



# **Medi-Cal Access to Care Quarterly Monitoring Report: 2011 Quarter 4**



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## **Abstract**

*Medi-Cal's assessment of healthcare access for the fourth quarter of calendar year (CY) 2011 disclosed that, for the most part, enrollment trends, provider supply, and utilization rates were within expected ranges. DHCS' quarterly analysis included an evaluation of four areas identified as providing some means of detecting the early signs of health care access disruptions. These areas included: evaluating changes in Medi-Cal enrollment, evaluating population to provider ratios, evaluating service rates per 1000 member months, and evaluating beneficiary hotline calls.*

*Over the past several years, Medi-Cal has undergone a transformation, away from its traditional FFS system and towards managed care delivery systems. In 2011, this shift in delivery systems accelerated as a number of counties initiated county organized health system (COHS) models and populations such as the seniors and persons with disabilities (SPD) were mandatorily enrolled into managed care plans. Today roughly 66% of Medi-Cal's entire population receives health care through a Medi-Cal managed care plan in 30 counties. As a result of this transformation, Medi-Cal's supply of providers dedicated to its FFS population eligible for Medi-Cal only<sup>1</sup> actually increased slightly during the four quarters of CY 2011. The Medi-Cal physician supply was found to contain an adequate number of overall physicians as well as primary care physicians. Utilization, or realized access, was generally within upper and lower expected bounds for most service categories and populations, although baseline standards used as benchmarks were found to be materially influenced by recent Medi-Cal program changes. In some cases, the changes occurring between 2007 and 2009—in response to the national recession—dramatically impacted utilization in the observed period when compared to the baseline. The elimination of optional benefits, effective July 2009, represents an example of such a change.*

*DHCS' beneficiary hotline, developed as part of the Rate Reduction SPA, was not established until December 2011; therefore, data pertaining to this quarterly measure was obtained through DHCS' Medi-Cal Managed Care Office of the Ombudsman. Beneficiaries enrolled in FFS contacted the ombudsman throughout the year and DHCS used this data source for the 4<sup>th</sup> quarter of 2011. A review of the data disclosed that increased calls received from beneficiaries enrolled in Medi-Cal's FFS system during CY 2011 coincided with major policy changes such as the elimination of adult day health care services (ADHC) and the mandatory enrollment of SPDs into managed care plans. In many cases, these calls focused on ascertaining information about the ADHC elimination or enrolling into managed care plans.*

*While Medi-Cal's transformation and policy changes added additional complexity to the analysis of the selected access measures, the changing nature of the program provided an opportunity for assessing whether measures selected for monitoring beneficiary access to health care services are informative. The known policy changes all left some type of footprint in the measures evaluated and did move the dial, indicating that a change occurred.*

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<sup>1</sup> These are Medi-Cal beneficiaries who are eligible for Medi-Cal, but not Medicare.

## Executive Summary

### Background

This Medi-Cal access report represents the first in a series of reports concerning health care access among Medi-Cal's population. This report was designed to provide information for evaluating the early signs of potential health access problems related to beneficiaries who are eligible for Medi-Cal only and participating in Medi-Cal's fee-for-service (FFS) system. This initial report presents information covering the fourth quarter of calendar year (CY) 2011. During CY 2011, Medi-Cal's provider payment reduction enacted by assembly bill (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.

The Department of Health Care Services (DHCS) established a quarterly health care access monitoring system in conjunction with its implementation of the provider payment reductions promulgated in AB 97. AB 97 allowed DHCS to implement up to a 10% Medi-Cal provider payment reduction. To operationalize this provider rate reduction, DHCS amended its Medi-Cal state plan and developed and implemented a systematic process for monitoring access to health care services. This health care access monitoring system, approved by the Centers for Medicare and Medicaid Services (CMS), requires DHCS to continuously monitor health care access and produce both quarterly and annual reports. The quarterly access monitoring report requires DHCS to assess specific *early warning* measures that encompass the following:

- Change in Medi-Cal enrollment
- Population to provider ratios
- Service rates per 1000 member months
- Beneficiary hotline calls

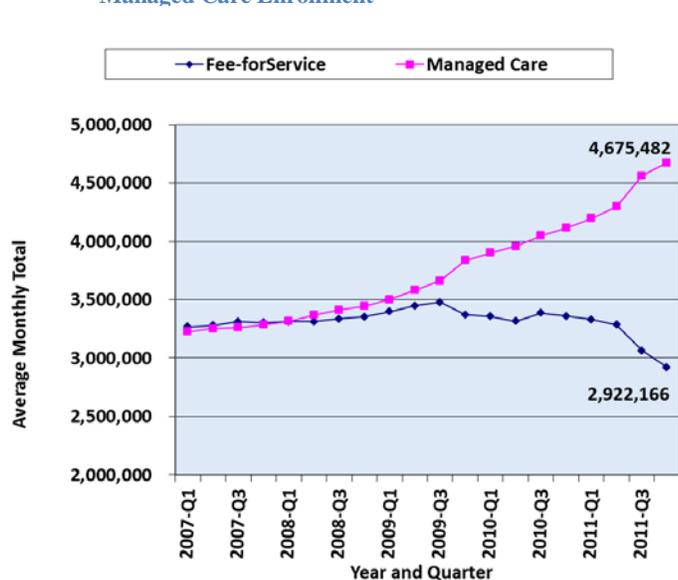
Recent changes in the Medi-Cal program have impacted benefits, health care delivery, and the FFS population characteristics. All of these changes influenced the measures evaluated in Medi-Cal's quarterly access report. DHCS' systematic access monitoring system required the establishment of baseline statistics. These baseline statistics were established using data which incorporated dates-of-service occurring between 2007 through 2009. Since 2007, Medi-Cal evolved in response to recessionary pressures and efforts directed at reforming its health care delivery system, an evolutionary process which continues today. In some cases, these changes dramatically affected Medi-Cal's FFS population, impacting how beneficiaries receive services and the benefits they receive. As a result, the present baseline metrics, which were established during Medi-Cal's transformational period, may not always reflect the new reality. Therefore, the baseline statistics, or benchmarks, may require modification.

As the national recession—which commenced in December 2007—deepened, California's state revenues declined precipitously. Medi-Cal, like all government programs, was looked to for solutions, since it accounts for roughly 14% of state general fund spending. In response to the state's economic malaise, program changes were sought that would create both an efficient delivery system and reduce general fund spending. While the economic recession was the impetus for many recent program

changes, Medi-Cal was also undergoing a transformation prior to the downturn. These efforts were primarily focused on establishing coordinated health care delivery models. These efforts involved transforming the traditional FFS delivery model into a system that coordinated care through health maintenance organizations, health homes, etc. During 2008 through 2011, significant changes occurred within Medi-Cal’s delivery system that impacted enrollment distributions between Medi-Cal’s traditional FFS system and managed care. These shifts in enrollment, from FFS to Medi-Cal managed care, significantly impacted the number of beneficiaries for whom this quarterly access monitoring effort is directed towards (Figure ES-1); access monitoring efforts focus on beneficiaries who are eligible for Medi-Cal only and participating in the FFS system.

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. From 2008 through 2011, the counties of San Luis Obispo, Sonoma, Merced, Kings, Madera, Ventura, Mendocino, and Marin 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<sup>2</sup>. In addition to the establishment of managed care models within former FFS counties, Medi-Cal also directed seniors and person with disabilities (SPD), who were formerly receiving care through the FFS system, into Medi-Cal managed care plans in the Two-Plan and geographic managed care (GMC) counties. Roughly 300,000 SPD beneficiaries were directed 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 billion<sup>3</sup> in annual health care spending. All of these shifts, from the FFS to managed care delivery models, occurred during either the baseline period (i.e., 2007 – 2009) or during the present measurement period (i.e., CY 2011). For example, the SPD transition commenced in June 2011 and was phased-in over 12 months. This means that during the 4<sup>th</sup> quarter of 2011, beneficiaries who were formerly receiving health care services via the FFS system were now receiving care through managed care plans.

Figure ES-1; Trend in Quarterly FFS vs. Managed Care Enrollment



<sup>2</sup> Part of the 306,000 included “Working Disabled” individuals who were transitioned into managed care delivery systems (11,382).

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

Shifting health care delivery systems materially influenced provider supply and utilization access measures. For example in those counties that shifted from a FFS delivery system to a managed care model, the number of beneficiaries participating in Medi-Cal's FFS system declined significantly. The impact of these changes was recognized in measures such as the population-to-primary care provider ratio and service rates per 1000 member months.

Because Medi-Cal provider supply did not decline over this period, the ratio of population to providers actually improved. Measuring the population to overall physician supply ratio disclosed that the number of providers increased slightly over the four quarters evaluated, but the most significant driver in the improvement in the population to provider ratio was driven by the reduction in the numerator, in this case the number of beneficiaries eligible for Medi-Cal only and participating in FFS. Shifts in enrollment, from FFS to managed care, may also materially alter utilization rates. When populations are shifted from FFS to managed care, the potential exists for case mix changes to occur. Beneficiaries who remain in FFS may exhibit health characteristics that are very different from the pre-shift population, resulting in changes in utilization rates. In some cases, utilization rates may rise, if for example populations that remain in FFS tend to represent high utilizers. As counties are transitioned to managed care delivery systems, the beneficiaries who remain in FFS and the utilization associated with FFS member months tend to be either those who are exempted out of managed care enrollment, those initially eligible for Medi-Cal, or the FFS member months may be associated with months of eligibility occurring during retroactive months of eligibility.

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

In addition to shifts in enrollment, Medi-Cal also eliminated optional services that impacted service utilization rates. Assembly Bill X3 5 (Chapter 20, Statutes of 2009), added Section 14131.10 of the Welfare and Institutions Code (W&I Code) to exclude several optional benefits categories from coverage under the Medi-Cal program, which was implemented on July 1, 2009. The following optional benefits were excluded from coverage under the Medi-Cal program: Acupuncture services, adult dental services, audiology services, chiropractic services, incontinence creams and washes, optometric and optician services, podiatric services, psychology services, and speech therapy services. 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. In some cases, these changes distorted the data and utilization trends. 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 through 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. As the benefit change is absorbed into the system, the utilization will settle to a “stable” level which oscillates around the mean. Baseline control limits established during major program changes may not truly reflect the new reality, and may require additional analysis in the future to adjust the mean and control limits. Similarly, these benefit changes and shifts in systems of care also influenced beneficiary call center activity.

During CY 2011, DHCS began discussions regarding the elimination of adult day health center (ADHC) services. While ADHC services were eventually eliminated for services delivered on or after April 1, 2012, the initial discussions regarding this benefit elimination prompted beneficiaries to contact DHCS’ call center. Reviewing call center data revealed a noticeable increase in calls on or around this time related to this topic.

While Medi-Cal’s transformation and policy changes resulted in interpretation complexity, the changing nature of the program did disclose that the measures selected for monitoring health care utilization and beneficiary interaction with Medi-Cal’s delivery system are informative. The policy changes noted above all left some type of footprint in the selected measures evaluated. In some cases a definitive reason for observed trends could be identified. In other cases, additional analyses and assessment in future reports will provide further clarification.

## **Findings**

Presented below are summary findings for the four measures evaluated in this quarterly access report: (1) Change in Medi-Cal enrollment, (2) Population to provider ratios, (3) Service rates per 1000 member months, and (4) Beneficiary hotline calls.

### *Change in Medi-Cal enrollment*

Understanding the unique complexities of the Medi-Cal sub-populations 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 sub-population 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 and whether populations are shifting from one delivery model to another is also vitally important.

- Beneficiaries eligible for Medi-Cal only and participating in the FFS system are a culturally and ethnically diverse population. The majority self-describe as Hispanic. About half use Spanish as a first language.
- Several Medi-Cal populations eligible for Medi-Cal only and participating in FFS were transitioned into managed care delivery models. During late 2010 and CY 2011, the counties of Kings, Madera, Ventura, Mendocino, and Marin were transitioned from FFS to managed care delivery models. In addition, roughly 300,000 seniors and persons with disabilities were mandatorily enrolled in managed care health plans in the Two-Plan and GMC counties. These changes, in Medi-Cal's health delivery system, resulted in a decline in the number of beneficiaries participating in the FFS system.
- The number of beneficiaries eligible for Medi-Cal only and participating in FFS, entitled to full scope benefits decreased 8.3% in the last two quarters of CY 2011, and 21.6% when comparing enrollments for the first and last quarters, reflective of Medi-Cal's shift to managed care.
- The greatest decrease in FFS participation was observed among beneficiaries eligible for Medi-Cal only, entitled to full scope benefits enrolled in Aged and Blind/Disabled aid codes. The decrease in enrollment among these subpopulations was expected, given DHCS initiative aimed at transitioning SPDs into managed care plans.
- Overall, enrollment trends for Medi-Cal's FFS population were similar in metropolitan and non-metropolitan counties for CY 2011. For the last two quarters, enrollment continued to decrease in metropolitan counties, with only slight changes noted for non-metropolitan counties.
- Beneficiaries eligible for Medi-Cal only participating in FFS and enrolled in the Aged category residing in both metropolitan and non-metropolitan counties experienced the greatest decline in FFS participation from Q1 to Q4. Undocumented children, residing in non-metropolitan counties, also experienced significant declines in enrollment, particularly during the last two quarters of CY 2011. Unlike the populations discussed previously, shifts in system participation (i.e., from FFS to managed care) were not responsible for the declines recognized in the undocumented population. Undocumented beneficiaries are generally not eligible for Medi-Cal managed care enrollment. Declines recognized in the undocumented population were the result in declining enrollment in the Medi-Cal program.

## *Population to provider ratios*

Evaluating provider supply is designed to provide decision makers with a sense of whether Medi-Cal's network of providers is decreasing, increasing, or remaining stable over time. Provider supply provides a measure of the number of providers who are "potential" care providers, but does not represent the number of providers who are actively rendering care. For many patients, an interaction with a physician represents the entryway into the health care system. It is estimated that physician's clinical decisions affect how up to 90 percent of every health care dollar is spent<sup>4</sup>. Their decisions influence access to a whole host of medical services throughout the system.

- DHCS evaluated all 58 counties and beneficiaries eligible for Medi-Cal only participating in the FFS system with respect to overall physician provider supply. The findings indicate that the supply of physician providers available was more than adequate.
- The population-to-physician provider site ratios disclosed no deterioration in overall physician supply available to beneficiaries eligible for Medi-Cal only participating in FFS over the four quarters evaluated, but did disclose differences among regions of the state. In general, the primarily rural counties utilizing the FFS model reported the lowest physician supply relative to the target population. Counties utilizing the Two-Plan managed care model and having a more urbanized population reported greater physician supply compared to Two-Plan counties in more rural areas. In this respect, physician supply for Medi-Cal beneficiaries mirrored that of the entire state population.
- The statewide population to physician provider site ratio was found to be 134.2. This ratio indicates that the supply of primary providers was more than adequate to meet demand. Over the four quarters evaluated, the population to primary care physician ratio declined from 41.9 to 32.1, indicating greater primary care physician supply. The aggregate number of primary care physician counts increased during the four quarters evaluated from 38,114 to 39,068<sup>5</sup>. In no case did the population to primary physician provider ratio exceed commonly referred to benchmarks (Figure ES-2).

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<sup>4</sup> Sager, Alan, and Deborah Socolar, *Health Costs Absorb One-Quarter of Economic Growth, 2000–2005*, Data Brief No. 5, Boston University School of Public Health (Feb. 9, 2005); Eisenberg, John, "Physician Utilization The State of Research About Physicians' Practice Patterns," *Medical Care*, Vol. 40, No. 11 (2002).

<sup>5</sup> Although provider site counts are presented here, the unique count of providers did not materially differ. For example, the unique number of providers for the first quarter of 2011 totaled 39,856, while the unique count for the 4<sup>th</sup> quarter equaled 40,852.

**Figure ES-2; Primary Care Physicians; Population-to-Provider Site Ratio – 2011, 4<sup>th</sup> Quarter**

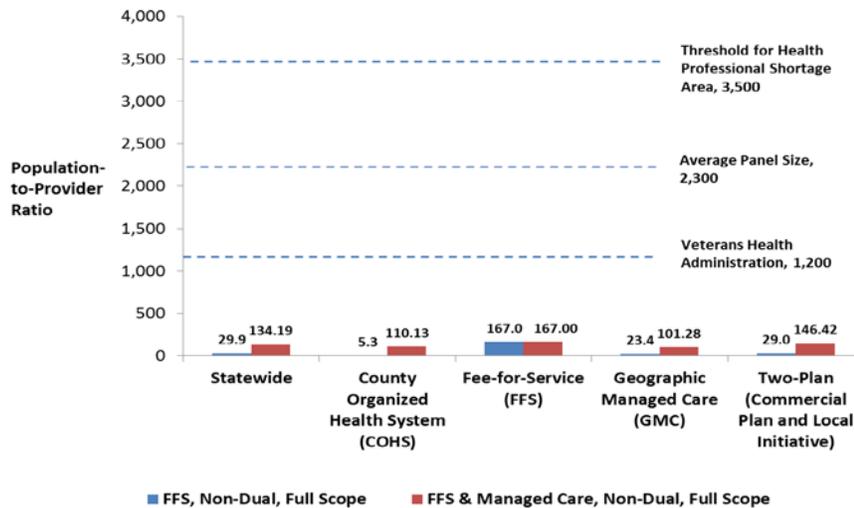


Figure ES-2 presents population to primary care physician site ratios for beneficiaries eligible for Medi-Cal only participating in FFS. The X-axis presents the Medi-Cal system or counties in which the FFS beneficiaries are participating. For example, "COHS" presents population to provider ratios for beneficiaries participating in Medi-Cal's FFS system in a COHS county.

- Based on the beneficiary population eligible for Medi-Cal only participating in FFS and a panel size of 2,100 patients, Medi-Cal would need a primary care physician supply totaling roughly 600. If the current Medi-Cal supply of 39,068 primary care physicians dedicated only 1.5% of their practice to Medi-Cal patients, the demand for services would be met. Certainly, this is overly simplistic but this provides some context for the size of the Medi-Cal potential provider capacity.
- The number of enrolled OB/GYN specialty physicians rose slightly during the four quarters measured. For non-elderly adult women eligible for Medi-Cal only participating in the FFS system and entitled to full scope services, the population to OB/GYN specialty physician site ratio declined from 135.2 to 115.3. Site ratios relative to all non-elderly adult women (includes those participating in FFS and managed care) decreased slightly from 271.9 to 268.4.
- The number of enrolled pediatric specialty physicians rose slightly during the four quarters measured. The ratio of population to pediatric specialty physician sites declined from 74.2 to 61.2 for children eligible for Medi-Cal only participating in the FFS system and entitled to full scope benefits. The reduction in the ratio indicates that pediatric specialty physician supply increased during this measurement period. Evaluating all children, including those enrolled in FFS and managed care delivery systems and entitled to full scope services disclosed that the site ratio decreased from 628.9 to 619.2, indicating greater overall supply.

- The numbers of physician groups, clinics and outpatient hospitals enrolled as active Medi-Cal providers was unchanged over the four quarters evaluated.

### *Service rates per 1000 member months for Adult Beneficiaries*

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

Evaluating FFS utilization across all Medi-Cal provider types was an integral element of the quarterly monitoring effort. DHCS grouped all provider types into nine unique service categories which included: (1) physicians and clinics, (2) emergency transportation, (3) non-emergency transportation, (4) home health, (5) hospital inpatient, (6) hospital outpatient, (7) nursing facility, (8) pharmacy, and (9) other. DHCS constructed control charts for each service category based on historical utilization patterns and established the mean value as well as upper and lower bounds. The rate of measurement represented the utilization rate per 1,000 beneficiaries. For example, physician and clinic services were measured in terms of visits per 1000 beneficiaries, while pharmacy services were measured in prescriptions per 1000 beneficiaries. In general, utilization rates found to be within the upper and lower bounds were considered within expected ranges.

- Service utilization for adults in various aid categories exhibited utilization rates that were generally within the expected ranges established during the baseline period (i.e., CY 2007 to 2009). Some service categories exhibited utilization levels that were consistently below the baseline average. Most notably, adults enrolled in each of the analyzed aid categories exhibited *Other* services utilization rates below the average baseline levels. This particular *shift* in utilization is most likely explained by fundamental changes implemented in the Medi-Cal program in July 2009, which eliminated several optional services from this category and subsequently made them unavailable to beneficiaries in CY 2011. In addition, adults in most of the aid categories, displayed utilization rates that were below the baseline average, but within the upper and lower ranges for Physician/Clinic, Home Health, and Inpatient Hospital services during CY 2011. As noted previously, these shifts in utilization are most likely due to the transformation of the Medi-Cal program from a FFS delivery system to a managed care delivery system. Beneficiaries who constitute the population eligible for Medi-Cal only and participating in the FFS system in CY quarter 4 are different from those who were participants in CYs 2007 through 2009, when the baseline was established.

- Service utilization rates for adults in the Families and Undocumented aid categories exhibited below average Physician/Clinic, Home Health, Emergency Transportation and Inpatient Hospital services utilization rates throughout CY 2011. Among younger adults (age < 65) in these aid categories, these service categories are generally associated with pregnancy-related care. For example, the most common reason for Hospital Inpatient use among Medi-Cal beneficiaries under age 65 is childbearing, while many beneficiaries in Families and Undocumented aid codes use Home Health services for postpartum and well-baby check-ups. In addition, Physician/Clinic services use among this subpopulation is likely attributable to prenatal and postpartum care visits. Declines in these service use categories may be the result of declining birth rates state-wide<sup>6</sup>, but further investigation is needed to definitively identify factors influencing these service use patterns.
- In addition to below average service use among adults in the Families and Undocumented aid categories, those in the Blind / Disabled aid category exhibited below average utilization of Home Health, Inpatient Hospital, and Other services during the study period. Adults in the Aged aid category displayed below average utilization of Physician / Clinic, Home Health, Pharmacy, and Other Services. Adults in both the Aged and Blind / Disabled aid categories displayed upward trends in Nursing Facility and Non-Emergency Medical Transportation services utilization that reached levels well above the expected range. Additionally, Aged adults exhibited upward trends in the use of Emergency Transportation and Inpatient Hospital Services. RASB hypothesizes that there may be several factors that likely influence these trends. For example, among adults in the Aged and Blind/Disabled aid categories, growing older and developing more serious medical conditions may have supplanted the need for outpatient care such as Physician/Clinic and Home Health services with more concentrated care including Inpatient Hospital and Nursing Facility services. In addition, these variances in service utilization may have potentially been influenced by shifts in adult enrollment trends occurring in CY 2011 which may have altered the case mix of the population. For instance, the average member months for adults in the Aged and Blind / Disabled aid categories decreased by 30,101 and 138,962 respectively in CY 2011. These large shifts in enrollment, from Medi-Cal's traditional FFS system to managed care delivery systems, are

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<sup>6</sup> <sup>6</sup> Data published on the California Department of Public Health website, found at <http://www.cdph.ca.gov/data/statistics/Documents/VSC-2010-0202.pdf>

associated with several Departmental initiatives that transitioned FFS beneficiaries into managed care plans.

The Department changed its policy regarding the enrollment of SPDs into managed care, from voluntary to mandatory enrollment. This means that SPD beneficiaries residing in Two-Plan and GMC counties are now required to enroll into managed care plans, unless a medical exemption is secured or a beneficiary is a member of a group that is exempted. This policy change resulted in a significant alteration in the case mix relative to Medi-Cal's traditional FFS system. All newly eligible SPDs, after July 2011, 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 receive a medical exemption or who were members of a group that was exempted from mandatory managed care enrollment. This influenced service use among those remaining in FFS. For example, the SPD beneficiaries remaining in FFS most likely represent beneficiaries who were medically compromised and suffering from severe chronic health conditions. In turn, they represented a group most likely to become LTC service utilizers. 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 time frame, 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 utilization 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 will be mandatorily enrolled into managed care plans. In most cases, this occurs within 45 days of becoming eligible for Medi-Cal. Therefore, these newly eligible SPDs will most likely not utilize home health services during their initial two-month FFS participation. These SPD beneficiaries will participate in Medi-Cal's FFS system for roughly two months and will most likely not utilize home health services.

During the study period evaluated, these enrollment 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 use 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 mostly likely

contributed to the utilization changes presented (i.e., the increase in LTC service utilization rate and decrease in home health utilization rate).

- Adults in the Families aid category exhibited upward trends in the use of Non-Emergency Medical Transportation and Nursing Facility services. These trends are difficult to interpret and would require additional studies to identify potential causes for these utilization shifts.

Table ES-1 presents the results of DHCS’ analysis of the utilization trends among adults by aid code and service category. Service utilization trends for children are examined in detail within the document, but have been excluded from this Executive Summary.

The table is color coded to identify those cases when a particular cell, which presents utilization by aid code and service category, generated a utilization rate that was either lower or higher than the established confidence level. Those cells highlighted in beige represent 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. In some the 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 ES-1; Summary of Service Utilization Trends Among Adults by Aid Category and Service Category**

<b>Aid Category</b>	<b>Physician / Clinic Visits</b>	<b>Non-Emergency Transportation</b>	<b>Emergency Medical Transportation</b>	<b>Home Health Services</b>	<b>Inpatient Hospital Services</b>	<b>Outpatient Hospital Services</b>	<b>Nursing Facility Services</b>	<b>Pharmacy Services</b>	<b>Other Services</b>
<b><i>Aged</i></b>	Within Expected Range	Above the Expected Range, Upward Trend (Jan-Dec)	Within Expected Range, Upward Trend (Jul-Dec).	Mostly Below the Expected Range	Mostly Within Expected Range, Upward Trend (Jul-Dec), but Below Average.	Within Expected Range	Mostly outside of Expected Range Upward Trend (Jun-Dec).	Within Expected Range	Mostly Within Expected Range, below baseline average.
<b><i>Blind / Disabled</i></b>	Within Expected Range	Above the Expected Range, Upward Trend (Jan-Dec).	Mostly Within Expected Range	Mostly Within the Expected Range	Mostly Within the Expected Range	Within Expected Range	Mostly Above Expected Range, Upward Trend (Jun-Dec)	Within Expected Range	Within Expected Range, below baseline average.

Aid Category	Physician / Clinic Visits	Non-Emergency Transportation	Emergency Medical Transportation	Home Health Services	Inpatient Hospital Services	Outpatient Hospital Services	Nursing Facility Services	Pharmacy Services	Other Services
<b>Families</b>	Within Expected Range	Above the Expected Range, Upward Trend,	Within Expected Range	Mostly Below the Expected Range	4 Consecutive Months Below Expected Range, Below Average	Mostly Within Expected Range, Downward Trend	Mostly within Expected Range, Upward Trend (Feb-Dec)	Within Expected Range	Mostly Within Expected Range, below baseline average.
<b>Other</b>	Within Expected Range	Above the Expected Range	Within Expected Range	Within Expected Range	Below Average with 3 Consecutive Months Below Expected Range	<i>Within Expected Range</i>	Mostly Within Expected Range, but Below Average	Within Expected Range	Within Expected Range, below baseline average.
<b>Undocumented</b>	4 Consecutive Months Below Expected Range, Below Average	N/A	Below the Expected Range	N/A	Below the Expected Range	Mostly Within the Expected Range	N/A	Within the Expected Range	Below the Expected Range

### *Beneficiary hotline calls*

The Medi-Cal beneficiary help line was implemented in December 2011, and is similar to the call center that addresses the needs of Medi-Cal managed care beneficiaries. Beneficiary calls to the FFS help line will capture data pertaining to difficulties in accessing care, and will provide data relating to healthcare access issues in the Medi-Cal FFS program. The rate with which Medi-Cal FFS beneficiaries contact the help line for information and complaints can offer one measure of how well the program is meeting the needs of its FFS beneficiaries and solving problems when they arise.

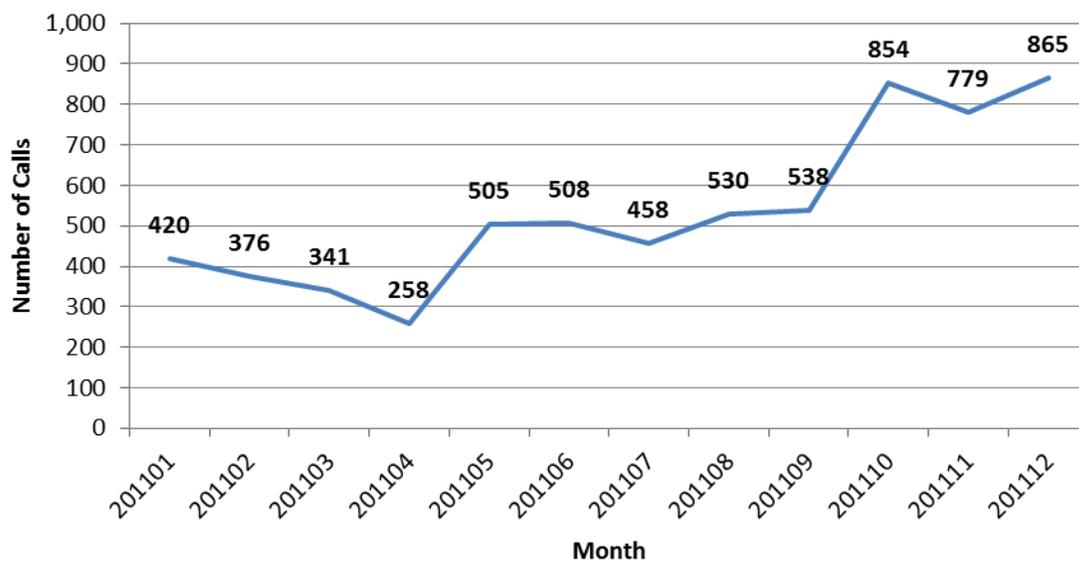
Data collected for this purpose will provide DHCS with the only source of “real time” data pertaining to health care access problems encountered by beneficiaries in the FFS delivery model, and will enable DHCS to identify and correct health care access problems soon after they arise.

Since the Medi-Cal FFS beneficiary call center did not begin receiving calls until December 2011, the data from this source could not be analyzed for this current quarterly report. Therefore, data for FFS beneficiaries calling into the Medi-Cal Managed Care Office of the Ombudsman were obtained for this purpose. Although the Ombudsman’s Office mainly handles calls from managed care beneficiaries, a large number of inquiries are received from FFS beneficiaries. Many of these FFS

beneficiaries may have been sent letters by the Department notifying them of program changes. The Office of the Ombudsman call center documented 6,432 calls from FFS beneficiaries during CY 2011. For each of these calls, the call center recorded the date and time of call, beneficiary aid code and county of residence, and reasons for the call. Data for these calls were summarized by month received, county, six aid code category groupings (Families, Blind/Disabled, Aged, Foster Care, Undocumented, and Other), and reason for call. Results of these analyses appear below.

- The figure below presents the trend in calls received from FFS beneficiaries during 2011 by month. Call volume doubled from the beginning of the year (420) to the end of the year (865). There was a slight decline in call volume in the first quarter of the year, followed by a significant increase in calls beginning in May. From May to September, there was a relatively steady volume of calls received and then a sharp increase in calls was observed beginning in October and continuing through the end of the year.

Figure ES-3; Calls received by FFS Beneficiaries by Month, CY 2011



Source. Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received by FFS beneficiaries during CY 2011.

The increase in call volume during May 2011 is likely due to the call center’s addition of five call operators to their current staff. The increase in staffing capacity enabled the call center to receive and handle more calls that were anticipated with the transition of SPDs into managed care plans. Under the terms of California’s Section 1115 “Bridge to Reform” waiver with the Federal government, SPDs were mandatorily enrolled in managed care plans. Beginning

in June 2011 and scheduled to continue through May 2012, the Department began the process of enrolling SPDs residing in Two-Plan and GMC counties into health plans. The addition of the five call center staff may have helped stabilize and maintain the call center's ability to handle more calls, which possibly explains the relatively steady call levels seen from May to September.

- A significant increase in call volume beginning in October coincides with the elimination of the Adult Day Health Care (ADHC) benefit scheduled for the end of 2011. In late August, beneficiaries received notices that the ADHC benefit would be eliminated. In Two-Plan and Geographic Managed Care counties, beneficiaries received an enrollment packet that informed them they would be enrolled into managed care on October 1<sup>st</sup>. Notices such as these contain the contact information of the Office of the Ombudsman for beneficiaries to obtain assistance and information. This may be one factor contributing to the significant increase in calls received by the Ombudsman call center beginning in October.
- The Ombudsman's Office received an increase in calls from FFS beneficiaries during the last three quarters of CY 2011. Call volume increased notably among beneficiaries in the Blind/Disabled aid categories and among beneficiaries in the Families aid codes. Some of this increase in call volume may be attributed to Departmental initiatives that transitioned the SPD population into managed care plans. A large proportion of calls that were received by the Ombudsman's Office from FFS beneficiaries were pertaining to Enrollment/Disenrollment issues; however, the data in most cases were too ambiguous to identify whether beneficiaries encountered healthcare access problems.

## Introduction

In 2011, the California Legislature passed, and the governor signed into law, assembly bill (AB) 97 that required the Department of Health Care Services (DHCS) to implement up to a 10% Medi-Cal provider payment reduction.<sup>7</sup> Prior to implementation, DHCS amended its Medicaid State Plan to incorporate the proposed provider rate reductions, and developed a monitoring system for its Medi-Cal Fee-for-Service (FFS) beneficiaries to assure that access to needed services would not be impaired. On October 27th, 2011, the Centers for Medicare & Medicaid Services (CMS), the federal agency which oversees State Medicaid programs, approved California's State Plan Amendment (SPA) and healthcare access monitoring system.

The healthcare access monitoring system developed by DHCS incorporates long-standing and widely accepted methods for measuring and evaluating healthcare access as reported in the literature, and includes healthcare access and quality monitoring recommendations described by national agencies and expert workgroups.<sup>8</sup> The Department's framework for monitoring healthcare access incorporates the idea that access is the act of linking a population to needed and appropriate healthcare services, and that monitoring access to healthcare services requires the identification of various factors inhibiting access.<sup>9</sup> The healthcare access monitoring system that DHCS developed emphasizes four key areas:

1. the unique characteristics and healthcare needs of Medi-Cal enrollees;
2. the availability of Medi-Cal providers;
3. the appropriate utilization of healthcare services by Medi-Cal beneficiaries; and
4. resulting health outcomes.

The Department selected 23 measures identified in each of these four key areas. Combined, these access measures provide a multidimensional portrayal of healthcare access in the Medi-Cal program, while taking into account the limitations of readily available data sources. DHCS will report on all 23 measures annually, but has identified a subset of early warning measures or

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<sup>7</sup> Addressed in AB 97 are all services except contract acute hospital inpatient services, critical access hospitals, federal rural referral centers, federally qualified health centers (FQHCs), rural health clinics (RHCs), services provided through the Breast and Cervical Cancer Treatment and Family PACT programs, hospice services, facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services, and federal payments generated by certified public expenditures and intergovernmental transfers. operated by the State Department of Mental Health or the State Department of Developmental Services, and federal payments generated by certified public expenditures and intergovernmental transfers.

<sup>8</sup> Among the authoritative bodies consulted were the Institute of Medicine, the Agency for Health Care Research and Quality, and the Medicaid and CHIP Payment and Access Commission (MACPAC), a federal commission established by Congress to study and make recommendations on beneficiary access to care in the Medicaid and Children's Health Insurance Program (CHIP).

<sup>9</sup> The Department's healthcare access monitoring framework is discussed in detail in the following document, "Monitoring Access to Medi-Cal Covered Health Care Services," located at [www.dhcs.ca.gov/Documents/Rate%20Reductions/CA%20-%20Developing%20a%20Healthcare%20Access%20Monitoring%20System%20092811.pdf](http://www.dhcs.ca.gov/Documents/Rate%20Reductions/CA%20-%20Developing%20a%20Healthcare%20Access%20Monitoring%20System%20092811.pdf)

signals<sup>10</sup> for identifying potential healthcare access problems. These early warning measures, which will be reported quarterly, encompass the following:

- Change in Medi-Cal enrollment
- Population to provider ratios
- Service rates per 1000 member months
- Beneficiary hotline calls

When considered together, these four early warning measures are designed to provide the Department with an analytic tool that has the potential to detect, if and when, Medi-Cal beneficiaries are experiencing barriers to accessing medically necessary healthcare services. The report that follows is the Department's first Quarterly Healthcare Access Report for beneficiaries receiving care through Medi-Cal's traditional FFS delivery model.

### **Medi-Cal Population for Whom These Access Monitoring Activities Are Intended**

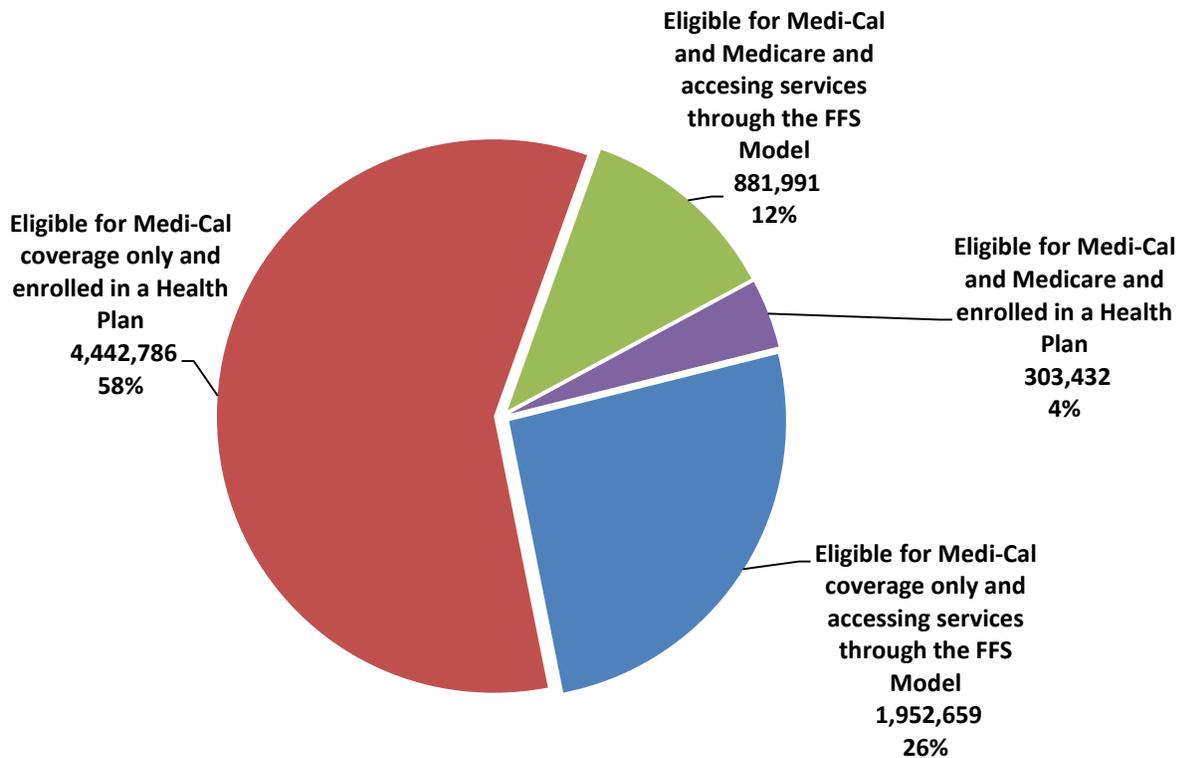
The Department's quarterly monitoring effort is designed to evaluate health care access among beneficiaries participating in Medi-Cal's FFS system. Beneficiaries enrolled in managed care delivery systems are excluded from this analysis. On January 1, 2012 there were 7,559,147 certified eligibles<sup>11</sup> enrolled in the Medi-Cal program, of whom nearly 63% were enrolled in Medi-Cal managed care health plans and the remaining 37% received care through the traditional FFS delivery of care model. For beneficiaries enrolled in Medi-Cal managed care plans, the Department's Medi-Cal Managed Care Division monitors access and enforces contractual requirements designed to ensure that enrolled beneficiaries receive timely and medically necessary care. DHCS is also responsible for ensuring healthcare access to individuals who are disenrolled from managed care health plans or for some reason remain outside the reach of Medi-Cal health plan enrollment. These beneficiaries are generally those who have been exempted from managed care enrollment or who are newly eligible for Medi-Cal and spend the first 60 days or so in the FFS system.

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<sup>10</sup> Bindman, A.B., & Smith, V. (2010). *MACPAC: Developing a Framework for an Early Warning System (EWS) on Access. Medicaid and CHIP Payment and Access Commission* URL: [http://www.macpac.gov/home/meetings/2010\\_12](http://www.macpac.gov/home/meetings/2010_12)

<sup>11</sup> The term *certified eligible* includes beneficiaries who have been determined eligible for Medi-Cal based on a valid eligibility determination. *Certified Eligibles* do not include beneficiaries who may be eligible to enroll in the Program, but have not enrolled. In addition, the definition used here only includes beneficiaries who are eligible to receive Medi-Cal covered health care services during the month. This means that beneficiaries with a SOC obligation, but who have not met their monthly SOC obligation are not included in these counts. And finally, specific populations, such as California's Family PACT<sup>11</sup> and Presumptive eligibles<sup>11</sup>, are also not included in the *certified eligible* counts.

**Figure 1 Distribution of Medi-Cal Beneficiaries by Delivery of Care Model and Coverage Type; as of January 1, 2012.**



**Source:** Prepared by DHCS Research and Analytic Studies Branch using data from the MEDS System MMEF files, January 2012.

### **Benefits of a Systematic Approach to Healthcare Access Monitoring**

Monitoring healthcare access provides DHCS administrators with a better understanding of whether there are sufficient Medi-Cal providers available to beneficiaries, and whether or not beneficiaries appropriately use and receive high-quality and efficient care. Evaluating healthcare access can also assist DHCS in determining whether Medi-Cal FFS programs are positively affecting beneficiaries' health outcomes. For example, studies have shown that people who live in communities with high levels of primary care physician supply tend to have lower mortality rates, longer life expectancy, and better birth outcomes. Other studies acknowledge that people who have a usual source of healthcare are more likely to gain access to routine primary care and preventive services, which reduces disease complications, and lowers morbidity and mortality.

## The Medi-Cal Access Monitoring Framework

DHCS developed a healthcare access monitoring framework which adapts the work of several sources, including work from the MACPAC<sup>12</sup> report to congress, Agency for Healthcare Research and Quality Safety Net Monitoring Initiative, and published works of health services researchers including Andersen.<sup>13</sup> The framework, depicted in **Figure 2**, incorporates the idea that “access” is the act of linking a population to needed and appropriate healthcare services. When beneficiaries successfully navigate the system or overcome access barriers, then appropriate and timely healthcare services are used, and positive health outcomes follow.

*Predisposing Characteristics of the Population:* Predisposing characteristics such as age, gender, race/ethnicity, primary language spoken, and disability status often drive the need for healthcare services. For example, a population comprised of women of reproductive age places demand on obstetric and gynecological services, while a population of older adults places demand on a different set of services such as those to manage chronic conditions. Individual health beliefs and attitudes are also believed to contribute to a person’s propensity for health care utilization.

*Need:* Need refers to how individuals perceive that their condition demands medical care, whether they think such care is of value, and the extent to which a health care professional believes an individual needs care.

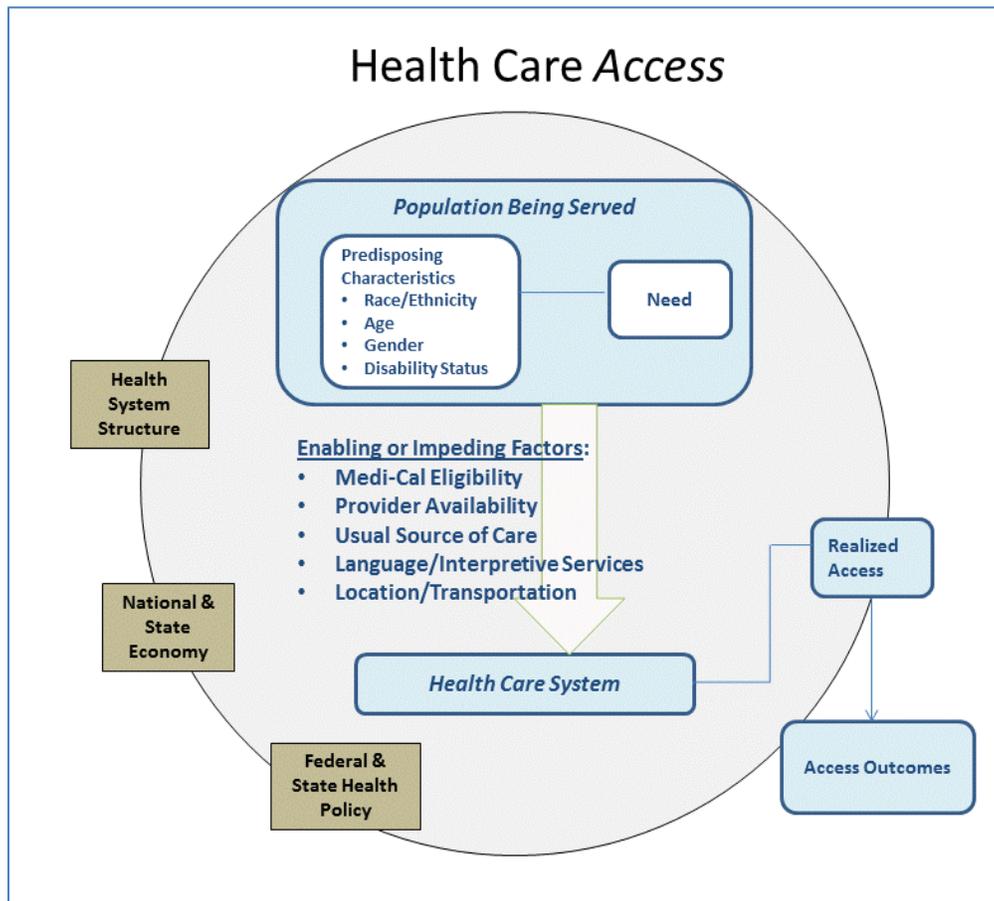
*Enabling or Impeding Factors:* Many factors, including national and state economic and political influences, financial, as well as health system factors, can impact access to healthcare services. In the process of obtaining services, beneficiaries may encounter many enabling or impeding factors along the pathway to realized access, such as inadequate provider networks, the burden of long transportation times and out-of-pocket expenses, availability of interpretive services, geographic location of services and lack of accommodations for physically disabled beneficiaries.

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<sup>12</sup> MACPAC’s Report to Congress<sup>12</sup> contains recommendations derived from reviewing over 30 years of health services literature, and parallels healthcare access strategies proposed by the Institute of Medicine, the Agency for Healthcare Research and Quality, and other national health organizations. These strategies include many elements of the Andersen Behavioral Model of Health Service Use.<sup>12</sup> Andersen’s model has been used widely in the health administration and health services research fields to explain utilization of health services. The original model postulates that people’s use of health services was a function of their predisposing characteristics, the resources that enabled or impeded their use of services, and their need for care.

<sup>13</sup> The Andersen Behavioral Model of Health Service Use has been used widely in the health administration and health services research fields to explain utilization of health services. The original model postulates that people’s use of health services was a function of their predisposing characteristics, the resources that enabled or impeded their use of services, and their need for care.

**Figure 2 Medi-Cal Access Monitoring Model**



**Source:** Adapted from Anderson and Davidson, *Improving Access to Care in America*, in *Changing the U.S. Health Care System: Key Issues in Health Services Policy and Management*, 3rd edition, 2007 .

**Realized Access:** The Department will use data pertaining to health encounters, claims, etc. to serve as outputs or evidence that healthcare access was realized. Examples of realized access identified through administrative data include claims reflecting physician visits, dental visits, emergency room visits, hospital inpatient stays, and other healthcare services. Realized access also includes data reflecting a beneficiary’s experience with the Medi-Cal system. For example, information on healthcare experiences may include whether beneficiaries experienced delays in obtaining healthcare services, whether beneficiaries had problems obtaining appointments with specialists, or how satisfied beneficiaries are with their providers. The Department has recently implemented a call center to help beneficiaries navigate the system and to field complaints and address healthcare access problems. Data obtained from this call center will provide the Department with information regarding beneficiaries who are experiencing problems accessing healthcare services, and reasons for these access difficulties.

*Access Outcomes:* Outcomes refer to the effectiveness of appropriate and timely use of healthcare services. When Medi-Cal beneficiaries successfully participate in the healthcare system and receive services that are most appropriate for their particular healthcare needs, the best possible health outcomes are achieved. The Department will monitor health outcomes as an indication of successful healthcare access, using indicators such as positive birth outcomes (low proportions of preterm and low birth weight deliveries), and rates of preventable hospitalizations. These health outcomes will be reported in the Department’s annual access report.

The framework developed by DHCS provides the necessary basis for examining a myriad of issues that may impact healthcare access in the Medi-Cal program.<sup>14</sup> DHCS has created the current report, and will evaluate access and any deficiencies in access to healthcare services in light of this framework.

### **Principles of the Medi-Cal Access Monitoring System**

The Department’s access monitoring system is modeled after a public health surveillance system. The Centers for Disease Control and Prevention (CDC) define a public health surveillance system as “the ongoing and systematic collection, analysis, and interpretation of data for use in the planning, implementation, and evaluation of public health practice.”<sup>15</sup> By this definition, a surveillance system includes the capacity for data collection and analysis, as well as the timely dissemination of information to persons or groups who can take effective actions to prevent or control factors that have a harmful effect on a population’s health.

The Department will continuously monitor healthcare access for its FFS beneficiaries through the reporting of a subset of access measures on a quarterly basis, and will disseminate this information throughout the Department to expert Program staff. The Department will use the quarterly access monitoring report as a tool to identify whether a change has occurred in light of past data reporting.

These quarterly access monitoring efforts have been designed to achieve the best portrayal of healthcare access, while considering cost-efficiency and the availability of data. Data collected and analyzed for the Department’s quarterly healthcare access monitoring efforts may potentially identify significant shifts in enrollment or service utilization trends, but may not identify small changes in access to healthcare services. Systems or tools designed to detect deviations in processes, volume, output, etc., are all designed to specific sensitivity thresholds. Systems designed to detect even the slightest deviation—even immaterial or insignificant deviations—would not be cost effective in most circumstances. Therefore, most systems designed for these endeavors must balance cost and sensitivity. The system should identify meaningful deviations in a cost effective manner, with the understanding that some sensitivity must be sacrificed. In addition to cost, a system that identifies insignificant deviations time-

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<sup>14</sup> For details of the Department’s healthcare access monitoring framework, see Monitoring Access to Medi-Cal Covered Health Care Services at [www.dhcs.ca.gov/Documents/Rate%20Reductions/CA%20-%20Developing%20a%20Healthcare%20Access%20Monitoring%20System%20092811.pdf](http://www.dhcs.ca.gov/Documents/Rate%20Reductions/CA%20-%20Developing%20a%20Healthcare%20Access%20Monitoring%20System%20092811.pdf)

<sup>15</sup> Thacker SB, Berkelman RL. Public health surveillance in the United States. *Epidemiol Rev.* 1988;10:164–190.

after-time, or false positives, will also create Program disruption and lead to confusion for all stakeholders.

### **Limitations of the Medi-Cal Early Warning System**

The Department's quarterly healthcare access monitoring reports primarily consist of data points covering the most current quarter, as well as the last three previous quarters to allow for comparisons over time. Administrative data is the primary source used for calculating population-to-provider ratios, enrollment, and service utilization trends. Administrative claims data sources used to capture use of program services are considered "complete" when a 12-month time period has elapsed between the date-of-service and date-of-payment. Similarly, to ensure the most complete eligibility data set, a sufficient time lag must be achieved, generally 12-months. There are two primary reasons to allow for this 12-month lag in the reporting of administrative data.

With regards to enrollment, changes and updates to the enrollment records for a specific month may be made subsequent to that month, reflecting the addition of beneficiaries with retroactive eligibility, as well as other changes to the enrollment record as information is updated at the county level. Beneficiaries usually are eligible for Medi-Cal before services are used. However, a significant percent of all beneficiaries become eligible retroactively, after medical costs are incurred.<sup>16</sup> The effect is a significant growth in eligibility counts after a given month of eligibility. And, while providers have a strong incentive to submit claims data in order to receive reimbursement for services, these claims are not always submitted timely or may undergo a lengthy adjudication process (see Appendix A). For example, though 99% of all pharmacy claims are processed and paid within four months of the date of service, only 82% of non-emergency medical transportation claims are complete within the same time period.

In order to continuously monitor health care access for its beneficiaries, the Department opted to examine program enrollment and service use data on a quarterly basis, creating analytic data files with a 4-month lag. This shortened lag period was chosen to allow the Department to balance data completeness with timeliness.

In addition to the limitations in data noted above, there are several important initiatives being undertaken by the Department that may complicate the interpretation of data trends in this report. For example, the Department has embarked on two major initiatives that will significantly decrease the number of beneficiaries receiving services in the Medi-Cal FFS program: 1) the transition of counties that have primarily delivered Medi-Cal services through a FFS model to that of a managed care delivery model; and 2) the move of beneficiaries enrolled in one of 23 distinct aged, blind and disabled aid codes (a subpopulation know as Seniors and Persons with Disabilities, or SPDs) into managed care health plans. Initiatives such as these will

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<sup>16</sup> Medi-Cal eligibility begins on the first day of the month of the application date provided the eligibility criterion is met. If the criterion is not met during the month of application, eligibility begins on the first day of the subsequent month that the eligibility criterion is met. (22 CCR 50193 Beginning Date of Eligibility). Also retroactive eligibility may start up to 3 months prior to the month of application or reapplication if an individual is otherwise eligible during the retroactive period (22 CCR 50197 Retroactive Eligibility). After an application or restoration has been approved, Medi-Cal eligibility is redetermined at least once every 12 months (22 CCR 50189 Redetermination – Frequency and Process).

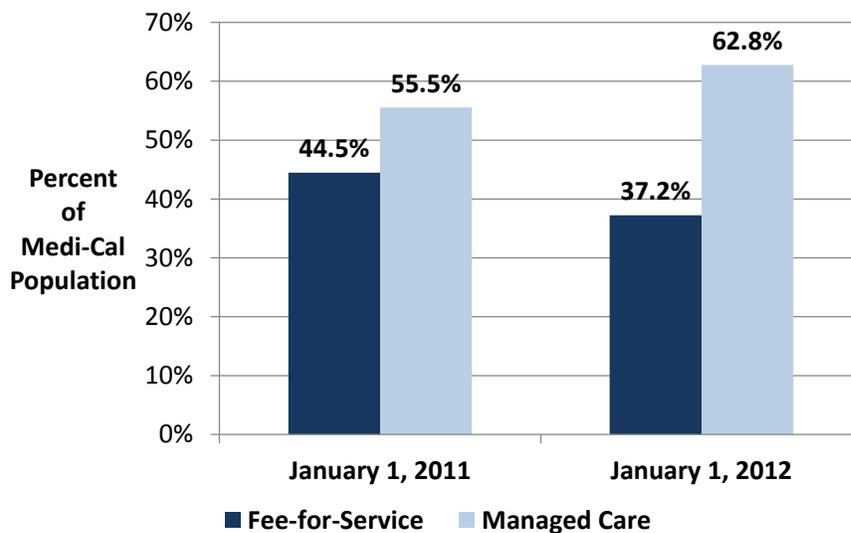
have a large impact on the enrollment trends reported here, and may likely influence service utilization rates as the case mix within the FFS system is altered.

## Summary of Major Changes to Medi-Cal's Health Care Delivery System

The Medi-Cal program has steadily transformed its health care delivery system from a traditional FFS system to managed care. On January 1, 2011, there were 7,559,147 certified eligible beneficiaries enrolled in the Medi-Cal program. Roughly 4.7 million, or 62.8%, of these beneficiaries were enrolled in Medi-Cal managed care health plans, while 2.8 million, or 37.2%, received care under Medi-Cal's traditional FFS delivery of care model (Figure 3).

Overall there was a net shift of 575,694 beneficiaries, or 7.3% of the Medi-Cal population, from the FFS to the managed care delivery of care model, between January 2011 and January 2012.

**Figure 3 Change in Distribution of Beneficiaries by Delivery of Care Model from January 2011 to January 2012**



Source: Medi-Cal Enrollment Files

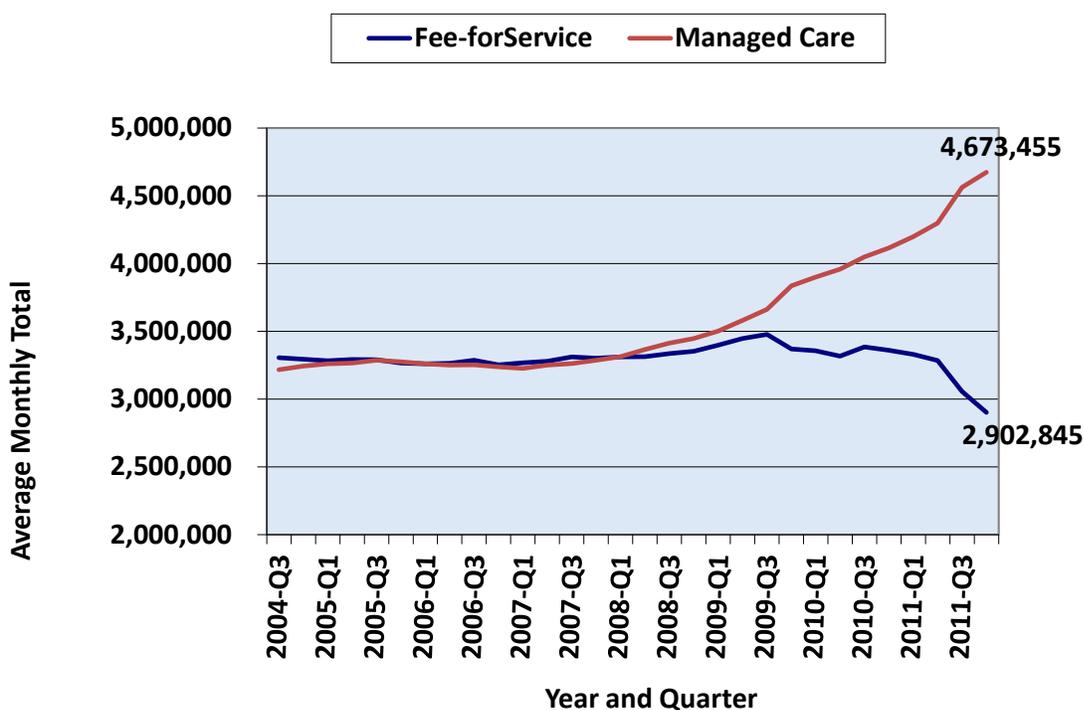
A notable trend in Medi-Cal enrollment has been the expansion of the managed care delivery model to greater numbers of Medi-Cal beneficiaries. The Medi-Cal Managed Care program has developed over the years to include three different county plan model types: the County Organized Health Care System (COHS), the Two-Plan Model (Commercial and Local Initiative), and Geographic Managed Care (GMC)<sup>17</sup>. By 2004, the Medi-Cal program had expanded its use

<sup>17</sup> The two-plan model is the newest of California's Medi-Cal managed care models. In use since 1996, it was developed to provide some protection for traditional providers while also encouraging broader provider participation in the Medi-Cal program. Under the two-plan model, Medi-Cal beneficiaries can enroll in either a local initiative plan—a county-operated or community-based entity that is required to contract with traditional providers—or a

of managed care to provide services to roughly 3.25 million, or half of the beneficiaries enrolled in the Medi-Cal program. The distribution of beneficiaries enrolled in FFS and managed care between 2004 and 2007 remained constant, at a roughly fifty-fifty split.

However, in 2008 a surge in managed care enrollment began (Figure 4). This rapid growth of beneficiaries enrolled in the managed care model reflects two developments. First, the majority of new beneficiaries enrolled in Medi-Cal after 2007 due to the economic downturn qualified for coverage under “Family” aid categories. These aid categories required mandatory enrollment in managed care health plans in all managed care counties. Second, rising managed care enrollment also reflected the transition of additional counties from the FFS to the managed care model (Table 1).

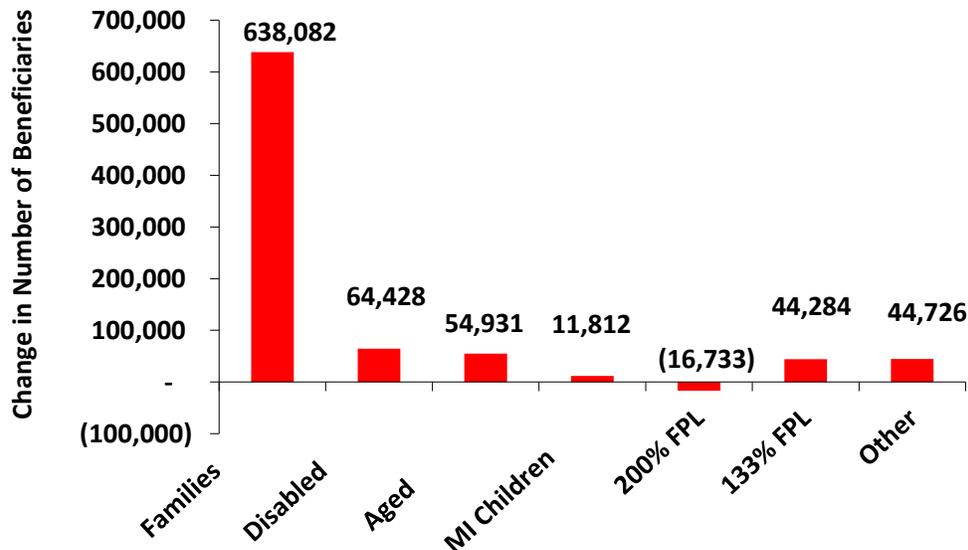
**Figure 4 Trend in Enrollment July 2003 – January 2011; Average Monthly Eligibles by Health Plan Enrollment Status**



Source: Medi-Cal Enrollment Files

commercial plan. In the GMC model, the state contracts with multiple commercial health plans on a capitated basis to provide services within a designated geographic area. It was first implemented by Sacramento County in 1994, followed by San Diego County in 1998. Currently, these are the only two counties using the GMC model. In Sacramento County, the state contracts with six plans; in San Diego County, it contracts with seven. (“Managed Care and Low-Income Populations: A Case Study of Managed Care in California” Henry J. Kaiser Foundation, December 1999),

**Figure 5 Change in Number of Beneficiaries By Aid Category; from the First Quarter of 2007 to Fourth Quarter of 2010.**



Source:

Medi-Cal Budget estimate

As noted, there was a net shift of 575,694 beneficiaries, or 7.3% of the Medi-Cal population, from the traditional FFS to the managed care delivery of care model, between January 2011 and January 2012 (Chart 1). Two initiatives are primarily responsible for this shift. Under the terms of California’s Section 1115 “Bridge to Reform” waiver, the managed care enrollment requirement for beneficiaries in aid codes for “Seniors and Persons with Disabilities” (SPDs) was transformed from “voluntary” to “mandatory<sup>18</sup>.” In June 2011 the department began the process of enrolling SPDs residing in Two-Plan and GMC counties into health plans over the course of twelve scheduled monthly increments. In the month prior to mandatory enrollment (i.e., May 2011), there were approximately 394,582 SPD beneficiaries enrolled in Medi-Cal’s traditional FFS system in Two-Plan and GMC counties.

Also in 2011, Ventura, Marin and Mendocino counties shifted Medi-Cal populations from the FFS delivery system to the County Organized Health System (COHS) managed care model, moving an additional 140,944 beneficiaries from the FFS model into health plans. (See [Table 1](#)).

<sup>18</sup> See Special Terms and Conditions (STCs) for California’s Bridge to Reform section 1115(a) Medicaid Demonstration, 77. Mandatory Enrollment of SPDs. URL: <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CA%20Special%20Terms%20%20Conditions.pdf>

**Table 1 Transition of Counties and Groups from the Fee-for-Service to the Managed Care Model**

County or Group	Plan Model Type	Implementation Date	Estimated Total Annual Member Months	Average Monthly Eligibles
San Luis Obispo	COHS	Mar 1, 2008	206,224	<b>25,778</b>
Working Disabled	Mixed	July 1, 2009	136,583	<b>11,382</b>
Sonoma	COHS	Oct. 1, 2009	529,872	<b>44,156</b>
Merced	COHS	Oct. 1, 2009	767,364	<b>63,947</b>
Kings	Two-Plan	Oct. 1, 2010	286,768	<b>23,897</b>
Madera	Two-Plan	Oct. 1, 2010	333,975	<b>27,831</b>
Seniors and Persons with Disabilities (Not Medicare Eligible)	Two-Plan, GMC	June 2011 – May 2012	4,734,984	<b>394,582</b>
Ventura	COHS	July 1, 2011	1,193,784	<b>99,482</b>
Mendocino	COHS	July 1,, 2011	257,040	<b>21,420</b>
Marin	COHS	July 1 2011	195,984	<b>16,332</b>

## Medi-Cal Physician Supply

### Introduction

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

Evaluating provider supply is designed to provide decision makers with a sense of whether Medi-Cal’s network of providers 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 providers combined with other information may provide insight into various aspects of health care access. Long term trends may help decision makers evaluate policy that may be inhibiting provider supply. Provider supply provides a measure of the number of providers who are “potential” care providers, but does not represent the number of providers who are actively rendering care.

The Population-to-Provider ratios report the number of beneficiaries enrolled under the FFS delivery of care model with Medi-Cal coverage only for every provider. A low ratio indicates that there is a greater number of providers relative to the population, while a high ratio indicates that there are fewer providers relative to the population. Population-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.

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

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

### Approaches for Measuring Provider Supply

There are three complementary methodologies available for evaluating the adequacy of provider supply. These include relative benchmarking, normative benchmarking and economic analysis of the physician labor market.<sup>19</sup> Relative benchmarking compares the ratio of certain types of providers to the population in the geographic area of interest to other geographic areas.

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

A variation of the normative benchmark is physician “panel” size. Panel size is simply defined as the number of individual patients under the care of a specific provider--the number of patients for which each provider can realistically be accountable. While the maximum panel size is typically defined as 2,000-2,500 patients per provider, there are limitations to using panel size as a normative benchmark. For example, some physicians may have other physicians or physician extenders (Physician Assistants and Nurse Practitioners) available at their location,

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<sup>13</sup> Janet Coffman, Brian Quinn, Timothy T. Brown, Richard Scheffler, “Is There a Doctor in the House? An Examination of the Physician Workforce in California over the Past 25 Years”, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare at the University of California, Berkeley 2004

giving them the potential to manage a larger panel size. On the other hand, the physicians who are at the location may not be full-time-equivalent (FTE) clinical providers, but may devote a portion of their time spent on non-appointment or nonclinical duties such as hospital rounds, operating room duties, procedures, management duties and meeting time. Another consideration in determining panel size is the health status of patients seen by the physician. A panel of 2,000 elderly patients represents a much different workload than 2,000 patients in their 20s and 30s. Patients who suffer from complex health conditions and multiple comorbidities may garner greater resources.

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

The third approach towards evaluating provider supply adequacy is through analysis of the provider “market,” and the impact of reimbursement rates and compensation, as various health care organizations compete for the limited supply of physician services by offering higher payments. However, as our previous discussion on participation by different types of providers illustrates, not all share the same sensitivity, or elasticity to price. Some physicians are able to accommodate a greater number of Medi-Cal beneficiaries as a percentage of their overall practice than others. “Although high fee levels increase the probability that individual physicians will accept Medicaid patients, high fee levels do not necessarily lead to high levels of physician Medicaid acceptance in an area. Numerous other physician practice, health system, and community characteristics also affect Medicaid acceptance. The effects of Medicaid fees on Medicaid acceptance are substantially lower in areas with high Medicaid managed care penetration and for physicians who practice in institutional settings. The results suggest that a broad range of factors need to be considered to increase access to physicians for Medicaid enrollees.”<sup>20</sup>

Many provider market analyses seek to build in estimates based on future events to determine whether provider shortages may occur in the years ahead. These analyses look at such variables as the number of medical school graduates choosing specialty medicine over primary care, the attractiveness of medicine as a profession and number of future physicians overall, the aging of the population that will need to access services, and the growth of the economy<sup>21</sup>. The impact of the Affordable Care Act and the resulting expansion of the population with health care coverage is a recent addition to this list.

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<sup>20</sup> Peter J. Cunningham, Len M. Nichols, “The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective”, Center for Studying Health System Change, December 2005.

<sup>21</sup> David Blumenthal, “New Steam from an Old Cauldron — The Physician-Supply Debate”, New England Journal of Medicine, April 22, 2004

## Methods

### Primary Care Provider Enrollment Status

The numbers of physicians reported and reflected in the population-to-provider ratios are those physicians who have gone through the Medi-Cal provider application and enrollment process<sup>22</sup> and who have a current “Active” (Billing) or “Indirect” (Rendering) enrollment status for the period reported.

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 provider’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. The 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<sup>23,24</sup>.

### Data Source

The Medi-Cal Provider Master Enrollment File (PMF) was used as the primary data source for measuring provider supply. Quarterly counts are presented, based on the 1st month of each quarter, except for the third quarter of 2011, where August 2011 data was substituted for July 2011 data, which was unavailable. Only physicians enrolled and coded with a valid California county were included. The PMF presents providers in one of nine 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 providers that have a current “Active” (Billing) or “Indirect” (Rendering) enrollment status for the period reported

### How are Physicians Counted?

There are various ways to count providers, each of which produces dramatically different totals. Providers can be counted as (1) the number of distinct individuals or billing organizations, (2) as the number of individuals or organizations at distinct service locations, or (3) as the number of individuals or organizations at distinct service locations providing specific categories of service. For example, it is not unusual for a single hospital organization to have multiple locations, and at some of those locations provide multiple categories of services (e.g. inpatient, outpatient, clinic, dialysis, rehabilitation, etc.).

For the purpose of evaluating beneficiary access to care using provider-to-population ratios, the last method is most appropriate, since geographic accessibility and appropriateness of care are two major elements of access. The reporting unit for providers in this report is the unique combination of the provider ID, location identifier, and provider type. For individual

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<sup>22</sup> “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](https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/05enrollment_regulations.pdf)

<sup>23</sup> “Medi-Cal Provider Enrollment, Frequently asked Questions”: URL: <http://www.dhcs.ca.gov/provgovpart/Pages/PEDFrequentlyAskedQuestions.aspx>

<sup>24</sup> Medi-Cal provider Agreement; URL: [http://files.medi-cal.ca.gov/pubsdoco/provappsenroll/02enrollment\\_DHCS6208.pdf](http://files.medi-cal.ca.gov/pubsdoco/provappsenroll/02enrollment_DHCS6208.pdf)

physicians, the provider ID number is their license number as reported to the Medical Board of California. All other providers, including physician groups, are traced back to their original provider number, usually to one that pre-dates the onset of the National Provider ID (NPI).

This method is necessary in order to avoid double-counting providers who have successfully applied for multiple NPI's, a common occurrence that has a cumulative effect over time. However, it has the adverse effect of potentially undercounting a few truly distinct providers with distinct NPI's that have the same original provider number but no other way to confirm their distinctness. For example, a provider who has moved out of a group of nurse practitioners may be traced back to be associated with its original provider number, and thereby not counted separately. The net effect is a slight undercount of non-physician providers. Fortunately, this inaccuracy does not apply to counting physicians since their license numbers are not traced back to an original provider number.

### **Calculation of the Denominator**

The denominator for the population-to-physician 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 denominator 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 population-to-provider ratios between different counties or different periods of measurement. For this reason, both the number of physicians and the ratios are displayed. During calendar year 2011, the measurement year for the reports which follow, there was a significant shift of beneficiaries participating in the FFS system to the managed care system. In certain counties, the sharp decrease in beneficiaries participating in the FFS system was responsible for the sudden change in the population-to-physician ratios from one quarter to the next. To help the reader understand the impact of these changes, tables were prepared that present the population-to-physician ratios, for both FFS- and managed care-participating beneficiaries combined. These tables are provided for comparison purposes only, since network adequacy for beneficiaries enrolled in managed care health plans is governed by separate statutory and contractual requirements and enforced and monitored by Medi-Cal's Managed Care Division.

### **Results – Physician Supply**

The following tables report the number of physicians, primary care physicians, and other primary care providers, as well as the ratio of beneficiaries (population) to physician and provider. The tables span four consecutive quarters during calendar year 2011 and indicate the magnitude of change over this period.

**Table 2 Summary and Description of Physician Supply tables**

Tables	Denominator	Numerator	
		Tables 4,6,8, 10, and 12	Tables 3,5,7,9, and 11
3 & 4	All Enrolled Physicians with an Active or Indirect status. Include both Primary Care and Specialty physicians	Eligibles entitled to full scope services, covered by Medi-Cal Only, and participating in Fee-f0r-Service.	Eligibles entitled to full scope services, covered by Medi-Cal Only, and participating in either Fee-f0r-Service or Managed Care.
5 & 6	All Enrolled <b>Primary Care</b> Physicians with an Active or Indirect status	Eligibles entitled to full scope services, covered by Medi-Cal Only, and participating in Fee-f0r-Service.	Eligibles entitled to full scope services, covered by Medi-Cal Only, and participating in either Fee-f0r-Service or Managed Care.
7 & 8	All Physicians with an <b>OB/GYN</b> Specialty and an Active or Indirect status	<b>Non-elderly, adult women</b> , covered by Medi-Cal Only, and participating in Fee-f0r-Service.	<b>Non-elderly, adult women</b> , covered by Medi-Cal Only, and participating in either Fee-f0r-Service or Managed Care.
9 & 10	All Physicians with an <b>Pediatrics</b> Specialty and an Active or Indirect status	<b>Children</b> entitled to full scope services, covered by Medi-Cal Only, and participating in Fee-f0r-Service.	<b>Children</b> entitled to full scope services, covered by Medi-Cal Only, and participating in either Fee-f0r-Service or Managed Care.
11 & 12	All <b>settings of care</b> where physicians provide services. These include Physician and Physician group offices, clinics and Outpatient Hospitals.  The total number of <b>indirect (rendering) physicians</b> providing services in any of these settings is reported separately	Eligibles entitled to full scope services, covered by Medi-Cal Only, and participating in Fee-f0r-Service.	Eligibles entitled to full scope services, covered by Medi-Cal Only, and participating in either Fee-f0r-Service or Managed Care.

The DHCS calculated provider supply counts and population-to-provider ratios, both by county and by plan model type, in order to detect changes over the four quarters of 2011 and to discern differences between counties and between plan model types. [Plan model](#) type is determined by county of enrollment.

As summarized above, the first eight tables presented below display population to provider ratios. Four tables present population to provider ratios for beneficiaries eligible for Medi-Cal only and participating in the FFS system, while another four tables present population to provider ratios for beneficiaries eligible for Medi-Cal only and participating in both FFS and managed care systems of care. DHCS also aggregated the count of providers and provided ratios for each of the four county plan model types utilized by Medi-Cal. Differences in the ratios for the four models reflected differences in both beneficiaries and providers. The COHS counties,

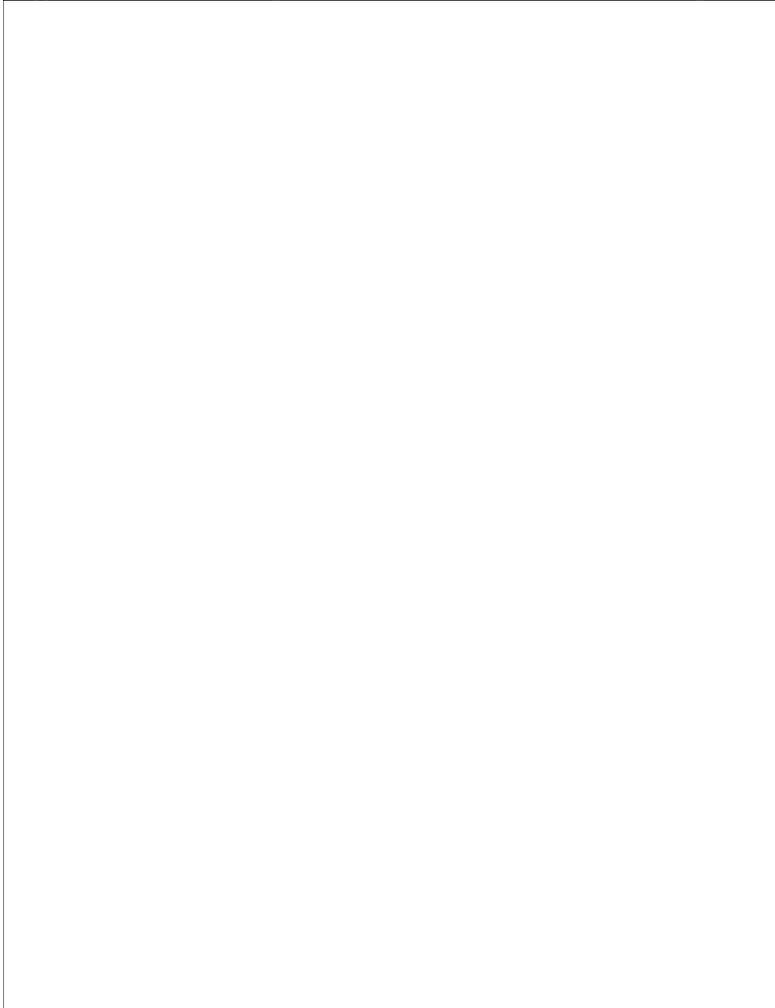
where health plan enrollment is mandatory for all beneficiaries but the undocumented, had the smallest FFS populations and therefore the lowest ratios of FFS population-to-provider ratios. The Two Plan and GMC counties that include both managed care and FFS populations, had higher ratios of FFS population-to-provider, and the 28 primarily rural counties utilizing the FFS model had the highest ratios of population-to-providers.

However, the higher population-to-provider ratios in the 28 primarily rural FFS counties appeared to not only reflect a greater number of beneficiaries relative to providers, but also fewer providers overall. When DHCS measured the number of providers relative to beneficiaries enrolled in both managed care and FFS, the population-to-provider ratio in the FFS counties remained significantly higher than in the other three plan model counties. This finding would be consistent with other research and survey data that has reported that rural areas are also frequently health professional shortages areas. Map 1 below displays the location of areas designated as MUA/P, “Medically Underserved Areas /Populations<sup>25</sup>”. Some Two-Plan counties also contained medically underserved rural areas which may have also accounted for higher population-to-provider ratios in that model type compared to the COHS and GMC counties.

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<sup>25</sup> According to 42 USCS § 300e-1 [Title 42. The Public Health and Welfare; Chapter 6a. The Public Health Service; Health Maintenance Organizations], medically underserved population means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services. Such a designation may be made by the Secretary only after consideration of the comments (if any) of (A) each State health planning and development agency which covers (in whole or in part) such urban or rural area or the area in which such population group resides, and (B) each health systems agency designated for a health service area which covers (in whole or in part) such urban or rural area or the area in which such population group resides

**Figure 6 Medically Underserved Areas and Populations in California.**



Source: Shortage Designation Branch (SDB) of the Health Resources and Services Administration.

**Ratio of Full Scope Beneficiaries Eligible For Medi-Cal Only and Participating in Medi-Cal’s FFS System to All Physicians**

**Table 3** and **Table 4** are the broadest reports.

**Table 5** presents all physician specialties and the ratio of full scope beneficiaries eligible for Medi-Cal only and participating in FFS to physicians. Physician counts range from as few as 2 in Alpine and fewer than 20 in four other counties, to just over 10,000 in San Diego and almost 30,000 in Los Angeles. Glenn County has the highest ratio of beneficiaries per physician (244) and Marin, which moved to the COHS plan model in July 2001, has the lowest ratio, averaging a mere 0.7. Imperial is the only other county with over 200 beneficiaries per physician. Full county summaries are available in Appendix C.

Physician enrollment in the 1<sup>st</sup> quarter of 2011 is 4.6 percent more than the calendar year 2010 figure of 100,544 reported by the Medical Board of California<sup>26</sup>, and 10.5% greater than the July 1, 2010 count of active physicians in California as reported by the American Medical Association. As noted, the DHCS counted the combination of physician and physician location, rather than only the individual physician. For this reason the number of physicians slightly exceeded the total number of practicing in-state physicians as reported in other sources such as the California Medical License Board and the American Medical Association Physician Master file.<sup>27</sup> In the first quarter of 2011 there were 101,392 **unduplicated** physicians counted in the Medi-Cal Provider Master Enrollment File, compared to 105,216 physician locations.

Physician counts from the Medi-Cal Provider Master Enrollment File changed little overall from quarter to quarter in 2011, increasing only 2.7% over three quarters, from 105,216 to 108,057.

**Table 3 Physician Supply - All Enrolled Physician Sites - FFS Medi-Cal Only Beneficiaries. See Appendix C for County-Level Detail.**

	Number of Providers				Population-to-Provider Ratio			
	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter
<b>Statewide</b>	<b>105,216</b>	<b>105,978</b>	<b>107,332</b>	<b>108,057</b>	<b>15.2</b>	<b>14.6</b>	<b>12.7</b>	<b>11.6</b>
<b>County Plan Model Type</b>								
<b>County Organized Health System (COHS)</b>	<b>20,174</b>	<b>20,350</b>	<b>20,560</b>	<b>20,670</b>	<b>7.8</b>	<b>7.8</b>	<b>2.3</b>	<b>2.0</b>
<b>Fee-for-Service (FFS)</b>	<b>4,038</b>	<b>4,072</b>	<b>4,100</b>	<b>4,132</b>	<b>77.0</b>	<b>77.0</b>	<b>76.3</b>	<b>74.9</b>
<b>Geographic Managed Care (GMC)</b>	<b>15,614</b>	<b>15,699</b>	<b>15,976</b>	<b>16,108</b>	<b>10.5</b>	<b>10.3</b>	<b>9.4</b>	<b>8.6</b>
<b>Two-Plan (Commercial Plan and Local)</b>	<b>65,390</b>	<b>65,857</b>	<b>66,696</b>	<b>67,147</b>	<b>14.8</b>	<b>13.9</b>	<b>12.8</b>	<b>11.4</b>

<sup>26</sup> Medical Board of California, 2010-11 Annual Report; URL: [http://www.mbc.ca.gov/publications/annual\\_report\\_2010-2011.pdf](http://www.mbc.ca.gov/publications/annual_report_2010-2011.pdf)

<sup>27</sup> 2011 State Physician Workforce Data Book, Association of American Medical Colleges, URL: <https://www.aamc.org/download/263512/data/statedata2011.pdf>

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

However, the ratio of FFS beneficiaries per physician changed significantly between the 1<sup>st</sup> and 4<sup>th</sup> quarters, dropping 23.6% (from 15.2 to 11.6). The most sudden drop occurred amongst COHS counties, in which the ratio fell from 7.8 to 2.3 between the 2<sup>nd</sup> and 3<sup>rd</sup> quarters. The decrease is attributable to a significant decline in the FFS eligibles enrolled beginning in mid-2011. These reductions in Medi-Cal beneficiaries participating in the FFS system were the result of establishing COHS in Ventura, Mendocino, and Marin counties. This shift resulted in a dramatic drop in the number of beneficiaries receiving care through Medi-Cal's FFS system.

**Table 4 Physician Supply - All Enrolled Physician Sites - All Medi-Cal Only Beneficiaries. See Appendix C for county-level detail.**

	Number of Providers				Population-to-Provider Ratio			
	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter
Statewide	105,216	105,978	107,332	108,057	52.8	52.8	52.6	52.1
<b>County Plan Model Type</b>								
County Organized Health System (COHS)	20,174	20,350	20,560	20,670	42.4	42.5	42.5	42.1
Fee-for-Service (FFS)	4,038	4,072	4,100	4,132	77.4	77.3	76.7	75.4
Geographic Managed Care (GMC)	15,614	15,699	15,976	16,108	37.5	37.7	37.3	37.1
Two-Plan (Commercial Plan and Local)	65,390	65,857	66,696	67,147	58.1	58.1	57.9	57.3

	Number of Providers				Population-to-Provider Ratio			
	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter
Initiative)								

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

**Table 6**, which includes managed care beneficiaries, further reveals the source of this decline. Though otherwise identical, the inclusion of managed care beneficiaries renders ratios virtually unchanged throughout 2011. Statewide this ratio remained steady between 52 and 53 beneficiaries per physician throughout the year. Glenn County also has the highest ratio (244.7) when managed care beneficiaries are included in the counts. San Francisco has the lowest ratio (12.1), while Marin still has one of the lowest ratios, ranking 3<sup>rd</sup> lowest with 17.4 beneficiaries per physician.

### Ratio of Full Scope Eligibles to Primary Care Physicians

Table 5 and **Table 6** follow trends similar to **Table 3**. Only primary care physicians and the ratio of full scope eligibles to primary care physicians are included. Counts range from only one in Alpine and 10 or fewer in three other counties, to about 3,400 in San Diego and over 11,000 in Los Angeles. Imperial County has the highest FFS ratios, ranging from 714 to 796 FFS beneficiaries per primary care physician throughout the year, while San Mateo has the lowest ratio at 3.1. .

Primary care physician enrollment changed little throughout 2011, increasing steadily over three quarters by just 2.5%, from 38,114 to 39,068. Again, however, the ratios declined rapidly in this period from 41.9 to 32.1 FFS beneficiaries per primary care physician statewide, a 23.4% decline that matches the rate of decline of overall physician ratios. Meanwhile, the same ratios in **Table 6**, which include managed care beneficiaries, remained virtually unchanged, declining by only 1.1% over the 4 quarters.

**Table 5 Primary Care Physician Supply - All Enrolled Physician Sites - FFS, Full Scope, Medi-Cal Only Beneficiaries. See Appendix C for County-Level Detail.**

	Number of Providers				Population-to-Provider Ratio			
	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter
<b>Statewide</b>	38,114	38,373	38,833	39,068	41.9	40.4	35.2	32.1
<b>County Plan Model Type</b>								
County Organized Health System (COHS)	7,157	7,231	7,315	7,369	22.0	22.1	6.4	5.7
Fee-for-Service (FFS)	1,726	1,738	1,744	1,758	180.2	180.3	179.3	176.1
Geographic Managed Care (GMC)	5,310	5,341	5,418	5,458	30.9	30.3	27.8	25.3
Two-Plan (Commercial Plan and Local Initiative)	23,921	24,063	24,356	24,483	40.3	38.1	35.1	31.1

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

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

**Table 6 Primary Care Physician Supply - All Enrolled Physician Sites - All Full Scope, Medi-Cal Only Beneficiaries. See Appendix C for County-Level Detail.**

	Number of Providers				Population-to-Provider Ratio			
	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter
<b>Statewide</b>	38,114	38,373	38,833	39,068	145.6	145.9	145.4	144.0
<b>County Plan Model Type</b>								
County Organized Health System (COHS)	7,157	7,231	7,315	7,369	119.6	119.7	119.4	118.2
Fee-for-Service (FFS)	1,726	1,738	1,744	1,758	181.1	181.2	180.4	177.2
Geographic Managed Care (GMC)	5,310	5,341	5,418	5,458	110.3	110.7	110.1	109.3
Two-Plan (Commercial Plan and Local Initiative)	23,921	24,063	24,356	24,483	158.7	159.1	158.5	157.1

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

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

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

**Table 7** and **Table 8** present all female eligibles between 18 and 64, including limited scope eligibles, as well as the corresponding ratio to OB/GYN physicians. Los Angeles County has 1,775 OB/GYNs enrolled in Medi-Cal. However, 19 counties have 5 or less, four disclosing no providers indicating an OB\GYN designation. All such counties are small and rural and offer only the FFS plan model. Such low provider counts result in widely varying (and sometimes nonexistent) population-to-provider ratios by county. These counties have little or no provider presence according to California's Medical Board provider counts.

First quarter 2011 OB/GYN enrollment of 6,346 increased only 1.7% statewide through the 4<sup>th</sup> quarter, not quite keeping pace with the 2.7% increase in overall physician enrollment. The FFS population-to-provider ratios fell 14.7% in this period, less than the 23.6 % rate of decline for the ratio of all full scope FFS eligibles to all physicians. Including managed care beneficiaries moderates the decline in the OB/GYN ratio in this period to 1.3%, identical to the overall decline in the population at large over the same time period.

**Table 7 Physician Supply - Physicians with an OB/GYN Specialty - FFS, Medi-Cal Only, Non-Elderly, Adult Females. See Appendix C for County-Level Detail.**

	Number of Providers				Population-to-Provider Ratio			
	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter
<b>Statewide</b>	<b>6,346</b>	<b>6,379</b>	<b>6,422</b>	<b>6,456</b>	<b>135.2</b>	<b>132.6</b>	<b>122.3</b>	<b>115.3</b>
<b>County Plan Model Type</b>								
<b>County Organized Health System (COHS)</b>	<b>1,321</b>	<b>1,334</b>	<b>1,341</b>	<b>1,341</b>	<b>91.1</b>	<b>90.1</b>	<b>70.2</b>	<b>68.8</b>
<b>Fee-for-Service (FFS)</b>	<b>228</b>	<b>228</b>	<b>230</b>	<b>232</b>	<b>414.2</b>	<b>416.1</b>	<b>409.9</b>	<b>401.6</b>
<b>Geographic Managed Care (GMC)</b>	<b>799</b>	<b>799</b>	<b>810</b>	<b>817</b>	<b>90.9</b>	<b>89.5</b>	<b>81.5</b>	<b>73.9</b>
<b>Two-Plan (Commercial Plan and Local Initiative)</b>	<b>3,998</b>	<b>4,018</b>	<b>4,041</b>	<b>4,066</b>	<b>142.7</b>	<b>139.1</b>	<b>131.4</b>	<b>122.6</b>

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

**Table 8 Physician Supply - Physicians with an OB/GYN Specialty - All Medi-Cal Only, Non-Elderly, Adult Females. See Appendix C for County-Level Detail.**

	Number of Providers				Population-to-Provider Ratio			
	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter
Statewide	6,346	6,379	6,422	6,456	271.9	272.3	271.0	268.4
<b>County Plan Model Type</b>								
County Organized Health System (COHS)	1,321	1,334	1,341	1,341	205.3	204.6	203.2	201.9
Fee-for-Service (FFS)	228	228	230	232	415.6	417.4	411.6	403.4
Geographic Managed Care (GMC)	799	799	810	817	216.1	217.1	214.3	212.1
Two-Plan (Commercial Plan and Local Initiative)	3,998	4,018	4,041	4,066	296.8	297.5	296.9	294.0

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

### Ratio of Full Scope Eligible Children to Pediatricians

**Table 9** and **Table 10** present pediatricians and the ratio of full scope beneficiaries eligible for Medi-Cal only and participating in the FFS system under age 18 to pediatricians. The 4<sup>th</sup> quarter 2011 statewide total enrollment is 11,007 pediatricians, representing a 2.9% increase from the 1<sup>st</sup> quarter. Los Angeles predictably has the highest number, 2,973, and Santa Clara is the only other county with over 1,000 pediatricians (1,118). As with the OB/GYNs, low provider counts result in widely varying and sometimes nonexistent population-to-provider ratios by county. Less than six physicians have declared a specialty of pediatrics in sixteen counties, seven of which do not disclose a provider that declares a specialty of pediatrics. This does not necessarily mean that beneficiaries do not have access to health care services, only that physicians that have enrolled in the Medi-Cal program have not declared pediatrics as a specialty. Providers in these geographic regions may have declared a specialty other than pediatrics, but still render care to children enrolled in the Medi-Cal program. In many cases, general practitioners and or clinics render care to various subpopulations.

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

average over 600 while all other plan models average less than 75 children per pediatrician. When beneficiaries enrolled in managed care plans are included in the population, they only rise to 329 in the Two-Plan counties, 240 for the GMC counties, and 317 statewide.

The FFS population-to-provider ratios fell from 74 to 61 statewide between the 1<sup>st</sup> and 4<sup>th</sup> quarters of 2011. This 17.5% decline is less than the 23.6 % rate of decline for the ratio of all full scope beneficiaries eligible for Medi-Cal only and participating in FFS population to all physicians, but slightly more than the 14.7 % ratio for OB/GYNs. The ratio of all full scope children to pediatricians (**Table 10**) fell only 1.5% during this same period.

**Table 9 Physician Supply - Physicians with a Pediatric Specialty - FFS, Full Scope, Medi-Cal Only Children. See Appendix C for County-Level Detail.**

	Number of Providers				Population-to-Provider Ratio			
	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter
Statewide	10,692	10,769	10,921	11,007	74.2	71.4	64.3	61.2
<b>County Plan Model Type</b>								
County Organized Health System (COHS)	1,906	1,926	1,944	1,948	54.4	54.9	17.0	14.8
Fee-for-Service (FFS)	271	271	274	275	628.9	633.6	627.5	619.2
Geographic Managed Care (GMC)	1,437	1,449	1,462	1,484	52.7	51.9	51.6	50.1
Two-Plan (Commercial Plan and Local Initiative)	7,078	7,123	7,241	7,300	62.7	58.5	58.3	54.8

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

**Table 10 Physician Supply - Physicians with a Pediatric Specialty - All Full Scope, Medi-Cal Only Children. See Appendix C for County-Level Detail.**

	Number of Providers				Population-to-Provider Ratio			
	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter
Statewide	10,692	10,769	10,921	11,007	322.2	322.6	321.3	317.2
<b>County Plan Model Type</b>								
County Organized Health System (COHS)	1,906	1,926	1,944	1,948	290.9	291.3	291.8	289.8
Fee-for-Service (FFS)	271	271	274	275	632.6	637.4	632.0	623.6
Geographic Managed Care (GMC)	1,437	1,449	1,462	1,484	243.1	243.5	244.0	240.3
Two-Plan (Commercial Plan and Local Initiative)	7,078	7,123	7,241	7,300	334.8	335.2	333.1	328.6

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

### **Primary Care Providers Ratios for Full Scope Eligibles (Statewide)**

While **Table 3** through **Table 10** present the supply of physicians, **Table 11** and **Table 12** disclose the numbers of physicians with an active (billing) status and an indirect (rendering status). In addition, these two tables also display the number and ratios for other provider types that may serve as settings for primary care. These include Physician Group, Clinic and Outpatient Hospital providers.

**Table 11** tracks the rates of physicians and provider groups enrolled statewide that provided primary care services over the four quarters of 2011. The provider groups consist of physician groups, county and community hospital outpatient services, and various types of clinics.

In

**Table 5** and **Table 6**, beneficiary-to-primary care physician ratios (for individually enrolled physicians) declined rapidly, equating to a rapid rise in providers per beneficiary (its inverse measure) by the same 23.6% rate for FFS beneficiaries. For every 100,000 full scope FFS Medi-Cal eligibles in the 4<sup>th</sup> quarter, the services of about 3,350 individual primary care physicians took place through, and sometimes in addition to, the services of 403 separately enrolled primary care provider groups. The overall rate of enrollment per FFS beneficiary for these provider types, excluding the individual physicians, increased 32% between the 1<sup>st</sup> and 4<sup>th</sup> quarters.

Including managed care beneficiaries shrinks these rates to 745 individual physicians and about 90 provider groups per 100,000 full scope eligibles. The rate per beneficiary increased minimally over time for this broader beneficiary population. Whether or not managed care beneficiaries are counted, provider supply per beneficiary rose each quarter throughout 2011 for nearly every primary care provider type.

**Table 11 Primary Care Providers by Provider Type and Enrollment Status - FFS, Full Scope, Medi-Cal Only Beneficiaries (Statewide only)**

Provider Enrollment Status	Provider Type	Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Active	<b>Physicians</b>								
	Physicians	7,182	7,193	7,217	7,227	222.4	215.6	189.2	173.2
	Physicians Group	2,998	3,022	3,053	3,080	532.7	513.1	447.3	406.5
	<b>Clinics</b>								
	RHC/FQHC	592	590	596	595	2,697.5	2,628.3	2,291.2	2,104.2
	Free Clinic	9	9	9	9	177,437.3	172,298	151,730.4	139,108
	Community Clinic	375	383	387	385	4,258.5	4,048.8	3,528.6	3,251.9
	Surgical Clinic	297	306	326	328	5,376.9	5,067.6	4,188.9	3,817.0
	Clinic exempt from licensure	140	142	156	168	11,406.7	10,920.3	8,753.7	7,452.2
	County Clinic not w/ Hospital	35	35	36	35	45,626.7	44,305.3	37,932.6	35,770
	Indian Health Services	39	39	39	38	40,947.1	39,761.2	35,014.7	32,946.6
	<b>Outpatient Hospital</b>								
	County Outpatient Hospital	39	39	38	38	40,947.1	39,761	35,936	32,946.6
	Community Outpatient Hospital	344	355	357	362	4,642.3	4,368.	3,825	3,458.5
<b>Indirect / Rendering Physicians</b>	<b>33,691</b>	<b>33,991</b>	<b>34,447</b>	<b>34,707</b>	<b>47.4</b>	<b>45.6</b>	<b>39.6</b>	<b>36.1</b>	

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

**Table 12 Primary Care Providers By Provider Type and Enrollment Status - All Full Scope, Medi-Cal Only Beneficiaries (Statewide Only)**

Provider Enrollment Status	Provider Type	Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Active	Physicians								
	Physicians	7,182	7,193	7,217	7,227	772.8	778.6	782.2	778.5
	Physicians Group	2,998	3,022	3,053	3,080	1,851.3	1,853.2	1,849.1	1,826.6
	RHC/FQHC	592	590	596	595	9,375.4	9,492	9,471.8	9,455.3
	Free Clinic	9	9	9	9	616,695.0	622,246	627,241.1	625,101.0
	Community Clinic	375	383	387	385	14,800.7	14,622	14,587.0	14,612.8
	Surgical Clinic	297	306	326	328	18,687.7	18,301.4	17,316.5	17,152.2
	Clinic exempt from licensure	140	142	156	168	39,644.7	39,438.1	36,187.0	33,487.6
	County Clinic not w/ Hospital	35	35	36	35	158,578.7	160,006	156,810.3	160,740.3
	Indian Health Services	39	39	39	38	142,314.2	143,595	144,748.0	148,050.2
	County Outpatient Hospital	39	39	38	38	142,314	143,595	148,557	148,050
	Community Outpatient Hospital	344	355	357	362	16,134	15,775	15,813	15,541
	Indirect / Rendering Physicians		33,691	33,991	34,447	34,707	164.7	164.8	163.9

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

## Conclusions – Primary Care Provider Supply

- DHCS evaluated all 58 counties and plan model types (i.e., Two-Plan, GMC, and FFS) with respect to physician provider supply. The findings indicate that the supply of physician providers available to beneficiaries eligible for Medi-Cal only and participating in FFS was more than adequate.
- The population-to-provider ratios disclosed no deterioration in overall physician supply available to Medi-Cal's FFS population over the four quarters evaluated, but did report significant differences between regions of the state. In general, the primarily rural counties utilizing the FFS model reported the lowest physician supply relative to the target population. Counties utilizing the Two-Plan managed care model and having a more urbanized population reported greater physician supply compared to Two-Plan counties in more rural areas. In this respect, physician supply for Medi-Cal beneficiaries mirrored that of the entire state population.
- The statewide population to primary care provider ratio was found to be 144.0. Again, this ratio indicates that the supply of primary providers was more than adequate to meet demand. Over the four quarters evaluated, the population to primary care provider ratio for Medi-Cal's FFS population declined from 41.9 to 32.1, indicating greater primary care provider supply. The aggregate number of primary providers increased during the four quarters evaluated from 38,114 to 39,068. In no case did the population to physician provider ratio exceed commonly referred to benchmarks.
- Based on the beneficiary population eligible for Medi-Cal only participating in FFS and a panel size of 2,100 patients, Medi-Cal would need a primary care physician supply totaling roughly 600. If the current Medi-Cal supply of 39,068 primary care physicians dedicated only 1.5% of their practice to Medi-Cal patients, the demand for services would be met. Certainly, this is overly simplistic, but this provides some context for the size of the Medi-Cal potential provider capacity.
- The number of enrolled OB/GYN specialty physicians rose slightly during the four quarters measured. For non-elderly adult women eligible for Medi-Cal only participating in the FFS system and entitled to full scope services, the population to OB/GYN specialty physician ratio declined from 135.2 to 115.3. Ratios relative to all non-elderly adult women (includes those participating in FFS and managed care) decreased slightly from 271.9 to 268.4.
- The number of enrolled pediatric specialty physicians rose slightly during the four quarters measured. The ratio of population to pediatric specialty physicians declined from 74.2 to 61.2 for children eligible for Medi-Cal only participating in the FFS system and entitled to full scope benefits. The reduction in the ratio indicates that pediatric specialty physician supply increased during this measurement period. Evaluating all

children, including those enrolled in FFS and managed care delivery systems and entitled to full scope services disclosed that the ratio decreased from 628.9 to 619.2, indicating greater overall supply.

- The numbers of physician groups, clinics and outpatient hospitals enrolled as active Medi-Cal providers remained unchanged over the four quarters measured.

## Medi-Cal FFS Beneficiary Enrollment Trends

### Introduction

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

Historically, Medi-Cal eligibility was subject to categorical restrictions that limited enrolled coverage to the elderly, persons with disabilities, members of families with dependent children, specific other pregnant women and children, certain women with breast or cervical cancer, and uninsured individuals with tuberculosis. To qualify, an individual's income and resources had to meet specific thresholds. While many of Medi-Cal's initial eligibility pathways were tied to receipt of cash assistance under programs such as Aid to Families with Dependent Children, or the SSI program, Medicaid changes in recent years have shifted eligibility determination to an income based approach. The range of benefits offered by the Medi-Cal program also varies among groups. For example, some groups may gain access to Medi-Cal services only after experiencing an acute care hospital admission, in which case individuals are not eligible for Medi-Cal at the time of admission but gain it retroactively. Other groups, such as undocumented immigrants, are only entitled to a limited scope of healthcare services.

Understanding the unique complexities of the Medi-Cal sub-populations 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 sub-population 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.

**Table 13** below shows the most prevalent clinical conditions affecting various Medi-Cal sub-populations.

**Table 13 Most common clinical conditions of Medi-Cal beneficiaries by age and aid category.**

<b>Aid Category</b>	<b>Leading Clinical Conditions</b>
<b>Adults (21 years and older)</b>	
Aged (above 65 years)	Essential hypertension Blindness and vision defects Diabetes mellitus without complication Disorders of lipid metabolism Lower respiratory diseases
Blind/Disabled	Essential hypertension Blindness and vision defects Mood disorders Spondylosis; intervertebral disc disorders; other back problems Lower respiratory diseases
Families	Pregnancy-related conditions Lower respiratory diseases
Undocumented	Pregnancy-related conditions Lower respiratory diseases Abdominal pain Injuries and conditions due to external causes
<b>Children (0-21 years)</b>	
Blind/Disabled	Blindness and vision defects Developmental disorders Other congenital anomalies Paralysis
Foster Care	Upper and respiratory infections Lower respiratory diseases Otitis media and related conditions Developmental disorders
Families	Upper respiratory infections Otitis media and related conditions Lower respiratory diseases
Undocumented	Lower respiratory disease s Injuries and conditions due to external causes

The degree of responsibility for ensuring access to care may vary depending on the sub-population and type of service. For example, approximately one third 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 half of this population is enrolled in Family aid codes, while one fourth is enrolled in Blind and or Disabled aid codes.

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

Between January 2011 and January 2012 there was a net shift of 575,695 beneficiaries, or 7.2% of the Medi-Cal population, from FFS to the managed care delivery model. Two developments are responsible for the shift in enrollment between the two health care delivery models. First, under the terms of California's Section 1115 "Bridge to Reform" waiver, beneficiaries enrolled in Seniors and Persons with Disabilities" (SPDs) aid codes were required to enroll in managed care programs. From May 1, 2011 until January 1, 2012, the number of SPD beneficiaries participating in Medi-Cal's FFS system decreased from 394,582 to 158,771. The second development responsible for the shift into managed care enrollment reflects the expansion in the number of counties that transitioned from the FFS to the managed care model. Between January 2011 and January 2012, three counties shifted Medi-Cal populations from the FFS to the managed care model: Ventura, Mendocino, and Marin, affecting 140,944 beneficiaries.

The proportion of Medi-Cal beneficiaries receiving services under the FFS model will continue to decline as DHCS focuses on the transition of beneficiaries who are dually eligible for Medi-Cal and Medicare coverage to managed care plans. Under California's proposed Coordinated Care Initiative (CCI) demonstration, dual eligible beneficiaries will enroll in capitated plans designed to coordinate both Medi-Cal and Medicare services.

## Methods

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

Beneficiary enrollment summaries were derived from the Medi-Cal Eligibility System Monthly Extract File (MMEF). This data source provides information on a monthly basis on a beneficiaries' length of enrollment, 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 Areas (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 healthcare needs, beneficiaries participating in Medi-Cal's FFS system and not eligible for Medicare were grouped into homogeneous subpopulations based on eligibility category (blind/disabled, families, aged, foster care, undocumented, and other), scope of Medi-Cal services (full or restricted), age groups (0-17, 18-65, older than 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.<sup>28</sup>

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 enrolled in the first quarter.

## Results

### Full Scope Beneficiaries by Gender and Age

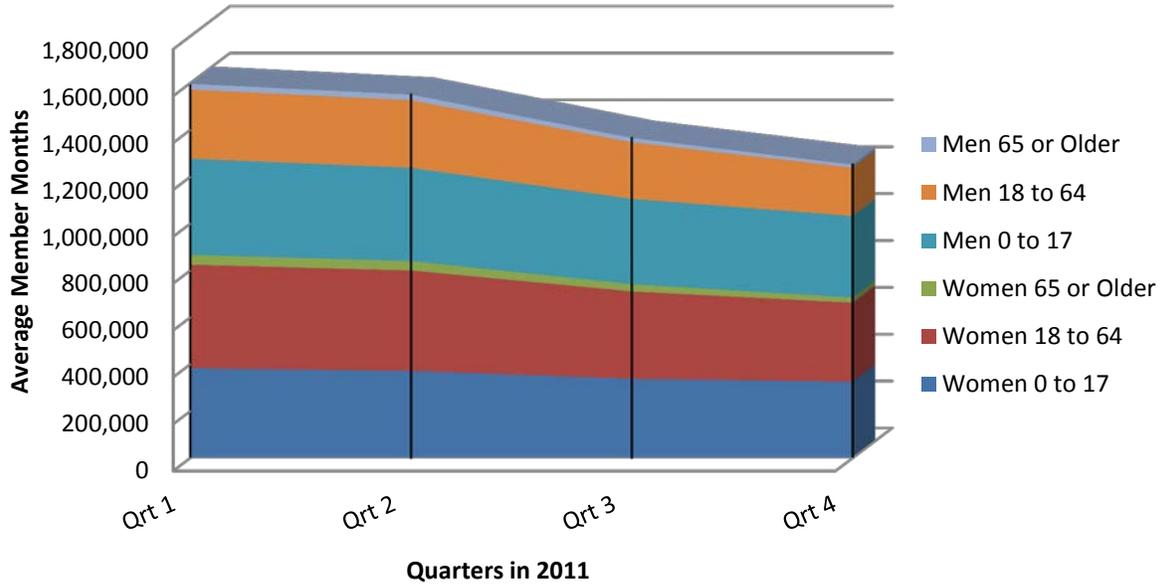
During 2011, participation in the FFS health care delivery system for Medi-Cal beneficiaries who were eligible for full scope services decreased for all age and gender groups, from 1,596,936 in the first quarter to 1,251,971 in the last quarter (**Figure 7**). For all groups, the decrease in FFS participation was steeper after the first quarter. Overall, the decline in FFS participation from the first to the last quarter of calendar year (CY) 2011 was 21.6 %, whereas the change within the last two quarters was 8.3% (see **Figure 7**).

As shown in **Figure 8**, the highest decrease in FFS participation was for individuals 65 years and older (48% decrease from the first to the fourth quarter). This decrease affected both gender groups equally. Among young adults (age 18 to 64 years), males experienced a larger decrease in FFS participation than females (30% and 24% respectively). The highest number of beneficiaries participating in the FFS health care delivery system with full scope benefits was found in age group 0-17. This group had the lowest decrease in FFS participation during 2011 at 15%.

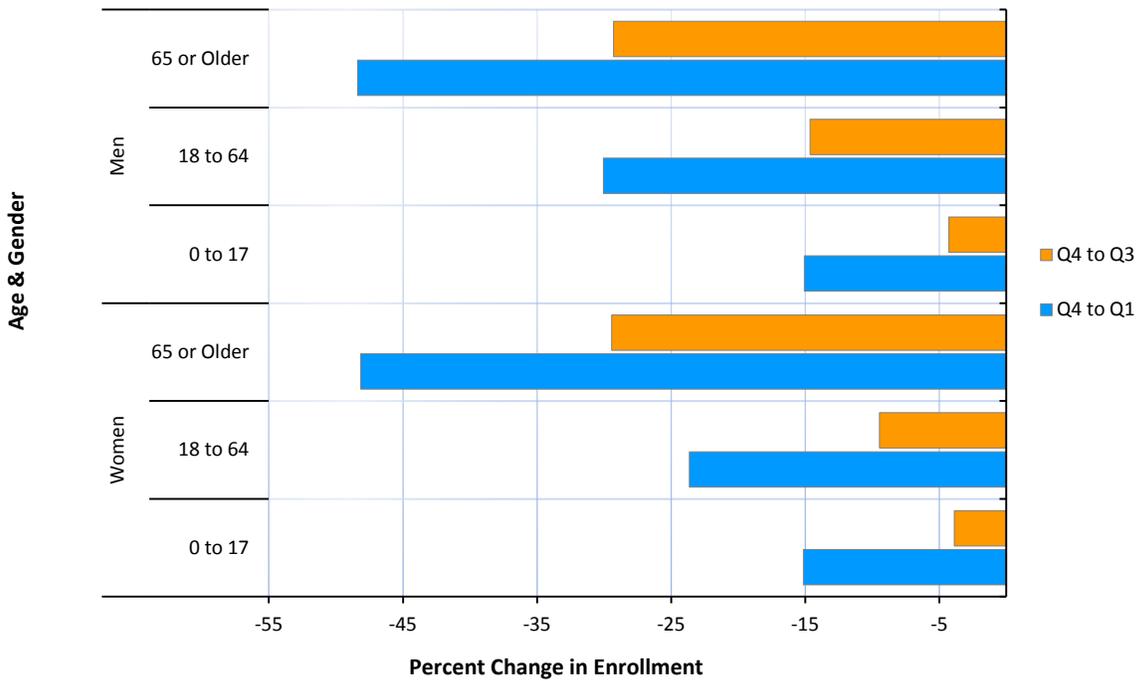
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<sup>28</sup> Metropolitan designations were identified using ERS Rural-Urban Continuum Codes. The Rural-Urban Continuum Codes are calculated by examining the size of a county and its proximity to a metropolitan area. Rural-Urban Continuum Codes form 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.

**Figure 7 Average Member Months for Full Scope FFS Medi-Cal Beneficiaries, by Gender and Age Group, CY 2011**



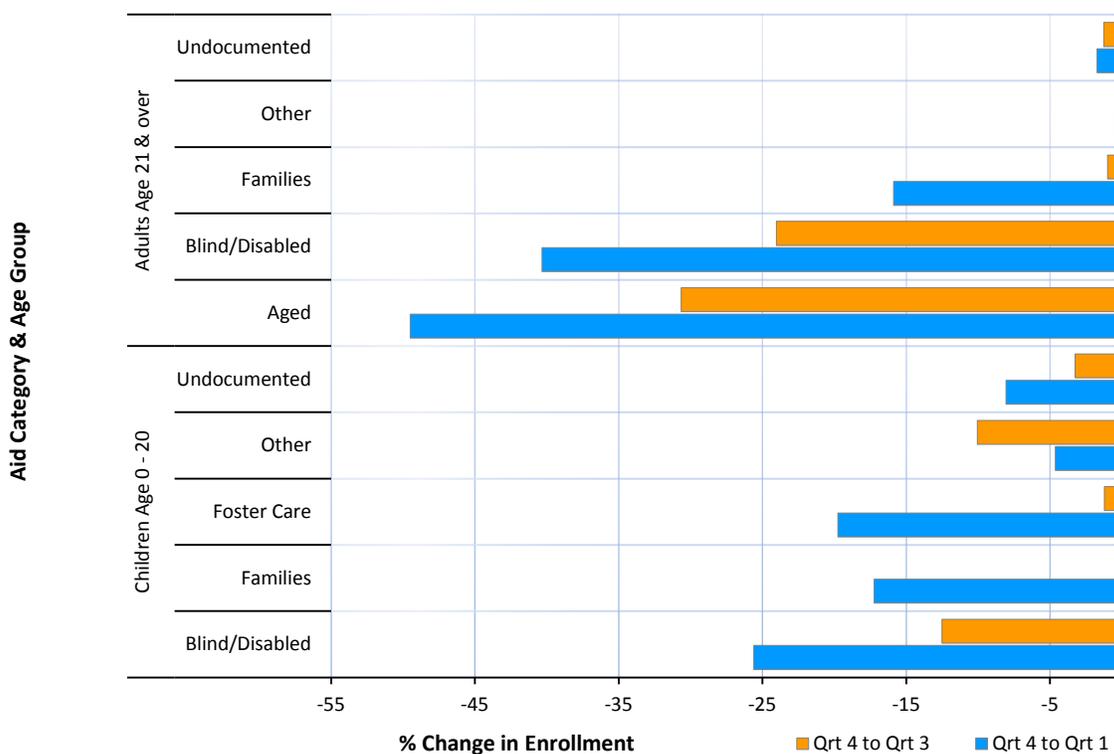
**Figure 8 Change in Enrollment for Full Scope FFS Medi-Cal Beneficiaries, by Gender and Age Group, CY 2011**



### Aid Category and Age

The following chart displays the change in FFS participation for beneficiaries with Medi-Cal only by age and aid category from the beginning to the end of CY 2011, and the last two quarters of the same year. FFS participation decreased gradually for all aid category and age groups during 2011. The largest decrease in FFS participation was found from the beginning (Q1) to the end (Q4) of CY 2011. Beneficiaries in the Aged aid category experienced the greatest decrease in FFS participation for comparisons made between Q1 and Q4 (49.5% decrease) and between Q3 and Q4 (30.6% decrease). The next largest decrease in FFS participation was observed among beneficiaries in the Blind/Disabled aid category (40.3% from Q1 to Q4, and 24% from Q3 to Q4). This trend reflects the implementation of the Bridge to Reform Waiver by which seniors and persons with disabilities (SPDs) were mandatorily shifted from the traditional FFS to managed care delivery of care model.

**Figure 9 Percent Change in FFS Medi-Cal Enrollment Across Quarters, by Age and Aid Category Statewide, CY 2011**



Among children, the largest decrease in FFS participation was in the Blind/Disabled group (25.6% decrease in FFS participation from Q1 to Q4, and 12.5% decrease from Q3 to Q4). For children in the Foster Care and the Families aid categories, changes in FFS participation

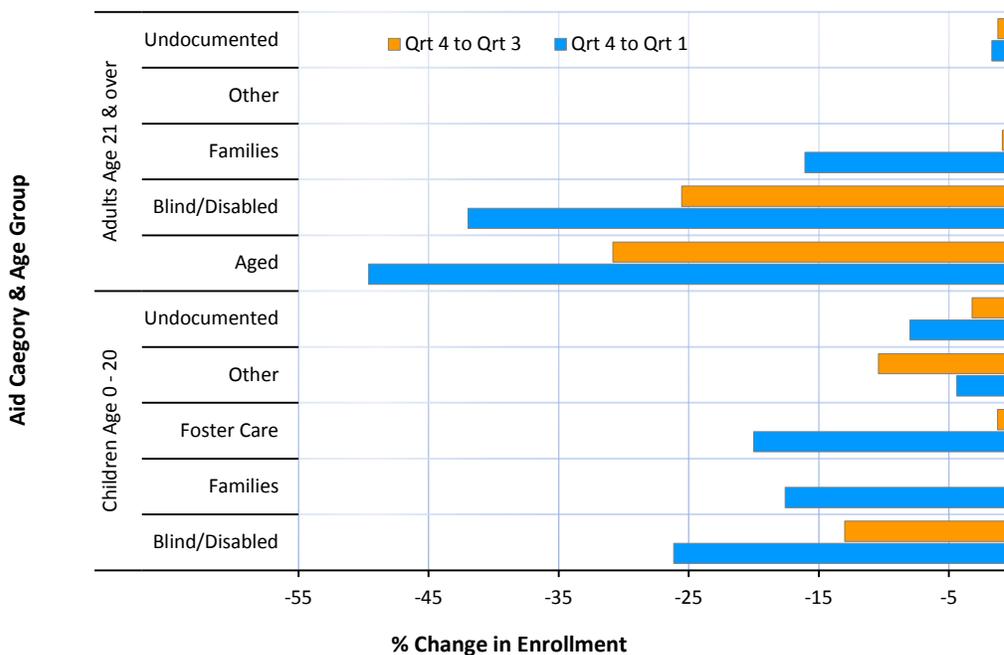
between the last and first quarters was relatively high (-19.8% and -17.2%, respectively), but was negligible for comparisons made from Q3 to Q4 (-1.2% and -0.2%, respectively).

### Enrollment in Metropolitan vs. Non-Metropolitan Counties

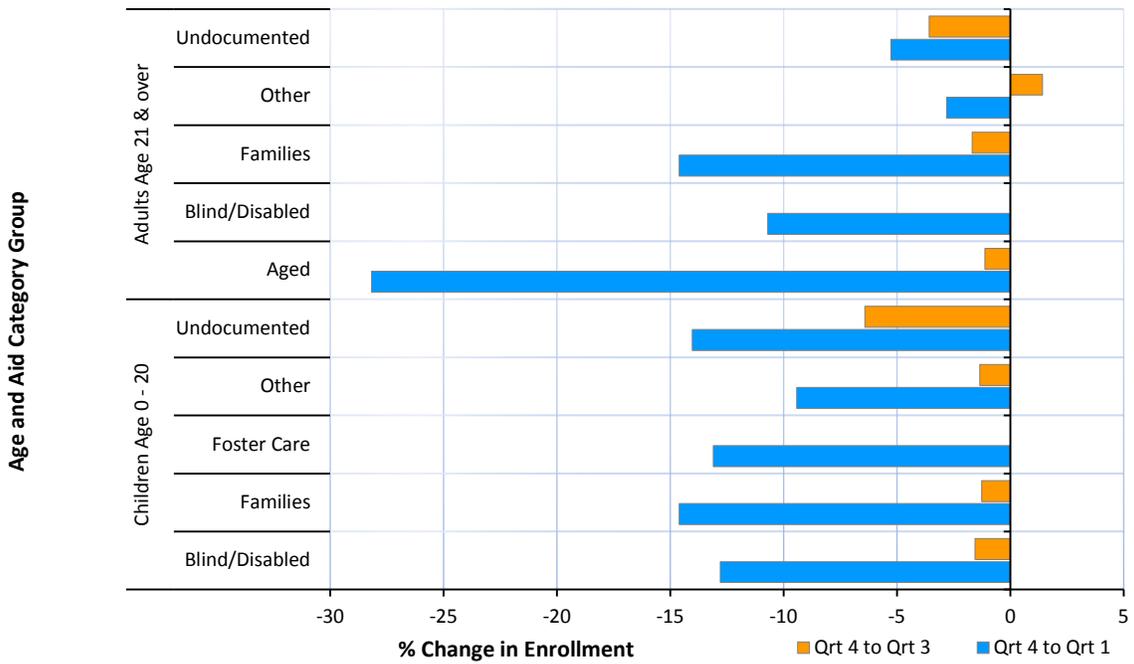
Overall, the change in FFS participation for comparisons made from Q1 to Q4 of CY 2011 was similar among those residing in metropolitan and non-metropolitan counties (see [Table 25](#) and [Table 26](#)). Beneficiaries residing in non-metropolitan counties experienced a 13.2% decline in FFS participation from Q1 to Q4, while FFS participation in metropolitan counties declined by 15.6%. The highest percent change in FFS participation was found among beneficiaries in the Aged aid category in the metropolitan counties (49.6% between quarters 4 and 1, and 30.8% between the last two quarters). Beneficiaries in the Aged aid category residing in non-metropolitan counties experienced a 28% decline in FFS participation from Q1 to Q4; however, from Q3 to Q4, the declines were negligible (1.1%).

Among younger beneficiaries age <21, no sizeable changes in FFS participation were noted for those in the Families, Foster Care and Undocumented aid categories living in metropolitan counties. However, for those living in metropolitan areas of the state and enrolled in the Blind/Disabled and Foster Care aid categories, FFS participation decreases were significant (26.1% and 20%, respectively) from Q1 to Q4. Comparisons made from Q3 to Q4 yielded only slight decreases in Medi-Cal FFS participation for these beneficiary subgroups. For children living in more rural parts of the state, large FFS participation decreases were observed in the Families and Undocumented aid categories (14.5% and 14%, respectively) from Q1 to Q4, but only slight changes in FFS participation were observed from Q3 to Q4.

**Figure 10 Percent Change in Medi-Cal FFS Participation Across Quarters by Age and Aid Category for Metropolitan Counties; CY 2011**



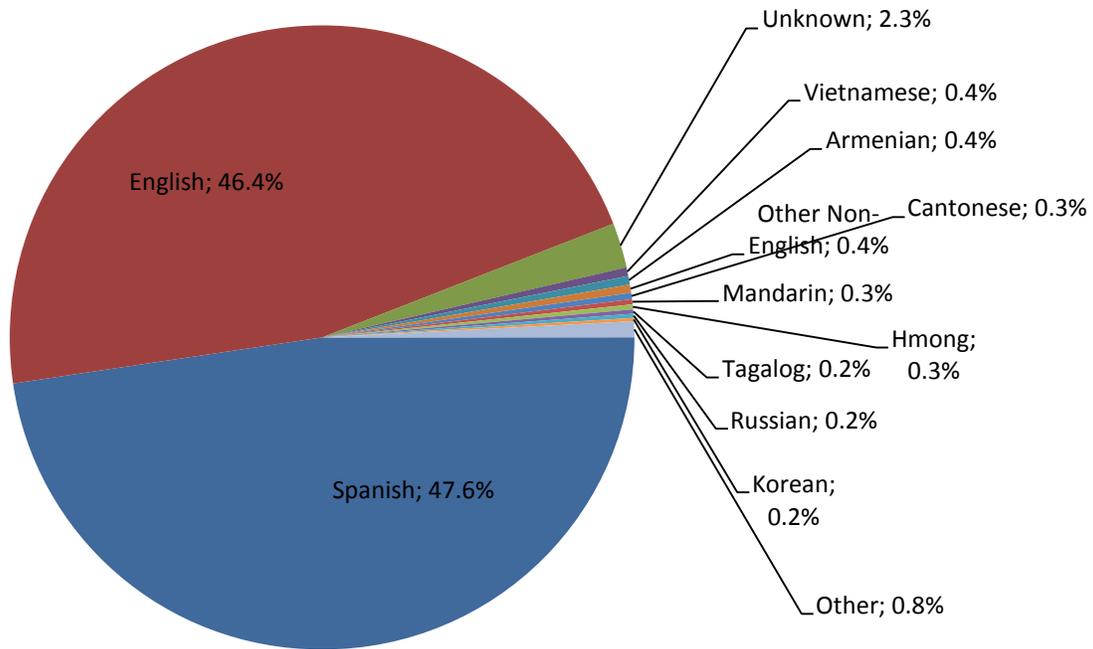
**Figure 11 Percent Change in Medi-Cal FFS Participation Across Quarters by Age and Aid Category for Non-Metropolitan Counties; CY 2011**



**Distribution of Medi-Cal Only Beneficiaries Participating in the FFS Delivery System, by Primary Language Spoken**

As displayed in the chart below, the primary language used by FFS Medi-Cal only beneficiaries was Spanish (47.6%), followed closely by English (46.4%). The language spoken by the remaining 5.9% of FFS Medi-Cal only beneficiaries included Vietnamese, Armenian, Hmong, Cantonese, Mandarin, Tagalog, and Russian.

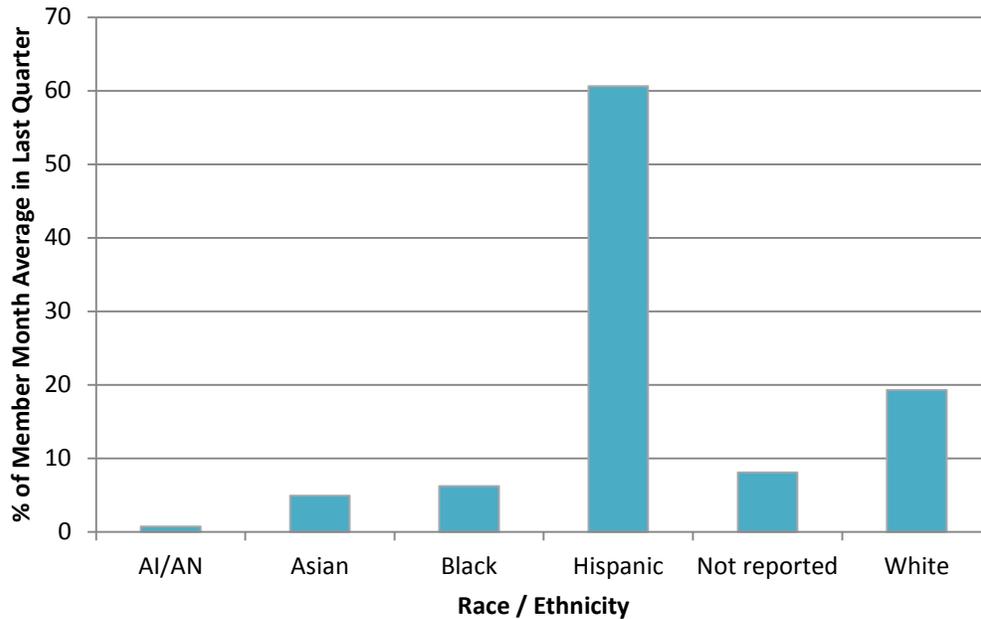
**Figure 12 Distribution of Medi-Cal Only Population Participating in the FFS Health Care Delivery System, by First Language; Last Quarter CY 2011**



**Distribution of Medi-Cal only Beneficiaries Participating in the FFS Health Care Delivery System, by Race/Ethnicity**

Hispanics account for the majority of Medi-Cal only beneficiaries participating in the FFS health care delivery system, representing 61% of the total FFS Medi-Cal only population. Whites account for 19 % of all FFS Medi-Cal beneficiaries, while African Americans and Asians represent a much smaller portion of the overall population (6% and 5%, respectively).

**Figure 13 Distribution of Medi-Cal Only Beneficiaries Participating in the FFS Health Care Delivery System, by Race/Ethnicity; Last Quarter 2011**

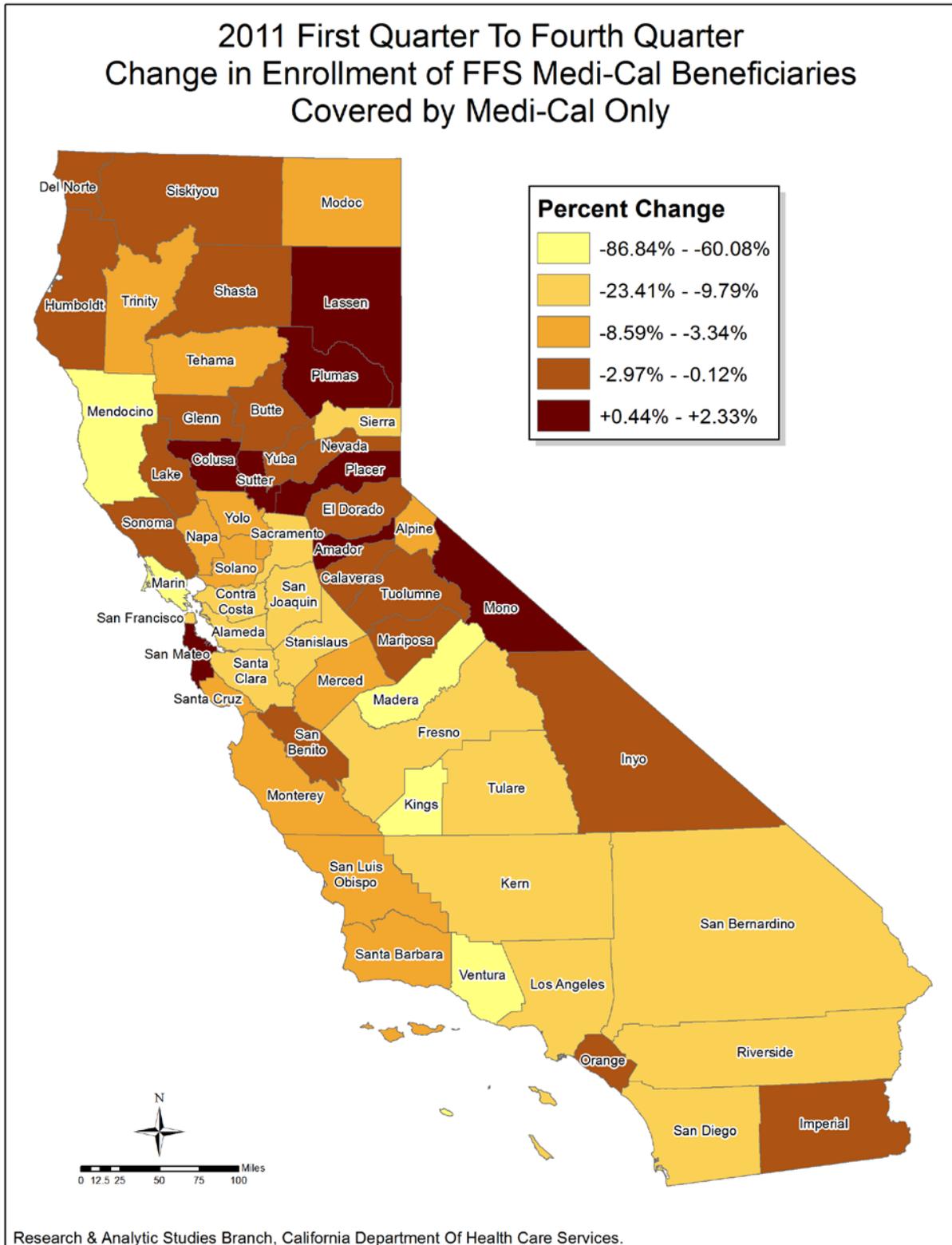


**Distribution of Medi-Cal only Beneficiaries Participating in the FFS Health Care Delivery System, by County**

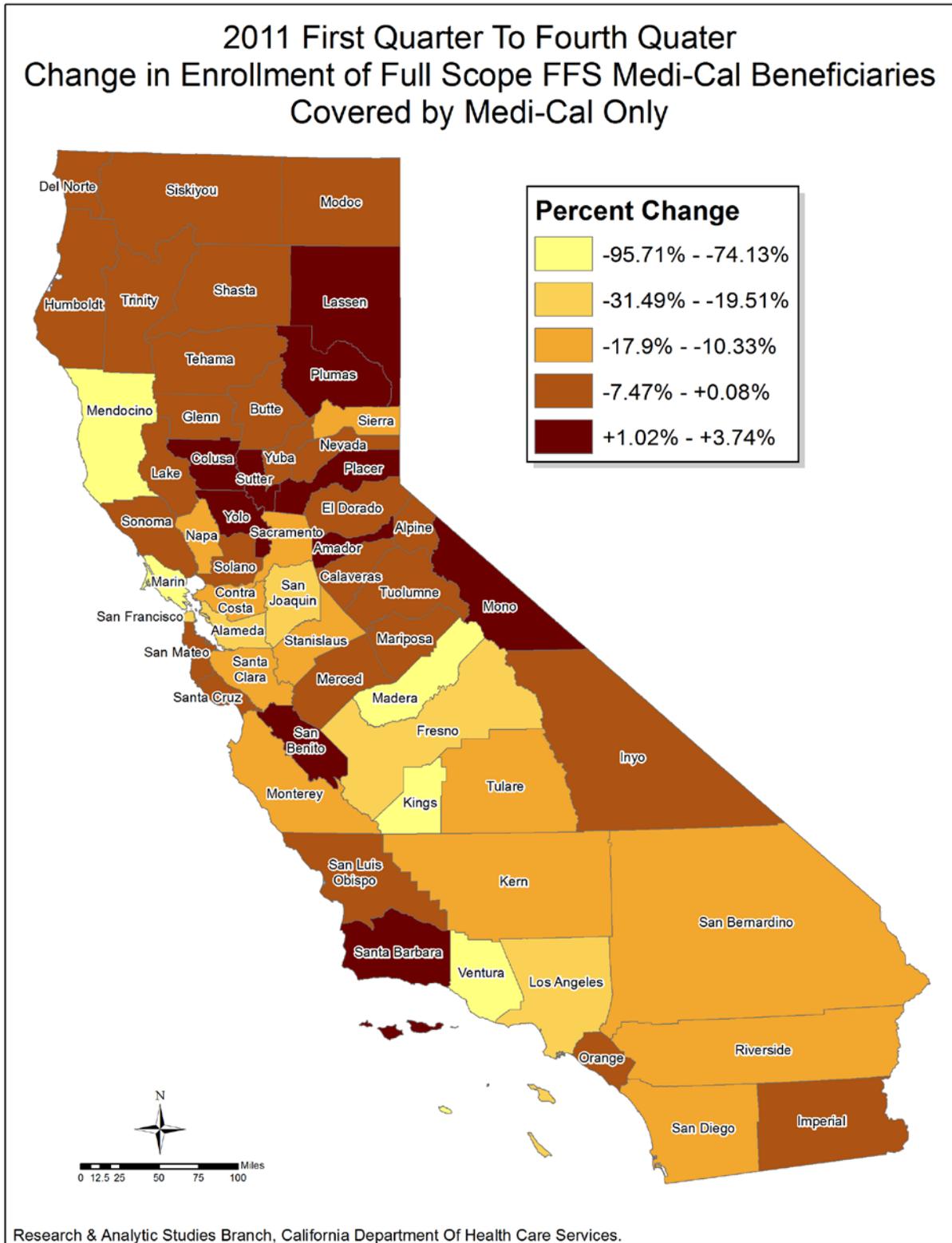
As shown in **Figure 14** below, most counties experienced a decrease in FFS participation by beneficiaries in all quarters in 2011. The counties with the steepest decrease in FFS participation were Mendocino, Ventura, Marin, Kings, and Madera between the first to the last quarter (87%, 82%, 70%, 65%, and 60% respectively). The counties of Mendocino, Ventura, and Marin implemented their transition from a FFS health care delivery model to a managed care model at different times during 2011, explaining the decrease in FFS participation by Medi-Cal only beneficiaries observed for those counties in CY 2011.

Similar changes in FFS participation were observed across all counties for Medi-Cal only beneficiaries under full scope coverage (**Figure 15** ).

**Figure 14 First and Fourth Quarter Comparison of FFS Participation by Medi-Cal Only Beneficiaries**



**Figure 15 First and Fourth Quarter Comparisons in FFS Participation by Full Scope Medi-Cal Only Beneficiaries**



## Conclusions – Beneficiary Enrollment

- Beneficiaries eligible for Medi-Cal only and participating in the FFS system are a culturally and ethnically diverse population. The majority self-describe as Hispanic. About half use Spanish as a first language.
- Several Medi-Cal populations eligible for Medi-Cal only and participating in FFS were transitioned into managed care delivery models. During late 2010 and CY 2011, the counties of Kings, Madera, Ventura, Mendocino, and Marin were transitioned from FFS to managed care delivery models. In addition, roughly 300,000 seniors and persons with disabilities were mandatorily enrolled in managed care health plans in the Two-Plan and GMC counties. These changes, in Medi-Cal's health delivery system, resulted in a decline in the number of beneficiaries participating in the FFS system.
- The number of beneficiaries eligible for Medi-Cal only and participating in FFS, entitled to full scope benefits decreased 8.3% in the last two quarters of CY 2011, and 21.6% when comparing enrollments for the first and last quarters, reflective of Medi-Cal's shift to managed care.
- The greatest decrease in FFS participation was observed among beneficiaries eligible for Medi-Cal only, entitled to full scope benefits enrolled in Aged and Blind/Disabled aid codes. The decrease in enrollment among these subpopulations was expected, given DHCS initiative aimed at transitioning SPDs into managed care plans.
- Overall, enrollment trends for Medi-Cal's FFS population were similar in metropolitan and non-metropolitan counties for CY 2011. For the last two quarters, enrollment continued to decrease in metropolitan counties, with only slight changes noted for non-metropolitan counties.
- Beneficiaries eligible for Medi-Cal only participating in FFS and enrolled in the Aged category residing in both metropolitan and non-metropolitan counties experienced the greatest decline in FFS participation from Q1 to Q4. Undocumented children, residing in non-metropolitan counties, also experienced significant declines in enrollment, particularly during the last two quarters of CY 2011. Unlike the populations discussed previously, shifts in system participation (i.e., from FFS to managed care) were not responsible for the declines recognized in the undocumented population. Undocumented beneficiaries are generally not eligible for Medi-Cal managed care enrollment. Declines recognized in the

undocumented population were the result in declining enrollment in the Medi-Cal program.

## **Use of Select Services by Medi-Cal FFS Beneficiaries**

### **Introduction**

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

There are many factors that affect healthcare utilization and the type of healthcare used by a given population, one of which 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 healthcare services. Some additional factors that influence utilization include the prevalence of chronic disease in the population, provider practice patterns, recommended medical practice guidelines for specific subgroups (i.e., 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 healthcare 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. Children, in general, have lower healthcare utilization rates than the elderly. However, infants born at low birth weight (< 2500 grams), and children with chronic health conditions and disabilities have both higher rates of healthcare use as well as utilize 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 healthcare utilization patterns should be undertaken with specific thought given to the characteristics of a population.

### **Methods**

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

1. Physician and clinics,
2. Emergency transportation
3. Non-emergency transportation,
4. Home health,
5. Hospital inpatient,
6. Hospital outpatient,
7. Nursing facility, and
8. Pharmacy services,
9. Other

Service use was measured in various ways, depending upon the provider type. The unit of measure for physician/clinic, home health, and hospital outpatient services was the number of unique visits or patient encounters. The unit of measure for pharmacy services was the unit counts of prescriptions. Individual encounters were used as the measure for both emergency and non-emergency transportation services, while the length of stay as measured in days was the unit of measure for hospital inpatient and nursing facility service use. 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 Medi-Cal's FFS system. Beneficiaries were classified into broad age groupings (children age 0 to 20 vs. adults age 21 and older) and aid codes as a proxy for health and disability status, factors which are known to influence utilization patterns.

DHCS plotted monthly service use rates per 1,000 member months for the period January 1, 2011 to December 31, 2011. DHCS used Shewhart control charts to identify whether healthcare service utilization rates changed over this time period and compared to low and high utilization thresholds calculated from the baseline period January 1, 2007 through December 31, 2009.<sup>29</sup> 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. Comparing the plotted measures to the mean and upper and lower control limits can lead to inferences regarding whether the data are within an expected or predictable range, or whether there are marked changes in the data over time. Potential marked changes include:

- Eight or more consecutive points, all either above or below the mean line, indicate a shift in utilization patterns.
- Six or more consecutive points, all going in the same direction (either up or down), indicate a trend.
- Two or more consecutive points plotted outside of these established limits will provide a signal indicating that healthcare utilization has deviated markedly from the expected range.

Changes in enrollment and provider capacity are important factors influencing healthcare 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 healthcare providers cannot absorb the increased demand, beneficiaries may experience difficulties accessing healthcare services<sup>30</sup>. In that case, one would expect to detect a decline in service use rates, as beneficiaries forego healthcare services. Under the second paradigm, if enrollment increases and the network of providers are able to absorb additional demand, then one would expect service use rates to remain constant, increase, or to experience

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<sup>29</sup> See various healthcare service utilization baseline analysis on the Department's website at [www.dhcs.ca.gov/pages/RateReductionInformation.aspx](http://www.dhcs.ca.gov/pages/RateReductionInformation.aspx)

<sup>30</sup> 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 use, utilization rates may actually decline. This decline may be driven more by the health characteristics than access difficulties.

no significant decreases<sup>31</sup>. Under the third paradigm, if enrollment decreases within a subpopulation and those that remain in the healthcare system have a significantly different case mix than the initial population, one would expect marked changes in healthcare utilization. For example, if the subpopulation that remains in the healthcare system has significantly greater medical needs than the initial population, one would expect service use rates to increase. However, if the subpopulation that remains is healthier, one would expect service use rates to decrease. Certain shifts in populations, from one health care system to another (i.e., 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 utilization trends for each of the nine service categories studied. Each section is introduced with a discussion that presents background material related to each unique service category. This background provides the reader with some introductory information regarding the types of services associated with the category, historical utilization, and types of providers, where applicable, contained within the service category. The reader should note that the background sections present utilization information that relates to CY 2010 and includes all FFS utilization, regardless of health care system participation (i.e., FFS or Managed care). In addition, utilization statistics associated with the background sections includes utilization associated with dual eligibles. Following the background information, utilization trends for each service category is presented. The utilization trends display statistics associated with beneficiaries eligible for Medi-Cal only and participating in Medi-Cal's FFS system.

### **Background Physician/Clinic Visits**

It is important for any healthcare delivery system to monitor trends in physician service use among its patients, because it is the first point of contact for most healthcare 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. Receipt of regular ambulatory healthcare visits has been widely recognized as a fundamental measure of successful healthcare 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 are determined by the US Department of Health and Human Services.

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<sup>31</sup> Assumes populations who enroll exhibit similar health needs as those who were enrolled prior.

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

Indian Health Services Clinics are those authorized by the US 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: physician and physician assistant services, nurse practitioner and nurse midwife services, visiting nurse services, clinical psychology and social work services, comprehensive perinatal care services, Early Periodic Screening, Diagnosis and Treatment Services (EPSDT), ambulatory and optometry services.

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

Many users of physician and clinic services are either being seen in physician group practices (2,413,502 or 46%) or in an FQHC or Rural Health Clinic (2,040,980 or 38.8%). Nearly half of all physician/clinic services are provided to children under the age of 20, and many are eligible for benefits under family aid codes. Most users of these services (75%) have on average between 1 and 5 visits annually.

### **Trend Analysis --- Physician/Clinic Visits, Beneficiaries Eligible For Medi-Cal Only and Participating in Medi-Cal's FFS System**

Among children age 0 to 20 in the Medi-Cal FFS program, monthly Physician / Clinic utilization rates ranged from 172.8 to 629.5 visits per 1,000 member months during CY 2011. Rates were notably higher among children in the Blind / Disabled aid category, most likely due to their inherent complex medical needs. Physician / Clinic utilization trends for CY 2011 were lower for most beneficiary subgroups than was observed in the baseline period of CY 2007 to CY 2009. Most notably, the utilization rates for children in the Undocumented aid category were well below the anticipated baseline ranges. Children in the Blind / Disabled aid category exhibited normal fluctuation in service use that remained within the expected baseline ranges, while children in the Families, Foster Care, and Other aid categories displayed lower average utilization rates during the last three quarters of CY 2011. These lower utilization rates coincide with the decrease in enrollment among Medi-Cal beneficiaries in this age group over the same time period.

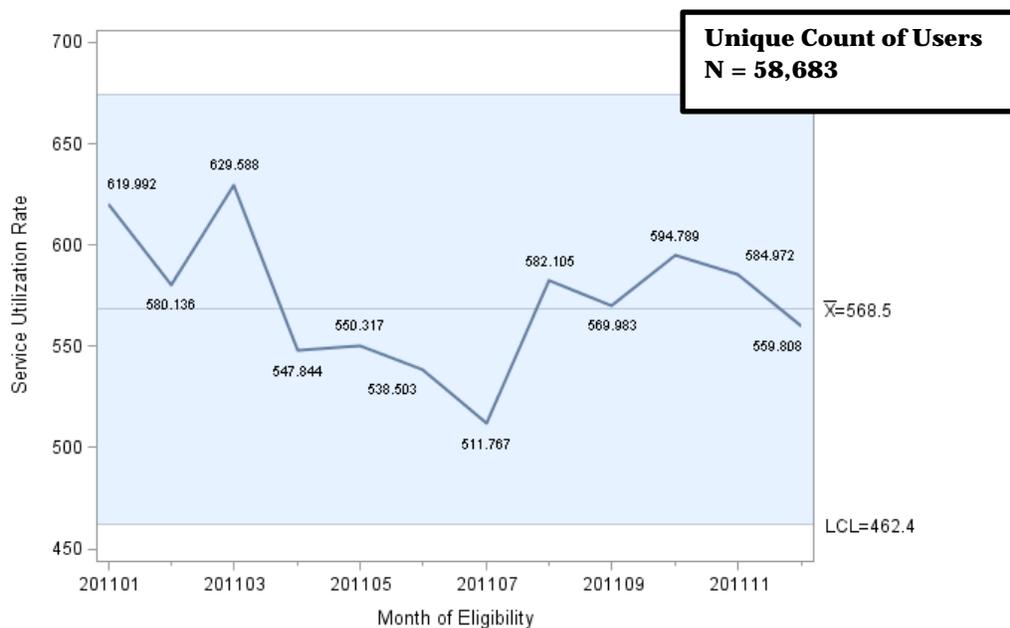
The monthly Physician / Clinic utilization rates for adults age 21 and older ranged from 217.1 to 1,359.0 visits per 1,000 member months in CY 2011. Adults in the Blind / Disabled and Other aid categories exhibited noticeably higher utilization rates than adult beneficiaries in other aid subgroups, while adults in the Families aid category exhibited a distinct decline in Physician/Clinic utilization over the last three quarters of CY 2011. Adult utilization trends in most aid categories were observed within the expected ranges. Similar to the trends for

children, the utilization rates for adults in the Undocumented aid category were below the anticipated baseline ranges. Additionally, the utilization rates for adults in the Aged aid category were notably below average throughout CY 2011. The lower utilization rates for adults in the Aged and Families aid categories also coincide with the decline in the overall Medi-Cal population during the same time frame.

There are many potential factors that may have influenced the decline in utilization of Physician /Clinic services among both children and adults in the Undocumented aid category. For instance, birth rates nationally experienced their sharpest decline in over thirty years from 2007 through 2010<sup>32</sup>, and data from the California Department of Public Health birth records indicate a similar trend state-wide<sup>33</sup>. Given that many beneficiaries in the Undocumented aid category become eligible for services because they are pregnant, it can be hypothesized that demand for Physician / Clinic services, particularly as it pertains to prenatal care and delivery, has decreased due to the decline in birth rates among this subgroup. A definitive explanation for deviations in trends for physician/clinic visits can only be reached, however, by undertaking further analysis.

### Trends in Physician/Clinic Use among Children

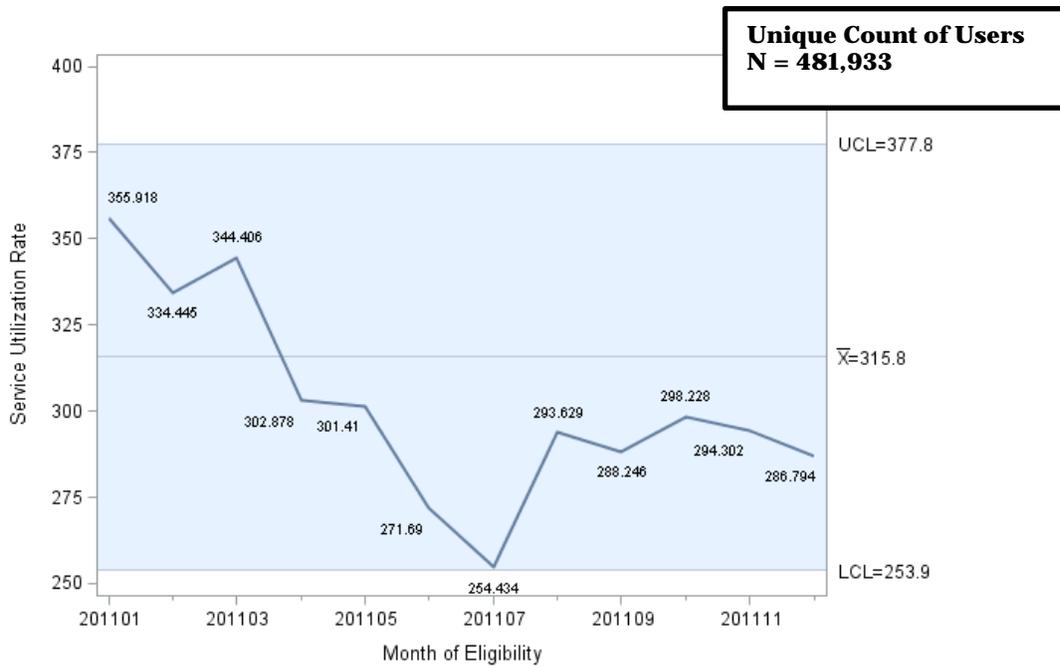
**Figure 16 Monthly Physician/Clinic Utilization Rates among Children (age 0-20) in the Blind/Disabled Aid Category, January thru December 2011**



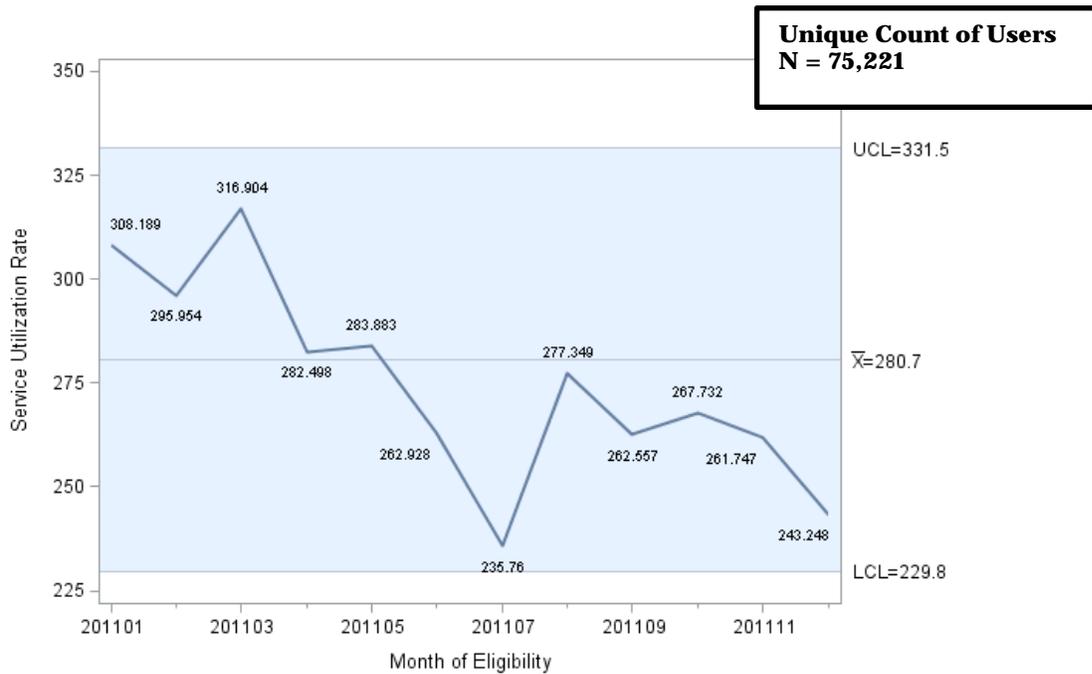
<sup>32</sup> Data from the National Vital Statistics System, found at <http://www.cdc.gov/nchs/data/databriefs/db60.pdf>

<sup>33</sup> Data published on the California Department of Public Health website, found at <http://www.cdph.ca.gov/data/statistics/Documents/VSC-2010-0202.pdf>

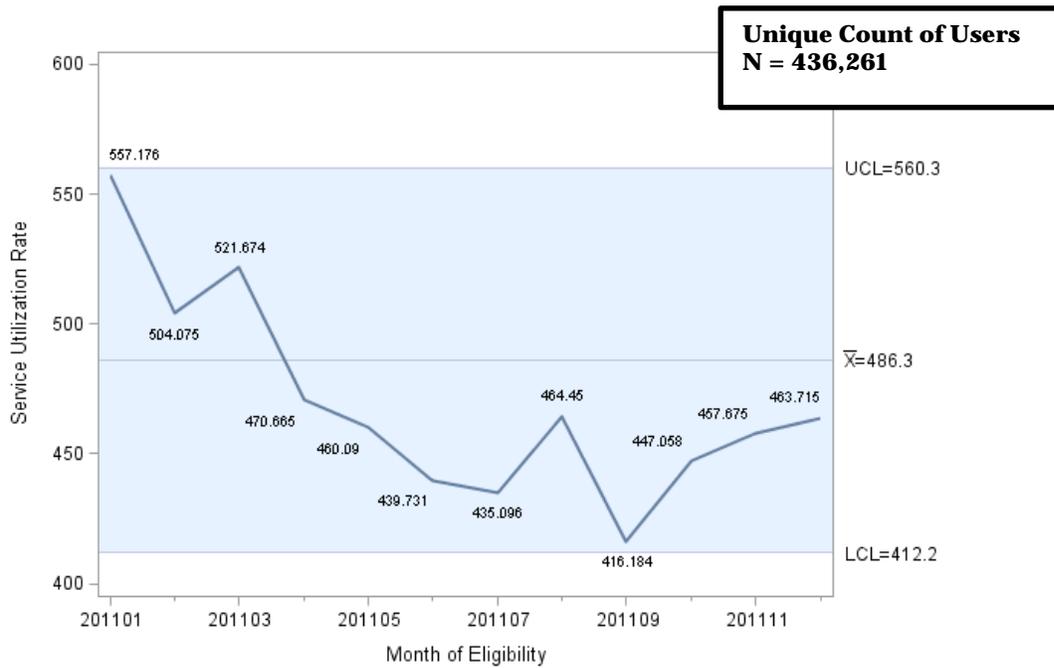
**Figure 17 Monthly Physician/Clinic Utilization Rates among Children (age 0-20) in the Families Aid Category, January thru December 2011**



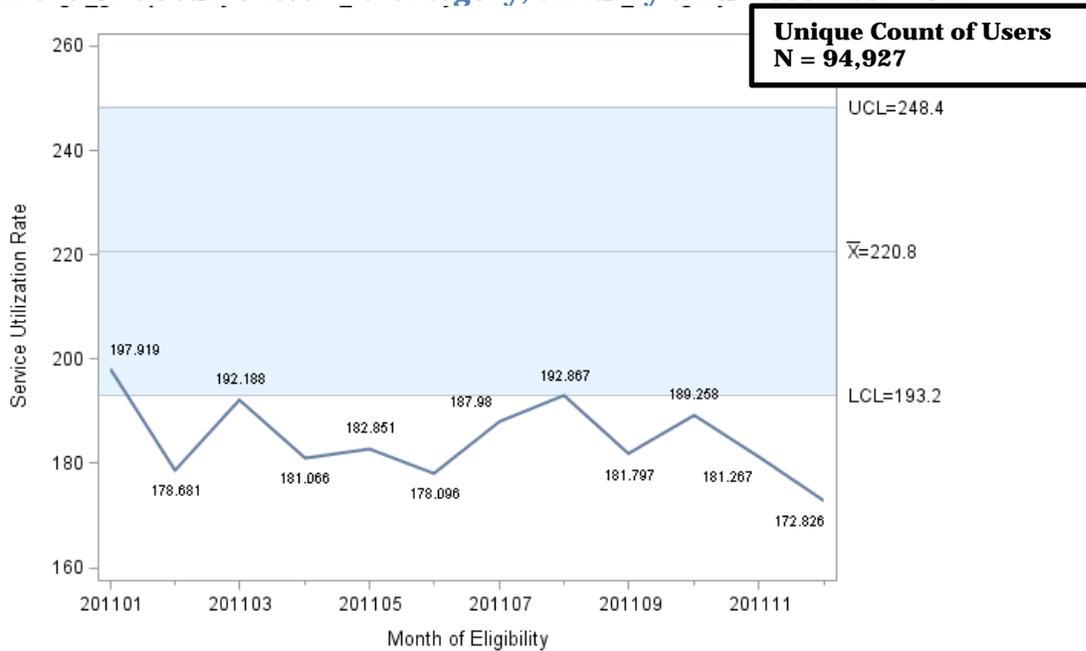
**Figure 18 Monthly Physician/Clinic Utilization Rates among Children (age 0-20) in the Foster Care Aid Category, January thru December 2011**



**Figure 19 Monthly Physician/Clinic Utilization Rates among Children (age 0-20) in the Other Aid Category, January thru December 2011**



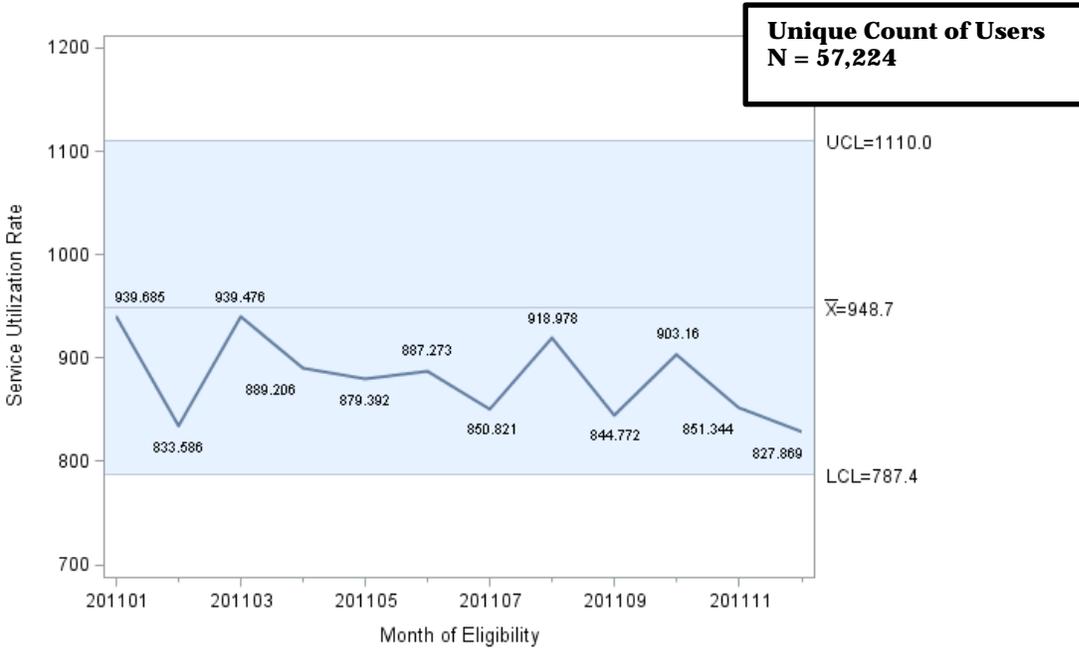
**Figure 20 Monthly Physician/Clinic Utilization Rates among Children (age 0-20) in the Undocumented Aid Category, January thru December 2011**



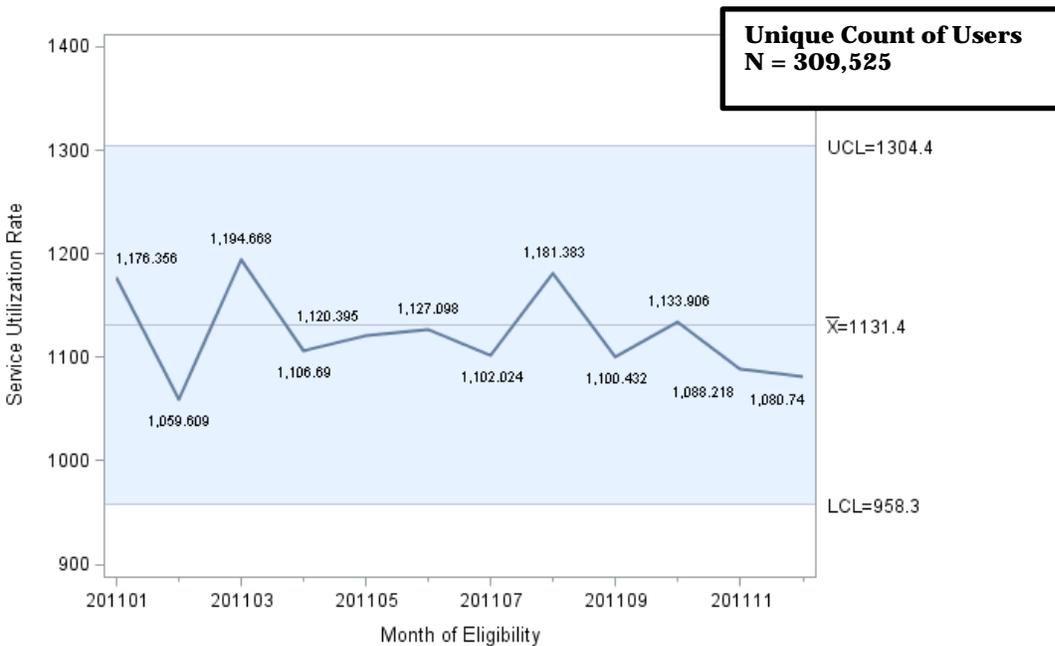
**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## Trends in Physician/Clinic Use among Adults

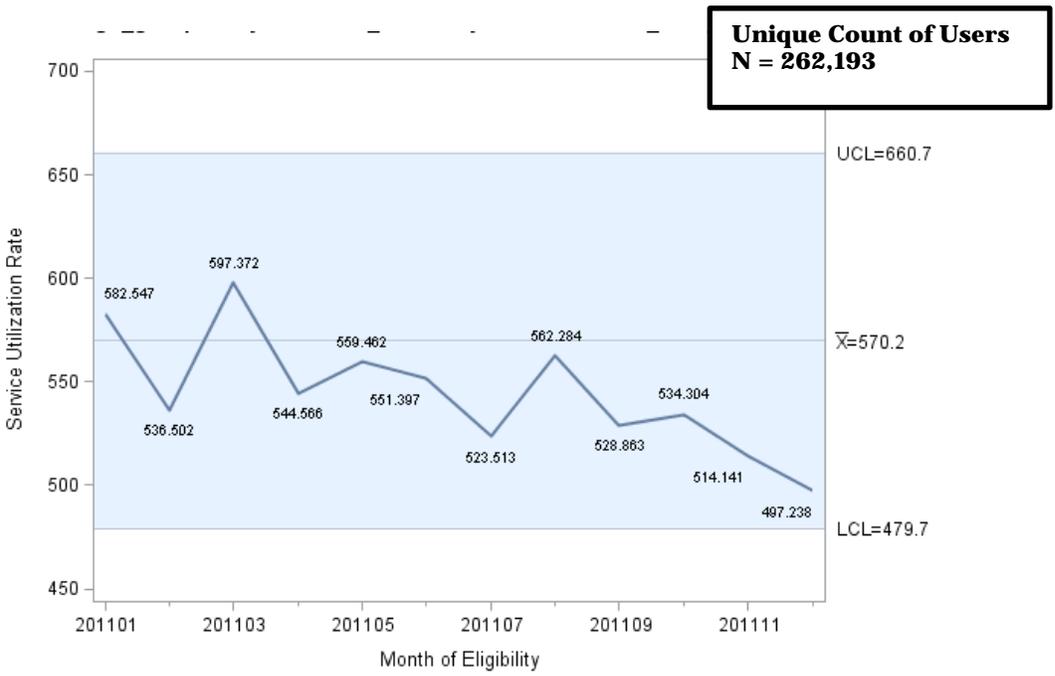
**Figure 21 Monthly Physician/Clinic Utilization Rates among Adults (age 21+) in the Aged Aid Category, January thru December 2011**



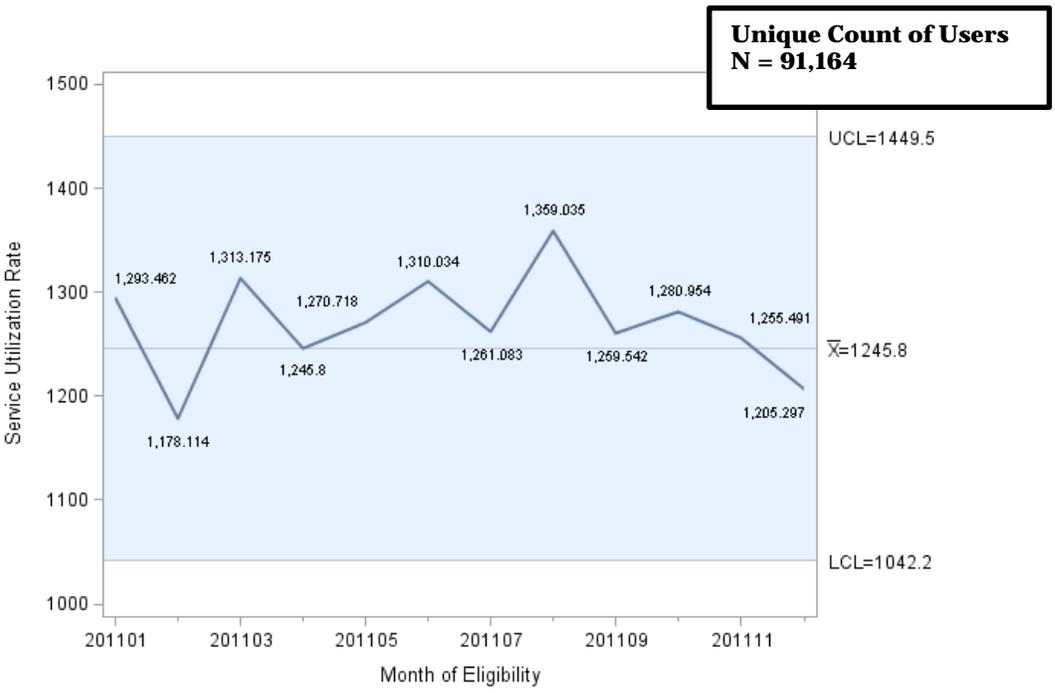
**Figure 22 Monthly Physician/Clinic Utilization Rates among Adults (age 21+) in the Blind/Disabled Aid Category, January thru December 2011**



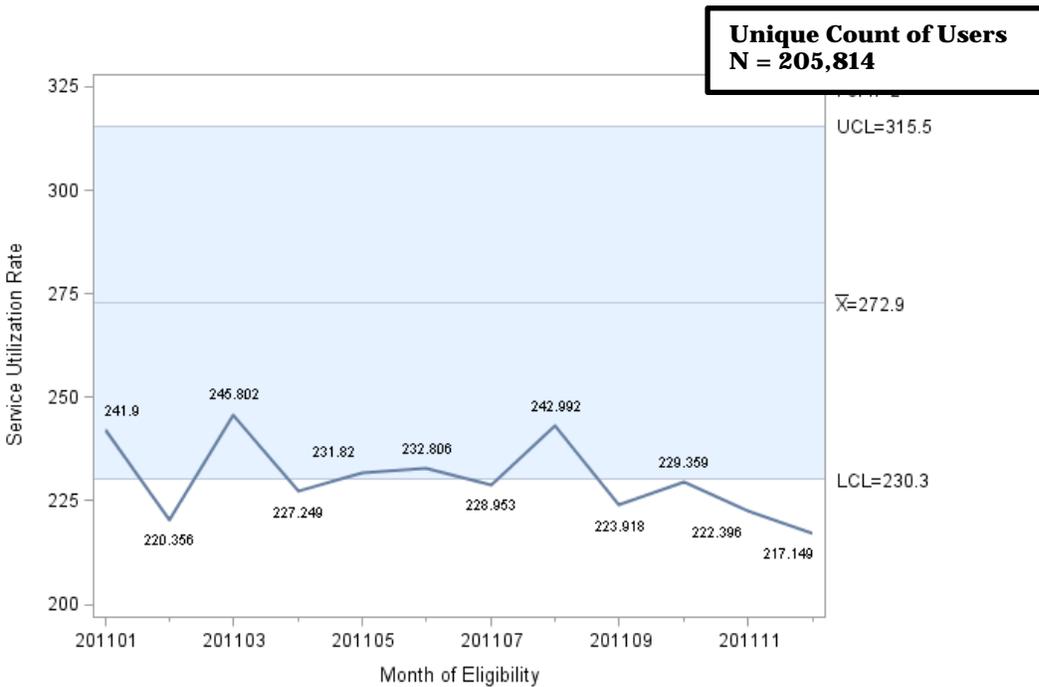
**Figure 23 Monthly Physician/Clinic Utilization Rates among Adults (age 21+) in the Families Aid Category, January thru December 2011**



**Figure 24 Monthly Physician/Clinic Utilization Rates among Adults (age 21+) in the Other Aid Category, January thru December 2011**



**Figure 25 Monthly Physician/Clinic Utilization Rates among Adults (age 21+) in the Undocumented Aid Category, January thru December 2011**



**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

### Background Non-Emergency Transportation

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 treatment 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 unfeasible.

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 medical transportation when transferring a patient being discharged from the hospital, or when plan members seek specific treatment such as organ transplantation services.

There are over 200,000 Medi-Cal beneficiaries that accessed 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 1 and 5 service encounters annually and are predominantly over the age of 65 (58%). Many beneficiaries who use these services are covered under disabled (45%), aged (30%), and long term care (18%) aid codes, and are seen for conditions such as renal failure, brain damage, congestive heart failure and other serious illnesses. Beneficiaries who use non-emergency medical transportation services 26 or more time annually represent a small segment of users (16%), a majority of whom have been diagnosed with renal failure (55%).

### **Trend Analysis --- Non-Emergency Medical Transportation, Beneficiaries Eligible for Medi-Cal Only and Participating in Medi-Cal's FFS System**

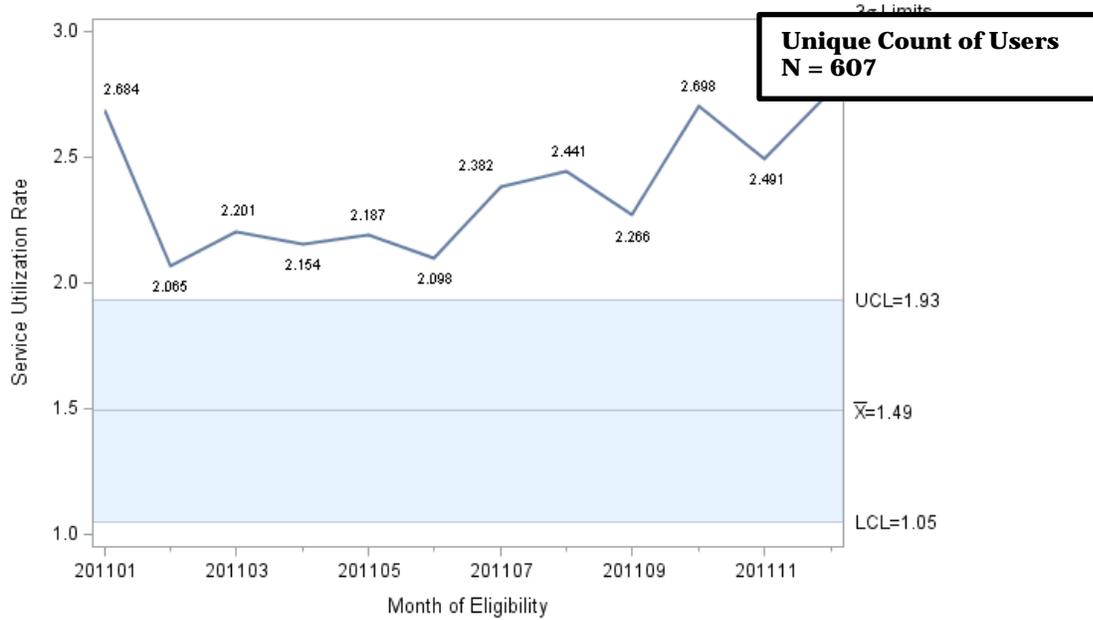
The monthly Non-Emergency Transportation utilization rates for children age 0 to 20 in the Medi-Cal FFS program ranged from .01 to 2.7 visits per 1,000 member months during CY 2011. Apart from children in the Blind/Disabled aid category, no other aid category exhibited a utilization rate approaching 1 or more visits per 1,000 member months. Non-emergency transportation utilization rates were well above baseline rates for children in the Blind / Disabled aid category, but were within expected baseline ranges for most other beneficiary subgroups. However, children in all of the analyzed aid categories experienced at least one month of utilization outside of the expected ranges observed in the baseline period of CY 2007 to CY 2009, and those in the Blind / Disabled, Families and Other aid categories experienced a positive spike in Non-Emergency Transportation utilization around October of CY 2011.

Among adults 21 and older, monthly Non-Emergency Transportation utilization rates ranged from 4.3 to 84.4 visits per 1,000 member months during CY 2011. Adults in the Aged and Blind /Disabled aid categories exhibited noticeably higher utilization rates ranging from 60.1 to 84.4 visits per 1,000 member months, while adults in the Families (4.5 to 5.7 visits per 1,000 member months) aid category utilized these services less frequently. Nonetheless, non-Emergency Transportation utilization trends for adults in all aid categories exhibited rates that were well above the baseline ranges established in 2007-2009, and in most cases these utilization rates exhibited an upward trend over the course of CY 2011.

Medi-Cal FFS beneficiaries in the Undocumented aid category are not entitled to Non-Emergency Services and, therefore; were excluded from this analysis.

## Trends in Non-Emergency Medical Transportation Use among Children

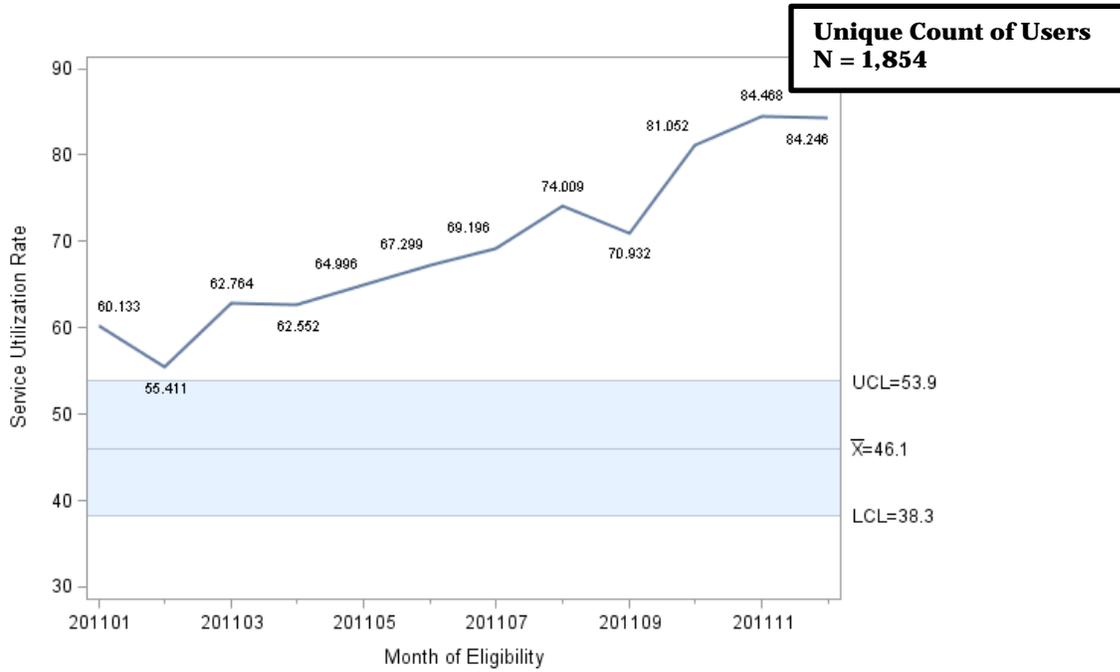
**Figure 26 Monthly Non-Emergency Transportation Utilization Rates among Children (age 0-20) in the Blind/Disabled Aid Category, Jan thru Dec 2011**



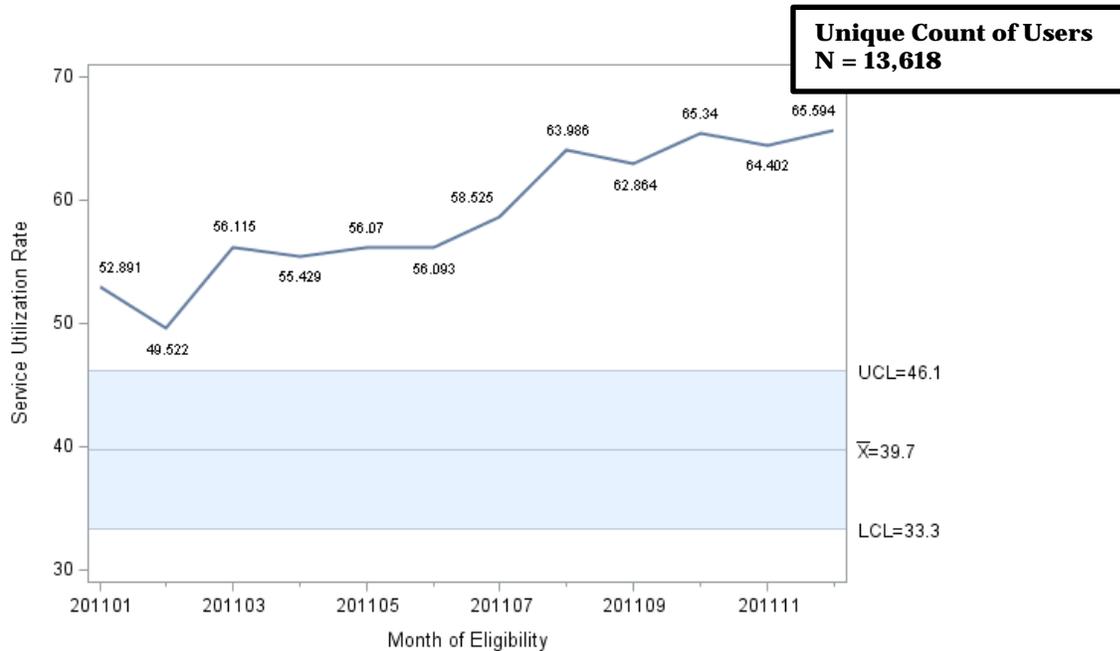
**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## Trends in Non-Emergency Medical Transportation Use among Adults

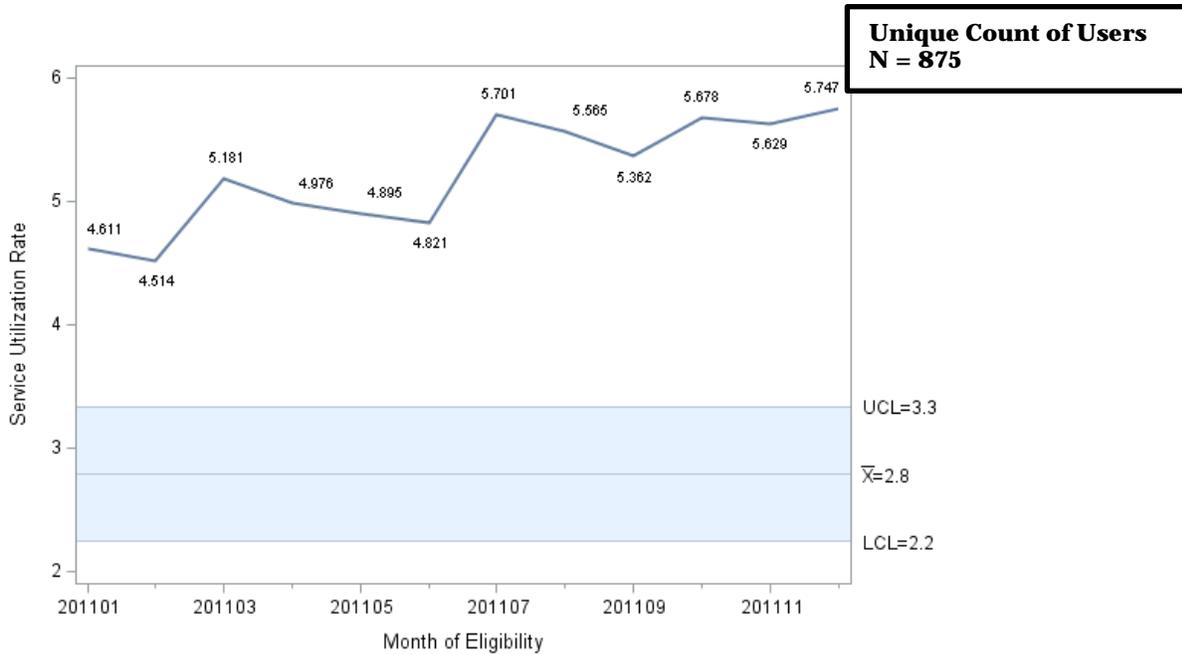
**Figure 27 Monthly Non-Emergency Transportation Utilization Rates among Adults (age 21+) in the Aged Aid Category, January thru December 2011**



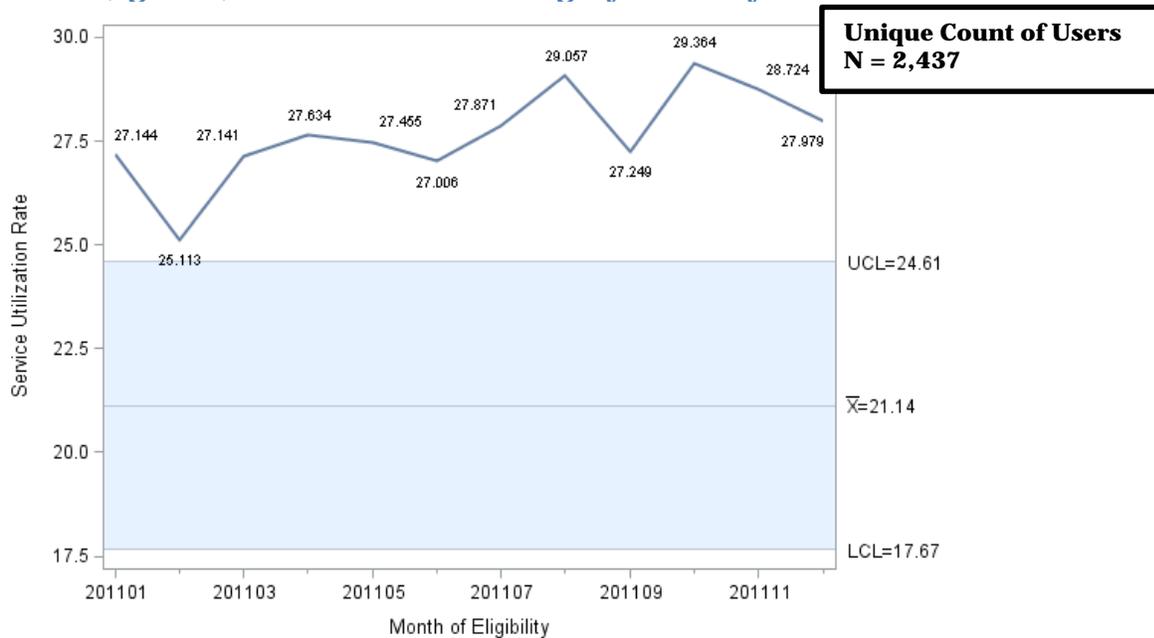
**Figure 28 Monthly Non-Emergency Transportation Utilization Rates among Adults (age 21+) in the Blind/Disabled Aid Category, January thru December 2011**



**Figure 29 Monthly Non-Emergency Transportation Utilization Rates among Adults (age 21+) in the Families Aid Category, January thru December 2011**



**Figure 30 Monthly Non-Emergency Transportation Utilization Rates among Adults (age 21+) in the Other Aid Category, January thru December 2011**



**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## **Background Emergency Medical Transportation, Beneficiaries Eligible For Medi-Cal Only and Participating in Medi-Cal's FFS System**

Emergency transportation is the transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated persons for medical treatment needed in life-threatening situations. Similarly 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 are inaccessible to ground transportation. Approximately 2.5% of all emergency transportation services are provided via 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% used emergency transportation, at a cost of \$56,777,111 or 32.3% of the total medical transportation expenditures. A large proportion of emergency medical transportation users utilize services just once annually (69%), while a small proportion (5%) have 6 or more emergency medical transportation service encounters annually. The predominant user groups of emergency transportation services are adults between the ages of 21 and 64 (66%), are in disabled aid codes (50%), and are being treated for abdominal and chest pain, injuries, epilepsy or convulsions, spondylosis and other back problems, and schizophrenia or other psychotic disorders.

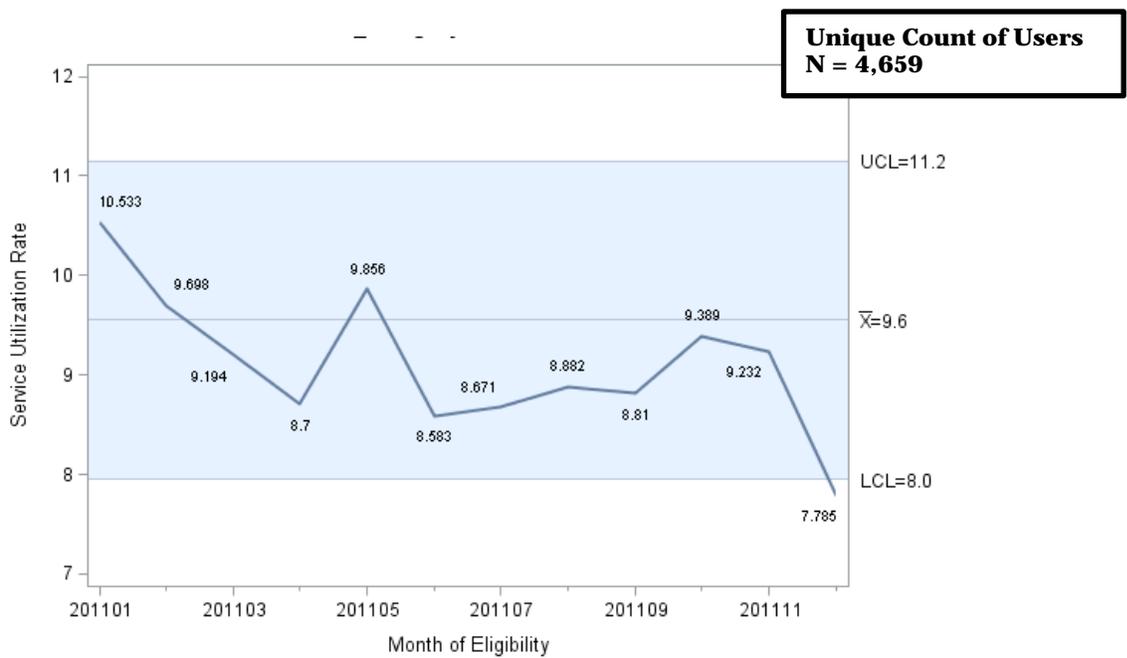
## **Trend Analysis --- Emergency Medical Transportation, Beneficiaries Eligible for Medi-Cal Only and Participating in Medi-Cal's FFS System**

Among children age 0 to 20 in the Medi-Cal FFS program, monthly Emergency Medical Transportation utilization rates ranged from 1.25 to 10.5 visits per 1,000 member months during CY 2011. Utilization rates were noticeably higher among children in the Blind / Disabled aid category, ranging from 7.8 to 10.5 visits per 1,000 member months, while utilization rates for children in the Families and Other aid categories ranged from 2.1 to 3.1 visits per 1,000 member months. Children in the Blind / Disabled, Families, Other, and Undocumented aid categories had utilization rates below the average baseline rates, and experienced downward trends in utilization for CY 2011, whereas those in the Foster Care aid category experienced utilization rates within the expected baseline ranges. The utilization trends for children in the Other and Undocumented aid categories fell below the expected ranges observed in the baseline period of CY 2007 to CY 2009. Children in both of these aid categories had two or more consecutive months of Emergency Medical Transportation utilization outside of the established baseline range.

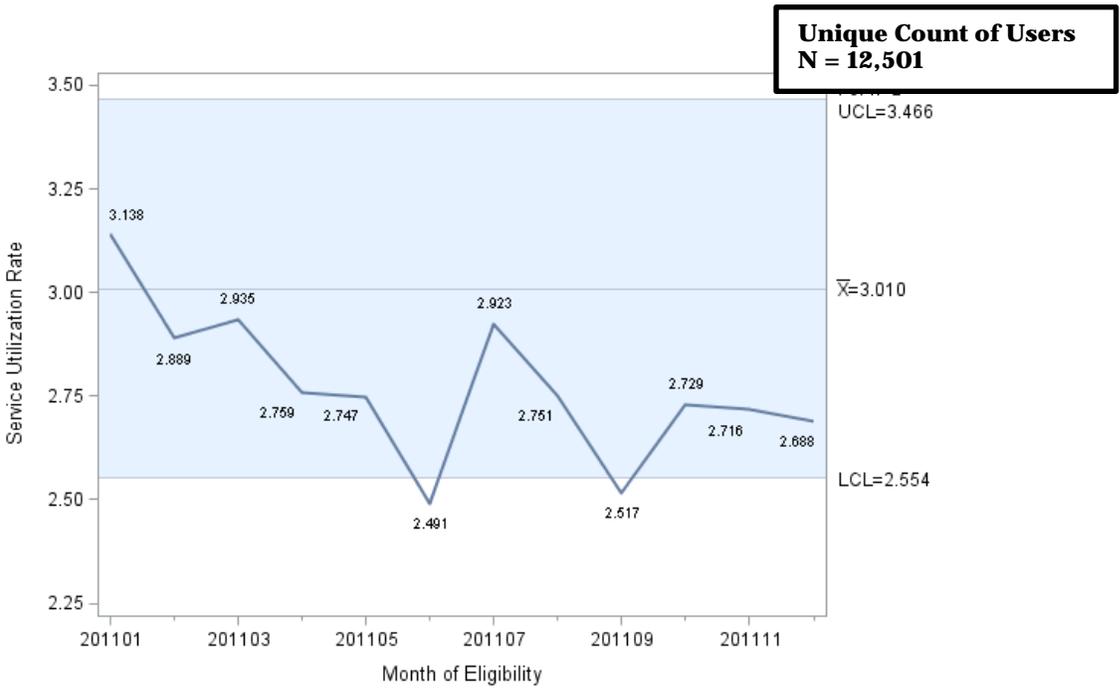
The monthly Emergency Medical Transportation utilization rates for adults age 21 and older ranged from 1.6 to 43.3 visits per 1,000 member months in CY 2011. The utilization rates were noticeably higher for adults in the Blind / Disabled aid category, while, in comparison, adults in the Undocumented aid category rarely utilized these services. Adults in the Aged and Blind / Disabled aid categories exhibited normal Emergency Medical Transportation utilization patterns during CY 2011, with those in the Aged aid category exhibiting an upward trend in use beginning in July. In contrast, the utilization rates for adults in the Families and Other aid categories were notably below average for the majority of CY 2011. The Emergency Medical Transportation utilization patterns for adults in the Undocumented aid category fell below the anticipated baseline ranges during the entirety of CY 2011.

### Trends in Emergency Medical Transportation Use among Children

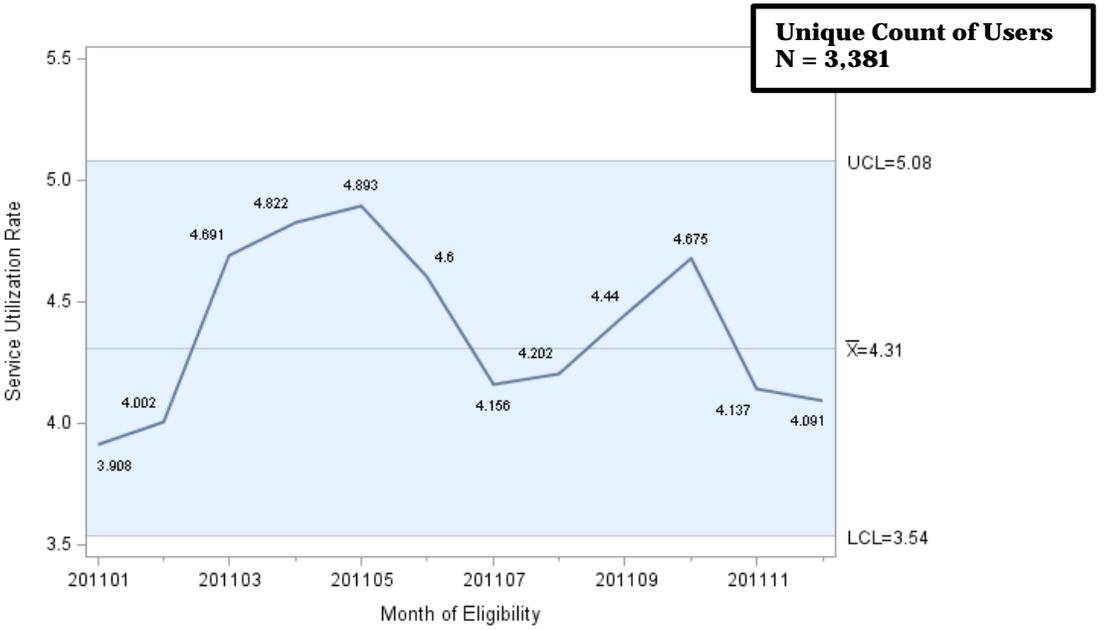
**Figure 31 Monthly Emergency Transportation Utilization Rates among Children (age 0-20) in the Blind/Disabled Aid Category, January thru December 2011**



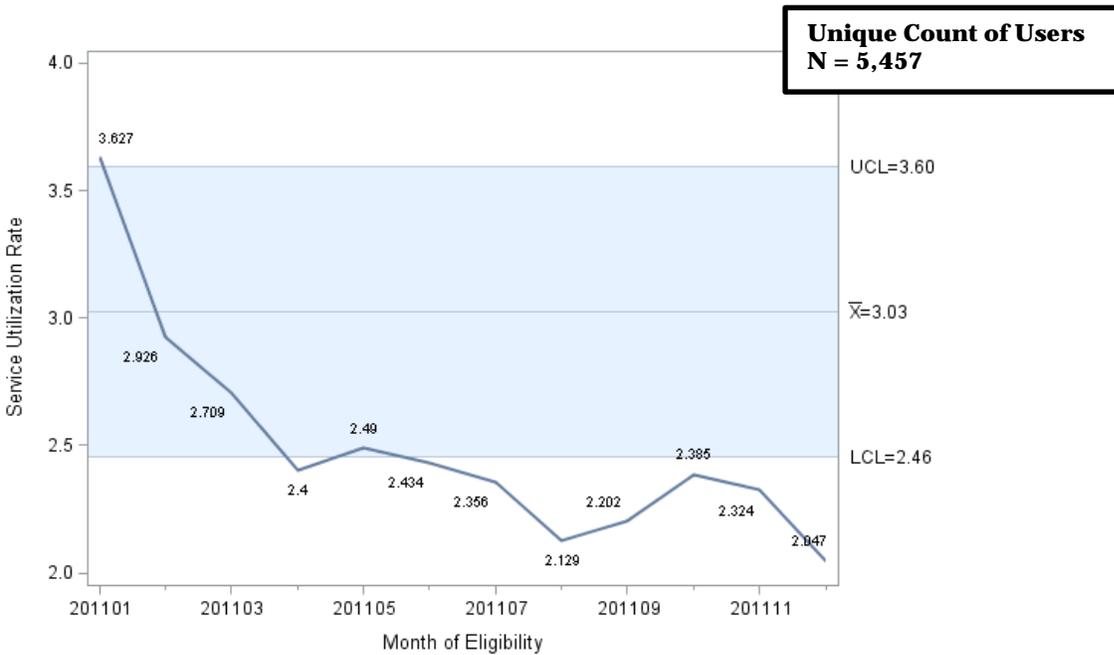
**Figure 32 Monthly Emergency Transportation Utilization Rates among Children (age 0-20) in the Families Aid Category, January thru December 2011**



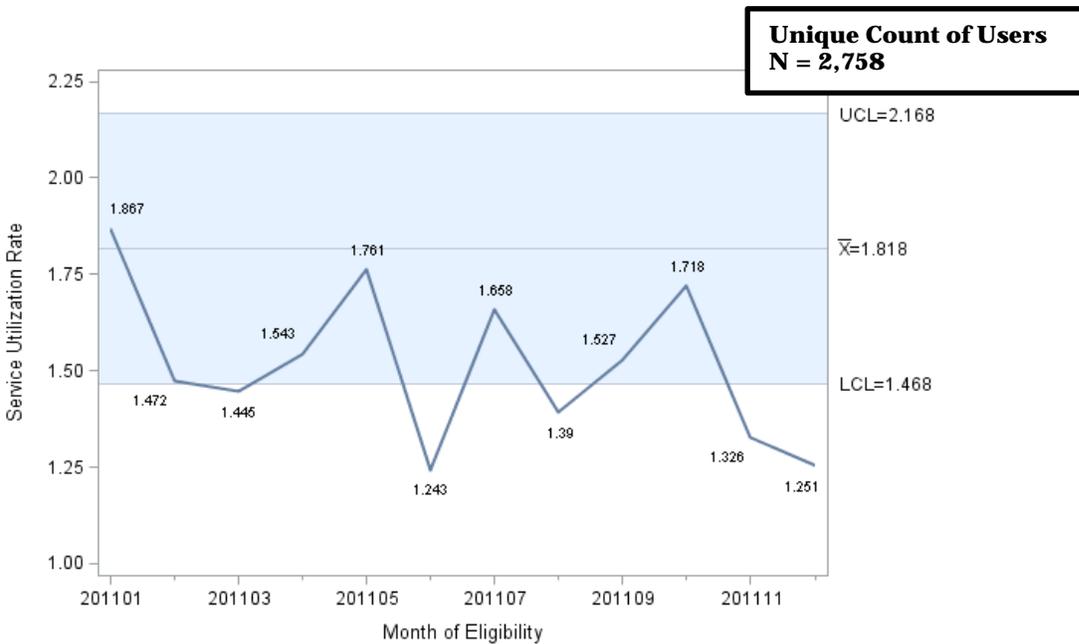
**Figure 33 Monthly Emergency Transportation Utilization Rates among Children (age 0-20) in the Foster Care Aid Category, January thru December 2011**



**Figure 34 Monthly Emergency Transportation Utilization Rates among Children (age 0-20) in the Other Aid Category, January thru December 2011**



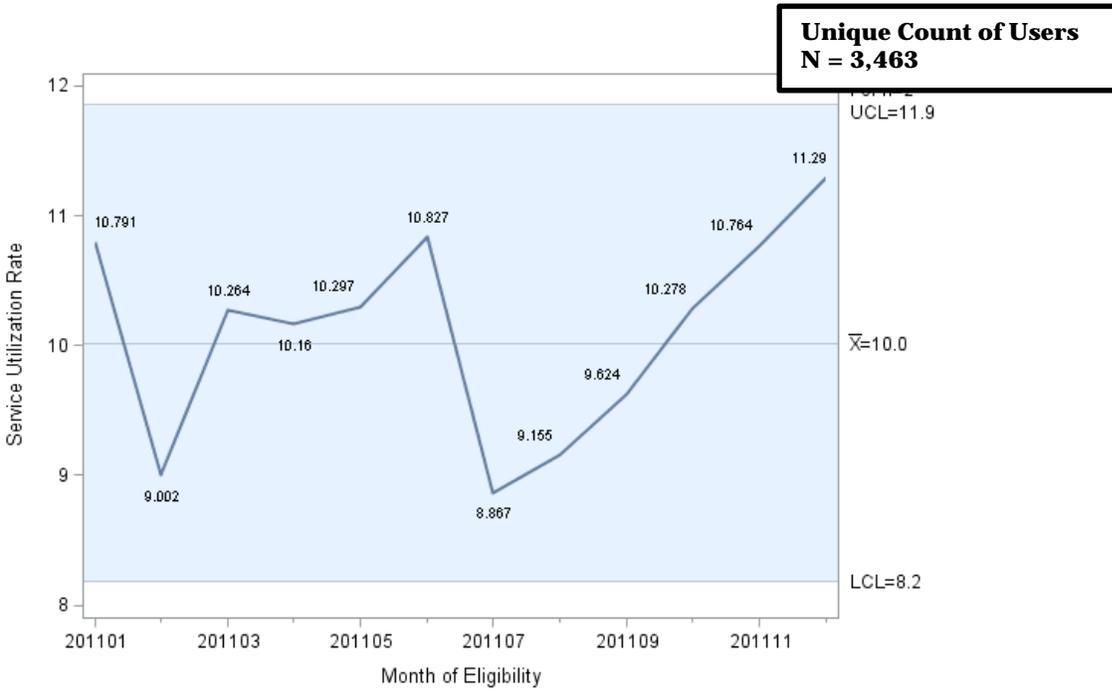
**Figure 35 Monthly Emergency Transportation Utilization Rates among Children (age 0-20) in the Undocumented Aid Category, January thru December 2011**



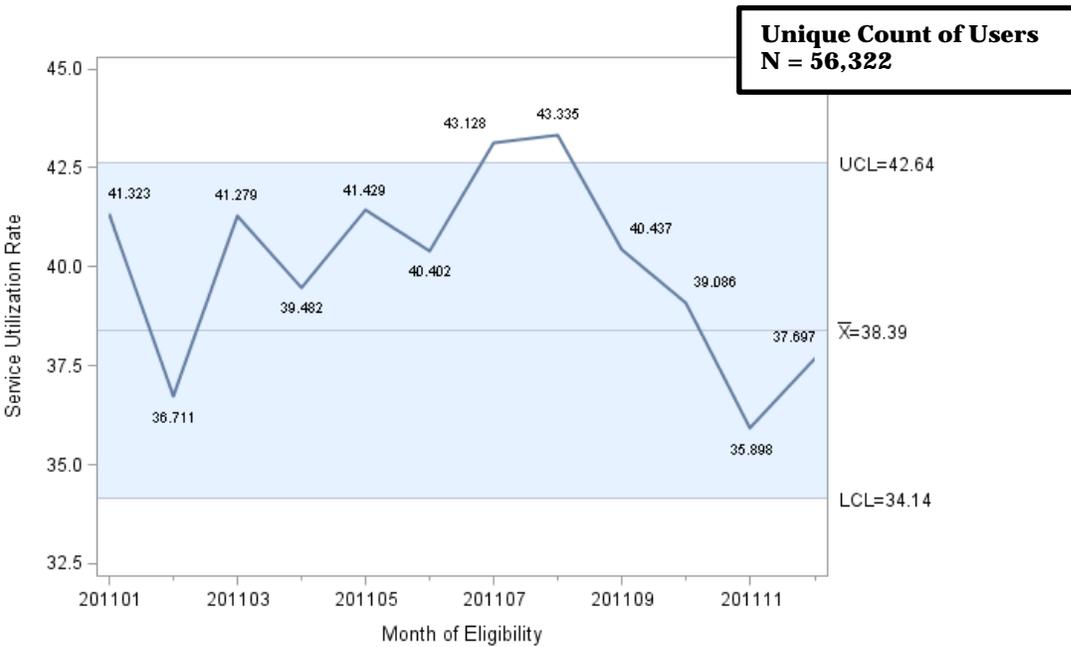
**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## Trends in Emergency Medical Transportation Use among Adults

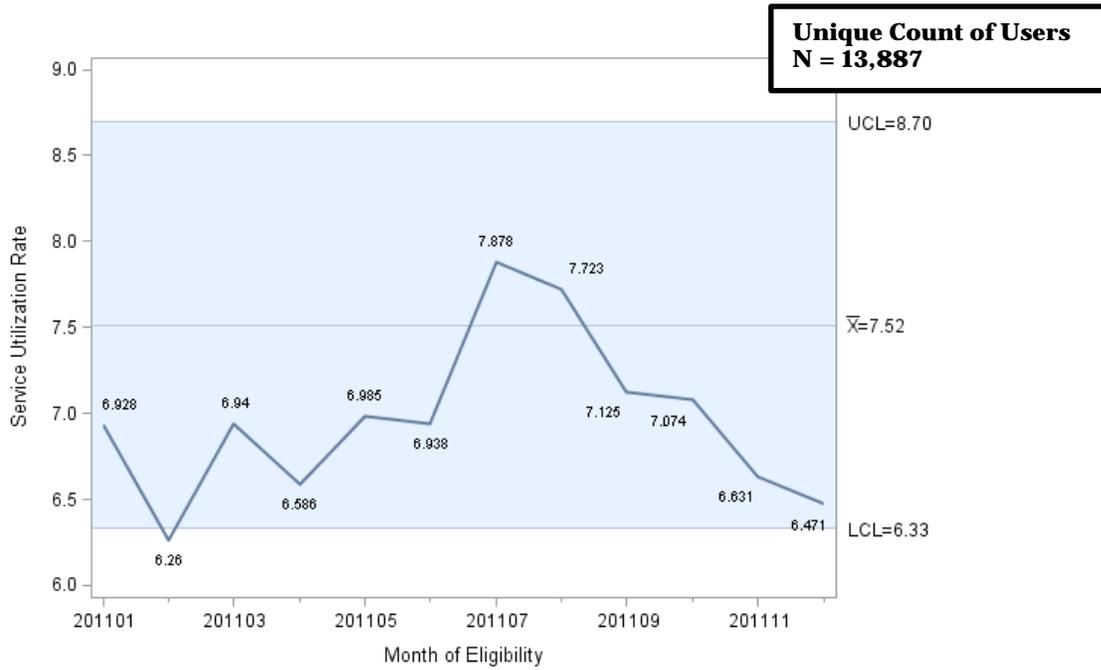
**Figure 36 Monthly Emergency Transportation Utilization Rates among Adults (age 21+) in the Aged Aid Category, January thru December 2011**



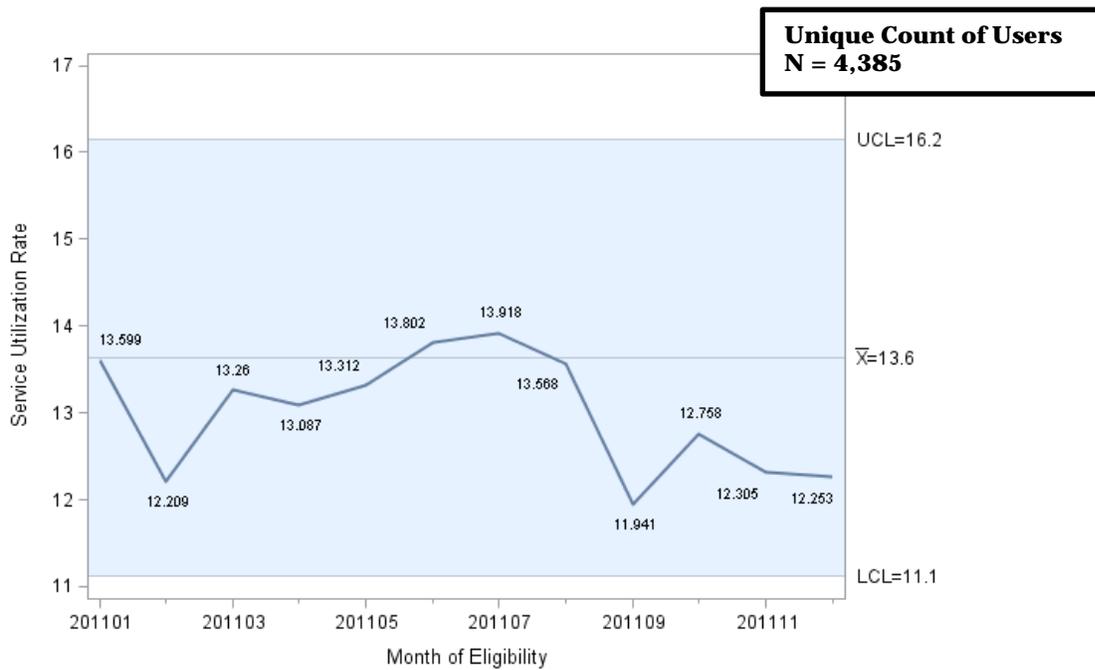
**Figure 37 Monthly Emergency Transportation Utilization Rates among Adults (age 21+) in the Blind/Disabled Aid Category, January thru December 2011**



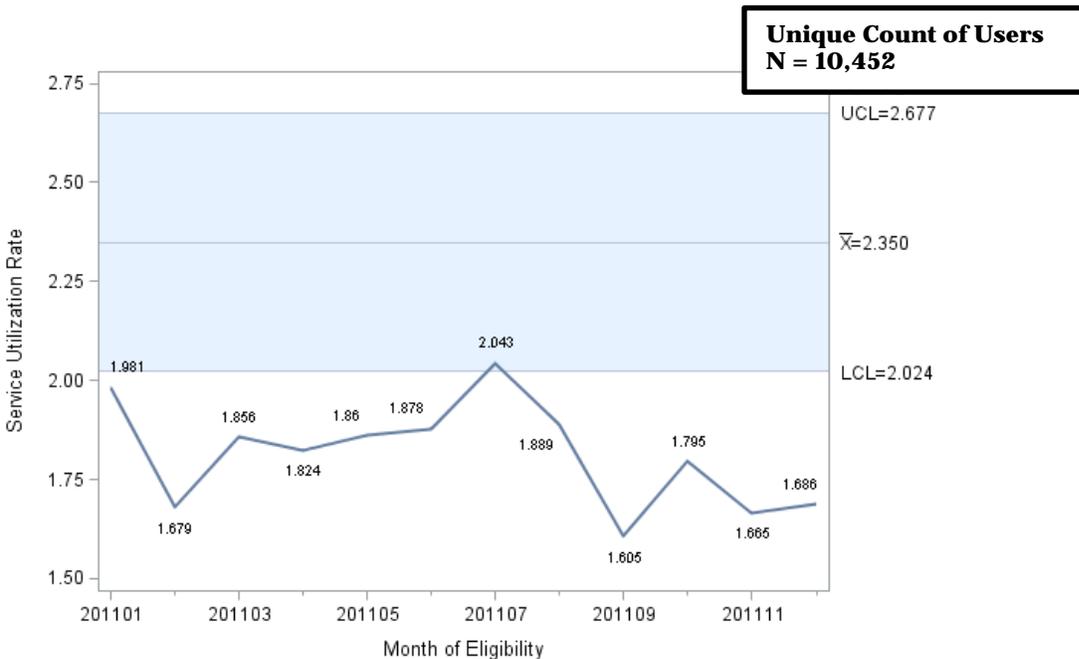
**Figure 38 Monthly Emergency Transportation Utilization Rates among Adults (age 21+) in the Families Aid Category, January thru December 2011**



**Figure 39 Monthly Emergency Transportation Utilization Rates among Adults (age 21+) in the Other Aid Category, January thru December 2011**



**Figure 40 Monthly Emergency Transportation Utilization Rates among Adults (age 21+) in the Undocumented Aid Category, January thru December 2011**



*Source:* Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## Background Home Health Services

Home health services provide outpatient care on an intermittent or part-time basis. Services include: part-time or intermittent skilled nursing by licensed nursing personnel; in-home medical care; physical, occupational, or speech therapy; home health aide; provision of medical supplies, excluding drugs and biological; medical social services; and use of medical appliances. These services must be prescribed by a physician under a written plan renewed every 60 days, and be provided at the recipient’s place of residence. Most services require prior authorization, except for services related to case evaluations and early discharge follow-up visits.

Home health services paid through fee-for-service 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 fee-for-service Medi-Cal. Most home health services users are adults age 21 and older (69%), while another 31% are children. Though children represent a small proportion of home health users, their expenditures are significant, accounting for 73% of total home health

service costs. Most of these expenditures are attributable to EPSDT private duty nursing that provides care for children with paralysis, nervous system disorders, epilepsy, and other congenital anomalies and hereditary conditions.

Private duty nursing and home and community-based waiver populations receive long-term home health services averaging 9.3 months. Most individuals receiving long-term care services have more chronic conditions, under age 21, and are covered under disabled aid codes. 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 codes , and an approximately 25% are in medically needy Families and Undocumented aid codes and most likely receive services for postpartum follow up care.

### **Trend Analysis --- Home Health Services, Beneficiaries Eligible for Medi-Cal Only and Participating in Medi-Cal's FFS System**

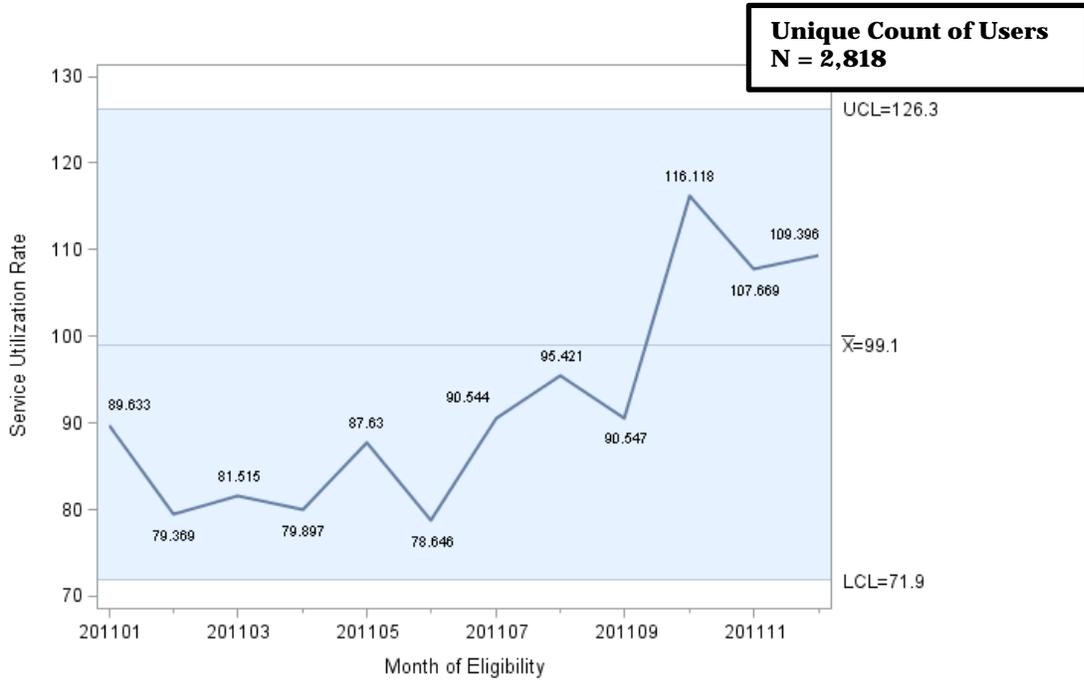
The monthly Home Health Services utilization rates for children age 0 to 20 in the Medi-Cal FFS program ranged from .49 to 116.1 visits per 1,000 member months in CY 2011. The utilization rates were noticeably higher for children in the Blind/ Disabled aid category, ranging from 78.6 to 116.2 visits per 1,000 member months, whereas children in the Families and Other aid categories rarely utilized these services during CY 2011. The Home Health Services utilization rates for children in most aid categories was noticeably below average at the beginning of CY 2011, and increasing above average for those in the Blind/Disabled, Families and Other aid categories in the last quarter of CY 2011. The utilization trends for CY 2011 fell, for the most part, within the expected ranges observed in the baseline period of CY 2007 to CY 2009. For children in the Other aid category, utilization rates remained below baseline averages throughout CY 2011.

Among adults 21 and older, monthly Home Health Services utilization rates ranged from .21 to 11.7 visits per 1,000 member months during CY 2011. Similar to the children's patterns, the utilization rates were noticeably higher for adults in the Adults in the Blind/ Disabled aid category. However, adult utilization rates for this service category exhibited much lower overall utilization rates than children. Adults in every aid category displayed home health service utilization rates that were noticeably below average throughout CY 2011, and fell below the baseline ranges for those in the Families aid category.

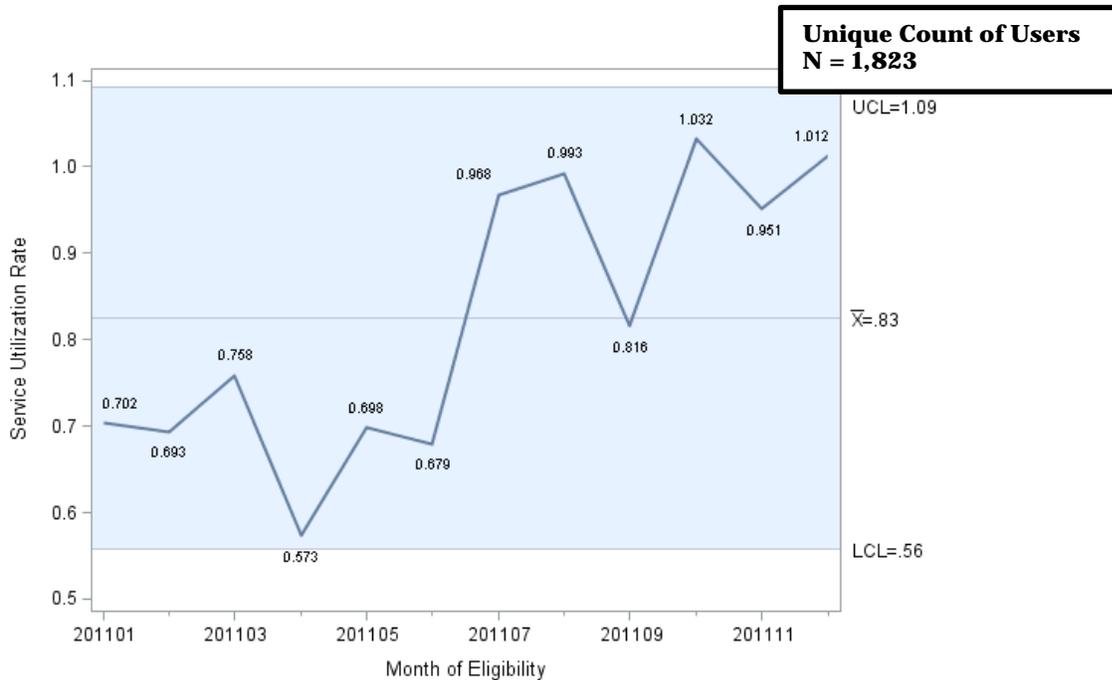
Medi-Cal FFS beneficiaries in the Undocumented aid category are not entitled to Home Health Services and, therefore, were excluded from this analysis.

## Trends in Home Health Service Use among Children

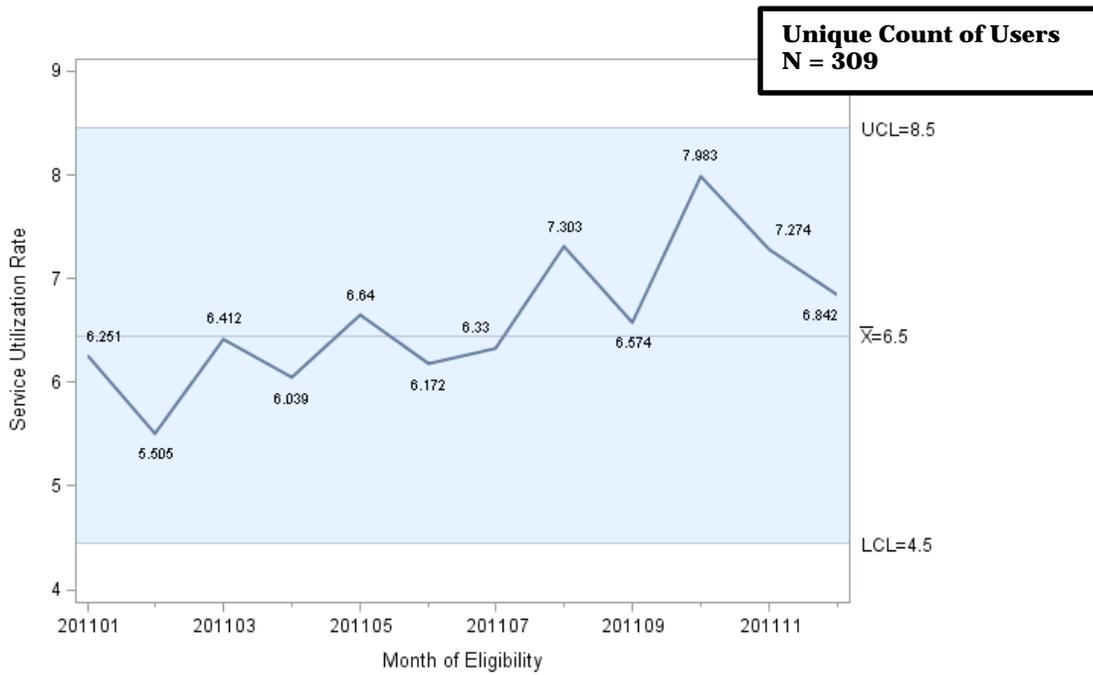
**Figure 41 Monthly Home Health Services Utilization Rates among Children (age 0-20) in the Blind/ Disabled Aid Category, January thru December 2011**



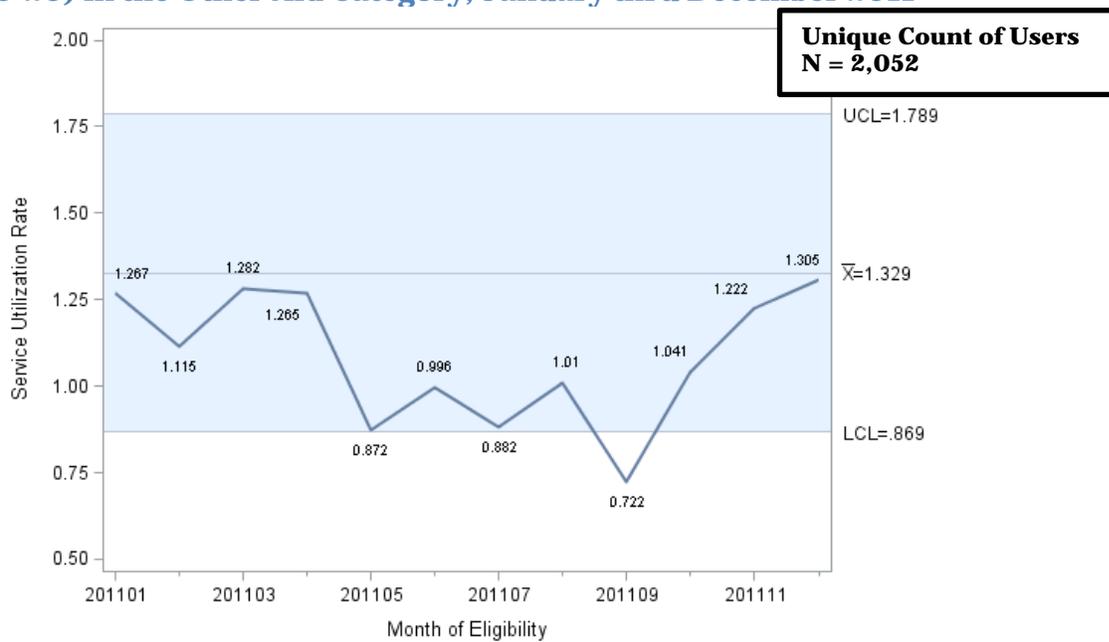
**Figure 42 Monthly Home Health Services Utilization Rates among Children (age 0-20) in the Families Aid Category, January thru December 2011**



**Figure 43 Monthly Home Health Services Utilization Rates among Children (age 0-20) in the Foster Care Aid Category, January thru December 2011**



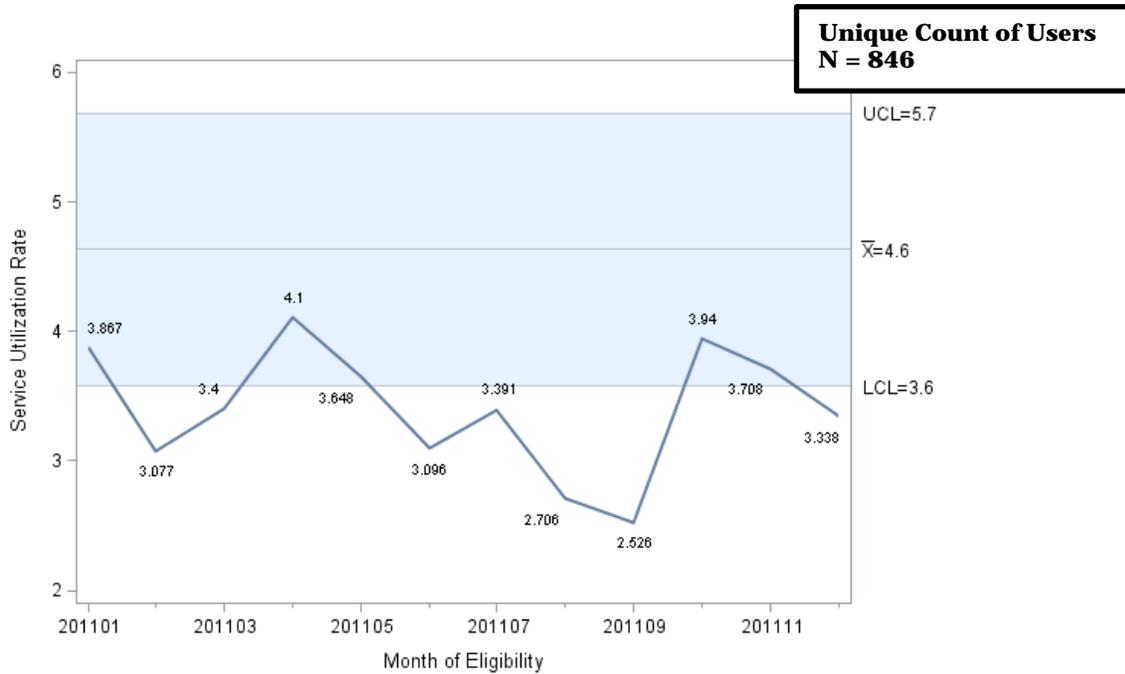
**Figure 44 Monthly Home Health Services Utilization Rates among Children (age 0-20) in the Other Aid Category, January thru December 2011**



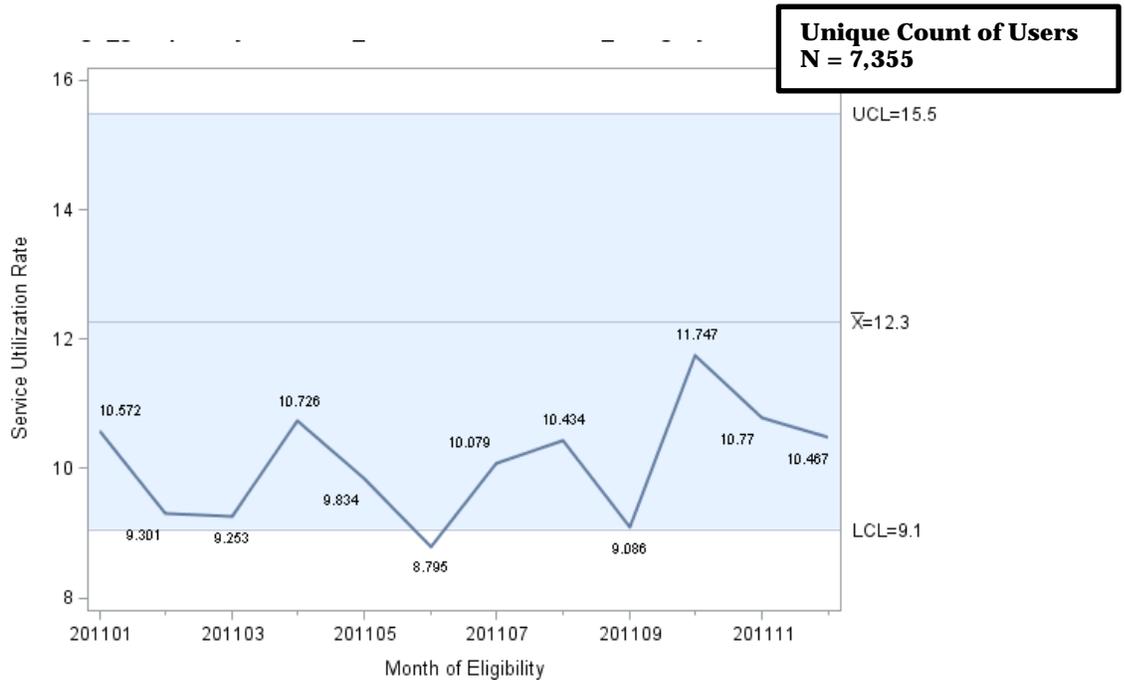
**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## Trends in Home Health Services Use among Adults

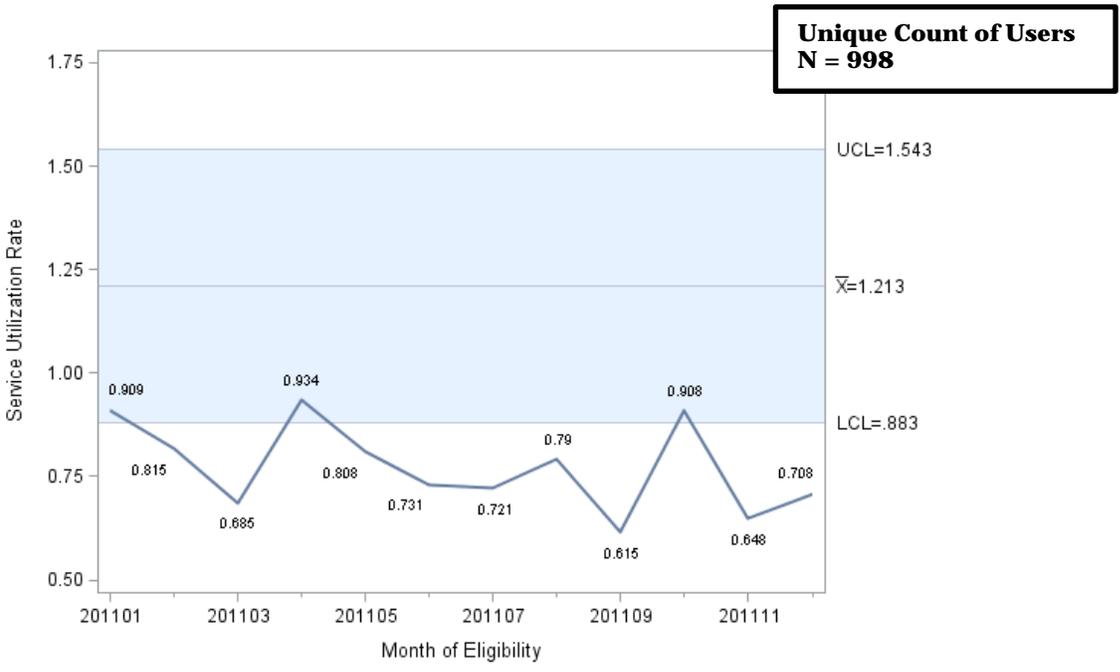
**Figure 45 Monthly Home Health Services Utilization Rates among Adults (age 21+) in the Aged Aid Category, January thru December 2011**



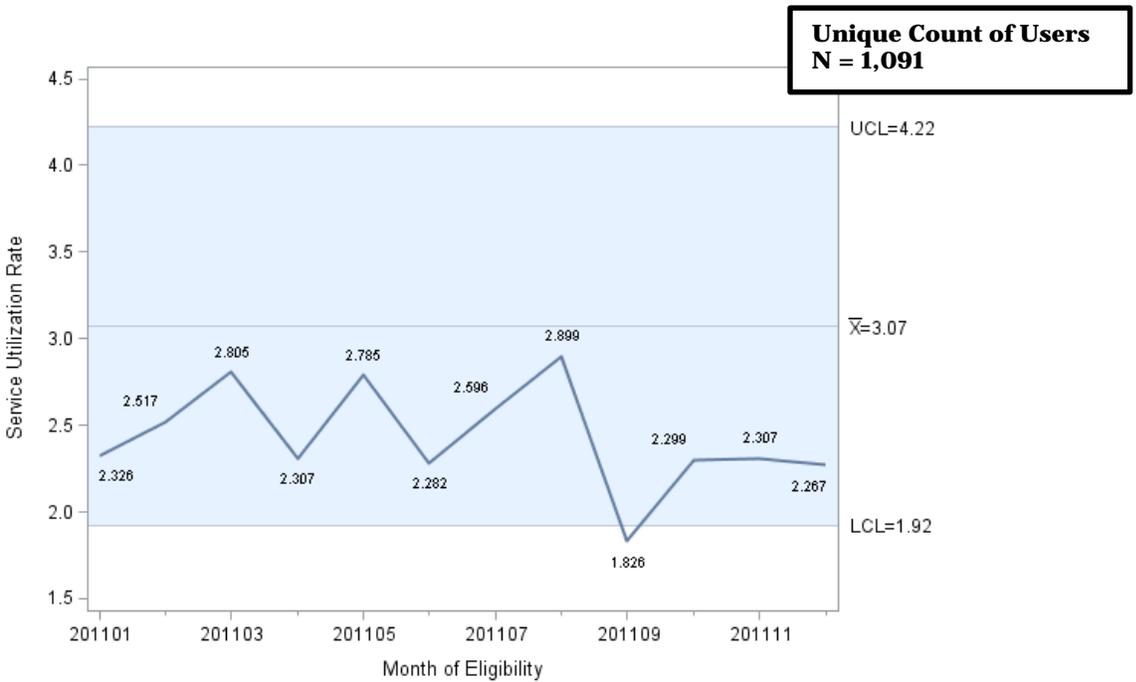
**Figure 46 Monthly Home Health Services Utilization Rates among Adults (age 21+) in the Blind/ Disabled Aid Category, January thru December 2011**



**Figure 47 Monthly Home Health Services Utilization Rates among Adults (age 21+) in the Families Aid Category, January thru December 2011**



**Figure 48 Monthly Home Health Services Utilization Rates among Adults (age 21+) in the Other Aid Category, January thru December 2011**



**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## **Hospital Inpatient Services**

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 child birth and pregnancy-related services.

A large proportion of hospital admissions are to Medi-Cal FFS beneficiaries between the ages of 21 to 64 (52%), and those in the Undocumented and Families aid code 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 repeatedly (3 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 --- Hospital Inpatient Services, Beneficiaries Eligible for Medi-Cal Only and Participating in Medi-Cal's FFS System**

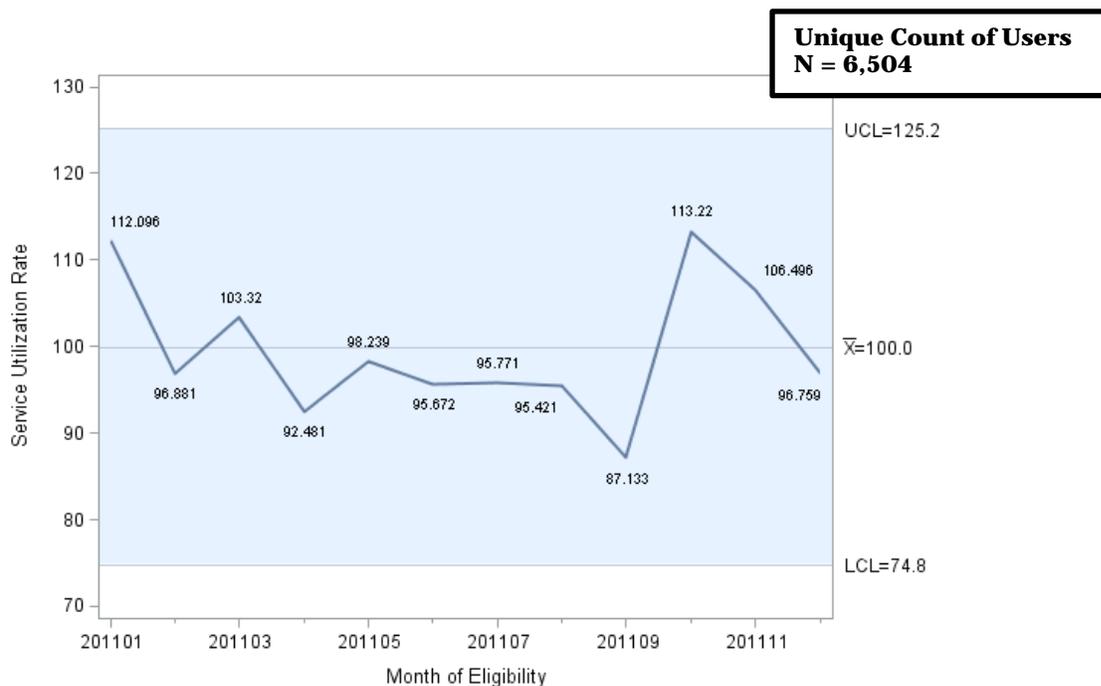
The monthly Inpatient Hospital Services utilization rates for children in the Medi-Cal FFS program age 0-20 ranged from 13.7 to 113.2 days per 1,000 member months in CY 2011. Inpatient Hospital utilization rates were notably higher among children in the Blind/Disabled aid category, a subgroup whose rates were 2 to 2.5 times higher than for children in the Families, Other and Undocumented aid categories, and 5 to 6 times higher than for children in the Foster Care aid category. Children in the Blind/Disabled aid category exhibited Inpatient Hospital utilization rates that were within expected ranges, while children in all other aid categories exhibited below average utilization of Inpatient Hospital Services. Additionally, children in Families and Other aid categories had notable declines in Inpatient Hospital use in the first half of CY 2011, and children in the Families, Foster Care, and Other aid categories exhibited below average use for most of CY 2011. Inpatient Hospital utilization patterns for

children in the Undocumented aid category fell below the expected range for the majority of CY 2011.

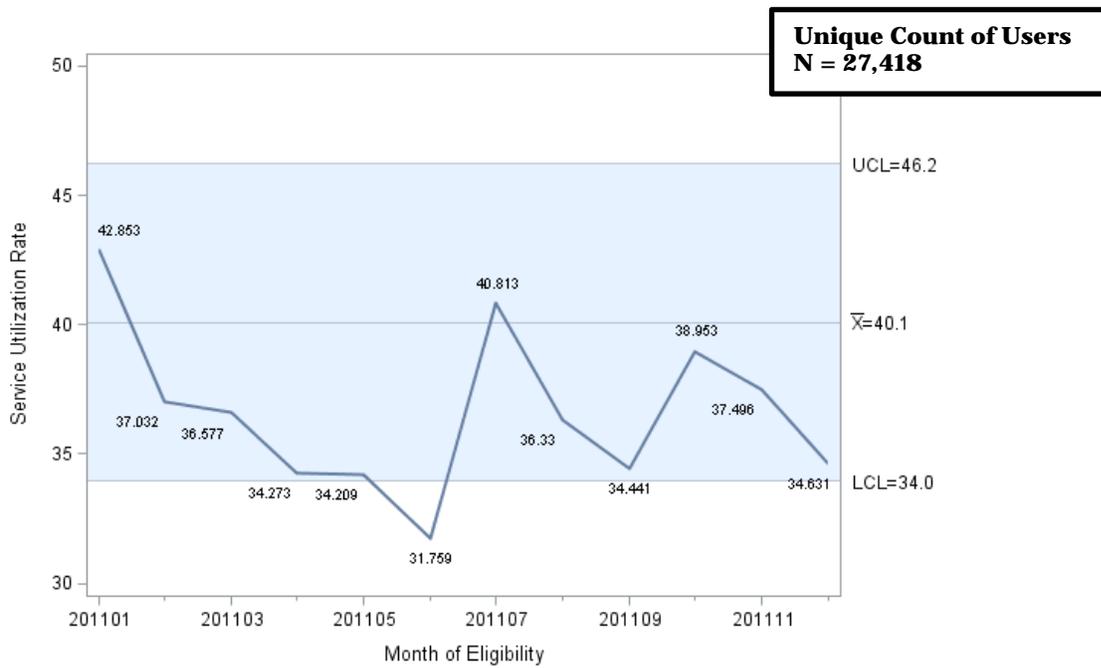
Among adults 21 and older, monthly Inpatient Hospital Services utilization rates ranged from 34.5 to 206.6 days per 1,000 member months during CY 2011. Inpatient Hospital use was noticeably higher for adults in the Other and Blind/Disabled aid categories. Similar to utilization patterns exhibited by children, adults in all aid categories exhibited Inpatient Hospital utilization rates that fell below average baseline rates during most of CY 2011. Additionally, adults in the Undocumented aid categories used Inpatient Hospital services at a rate below the expected baseline range.

### Trends in Home Hospital Inpatient Services Use among Children

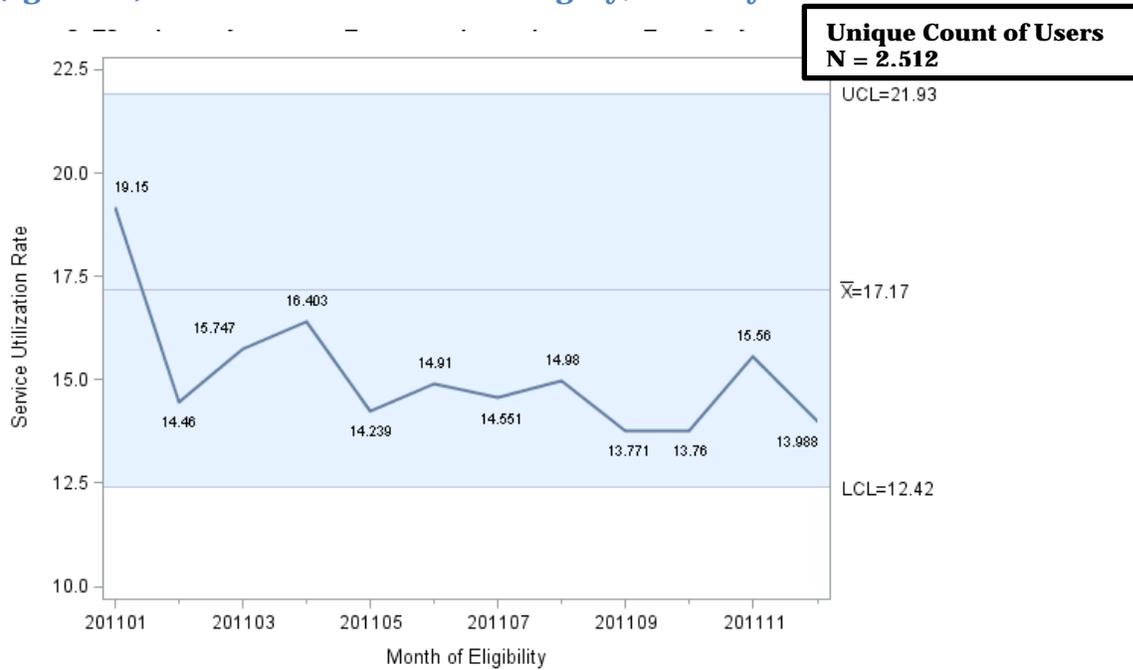
**Figure 49 Monthly Hospital Inpatient Services Utilization Rates among Children (age 0-20) in the Blind/Disabled Aid Category, January thru December 2011**



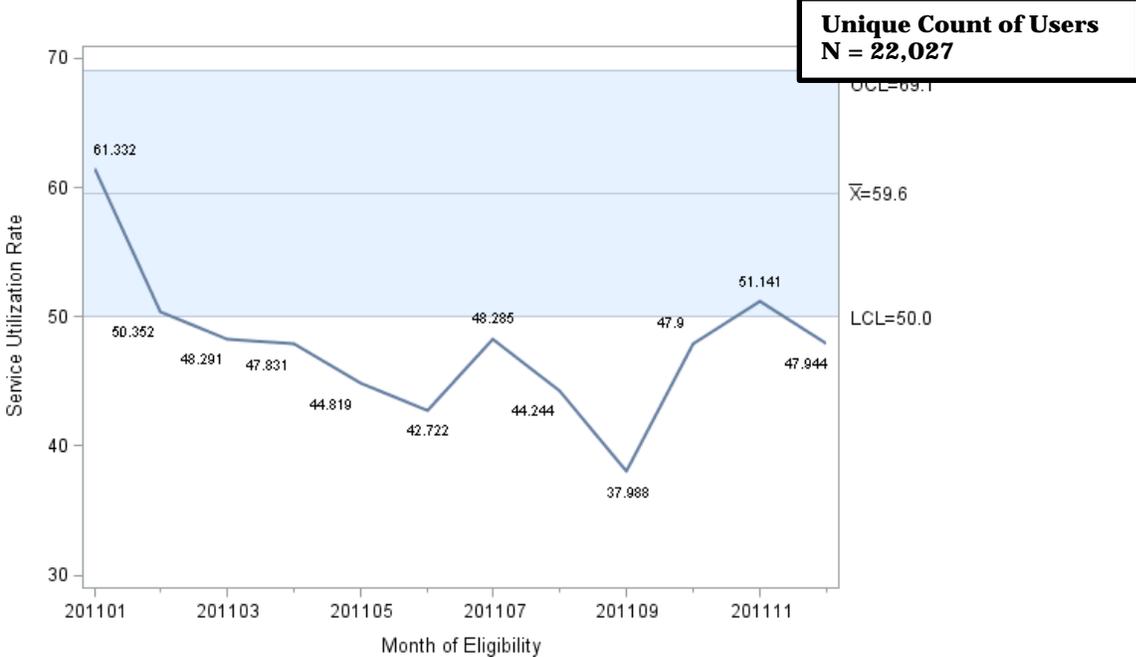
**Figure 50 Monthly Hospital Inpatient Services Utilization Rates among Children (age 0-20) in the Families Aid Category, January thru December 2011**



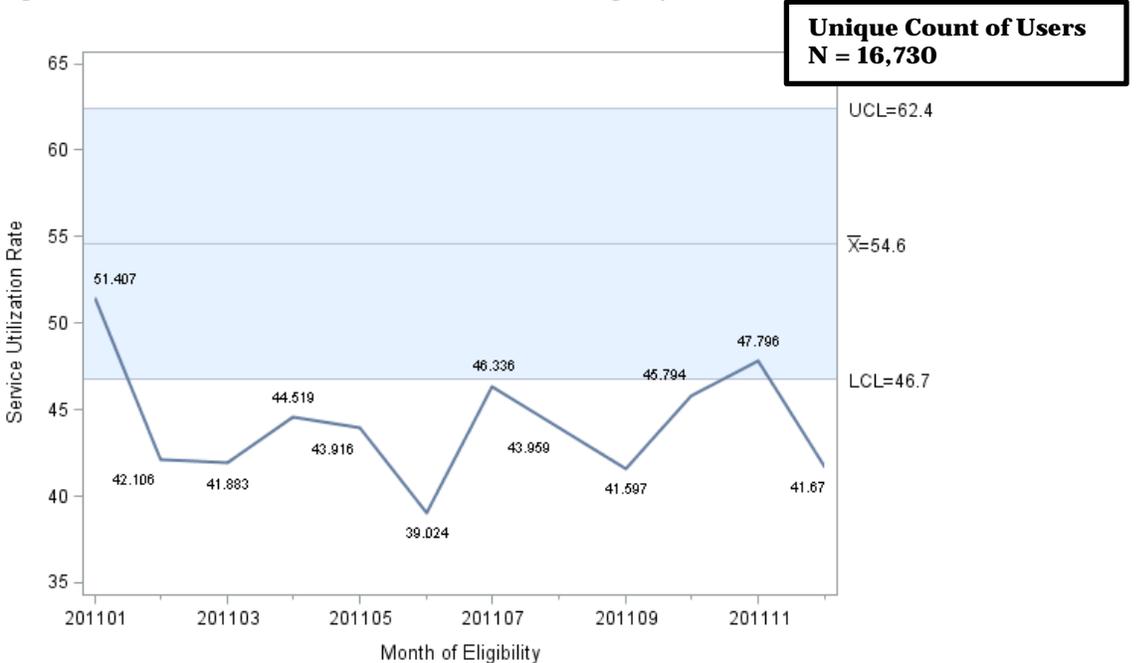
**Figure 51 Monthly Hospital Inpatient Services Utilization Rates among Children (age 0-20) in the Foster Care Aid Category, January thru December 2011**



**Figure 52 Monthly Hospital Inpatient Services Utilization Rates among Children (age 0-20) in the Other Aid Category, January thru December 2011**



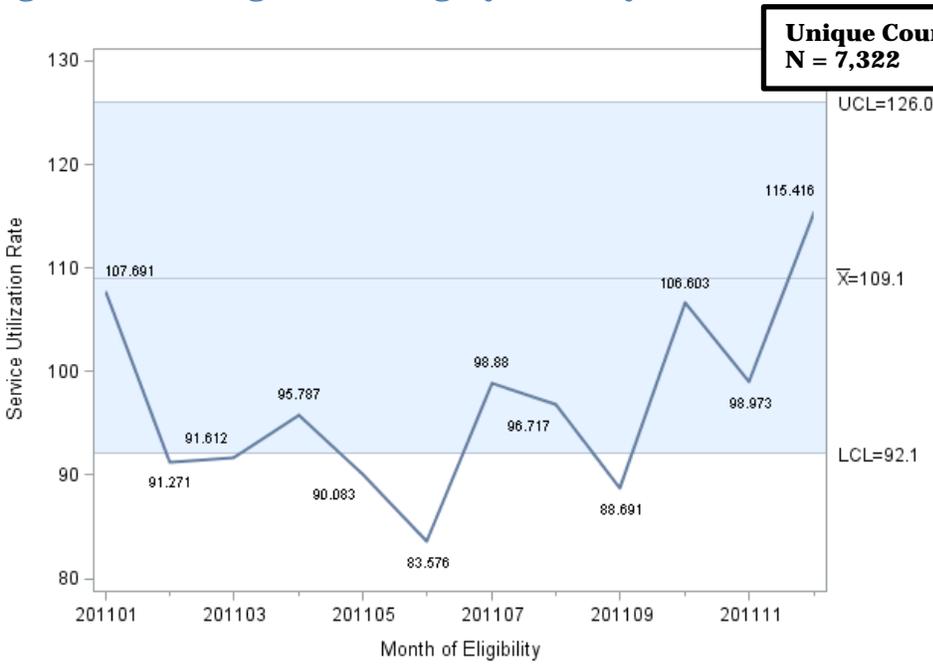
**Figure 53 Monthly Hospital Inpatient Services Utilization Rates among Children (age 0-20) in the Undocumented Aid Category, January thru December 2011**



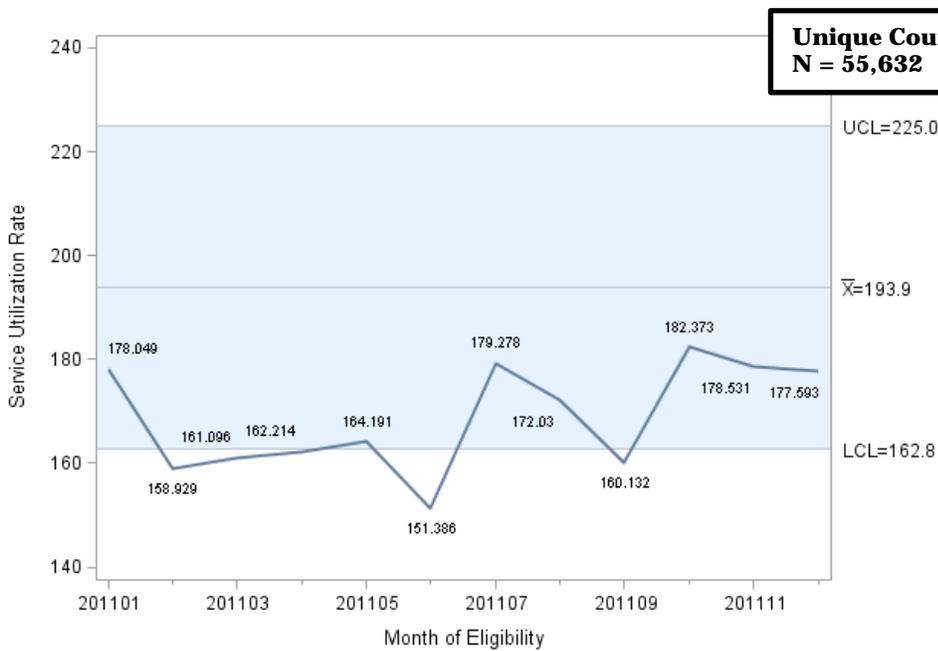
**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## Trends in Hospital Inpatient Services Use among Adults

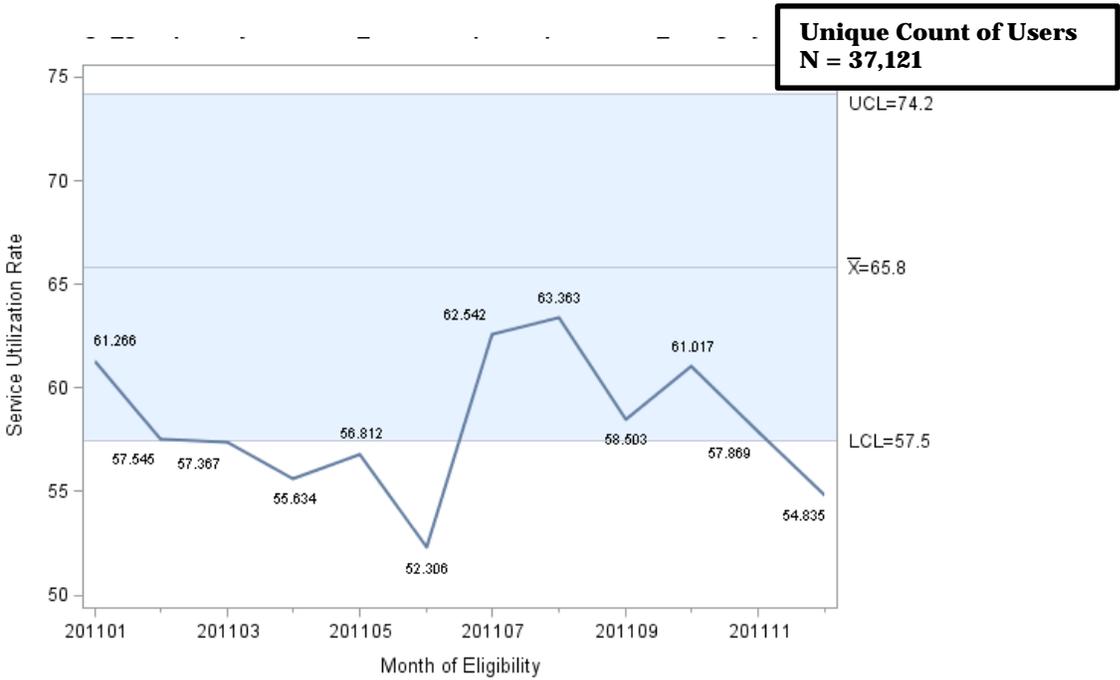
**Figure 54 Monthly Hospital Inpatient Services Utilization Rates among Adults (age 21+) in the Aged Aid Category, January thru December 2011**



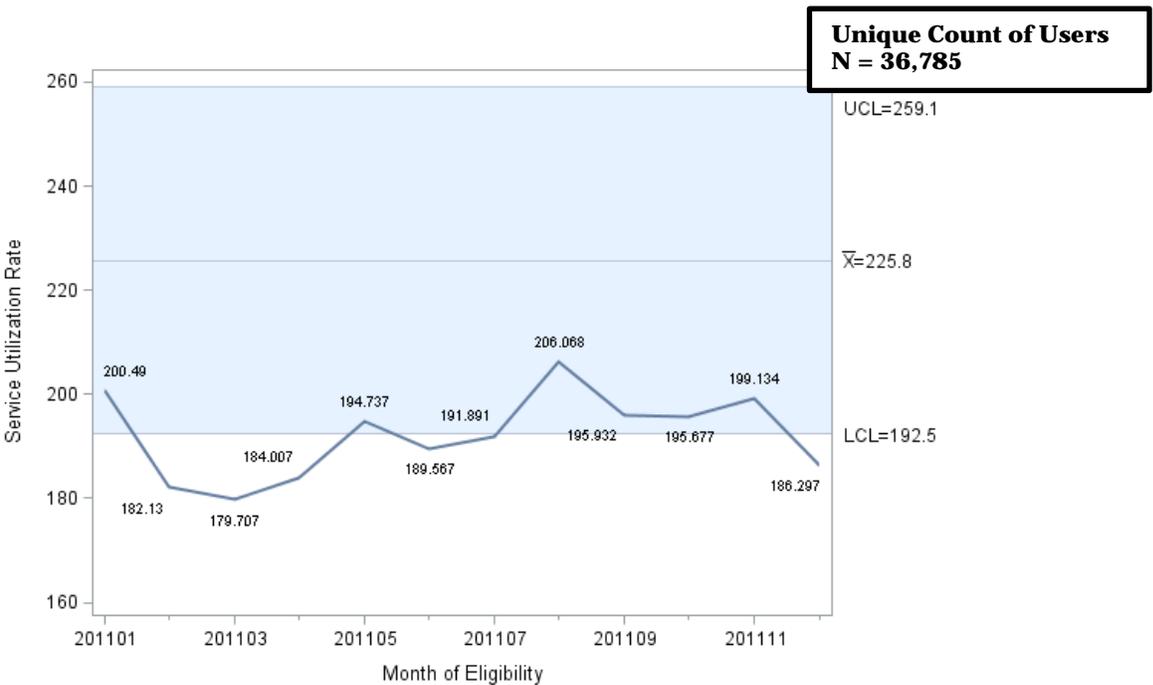
**Figure 55 Monthly Hospital Inpatient Services Utilization Rates among Adults (age 21+) in the Blind/Disabled Aid Category, January thru December 2011**



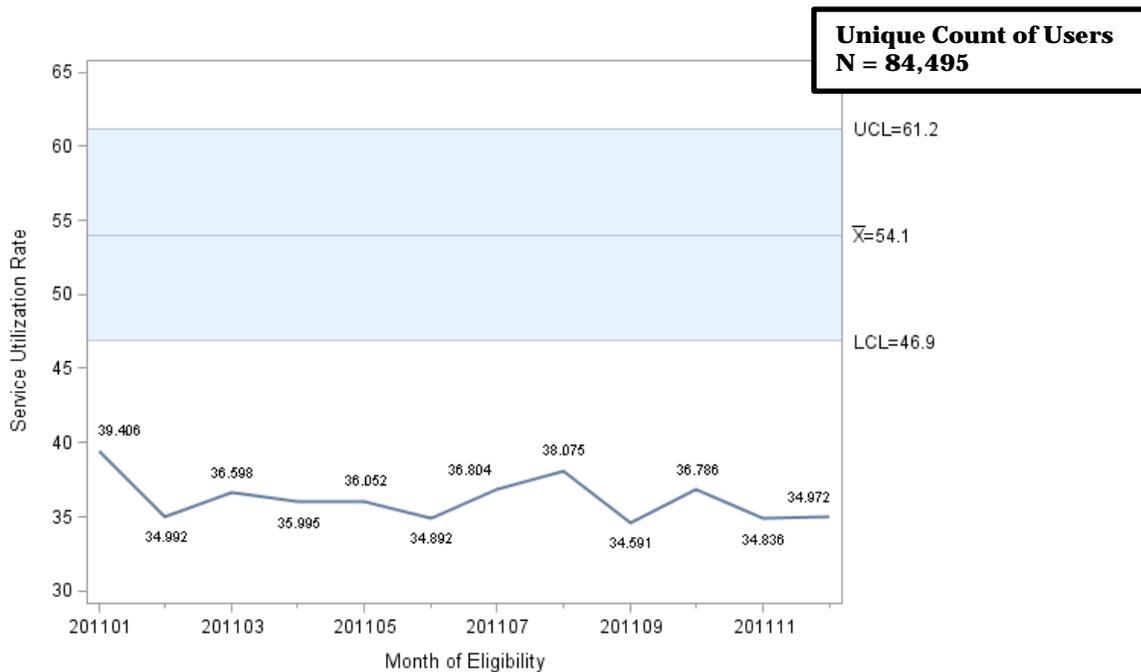
**Figure 56 Monthly Hospital Inpatient Services Utilization Rates among Adults (age 21+) in the Families Aid Category, January thru December 2011**



**Figure 57 Monthly Hospital Inpatient Services Utilization Rates among Adults (age 21+) in the Other Aid Category, January thru December 2011**



**Figure 58 Monthly Hospital Inpatient Services Utilization Rates among Adults (age 21+) in the Undocumented Aid Category, January thru December 2011**



*Source:* Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## Hospital Outpatient Services

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, 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 1,600,000 beneficiaries in the Medi-Cal program that use hospital outpatient services at any given time during the year, only 16% of whom utilize emergency services. A large

proportion of beneficiaries who use hospital outpatient services use these services only once during the year (44%), while more than half are repeat users of these services (56%). Among those using emergency hospital outpatient services, 70% use this service no more than once during the year.

Nearly 40% of non-emergency hospital outpatient service users are age 20 and younger, another 40% are between the ages of 21 to 64, and an additional 20% are elderly beneficiaries age 64 and over. Many users of non-emergency hospital services are enrolled in Families and Undocumented (40%) or in Aged and Disabled aid codes (34%). Beneficiaries who use emergency hospital outpatient services are predominantly adults between the ages of 21 and 64 (60%), and in Undocumented aid codes (45%).

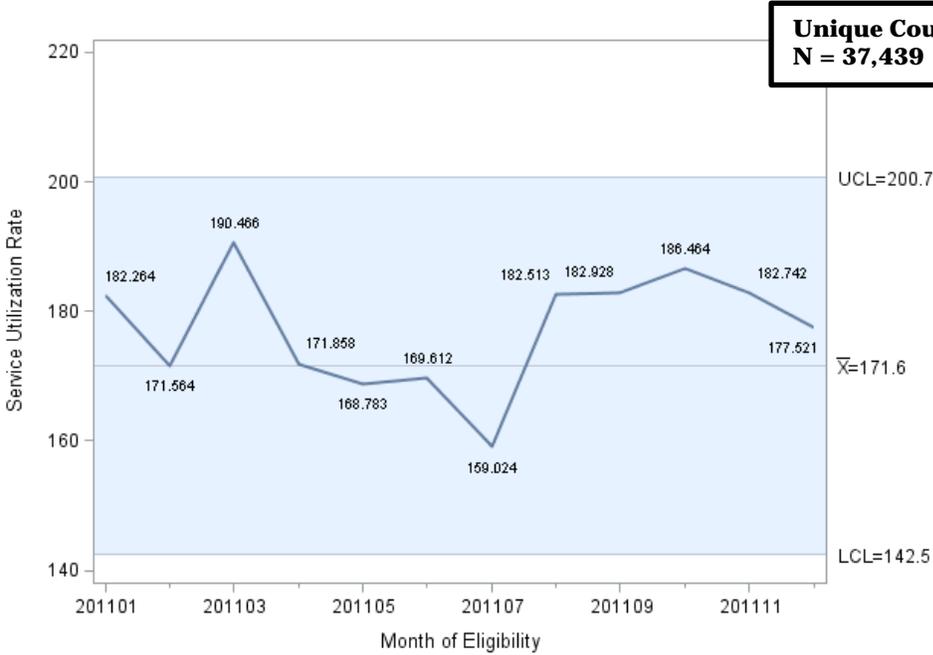
### **Trend Analysis --- Hospital Outpatient Services, Beneficiaries Eligible For Medi-Cal Only and Participating in Medi-Cal's FFS System**

Among children age 0 to 20 in the Medi-Cal FFS program, monthly Outpatient Hospital Service utilization rates ranged from 57.4 to 190.4 visits per 1,000 member months during CY 2011. Rates were noticeably higher among children in the Blind/Disabled aid category, ranging from 2 to 3 times higher than for children in any other aid category. Children in the Blind/Disabled aid category exhibited normal patterns of Outpatient Hospital Service use. In contrast, children in the Families, Foster Care and Other aid categories exhibited declines in service use rates for the first half of CY 2011. In addition, downward trends in Outpatient Hospital use reached levels below baseline thresholds for those in the Other aid category. Among Undocumented children, service use was below the average baseline levels established in CY 2007-2009. However, for the most part, Outpatient Hospital Service utilization trends in CY 2011 fell within the expected baseline ranges.

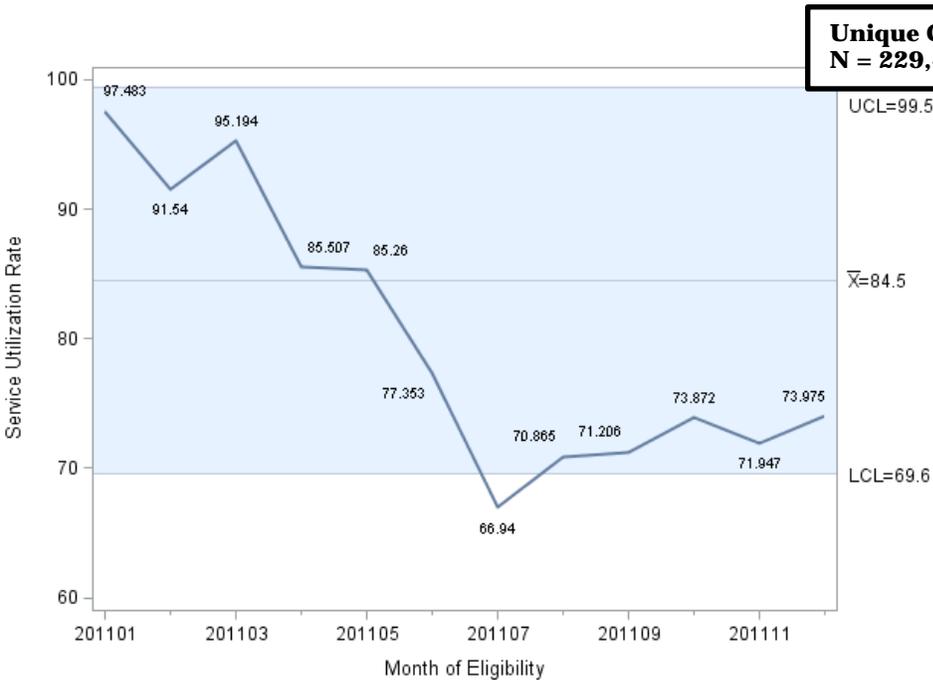
The monthly Outpatient Hospital Services utilization rates for adults age 21 and older ranged from 50.1 to 314.7 visits per 1,000 member months in CY 2011. Utilization rates were noticeably higher for adults in the Blind/Disabled and Other aid categories. Similar to utilization patterns observed for children, adults in the Families aid category exhibited a downward decline, approaching rates below baseline threshold levels in the final two months of the year. Adults in all other aid categories exhibited normal Outpatient Hospital Services utilization patterns during CY 2011. However, adults in the Undocumented aid category exhibited Outpatient Hospital use that fell below average for the entire year of 2011.

## Trends in Home Hospital Outpatient Services Use among Children

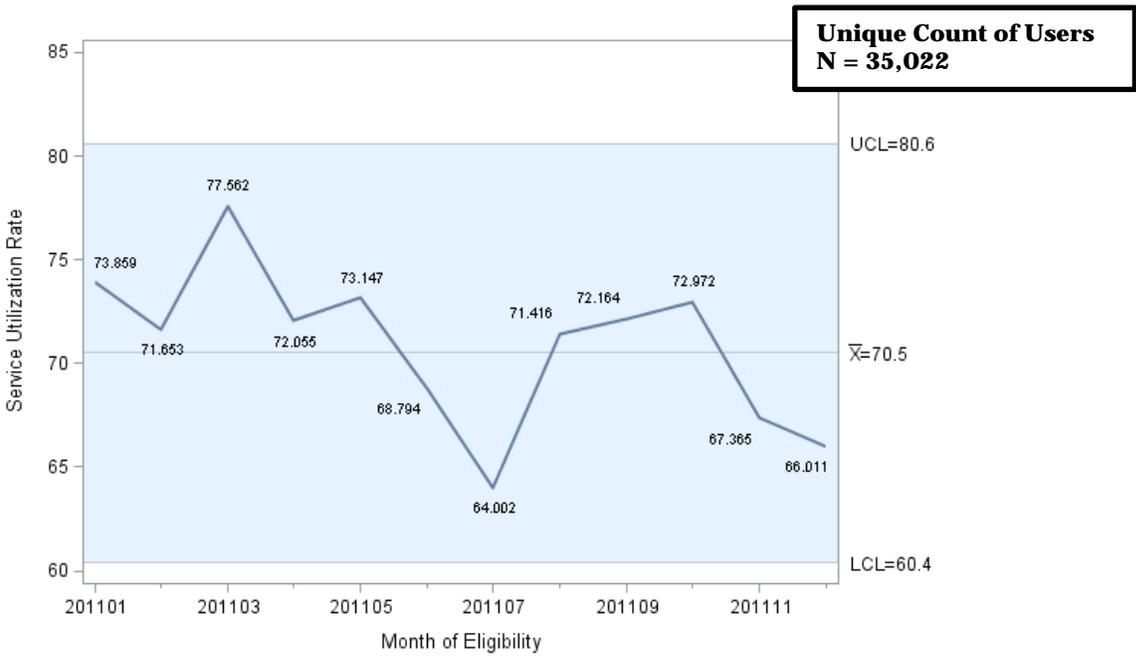
**Figure 59 Monthly Hospital Outpatient Services Utilization Rates among Children (age 0-20) in the Blind/Disabled Aid Category, January thru December 2011**



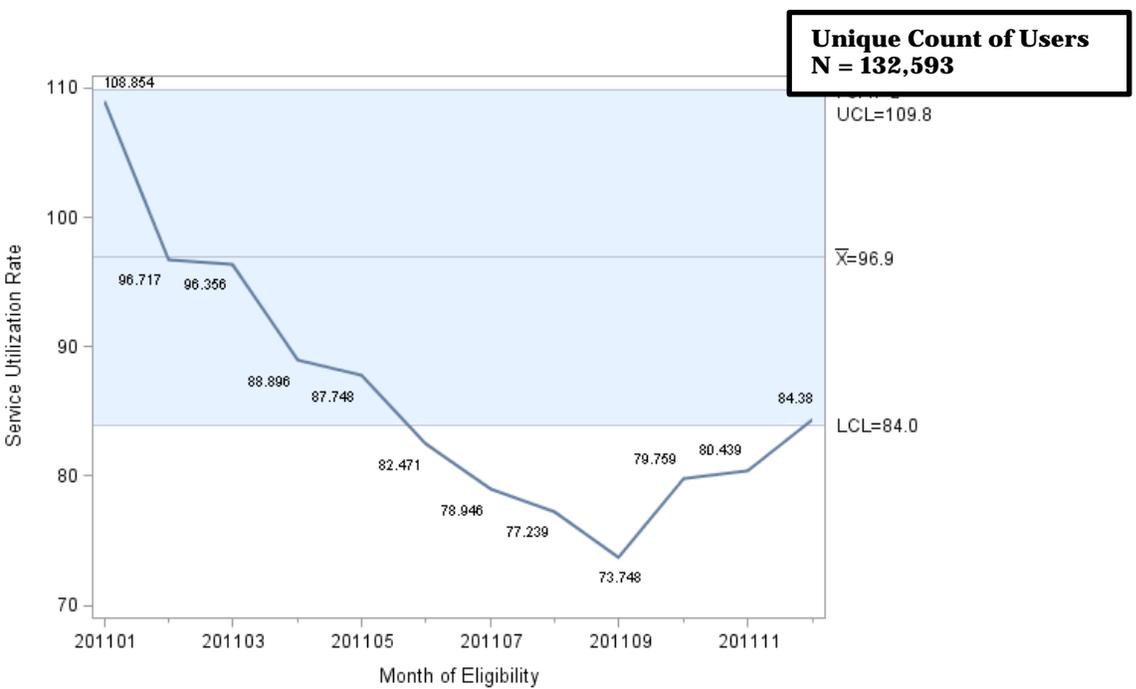
**Figure 60 Monthly Hospital Outpatient Services Utilization Rates among Children (age 0-20) in the Families Aid Category, January thru December 2011**



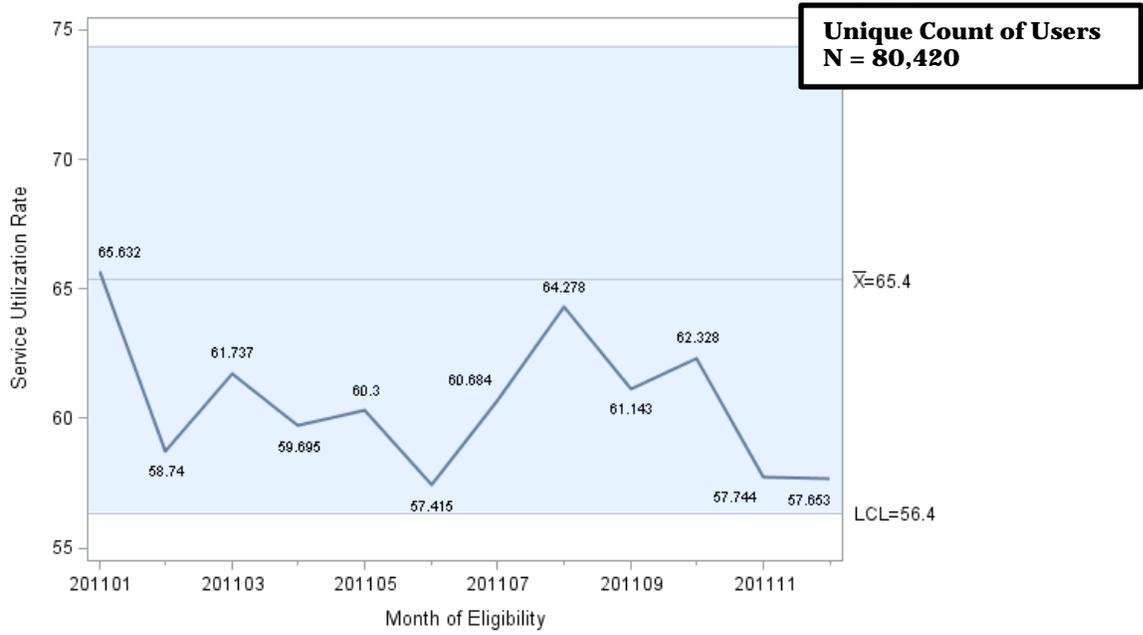
**Figure 61 Monthly Hospital Outpatient Services Utilization Rates among Children (age 0-20) in the Foster Care Aid Category, January thru December 2011**



**Figure 62 Monthly Hospital Outpatient Services Utilization Rates among Children (age 0-20) in the Other Aid Category, January thru December 2011**



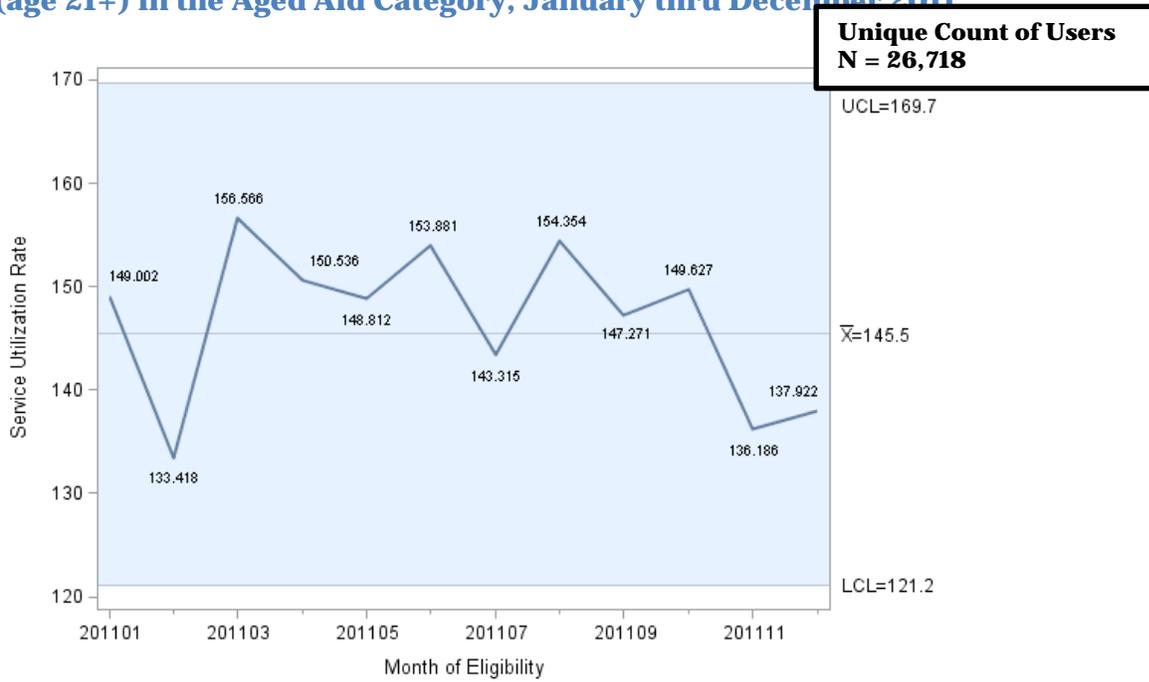
**Figure 63 Monthly Hospital Outpatient Services Utilization Rates among Children (age 0-20) in the Undocumented Aid Category, January thru December 2011**



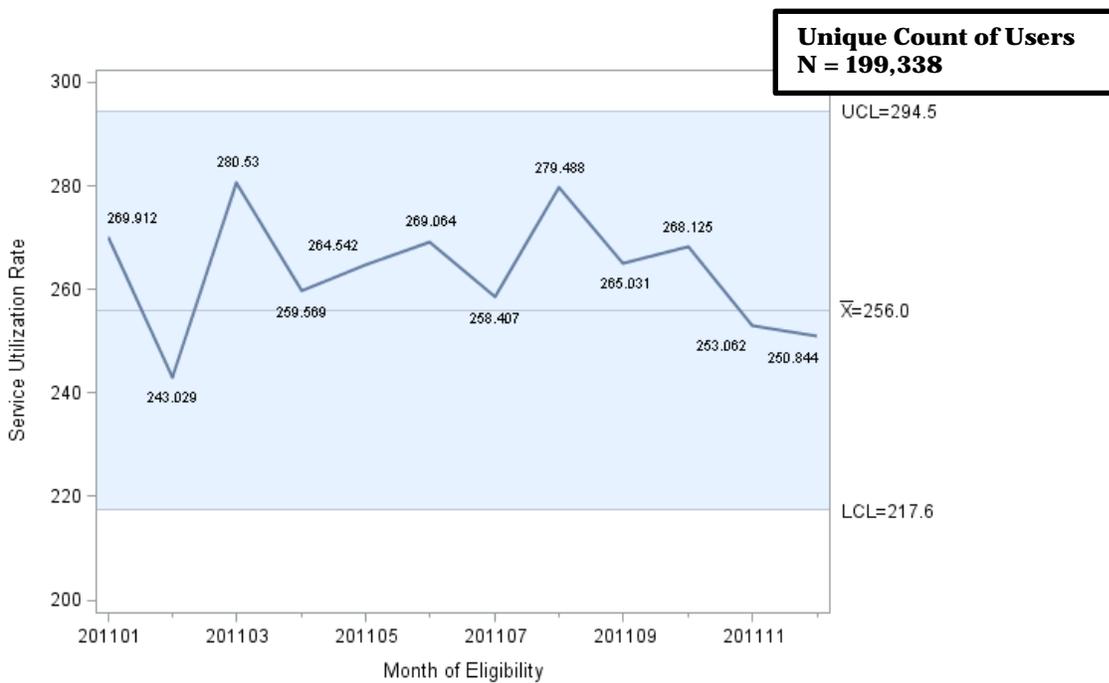
**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## Trends in Hospital Outpatient Services Use among Adults

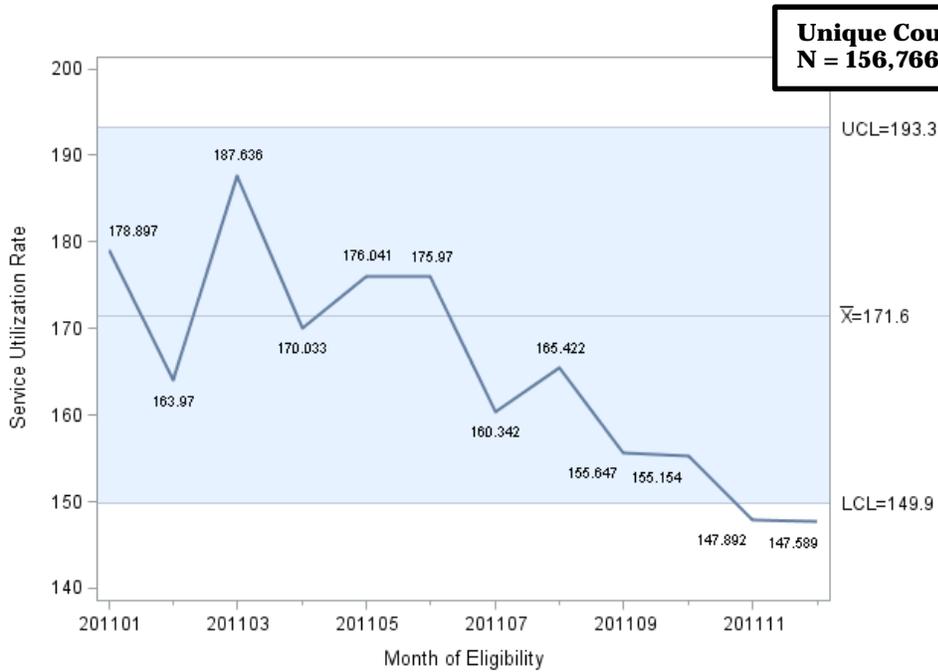
**Figure 64 Monthly Hospital Outpatient Services Utilization Rates among Adults (age 21+) in the Aged Aid Category, January thru December 2011**



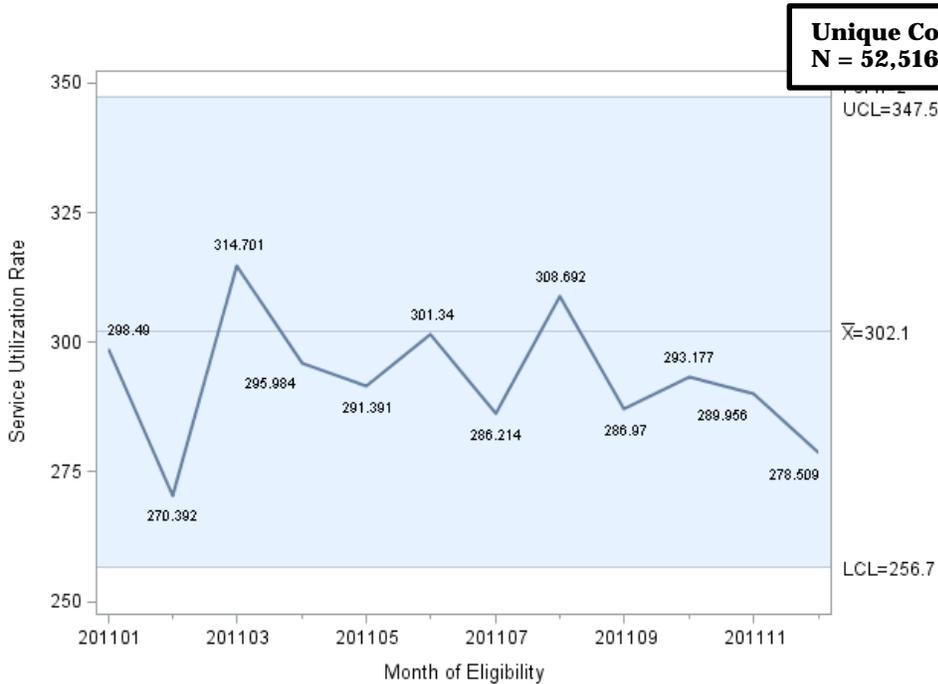
**Figure 65 Monthly Hospital Outpatient Services Utilization Rates among Adults (age 21+) in the Blind/Disabled Aid Category, January thru December 2011**



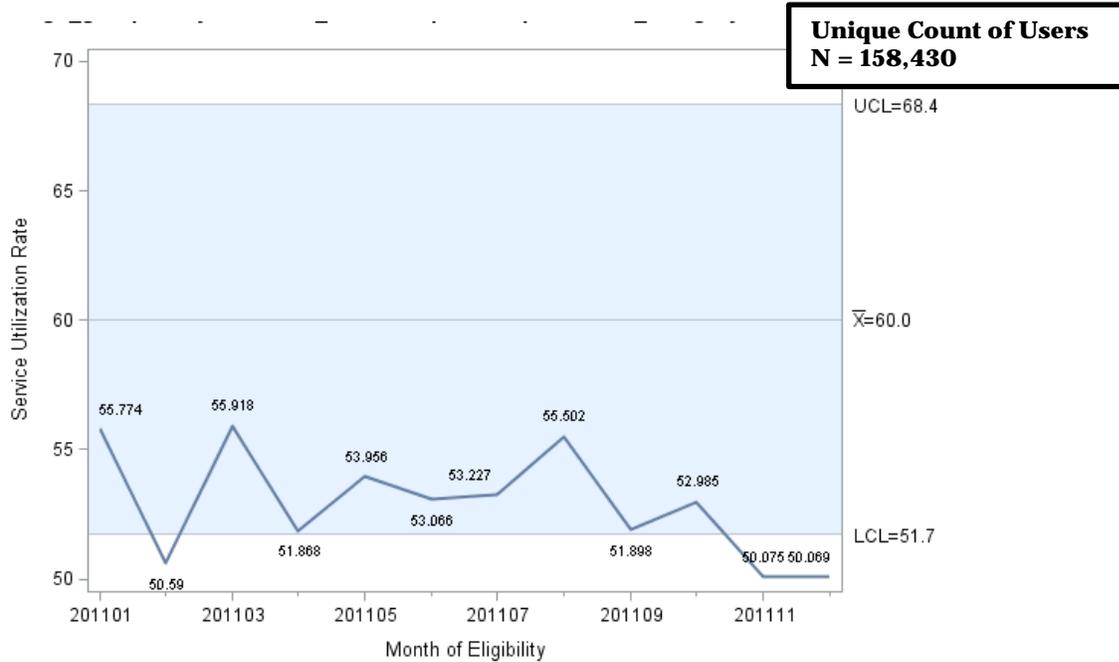
**Figure 66 Monthly Hospital Outpatient Services Utilization Rates among Adults (age 21+) in the Families Aid Category, January thru December 2011**



**Figure 67 Monthly Hospital Outpatient Services Utilization Rates among Adults (age 21+) in the Other Aid Category, January thru December 2011**



**Figure 68 Monthly Hospital Outpatient Services Utilization Rates among Adults (age 21+) in the Undocumented Aid Category, January thru December 2011**



*Source:* Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## Nursing Facility Services

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

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

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

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-A services are covered under long-term care (51.2%), aged (25.4%), and disabled (18.6%) aid codes, and are primarily older adults over the age of 65 (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. Most hospice recipients are elderly beneficiaries over age 65 (71.3%) and are covered under long-term care (39.3%), aged (27.5%) and disabled (20.9%) aid codes.

### **Trend Analysis --- Nursing Facility Services, Beneficiaries Eligible for Medi-Cal Only and Participating in Medi-Cal's FFS System**

Among children age 0 to 20 in the Medi-Cal FFS program, monthly Nursing Facility Services utilization rates ranged from 9.26 to 166.03 days per 1,000 member months during CY 2011. The utilization of Nursing Facility Services was notably concentrated among children in the Blind / Disabled aid category, which may be due to their inherent complex medical needs. These children displayed positive trends in utilization over the course of CY 2011. Children in the Blind / Disabled aid category experienced 7 consecutive months of utilization below the expected range established at baseline. With only one month of utilization barely outside of the baseline range, the utilization patterns for children in the Other aid category can be characterized as normal.

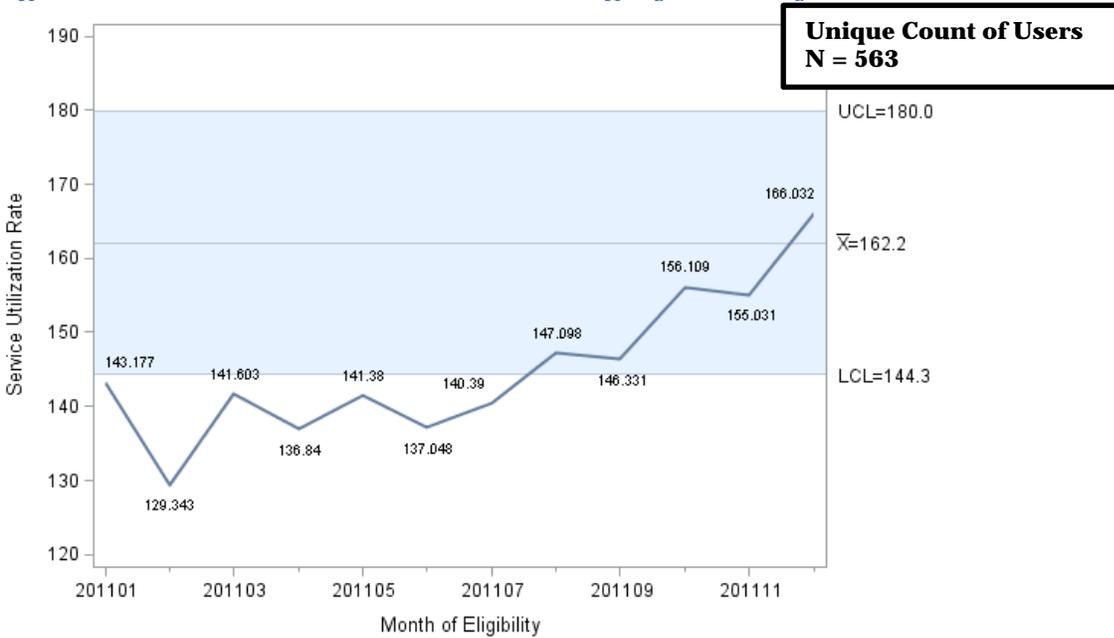
The monthly Nursing Facility Services utilization rates for adults age 21 and older ranged from 6.1 to 2,242.6 days per 1,000 member months in CY 2011. The utilization rates were noticeably higher for adults in the Other aid category. Despite their high Nursing Facility Services utilization rates, adults in the Other aid category exhibited below average utilization throughout CY 2011. Additionally, adults in the Blind / Disabled aid category exhibited significant

utilization, while adults in the Families aid code category utilized Nursing Facility Services at a lesser rate. Adults in the Aged and Blind / Disabled aid categories displayed a sharp increase in utilization starting in June of CY 2011. Adults in every analyzed aid category displayed at least one month of Nursing Facility Services utilization outside of the expected ranges. In particular, adults in the Aged and Families aid categories displayed only three months of utilization within the anticipated baseline range.

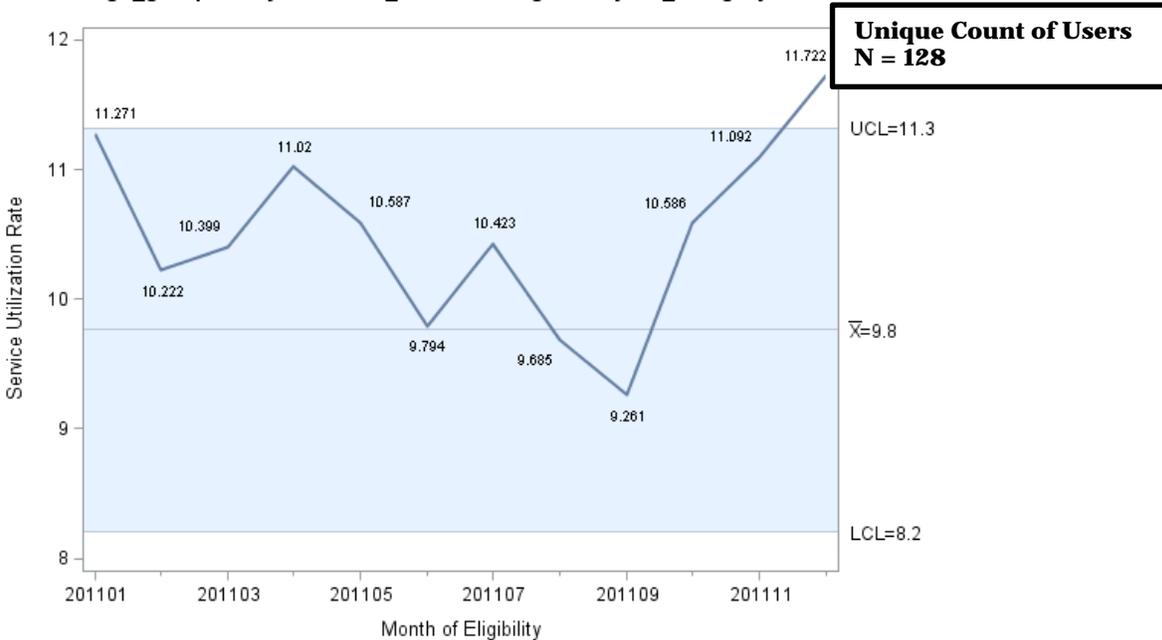
Medi-Cal FFS beneficiaries in the Undocumented aid category are not eligible for Nursing Facility Services and, therefore, were excluded from this analysis. Additionally, children in the Families and Foster Care aid code categories were excluded because of their relatively small users counts (<100).

## Trends in Nursing Facility Services Use among Children

**Figure 69 Monthly Nursing Facility Services Utilization Rates among Children (age 0-20) in the Blind/Disabled Aid Category, January thru December 2011**



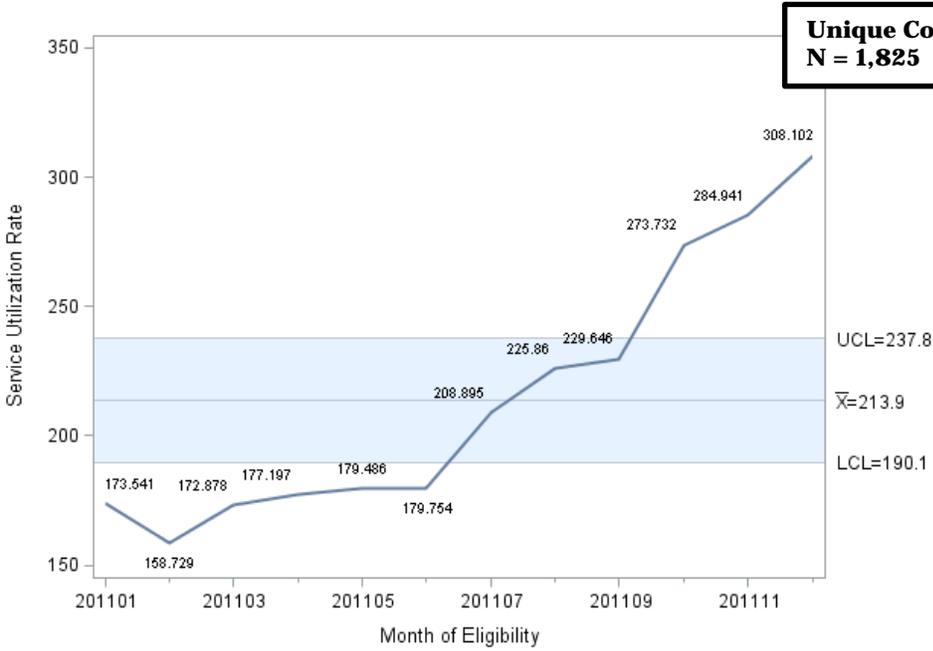
**Figure 70 Monthly Nursing Facility Services Utilization Rates among Children (age 0-20) in the Other Aid Category, January thru December 2011**



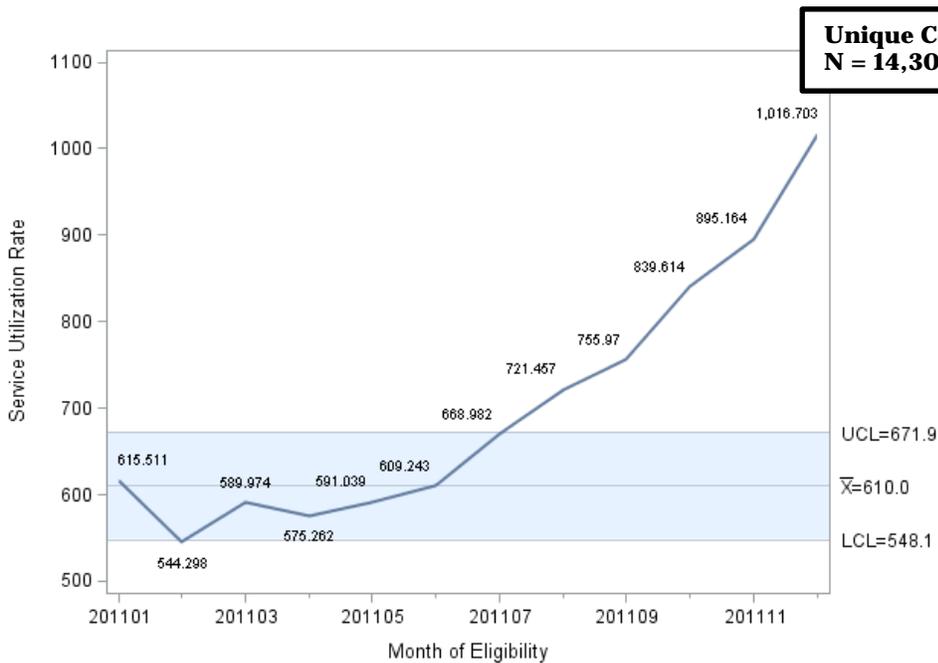
**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary's 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## Trends in Nursing Facility Services Use among Adults

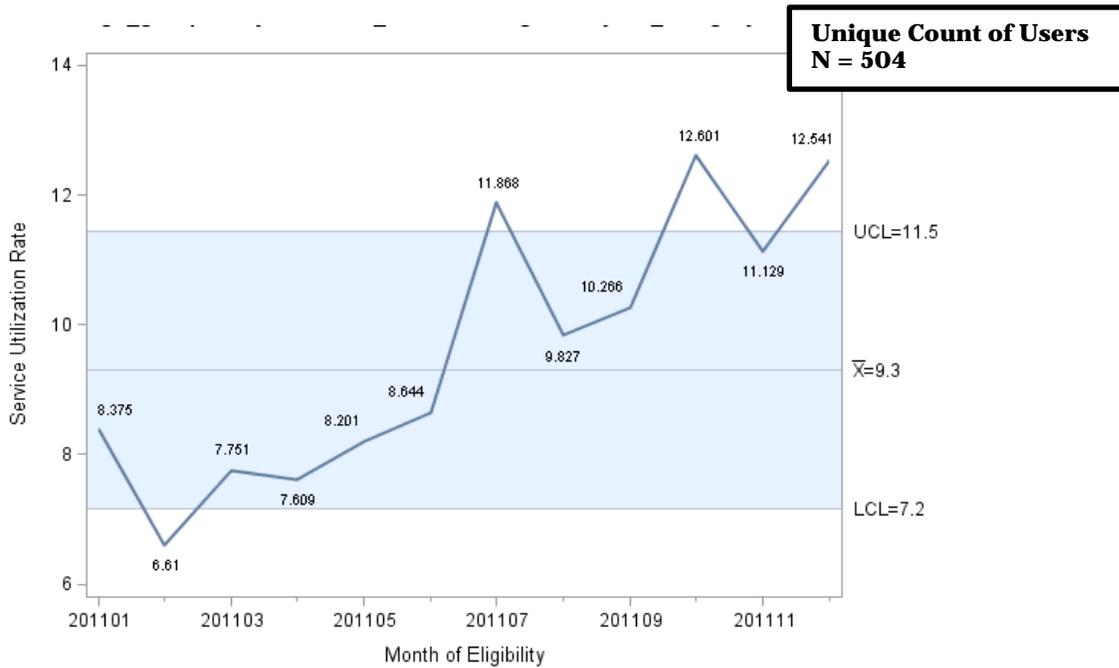
**Figure 71 Monthly Nursing Facility Services Utilization Rates among Adults (age 21+) in the Aged Aid Category, January thru December 2011**



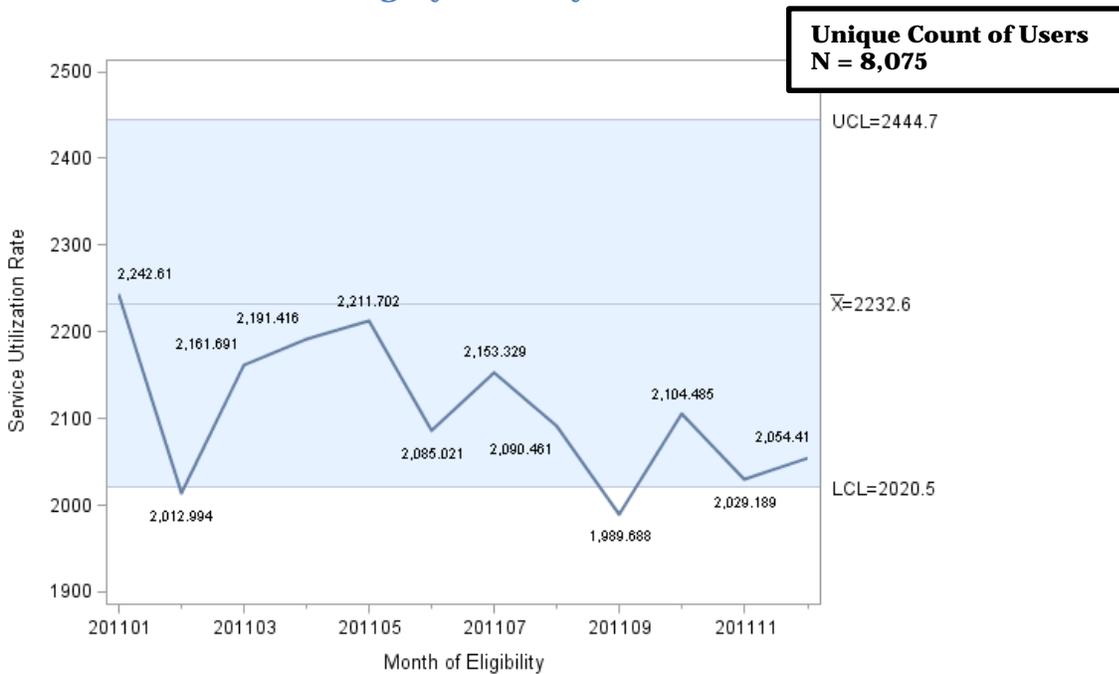
**Figure 72 Monthly Nursing Facility Services Utilization Rates among Adults (age 21+) in the Blind/Disabled Aid Category, January thru December 2011**



**Figure 73 Monthly Nursing Facility Services Utilization Rates among Adults (age 21+) in the Families Aid Category, January thru December 2011**



**Figure 74 Monthly Nursing Facility Services Utilization Rates among Adults (age 21+) in the Other Aid Category, January thru December 2011**



**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## Pharmacy Services

Pharmacy service is 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, but they also bill for over-the-counter drugs, enteral formula, medical supplies, incontinent supplies and durable medical equipment. Not all, but most, outpatient prescription drug claims are billed by pharmacy providers. Those that are not include physicians and clinics that may 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 healthcare provider.

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

In 2010, there were over 3 million beneficiaries who received at least one pharmacy service through the Medi-Cal FFS program. The majority of pharmacy service users (99%) accessed prescription drugs. Young beneficiaries under age 20 represent 35% of pharmacy service users, while adults age 21 to 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 codes. The most frequently dispensed pharmacy products are non-steroidal anti-inflammatory drugs (NSAIDs), penicillin, and analgesics.

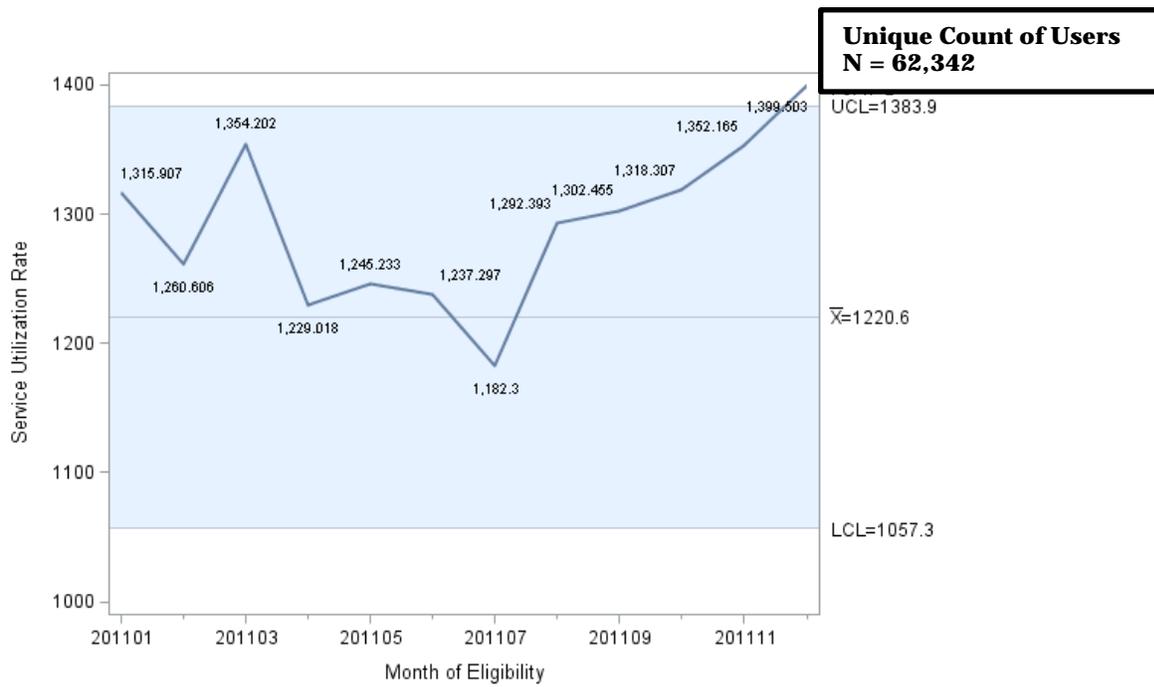
### **Trend Analysis --- Pharmacy Services, Beneficiaries Eligible for Medi-Cal Only and Participating in Medi-Cal's FFS System**

The monthly Pharmacy Services utilization rates for children age 0 to 20 in the Medi-Cal FFS program ranged from 68.5 to 1,399.5 prescriptions per 1,000 member months in CY 2011. The utilization of Pharmacy Services was noticeably higher among children in the Blind / Disabled aid category, who had rates two to three times higher than Children in the Foster Care aid category, and four to five times higher than Children in the Families and Other aid categories. Though pharmacy utilization remained within expected ranges, children in most aid categories displayed downward trends in utilization during the first two quarters of CY 2011, and upward trends in utilization beginning in July. The Pharmacy Services utilization patterns for children in the Families and Other aid categories displayed downward trends for the entire year of 2011, but remained within expected ranges observed in the baseline period of CY 2007 to CY 2009.

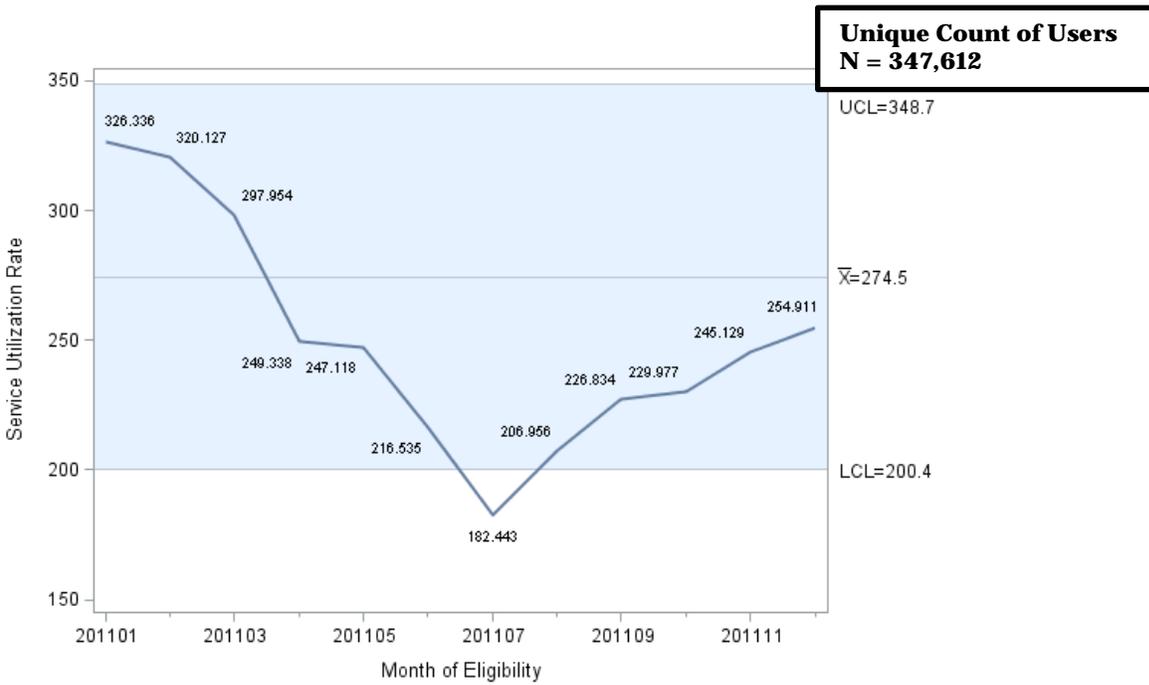
Among adults 21 and older, monthly Pharmacy Services utilization rates ranged from 180.9 to 3,590.8 visits per 1,000 member months during CY 2011. The utilization rates were noticeably higher for adults in the Aged and Blind / Disabled aid categories. Adults in the Other aid category also exhibited significant utilization rates of pharmacy services, while adults in the Undocumented aid category utilized these services at much lower rates. Pharmacy utilization among adults were, for the most part, within expected baseline ranges; however, among those in the Aged and Families aid categories, utilization was below baseline averages, and exhibited slight downward trends during CY 2011. In contrast, adults in the Other and Undocumented aid categories exhibited pharmacy utilization rates that were slightly above baseline averages.

### Trends in Pharmacy Services Use among Children

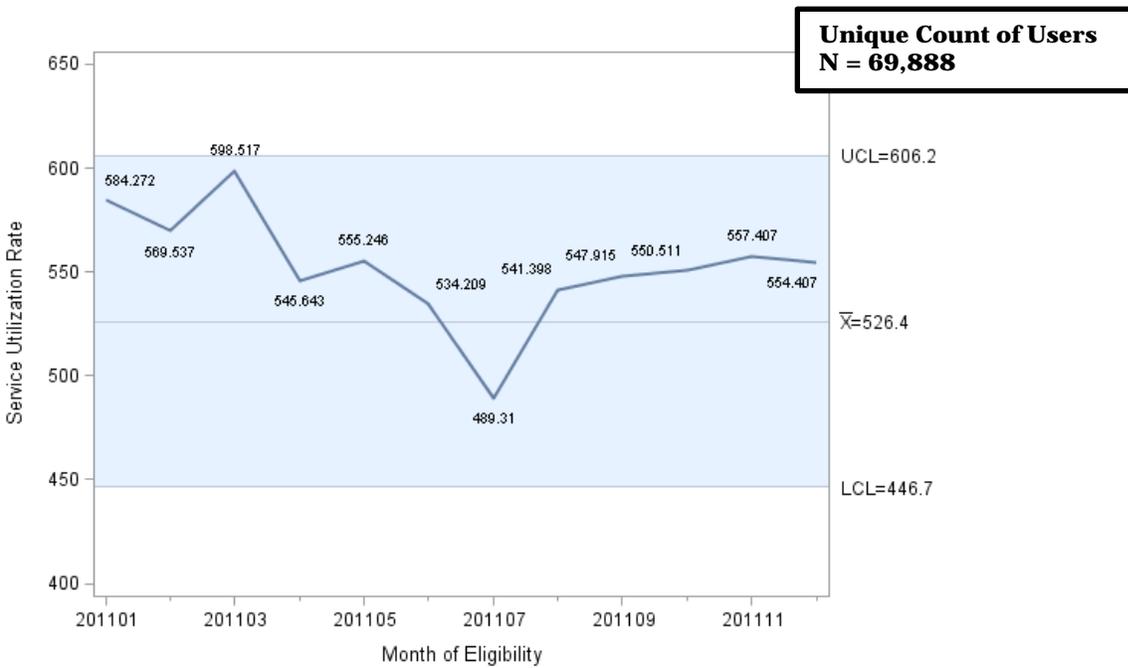
**Figure 75 Monthly Pharmacy Services Utilization Rates among Children (age 0-20) in the Blind/Disabled Aid Category, January thru December 2011**



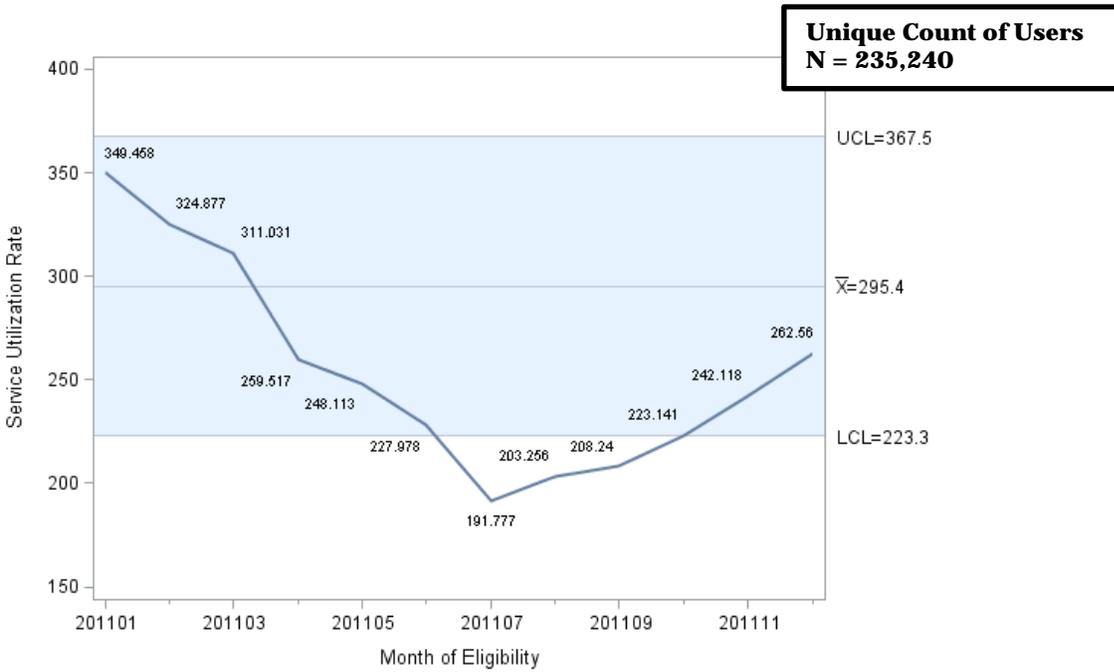
**Figure 76 Monthly Pharmacy Services Utilization Rates among Children (age 0-20) in the Families Aid Category, January thru December 2011**



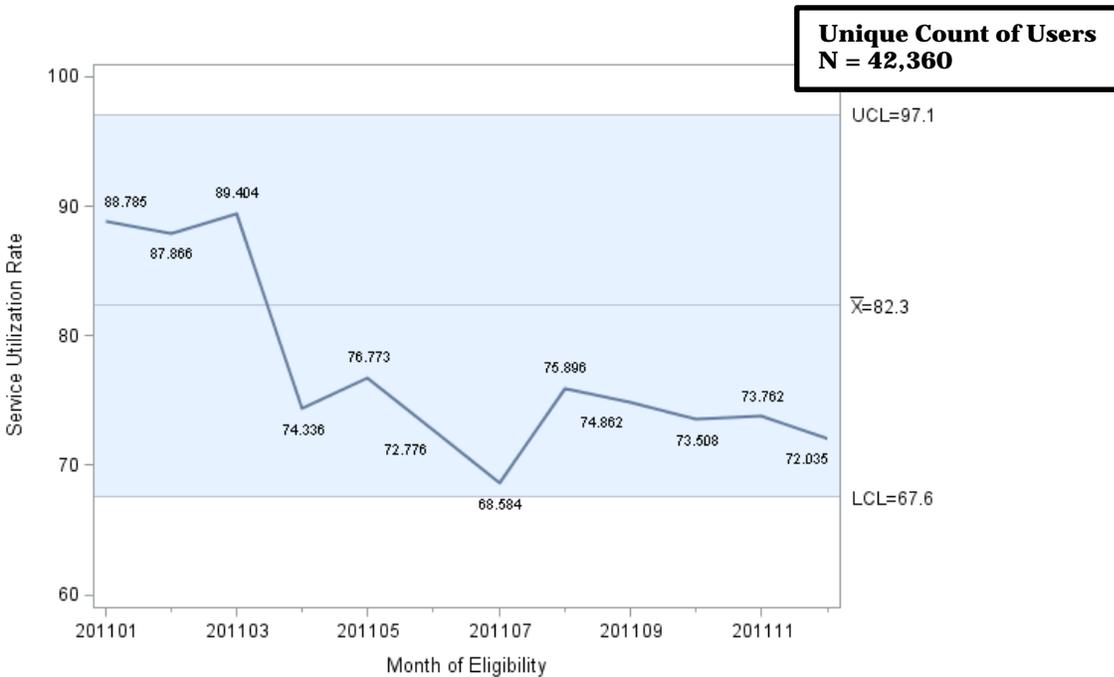
**Figure 77 Monthly Pharmacy Services Utilization Rates among Children (age 0-20) in the Foster Care Aid Category, January thru December 2011**



**Figure 78 Monthly Pharmacy Services Utilization Rates among Children (age 0-20) in the Other Aid Category, January thru December 2011**



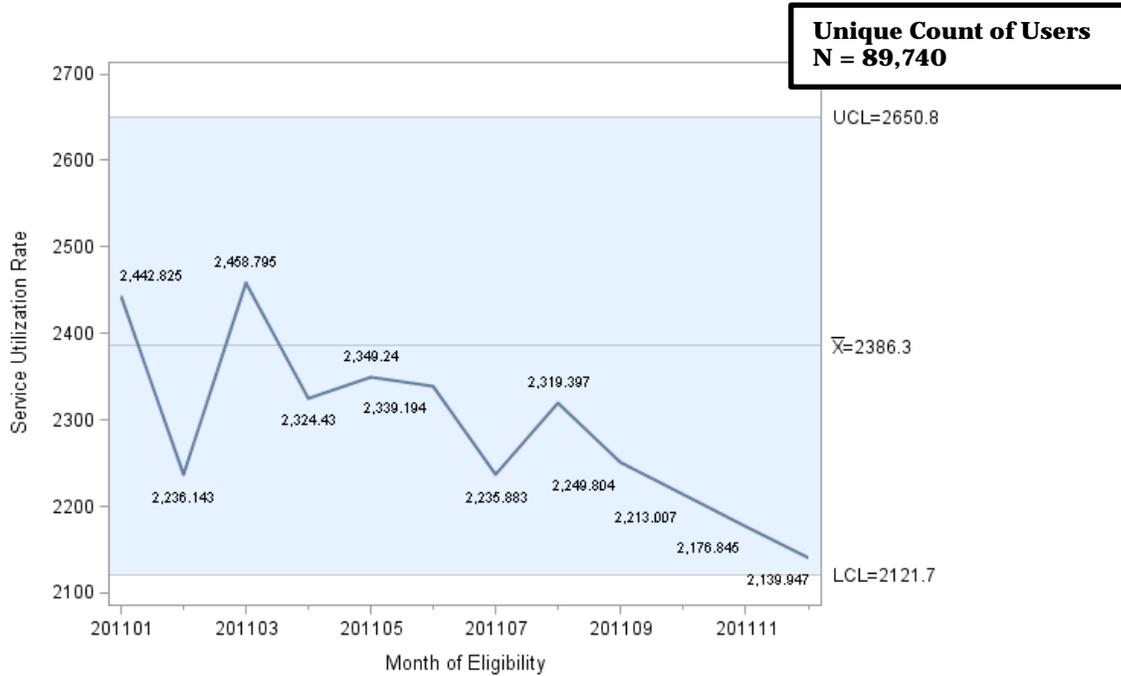
**Figure 79 Monthly Pharmacy Services Utilization Rates among Children (age 0-20) in the Undocumented Aid Category, January thru December 2011**



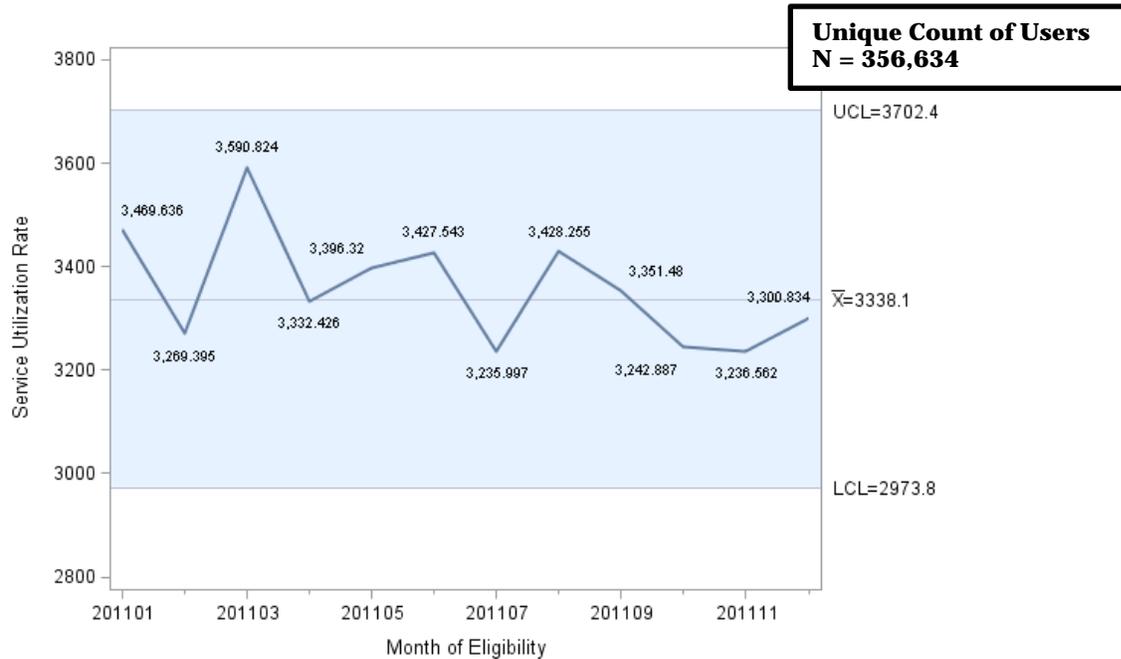
**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## Trends in Pharmacy Services Use among Adults

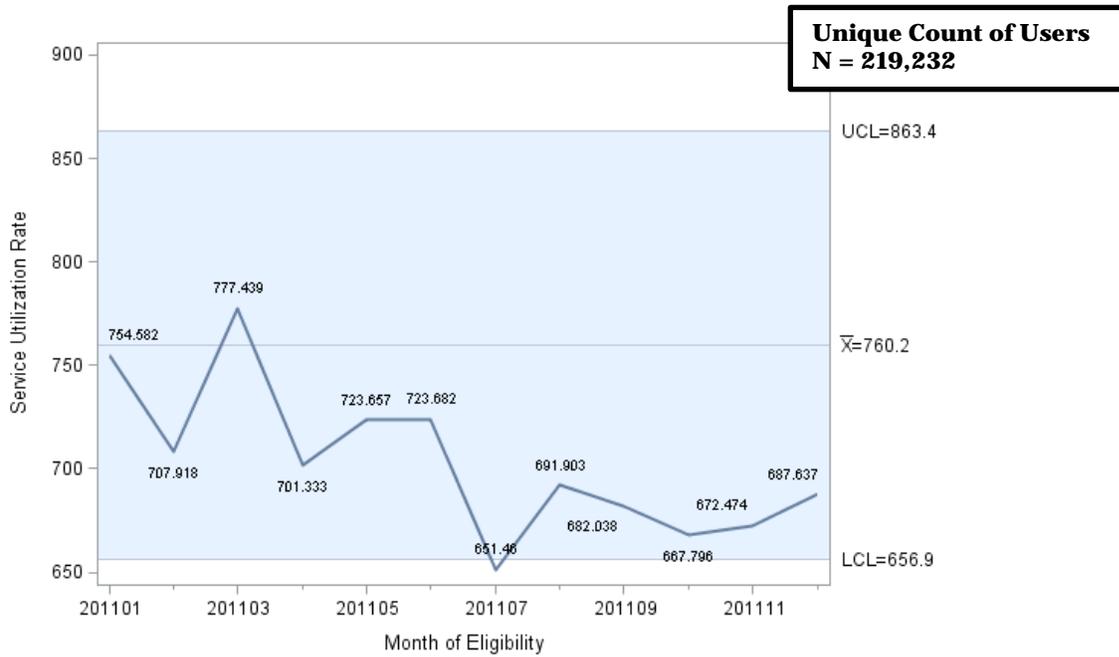
**Figure 80 Monthly Pharmacy Services Utilization Rates among Adults (age 21+) in the Aged Aid Category, January thru December 2011**



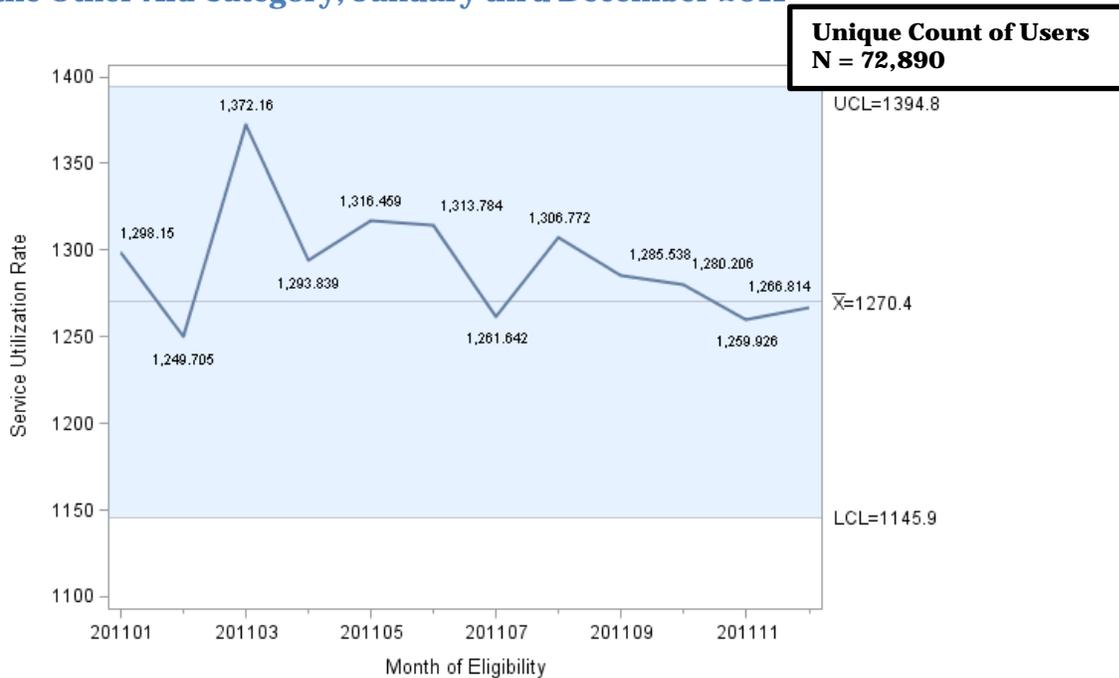
**Figure 81 Monthly Pharmacy Services Utilization Rates among Adults (age 21+) in the Blind/Disabled Aid Category, January thru December 2011**



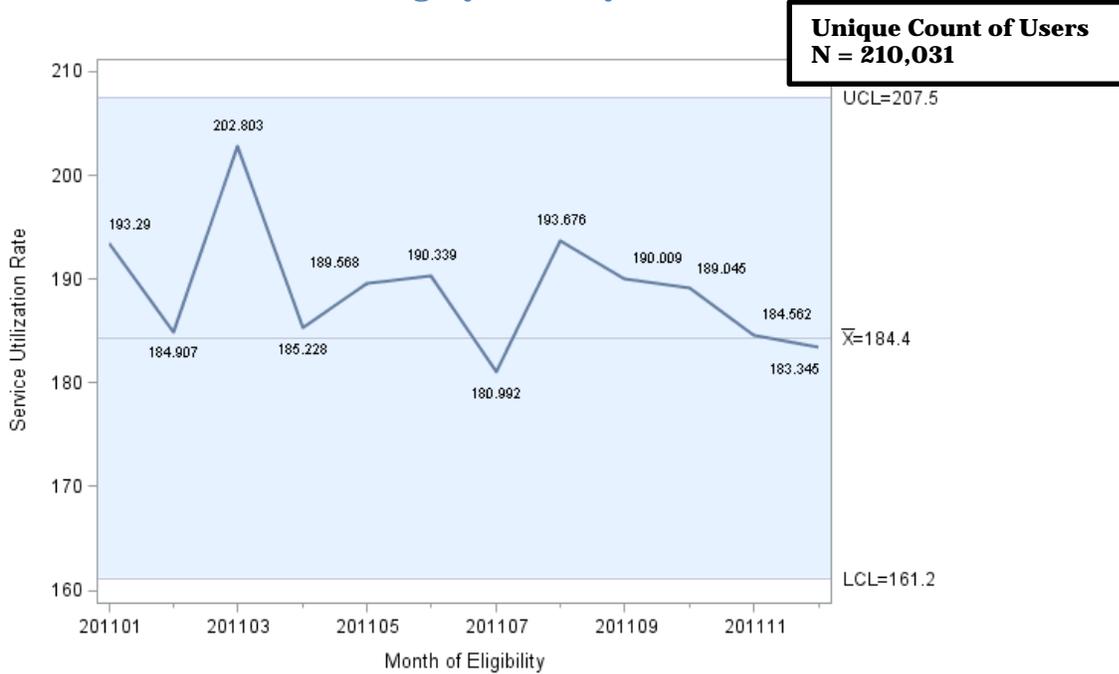
**Figure 82 Monthly Pharmacy Services Utilization Rates among Adults (age 21+) in the Families Aid Category, January thru December 2011**



**Figure 83 Monthly Pharmacy Services Utilization Rates among Adults (age 21+) in the Other Aid Category, January thru December 2011**



**Figure 84 Monthly Pharmacy Services Utilization Rates among Adults (age 21+) in the Undocumented Aid Category, January thru December 2011**



**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

### Other Services

Service providers covered under “Other” 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 Practitioner, Pediatric Nurse Practitioners
- Physical, Occupational and Speech Therapist
- Orthotists and Prosthetists
- Podiatrists
- Psychologists
- Genetic Disease Testing
- Local Education Agency (LEA)
- Respiratory Care Practitioner
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services Provider
- Health Access Program (HAP)

For a full list of provider types, see Appendix D.

It is important to note that, beginning in July 2009, several optional benefits were excluded from the Medi-Cal program. These benefits comprise of 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, and beneficiaries enrolled in PACE:

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

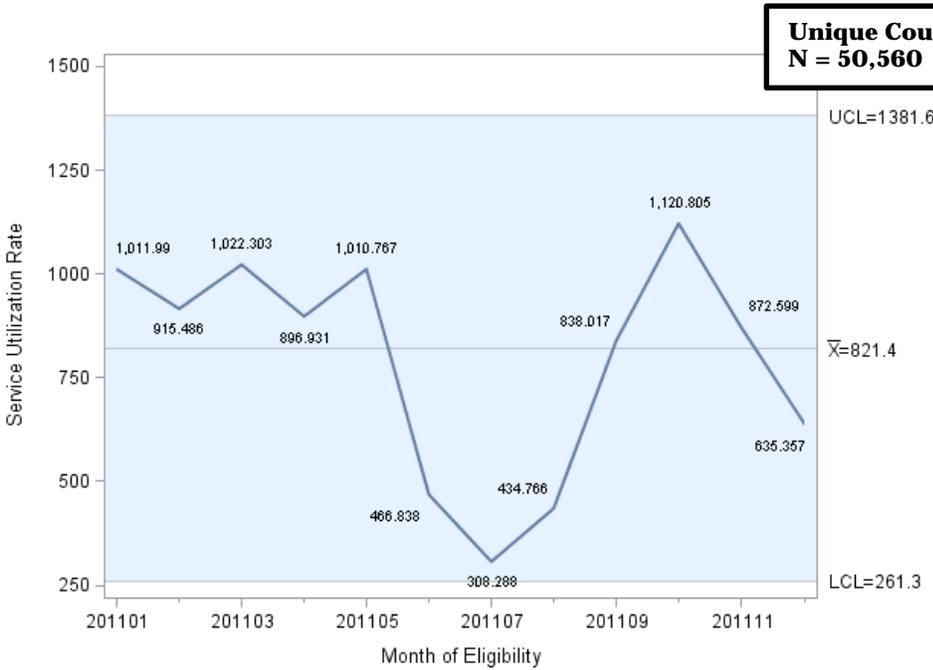
### **Trend Analysis --- Other Services**

Among children age 0 to 20 in the Medi-Cal FFS program, monthly utilization rates for Other Services ranged from 14.3 to 1,120.8 visits per 1,000 member months during CY 2011. The utilization of Other Services was noticeably higher among children in the Blind / Disabled aid category, a subgroup whose utilization was four to five times higher than for children in the Foster Care aid category, and ten times higher than for children in the Families and Other aid categories. Children in most aid categories exhibited a distinct decline in Other Services utilization in July, resuming to normal levels thereafter. However, the utilization rates for children in the Other aid category experienced downward trends in the last quarter of 2011, and utilization rates for those in the Undocumented aid category were well below the anticipated baseline ranges for the entire year of 2011.

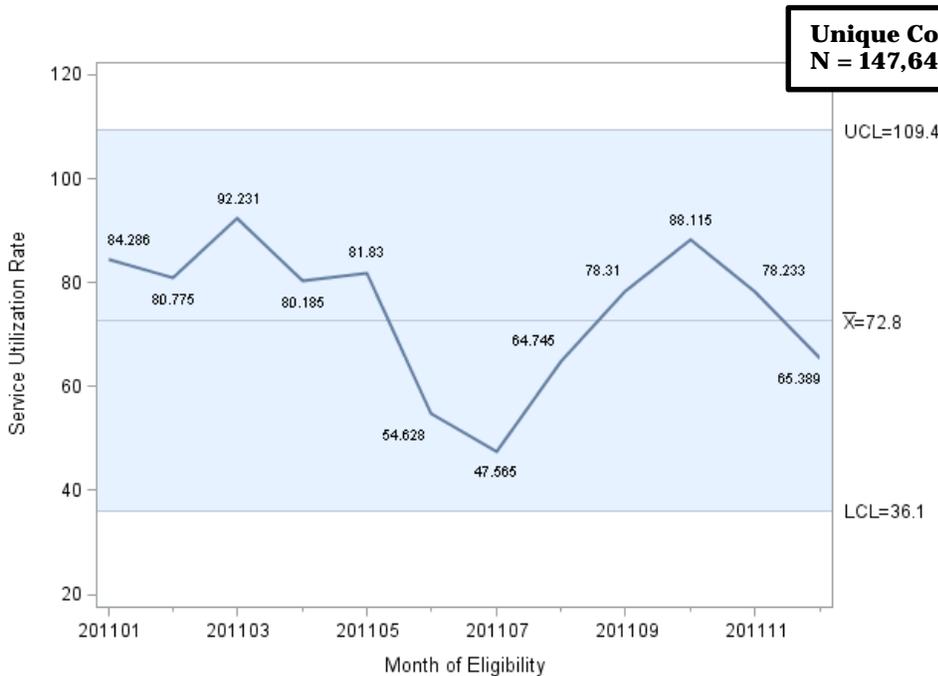
The monthly utilization rates for Other Services among adults age 21 and older ranged from 42.1 to 324.8 visits per 1,000 member months in CY 2011. The utilization rates were noticeably higher for adults in the Aged, Blind / Disabled, and Other aid categories, and lowest for adults in the Undocumented aid category. Utilization of Other Services among adults in most aid categories were found to be below the average baseline rates, but fell within expected ranges. For adults in the Undocumented aid category, however, utilization rates for Other Services fell well below the calculated baseline ranges established in CY 2007-2009.

## Trends in Other Service Use among Children

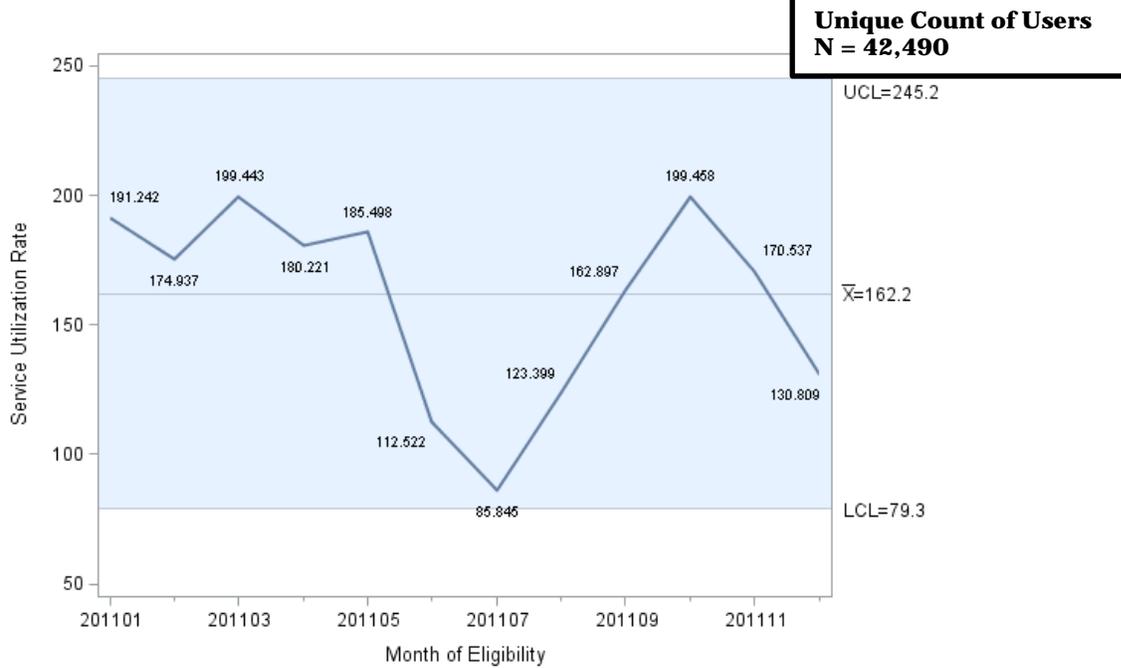
**Figure 85 Monthly Other Services Utilization Rates among Children (age 0-20) in the Blind/Disabled Aid Category, January thru December 2011**



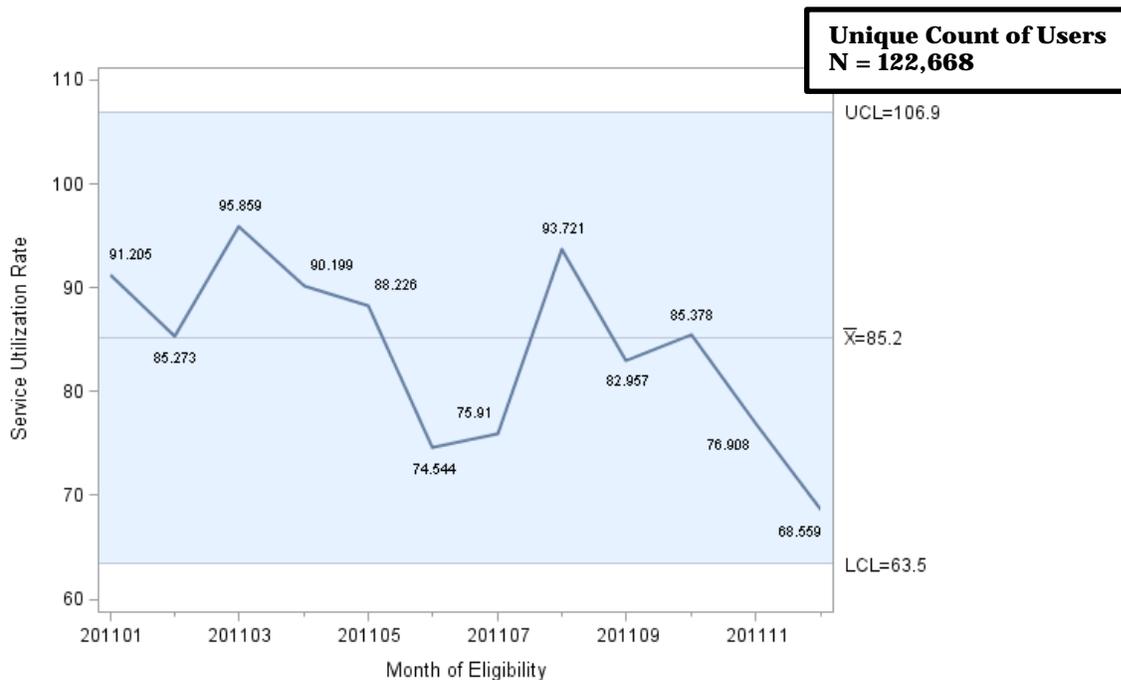
**Figure 86 Monthly Other Services Utilization Rates among Children (age 0-20) in Families Aid Category, January thru December 2011**



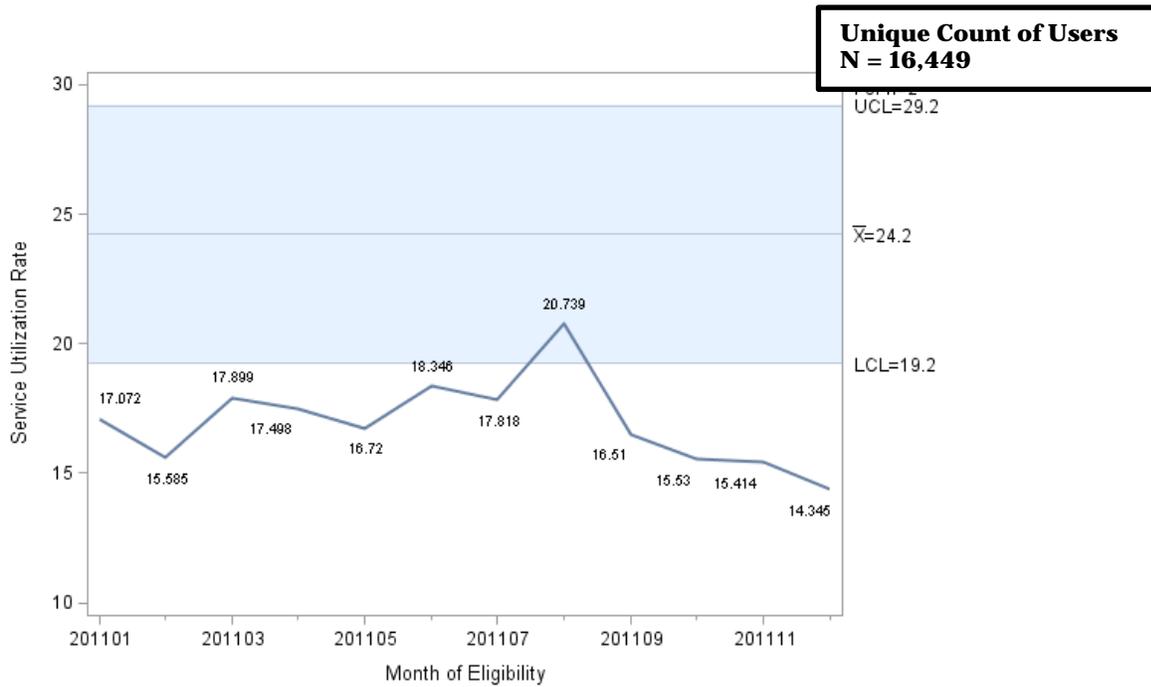
**Figure 87 Monthly Other Services Utilization Rates among Children (age 0-20) in the Foster Care Aid Category, January thru December 2011**



**Figure 88 Monthly Other Services Utilization Rates among Children (age 0-20) in the Other Aid Category, January thru December 2011**



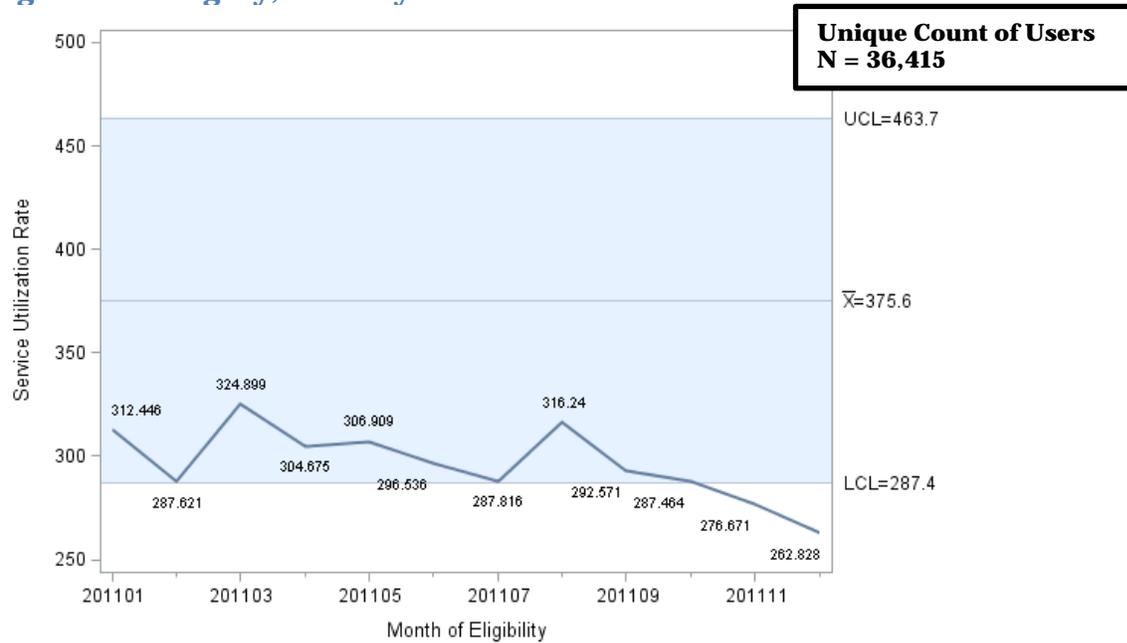
**Figure 89 Monthly Other Services Utilization Rates among Children (age 0-20) in the Undocumented Aid Category, January thru December 2011**



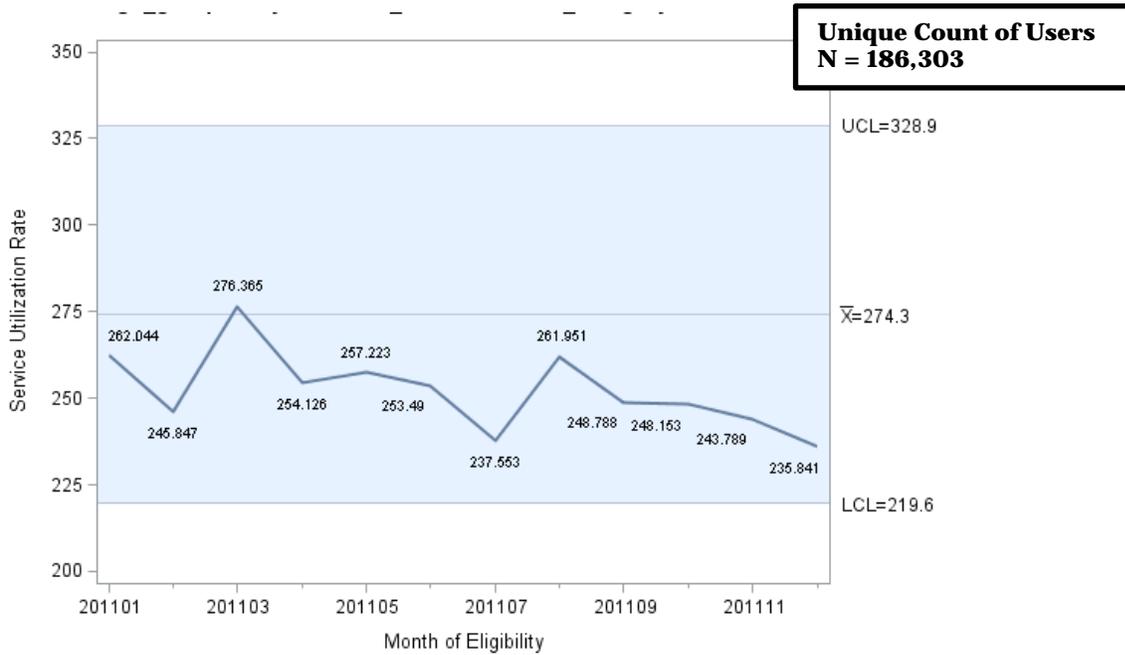
**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

**Trends in Other Service Use among Adults**

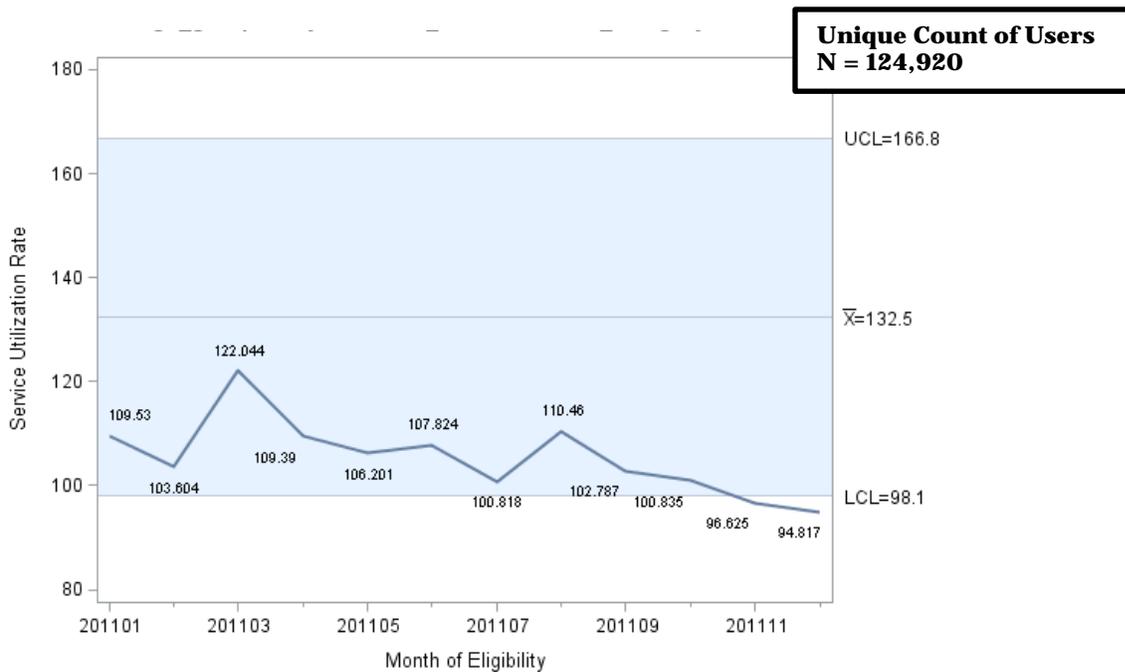
**Figure 90 Monthly Other Services Utilization Rates among Adults (age 21+) in the Aged Aid Category, January thru December 2011**



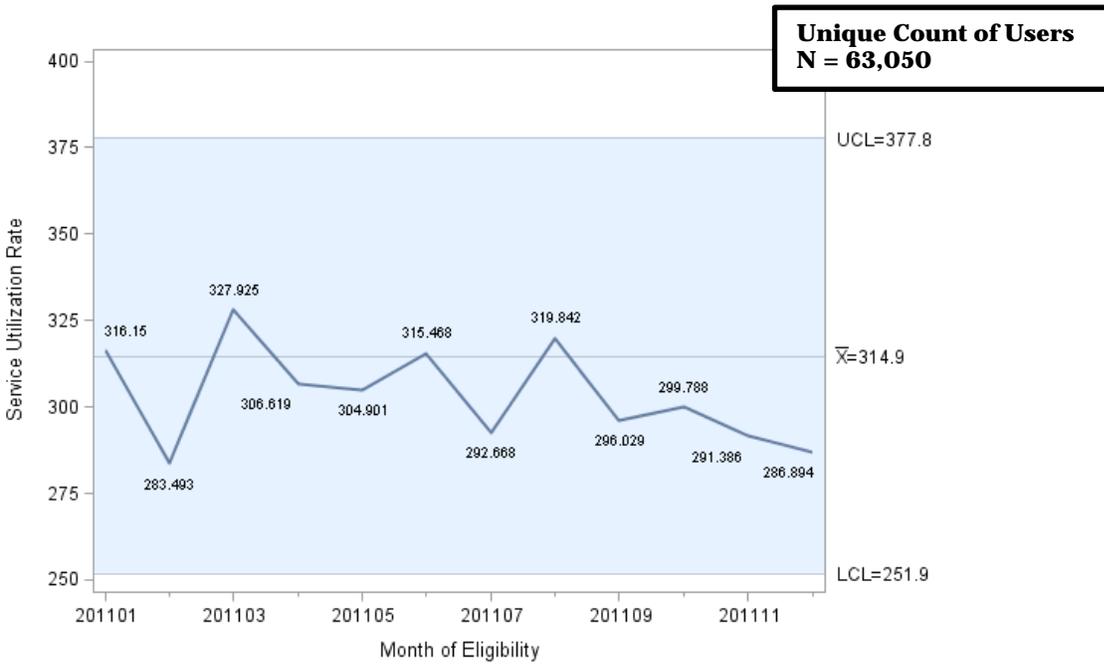
**Figure 91 Monthly Other Services Utilization Rates among Adults (age 21+) in the Blind/Disabled Aid Category, January thru December 2011**



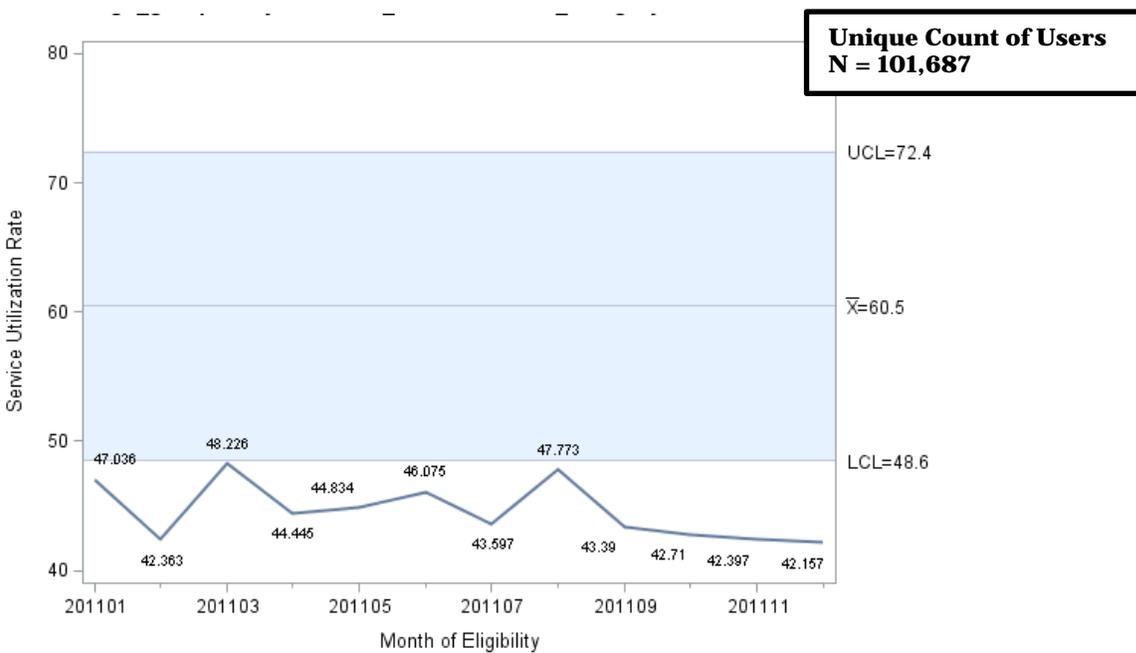
**Figure 92 Monthly Other Services Utilization Rates among Adults (age 21+) in the Families Aid Category, January thru December 2011**



**Figure 93 Monthly Other Services Utilization Rates among Adults (age 21+) in the Other Aid Category, January thru December 2011**



**Figure 94 Monthly Other Services Utilization Rates among Adults (age 21+) in the Undocumented Aid Category, January thru December 2011**



**Source:** Data prepared by DHCS Research and Analytic Studies Branch, using data from the Fiscal Intermediary’s 35-file of paid claims records with dates of service from January thru December 2011, and data from the MEDS eligibility system, MMEF File. Quarterly data reflects a 4-month lag.

## Conclusions – Service Utilization

**Table 14 Summary of Service Utilization Trends Among Children by Aid Category and Service Category**

<b>Aid Category</b>	<b>Physician / Clinic Visits</b>	<b>Non-Emergency Transportation</b>	<b>Emergency Medical Transportation</b>	<b>Home Health Services</b>	<b>Inpatient Hospital Services</b>	<b>Outpatient Hospital Services</b>	<b>Nursing Facility Services</b>	<b>Pharmacy Services</b>	<b>Other Services</b>
<b>Blind/ Disabled</b>	Within Expected Range	Above Expected Range and Upward Trends (Jul-Dec)	Downward Trend (Jan-Apr) and Below Average but Mostly Within Expected Range (Jun-Dec)	Upward Trend (Jun-Dec) and Within Expected Range	Within Expected Range	Within Expected Range	Upward Trend (Jul-Dec), Below Average and Below Expected Range	Upward Trend (Jul-Dec), Above Average and Mostly Within Expected Range	Within Expected Range with a Drop in July
<b>Families</b>	Downward Trend (Jan-Jul), Below Average but Within Expected Range	N/A	Downward Trend (Jan-Jun) and Below Average but Mostly Within Expected Range	Upward Trend (Jul-Dec) and Within Expected Range	Downward Trend (Jan-Jun), Below Average but Within Expected Range	Downward Trend (Jan-Jul), Below Average (Jul-Dec) but Mostly Within Expected Range	N/A	Downward Trend (Jan-Jul), Below Average but Mostly Within Expected Range	Within Expected Range with a Drop in July
<b>Foster Care</b>	Downward Trend (Jan-Jul), Below Average but Within Expected Range	N/A	Within the Expected Range	Above Average (Aug-Dec) but Within Expected Range	Below Average but Within Expected Range	Within Expected Range	N/A	Within Expected Range	Within Expected Range with a Drop in July
<b>Other</b>	Downward Trend (Jan-Jul), Below Average but Within Expected Range (Aug-Dec)	N/A	Downward Trend (Jan-Apr) and Below Average with 8 Consecutive Months Below Expected Range	Below Average but Within Expected Range	Downward Trend (Jan-Jun) and Below Expected Range	Downward Trend (Jan-Sep) and Below Average with 6 Consecutive Months Below Expected Range	Above Average But Mostly Within Expected Range	Downward Trend (Jan-Jul), Below Average with 3 Consecutive Months Below Expected Range	Within Expected Range
<b>Undocumented</b>	Below Average and Below Expected Range	N/A	Below Average with Various Point Below Expected Range	N/A	Below Expected Range	Below Average but Within Expected Range	N/A	Downward Trend (Mar-Jul), Below Average but Within Expected Range	Below Expected Range

## Conclusions – Service Use among FFS Children

- Children’s service utilization patterns for physician/clinic visits were predominantly within the expected ranges as established during the baseline analysis, with the exception of children enrolled in the Undocumented aid category where service utilization rates were reported below the baseline thresholds. Downward trends in physician/clinic visits were noted at the beginning of CY2011 among children in the Foster Care and Other aid categories, and utilization was below average for children in the Families aid category, indicating a possible change in the case mix of the population as FFS participation dwindles. These shifts in service use patterns warrant revision of baseline threshold values to be implemented in future analyses.
- Non-Emergency Medical Transportation use among Medi-Cal children participating in the FFS health care delivery system was assessed only for those enrolled in the Blind/Disabled aid category because others exhibited limited use of these services. Among this subgroup, service use was reported above baseline thresholds, with upward trends at the end of CY2011.
- Emergency Medical Transportation service use was mostly within expected ranges for Medi-Cal children enrolled in the Blind/Disabled, Families and Foster Care aid categories. Downward trends were reported for those in the Blind/Disabled, Families and Other aid categories for the first part of CY2011, and service use reached levels below baseline thresholds for those in the Other and Undocumented aid groups. These shifts in service use patterns may indicate a change in case mix, and may warrant revision of baseline threshold values.
- Home health service use among children was predominantly within expected baseline ranges. However, above average use was reported in the latter part of CY2011, indicating a possible shift in case mix correlated with declines in FFS participation during this same time period.
- Children’s use of Inpatient Hospital Services was within expected ranges for those in the Blind/Disabled, Families and Foster Care aid categories. For children in Undocumented and Other aid categories, Inpatient Hospital Service use reached levels below baseline thresholds. Downward trends were also reported for those in the Families and Other aid code categories during the beginning of CY2011, which correlates to decreases noted in FFS participation during this same time period.
- Utilization patterns for Outpatient Hospital Service were mainly within expected baseline ranges. From January to mid-year, downward trends in Outpatient Hospital Service use were noted among children in the Families and Other aid categories, and rates reached levels below baseline thresholds for children in the Undocumented aid category.

- Nursing Facility Service utilization was only assessed for children enrolled in the Blind/Disabled and Other aid categories because use among other subgroups was limited. Upward trends in Nursing Facility Service use were reported in the last half of CY2011 for children in the Blind/Disabled aid category; however, use among this subgroup was below expected ranges for the first half of the year.
- Pharmacy Service use among Medi-Cal children was predominantly within baseline levels, with some downward trends noted for children in the Families, Other and Undocumented aid categories in the beginning of CY2011.
- Utilization patterns for Other Services with within expected ranges, except among children in the Undocumented aid category where utilization levels reached below baseline thresholds.

## Summary of Service Utilization among FFS Adults

**Table 15** presents the results of DHCS' analysis of the utilization trends among adults by aid code and service category. The table is color coded to identify those cases when a particular cell, which presents utilization by aid code and service category, generated a utilization rate that was either lower or higher than the established confidence level. Those cells highlighted in yellow represent 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. In some the 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 15 Summary of Service Utilization Trends Among Adults by Aid Category and Service Category**

<b>Aid Category</b>	<b>Physician / Clinic Visits</b>	<b>Non-Emergency Transportation</b>	<b>Emergency Medical Transportation</b>	<b>Home Health Services</b>	<b>Inpatient Hospital Services</b>	<b>Outpatient Hospital Services</b>	<b>Nursing Facility Services</b>	<b>Pharmacy Services</b>	<b>Other Services</b>
<b><i>Aged</i></b>	Within Expected Range	Above the Expected Range, Upward Trend (Jan-Dec)	Within Expected Range, Upward Trend (Jul-Dec).	Mostly Below the Expected Range	Mostly Within Expected Range, Upward Trend (Jul-Dec), but Below Average	Within Expected Range	Mostly outside of Expected Range Upward Trend (Jun-Dec)	Within Expected Range	Mostly Within Expected Range, below baseline average.
<b><i>Blind / Disabled</i></b>	Within Expected Range	Above the Expected Range, Upward Trend (Jan-Dec).	Mostly Within Expected Range	Mostly Within the Expected Range	Mostly Within the Expected Range	Within Expected Range	Mostly Above Expected Range, Upward Trend (Jun-Dec).	Within Expected Range	Within Expected Range, below baseline average.
<b><i>Families</i></b>	Within Expected Range	Above the Expected Range, Upward Trend,	Within Expected Range	Mostly Below the Expected Range	4 Consecutive Months Below Expected Range, Below Average	Mostly Within Expected Range, Downward Trend	Mostly within Expected Range, Upward Trend (Feb-Dec)	Within Expected Range	Mostly Within Expected Range, below baseline average.
<b><i>Other</i></b>	Within Expected Range	Above the Expected Range	Within Expected Range	Within Expected Range	Below Average with 3 Consecutive Months Below Expected Range	Within Expected Range	Mostly Within Expected Range Below Average	Within Expected Range	Within Expected Range, below baseline average.
<b><i>Undocumented</i></b>	4 Consecutive Months Below Expected Range, Below Average	N/A	Below the Expected Range	N/A	Below the Expected Range	Mostly Within the Expected Range	N/A	Within the Expected Range	Below the Expected Range

## Conclusions --- Service Use among FFS Adult Beneficiaries

- Service utilization for adults in various aid categories exhibited utilization rates that were generally within the expected ranges established during the baseline period (i.e., CY 2007 to 2009). Some service categories exhibited utilization levels that were consistently below the baseline average. Most notably, adults enrolled in each of the analyzed aid categories exhibited *Other* services utilization rates below the average baseline levels. This particular *shift* in utilization is most likely explained by fundamental changes implemented in the Medi-Cal program in July 2009, that eliminated several optional services from this category and subsequently made them unavailable to beneficiaries in CY 2011. In addition, adults in most of the aid categories, displayed utilization rates that were below the baseline average, but within the upper and lower ranges for Physician/Clinic, Home Health, and Inpatient Hospital services during CY 2011. As noted previously, these shifts in utilization are most likely due to the transformation of the Medi-Cal program from a FFS delivery system to a managed care delivery system. Beneficiaries who constitute the population eligible for Medi-Cal only and participating in the FFS system in CY quarter 4 are different from those who were participants in CYs 2007 through 2009, when the baseline was established.
- Service utilization rates for adults in the Families and Undocumented aid categories exhibited below average Physician/Clinic, Home Health, Emergency Transportation and Inpatient Hospital services utilization rates throughout CY 2011. Among younger adults (age < 65) in these aid categories, these service categories are generally associated with pregnancy-related care. For example, the most common reason for Hospital Inpatient use among Medi-Cal beneficiaries under age 65 is childbearing, while many beneficiaries in Families and Undocumented aid codes use Home Health services for postpartum and well-baby check-ups. In addition, Physician/Clinic services use among this subpopulation is likely attributable to prenatal and postpartum care visits. Declines in these service use categories may be the result of declining birth rates state-wide<sup>[1]</sup>, but further investigation is needed to definitively identify factors influencing these service use patterns.
- In addition to below average service use among adults in the Families and Undocumented aid categories, those in the Blind / Disabled aid category

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[1] [1] Data published on the California Department of Public Health website, found at <http://www.cdph.ca.gov/data/statistics/Documents/VSC-2010-0202.pdf>

exhibited below average utilization of Home Health, Inpatient Hospital, and Other services during the study period. Adults in the Aged aid category displayed below average utilization of Physician / Clinic, Home Health, Pharmacy, and Other Services. Adults in both the Aged and Blind / Disabled aid categories displayed upward trends in Nursing Facility and Non-Emergency Medical Transportation services utilization that reached levels well above the expected range. Additionally, Aged adults exhibited upward trends in the use of Emergency Transportation and Inpatient Hospital Services. RASB hypothesizes that there may be several factors that likely influence these trends. For example, among adults in the Aged and Blind/Disabled aid categories, growing older and developing more serious medical conditions may have supplanted the need for outpatient care such as Physician/Clinic and Home Health services with more concentrated care including Inpatient Hospital and Nursing Facility services. In addition, these variances in service utilization may have potentially been influenced by shifts in adult enrollment trends occurring in CY 2011 which may have altered the case mix of the population. For instance, the average member months for adults in the Aged and Blind / Disabled aid categories decreased by 30,101 and 138,962 respectively in CY 2011. These large shifts in enrollment, from Medi-Cal's traditional FFS system to managed care delivery systems, are associated with several Departmental initiatives that transitioned FFS beneficiaries into managed care plans.

The Department changed its policy regarding the enrollment of SPDs into managed care, from voluntary to mandatory enrollment. This means that SPD beneficiaries residing in Two-Plan and GMC counties are now required to enroll into managed care plans, unless a medical exemption is secured or a beneficiary is a member of a group that is exempted. This policy change resulted in a significant alteration in the case mix relative to Medi-Cal's traditional FFS system. All newly eligible SPDs, after July 2011, 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 receive a medical exemption or who were members of a group that was exempted from mandatory managed care enrollment. This influenced service use among those remaining in FFS. For example, the SPD beneficiaries remaining in FFS most likely represent beneficiaries who were medically compromised and suffering from server chronic health conditions. In turn, they represented a group most likely to become LTC service utilizers. 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

time frame, 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 utilization 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 will be mandatorily enrolled into managed care plans. In most cases, this occurs within 45 days of becoming eligible for Medi-Cal. Therefore, these newly eligible SPDs will most likely not utilize home health services during their initial two-month FFS participation. These SPD beneficiaries will participate in Medi-Cal's FFS system for roughly two months and will most likely not utilization home health services.

During the study period evaluated, these enrollment 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 use 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 mostly likely contributed to the utilization changes presented (i.e., the increase in LTC service utilization rate and decrease in home health utilization rate).

- Adults in the Families aid category exhibited upward trends in the use of Non-Emergency Medical Transportation and Nursing Facility services. These trends are difficult to interpret and would require additional studies to identify potential causes for these utilization shifts.

## **Beneficiary Feedback**

### **Introduction**

In 2011, the Centers for Medicare and Medicaid Services (CMS) strongly encouraged the Department to implement a beneficiary help line as part of the Department's comprehensive health care access monitoring plan. Though the Department 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 the Department 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 not only address this gap in the Department's information for monitoring healthcare access, but will provide needed assistance to FFS beneficiaries having difficulties navigating the health care system.

The Medi-Cal beneficiary help line was implemented in December 2011, and is similar to the call center that addresses the needs of Medi-Cal managed care beneficiaries. Beneficiary calls to the FFS help line will capture data pertaining to difficulties in accessing care, and will provide data pertaining to healthcare access issues in the Medi-Cal FFS program. The rate with which Medi-Cal FFS beneficiaries contact the help line for information and complaints can offer one measure of how well the program is meeting the needs of its FFS beneficiaries and solving problems when they arise.

Data collected for this purpose will provide DHCS with the only source of “real time” data pertaining to health care access problems encountered by beneficiaries in the FFS delivery model, and will enable DHCS to identify and correct health care access problems soon after they arise.

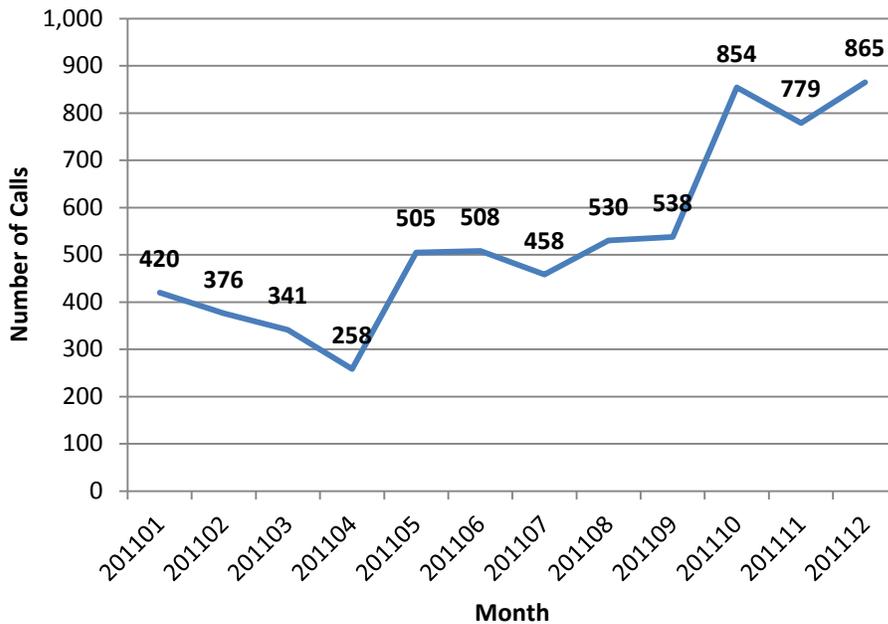
## **Method**

Since the Medi-Cal FFS beneficiary call center did not begin receiving calls until December 2011, the data from this source could not be analyzed for Calendar Year (CY) 2011. Therefore, data for FFS beneficiaries calling into the Medi-Cal Managed Care Office of the Ombudsman were obtained for this purpose. Although the Ombudsman’s Office mainly handles calls from managed care beneficiaries, a large number of inquiries are received from FFS beneficiaries. Many of these FFS beneficiaries may have been sent letters by the Department notifying them of program changes. The Office of the Ombudsman call center documented 6,432 calls from FFS beneficiaries during CY 2011. For each of these calls, the call center recorded the date and time of call, beneficiary aid code and county of residence, and reasons for the call. Data for these calls were summarized by month received, county, six aid code category groupings (Families, Blind/Disabled, Aged, Foster Care, Undocumented, and Other), and reason for call. Results of these analyses appear below.

## **Results**

**Figure 95** provides a graph of the total calls received from FFS beneficiaries during 2011 by month. Call volume doubled from the beginning of the year (420) to the end of the year (865). There was a slight decline in call volume in the first quarter of the year, followed by a significant increase in calls beginning in May. From May to September, there was a relatively steady amount of calls received and then a sharp increase in calls was observed beginning in October and continuing through the end of the year.

**Figure 95 Calls received by FFS Beneficiaries by Month, CY 2011**



*Source.* Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received by FFS beneficiaries during CY 2011.

The increase in call volume during May 2011 is likely due to the call center’s addition of five call operators to their current staff. The increase in staffing capacity enabled the call center to receive and handle more calls that were anticipated with the transition of Seniors and Persons with Disabilities (SPDs) into managed care plans. Under the terms of California’s Section 1115 “Bridge to Reform” waiver with the Federal government, the managed care enrollment requirement for beneficiaries in aid codes for SPDs was changed from voluntary to mandatory. Beginning in May 2011 and scheduled to continue through May 2012, the Department began the process of enrolling SPDs residing in Two-Plan and GMC counties into health plans. The addition of the five call center staff may have helped stabilize and maintain the call center’s ability to handle more calls, which possibly explains the relatively steady call levels seen from May to September.

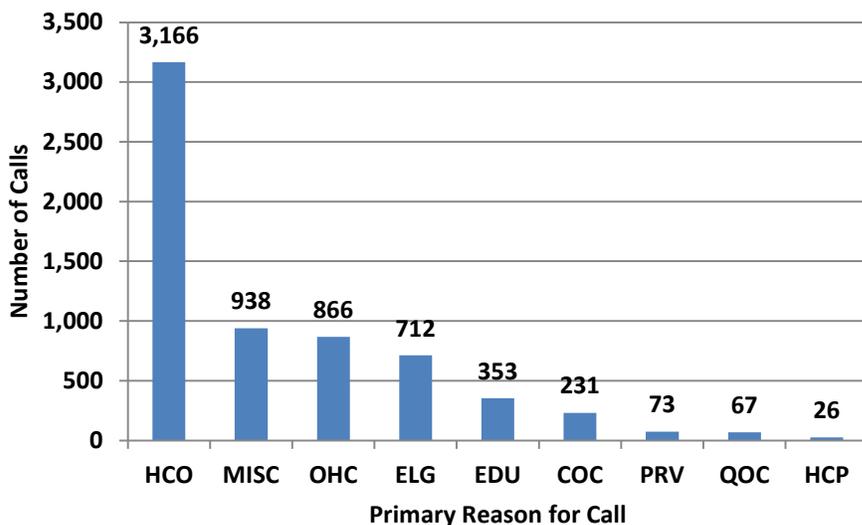
A significant increase in call volume beginning in October coincides with the elimination of the Adult Day Health Care (ADHC) benefit scheduled for the end of 2011. In late August, beneficiaries received notices that the ADHC benefit would be eliminated. In Two-Plan and Geographic Managed Care counties, beneficiaries received an enrollment packet that informed them they would be enrolled into managed care on October 1<sup>st</sup>. Notices such as these contain the contact information of the Office of the Ombudsman for beneficiaries to obtain assistance and information. This may be one factor contributing to the significant increase in calls received by the Ombudsman call center beginning in October.

Data collected by the Ombudsman’s Office were categorized by call center staff into one of the following categories based on the primary reason for each call:

1. Continuity of Care (COC)
2. Education & Outreach (EDU)
3. Eligibility (ELG)
4. Enrollment/Disenrollment (HCO)
5. Health Care Plan Issues (HCP)
6. Other Health Coverage (OHC)
7. Plan Subcontractor/Provider Issues (PRV)
8. Quality of Care (QOC)
9. Miscellaneous Issues (MISC)

**Figure 96** provides a breakdown of the calls received from FFS beneficiaries by these primary reasons. The largest proportion of calls received (49%) were pertaining to Enrollment/Disenrollment matters, followed by Miscellaneous issues (15%), Other Health Coverage matters (14%), and Eligibility issues (11%).

**Figure 96 Calls Received by FFS Beneficiaries by Primary Reason for Call, CY 2011**



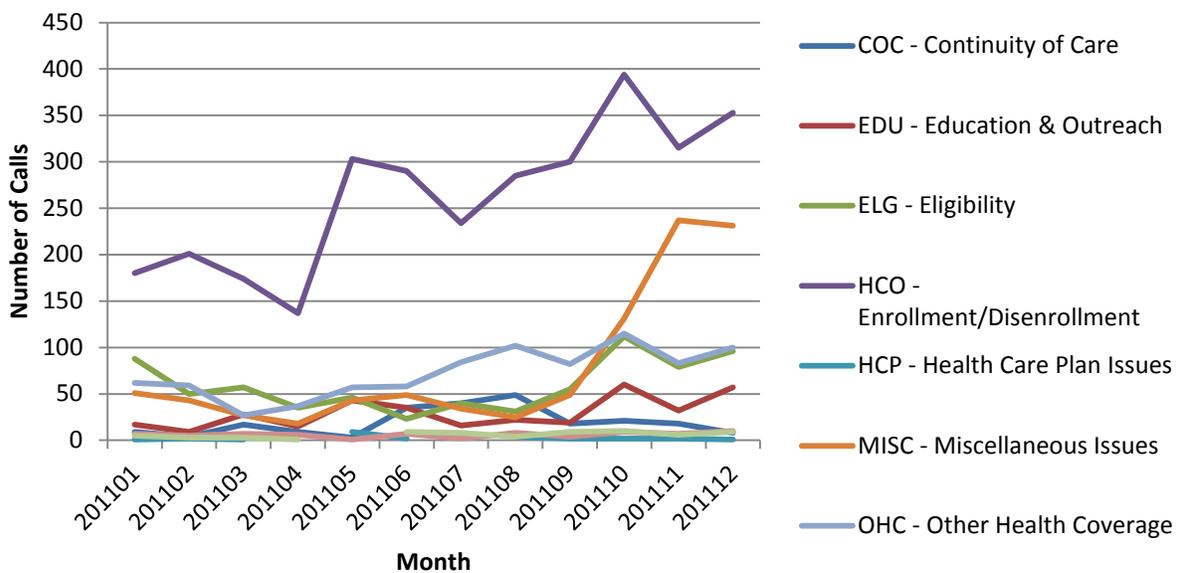
*Source.* Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received by FFS beneficiaries during CY 2011. Definitions: COC - Continuity of Care, EDU - Education & Outreach, ELG – Eligibility, HCO - Enrollment/Disenrollment, HCP - Health Care Plan Issues, MISC - Miscellaneous Issues, OHC - Other Health Coverage, PRV - Plan Subcontractor/Provider Issues, QOC - Quality of Care.

It is not surprising to find that many FFS beneficiary calls into the Ombudsman’s Office pertain to health plan enrollment issues since the Department undertook several large initiatives to move beneficiaries into managed care plans in 2011. As noted earlier, the SPD transition began in May 2011. Also, the counties of Ventura, Marin, and Mendocino shifted to the County Organized Health System (COHS) managed care model, moving beneficiaries from the FFS

model into health plans. It is possible that many calls categorized under Enrollment/Disenrollment may be due to these transitions, since the program saw a net shift of 7.2% of Medi-Cal beneficiaries from FFS into the managed care delivery model during 2011.

**Figure 97** displays calls by primary reason for call and month. The table illustrates that calls pertaining to Enrollment/Disenrollment represent the largest proportion of calls, and experiences the greatest increase in call volume during CY 2011. Additionally, an increase in call volume for Miscellaneous issues occurred in October 2011. Unfortunately, this category is too ambiguous to interpret.

**Figure 97 Calls Received by FFS Beneficiaries, Primary Reason for Call by Month, CY 2011**



Source. Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received by FFS beneficiaries during CY 2011.

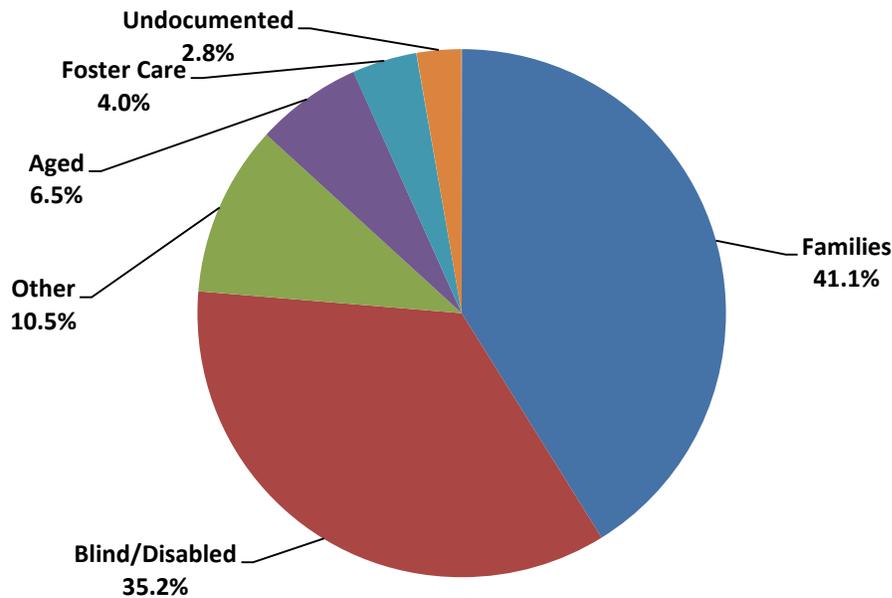
Since the Ombudsman's data collection system was designed, there may have been several call issues encountered by staff that do not easily fall into the coding scheme that was initially established. Therefore, labels such as Miscellaneous are used by call center staff as a catch-all category.

Additional analyses were undertaken to identify the issues categorized under primary reason codes. Staff have the option to assign a secondary reason for each call. Among the top primary reasons for call, calls with a secondary reasons assigned to them were investigated. Of the calls categorized under, "Enrollment/Disenrollment," the most common secondary reason assigned was "Requesting new enrollment into Plan," followed by "Wants to disenroll from plan to become FFS." Calls categorized under, "Miscellaneous," frequently had the secondary reason of "Other (please specify in notes)" and "Voice Mail Call – Issue Resolved." Among calls categorized under, "Other Health Coverage," the most common secondary reasons assigned to calls was, "Conflicting information about OHC Status." Lastly, calls recorded under, "Eligibility," had the following secondary reasons most of the time, "Medi-Cal Eligibility Terminated" and "Address Correction/Beneficiary Moved."

Further investigation was undertaken to explore whether primary reasons for calls by FFS beneficiaries varied by aid code category. A majority of beneficiaries in each of the aid code categories cited that the reason for their call was an Enrollment/Disenrollment issue, except among those in the Undocumented aid code category where the primary reason was Other Health Coverage.

**Figure 98** illustrates a breakdown of calls received from FFS beneficiaries by aid code category. Over 40% of calls received were from beneficiaries in Family aid codes and another 35% were from beneficiaries in Blind/Disabled aid codes. The large proportion of calls by beneficiaries in the Families aid codes reflects their large over-all numbers in the Medi-Cal program.

**Figure 98 Calls Received by FFS Beneficiaries by Aid Code Category, CY 2011**

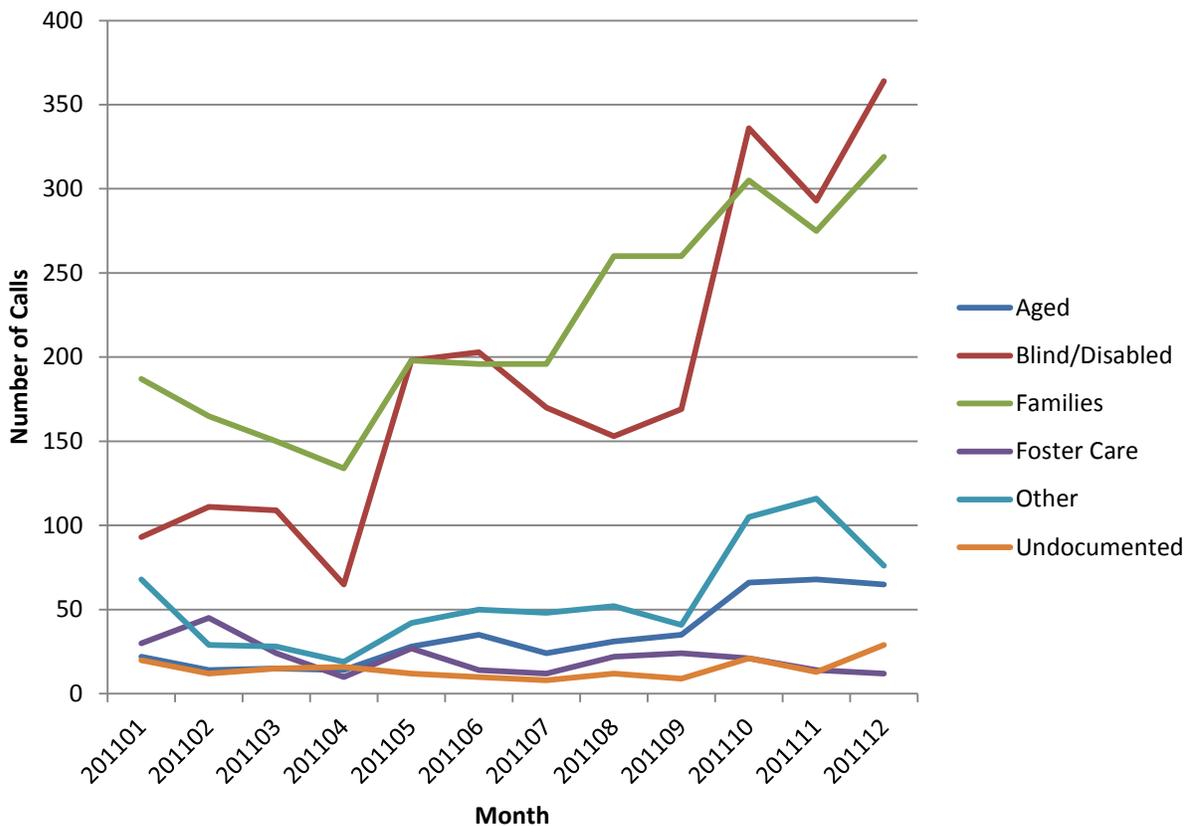


*Source.* Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received by FFS beneficiaries during CY 2011.

Over 40% of all calls received were from beneficiaries in Blind/Disabled aid codes and Aged aid codes combined. This large proportion of calls from those in the Blind/Disabled and Aged aid code categories may be attributable to the SPD and ADHC transitions that began in 2011. However, data coding schemes implemented by the Ombudsman’s call center do not contain the level of detail necessary to identify these specific Department initiatives.

**Figure 99** presents calls received by aid category and month. The chart illustrates the concentration of calls from the Families and Blind/Disabled categories as compared with the other categories that occurred at a relatively constant rate throughout the year. The spikes and dips in the calls for the Families and Blind/Disabled categories again coincide with the Departmental initiatives of the SPD and ADHC transitions. However, no definitive explanations for these fluctuations can be reached with this available data.

**Figure 99 Calls Received by FFS Beneficiaries, Aid Category by Month, CY 2011**



Source. Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received by FFS beneficiaries during CY 2011.

**Table 16** provides the top 10 counties from which FFS beneficiaries called. The largest proportion of calls received were from FFS beneficiaries residing in Los Angeles County (29%), followed by San Bernardino (13%) and Riverside (12%). Variations in reason for call were analyzed, stratifying by county. This analysis yielded results that varied little from county-to-county, and identified that for most counties Enrollment/Disenrollment issues were the most frequent reason for calls.

**Table 16 Calls Received from FFS Beneficiaries, Top 10 Counties**

<b>County</b>	<b>Number of Calls Received</b>	<b>Percent of Total Calls Received</b>
Los Angeles	1,869	29.1%
San Bernardino	815	12.7%
Riverside	758	11.8%
San Diego	660	10.3%
Sacramento	389	6.0%
Alameda	367	5.7%
Contra Costa	217	3.4%
Santa Clara	198	3.1%
Orange	165	2.6%
San Joaquin	159	2.5%

*Source.* Office of the Ombudsman, Medi-Cal Managed Care Division. Calls received by FFS beneficiaries during CY 2011.

## **Conclusions – Beneficiary Feedback**

The Ombudsman’s Office received an increase in calls from FFS beneficiaries during the last three quarters of CY 2011. Call volume increased notably among beneficiaries in the Blind/Disabled aid categories and among beneficiaries in the Families aid codes. Some of this increase in call volume may be attributed to Departmental initiatives that transition the SPD population into managed care plans. A large proportion of calls that were received by the Ombudsman’s Office from FFS beneficiaries were pertaining to Enrollment/Disenrollment issues; however, the data in most cases are too ambiguous to identify whether beneficiaries encountered healthcare access problems.

Data collected by the Ombudsman call center supports the need for a FFS beneficiary help line since a significant number of FFS beneficiaries sought assistance from the Ombudsman during 2011. The Ombudsman call data provided some insight into the reasons why FFS beneficiaries sought help from the Ombudsman’s Office. However, these data are not at the detail necessary to identify the exact issues faced by this population. For example, the Miscellaneous call category used by the Ombudsman is too ambiguous to understand the true nature of these calls or to pinpoint specific problems beneficiaries are having with the healthcare system. In addition, the reports generated by the Ombudsman’s Office data tracking system cannot identify how many times a beneficiary called the center, whether they called at different times of the year with different issues, and whether their issues were successfully address by Ombudsman staff. These are some important details to collect to help the Department successfully monitor health care access for this beneficiary subpopulation.

Data from the Ombudsman’s Office was never intended for use as an access monitoring tool, and the data coding schemes developed for the Ombudsman’s Office data tracking system cannot accommodate the myriad of issues that beneficiaries with healthcare access problems

may encounter. Because the Department is required to monitor healthcare access for its FFS population using such a tool, it is critical that the newly established FFS hot line collect meaningful data reflecting reasons for beneficiary calls, particularly as they pertain to healthcare access difficulties. Call data that provides an adequate amount of detail pertaining to call issues will increase the capacity for future analyses, and will provide the Department with better information regarding what problems exist in this beneficiary pool.

## **Appendix A --- Overview of Medi-Cal Claims Processing**

Medi-Cal claims can be processed either through a hard-copy or electronic claim submission process. Hard copy claim submissions require staff at the Fiscal Intermediary to manually examine the documents for completeness and sorted for data entry. If the claim is neatly-typed or computer-printed, it can be scanned into the system. All other claim forms must be entered manually by key data entry operators. Once it is entered into the system, the claim can be adjudicated. Electronic claim submission bypasses the claims examination and data entry process, allowing claims to be adjudicated almost immediately as in the case of most pharmacy claims.

The original Medi-Cal claim must be received by the Fiscal Intermediary within six months following the month in which the services were rendered. Late submissions are subject to a payment cut-back and eventually denied if submitted twelve months following the date of service.

Claims entering the adjudication process are examined on a line-by-line basis except for inpatient hospital claims. Inpatient claims are adjudicated based on the entire claim. Each claim is subject to various edits to determine if the claim should be paid, denied or suspended for manual review by a claims examiner or medical professional. As part of the adjudication process, claims are verified for items such as provider/recipient eligibility, any third party liability, duplication of claims and authorization requirements.

If a claim suspends for a manual review and an input error is detected, the error must be corrected and the claim continues processing. If there is questionable or missing information on the claim, a Resubmission Turnaround Document (RTD) is sent to the provider. This document allows providers to add or correct the requested information before the claim is denied. If the provider does not return the document within a 60-day period, the claim is automatically denied.

If a claim can be adjudicated, the claims processing system makes a determination on payment. Claims can be paid, denied or adjusted. Paid claims/claim lines passing the final adjudication process may be reimbursed as submitted or at reduced amounts based on Medi-Cal program specifications. Denied claims/claim lines are deemed unacceptable for payment if they reflect a non-Medi-Cal program benefit, the claim information cannot be validated by the Fiscal Intermediary, the line item fails the edit process, or the provider fails to return the RTD in the 60-day period. Claim/claim lines may be adjusted if an error in payment occurs. The original claim/claim line will be voided and a new claim/claim line will reflect the adjusted payment.

The provider can submit a Claims Inquiry Form (CIF) if the provider is requesting an adjustment, reconsideration of a denied claim, or if the provider requests a tracer on a status of a claim. In cases of adjustments and reconsideration of the denied claim, the provider has six months from the date of action to submit the CIF. Tracers may be submitted at any time.

If the provider is unable to resolve a claim issue to their satisfaction, the provider may submit an appeal. Appeals may be submitted for unsatisfactory responses to the processing, payment and

resubmission of a claim or claim inquiry. Providers must submit their appeal in writing within 90 days of the action/inaction precipitating the complaint; otherwise it is an automatic denial. If the provider is not satisfied with the appeal decision, they can seek judicial relief by filing a suit in the local court, naming DHCS as the defendant. The provider has one year after the appeal decision to file a suit.

Due to the complex and sometimes lengthy claims adjudication process as described above, there may be a significant time lag between the date that Medi-Cal beneficiaries receive a service and the actual final reporting/payment on the claim. Time lags between the date of payment and date of services were analyzed for each service category contained in this Quarterly Report, and are presented in the table below. Service utilization data in this Quarterly Report are based on a 4-month lag period.

**Table 17 Claim Lag Times for Select Services**

<b>Regular Visit Lags - Services Provided During Fiscal Year 2007-08</b>												
<b>Service Category</b>	<i>Months between Service Date and Date Claims were Paid</i>											
	<b>Same Month</b>	<b>+1</b>	<b>+2</b>	<b>+3</b>	<b>+4</b>	<b>+5</b>	<b>+6</b>	<b>+7</b>	<b>+8</b>	<b>+9</b>	<b>+10</b>	<b>+11</b>
Home Health	0.0551	0.3126	0.6147	0.7679	0.8563	0.9065	0.9386	0.9610	0.9738	0.9842	0.9917	1.0000
Hospital Inpatient	0.0450	0.4822	0.6933	0.8082	0.8687	0.9050	0.9312	0.9497	0.9646	0.9761	0.9859	1.0000
Hospital Outpatient	0.0964	0.5919	0.7770	0.8561	0.8972	0.9227	0.9420	0.9566	0.9681	0.9776	0.9860	1.0000
Nursing Facility	0.2770	0.7908	0.8798	0.9300	0.9586	0.9720	0.9824	0.9874	0.9920	0.9948	0.9974	1.0000
Pharmacy	0.4532	0.9530	0.9764	0.9849	0.9900	0.9933	0.9957	0.9971	0.9979	0.9985	0.9990	1.0000
Physician/Clinic	0.1039	0.5802	0.7627	0.8430	0.8907	0.9206	0.9423	0.9577	0.9696	0.9794	0.9880	1.0000
ER Transportation	0.0596	0.4656	0.6869	0.7942	0.8544	0.8914	0.9199	0.9420	0.9611	0.9753	0.9853	1.0000
Non-ER Transportation	0.1680	0.4933	0.6566	0.7558	0.8249	0.8748	0.9098	0.9385	0.9549	0.9692	0.9839	1.0000

## Appendix B --- Enrollment Detail Tables

**Table 18 FFS Beneficiaries Covered by Medi-Cal Only, Average Member Months per Quarter by County; Calendar Year 2011**

County	Average Member Months				Percent Change	
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Change from Q1 to Q4	Change from Q3 to Q4
Alameda	72,164	70,664	65,975	60,254	-16.5	-8.7
Alpine	171	163	152	162	-4.9	6.6
Amador	3,586	3,645	3,651	3,650	1.8	0.0
Butte	42,596	42,496	41,917	41,425	-2.7	-1.2
Calaveras	5,564	5,545	5,577	5,530	-0.6	-0.8
Colusa	3,905	4,004	4,012	3,965	1.5	-1.2
Contra Costa	43,539	43,246	40,453	37,882	-13.0	-6.4
Del Norte	6,789	6,788	6,757	6,725	-0.9	-0.5
El Dorado	15,735	15,889	15,757	15,603	-0.8	-1.0
Fresno	72,624	70,601	67,728	63,439	-12.6	-6.3
Glenn	6,083	6,134	6,084	5,999	-1.4	-1.4
Humboldt	21,859	21,902	21,923	21,777	-0.4	-0.7
Imperial	46,373	46,545	46,416	46,091	-0.6	-0.7
Inyo	2,921	2,920	2,935	2,899	-0.8	-1.2
Kern	71,304	71,154	67,869	62,891	-11.8	-7.3
Kings	25,011	10,170	9,431	8,776	-64.9	-6.9
Lake	14,229	14,245	14,115	13,923	-2.2	-1.4
Lassen	4,136	4,228	4,252	4,199	1.5	-1.3
Los Angeles	724,738	717,924	692,151	639,689	-11.7	-7.6
Madera	32,295	15,027	13,625	12,891	-60.1	-5.4
Marin	17,352	17,485	5,356	5,118	-70.5	-4.4
Mariposa	2,265	2,291	2,273	2,198	-3.0	-3.3
Mendocino	18,947	18,930	2,582	2,493	-86.8	-3.5
Merced	10,529	10,569	10,594	10,178	-3.3	-3.9
Modoc	1,660	1,648	1,625	1,589	-4.3	-2.2
Mono	1,194	1,240	1,233	1,210	1.3	-1.8
Monterey	21,826	21,890	21,104	19,951	-8.6	-5.5
Napa	2,754	2,729	2,754	2,621	-4.8	-4.9
Nevada	9,233	9,244	9,213	9,213	-0.2	0.0
Orange	74,162	74,876	75,536	72,060	-2.8	-4.6
Placer	24,310	24,780	24,978	24,872	2.3	-0.4
Plumas	2,387	2,408	2,419	2,434	2.0	0.6

County	Average Member Months				Percent Change	
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Change From Q1 to Q4	Change from Q3 to Q4
Riverside	113,463	113,636	109,459	102,091	-10.0	-6.7
Sacramento	77,207	76,346	70,796	65,340	-15.4	-7.7
San Benito	8,806	8,959	8,924	8,796	-0.1	-1.4
San Bernardino	140,066	139,775	134,580	125,853	-10.1	-6.5
San Diego	129,715	128,045	121,431	113,309	-12.6	-6.7
San Francisco	36,745	36,053	31,915	28,143	-23.4	-11.8
San Joaquin	49,301	48,349	44,403	40,627	-17.6	-8.5
San Luis Obispo	4,298	4,327	4,198	4,050	-5.8	-3.5
San Mateo	13,793	13,892	13,854	13,853	0.4	0.0
Santa Barbara	16,207	16,370	16,122	15,626	-3.6	-3.1
Santa Clara	78,264	75,544	71,686	69,287	-11.5	-3.3
Santa Cruz	6,890	6,781	6,578	6,443	-6.5	-2.1
Shasta	33,041	33,351	33,444	32,745	-0.9	-2.1
Sierra	399	368	343	334	-16.4	-2.6
Siskiyou	8,446	8,523	8,371	8,277	-2.0	-1.1
Solano	6,978	7,001	6,951	6,714	-3.8	-3.4
Sonoma	9,063	9,291	9,153	8,841	-2.5	-3.4
Stanislaus	44,016	43,638	41,442	39,031	-11.3	-5.8
Sutter	19,100	19,476	19,606	19,546	2.3	-0.3
Tehama	15,256	15,217	15,025	14,455	-5.3	-3.8
Trinity	2,298	2,211	2,199	2,217	-3.5	0.8
Tulare	43,782	42,324	41,187	39,495	-9.8	-4.1
Tuolumne	6,430	6,478	6,495	6,378	-0.8	-1.8
Ventura	106,788	107,279	20,583	19,606	-81.6	-4.7
Yolo	4,043	4,025	4,050	3,892	-3.7	-3.9
Yuba	17,868	17,972	17,921	17,559	-1.7	-2.0
<b>Total</b>	<b>2,394,502</b>	<b>2,346,614</b>	<b>2,151,164</b>	<b>2,024,217</b>	<b>-15.5</b>	<b>-5.9</b>

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

**Table 19 FFS Full Scope Beneficiaries Covered by Medi-Cal Only By County, per Quarter; Calendar Year 2011**

County	Average Member Months				Percent Change	
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Change from Q1 to Q4	Change from Q3 to Q4
Alameda	51,310	49,634	44,954	39,254	-23.50	-12.68
Alpine	171	163	152	162	-4.88	6.56
Amador	3,460	3,515	3,517	3,537	2.24	0.57
Butte	40,942	40,984	40,507	40,103	-2.05	-1.00
Calaveras	5,412	5,396	5,412	5,370	-0.76	-0.77
Colusa	3,431	3,527	3,557	3,524	2.70	-0.94
Contra Costa	28,715	28,468	25,929	23,575	-17.90	-9.08
Del Norte	6,577	6,586	6,564	6,540	-0.56	-0.36
El Dorado	14,509	14,675	14,597	14,506	-0.02	-0.63
Fresno	42,550	40,495	38,207	34,230	-19.55	-10.41
Glenn	5,423	5,461	5,429	5,367	-1.03	-1.13
Humboldt	21,127	21,203	21,260	21,143	0.08	-0.55
Imperial	45,156	45,377	45,294	45,029	-0.28	-0.58
Inyo	2,600	2,602	2,610	2,576	-0.91	-1.28
Kern	46,857	46,601	43,841	39,547	-15.60	-9.79
Kings	21,612	6,740	6,132	5,591	-74.13	-8.83
Lake	13,450	13,502	13,387	13,230	-1.63	-1.17
Lassen	3,973	4,082	4,110	4,074	2.53	-0.89
Los Angeles	397,080	391,886	367,363	319,603	-19.51	-13.00
Madera	24,652	7,409	6,303	5,645	-77.10	-10.43
Marin	12,386	12,556	582	531	-95.71	-8.82
Mariposa	2,201	2,218	2,203	2,133	-3.09	-3.21
Mendocino	17,145	17,149	804	740	-95.68	-7.92
Merced	2,257	2,319	2,455	2,179	-3.46	-11.24
Modoc	1,580	1,567	1,548	1,518	-3.90	-1.90
Mono	945	975	975	980	3.74	0.51
Monterey	3,124	3,317	3,368	2,802	-10.33	-16.82
Napa	716	668	706	636	-11.26	-9.96
Nevada	8,883	8,889	8,848	8,859	-0.27	0.13
Orange	16,006	16,662	17,948	15,423	-3.64	-14.07
Placer	23,110	23,566	23,804	23,746	2.75	-0.24
Plumas	2,338	2,349	2,357	2,373	1.48	0.66
Riverside	84,214	83,746	79,802	72,758	-13.60	-8.83
Sacramento	61,617	61,054	56,012	50,891	-17.41	-9.14

County	Average Member Months				Percent Change	
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Change from Q1 to Q4	Change from Q3 to Q4
San Benito	7,634	7,800	7,803	7,712	1.02	-1.17
San Bernardino	106,643	105,668	100,730	92,566	-13.20	-8.10
San Diego	102,223	100,609	94,624	87,141	-14.75	-7.91
San Francisco	27,508	26,769	22,648	18,845	-31.49	-16.79
San Joaquin	34,019	33,196	29,510	26,112	-23.24	-11.51
San Luis Obispo	1,248	1,284	1,273	1,233	-1.18	-3.12
San Mateo	3,107	3,126	3,077	2,875	-7.47	-6.56
Santa Barbara	3,170	3,302	3,422	3,253	2.63	-4.93
Santa Clara	43,088	40,761	37,650	35,664	-17.23	-5.27
Santa Cruz	1,590	1,552	1,564	1,552	-2.39	-0.79
Shasta	32,552	32,862	32,958	32,298	-0.78	-2.00
Sierra	389	362	340	331	-14.75	-2.45
Siskiyou	8,238	8,331	8,201	8,112	-1.54	-1.09
Solano	1,918	1,942	1,979	1,856	-3.22	-6.18
Sonoma	2,812	3,006	2,947	2,772	-1.40	-5.94
Stanislaus	32,692	32,364	30,464	28,363	-13.24	-6.90
Sutter	17,453	17,833	17,980	17,953	2.86	-0.15
Tehama	14,099	14,088	13,942	13,444	-4.65	-3.57
Trinity	2,277	2,192	2,182	2,202	-3.29	0.93
Tulare	23,847	22,514	21,763	20,415	-14.39	-6.20
Tuolumne	6,349	6,405	6,425	6,319	-0.47	-1.64
Ventura	90,192	90,885	4,962	4,603	-94.90	-7.23
Yolo	1,646	1,663	1,790	1,699	3.26	-5.08
Yuba	16,714	16,830	16,803	16,474	-1.44	-1.96
<b>Total</b>	<b>1,596,936</b>	<b>1,550,685</b>	<b>1,365,574</b>	<b>1,251,971</b>	<b>-21.60</b>	<b>-8.32</b>

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

**Table 20 FFS Full Scope Children (0-17Years-old) Average Member Months by County, per Quarter; Calendar Year 2011**

County	Average Member Months				Percent Change	
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Change from Q1 to Q4	Change from Q4 to Q3
Alameda	20,091	19,419	19,028	18,452	-8.16	-3.03
Alpine	87	83	81	84	-2.69	3.69
Amador	1,857	1,879	1,866	1,861	0.23	-0.29
Butte	21,457	21,448	21,187	20,963	-2.30	-1.06
Calaveras	2,788	2,773	2,804	2,802	0.48	-0.07
Colusa	2,302	2,381	2,391	2,351	2.11	-1.69
Contra Costa	12,103	12,030	11,590	11,649	-3.76	0.51
Del Norte	3,365	3,362	3,336	3,334	-0.92	-0.07
El Dorado	8,050	8,131	8,111	8,083	0.41	-0.35
Fresno	19,498	18,536	18,903	17,956	-7.91	-5.01
Glenn	3,379	3,382	3,397	3,380	0.03	-0.50
Humboldt	10,814	10,912	11,037	11,002	1.74	-0.32
Imperial	25,541	25,653	25,695	25,541	0.00	-0.60
Inyo	1,500	1,494	1,528	1,518	1.20	-0.63
Kern	25,024	24,929	24,812	23,168	-7.42	-6.63
Kings	13,399	3,600	3,462	3,290	-75.44	-4.96
Lake	6,939	6,971	6,949	6,831	-1.56	-1.71
Lassen	2,068	2,127	2,155	2,141	3.56	-0.62
Los Angeles	168,267	167,937	174,068	162,774	-3.26	-6.49
Madera	16,055	3,935	3,554	3,386	-78.91	-4.72
Marin	7,856	7,960	374	330	-95.79	-11.75
Mariposa	1,153	1,176	1,170	1,128	-2.14	-3.62
Mendocino	9,567	9,512	475	420	-95.61	-11.51
Merced	1,518	1,599	1,718	1,453	-4.26	-15.44
Modoc	834	829	830	817	-1.96	-1.57
Mono	649	663	674	673	3.64	-0.20
Monterey	2,276	2,484	2,488	1,967	-13.59	-20.94
Napa	486	447	467	398	-18.16	-14.78
Nevada	4,672	4,675	4,652	4,657	-0.31	0.11
Orange	11,265	11,911	13,175	10,850	-3.68	-17.65
Placer	13,391	13,674	13,835	13,802	3.07	-0.24
Plumas	1,233	1,228	1,250	1,280	3.78	2.40
Riverside	46,278	45,859	46,574	43,674	-5.63	-6.23
Sacramento	25,255	25,342	25,269	25,310	0.22	0.16
San Benito	4,818	4,959	4,976	4,904	1.80	-1.45

County	Average Member Months				Percent Change	
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Change from Q1 to Q4	Change from Q3 to Q4
San Bernardino	55,582	54,960	55,158	51,995	-6.45	-5.73
San Diego	50,405	49,889	50,130	49,085	-2.62	-2.08
San Francisco	6,188	6,028	5,982	5,788	-6.47	-3.24
San Joaquin	16,381	16,074	15,157	14,190	-13.38	-6.38
San Luis Obispo	719	796	791	778	8.21	-1.64
San Mateo	1,967	2,029	2,038	1,851	-5.90	-9.16
Santa Barbara	2,278	2,457	2,599	2,433	6.82	-6.39
Santa Clara	17,196	16,154	16,477	17,406	1.22	5.64
Santa Cruz	1,030	1,030	1,027	1,020	-1.00	-0.68
Shasta	16,833	17,006	17,097	16,788	-0.27	-1.81
Sierra	196	186	167	157	-19.86	-5.60
Siskiyou	4,216	4,283	4,235	4,206	-0.25	-0.69
Solano	1,207	1,218	1,276	1,217	0.83	-4.62
Sonoma	1,849	1,993	2,009	1,872	1.24	-6.85
Stanislaus	15,925	15,736	15,443	14,971	-5.99	-3.06
Sutter	10,336	10,532	10,697	10,629	2.83	-0.64
Tehama	8,195	8,138	8,061	7,792	-4.91	-3.33
Trinity	1,142	1,071	1,054	1,076	-5.84	2.09
Tulare	11,937	11,348	11,899	11,603	-2.80	-2.49
Tuolumne	3,282	3,279	3,277	3,216	-2.03	-1.88
Ventura	60,425	61,106	3,333	3,027	-94.99	-9.18
Yolo	1,175	1,198	1,305	1,227	4.40	-6.00
Yuba	9,332	9,416	9,418	9,268	-0.69	-1.59
<b>Total</b>	<b>793,631</b>	<b>769,226</b>	<b>702,513</b>	<b>673,826</b>	<b>-15.10</b>	<b>-4.08</b>

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

**Table 21 FFS Women 18 to 64 Years-old Covered by Medi-Cal Only, Average Member Months by County, per Quarter; Calendar Year 2011**

County	Average Member Months				Percent Change	
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Change from Q1 to Q4	Change from Q3 to Q4
Alameda	25,824	25,244	23,714	21,908	-15.16	-7.61
Alpine	48	46	39	45	-6.90	15.38
Amador	1,045	1,084	1,105	1,113	6.54	0.78
Butte	12,441	12,406	12,267	12,114	-2.63	-1.24
Calaveras	1,674	1,668	1,668	1,653	-1.27	-0.90
Colusa	989	1,002	1,004	1,005	1.62	0.07
Contra Costa	15,597	15,441	14,535	13,590	-12.87	-6.50
Del Norte	1,969	1,980	1,992	1,978	0.44	-0.72
El Dorado	4,552	4,571	4,494	4,462	-1.97	-0.71
Fresno	27,337	26,738	25,325	23,970	-12.31	-5.35
Glenn	1,657	1,672	1,645	1,607	-3.00	-2.31
Humboldt	6,578	6,547	6,495	6,432	-2.21	-0.97
Imperial	13,483	13,512	13,444	13,431	-0.38	-0.10
Inyo	845	846	831	815	-3.63	-1.93
Kern	24,294	24,339	22,885	21,350	-12.12	-6.71
Kings	6,900	3,505	3,215	2,993	-56.62	-6.90
Lake	4,270	4,263	4,180	4,141	-3.01	-0.93
Lassen	1,238	1,263	1,269	1,247	0.70	-1.71
Los Angeles	284,876	282,572	271,222	254,311	-10.73	-6.24
Madera	9,017	5,651	5,188	4,894	-45.72	-5.66
Marin	5,335	5,341	2,687	2,591	-51.44	-3.57
Mariposa	672	666	664	655	-2.53	-1.26
Mendocino	5,466	5,495	1,075	1,061	-80.60	-1.33
Merced	4,612	4,599	4,577	4,543	-1.50	-0.75
Modoc	487	488	470	445	-8.63	-5.32
Mono	300	323	309	301	0.33	-2.69
Monterey	10,193	10,142	9,862	9,597	-5.85	-2.68
Napa	1,279	1,281	1,297	1,266	-0.99	-2.39
Nevada	2,768	2,798	2,796	2,799	1.14	0.12
Orange	36,986	37,013	36,780	36,123	-2.33	-1.79
Placer	6,695	6,800	6,829	6,763	1.02	-0.96
Plumas	715	729	728	724	1.26	-0.55
Riverside	38,037	38,377	35,992	33,958	-10.72	-5.65
Sacramento	27,703	27,281	24,715	22,157	-20.02	-10.35
San Benito	2,446	2,449	2,430	2,410	-1.49	-0.84

County	Average Member Months				Percent Change	
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Change from Q1 to Q4	Change from Q3 to Q4
San Bernardino	47,500	47,787	45,279	42,675	-10.16	-5.75
San Diego	44,920	44,245	41,300	38,252	-14.84	-7.38
San Francisco	13,490	13,269	11,814	10,605	-21.38	-10.23
San Joaquin	16,876	16,555	15,181	13,967	-17.24	-8.00
San Luis Obispo	1,931	1,897	1,846	1,798	-6.90	-2.62
San Mateo	6,503	6,495	6,462	6,537	0.51	1.15
Santa Barbara	7,931	7,880	7,697	7,541	-4.92	-2.03
Santa Clara	29,669	28,918	27,591	26,814	-9.62	-2.82
Santa Cruz	3,455	3,365	3,270	3,197	-7.47	-2.23
Shasta	9,860	9,917	9,926	9,695	-1.67	-2.33
Sierra	116	102	97	96	-17.77	-1.71
Siskiyou	2,533	2,542	2,467	2,442	-3.62	-1.04
Solano	3,052	3,090	3,041	2,944	-3.54	-3.19
Sonoma	4,292	4,348	4,250	4,137	-3.63	-2.66
Stanislaus	15,019	14,899	14,013	13,021	-13.30	-7.08
Sutter	5,126	5,210	5,188	5,190	1.26	0.04
Tehama	4,198	4,231	4,172	4,013	-4.41	-3.81
Trinity	708	694	696	687	-3.06	-1.34
Tulare	16,202	15,716	15,012	14,410	-11.06	-4.01
Tuolumne	1,939	1,970	1,999	1,968	1.48	-1.53
Ventura	27,780	27,632	9,731	9,418	-66.10	-3.22
Yolo	1,563	1,557	1,526	1,495	-4.35	-2.01
Yuba	5,077	5,087	5,074	4,941	-2.69	-2.61
<b>Total</b>	<b>858,069</b>	<b>845,540</b>	<b>785,361</b>	<b>744,297</b>	<b>-13.26</b>	<b>-5.23</b>

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

**Table 22 FFS Full Scope Average Member Months by Gender and Age Group, per Quarter; CY 2011**

Full Scope		Average Member Months				Percent Change	
Gender	Age Category	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Change from Q1 to Q4	Change from Q3 to Q4
Women	0 to 17	383,167	371,148	338,311	325,198	-15.1	-3.9
	18 to 64	441,685	429,067	372,547	337,321	-23.6	-9.5
	65 or Older	41,728	40,189	30,667	21,638	-48.1	-29.4
Men	0 to 17	410,464	398,078	364,203	348,628	-15.1	-4.3
	18 to 64	295,119	288,382	241,764	206,397	-30.1	-14.6
	65 or Older	24,765	23,811	18,073	12,781	-48.4	-29.3
All	0 to 17	793,631	769,226	702,513	673,826	-15.1	-4.1
	18 to 64	736,804	717,450	614,312	543,718	-26.2	-11.5
	65 or Older	66,494	64,000	48,740	34,419	-48.2	-29.4
<b>Total</b>		<b>1,596,936</b>	<b>1,550,685</b>	<b>1,365,574</b>	<b>1,251,971</b>	<b>-21.6</b>	<b>-8.3</b>

**Table 23 FFS Restricted Scope Average Member Months by Gender and Age, per Quarter; Calendar Year 2011**

Restricted Scope		Average Member Months				Percent Change	
Gender	Age Category	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Change from Q1 to Q4	Change from Q3 to Q4
Women	0 to 17	70,070	68,447	66,456	64,082	-8.5	-3.6
	18 to 64	416,385	416,473	412,814	406,976	-2.3	-1.4
	65 or Older	11,097	10,988	10,898	10,902	-1.8	0.0
Men	0 to 17	71,601	70,058	68,054	65,712	-8.2	-3.4
	18 to 64	222,986	224,588	221,992	219,124	-1.7	-1.3
	65 or Older	5,420	5,366	5,366	5,438	0.3	1.3
All	0 to 17	141,671	138,505	134,510	129,794	-8.4	-3.5
	18 to 64	639,371	641,061	634,806	626,100	-2.1	-1.4
	65 or Older	16,517	16,354	16,264	16,340	-1.1	0.5
<b>Total</b>		<b>797,567</b>	<b>795,930</b>	<b>785,591</b>	<b>772,246</b>	<b>-3.2</b>	<b>-1.7</b>

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

**Table 24 FFS Average Member Months by Age and Aid Category per Quarter;  
Calendar Year 2011\***

Statewide		Average Member Months				Percent Change	
Age Group	Aid Category	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Change from Q1 to Q4	Change from Q3 to Q4
<b>Children Age 0 - 20</b>	<b>Blind/Disabled</b>	82,702	81,192	70,342	61,535	-25.6	-12.5
	<b>Families</b>	496,906	467,258	412,180	411,342	-17.2	-0.2
	<b>Foster Care</b>	107,959	105,655	87,688	86,623	-19.8	-1.2
	<b>Other</b>	208,970	214,797	221,541	199,278	-4.6	-10.0
	<b>Undocumented</b>	182,101	178,027	173,069	167,425	-8.1	-3.3
<b>Adults Age 21 &amp; over</b>	<b>Aged</b>	60,821	58,593	44,294	30,720	-49.5	-30.6
	<b>Blind/Disabled</b>	344,539	337,458	270,616	205,577	-40.3	-24.0
	<b>Families</b>	238,948	230,397	203,053	201,017	-15.9	-1.0
	<b>Other</b>	56,083	55,325	55,853	55,871	-0.4	0.0
	<b>Undocumented</b>	615,458	617,893	612,510	604,809	-1.7	-1.3
<b>Total</b>		<b>2,394,502</b>	<b>2,346,614</b>	<b>2,151,164</b>	<b>2,024,217</b>	<b>-15.5</b>	<b>-5.9</b>

**Table 25 FFS Average Member Months by Age and Aid Category for Metropolitan Counties, per Quarter; Calendar Year 2011\***

Metropolitan County		Average Member Months				Percent Change	
Age Group	Aid Category	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Change from Q1 to Q4	Change From Q3 to Q4
Children Age 0 - 20	Blind/Disabled	79,275	77,747	67,306	58,547	-26.1	-13.0
	Families	435,519	405,555	359,085	358,921	-17.6	0.0
	Foster Care	104,040	101,708	84,283	83,218	-20.0	-1.3
	Other	199,180	205,162	212,552	190,410	-4.4	-10.4
	Undocumented	179,861	175,909	171,011	165,499	-8.0	-3.2
Adults Age 21 & over	Aged	60,454	58,233	44,027	30,457	-49.6	-30.8
	Blind/Disabled	326,490	319,355	254,494	189,458	-42.0	-25.6
	Families	207,384	198,548	175,641	174,066	-16.1	-0.9
	Other	54,518	53,805	54,353	54,350	-0.3	0.0
	Undocumented	610,008	612,440	607,155	599,646	-1.7	-1.2
<b>Total</b>		<b>2,256,744</b>	<b>2,208,481</b>	<b>2,029,928</b>	<b>1,904,591</b>	<b>-15.6</b>	<b>-6.2</b>

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

\*- 73 records were excluded from this table because of unknown or invalid age data

**Table 26 FFS Average Member Months by Age and Aid Category for Non Metropolitan Counties, per quarter; Calendar Year 2011**

Non Metropolitan County		Average Member Months				Percent Change	
Age Group	Aid Category	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Change from Q1 to Q4	Change from Q3 to Q4
Children Age 0 - 20	Blind/Disabled	3,427	3,446	3,036	2,988	-12.8	-1.6
	Families	61,387	61,703	53,095	52,421	-14.6	-1.3
	Foster Care	3,919	3,946	3,405	3,405	-13.1	0.0
	Other	9,790	9,634	8,989	8,868	-9.4	-1.3
	Undocumented	2,240	2,119	2,058	1,926	-14.0	-6.4
Adults Age 21 & over	Aged	367	361	266	263	-28.2	-1.1
	Blind/Disabled	18,050	18,103	16,121	16,119	-10.7	0.0
	Families	31,564	31,849	27,411	26,951	-14.6	-1.7
	Other	1,565	1,521	1,500	1,521	-2.8	1.4
	Undocumented	5,450	5,453	5,355	5,163	-5.3	-3.6
<b>Total</b>		<b>137,758</b>	<b>138,134</b>	<b>121,236</b>	<b>119,626</b>	<b>-13.2</b>	<b>-1.3</b>

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

## Appendix C --- Provider Supply Detail Tables

**Table 27 Physician Supply - All Enrolled Physicians - FFS Medi-Cal Only Beneficiaries**

	Number of Providers				Population-to-Provider Ratio				
	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	
<b>Statewide</b>	105,216	105,978	107,332	108,057	15.2	14.6	12.7	11.6	
<b>County Plan Model Type</b>									
County Organized Health System (COHS)	20,174	20,350	20,560	20,670	7.8	7.8	2.3	2.0	
Fee-for-Service (FFS)	4,038	4,072	4,100	4,132	77.0	77.0	76.3	74.9	
Geographic Managed Care (GMC)	15,614	15,699	15,976	16,108	10.5	10.3	9.4	8.6	
Two-Plan (Commercial Plan and Local Initiative)	65,390	65,857	66,696	67,147	14.8	13.9	12.8	11.4	
<b>County</b>									
Alameda	Two-Plan	4,666	4,699	4,724	4,755	11.0	10.6	9.5	8.3
Alpine	FFS	2	2	2	2	85.5	81.5	76.0	81.0
Amador	FFS	54	55	56	57	64.1	63.9	62.8	62.1
Butte	FFS	505	510	516	519	81.1	80.4	78.5	77.3
Calaveras	FFS	48	50	49	49	112.8	107.9	110.5	109.6
Colusa	FFS	41	41	40	40	83.7	86.0	88.9	88.1
Contra Costa	Two-Plan	2,827	2,852	2,863	2,872	10.2	10.0	9.1	8.2
Del Norte	FFS	52	53	53	54	126.5	124.3	123.9	121.1
El Dorado	FFS	273	273	280	283	53.2	53.8	52.1	51.3
Fresno	Two-Plan	1,968	1,983	2,002	2,014	21.6	20.4	19.1	17.0
Glenn	FFS	21	21	22	22	258.2	260.1	246.8	244.0
Humboldt	FFS	399	406	409	411	53.0	52.2	52.0	51.4
Imperial	FFS	210	213	216	225	215.0	213.0	209.7	200.1
Inyo	FFS	38	39	39	39	68.4	66.7	66.9	66.1

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Kern	Two-Plan	1,758	1,767	1,789	1,793	26.7	26.4	24.5	22.1
Kings	Two-Plan	185	188	189	194	116.8	35.9	32.4	28.8
Lake	FFS	121	121	120	121	111.2	111.6	111.6	109.3
Lassen	FFS	29	29	31	31	137.0	140.8	132.6	131.4
Los Angeles	Two-Plan	29,182	29,370	29,737	29,910	13.6	13.3	12.4	10.7
Madera	Two-Plan	284	284	288	294	86.8	26.1	21.9	19.2
Marin *	COHS	752	754	770	773	16.5	16.7	0.8	0.7
Mariposa	FFS	19	19	19	19	115.8	116.7	116.0	112.3
Mendocino *	COHS	202	203	206	206	84.9	84.5	3.9	3.6
Merced	COHS	363	364	366	371	6.2	6.4	6.7	5.9
Modoc	FFS	14	14	14	14	112.9	111.9	110.6	108.4
Mono	FFS	46	45	45	45	20.5	21.7	21.7	21.8
Monterey	COHS	900	907	911	916	3.5	3.7	3.7	3.1
Napa	COHS	376	378	379	379	1.9	1.8	1.9	1.7
Nevada	FFS	196	195	194	195	45.3	45.6	45.6	45.4
Orange	COHS	8,212	8,264	8,350	8,400	2.0	2.0	2.2	1.8
Placer	FFS	745	751	753	760	31.0	31.4	31.6	31.2
Plumas	FFS	35	35	35	35	66.8	67.1	67.3	67.8
Riverside	Two-Plan	2,899	2,927	2,957	2,978	29.1	28.6	27.0	24.4
Sacramento	GMC	5,695	5,737	5,851	5,889	10.8	10.6	9.6	8.6
San Benito	FFS	66	67	67	67	115.7	116.4	116.5	115.1
San Bernardino	Two-Plan	4,481	4,517	4,578	4,625	23.8	23.4	22.0	20.0
San Diego	GMC	9,919	9,962	10,125	10,219	10.3	10.1	9.4	8.5
San Francisco	Two-Plan	6,298	6,330	6,485	6,525	4.4	4.2	3.5	2.9
San Joaquin	Two-Plan	1,445	1,471	1,488	1,496	23.5	22.6	19.8	17.5
San Luis Obispo	COHS	478	480	483	485	2.6	2.7	2.6	2.5
San Mateo	COHS	2,848	2,859	2,876	2,888	1.1	1.1	1.1	1.0
Santa Barbara	COHS	1,097	1,153	1,159	1,163	2.9	2.9	3.0	2.8
Santa Clara	Two-Plan	7,402	7,454	7,560	7,627	5.8	5.5	5.0	4.7
Santa Cruz	COHS	628	630	635	636	2.5	2.5	2.5	2.4

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Shasta	FFS	483	486	491	493	67.4	67.6	67.1	65.5
Sierra	FFS	5	5	5	5	77.8	72.4	68.0	66.2
Siskiyou	FFS	88	88	88	89	93.6	94.7	93.2	91.2
Solano	COHS	1,296	1,308	1,313	1,322	1.5	1.5	1.5	1.4
Sonoma	COHS	1,134	1,142	1,157	1,161	2.5	2.6	2.6	2.4
Stanislaus	Two-Plan	1,273	1,285	1,300	1,323	25.7	25.2	23.4	21.4
Sutter	FFS	166	168	168	169	105.1	106.2	107.0	106.2
Tehama	FFS	101	101	101	101	139.6	139.5	138.0	133.1
Trinity	FFS	12	13	13	13	189.8	168.6	167.9	169.4
Tulare	Two-Plan	722	730	736	741	33.0	30.8	29.6	27.6
Tuolumne	FFS	105	105	107	106	60.5	61.0	60.1	59.6
Ventura **	COHS	1,422	1,441	1,485	1,497	63.4	63.1	3.3	3.1
Yolo	COHS	466	467	470	473	3.5	3.6	3.8	3.6
Yuba	FFS	164	167	167	168	101.9	100.8	100.6	98.1

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

\*\* Shifted from FFS to COHS Model on January 1, 2011

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

**Table 28 Physician Supply - All Enrolled Physicians - All Medi-Cal Only Beneficiaries**

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
<b>Statewide</b>		105,216	105,978	107,332	108,057	52.8	52.8	52.6	52.1
<b>County Plan Model Type</b>									
County Organized Health System (COHS)		20,174	20,350	20,560	20,670	42.4	42.5	42.5	42.1
Fee-for-Service (FFS)		4,038	4,072	4,100	4,132	77.4	77.3	76.7	75.4
Geographic Managed Care (GMC)		15,614	15,699	15,976	16,108	37.5	37.7	37.3	37.1
Two-Plan (Commercial Plan and Local Initiative)		65,390	65,857	66,696	67,147	58.1	58.1	57.9	57.3
<b>County</b>									
Alameda	Two-Plan	4,666	4,699	4,724	4,755	38.2	38.2	38.3	38.2
Alpine	FFS	2	2	2	2	86.0	82.0	76.5	81.5
Amador	FFS	54	55	56	57	64.4	64.2	63.1	62.5
Butte	FFS	505	510	516	519	81.4	80.6	78.9	77.7
Calaveras	FFS	48	50	49	49	113.4	108.6	111.4	110.5
Colusa	FFS	41	41	40	40	84.0	86.3	89.3	88.4
Contra Costa	Two-Plan	2,827	2,852	2,863	2,872	35.9	35.9	36.0	36.2
Del Norte	FFS	52	53	53	54	126.6	124.5	124.1	121.4
El Dorado	FFS	273	273	280	283	53.5	54.1	52.5	51.6
Fresno	Two-Plan	1,968	1,983	2,002	2,014	126.3	126.2	125.8	124.9
Glenn	FFS	21	21	22	22	259.0	260.7	247.5	244.7
Humboldt	FFS	399	406	409	411	53.1	52.4	52.2	51.7
Imperial	FFS	210	213	216	225	216.0	214.3	211.3	201.6
Inyo	FFS	38	39	39	39	68.6	66.8	67.0	66.2
Kern	Two-Plan	1,758	1,767	1,789	1,793	106.6	107.2	106.4	105.2
Kings	Two-Plan	185	188	189	194	155.1	153.8	153.4	148.5
Lake	FFS	121	121	120	121	112.1	112.5	112.8	110.6
Lassen	FFS	29	29	31	31	137.8	141.3	133.1	132.1
Los Angeles	Two-Plan	29,182	29,370	29,737	29,910	57.9	57.8	57.6	57.0

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Madera	Two-Plan	284	284	288	294	116.4	118.7	118.0	115.3
Marin *	COHS	752	754	770	773	17.8	18.0	17.7	17.4
Mariposa	FFS	19	19	19	19	117.8	118.4	118.0	115.0
Mendocino *	COHS	202	203	206	206	85.4	85.1	84.4	84.7
Merced	COHS	363	364	366	371	180.8	183.2	183.3	180.0
Modoc	FFS	14	14	14	14	113.1	111.9	110.6	108.6
Mono	FFS	46	45	45	45	20.6	21.8	21.8	21.8
Monterey	COHS	900	907	911	916	73.3	73.4	73.5	72.5
Napa	COHS	376	378	379	379	30.9	31.0	31.5	31.4
Nevada	FFS	196	195	194	195	45.5	45.8	45.8	45.6
Orange	COHS	8,212	8,264	8,350	8,400	38.3	38.5	38.7	38.4
Placer	FFS	745	751	753	760	31.3	31.6	31.9	31.6
Plumas	FFS	35	35	35	35	67.0	67.4	67.6	68.1
Riverside	Two-Plan	2,899	2,927	2,957	2,978	109.3	110.3	111.0	109.9
Sacramento	GMC	5,695	5,737	5,851	5,889	44.9	44.9	44.3	44.1
San Benito	FFS	66	67	67	67	118.1	118.7	118.9	117.5
San Bernardino	Two-Plan	4,481	4,517	4,578	4,625	85.5	85.9	85.5	84.3
San Diego	GMC	9,919	9,962	10,125	10,219	33.3	33.5	33.3	33.0
San Francisco	Two-Plan	6,298	6,330	6,485	6,525	12.4	12.5	12.3	12.1
San Joaquin	Two-Plan	1,445	1,471	1,488	1,496	96.9	97.1	96.7	95.9
San Luis Obispo	COHS	478	480	483	485	50.5	50.9	50.7	50.2
San Mateo	COHS	2,848	2,859	2,876	2,888	16.4	16.6	16.7	16.9
Santa Barbara	COHS	1,097	1,153	1,159	1,163	52.1	50.1	50.2	49.7
Santa Clara	Two-Plan	7,402	7,454	7,560	7,627	23.6	23.4	23.1	22.9
Santa Cruz	COHS	628	630	635	636	48.1	48.6	48.4	48.1
Shasta	FFS	483	486	491	493	67.6	67.8	67.3	65.7
Sierra	FFS	5	5	5	5	78.0	72.6	70.2	68.4
Siskiyou	FFS	88	88	88	89	93.9	94.9	93.5	91.4
Solano	COHS	1,296	1,308	1,313	1,322	40.1	40.0	40.1	39.7
Sonoma	COHS	1,134	1,142	1,157	1,161	38.7	39.1	38.9	38.8

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Stanislaus	Two-Plan	1,273	1,285	1,300	1,323	83.1	83.3	82.6	81.1
Sutter	FFS	166	168	168	169	105.5	106.5	107.5	106.7
Tehama	FFS	101	101	101	101	139.9	139.8	138.5	133.5
Trinity	FFS	12	13	13	13	190.6	168.9	168.3	170.0
Tulare	Two-Plan	722	730	736	741	181.0	180.2	180.6	179.1
Tuolumne	FFS	105	105	107	106	60.8	61.4	60.6	60.3
Ventura **	COHS	1,422	1,441	1,485	1,497	63.6	63.3	61.5	60.3
Yolo	COHS	466	467	470	473	49.8	49.8	49.8	49.3
Yuba	FFS	164	167	167	168	102.4	101.2	101.1	98.5

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

\*\* Shifted from FFS to COHS Model on January 1, 2011

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

**Table 29 Primary Care Physician Supply - All Enrolled Physicians - FFS, Full Scope, Medi-Cal Only Beneficiaries**

		Number of Providers					Population-to-Provider Ratio						
		2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	Average # of Providers	% Change In Number of Providers	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	Avg Ratio	% Change in Ratio
<b>Statewide</b>		38,114	38,373	38,833	39,068	38,597	2.5%	41.9	40.4	35.2	32.1	37.4	-23.4%
<b>County Plan Model Type</b>													
County Organized Health System (COHS)		7,157	7,231	7,315	7,369	7,268	3.0%	22.0	22.1	6.4	5.7	14.1	-74.1%
Fee-for-Service (FFS)		1,726	1,738	1,744	1,758	1,742	1.9%	180.2	180.3	179.3	176.1	179.0	-2.3%
Geographic Managed Care (GMC)		5,310	5,341	5,418	5,458	5,382	2.8%	30.9	30.3	27.8	25.3	28.6	-18.1%
Two-Plan (Commercial Plan and Local Initiative)		23,921	24,063	24,356	24,483	24,206	2.3%	40.3	38.1	35.1	31.1	36.2	-22.8%
<b>County</b>													
Alameda	Two-Plan	1,614	1,624	1,634	1,639	1,628	1.5%	31.8	30.6	27.5	24.0	28.5	-24.5%
Alpine	FFS	1	1	1	1	1	0.0%	171.0	163.0	152.0	162.0	162.0	-5.3%
Amador	FFS	31	31	33	33	32	6.5%	111.6	113.4	106.6	107.2	109.7	-3.9%
Butte	FFS	192	193	192	190	192	-1.0%	213.2	212.4	211.0	211.1	211.9	-1.0%
Calaveras	FFS	24	25	24	25	25	4.2%	225.5	215.8	225.5	214.8	220.4	-4.7%
Colusa	FFS	31	31	30	30	31	-3.2%	110.7	113.8	118.6	117.5	115.2	6.1%
Contra Costa	Two-Plan	1,082	1,088	1,096	1,100	1,092	1.7%	26.5	26.2	23.7	21.4	24.5	-19.2%
Del Norte	FFS	25	25	25	26	25	4.0%	263.1	263.4	262.6	251.5	260.2	-4.4%
El Dorado	FFS	101	101	103	103	102	2.0%	143.7	145.3	141.7	140.8	142.9	-2.0%
Fresno	Two-Plan	730	730	733	738	733	1.1%	58.3	55.5	52.1	46.4	53.1	-20.4%
Glenn	FFS	9	9	9	9	9	0.0%	602.6	606.8	603.2	596.3	602.2	-1.0%
Humboldt	FFS	176	181	183	184	181	4.5%	120.0	117.1	116.2	114.9	117.1	-4.3%
Imperial	FFS	57	57	57	63	59	10.5%	792.2	796.1	794.6	714.8	774.4	-9.8%
Inyo	FFS	17	18	18	18	18	5.9%	152.9	144.6	145.0	143.1	146.4	-6.4%

		Number of Providers						Population-to-Provider Ratio					
		2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	Average # of Providers	% Change In Number of Providers	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	Avg Ratio	% Change in Ratio
Kern	Two-Plan	687	692	703	701	696	2.0%	68.2	67.3	62.4	56.4	63.6	-17.3%
Kings	Two-Plan	78	79	79	83	80	6.4%	277.1	85.3	77.6	67.4	126.9	-75.7%
Lake	FFS	48	48	47	48	48	0.0%	280.2	281.3	284.8	275.6	280.5	-1.6%
Lassen	FFS	14	14	14	14	14	0.0%	283.8	291.6	293.6	291.0	290.0	2.5%
Los Angeles	Two-Plan	11,142	11,195	11,327	11,363	11,257	2.0%	35.6	35.0	32.4	28.1	32.8	-21.1%
Madera	Two-Plan	64	64	64	65	64	1.6%	385.2	115.8	98.5	86.9	171.6	-77.4%
Marin *	COHS	307	306	309	310	308	1.0%	40.4	41.0	1.9	1.7	21.3	-95.8%
Mariposa	FFS	12	12	12	12	12	0.0%	183.4	184.8	183.6	177.8	182.4	-3.1%
Mendocino *	COHS	70	71	71	71	71	1.4%	244.9	241.5	11.3	10.4	127.0	-95.8%
Merced	COHS	161	160	162	166	162	3.1%	14.0	14.5	15.2	13.1	14.2	-6.4%
Modoc	FFS	11	11	11	11	11	0.0%	143.6	142.5	140.7	138.0	141.2	-3.9%
Mono	FFS	19	19	19	19	19	0.0%	49.7	51.3	51.3	51.6	51.0	3.8%
Monterey	COHS	334	335	336	339	336	1.5%	9.4	9.9	10.0	8.3	9.4	-11.7%
Napa	COHS	111	112	112	112	112	0.9%	6.5	6.0	6.3	5.7	6.1	-12.3%
Nevada	FFS	88	88	88	88	88	0.0%	100.9	101.0	100.6	100.7	100.8	-0.2%
Orange	COHS	2,648	2,676	2,699	2,717	2,685	2.6%	6.0	6.2	6.7	5.7	6.2	-5.0%
Placer	FFS	343	346	348	352	347	2.6%	67.4	68.1	68.4	67.5	67.9	0.1%
Plumas	FFS	25	25	25	25	25	0.0%	93.5	94.0	94.3	94.9	94.2	1.5%
Riverside	Two-Plan	1,172	1,184	1,192	1,198	1,187	2.2%	71.9	70.7	67.0	60.7	67.6	-15.6%
Sacramento	GMC	1,923	1,934	1,970	1,975	1,951	2.7%	32.0	31.6	28.4	25.8	29.5	-19.4%
San Benito	FFS	24	24	23	24	24	0.0%	318.1	325.0	339.3	321.3	325.9	1.0%
San Bernardino	Two-Plan	1,820	1,832	1,860	1,878	1,848	3.2%	58.6	57.7	54.2	49.3	55.0	-15.9%
San Diego	GMC	3,387	3,407	3,448	3,483	3,431	2.8%	30.2	29.5	27.4	25.0	28.0	-17.2%
San Francisco	Two-Plan	1,943	1,948	2,005	2,019	1,979	3.9%	14.2	13.7	11.3	9.3	12.1	-34.5%
San Joaquin	Two-Plan	530	541	553	556	545	4.9%	64.2	61.4	53.4	47.0	56.5	-26.8%

		Number of Providers						Population-to-Provider Ratio					
		2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	Average # of Providers	% Change In Number of Providers	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	Avg Ratio	% Change in Ratio
San Luis Obispo	COHS	162	162	164	165	163	1.9%	7.7	7.9	7.8	7.5	7.7	-2.6%
San Mateo	COHS	969	970	976	983	975	1.4%	3.2	3.2	3.2	2.9	3.1	-9.4%
Santa Barbara	COHS	328	353	354	356	348	8.5%	9.7	9.4	9.7	9.1	9.5	-6.2%
Santa Clara	Two-Plan	2,293	2,308	2,330	2,355	2,322	2.7%	18.8	17.7	16.2	15.1	17.0	-19.7%
Santa Cruz	COHS	241	242	242	242	242	0.4%	6.6	6.4	6.5	6.4	6.5	-3.0%
Shasta	FFS	201	202	205	205	203	2.0%	162.0	162.7	160.8	157.6	160.8	-2.7%
Sierra	FFS	5	5	5	5	5	0.0%	77.8	72.4	68.0	66.2	71.1	-14.9%
Siskiyou	FFS	38	38	38	39	38	2.6%	216.8	219.2	215.8	208.0	215.0	-4.1%
Solano	COHS	526	533	537	542	535	3.0%	3.7	3.6	3.7	3.4	3.6	-8.1%
Sonoma	COHS	481	487	494	498	490	3.5%	5.9	6.2	6.0	5.6	5.9	-5.1%
Stanislaus	Two-Plan	510	518	520	530	520	3.9%	64.1	62.5	58.6	53.5	59.7	-16.5%
Sutter	FFS	78	78	77	79	78	1.3%	223.8	228.6	233.5	227.3	228.3	1.6%
Tehama	FFS	49	49	48	48	49	-2.0%	287.7	287.5	290.5	280.1	286.5	-2.6%
Trinity	FFS	5	5	5	5	5	0.0%	455.4	438.4	436.4	440.4	442.7	-3.3%
Tulare	Two-Plan	256	260	260	258	259	0.8%	93.2	86.6	83.7	79.1	85.7	-15.1%
Tuolumne	FFS	43	42	44	42	43	-2.3%	147.7	152.5	146.0	150.5	149.2	1.9%
Ventura *	COHS	602	606	642	649	625	7.8%	149.8	150.0	7.7	7.1	78.7	-95.3%
Yolo	COHS	217	218	217	219	218	0.9%	7.6	7.6	8.3	7.8	7.8	2.6%
Yuba	FFS	59	60	60	60	60	1.7%	283.3	280.5	280.1	274.6	279.6	-3.1%

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

\*\* Shifted from FFS to COHS Model on January 1, 2011

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

**Table 30 Primary Care Physician Supply - All Enrolled Physicians - All Full Scope, Medi-Cal Only Beneficiaries**

		Number of Providers					Population-to-Provider Ratio						
		2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	Average Number of Providers	% Change In # of Providers	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	Average Number of Providers	% Change In # of Providers
<b>Statewide</b>		38,114	38,373	38,833	39,068	38,597	2.5%	145.6	145.9	145.4	144.0	145	-1.1%
<b>County Plan Model Type</b>													
County Organized Health System (COHS)		7,157	7,231	7,315	7,369	7,268	3.0%	119.6	119.7	119.4	118.2	119	-1.2%
Fee-for-Service (FFS)		1,726	1,738	1,744	1,758	1,742	1.9%	181.1	181.2	180.4	177.2	180	-2.1%
Geographic Managed Care (GMC)		5,310	5,341	5,418	5,458	5,382	2.8%	110.3	110.7	110.1	109.3	110	-0.9%
Two-Plan (Commercial Plan and Local Initiative)		23,921	24,063	24,356	24,483	24,206	2.3%	158.7	159.1	158.5	157.1	158	-1.0%
<b>County</b>													
Alameda	Two-Plan	1,614	1,624	1,634	1,639	1,628	1.5%	110.6	110.4	110.8	110.9	111	0.3%
Alpine	FFS	1	1	1	1	1	0.0%	172.0	164.0	153.0	163.0	163	-5.2%
Amador	FFS	31	31	33	33	32	6.5%	112.2	113.9	107.2	107.9	110	-3.8%
Butte	FFS	192	193	192	190	192	-1.0%	214.0	213.1	212.0	212.2	213	-0.8%
Calaveras	FFS	24	25	24	25	25	4.2%	226.7	217.2	227.4	216.5	222	-4.5%
Colusa	FFS	31	31	30	30	31	-3.2%	111.1	114.2	119.0	117.9	116	6.1%
Contra Costa	Two-Plan	1,082	1,088	1,096	1,100	1,092	1.7%	93.7	94.2	94.1	94.6	94	1.0%
Del Norte	FFS	25	25	25	26	25	4.0%	263.3	263.8	263.1	252.0	261	-4.3%
El Dorado	FFS	101	101	103	103	102	2.0%	144.6	146.3	142.8	141.8	144	-1.9%
Fresno	Two-Plan	730	730	733	738	733	1.1%	340.5	342.8	343.7	340.8	342	0.1%
Glenn	FFS	9	9	9	9	9	0.0%	604.3	608.3	605.0	598.1	604	-1.0%
Humboldt	FFS	176	181	183	184	181	4.5%	120.4	117.5	116.6	115.4	117	-4.1%
Imperial	FFS	57	57	57	63	59	10.5%	795.8	800.9	800.5	719.8	779	-9.6%
Inyo	FFS	17	18	18	18	18	5.9%	153.3	144.7	145.2	143.5	147	-6.4%

		Number of Providers						Population-to-Provider Ratio					
		2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	Average Number of Providers	% Change In # of Providers	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	Average Number of Providers	% Change In # of Providers
Kern	Two-Plan	687	692	703	701	696	2.0%	272.9	273.6	270.8	269.0	272	-1.4%
Kings	Two-Plan	78	79	79	83	80	6.4%	367.8	365.9	366.9	347.0	362	-5.7%
Lake	FFS	48	48	47	48	48	0.0%	282.6	283.5	288.0	278.8	283	-1.3%
Lassen	FFS	14	14	14	14	14	0.0%	285.4	292.7	294.7	292.5	291	2.5%
Los Angeles	Two-Plan	11,142	11,195	11,327	11,363	11,257	2.0%	151.6	151.7	151.3	150.0	151	-1.1%
Madera	Two-Plan	64	64	64	65	64	1.6%	516.6	526.6	531.1	521.3	524	0.9%
Marin *	COHS	307	306	309	310	308	1.0%	43.5	44.3	44.1	43.5	44	-0.1%
Mariposa	FFS	12	12	12	12	12	0.0%	186.6	187.4	186.8	182.1	186	-2.4%
Mendocino *	COHS	70	71	71	71	71	1.4%	246.5	243.3	244.9	245.8	245	-0.3%
Merced	COHS	161	160	162	166	162	3.1%	407.7	416.8	414.1	402.3	410	-1.3%
Modoc	FFS	11	11	11	11	11	0.0%	143.9	142.5	140.8	138.3	141	-3.9%
Mono	FFS	19	19	19	19	19	0.0%	49.9	51.6	51.6	51.7	51	3.7%
Monterey	COHS	334	335	336	339	336	1.5%	197.4	198.6	199.2	195.9	198	-0.8%
Napa	COHS	111	112	112	112	112	0.9%	104.6	104.8	106.6	106.4	106	1.7%
Nevada	FFS	88	88	88	88	88	0.0%	101.3	101.4	101.0	101.0	101	-0.3%
Orange	COHS	2,648	2,676	2,699	2,717	2,685	2.6%	118.7	119.0	119.6	118.6	119	-0.1%
Placer	FFS	343	346	348	352	347	2.6%	67.9	68.7	69.1	68.2	68	0.3%
Plumas	FFS	25	25	25	25	25	0.0%	93.8	94.3	94.7	95.4	95	1.7%
Riverside	Two-Plan	1,172	1,184	1,192	1,198	1,187	2.2%	270.4	272.7	275.3	273.2	273	1.1%
Sacramento	GMC	1,923	1,934	1,970	1,975	1,951	2.7%	133.1	133.2	131.6	131.6	132	-1.1%
San Benito	FFS	24	24	23	24	24	0.0%	324.8	331.3	346.3	327.9	333	1.0%
San Bernardino	Two-Plan	1,820	1,832	1,860	1,878	1,848	3.2%	210.5	211.8	210.4	207.5	210	-1.4%
San Diego	GMC	3,387	3,407	3,448	3,483	3,431	2.8%	97.4	97.9	97.8	96.7	97	-0.7%
San Francisco	Two-Plan	1,943	1,948	2,005	2,019	1,979	3.9%	40.3	40.6	39.6	39.2	40	-2.7%
San Joaquin	Two-Plan	530	541	553	556	545	4.9%	264.2	264.0	260.2	258.0	262	-2.4%

		Number of Providers						Population-to-Provider Ratio					
		2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	Average Number of Providers	% Change In # of Providers	2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	Average Number of Providers	% Change In # of Providers
San Luis Obispo	COHS	162	162	164	165	163	1.9%	149.1	150.9	149.4	147.6	149	-1.0%
San Mateo	COHS	969	970	976	983	975	1.4%	48.2	48.8	49.3	49.5	49	2.6%
Santa Barbara	COHS	328	353	354	356	348	8.5%	174.1	163.6	164.4	162.4	166	-6.7%
Santa Clara	Two-Plan	2,293	2,308	2,330	2,355	2,322	2.7%	76.1	75.6	74.9	74.1	75	-2.7%
Santa Cruz	COHS	241	242	242	242	242	0.4%	125.4	126.5	126.9	126.5	126	0.9%
Shasta	FFS	201	202	205	205	203	2.0%	162.4	163.1	161.2	158.0	161	-2.7%
Sierra	FFS	5	5	5	5	5	0.0%	78.0	72.6	70.2	68.4	72	-12.3%
Siskiyou	FFS	38	38	38	39	38	2.6%	217.4	219.9	216.5	208.6	216	-4.0%
Solano	COHS	526	533	537	542	535	3.0%	98.8	98.2	98.2	96.9	98	-1.9%
Sonoma	COHS	481	487	494	498	490	3.5%	91.2	91.7	91.1	90.5	91	-0.8%
Stanislaus	Two-Plan	510	518	520	530	520	3.9%	207.4	206.6	206.6	202.4	206	-2.4%
Sutter	FFS	78	78	77	79	78	1.3%	224.5	229.5	234.5	228.3	229	1.7%
Tehama	FFS	49	49	48	48	49	-2.0%	288.5	288.1	291.5	281.0	287	-2.6%
Trinity	FFS	5	5	5	5	5	0.0%	457.4	439.2	437.6	442.0	444	-3.4%
Tulare	Two-Plan	256	260	260	258	259	0.8%	510.5	505.8	511.3	514.5	511	0.8%
Tuolumne	FFS	43	42	44	42	43	-2.3%	148.4	153.5	147.5	152.1	150	2.5%
Ventura *	COHS	602	606	642	649	625	7.8%	150.3	150.4	142.1	139.1	145	-7.4%
Yolo	COHS	217	218	217	219	218	0.9%	107.0	106.6	107.9	106.5	107	-0.4%
Yuba	FFS	59	60	60	60	60	1.7%	284.7	281.6	281.4	275.7	281	-3.1%

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

\*\* Shifted from FFS to COHS Model on January 1, 2011

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



**Table 31 Physician Supply - Physicians with an OB/GYN Specialty - FFS, Medi-Cal Only, Non-Elderly, Adult Females**

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
<b>Statewide</b>		6,346	6,379	6,422	6,456	135.2	132.6	122.3	115.3
<b>County Plan Model Type</b>									
County Organized Health System (COHS)		1,321	1,334	1,341	1,341	91.1	90.1	70.2	68.8
Fee-for-Service (FFS)		228	228	230	232	414.2	416.1	409.9	401.6
Geographic Managed Care (GMC)		799	799	810	817	90.9	89.5	81.5	73.9
Two-Plan (Commercial Plan and Local Initiative)		3,998	4,018	4,041	4,066	142.7	139.1	131.4	122.6
<b>County</b>									
Alameda	Two-Plan	290	291	294	298	89.1	86.8	80.7	73.5
Alpine	FFS	-	-	-	-	-	-	-	-
Amador	FFS	5	5	5	5	209.0	216.8	221.0	222.6
Butte	FFS	31	31	31	32	401.3	400.2	395.7	378.6
Calaveras	FFS	1	1	1	1	1,674.0	1,668.0	1,668.0	1,653.0
Colusa	FFS	1	1	1	1	989.0	1,002.0	1,004.0	1,005.0
Contra Costa	Two-Plan	146	147	146	147	106.8	105.0	99.6	92.5
Del Norte	FFS	3	3	3	3	656.3	660.0	664.0	659.3
El Dorado	FFS	15	15	15	15	303.5	304.7	299.6	297.5
Fresno	Two-Plan	126	127	129	131	217.0	210.5	196.3	183.0
Glenn	FFS	1	1	1	1	1,657.0	1,672.0	1,645.0	1,607.0
Humboldt	FFS	18	18	19	19	365.4	363.7	341.8	338.5
Imperial	FFS	18	18	19	19	749.1	750.7	707.6	706.9
Inyo	FFS	3	3	3	3	281.7	282.0	277.0	271.7
Kern	Two-Plan	104	105	106	106	233.6	231.8	215.9	201.4
Kings	Two-Plan	11	11	11	11	627.3	318.6	292.3	272.1
Lake	FFS	4	4	4	4	1,067.5	1,065.8	1,045.0	1,035.3
Lassen	FFS	1	1	1	1	1,238.0	1,263.0	1,269.0	1,247.0

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Los Angeles	Two-Plan	1,775	1,782	1,787	1,794	160.5	158.6	151.8	141.8
Madera	Two-Plan	15	15	15	15	601.1	376.7	345.9	326.3
Marin *	COHS	33	33	33	33	161.7	161.9	81.4	78.5
Mariposa	FFS	-	-	-	-	-	-	-	-
Mendocino *	COHS	22	22	22	22	248.5	249.8	48.9	48.2
Merced	COHS	22	22	22	22	209.6	209.1	208.1	206.5
Modoc	FFS	1	1	1	1	487.0	488.0	470.0	445.0
Mono	FFS	2	1	1	1	150.0	323.0	309.0	301.0
Monterey	COHS	73	75	75	75	139.6	135.2	131.5	128.0
Napa	COHS	15	15	16	16	85.3	85.4	81.1	79.1
Nevada	FFS	14	14	14	14	197.7	199.9	199.7	199.9
Orange	COHS	608	611	613	613	60.8	60.6	60.0	58.9
Placer	FFS	52	52	52	53	128.8	130.8	131.3	127.6
Plumas	FFS	1	1	1	1	715.0	729.0	728.0	724.0
Riverside	Two-Plan	192	194	197	199	198.1	197.8	182.7	170.6
Sacramento	GMC	291	291	295	295	95.2	93.8	83.8	75.1
San Benito	FFS	4	4	4	4	611.5	612.3	607.5	602.5
San Bernardino	Two-Plan	241	245	247	247	197.1	195.1	183.3	172.8
San Diego	GMC	508	508	515	522	88.4	87.1	80.2	73.3
San Francisco	Two-Plan	341	341	344	344	39.6	38.9	34.3	30.8
San Joaquin	Two-Plan	111	111	112	113	152.0	149.1	135.5	123.6
San Luis Obispo	COHS	32	33	33	33	60.3	57.5	55.9	54.5
San Mateo	COHS	135	136	136	137	48.2	47.8	47.5	47.7
Santa Barbara	COHS	76	79	79	79	104.4	99.8	97.4	95.5
Santa Clara	Two-Plan	494	497	501	505	60.1	58.2	55.1	53.1
Santa Cruz	COHS	39	40	40	40	88.6	84.1	81.8	79.9
Shasta	FFS	19	19	19	19	519.0	522.0	522.4	510.3
Sierra	FFS	-	-	-	-	-	-	-	-
Siskiyou	FFS	4	4	4	4	633.3	635.5	616.8	610.5
Solano	COHS	77	77	77	77	39.6	40.1	39.5	38.2

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Sonoma	COHS	61	62	63	63	70.4	70.1	67.5	65.7
Stanislaus	Two-Plan	74	74	74	75	203.0	201.3	189.4	173.6
Sutter	FFS	13	14	14	14	394.3	372.1	370.6	370.7
Tehama	FFS	5	5	5	5	839.6	846.2	834.4	802.6
Trinity	FFS	-	-	-	-	-	-	-	-
Tulare	Two-Plan	78	78	78	81	207.7	201.5	192.5	177.9
Tuolumne	FFS	8	8	8	8	242.4	246.3	249.9	246.0
Ventura **	COHS	100	101	104	103	277.8	273.6	93.6	91.4
Yolo	COHS	28	28	28	28	55.8	55.6	54.5	53.4
Yuba	FFS	4	4	4	4	1,269.3	1,271.8	1,268.5	1,235.3

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

\*\* Shifted from FFS to COHS Model on January 1, 2011

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

**Table 32 Physician Supply - Physicians with an OB/GYN Specialty - All Medi-Cal Only, Non-Elderly, Adult Females**

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
<b>Statewide</b>		6,346	6,379	6,422	6,456	271.9	272.3	271.0	268.4
<b>County Plan Model Type</b>									
County Organized Health System (COHS)		1,321	1,334	1,341	1,341	205.3	204.6	203.2	201.9
Fee-for-Service (FFS)		228	228	230	232	415.6	417.4	411.6	403.4
Geographic Managed Care (GMC)		799	799	810	817	216.1	217.1	214.3	212.1
Two-Plan (Commercial Plan and Local Initiative)		3,998	4,018	4,041	4,066	296.8	297.5	296.9	294.0
<b>County</b>									
Alameda	Two-Plan	290	291	294	298	201.5	201.1	200.5	198.3
Alpine	FFS	-	-	-	-	-	-	-	-
Amador	FFS	5	5	5	5	210.0	217.6	222.2	224.2
Butte	FFS	31	31	31	32	402.1	400.8	397.1	380.0
Calaveras	FFS	1	1	1	1	1,680.0	1,673.0	1,678.0	1,666.0
Colusa	FFS	1	1	1	1	992.0	1,005.0	1,006.0	1,007.0
Contra Costa	Two-Plan	146	147	146	147	224.0	224.2	226.6	225.8
Del Norte	FFS	3	3	3	3	657.3	661.0	665.0	661.0
El Dorado	FFS	15	15	15	15	304.6	305.9	301.1	298.5
Fresno	Two-Plan	126	127	129	131	585.4	584.4	576.4	568.2
Glenn	FFS	1	1	1	1	1,660.0	1,674.0	1,647.0	1,609.0
Humboldt	FFS	18	18	19	19	366.2	364.7	343.0	339.9
Imperial	FFS	18	18	19	19	751.8	754.2	711.3	710.4
Inyo	FFS	3	3	3	3	282.3	282.7	277.3	272.7
Kern	Two-Plan	104	105	106	106	530.6	530.8	524.1	519.9
Kings	Two-Plan	11	11	11	11	773.6	779.2	779.1	775.2
Lake	FFS	4	4	4	4	1,073.0	1,070.0	1,051.3	1,043.8
Lassen	FFS	1	1	1	1	1,244.0	1,268.0	1,274.0	1,253.0
Los Angeles	Two-Plan	1,775	1,782	1,787	1,794	312.8	313.0	313.7	310.6

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Madera	Two-Plan	15	15	15	15	710.8	720.7	714.2	706.5
Marin *	COHS	33	33	33	33	170.9	171.4	169.8	165.6
Mariposa	FFS	-	-	-	-	-	-	-	-
Mendocino *	COHS	22	22	22	22	249.4	250.8	252.1	252.3
Merced	COHS	22	22	22	22	901.1	912.7	914.3	912.6
Modoc	FFS	1	1	1	1	487.0	488.0	470.0	447.0
Mono	FFS	2	1	1	1	150.0	325.0	310.0	301.0
Monterey	COHS	73	75	75	75	312.4	305.5	301.0	296.8
Napa	COHS	15	15	16	16	249.0	249.9	236.9	236.9
Nevada	FFS	14	14	14	14	198.3	200.4	200.4	200.5
Orange	COHS	608	611	613	613	159.4	160.3	160.6	160.0
Placer	FFS	52	52	52	53	129.7	131.7	132.5	128.9
Plumas	FFS	1	1	1	1	715.0	731.0	729.0	725.0
Riverside	Two-Plan	192	194	197	199	448.0	452.3	449.0	445.8
Sacramento	GMC	291	291	295	295	263.2	264.2	260.9	261.3
San Benito	FFS	4	4	4	4	620.8	620.3	615.8	610.0
San Bernardino	Two-Plan	241	245	247	247	447.3	447.1	445.3	444.2
San Diego	GMC	508	508	515	522	189.1	190.1	187.6	184.2
San Francisco	Two-Plan	341	341	344	344	79.0	79.9	79.1	78.5
San Joaquin	Two-Plan	111	111	112	113	385.4	391.1	389.7	385.4
San Luis Obispo	COHS	32	33	33	33	239.6	233.1	231.6	228.9
San Mateo	COHS	135	136	136	137	111.4	111.5	112.8	113.8
Santa Barbara	COHS	76	79	79	79	247.3	237.8	235.4	232.9
Santa Clara	Two-Plan	494	497	501	505	116.9	115.9	114.2	113.2
Santa Cruz	COHS	39	40	40	40	257.3	251.3	248.8	246.1
Shasta	FFS	19	19	19	19	519.7	522.6	523.3	511.3
Sierra	FFS	-	-	-	-	-	-	-	-
Siskiyou	FFS	4	4	4	4	635.3	636.8	617.8	611.5
Solano	COHS	77	77	77	77	214.7	215.7	216.5	215.2
Sonoma	COHS	61	62	63	63	227.4	226.7	222.4	220.6

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Stanislaus	Two-Plan	74	74	74	75	435.7	440.5	439.3	429.4
Sutter	FFS	13	14	14	14	395.1	373.0	371.6	372.1
Tehama	FFS	5	5	5	5	841.0	846.6	836.2	804.0
Trinity	FFS	-	-	-	-	-	-	-	-
Tulare	Two-Plan	78	78	78	81	496.5	497.5	497.4	479.1
Tuolumne	FFS	8	8	8	8	243.0	247.0	250.5	247.0
Ventura **	COHS	100	101	104	103	278.3	274.1	261.1	259.6
Yolo	COHS	28	28	28	28	249.9	250.1	250.1	249.3
Yuba	FFS	4	4	4	4	1,273.5	1,275.0	1,272.0	1,238.0

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

\*\* Shifted from FFS to COHS Model on January 1, 2011

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

**Table 33 Physician Supply - Physicians with a Pediatric Specialty - FFS, Full Scope, Medi-Cal Only Children**

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
<b>Statewide</b>		10,692	10,769	10,921	11,007	74.2	71.4	64.3	61.2
<b>County Plan Model Type</b>									
County Organized Health System (COHS)		1,906	1,926	1,944	1,948	54.4	54.9	17.0	14.8
Fee-for-Service (FFS)		271	271	274	275	628.9	633.6	627.5	619.2
Geographic Managed Care (GMC)		1,437	1,449	1,462	1,484	52.7	51.9	51.6	50.1
Two-Plan (Commercial Plan and Local Initiative)		7,078	7,123	7,241	7,300	62.7	58.5	58.3	54.8
<b>County</b>									
Alameda	Two-Plan	725	731	735	741	27.7	26.6	25.9	24.9
Alpine	FFS	-	-	-	-	-	-	-	-
Amador	FFS	2	2	2	2	928.5	939.5	933.0	930.5
Butte	FFS	25	25	25	25	858.3	857.9	847.5	838.5
Calaveras	FFS	2	2	2	2	1,394.0	1,386.5	1,402.0	1,401.0
Colusa	FFS	-	-	-	-	-	-	-	-
Contra Costa	Two-Plan	237	241	241	241	51.1	49.9	48.1	48.3
Del Norte	FFS	5	5	5	5	673.0	672.4	667.2	666.8
El Dorado	FFS	15	15	17	17	536.7	542.1	477.1	475.5
Fresno	Two-Plan	181	183	184	186	107.7	101.3	102.7	96.5
Glenn	FFS	2	2	2	2	1,689.5	1,691.0	1,698.5	1,690.0
Humboldt	FFS	16	16	16	17	675.9	682.0	689.8	647.2
Imperial	FFS	20	20	20	20	1,277.1	1,282.7	1,284.8	1,277.1
Inyo	FFS	5	5	5	5	300.0	298.8	305.6	303.6
Kern	Two-Plan	138	139	143	144	181.3	179.4	173.5	160.9
Kings	Two-Plan	11	12	12	12	1,218.1	300.0	288.5	274.2
Lake	FFS	6	6	6	6	1,156.5	1,161.8	1,158.2	1,138.5
Lassen	FFS	2	2	2	2	1,034.0	1,063.5	1,077.5	1,070.5
Los Angeles	Two-Plan	2,883	2,893	2,949	2,973	58.4	58.1	59.0	54.8

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Madera	Two-Plan	137	137	140	142	117.2	28.7	25.4	23.9
Marin *	COHS	67	67	71	71	117.3	118.8	5.3	4.7
Mariposa	FFS	-	-	-	-	-	-	-	-
Mendocino *	COHS	14	14	14	14	683.4	679.4	33.9	30.0
Merced	COHS	23	23	23	24	66.0	69.5	74.7	60.5
Modoc	FFS	-	-	-	-	-	-	-	-
Mono	FFS	5	5	5	5	129.8	132.6	134.8	134.6
Monterey	COHS	87	88	88	87	26.2	28.2	28.3	22.6
Napa	COHS	22	23	23	23	22.1	19.4	20.3	17.3
Nevada	FFS	11	11	11	11	424.7	425.0	422.9	423.4
Orange	COHS	880	894	902	906	12.8	13.3	14.6	12.0
Placer	FFS	88	88	88	88	152.2	155.4	157.2	156.8
Plumas	FFS	-	-	-	-	-	-	-	-
Riverside	Two-Plan	234	237	239	240	197.8	193.5	194.9	182.0
Sacramento	GMC	512	519	525	534	49.3	48.8	48.1	47.4
San Benito	FFS	4	4	4	4	1,204.5	1,239.8	1,244.0	1,226.0
San Bernardino	Two-Plan	508	513	517	521	109.4	107.1	106.7	99.8
San Diego	GMC	925	930	937	950	54.5	53.6	53.5	51.7
San Francisco	Two-Plan	662	664	682	689	9.4	9.1	8.8	8.4
San Joaquin	Two-Plan	120	122	123	125	136.5	131.8	123.2	113.5
San Luis Obispo	COHS	51	51	51	51	14.1	15.6	15.5	15.3
San Mateo	COHS	272	273	275	275	7.2	7.4	7.4	6.7
Santa Barbara	COHS	96	96	97	97	23.7	25.6	26.8	25.1
Santa Clara	Two-Plan	1,082	1,089	1,110	1,118	15.9	14.8	14.8	15.6
Santa Cruz	COHS	44	44	44	44	23.4	23.4	23.3	23.2
Shasta	FFS	22	22	22	22	765.1	773.0	777.1	763.1
Sierra	FFS	-	-	-	-	-	-	-	-
Siskiyou	FFS	3	3	3	3	1,405.3	1,427.7	1,411.7	1,402.0
Solano	COHS	119	120	121	121	10.1	10.2	10.6	10.1

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Sonoma	COHS	66	66	67	67	28.0	30.2	30.0	27.9
Stanislaus	Two-Plan	79	80	83	84	201.6	196.7	186.1	178.2
Sutter	FFS	12	12	12	12	861.3	877.7	891.4	885.8
Tehama	FFS	9	9	10	10	910.6	904.2	806.1	779.2
Trinity	FFS	-	-	-	-	-	-	-	-
Tulare	Two-Plan	81	82	83	84	147.4	138.4	143.4	138.1
Tuolumne	FFS	10	10	10	10	328.2	327.9	327.7	321.6
Ventura **	COHS	122	123	123	123	495.3	496.8	27.1	24.6
Yolo	COHS	43	44	45	45	27.3	27.2	29.0	27.3
Yuba	FFS	7	7	7	7	1,333.1	1,345.1	1,345.4	1,324.0

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

\*\* Shifted from FFS to COHS Model on January 1, 2011

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

**Table 34 Physician Supply - Physicians with a Pediatric Specialty - All Full Scope, Medi-Cal Only Children**

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
<b>Statewide</b>		10,692	10,769	10,921	11,007	322.2	322.6	321.3	317.2
<b>County Plan Model Type</b>									
County Organized Health System (COHS)		1,906	1,926	1,944	1,948	290.9	291.3	291.8	289.8
Fee-for-Service (FFS)		271	271	274	275	632.6	637.4	632.0	623.6
Geographic Managed Care (GMC)		1,437	1,449	1,462	1,484	243.1	243.5	244.0	240.3
Two-Plan (Commercial Plan and Local Initiative)		7,078	7,123	7,241	7,300	334.8	335.2	333.1	328.6
<b>County</b>									
Alameda	Two-Plan	725	731	735	741	137.0	136.7	137.4	136.9
Alpine	FFS	-	-	-	-	-	-	-	-
Amador	FFS	2	2	2	2	932.5	943.5	938.0	936.0
Butte	FFS	25	25	25	25	862.8	862.2	852.8	844.4
Calaveras	FFS	2	2	2	2	1,404.0	1,399.5	1,418.0	1,413.0
Colusa	FFS	-	-	-	-	-	-	-	-
Contra Costa	Two-Plan	237	241	241	241	254.6	252.6	253.8	256.3
Del Norte	FFS	5	5	5	5	673.4	673.6	669.2	668.0
El Dorado	FFS	15	15	17	17	540.8	546.6	481.7	479.4
Fresno	Two-Plan	181	183	184	186	856.3	851.4	853.4	841.4
Glenn	FFS	2	2	2	2	1,696.0	1,696.5	1,705.0	1,695.5
Humboldt	FFS	16	16	16	17	677.9	684.3	692.4	649.8
Imperial	FFS	20	20	20	20	1,283.7	1,291.1	1,295.0	1,286.6
Inyo	FFS	5	5	5	5	300.8	299.0	306.0	304.2
Kern	Two-Plan	138	139	143	144	874.5	876.7	860.1	844.4
Kings	Two-Plan	11	12	12	12	1,645.3	1,519.9	1,526.8	1,517.3
Lake	FFS	6	6	6	6	1,169.8	1,174.5	1,175.3	1,154.3
Lassen	FFS	2	2	2	2	1,042.0	1,068.5	1,082.0	1,076.0

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Los Angeles	Two-Plan	2,883	2,893	2,949	2,973	369.8	370.2	366.8	361.2
Madera	Two-Plan	137	137	140	142	160.4	163.1	161.8	159.7
Marin *	COHS	67	67	71	71	124.6	126.6	120.0	118.8
Mariposa	FFS	-	-	-	-	-	-	-	-
Mendocino *	COHS	14	14	14	14	688.9	685.2	694.6	698.6
Merced	COHS	23	23	23	24	1,763.4	1,786.0	1,801.9	1,716.8
Modoc	FFS	-	-	-	-	-	-	-	-
Mono	FFS	5	5	5	5	130.6	133.0	135.6	135.2
Monterey	COHS	87	88	88	87	519.6	518.7	524.1	525.7
Napa	COHS	22	23	23	23	333.3	323.0	328.7	326.0
Nevada	FFS	11	11	11	11	426.6	427.3	425.1	424.8
Orange	COHS	880	894	902	906	237.2	236.4	237.7	235.5
Placer	FFS	88	88	88	88	153.5	156.8	158.7	158.4
Plumas	FFS	-	-	-	-	-	-	-	-
Riverside	Two-Plan	234	237	239	240	897.7	902.1	911.3	900.4
Sacramento	GMC	512	519	525	534	283.4	281.4	280.1	275.8
San Benito	FFS	4	4	4	4	1,231.5	1,265.5	1,271.8	1,254.0
San Bernardino	Two-Plan	508	513	517	521	483.9	484.6	486.0	478.7
San Diego	GMC	925	930	937	950	220.8	222.4	223.7	220.4
San Francisco	Two-Plan	662	664	682	689	54.4	54.6	53.7	53.1
San Joaquin	Two-Plan	120	122	123	125	701.2	703.8	703.0	688.1
San Luis Obispo	COHS	51	51	51	51	286.1	290.1	291.8	291.2
San Mateo	COHS	272	273	275	275	109.9	110.9	111.9	112.8
Santa Barbara	COHS	96	96	97	97	405.7	411.9	412.1	409.1
Santa Clara	Two-Plan	1,082	1,089	1,110	1,118	96.8	96.1	94.6	93.8
Santa Cruz	COHS	44	44	44	44	430.9	436.8	439.3	438.7
Shasta	FFS	22	22	22	22	768.1	775.6	779.9	765.9
Sierra	FFS	-	-	-	-	-	-	-	-
Siskiyou	FFS	3	3	3	3	1,409.3	1,433.3	1,418.0	1,407.7
Solano	COHS	119	120	121	121	254.2	253.7	253.4	252.4

		Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Sonoma	COHS	66	66	67	67	416.7	424.3	423.4	424.5
Stanislaus	Two-Plan	79	80	83	84	799.1	797.4	772.5	763.6
Sutter	FFS	12	12	12	12	865.3	881.7	896.3	890.5
Tehama	FFS	9	9	10	10	913.3	907.0	809.4	782.2
Trinity	FFS	-	-	-	-	-	-	-	-
Tulare	Two-Plan	81	82	83	84	1,038.0	1,032.0	1,034.0	1,017.8
Tuolumne	FFS	10	10	10	10	330.6	331.1	332.9	327.2
Ventura **	COHS	122	123	123	123	496.8	498.4	500.8	494.7
Yolo	COHS	43	44	45	45	321.6	314.6	310.6	308.6
Yuba	FFS	7	7	7	7	1,341.1	1,351.6	1,353.4	1,331.0

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

\*\* Shifted from FFS to COHS Model on January 1, 2011

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

**Table 35 Primary Care Providers By Provider Type and Enrollment Status - FFS, Full Scope, Medi-Cal Only Beneficiaries (Statewide only)**

Provider Enrollment Status	Provider Type	Number of Providers				Population-to-Provider Ratio			
		2011-1st Quarter	2011-2nd Quarter	2011-3rd Quarter	2011-4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
Active	<b>Physicians</b>								
	Physicians	7,182	7,193	7,217	7,227	222.4	215.6	189.2	173.2
	Physicians Group	2,998	3,022	3,053	3,080	532.7	513.1	447.3	406.5
	<b>Clinics</b>								
	RHC/FQHC	592	590	596	595	2,697.50	2,628.30	2,291.20	2,104.20
	Free Clinic	9	9	9	9	177,437.30	172,298.30	151,730.40	139,107.90
	Community Clinic	375	383	387	385	4,258.50	4,048.80	3,528.60	3,251.90
	Surgical Clinic	297	306	326	328	5,376.90	5,067.60	4,188.90	3,817.00
	Clinic exempt from licensure	140	142	156	168	11,406.70	10,920.30	8,753.70	7,452.20
	County Clinic not w/ Hosp	35	35	36	35	45,626.70	44,305.30	37,932.60	35,770.60
	Indian Health Services	39	39	39	38	40,947.10	39,761.20	35,014.70	32,946.60
	<b>Outpatient Hospital</b>								
	County Outpatient Hospital	39	39	38	38	40,947.10	39,761.20	35,936.20	32,946.60
	Community Outpatient Hospital	344	355	357	362	4,642.30	4,368.10	3,825.10	3,458.50
<b>Indirect / Rendering Physicians</b>									
		33,691	33,991	34,447	34,707	47.4	45.6	39.6	36.1

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

**Table 36 Primary Care Providers By Provider Type and Enrollment Status - All Full Scope, Medi-Cal Only Beneficiaries (Statewide Only)**

Provider Enrollment Status	Provider Type	Number of Providers				Population-to-Provider Ratio			
		2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter	2011- 1st Quarter	2011- 2nd Quarter	2011- 3rd Quarter	2011- 4th Quarter
<b>Active</b>	<b>Physicians</b>								
	Physicians	7,182	7,193	7,217	7,227	772.8	778.6	782.2	778.5
	Physicians Group	2,998	3,022	3,053	3,080	1,851.3	1,853.2	1,849.1	1,826.6
	<b>Clinics</b>								
	RHC/FQHC	592	590	596	595	9,375.4	9,491.9	9,471.8	9,455.3
	Free Clinic	9	9	9	9	616,695.0	622,246.2	627,241.1	625,101.0
	Community Clinic	375	383	387	385	14,800.7	14,622.0	14,587.0	14,612.8
	Surgical Clinic	297	306	326	328	18,687.7	18,301.4	17,316.5	17,152.2
	Clinic exempt from licensure	140	142	156	168	39,644.7	39,438.1	36,187.0	33,487.6
	County Clinic not w/ Hosp	35	35	36	35	158,578.7	160,006.2	156,810.3	160,740.3
	Indian Health Services	39	39	39	38	142,314.2	143,595.3	144,748.0	148,050.2
	<b>Outpatient Hospital</b>								
	County Outpatient Hospital	39	39	38	38	142,314.2	143,595.3	148,557.1	148,050.2
	Community Outpatient Hospital	344	355	357	362	16,134.5	15,775.3	15,812.8	15,541.2
<b>Indirect / Rendering Physicians</b>									
		33,691	33,991	34,447	34,707	167.7	164.8	163.9	162.1

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

## **Appendix D --- Detailed List of Other Providers**

Community-Based Adult Services Program (formerly called Adult Day Health Care) (Provider Type (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)

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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)