



# MEDI-CAL STATISTICAL BRIEF

OCTOBER 2012

## FINDING CALIFORNIA'S MEDI-CAL POPULATION:

### *CHALLENGES AND METHODS IN CALCULATING MEDI-CAL ENROLLMENT NUMBERS*

#### **Introduction**

A frequent inquiry posed to the Department of Health Care Services (DHCS) is how many residents of California are currently enrolled in California's Medi-Cal Program. The interest is understandable – Medi-Cal is a \$50 billion,<sup>1</sup> publically-funded program that, by virtue of its size and scope, impacts millions of beneficiaries, their families, providers and numerous other stakeholders. Unfortunately, the size, complexity, and continued evolution of the Medi-Cal program have yielded a dense lexicon of terminology and methodologies for counting Medi-Cal eligibles.

Since its creation in 1966, the Medi-Cal program has shifted and expanded in response to various legislative acts and state plan amendments designed to meet the changing needs of California's healthcare environment. In addition to new beneficiaries, these changes brought new reporting requirements and sophisticated techniques and definitions for measuring the program's performance, size, and cost. The partnership of federal, state, and local administrators adds complexity as well, as

each party is responsible for different elements of the program and reports to, in many cases, different constituencies. This intricate web of responsibilities and reporting relationships has resulted in a morass of terms and definitions that change a simple information request, like the number of Californians enrolled in Medi-Cal, into a sometimes confusing and frustrating exercise.

DHCS understands that details regarding Medi-Cal enrollment and services should be as transparent as possible. What follows is an in-depth description of how the DHCS determines who is counted as a Medi-Cal *certified eligible*, three different techniques for calculating that population, and the ways that this number can be applied to reveal the percentage of the California population enrolled in Medi-Cal. To provide context, a description of the demographic composition of the Medi-Cal population and recent enrollment trends are also included.

For quick reference, the section entitled "[Summary of the Most Recent Figures and Data for California](#)" provides a chart of

current population data and percentages (see page 7).

### How is Terminology the Source of the Confusion?

The challenge faced by administrators in conveying the Medi-Cal population is the ambiguity of terms used to communicate the data. Medi-Cal has many stakeholders, including millions of beneficiaries, health providers, and administrators at the federal, state, and county levels. Unfortunately, not all of these stakeholders use or understand key terms in the same fashion. When relaying enrollment data, the potential for miscommunication centers on the definition of the term “eligible” and an understanding of the time period which the member count represents. While these concerns may seem academic or abstract, an inconsistent understanding of these guidelines can produce Medi-Cal population estimates that differ by over a million members – each correct and produced by a reputable authority on the program.

For example, the Center for Medicare and Medicaid Services (CMS), the federal regulatory authority for Medicaid programs, defines “eligible” members broadly, including in many of their counts any individual enrolled in Medicaid for one month during the year, as well as members of the Family PACT (Planning, Access, Care, and Treatment) program. A data set using

these eligibility criteria is assembled annually within CMS’ Medicaid Statistical Information System (MSIS), which includes detailed, automated enrollment and claims data for each state. Established in 1997 by the Balanced Budget Act to address the need for more accurate and complete Medicaid data, the MSIS mandates state participation and has greatly improved the accessibility of Medicaid information. In 1999, CMS further improved the quality of available Medicaid data by implementing stringent data validation and editing procedures for information submitted to the MSIS.

Utilizing the CMS definition of eligibility and data from the MSIS, the Kaiser Commission on Medicaid and the Uninsured estimated that there were **11,027,600** Medi-Cal members in California during the federal fiscal year 2009 (October 1, 2008 through September 30, 2009).<sup>2</sup> By contrast, the DHCS monthly enrollment average for the same period was **6,966,895** members. Despite the significant difference in these estimates, both are accurate representations of the 2009 populations of concern.

The discrepancy between the estimates listed above is an excellent example of the two-part miscommunication common when discussing Medi-Cal enrollment. First, the two estimates were calculated differently. While both depict the Medi-Cal population

in 2009, the MSIS estimate is intended to show the complete number of unduplicated members who were enrolled, however intermittently, in Medi-Cal at some point during the year. DHCS provides instead an estimate that shows the average number of Medi-Cal beneficiaries enrolled during a given year, a calculation which accounts for the fact that many members are not enrolled for all 12 months of a year. Both of these calculations are correct and serve important, if different, functions in describing the size of the Medi-Cal population. Both calculations will be discussed in detail later in this report.

The second source of miscommunication stems from the definition of the term “eligible” and how that shapes the population that these stakeholders are assessing. As noted previously, CMS uses a broad definition of eligibility in curating the MSIS, which includes anyone enrolled in Medicaid for one month during the year, including pregnant women granted “presumptive” eligibility into Medi-Cal, and recipients of family planning services offered by the Family PACT program. The DHCS estimate uses a definition of eligible – *certified eligible*, a definition discussed at length in this report – that is more rigorous and excludes members of some programs, including Family PACT and women granted “presumptive” eligibility. This example illustrates how incompatible eligibility

definitions lead stakeholders to generate conflicting estimates; Family PACT served an estimated **1.79 million** members in 2009, insuring a deviation of over a million members between estimates that include Family PACT members as eligible and those that don't.<sup>3</sup>

The sections that follow will provide a definition of Medi-Cal *certified eligibles* and show how DHCS arrives at commonly used population counts. These definitions are provided with the intent of both informing the reader and combating the confusion inherent within the terminology used to describe the program.

### **Who Are Counted As Medi-Cal Certified Eligibles?**

To determine the number of current enrollees DHCS uses a special definition of Medi-Cal beneficiaries referred to as *certified eligibles*. This classification is used by DHCS to report official budget statistics and maintain its extensive website of enrollment count data sets and will be used in all the calculations that follow.<sup>4</sup> A demographic representative of this classification can be found later in this report in the section entitled, “[What do Medi-Cal Certified Eligibles Look like Demographically?](#)”

*Certified eligibles* are defined as those beneficiaries who are deemed qualified for Medi-Cal by a valid eligibility determination

and have enrolled in the program. Thus, those beneficiaries who may be eligible for Medi-Cal, but have not enrolled, are not counted as *certified*. This classification also excludes Share-of-Cost (SOC) beneficiaries who have not met their monthly SOC obligation and are not eligible for Medi-Cal benefits.<sup>5</sup>

Finally, some specific populations are excluded from *certified eligible* counts, including California’s Family PACT members and pregnant women granted provisional Medi-Cal enrollment under the Presumptive Eligibility (PE) program. A further discussion on the excluded populations can be found later in this report in the section entitled, “How Significant Are Populations Not Counted as *Certified Eligible?*”

### **Techniques for Counting Medi-Cal’s *Certified Eligibles***

There are three primary techniques that DHCS uses to calculate and convey the number of *certified eligibles* enrolled in Medi-Cal. Each of these methods produces a different count and is used to convey specific information. All are correct methods and the use of a particular technique is determined by the question posed.

### **Option 1 - Counting the Number of *Certified Eligibles* over a Specific Month**

Option 1: Medi-Cal beneficiaries can be calculated by counting the number of *certified eligibles* during a given month. For example, the number of *certified eligibles* in July 2010 totaled **7,397,966** (see Table 1). However, this method only provides a snap-shot – if the number of beneficiaries fluctuates significantly during a reporting period (such as a fiscal or calendar year), a single month’s count may not be representative.

**Table 1 – Snap-Shot Method: Monthly Enrollment of *Certified Eligibles*, July 2010 to June 2011**

<b>Month and Year</b>	<b>Member Months (Months of Enrollment)</b>
07/01/2010	7,397,966
08/01/2010	7,440,138
09/01/2010	7,462,256
10/01/2010	7,469,957
11/01/2010	7,473,439
12/01/2010	7,480,508
01/01/2011	7,505,841
02/01/2011	7,524,030
03/01/2011	7,552,153
04/01/2011	7,573,219
05/01/2011	7,580,678
06/01/2011	7,577,841
<b>Total Member Months of Enrollment</b>	<b>90,057,785</b>

Source: Created by the Research and Analytic Studies Branch using data extracted and summarized from the Medi-Cal Eligibility Data System (MEDS).

As seen in Table 1, the number of *certified eligibles* in January 2011 is listed at **7,505,841**, which shows an increase of roughly **108,000** from July 2010. Due to this kind of variation, there are times when using a specific monthly count may not be appropriate. When enrollment data is used to estimate and influence fiscal policy, for example, using the average number of *certified eligibles* over a year may be more accurate.

### **Option 2 – Taking the Average Number of Certified Eligibles During a Year**

Counting the average number of monthly *certified eligibles* over the period of a year is a useful tool for evaluating trends in enrollment and is commonly used to determine changes in Medi-Cal caseload. In this case, a count of certified eligibles is taken each month and these 12 monthly counts are averaged. This method produces a metric that can be used to evaluate the year-over-year caseload change. It is used within the Medi-Cal Local Assistance Estimate to compare year-over-year changes in the Medi-Cal caseload.<sup>6</sup> Accordingly, average enrollment is a measure more appropriate for reporting changes between two or more annual periods, and less appropriate for reporting changes occurring within a single annual period.

The average monthly *certified eligibles* over a year are determined by summing the total number of eligible months for each certified eligible and dividing by 12.<sup>7</sup> Multiple eligibles contribute to the annual member months total (i.e., beneficiary A might contribute 8 months while beneficiary B contributes 4 months of eligibility); therefore, this calculation also provides the number of composite *certified eligibles* that were eligible for the entire year.

The formula for this metric is listed below, followed by an example using the data from Table 1, above.

$$\begin{aligned} & \Sigma (\text{Member Months for Each } \textit{certified eligible}) \div 12 \\ & \text{Months} = \textbf{average monthly } \textit{certified eligibles} \\ & \mathbf{90,057,785} (\text{Member Months for } \textit{certified eligibles}) \\ & \div 12 \text{ Months} = \mathbf{7,504,815} \end{aligned}$$

Using this calculation, the DHCS was able to determine that the average monthly *certified eligibles* enrolled in Medi-Cal during the fiscal year 2010-2011 was **7,504,815**.

### **Option 3 – Certified Eligibles Enrolled for at Least One Month During a Year**

The final technique used by the DHCS to convey Medi-Cal enrollment calculates the number of *certified eligibles* who were enrolled in Medi-Cal for at least one month during the year. This value will be higher than either of the previous calculations because it will not depict average monthly *certified eligibles* (see Option 2) but the number of individuals who were *certified eligible* to receive Medi-Cal benefits for at least one month during the year (or measurement period). This count is also referred to as the number of *unduplicated eligibles* or is sometimes referred to as *the number of beneficiaries “ever” enrolled during the year*. This methodology allows DHCS to assess exactly how many residents

of California were ever Medi-Cal eligible throughout the year, however temporary or intermittent their eligibility.

Using the state fiscal year 2010-2011 as defined in Table 1, above, DHCS identified the number of *certified eligibles* who were eligible for at least one month during that period to be **9,154,637**. The count is greater than the average monthly total of *certified eligibles* for that period, which equaled **7,504,815**. Table 2, below, displays data for state fiscal years 2003-2004 through 2010-2011, represented in monthly average *certified eligibles*, January 1 snapshot values, and total unduplicated *certified eligibles* enrolled for at least one month during the year.

**Table 2 – Using the Three Techniques: Count of Certified Eligibles, SFY 2003-04 to SFY 2010-11**

<b>Fiscal Year</b>	<b>Monthly Average Certified Eligibles</b>	<b>Certified Eligibles At Jan of the SFY</b>	<b>Unduplicated Certified Eligibles enrolled at Least One Month of Year</b>
<b>2003-04</b>	6,516,362	6,530,428	8,186,619
<b>2004-05</b>	6,540,835	6,535,728	8,209,763
<b>2005-06</b>	6,539,029	6,517,739	8,219,671
<b>2006-07</b>	6,514,401	6,486,698	8,206,486
<b>2007-08</b>	6,617,095	6,602,041	8,299,713
<b>2008-09</b>	6,868,828	6,857,201	8,576,542
<b>2009-10</b>	7,246,414	7,249,768	8,883,943
<b>2010-11</b>	7,504,815	7,505,841	9,154,637

Source: Created by the Research and Analytic Studies Branch using data extracted and summarized from the Medi-Cal Eligibility Data System (MEDS).

### Summary of the Most Recent Figures and Data for California

Now that an understanding of the qualifications and methodologies used by DHCS to calculate the number of Medi-Cal beneficiaries has been developed, these values can be understood in the context of today's population. Table 3, below, provides

another way of interpreting the data we discussed in Table 1 and Table 2. Using this table we can see that during state fiscal year 2010-2011 an average of **20.1%** of California's population was enrolled in Medi-Cal each month, while **24.6%** of Californians were enrolled at least one month during the year or "ever" enrolled.

**Table 3 - Using the Three Techniques: Proportion of California's Population Eligible for Medi-Cal, SFY 2010-11**

	<i>Certified Eligibles</i>	California Population (Static) <sup>8</sup>	Percentage of Population
<b>Calculation Techniques</b>			
<b><i>Certified Eligibles enrolled at least 1 month during the year</i></b>	9,154,637	37,318,481	24.5%
<b><i>Monthly Average Certified Eligibles</i></b>	7,504,815	37,318,481	20.1%
<b><i>Certified Eligibles on January 2011 (Snap-Shot)</i></b>	7,505,841	37,318,481	20.1%
Source: Created by the Research and Analytic Studies Branch using data extracted and summarized from the Medi-Cal Eligibility Data System (MEDS). California population data found in the California Department of Finance <i>Population Estimates and Components of Change by County July 1 2010-2011</i> . Report is located at: <a href="http://www.dof.ca.gov/research/demographic/reports/estimates/e-2/view.php">http://www.dof.ca.gov/research/demographic/reports/estimates/e-2/view.php</a> .			

### What Do Certified Eligibles Look Like Demographically?

In previous sections of this report, *certified eligibles* have been defined as those beneficiaries who are deemed qualified for Medi-Cal by a valid eligibility determination and have enrolled in the program, and are eligible to receive Medi-Cal covered services. Because certified eligible members are used by DHCS to calculate Medi-Cal enrollment and formulate statistics regarding the program, the demographic make-up of this population is worth examining. The section that follows will explore the demographic distribution of this important population.

### Age and Gender Distribution

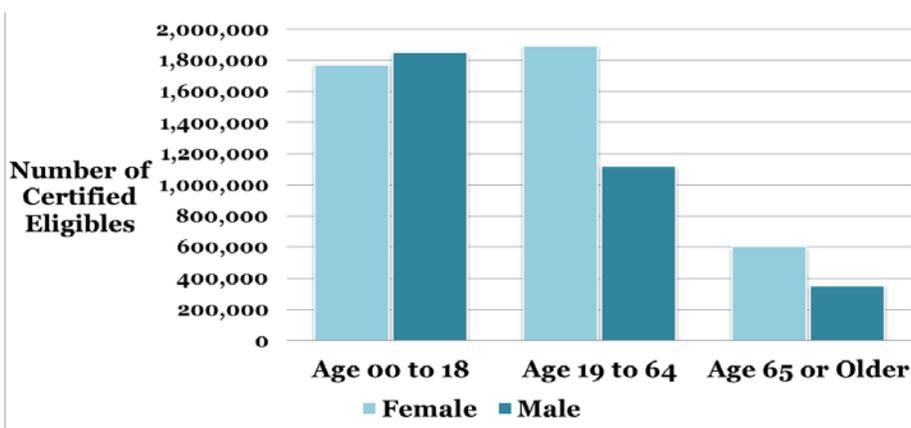
Chart 1, below, displays the distribution of *certified eligibles* by age group and gender at July 2011 using the snap-shot method outlined in Option 1, above. Approximately **56%** were female and **44%** were male. Children make up almost half of the

*certified eligible* population; roughly **3.6 million (48%)** were between 0 and 18 years of age. Adults between the ages of 19 and 64 made up the next largest portion at **3 million (40%)**, and **954 thousand (12%)** were 65 years of age or older.

Among non-elderly adults, females greatly outnumbered males, reflecting current federal and state eligibility guidelines. Parents with dependent children and pregnant women comprise the majority of non-disabled adults in the Medi-Cal program, qualifying on the basis of either deprivation or pregnancy.

Among eligibles 65 years of age and older females also outnumbered males, although for demographic rather than administrative reasons. According to the Centers for Disease Control (CDC) the average life expectancy of men at 65 years was 17.6 years, compared to 20.3 years for women.<sup>9</sup>

**Chart 1 - Snap-Shot Method: Certified Eligibles by Age Group and Gender, July 2011; Total Certified Eligibles at 7,594,872**



### What are Eligibility Pathways?

The Medicaid program is a public health insurance program that provides comprehensive health care services at no or low cost for low-income individuals including families with parents and children, seniors, persons with disabilities, foster care children, and pregnant women. Medi-Cal's various aid codes represent the numerous statutory and regulatory "pathways" for establishing eligibility for Medi-Cal benefits as well as the scope of coverage allowed under each. Each pathway is defined by specific income and resource requirements that are determined by each state within federal guidelines. Some of these pathways apply in all states; for example, all states must cover pregnant women with family incomes below **133%** of the federal poverty level. Other eligibility pathways are available only in those states that choose to cover them.

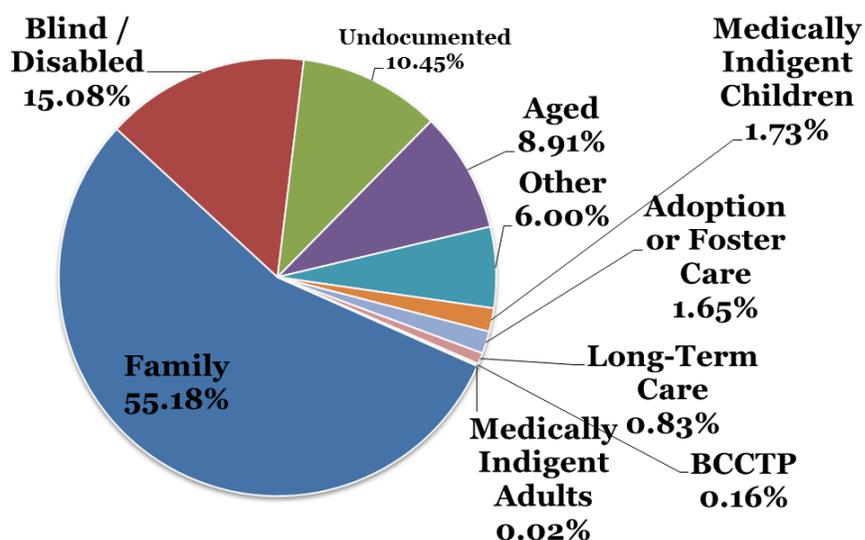
The CMS in its Medicaid Statistical Information System (MSIS) reports classifies the various eligibility pathways using the terms "Maintenance Assistance Status," and "Basis of Eligibility." **Maintenance Assistance Status** refers to mandatory and optional categories of eligibles that under Title XIX, Medicaid programs must, or may, provide benefits. These include the Categorically Needy,

individuals who fall into a specific category (or criteria) of mandatory Medicaid eligibility, and the Medically Needy, who are individuals whose income or assets might be too high to qualify for Medicaid, but also have health expenses that are higher than average. Medically Needy individuals may qualify for Medicaid because the cost of their care lowers their income to levels that would otherwise make them eligible. **Basis of Eligibility** refers to the broad demographic cohorts eligible for Medicaid benefits. The largest of these are the Aged (65 years and over), the Blind and Disabled, Adults in Families with Dependent Children, and Children under age 21.

### Aid Code Distribution

In July 2011, under **4.2 million (55%) certified eligibles** were enrolled in Public Assistance or Medically Needy Family aid codes (shown in Chart 2, below, grouped together as "Family"). Family aid codes include eligibles who qualified for benefits as adults in families with dependent children, and children under age 21. Within this category the majority of eligibles were enrolled under aid code 3N, AFDC-MN-1931(B) Non-CalWORKS.<sup>10</sup> The **2.2 million** eligibles in this aid code comprised **53%** of eligibles enrolled under Family aid codes and **29%** of Medi-Cal certified eligibles overall.

**Chart 2 - Snap-Shot Method: Distribution of *Certified Eligibles* by Aid Category, July 2011; Total *Certified Eligibles* at 7,594,872**



Source: Created by the Research and Analytic Studies Branch using data extracted and summarized from the Medi-Cal Eligibility Data System (MEDS)

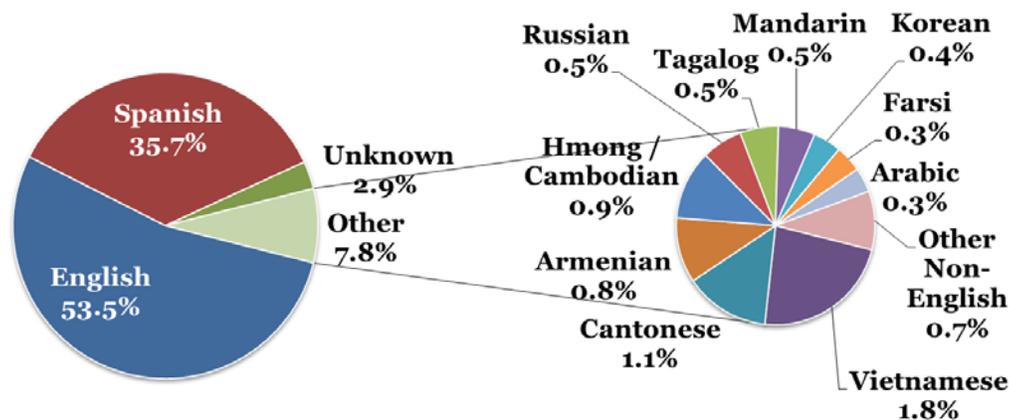
Chart 2, above, displays the distribution of certified eligibles by aid code grouping at July 2011.

There were **1.1 million (15.08%)** enrolled in the Blind and Disabled aid codes, and **793 thousand (10.45%)** enrolled as Undocumented Aliens entitled to restricted scope benefits.<sup>11</sup> Roughly **676 thousand (8.91%)** eligibles were enrolled under aid codes for the Aged and **62 thousand (.83%)** in aid codes for beneficiaries residing in Long-Term Care facilities. Finally, there were **125 thousand (1.65%)** eligible children enrolled in Adoption and Foster Care aid codes<sup>12</sup> and **131 thousand (1.73%)** within aid codes for Medically Indigent Children.

### Primary Language Distribution

As indicated in Chart 3, below, roughly **43.5%** of Medi-Cal *certified eligibles* identified a primary language other than English. After English (**53.5%**), Spanish was the most widely spoken language (**35.7%**) and the only other language to contribute a substantial percentage of the population. While these results mimic wider patterns in the population of California, the ratio of non-English speakers was higher among Medi-Cal beneficiaries. The U.S. Census Bureau found in 2007 that **42.6%** of Californians spoke a language other than English at home and categorized California among states with the highest percentage of Spanish-speakers (**22.2% to 29.3%**) in the United States.<sup>13</sup>

**Chart 3 - Snap-Shot Method: Distribution of *Certified Eligibles* by Primary Language Spoken, July 2011; Total *Certified Eligibles* at 7,594,872**



Source: Created by the Research and Analytic Studies Branch using data extracted and summarized from the Medi-Cal Eligibility Data System (MEDS).

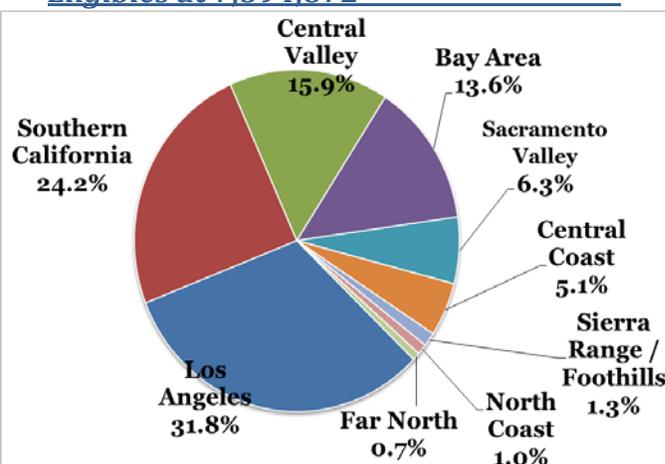
**Geographic Distribution**

Studying the geographic distribution of *certified eligibles* in California provides a valuable resource for Medi-Cal administrators looking for regional trends and local health care administrators seeking to understand the make-up of their patient population. Because a portion of Medi-Cal administration (including eligibility determination) happens at the county level, it is also useful to note the regions and counties where substantial *certified eligible* populations reside. As displayed in Chart 4, below, the geographic distribution for the Medi-Cal program reflected that of the statewide population overall.

The regions of Los Angeles County and Southern California claim the largest percentage of Medi-Cal *certified eligibles*, with **56%** of the total Medi-Cal population. The counties of the Central Valley, as well as

Lake and Tehama counties in the north, however, had the greatest percentage of their overall population identified as *certified eligibles*.

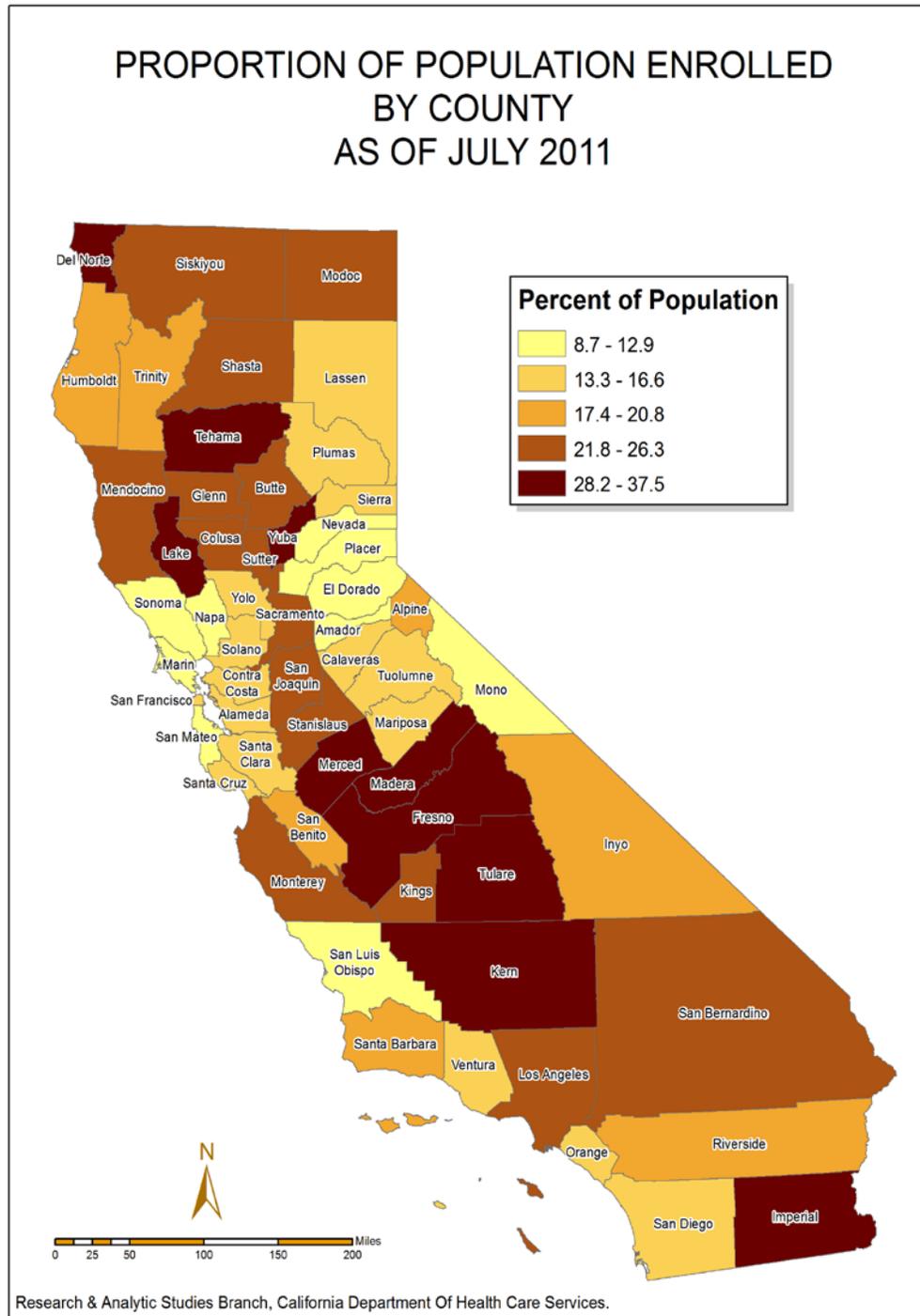
**Chart 4 - Snap-Shot Method: Distribution of *Certified Eligibles* by State Region, July 2011; Total *Certified Eligibles* at 7,594,872**



Source: Created by RASB. In this chart certified eligibles are assigned to regions based on their county of eligibility.

Chart 5, below, depicts the proportion of populations in each county enrolled in Medi-Cal.

**Chart 5 - Snap-Shot Method: *Certified Eligibles* as Percent of Total Population by County, July 2011**



**Source:** Created by the Research and Analytic Studies Branch; more studies of this nature can be found at their website: [http://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASB\\_Enrollment\\_by\\_Geographic\\_Region.aspx](http://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASB_Enrollment_by_Geographic_Region.aspx)

Understanding the proportion of a county's population enrolled in Medi-Cal is useful in determining the economic vitality of a region apart from the size of its population as well as the level of need and potential demand for public health care services.

### **How Significant Are Populations Not Counted as *Certified Eligible*?**

This section will provide a discussion regarding the importance of populations excluded from the *certified eligible* count and therefore excluded from the primary calculations presented in this report.

### **Share of Cost Exclusion**

As previously noted, beneficiaries enrolled in Medi-Cal's Share of Cost (SOC) program are not always included in the *certified eligible* classification. The SOC program is designed to assist individuals and families whose incomes are too high to qualify for cash assistance but insufficient to cover their medical expenses. Unlike traditional or no-cost Medi-Cal coverage, SOC beneficiaries must contribute to their coverage by paying their medical expenses up to a predetermined threshold (also called the SOC obligation) each month. In contrast to other forms of cost-sharing (i.e., copayments or deductibles), it is only after beneficiaries meet their monthly SOC obligation that they qualify for Medi-Cal benefits. For this reason SOC beneficiaries are not counted as *certified eligible* in

months when they do not meet their SOC obligations, because they are not eligible to receive Medi-Cal covered benefits.

Table 4, below, shows the number of SOC beneficiaries enrolled in July 2011 and the ratio by which they qualified as *certified eligibles*. Of the **464,258** beneficiaries represented, only the **72,720** beneficiaries who met their SOC are counted as *certified eligibles*. In Table 4 this relationship is broken down by the SOC obligation thresholds to provide context.

### **California's Family PACT Exclusion**

The count of Medi-Cal certified eligibles does not include those individuals receiving family planning and sexually-transmitted disease prevention services through California's Family PACT (Planning, Access, Care, and Treatment) Program. Preliminary data show that the Family PACT Program served **1.79 million** clients in fiscal year 2010-11. When all claims have been processed and retroactive eligibility is calculated, this number is expected to increase to **1.90 million**.<sup>14</sup>

**Table 4 - Snap-Shot Method: SOC Population Distribution by SOC Amount, July 2011;  
Total SOC Population at 464,258**

<b>SOC Monthly Obligation</b>	<b>Total SOC Beneficiaries</b>	<b>Did Not Meet SOC – Not <i>Certified Eligibles</i></b>	<b>Met SOC – <i>Certified Eligibles</i></b>
<b>\$ 1-499</b>	56,376	44,006	12,370
<b>\$ 500-999</b>	158,152	128,655	29,497
<b>\$1000-1499</b>	117,236	98,242	18,994
<b>\$1500-1999</b>	62,523	55,705	6,818
<b>\$2000+</b>	69,971	64,930	5,041
<b>Total</b>	<b>464,258</b>	<b>391,538</b>	<b>72,720</b>

Source: Created by the Research and Analytic Studies Branch using data extracted and summarized from the Medi-Cal Eligibility Data System (MEDS).

### **Presumptive Eligibility Program Exclusion**

Another population excluded from the *certified eligible* classification is pregnant women granted provisional Medi-Cal enrollment under the Presumptive Eligibility (PE) program. The PE program allows qualified providers to grant immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs for conditions related to pregnancy to low-income patients, pending their formal Medi-Cal application.

For purposes of clarity, women covered under the PE program are excluded from *certified eligible* counts. PE coverage is

provisional and should be issued pending an official Medi-Cal eligibility determination. Thus confirmation of pregnancy, and a valid eligibility determination, will lead to classification under a permanent *certified eligible* status under the applicable aid code and eligibility pathway, while a negative finding for pregnancy will terminate benefits at the end of the month.

## **How Are Today's Medi-Cal Counts Understood Historically?**

One of the advantages of utilizing consistent methods from year-to-year to count Medi-Cal eligibles is the ability to place current counts in context by comparing them to statistics from previous years. For a program like Medi-Cal, whose enrollment fluctuates in response to policy changes, economic developments, and various other influencers, an understanding of historic patterns of enrollment provides useful information for anticipating future enrollment trends. Additionally, an understanding of the trends and distribution of enrollment by health care delivery model (FFS versus managed care) can also help administrators understand the changing nature of Medi-Cal's health care delivery system and its logistical and administrative implications in terms of areas such as provider enrollment, audits and investigations, and claims processing capacity.

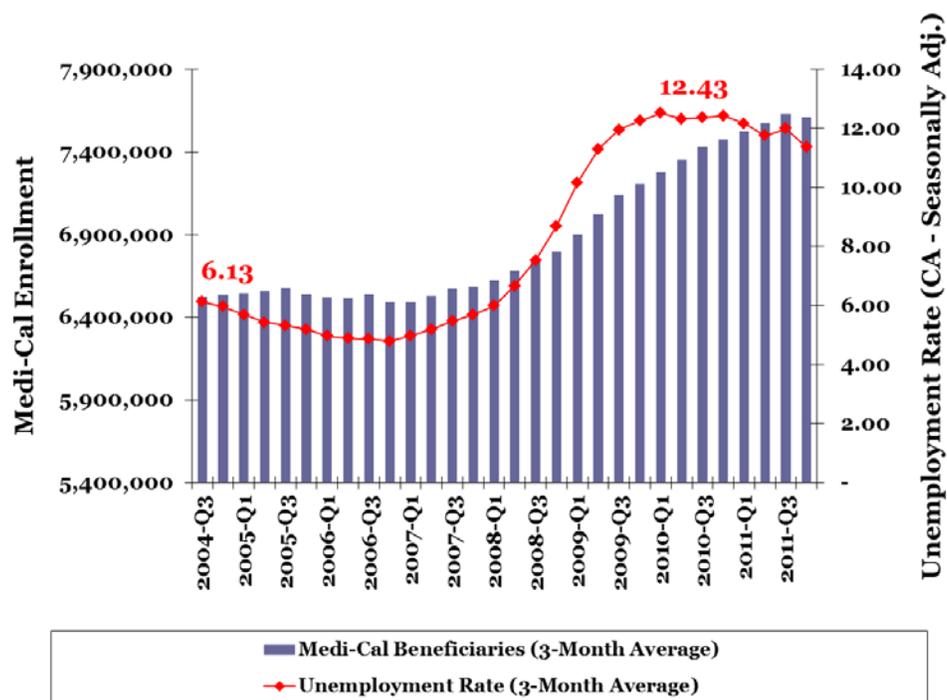
## **Economic Trends**

To better understand the *certified eligible* data for fiscal year 2010-2011 as shown in

Table 3, above, the values can be viewed as part of a trend rather than as an individual data set. Since late 2007,<sup>15</sup> increases in Medi-Cal enrollment have been driven by the national recession,<sup>16</sup> which substantially weakened the job market, doubled the unemployment rate, and led to sharp growth in the number of uninsured. While the effects of the recession were felt all across the United States, the reaction was particularly acute in California due to the collapse of the housing market. The housing market has long been a key facet of the California economy, and its collapse precipitated job loss in many industries, such as construction, real estate brokerage, and home improvement supply sales.<sup>17</sup>

As the unemployment rate in California increased dramatically, participation in public programs like Medi-Cal rose in tandem. Lately an identical trend can be seen in reverse: as the California unemployment rate has leveled off and declined slightly, the monthly increases in the number of Medi-Cal eligibles have also abated. Chart 6, below, shows this relationship.

**Chart 6 - Medi-Cal Enrollment and California's Unemployment Rate, July 2004 to December 2011**



**Source:** Created by RASB, using enrollment data from the Medi-Cal Eligibility Data System (MEDS) system and unemployment data from the California Employment Development Department.

**Trends in Service and Enrollment: Expansion in Managed Care**

Another significant development in Medi-Cal is the growth in managed care as an alternative service delivery model to the traditional FFS system. Historically, Medi-Cal services were delivered through its traditional FFS system, in which medical providers billed Medi-Cal for individual services delivered to Medi-Cal beneficiaries (providers submitted a claim for reimbursement for each service performed or product delivered). Under the FFS delivery system, Medi-Cal administrators deal directly with participating providers statewide, regarding participation, medical

care policies, and payment. Under managed care systems, HMOs, or comparable entities, agree to provide a specific set of services to Medi-Cal enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner.

Under managed care, health plans receive a specific monthly prepayment for managing the care of each beneficiary and assume the risk for the cost of the services delegated. Furthermore, when enrolled in a Medi-Cal managed care health plan, eligibles ideally select, or are assigned to, a primary care

physician responsible for coordinating care. The health plans are directed to provide care coordination and management, and to make available a broad range of covered benefits that are specified in their contracts with the California DHCS.<sup>18</sup>

Although the managed care population of California has increased significantly in recent years, managed care is not a new health care development. In 1973 Congress enacted the Health Maintenance Organization (HMO) Act in an effort to encourage more efficient delivery and financing systems in health care. This act established guidelines for and supported the development of HMOs as an alternative to the FFS system and authorized them to serve Medicare and Medicaid recipients.<sup>19</sup>

Several health plans were organized to serve local Medi-Cal populations following the HMO Act, however, the modern foundation for managed care in California was developed in 1975. In that year Governor Jerry Brown established the Prepaid Health Plan Advisory Committee in response to the increased presence of Prepaid Health Plans (PHPs) and HMOs in California<sup>20</sup>. These efforts resulted in the transfer of regulatory authority from the Attorney General to the Department of Corporations (later to the Department of Managed Health Care) and the passage of the Knox-Keene Health Care Service Plan Act of 1975. The Knox-Keene

Act fulfilled the regulatory requirements set by the federal HMO Act of 1973 and provides the framework for regulating managed care today.<sup>21</sup>

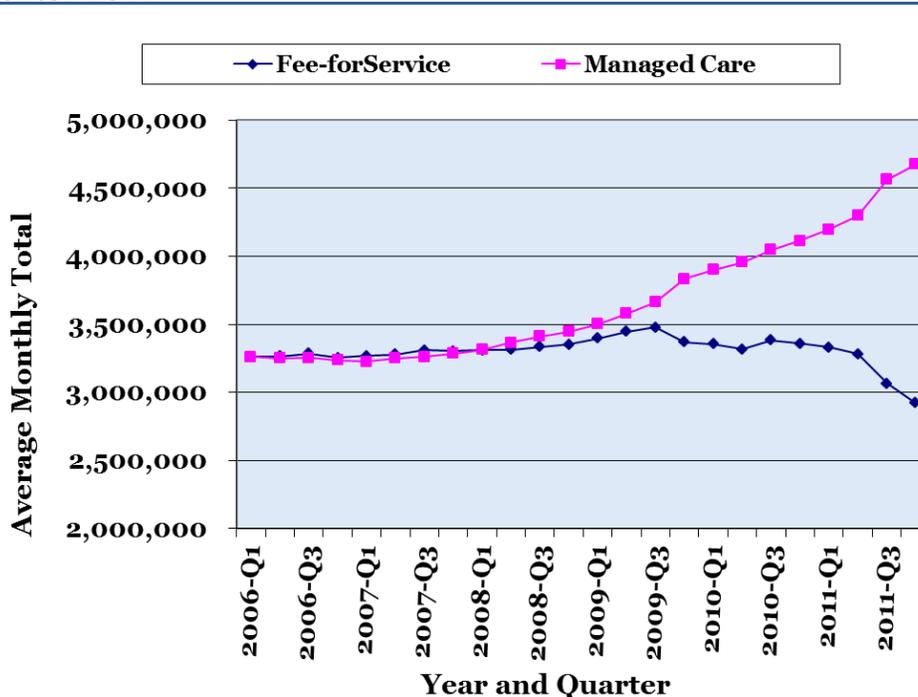
In the early 1980's and 1990's California implemented additional programs including Primary Care Case Management (PCCM), intended as a transition to managed care, and the County Organized Health System (COHS), which essentially enrolled all Medi-Cal beneficiaries within a county into one health plan.<sup>22,23</sup> In 1993 the state established the Geographic Managed Care (GMC) and the Two-Plan models.<sup>24</sup> The two plan model called for a local initiative – a locally developed, California-licensed HMO initiated by the county board of supervisors – and a commercial plan organized by the private sector.

By 2004, the Medi-Cal program had expanded the managed care program to service roughly **3.25 million** beneficiaries, or half of the enrolled Medi-Cal population. Between 2004 and 2007 the distribution of beneficiaries enrolled in FFS and managed care remained constant, at a roughly fifty-fifty split. As shown in Charts 7 and 9 which follow, a surge in managed care enrollment began in 2008 that continues today and which has altered that distribution dramatically.

The rapid growth of the managed care model reflects two developments. First, a number of additional counties have transitioned from a FFS delivery of care model to the managed care model during the studied time period, making managed care the obligatory choice for many beneficiaries in those regions. Second, the majority of new beneficiaries following the onset of the recession in 2007 qualified for coverage under Needy Family aid codes, which mandate enrollment in managed care

health plans in applicable counties. Over the next few years the proportion of Medi-Cal beneficiaries receiving services under the FFS model is expected to shrink further, as DHCS seeks to transition its disabled, dual eligible (*certified eligibles* who are also eligible for Medicare) beneficiaries, and FFS populations residing in rural counties into the managed care delivery model.

**Chart 7 - Fee-for-Service (FFS) and Managed Care Enrollment, First Quarter 2006 to Fourth Quarter 2011**

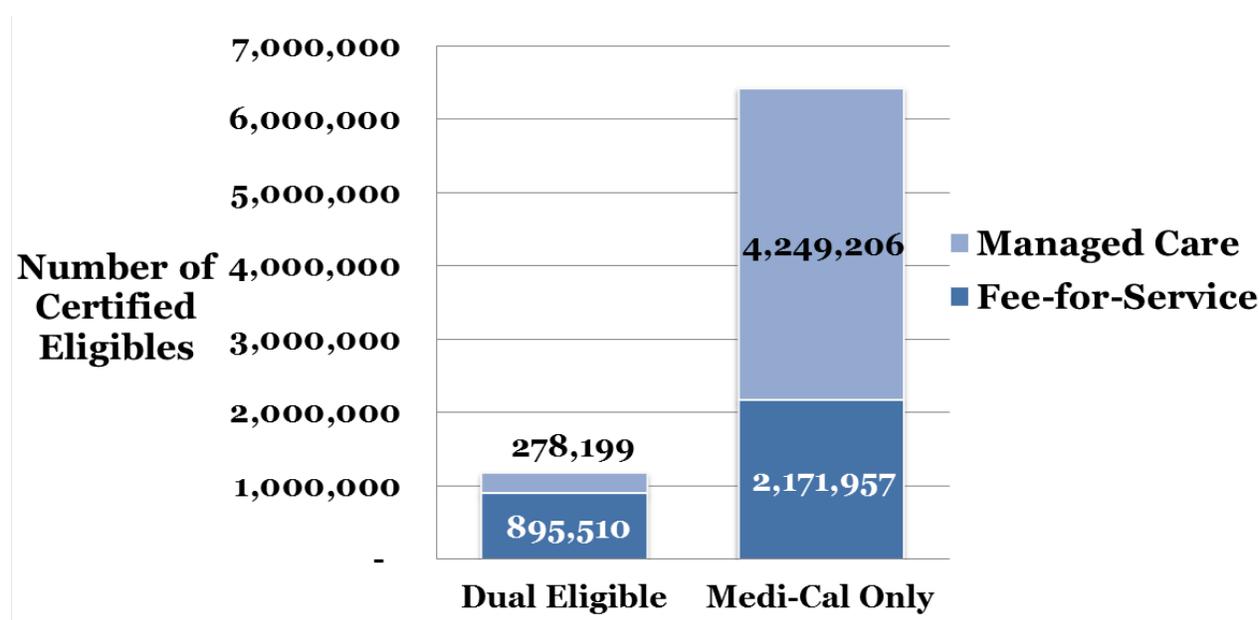


Source: Created by the Research and Analytic Studies Branch using data extracted and summarized from the Medi-Cal Eligibility Data System (MEDS).

Chart 8, below, shows the distribution of eligible beneficiaries during July 2011. At that time there were approximately **6.4 million certified eligibles** covered by Medi-Cal exclusively. The portion of *certified eligibles* that is also dual eligible accounts for roughly **15%** of the Medi-Cal population and is estimated to include **1.17 million**

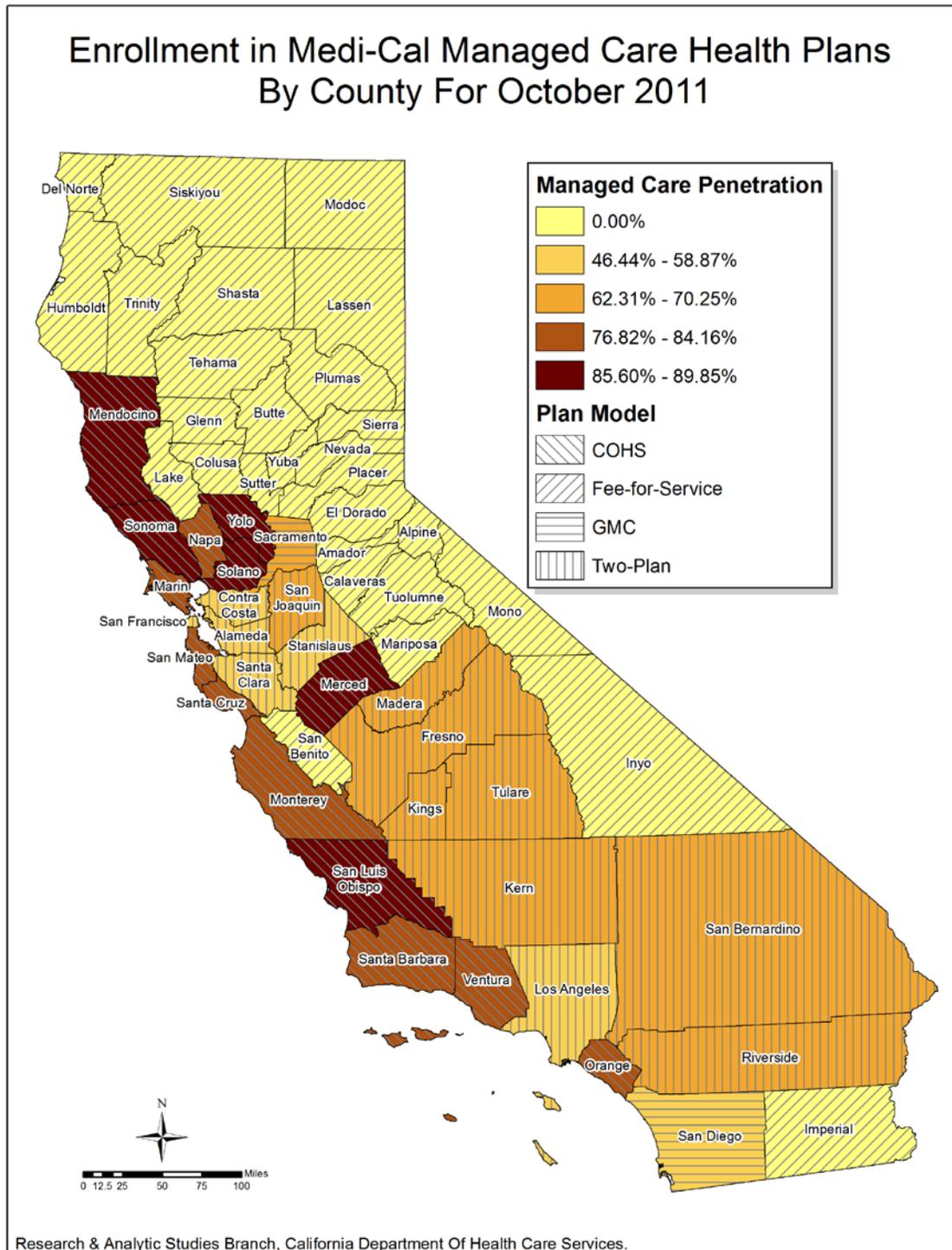
beneficiaries.<sup>25</sup> Currently the majority (**76%**) of Medi-Cal’s dual eligible beneficiaries receive care under the FFS model and **24%** under the managed care model (Chart 8). Of the beneficiaries eligible for Medi-Cal only, **66%** were enrolled in a managed care health plan.

**Chart 8- Snap Shot Method: Distribution of *Certified Eligible* by Coverage Category and Delivery of Care Model, July 2011; Total *Certified Eligibles* at 7,594,872**



**Source:** Created by the Research and Analytic Studies Branch using data extracted and summarized from the Medi-Cal Enrollment Data System (MEDS).

**Chart 9 - Snap-Spot Method: Percentage of *Certified Eligibles* Enrolled in Medi-Cal Managed Care Health Plans by County, October 2011**



**Source:** Created by the Research and Analytic Studies Branch using data extracted and summarized from the Medi-Cal Enrollment Data System (MEDS).

### Managed Care Expansion Efforts in 2011

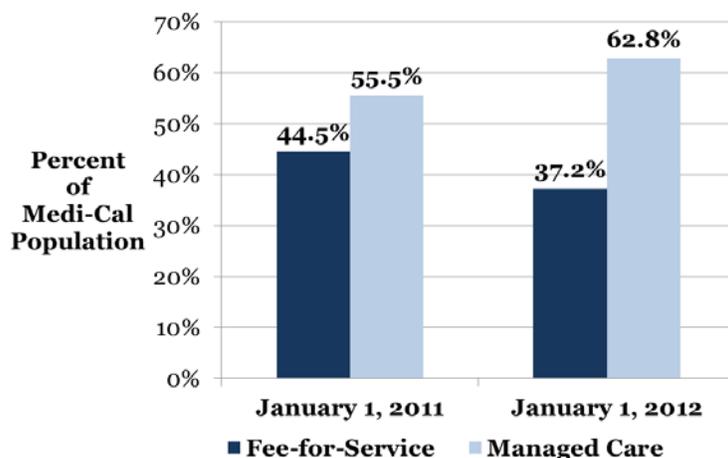
On January 1, 2012 there were **7,559,147** certified eligible beneficiaries enrolled in the Medi-Cal program. Roughly **4,743,545**, or **62.8%**, of these beneficiaries were enrolled in Medi-Cal managed care health plans, while **2,815,602** or **37.2%** received care under the traditional FFS delivery of care model. Overall there was a net shift of **575,694** beneficiaries, or **7.3%** of the Medi-Cal population, from the FFS to the managed care delivery of care model, between January 2011 and January 2012.

Two initiatives strongly contributed to this shift. Under the terms of California’s Section 1115 “Bridge to Reform” waiver with the federal government, the managed care enrollment requirement for beneficiaries in aid codes for “Seniors and Persons with Disabilities” (SPDs) was changed from

“voluntary” to “mandatory.”<sup>26</sup> In May 2011 the department began the process of enrolling SPDs residing in Two-Plan and GMC model counties into health plans, with plan enrollment occurring in twelve scheduled monthly increments. In May 2011 there were approximately **394,582** SPD beneficiaries enrolled under traditional FFS. By January 1, 2012 the number of SPD beneficiaries enrolled under FFS had decreased to **158,771**, and by May 1, 2012 the number had fallen to **77,949**.

Also in 2011, Ventura, Marin and Mendocino counties shifted to the County Organized Health System (COHS) managed care model moving an additional **140,944** beneficiaries from the FFS model into health plans.

**Chart 10 - Change in Distribution of Beneficiaries by Delivery of Care Model, January 2011 to January 2012**



**Source:** Created by the Research and Analytic Studies Branch using data extracted and summarized from the Medi-Cal Enrollment Data System (MEDS).

## Where Can I Find More Information on the Medi-Cal Population?

Analysis for this report was done by the Research and Analytic Studies Branch (RASB) of the DHCS. The function of RASB is to compile official statistics and perform analytical studies to further the goals of the DHCS, inform policy decisions, and monitor health outcomes for Medi-Cal beneficiaries. The staff of RASB has undertaken this report in an effort to provide internal and external stakeholders with actionable information and useful analytical resources. More information regarding Medi-Cal enrollment, program expenditures, and

other relevant topics is available at the RASB website.

To find more reports like this one or to learn more about the Medi-Cal population, please use the many resources available at the following websites:

The DHCS Research and Analytic Studies Branch web address is:

[http://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASS\\_Default.aspx](http://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASS_Default.aspx)

The DHCS Medi-Cal Budget Estimates can be found at the following web address:

<http://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/default.aspx>

**IF YOU PLAN TO CITE THIS PAPER IN A SUBSEQUENT WORK, WE SUGGEST THE FOLLOWING CITATION:**

California Department of Health Care Services, Research and Analytic Studies Branch. *Finding California's Medi-Cal Population: Challenges and Methods in Calculating Medi-Cal Enrollment Numbers*. Sacramento, CA: California Department of Health Care Services.

**PLEASE NOTE:**

This document provides a brief summary of complex subjects and should be used only as an overview and general guide to the Medi-Cal program. The views expressed herein do not necessarily reflect the policies or legal positions of the California Health and Human Services Agency (CHHS) or the California Department of Health Care Services (DHCS). These summaries do not render any legal, accounting, or other professional advice, nor are they intended to explain fully all of the provisions or exclusions of the relevant laws, regulations, and rulings of the Medicare and Medicaid programs. Original sources of authority should be researched and utilized.

## References and Resources

<sup>1</sup> “MAY 2012 MEDI-CAL LOCAL ASSISTANCE ESTIMATE for FISCAL YEARS 2011-12 and 2012-13: Management Summary,” Department of Health Care Services; May 2012.

[http://www.dhcs.ca.gov/dataandstats/reports/mceestimates/Documents/2012\\_May\\_Estimate/M12\\_01MS\\_Mgmt\\_Summ\\_Tab.pdf](http://www.dhcs.ca.gov/dataandstats/reports/mceestimates/Documents/2012_May_Estimate/M12_01MS_Mgmt_Summ_Tab.pdf)

<sup>2</sup> “Medicaid and CHIP – California – Kaiser State Health Facts,” The Kaiser Family Foundation; Accessed August 2012.

<http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=52&rgn=6>

<sup>3</sup> Family PACT Preliminary Report; FY 2008-09. URL:

[http://www.familypact.org/Files/Provider/Research%20Reports/FamPACT\\_AnnualReport\\_FY0809\\_2010-0901.pdf](http://www.familypact.org/Files/Provider/Research%20Reports/FamPACT_AnnualReport_FY0809_2010-0901.pdf)

<sup>4</sup> The data sets present summary data by aid category, age group, county, health system enrollment, etc. and information can be accessed at:

[http://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASS\\_Medi-Cal\\_Enrollment\\_Trends.aspx](http://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASS_Medi-Cal_Enrollment_Trends.aspx)

<sup>5</sup> SOC beneficiaries are those members who qualify for Medi-Cal assistance only when their medical expenses exceed a predetermined monthly threshold.

<sup>6</sup> For an example of this metric, see the May 2011 Medi-Cal Local Assistance Estimate, Caseload Tab at: [http://www.dhcs.ca.gov/dataandstats/reports/mceestimates/Documents/2011\\_May\\_Estimate/M11\\_CL\\_Doc\\_A.pdf](http://www.dhcs.ca.gov/dataandstats/reports/mceestimates/Documents/2011_May_Estimate/M11_CL_Doc_A.pdf)

<sup>7</sup> This calculation is also referred to as finding

*beneficiary years*. The term is used interchangeably with “average monthly *certified eligibles*” in literature regarding this methodology.

<sup>8</sup> California Department of Finance, E-2. State of California, Department of Finance, Population Estimates and Components of Change by County. Revised July 1, 2010.

<http://www.dof.ca.gov/research/demographic/reports/estimates/e-2/view.php>

<sup>9</sup> Centers for Disease Control, FASTSTATS; [http://www.cdc.gov/nchs/fastats/older\\_americans.htm](http://www.cdc.gov/nchs/fastats/older_americans.htm)

<sup>10</sup> The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) replaced Aid to Families with Dependent Children (AFDC) with Temporary Assistance for Needy Families (TANF), decoupling the program from Medicaid. However Congress also specified in section 1931

of the Social Security Act that beneficiaries who meet the prior eligibility criteria of the defunct AFDC program must continue to receive Medicaid benefits. California families who no longer receive CalWORKS benefits (California’s TANF program), but continue to meet the program’s requirements can receive Medi-Cal benefits. These families are referred to as “1931(b) non-cash” beneficiaries in reference to the Social Security Act statute. Source: Medi-Cal Policy Institute, Section 1931(b) Medi-Cal Fact Sheet No. 7”, 1999.

<sup>11</sup> Restricted scope Medi-Cal benefits cover emergency situations, health care for pregnant women, kidney dialysis, nursing home care and treatment for breast and cervical cancer. The two most influential pieces of Federal legislation defining the Medicaid services that undocumented aliens may receive are the Omnibus Budget Reconciliation Act of 1986 (OBRA) (PL 99-509) and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (PL 104-193). Under OBRA, Congress amended Title XIX § 1903 of the Social Security Act (SSA) [42 USC 1396b] establishing that no Federal payment shall be made to a State for medical assistance to an alien who is not a legal permanent resident or PRUCOL, with the exception of care and services that are necessary for the treatment of an emergency medical condition. PRWORA provided new definitions identifying those aliens who are considered “qualified” for federal public benefits (8 USC 1641), by doing so, an alien not defined under PRWORA is not qualified for Federal public benefits, this includes undocumented aliens, as well as PRUCOL aliens. PRWORA made unqualified aliens ineligible for any Federal public benefits with the exception of the care and services necessary for the treatment of an emergency medical condition (8 USC 1611) as defined in XIX SSA 1903(v)(3) [42 USC 1396b(v)(3)].

<sup>12</sup> The statutory authority mandating coverage for Adoption and Foster Care children is found under Title IV-E of the Social Security Act (42 U.S.C. §§ 671-679b). Title IV-E provides for federal reimbursement for a portion of the maintenance and administrative costs of foster care for children who meet specified federal eligibility requirements.

<sup>13</sup> “Language Use in the United States: 2007,” U.S. Department of Commerce, U.S. Census Bureau; 2010. <http://www.census.gov/hhes/socdemo/language/>

<sup>14</sup> Family PACT Preliminary Report; FY 2010-11.  
URL: [http://www.familypact.org/Files/Reports-and-Briefs/2011-](http://www.familypact.org/Files/Reports-and-Briefs/2011-1108_FamPACTPreliminaryReport_508.pdf)

[1108\\_FamPACTPreliminaryReport\\_508.pdf](http://www.familypact.org/Files/Reports-and-Briefs/2011-1108_FamPACTPreliminaryReport_508.pdf)

<sup>15</sup> According to the National Bureau of Economic Research the most recent recession began in December 2007 and ended in June 2009.

Source: “US Business Cycle Expansions and Contractions,” NBER;

<http://www.nber.org/cycles.html>

<sup>16</sup> Bardhan, Ashok, Walker, Richard, *California, Pivot of the Great Recession*, Institute for Research on Labor & Employment, University of California, Berkeley.

[http://metrostudies.berkeley.edu/pubs/reports/Walker\\_93.pdf](http://metrostudies.berkeley.edu/pubs/reports/Walker_93.pdf)

<sup>17</sup> Bardhan, Ashok, Walker, Richard, *California, Pivot of the Great Recession*, Institute for Research on Labor & Employment, University of California, Berkeley.

[http://metrostudies.berkeley.edu/pubs/reports/Walker\\_93.pdf](http://metrostudies.berkeley.edu/pubs/reports/Walker_93.pdf)

<sup>18</sup> See “Medi-Cal Managed Care Boilerplate Contracts”<http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>

<sup>19</sup> “Measuring the Quality of Medicaid Managed Care: An Introduction to State Efforts”, Council of State Governments, 2000.

<http://www.csg.org/knowledgecenter/docs/Misc00Medicaid.pdf>

<sup>20</sup> “Making Sense of Managed Care Regulation in California,” California Health Care Foundation; November 2001.

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MakingSenseManagedCareRegulation.pdf>

<sup>21</sup> “Making Sense of Managed Care Regulation in California,” California Health Care Foundation; November 2001.

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MakingSenseManagedCareRegulation.pdf>

<sup>22</sup> E. Kathleen Adams, Janet M. Bronstein, Edmund R. Becker., “Medi-Cal and Managed Care: Risk, Costs, and Regional Variation”, Public Policy Institute of California, 2000.

[http://www.ppic.org/content/pubs/report/r\\_1200kar.pdf](http://www.ppic.org/content/pubs/report/r_1200kar.pdf)

<sup>23</sup> The term “essentially” is used here because there are some populations, such as the undocumented, that are not mandatorily enrolled in COHS managed care plans.

<sup>24</sup> Ibid

<sup>25</sup> The number of dual eligible beneficiaries reported includes those fully eligible for

Medicare Parts A, B and D, and those partially eligible for some, but not all of the three. The count of dual eligibles does not include individuals participating in Medicare Savings Plans for whom the Medi-Cal program pays premiums and cost-sharing, but pays for no other services.

<sup>26</sup> See Special Terms and Conditions (STCs) for California’s Bridge to Reform section 1115(a) Medicaid Demonstration, 77. Mandatory Enrollment of SPDs.

<http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CA%20Special%20Terms%20%20Conditions.pdf>