



**Medi-Cal Access to Care  
Quarterly Monitoring Report #10  
2014 Quarter 1  
Beneficiary Feedback**

**November 2015**

California Department of Health Care Services  
Research and Analytic Studies Division  
MS 1250, P.O. Box 997413  
Sacramento, CA 95899-7413

## Contents

Contents .....	ii
Figures.....	iii
Tables.....	iv
Key Points .....	1
Introduction .....	1
Background .....	1
Assembly Bill 97 .....	2
Medi-Cal Enrollment Transitions .....	2
Implementation of the Affordable Care Act .....	2
Expansion of Medi-Cal Managed Care .....	2
Healthy Families Transition.....	4
Methods.....	4
Limitations .....	4
Results.....	4
Call Volume, by Quarter.....	6
Modified Call Categories .....	6
Distribution of Calls, by Call Category.....	8
Distribution of Calls, by Aid Category.....	9
Distribution of Calls from Beneficiaries in Parent/Caretaker Relative & Child Aid Codes, by Call Category .....	11
Distribution of Calls from Beneficiaries in SPD Aid Codes, by Call Category.....	12
Reason for Call .....	13
Conclusions .....	15

## Figures

Figure BF-1: Calls Received from FFS Beneficiaries from Quarter 2, 2013, to Quarter 1, 2014, by Month .....	5
Figure BF-2: Calls Received from FFS Beneficiaries from Quarter 2, 2013, to Quarter 1, 2014, by Call Category .....	8
Figure BF-3: Monthly Call Volume from Beneficiaries in Parent/Caretaker Relative & Child Aid Codes from Quarter 2, 2013, to Quarter 1, 2014, by Call Category .....	11
Figure BF-4: Monthly Call Volume from Beneficiaries in Seniors and Persons with Disabilities Aid Codes from Quarter 2, 2013, to Quarter 1, 2014, by Call Category .....	12

## Tables

Table BF-1: FFS Medi-Cal Only Beneficiaries Transitioned to Medi-Cal Managed Care in September and November 2013 .....	3
Table BF-2: Number of Calls Received from FFS Beneficiaries from Quarter 2, 2013 to Quarter 1, 2014, by Quarter .....	6
Table BF-3: Modified Call Categories.....	7
Table BF-4: Calls for Enrollment/Continuity of Care and Provider/Availability Issues from Quarter 2, 2013, to Quarter 1, 2014, by Aid Category .....	10
Table BF-5: Top Four Reasons for Calls from Beneficiaries in Parent/Caretaker Relative & Child Aid Codes from Quarter 2, 2013 to Quarter 1, 2014.....	13
Table BF-6: Top Four Reasons for Calls from Beneficiaries in Seniors and Persons with Disabilities Aid Codes from Quarter 2, 2013, to Quarter 1, 2014, by Call Category.....	14

## Key Points

- Call volume increased substantially to 15,643 calls in the current study period, compared with 12,306 calls in the last study period.
- Enrollment/Continuity of Care and Miscellaneous call categories comprised 89.3% of calls.
- Of calls regarding Enrollment/Continuity of Care and Provider/Availability matters, 79.0% were received from beneficiaries in the Parent/Caretaker Relative & Child, Seniors and Persons with Disabilities, and Children's Health Insurance Program aid categories.
- The increase in call volume from July to September 2013 may be a result of the establishment of a County Organized Health System in eight counties during September 2013.
- The increase in call volume from November to December 2013 may be due to two factors: the expansion of Regional/Other managed care models into 20 counties in November 2013; and the inaugural open enrollment period for the Medicaid expansion component of the Patient Protection and Affordable Care Act (ACA) of 2010.
- The increase in call volume from December 2013 to February 2014 and slightly lower but still heavy volume in March 2014 are likely due to the inaugural open enrollment period for the Medicaid expansion component of the ACA.

## Introduction

Help lines provide needed assistance to Fee-for-Service (FFS) Medi-Cal beneficiaries experiencing difficulties navigating the health care system and assist the California Department of Health Care Services (DHCS) in ensuring health care access. While several administrative data sources can be used to monitor Medi-Cal participation and utilization, help lines provide DHCS with information regarding beneficiaries' experiences, including difficulties enrolling in the program, finding a provider, and receiving referrals to specialists. This type of feedback enables DHCS to identify potential factors impeding beneficiaries' use of services.

The following two help lines are available to FFS Medi-Cal beneficiaries: [DHCS' Medi-Cal Member and Provider Helpline](#) and the Medi-Cal Managed Care Office of the Ombudsman call center. DHCS' Medi-Cal Member and Provider Helpline serves as a direct source of information for providers, beneficiaries, and prospective enrollees. DHCS is currently working to identify how data and information generated from this help line can be best incorporated into this measure. Although it is primarily focused on assisting Medi-Cal managed care beneficiaries, the Medi-Cal Managed Care Office of the Ombudsman call center provides FFS Medi-Cal beneficiaries with general program information. Until data from DHCS' help line becomes serviceable, this report will present data from the Medi-Cal Managed Care Office of the Ombudsman call center.

## Background

### Assembly Bill 97

In March 2011, Assembly Bill (AB) 97 was signed into law and instituted a 10% reduction in Medi-Cal reimbursements to select providers. Court injunctions delayed the implementation of AB 97 until September 2013.

The reimbursement reductions do not apply to all Medi-Cal providers and services. Providers and services that are exempt from the 10% reduction in Medi-Cal reimbursement rates include but are not limited to:

- Physician services to children ages 0–20;
- Federally Qualified Health Centers (FQHCs);
- Rural Health Clinics (RHCs); and
- Breast and cervical cancer treatment services.<sup>1,2,3</sup>

### Medi-Cal Enrollment Transitions

***Implementation of the Affordable Care Act*** – The Patient Protection and Affordable Care Act, referred to as simply the Affordable Care Act (ACA), was signed into law by President Obama in March 2010. Under the ACA, states gained the option to expand Medicaid eligibility to previously ineligible low-income adults ages 19-64 (at or below 138% Federal Poverty Level) without dependent children.<sup>4</sup> On June 27, 2013, Governor Brown signed into law [AB](#) and [Senate Bill \(SB\) 1-1, §25](#), authorizing California to expand the Medi-Cal program to include this optional population effective January 1, 2014. State administrative policy requires this new Medi-Cal population to enroll in managed care health plans. However, most certified eligibles that are required to enroll in managed care enter the Medi-Cal system through FFS, and they remain in FFS until their health plan selection is complete. As a result, while this large influx of new eligibles is required to enroll in managed care, many temporarily participate in FFS.

***Expansion of Medi-Cal Managed Care*** – Several subpopulations transitioned from the FFS health delivery system into managed care plans during the study period. For instance, 81,488 FFS beneficiaries who are eligible for Medi-Cal but not Medicare (FFS Medi-Cal Only) enrolled into a Medi-Cal managed care plan in September 2013 due to the establishment of a County Organized Health System (COHS) in Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity counties. Another 165,780 FFS Medi-Cal Only beneficiaries enrolled into

<sup>1</sup> California Assembly Bill 97, (2011).

<sup>2</sup> California Department of Health Care Services, Implementation of AB97 Reductions. Retrieved from <http://www.dhcs.ca.gov/Documents/AB97ImplementationAnnouncemen081413.pdf>

<sup>3</sup> California Department of Health Care Services, State Plan Amendment, SPA 11-009.

<sup>4</sup> On June 28, 2012, the United States Supreme Court issued a majority opinion in National Federation of Independent Business v. Sebelius which found that the mandatory expansion of states' Medicaid eligibility rules to include childless adults was unconstitutional. California was one of 30 states to date, including the District of Columbia, to exercise the optional expansion of Medicaid eligibility rules.

managed care plans in November 2013 due to the establishment of managed care in Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, and Yuba counties (Table BF-1).

**Table BF-1:** FFS Medi-Cal Only Beneficiaries Transitioned to Medi-Cal Managed Care in September and November 2013

Managed Care Plan Type	Month of Transition	Transition Counties	Approximate Number of Medi-Cal Only Beneficiaries
COHS	September 2013	Del Norte	5,837
COHS	September 2013	Humboldt	19,913
COHS	September 2013	Lake	12,749
COHS	September 2013	Lassen	3,507
COHS	September 2013	Modoc	1,376
COHS	September 2013	Shasta	28,430
COHS	September 2013	Siskiyou	7,736
COHS	September 2013	Trinity	1,940
			<b>Subtotal = 81,488</b>
Managed Care Plan Type	Month of Transition	Transition Counties	Approximate Number of Medi-Cal Only Beneficiaries
Regional/Other	November 2013	Alpine	106
Regional/Other	November 2013	Amador	2,522
Regional/Other	November 2013	Butte	28,365
Regional/Other	November 2013	Calaveras	3,817
Regional/Other	November 2013	Colusa	2,820
Regional/Other	November 2013	El Dorado	10,621
Regional/Other	November 2013	Glenn	4,514
Regional/Other	November 2013	Imperial	36,927
Regional/Other	November 2013	Inyo	1,977
Regional/Other	November 2013	Mariposa	1,669
Regional/Other	November 2013	Mono	945
Regional/Other	November 2013	Nevada	6,764
Regional/Other	November 2013	Placer	16,815
Regional/Other	November 2013	Plumas	1,622
Regional/Other	November 2013	San Benito	5,401
Regional/Other	November 2013	Sierra	257
Regional/Other	November 2013	Sutter	14,372
Regional/Other	November 2013	Tehama	10,372
Regional/Other	November 2013	Tuolumne	4,519
Regional/Other	November 2013	Yuba	11,375
			<b>Subtotal = 165,780</b>
			<b>Statewide Total = 247,268</b>

**Source:** Created by DHCS Research and Analytic Studies Division using data from the Management Information System/Decision Support System's (MIS/DSS) eligibility tables for December 2013. Data were extracted from the MIS/DSS four months after the corresponding time period to allow for updates to enrollment.

***Healthy Families Transition*** – On January 1, 2013, DHCS began the first of four phases in 2013 to transition approximately 860,000 children from the Healthy Families Program (HFP) into Medi-Cal. To ensure minimal disruption to coverage, DHCS assigned certain children presumptive eligibility for Medi-Cal benefits under the FFS health delivery system until the date of their annual eligibility review for Medi-Cal. These children with presumptive eligibility under the FFS health delivery system are classified under the Children’s Health Insurance Program (CHIP) aid category in this report. Participation rates for these children are expected to decline throughout 2013 and beyond as they are redetermined into aid codes that require enrollment in a Medi-Cal managed care health plan.

## **Methods**

As data from the Department’s help line has yet to become serviceable, this report relies on data obtained from the Medi-Cal Managed Care Office of the Ombudsman for the purpose of monitoring health care access.

Upon receiving a call, the Office of the Ombudsman identifies whether a beneficiary is enrolled in FFS by their Medi-Cal identification number. The Office of the Ombudsman call center documented 15,643 calls from FFS beneficiaries from the second quarter of 2013 to the first quarter of 2014. For each of these calls, the call center recorded the date and time of their call, beneficiary aid category, county of residence, and reason for the call. Data for these calls were summarized by month received, seven aid categories, and reason for call.

Starting with this report, the aid categories have been updated to account for newly eligible individuals and changes in eligibility criteria. These changes stemmed from the transition of the HFP into Medi-Cal throughout 2013 and the implementation of the ACA in January 2014. Subsequently, the six aid categories referenced in previous quarterly reports have been redefined into seven categories based on the updated eligibility criteria. Starting with this report, beneficiaries participating in FFS Medi-Cal Only have been grouped as homogeneous subpopulations into one of seven aid categories: Seniors and Persons with Disabilities (SPD), Parent/Caretaker Relative & Child, Adoption/Foster Care, ACA Expansion Adult - Age 19-64, CHIP, Undocumented, and Other. The updated aid categories will provide DHCS with a better representation of FFS Medi-Cal’s current population.

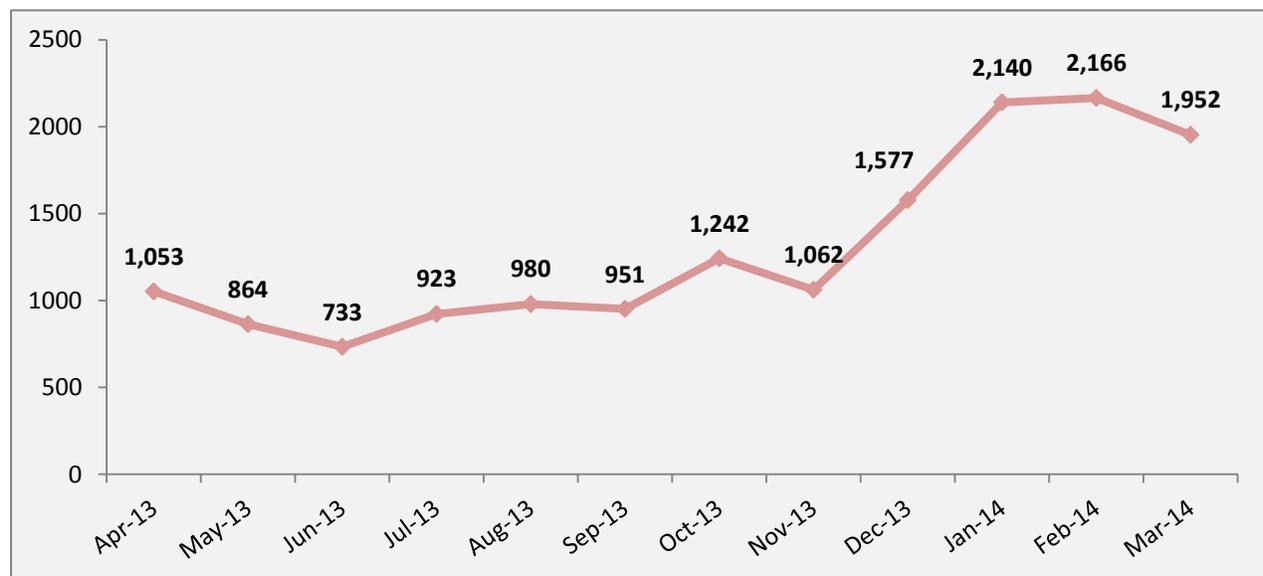
## **Limitations**

As the contact information for the Office of the Ombudsman call center is listed on notices for managed care transitions, calls received from FFS beneficiaries may be skewed in reflecting transition-related issues, such as questions about their pending enrollment or whether their FFS provider will be available to them in managed care.

## Results

Between April 2013 and March 2014, the Office of the Ombudsman call center documented a total of 15,643 calls received from FFS Medi-Cal beneficiaries. FFS call volume was noticeably higher for this period than the previous reporting period (12,306 calls for January 2013 to December 2013). Call volume decreased from April to June, and then increased again until August. After September, call volume sharply increased overall, especially in October and December. The increase from June to October, and especially the notable increase from September to October, can likely be attributed to the HFP transition and the expansion of Medi-Cal managed care to 28 counties. The jump from November 2013 to February 2014 and a still high if downward-trending number in March 2014 were likely due to the inaugural open enrollment period for the Medicaid expansion component of the ACA (Figure BF-1). The expansion of Regional/Other managed care models into 20 counties in November also likely contributed to the increase from November to December.

**Figure BF-1:** Calls Received from FFS Medi-Cal Beneficiaries from Quarter 2, 2013, to Quarter 1, 2014, by Month



**Source:** DHCS Research and Analytic Studies Division analyzed FFS calls received from April 2013–March 2014 by the Medi-Cal Managed Care Division’s Office of the Ombudsman call center.

## Call Volume, by Quarter

In the second quarter of 2013, call volume decreased 9.3% from the previous quarter.

For all subsequent quarters in the study period, however, there were increases in call volume. Each quarter's increase was progressively and substantially larger than that of the respective previous quarter. Call volume increased 7.7% during the third quarter of 2013, 36.0% during the fourth quarter of 2013, and 61.2% during the first quarter of 2014. Call volume reached its highest level during February 2014 (Table BF-2).

**Table BF-2:** Number of Calls Received from FFS Medi-Cal Beneficiaries from Quarter 2, 2013 to Quarter 1, 2014, by Quarter

Quarter	Total Calls per Quarter	% Change from Previous Quarter
April–June 2013	2,650	-9.3%
July–Sept. 2013	2,854	7.7%
Oct.–Dec. 2013	3,881	36.0%
Jan.–March 2014	6,258	61.2%

**Source:** DHCS Research and Analytic Studies Division analyzed FFS calls received April 2013–March 2014 by the Medi-Cal Managed Care Division's Office of the Ombudsman call center.

## Modified Call Categories

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

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

Table BF-3 presents these groupings and a description of the codes that fall within each category. The first two categories, Enrollment/Continuity of Care and Provider/Availability issues, are key elements in understanding whether beneficiaries are experiencing access-related problems.

**Table BF-3:** Modified Call Categories

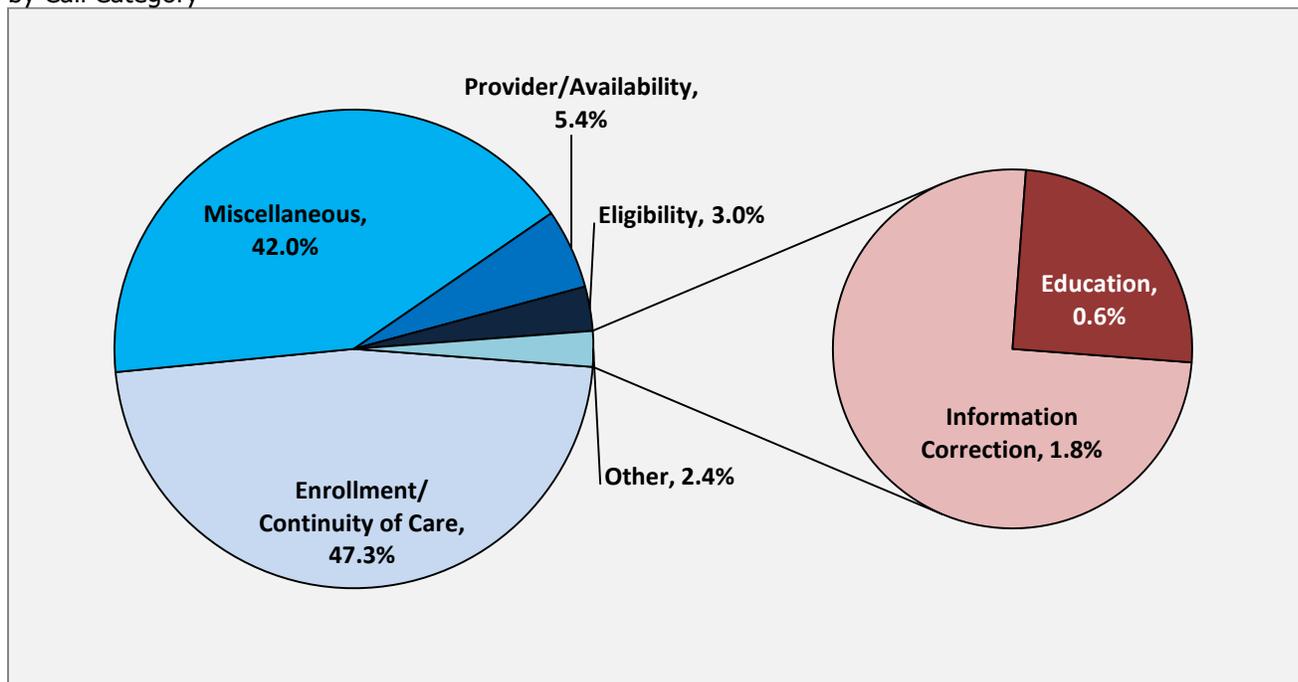
Call Category	Reason for Call
Enrollment/ Continuity of Care	<ul style="list-style-type: none"> <li>• Seeking information about new enrollment into plan</li> <li>• Wanting to change plans or disenroll from managed care</li> <li>• Seeking medical exemptions</li> <li>• Emergency plan disenrollment requests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

**Note:** The modified call categories in the first column were developed based on the reasons for call in the second column, which represent the call codes used by the Medi-Cal Managed Care Division's Office of the Ombudsman.

## Distribution of Calls, by Call Category

Enrollment/Continuity of Care represented 47.3% of calls, while another 42.0% of calls were categorized as Miscellaneous. The remaining 10.8% of calls pertained to Provider/Availability, Eligibility, Information Correction, and Education issues (Figure BF-2).

**Figure BF-2:** Calls Received from FFS Medi-Cal Beneficiaries from Quarter 2, 2013, to Quarter 1, 2014, by Call Category



**Source:** DHCS Research and Analytic Studies Division analyzed FFS calls received from April 2013–March 2014 by the Medi-Cal Managed Care Division’s Office of the Ombudsman call center.

As key elements in understanding whether beneficiaries are experiencing access-related problems, the remainder of this analysis will focus on two call categories: Enrollment/Continuity of Care and Provider/Availability.

## **Distribution of Calls, by Aid Category**

The Medi-Cal aid codes reported by FFS beneficiary callers were collapsed into seven aid code categories. Table BF-4 presents the calls received from FFS beneficiaries based on the primary access issue (Enrollment/Continuity of Care and Provider/Availability) and aid category in which the beneficiary was enrolled.

Of the total calls received, 7,402 were categorized as Enrollment/Continuity of Care, and 841 as Provider/Availability. Patterns of call volume by aid category were somewhat similar between Enrollment/Continuity of Care and Provider/Availability, but not as much as with prior study periods. A plurality of calls for the Enrollment/Continuity of Care call category were received from beneficiaries in the Parent/Caretaker & Child aid category, followed by significant proportions of beneficiaries in the SPD and CHIP aid categories. A plurality of calls for the Provider/Availability call category were received from beneficiaries in the Other aid category, followed by significant proportions of beneficiaries in the Parent/Caretaker & Child and SPD aid categories (Table BF-4).

In general, a large proportion of calls received by the Ombudsman's Office pertained to Enrollment/Continuity of Care issues as compared with Provider/Availability issues. However, among beneficiaries enrolled in Undocumented aid codes, a higher volume of calls pertained to Provider/Availability issues (Table BF-4).

**Table BF-4:** Calls for Enrollment/Continuity of Care and Provider/Availability Issues from Quarter 2, 2013, to Quarter 1, 2014, by Aid Category

Aid Category	Enrollment/Continuity of Care - Calls	Enrollment/Continuity of Care - % of Calls	Provider/Availability - Calls	Provider/Availability - % of Calls
Parent/Caretaker Relative & Child	3,162	42.7%	258	30.7%
SPD	1,473	19.9%	152	18.1%
CHIP	1,440	19.5%	23	2.7%
ACA Expansion Adult - Age 19 to 64	573	7.7%	16	1.9%
Other	377	5.1%	348	41.4%
Adoption/Foster Care	352	4.8%	9	1.1%
Undocumented	25	0.3%	35	4.2%
<b>Total</b>	<b>7,402</b>	<b>100.0%</b>	<b>841</b>	<b>100.0%*</b>

**Source:** DHCS Research and Analytic Studies Division analyzed FFS calls received from April 2013–March 2014 by the Medi-Cal Managed Care Division’s Office of the Ombudsman call center.

\*Percent total for calls regarding Provider/Availability issues do not equal 100.0% due to rounding.

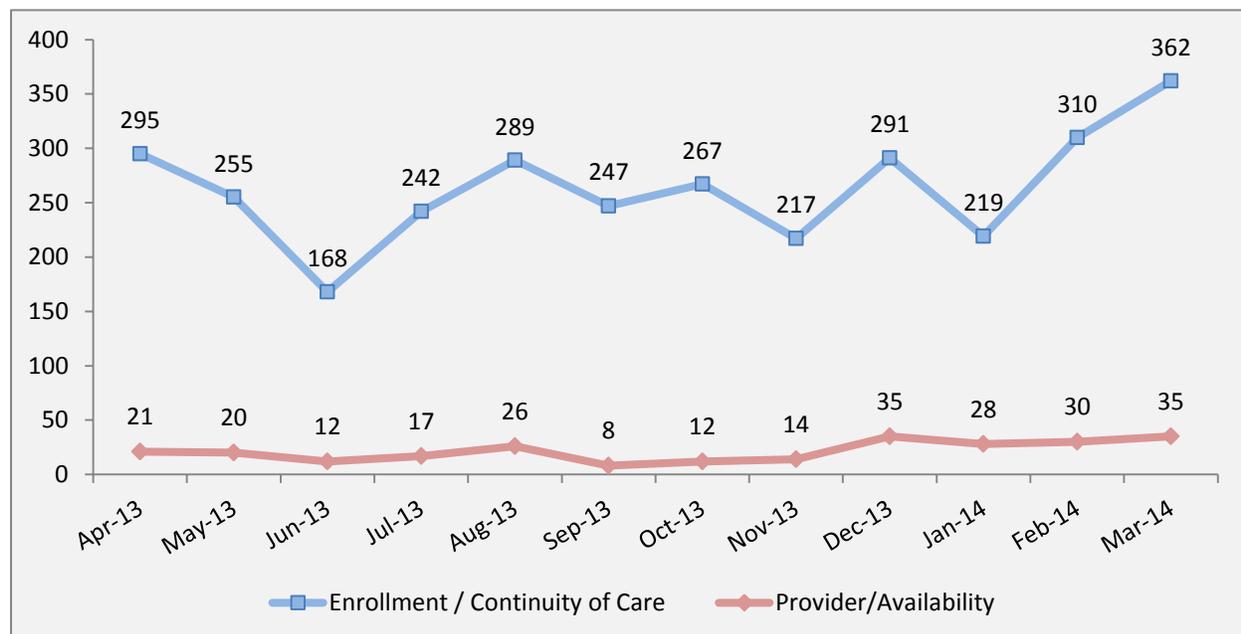
As beneficiaries in Parent/Caretaker Relative & Child and SPD aid codes accounted for the most calls related to Enrollment/Continuity of Care and Provider/Availability issues, the following sections will focus on calls received from beneficiaries in these two aid categories.

## Distribution of Calls from Beneficiaries in Parent/Caretaker Relative & Child Aid Codes, by Call Category

Among FFS beneficiaries enrolled under Parent/Caretaker Relative & Child aid codes, there were numerous fluctuations in the number of calls pertaining to Enrollment/Continuity of Care issues throughout the reporting period. There was a sharp decrease in the number of calls from April to June of 2013 (-127), but the amount of the increase from June to August 2013 (+121) was almost the same. Also, there was a 65.3% increase in calls from January to March 2014. The number of calls peaked in March 2014 (Figure BF-3).

Calls pertaining to Provider/Availability issues were less frequent but mostly stable (Figure BF-3).

**Figure BF-3:** Monthly Call Volume from Beneficiaries in Parent/Caretaker Relative & Child Aid Codes from Quarter 2, 2013, to Quarter 1, 2014, by Call Category



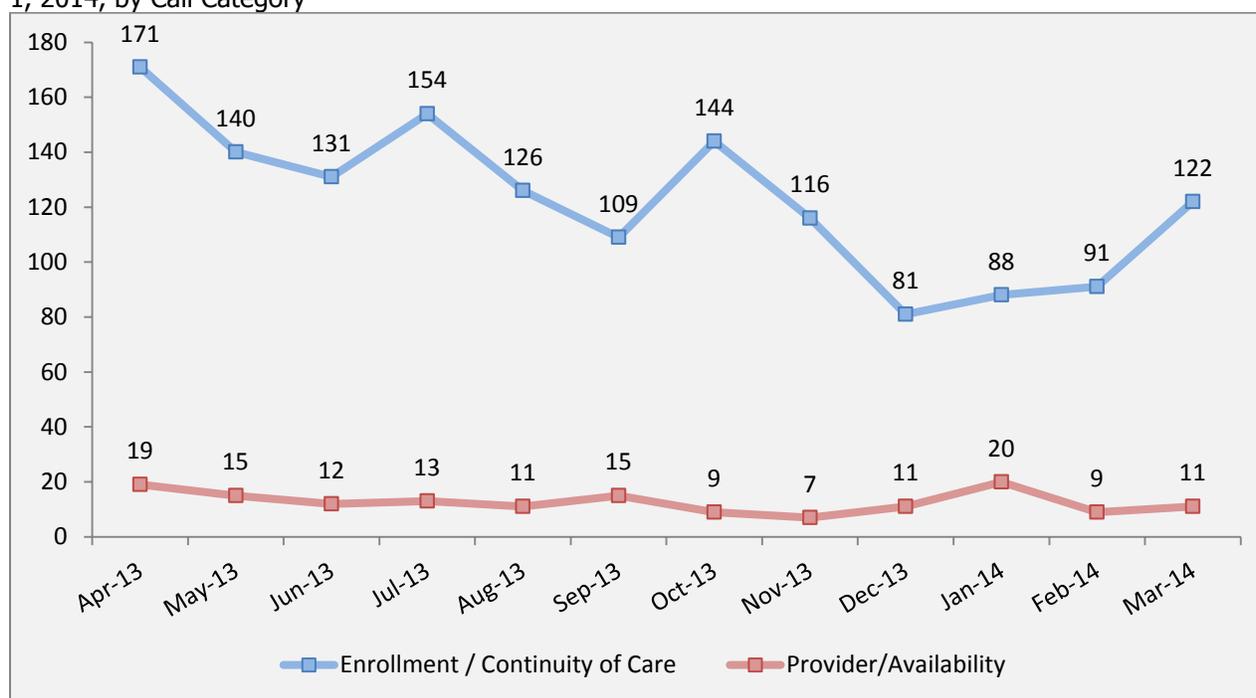
**Source:** DHCS Research and Analytic Studies Division analyzed FFS calls received from April 2013-March 2014 by the Medi-Cal Managed Care Division's Office of the Ombudsman call center.

## Distribution of Calls from Beneficiaries in SPD Aid Codes, by Call Category

Among beneficiaries enrolled under SPD aid codes, the number of calls pertaining to Enrollment/Continuity of Care matters fluctuated but mostly decreased from April to December 2013. There were a few months in that time that calls increased, but those were temporary interruptions to the overall pattern. Calls increased 34.1% from February to March 2014 (Figure BF-4).

Calls pertaining to Provider/Availability issues were infrequent and primarily stable (Figure BF-4).

**Figure BF-4:** Monthly Call Volume from Beneficiaries in SPD Aid Codes from Quarter 2, 2013, to Quarter 1, 2014, by Call Category



**Source:** DHCS Research and Analytic Studies Division analyzed FFS calls received from April 2013–March 2014 by the Medi-Cal Managed Care Division’s Office of the Ombudsman call center.

## Reason for Call

To further investigate calls received from FFS beneficiaries, the top reasons for calls under each call category were identified. Among beneficiaries enrolled under Parent/Caretaker Relative & Child aid codes, 89.3% of calls categorized as Enrollment/Continuity of Care pertained to requests for new enrollment. Another 2.9% of Enrollment/Continuity of Care calls were regarding Adoption/Foster Care disenrollment exemption requests (Table BF-5).

Additionally, 89.9% of the calls categorized under Provider/Availability related to the termination of Medi-Cal eligibility. Calls related to beneficiaries being billed for services accounted for 4.7% of calls. Another 1.9% concerned refusal of medications (Table BF-5).

**Table BF-5:** Top Four Reasons for Calls from Beneficiaries in Parent/Caretaker Relative & Child Aid Codes from Quarter 2, 2013 to Quarter 1, 2014

Reason for Call	# of Calls*	% of All Calls in Category*
<b>Enrollment/Continuity of Care (n=3,162)</b>		
Requesting New Enrollment into Plan	2,824	89.3%
Foster Care/Adoption Disenrollment Exemption Request	92	2.9%
Hold on Plan	57	1.8%
Wants to Disenroll from Plan and Enroll in FFS	40	1.3%
<b>Provider/Availability (n=258)</b>		
Medi-Cal Eligibility Terminated	232	89.9%
Beneficiary Being Billed	12	4.7%
All Other Reasons	9	3.5%
Refusal of Medications	5	1.9%

**Source:** DHCS Research and Analytic Studies Division analyzed FFS calls received from April 2013–March 2014 by the Medi-Cal Managed Care Division’s Office of the Ombudsman call center.

\* Percentages and call counts are based on all calls received during the study period. Only the top four call subcategories are displayed here, so percentages and totals will not sum to 100.0%.

Among beneficiaries enrolled under SPD aid codes, 66.4% of the calls categorized as Enrollment/Continuity of Care involved callers requesting new enrollment. Calls regarding requests to disenroll from managed care plans and become a FFS participant accounted for 10.0% of these calls, while 8.2% related to medical exemption requests or emergency disenrollment exemption requests, and 2.9% pertained to long-term care issues (Table BF-6).

Additionally, of the calls categorized under Provider/Availability, 80.2% involved termination of Medi-Cal eligibility, 12.1% were from beneficiaries who were erroneously billed for services, 11.2% pertained to refusal of medication, and 6.0% were regarding denial or delay of prior authorization (Table BF-6).

**Table BF-6:** Top Four Reasons for Calls from Beneficiaries in SPD Aid Codes from Quarter 2, 2013, to Quarter 1, 2014, by Call Category

Reason for Call	# of Calls*	% of All Calls in Category*
<b>Enrollment/Continuity of Care (n=1,187)</b>		
Requesting New Enrollment into Plan	978	66.4%
Wants to Disenroll from Plan to Become FFS	147	10.0%
Status Checks on Medical Exemptions and Emergency Disenrollments	121	8.2%
SPD Long-Term Care Issues	43	2.9%
<b>Provider/Availability (n=116)</b>		
Medi-Cal Eligibility Terminated	93	80.2%
Beneficiary Being Billed	14	12.1%
Refusal of Medications	13	11.2%
Prior Authorization Denial/Delay	7	6.0%

**Source:** DHCS Research and Analytic Studies Division analyzed FFS calls received from April 2013–March 2014 by the Medi-Cal Managed Care Division's Office of the Ombudsman call center.

\* Percentages and call counts are based on all calls received during the study period. Only the top four call subcategories are displayed here, so percentages and totals will not sum to 100.0%.

## Conclusions

- Between April 2013 and March 2014, the Medi-Cal Managed Care Division's Office of the Ombudsman call center staff documented 15,643 calls from FFS Medi-Cal beneficiaries. Call volume during this 12-month period was approximately 27% higher than it was from January 2013 to December 2013.
- 47.3% of calls pertained to Enrollment/Continuity of Care issues. Another 42.0% were categorized under Miscellaneous. Due to the ambiguity of Miscellaneous calls, they were not further analyzed. The focus of this analysis was on calls related to Enrollment/Continuity of Care and Provider/Availability issues, as these key elements help identify access-related problems experienced by beneficiaries.
- Call volume increased in each quarter of the study period. Each quarter's increase was progressively and substantially larger than that of the respective previous quarter.
- Among calls categorized as Enrollment/Continuity of Care, a large majority of calls were from FFS beneficiaries enrolled under Parent/Caretaker Relative & Child, SPD, and CHIP aid codes.
- Among calls categorized as Provider/Availability, a large majority of calls were from FFS beneficiaries enrolled under Other, Parent/Caretaker Relative & Child, and SPD aid codes.
- Callers enrolled under Parent/Caretaker Relative & Child aid codes were primarily interested in requesting new enrollment. Other Enrollment/Continuity of Care matters important to these callers included Adoption/Foster Care disenrollment exemption requests, and holds on plans. These callers also sought information regarding the termination of their Medi-Cal eligibility, being billed erroneously for services, and refusal of medications.
- Callers enrolled under SPD aid codes were primarily interested in requesting new enrollment. These callers also called about disenrollment from managed care, status checks on medical exemptions and emergency disenrollment exemptions, and long-term care issues. Other reasons for these calls included termination of Medi-Cal eligibility, being billed erroneously for services, refusal of medication, and prior authorization denial or delay.