

## **Chartbook Number 1**

### **Analysis of Medicaid Expenditures for Long-Term Care Participants in HCBS Services and in Institutions in 2001**

**(1st in a series of 6 special quantitative reports)**

**Submitted to the  
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**January 29, 2008**

**Revision, May 2008**

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The overall Rebalancing Research is being conducted through a Task Order under a CMS Master Contract between CMS and the CNA Corporation, Arlington, VA, and subcontracts and consultant agreements between CNAC and the various researchers. Rosalie A. Kane is the principal investigator from the University of Minnesota and Elizabeth Williams is the CNAC project director. The special quantitative studies are under the direction of Robert L. Kane. The statements and opinions in the report are those of the writers and do not necessarily reflect the views of CMS or any of its staff, or the State liaisons to the project, or any other state staff or persons who spoke to us from participating states. We thank our CMS Project Officer, William D. Clark of CMS (ORDI), for his comments in an earlier version of this report.

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## Preface

In 2003, Congress directed the Centers for Medicare & Medicaid Services (CMS) to commission a study in up to 8 States to explore the various management techniques and programmatic features that States have put in place to rebalance their Medicaid long-term care (LTC) systems and their investments in long-term support services towards community care. The States of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington are participating in this 3-year Rebalancing Study. For the study, CMS defined rebalancing as reaching “a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services (i.e., Nursing Facilities [NF] and Intermediate Care Facilities for the Mentally Retarded [ICFs-MR]) and those used for community-based supports under its State Plan and waiver options.” CMS further clarified that a balanced LTC system “offers individuals a reasonable array of balanced options, particularly adequate choices of community and institutional options.”

The products for the entire study include 3 iterations of State-specific case studies that qualitatively and quantitatively examine each State’s management approaches to rebalance its long-term care systems; 6 cross-cutting topic papers on issues in rebalancing; and a series of 6 Chartbooks with special quantitative analyses. A list of all products with web links for completed documents is provided in the Appendix. Various products are posted on <http://www.hcbs.org>, on the CMS website at [http://www.cms.hhs.gov/NewFreedomInitiative/035\\_Rebalancing.asp#TopOfPage](http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage), and on the study director’s website at University of Minnesota at

<http://www.hsr.umn.edu/LTCResourceCenter>. The special quantitative work was performed under the direction of Robert L. Kane. We thank Glenn Mitchell and Su Wang (in Florida), Mike Baldwin and Bob Myers (in Minnesota), Kathy Leitch, Bill Moss, Patricia Richards, and Terry Rupp (in Washington) and Bill Clark and Karyn Anderson (at CMS) for their cooperation and assistance but the responsibility for all material rests with the authors.

The special quantitative studies for this project used secondary data from State and Federal sources to explore enrollment, service utilization, and expenditures for state LTC program recipients. In general, they compared Medicaid expenditures for participants in HCBS and nursing homes, as well as Medicare expenditures for individuals dually eligible for Medicaid and Medicare. This quantitative paper, Chartbook Number 1 uses 2001 data to compare all Medicaid expenditures for participants receiving LTSS in the community (under Medicaid waivers or State plans) and those receiving LTSS services in institutions.

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## **Executive Summary**

Most attention about the use of waivers to increase the use of home and community-based services (HCBS) to provide long-term care (LTC) under Medicaid has been directed towards LTC expenditure patterns. As part of a study of rebalancing in eight states (Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Washington, and Vermont), this paper presents *preliminary* analyses of Medicaid Analytic eXtract (MAX) data for 2001 on the utilization of LTC and medical care services by Medicaid LTC recipients.

This report is the first in a series of reports using MAX data, which is a refined data set built (under a contract with MPR) from the Medicaid claims data submitted by each state as part of its Medicaid Statistical Information System (MSIS). The data presented here are restricted to Medicaid fee-for-service (FFS) payments. Subsequent reports will present analyses based on 2002 and 2003 data, as well as combined Medicare

and Medicaid data from the dual eligible enrollees. The purpose of this first report is to acquaint readers with the range of data available and the possible analyses that can come from it. This initial presentation is in the form of a chartbook with initial analyses and interpretations. Because the focus is on rebalancing, the analyses look separately at program participants who are covered by Medicaid HCBS waivers and those covered by Medicaid state plan services.

The research questions driving these analyses are:

1. How do the utilization and cost of LTC services (nursing facility, intermediate care facility [ICF], personal care, home health care and transportation) by Medicaid HCBS waiver participants and LTC state plan recipients differ across recipient groups and states?
2. How do the utilization and cost of medical services (hospital, emergency room, physician, physical therapy/occupational therapy/others, other practitioner,

- outpatient service, rehabilitation, hospice, other services, and pharmaceuticals) by Medicaid Home and Community-Based Services (HCBS) waiver participants, and state plan recipients receiving LTC services differ across recipient groups and states?
3. How do the utilization and Medicaid cost of these services differ for dual eligible HCBS recipients and recipients covered only by Medicaid?
  4. How consistent is utilization of medical and LTC services across years? (This specific report calculates a medical/long term care ratio for only a single year.)
  5. How does utilization vary by participant characteristics?

Finder files were created by each state based on persons enrolled in each relevant waiver program or who had used state plan LTC services. Person month is the unit of analysis. Specific waiver groups in each state were regrouped (based on their eligible population) into the following two waiver

categories of interest: Aging and (Physical) Disability and Mental Retardation/Developmental Disability (MR/DD). Our state plan groups of interest across eight states were limited to individuals who used nursing facility, intermediate care facility (ICF), home health, and personal care services. Our analysis is limited to Medicaid enrollees (including dual eligible) in FFS plans. Because reliable measures of utilization of services and their associated payment could not be obtained for Medicaid managed care enrollees, those covered by managed care were eliminated from this analysis. The number of person months in Medicaid managed care greatly varied across states, ranging from virtually none in Arkansas, to over half for persons in nursing facilities in Minnesota. We analyzed both medical care services (including inpatient hospital, physician, physical therapy/occupational therapy/others, other practitioner, outpatient service, rehabilitation, hospice, other services, and prescription drugs) and LTC services (including nursing

facility, ICF, home health, personal care, and transportation).

Our results look at each type of service separately.

Although this initial report is based on data drawn from the period early in the study, before many rebalancing activities were actively underway, it offers two sets of potential lessons. Even this level of aggregated data generates a number of policy implications. There are also some more technical lessons about using MAX data.

The policy lessons can be summarized as follows:

- There is substantial variation in the use of different types of health care services within and across states and among waiver groups and state plan recipients. For example, recipients of home health state plan services have much higher inpatient utilization rates than waiver groups. New Mexico is frequently higher than the other seven states in terms of inpatient hospital utilization.

More work is needed to understand how much of this

difference is explained by differences in case mix (personal factors such as age, gender, and existing diagnoses or medical conditions). This will be the subject of subsequent reports. State differences will likely remain due to other factors, such as the cost of labor across states.

- The amount spent on medical care (including acute care services) and on LTC per client also varies across participants and states. For example, inpatient hospital expenditures for waiver clients are generally lower than other beneficiaries, whereas expenditures for home health clients are higher. For example, expenditures for acute care for home health state plan recipients range across states from \$450 per person month in Vermont to over \$4,000 in Washington. The average cost of nursing home care is lower than for ICFs. If the differences in spending

are not matched by differences in outcomes, issues of efficiency should be explored.

- There is some correspondence between waiver and state plan spending by target group (i.e., MR/DD and ICF); medical care for younger persons generally costs less than for older beneficiaries. The difference in payments for inpatient hospital care is more pronounced, but the pattern continues for ambulatory care and prescription drug payments with MR/DD and ICF groups being lower than aging and disabled and nursing facility groups.
- Medical costs constitute a substantial Medicaid cost for persons receiving home and community based LTC services, particularly home care services in a number of states. One possible reason for this may be a higher acuity level of those individuals receiving home care services. These higher medical expenditures may represent an area

where savings in medical costs could be used to support more LTC.

- Contrary to expectations, the utilization of dual eligible participants regardless of waiver group or state plan service group, was often lower than the non duals. This finding suggests that the dual eligible population may not be as frail as previous reported. Subsequent reports that adjust for case mix will shed more light on this finding.

There are several data limitations in using the MAX data. Medicaid data collected by states and reported through the MSIS reflect individual state differences. Medicaid eligibility and coverage vary by state. In addition, eligibility and coverage within states can change over time. Coding of services and procedures have been modified to meet specific state needs rather than to follow a uniform system. The data set thereby may overlook or misreport unique state differences.

## Introduction

This paper is one of several *Topics in Rebalancing* papers being produced by the University of Minnesota as a deliverable for the Centers for Medicare and Medicaid Services (CMS) funded project “Research on Program Management Techniques by States to Rebalance Their Long-Term Care Systems.” This three-year project examines, through the use of both qualitative and quantitative methods, the management processes that states use to shift long-term care (LTC) resources, especially those funded through Medicaid, away from traditional LTC institutions to home and community-based services (HCBS). The qualitative component of the project was focused on identifying and describing the management approaches states use to “rebalance” their LTC services, including service expansion, service access, and budgetary and service linkage strategies. The quantitative portion of the project used secondary data from State and Federal sources to explore

enrollment, service utilization, and expenditures for state LTC program recipients. More information about the full project, including an Executive Summary, case studies on each of the participating states, and other topic papers may be found at <http://www.hsr.umn.edu/LTCResourceCenter> as well as <http://www.hcbs.org>.

This paper presents *preliminary* analyses using Medicare Analytic eXtract (MAX) data of the utilization of and expenditure on LTC and medical care services among Medicaid LTC recipients in the eight states participating in the study. The data presented here are restricted to Medicaid fee-for-service (FFS) payments. Subsequent reports present analyses based on 2002 and 2003 data, as well as combined Medicare and Medicaid data from the dual eligible enrollees and Diagnostic Cost Group (DCG) case mix adjustments. The purpose of this first report is to acquaint readers with the range of data available and the possible analyses that can come from

it. This initial presentation is in the form of a chartbook with sample analyses and interpretations.

### **Research Questions**

1. How do the utilization and cost of LTC services (nursing facility, intermediate care facility (ICF), personal care, home health care and transportation) by Medicaid HCBS waiver participants and LTC state plan recipients differ across recipient groups and states?\*
2. How do the utilization and cost of medical services (hospital, emergency room, physician, physical therapy/occupational therapy/others, other practitioner, outpatient service, rehabilitation, hospice, other services, and pharmaceuticals) by Medicaid Home and Community-Based Services (HCBS) waiver participants, and state plan recipients receiving LTC services differ across recipient groups and states?\*
3. How do the utilization and Medicaid costs of these services differ for dual eligible HCBS recipients and recipients covered only by Medicaid?\*

4. How consistent is utilization of medical and LTC services across years? (This specific report calculates a medical/ long term care ratio\* for only a single year.)
5. How does utilization vary by participant characteristics?

Because the focus is on states' efforts to rebalance use of institutional and HCBS through implementing waiver programs, the analyses look separately at those program participants who are covered by Medicaid LTC waivers and those covered by Medicaid state plan services.

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\* These items are specifically addressed in this paper. Additional items will be addressed in subsequent reports.

## **Background**

Currently, states are in varying stages of rebalancing their LTC systems. The historical contexts in which states' LTC systems have developed are diverse, and states differ in their LTC policies and programs, service delivery, and management approaches. States use a combination of Medicaid state program funds (state plan services) as well as Medicaid HCBS waivers to fund and provide LTC services. Eight states are participating in the project: Arkansas, Florida, Minnesota, Pennsylvania, New Mexico, Texas, Vermont, and Washington. Each of these eight states offers a number of institutional and HCBS programs through its Medicaid state plans, including nursing homes and intermediate care facilities (ICFs) for the mentally retarded as well as hospice, home health care, and personal care. The full scope of LTC state plan services and the nature of these services, however, vary across the states. Regarding HCBS waivers, states vary in terms of whether a

state provides numerous specialized waivers versus fewer consolidated programs, emphasizes waivers over state plan services, or provides waiver services through FFS or managed care programs. A list of the waiver programs offered in 2001 by each of the states participating in the project is found in Table 1.

## Data Acquisition

### State Finder File Data

*Our study population consists of all Medicaid LTC recipients in each state during 2001, 2002, and 2003. CMS collects Medicaid enrollment and utilization data from states through its Medicaid Statistical Information System (MSIS). This data collection has only recently allowed for specific waiver participants to be identified. Therefore, we collected similar data from each of the eight states. We asked states to provide a “finder file” including all individuals who were eligible for a HCBS waiver at least at one point during a year and including all individuals who received an LTC service under the state plan during a year. These files were then matched against the CMS Medicaid and Medicare claims data (discussed below) to permit analysis of medical and LTC service utilization among HCBS waiver and other Medicaid LTC beneficiaries.*

Each state provided finder file data for their relevant HCBS waivers (Table 1). Some states were not able to furnish data for

some of the state plan services we requested, but all states did provide finder file data for nursing facility and ICF recipients.

Additionally, states that provided hospice, personal care, and home health services under their state plan (and for which data were readily available) provided data for these recipients as well (Table 2). Table 3 summarizes the data extraction approaches used by each of the states to produce the HCBS and state plan finder files. Differences in utilization rates may be a result of different selection criteria used rather than actual differences in utilization (selection criteria based upon service use may show higher utilization than a method based upon authorization).

**Table 1: HCBS Waivers offered in Each State (2001)**

State	Waivers in Each State	Number Served or Authorized in 2001
Arkansas	ElderChoices Waiver	8,541
	Alternatives for Adults with Physical Disabilities Waiver	909
	Alternative Community Services Waiver (DD)	2,502
Florida	Aging and Disabled Adults Waiver	14,530
	Nursing Home Diversion Waiver	1,006
	Assisted Living for Elderly Waiver	2,476
	Disability Services Waiver	22,504
	Family/Supported Living Waiver	17
	Channeling Waiver	1,564
	Project AIDS Care Waiver	6,743
Minnesota	Katie Beckett Waiver	3
	TBI and Spinal Cord Injury Waiver	132
	Elderly Waiver	11,992
New Mexico	Community Alternative Care Waiver	134
	Community Alternative for Disabled Individuals Waiver	5,460
	DD-MR/Related Conditions Waiver	14,986
	Traumatic Brain Injury Waiver	536
New Mexico	Disabled and Elderly Waiver	3,000
	Mental Retardation/Developmental Disability Waiver	2,6245
	Developmental Disability with Medically Fragile Condition Waiver	289
	HIV/AIDS Waiver	46

State	Waivers in Each State	Number Served or Authorized in 2001
Pennsylvania	PA Department of Aging Waiver	12,030
	Attendant Care Waiver	3,351
	Elwyn Waiver	44
	Michael Dallas Waiver	60
	OBRA Waiver	546
	Independence Waiver	339
	Consolidated MR/DD Waiver	14,027
Texas	Infant, Toddlers, and Families Waiver	2,972
	Person/Family Directed Support Waiver	5,381
	Community-Based Alternatives Waiver	35,976
Texas	Community Living Assistance and Support Services Waiver	1,501
	Medically-Dependent Children's Program Waiver	1,031
	Deaf-Blind Multiple Disabilities Waiver	190
	Consolidated Waiver Program	5
	Home and Community-Based Services Waiver	5,157
Vermont	Enhanced Residential Care Waiver	174
	Home-Based Waiver	1,200
	Developmental Services (DD) Waiver	1,846
	Traumatic Brain Injury (TBI) Waiver	54
Washington	Community Options Program Entry System (COPES)	30,532
	Community Alternative Program	11,823

**Table 2: Summary of State Plan Finder File Data by State**

State	State Plan Groups			
	Homecare	Intermediate Care Facility	Nursing Facility	Personal Care
Arkansas	X	X	X	X
Florida	X	X	X	-
New Mexico	X	X	X	X
Minnesota	X	X	X	X
Pennsylvania	X	X	X	-
Texas	-	X	X	X
Vermont	X	X	X	-
Washington	X	X	X	X

**Table 3: Summary of State Finder File Data Extraction Approaches**

State	Selection Criterion			
	State Plan Services		HCBS Waivers	
	Authorization/ Eligibility	Services Use; Claims	Authorization/ Eligibility	Services Use; Claims
Arkansas		X	X	
Florida		X		X
Minnesota		X	X	
New Mexico		X		X
Pennsylvania		X	MR/DD	Aging
Texas	X		X	
Vermont		X		X
Washington		X	MR/DD	Aging

### *CMS Medicaid Data*

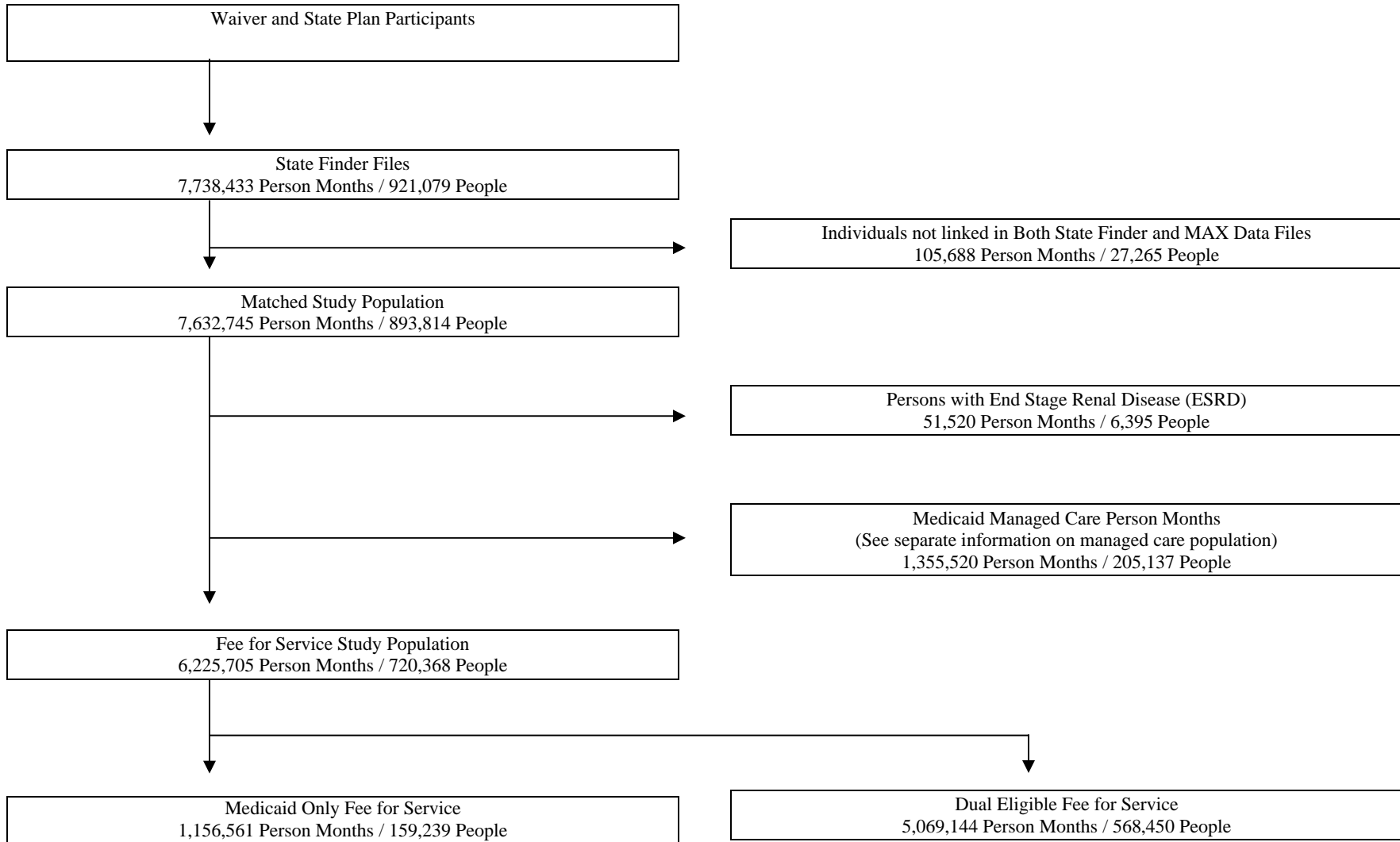
Utilization and cost data for medical and LTC services were obtained from the MAX files created by CMS. Using the CMS Eligible Identifier Number obtained from the MAX PS file, we then extracted all claims from the MAX utilization files (MAX IP: inpatient, MAX LT: long-term care, MAX OT: other services, MAX RX: prescription drugs) which pertain to the persons identified. For inpatient hospital and LTC claims, we also produced secondary files which combine individual claims into contiguous “stays” for analysis of admissions. Claims are combined into a stay when there is a continuous record of claims with no internal gap of more than 7 days.

Our study population includes individuals who are enrolled in a relevant Medicaid waiver or LTC state plan service, including dual eligible recipients, or those enrolled in both Medicaid and Medicare as a result of age or disability. We linked state finder files with MAX data. Fewer than three

percent of all individuals across the eight states failed to match MAX records. Figure 1 traces the development of our analytic sample.

We excluded from our study population those individuals identified as having end stage renal disease, (ESRD). Although they represent a small portion of the population (less than 1% across the eight states), their high utilization of services could skew the results. Therefore, these individuals, identified through diagnoses associated with their claims data, were excluded from our study population.

**Figure 1: Study Sample Development Process**



*Creation of Person Months and Waiver/State Plan Analytic Groups*

Person month was chosen as the unit of analysis. For each person, we identified the primary waiver program (if any) in which they were enrolled in each month, and flagged the utilization of the various services of interest. In months where no waiver enrollment was indicated, but utilization of a state plan LTC service of interest was reported, we classified the person month as “state plan.”

Specific waiver groups in each state were then regrouped (based on their eligible population) into the following two waiver categories of interest: Aging and (Physical) Disability and Mental Retardation/Developmental Disability (MR/DD). For instance, in Arkansas, enrollees in the Alternative Community Services Waiver were placed in the MR/DD category and those in the Elderly Choice waiver or the Alternatives for Adults with Physical Disability waiver were

both included in the Aging and Disability category. Specific waiver groups that did not fall into the waiver categories were excluded from the analysis. Our analysis summarized in this report focuses primarily on the larger HCBS waivers in each state serving the aging and disabled populations.

Our state plan groups of interest across the eight states consisted of those individuals who used nursing facility, ICF, home health, and personal care services. For each person month classified as “state plan” we identified the primary LTC state plan service used by each individual during that month. Use of a state plan service was used to assign person months to state plan groups for comparison purposes. Some individuals were listed in some state finder files as utilizing exclusively hospice or targeted case management state plan services. Because the provision of these services and what types of specific assistance were included varied widely across states we

excluded the individuals receiving only these services from our analysis.

The waiver and state plan analytic groups from each state that are included in our cross-state comparison are presented in Table 4. All eight states have waiver groups in the MR/DD and Aging & Disability categories. All eight states also have ICF/MR and nursing facility state plan analytic groups. Texas does not have home health; and Florida, Pennsylvania, and Vermont do not have personal care as a state plan group.

**Table 4: Summary of Waiver and State Plan Analytic Groups in 2001 for Cross-state Comparison**

State	Waiver Groups		State Plan Groups			
	Mental Retardation/Developmental Disability	Aging & Disability	Nursing Facility	Intermediate Care Facility	Home Health	Personal Care
Arkansas	Alternative Community Services Waiver	<ul style="list-style-type: none"> <li>Elderly Choice Waiver</li> <li>Alternatives for Adults with Physical disability Waiver</li> </ul>	Yes	Yes	Yes	Yes
Florida	Developmental Disability Waiver	Aging and Disabled Adults Waiver	Yes	Yes	Yes	-
New Mexico	Mental Retardation/Developmental Disability Waiver	Disabled Elderly Waiver	Yes	Yes	Yes	Yes
Minnesota	Mental Retardation/Related Conditions Waiver	<ul style="list-style-type: none"> <li>Elderly Waiver</li> <li>Community Alternative for Disabled Individuals Waiver</li> </ul>	Yes	Yes	Yes	Yes
Pennsylvania	Consolidated Mental Retardation/Developmental Disability Waiver	<ul style="list-style-type: none"> <li>PA Department of Aging Waiver</li> <li>Attendant Care Waiver</li> </ul>	Yes	Yes	Yes	-
Texas	<ul style="list-style-type: none"> <li>Home and Community-Based Services Waiver</li> <li>Community Living Assistance and Support Services Waiver</li> </ul>	Community-Based Alternatives Waiver	Yes	Yes	-	Yes
Vermont	Developmental Services Waiver	<ul style="list-style-type: none"> <li>Enhanced Residential Care Waiver</li> <li>Adult Disability Waiver</li> </ul>	Yes	Yes	Yes	-
Washington	Community Alternatives Program	Community Options Program Entry System	Yes	Yes	Yes	Yes

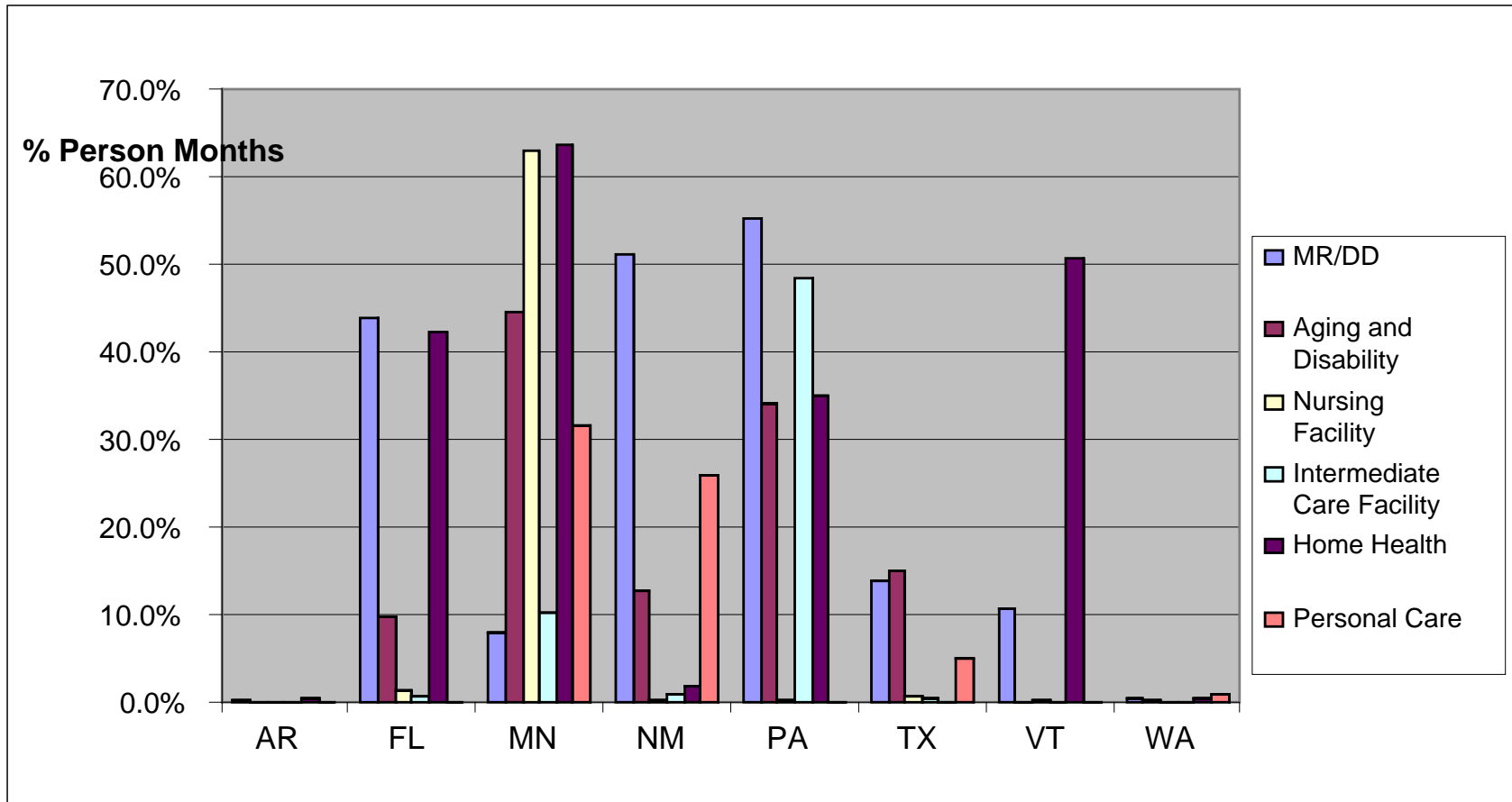
*Exclusion of Managed Care Person Months from Analysis*

Our analysis is limited to Medicaid enrollees in FFS plans (including dual eligible). MAX data include enrollment in prepaid Medicaid plans as well as premium payments made by Medicaid into prepaid plans. Some service data are found in the MAX files, but the data are inconsistently reported, and there are no cost data available. Managed care claims were reported either as FFS claims with associated payments, encounter claims without payment details, or in some cases went unreported despite enrollment in the group. Reliable measures of service utilization and associated payment could not be obtained for Medicaid managed care enrollees. We therefore excluded managed care person months from the analysis (Figure 1).

The proportion of person months in Medicaid managed care greatly varied across states (Figure 2), ranging from almost 0% in Arkansas, to as high as 60% for nursing facility

state plan in Minnesota. Minnesota had the highest percentage of Medicaid managed care enrollment across the waiver and state plan services among the eight states, followed by Pennsylvania and Florida. Managed care enrollment indicated in the MAX data represents different variants of managed care. Managed care enrollees can be enrolled in a comprehensive plan, a dental plan, a behavioral plan, a primary care case management plan, some other managed care plan, or a combination of plans. Comprehensive Medicaid managed care plans may include comprehensive acute health care services but may not include some or all LTC services such as nursing home stays. Some of the waiver programs in some states are also offered through a managed care plan.

**Figure 2: Percentage of Person Months in Medicaid Managed Care in Analytic Groups-2001**



Tables 5 through 8 show basic demographic data on the managed care individuals excluded from our analysis compared to Medicaid only FFS individuals in our analysis. In those states where the managed care population is larger, such as Minnesota, Pennsylvania, and Florida, the pattern of age, gender and race is fairly consistent with the FFS population. However, in some instances, the managed care population is slightly younger, and fewer are white. In many instances the managed care population is more urban than the FFS enrollees. There are considerably fewer managed care enrollees who are dual eligible for Medicaid and Medicare (except in Minnesota) than the FFS population in each state.

**Table 5. Demographic Summary for Medicaid FFS and Managed Care Enrollees by Waiver Analytic Group (2001)**

State	Demographic		Medicaid FFS Waiver Groups		Medicaid Managed Care Waiver Groups	
			MR/DD	Aging/Disability	MR/DD	Aging/Disability
AR	N	# Persons	2,381	8,349	2	0
		Mean Age	32	79	17	-
	Age	Range (Min-Max)	3-82	17-113	14-19	-
	Gender	% Female	44.6%	74.5%	0.0%	-
	Race	% White	77.1%	75.5%	50.0%	-
	Urban	% Metro	53.4%	35.2%	100.0%	-
FL	N	# Persons	11,186	11,957	9,059	1,244
		Mean Age	45	78	31	68
	Age	Range (Min-Max)	17-108	21-108	17-101	21-106
	Gender	% Female	49.1%	77.9%	44.5%	73.6%
	Race	% White	76.5%	59.8%	58.6%	50.3%
	Urban	% Metro	87.5%	84.1%	89.7%	88.0%
MN	N	# Persons	12,235	10,503	650	4,997
		Mean Age	32	67	51	70
	Age	Range (Min-Max)	0-95	1-107	1-96	1-107
	Gender	% Female	42.1%	71.1%	44.9%	80.8%
	Race	% White	89.8%	92.0%	87.2%	89.7%
	Urban	% Metro	65.6%	54.3%	62.6%	60.5%
NM	N	# Persons	1,227	1,777	1,302	329
		Mean Age	41	73	28	42
	Age	Range (Min-Max)	5-88	3-106	0-100	2-100
	Gender	% Female	43.0%	70.8%	39.4%	60.5%
	Race	% White	46.5%	39.2%	47.8%	38.9%
	Urban	% Metro	66.0%	43.0%	73.2%	62.0%
PA	N	# Persons	5,681	9,999	6,624	5,021
		Mean Age	42	74	41	62
	Age	Range (Min-Max)	4-96	17-108	3-95	16-104
	Gender	% Female	43.5%	74.7%	42.3%	73.8%
	Race	% White	92.9%	79.0%	78.0%	51.7%
	Urban	% Metro	70.7%	72.2%	94.8%	96.3%
TX	N	# Persons	5,041	26,211	711	4,932
		Mean Age	33	73	29	67
	Age	Range (Min-Max)	1-90	20-112	6-84	21-106
	Gender	% Female	41.3%	70.0%	39.9%	71.6%
	Race	% White	64.3%	52.7%	63.6%	44.1%
	Urban	% Metro	83.9%	63.8%	96.5%	96.1%
VT	N	# Persons	1,643	1,129	141	24
		Mean Age	38	76	20	53
	Age	Range (Min-Max)	1-91	15-103	2-57	21-94
	Gender	% Female	43.0%	71.2%	42.9%	58.3%
	Race	% White	79.0%	77.9%	67.1%	91.7%
	Urban	% Metro	26.7%	33.6%	40.7%	50.0%
WA	N	# Persons	11,387	20,537	61	57
		Mean Age	29	72	11	36
	Age	Range (Min-Max)	0-91	0-108	1-38	2-82
	Gender	% Female	42.2%	72.4%	50.8%	71.9%
	Race	% White	86.9%	84.8%	73.8%	66.7%
	Urban	% Metro	88.7%	84.2%	88.5%	77.2%

**Table 6: Demographic Summary for Medicaid FFS and Managed Care Enrollees by State Plan Analytic Group (2001)**

State	Demographic		Medicaid FFS State Plan Groups				Medicaid Managed Care State Plan Groups			
			NF	ICF	Home Health	Personal Care	NF	ICF	Home Health	Personal Care
AR	N	# Persons	16,438	1,728	1,674	7,206	0	1	2	0
	Age	Mean Age	81	36	28	67	-	16	12	-
		Range (Min-Max)	13-119	2-74	0-98	1-122	-	-	6-18	-
	Gender	% Female	72.2%	39.9%	58.4%	75.5%	-	100.0%	50.0%	-
	Race	% White	81.7%	77.0%	55.6%	53.6%	-	0.0%	50.0%	-
	Urban	% Metro	39.4%	59.2%	40.2%	30.2%	-	0.0%	50.0%	-
FL	N	# Persons	68,300	3,345	47,541	-	1,648	29	48,513	-
	Age	Mean Age	80	43	54	-	58	28	21	-
		Range (Min-Max)	0-125	5-88	0-121	-	0-104	8- 52	0-101	-
	Gender	% Female	69.7%	42.4%	62.9%	-	55.7%	31.6%	51.5%	-
	Race	% White	76.3%	72.4%	54.9%	-	39.6%	31.6%	35.3%	-
	Urban	% Metro	89.6%	85.0%	84.4%	-	93.3%	84.2%	83.5%	-
MN	N	# Persons	17,444	2,560	6,360	5,225	14,614	187	7,772	645
	Age	Mean Age	79	43	28	27	86	73	20	72
		Range (Min-Max)	17-109	8-88	0-107	0-94	19-114	12-95	0-99	2-97
	Gender	% Female	67.2%	45.4%	68.4%	44.4%	76.1%	52.4%	73.3%	67.9%
	Race	% White	94.0%	95.4%	60.7%	70.1%	95.9%	98.9%	43.5%	29.6%
	Urban	% Metro	53.6%	61.8%	60.8%	85.5%	66.3%	58.3%	77.0%	97.8%
NM	N	# Persons	6,032	274	351	3,113	15	7	10	1,165
	Age	Mean Age	80	43	34	73	39	31	2	51
		Range (Min-Max)	9-114	9-91	0-103	21-106	0-81	20-50	0-16	1-97
	Gender	% Female	67.1%	44.5%	61.3%	74.0%	20.0%	57.1%	40.0%	67.4%
	Race	% White	61.2%	66.4%	21.9%	42.8%	13.3%	71.4%	30.0%	41.3%
	Urban	% Metro	48.0%	60.2%	50.7%	39.6%	53.3%	42.9%	60.0%	42.1%

**Table 6 continued: Demographic Summary for Medicaid FFS and Managed Care Enrollees by State Plan Analytic Group (2001)**

State	Demographic		Medicaid FFS State Plan Groups				Medicaid Managed Care State Plan Groups			
			NF	ICF	Home Health	Personal Care	NF	ICF	Home Health	Personal Care
PA	N	# Persons	74,442	2,469	4,909	-	1,121	2,259	1,352	-
	Age	Mean Age	82	48	33	-	71	42	18	-
		Range (Min-Max)	0-113	5-92	0-97	-	5-104	2-96	0-82	-
	Gender	% Female	74.3%	45.2%	71.9%	-	68.8%	44.1%	67.8%	-
	Race	% White	87.3%	89.6%	79.1%	-	59.0%	76.4%	75.5%	-
	Urban	% Metro	81.1%	57.0%	66.8%	-	94.5%	99.6%	70.0%	-
TX	N	# Persons	82,959	7,815	-	94,318	1,171	100	-	4,855
	Age	Mean Age	80	40	-	71	68	26	-	61
		Range (Min-Max)	0-118	2-88	-	0-110	1-105	8-56	-	1-107
	Gender	% Female	70.2%	44.1%	-	71.9%	65.1%	38.0%	-	77.1%
	Race	% White	72.1%	70.4%	-	41.0%	38.5%	51.0%	-	31.7%
	Urban	% Metro	69.8%	82.7%	-	72.1%	95.5%	92.0%	-	94.6%
VT	N	# Persons	3,002	12	991	-	23	0	962	-
	Age	Mean Age	83	52	52	-	52	-	30	-
		Range (Min-Max)	2-117	26-77	0-100	-	20-71	-	0-91	-
	Gender	% Female	71.7%	66.7%	62.0%	-	78.3%	-	59.1%	-
	Race	% White	77.0%	91.7%	79.9%	-	87.0%	-	75.8%	-
	Urban	% Metro	20.0%	0.0%	27.1%	-	26.1%	-	32.1%	-
WA	N	# Persons	17,663	60	1,179	8,061	8	0	8	100
	Age	Mean Age	79	48	52	64	70	-	25	36
		Range (Min-Max)	3-112	22-84	0-100	0-104	27-98	-	0-62	1-57
	Gender	% Female	67.3%	65.0%	60.9%	71.7%	75.0%	-	37.5%	87.0%
	Race	% White	89.4%	91.7%	75.0%	70.5%	25.0%	-	87.5%	80.0%
	Urban	% Metro	90.0%	100.0%	82.4%	88.1%	100.0%	-	62.5%	71.0%

**Table 7: Medicaid FFS Person Months in Waiver and State Plan Analytic Groups by Dual Eligible Status (2001)**

State	Number of Person Months	Waiver Groups		State Plan Groups			
		MR/DD	Aging/ Disability	NF	ICF	Home Health	Personal Care
AR	Total	27,299	84,458	169,094	20,553	11,632	84,278
	Medicaid Only	15,663	7,470	16,403	10,167	8,285	20,841
	Dual	11,636	76,988	152,691	10,386	3,347	63,437
	% Dual	42.6%	91.2%	90.3%	50.5%	28.8%	75.3%
FL	Total	128,628	109,444	575,360	38,638	201,607	-
	Medicaid Only	12,042	1,356	41,963	15,719	25,202	-
	Dual	116,586	108,088	533,397	22,919	176,405	-
	% Dual	90.6%	98.8%	92.7%	59.3%	87.5%	-
MN	Total	143,006	92,361	117,260	29,060	24,761	43,121
	Medicaid Only	72,248	20,480	11,781	8,115	14,768	31,247
	Dual	70,758	71,881	105,479	20,945	9,993	11,874
	% Dual	49.5%	77.8%	90.0%	72.1%	40.4%	27.5%
NM	Total	13,795	13,330	52,673	2,679	1,012	24,444
	Medicaid Only	1,450	333	4,876	1,160	588	1,060
	Dual	12,345	12,997	47,797	1,519	424	23,384
	% Dual	89.5%	97.5%	90.7%	56.7%	41.9%	95.7%
PA	Total	68,592	105,837	657,988	27,915	37,978	-
	Medicaid Only	23,632	7,423	35,730	6,472	36,865	-
	Dual	44,960	92,527	622,258	21,443	1,113	-
	% Dual	65.5%	92.6%	94.6%	76.8%	2.9%	-
TX	Total	47,965	282,690	792,114	88,252	-	883,613
	Medicaid Only	27,471	31,775	63,028	40,516	-	120,667
	Dual	20,494	250,915	729,086	47,736	-	762,946
	% Dual	42.7%	88.8%	92.0%	54.1%	-	86.3%
VT	Total	18,608	10,441	27,274	137	4,694	-
	Medicaid Only	7,174	871	1,120	60	1,104	-
	Dual	11,434	9,570	26,154	77	3,590	-
	% Dual	61.4%	91.7%	95.9%	56.2%	76.5%	-
WA	Total	132,058	181,447	149,763	714	2,841	77,529
	Medicaid Only	80,250	26,786	10,861	190	2,446	36,319
	Dual	51,808	154,661	138,902	524	395	41,210
	% Dual	39.2%	85.2%	92.7%	73.4%	13.9%	53.2%

**Table 8: Medicaid Managed Care Person Months in Waiver and State Plan Analytic Groups by Dual Eligible Status (2001)**

State	Number of Person Months	Waiver Groups		State Plan Groups			
		MR/DD	Aging/ Disability	NF	ICF	Home Health	Personal Care
AR	Total	9	0	0	3	30	1
	Medicaid Only	9	0	0	3	30	1
	Dual	0	0	0	0	0	0
	% Dual	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
FL	Total	100,951	11,680	7,040	208	148,322	-
	Medicaid Only	89,532	6,976	5,219	208	144,775	-
	Dual	11,419	4,704	1,821	0	3,547	-
	% Dual	11.3%	40.3%	25.9%	0.0%	2.4%	-
MN	Total	6,133	57,900	179,285	2,348	17,596	5,478
	Medicaid Only	1,011	1,344	2,470	130	12,944	1,092
	Dual	5,122	56,556	176,815	2,218	4,652	4,386
	% Dual	83.5%	97.7%	98.6%	94.5%	26.4%	80.1%
NM	Total	14,471	1,933	66	20	18	8,578
	Medicaid Only	13,037	1,749	66	17	18	8,170
	Dual	1,434	184	0	3	0	408
	% Dual	9.5%	9.9%	0.0%	15.0%	0.0%	4.8%
PA	Total	84,499	54,526	1,627	26,346	20,402	-
	Medicaid Only	34,250	16,536	551	10,577	20,220	-
	Dual	50,249	37,990	1,076	15,769	182	-
	% Dual	59.5%	69.6%	66.1%	59.9%	0.9%	-
TX	Total	7,726	50,006	5,423	360	-	45,948
	Medicaid Only	5,466	10,939	1,902	271	-	20,338
	Dual	2,260	39,067	3,521	89	-	25,610
	% Dual	29.3%	78.1%	64.9%	24.7%	-	55.7%
VT	Total	2,237	1	62	0	4,817	-
	Medicaid Only	2,046	190	34	0	3,945	-
	Dual	191	29	9	0	159	-
	% Dual	8.5%	13.2%	20.9%	-	3.9%	-
WA	Total	427	379	22	0	9	593
	Medicaid Only	427	359	6	0	9	573
	Dual	0	20	16	0	0	20
	% Dual	0.0%	5.3%	72.7%	-	0.0%	3.4%

## Results

### Inpatient Hospital Utilization Rate (%)

#### *What is being measured?*

Figures 3a and b show the admission rate to an acute care hospital per month for persons belonging to specific waivers or state plan services for each of the eight states. The groups presented include two waiver groups (MR/DD and Aging and Disability), two institutional state plan services (NF and ICF) and two community-based LTC state plan services (Home Health and Personal Care)

Figure 3a reports data for those individuals who are eligible for only FFS Medicaid. Figure 3b reports data for those individuals who are eligible for both FFS Medicaid and FFS Medicare. While at this time only Medicaid data are being reported, because Medicaid typically pays a deductible for Medicare covered stays, all inpatient admissions regardless of payer should be captured in the Medicaid data.

We have separated the two groups assuming that the characteristics of the two groups may be different. Previous research has shown that dual eligible enrollees use more health care services in general than non-dual eligible enrollees.

#### *Descriptive Results:*

##### Figure 3a Medicaid Only FFS:

- None of the beneficiaries in the two waiver programs across each of the eight states has admission rates above 10%. At the same time, six of the seven states that offer

home health have rates above 10%, several at or above 25% and reaching as high as 30%.

- There is variation across states in both waiver groups and across state plan services. For example, New Mexico is frequently higher than the other seven states. The greater variation by state is found in the community based LTC service groups.
- Consistent across states, among waiver clients, older and disabled clients are more likely to be hospitalized than those with MR/DD.
- The hospitalization rate pattern for nursing home residents is similar to that of clients in the aging and disability waiver as well as those receiving personal care services but much higher than those in ICFs.

##### Figure 3b Dual FFS Enrollees:

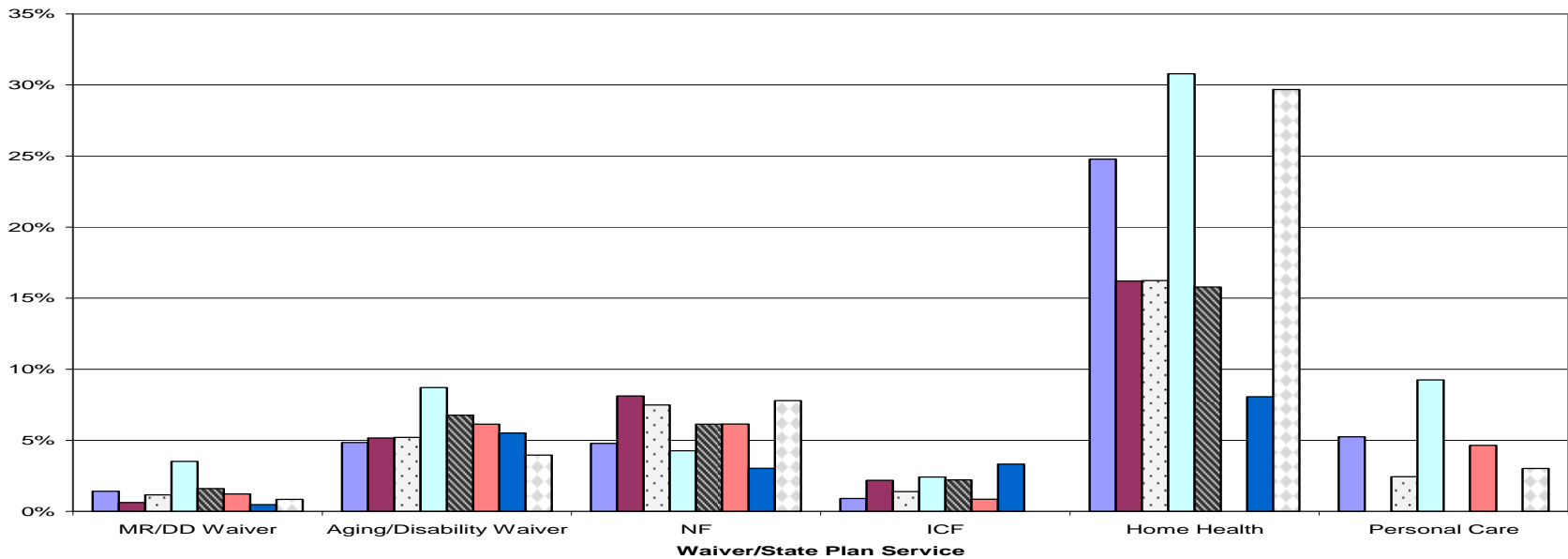
- On the basis of previously reported findings, we had expected to find higher hospital admission rates for dual eligible participants consistent with the assumption of a more frail population. Instead we found the reverse. The hospital admission rates for dual eligible participants are generally lower than for the Medicaid only FFS participants, with the exception of New Mexico. The issue of relative frailty will have to await later analyses that correct for case mix.
- Inpatient utilization rates for the Aging and Disability waiver and NF residents are higher than for the MR/DD waiver, ICF residents, and personal care clients.

- Again, home health clients have the highest inpatient hospitalization admission rate of the groups presented.

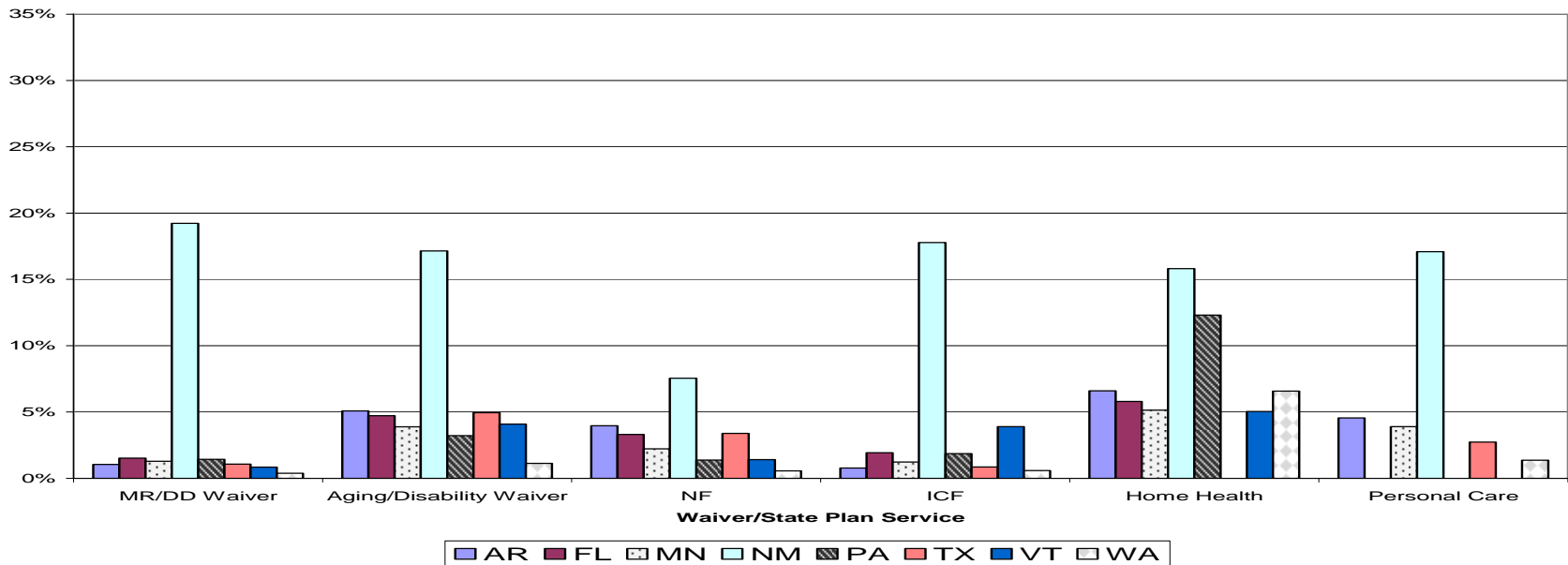
*Interpretation*

- Higher inpatient hospitalization rates in the aging/disability waiver and NF populations could reflect the age and type of chronic illnesses presented in those populations compared to the MR/DD and ICF populations.
- These data do not necessarily support the assumption that dual eligible enrollees are frailer and therefore higher utilizers of health care services.
- The higher inpatient hospitalization rates for home health clients may be due in part to the case mix of the population. Many of the states offer more skilled acute care services as part of their home health programs to sicker, younger populations – the home health programs are not a typical LTC service but more a community-based acute care service.

**Figure 3a. Inpatient Hospital Utilization Rate (%) per Person Month, by Waiver/State Plan Service Group – Medicaid-Only FFS Enrollees (2001)**



**Figure 3b. Inpatient Hospital Utilization Rate (%) per Person Month, by Waiver/State Plan Service Group – Dual FFS Enrollees (2001)**



### **Inpatient Hospital MA Payment (\$) per Person Month in Group**

*What is being measured?*

The annual Medicaid payment amount per person month in an analytic group – total inpatient hospital Medicaid payments divided by the total number of person months in the analytic group (users and nonusers of the service).

*Descriptive Results:*

#### **Figure 4a Medicaid Only FFS**

- There is a difference in the pattern of monthly Medicaid expenditures for inpatient hospital care compared to admission rates.
- Inpatient hospital expenditures for waiver clients are generally lower.
- Home Health clients have higher expenditures with especially high expenditures in Washington and New Mexico compared to the other six states presented.
- MR/DD clients in either institutions (ICF) or the community (MR/DD waiver program) have lower expenditures than the aging and disability waiver group.

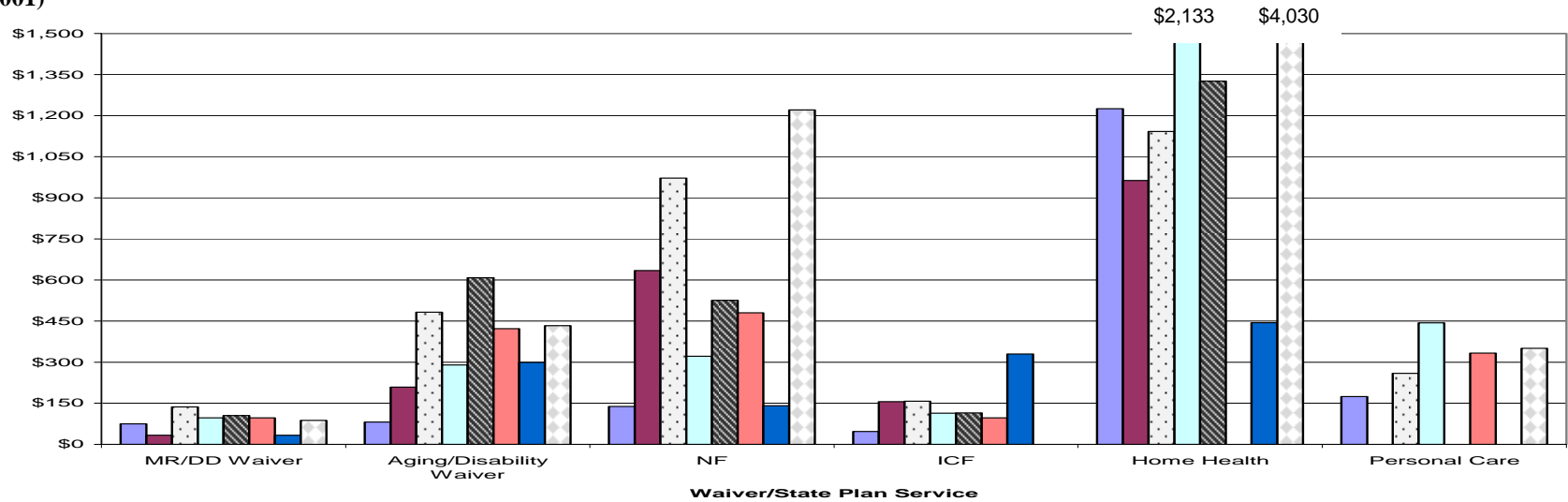
#### **Figure 4b Dual FFS Enrollees**

- The expenditures on hospitalizations are dramatically lower in the dual eligible group compared to the Medicaid only group. Medicare expenditures are not captured in the data presented. This is likely due to two elements: 1] the absence of Medicare payments and 2] the lower inpatient utilization rate for the dual eligible group.

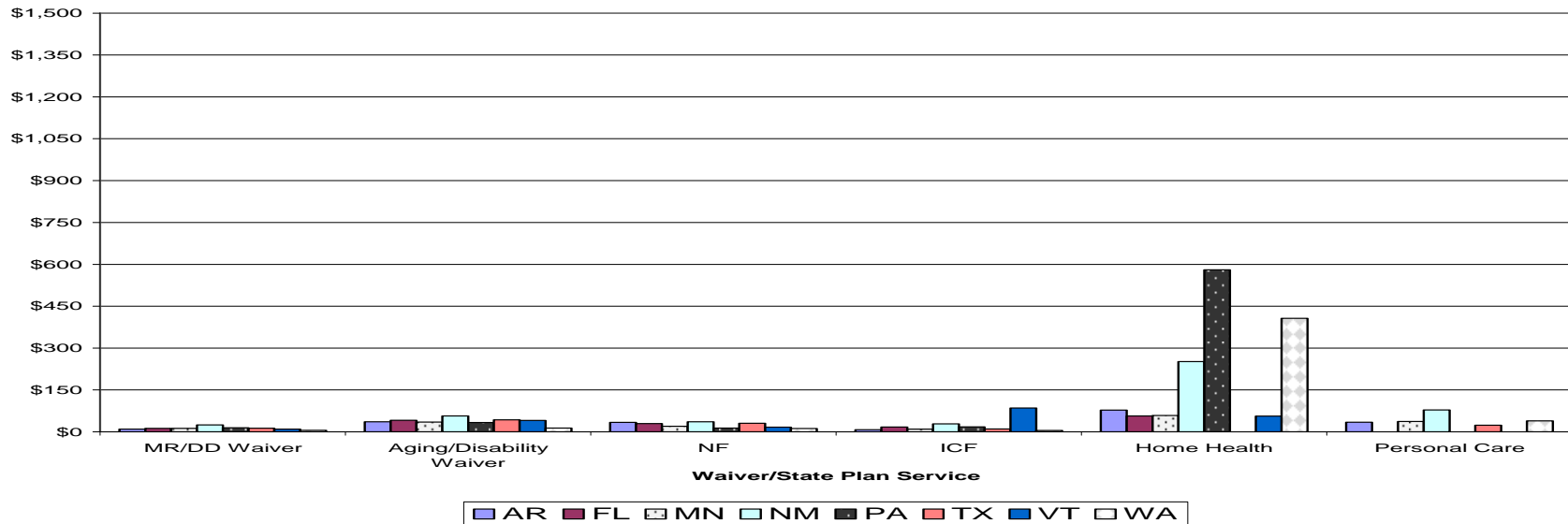
*Interpretation*

The different pattern of expenditures compared to utilization rates could be a reflection of variations by state in the base cost of inpatient hospital care.

**Figure 4a. Inpatient Hospital Medicaid Payment (\$) per Person Month in Group, by Waiver/State Plan Service Group – Medicaid-Only FFS Enrollees (2001)**



**Figure 4b. Inpatient Hospital Medicaid Payment (\$) per Person Month in Group, by Waiver/State Plan Service Group – Dual FFS Enrollees (2001)**



## **Residential LTC Utilization Rate and Medicaid Payment per Person Month (\$) in Group**

### *What is being measured?*

The utilization rate for nursing home and ICF stays (i.e., counting if a person was in the nursing home in a given month or not) as well as the average Medicaid payment amount per person month in an analytic group across the year total Medicaid payments for nursing home and intermediate care for all beneficiaries in the year divided by the total number of person months in the analytic group (users and nonusers of the service).

### *Descriptive Results:*

#### Medicaid Only FFS –

- There is virtually no use of nursing facilities or intermediate care facilities by waiver participants or Medicaid recipients utilizing other LTC services, such as home health or personnel care.
- The average cost of nursing home care is lower than for ICFs.
- The average cost of nursing facility is very similar across states, whereas the range of expenditures for ICF is greater, ranging from approximately \$4,000 in Texas to over \$12,000 in Vermont.

#### Dual FFS Enrollees

- The expenditures on nursing homes and ICF are lower in the dual eligible group compared to the Medicaid only group. Medicare expenditures are not captured in the data presented. This is consistent with expectations.

### *Interpretation*

- Residential LTC options, including nursing homes and ICF, are not being used by participants primarily utilizing HCBS.

### **Total Ambulatory Service Utilization Rate (%)**

#### *What is being measured?*

The utilization rate for ambulatory services - the number of person-months with at least one claim for ambulatory services divided by the total number of person months with the same service type (the proportion of beneficiaries using the service in a given month, i.e., it does not distinguish heavy users in a given month from those who use the service only once in that month). Ambulatory services include physician, other practitioner (such as nurse practitioner and nurse midwife), and outpatient services (including outpatient hospital and clinic visits).

#### *Descriptive Results:*

##### Figure 5a Medicaid Only FFS

- Waiver clients generally use less ambulatory care than do those in the state plans.
- The difference between MR/DD waiver clients and those in ICFs is not great.
- Home care clients (except Pennsylvania and Vermont) are the highest users of ambulatory services compared to waiver and other state plan clients.

##### Figure 5b Dual FFS Enrollees

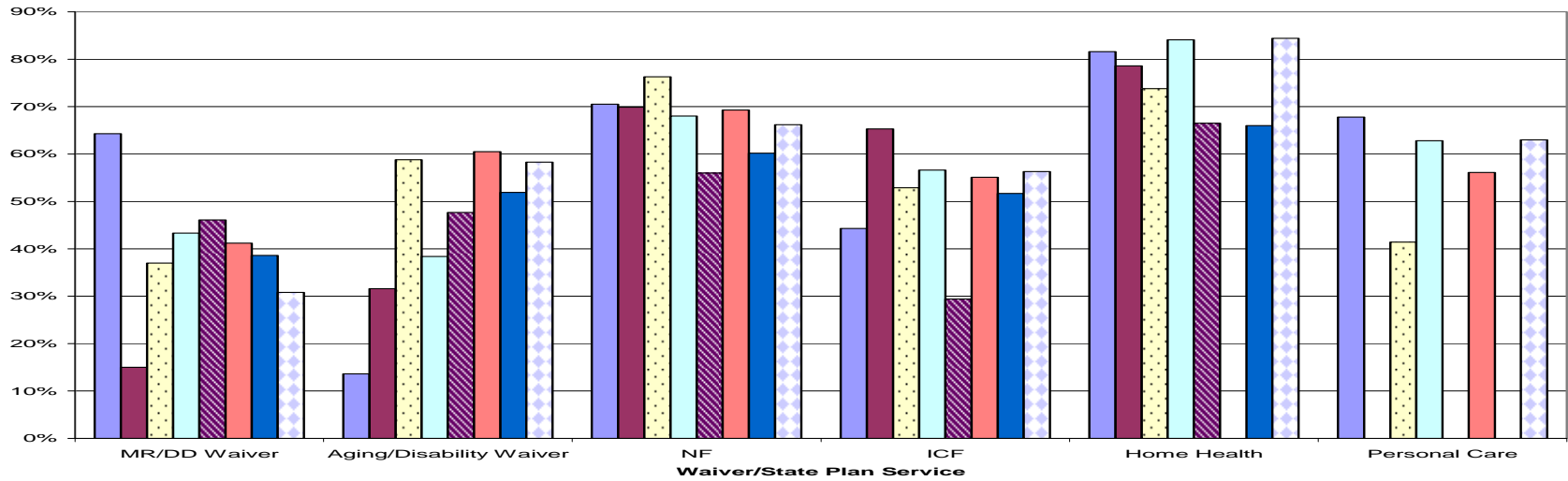
- The ambulatory care utilization for dual eligible beneficiaries is less than that for MA beneficiaries. Again this is contrary to conventional wisdom, which suggests that the dual eligible population is more frail and consumes more health care services.

- As with the Medicaid patterns, the rates for Arkansas MR/DD waiver and PCA clients are high, but all rates are much lower than with Medicaid clients.
- There is greater variation between states within waiver or state plan group for the dual eligible population than for the Medicaid only population. For example, rates of ambulatory service utilization were all above 50% for the Medicaid only nursing facility group. In the dual eligible group, four states remained comparatively high, while three states, Florida, Pennsylvania, and Washington, dropped significantly.

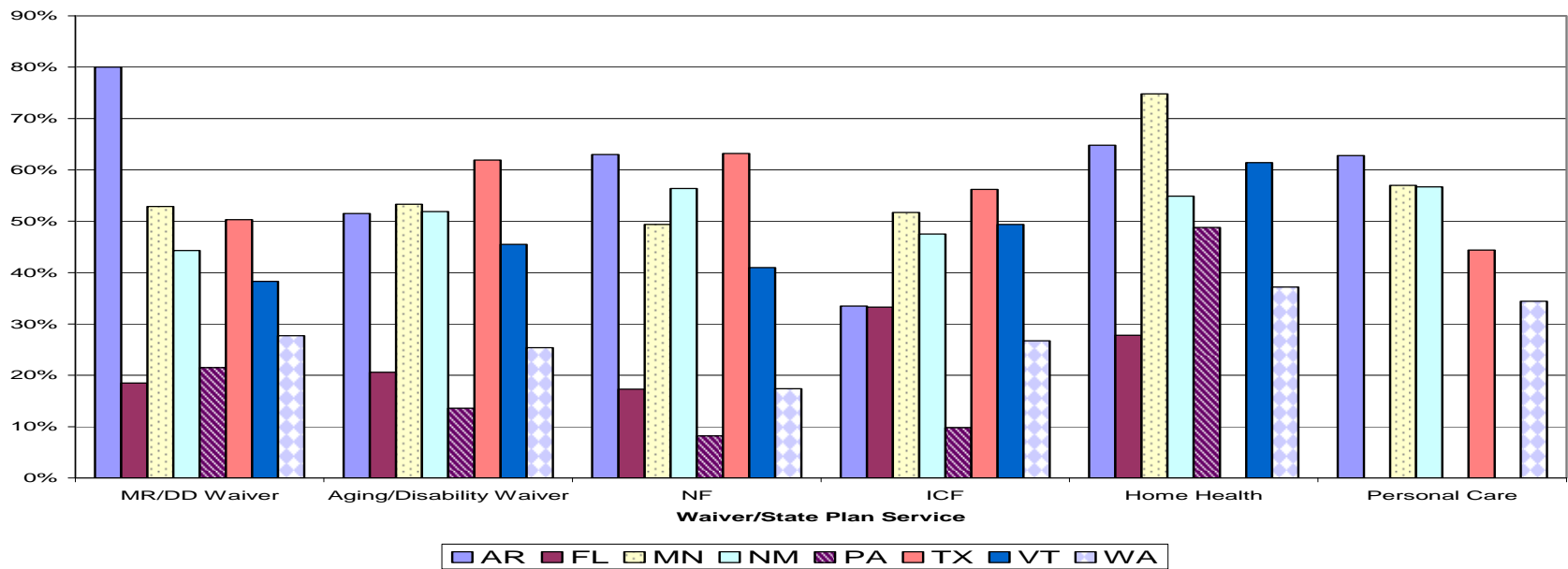
#### *Interpretation*

- If the difference in hospitalization rates between MR/DD and Aging and Disability was attributable to case mix, it is not seen here.
- The higher ambulatory service utilization rates for home health clients may be due in part to the case mix of the population, reflecting a more acute use of services than LTC.
- These data do not necessarily support the assumption that dual eligible enrollees are frailer and therefore higher utilizers of health care services.

**Figure 5a. Total Ambulatory Service Utilization Rate (%), by Waiver/State Plan Service Group – Medicaid-Only FFS Enrollees (2001)**



**Figure 5b. Total Ambulatory Service Utilization Rate (%), by Waiver/State Plan Service Group – Dual FFS Enrollees (2001)**



## Total Ambulatory Service Medicaid Payment (\$) per Person Month in Group

### *What is being measured?*

The annual Medicaid payment amount for ambulatory services per person month in an analytic group divided by the total number of person months in the analytic group (users and non users of the service).

### *Descriptive Results:*

#### Figure 6a Medicaid Only FFS

- There are similarities in ambulatory service payments between MR/DD waiver clients and ICF as well as between aging and disability waiver clients and nursing facilities.
- Home care payments (except in Pennsylvania) are the highest across the waiver and state plan groups; PCA clients also have a substantial amount of total payments for ambulatory services.
- Pennsylvania consistently has a lower total payment for ambulatory care.

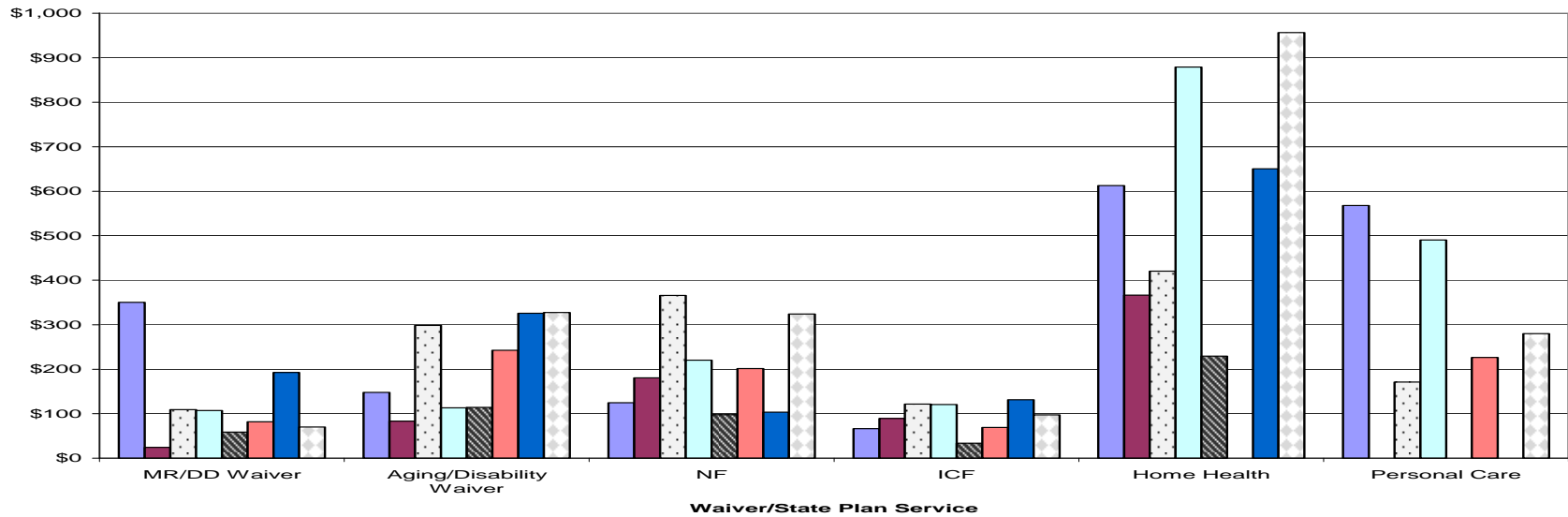
#### Figure 6b Dual FFS Enrollees

- The ambulatory care expenditures for dual eligible beneficiaries are substantially lower than that for Medicaid only beneficiaries.
- As with the Medicaid patterns, the rates for Arkansas MR/DD waiver, home care, and PCA clients are high, but all rates are much lower than with Medicaid clients.

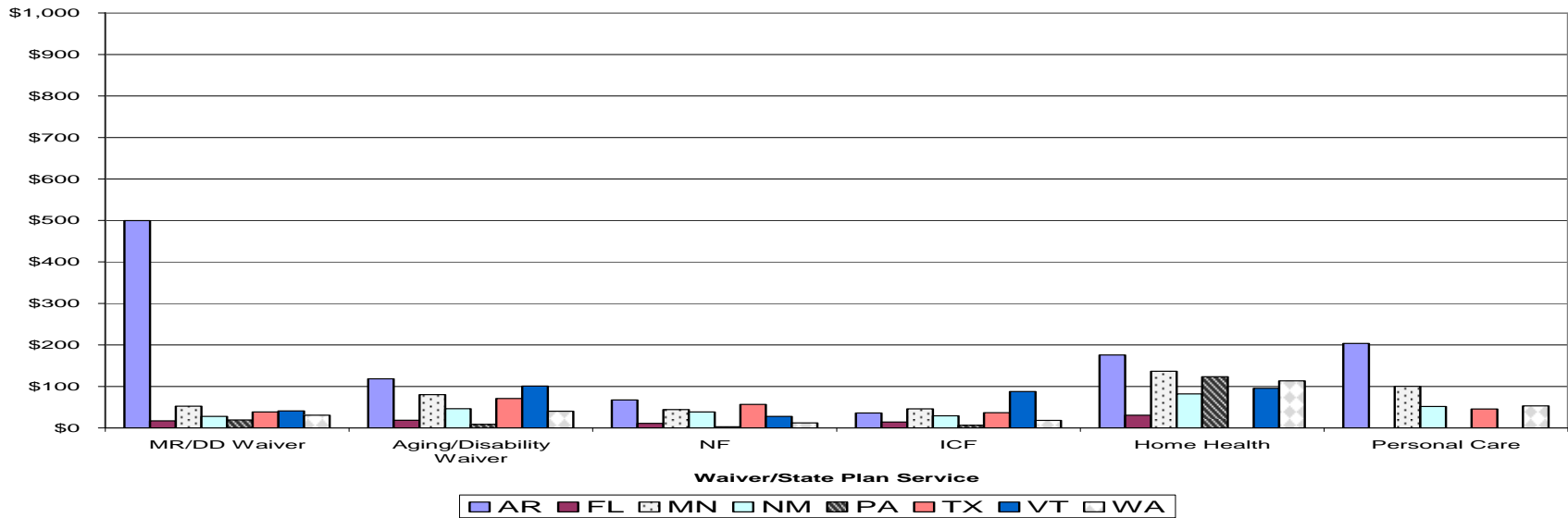
### *Interpretation*

- The difference between Medicaid only payments and dual eligible payments reflects the role of Medicare coverage, which is not reported in this data.
- Total payments show a similar pattern across groups and states as the pattern of utilization, suggesting a more comparable base rate for ambulatory services across states than shown previously for inpatient services.

**Figure 6a. Total Ambulatory Service Medicaid Payment (\$) per Person Month in Group, by Waiver/State Plan Service Group – Medicaid-Only FFS Enrollees (2001)**



**Figure 6b. Total Ambulatory Service Medicaid Payment (\$) per Person Month in Group, by Waiver/State Plan Service Group – Dual FFS Enrollees (2001)**



### **Prescription Drug Medicaid Payment (\$) per Person Month in Group**

*What is being measured?*

The annual Medicaid payment amount per person month in an analytic group for prescription drugs divided by the total number of person-months in the analytic group.

*Descriptive Results:*

#### Figure 7a Medicaid Only FFS

- There is a modest difference between MR/DD and aging and disability waiver groups.
- Medication costs are generally higher for state plan recipients, particularly nursing home recipients.
- There is no clear pattern across programs.
- The relative pattern among states varies across service group.

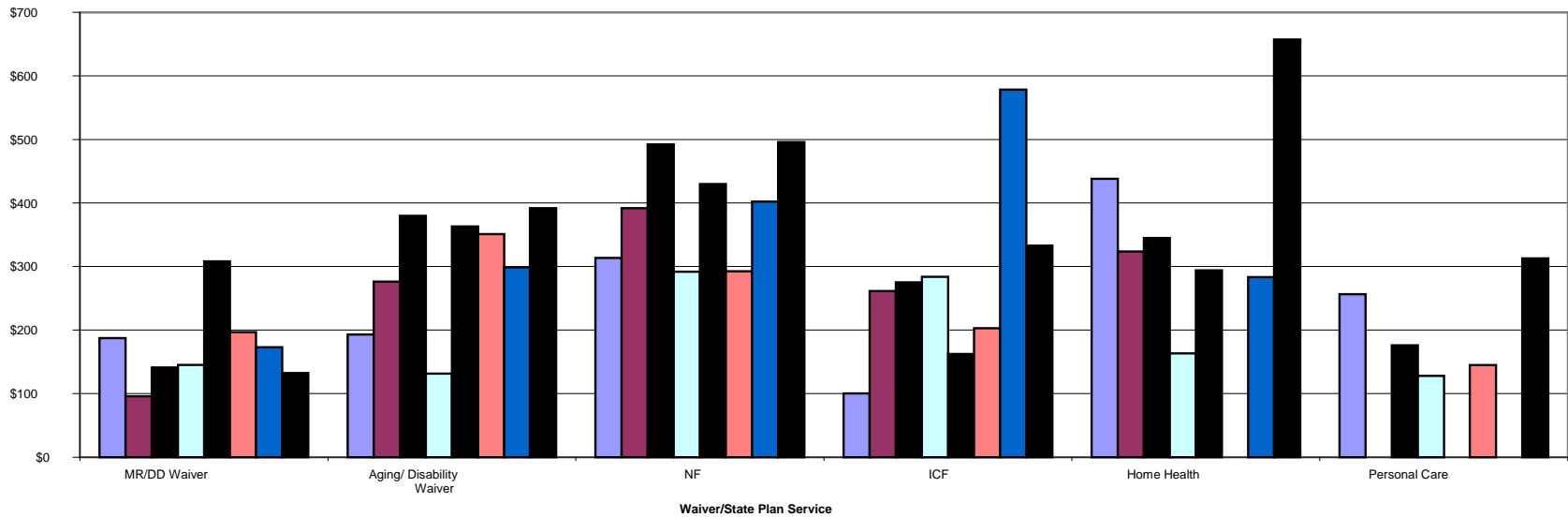
#### Figure 7b Dual FFS Enrollees

- Payments for prescription drugs are similar between Medicaid only and dual eligible participants, with dual eligible being slightly lower.
- Overall patterns among states and service categories are similar to Medicaid only beneficiaries.

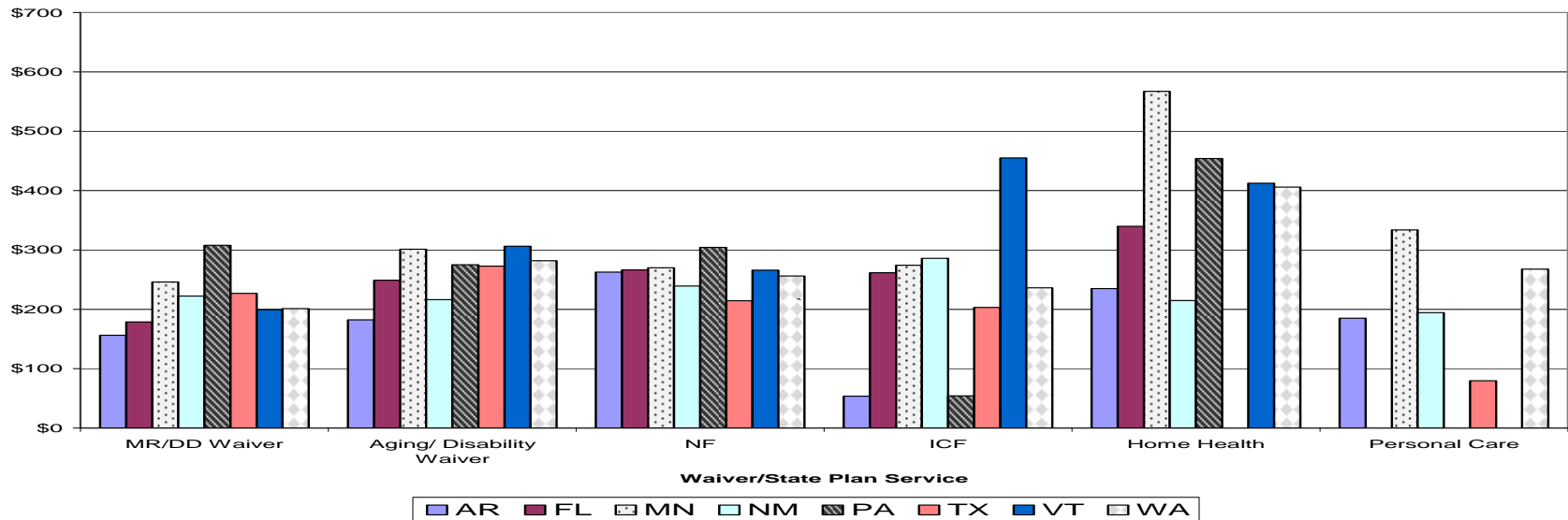
*Interpretation*

- Prescription drug coverage by Medicare was limited in 2001.

**Figure 7a. Prescription Drug Medicaid Payment (\$) per Person Month in Group, by Waiver/State Plan Service Group – Medicaid-Only FFS Enrollees (2001)**



**Figure 7b. Prescription Drug Medicaid Payment (\$) per Person Month in Group, by Waiver/State Plan Service Group – Dual FFS Enrollees (2001)**



### Ratio of Medical Care to LTC Medicaid Payment per Person Month in Group – Medicaid Only

#### *What is being measured?*

The ratio of Medicaid payments for each LTC service group aggregated into medical care and LTC.

#### *Descriptive Results:*

##### Figure 8a Medicaid only Waiver groups

- The ratios vary by waiver group as well as by state.
- In four states expenditures for LTC services exceeded payments for medical care – Arkansas, Florida, New Mexico, and Vermont. In four states expenditures for medical care exceed and in some cases far exceed the cost of long term care – Minnesota, Pennsylvania, Texas, and Washington.

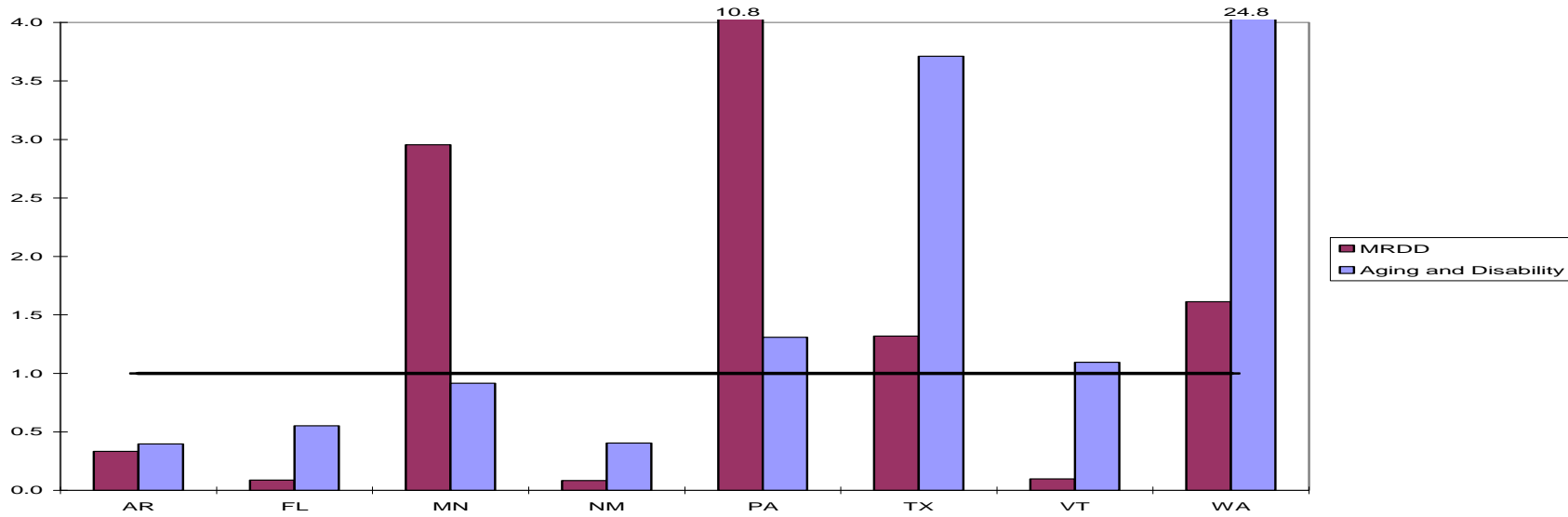
##### Figure 8b Medicaid only State Plan groups

- As anticipated, in all states the expenditures for LTC services for those participants utilizing residential LTC in nursing homes or ICFs far exceeds expenditures on medical care.
- The opposite is true for participants utilizing home care services. In all states the expenditures for medical care for participants utilizing home care state plan services far exceed expenditures for LTC services.
- The ratio of medical care to long-term care expenditures is mixed across states for personal care services.

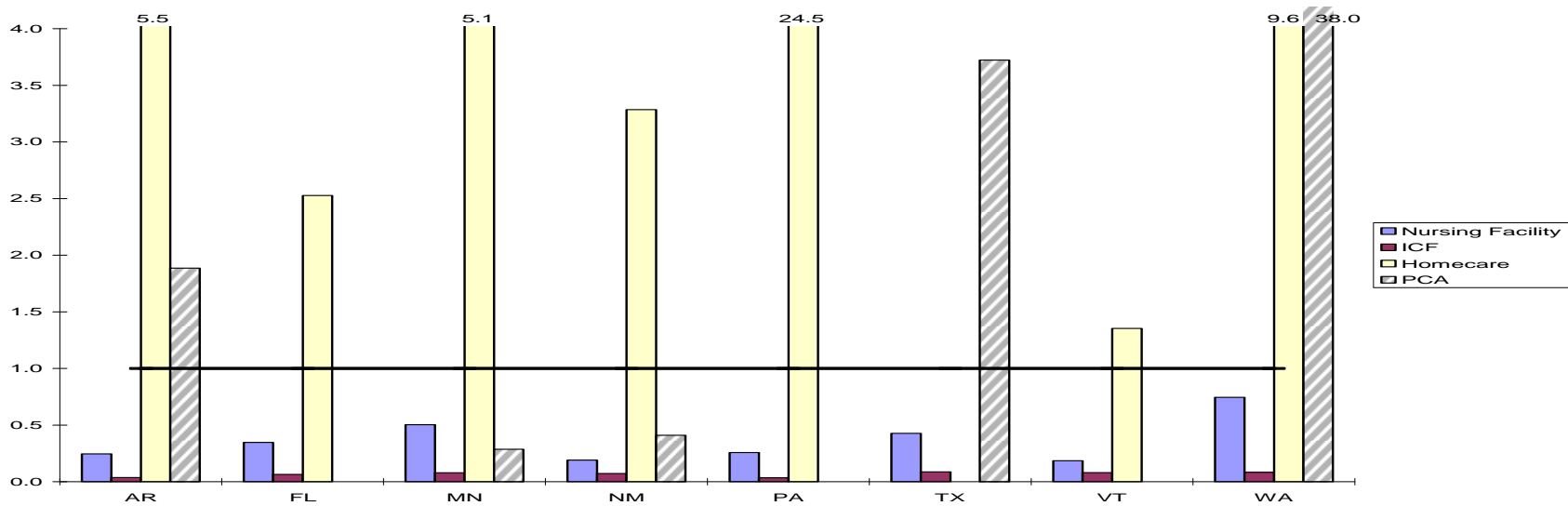
#### *Interpretation*

- The dark horizontal bar represents a ratio equal to one. Bars above that line indicate greater spending on medical care. Bars below that line indicate greater spending on LTC. Care must be paid in interpreting the ratios. Those greater than one are self-evident, but those less than one must be translated to make them comparable. For example, a ratio of 2 is equivalent to a ratio of 0.5.
- The higher ratios for home care participants may reflect a higher acuity level for this service group, while the actual home care expenditures are well below those for institutional care.
- Medical costs represent a substantial Medicaid cost for persons receiving HCBS LTC services. LTC program personnel should take greater account of these medical costs. They may represent an area where savings can be achieved and the funds redirected. Savings in medical costs could be used to support more LTC.

**Figure 8a: Ratio of Medical Care to LTC Medicaid Payment per Person Month in Waiver Groups 2001: Non-dual Eligible FFS Enrollees**



**Figure 8b: Ratio of Medical Care to LTC Medicaid Payment per Person Month in State Plan Group 2001: Non-dual Eligible FFS Enrollees**



### **Ratio of Medical Care to LTC Medicaid Payment per Person Month in Group – Dual Eligible**

*What is being measured?*

The ratio of Medicaid payments for each LTC service group aggregated into medical care and LTC

*Descriptive Results:*

Figure 9a Dual Eligible Waiver groups

- The pattern across states is similar between the Medicaid only waiver groups and dual eligible waiver groups; however, in those states where medical expenditures are higher than LTC expenditures, the ratio is even higher, particularly in the MR/DD group.

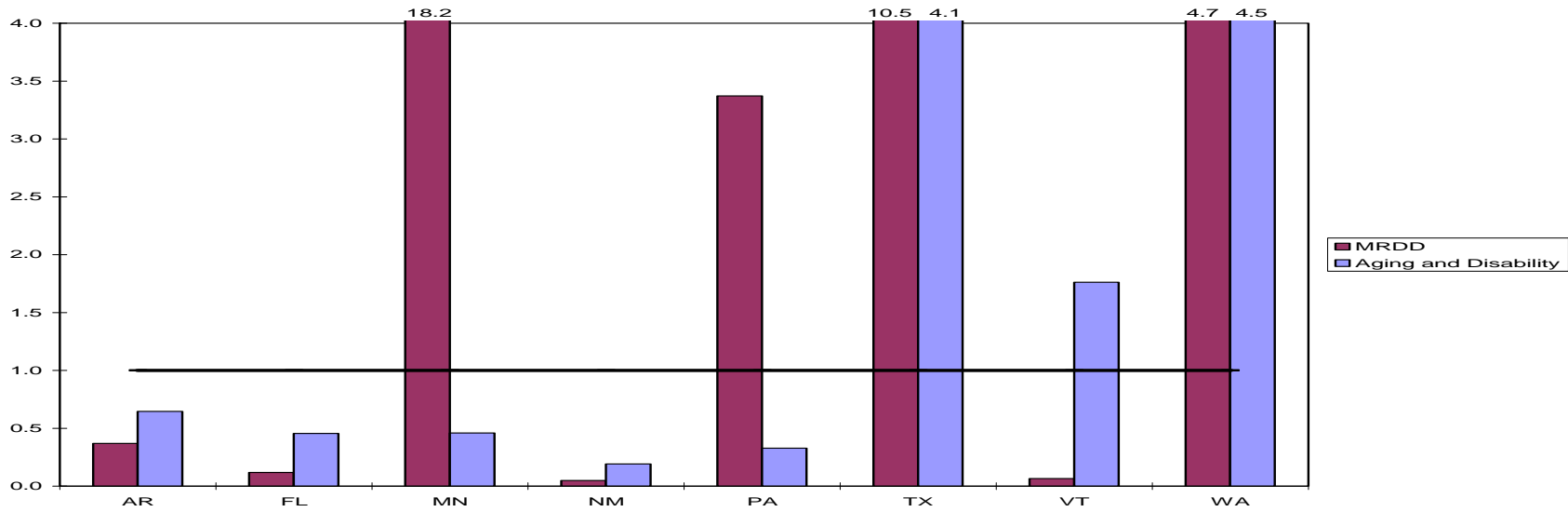
Figure 9b Dual Eligible State Plan groups

- The pattern within states and across states is similar between Medicaid only and dual eligible participants.
- The ratios in general are not as high in the dual eligible group as in the Medicaid only group. This could reflect the role of Medicare coverage, which is not reported in this data. Medicare covers more medical care services than LTC services.

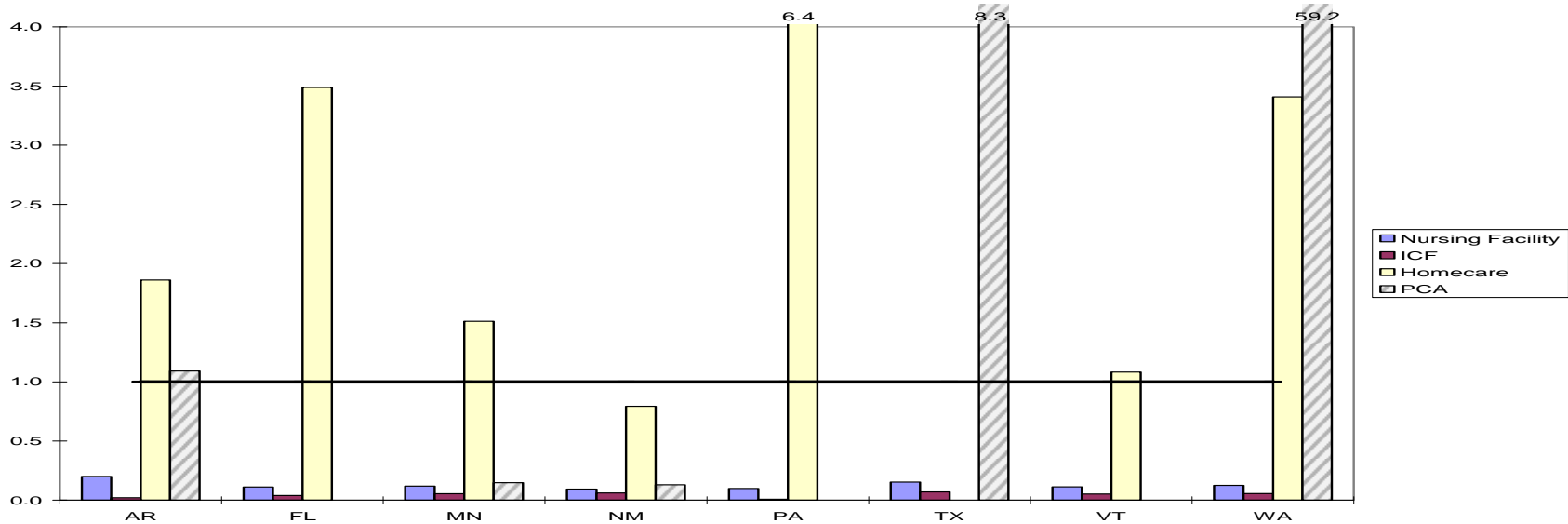
*Interpretation*

- Not only are there opportunities to achieve savings by working with both Medicare and Medicaid payments, but attention to only the Medicaid portion of costs for the dual eligible participants may be useful in identifying possible savings.

**Figure 9a: Ratio of Medical Care to LTC Medicaid Payment per Person Month in Waiver Groups 2001: Dual Eligible FFS Enrollees**



**Figure 9b: Ratio of Medical Care to LTC Medicaid Payment per Person Month in State Plan Groups: Dual Eligible FFS Enrollees**



## Conclusion

- There is substantial variation in the use of different types of health care services within and across states and among waiver groups and state plan recipients. For example, recipients of home health state plan services have much higher inpatient utilization rates than waiver groups. New Mexico is frequently higher than the other seven states in terms of inpatient hospital utilization. More work is needed to understand how much of this difference is explained by differences in case mix (personal factors such as age, gender, and existing diagnoses or medical conditions). State differences will likely remain due to other factors, such as the cost of labor across states.
- The amount spent on medical care including acute care services and on LTC per client also varies across participants and states. For example, inpatient hospital

expenditures for waiver clients are generally lower than other beneficiaries, whereas expenditures for home health clients are higher. For example, expenditures for acute care for home health state plan recipients range across states from \$450 per person month in Vermont to over \$4,000 in Washington. The average cost of nursing home care is lower than for ICFs. If the differences in spending are not matched by differences in outcomes, issues of efficiency should be explored.

- There is some correspondence between waiver and state plan spending by target group (i.e., MR/DD and ICF); medical care for younger persons generally costs less than for older beneficiaries. The difference in payments for inpatient hospital care is more pronounced, but the pattern continues for ambulatory care and prescription drug payments with MR/DD and ICF groups being

lower than aging and disabled and nursing facility groups.

- Medical costs constitute a substantial Medicaid cost for persons receiving home and community based LTC services in a number of states. One possible reason for this may be a higher acuity level of those individuals receiving home care services. They may represent an area where savings in medical costs could be used to support more LTC.
- Contrary to expectations, the utilization of dual eligible participants regardless of waiver group or state plan service group. This suggests that the dual eligible population may not be as frail as previous reported.

There are several data limitations in using the MAX data. Medicaid data collected by states and reported through the MSIS reflect individual state differences. Medicaid eligibility and coverage vary by state. In addition, eligibility and coverage

within states can change over time. Coding of services and procedures have been modified to meet specific state needs rather than to follow a uniform system. The data set thereby may overlook or misreport unique state differences.