



**Medi-Cal Fee-for-Service
Access to Care
Quarterly Monitoring Report #10
2014 Quarter 1**

Executive Summary

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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 help line feedback.

DHCS' assessment of health care access for the first quarter of 2014 coincides with the implementation of the Affordable Care Act (ACA), which brought millions of new beneficiaries into the Medi-Cal program. While this new population is required to enroll in managed care health plans, many enter the Medi-Cal system through FFS and remain in FFS until their health plan selection is complete. As a result, this large influx of new eligibles temporarily participating in FFS altered the size and case mix of the subpopulations evaluated in this report. The ACA's impact on the FFS Medi-Cal subpopulation is noticeable in each of the measures presented in this report. Key findings of this report are summarized below.

Key Findings

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 Healthy Families Program (HFP) into Medi-Cal throughout 2013 and the implementation of the Affordable Care Act (ACA) in January 2014.

- 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 3.8% from the second quarter of 2013 to the first quarter of 2014. Physician specialists such as primary care, Obstetrics and Gynecology, and Pediatricians also experienced similar growth.
- Overall, the number of FFS Medi-Cal Only beneficiaries entitled to full-scope benefits increased 33.7% from the second quarter of 2013 to the first quarter of 2014, from 1,193,739 to 1,596,228 average monthly eligibles. The participation of FFS Medi-Cal Only beneficiaries entitled to full-scope benefits increased 62.6% between the fourth quarter of 2013 and the first quarter of 2014, in large part due to the implementation of the ACA in January 2014.
- As a result of the new aid categories, it was necessary to update the service utilization baseline data to reflect the redefined groupings. Service utilization patterns for Quarter 1, 2014 in most aid categories primarily fell within the expected ranges of the updated baseline. Some shifts in utilization were observed in this report and may be attributable to a change in population case mix as a result of the continued expansions in Medi-Cal managed care and the transition of the HFP population in 2013. In particular, the utilization of Radiology services in most of the analyzed aid categories reached above the expected ranges.
- Beneficiaries participating in FFS continue to call into the DHCS Medi-Cal Managed Care Division's Office of the Ombudsman for assistance. Between April 2013 and March 2014, the Office of the Ombudsman documented a total of 15,643 calls received from FFS Medi-Cal beneficiaries, which marks a noticeable increase in call volume from the previous reporting period. The increase in call volume during the study period likely reflects the expansion of County Organized Health Systems and Regional/Other managed care, the final phase of the Healthy Families Program transition, as well as the ACA implementation during January 2014.

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 10th in a series of quarterly reports analyzing health care access for FFS Medi-Cal Only¹ 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 first quarter of 2014, and presents data from the three previous quarters for comparison purposes. This Quarter 1 2014 Access to Care Monitoring Report presents the following four specific early-warning measures:

- Physician Supply;
- Medi-Cal Beneficiary Participation;
- Service Utilization Rates per 1,000 Member Months; and
- Beneficiary Help Line 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.^{2,3,4}

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)

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

² California Assembly Bill 97, (2011).

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

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

without dependent children.⁵ 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 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 FFS Medi-Cal Only 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
			Subtotal = 81,488
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

⁵ 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.

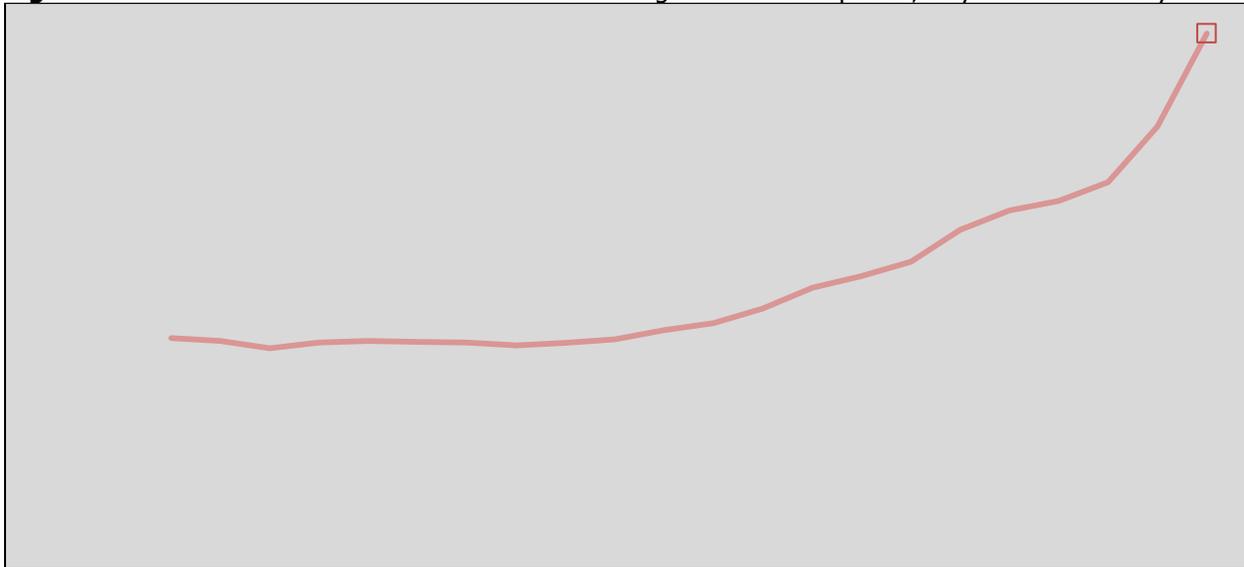
Managed Care Plan Type	Month of Transition	Transition Counties	Approximate Number of Medi-Cal Only Beneficiaries
Regional/Other	November 2013	Inyo	1,977
Regional/Other	November 2013	Mariposa	1,669
Regional/Other	November 2013	Mono	945
Regional/Other	November 2013	Nevada	6,764
Regional/Other	November 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
			Subtotal = 165,780
			Total = 247,268

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 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.

Medi-Cal Program Composition

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

Figure ES-1: Trend in Biannual FFS Medi-Cal vs. Managed Care Participation, July 2003 to January 2014

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 with dates of eligibility from July 2013–January 2014. 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 and new beneficiaries are added with the implementation of the ACA, the size and case mix of subpopulations evaluated in this report are altered. Beneficiaries 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.⁶

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. For example, beneficiaries who entered FFS Medi-Cal as a result of the ACA and whose medical needs are largely unknown may place a greater demand on FFS Medi-Cal services. 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.

⁶ 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)

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.

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.

DHCS also 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.

Additionally, starting with this report, DHCS presents the total of physicians participating in FFS Medi-Cal and the ratio of the FFS full-scope Medi-Cal Only population to participating FFS Medi-Cal physicians. For the purpose of evaluating provider participation, an encounter — also referred to as a distinct visit — is defined as a contact between a physician and a Medi-Cal beneficiary in which a Medi-Cal claim record(s) for reimbursement is generated and submitted for payment. The inclusion of statewide physician participation counts will provide DHCS with a better representation of the role of physicians in FFS Medi-Cal.

The total number of available physicians increased 3.8%, from 78,534 to 81,528 during the study period. The aggregate number of primary care physicians increased 3.4%, from 41,135 to 42,540. 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 increased during the last quarter of 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 particular, the primarily rural counties experienced a dramatic decrease in beneficiary-to-physician ratios. This decrease was expected given the continued expansions shifting the FFS population into managed care.

The statewide provider participation counts and the ratio of FFS full-scope Medi-Cal Only beneficiaries to physicians participating in FFS Medi-Cal mirrored the patterns identified for physician supply.

Beneficiary Participation

Overall, the number of FFS Medi-Cal Only beneficiaries entitled to full-scope benefits increased 33.7% from the second quarter of 2013 to the first quarter of 2014, from 1,193,739 to 1,596,228 average monthly eligibles. Participation increased 62.6% between the fourth quarter of 2013 and the first quarter of 2014, due to the implementation of the ACA in January 2014.

Decreases in FFS participation among FFS Medi-Cal Only beneficiaries, both adults and children, occurred in the Parent/Caretaker Relative & Child, SPD, and Undocumented aid categories from the fourth quarter of 2013 to the first quarter of 2014. Children in the Adoption/Foster Care and CHIP aid categories also exhibited a decrease in participation. The decrease in participation among beneficiaries in the Parent/Caretaker Relative & Child and SPD aid categories is likely due to the COHS expansion in September 2013 and the Regional/Other managed care expansion in November 2013.

In contrast, increases in FFS participation among both FFS Medi-Cal Only children and adults were seen in the ACA Expansion Adult Age 19-64 and Other aid categories.

During the study period, there was a stark contrast in participation among FFS Medi-Cal Only beneficiaries by county. About half of counties, 30, saw increases in FFS participation while 28 counties experienced decreases. San Luis Obispo (80.2%) and San Francisco (79.7%) counties experienced the greatest increases in FFS Medi-Cal Only participation, while Del Norte (-84.6%) and Shasta (-78.9%) counties saw the greatest decreases in participation. Decreases in beneficiary participation in most counties were most likely due to the COHS and Regional/Other managed care expansions in September and November 2013, respectively.

Participation trends for Medi-Cal's FFS population were similar between metropolitan and non-metropolitan areas from the second quarter of 2013 to the first quarter of 2014. While exhibiting similar patterns, decreases among both children and adults in the SPD and Parent/Caretaker Relative & Child aid categories were more pronounced in non-metropolitan areas. These decreases were most likely due to the COHS and Regional/Other managed care expansions in September and November 2013, respectively.

Service Utilization

Recalculation of Baseline Levels for 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. As a result of the new aid categories, it was necessary to update the service utilization baseline data to reflect the redefined groupings. Therefore, starting with this report, the baseline statistics — or benchmarks — have been recalculated to reflect the new aid code groupings for dates of service between January 1, 2011 and December 31, 2012. The updated baseline data 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. Non-Emergency Transportation
3. 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, the transition of the HFP into Medi-Cal, and the implementation of the ACA. 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

- As a result of the new aid categories, it was necessary to update the service utilization baseline data for children to reflect the redefined groupings. Service utilization patterns for children in Quarter 1, 2014 in most aid categories primarily fell within the expected ranges of the updated baseline. However, some shifts in utilization were observed in this report and may be attributable to a change in population case mix as a result of the continued expansions in Medi-Cal managed care and the transition of the HFP population in 2013. In particular, the utilization of Radiology services among children in most of the analyzed aid categories reached above the expected ranges.
- Children in most of the analyzed aid code categories mostly exhibited below-average and lower-than-expected use of Hospital Outpatient, Pharmacy, and Other services.
- Children in the Other and Parent/Caretaker Relative & Child aid categories exhibited utilization of several service categories (e.g., Emergency Medical Transportation, Hospital Outpatient, Pharmacy, Physician/Clinic, and Other) that mostly fell below either the average rates or the expected ranges established during the baseline period.
- Physician/Clinic service use patterns among children in most of the analyzed aid categories fell below the average rates established during the baseline period. The lower utilization rates among children in the Adoption/Foster Care, Other, Parent/Caretaker Relative & Child, and Undocumented aid categories may be influenced, in part, by the change in population case mix as a result of the continued expansions in Medi-Cal managed care and the transition of the HFP population in 2013.
- As the FFS Medi-Cal population case mix continued to change, many service categories (e.g.; Non-Emergency Transportation, Home Health, and Nursing Facility services) experienced a noticeable decline in user counts that made the data unsuitable for analysis.

Adults Ages 21 and Older

- Similar to children, it was also necessary to update the service utilization baseline data for adults to reflect the redefined aid code groupings. Service utilization patterns for adults in Quarter 1, 2014 in most aid categories primarily fell within the expected ranges of the updated baseline. However, some shifts in utilization were observed in this report and may be attributable to a change in population case mix as a result of the continued expansions in Medi-Cal managed care and the transition of the HFP population in 2013. In particular, the utilization of Radiology services among adults in most of the analyzed aid categories reached above the expected ranges.
- Adults in the SPD aid category mostly exhibited utilization of several service categories (e.g., Emergency Transportation, Non-Emergency Transportation, Nursing Facility, and Radiology services) that fell above either the average rates or the expected ranges established during the baseline period.
- The utilization of all of the analyzed service categories, except for Radiology, by adults in the Other and Parent/Caretaker Relative & Child aid code categories mostly fell below either the average rates or the expected ranges.
- Similar to children, it was also necessary to update the service utilization baseline data for adults to reflect the redefined aid code groupings. Service utilization patterns for adults in Quarter 1, 2014 in most aid categories primarily fell within the expected ranges of the updated baseline. However, some shifts in utilization were observed in this report and may be attributable to a change in population case mix as a result of the continued expansions in Medi-Cal managed care and the transition of the HFP population in 2013. In particular, the utilization of Radiology services among adults in most of the analyzed aid categories reached above the expected ranges.
- Adults in the Undocumented aid category, who are only eligible for emergency and pregnancy-related services, also continued to exhibit below-average and lower-than-expected use of Emergency Transportation, Hospital Inpatient, Hospital Outpatient, and Other services, as well as Physician/Clinic visits.

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.
- Blue – Represents utilization rates where no potential expected confidence intervals are available.
- 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.

Executive Summary

Table ES-2: Summary of Service Utilization Trends among FFS Medi-Cal Only Children Ages 0–20, by Aid Category and Service Category^{7,8}

	<i>Physician / Clinic Visits</i>	<i>Emergency Medical Transportation</i>	<i>Home Health Services</i>	<i>Hospital Inpatient Services</i>	<i>Hospital Outpatient Services</i>	<i>Pharmacy Services</i>	<i>Other Services</i>	<i>Radiology Services</i>
ACA Expansion Adults - Age 19-64	Upward Trend.	N/A	N/A	N/A	No Significant Pattern.	Upward Trend.	Upward Trend.	Upward Trend.
Adoption/Foster Care	Mostly Below Average and Within the Expected Range.	Mostly Above Average and Mostly Within the Expected Range.	N/A	Mostly Within the Expected Range.	Mostly Below Average and Within the Expected Range.	Mostly Within the Expected Range.	Mostly Below Average and Mostly Within Expected Range.	Above the Expected Range.
CHIP	Mostly Below Average with 4 Consecutive Months Below the Expected Range (Dec 2013 – Mar 2014).	N/A	N/A	Mostly Within the Expected Range.	Below Average with 5 Consecutive Months Below the Expected Range (Nov 2013 – Mar 2014).	Below Average with 5 Consecutive Months Below the Expected Range (Nov 2013 – Mar 2014).	Below Average and Within Expected Range.	Mostly Above the Expected Range.
Other	Mostly Below Average and Mostly Within the Expected Range.	Mostly Below Average with 4 Consecutive Months Below the Expected Range (Dec 2013 – Mar 2014).	N/A	Mostly Above the Expected Range. ⁹	Below Average with Several Months Below the Expected Range.	Below Average with Several Months Below the Expected Range.	Below Average with 5 Consecutive Months Below the Expected Range (Nov 2013 – Mar 2014).	Mostly Above the Expected Range.
Parent/Caretaker Relative & Child	Mostly Below Average and Mostly Within the Expected Range.	Mostly Below Average and Mostly Within the Expected Range.	Mostly Below Average and Mostly Within the Expected Range.	Mostly Above the Expected Range. ¹¹	Below Average with Several Months Below the Expected Range.	Below Average and Mostly Below the Expected Range.	Below Average and Within Expected Range.	Above the Expected Range.
SPD	Mostly Below Average and Within Expected Range.	Mostly Below Average and Mostly Within Expected Range.	Above Expected Range.	Mostly Within Expected Range.	Mostly Below Average and Mostly Within Expected Range.	Within Expected Range.	Below Average and Within Expected Range.	Above the Expected Range.
Undocumented	Mostly Below Average and Within Expected Range.	Mostly Above Average and Within Expected Range.	N/A	Mostly Above Expected Range. ¹¹	Within Expected Range.	Mostly Below Average and Within Expected Range.	Mostly Below Average and Mostly Within Expected Range.	Above the Expected Range.

⁷ Children were excluded from analyses of Non-Emergency Medical Transportation and Nursing Facility services utilization due to low user counts (n<500).

⁸ Subpopulation user counts can be found in corresponding figures located in the Service Utilization measure.

⁹ 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 Only Adults Ages 21+, by Aid Category and Service Category¹⁰

	<i>Physician / Clinic Visits</i>	<i>Non-Emergency Transportation</i>	<i>Emergency Medical Transportation</i>	<i>Home Health Services</i>	<i>Hospital Inpatient Services</i>	<i>Hospital Outpatient Services</i>	<i>Nursing Facility Services</i>	<i>Pharmacy Services</i>	<i>Other Services</i>	<i>Radiology Services</i>
ACA Expansion Adults - Age 19-64	No Significant Pattern.	Upward Trend.	No Significant Pattern.	N/A	Downward Trend.	No Significant Pattern.	No Significant Pattern.	Upward Trend.	Upward Trend.	No Significant Pattern.
Parent/Caretaker Relative & Child	Below Average with 5 Consecutive Months Below the Expected Range (Nov 2013 – Mar 2014).	N/A	Mostly Below Average with 3 Consecutive Months Below the Expected Range (Jan 2014 – Mar 2014).	N/A	Mostly Below Average with Several Months Below the Expected Range.	Below Average with 5 Consecutive Months Below the Expected Range (Nov 2013 – Mar 2014).	N/A	Below Average with 7 Consecutive Months Below the Expected Range (Sep 2013 – Mar 2014).	Mostly Below the Expected Range.	Mostly Above Expected Range.
Other	Below Average with 5 Consecutive Months Below the Expected Range (Nov 2013 – Mar 2014).	Mostly Below Average with 4 Consecutive Months Below the Expected Range (Dec 2013 – Mar 2014).	Below Average with 7 Consecutive Months Below the Expected Range (Sep 2013 – Mar 2014).	N/A	Below the Expected Range. Downward Trend (Oct 2013 – Mar 2014).	Below Average with 5 Consecutive Months Below the Expected Range (Nov 2013 – Mar 2014).	Mostly Below the Expected Range.	Below Average with 5 Consecutive Months Below the Expected Range (Nov 2013 – Mar 2014).	Mostly Below Average with 4 Consecutive Months Below the Expected Range (Dec 2013 – Mar 2014).	Mostly Above Expected Range.
SPD	Mostly Below Average Within the Expected Range.	Above Average with 4 Consecutive Months Above the Expected Range (Dec 2013 – Mar 2014).	Above Average and Mostly Within the Expected Range.	Mostly Below Average and Mostly Within the Expected Range.	Within the Expected Range.	Within the Expected Range.	Above the Expected Range.	Below Average and Mostly Within the Expected Range.	Below Average and Within the Expected Range.	Above the Expected Range.
Undocumented	Mostly Below Average with Several Months Below the Expected Range.	N/A	Mostly Below Average and Within the Expected Range.	N/A	Mostly Below the Expected Range.	Mostly Below Average and Within the Expected Range.	N/A	Within the Expected Range.	Below Average and Mostly Within the Expected Range.	Above the Expected Range.

¹⁰ Subpopulation user counts can be found in corresponding figures located in the Service Utilization measure.

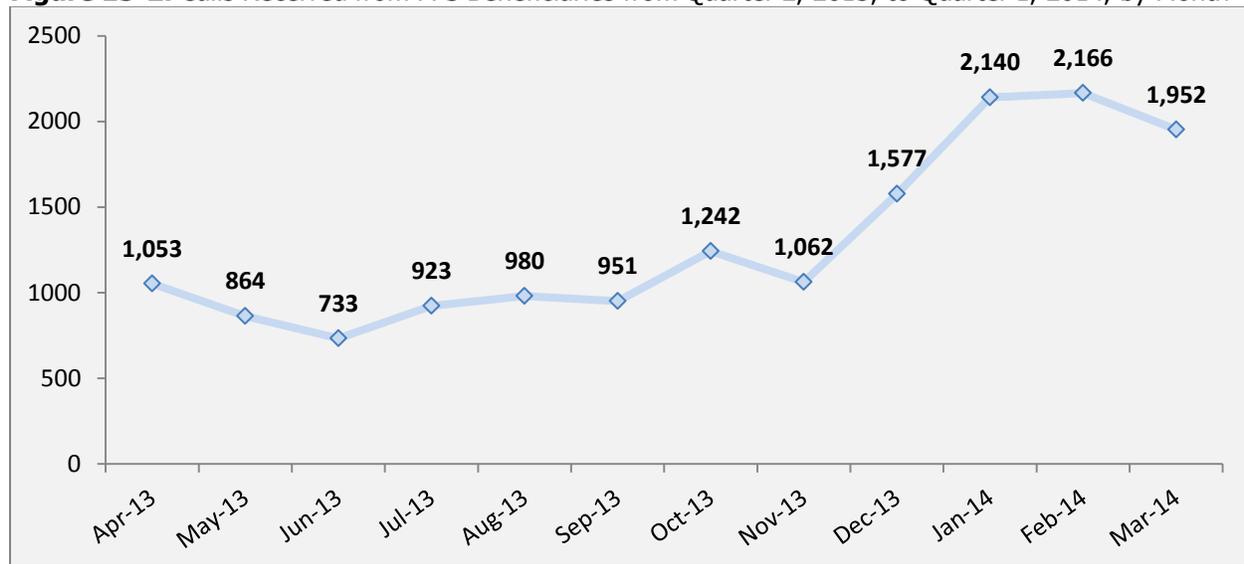
Beneficiary Feedback

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 April 2013 and March 2014, the Office of the Ombudsman documented a total of 15,643 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, seven aid category groupings (SPD, Parent/Caretaker Relative & Child, Adoption/Foster Care, ACA Expansion Adult Ages 19-64, CHIP, Undocumented, and Other), and reason for call.

FFS call volume was noticeably higher for this period than during the previous reporting period (12,306 calls from January 2013 to December 2013). The increase in call volume from July to October 2013 likely reflects the expansion of COHS and Regional/Other managed care, as well as the final phase of the HFP transition. Additionally, the stark increase in call volume from November 2013 to February 2014 is likely attributable to the ACA implementation during January 2014 (Figure ES-2).

Figure ES-2: Calls Received from FFS 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.