Connecticut Medicare and Medicaid Eligibles: Review of Key Data Findings

April 27, 2012

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Caveats

- Base data was validated by Mercer in JEN Associate's IMMRs system
- All base data taken at face value
- Additional analysis is required for greater refinement and action
  - This analysis is only a start; information is illustrative
  - JEN has data ready for additional analysis

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Data Purpose

- To analyze and describe the Medicare and Medicaid Eligible (MME) population that will be served by the Demonstration Application
- To develop a data-driven MME program design
- To identify opportunities to improve quality of care and potential savings under the Demonstration

Population Size

- What is the overall size of the population of MMEs?

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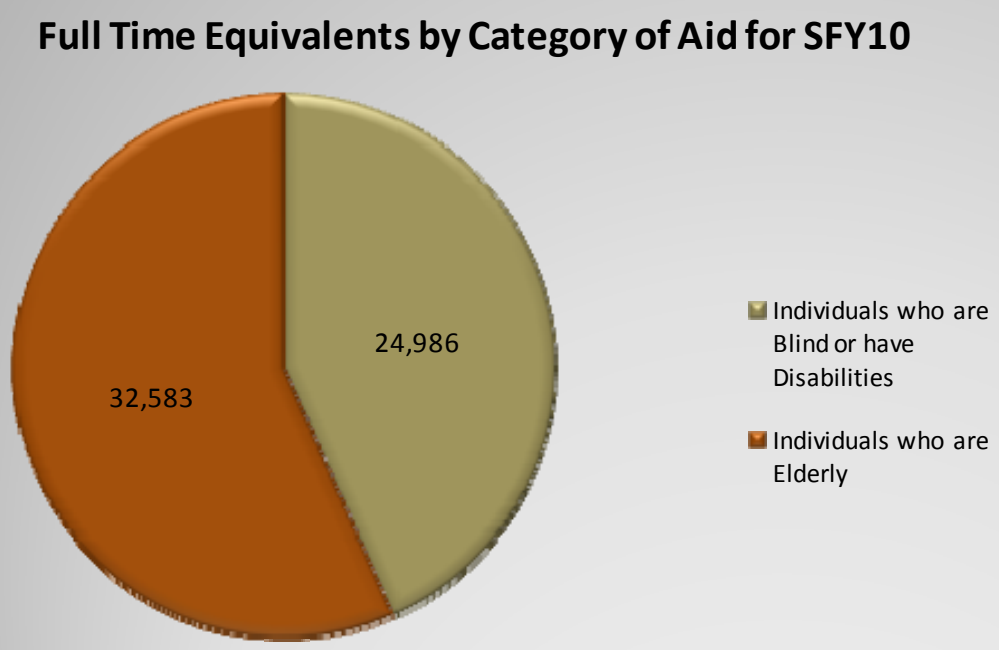
Population Size (cont.)

- Who is eligible?



The elder population makes up 57% of all MMEs while individuals with disabilities comprise 43% of the total MME population

The total population of MMEs that is eligible for the Demonstration is 57,569 individuals*

*Population count based on Mercer data

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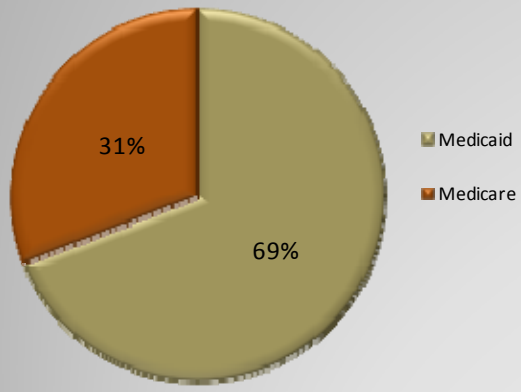
Population Size (cont.)

- Who is the payor?

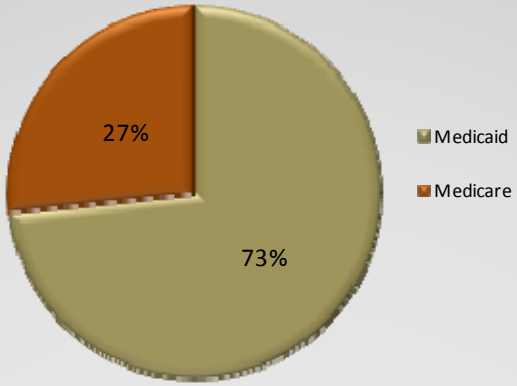
SFY10 Medicare and Medicaid Spending

Total: $3.1 Billion



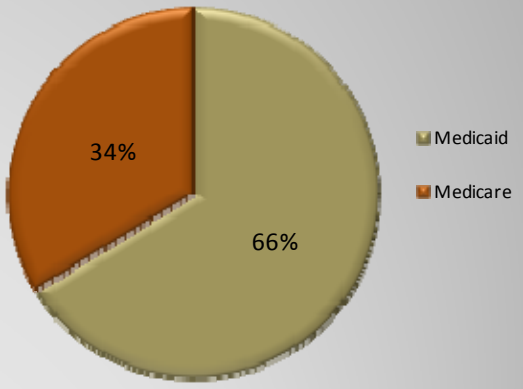
Medicaid - $2.1 Billion, $37,000 per Person
Medicare - $1.0 Billion, $16,500 per Person

Individuals who are Blind or have Disabilities: $1.3 Billion



Medicaid - $1.0 Billion, $36,800 per Person
Medicare - $0.3 Billion, $13,400 per Person

Individuals who are Elderly: $1.8 Billion



Medicaid - $1.2 Billion, $37,200 per Person
Medicare - $0.6 Billion, $19,000 per Person

Medicaid covers two-thirds of spending for elders and nearly three-quarters of all spending for those < age 65

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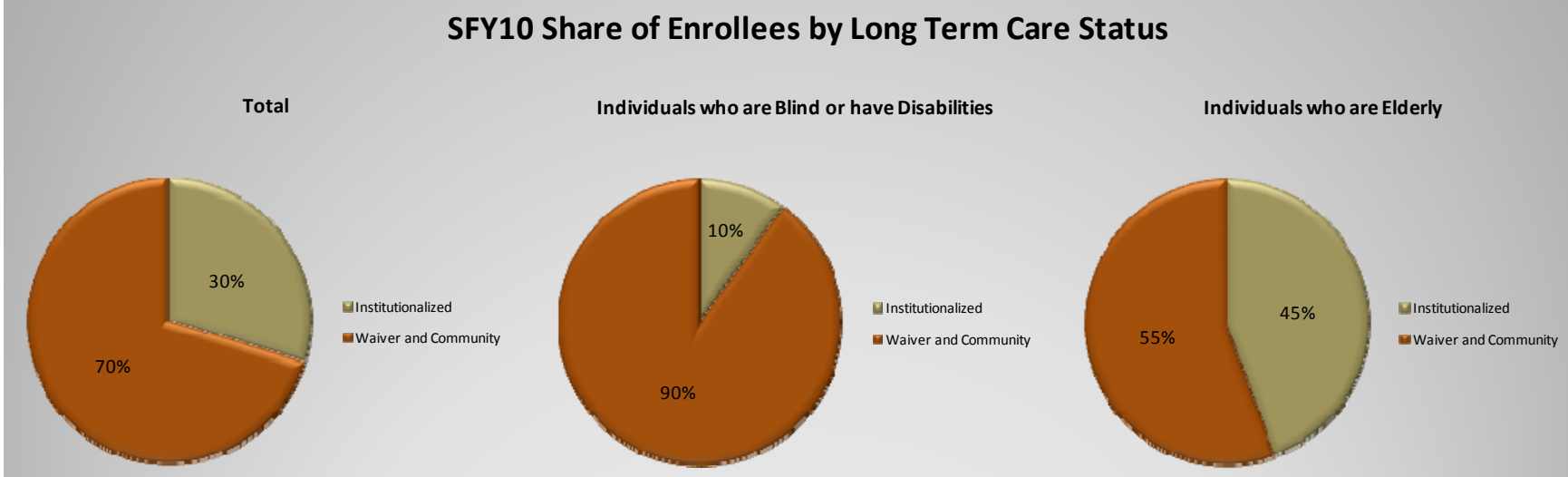
Population Size (cont.)

- Where are services received at a high level?



Only 10% of individuals with disabilities < age 65 live in long-term care facilities as compared with 45% of all elders who are MME

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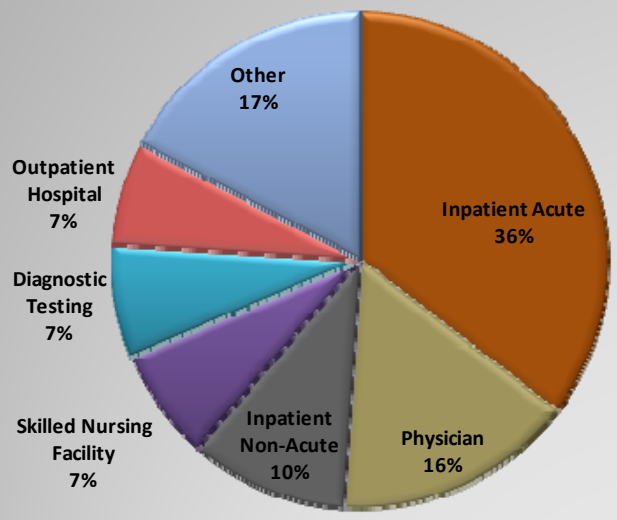
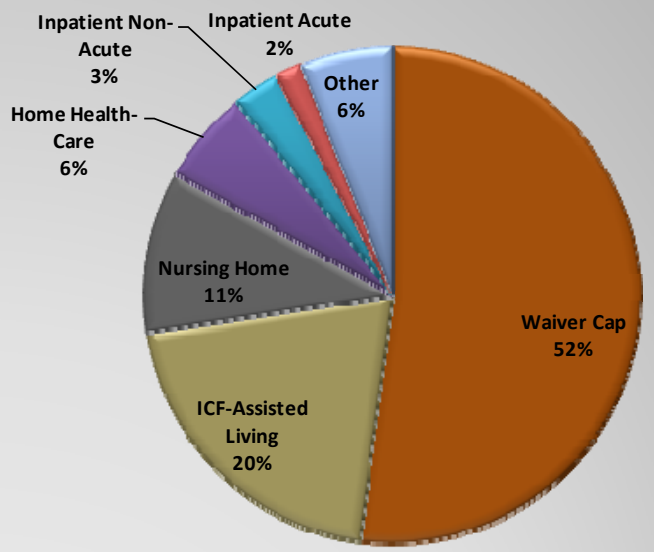
Population Size (cont.)

- Where are services received at a detailed cost level for individuals who are blind or have disabilities?



SFY10 Medicare Spending



SFY10 Medicaid Spending

Nursing home payments are relatively low for individuals who have Medicare and Medicaid coverage with disabilities < age 65, (especially as compared with elders) and the majority of Medicaid Spending for this population is for Waiver Cap services

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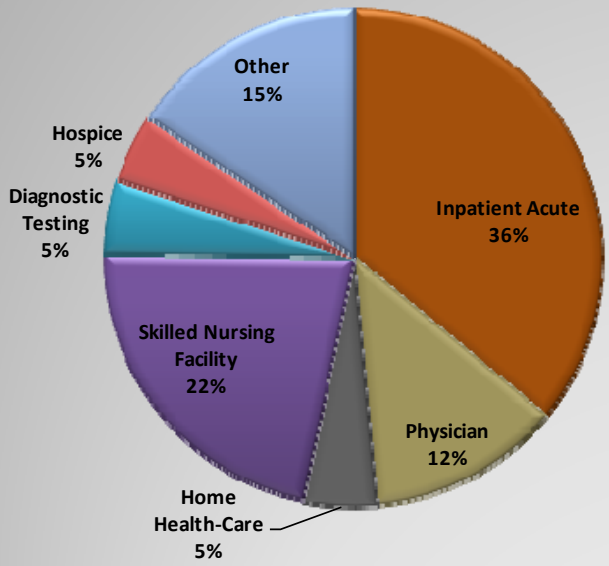
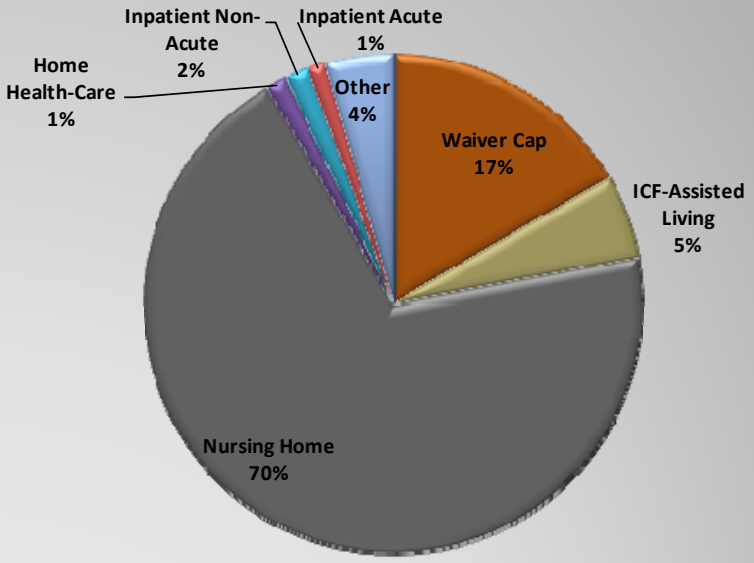
Population Size (cont.)

- Where are services received at a detailed cost level for the elderly?



SFY10 Medicare Spending



SFY10 Medicaid Spending

Nursing facility payments represent 22% of Medicare payments and 70% of Medicaid payments for MMEs > age 65

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Expenditure Profile

- What is the expenditure profile for the population by eligibility group?

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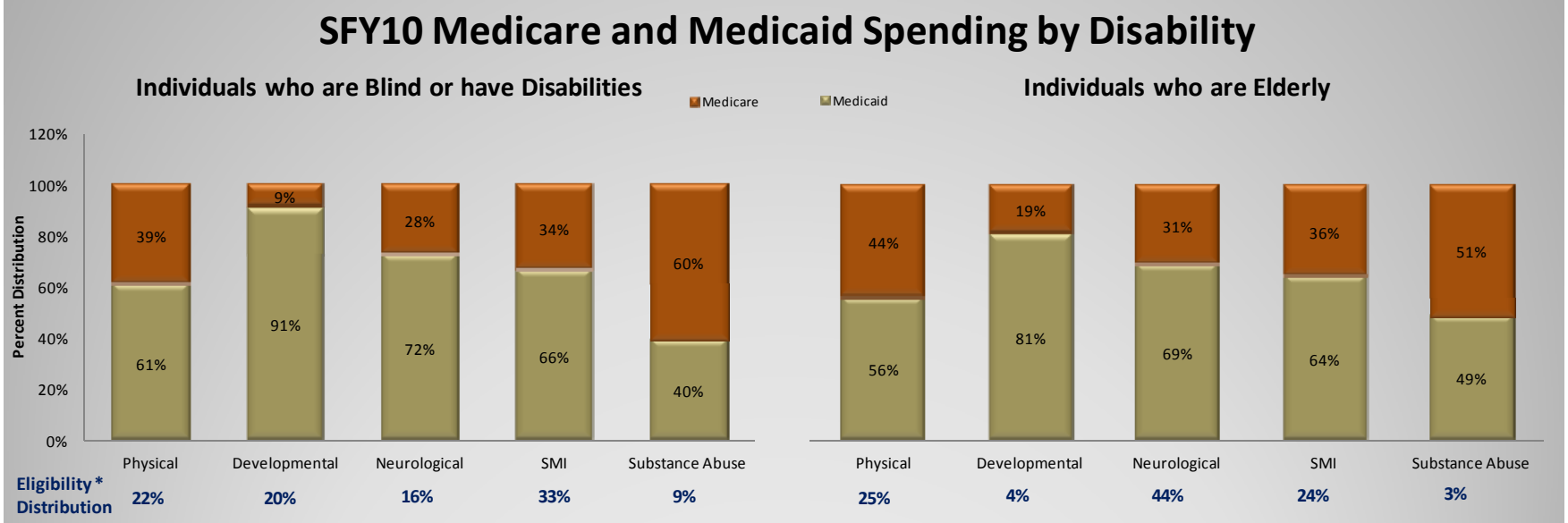
Expenditure Profile (cont.)

- Cost allocation by disability type



The share of Medicare vs. Medicaid expenditures is similar for elders and individuals <65 when disability status is taken into account

*The eligibility distribution represents the percentage of people that are in each disability type for each aid category

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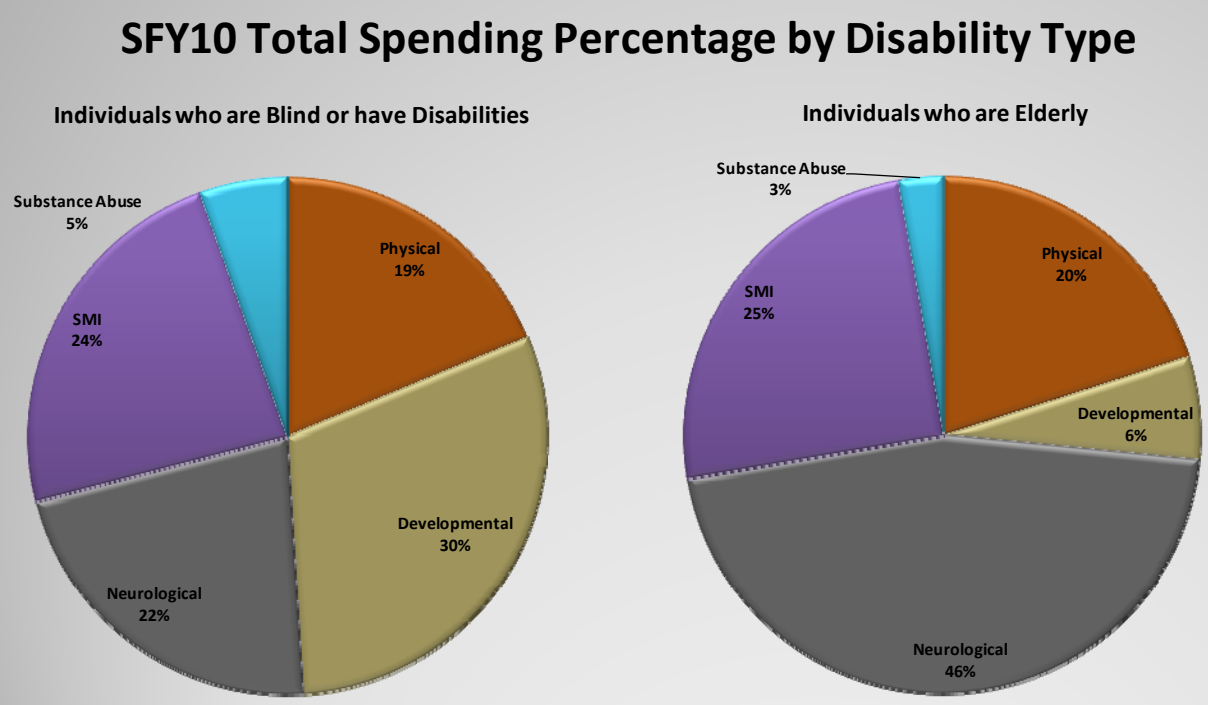
Expenditure Profile (cont.)

- Total spend by disability type



Spending by disability type varies as expected across MME individuals with disabilities and elders > age 65

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COS and LTS Setting

- What is the population distribution and PMPM by Category of Service by LTS setting?

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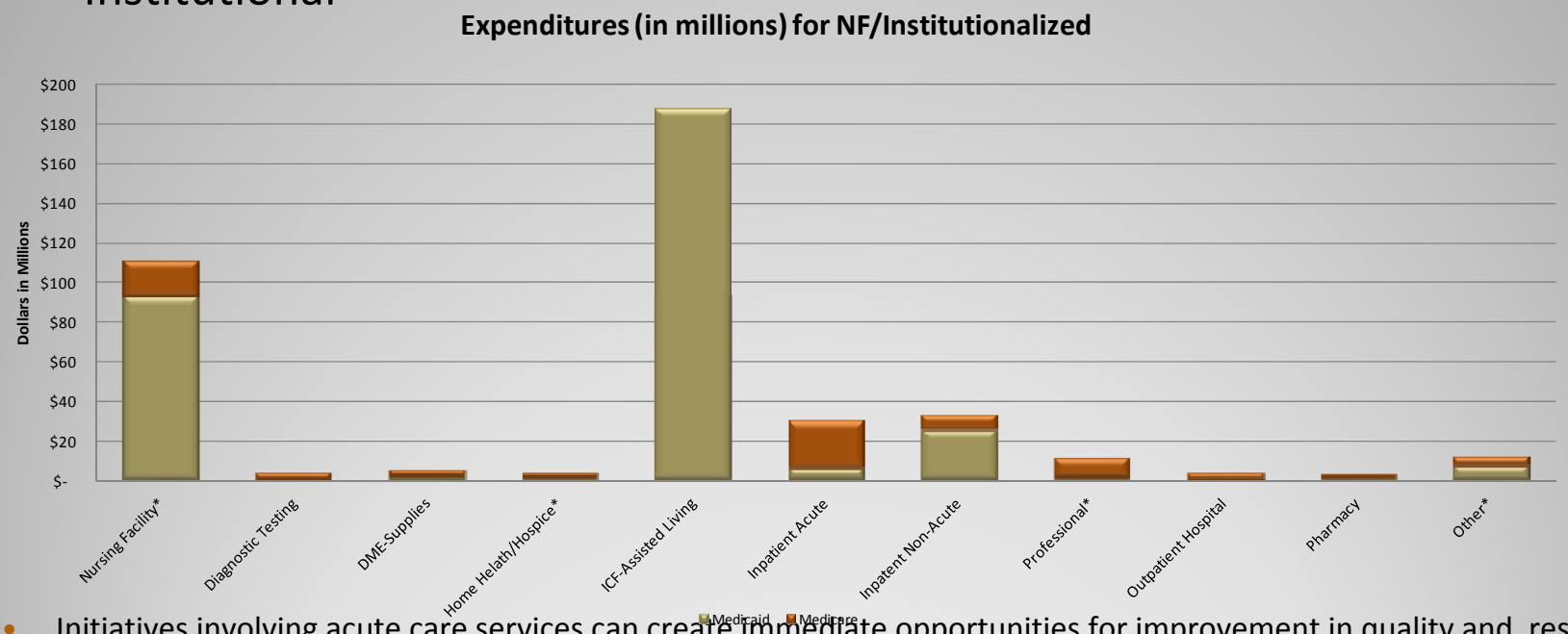
COS and LTS Setting (cont.)

- Payor distribution for individuals who are blind or have disabilities by COS - Institutional



- Initiatives involving acute care services can create immediate opportunities for improvement in quality and result in Medicare savings
- Opportunity for significant savings can be created by shifting consumers to home and community based services; however, such opportunities will take time to realize as the system is re-balanced
- The "Other" COS is driven mostly by Waiver Cap services

*Other - Day Health-Day Habilitation, Mental Health-SA Clinic, Misc, Population Denominator, Transport, Unassigned, and Waiver Cap
Nursing Facility - Skilled Nursing Facility and Nursing Home
Home Health/Hospice - Home Health Care and Hospice
Professional – Physician and Non-Physician Practitioner

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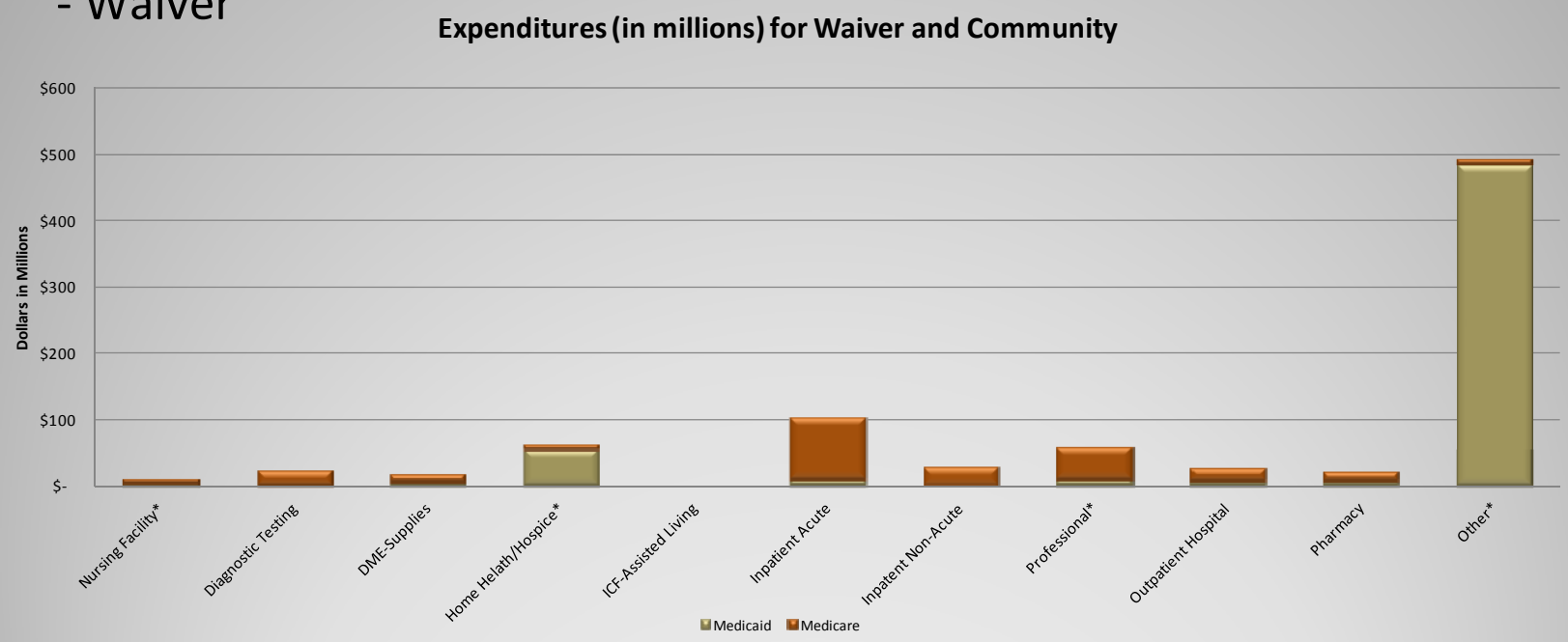
COS and LTS Setting (cont.)

- Payor distribution for individuals who are blind or have disabilities by COS - Waiver



- The State may consider reviewing existing utilization of waiver services (e.g. are consumers receiving more services than they require?) for appropriateness
- The "Other" COS is driven mostly by Waiver Cap services

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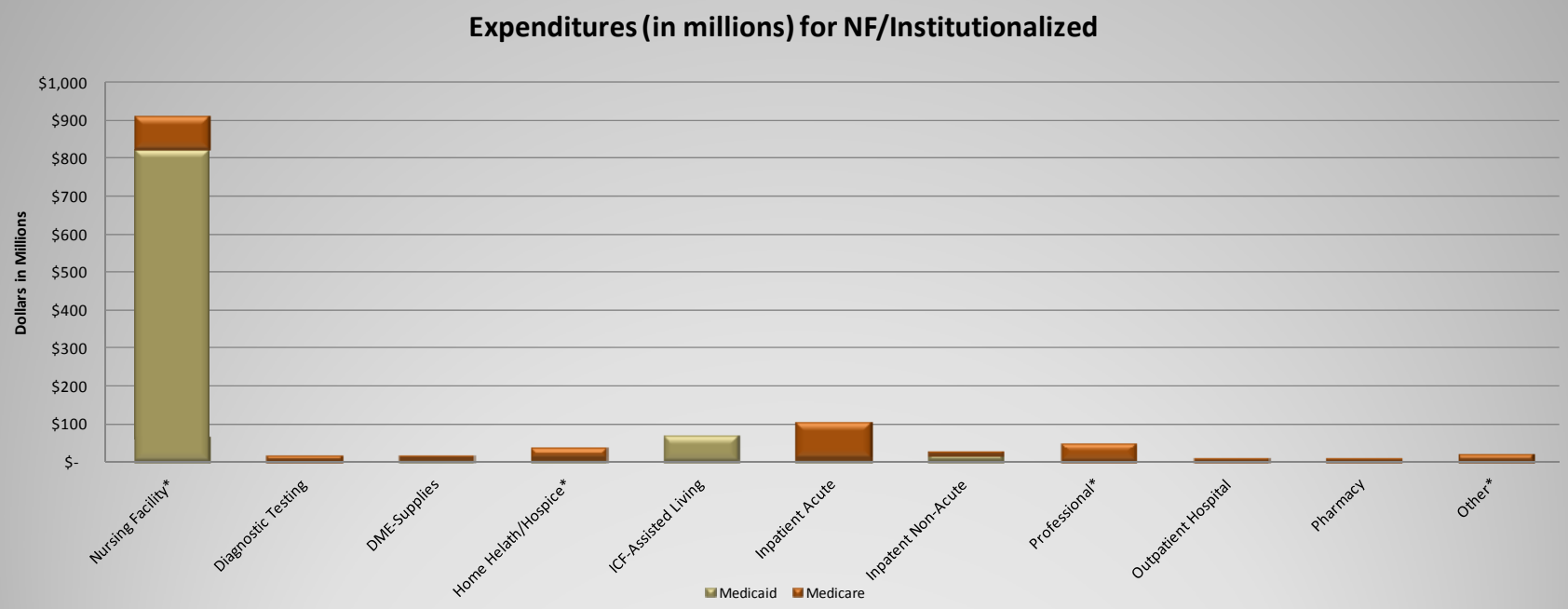
COS and LTS Setting (cont.)

- Payor distribution for elders by COS – Institutional



- Initiatives involving acute care services can create improvements in quality and immediate Medicare savings
- Opportunity for significant savings can be created by shifting consumers from Nursing Facilities to home and community based services where appropriate
- The "Other" COS is driven mostly by Waiver Cap services

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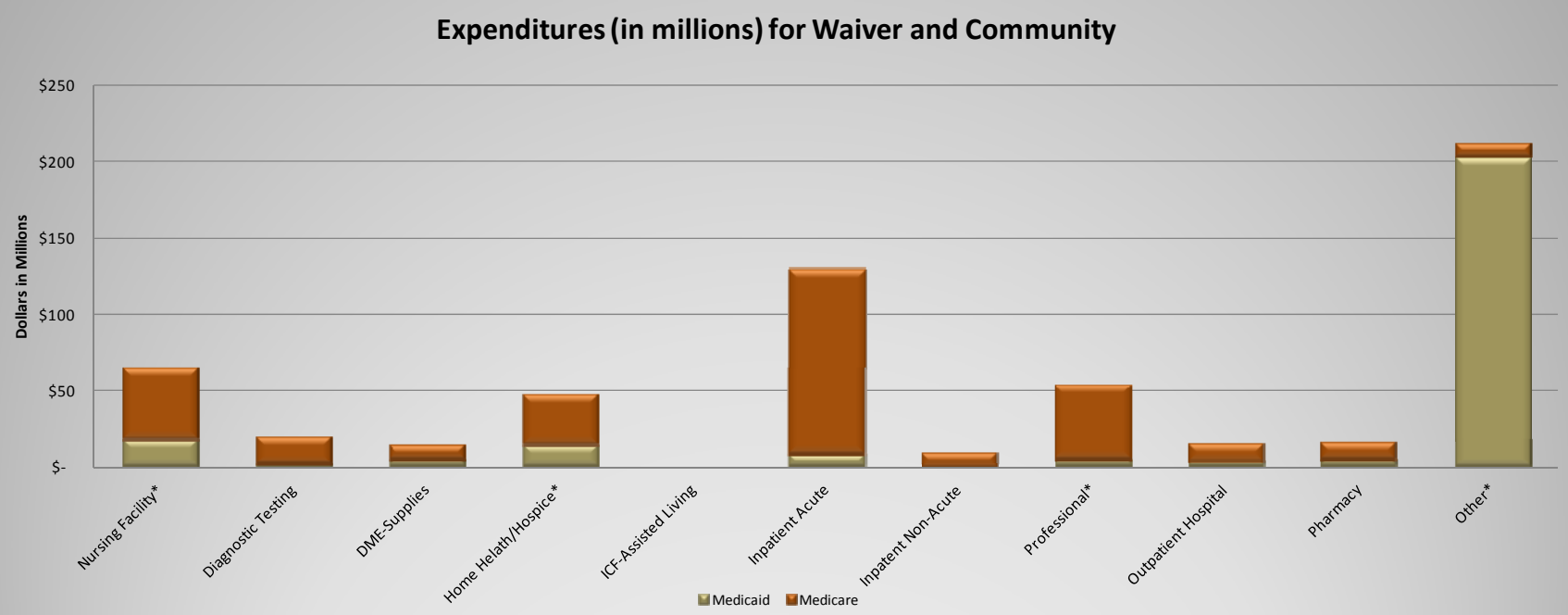
COS and LTS Setting (cont.)

- Payor distribution for elders by COS - Waiver



- Shifting consumers to home and community based services will result in overall savings. At the same time, the Medicare portion of total spend may increase due to a larger portion of care being associated with acute care services, resulting in a decrease in Medicaid spend associated with cost sharing
- The "Other" COS is driven mostly by Waiver Cap services

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Disability Subgroups

- What is the population distribution segmented by subgroups of individuals with disabilities, by LTS setting by level of need?

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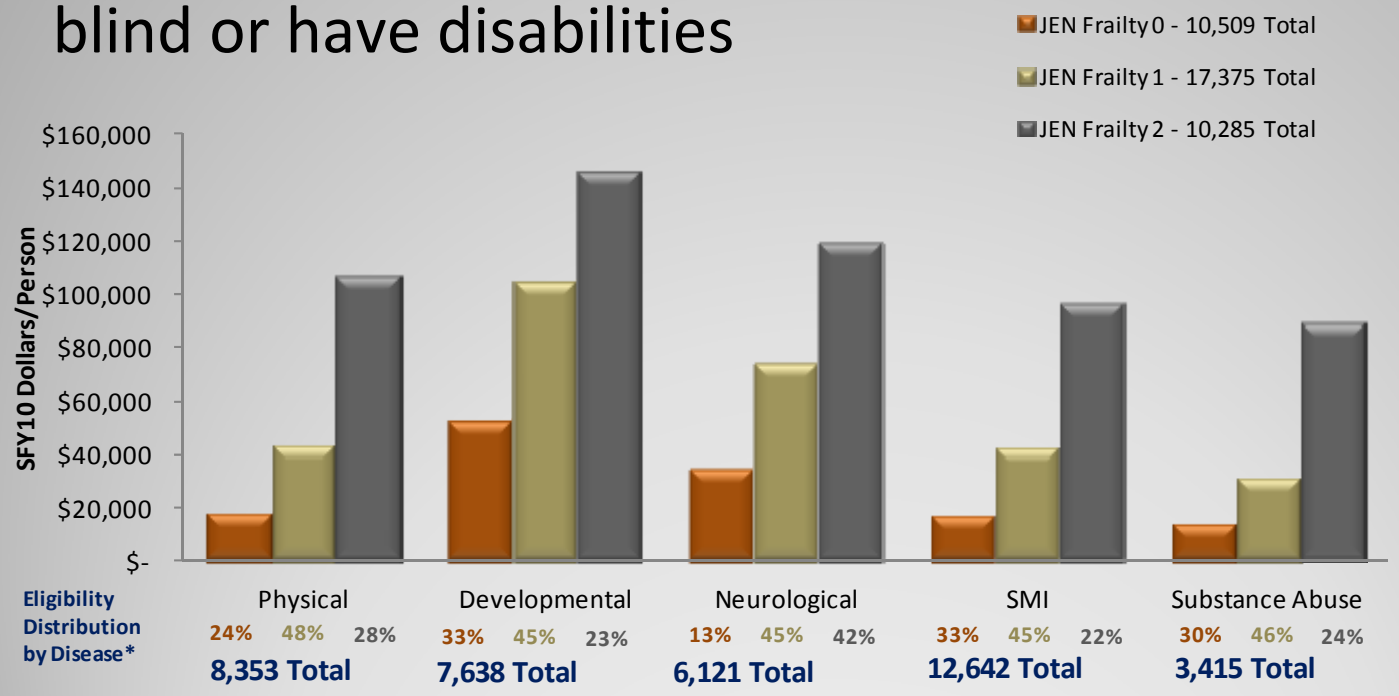
Disability Subgroups (cont.)

- JEN frailty by type of disability for individuals who are blind or have disabilities



- A large portion of individuals with disabilities receive home and community-based services

*The eligibility distribution represents the percentage of people that are in each JEN Frailty category for each disease type

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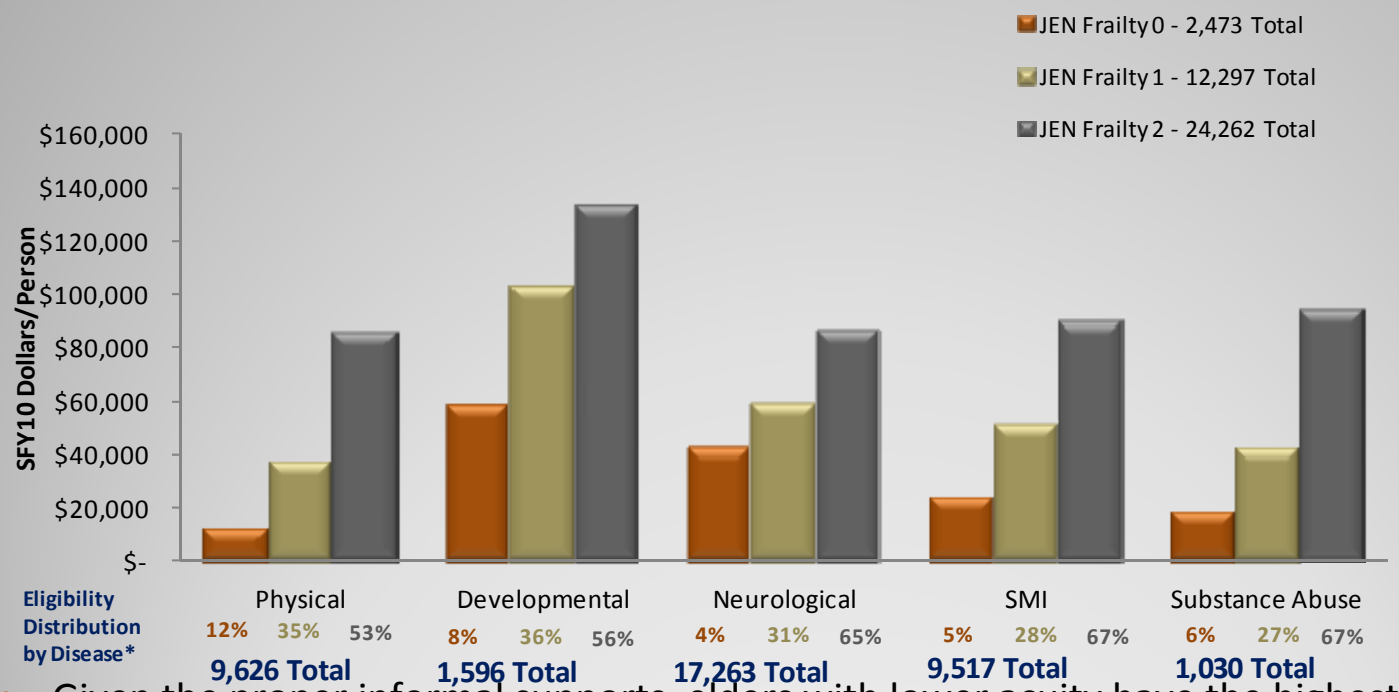
Disability Subgroups (cont.)

- JEN frailty by type of disability for elders



- Given the proper informal supports, elders with lower acuity have the highest potential to shift to a home and community based setting resulting in greater consumer satisfaction and potentially, significant Medicaid savings

*The eligibility distribution represents the percentage of people that are in each JEN Frailty category for each disease type

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Actionable Health Care Measures

- What are the current health outcomes related to actionable health care measures for MMEs?

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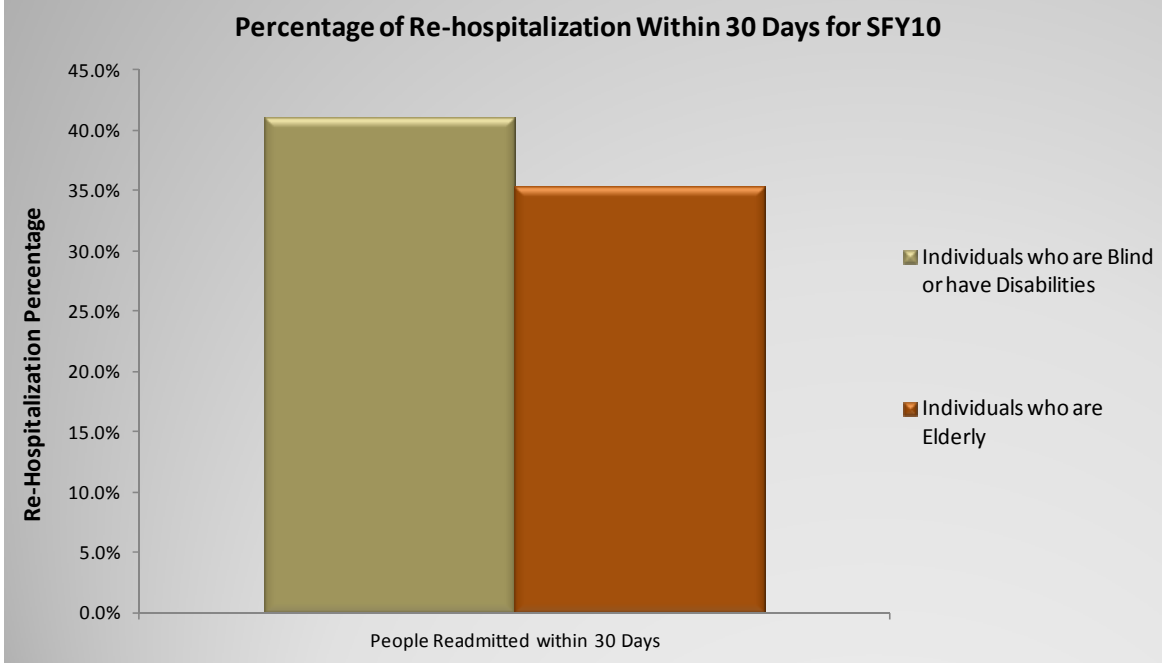
Actionable Health Care Measures (cont.)

- Immediate Medicare savings - Re-hospitalization percentages



There is potentially an opportunity to realize improvements in quality of care and in Medicare savings based on readmissions among MMEs within thirty days of discharge which compare unfavorably with national trends*

* 17-20% nationally within 30 days; 34% - 90 days; 50% - 1 year from MEDPAC and NE Journal of Medicine

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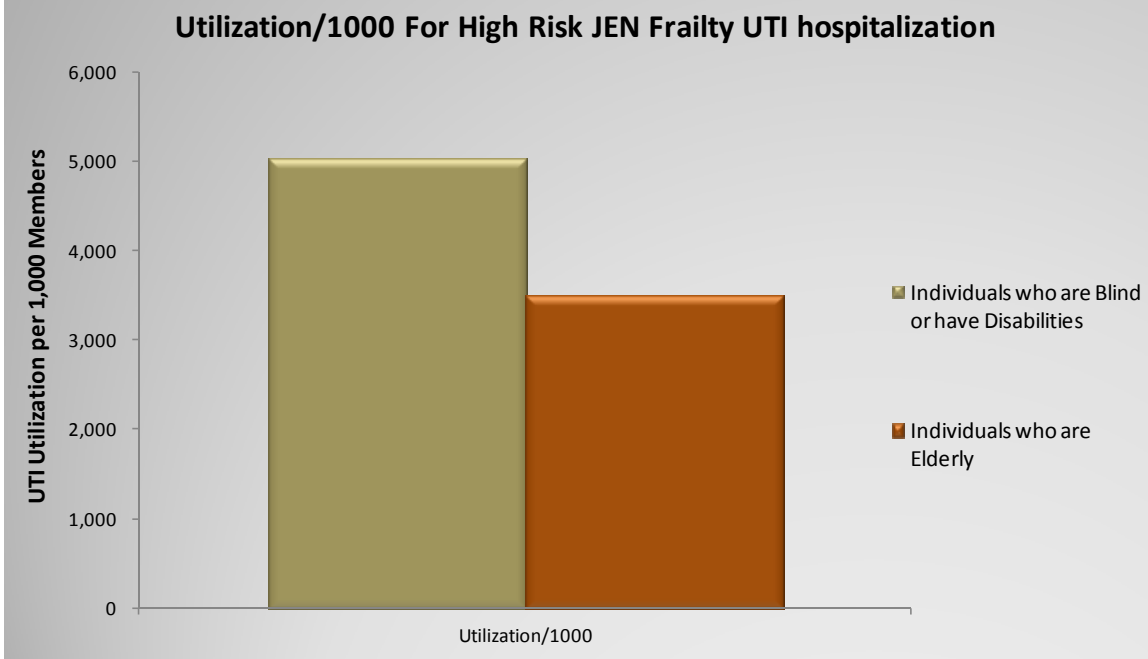
Actionable Health Care Measures (cont.)

- Immediate Medicare savings - Example of controllable health care action - UTI



Urinary Tract Infections represent one example of a potentially controllable health care condition where utilization is higher than expected for this ambulatory sensitive condition

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Actionable Health Care Measures (cont.)

- Long term Medicaid savings – Shift from nursing facility/institutional to the community

Actionable Health Care Measures (cont.)

- Long term Medicaid savings – transitions

Individual who are Elderly

	SFY10 PMPM	Current Membership %	Potential Membership %
NF/Institutionalized	$ 7,125.56	45%	40%
Waiver and Community	$ 2,708.01	55%	60%

Implied Percent Savings From Membership Shift:	2.6%
Implied Dollars Savings From Membership Shift:	$ 47,861,918

- As is illustrated above by a 5% shift in population, significant long-term Medicaid savings can yield from transitioning MMEs to home and community-based services. These savings have already been taken into account in budgeting for Connecticut's re-balancing effort.

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Long-Term NF Following Admit

- What are the characteristics of individuals admitted long-term to nursing facilities following hospitalization?

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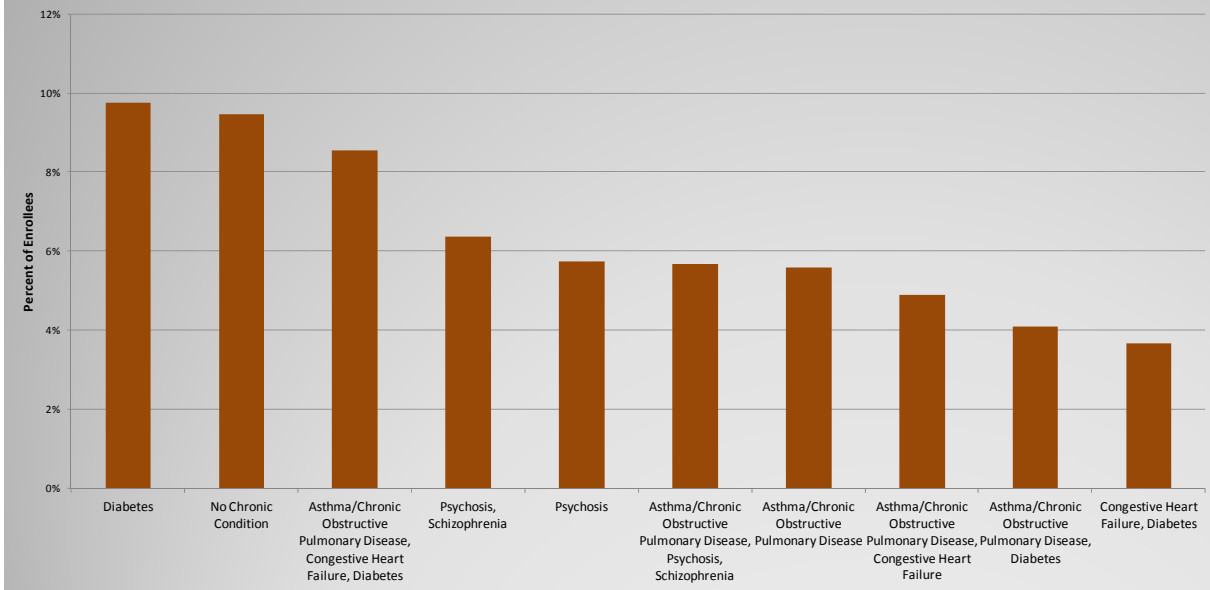
Long-Term NF Following Admit (cont.)

- NF long stay among individuals who are blind or have disabilities after hospital admission in SFY10



Among individuals with disabilities, nearly 10% have diabetes and nearly as many have no specific chronic disease. Asthma/Chronic Obstructive Pulmonary Disease, Congestive Heart Failure and diabetes are the most commonly co-occurring conditions seen in just over 8% of the population

Initiatives involving acute services (potentially preventable admissions) may create immediate Medicare savings

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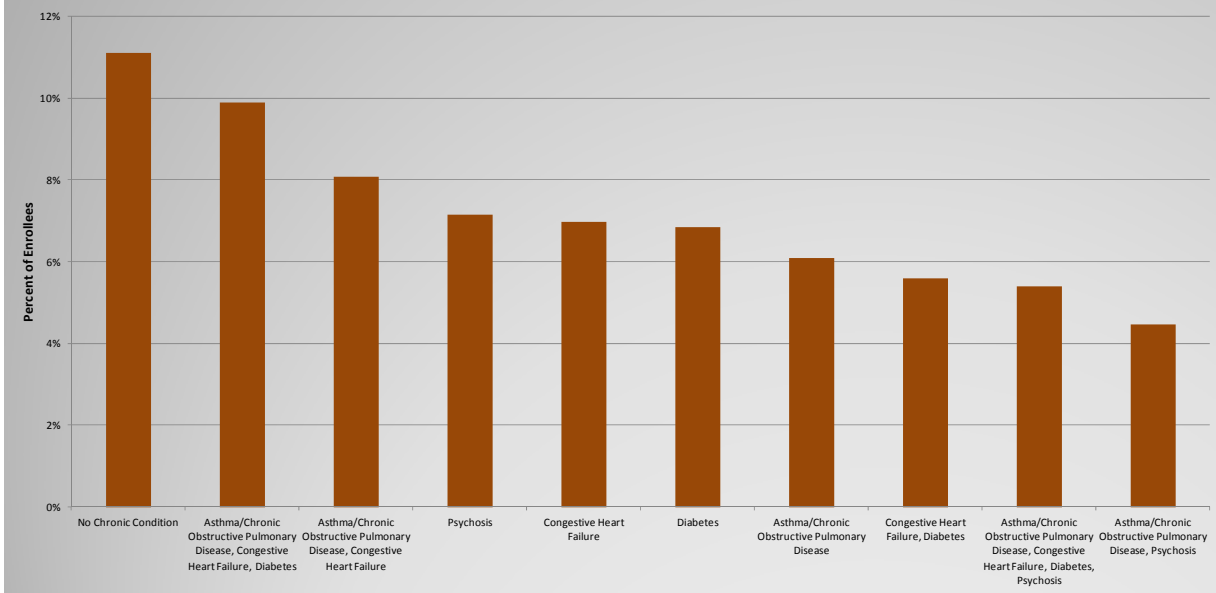
Long-Term NF Following Admit (cont.)

- NF long stay among elders after hospital admission in SFY10



Among elderly MMEs, just over 11% do not have a chronic condition while the most common co-morbid set of conditions is Asthma/Chronic Obstructive Pulmonary Disease, Congestive Heart Failure and Diabetes (8%) followed by Psychosis (7%)

Initiatives involving acute services (potentially preventable admissions) may create immediate Medicare savings

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High Cost Users

- What are the major cost drivers for MME members whose combined Medicaid and Medicare payments are over $40k per year?

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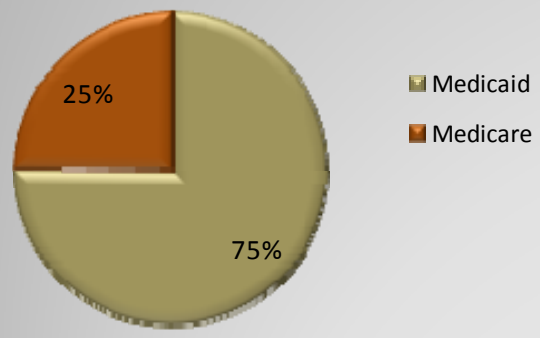
High Cost Users (cont.)

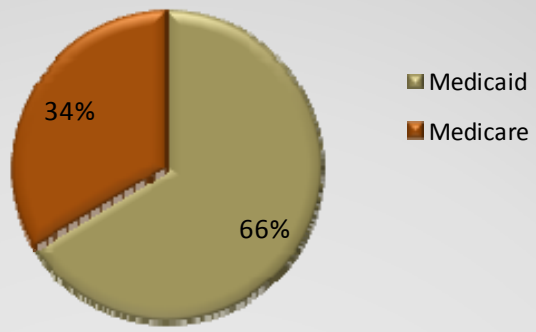
- Member distribution for those whose combined Medicaid and Medicare payments are over $40k per year

Individuals who are Blind or have Disabilities



Total Member Count - 7,299
Average Cost per Month - $11,402

Individuals who are Elderly



Total Member Count - 16,253
Average Cost per Month - $7,583

25% of individuals with disabilities are high-cost vs. 34% of elders with a greater proportion of MMEs with disabilities having their costs covered by Medicaid

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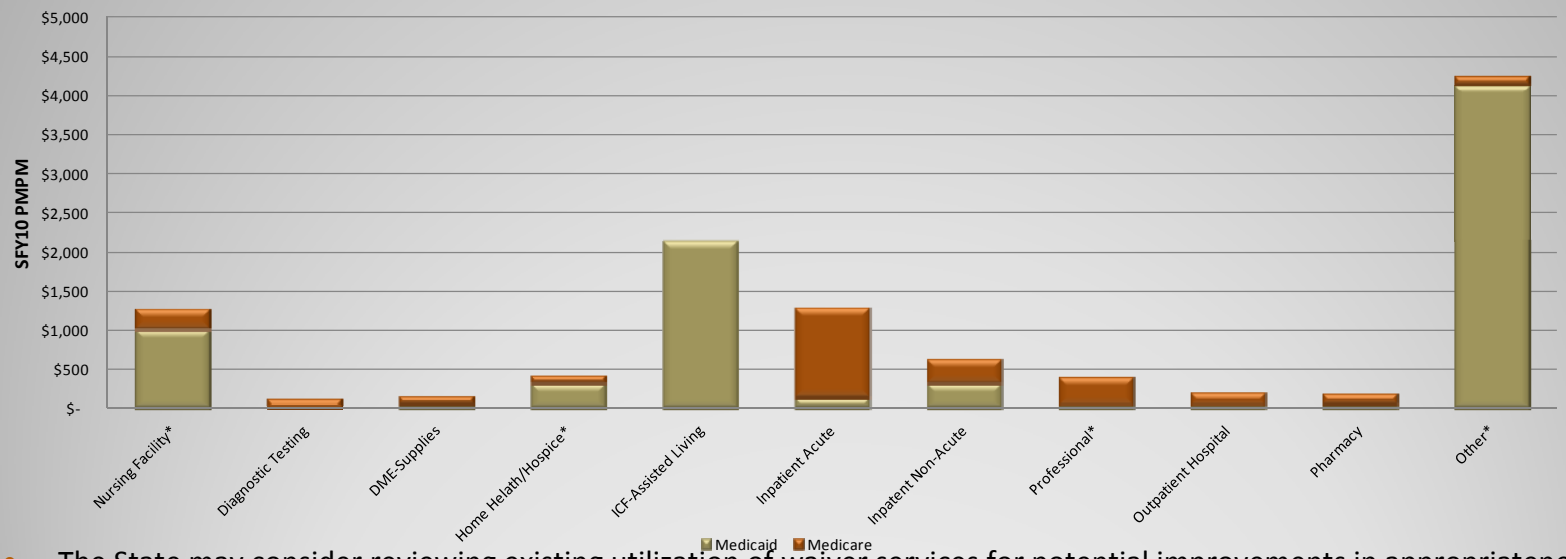
High Cost Users (cont.)

- PMPM payor distribution for individuals who are blind or have disabilities by COS with payments over $40k in SFY10



- The State may consider reviewing existing utilization of waiver services for potential improvements in appropriateness and for savings opportunities
- Initiatives involving acute care services will create opportunities to improve quality and immediate Medicare savings where Medicaid savings take longer to realize
- The "Other" COS is driven mostly by Waiver Cap services

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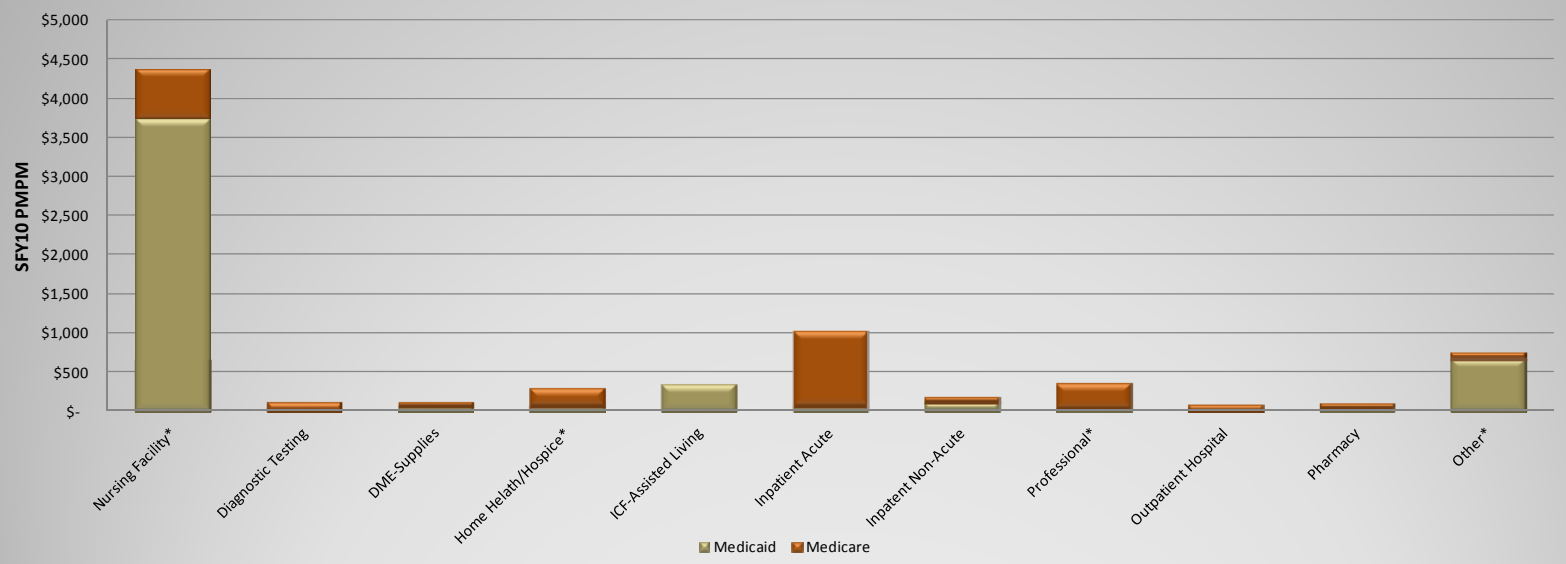
High Cost Users (cont.)

- PMPM payor distribution for elders by COS for members who have payments over $40k in SFY10



- Initiatives involving acute care services will create opportunities to improve quality and immediate Medicare savings where Medicaid savings take longer to generate
- There is an opportunity for significant savings created by helping shift consumers to home/community based services
- The "Other" COS is driven mostly by Waiver Cap services

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Conclusions

- In year 1, savings are likely to accrue for Medicare-covered services
  - There are immediate opportunities to improve quality using Medicare data to identify inappropriate ED use and preventable hospitalizations
  - The bulk of short-term savings is likely to accrue to Medicare and could be as high as 10% for unmanaged acute care services (e.g. Inpatient Hospitalization and Emergency Department spending and Primary Care services)
  - Short-term Medicaid savings will be residual (e.g. as the result of the cost-share on Medicare savings); Medicaid savings will likely be balanced by additional spending on Waiver services which would be required to maintain individuals outside of institutional settings
  - The state should continue to review waiver service utilization for appropriateness

Conclusions (cont)

- In Year 2, savings are possible in both Medicare and Medicaid due to increased coordination
  - Opportunities to improve quality continue as Medicare data will be leveraged
  - The majority of mid-term savings is likely to accrue to Medicare and could be as high as 5% for unmanaged acute care services
  - Medium-term Medicaid savings will result only from the residual liability in Medicare-covered services, as is the case for Year-1
  - With regard to Medicaid savings, as individuals leave the NF setting, they will require waiver services as a substitute for NF care trading one cost for another
  - The State is likely to experience the results of delayed transitions to nursing facilities as a result of both the re-balancing and MME initiatives; a small percentage of individuals at lower frailty levels should be able to leave the institution with sufficient community-based supports
  - The state should continue to review waiver service utilization for appropriateness

Conclusions (cont)

- In Year 3, savings should come from both Medicare and Medicaid covered services due to coordination. Additional savings should come from the movement of individuals out of nursing homes to the community.
  - Opportunities to improve quality continue in Medicare and Medicaid
  - Some savings will continue to accrue in the long-term for Medicare acute care services
  - Medicaid savings in the long-term will result as a delay of people transitioning to a nursing facility and, as a result of a small percentage of consumers remaining in the community, which represents the greatest proportion of MME spending
  - Some Medicaid savings will continue to accrue for residual liability for Medicare acute care services
  - The state should continue to review waiver service utilization for appropriateness

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