

# Analysis of The Length of Time Between Initial Medi-Cal Enrollment and Becoming Medicare Eligible

## Background

The Department of Health Services (DHS) Medi-Cal redesign plan calls for the expanded use of managed health care systems. Under the expansion plan, aged, blind, and disabled (ABD) eligibles will be mandatorily enrolled into participating managed care health plans.

The managed care expansion plan for ABD eligibles includes enrollment into existing managed care models as well as enrollment in 13 new counties. The Medi-Cal managed care models are: (1) Two-Plan, (2) Geographic Managed Care (GMC), (3) County Organized Health Systems (COHS), and (4) Acute and Long-Term Care Integration (ALTCI).

Unique mandatory enrollment criteria have been established for each managed care plan model type that is associated with a distinct county. For example, Los Angeles County is considered a Two-Plan model county, while Orange County is considered a COHS. The primary difference between the Two-Plan/GMC plan model types and the COHS is that beneficiaries eligible for Medicare will not be mandatorily enrolled into Two-Plan/GMC managed care health plans.

In terms of Medi-Cal managed care expansion, this has some potentially significant consequences. For example, in Two-Plan and GMC counties—which do not mandatorily enroll Medicare eligible beneficiaries—an important question must be considered: will specific groups of beneficiaries be enrolled into managed care plans for a short period of time and then be redirected back into fee-for-service (FFS) due to gaining Medicare eligibility? In this paper, we will attempt to answer this question by evaluating a group of beneficiaries over time. We will provide information regarding the proportion of the population that gains Medicare eligibility over 12 months, 24 months, etc.

## Population Statistics

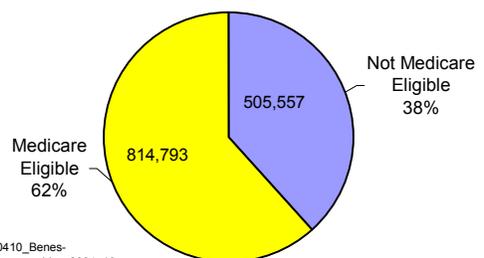
For the most part, the population that will be impacted by Medicare eligibility is associated with the ABD categories. Further, within these categories, one aid code accounts for a significant proportion of the potential shift from Medi-Cal eligibility only to Medicare eligibility (i.e., dual eligibility status). In the context of the present discussion, populations having a significant proportion of their eligibles with the potential to become Medicare eligible throughout the

year have the greatest likelihood of shifts in Medi-Cal managed care enrollment back to FFS.

Roughly 62 percent of the FFS ABD population is Medicare eligible, while 38 percent or 500,000 eligibles are not presently eligible for Medicare (Figure I). This population, FFS ABDs without Medicare eligibility, represents the population of interest in the present case. This population constitutes beneficiaries that may become Medicare eligible throughout the year and—based on their county of residence and Medi-Cal managed care model type—be moved back into FFS.

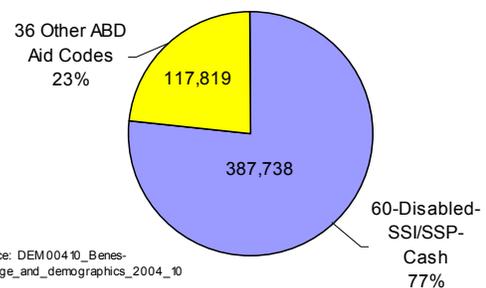
By far the greatest numbers of eligibles with the potential to be shifted back into the Medi-Cal FFS system due to Medicare eligibility are associated with aid code 60 (Disabled SSI/SSP - Cash). Roughly 77 percent of the ABD beneficiaries that are not Medicare eligible are aid code 60 eligibles (Figure II).

Figure I  
Percentage of FFS ABDs Medi-Cal vs. Medicare Eligible  
Month-of-Eligibility October 2004  
N = 1,320,350



Source: DEM00410\_Benes-By\_age\_and\_demographics\_2004\_10

Figure II  
FFS ABD Aid Code 60 Population vs. All Other ABD Aid Codes  
Month-of-Eligibility October 2004  
N = 505,557



Source: DEM00410\_Benes-By\_age\_and\_demographics\_2004\_10

## Methodology

To evaluate the potential impact of shifting from managed care eligible status to FFS status, we focused on the population that will have the greatest impact—aid code 60 eligibles.

Evaluating the number of eligibles that will be shifted into Medicare eligibility status requires an evaluation of a distinct population over time. To compile our data set, we developed an aid code 60 cohort and traced their eligibility status (Medicare vs non-Medicare eligibility) over a 48-month period (July 1999 through July 2003). To allow for a sufficient time to elapse between initial Medi-Cal enrollment and potential Medicare eligibility, our universe consisted of all “new” monthly aid code 60 eligibles entering Medi-Cal during the period July 1999 through July 2000. Further, we limited our analysis to only those “new” beneficiaries that were not eligible for Medi-Cal during the previous 12 months.

“New” beneficiaries were identified as beneficiaries having at least a one-month break in Medi-Cal eligibility and an eligibility status code of 001 or 002 or 003<sup>1</sup>.

After identifying the number of monthly “new” aid code 60 eligibles during the period July 1999 through July 2000, we selected the month of July 1999 for analysis<sup>2</sup> (Tables I & II). The population cohort (i.e., July 1999 “new” aid code 60 eligibles) was then evaluated over time with respect to Medicare eligibility status.

**Table I- “New” Aid Code 60 Eligibles July 1999 Cohort**

	Eligibles	% Of Total
At Least 1 Month of Prior Eligibility	824	26.14%
No Eligibility In Prior 12 Months	2,328	73.86%
<b>Total</b>	<b>3,152</b>	<b>100.00%</b>

<sup>1</sup> Eligibility status codes 001, 002, and 003 represent regular eligibility reported timely, reported retroactively, and three month retroactive eligibility respectively.

<sup>2</sup> We also selected the month of July 2000 and performed a similar analysis to evaluate our findings. We found no significant difference in the proportion of the population becoming Medicare eligible over time. When evaluating the entire population of “new” eligibles without regard to age, the July 2000 cohort disclosed that roughly 9% of the population became Medicare eligible after 12 months and 22 % after 24 months.

**Table II – Age Distribution July 1999 Cohort**

Age Group	Eligibles
<1	120
1-20	390
21-40	552
41-60	1,011
61-80	255
<b>Total</b>	<b>2,328</b>

## Findings

Based on our analysis, roughly 9 percent of the “new” aid code 60 eligibles became Medicare eligible within 12 months (Figure III). After 24 months, this figure rose to 27 percent.

Our analysis does not consider continuous enrollment. That is, a beneficiary may have become ineligible for Medi-Cal at some time during the 48-month evaluation period (i.e., July 1999 through July 2003) and regained eligibility. The percentage displayed represents the proportion of the monthly cohort population Medicare eligible.

As would be expected, age played a distinct role in whether a beneficiary became Medicare eligible. For example, we found little difference between the two age groups 21 to 40 and 41 to 60 years of age. Consistent with the overall group, roughly 30 percent of the “new” population cohort became Medicare eligible after 24 months. Between 9 to 11 percent of these age group cohorts became Medicare eligible after 12 months (Figures IV & V). Differences were noted in the 1 to 20 age group and beneficiaries reaching 65 years of age. In the 1 to 20 age group cohort, roughly 1 percent of the cohort population became Medicare eligible after 12 months and only 5 percent after 24 months. As would be expected, the greatest proportion of the population becoming Medicare eligible was associated with individuals reaching 65 years of age during the evaluation period (Figure VI).

The initial cohort contained 2 beneficiaries that were 65 years of age at July 1999. As the population cohort aged throughout the evaluation period, the proportion of individuals 65 years of age that were Medicare eligible at any point in time was roughly 85 percent (Figure VII).

Consistent with expectations, eligibles at or near 65 years of age tended to become Medicare eligible much quicker than their younger counterparts. As a result, the Department intends to further evaluate specific age groups within the ABD population relative to mandatory enrollment.

## **D**ata Sources:

- MCSS Pivot table  
DEM00410\_Benes\_by\_age\_and\_demographics\_2004\_10
- MIS/DSS Data warehouse Eligibility Table—Data set run on February 25, 2005

Document Prepared by MCSS  
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Questions Regarding This Document Should Be  
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Figure III - Beneficiaries Becoming Medicare Eligible Over Time  
All "New" Aid Code 60 Beneficiaries Without Regard to Age

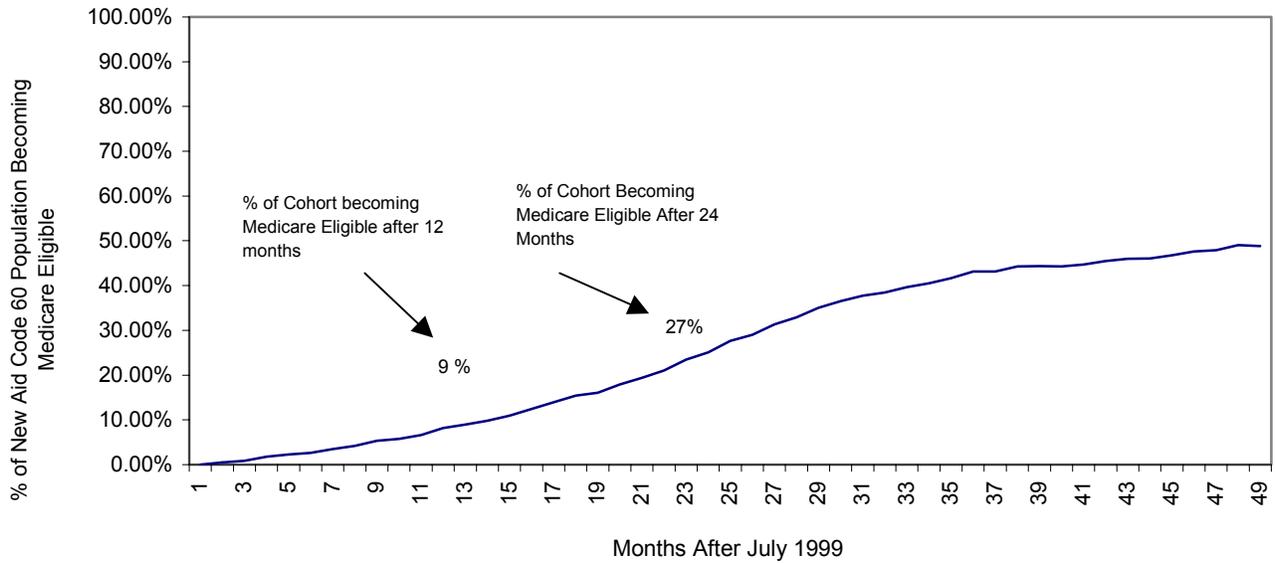


Figure IV - % of "New" Aid Code 60 Beneficiaries Becoming Medicare Eligible By Month  
21 to 40 Years of Age At Enrollment  
n At July 1999 = 552

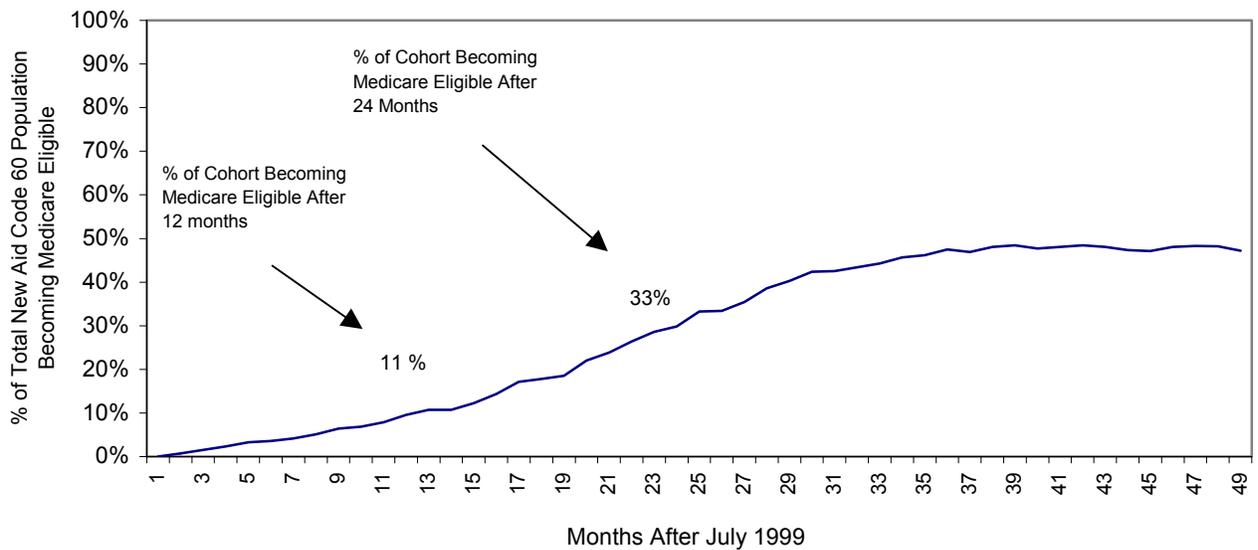


Figure V - % of "New" Aid Code 60 Beneficiaries Becoming Medicare Eligible By Month  
 41 to 60 Years of Age At Enrollment Date of 7/99  
 n at July 1999 = 1,011

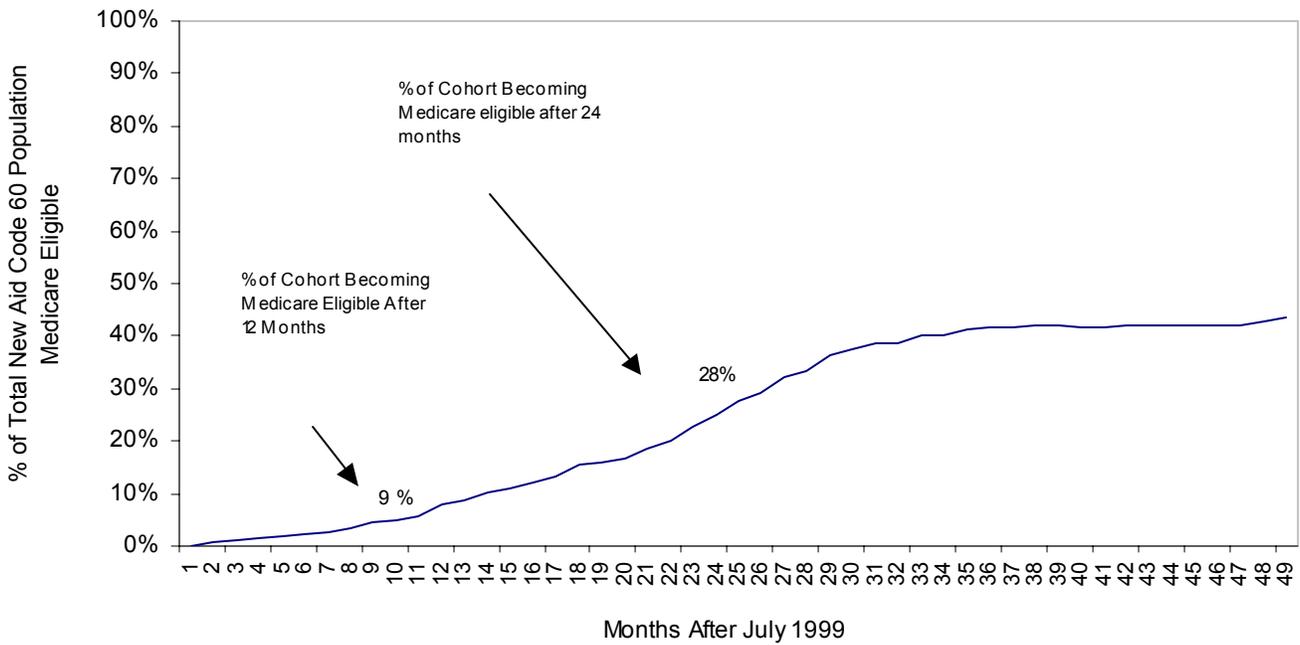


Figure VI  
 Number of Individuals 65 Years of Age At Enrollment or Turning 65 Throughout The Evaluation  
 Period

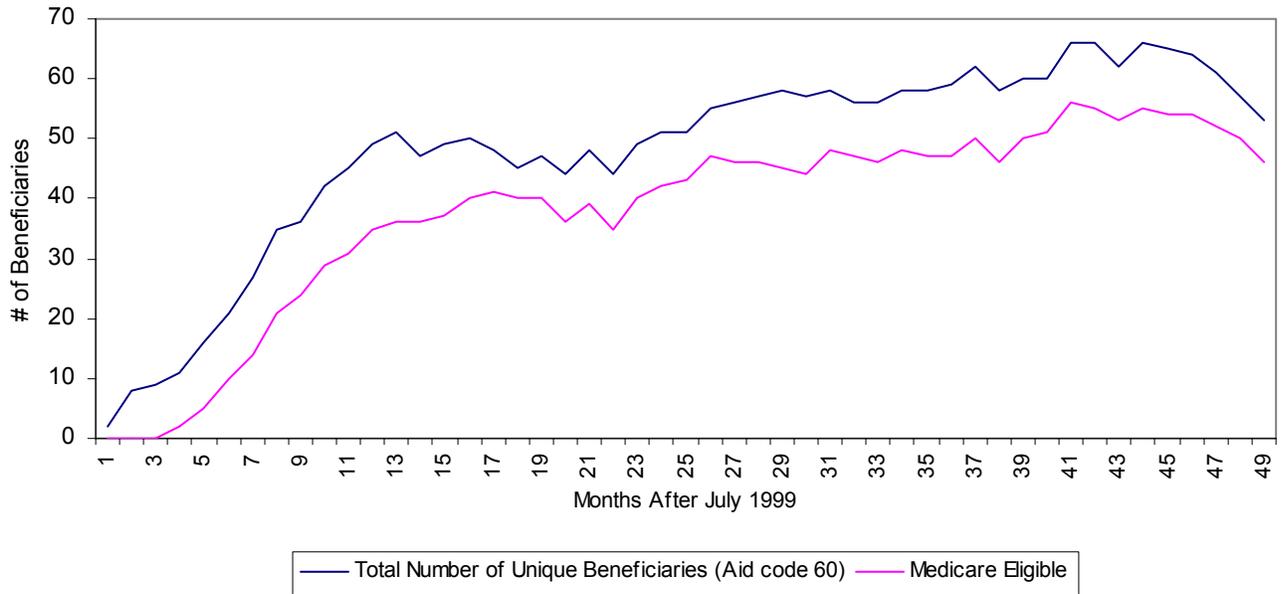


Figure VII  
% of "New" Aid Code 60 Beneficiaries Becoming Medicare Eligible By Month  
Beneficiaries 65 Years of Age At Enrollment or Turning 65 Years of Age  
Throughout the  
Evaluation Period

