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VERMONT'S MEDICARE/MEDICAID DUAL ELIGIBLE POPULATION: 2007 FURTHER ANALYSIS OF EXPENDITURES AND CHRONIC CONDITIONS

Highlights

- Total Medicare expenditures for dual eligible beneficiaries for Part A (inpatient) claims averaged \$1,579 per beneficiary per month in 2007. Expenditures for dual eligible beneficiaries for a Part B (outpatient) claims averaged \$154 per beneficiary per month.
- The median Medicare expenditure for dual eligible beneficiaries was not meaningfully different than the median expenditure for non-dual eligible beneficiaries in 2007 (for both Part A (inpatient) and Part B (outpatient)).
- Beneficiaries that are eligible for Medicare through disability were 2-3 times more likely to be dual eligible than beneficiaries that are eligible because of age in 2007 (for both Part A (inpatient) and Part B (outpatient)).

Introduction

This is the second report characterizing the Medicare/Medicaid dual eligible population in Vermont. The first report (<http://www.vpqhc.org/uploads/1268670926.pdf>) described the overall profile of the dual eligible population, including age, gender, and county of residence. This report provides more details on this population. Comparisons of Medicare expenditures for Part A (inpatient) and Part B (outpatient) claims are presented, as well as analysis regarding Medicare eligibility status and chronic condition diagnoses.

For this and other Medicare claims analysis, the Vermont Program for Quality in Health Care (VPQHC) has obtained comprehensive 2007 Vermont Medicare claims data. This data includes Part A and Part B claims files as well as durable medical equipment and assessment files (files that contain the functional and health status of beneficiaries). All files are linked by a unique and anonymous beneficiary identification code. These data do not include Medicare Part D claims information.

Medicare

Medicare is the government health insurance program administered by the Centers for Medicare & Medicaid Services (CMS). Medicare is the largest health insurance service in the country, with around 40 million Americans participating. Individuals are typically eligible for Medicare services if they meet one



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of the following requirements: are 65 years of age or older, are less than 65 years of age but have certain disabilities, or have End-Stage Renal Disease (kidney failure that requires a transplant or dialysis).

Identification of dual eligible beneficiaries in Medicare claims data

Dual eligible beneficiaries are first and foremost Medicare beneficiaries, meaning that they fulfill one of the base requirements for Medicare coverage (see *Medicare* section above). Based on the Medicare beneficiary's income level, the state's Medicaid program may cover some or all of the beneficiary's Medicare Part B premiums, Medicare cost-sharing amounts, and/or additional benefits.

In the Medicare claims data available to VPQHC, it is not possible to identify what health care costs are covered by the state's Medicaid program. The identification of dual eligibility is based solely on the state's reported payment of Medicare Part B premiums. This provides a reasonable estimate of the dual eligible population, but does not provide full information on the number of Medicare beneficiaries who are eligible for additional Medicaid support¹. VPQHC anticipates linking the current Medicare claims data to Medicaid data in the future, which would provide a full picture of dual eligibility.

In the Medicare claims data, each beneficiary record includes an indication of the number of months in which the state reported payment of the beneficiary's Medicare Part B premiums (state buy-in). Each beneficiary therefore falls into one of three categories:

- No (zero months) state buy-in in 2007
- Full (12 months) state buy-in in 2007
- Some (1-11 months) state buy-in in 2007

In this and previous analysis, a beneficiary is considered dual eligible if they received one or more months of state buy-in. In addition to state buy-in information, this analysis also makes use of the Medicare Beneficiary Summary file, which provides demographic information for each beneficiary in Vermont, as well as Part A (inpatient) and Part B (outpatient) claims files.

ESRD Medicare Status

The 0.6% of the beneficiary population that is eligible for Medicare due to ESRD (End-Stage Renal Disease) is removed from the dataset for this analysis. Previous reports have shown that the population eligible due to ESRD tends to have disproportionately high utilization of services. Despite the relatively small number of beneficiaries, the high utilization and cost associated with this subgroup has the potential to skew the results of this analysis. As a result, this population has been excluded from the dataset.

Findings

¹ For further information on the definition of the dual eligible population, please reference: *Dual Medicare-Medicaid Enrollees and the Medicare Denominator File*. Technical Note, ResDAC Publication Number TN-010, March, 2006. Research Data Assistance Center, University of Minnesota, Minneapolis, MN.
<http://www.resdac.umn.edu>



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In 2007, the Vermont Medicare population was composed of 106,791 beneficiaries. Of these, 657 were eligible for Medicare benefits due to ESRD (End-Stage Renal Disease) and are removed from this analysis. Of the remaining 106,134 beneficiaries, 24,867 (23%) were dual eligible (received at least one month of state buy-in) in 2007.

Claim Reimbursements – Medicare Part A (Inpatient)

A total of \$79.9M was expended on behalf of dual eligible beneficiaries in 2007 on Medicare Part A (inpatient) claims. This represents 4972 dual eligible beneficiaries with a total of 50,561 months of state buy-in (average 10.2 months per beneficiary). An average of \$16,061 was expended per beneficiary on Part A (inpatient) claims, or \$1,579 per beneficiary per month.

On a monthly basis, the average Medicare Part A expenditure per dual eligible beneficiary was \$1,579 (total expenditures in 2007 divided by total beneficiary-months in 2007). The number of beneficiaries who were dual eligible (received at least one month of state buy-in) and the average expenditure per dual eligible beneficiary were reasonably constant from month to month in 2007 (see Figure 1). The count of dual eligible beneficiaries that accrued Part A expenditures in 2007 ranged from a high of 4,482 in February to a low of 3,847 in December.

In 2007, the median expenditure for dual eligible beneficiaries with a Part A (inpatient) claim was not meaningfully different from the median expenditure for equivalent non-dual eligible beneficiaries. The median expenditure for dual eligible beneficiaries was \$10,411, compared to a median expenditure of \$9,712 for non-dual eligible beneficiaries (a difference of less than 7%).

Claim Reimbursements – Medicare Part B (Outpatient)

A total of \$36.7M was expended on behalf of dual eligible beneficiaries in 2007 on Medicare Part B (outpatient) claims. This represents 22,211 dual eligible beneficiaries with a total of 238,126 months of state buy-in (about 10.7 months per beneficiary). An average of \$1,653 was expended per beneficiary on Part B (outpatient) claims, or \$154 per beneficiary per month.

Per month, the average Medicare Part B expenditure per dual eligible beneficiary was \$154 (total expenditures in 2007 divided by total beneficiary-months in 2007). Similar to the inpatient data, the count of dual eligible beneficiaries that accrued Part B claims did not show substantial variation from month to month in 2007 (see Figure 2). This count ranged from a high of 20,369 beneficiaries in July to a low of 19,265 beneficiaries in December. The average Part B expenditure per beneficiary per month showed more variation, with a low of \$129 per dual eligible beneficiary in February to \$193 per dual eligible beneficiary in October (a change of almost 40%).

The median expenditure for dual eligible beneficiaries with a Part B (outpatient) claim was \$781 in 2007, compared to \$591 for the non-dual eligible population. Because of large sample sizes, this difference is statistically significant, but may not represent a meaningful difference from a programmatic perspective.



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Medicare Status

For beneficiaries with a Medicare Part A (inpatient) claim in 2007, there was a considerable difference in the proportion of dual eligible beneficiaries by Medicare status. Of those eligible for Medicare through age, 25% of Part A claims were for dual eligible beneficiaries (received at least one month of state buy-in). Of those eligible for Medicare through disability, 67% of Part A claims were for dual eligible beneficiaries. The situation was similar for Medicare Part B (outpatient) claims in 2007. These results are summarized in Table 1.

Chronic Conditions

Over 73% of dual eligible beneficiaries were diagnosed with at least one chronic condition in 2007. This is significantly higher than non-dual eligible beneficiaries, of which 67% were diagnosed with at least one chronic condition (see Table 2). Figure 3 shows the percent of the dual eligible and non-dual eligible beneficiaries with different counts of chronic conditions in 2007. For one or two chronic conditions, the dual eligible population was similar to the non-dual eligible population. However, as the count of chronic conditions increases, the percent of dual eligible beneficiaries exceeds the percent of non-dual eligible beneficiaries.

The specific chronic conditions diagnosed for dual eligible beneficiaries are somewhat different from those diagnosed for non-dual eligible beneficiaries. For the non-dual eligible beneficiaries, the most common chronic conditions are ischemic heart disease (IHD) and cataracts. In contrast, the dual eligible population was most often diagnosed with diabetes and depression. A summary of the top six chronic conditions in each group is presented in Figure 4.



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Table 1: Dual eligibility by Medicare Status, Vermont 2007

Medicare Status	N (# of claims)	% associated with dual eligible beneficiaries
Inpatient claims		
Age	21,103	25%
Disability	4,260	67%
Outpatient claims		
Age	639,253	21%
Disability	132,907	70%

Note: Beneficiaries eligible for Medicare through ESRD (n=657) were removed from this analysis

Table 2: Beneficiaries with a chronic condition by dual eligibility and Medicare status

Medicare Status	N (# of beneficiaries)	% with at least one chronic condition	Significant difference*
Age			
Dual eligible	14,295	84%	*
Non-dual eligible	73,276	69%	
Disability			
Dual eligible	10,572	59%	*
Non-dual eligible	7,991	44%	

* Measured at the 0.05 level of significance

Note: Beneficiaries eligible for Medicare through ESRD (n=657) were removed from this analysis



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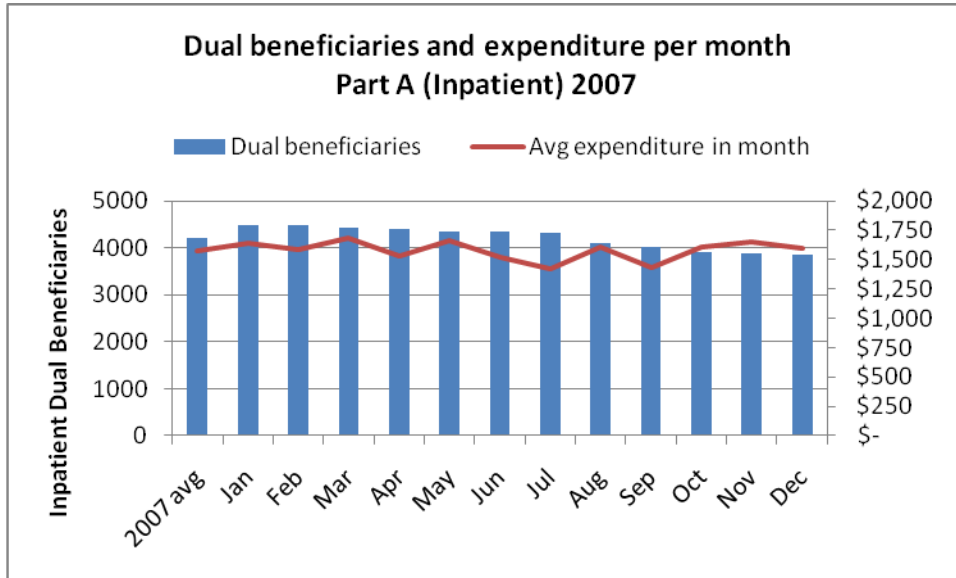


Figure 1: Number of Medicare/Medicaid dual eligible beneficiaries (Part A, inpatient) and average expenditure per dual eligible beneficiary in month, Vermont 2007

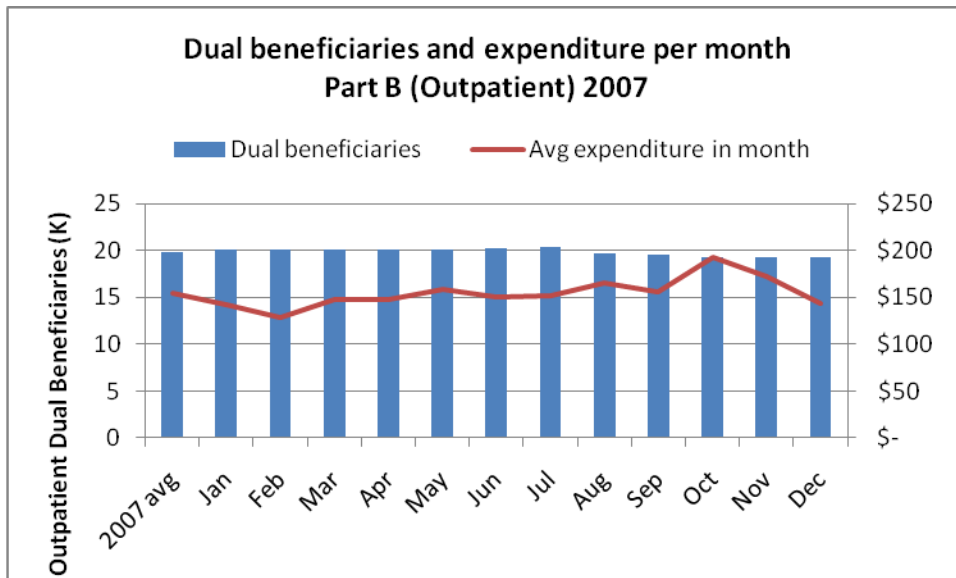


Figure 2: Number of Medicare/Medicaid dual eligible beneficiaries (Part B, outpatient) and average expenditure per dual eligible beneficiary in month, Vermont 2007



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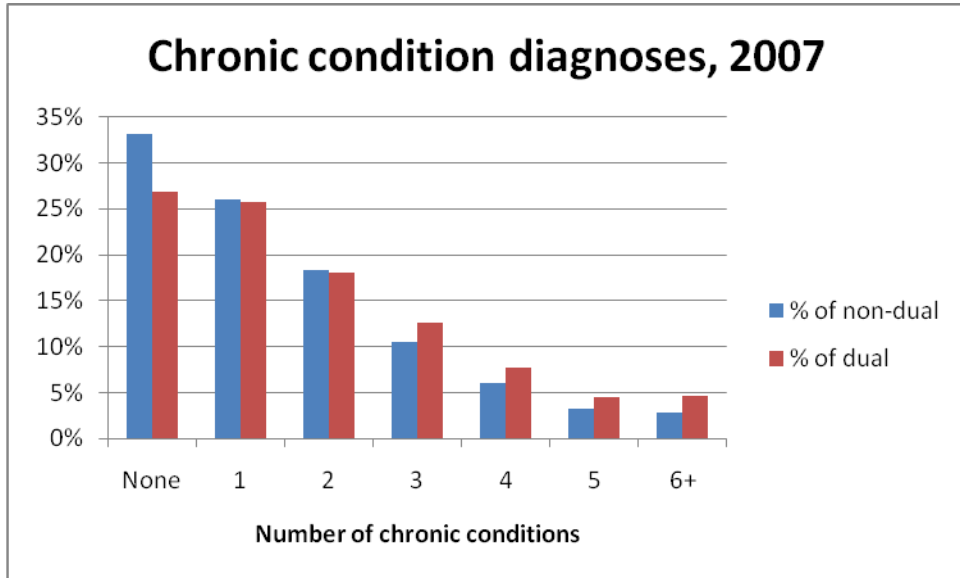
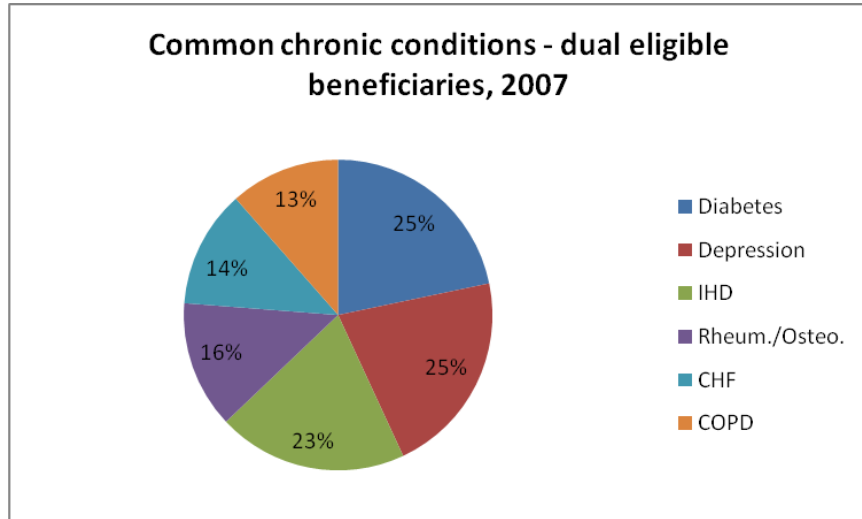
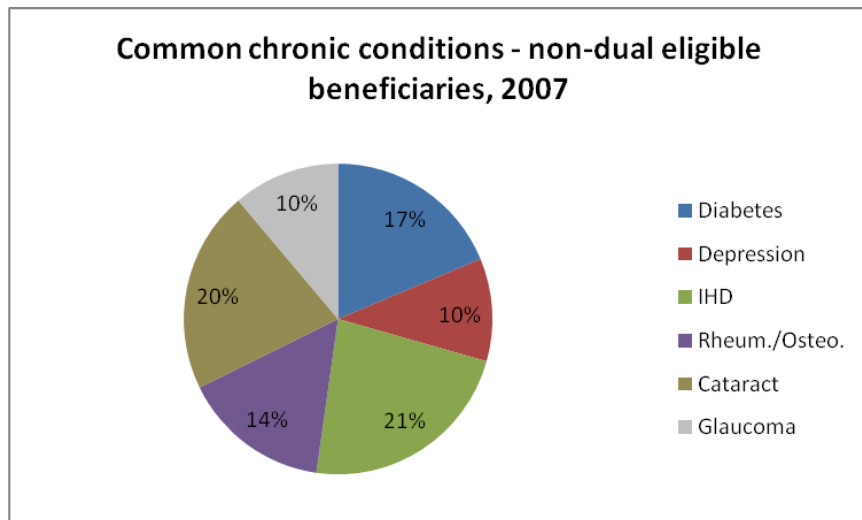


Figure 3: Number of chronic conditions for dual eligible and non-dual eligible beneficiaries, Vermont 2007

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Note: Beneficiaries may have more than one chronic condition diagnosis, so categories will sum to more than 100%



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Figure 4: Common chronic conditions for dual eligible and non-dual eligible beneficiaries, Vermont 2007