Care Management for Medicare-Medicaid Enrollees

Prepared by
James M. Verdier
Mathematica Policy Research
And the
Integrated Care Resource Center
For the
2012 CMS Region 8 (Denver) State Medicaid Directors’ Meeting
June 12, 2012
Introduction and Overview

- Medicare-Medicaid enrollees (dual eligibles) under age 65 often have characteristics and care needs that differ from those of duals age 65 and over.

- Dual eligibles age 65 and older are generally sicker and poorer than non-dual Medicare beneficiaries age 65 and older.

- Overall Medicare and Medicaid expenditures for dual eligibles are approximately the same, but expenditures are mostly for very different services.

- Medicare and Medicaid financing, care delivery, and accountability are intertwined in exceedingly complex ways.

- There are major challenges in coordinating care for dual eligibles, but the Medicare-Medicaid Coordination Office (MMCO) and the Integrated Care Resource Center (ICRC) are making extensive resources available to states to help with coordination and integration.
Composition of the Dual Eligible Population

- 9.1 million dual eligibles in 2008 (Kaiser, April 2012a)
  - 61 percent were age 65 or older, and 39 percent were under age 65
  - 77 percent were “full duals” receiving full Medicaid benefits
    - For “partial duals,” Medicaid pays only Medicare Part A and/or B premiums and – for some but not all – Medicare beneficiary cost sharing (deductibles, coinsurance, copayments)
Characteristics and Care Needs

- **Duals under age 65 compared to duals age 65 and older**
  (Kaiser, April 2009, July 2010 and April 2012a,b,c; MedPAC, June 2010 and June 2011)

- **Duals under age 65 have:**
  - Similar low income and education levels *(MedPAC, June 2011)*
  - Lower incidence of physical illnesses (72% vs. 93%)
  - Higher incidence of physical disabilities
  - Higher incidence of mental/cognitive conditions (49% vs. 34%)
    - Higher levels of schizophrenia, depression, intellectual/developmental disabilities, and affective and other serious disorders
    - Lower levels of Alzheimer’s and other dementia
  - Lower nursing facility use
Characteristics and Care Needs (Cont.)

- Duals age 65 and older compared to other over-65 Medicare beneficiaries (Kaiser, April 2009, July 2010 and April 2012a,b,c; MedPAC June 2011)

- Duals have:
  - Lower income and education levels
  - Higher incidence of physical illnesses (92% vs. 83%)
    - Higher levels of heart and lung disease and diabetes
  - Higher incidence of mental/cognitive conditions (34% vs. 18%)
    - Higher levels of Alzheimer’s, other dementia, and depression
  - Higher nursing facility use
Users of Long-Terms Supports and Services (LTSS) Among Dual Eligibles

- **Medicaid LTSS users (2007)** *(CMS, June 2012)*
  - Long-stay institutional – 13%
  - Short-stay institutional – 3%
  - Other institutional – 2%
  - Community LTSS – 19%

- **Medicaid institutional LTC users, by age (2007)** *(Kaiser, April 2012c)*
  - Under age 65 – 6.7%
  - Age 65 and older – 21.6%

- **Medicare skilled nursing facility users (2007)** *(Kaiser, April 2012c)*
  - Under age 65 – 4.5%
  - Age 65 and older – 11.9%
## Behavioral Health Conditions Among Dual Eligibles

*(Kaiser, July 2010)*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Under Age 65</th>
<th>Age 65-79</th>
<th>Age 80+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s/ other dementia</td>
<td>6%</td>
<td>13%</td>
<td>39%</td>
</tr>
<tr>
<td>Depression</td>
<td>28</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td>Intellectual disabilities</td>
<td>7</td>
<td>&lt;1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>12</td>
<td>4</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Affective and other serious disorders</td>
<td>27</td>
<td>17</td>
<td>21</td>
</tr>
<tr>
<td><strong>TOTAL with any mental/cognitive conditions</strong></td>
<td><strong>49</strong></td>
<td><strong>34</strong></td>
<td><strong>53</strong></td>
</tr>
</tbody>
</table>
Costs to Medicaid and Medicare

- 15 percent of total Medicaid beneficiaries in 2007, and 35 percent of Medicaid expenditures (CMS, June 2012)

- 20 percent of Medicare beneficiaries in 2007, and 32 percent of Medicare expenditures (CMS, June 2012)

- In 2007, Medicare paid 54 percent of total costs of full benefit Medicare-Medicaid enrollees and Medicaid paid for 46 percent (CMS, June 2012)
  - Medicaid share ranged from 66% (MI and SC) to 31% (ND)
  - Based on linked Medicare and Medicaid claims data
  - Includes Medicare and Medicaid capitated managed care payments
  - Does not include Medicaid payments for Medicare premiums (about 5 percent of total combined expenditures)
While each program pays about half of total dual eligible costs, payment is mostly for very different services.

Medicaid spending by service, 2008 (Kaiser, April 2012)
- Long-term care – 69%
  - 2/3 institutional and 1/3 community
- Acute care not covered by Medicare and Rx drugs – 6%
- Medicare acute care cost sharing (16%) and premiums (9%)

Average annual Medicare payment per dual eligible by service, 2007 (MedPAC, June 2011)
- TOTAL - $16,512
  - Inpatient and outpatient hospital - $7,016
  - Rx drugs – $4,262
  - Physician and related services - $2,884
  - Skilled nursing facility - $1,160
  - Home health - $752
  - Hospice - $403
<table>
<thead>
<tr>
<th>Service</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Care</td>
<td>$7,864</td>
<td>$448</td>
<td>$8,312</td>
</tr>
<tr>
<td>Ambulatory Care</td>
<td>2,629</td>
<td>1,299</td>
<td>3,928</td>
</tr>
<tr>
<td>Rx Drugs</td>
<td>2,878</td>
<td>83</td>
<td>2,961</td>
</tr>
<tr>
<td>Other Acute Care</td>
<td>413</td>
<td>1,613</td>
<td>2,026</td>
</tr>
<tr>
<td>SNF/NF</td>
<td>1,139</td>
<td>6,789</td>
<td>7,928</td>
</tr>
<tr>
<td>Home Health</td>
<td>928</td>
<td>464</td>
<td>1,392</td>
</tr>
<tr>
<td>HCBS and Related Care</td>
<td>0</td>
<td>3,321</td>
<td>3,321</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>15,850</strong></td>
<td><strong>14,018</strong></td>
<td><strong>29,868</strong></td>
</tr>
</tbody>
</table>
Medicaid Rx Drug Use by Dual Eligibles in 2005

- Medicaid Rx drug use by dual eligibles in 2005 (Mathematica-CMS, June 2009)
  - Under age 65
    - 39% used antipsychotics and 58% used antidepressants
  - Age 65 and over
    - 16% used antipsychotics and 35% used antidepressants
  - Full-year residents of nursing facilities
    - 45% used antipsychotics and 64% used antidepressants
Major Challenges in Coordinating Care

- Dual eligible users of Medicaid LTSS receive almost all acute care services (inpatient, physician, Rx drugs) from Medicare, but states and LTSS providers currently have almost no information on these Medicare services.

- Dual eligibles – especially those under age 65 – have major behavioral health needs that Medicare does not fully cover, and Medicaid lacks information on their Medicare Rx drug, inpatient, ER, and physician service use.

- Services that both programs cover – nursing facility, home health, durable medical equipment, and hospice – intersect in complex and little-understood ways.
Medicaid payment of Medicare premiums and beneficiary cost sharing is incomplete and administratively complex.

Data linking Medicare and Medicaid service use and expenditures at the individual level have been lacking.

The MMCO has now linked Medicare and Medicaid claims and eligibility data for all 9 million duals for 2007, and has prepared State Profiles for all states and the nation that will be published shortly.

- Linked files provide data on service use and expenditures, by type of service.
- Includes diagnoses recorded on claims:
  - Diagnoses for conditions prevalent among dual eligibles under age 65 (schizophrenia, bipolar disorder, HIV/AIDS, developmental disorders, substance use disorders, and others) will soon be added.
“Low-Cost, Low-Administrative Burden Ways to Better Integrate Care for Medicare-Medicaid Enrollees” (ICRC, June 2012)

- Form partnerships with stakeholders
- Strengthen relationships between primary care providers and other service and support providers
- Expand knowledge of LTSS and behavioral health service providers
- Improve the flow of information in care transitions
- Obtain real-time information on hospital and emergency room use
- Use capitated managed care programs to improve linkages between primary care, behavioral health care, and LTSS
Opportunities for States to Coordinate Care *(Cont.)*

- “Integrating Care for Medicare-Medicaid Enrollees Using a Managed Fee-for-Service Model” (ICRC, February 2012)
  - Available at: [http://www.integratedcareresourcecenter.com/pdfs/ICRCManagedFFSModels031912.pdf](http://www.integratedcareresourcecenter.com/pdfs/ICRCManagedFFSModels031912.pdf)

- What is needed:
  - Clear vision for integration
  - Accountable entity or entities
  - Identification of high-need, high-cost beneficiaries
  - Multidisciplinary care teams
  - Comprehensive assessments
  - Patient-centered care plans
  - Comprehensive care management interventions
  - Real-time information exchange
  - Financial alignment
Beneficiary Annual Summary File (BASF)
- Contains measures of utilization and expenditures per year by beneficiary and by type of service
- Includes diagnoses from CMS Chronic Condition Warehouse

Part A/B/D claims/event/eligibility data files
- Contains data on amounts paid per-service and per beneficiary, as well as demographic and service-level identifiers and diagnoses
- Not aggregated at individual beneficiary level or over periods of time

For more detail on Medicare data for dual eligibles and how to obtain data files, visit:
http://www.integratedcareresourcecenter.com/icmdatatoolkit.aspx
Beneficiary Annual Summary File

- **Advantages**
  - Can be used for program design and planning purposes to identify overlaps, gaps, and duplication in Medicare and Medicaid coverage; to identify savings opportunities; and for capitated rate-setting
  - Easier to use than raw Medicare claims data; can be linked to annual Medicaid data at individual level
  - Shorter lead time to start using data
  - Easier to identify patterns of service use and costs

- **Limitations**
  - Contains only limited individual claim-level data, so many details of individual service use (number and type of physician visits, for example) are not available
  - Does not include Part D prescription drug data
  - Most recent data are for CY 2010
  - Data for beneficiaries in Medicare managed care plans are not available
Claim/Event/Eligibility Data Files

- **Advantages**
  - Can be used to support individual care coordination activities
  - Data are timelier than the BASF summary files
  - Includes Part D data (but must be requested separately)
  - Can be linked to Medicaid data at individual level

- **Limitations**
  - Data files are large, hard to use
  - Data may not be current and complete for all services
  - Non-final-action claims sets may need to be unduplicated
  - Privacy Act requirements may limit sharing of data
  - Price/cost information is not available for Part D data
  - Data for beneficiaries in Medicare managed care plans are not available
About the Integrated Care Resource Center (ICRC)

- Established by CMS to advance integrated care models for Medicaid beneficiaries with high costs and high needs
- Provides technical assistance (TA) to help states integrate care for:
  - Individuals who are dually eligible for Medicare and Medicaid
  - High-need, high cost Medicaid populations via Health Homes as well as other emerging models
- TA is coordinated by Mathematica Policy Research and the Center for Health Care Strategies
  - Visit [http://www.integratedcareresourcecenter.com/](http://www.integratedcareresourcecenter.com/) to download resources, including briefs and practical tools to help address implementation, design, and policy challenges
  - Use the ICRC email address to request TA: integratedcareresourcecenter@cms.hhs.gov
Examples of ICRC Technical Assistance

- Potential TA topics
  - Operations and administration
  - Reimbursement
  - Data management
  - Clinical functions
  - Monitoring and evaluation
  - Contracting and authority

- Vehicles for TA
  - Ongoing regularly scheduled consultation with subject matter experts
  - Support for stakeholder engagement
  - Identification of training needs and development of training materials
  - In-depth assistance on special topics through multi-day TA sessions of staff extenders
Sources

- CMS. “Medicare-Medicaid Enrollee State Profile: The National Summary.” June 2012

- Katherine Young, et al. “Medicaid’s Role for Dual Eligible Beneficiaries.” Kaiser Commission on Medicaid and the Uninsured, April 2012a

- Gretchen Jacobson, et al. “Medicare’s Role for Dual Eligible Beneficiaries.” Kaiser Family Foundation, April 2012b

- Teresa Coughlin, et al. “The Diversity of Dual Eligible Beneficiaries: An Examination of Services and Spending for People Eligible for Both Medicaid and Medicare.” Kaiser Commission on Medicaid and the Uninsured, April 2012c

- MedPAC. “A Data Book.” Section 3, Dual-eligible beneficiaries, June 2011
Sources (Cont.)


- Judy Kasper, et al. “Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending.” Kaiser Commission on Medicaid and the Uninsured, July 2010


Contact Information

James M. Verdier
Mathematica Policy Research, Inc.
1100 1st St., NE
12th Floor
Washington, DC 20002-4221
jverdier@mathematica-mpr.com