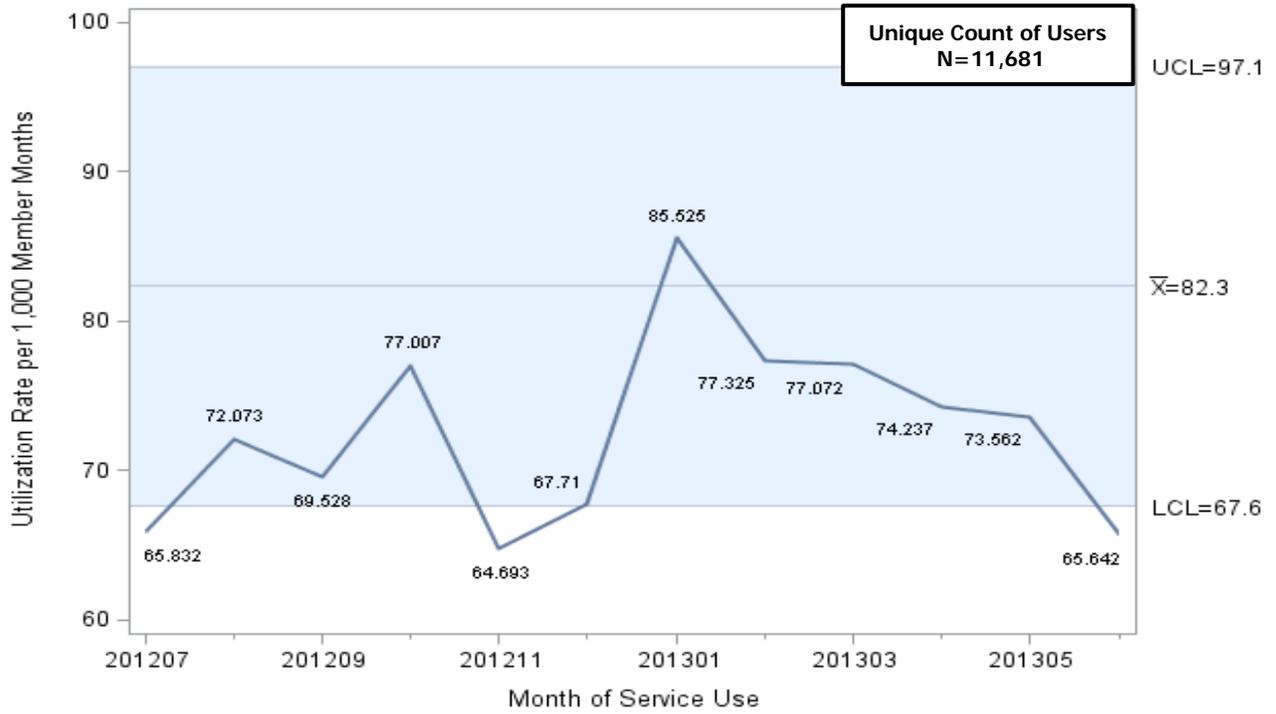


Figure SU-51. Pharmacy Utilization Rates among Children (Age 0-20) in the Undocumented Aid Category, July 2012-June 2013



Source: Data for figures SU-47 to SU-51 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012-June 2013, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends of Monthly Pharmacy Services Utilization Rates among Adults, July 2012–June 2013

Figure SU-52. Pharmacy Utilization Rates among Adults (Age 21+) in the Aged Aid Category, July 2012–June 2013

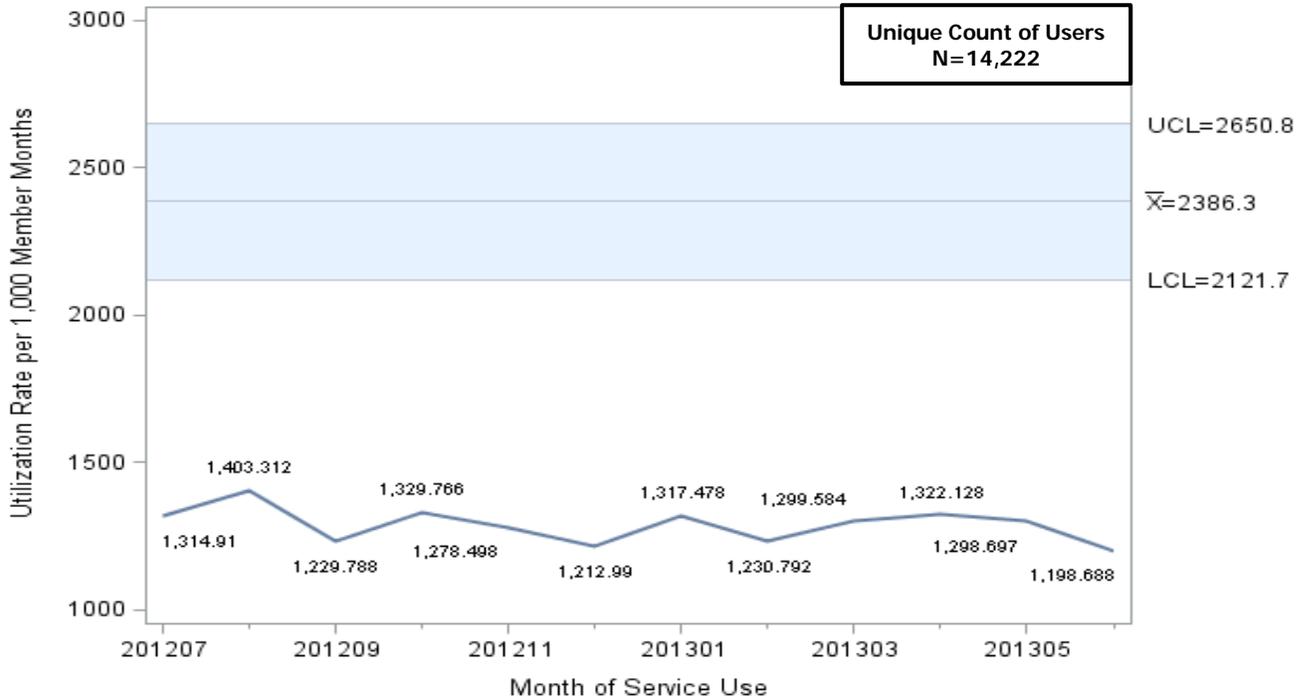


Figure SU-53. Pharmacy Utilization Rates among Adults (Age 21+) in the Blind/Disabled Aid Category, July 2012–June 2013

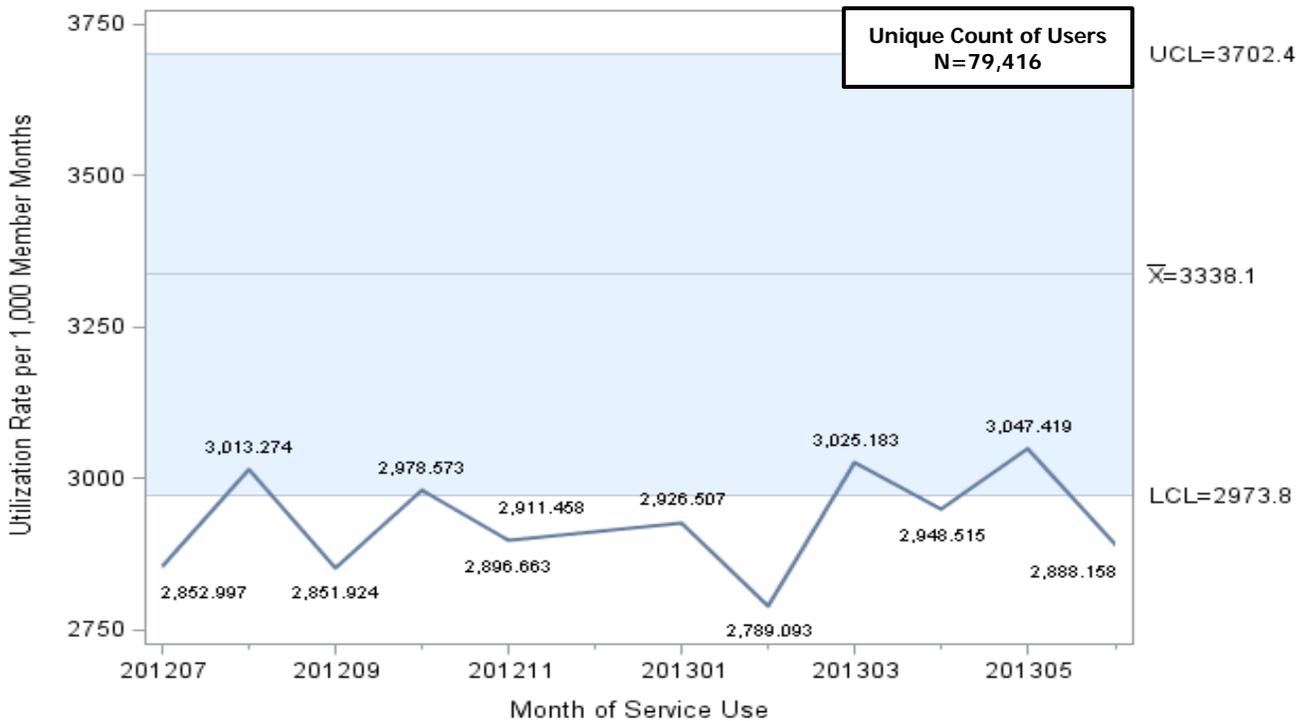


Figure SU-54. Pharmacy Utilization Rates among Adults (Age 21+) in the Families Aid Category, July 2012–June 2013

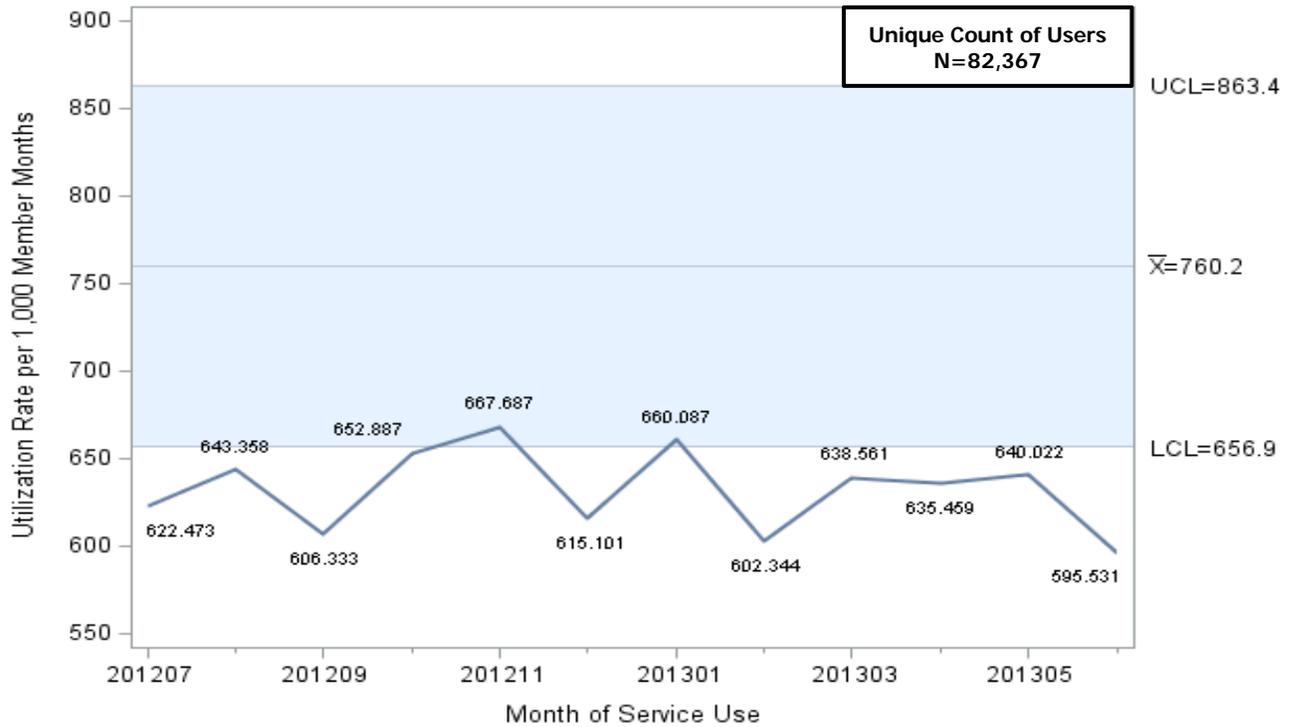


Figure SU-55. Pharmacy Utilization Rates among Adults (Age 21+) in the Other Aid Category, July 2012–June 2013

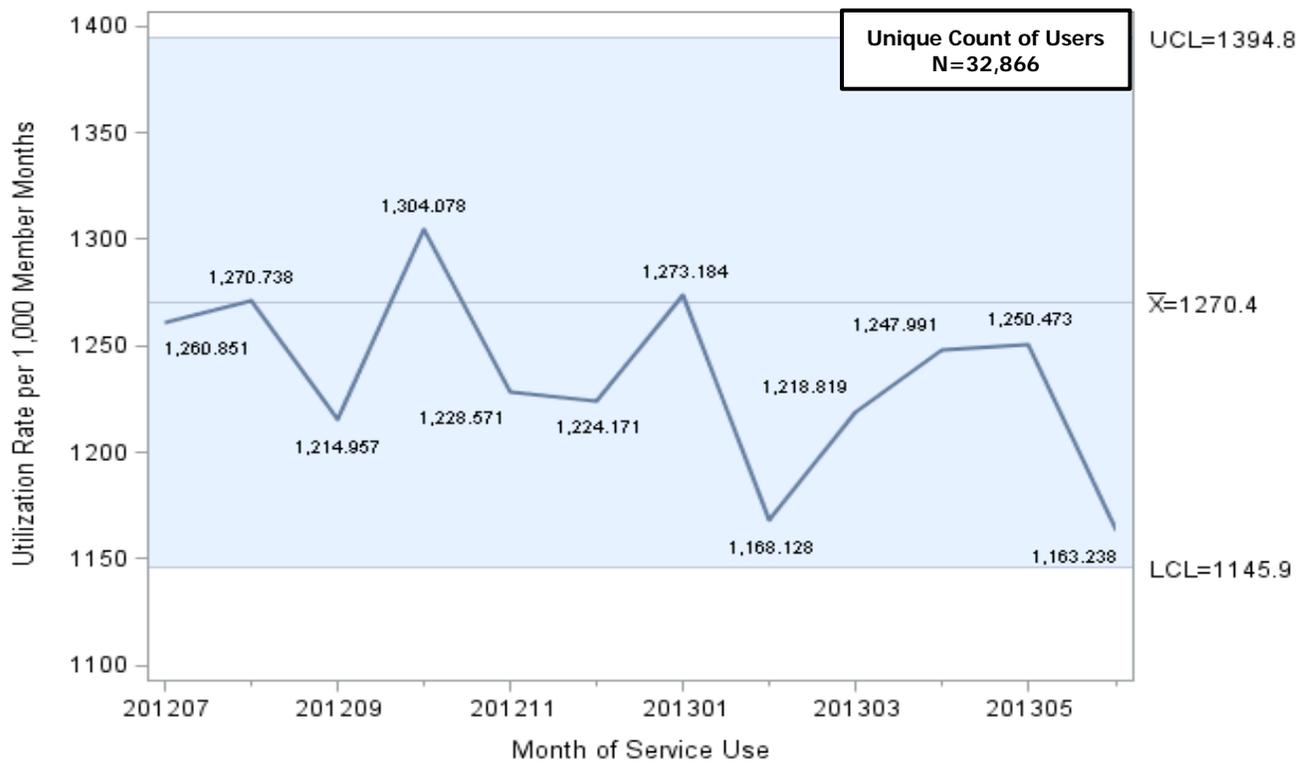
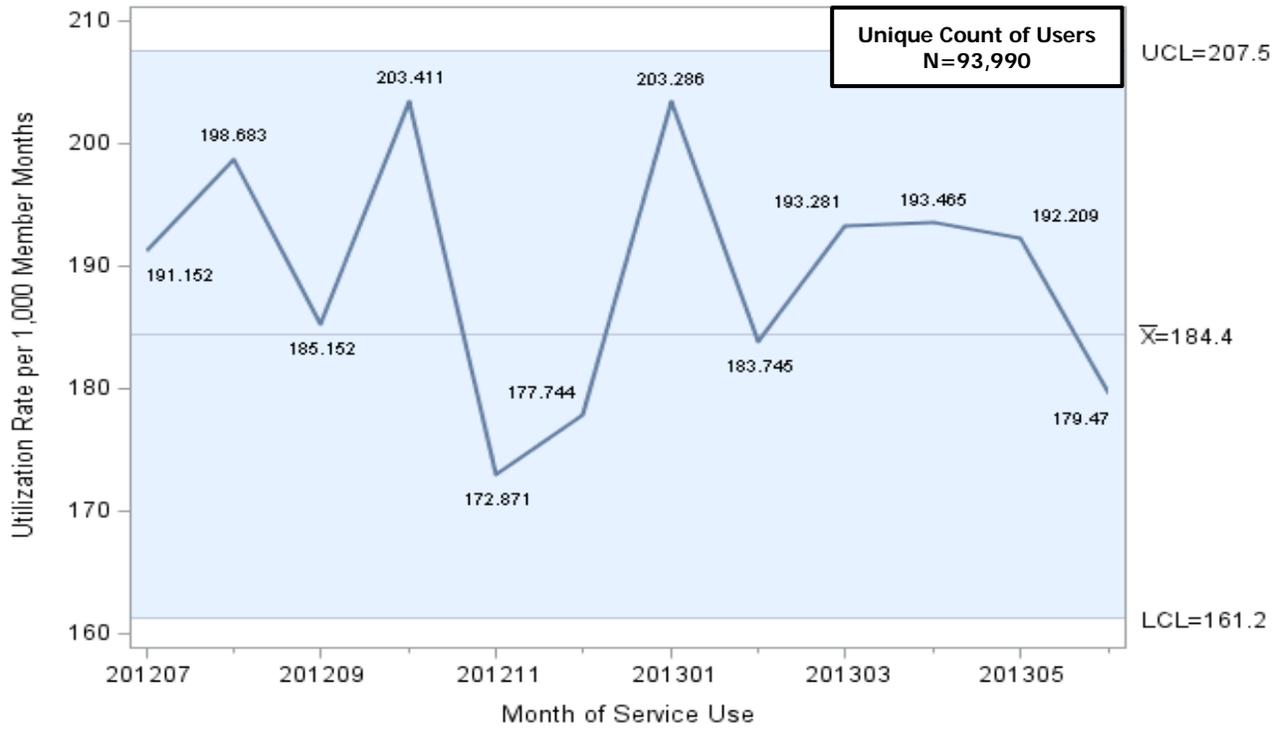


Figure SU-56. Pharmacy Utilization Rates among Adults (Age 21+) in the Undocumented Aid Category, July 2012–June 2013



Source: Data for figures SU-52 to SU-56 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, 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 to 20 in the Medi-Cal FFS program, monthly utilization rates for Other services ranged from 13.5 to 1,424.0 visits per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

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, and Foster Care aid categories exhibited mostly normal utilization of Other services. 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 to 2009. Of particular note, children in the Blind/Disabled, Families, Foster Care, and Other aid categories displayed a decline in utilization during the last quarter of the study period.

Use of Other services by children in Blind/Disabled, Families, Foster Care, and Other aid categories declined in the last quarter of the study period.

Adults

The monthly utilization rates for Other services among adults age 21 and older ranged from 36.7 to 314.7 visits per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

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 throughout the study period. Additionally, adults in the Aged and Undocumented aid categories again displayed utilization rates below the expected ranges throughout most of the study period.

Utilization rates of Other services were noticeably higher among adults in the Aged, Blind/Disabled, and Other aid categories.

The following figures SU-57 to SU-66 represent the control chart analysis for both children and adults from the third quarter of 2012 to the second quarter of 2013.

Trends of Monthly Other Services Utilization Rates among Children, July 2012–June 2013

Figure SU-57. Other Services Utilization Rates among Children (Age 0–20) in the Blind/Disabled Aid Category, July 2012–June 2013

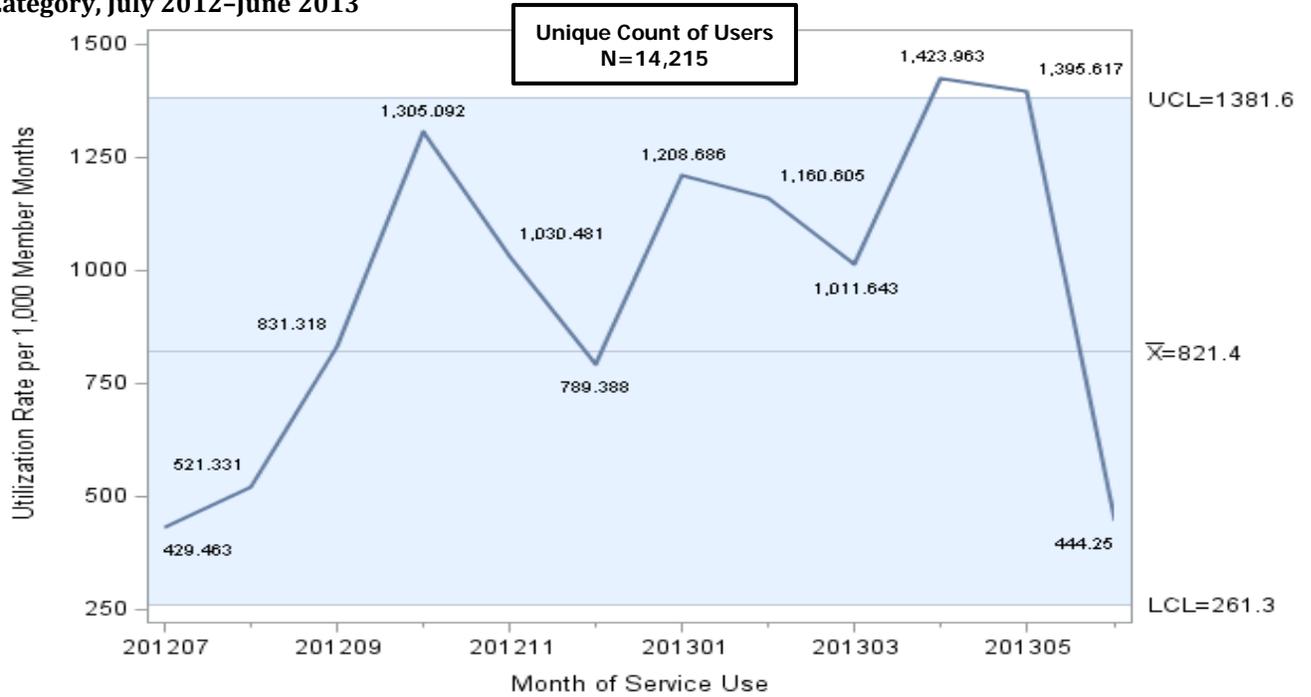


Figure SU-58. Other Services Utilization Rates among Children (Age 0–20) in the Families Aid Category, July 2012–June 2013

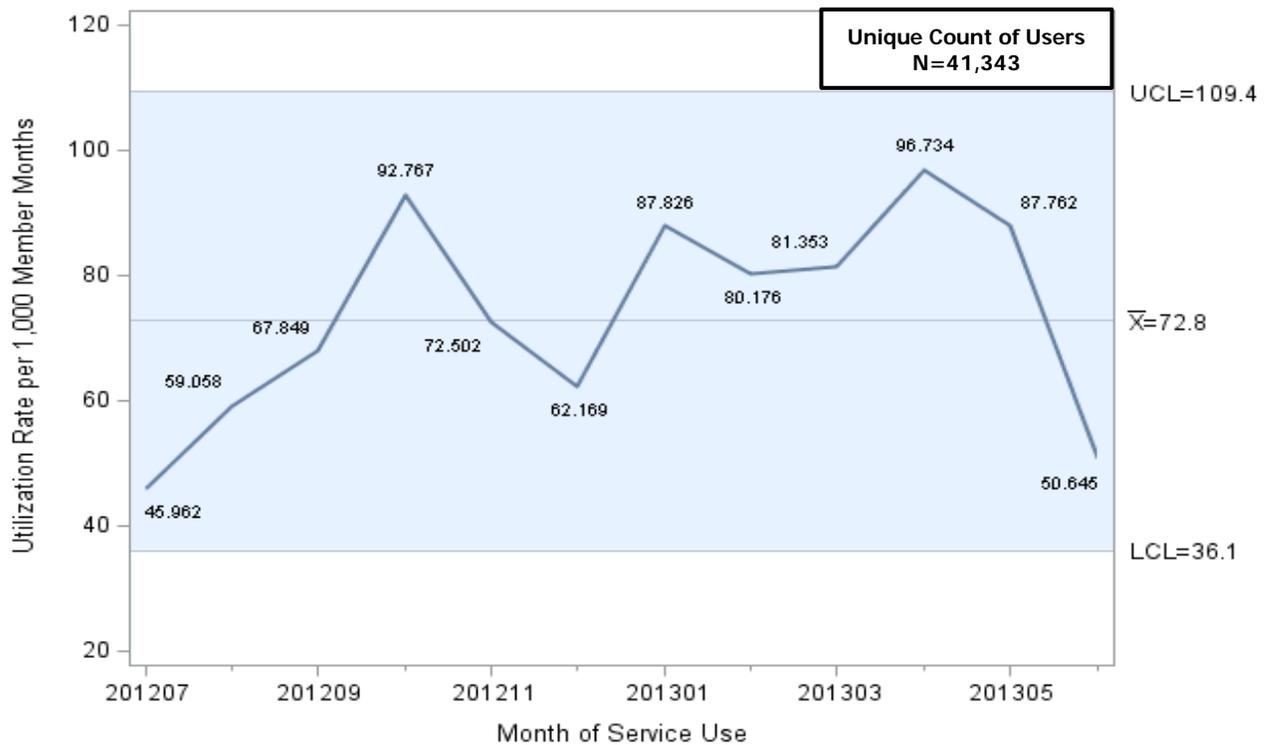


Figure SU-59. Other Services Utilization Rates among Children (Age 0–20) in the Foster Care Aid Category, July 2012–June 2013

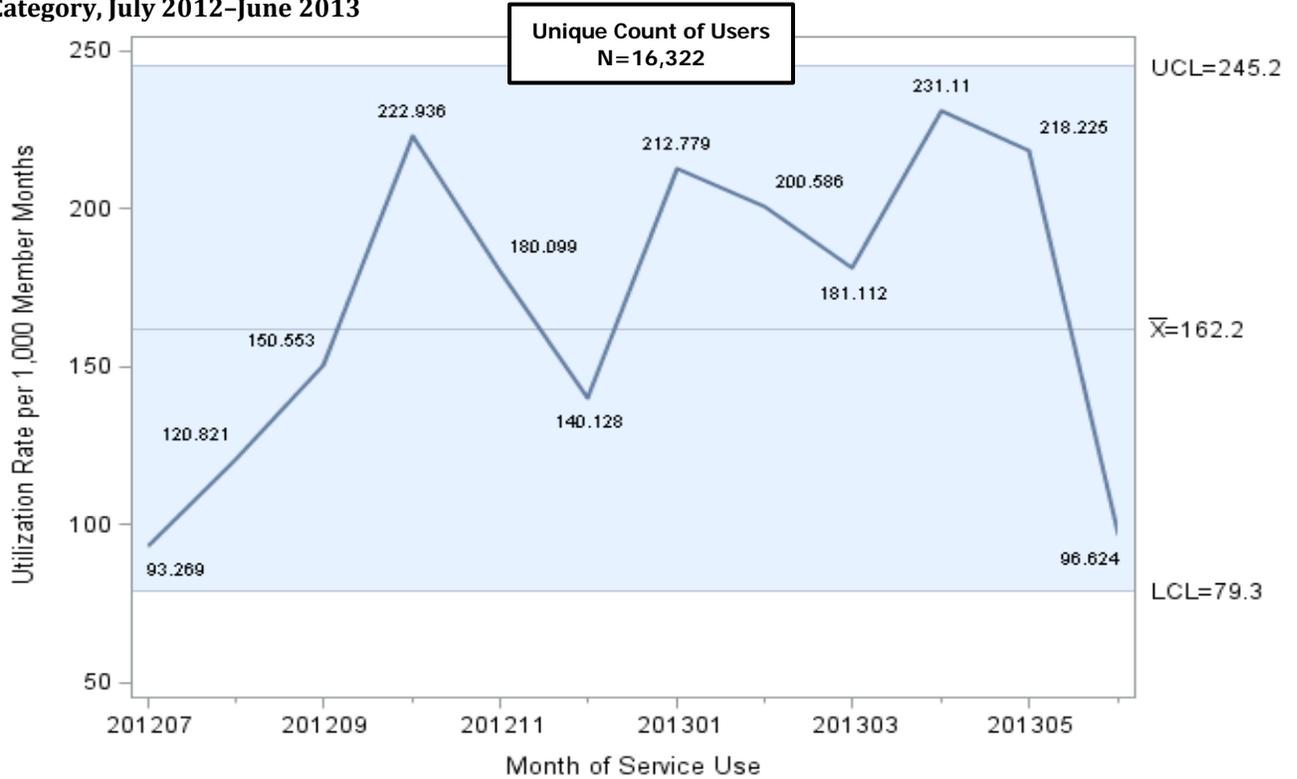


Figure SU-60. Other Services Utilization Rates among Children (Age 0–20) in the Other Aid Category, July 2012–June 2013

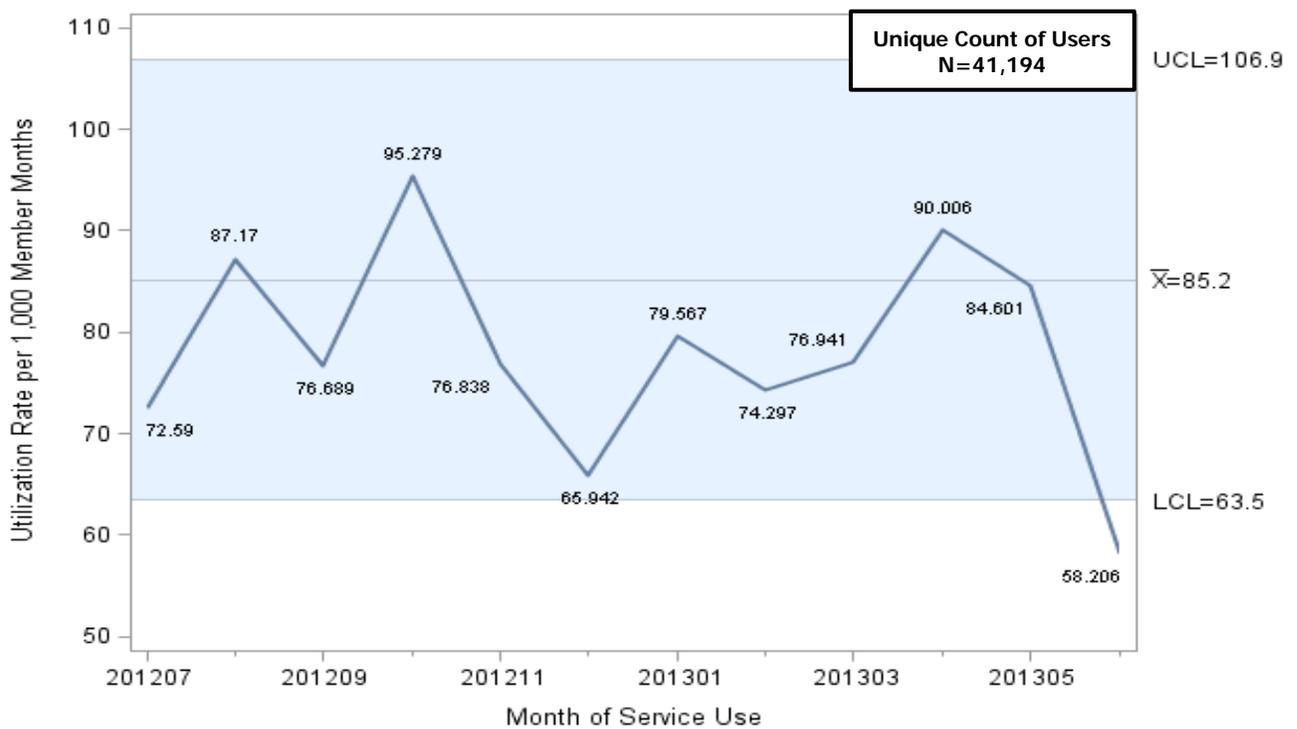
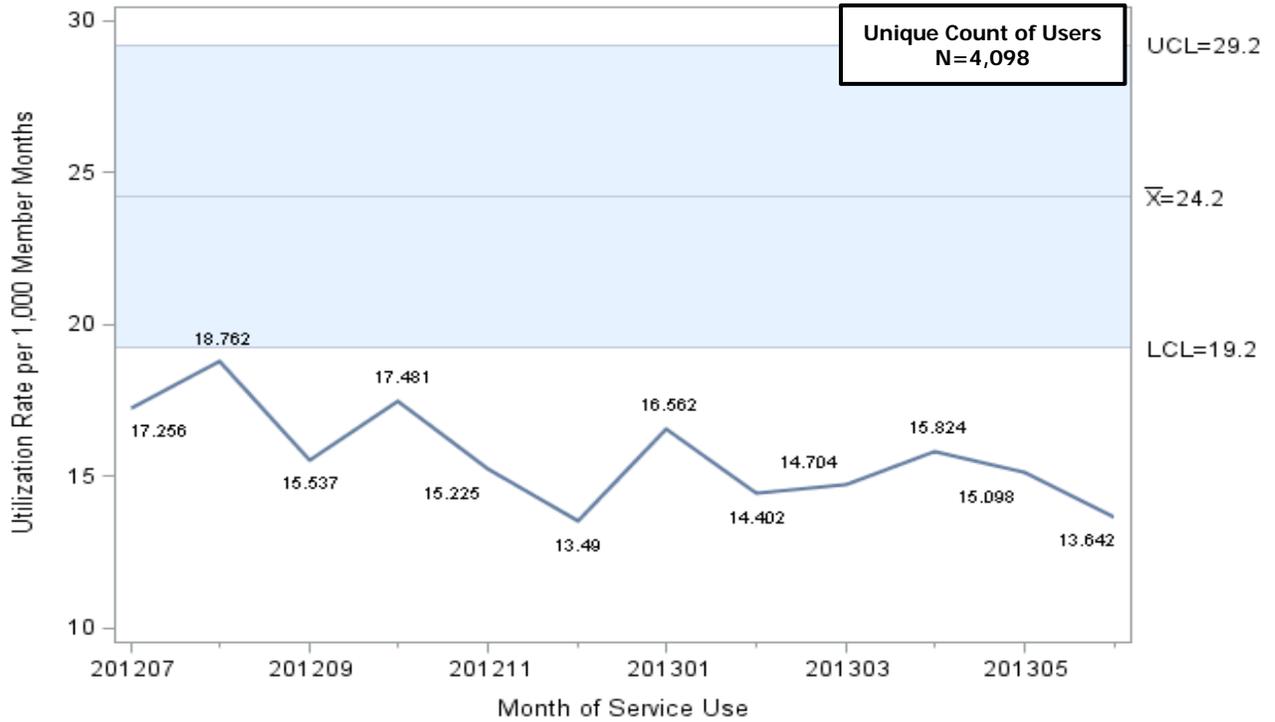


Figure SU-61. Other Services Utilization Rates among Children (Age 0–20) in the Undocumented Aid Category, July 2012–June 2013



Source: Data for figures SU-57 to SU-61 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends of Monthly Other Services Utilization Rates among Adults, July 2012–June 2013

Figure SU-62. Other Services Utilization Rates among Adults (Age 21+) in the Aged Aid Category, July 2012–June 2013

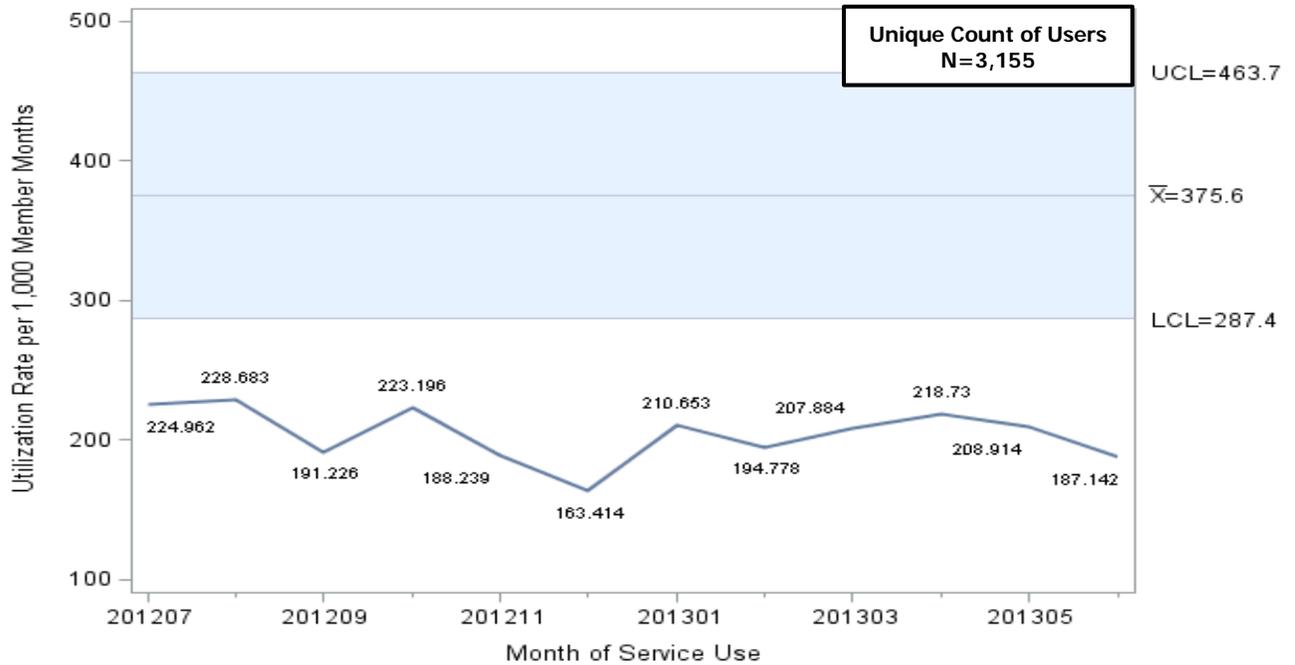


Figure SU-63. Other Services Utilization Rates among Adults (Age 21+) in the Blind/Disabled Aid Category, July 2012–June 2013

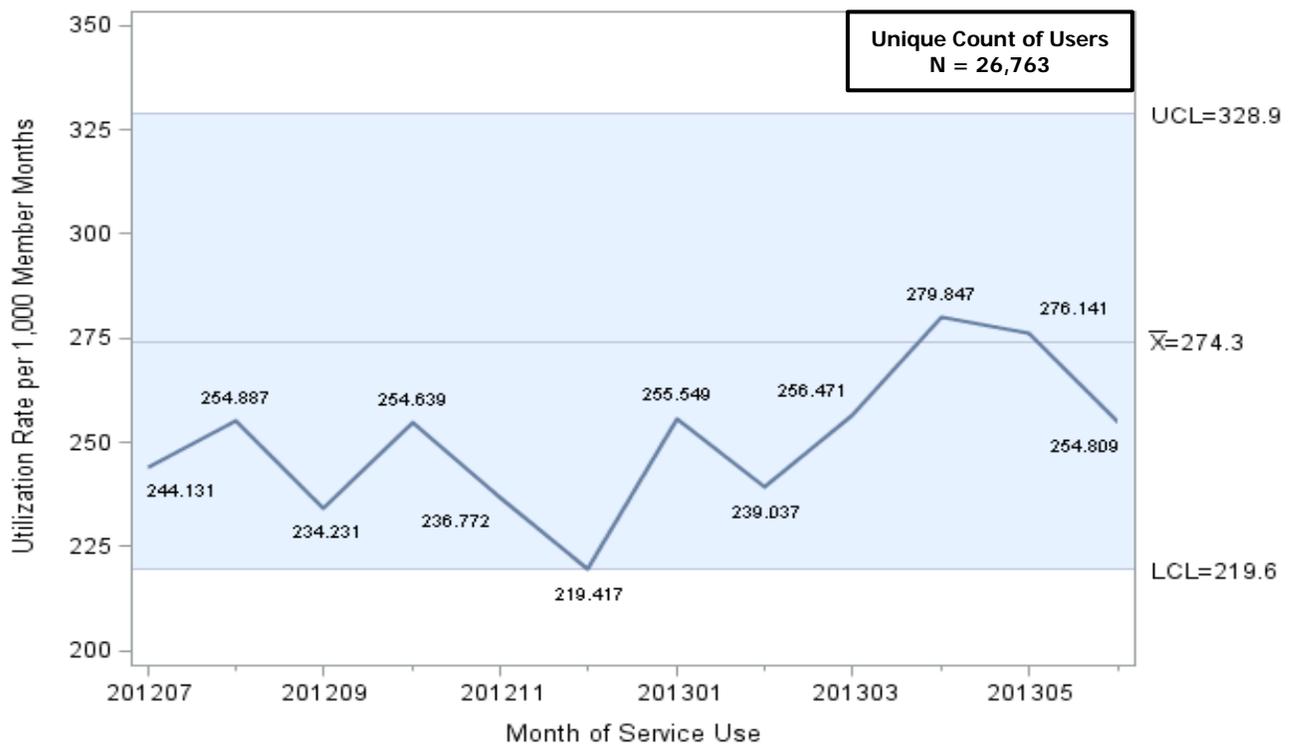


Figure SU-64. Other Services Utilization Rates among Adults (Age 21+) in the Families Aid Category, July 2012–June 2013

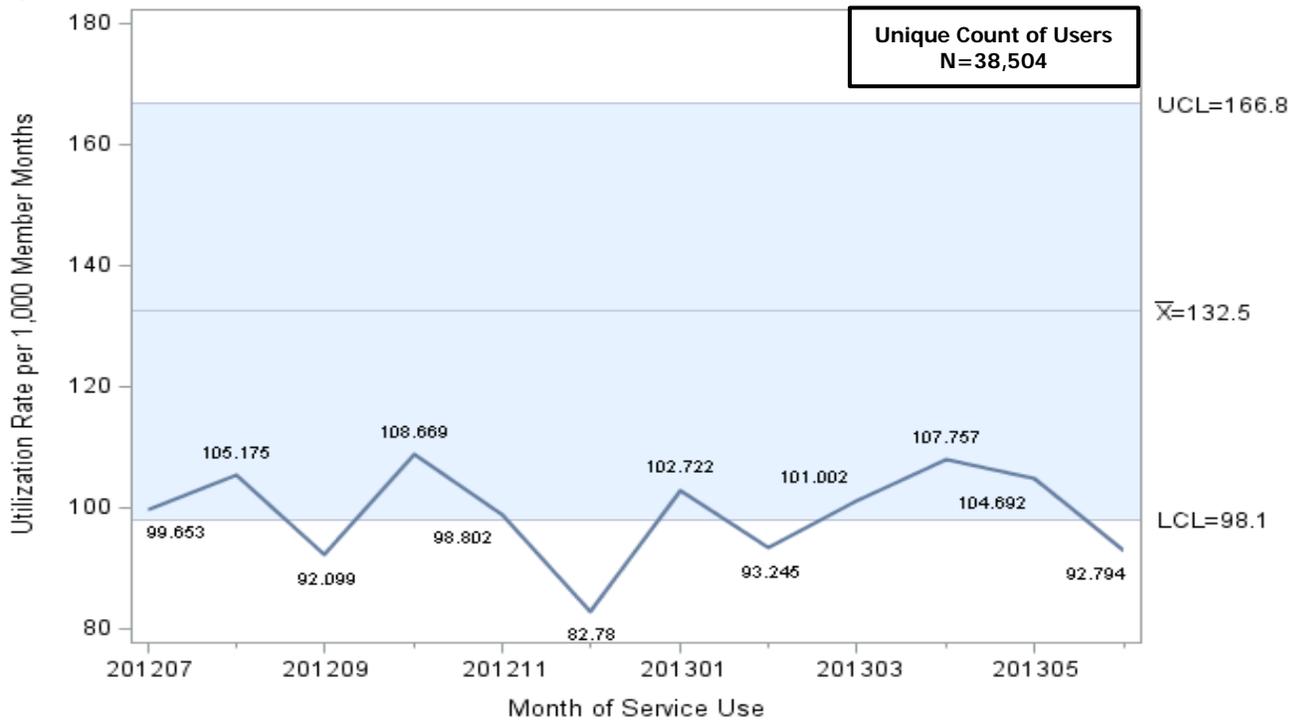


Figure SU-65. Other Services Utilization Rates among Adults (Age 21+) in the Other Aid Category, July 2012–June 2013

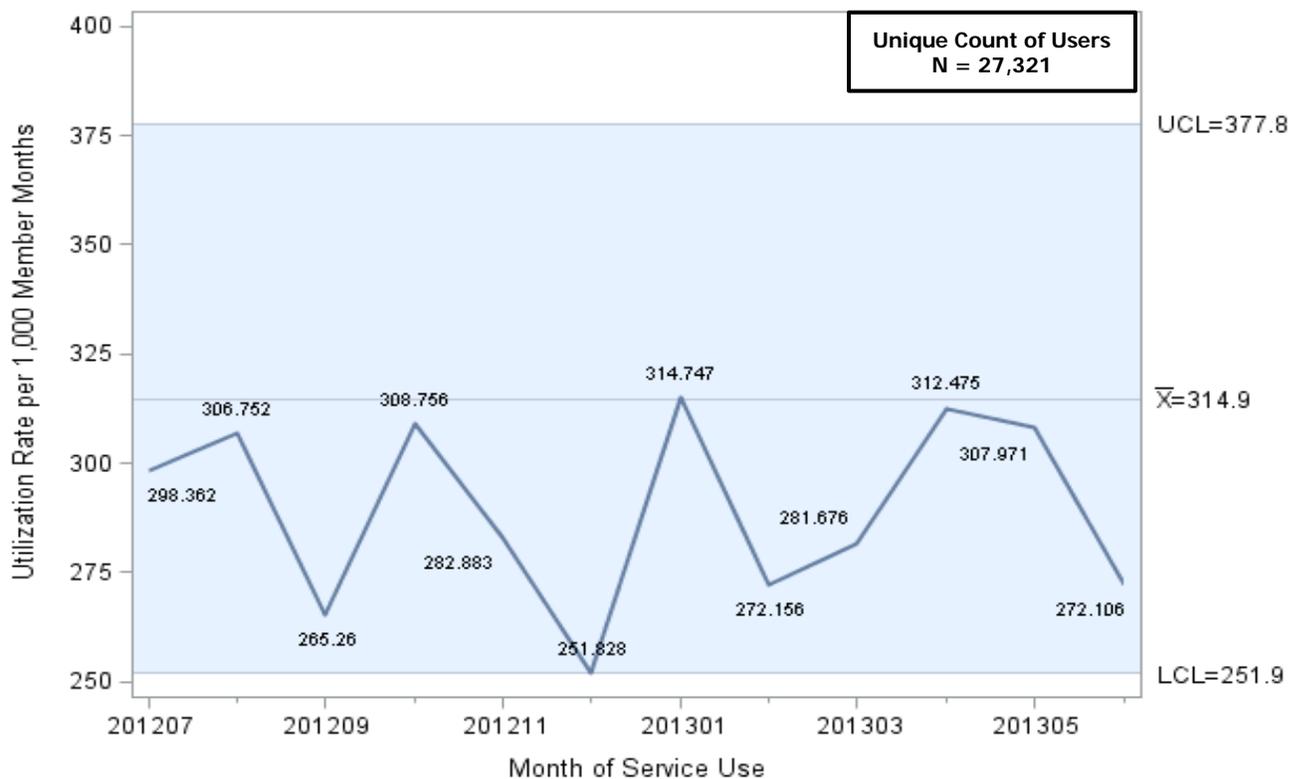
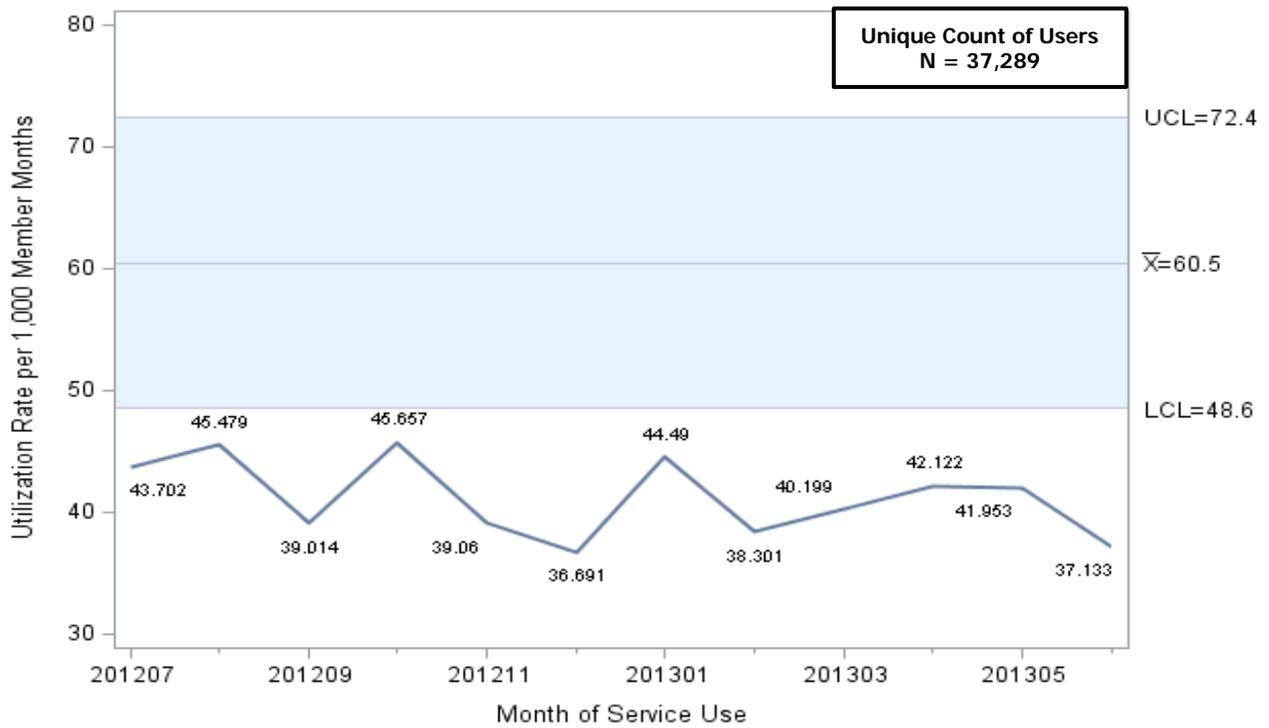


Figure SU-66. Other Services Utilization Rates among Adults (Age 21+) in the Undocumented Aid Category, July 2012–June 2013



Source: Data for figures SU-62 to SU-66 was prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, 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.⁶

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

Children

Among children age 0 to 20 in the Medi-Cal FFS program, monthly Radiology services utilization rates ranged from 30.5 to 113.9 visits per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

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 to 2009. Children in the Blind/Disabled, Families, Foster Care, and Undocumented aid categories displayed service utilization rates that primarily fell within the baseline ranges, while rates for those in the Other aid category fell below the expected ranges between February 2013 and June 2013. Of particular note, children in the Blind/Disabled and Families aid categories exhibited a decline in utilization in the last quarter of the study period.

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 333.2 visits per 1,000 member months from the third quarter of 2012 to the second quarter of 2013.

Services utilization rates were again highest 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 often reached levels above the expected baseline ranges. Radiology utilization rates for adults in the other analyzed aid categories (Families, Other, and Undocumented) again fell within the expected baseline ranges throughout the study period.

Utilization rates were highest among adults in the Blind/Disabled and Other aid categories.

Charts SU-67 to SU-76 represent the analysis of Radiology services utilization for both children and adults from the third quarter of 2012 to the second quarter of 2013.

Trends of Monthly Radiology Services Utilization Rates among Children, July 2012–June 2013

Figure SU-67. Radiology Utilization Rates among Children (Age 0-20) in the Blind/Disabled Aid Category, July 2012–June 2013

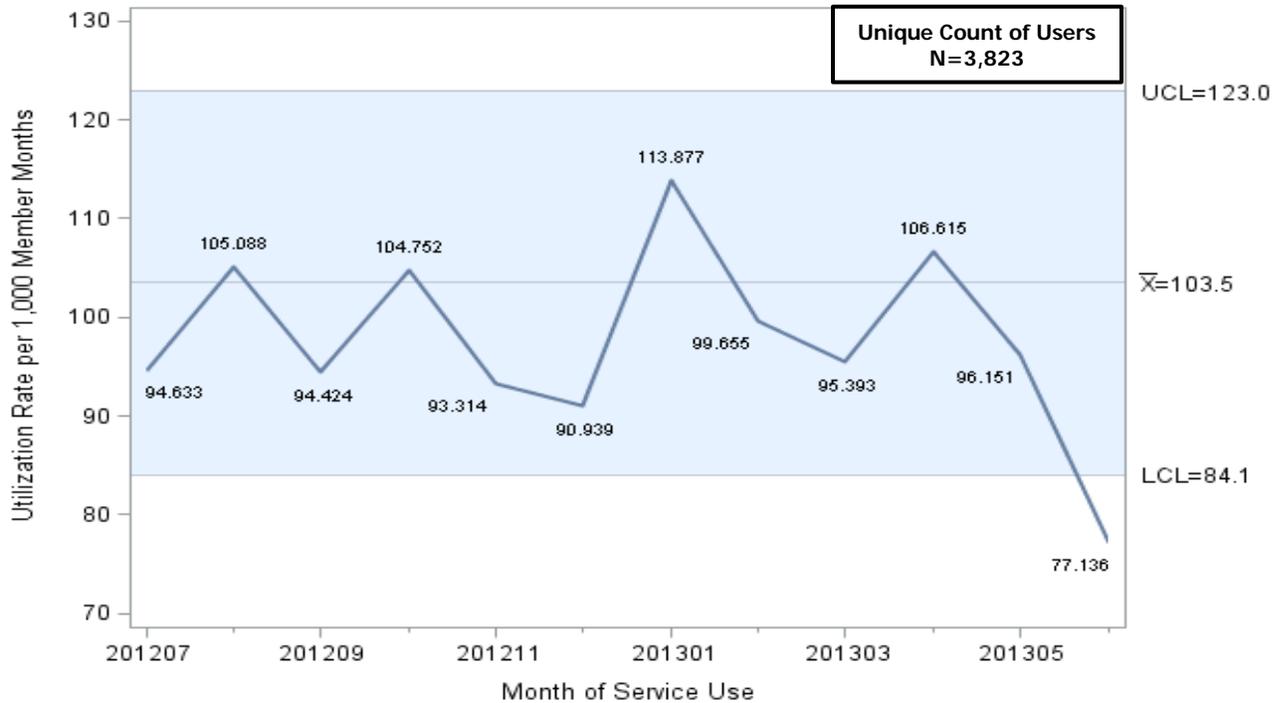


Figure SU-68. Radiology Utilization Rates among Children (Age 0-20) in the Families Aid Category, July 2012–June 2013

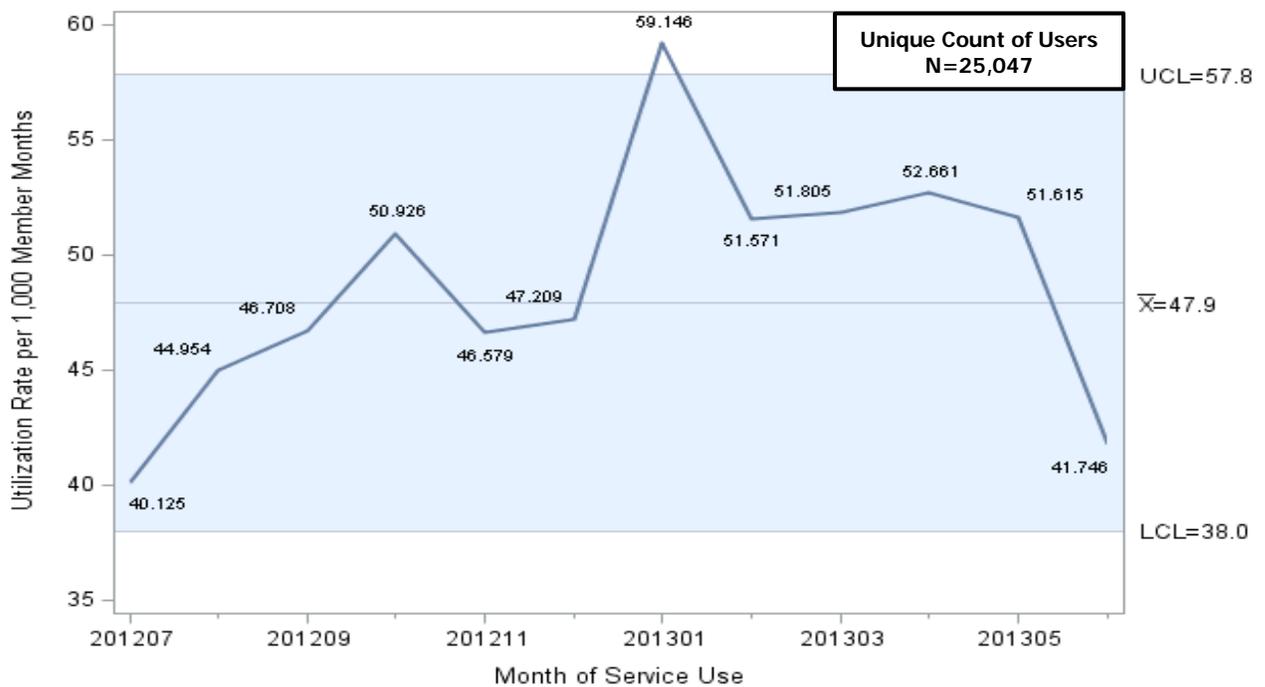


Figure SU-69. Radiology Utilization Rates among Children (Age 0-20) in the Foster Care Aid Category, July 2012–June 2013

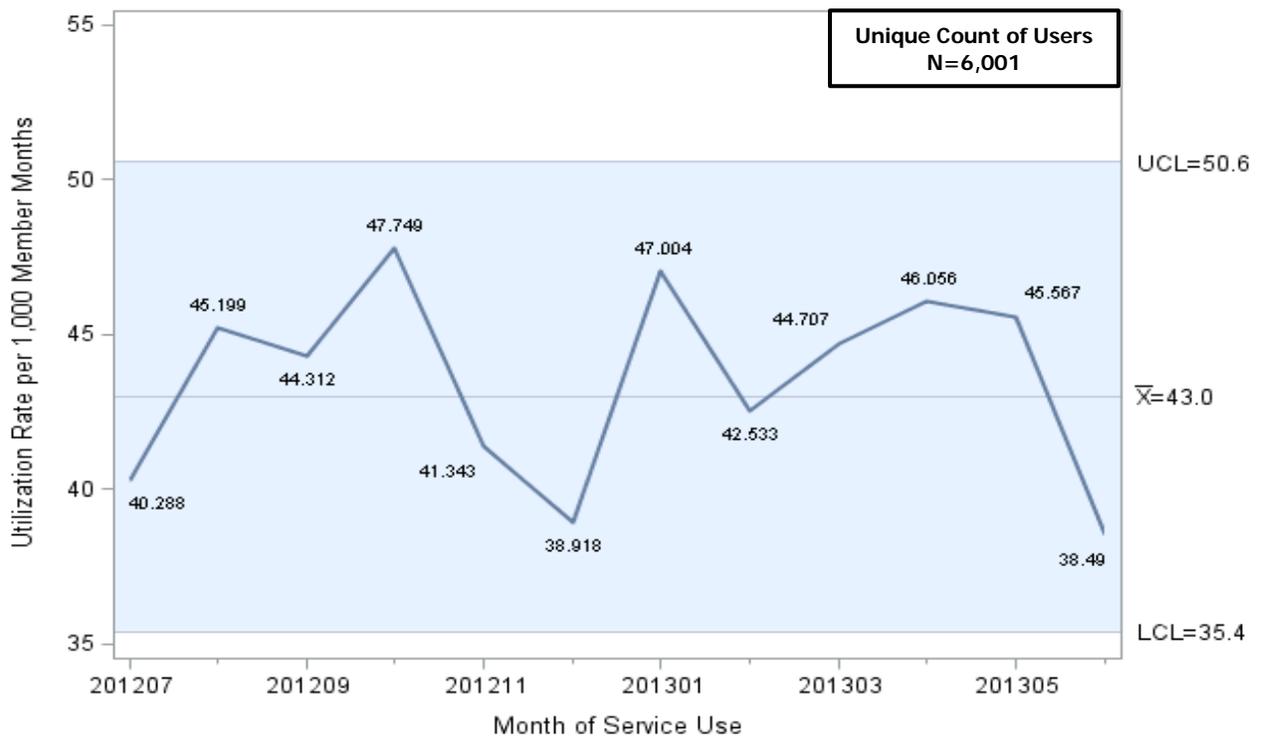


Figure SU-70. Radiology Utilization Rates among Children (Age 0-20) in the Other Aid Category, July 2012–June 2013

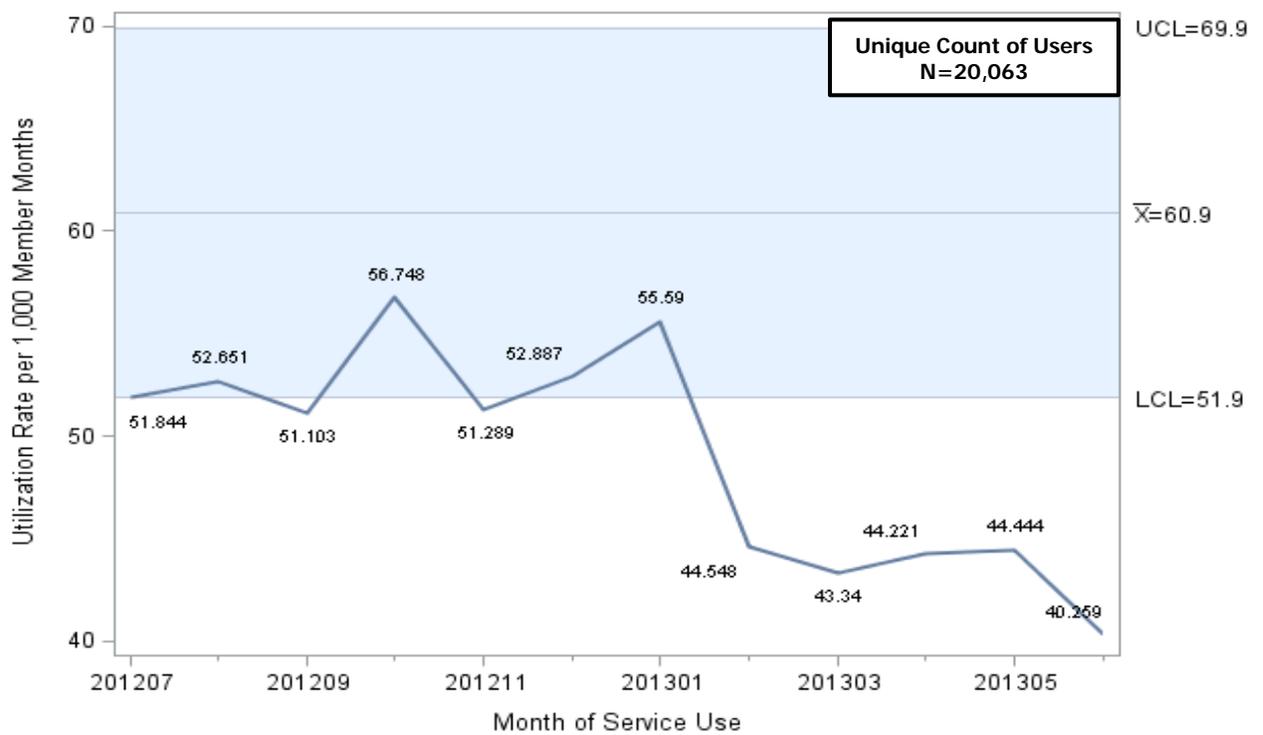
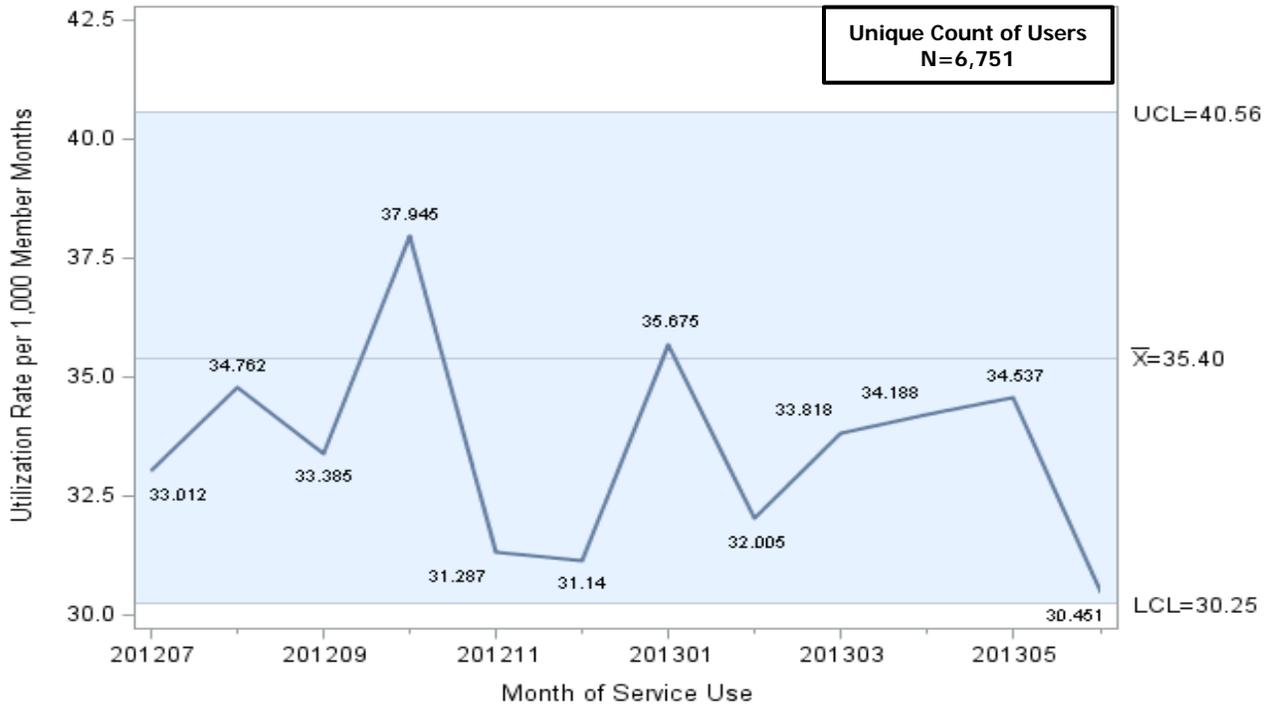


Figure SU-71. Radiology Utilization Rates among Children (Age 0-20) in the Undocumented Aid Category, July 2012–June 2013



Source: Figures SU-67 to SU-71 were prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

Trends of Monthly Radiology Services Utilization Rates among Adults, July 2012–June 2013

Figure SU-72. Radiology Utilization Rates among Adults (Age 21+) in the Aged Aid Category, July 2012–June 2013

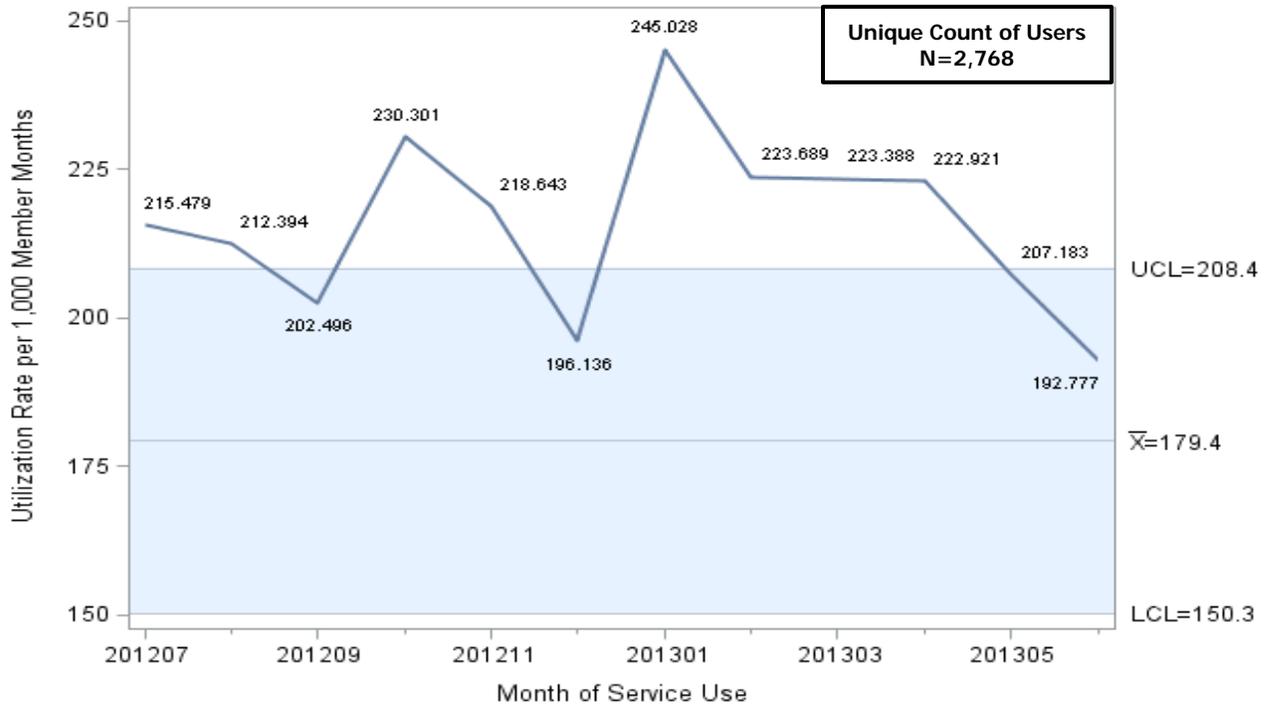


Figure SU-73. Radiology Utilization Rates among Adults (Age 21+) in the Blind/Disabled Aid Category, July 2012–June 2013

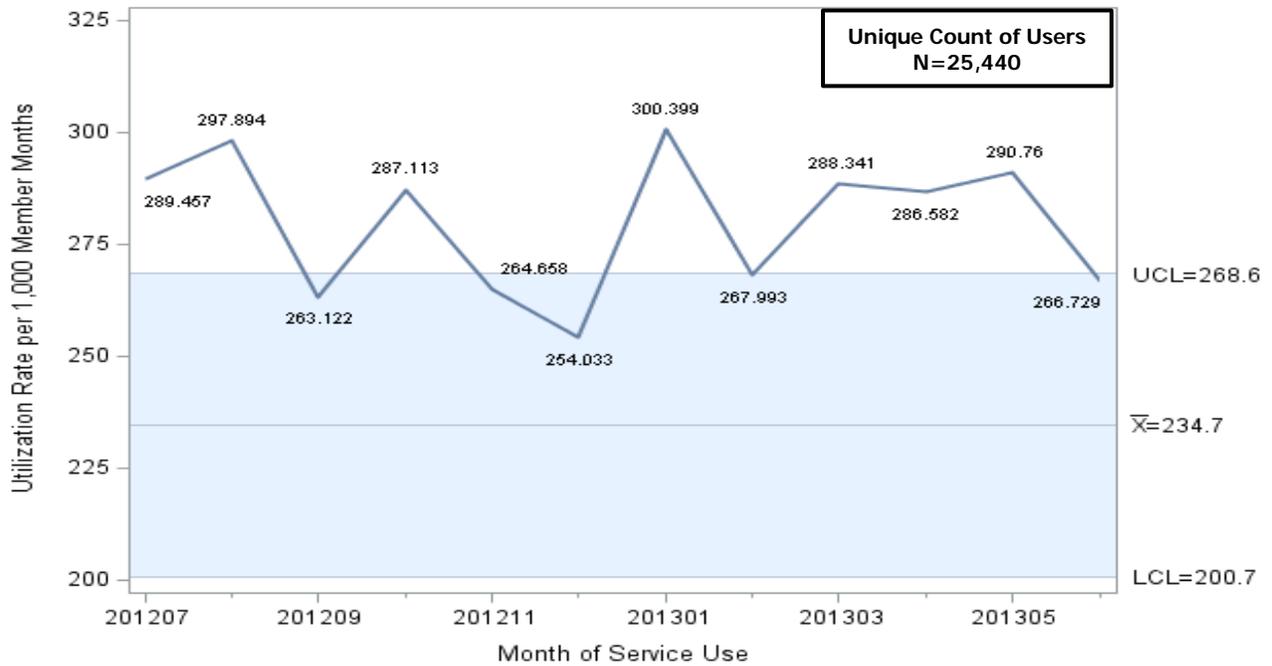


Figure SU-74. Radiology Utilization Rates among Adults (Age 21+) in the Families Aid Category, July 2012–June 2013

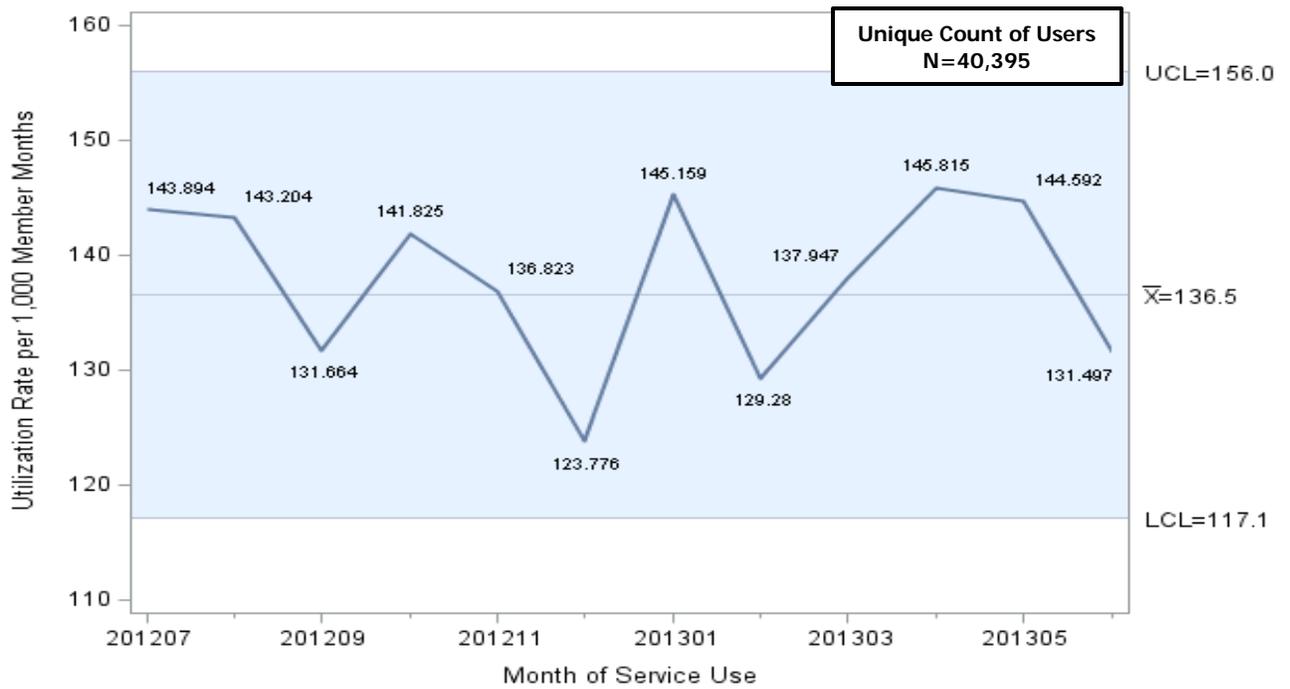


Figure SU-75. Radiology Utilization Rates among Adults (Age 21+) in the Other Aid Category, July 2012–June 2013

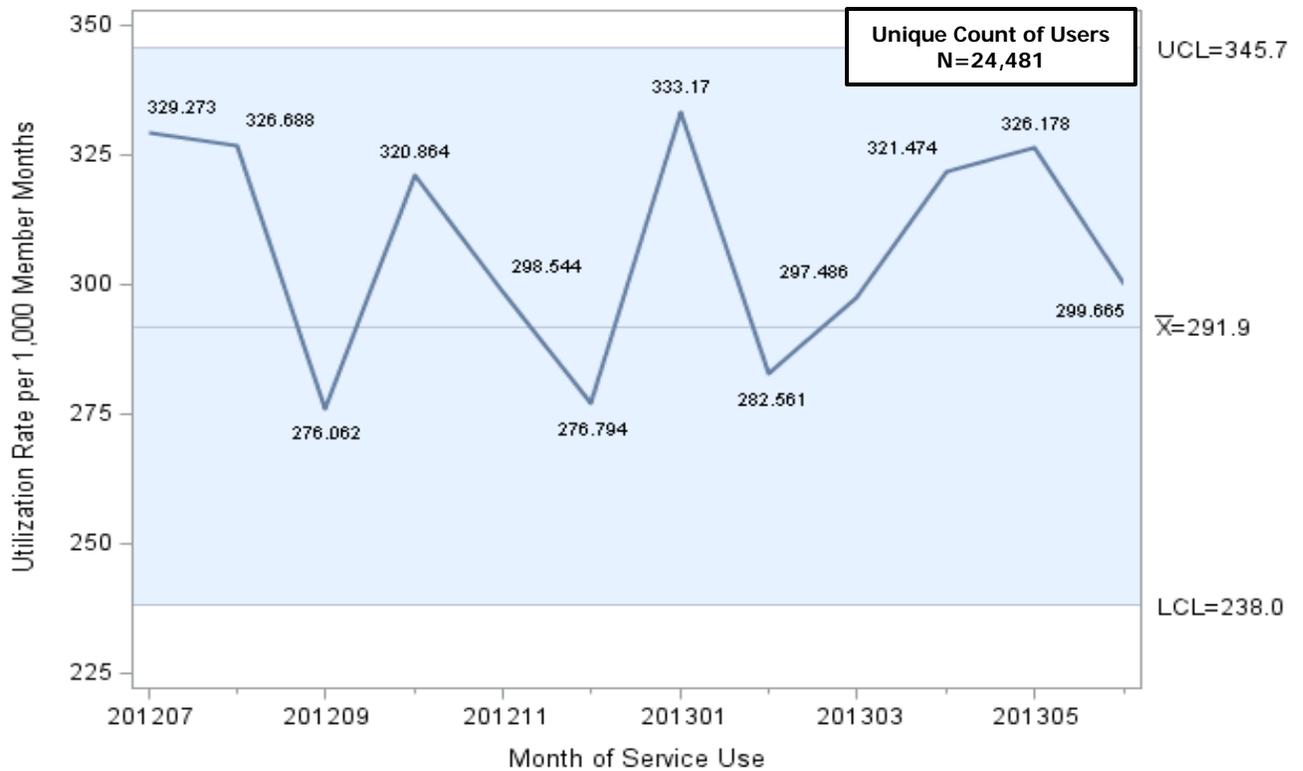
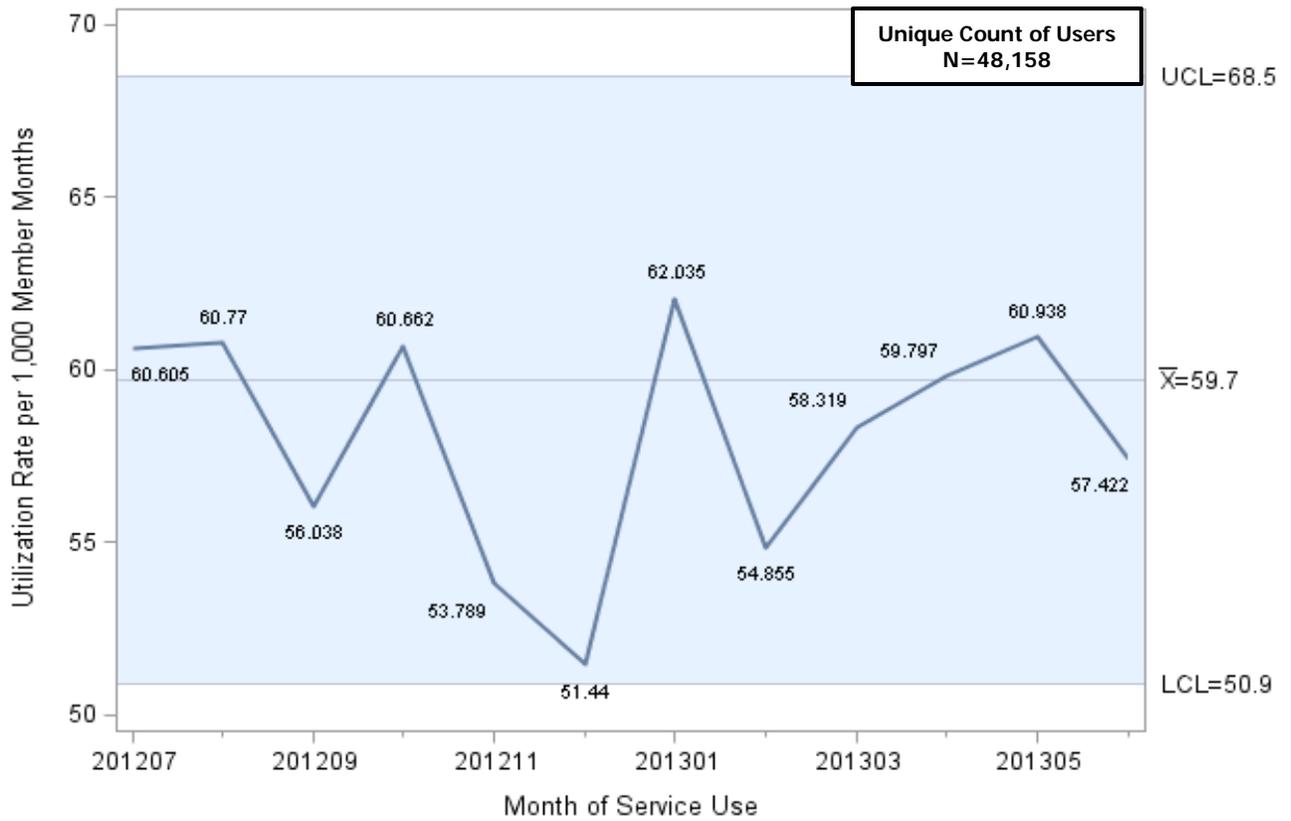


Figure SU-76. Radiology Utilization Rates among Adults (Age 21+) in the Undocumented Aid Category, July 2012–June 2013



Source: Figures SU-72 to SU-76 were prepared by DHCS Research and Analytic Studies Division, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from July 2012–June 2013, 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 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.
- 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	Within Expected Range. Mostly Below Average During Last 3 Quarters. Decline in Jun 2013.	Below Average and Mostly Within Expected Range. Slight Downward Trend Jan 2013 – Jun 2013.	Above Expected Range.	Mostly Above Average and Mostly Within Expected Range. Decline in Jun 2013.	Mostly Above Average and Within Expected Range. Decline in Jun 2013.	Above Average and Within Expected Range. Decline in Jun 2013.	Mostly Within Expected Range. Decline in Jun 2013.	Mostly Below Average and Mostly Within Expected Range. Decline in Jun 2013.
Families	Mostly Below Average and Mostly Within Expected Range. Decline in Jun 2013.	Mostly Within Expected Range. Decline in Jun 2013.	N/A	Mostly Above Average and Mostly Within Expected Range.	Mostly Below Average and Mostly Within Expected Range. Downward Trend Jan 2013–Jun 2013.	Mostly Below Average. Downward Trend Jan 2013–Jun 2013.	Within Expected Range. Decline in Jun 2013.	Mostly Within Expected Range. Decline in Jun 2013.
Foster Care	Mostly Below Average and Mostly Within Expected Range. Decline in Jun 2013.	Mostly Above Average and Mostly Within Expected Range. Decline in Jun 2013.	N/A	Mostly Below Average and Within Expected Range.	Mostly Within Expected Range. Downward Trend Aug 2012–Dec 2012. Decline in Jun 2013.	Mostly Within Expected Range. Decline in Jun 2013.	Within Expected Range. Decline in Jun 2013.	Within Expected Range. Decline in Jun 2013.
Other	Below Average with 5 Consecutive Months Below Expected Range Feb 2013–Jun 2013.	Below Average with 5 Consecutive Months Below Expected Range Feb 2013–Jun 2013.	N/A	Below Average with 5 Consecutive Months Below Expected Range Feb 2013–Jun 2013.	Below Expected Range. Downward Trend Jan 2013–Jun 2013.	Below Average and Mostly Below Expected Range. Slight Downward Trend Jan 2013–Jun 2013).	Mostly Below Average and Mostly Within Expected Range. Decline in Jun 2013.	Below Average with 5 Consecutive Months Below Expected Range Feb 2013–Jun 2013.
Undocumented	Below Average and Mostly Below Expected Range.	Mostly Below Average and Within Expected Range.	N/A	Below Average with 5 Consecutive Months Below Expected Range Feb 2013–Jun 2013.	Below Average and Mostly Within Expected Range.	Mostly Below Average and Mostly Within Expected Range. Downward Trend Jan 2013–Jun 2013.	Below Expected Range.	Mostly Below Average and Within Expected Range.

Note: Children were excluded from analyses of non-Emergency Medical Transportation and Nursing Facility services utilization due to low user counts (n<500).

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 Transportation	Emergency Medical Transportation	Home Health Services	Hospital Inpatient Services	Hospital Outpatient Services	Nursing Facility Services	Pharmacy Services	Other Services	Radiology Services
Aged	Below Average and Mostly Within Expected Range. Decline in Last Quarter.	N/A	N/A	N/A	Above Expected Range.	Mostly Above Average and Mostly Within Expected Range. Decline in Last Quarter.	Above Expected Range.	Below Expected Range.	Below Expected Range.	Above Average and Mostly Above Expected Range. Decline in Last Quarter.
Blind/Disabled	Mostly Below Average and Mostly Within Expected Range. Downward Trend Aug 2012–Dec 2012. Decline in Jun 2013.	Above Expected Range.	Above Average with Several Months Above Expected Range.	Mostly Above Average and Within Expected Range.	Mostly Above Expected Range.	Mostly Above Average and Mostly Within Expected Range.	Above Expected Range.	Mostly Below Expected Range.	Mostly Below Average and Within Expected Range.	Above Average and Mostly Above Expected Range.
Families	Mostly Below Expected Range. Downward Trend Aug 2012–Dec 2012).	N/A	Mostly Below Average and Within Expected Range. Downward Trend Jul 2012–Dec 2012.	N/A	Mostly Below Average with Several Months Below Expected Range.	Mostly Below Expected Range. Downward Trend Aug 2012–Dec 2012.	N/A	Mostly Below Expected Range.	Below Average with Several Non-Consecutive Months Below Expected Range.	Within Expected Range.
Other	Mostly Below Average and Mostly Within Expected Range. Downward Trend Aug 2012–Dec 2012.	Above Expected Range.	Within Expected Range.	N/A	Below Average with 5 Consecutive Months Below Expected Range Feb 2013–Jun 2013.	Mostly Below Average and Mostly Within Expected Range. 3 Non-Consecutive Months Below Expected Range.	Mostly Below Expected Range.	Mostly Below Average and Within Expected Range.	Below Average and Within Expected Range.	Mostly Above Average and Within Expected Range.
Undocumented	Mostly Below Range. Downward Trend Aug 2012–Dec 2012.	N/A	Below Average with Several Months Below Expected Range.	N/A	Below Expected Range.	Mostly Below Expected Range. Downward Trend Aug 2012–Dec 2012.	N/A	Mostly Above Average and Within the Expected Range.	Below 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. After displaying increased utilization in Emergency Medical Transportation, Hospital Inpatient, Hospital Outpatient, Pharmacy services, and Physician/Clinic visits during the first quarter of 2013, 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. Additionally, despite these shifts in utilization, children in the Blind/Disabled aid category continued 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 birthrates over the same time period.⁷
4. The utilization of all the evaluated services by children in the Other aid category again mostly fell below either the average rates or the expected ranges established during the baseline period. Of particular note, this population's utilization of Emergency Transportation, Hospital Inpatient, Hospital Outpatient, Radiology, and Pharmacy services, and Physician/Clinic visits noticeably declined below the expected ranges during the last two quarters of the study period. The change in utilization is most likely due to the transition of children from the Healthy Families program into Medi-Cal that started in January 2013. The Other aid category includes children as they temporarily enter FFS, but are subsequently enrolled in managed care according to program policy. Utilization rates are expected to stabilize by the end of 2013.
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

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

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. Adults in the Blind/Disabled aid category continued to place a great demand on Emergency Transportation, Hospital Inpatient, Hospital Outpatient, Nursing Facility, and Radiology services. Additionally, despite experiencing a downward trend in Non-Emergency Transportation services utilization during the first two quarters of the study period, Blind/Disabled adults again utilized these services at rates well above the expected baseline ranges.
2. Physician/Clinic service use patterns among adults in all of the analyzed aid categories again fell below either the average rates or the expected ranges established during the baseline period. Additionally, adults in most of the aid categories displayed downward trends in Physician/Clinic visits over the last two quarters of 2012. For some beneficiary subgroups (Aged, Blind/Disabled, and Undocumented), these shifts in utilization may indicate the development of new 'normal' service use patterns resulting from 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, Hospital Inpatient services, and 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 birthrate.⁸
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, Hospital Inpatient services, and 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, which is most noticeable among the immigrant population.⁹
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 at above average rates that often fall above the expected ranges. These

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

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

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.

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 #7 2013 Quarter 2



Beneficiary Feedback

February 2014

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

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Beneficiary Help Line Feedback

Introduction

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

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

Highlights

Call volume increased to 9,260 calls in the current study period compared with 8,541 calls in the last study period.

The three top call categories continued to be related to issues regarding Provider/Availability, Miscellaneous, and Enrollment/Continuity of Care.

The majority of calls for Enrollment/Continuity of Care and Provider/Availability issues were received from beneficiaries in Families and Blind/Disabled aid categories.

The increase in call volume that began in September 2012 and continued through April 2013 likely reflects the transition of children in the Healthy Families program into Medi-Cal that began January 1, 2013.

Methods

DHCS relies on data obtained from the Medi-Cal Managed Care Division's Office of the Ombudsman for the purpose of monitoring health care access. The Office of the Ombudsman call center documented 9,260 calls from FFS beneficiaries from the third quarter of 2012 to the second quarter of 2013. For each of these calls, the call center recorded the date and time of call, beneficiary aid category, county of residence, and reasons for the call. Data for these calls were summarized by month received, six aid category groupings (Families, Blind/Disabled, Aged, Foster Care, Undocumented, and Other), and reason for call.

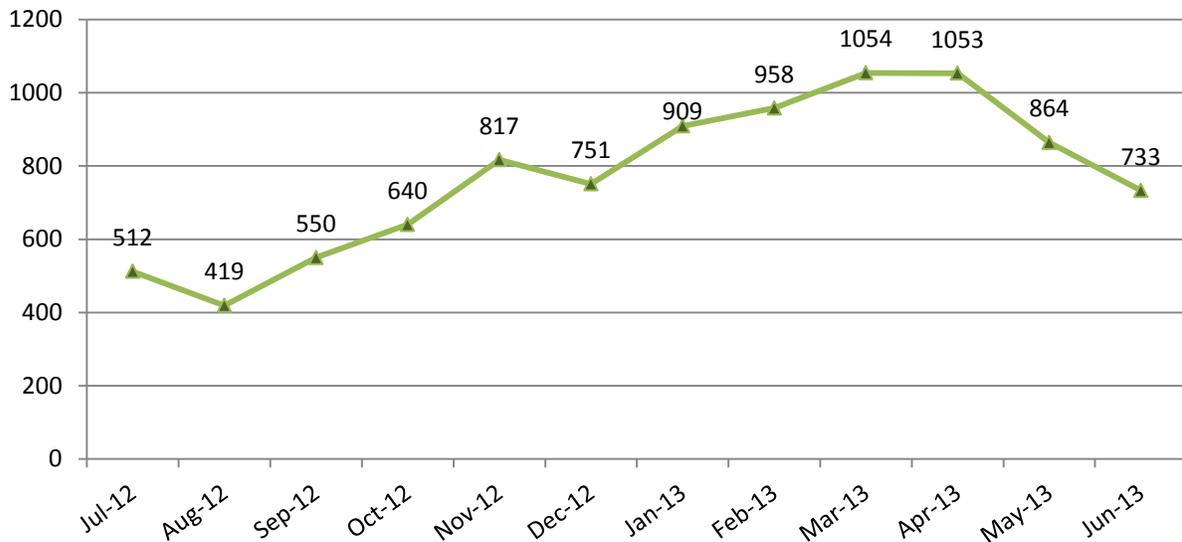
Results

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

FFS call volume was slightly higher this period than for the previous reporting period (8,541 calls for April 2012 to March 2013). Figure BF-1 provides a graph of the total calls received during the current reporting period by month. An upward trend in call volume was observed beginning in August 2012, with call volume decreasing for the months of May 2013 and June 2013.

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

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



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

Call Volume by Quarter

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

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

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

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

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

Modified Call Categories

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

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

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

Table BF-2. Modified Call Categories

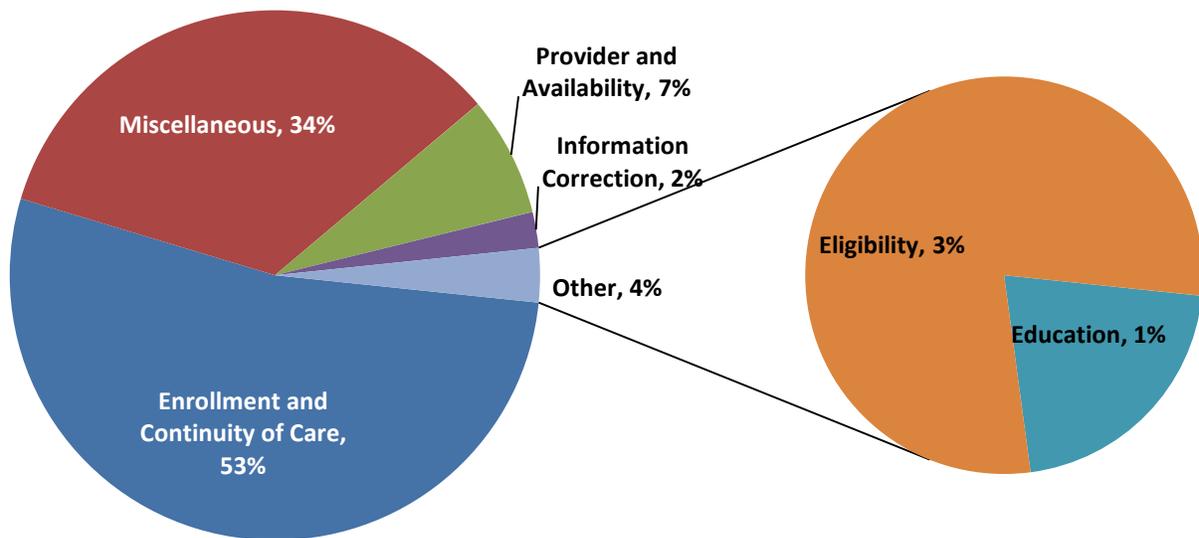
Call Category	Reason for Call
Enrollment and Continuity of Care	<ul style="list-style-type: none"> • Seeking information for new enrollment into plan • Wanting to change plans or disenroll from managed care • Seeking medical exemptions • Emergency plan disenrollment requests • Pregnancy or other qualifying conditions • Enrollment issues for specific beneficiary groups such as Seniors and Persons with Disabilities (SPDs) and foster care • Mandatory enrollment issues • Change or default into other managed care plan • Issues regarding dental plan enrollment
Provider and Availability Issues	<ul style="list-style-type: none"> • Medi-Cal eligibility was terminated • Seeking to obtain or change provider • Issue with transportation or distance to provider • Issue with disability/physical access • Was refused care or given inappropriate care • Was refused medications, Durable Medical Equipment (DME), or medical supplies • Delayed referral or appointment • Unable to access primary care physician/specialist/provider • Language access issues • Delay of prior authorization
Information Correction	<ul style="list-style-type: none"> • Need to correct beneficiary information (aid code, county code, address) • Need to fix provider billing issues
Education	<ul style="list-style-type: none"> • Seeking information about Medi-Cal program (e.g., Adult Day Health Center, Healthy Families) • Seeking information regarding notice of action
Eligibility	<ul style="list-style-type: none"> • Beneficiary has share of cost (SOC) or restricted aid code • Beneficiary resides in a restricted or carved out zip code
Miscellaneous	<ul style="list-style-type: none"> • Voicemail calls • Complaints about plan/provider staff • Referrals to external organizations such as Social Security Administration, County Eligibility, Medicare • Other issues

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

Distribution of Calls by Call Category

Figure BF-2 presents the distribution of total calls received from FFS beneficiaries and reasons for their call. Enrollment/Continuity of Care represented 53% of calls, while another 34% of calls were categorized as Miscellaneous. The remaining 13% of calls pertained to Provider and Availability, Information Correction, Education, and Eligibility issues.

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



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

As key elements in understanding whether beneficiaries are experiencing access-related problems, the remainder of this analysis will focus on two call categories: Enrollment/Continuity of Care and Provider/Availability issues. Of the total calls received, there were 4,909 calls categorized as Enrollment/Continuity of Care and 680 calls categorized as Provider/Availability.

Calls by Aid Code Category

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

The majority of calls for both call categories were received from beneficiaries in the Families aid category.

Patterns of call volume by aid category were similar between Enrollment/Continuity of Care and Provider/Availability. Nearly half (49.3%) of all calls received in the Enrollment/Continuity of Care category were from beneficiaries in the Families aid category, followed by beneficiaries in the Blind/Disabled, Other, and Aged aid categories. For Provider/Availability, the greatest percentage of calls came from beneficiaries in the Families and Other aid categories. The calls in the Other aid category are primarily due to the transition of children from the Healthy Families program into Medi-Cal starting January 1, 2013.

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

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

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

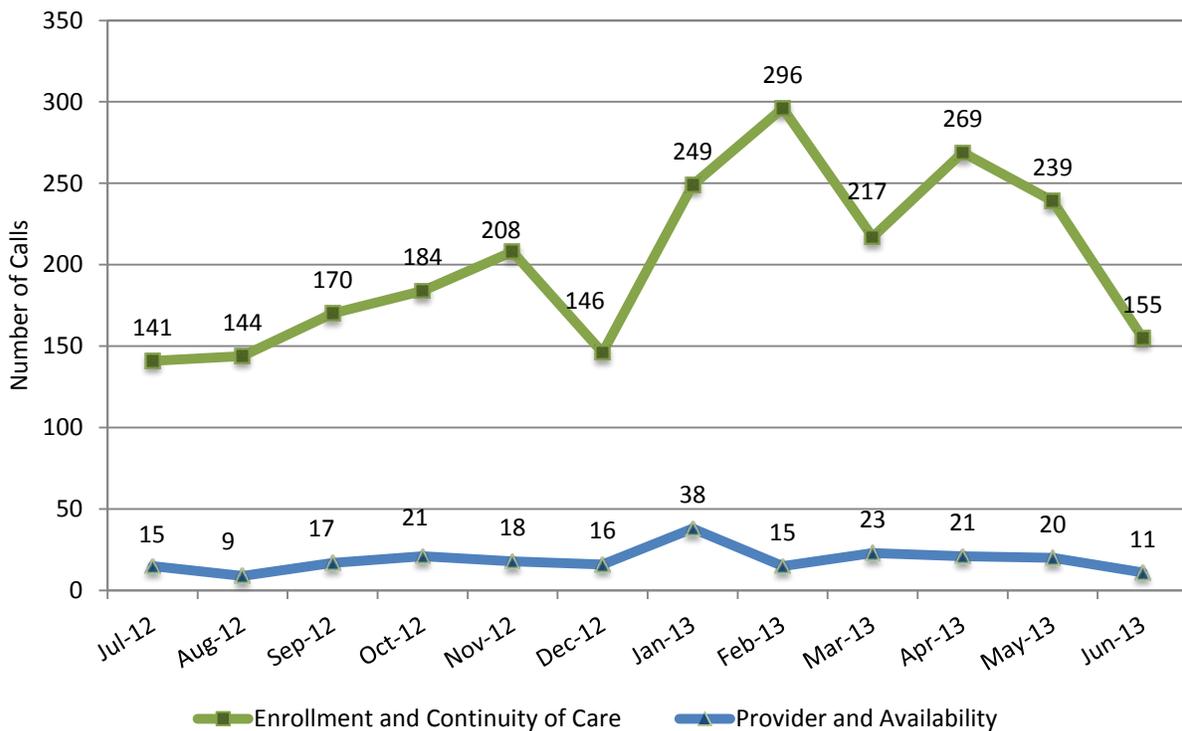
In general, a large proportion of calls received by the Ombudsman's Office pertained to Enrollment/Continuity of Care issues as compared with Provider/Availability issues. However, among beneficiaries enrolled in Undocumented aid codes, a larger volume of calls pertained to Provider/Availability issues.

Distribution of Calls from Family Aid Codes by Call Category

Since the majority of calls were received from callers in Family and Blind/Disabled aid codes, the following sections of the report will focus on calls received from beneficiaries in these two aid categories, analyzed by month and call category. Although beneficiaries in the Other aid category also accounted for a substantial percentage, the calls are primarily due to the transition of children from the Healthy Families program into Medi-Cal starting January 1, 2013.

Figure BF-3 represents calls made by FFS beneficiaries enrolled in the Families aid category. Calls pertaining to Enrollment/Continuity of Care issues from beneficiaries in the Families aid category increased modestly from July to November 2012, but increased nearly two fold from December 2012 through February. Calls pertaining to Provider/Availability issues were less frequent but stable during the period under study.

Figure BF-3. Monthly Call Volume from Family Aid Codes by Call Category, Quarter 3, 2012–Quarter 2, 2013

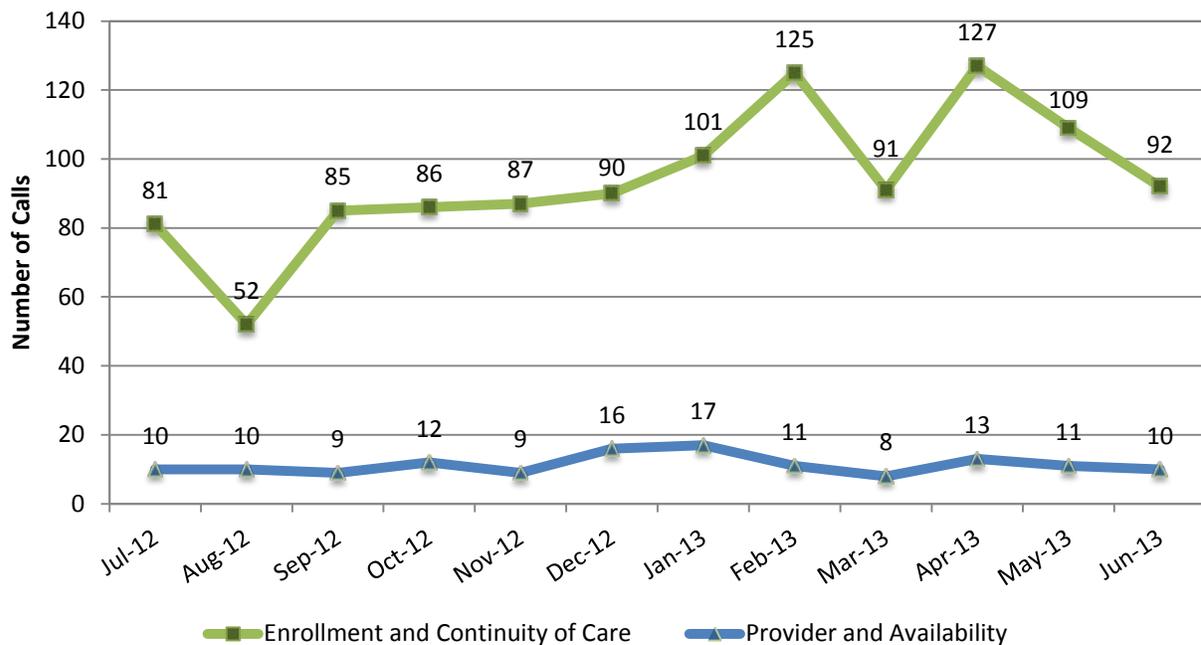


Source: Analysis of FFS calls received by the Office of the Ombudsman, Medi-Cal Managed Care Division, prepared by DHCS Research and Analytic Studies Division. Calls received by the Ombudsman for the period July 2012–June 2013.

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

Figure BF-4 presents the distribution of calls from FFS beneficiaries in Blind/Disabled aid codes by call category and month. Among this beneficiary subgroup, calls pertaining to Enrollment/Continuity of Care were relatively stable during the 3rd and 4th quarters of 2012, but increased slightly in January and February of 2013. Call volume returned to normal levels at the end of the second quarter of 2013. Calls pertaining to Provider/Availability issues were infrequent but stable for most of the study period.

Figure BF-4. Monthly Calls from Blind/Disabled Beneficiaries by Call Category, Quarter 3, 2012–Quarter 2, 2013



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

Reason for Call

To further investigate calls received from FFS beneficiaries, the top reasons for calls under each call category were identified. Table BF-4 presents the top four reasons for calls among calls received from beneficiaries in the Family aid category. Nearly 87% of calls categorized as Enrollment and Continuity of Care pertained to requests for new enrollment. Another 3% of Enrollment and Continuity of Care calls were regarding Foster Care disenrollment exemption requests, 2% pertained to requests to disenroll from managed care, and another 2% were calls pertaining to health plan holds.

Requesting New Enrollment into Plan was the top reason for calls under the Enrollment/Continuity of Care call category; Medi-Cal Eligibility Terminated was the top reason under the Provider/Availability call category.

Of the calls categorized under Provider and Availability, over 84% were addressing the termination of Medi-Cal eligibility. Nearly 9% were related to beneficiaries being billed for services, 2% concerned refusal of medications, and another 1% pertained to delays or denials of referrals or appointments.

Table BF-4. Top 4 Reasons for Calls from Family Aid Codes, Quarter 3, 2012–Quarter 2, 2013

Reason for Call	# of Calls	% of All Calls*
Enrollment/Continuity of Care (n=2,418)		
Requesting New Enrollment into Plan	2,091	86.5%
Foster Care/Adoption Disenrollment Exemption Request	81	3.4%
Wants to Disenroll from Plan to Become FFS	56	2.3%
Hold on Plan	51	2.1%
Provider/Availability (n=224)		
Medi-Cal Eligibility Terminated	188	84.3%
Beneficiary Being Billed	19	8.5%
Refusal of Medications	5	2.2%
Delay/Denial of Referrals or Appointments	3	1.3%

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

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

Table BF-5 presents the top four reasons for calls among calls received from beneficiaries in the Blind/Disabled aid category. Just over 56% of the calls categorized as Enrollment/Continuity of Care involved callers requesting new enrollment. Thirteen percent concerned Medical Exemption Requests (MERs) or Emergency Disenrollment Exemption Requests (EDERs), nearly 11% pertained to calls from beneficiaries wanting to disenroll from managed care to become a FFS participant, and 4% of calls were pertaining to long term care disenrollment emergency requests.

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

Requesting New Enrollment into Plan was the top reason for calls under the Enrollment/Continuity of Care category; Medi-Cal Eligibility Terminated was the top reason for calls under the Provider/Availability call category.

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

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

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

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

Conclusions

1. Between July 2012 and June 2013, the Ombudsman call center staff documented 9,260 calls from FFS beneficiaries in the Medi-Cal program. Call volume during this 12-month period was slightly higher than for the period April 2012–March 2013.
2. About 53% of the calls pertained to Enrollment/Continuity of Care. Another 34% of calls were categorized under Miscellaneous. Due to the ambiguity of Miscellaneous calls, they were not further analyzed. The focus of the analyses were on calls related to Enrollment/Continuity of Care and Provider/Availability as these key elements help identify access-related issues experienced by beneficiaries.
3. Among calls categorized as Enrollment/Continuity of Care and Provider/Availability, the majority of calls were from FFS beneficiaries enrolled in Family, Blind/Disabled, and Other aid categories.
4. Callers in Family aid codes were primarily concerned with requesting new enrollment. Other important issues included foster care/adoption issues and disenrolling from managed care and changing to FFS. These callers also sought information regarding the termination of their Medi-Cal eligibility, as well as being erroneously billed for services and refusal of medications.
5. Callers from Blind/Disabled aid codes were primarily concerned with requesting new enrollment. These callers also requested medical exemptions and emergency disenrollment exemption requests, as well as requesting disenrollment for managed care and emergency disenrollment from long term care. Other reasons for these calls included termination of Medi-Cal eligibility, refused medications, being billed erroneously for services, and denial of durable medical equipment.