

RASS Month of Service - Utilization Tables - Analytic Notes

Month of Service Lag

Paid claims data used in these tables are based on month of service, but the source files for the data are based on month of payment. Month of service claims are identified by the starting date of service (aka from date of service) on the claim and are based on claims paid as of June 30, twelve months after the end of the last month of service. These data are considered to be approximately 99% complete.

Member Months

One member month is counted for each eligible person who was enrolled in the Medi-Cal program and who did not have an unmet share of cost during that month. Member months is the summarization of the total months of Medi-Cal enrollment.

Member months counts reflect the universe of “certified” Medi-Cal beneficiaries. Certified beneficiaries are those individuals enrolled in Medi-Cal *without* an unmet share of cost obligation.

Per Member Per Month (PMPM)

PMPM rates are calculated as the total expenditures for the year divided by the total member months for the year (total annual expenditures/total annual member months = PMPM rate). The PMPM rate has been excluded in some cases due to small cell sizes.

Medi-Cal/Medicare Dual Eligibility

Dual Eligibility for Medi-Cal beneficiaries is determined by the Medicare crossover status field on the claims file and by the Medicare enrollment status field on the enrollment file. Medi-Cal beneficiaries who are also enrolled in any one or combination of the following: Medicare Part A, Part B, or Part D, are considered dually eligible for both Medicare and Medi-Cal.

Beneficiaries that are not considered dually eligible are categorized as Medi-Cal only.

FFS Carve-Out Expenditures vs. Fee-For-Service (FFS) Expenditures

A carve-out expenditure is a Medi-Cal covered service, billed for a Medi-Cal Managed Care beneficiary, that is not covered in the managed care plan contract. The service is then reimbursed through Fee-For-Service Medi-Cal. Carve-out expenditures for managed care eligibles reflect services paid outside the managed care arrangement and are in addition to the capitation paid directly to the plan.

Carve-out expenditures are identified by the health plan code field on the claim. If a beneficiary is enrolled in a full risk managed care plan at the time of service, the health plan code field would contain the plan number. Expenditures for beneficiaries not enrolled in a full risk managed care plan at the time of service are identified as “FFS Expenditures.” For a description of full risk managed care plans, see the next section: *Managed Care Eligibles vs. Fee-For-Service (FFS) Eligibles*.

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Managed Care Eligibles vs. Fee-For-Service (FFS) Eligibles

Beneficiaries enrolled in a managed care plan (“Managed Care Eligibles”) are identified by managed care risk status field on the enrollment file. Managed care enrollment is defined as a beneficiary being enrolled in a full risk plan where a capitation has been paid and the health care plan assumes responsibility for all services to the beneficiary.

Partial and no risk enrollment types are identified as “FFS Eligibles” for this reporting. Partial risk plans receive a capitation for beneficiary enrollment and assume responsibility for a limited set of services to the beneficiary. No risk means that there is no capitation paid, the beneficiary is not enrolled into a managed care health plan, and the beneficiary’s claims are paid via Fee-For-Service; no health care plan assumes any responsibility for services to the beneficiary.

Age Groups

Beneficiary age is grouped into two categories: Children (ages 0 – 20) and Adults (ages 21 and over). Invalid age values and designations of unknown or unborn on the enrollment source file have been excluded from the Medi-Cal only tables.

The value of age on the claims file is calculated using beneficiary date of birth and starting date of service. The value of age on the enrollment file is calculated using beneficiary date of birth and the first day of the month of eligibility. Invalid age values and designations of unknown or unborn on the claims file have been excluded from the Medi-Cal only tables.

Enrollment Reporting by Aid Code

Under Medi-Cal, a beneficiary may be eligible under more than one aid code. Enrollment in multiple aid codes can be due to a variety of reasons, such as: having an unmet share of cost obligation, as described above, or being enrolled in a transitional, limited term, or limited scope aid code. To avoid double counting and over reporting, the certified aid code in the first position is the only aid code represented in the member months counts. In most cases, this also appropriately reflects the size of each program. However, in cases where one person is served under a number of programs, the secondary program may be underrepresented in counts by Aid Code. The Breast and Cervical Cancer Treatment Program (BCCTP) is one of these secondary programs where the number of persons served would be undercounted if limited to only the first certified aid code, often by 12-13%. For the most accurate information on BCCTP enrollment, please visit our Medi-Cal and Women’s Health page.

Expenditure Reporting by Aid code

The beneficiary aid code reported on the claim file identified which aid code the claim was paid under.

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Aid Population Exclusions

The universe of beneficiaries does not include recipients of FPACT family planning services or maternity care provided under presumptive eligibility. Eligibility and enrollment for these programs is determined by providers and is not available in the MEDS Eligibility System.

The dual eligible tables exclude aid populations due to their relevance to the topic, impact on the population, and small cell sizes. These aid populations include Medically Needy-Families, Public Assistance-Families, Percent of Poverty, Refugees, and the Other aid codes excluded from the DHCS, Medi-Cal, Base Estimate process (see category descriptions below).

Aid Categories - Tables

Aid Categories are based on the following groupings maintained by the DHCS, Fiscal Forecasting and Data Management Branch, Base Estimates Unit.

Public Assistance-Aged

10, 16, 18, 1E

Public Assistance-Blind

20, 26, 28, 2E, 6A

Public Assistance-Disabled

36, 60, 66, 68, 6C, 6E, 6N, 6P

Public Assistance-Families

30, 32, 33, 35, 38, 40, 42, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3P, 3R, 3U, 3W, 4F, 4G

Long Term Care-Aged

13

Long Term Care-Blind

23

Long Term Care-Disabled

63

Medically Needy-Aged

14, 17, 1H, 1U, 1X, 1Y

Medically Needy-Blind

24, 27, 2H

Medically Needy-Disabled

64, 65, 67, 6G, 6H, 6S, 6U, 6V, 6W, 6X, 6Y, 8G

Medically Needy-Families

34, 37, 39, 3D, 3N, 3T, 3V, 54, 59, 5J, 5R, 5T, 5W, 6J, 6R, 7J, 7K

Medically Indigent-Children

03, 04, 06, 45, 46, 82, 83, 2A, 4A, 4K, 4M, 5E, 5K, 7M, 7N, 7P, 7R, 7T, 8E, 8W

Medically Indigent-Adult

53, 81, 86, 87

Refugees

01, 02, 08, 0A

OBRA*-Undocumented

55, 58, 5F, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9

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200 Percent of Poverty

44, 47, 48, 69, 76, 7F, 7G, 8U, 8V, 49

133 Percent of Poverty

72, 74, 8N, 8P

100 Percent of Poverty

7A, 7C, 8T, 8R

Other Excluded from Base Estimate

All other aid codes (this category includes Qualified Medicare Beneficiaries, Breast & Cervical Cancer Treatment, Medi-Cal Dialysis, Tuberculosis, Total Parenteral Nutrition and other Medi-Cal programs).

Aid Categories - Graphics

The aid categories described above were used in the tables displayed in this report. These categories were further grouped into larger categories for graphic display.

Aged

10, 16, 18, 1E, 14, 17, 1H, 1U, 1X, 1Y

Blind

20, 26, 28, 2E, 6A, 24, 27, 2H

Disabled

36, 60, 66, 68, 6C, 6E, 6N, 6P, 64, 65, 67, 6G, 6H, 6S, 6U, 6V, 6W, 6X, 6Y, 8G

Families

30, 32, 33, 35, 38, 40, 42, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3P, 3R, 3U, 3W, 4F, 4G, 34, 37, 39, 3D, 3N, 3T, 3V, 54, 59, 5J, 5R, 5T, 5W, 6J, 6R, 7J, 7K

Long Term Care

13, 23, 63

Medically Indigent

03, 04, 06, 45, 46, 82, 83, 2A, 4A, 4K, 4M, 5E, 5K, 7M, 7N, 7P, 7R, 7T, 8E, 8W, 53, 81, 86, 87

Other

All other aid codes (this category includes Refugees, OBRA*-Undocumented, Percent of Poverty, Qualified Medicare Beneficiaries, Breast & Cervical Cancer Treatment, Medi-Cal Dialysis, Tuberculosis, Total Parenteral Nutrition and other Medi-Cal programs).

***Federal Omnibus Budget Reconciliation Act of 1986 (OBRA)**

Restricted or full-scope Medi-Cal benefits were extended to previously ineligible aliens, effective October 1, 1988. This program was mandated by the Federal Omnibus Budget Reconciliation Act of 1986 (OBRA) and the Immigration Reform and Control Act of 1986 (IRCA). IRCA created a legalization program under which the status of certain aliens unlawfully residing in the United States may be adjusted over time to permanent resident status. In granting these aliens amnesty, the law specifies that their participation in certain assistance programs be restricted for five years. OBRA applies to other aliens such as undocumented aliens and temporary visitors. More information on individual OBRA aid codes can be found in the Medi-Cal Provider Manual on the internet at: http://files.medi-cal.ca.gov/publications/masters-mtp/part1/obra_z01.doc.

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More detailed information on individual aid codes can be found in the Medi-Cal Provider Manual on the internet at:

http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/aidcodes_z01c00.doc

Source for Medi-Cal Expenditures: Fee-For-Service, DHCS administered, Medi-Cal '35' file paid claims data.

Source for Medi-Cal Eligibility Member Months: MEDS Eligibility System, MMEF File.

Suggested Citation: State of California, Department of Health Care Services, Medi-Cal Month of Service – Utilization - Statistical Tables - Analytic Notes.

HIPPA Compliance: Data in this table has been aggregated to comply with the California Welfare and Institutions Code, Section 14100.2, and the HIPAA Privacy Rule, 45 CFR, Parts 160 and 164, which are designed to safeguard Protected Health Information and Personal Confidential Information