



**Medi-Cal Fee-for-Service  
Access to Care  
Quarterly Monitoring Report #9  
2013 Quarter 4**

**Executive Summary**

**February 2015**

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## Abstract

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

Medi-Cal's assessment of health care access for the fourth quarter of 2013 disclosed that for the most part participation trends, provider supply, and service utilization rates were within expected ranges. Key findings regarding these study areas are summarized below.

## Key Findings

- Overall findings indicate that the statewide supply of physicians potentially available to FFS full-scope Medi-Cal Only beneficiaries continued to grow modestly during the study period. For instance, the site-specific overall physician supply, or total physicians at distinct locations, increased 3.2%, from 77,787 to 80,272. Physician specialists such as primary care, Obstetrics and Gynecology (OB/GYN), and Pediatricians also experienced modest growth.
- Overall, the number of FFS Medi-Cal Only beneficiaries entitled to full-scope benefits decreased 18.4% from the first quarter of 2013 to the fourth quarter of 2013, from 1,197,881 to 977,547 average monthly eligibles. The participation of FFS Medi-Cal Only beneficiaries entitled to full-scope benefits decreased 15.8% between the third quarter of 2013 and the fourth quarter of 2013.
- Starting with this report, baseline statistics — or benchmarks — were recalculated to reflect dates of service for January 1, 2011, to December 31, 2012. The newly established baseline slightly impacted utilization trends exhibited by children and adults in various aid categories. In particular, the utilization of particular services exhibited by children and adults in the Undocumented aid category, which reached outside of the baseline limits in prior reports, fell within the expected ranges of the new baseline.
- Beneficiaries participating in FFS continue to call into the DHCS Medi-Cal Managed Care Division's Office of the Ombudsman for assistance. Between January 2013 and December 2013, the Office of the Ombudsman documented a total of 12,306 calls received from Medi-Cal FFS beneficiaries, which marks a noticeable increase in call volume from the previous reporting period. The increase in call volume in 2013 likely reflects the transition of children from the Healthy Families Program into Medi-Cal that began January 1, 2013, as well as the establishment of a County Organized Health System in eight counties during September 2013 and Regional/Other managed care models in 20 counties during November 2013.

## Introduction

DHCS is directly responsible for ensuring access to health care services for beneficiaries enrolled in the FFS delivery system, where the Medi-Cal program serves as the primary source of coverage. This report is the ninth in a series of quarterly reports analyzing health care access for FFS Medi-Cal Only<sup>1</sup> beneficiaries. The information presented in this report serves as an early-warning mechanism for alerting State administrators to potential barriers to accessing FFS Medi-Cal services.

This report covers the fourth quarter of 2013, and presents data from the three previous quarters for comparison purposes. This 2013 Quarter 4 Access to Care Monitoring Report presents the following four specific early warning measures:

- Physician Supply
- Medi-Cal Beneficiary Participation
- Service Utilization per 1,000 Member Months
- Beneficiary Helpline Feedback

## 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 Program services.<sup>2,3,4</sup>

### Medi-Cal Enrollment Transitions

**Expansion of Medi-Cal Managed Care** – Several subpopulations transitioned from the Fee-for-Service (FFS) health delivery system into managed care plans during the study period. For instance, 81,488 FFS Medi-Cal Only beneficiaries 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

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<sup>1</sup> The term “Medi-Cal Only” refers to individuals eligible for Medi-Cal but not Medicare.

<sup>2</sup> California Assembly Bill 97, (2011).

<sup>3</sup> California Department of Health Care Services, Implementation of AB97 Reductions. Retrieved from <http://www.dhcs.ca.gov/Documents/AB97ImplementationAnnouncemen081413.pdf>

<sup>4</sup> California Department of Health Care Services, State Plan Amendment, SPA 11-009.

FFS Medi-Cal beneficiaries enrolled into 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 ES-1).

**Table ES-1:** FFS Medi-Cal Only Beneficiaries Shifting 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>
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>Total = 247,268</b>

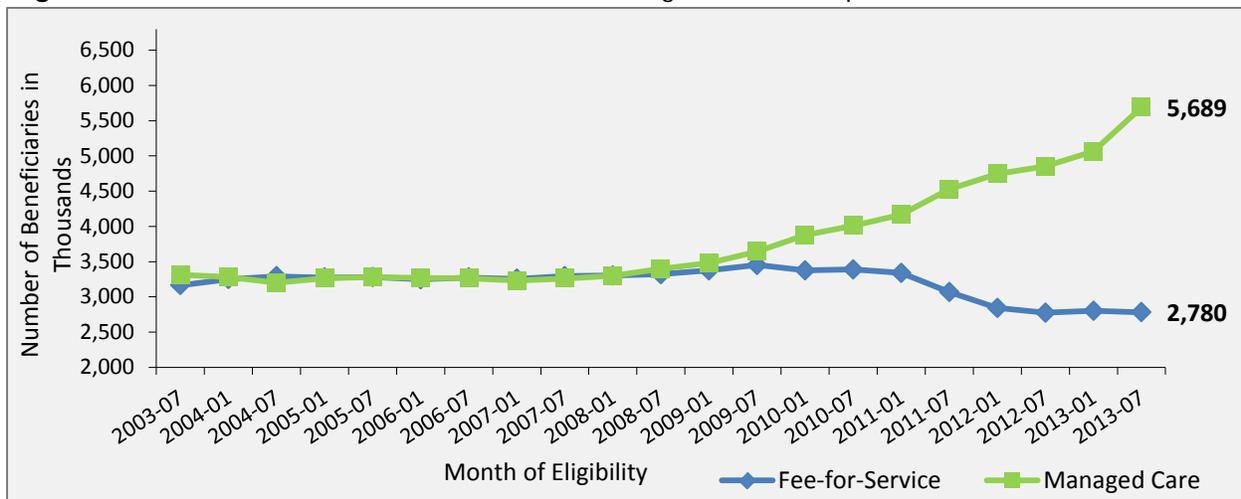
**Source:** Created by DHCS Research and Analytic Studies Division using data from the Medi-Cal Eligibility Data System-Monthly Medi-Cal Eligibility Files (MEDS-MMEF) for October 2013. Data reflect a four-month reporting lag.

**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 delivery system until the date of their annual eligibility review for Medi-Cal. These children with presumptive eligibility under the FFS delivery system are classified under the Other aid category in this report. FFS 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.

## Medi-Cal Program Composition

The continued transition of beneficiaries from FFS to managed care has greatly impacted the composition of the overall Medi-Cal program (Figure ES-1).

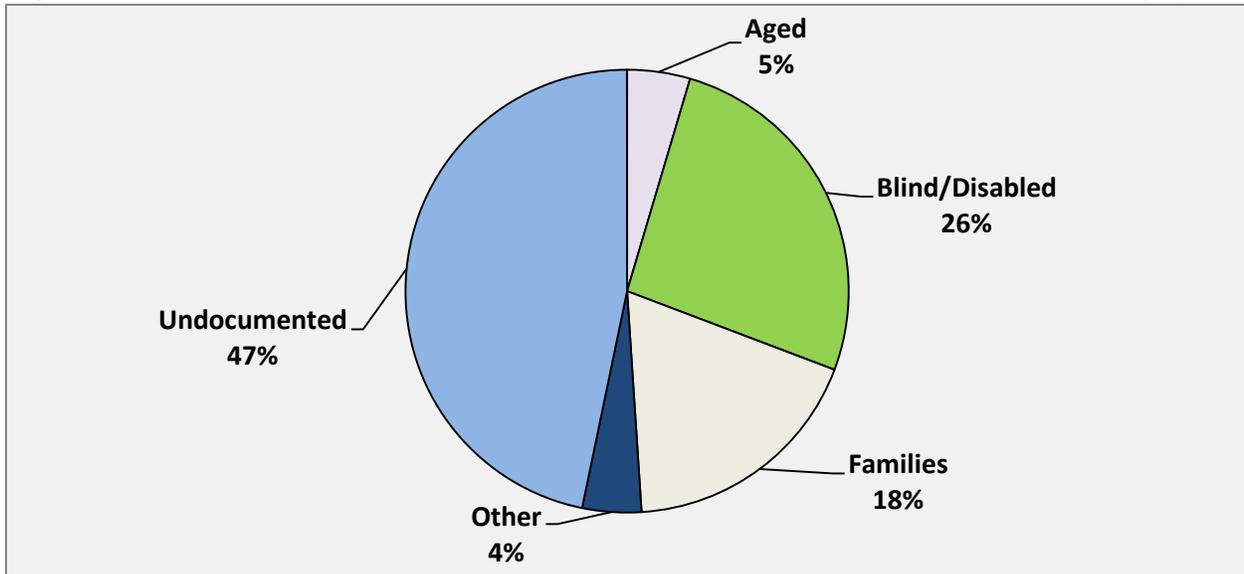
**Figure ES-1:** Trend in Biannual Medi-Cal FFS vs. Managed Care Participation, 2004–2013



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

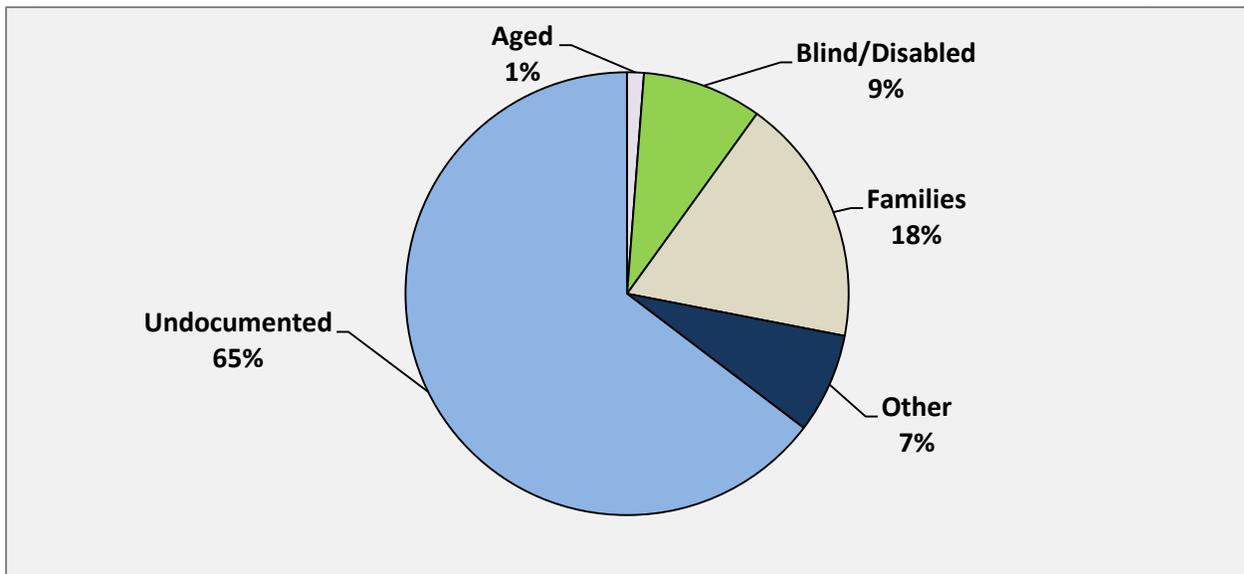
As beneficiaries are transitioned from FFS to managed care, the size and case mix of subpopulations evaluated in this report are altered. For instance, the proportion of the adult FFS Medi-Cal Only population enrolled in Undocumented aid codes constituted 47% of the population in January 2011 but represented 65% by December 2013 (Figures ES-2, ES-3).

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



**Source:** Created by DHCS Research and Analytic Studies Division using data from the Management Information System/Decision Support System (MIS/DSS) eligibility tables for January 2011. Data were extracted from the MIS/DSS four months after the corresponding time period to allow for updates to enrollment.

**Figure ES-3:** Distribution of Adult FFS Medi-Cal Only Population in Quarter 4, 2013, by Aid Category



**Source:** Created by DHCS Research and Analytic Studies Division using data from the Management Information System/Decision Support System (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.

As counties transition from FFS to managed care delivery systems, beneficiaries who remain in FFS and the service utilization associated with FFS member months tend to be either those exempt from managed care participation, those initially eligible for Medi-Cal but not yet established in a plan, or those with months of eligibility occurring retroactively.<sup>5</sup>

Beneficiaries exempt from managed care participation through the medical exemption process generally exhibit health care needs greater than the norm. As a result, these individuals will generate higher-than-average service utilization rates. Similarly, beneficiaries new to the Medi-Cal program may use services at particularly high rates during their initial months of participation. Utilization of services occurring during retroactive months of eligibility tends to display significantly different patterns than services used during timely enrollment. Services used during the retroactive period are most likely associated with inpatient acute care services. If a particular county shifts from FFS to a managed care delivery system, service utilization associated with the remaining FFS population will exhibit patterns that, in many cases, deviate significantly from the pre-shift FFS population.

An additional consequence of the declining number of beneficiaries participating in the FFS delivery system is the impact it leaves on service utilization rates solely due to the reduction in the denominator. When the denominator – or count of beneficiaries – declines significantly from one month to the next, service utilization rates may exhibit significant variation or wide swings above or below normal ranges. Additionally, if the denominator of a subpopulation declines below a particular threshold, any corresponding rates will become unstable.

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<sup>5</sup> Individuals applying for Medi-Cal in a given month may request retroactive coverage for unpaid medical expenses for three months prior to the month of application if the individual was otherwise eligible for Medi-Cal coverage during those three months. (22 CCR 50197 Retroactive Eligibility)

## Findings

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

### Physician Supply

This measure used site-specific physician counts as the primary provider supply metric. Site-specific physician counts are system-wide metrics designed to alert Department management to changes in the number of providers and provider sites over time. Much like an internal control, this metric was designed to identify system-wide trends that may adversely impact access to health care services in the future. Continuously monitoring these trends provides useful early-warning signs that adverse changes may be materializing (e.g., the number of enrolled Medi-Cal physicians is declining) or that the supply of physicians has been stable over time.

In addition, DHCS calculated the ratio of beneficiaries to physicians, both statewide and by county. 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. Beneficiary-to-provider ratios are useful for identifying differences in physician supply from one geographic area to another, from one measurement period to another, or between the study population and another population or normative benchmark.

The total number of physicians increased 3.2%, from 77,787 to 80,272. The aggregate number of primary care physicians increased 2.9%, from 40,737 to 41,917. Similarly, the total of physicians with specialties in Obstetrics and Gynecology (OB/GYN) and Pediatrics also slightly increased during the study period. The statewide beneficiary-to-physician ratios for FFS full-scope Medi-Cal Only beneficiaries showed no significant change during the study period.

This report's findings showed no deterioration in overall physician supply for FFS Medi-Cal Only beneficiaries over the four quarters studied, but did disclose differences among regions of the state. In general, the primarily rural counties using the FFS model reported the lowest physician supply relative to the target population.

In the 2013 Quarter 3 Access to Care Monitoring Report, DHCS evaluated and refined the criteria used to classify primary care physicians, including OB/GYNs and Pediatricians. While not impacting the count of total physicians overall, this revision in methodology resulted in an increase in the number of primary care physicians reported. Historical trending of available primary care physicians can only be conducted starting with the revised counts presented in the 2013 Quarter 3 Access to Care Monitoring Report.

## Beneficiary Participation

Overall, the number of FFS Medi-Cal Only beneficiaries entitled to full-scope beneficiaries decreased 18.4% from the first quarter of 2013 to the fourth quarter of 2013, from 1,197,881 to 977,547 average monthly eligibles. Participation also decreased 15.8% between the third quarter of 2013 and the fourth quarter of 2013, most likely due to the COHS expansion during September 2013.

Decreases in FFS participation among FFS Medi-Cal Only beneficiaries, both adults and children, occurred in the Families, Blind/Disabled, and Undocumented aid categories; and for children in the Foster Care and Other aid categories. The decrease in participation among beneficiaries in the Families and Blind/Disabled aid categories is likely due to the COHS expansion in September 2013 and regional managed care expansion in November 2013.

In contrast, increases in FFS participation among FFS Medi-Cal Only adult beneficiaries were seen in the Other and Aged aid categories.

A majority of counties (53) saw a decrease in FFS participation, with Del Norte County representing the greatest decrease. Five counties saw an increase in FFS participation. Four counties experienced less than one percentage point change in either direction over the 12-month study period.

Participation trends for Medi-Cal's FFS population were very different between metropolitan and non-metropolitan areas from the first quarter to the fourth quarter of 2013. The most significant difference was the decrease in participation among both adults and children in all aid categories in non-metropolitan areas, ranging from -4.2% to -75.9%. While metropolitan areas also experienced decreases for most ages and aid categories, adults saw increases in the Other and Aged aid categories.

FFS Medi-Cal participation among children in Undocumented aid codes residing in both metropolitan (-7.6%) and non-metropolitan (-6.5%) areas declined during the study period.

Unlike the populations discussed previously, shifts in system participation from FFS to managed care were not responsible for the reductions recognized in the Undocumented subpopulation, as these beneficiaries are not eligible to participate in Medi-Cal managed care plans.

## Service Utilization

### Recalculation of Baseline Levels for this Report

The DHCS access monitoring system required the development of baseline statistics for trend comparisons on Medi-Cal service utilization. Since the establishment of the original baseline period of 2007-2009, Medi-Cal has undergone dramatic changes spurred by a deep economic recession and continual efforts to restructure the program's health care delivery system. In some cases, these changes dramatically affected Medi-Cal's FFS population, thus impacting how beneficiaries receive services. As a result, the baseline metrics that were established during Medi-Cal's transformational period may not always reflect the new reality. Therefore, starting with this report, the baseline statistics — or benchmarks — have been recalculated to reflect dates of service between January 1, 2011 and December 31, 2012. This updated baseline period will enable DHCS to more effectively analyze present service use.

The DHCS quarterly access monitoring effort incorporates measures of service utilization, or realized access. While determining physician supply and potential access trends is an integral part of evaluating access, considering what is actually occurring regarding beneficiaries' service use is vitally important in assessing such a multifaceted concept as access.

Evaluating service utilization across all Medi-Cal provider types is an essential component of the quarterly monitoring effort. DHCS grouped all provider types into 10 unique service categories:

1. Physician/Clinics
2. Emergency Transportation
3. Non-Emergency Transportation
4. Home Health
5. Hospital Inpatient
6. Hospital Outpatient
7. Nursing Facility
8. Pharmacy
9. Other
10. Radiology

DHCS constructed control charts for each service category based on historical service utilization patterns, and established the mean value as well as upper and lower bounds. The unit of measurement represents the service utilization rate per 1,000 member months. For example, Physician/Clinic services are measured in terms of visits per 1,000 member months, while Pharmacy services are measured in prescriptions per 1,000 member months. In general, service utilization rates found within the upper and lower bounds were considered to be within expected ranges.

Several factors can impact service utilization. These factors include but are not limited to: birth trends; population case mix; Medi-Cal program changes; and the transition of beneficiaries from FFS into managed care. Influential factors that occurred during the study period include the expansion of COHS and Regional/Other managed care models, as well as the HFP transition. The shifts in utilization observed in this report may be attributable to a combination of the factors noted above.

The key findings for both children and adults are as follows:

### **Children Ages 0–20**

- Overall, service utilization patterns for children in most aid categories primarily followed the patterns identified in the previous quarterly access report. For example, utilization rates for children enrolled in Foster Care aid codes were again found to be within expected ranges across all analyzed service categories. Additionally, children in the Blind/Disabled aid category continued to place a disproportionate demand on services of all kinds.
- Children in the Other aid category continued to exhibit utilization in several service categories (e.g., Emergency Medical Transportation, Hospital Inpatient, Hospital Outpatient, Pharmacy, Physician/Clinic, and Radiology) that mostly fell below either the average rates or the expected ranges established during the baseline period. Of particular note, this population's utilization of Emergency Transportation, Radiology, Pharmacy, and Physician/Clinic services noticeably declined below the expected ranges starting in February 2013.
- The newly established baseline impacted utilization trends exhibited by children in the Undocumented aid category. For instance, this subpopulation's utilization of Other and Physician/Clinic services, which reached outside of the baseline limits in prior reports, fell within the expected ranges of the new baseline.
- As beneficiary participation shifted away from the FFS delivery system and into managed care, many service categories (e.g., Non-Emergency Transportation, Home Health, and Nursing Facility Services) again experienced a noticeable decrease in user counts that made the data unsuitable for analysis.

### **Adults Ages 21 and Older**

- As noted in the previous access quarterly reports, adults in the Blind/Disabled aid category continued to place a higher demand on Emergency Transportation, Hospital Outpatient, Non-Emergency Transportation, Nursing Facility, Physician/Clinic, and Radiology services.
- Adults in the Families aid category continued to display below-average utilization of Emergency Transportation and Hospital Inpatient services, as well as a downward trend in Physician/Clinic visits throughout most of the study period.
- The newly established baseline slightly impacted utilization trends exhibited by adults in various aid categories. In particular, adults enrolled in Undocumented aid codes exhibited utilization rates in several service categories (e.g., Emergency Transportation, Hospital Outpatient, Other, and Physician/Clinic) that reached outside of the baseline limits in prior reports but fell within the expected ranges of the new baseline.

- Adults in all analyzed aid categories exhibited Other services utilization that mostly fell below either the average rates or the expected ranges established during the baseline period.

The continued decline in Medi-Cal's FFS population, which is a result of the transition of Medi-Cal beneficiaries into managed care plans, has directly reduced the pool of users for particular services. For instance, the number of adults in Aged and Families aid categories that utilize Non-Emergency Transportation and Home Health services have declined to levels (<500) that render their use of these service categories inconsequential to the current analysis. The beneficiary subpopulations that continue to use these service categories exhibited utilization patterns at above-average rates that often fell above the expected ranges.

Tables ES-2 and ES-3 present the results of the analysis of utilization trends among children and adults, by aid and service categories. The tables are color-coded to identify those cases when a particular cell, which presents utilization by aid and service categories, generated a utilization rate that was either lower or higher than the established confidence interval.

- Beige – Represents utilization rates found to be within the expected confidence intervals.
- Green – Represents utilization rates found to be outside of the expected confidence intervals.

In some cases, the utilization rate was found to be greater than expected. As noted above, there are a number of reasons why this might occur, such as changes in population mix.

**Table ES-2:** Summary of Service Utilization Trends among FFS Medi-Cal Children Ages 0–20, by Aid Category and Service Category<sup>6,7</sup>

	Physician/ Clinic Services	Emergency Medical Transportation Services	Home Health Services	Hospital Inpatient Services	Hospital Outpatient Services	Pharmacy Services	Other Services	Radiology Services
<b>Blind/ Disabled Aid Category</b>	Mostly Above Average and Within Expected Range.	Mostly Within Expected Range.	Above Expected Range.	Mostly Within Expected Range.	Within Expected Range.	Within Expected Range.	Mostly Within Expected Range.	Mostly Within Expected Range.
<b>Families Aid Category</b>	Mostly Within Expected Range.	Mostly Within Expected Range.	N/A	Mostly Above Average with 6 Consecutive Months Above Expected Range (Jul 2013–Dec 2013). <sup>8</sup>	Mostly Within Expected Range.	Several Months Below Expected Range. Downward Trend (Jan 2013–Jun 2013).	Mostly Within Expected Range.	Mostly Within Expected Range.
<b>Foster Care Aid Category</b>	Mostly Within Expected Range.	Mostly Above Average and Mostly Within Expected Range.	N/A	Mostly Within Expected Range.	Within Expected Range.	Within Expected Range.	Within Expected Range.	Within Expected Range.
<b>Other Aid Category</b>	Below Average with 6 Consecutive Months Below Expected Range (Feb 2013–Jul 2013).	Mostly Below Expected Range.	Mostly Below Average and Within expected Range.	Mostly Below Expected Range Prior to July 2013 Admin Change. <sup>vii</sup>	Mostly Below Expected Range.	Mostly Below Expected Range. Downward Trend (Feb 2013–Jun 2013).	Mostly Below Average and Mostly Within Expected Range.	Mostly Below Expected Range.
<b>Undoc- umented Aid Category</b>	Above Average and Mostly Within Expected Range.	Within Expected Range.	N/A	6 Consecutive Months Above Expected Range (Jul 2013–Dec 2013). <sup>vii</sup>	Mostly Above Average and Mostly Within Expected Range.	Mostly Within Expected Range. Downward Trend (Jan 2013–Jun 2013).	Mostly Below Average and Mostly Within Expected Range.	Mostly Above Average and Mostly Within Expected Range.

<sup>6</sup> Children were excluded from analyses of Non-Emergency Medical Transportation and Nursing Facility services utilization due to low user counts (n<500).

<sup>7</sup> Subpopulation user counts can be found in corresponding figures located in the Service Utilization measure.

<sup>8</sup> Within expected range prior to July 2013 admin change which generated claims for infants previously billed on mother’s claim. Months shown as above expected range reflect a change in reporting and not a change in utilization

**Table ES-3:** Summary of Service Utilization Trends among FFS Medi-Cal Adults Ages 21 and Older, by Aid Category and Service Category<sup>9</sup>

	Physician/ Clinic Services	Non-Emergency Transportation Services	Emergency Medical Transportation Services	Home Health Services Services	Hospital Inpatient Services	Hospital Outpatient Services	Nursing Facility Services	Pharmacy Services	Other Services	Radiology Services
<b>Aged Aid Category</b>	Mostly Within Expected Range. Slight Downward Trend (July 2013–December 2013).	N/A	N/A	N/A	Above Average with Five Months Above Expected Range.	Within Expected Range.	Above Expected Range.	Below Expected Range.	Mostly Below Expected Range.	Mostly Above Expected Range.
<b>Blind/ Disabled Aid Category</b>	Above Average with Three Consecutive Months Above Expected Range (Mar 2013–May 2013).	Mostly Above Expected Range.	Mostly Above Average and Mostly Within Expected Range.	Above Average and Above Expected Range.	Mostly Within Expected Range.	Above Average with Several Non- Consecutive Months Above Expected Range	Above Expected Range.	Mostly Below Average and Mostly Within Expected Range.	Mostly Below Average and Mostly Within Expected Range.	Mostly Above Expected Range.
<b>Families Aid Category</b>	Mostly Within Expected Range. Downward Trend (July 2013–December 2013).	N/A	Mostly Below Average and within Expected Range.	N/A	Mostly Below Average with Several Months Below Expected Range.	Mostly Within Expected Range.	N/A	Below Average with 4 Consecutive Months Below Expected Range (Sep 2013–Dec 2013).	Mostly Below Average and Mostly Within Expected Range.	Mostly Within Expected Range.
<b>Other Aid Category</b>	Within Expected Range.	Above Average with Five Consecutive Months Above Expected Range (Apr 2013–Aug 2013).	Mostly Below Average and Mostly Within Expected Range.	N/A	Mostly Below Expected Range.	Within Expected Range.	Below Average and Mostly Below Expected Range.	Below Average and Mostly Within Expected Range.	Mostly Below Average and Within Expected Range.	Within Expected Range.
<b>Undoc- umented Aid Category</b>	Within Expected Range.	N/A	Within Expected Range.	N/A	Mostly Below Expected Range.	Mostly Above Average and Within Expected Range.	N/A	Within Expected Range.	Mostly Below Average and Mostly Within Expected Range.	Mostly Above Average and Within Expected Range.

<sup>9</sup> Subpopulation user counts can be found in corresponding figures located in the Service Utilization measure.

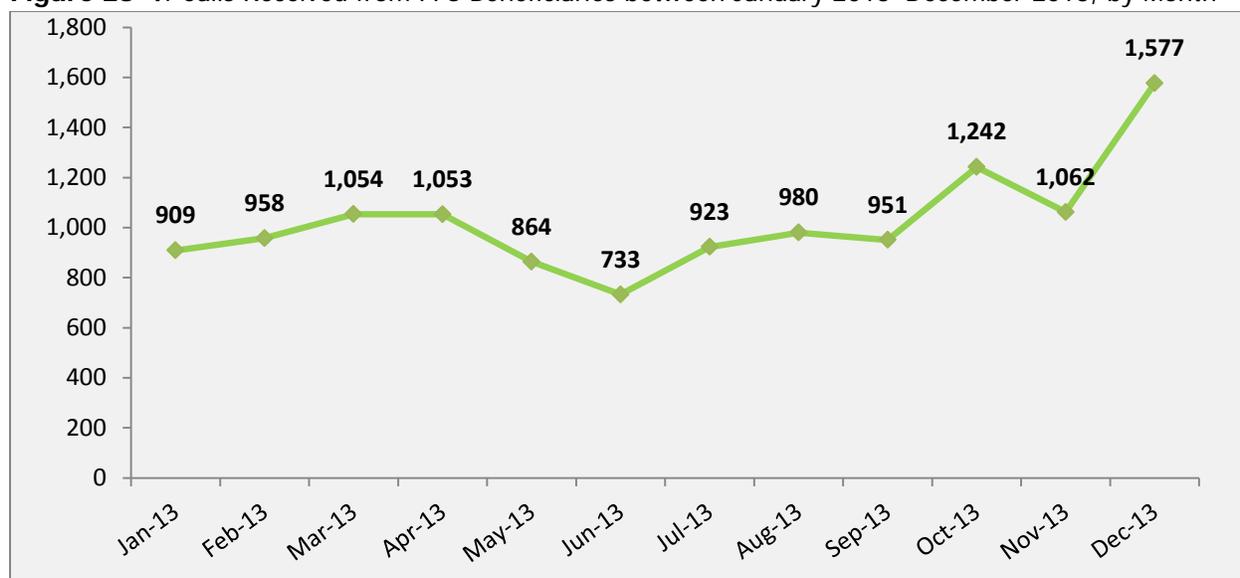
## Beneficiary Feedback

The rate at which FFS Medi-Cal beneficiaries contact the help line for information and complaints provides DHCS with one measure of how well the program is meeting the needs of its FFS beneficiaries and solving problems when they arise.

DHCS relies on data obtained from the Office of the Ombudsman for the purpose of monitoring health care access. Between January 2013 and December 2013, the Office of the Ombudsman documented a total of 12,306 calls received from FFS Medi-Cal beneficiaries. For each of these calls, the call center recorded the date and time of the call, beneficiary aid category, county of residence, and reasons for the call. Data for these calls were summarized by month received, six aid category groupings (Families, Blind/Disabled, Aged, Foster Care, Undocumented, and Other), and reason for call.

FFS call volume was noticeably higher for this period than during the previous reporting period (10,633 calls from October 2012 to September 2013). Call volume gradually increased from January to March, decreased from April to June, and then increased again until August. After September, call volume sharply increased overall, especially in October and December. Additionally, the increase in call volume from July to September 2013 likely reflects the expansion of COHS and Regional managed care, as well as the final phase of the HFP transition (Figure ES-4).

**Figure ES-4:** Calls Received from FFS Beneficiaries between January 2013–December 2013, by Month



**Source:** DHCS Research and Analytic Studies Division analyzed FFS calls received January 2013–December 2013 by the Office of the Ombudsman, Medi-Cal Managed Care Division.