



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

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Key Points

- Call volume increased to 12,306 calls in the current study period, compared with 10,633 calls in the last study period.
- Enrollment/Continuity of Care and Miscellaneous call categories comprised 89.2% of calls.
- Among calls regarding Enrollment/Continuity of Care and Provider/Availability matters, 87.5% were received from beneficiaries in the Families, Blind/Disabled, and Other aid categories.
- The increase in call volume from January through April 2013 likely reflects the transition of children from the Healthy Families Program (HFP) into Medi-Cal that began January 1, 2013.
- 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. Additionally, the increase in calls received during December 2013 may be due to the expansion of Regional/Other managed care models into 20 counties in November 2013.

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. Data and information generated from this help line will be incorporated into this measure once they become available. 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 available, 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 Program services.^{1,2,3}

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 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 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
	September 2013	Del Norte	5,837
COHS	September 2013	Humboldt	19,913
	September 2013	Lake	12,749
COHS	September 2013	Lassen	3,507
	September 2013	Modoc	1,376
COHS	September 2013	Shasta	28,430
	September 2013	Siskiyou	7,736
COHS	September 2013	Trinity	1,940
			Subtotal = 81,488

¹ California Assembly Bill 97, (2011).

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

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

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
			Subtotal = 165,780
			Total = 247,268

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 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 care delivery system until the date of their annual eligibility review for Medi-Cal. These children with presumptive eligibility through FFS 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.

Methods

As data from the Department's help line has yet to become available, 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 12,306 calls from FFS beneficiaries from the first quarter to the fourth quarter of 2013. For each of these calls, the call center recorded the date and time of call, beneficiary aid category, county of residence, and reasons for the call. Data for these calls were summarized by month received, six aid category groupings (Families, Blind/Disabled, Aged, Foster Care, Undocumented, and Other), and reason for call.

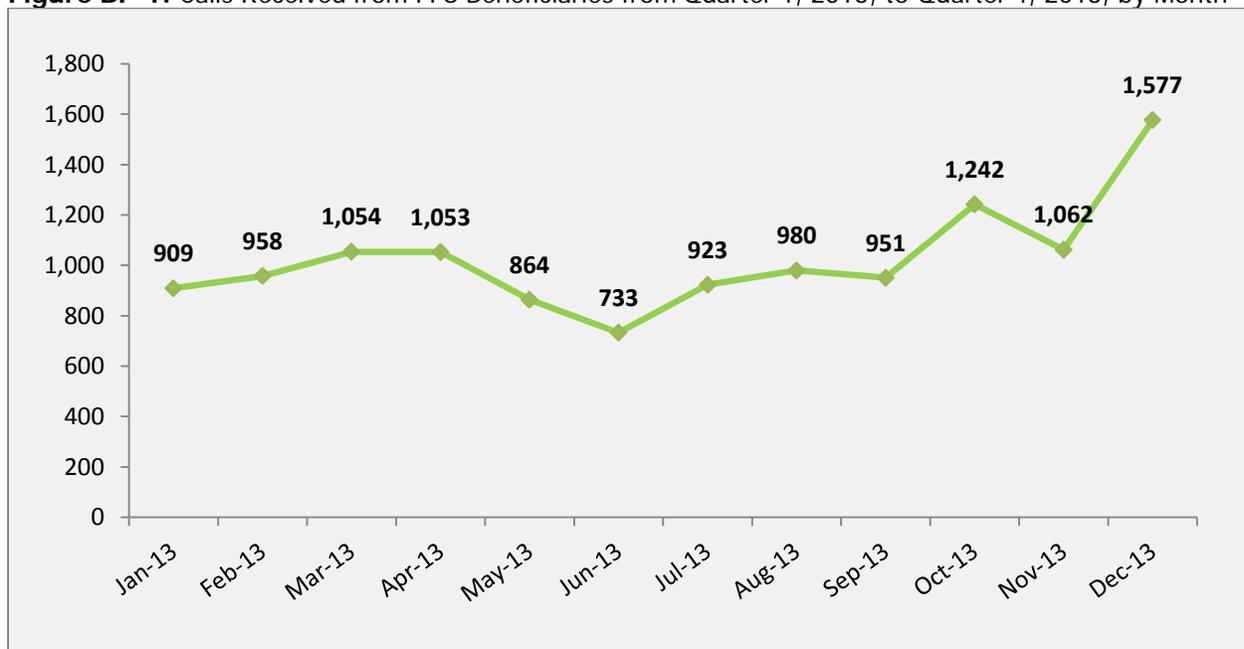
Limitations

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 January 2013 and December 2013, the Office of the Ombudsman call center documented a total of 12,306 calls received from FFS Medi-Cal beneficiaries. FFS call volume was noticeably higher for this period than the previous reporting period (10,633 calls for 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. The increase from June to October, and especially the notable increase from September to October, can likely be attributed to the expansion of Medi-Cal managed care to 28 counties, as well as the final phases of the HFP transition (Figure BF-1). The jump from November to December was likely due to the inaugural open enrollment period for the Medi-Cal expansion component of the Patient Protection and Affordable Care Act (ACA) of 2010.

Figure BF-1: Calls Received from FFS Beneficiaries from Quarter 1, 2013, to Quarter 4, 2013, by Month



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

Call Volume, by Quarter

Call volume increased 35.9% from the third quarter to the fourth quarter of 2013, and reached its highest level during December 2013. Call volume decreased 9.3% during the second quarter of 2013 and then increased 7.6% during the third quarter of 2013 (Table BF-2).

Table BF-2: Number of Calls Received from FFS Beneficiaries from Quarter 1, 2013 to Quarter 4, 2013, by Quarter

Quarter	Total Calls per Quarter	% Change from Previous Quarter
Jan.–March 2013	2,921	32.2%
April–June 2013	2,650	-9.3%
July–Sept. 2013	2,854	7.6%
Oct.–Dec. 2013	3,881	35.9%

Source: DHCS Research and Analytic Studies Division analyzed FFS calls received January 2013–December 2013 by the Medical 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

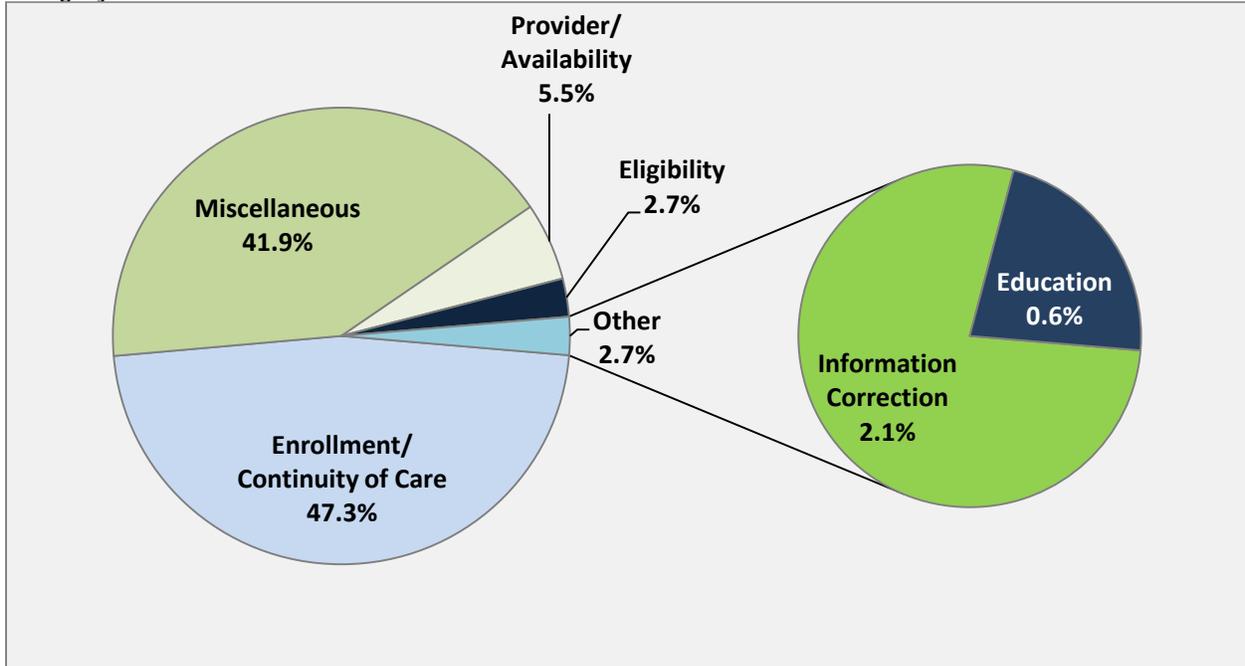
Call Category	Reason for Call
Enrollment/ Continuity of Care	<ul style="list-style-type: none"> • Seeking information about new enrollment into plan • Wanting to change plans or disenroll from managed care • Seeking medical exemptions • Emergency plan disenrollment requests • Pregnancy or other qualifying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

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 41.9% of calls were categorized as Miscellaneous. The remaining 10.9% of calls pertained to Provider/Availability, Information Correction, Education, and Eligibility issues (Figure BF-2).

Figure BF-2: Calls Received from FFS Beneficiaries from Quarter 1, 2013, to Quarter 4, 2013, by Call Category



Source: DHCS Research and Analytic Studies Division analyzed FFS calls received from January 2013–December 2013 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 six 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, 5,816 were categorized as Enrollment/Continuity of Care, and 678 as Provider/Availability. Patterns of call volume by aid category were similar between Enrollment/Continuity of Care and Provider/Availability. The majority of calls for each call category were received from beneficiaries in the Families aid category, followed by beneficiaries in the Blind/Disabled and Other aid categories.

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 1, 2013, to Quarter 4, 2013, by Aid Category

Aid Category	Enrollment/ Continuity of Care # of Calls	Enrollment/ Continuity of Care % of Calls	Provider/ Availability # of Calls	Provider/ Availability % of Calls
Families	2,866	49.3%	237	35.0%
Blind/Disabled	1,187	20.4%	116	17.1%
Other	1,037	17.8%	236	34.8%
Aged	414	7.1%	48	7.1%
Foster Care	291	5.0%	7	1.0%
Undocumented	21	0.4%	34	5.0%
Total	5,816	100%	678	100%

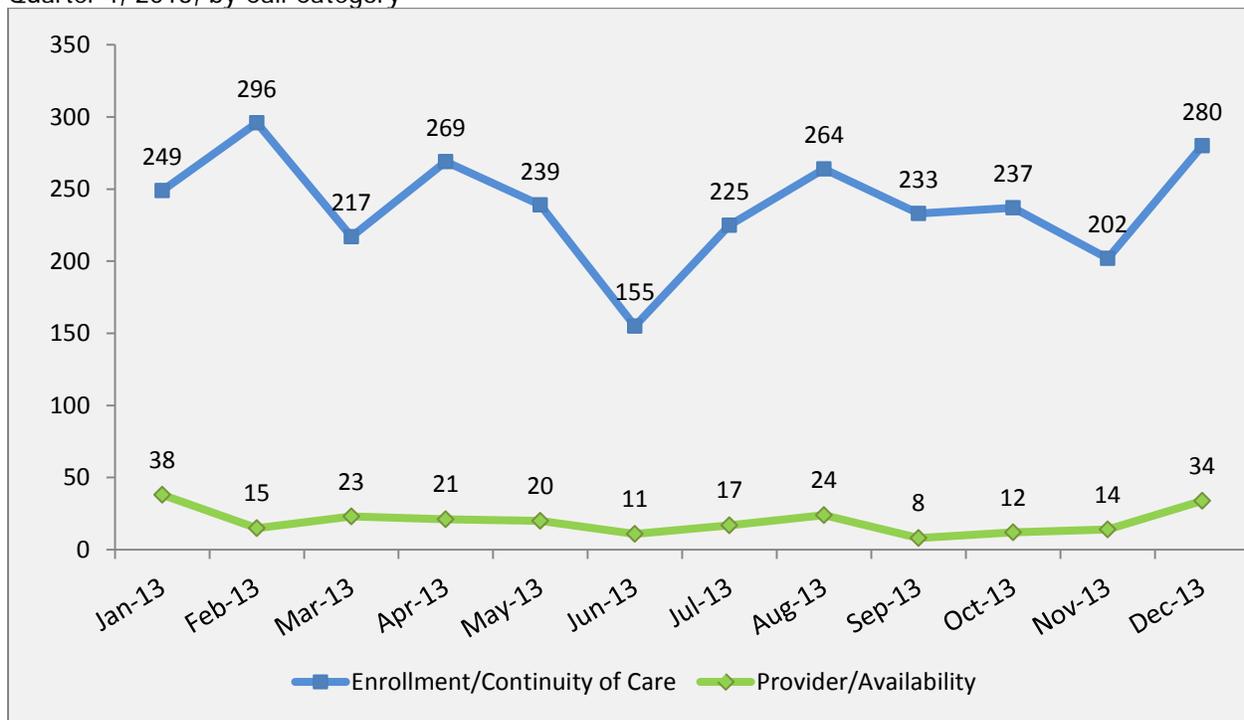
Source: DHCS Research and Analytic Studies Division analyzed FFS calls received from January 2013–December 2013 by the Medi-Cal Managed Care Division's Office of the Ombudsman call center.

As the majority of calls were received from beneficiaries in Families and Blind/Disabled aid codes, the following sections will focus on calls received from beneficiaries in these two aid categories.

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

Among FFS beneficiaries enrolled under Families 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 increase (70.3%) from June to August of 2013. Additionally, calls pertaining to Provider/Availability issues were less frequent but stable (Figure BF-3).

Figure BF-3: Monthly Call Volume from Beneficiaries in Families Aid Codes from Quarter 1, 2013, to Quarter 4, 2013, by Call Category

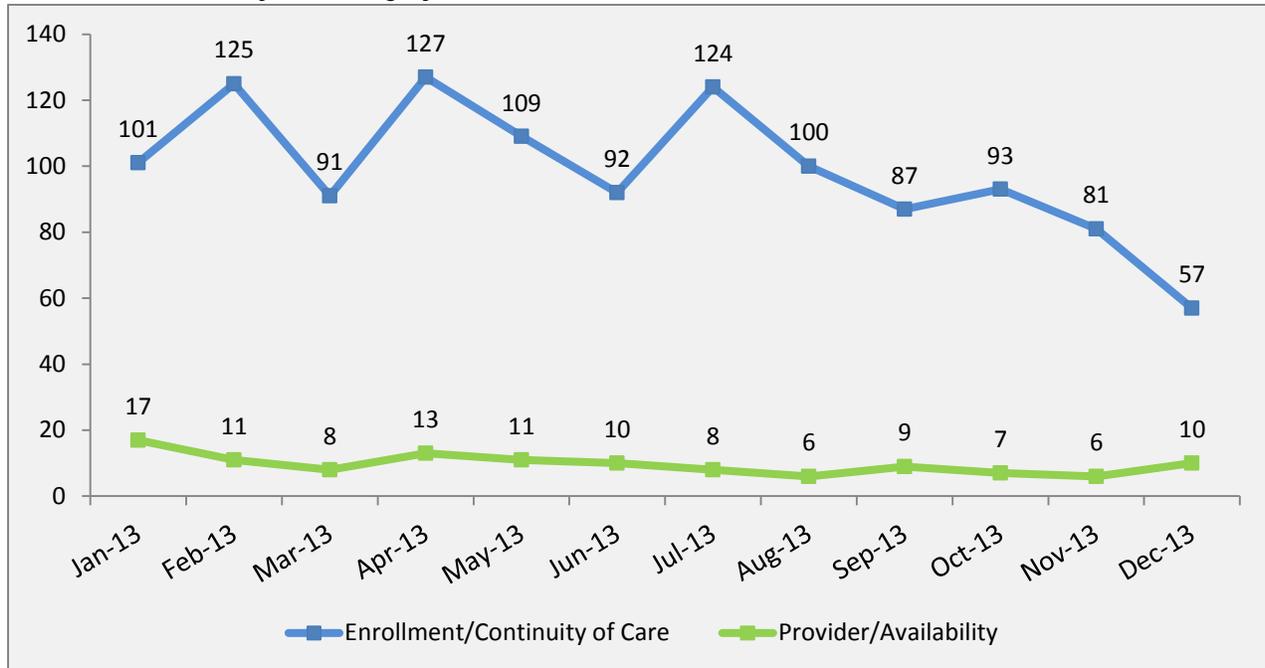


Source: DHCS Research and Analytic Studies Division analyzed FFS calls received from January 2013-December 2013 by the Medi-Cal Managed Care Division's Office of the Ombudsman call center.

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

Among beneficiaries enrolled under Blind/Disabled aid codes, the number of calls pertaining to Enrollment/Continuity of Care matters fluctuated before decreasing 54.0% over the last two quarters of the study period. Additionally, calls pertaining to Provider/Availability issues were infrequent and primarily stable (Figure BF-4).

Figure BF-4: Monthly Call Volume from Beneficiaries in Blind/Disabled Aid Codes from Quarter 1, 2013, to Quarter 4, 2013, by Call Category



Source: DHCS Research and Analytic Studies Division analyzed FFS calls received from January 2013–December 2013 by the Medical 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 Families aid codes, 88.5% of calls categorized as Enrollment/Continuity of Care pertained to requests for new enrollment. Another 3.5% of Enrollment/Continuity of Care calls were regarding Foster Care disenrollment exemption requests (Table BF-5).

Additionally, nearly 88.6% of the calls categorized under Provider/Availability related to the termination of Medi-Cal eligibility. Approximately 5.5% were related to beneficiaries being billed for services. Another 1.7% concerned refusal of medications, and 0.8% pertained to delays or denials of referrals or appointments.

Table BF-5: Top Four Reasons for Calls from Beneficiaries in Families Aid Codes from Quarter 1, 2013 to Quarter 4, 2013

Reason for Call	# of Calls	% of All Calls in Category*
Enrollment/Continuity of Care (n=2,866)		
Requesting New Enrollment into Plan	2,536	88.5%
Foster Care/Adoption Disenrollment Exemption Request	100	3.5%
Wants to Disenroll from Plan and Enroll in FFS	49	1.7%
Hold on Plan	31	1.1%
Provider/Availability (n=237)		
Medi-Cal Eligibility Terminated	210	88.6%
Beneficiary Being Billed	13	5.5%
Refusal of Medications	4	1.7%
Delay/Denial of Referrals or Appointments	2	0.8%

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

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

Among beneficiaries enrolled under Blind/Disabled aid codes, 62.5% of the calls categorized as Enrollment/Continuity of Care involved callers requesting new enrollment. Approximately 12.0% concerned medical exemption requests or emergency disenrollment exemption requests, while 9.8% related to requests to disenroll from managed care plans and become an FFS participant, and 3.0% of calls pertained to long-term care emergency disenrollment requests (Table BF-6).

Additionally, of the calls categorized under Provider/Availability, 62.9% involved termination of Medi-Cal eligibility, 12.1% pertained to refusal of medication, 8.6% were from beneficiaries who were erroneously billed for services, and 2.6% were regarding denials of Durable Medical Equipment.

Table BF-6: Top Four Reasons for Calls from Beneficiaries in Blind/Disabled Aid Codes from Quarter 1, 2013, to Quarter 4, 2013, by Call Category

Reason for Call	# of Calls	% of All Calls in Category*
Enrollment/Continuity of Care (n=1,187)		
Requesting New Enrollment into Plan	742	62.5%
Status Checks on Medical Exemptions and Emergency Disenrollments	143	12.0%
Wants to Disenroll from Plan and Enroll in FFS	116	9.8%
Long-Term Care Issues— Emergency Disenrollment Request	36	3.0%
Provider/Availability (n=116)		
Medi-Cal Eligibility Terminated	73	62.9%
Refusal of Medication	14	12.1%
Beneficiary Being Billed	10	8.6%
Denial of Durable Medical Equipment	3	2.6%

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

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

Conclusions

- Between January 2013 and December 2013, the Medi-Cal Managed Care Division's Office of the Ombudsman call center staff documented 12,306 calls from FFS Medi-Cal beneficiaries. Call volume during this 12-month period was approximately 16% higher than it was from October 2012 to September 2013.
- About 47.3% of calls pertained to Enrollment/Continuity of Care issues. Another 41.9% 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, as these key elements help identify access-related problems experienced by beneficiaries.
- Among calls categorized as Enrollment/Continuity of Care and Provider/Availability, a large majority of calls were from FFS beneficiaries enrolled under Families, Blind/Disabled, and Other aid codes.
- Callers enrolled under Families aid codes were primarily interested in requesting new enrollment. Other Enrollment/Continuity of Care matters important to these callers included foster care/adoption disenrollment exemption requests, and disenrollment from managed care to become an FFS participant. 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 Blind/Disabled aid codes were primarily interested in requesting new enrollment. These callers also requested status checks on medical exemptions and emergency disenrollment exemptions, disenrollment from managed care, and emergency disenrollment from long-term care. Other reasons for these calls included termination of Medi-Cal eligibility, refusal of medication, being billed erroneously for services, and denial of Durable Medical Equipment.