

# Managing Care for High-Cost Elderly Duals: A Challenge for Medicaid

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**The Medicaid Institute at United Hospital Fund is working to improve the Medicaid program in New York by providing information and analysis and developing a shared vision for change.**

**The Medicaid Institute  
at United Hospital Fund**

**James R. Tallon, Jr.  
President**

**David A. Gould  
Senior Vice President for Program**

**Medicaid Institute  
at United Hospital Fund  
Empire State Building  
350 Fifth Avenue, 23rd Floor  
New York, New York 10118-2300  
(212) 494-0700  
[www.medicaidinstitute.org](http://www.medicaidinstitute.org)**

**MICHAEL BIRNBAUM** Director of Policy, Medicaid Institute, United Hospital Fund  
**LESLIE POWELL** Policy Analyst, United Hospital Fund

Better managing high-cost Medicaid patients who are not enrolled in managed care plans is a priority for New York's health policymakers. This analysis considers a cohort of about 259,000 elderly individuals enrolled in both Medicare and Medicaid, focusing on the high-cost 20 percent who account for some \$3.5 billion in Medicaid spending annually. These individuals are typically contending with multiple conditions—chronic illnesses, behavioral health issues, and other health challenges. All of them rely on long-term care, which drives nearly all of their Medicaid costs. Preserving access to services, delivering high-quality care, and containing Medicaid spending for this group is essential, but designing and implementing a strategy to do so will be an immense challenge.

## The challenge of high-cost duals

It is well established that a minority of beneficiaries account for a large majority of Medicaid costs.<sup>1</sup> In New York, these individuals generally fall outside the scope of Medicaid managed care, which still accounts for less than 15 percent of program spending.<sup>2</sup> As a result, these vulnerable beneficiaries—who have complex and costly health care needs—are often left “unmanaged” in a fee-for-service Medicaid system. There is a strong consensus that improving care and reducing Medicaid spending for these high-cost beneficiaries will require some combination of better coordination among providers, centralized accountability for the care of individual beneficiaries, and financial incentives to provide less costly care.

Different approaches to managing high-cost Medicaid patients exist, but those under discussion in New York generally start with shared core assumptions.<sup>3</sup> First, a significant share of Medicaid spending on high-cost patients is avoidable. Second, Medicaid has considerable authority over how patients receive services and how providers are paid. Third, a successful management intervention can improve these patients’ health status, rationalize their service use, and save program dollars by keeping them out of the hospital. These assumptions fit many groups of high-cost Medicaid beneficiaries but do not hold for one of the largest and most costly: elderly beneficiaries who are enrolled in Medicare as well as Medicaid.

This group—called “high-cost duals” in this paper—is different from other high-cost groups in important ways. Medicaid is cast in the role of secondary insurer to Medicare, which covers most acute care services and some post-acute care. While Medicaid pays part of the cost of these services, and the full cost of some acute care services not covered by Medicare, managing duals’ use of acute care and setting the terms or rates of provider payment falls outside Medicaid’s jurisdiction. This policy presents a challenge, therefore, that is separate from the ongoing expansion of New York’s Medicaid managed care program to include more

<sup>1</sup> Birnbaum M. 2008. *Medicaid in New York: A Primer (Revised and Updated 2008)*. New York: United Hospital Fund.

<sup>2</sup> Sparer M. 2008. *Medicaid Managed Care Reexamined*. New York: United Hospital Fund.

<sup>3</sup> Billings J and T Mijanovich. November/December 2007. Improving the management of care for high-cost Medicaid patients. *Health Affairs* 26(6):1643-1654.

disabled and elderly beneficiaries. In addition, high-cost duals rely heavily on long-term care, for which Medicaid has full responsibility. Because of these differences, Medicaid policymakers need a new approach to pursue care management and cost containment for high-cost duals—an approach defined in part by the following questions:

- What does making the delivery of long-term care efficient and effective entail?
- Does embracing capitation and making plans responsible for providing long-term care promote desired goals, such as integration across service settings or reduction in spending?
- What can be accomplished by engaging providers directly, rather than engaging a plan as an intermediary, to improve the management of care?
- Should New York State seek support from federal policymakers for approaches that integrate Medicaid service delivery with Medicare?

### **Major characteristics**

Elderly and disabled dual enrollees represent 12 percent of Medicaid beneficiaries but account for 42 percent of Medicaid spending statewide.<sup>4</sup> In New York City, there are about 259,000 elderly duals with full Medicare coverage (Parts A and B) for the duration of their Medicaid coverage—a cohort that represents 35 percent of the estimated 740,000 elderly Medicare beneficiaries in New York City.<sup>5</sup> This analysis focuses on elderly duals because they are a more homogeneous group than disabled duals, demonstrating more consistent diagnostic, service use, and spending patterns; it focuses on New York City because the city’s long-term care delivery system is distinct from that of the rest of the state in organizational structure and service capacity; and it focuses on Medicaid service use and spending because the state has no authority over Medicare policy.

<sup>4</sup> Medicaid Institute at United Hospital Fund and Urban Institute analysis of Centers for Medicare & Medicaid Services Medicaid Statistical Information System (CMS MSIS) data for FFY 2004. Medicaid costs for duals include payments for Medicare premiums.

<sup>5</sup> Medicaid Institute at United Hospital Fund analysis of CMS Medicare enrollment data.

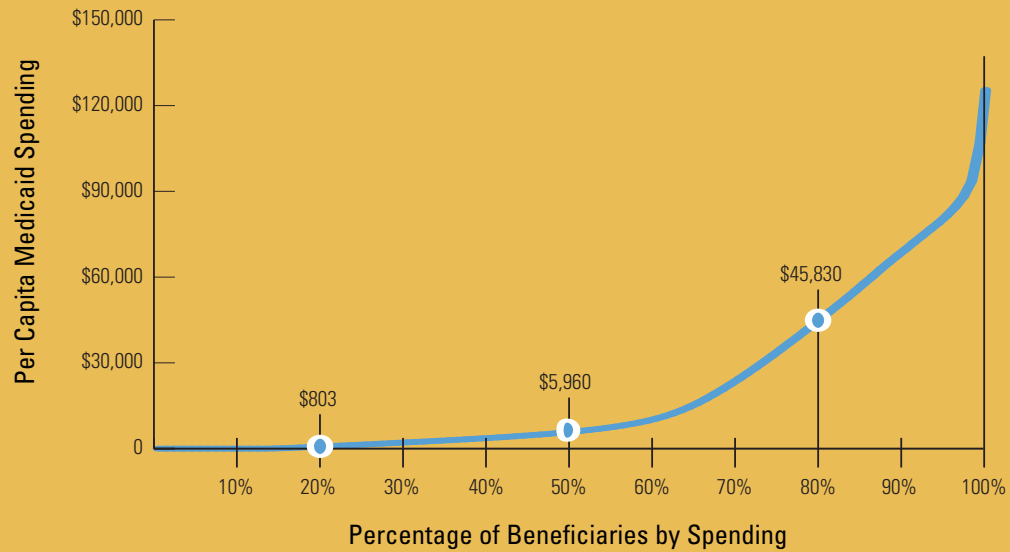
Elderly duals in New York City accounted for \$4.7 billion in Medicaid spending in 2005—not including costs for outpatient prescription drugs, which Medicare now covers for duals (Table 1). The most costly (high-cost) 20 percent of this group, about 52,000 beneficiaries, accounted for \$3.5 billion in Medicaid spending at a per capita cost of \$68,000. The least costly (low-cost) 80 percent, about 207,000 beneficiaries, accounted for \$1.2 billion in Medicaid spending at a per capita cost of \$6,000. While these figures do not include Medicare spending—and therefore do not reflect overall health care costs—in 2005 high-cost duals accounted for twelve times as much Medicaid spending as did their low-cost counterparts.

The distribution of Medicaid spending on elderly duals is notable in part for the share of beneficiaries with very low spending levels (Figure 1). For one in eight elderly duals—13 percent of the cohort, some 34,000 individuals—there was no Medicaid spending at all, because they used no health care services over the year, or because Medicare did not require cost sharing for the covered services it provided. For another 15 percent, costs were below \$2,000—roughly the average Medicaid cost for non-disabled children. While the median cost for the elderly dual cohort was about \$6,000, the top fifth of the distribution contained beneficiaries with substantial per capita Medicaid costs: about \$46,000 at the 80th percentile, the threshold for the high-cost group, and about \$70,000 at the 90th percentile, the midpoint of the high-cost group.

**Table 1**  
**Elderly Dual Characteristics, 2005**

	Elderly Duals		
	All	Low-cost	High-cost
Beneficiaries	258,936	207,148	51,788
Average Medicaid cost per beneficiary	<u>\$18,256</u>	<u>\$5,706</u>	<u>\$68,456</u>
Total Medicaid spending (in billions)	\$4.7	\$1.2	\$3.5
Average age	78	77	83
Females as share of group	68%	66%	74%
Share of group enrolled for full year	79%	75%	93%

**Figure 1**  
**Distribution of Medicaid Spending per Elderly Dual**  
**New York City, 2005**



High-cost duals have different demographic characteristics and enrollment patterns than their low-cost counterparts. On average, high-cost duals are six years older than low-cost duals, a reflection of the association between age and more severe health conditions. They are also more likely to be female, presumably because women typically live longer than men. And they are much more likely to be enrolled in Medicaid for the full year, reflecting the ongoing nature of their health challenges and health care needs. Duals with intermittent health care costs are more likely to spend down to Medicaid eligibility for only parts of the year.

### Health challenges

Duals have significant health challenges. A quarter have diabetes, more than half have hypertension, and a third have coronary heart disease (Table 2).<sup>6</sup> In addition, more than a fifth have been diagnosed with cancer and more than a third have been treated for an injury within the last seven years.

High-cost duals have a higher prevalence of most conditions and diagnoses than their low-cost counterparts; for several conditions, however, the difference between the two groups is striking. One-third of high-cost duals

<sup>6</sup> These estimated rates of diagnoses represent a lower boundary; they may undercount diagnoses that, in certain long-term care settings, do not correspond with higher provider reimbursements.

**Table 2**  
**Elderly Dual Diagnoses, 1999-2005**

	All	Elderly Duals	
		Low-cost	High-cost
<b>Common chronic conditions</b>			
Diabetes	26%	24%	36%
Hypertension	58%	55%	68%
Coronary heart disease	33%	29%	48%
Congestive heart failure	17%	13%	32%
Chronic obstructive pulmonary disease	11%	9%	18%
<b>Behavioral health</b>			
Dementia	14%	7%	42%
Severe mental illness	9%	7%	20%
<b>Other diagnoses</b>			
Cancer	22%	21%	25%
Stroke	15%	11%	31%
Injury	35%	31%	54%

have congestive heart failure, two and a half times the rate among low-cost duals; nearly one-fifth have chronic obstructive pulmonary disease—emphysema or chronic bronchitis—twice the low-cost group’s rate; and nearly one-third has had a stroke, nearly three times the rate of their low-cost counterparts. On average, high-cost duals had four of the chronic, behavioral health, and other conditions included in this study; by contrast, low-cost duals had an average of two. (For some detailed examples of high-cost duals’ multiple diagnoses, see the individual beneficiary profiles on page 7.)

High-cost duals also have dramatically higher rates of mental health conditions and cognitive impairments. One in five, nearly three times the rate among low-cost duals, has a severe mental illness—major depression, bipolar disorder, schizophrenia, or other psychosis. More than two in five suffer from dementia—including Alzheimer’s disease, the condition’s most common form—making high-cost duals at least six times more likely to have dementia than their low-cost counterparts. The share of high-cost duals with dementia may be even higher than the claims data indicate: because some community-based long-term care providers do not receive a higher reimbursement rate for treating dementia patients, as skilled nursing facilities (nursing homes) do, they do not include a dementia code on their service claim.<sup>7</sup>

<sup>7</sup> The New York State Department of Health’s Coordinating Council for Services Related to Alzheimer’s Disease and Other Dementias estimates that half of individuals over the age of 85 develop dementia.

## Spending Snapshot: Profiles of High-Cost Duals

The following profiles—snapshots of eight beneficiaries’ diagnoses, service use, and Medicaid costs over a six-year period from 2000 through 2005—provide a clearer picture of high-cost duals’ typical needs (Table 3). While there is significant variation in the combinations of diagnoses among patients, there is also remarkable consistency. Many have heart conditions, other chronic illnesses, and dementia. All depend heavily on long-term care and most have few hospital admissions. Finally, all account for significant Medicaid spending year after year.

**Table 3**  
**Individual Beneficiary Profiles**

Beneficiary	Ms. A	Ms. B	Mr. C	Ms. D	Ms. E	Mr. F	Mr. G	Ms. H
Age	74	95	69	76	86	77	70	68
<u>Medicaid costs (2000-2005)</u>								
2005	\$51,143	\$88,126	\$78,040	\$67,165	\$67,851	\$72,696	\$97,162	\$72,724
2004	\$51,213	\$88,762	\$75,036	\$52,163	\$69,228	\$91,078	\$96,094	\$68,551
2003	\$49,104	\$76,887	\$83,291	\$14,882	\$64,753	\$83,263	\$94,428	\$62,334
2002	\$49,750	\$70,547	\$43,158	\$11,023	\$61,616	\$46,440	\$91,846	\$47,382
2001	\$8,346	\$47,213		\$410	\$58,067	\$3,966	\$64,213	\$15,551
2000		\$10,017		\$1,396	\$41,321		\$77,438	
LTC as share of Medicaid spending	99.8%	99.7%	94.7%	98.4%	93.1%	94.0%	99.9%	99.9%
<u>Medicaid service use (2000-2005)</u>								
Months of Medicaid enrollment	50	67	43	66	72	53	72	60
Months in skilled nursing facility	50	0	3	0	0	9	72	46
Months using community care	0	67	40	48	72	42	0	6
Share of months with some LTC	100%	100%	100%	73%	100%	96%	100%	87%
Number of hospital admissions	0	0	1	3	3	7	3	0

- **Ms. A** has diabetes, hypertension, an abnormal heartbeat, back problems, depression, and paranoid schizophrenia. She also has suffered from pneumonia, bronchitis, tremors, gastritis, dermatitis, an ulcer, and an injury. She resided in a nursing home for over four years without any hospitalizations. Reflecting the fact that her service use was stable over time and consisted almost exclusively of nursing home care, the Medicaid costs associated with her care held steady at about \$50,000 per year.
- **Ms. B** has Alzheimer’s disease. She used home health services for five and a half years, as well as personal care for the first three years of this period. She, too, had no hospitalizations during this time. Her Medicaid costs grew as the monthly cost of her home health services increased from \$1,500 to over \$7,000.
- **Mr. C** has hypertension, cataracts, osteoarthritis, and rotator cuff problems. He also has suffered from bronchitis, cerebrovascular insufficiency, hip and wrist inflammation, prostatitis, and nerve inflammation. Mr. C has used both nursing home and community-based long-term care, living in a nursing home for the first three months of his Medicaid coverage, switching to home health services for the following eight months, and then transitioning to personal care. He was hospitalized once for bronchitis. His Medicaid costs reflect an average of about \$6,000 per month for community-based long-term care.

- **Ms. D** has congestive heart failure, cataracts, and anemia. She also has suffered from an upper respiratory infection, joint pain, low blood flow, and gallstones. She used no long-term care for the first two years she was enrolled in Medicaid. After being hospitalized for an upper respiratory infection, she began using personal care services. During this period, she was hospitalized two more times, for low blood flow and gallstones. Her annual Medicaid costs grew as the monthly cost of her personal care services rose from \$600 to over \$5,000.
- **Ms. E** has Alzheimer's disease, a psychosis, chronic renal failure, osteoporosis, cataracts, and glaucoma. She also has suffered from heart palpitations, bronchitis, kidney cysts, urinary tract infections, bacteremia, a pelvic fracture, and ringworm. She used personal care services for six years, the duration of her Medicaid coverage, and was hospitalized three times—twice for a urinary tract infection and once for bacteremia. Her annual Medicaid costs rose as the monthly cost of her personal care grew from \$1,200 to over \$5,000.
- **Mr. F** has congestive heart failure, hypertension, respiratory failure, chronic airway obstruction, chronic liver disease, and cataracts. He also has suffered from pneumonia, bronchitis, chronic airway obstruction, intermediate coronary syndrome, gastritis, anemia, and a blood infection. He used no long-term care for the first two months of his Medicaid coverage, then used home health services for one year, during which time he was hospitalized three times for bronchitis. After his third hospital stay, Mr. F entered a nursing home for three months. He resumed using home health services for the following three years, during which time he was hospitalized four times—twice for chronic airway obstruction, once for bronchitis, and once for intermediate coronary syndrome. After his last hospital stay, he entered a nursing home.
- **Mr. G** has depression, anxiety, cataracts, and hypertensive retinopathy, and has had a stroke and a heart attack. He resided in a nursing home for six years, during which time he was hospitalized three times—once each for seizures, limb pain, and paralysis. Mr. G's annual Medicaid costs grew as the monthly cost of his nursing home increased from \$6,000 to almost \$8,000.
- **Ms. H** has diabetes and hypothyroidism. She also has suffered from a skin infection and a urinary tract infection. She used no long-term care for the first eight months she was enrolled in Medicaid. After using home health services for six months, Ms. H entered a nursing home, where she remained for four years. She was not hospitalized during this period. Her annual Medicaid costs rose as the monthly cost of her nursing home increased from \$4,200 to over \$6,000.

**Table 4**  
**Annual Service Use, 2005**

	All	Elderly Duals	
		Low-cost	High-cost
<b>Long-term care</b>			
Nursing home only	14%	5%	48%
Community-based only	24%	19%	46%
Both	2%	1%	6%
No long-term care	60%	75%	0%
<b>Acute care</b>			
<b>Hospital Admissions</b>			
None	79%	82%	63%
One	16%	14%	26%
Two or more	5%	3%	12%

### Service Use and Spending

High-cost duals all rely on long-term care services.<sup>8</sup> In a given year, about half (54 percent) receive care in a nursing home; about half (52 percent) use community-based care—home health services, personal care, and adult day care. Very few (6 percent) use both in the same year (Table 4).<sup>9</sup> In 2005, Medicaid paid an average of \$65,000 annually on long-term care per high-cost dual, accounting for 94 percent of Medicaid spending on this cohort (Table 5). Among low-cost duals, Medicaid spent an average of just \$4,000 on long-term care.

High-cost duals' long-term care costs are greater than those of their low-cost counterparts because more of them use long-term care services and because the need for those services is ongoing. Fifty-four percent of high-cost duals had a nursing home stay over the course of the year, at an average cost of \$66,000;<sup>10</sup> by contrast, only 6 percent of low-cost duals had a nursing home stay, averaging \$16,000 per stay. Fifty-two percent of high-cost duals used community-based long-term care, accounting for an average of \$56,000 in Medicaid spending, compared to just 20 percent of low-cost duals, whose costs averaged \$16,000.

<sup>8</sup> Less than 0.5 percent of high-cost duals used no long-term care; their Medicaid spending was driven by hospital inpatient costs. In 2008, Medicare's inpatient benefit includes a \$1,024 deductible and daily co-payments ranging from \$256 to \$512. After 150 inpatient days during an episode of illness, and an exhaustion of the additional 60 lifetime reserve days covered by Medicare, Medicaid pays the full cost of a hospitalization.

<sup>9</sup> Home health services consist of medical care and some social support services that are delivered in the home by skilled professionals; personal care consists of assistance with activities of daily living in the home; adult day care includes a range of medical and social support services delivered in an adult day care facility.

<sup>10</sup> The \$66,000 cost to Medicaid does not represent the average full-year stay in a nursing home. Some high-cost duals have nursing home stays that last less than a year; others have longer stays that either begin or end during the year, in which case Medicaid will pay for a nursing home stay throughout the full calendar year.

**Table 5**  
**Spending by Service, 2005**

		Elderly Duals	
	All	Low-cost	High-cost
<hr/>			
Average cost per beneficiary			
Long term care	\$16,376	\$4,333	\$64,546
Acute care			
hospital inpatient	\$476	\$286	\$1,238
all other	\$1,404	\$1,088	\$2,671
subtotal	\$1,881	\$1,374	\$3,909
Total spending	\$18,256	\$5,706	\$68,456
Long term care as share of total	90%	76%	94%
<hr/>			
Average cost per long term care user			
Community-based LTC	\$31,788	\$16,405	\$55,977
Nursing home	\$50,430	\$16,190	\$66,152

More than one-third of high-cost duals were hospitalized each year—twice the frequency of their low-cost counterparts—and about one in ten high-cost duals had more than one hospital admission. But Medicaid spending on hospital inpatient care was low for all duals—an average of a little over \$1,000 for high-cost and far lower for low-cost duals. This reflects the fact that Medicare is the primary payer for hospital services, and Medicaid’s inpatient costs are mainly for Medicare co-payments and deductibles.<sup>11</sup>

<sup>11</sup> Duals with only Medicare Part B, as well as duals with Medicare Part A for only part of the year—neither of which are included in this sample—account for significantly higher Medicaid spending on hospital inpatient services.

## **The challenge of care management and cost containment**

Medicaid spending on duals is concentrated among high-cost beneficiaries, driven by long-term care use, and deployed to meet needs that are substantial and ongoing. Strategies to pursue care management and cost containment for this population will differ from those applied to other high-cost groups, which generally aim to reduce avoidable hospital admissions, because high-cost duals present three distinct challenges:

- Managing high-cost duals has more to do with maintaining health status over time than avoiding illness and costly episodes of care. These beneficiaries rely heavily on long-term care over years or months to cope with activities of daily living. “Curing” these individuals, or even reducing their dependence on care, may not be a reasonable care management goal; cutting next year’s Medicaid costs to a small fraction of this year’s is unlikely to be an appropriate cost containment goal.
- Medicaid is not responsible for providing most acute care services to high-cost duals. In fact, the program has no authority to influence whether they choose to receive these services through a Medicare Advantage managed care plan or through traditional fee-for-service Medicare. Moreover, in the typical case, Medicaid does not benefit financially from reducing beneficiaries’ reliance on Medicare.
- New York City is a national leader in making available alternatives to nursing home care: half of high-cost duals in the city are already living at home. It is unclear how many of those beneficiaries remaining in nursing homes could feasibly be transferred into community settings, or if Medicaid would realize significant savings. Ultimately, these elderly individuals with complex long-term care needs will be costly to Medicaid regardless of the setting in which they receive care.

### **Current options for managing long-term care**

Four voluntary programs designed primarily for elderly duals offer, to varying degrees, opportunities to integrate the financing, management, and delivery of long-term care services and, in some cases, connect either directly or indirectly to Medicare: Medicaid managed long-term care, the program for all-inclusive care for the elderly, Medicaid Advantage Plus, and the long-term home health care program.

- **Managed Long-Term Care (MLTC)**

Medicaid pays a monthly premium to a managed care plan to provide nursing home care, home health services, personal care, and adult day care. MLTC does not formally connect the delivery or financing of long-term care with acute care services provided to duals through Medicaid or Medicare. It enrolls about 20,000 beneficiaries in New York City.

- **Program for All-Inclusive Care for the Elderly (PACE)**

This program includes all Medicare and Medicaid acute and long-term care services for elderly duals. A single managed care plan delivers the services and receives monthly premiums from both Medicare and Medicaid. PACE enrolls about 2,000 duals in New York City.

- **Medicaid Advantage Plus**

This program, which builds on the existing Medicaid Advantage option,<sup>12</sup> includes all Medicare and Medicaid acute and long-term care services for duals. A single managed care plan delivers the services and receives monthly premiums from both Medicare and Medicaid. Medicaid Advantage Plus, which began enrollment in 2008, enrolls very few duals in New York City.

<sup>12</sup> The Medicaid Advantage option includes Medicare cost sharing, dental care, transportation, and private duty nursing, as well as behavioral health and home health services not covered by Medicare Advantage. It is not included in this discussion because, unlike Medicaid Advantage Plus, it does not contain a comprehensive long-term care benefit.

- Long-Term Home Health Care Program (LTHHCP)

This program provides a range of community-based long-term care services—including nursing care, rehabilitation services, personal care, and social support services—to beneficiaries who are medically eligible to be admitted to a nursing home but choose to receive care at home. Beneficiaries remain in the program as long as their annual home health costs do not exceed 75 percent of the applicable nursing home rate. There is no link to other Medicaid long-term care services or any acute care services provided by Medicaid or Medicare. LTHHCP enrolls about 14,000 beneficiaries in New York City.

All told, these programs enroll only 36,000 beneficiaries in New York City,<sup>13</sup> leaving the vast majority of duals outside any management framework. It remains unclear, however, whether any one of Medicaid's existing programs is the right approach for managing elderly beneficiaries who rely heavily on long-term care—in part because, for the individuals and services in question, the definitions of effective and efficient service use and successful cost containment remain elusive.

### **Moving forward**

A key component of meeting Medicaid's challenge—and a likely prerequisite to selecting one or more management approaches—is developing a framework to assess the effectiveness of service delivery, the level of spending relative to health outcomes, and other benchmarks and program goals. Considering the following issues will inform the development of such a framework.

- Efficient and effective long-term care requires practical guidelines and achievable goals—specifically, salient outcome measures for evaluating care management practices, and reasonable cost-containment goals for beneficiaries with substantial long-term care needs.

<sup>13</sup> Medicaid Institute at United Hospital Fund analysis of February 2008 New York State Department of Health Medicaid managed care enrollment reports. The estimate of combined enrollment is an upper-bound estimate for elderly duals, because MLTC includes some non-elderly beneficiaries and some elderly non-duals.

- The advantages and disadvantages of capitation should be assessed to determine whether putting plans at risk for providing long-term care may promote desired goals, such as integration across settings and reduction in spending.
- Engaging providers directly in care management (as the LTHHCP does), rather than using a plan as an intermediary (as do the MLTC, PACE, and Medicaid Advantage Plus programs), may improve outcomes and contain costs, but these outcomes need to be measured.
- Assessing the potential rewards and risks of linking Medicaid service delivery to Medicare policy and financing—over which New York has no control—will help determine whether the state should seek federal support for integrating the two.

The challenge of managing the delivery of care for high-cost duals represents, to a degree, the intersection of two separate but related Medicaid discussions in New York. One is a robust ongoing conversation about developing intensive care management interventions to keep current beneficiaries from becoming future high-cost cases, largely through preventing unnecessary hospital admissions. This challenge is of vital importance to Medicaid, but it has limited relevance to high-cost duals. The other discussion is about how to ensure beneficiaries' access to long-term care services in appropriate settings. This challenge is equally important, but does not fully address the goals of measuring the effectiveness of care and containing costs. Medicaid's additional challenges for high-cost duals are, first, to ensure the efficient and cost-effective use of long-term care services and, second, to pursue collaborative approaches that allow Medicaid to realize savings from any associated reductions in Medicare hospital stays.

## **Appendix: Data and Methods**

Data on Medicaid beneficiaries' spending, enrollment, utilization, and diagnostic patterns come from the Medicaid paid claims file provided to the United Hospital Fund by the New York State Department of Health under a data exchange contract. Each fee-for-service Medicaid claim contains detailed data on the services rendered, including diagnoses, procedures, and reimbursement. Ancillary eligibility and provider files contain information on each beneficiary's basis of eligibility and enrollment status, as well as provider characteristics. The Center for Health and Public Service Research at New York University's Wagner School of Public Service conducted the statistical programming of the paid claims file.

This analysis is based on the identification of Medicaid beneficiaries who were elderly for all of calendar year 2005 and had full Medicare coverage, defined as both Medicare Part A and Part B during each month of their Medicaid enrollment during the year. Beneficiaries with a diagnosis of mental retardation, or with any use of a service or program for individuals with mental retardation, are excluded from this analysis.

Reported diagnoses reflect cumulative claims for a seven-year period from 1999 through 2005; because this analysis does not examine data on all years of enrollment for all beneficiaries, it may understate the rates of health conditions. Medicaid spending totals have been adjusted to exclude outpatient prescription drugs because, with the implementation of Medicare Part D, Medicaid no longer has direct responsibility for administering this benefit to duals. Per capita spending levels reflect actual costs; they are not adjusted upward to reflect full-year enrollment.

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