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# DUAL ELIGIBLES IN MASSACHUSETTS: A PROFILE OF HEALTH CARE SERVICES AND SPENDING FOR NON-ELDERLY ADULTS ENROLLED IN BOTH MEDICARE AND MEDICAID

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FOR

THE MASSACHUSETTS MEDICAID POLICY INSTITUTE

IN COLLABORATION WITH THE MASSACHUSETTS MEDICAID PROGRAM

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## INTRODUCTION

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- This report provides an overview of the health care services, including long-term support services (LTSS), used by Massachusetts residents ages 21-64 who are enrolled in both Medicaid and Medicare. This population is referred to as “duals” in this document because of their dual eligibility for, and enrollment in, both the Medicaid and Medicare programs.
- For the past two years, the Massachusetts Medicaid program (“MassHealth”) has been working to develop a proposal to integrate care and financing for this population as a means to improve coordination, quality and cost-effectiveness of care.
- This report is meant to provide information for stakeholder discussions about the adult dual eligible population ages 21-64 in Massachusetts. The data has not been assembled for any actuarial or rate development purposes. Analytic staff at MassHealth, the University of Massachusetts Medical School, and MassHealth’s actuarial vendor will be working in concert with the Center for Medicare/Medicaid Services (CMS) to develop the data that will be used for both state and federal actuarial and rate development purposes. CMS has not yet selected or approved Massachusetts’ – or any state’s – demonstration proposal for implementation.
- The Massachusetts Medicaid Policy Institute (MMPI) produced this report in collaboration with staff from the MassHealth program. MMPI would like to thank Robin Callahan, Corrinne Altman Moore and Lori Cavanaugh for their review and input on this report.

## DEFINITION OF THE DUALS POPULATION

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- This report includes data on approximately 105,000 enrollees who were simultaneously enrolled in Medicare and Medicaid during calendar year 2008, and whose providers were paid on a fee-for-service basis. Individuals who were enrolled in managed care (e.g., Medicare Advantage or PACE) were not included in this data set.
- Duals receive coverage under the Medicare and Medicaid programs because they meet Medicaid financial eligibility rules and also have significant disability due to chronic illness, physical disability, behavioral health problems, or developmental disability.
- Under the Medicaid and Medicare programs, duals receive access to a comprehensive set of services. Medicare is the primary payer for acute services, such as hospital and physician services. Medicaid pays for long-term support services (LTSS) provided to duals living in the community and in long-term nursing facilities. Medicaid also acts as the secondary payer for some Medicare-covered services when it helps beneficiaries with payment of Medicare deductibles and copayments.
- It is important to note that persons ages 65 and older may also be simultaneously enrolled in the Medicaid and Medicare programs. However, data on dual eligible persons ages 65 and older are not included in this report.

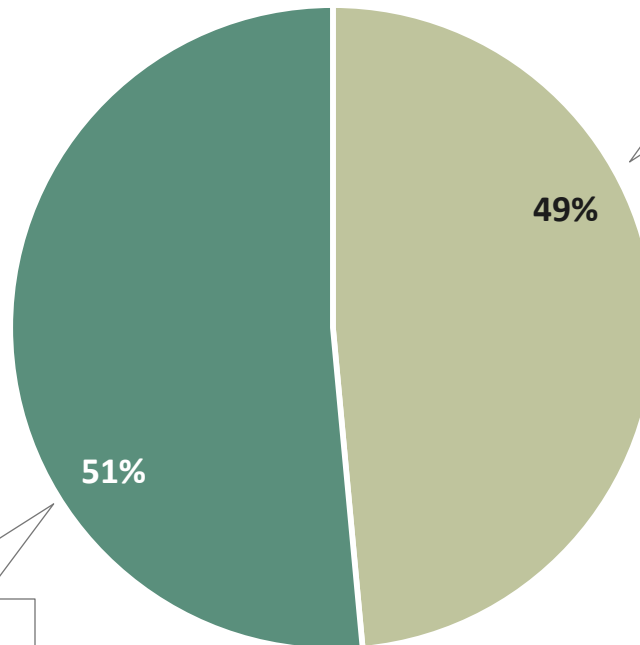
## KEY FACTS

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- In 2008, 115,000 Medicaid enrollees (approximately 10 percent of all Medicaid enrollees) were duals between the ages of 21 and 64. This report is based on a data set which includes paid health care claims for 105,000 duals who had fee-for-service coverage for both Medicare and Medicaid; those duals enrolled in managed care were not included in the data analyzed.
- Combined Medicaid and Medicare spending on these duals totaled \$2.5 billion in 2008, which translates into an average of \$23,700 per person per year. However, average per person spending masks the wide variation in spending and, in particular, the concentration of expenditures on high-cost individuals. Approximately six percent of duals incurred 37 percent of combined Medicaid and Medicare spending for duals in Massachusetts, while seventy percent of duals accounted for only 16 percent of combined spending.
- The financial responsibility for duals was split approximately evenly between the Medicaid and Medicare programs. Medicaid spent \$1.3 billion, while Medicare spent \$1.2 billion on these duals in 2008. Medicaid spending on these duals represented 20 percent of all Medicaid spending in Massachusetts, while Medicare spending represented 16 percent of all Medicare spending in Massachusetts.
- The vast majority of duals live in their communities, not in institutions.
- Nearly 60 percent of duals have diagnoses in two or more of three major diagnostic categories (physical, behavioral and developmental).

## TOGETHER MEDICAID AND MEDICARE SPENT \$2.5 BILLION FOR DUALS IN 2008

**COMBINED MEDICAID AND MEDICARE SPENDING FOR DUALS, 2008**  
**\$2.5 Billion / 105,000 Duals = \$23,700 average annual per capita**



**MEDICARE SPENDING**  
**\$1.2 BILLION**  
**(\$11,500 PER PERSON)**

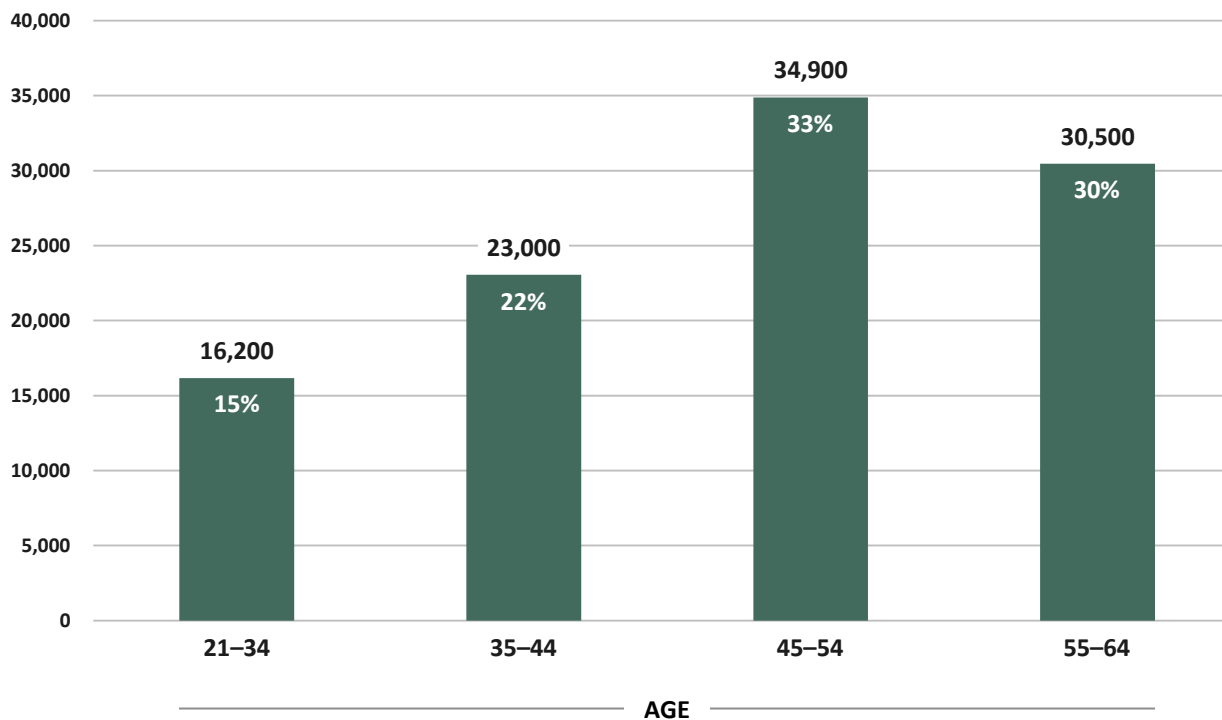
**MEDICAID SPENDING**  
**\$1.3 BILLION**  
**(\$12,200 PER PERSON)**

- In 2008, Medicaid and Medicare, combined, spent \$2.5 billion for health care services provided to approximately 105,000 duals.
- Medicaid spent \$1.3 billion or 51 percent of the combined spending total.
- Medicare spent \$1.2 billion or 49 percent of the combined spending total.

NOTE: For the purposes of this report "duals" is defined as persons eligible for Medicaid and Medicare ages 21–64.

## MORE THAN THREE OUT OF FIVE DUALS WERE AGES OF 45–64

NUMBER AND PERCENT OF DUALS 21–64 BY AGE, 2008

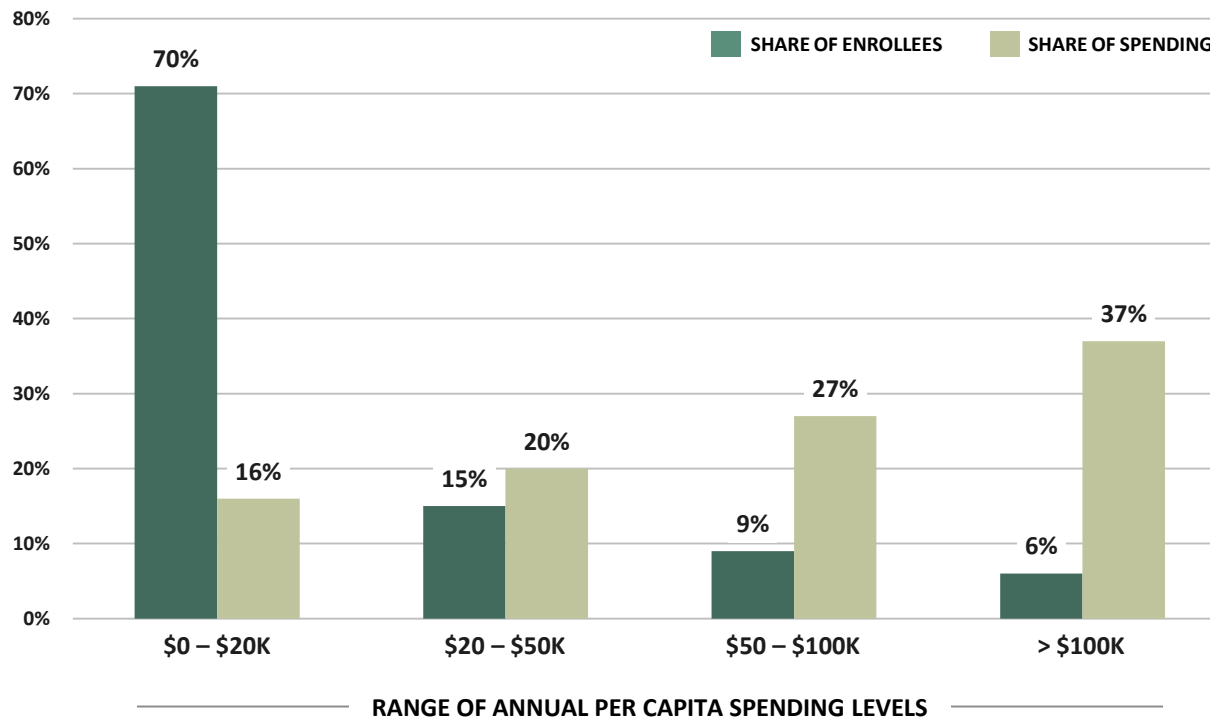


- Sixty-three percent of duals were ages 45–64.
- Twenty-two percent of duals were ages 35–44.
- Fifteen percent were ages 21–34.

NOTE: For the purposes of this report “duals” is defined as persons eligible for Medicaid and Medicare ages 21–64.

## A SMALL PROPORTION OF DUALS ACCOUNTED FOR A LARGE PROPORTION OF TOTAL SPENDING

PROPORTIONS OF DUALS AGES 21–64 AND EXPENDITURES, 2008



- Six percent of duals had annual per capita health care spending of more than \$100,000, accounting for 37 percent of combined Medicaid and Medicare expenditures for duals.
- Seventy percent of duals had annual per capita health care spending less than \$20,000, accounting for 16 percent of combined Medicaid and Medicare expenditures for duals.

NOTE: For the purposes of this report “duals” is defined as persons eligible for Medicaid and Medicare ages 21–64.



## WHERE DUALS LIVE AND HOW THEY RECEIVE SERVICES

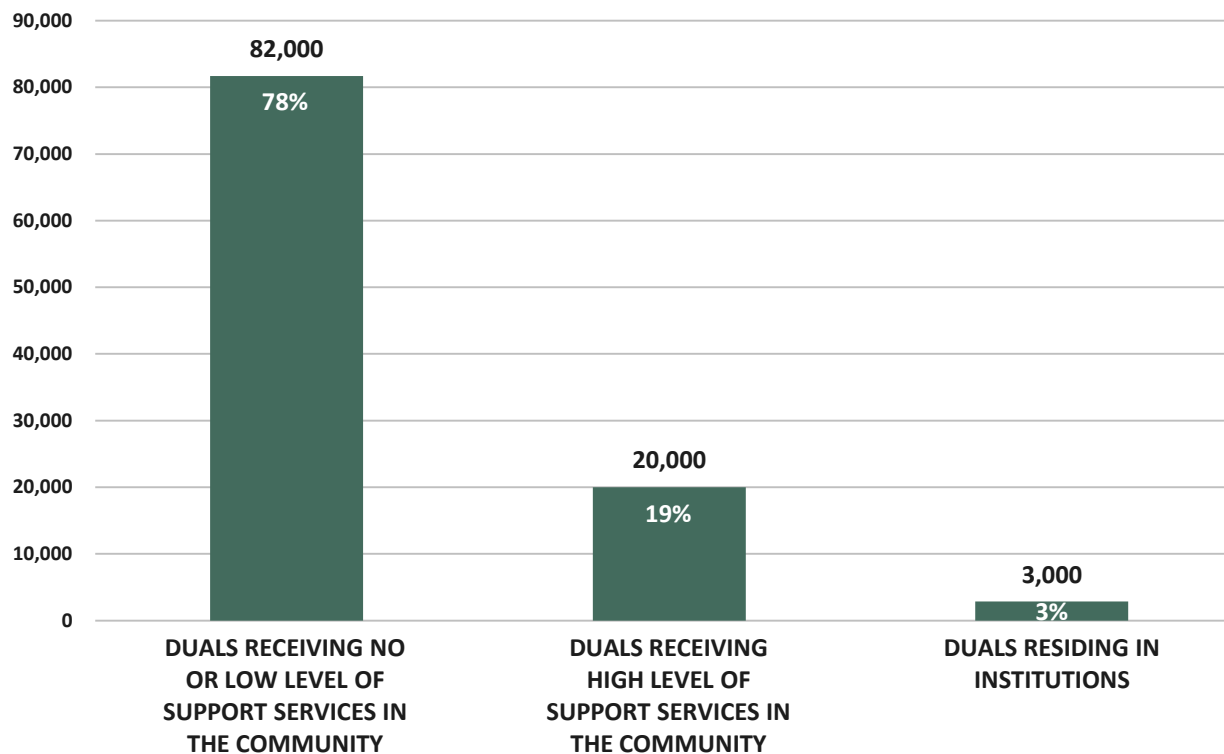
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- Nearly all duals lived in the community. Only three percent of duals lived in institutions.
- Close to ninety percent of all spending was for duals residing in the community.
- About twenty percent of duals resided in the community and also received a high level of long-term support services.
- On average, per capita spending for duals residing in the community and also receiving a high level of long-term support services was roughly half of spending for duals residing in institutions — \$56,200 vs. \$101,900.

NOTE: For the purposes of this report “duals” is defined as persons eligible for Medicaid and Medicare ages 21–64.

## NEARLY ALL DUALS LIVED IN THE COMMUNITY

NUMBER AND PERCENT OF DUALS AGES 21–64 LIVING IN THE COMMUNITY AND IN INSTITUTIONS, 2008

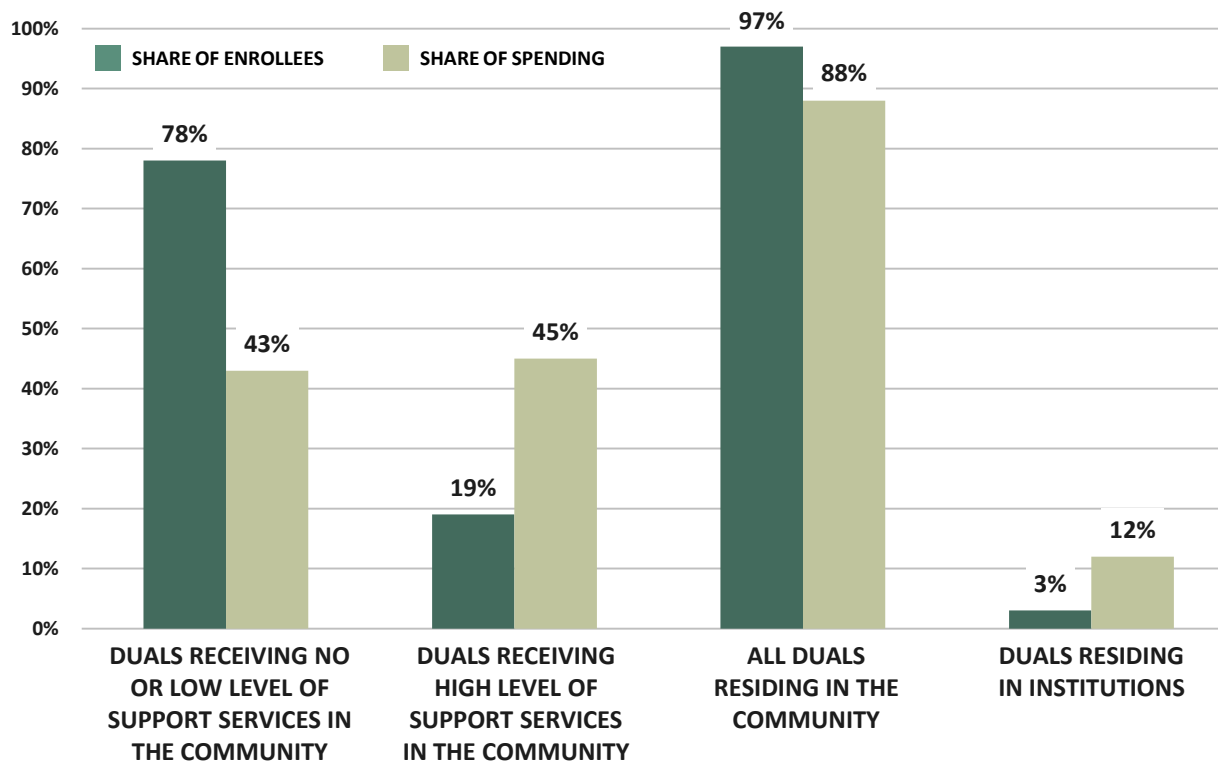


NOTES: “Duals receiving high level of support service” included individuals residing in the community who had been in a nursing facility within the past 3 months, individuals utilizing home and community based waiver services, or individuals who had received a high level of home health services. “Duals residing in institutions” includes those residing in an intermediate care facility, a nursing facility, or a chronic/rehab facility. For the purposes of this report “duals” is defined as persons eligible for Medicaid and Medicare ages 21–64.

- 97 percent of all duals lived in the community.
- Nearly four-fifths of duals living in the community received a low level of support services.
- Only three percent of all duals lived in an institution.

# NEARLY NINE OUT OF TEN HEALTH CARE DOLLARS WERE SPENT ON DUALS LIVING IN THE COMMUNITY

SHARE OF ENROLLEES AND EXPENDITURES FOR DUALS IN THE COMMUNITY AND IN INSTITUTIONS, 2008

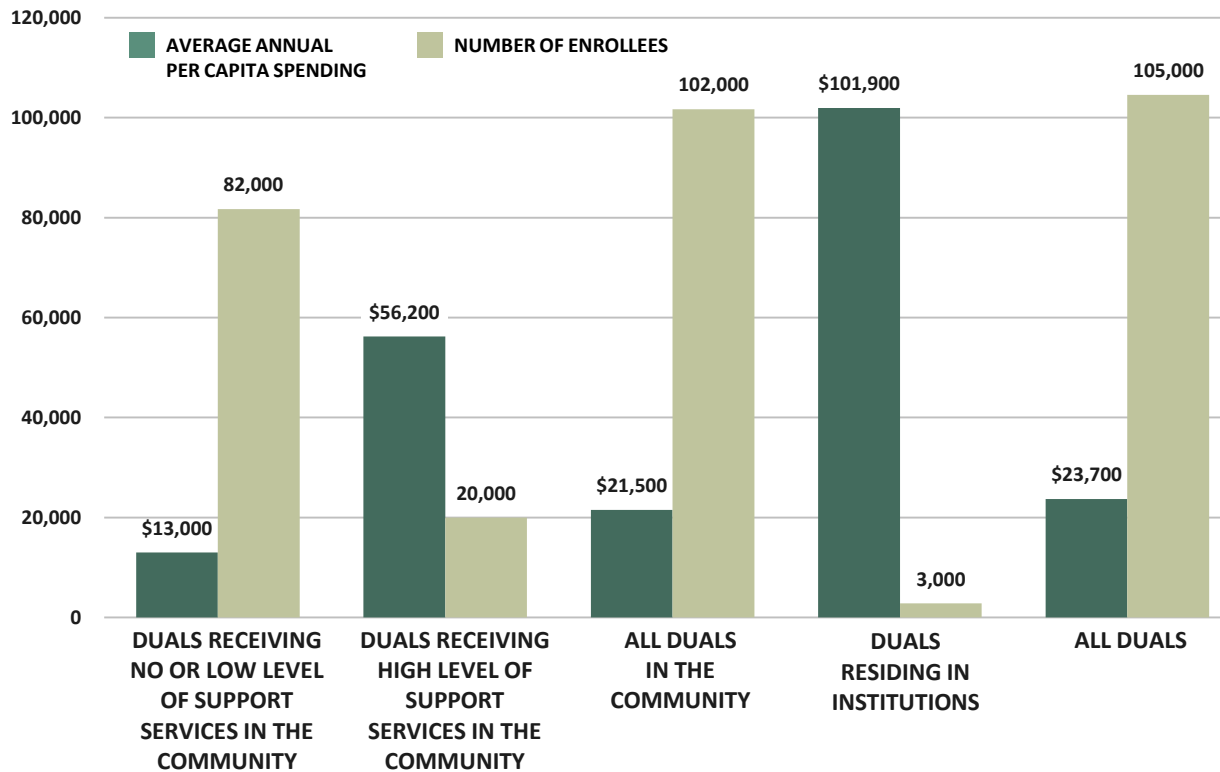


NOTES: "Duals receiving high level of support service" included individuals residing in the community who had been in a nursing facility within the past 3 months, individuals utilizing home and community based waiver services, or individuals who had received a high level of home health services. "Duals residing in institutions" includes those residing in an intermediate care facility, a nursing facility, or a chronic/rehab facility. For the purposes of this report "duals" is defined as persons eligible for Medicaid and Medicare ages 21–64.

- 88 percent of combined Medicaid and Medicare total dollars were spent on the 97 percent of the duals who were living in the community.
- Individuals in the community who require high levels of support services consumed the largest share of combined total spending. They represented 19 percent of all duals but incurred 45 percent of total spending.
- Individuals living in institutions represented only 3 percent of duals but incurred 12 percent of total spending.

## PER CAPITA SPENDING FOR DUALS RESIDING IN INSTITUTIONS WAS ALMOST DOUBLE THAT FOR DUALS RECEIVING A HIGH LEVEL OF SUPPORT SERVICES IN THE COMMUNITY

**AVERAGE ANNUAL PER CAPITA COMBINED MEDICAID AND MEDICARE SPENDING FOR DUALS IN THE COMMUNITY AND IN INSTITUTIONS, 2008**

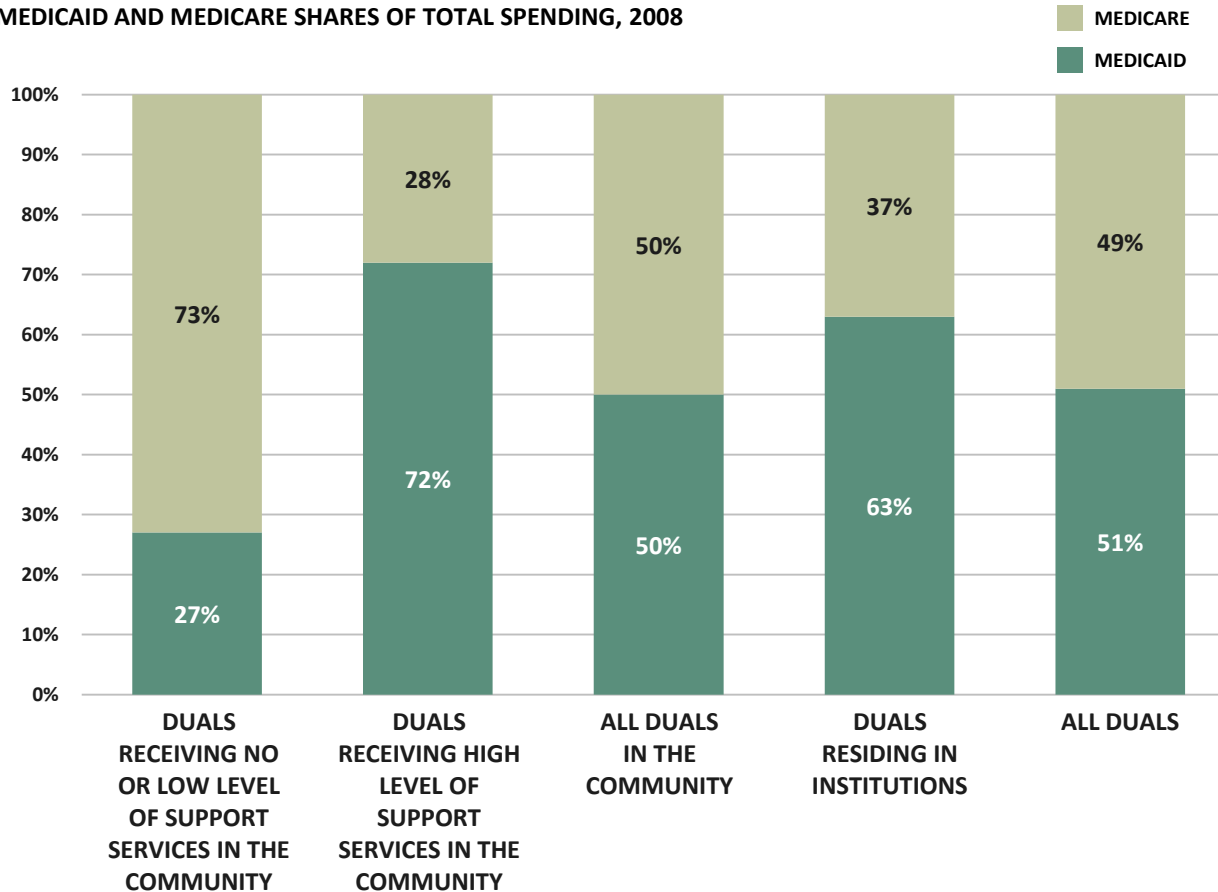


NOTES: "Duals receiving high level of support service" included individuals residing in the community who had been in a nursing facility within the past 3 months, individuals utilizing home and community based waiver services, or individuals who had received a high level of home health services. "Duals residing in institutions" includes those residing in an intermediate care facility, a nursing facility, or a chronic/rehab facility. For the purposes of this report "duals" is defined as persons eligible for Medicaid and Medicare ages 21–64.

- Average per capita health care spending for all duals in 2008 was \$23,700, based on a population of 105,000 duals.
- Average annual per capita health care spending for duals living in institutions was \$101,900, or about 4.5 times the average for all duals.
- Average annual per capita health care spending for duals receiving a high level of support while living in the community was \$56,200, or 55 percent of the annual per capita spending for duals in institutions.

# MEDICAID'S SHARE OF SPENDING WAS GREATER FOR DUALS WITH HIGH SUPPORT NEEDS IN THE COMMUNITY AND FOR DUALS IN INSTITUTIONS

MEDICAID AND MEDICARE SHARES OF TOTAL SPENDING, 2008



NOTE: For the purposes of this report "duals" is defined as persons eligible for Medicaid and Medicare ages 21–64.

- Medicaid pays for most long-term support services.
- Medicaid paid 72 percent of combined spending for duals who required a high level of support services in the community.
- Medicaid paid 63 percent of combined spending for duals residing in institutions.
- Medicaid's share of the combined spending total was lowest, at 27 percent, for duals in the community who received a low level of support services.

## ILLNESSES AND DISABILITIES AMONG DUALS

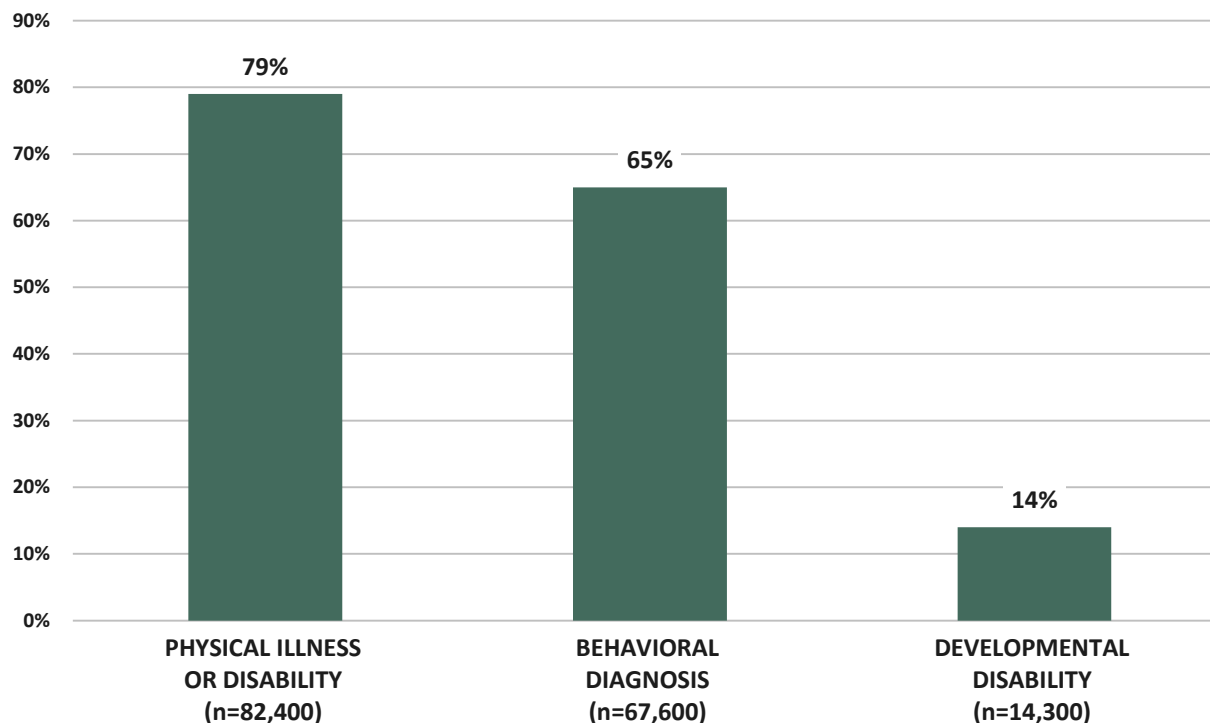
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- The diagnostic information in this report comes from illnesses and conditions reported in claims by physicians and hospitals. These reported diagnoses do not necessarily indicate the reasons for beneficiaries' disabilities or the full range of their health problems.
- The diagnoses in the data set were grouped into three major categories:
  - Physical illness and disability
  - Behavioral health diagnoses (including mental illness and substance abuse)
  - Developmental disability
- The diagnostic description of the dual population is preliminary, based on a limited number of diagnoses and only one year of data. A full analysis, using more diagnoses and more years of data, would produce a more detailed portrait of duals and their care needs.
- Key findings include:
  - Two out of three duals have a behavioral diagnosis
  - Nearly 60 percent of duals had diagnoses in two or more of the three major diagnostic categories.
  - Prevalent physical illnesses included diabetes, cardiovascular disease and lung conditions.
  - Almost half of the duals experienced depression or moderate mental illness, while a much smaller proportion had schizophrenia or other serious mental illness.
  - Duals with developmental disability and other diagnoses had especially high health care spending.

NOTE: See Data Notes in the Appendix for more information about the diagnostic categories used in this analysis.

# NEARLY FOUR OUT OF FIVE DUALS HAD A PHYSICAL ILLNESS OR DISABILITY AND TWO OUT OF THREE A BEHAVIORAL DIAGNOSIS

PERCENTAGES OF DUAL ELIGIBLES WITH DIAGNOSES IN THE THREE MAJOR DIAGNOSTIC CATEGORIES, 2008

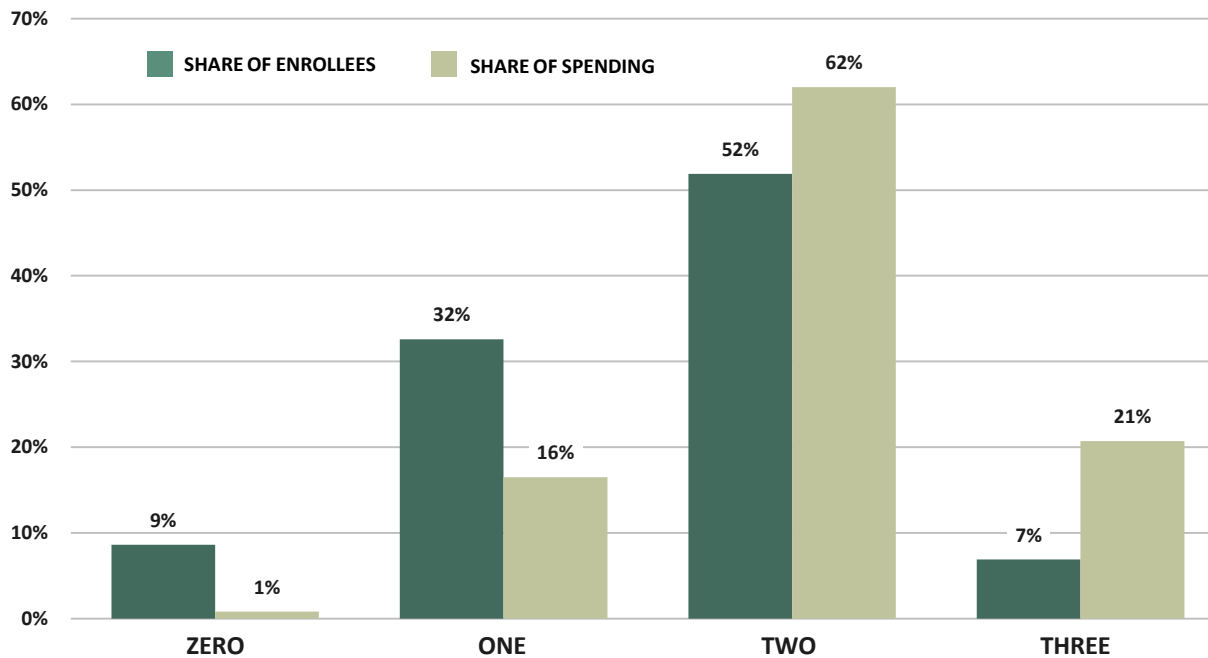


NOTES: Percentages add to more than 100 percent because many duals have diagnoses in more than one major category. For the purposes of this report “duals” is defined as persons eligible for Medicaid and Medicare ages 21–64.

- This analysis includes three diagnostic categories recorded in hospital and physician claims: physical illness or disability; behavioral diagnoses; and developmental disability.
- 79 percent of duals had a diagnosis of physical illness or disability.
- 65 percent of duals had a behavioral diagnosis.
- 14 percent of duals had a diagnosis of developmental disability.

## DUALS WITH DIAGNOSES IN TWO OR MORE MAJOR DIAGNOSTIC AREAS ACCOUNTED FOR MORE THAN 80 PERCENT OF SPENDING

PROPORTIONS OF DUAL ELIGIBLES WHO HAD DIAGNOSES RECORDED IN ZERO, ONE, TWO, OR THREE MAJOR DIAGNOSTIC CATEGORIES AND THEIR SPENDING, 2008



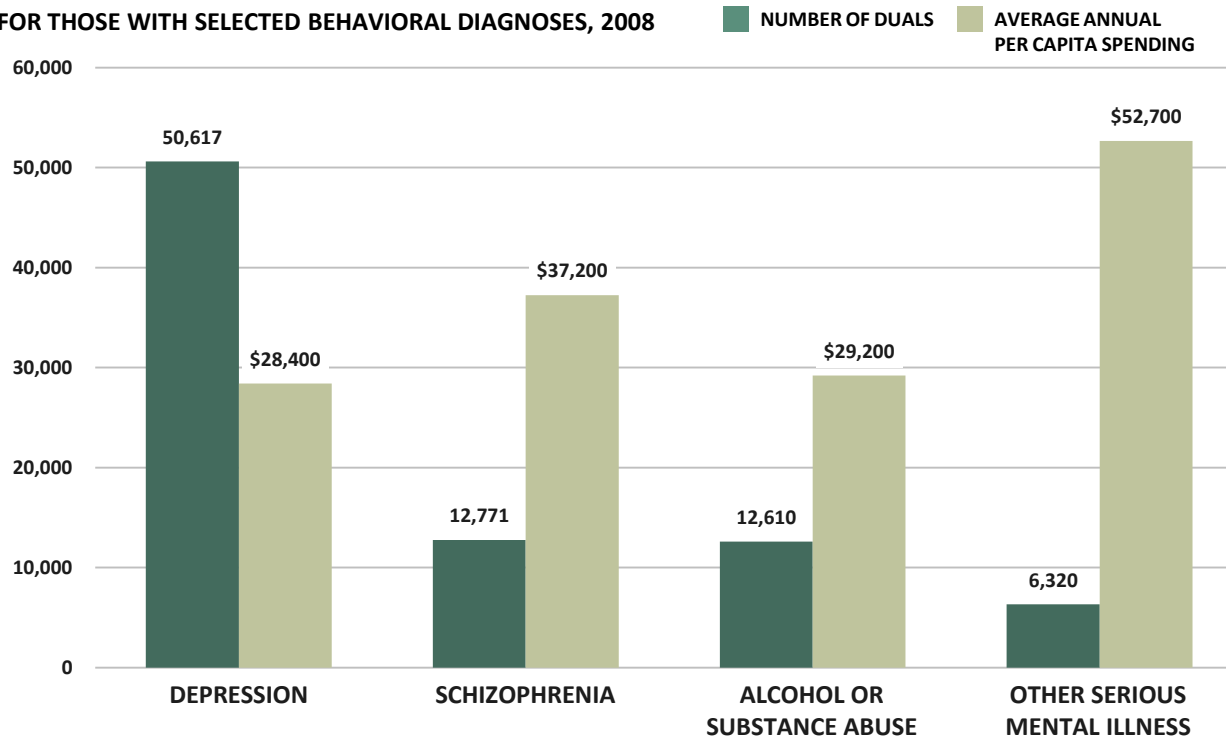
- Close to 60 percent of duals had a diagnosis in two or more major diagnostic categories. These duals accounted for more than 80 percent of total spending.
- Seven percent of duals had diagnoses in all three major categories and accounted for more than 20 percent of total spending.

NOTE: For the purposes of this report “duals” is defined as persons eligible for Medicaid and Medicare ages 21–64.



## DEPRESSION WAS THE MOST COMMON BEHAVIORAL DIAGNOSIS; HIGHEST PER CAPITA SPENDING WAS FOR THOSE WITH SERIOUS MENTAL ILLNESS

NUMBER OF DUALS AND AVERAGE ANNUAL EXPENDITURES FOR THOSE WITH SELECTED BEHAVIORAL DIAGNOSES, 2008

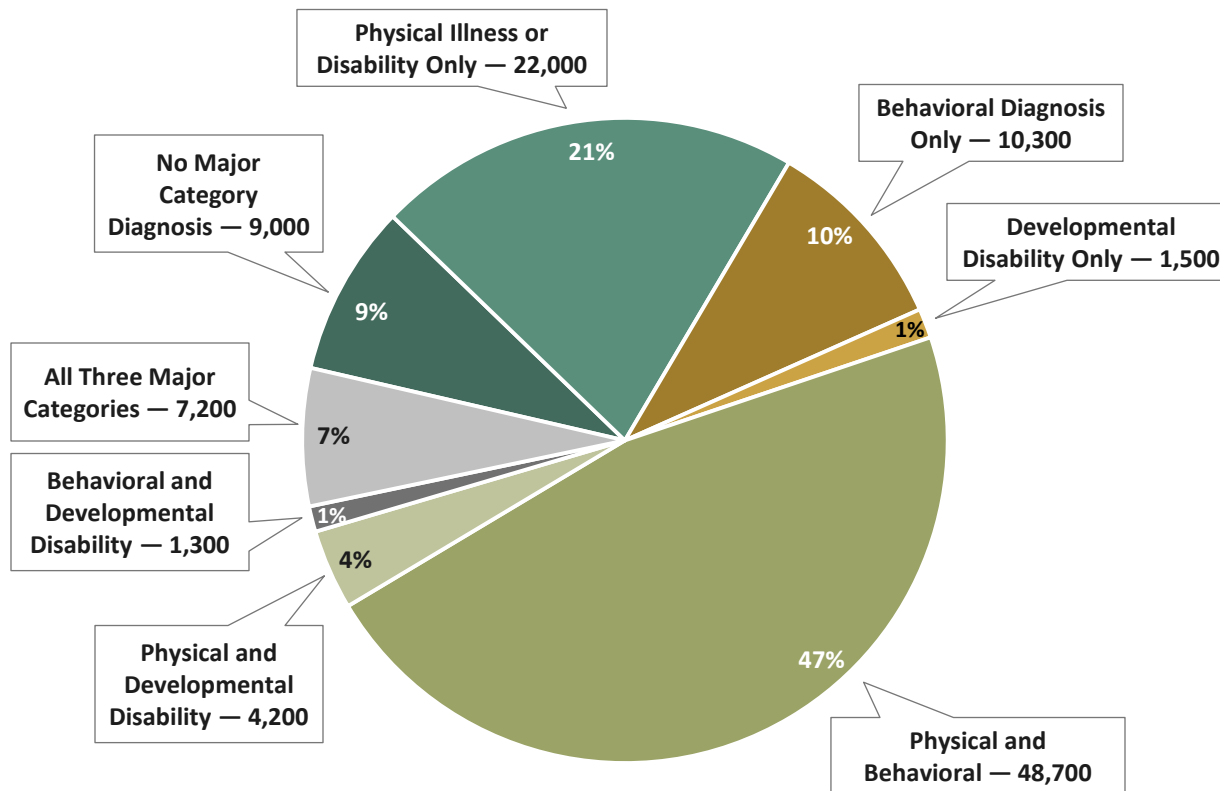


- About 68,000 duals, or 65 percent of all duals, had a behavioral diagnosis in claims. This group incurred 76 percent of the combined Medicaid and Medicare total spending (total spending not shown on this chart).
- Over 50,000 or 48 percent of duals had diagnoses of depression (including major or bipolar depression, anxiety, or other related mental health conditions).
- Average per capita spending was highest for duals with schizophrenia, \$37,200, and other serious mental illness, \$52,700.

NOTE: For the purposes of this report “duals” is defined as persons eligible for Medicaid and Medicare ages 21–64.

## MAJOR DIAGNOSTIC CATEGORIES FOR DUALS

DISTRIBUTION OF DUALS BY MAJOR DIAGNOSTIC CATEGORIES, 2008

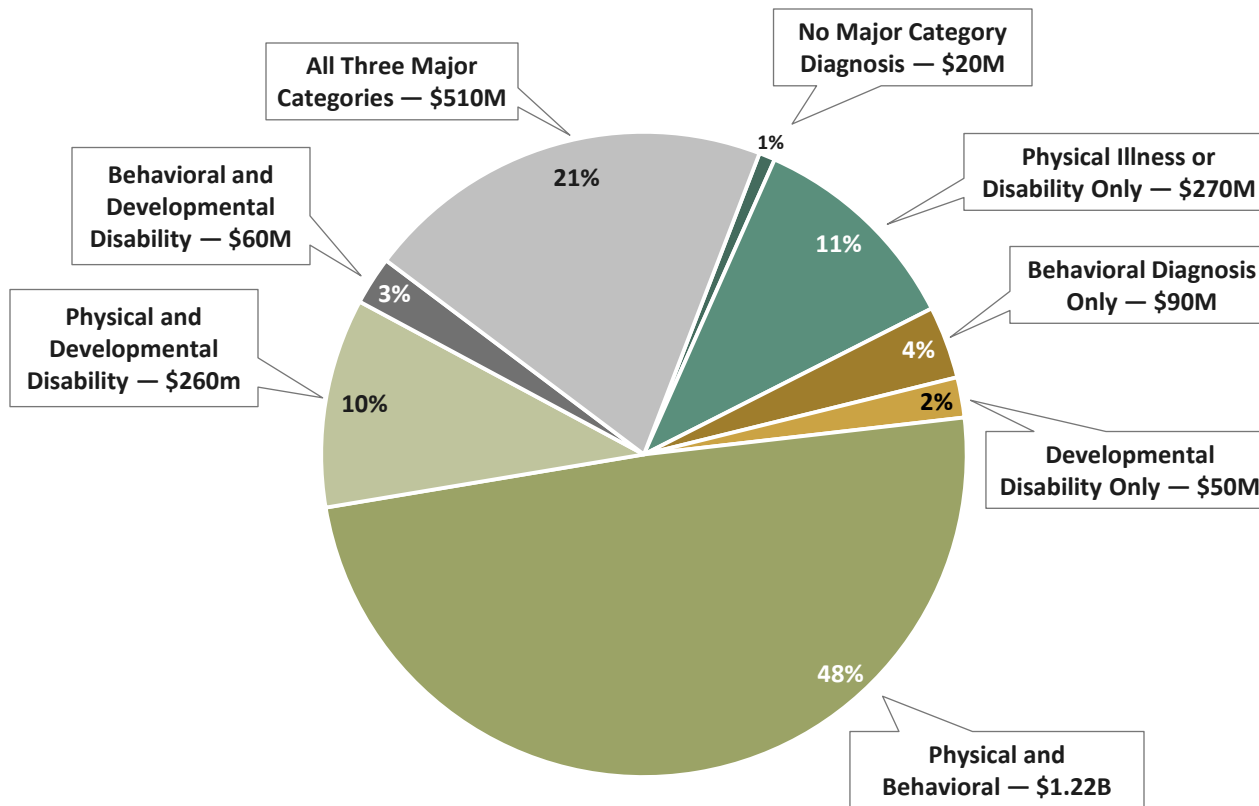


- 7 percent of duals had diagnoses from all three major categories – physical illness or disability; behavioral diagnoses; and developmental disability.
- 47 percent of duals had both physical and behavioral diagnoses.

NOTE: For the purposes of this report “duals” is defined as persons eligible for Medicaid and Medicare ages 21–64.

## DUALS WITH ALL THREE MAJOR CATEGORIES OF DIAGNOSES ACCOUNTED FOR A DISPROPORTIONATE SHARE OF SPENDING

DISTRIBUTION OF EXPENDITURES FOR DUALS BY MAJOR DIAGNOSTIC CATEGORIES, 2008

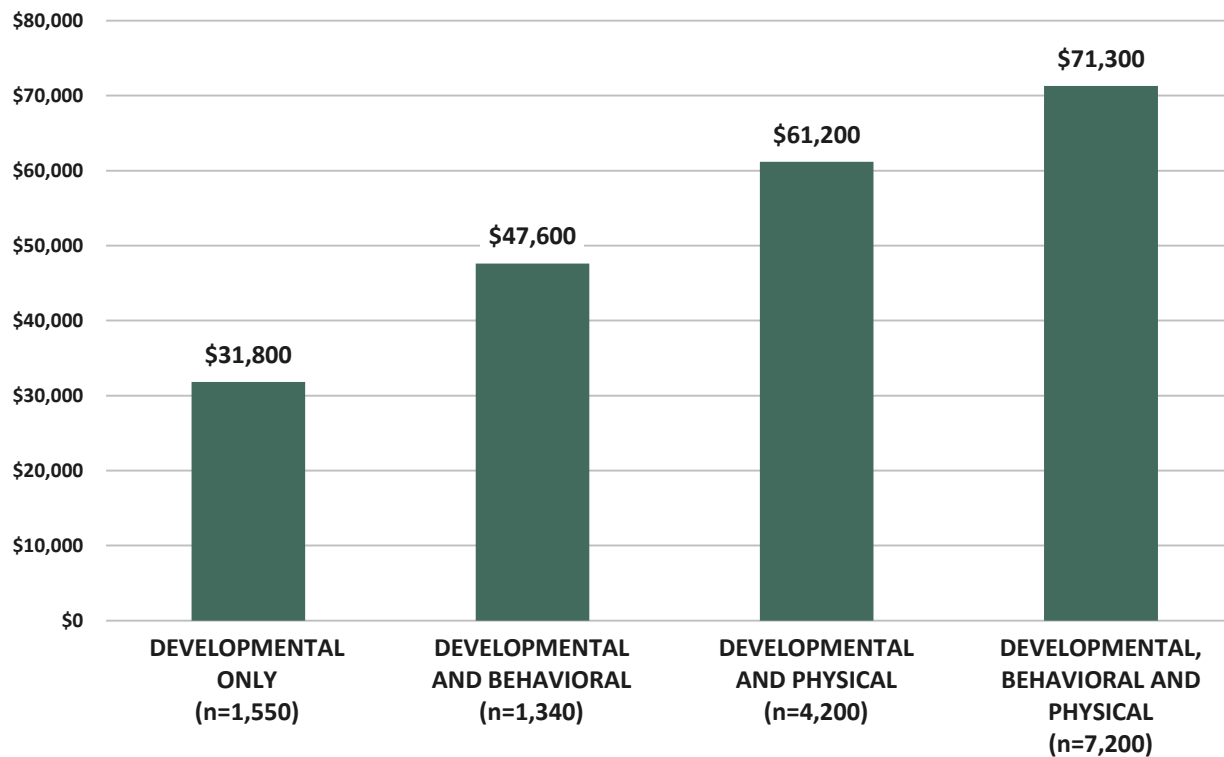


- Duals with diagnoses from all three major categories - physical illness or disability; behavioral diagnoses; and developmental disability - accounted for 21 percent of total spending but only 7 percent of the duals population.
- Duals with both physical and behavioral diagnoses accounted for 48 percent of total spending and 47 percent of the duals population.

NOTE: For the purposes of this report "duals" is defined as persons eligible for Medicaid and Medicare ages 21-64.

# DUALS WITH DEVELOPMENTAL DISABILITY AND DIAGNOSES FROM OTHER MAJOR CATEGORIES HAD HIGH AVERAGE HEALTH CARE EXPENDITURES

**AVERAGE ANNUAL PER CAPITA SPENDING FOR DUALS WITH DEVELOPMENTAL DISABILITY AND DIAGNOSES FROM OTHER MAJOR DIAGNOSTIC CATEGORIES, 2008**

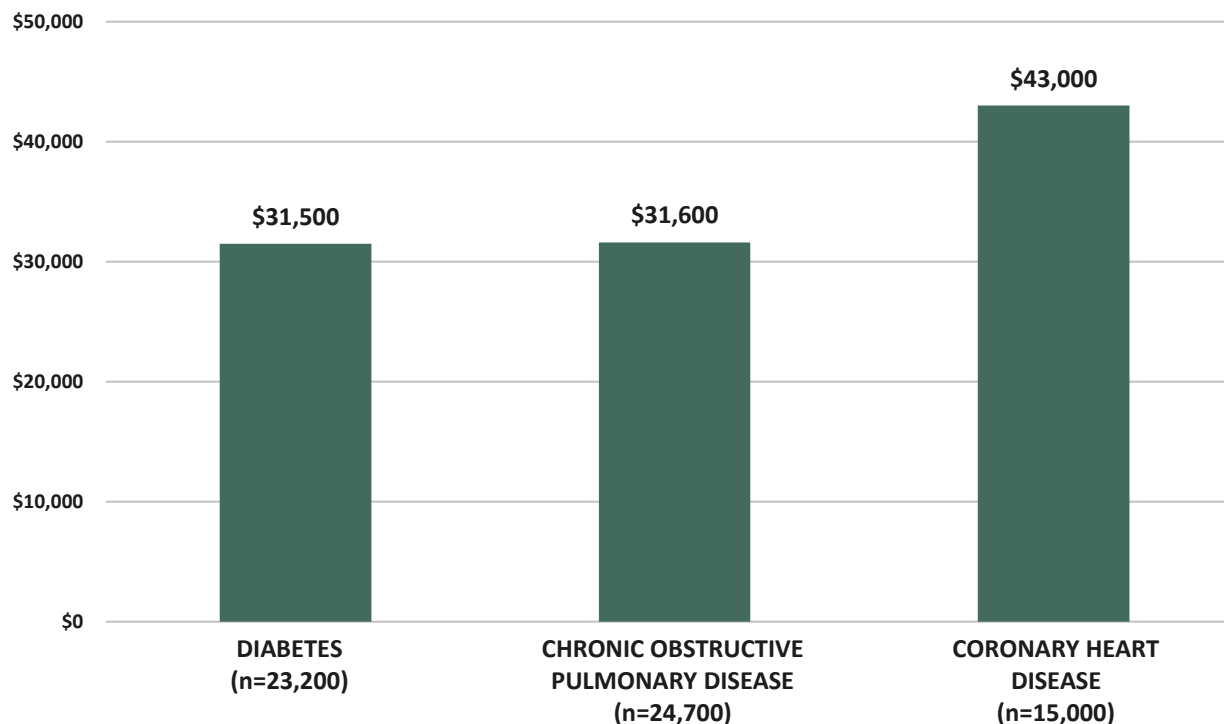


- Average annual per capita health care spending for duals with developmental disability alone was \$31,800, but for duals with developmental disability who also had diagnoses from the other two major categories (physical and behavioral) the average was more than twice as high at \$71,300.

NOTE: For the purposes of this report “duals” is defined as persons eligible for Medicaid and Medicare ages 21–64.

# ANNUAL HEALTH CARE SPENDING FOR DUALS WITH COMMON DIAGNOSES

AVERAGE ANNUAL PER CAPITA SPENDING FOR DUALS WITH COMMON DIAGNOSES, 2008



- 23,200 duals had diabetes. The average annual health care spending for their total care was approximately \$31,500.
- 24,700 duals had chronic obstructive pulmonary disease, such as chronic bronchitis or emphysema. The average annual health care spending for their total care was about \$31,600.
- 15,000 duals had coronary heart disease. The average annual health care spending for their total care was about \$43,000.

NOTES: Individuals cannot be summed, some individuals are counted in more than one category.  
For the purposes of this report "duals" is defined as persons eligible for Medicaid and Medicare ages 21–64.

## SPENDING ON DUALS BY SERVICE TYPE

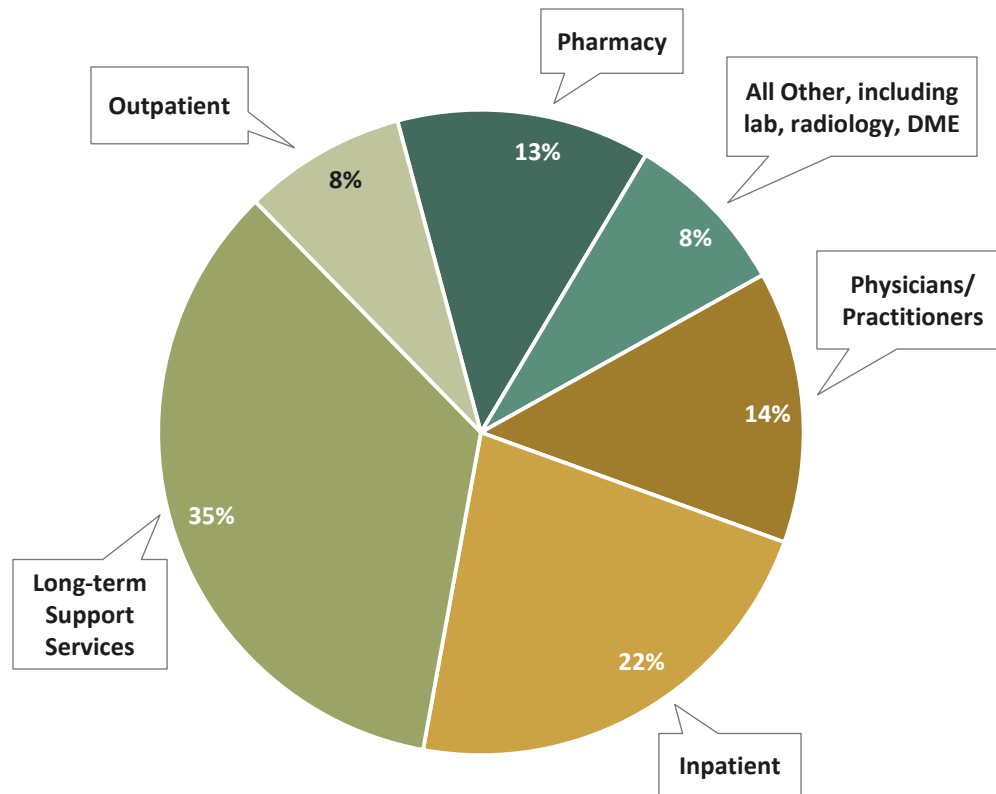
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- Thirty-five percent of combined Medicaid and Medicare spending for duals went to long-term support services (LTSS). Nearly half of spending on LTSS went towards home and community-based waiver services, which serve approximately 6 percent of enrollees.
- Twenty-two percent of combined Medicaid and Medicare spending for duals went to inpatient care. Eighteen percent of enrollees had at least one hospital day during the year.
- Pharmacy spending represented thirteen percent of total spending. Nearly forty percent of enrollees received more than five prescriptions per month.

NOTE: For the purposes of this report “duals” is defined as persons eligible for Medicaid and Medicare ages 21–64.

## 35 PERCENT OF COMBINED HEALTH CARE SPENDING WAS FOR LONG-TERM SUPPORT SERVICES AND 22 PERCENT FOR INPATIENT SERVICES

**DISTRIBUTION OF COMBINED MEDICAID AND MEDICARE SPENDING FOR DUAL ELIGIBLES BY SERVICE CATEGORIES, 2008**

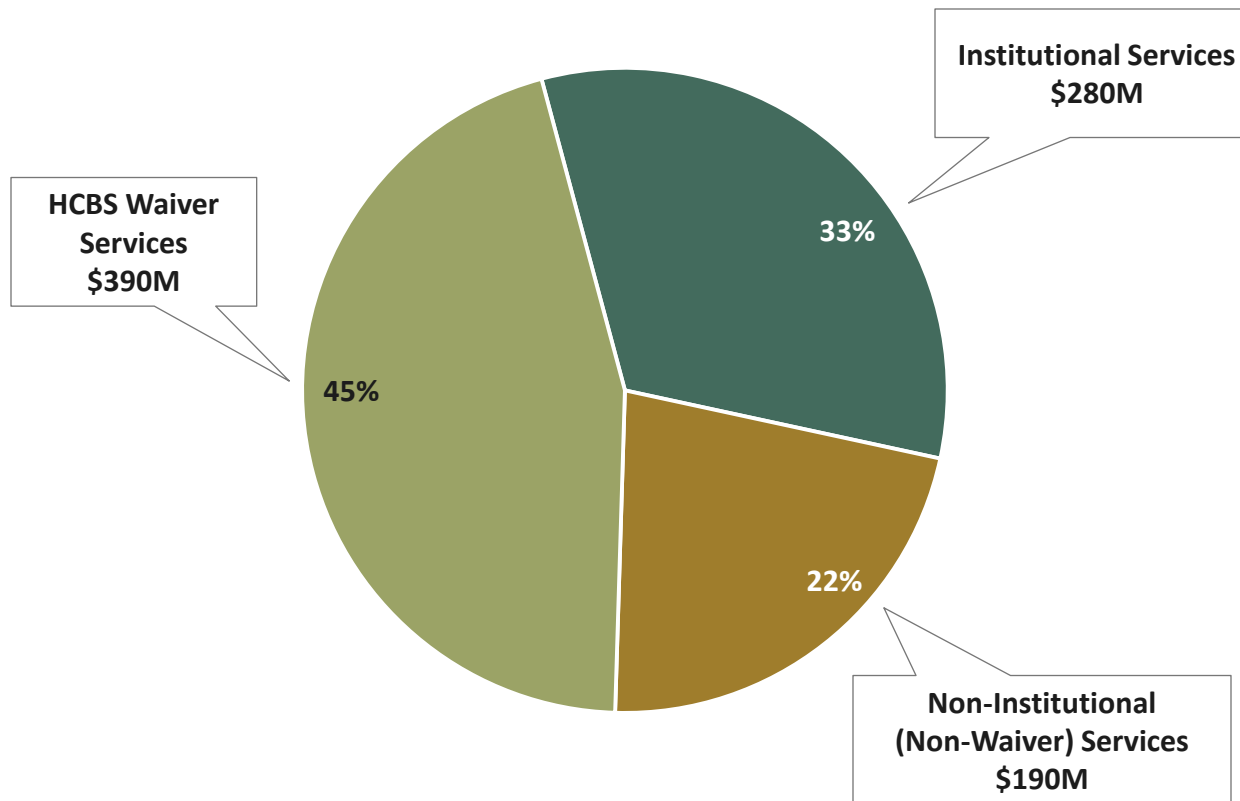


- Long-term support services (LTSS), including all institutional and non-institutional care, accounted for 35 percent of combined Medicaid and Medicare total spending.
- Inpatient services accounted for 22 percent of combined spending.
- Pharmacy accounted for 13 percent of combined spending.
- Physicians and other practitioners accounted for 14 percent of combined spending.
- The distribution of dollars is based on the totality of health care spending, including paid claims and Medicare beneficiary cost sharing paid for by Medicaid.

NOTE: For the purposes of this report “duals” is defined as persons eligible for Medicaid and Medicare ages 21–64.

## DISTRIBUTION OF LONG-TERM SUPPORT SERVICES (LTSS) SPENDING ON DUALS

TOTAL COMBINED MEDICAID AND MEDICARE SPENDING ON LTSS FOR DUALS, 2008



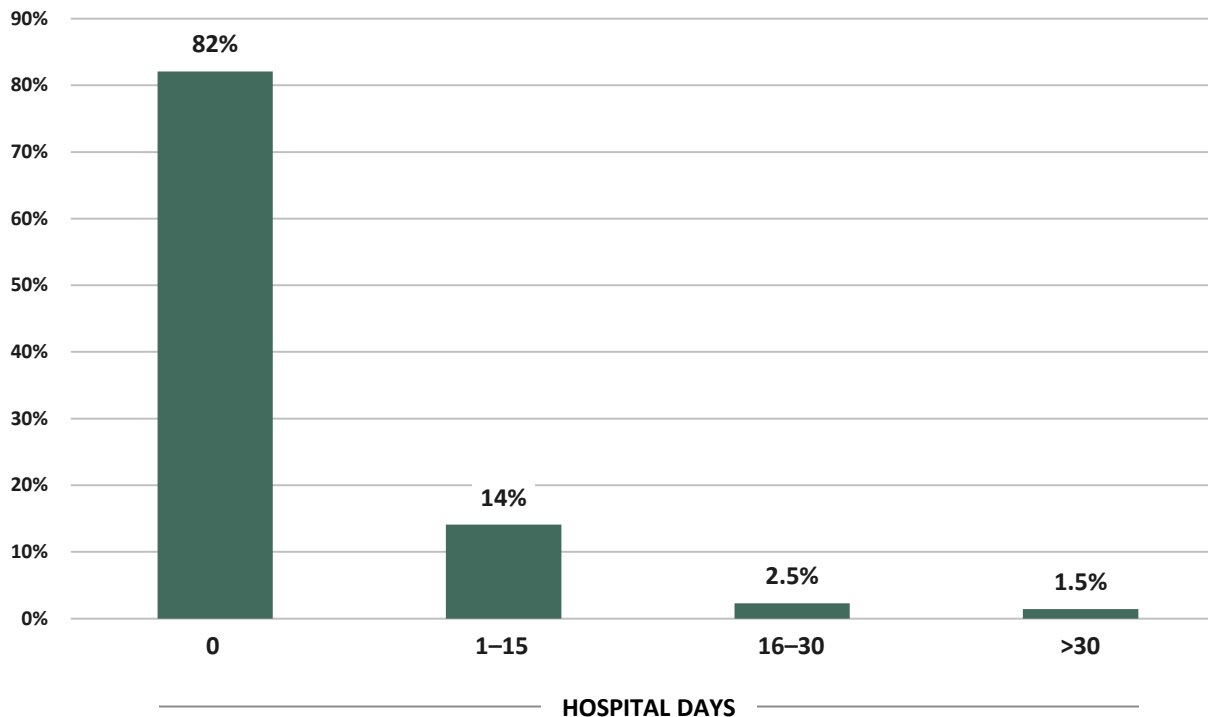
- Home and Community Based Services (HCBS) waiver programs available in Massachusetts for persons age 21 to 64 include one for elderly individuals (age 60+) at risk of nursing facility placement, one for adults with developmental disability at risk of institutionalization, and one for adults who have a traumatic brain injury.
- HCBS waiver services are paid for by Medicaid. In 2008, about six percent of duals were enrolled in a HCBS waiver program; HCBS waiver services accounted for 45 percent of LTSS spending on duals.

NOTES: Institutional services include nursing facilities and intermediate care facilities. Non-institutional (non-waiver) services include adult day health, home health, and hospice. For the purposes of this report "duals" is defined as persons eligible for Medicaid and Medicare ages 21–64.



# EIGHTEEN PERCENT OF DUALS SPENT AT LEAST ONE NIGHT IN THE HOSPITAL; FOUR PERCENT WERE HOSPITALIZED FOR MORE THAN FIFTEEN DAYS

PROPORTION OF DUALS AND THEIR USE OF INPATIENT CARE, 2008

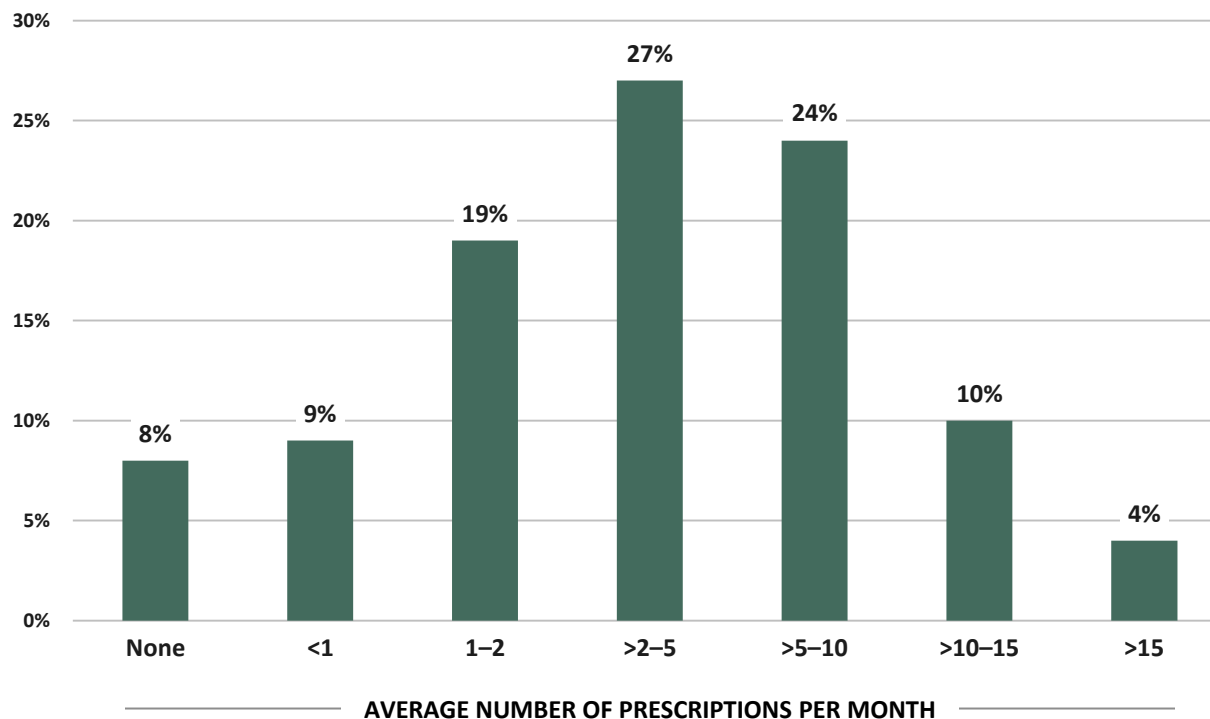


- 18 percent of duals used inpatient hospital care.
- By comparison, according to the 2007 National Health Interview Survey, 8 percent of the entire U.S. population used hospital care. That includes persons of all ages, all types of insurance, and all health conditions who had a short-term stay in a non-federal hospital.
- 80 percent of duals who had a hospital stay used between 1 and 15 days.

NOTE: For the purposes of this report “duals” is defined as persons eligible for Medicaid and Medicare ages 21–64.

# THIRTY-EIGHT PERCENT OF DUALS RECEIVED MORE THAN FIVE PRESCRIPTIONS PER MONTH

PROPORTIONS OF DUAL ELIGIBLES WITH AVERAGE NUMBER OF PRESCRIPTIONS PER MONTH, 2008



- Total spending on pharmacy for duals was \$315 million in 2008.
- 35 percent of duals received zero to two prescriptions per month.
- 27 percent of duals received more than two and up to five prescriptions per month.
- 38 percent of duals received more than five prescriptions per month.

NOTES: Medicaid paid for a portion of spending on pharmacy through “clawback” payments to Medicare, contributing to the spending of Medicare Part D.

See additional comments in the Data Notes of the Appendix . Numbers do not add to 100 percent due to rounding.

For the purposes of this report “duals” is defined as persons eligible for Medicaid and Medicare ages 21–64.

## APPENDIX

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- Data Notes 27
- Definitions 32

## DATA NOTES: GENERAL

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This report draws on fee-for-service claims for health care services in a linked Medicaid-Medicare data set for 2008. BD Group analyzed and presented the data, based on the work of JEN Associates in creating the linked data set and Mercer in organizing the data set. The data set excludes a small proportion of duals (and their spending), less than 5 percent, who are enrolled in Medicare managed care.

MMPI hopes that the information contained in this report will support discussion of the challenges and opportunities in creating an integrated program of care for the dual eligible population ages of 21-64; however, readers should be aware of the following limitations of the data presented in the report:

- The report is based on only one year of data. There are important data limitations inherent in presenting only one year of data. (1) The report does not reflect important changes in the Medicaid and Medicare programs since 2008, such as payments made by Medicaid towards Medicare Part D pharmacy expenditures. (2) The diagnoses only reflect what is captured by one year of claims, not across time.
- The data set, with the exception of data page 22 of this report, excludes any spending by Medicaid for Medicare cost sharing for duals. Medicare beneficiary cost sharing is not captured in the claims data set that was used to create this report.
- The report does not draw on data on services that are not reimbursed by Medicaid from sources maintained by the Department of Mental Health or the Department of Developmental Services that could inform the design of services for dual eligibles.
- The report includes a small amount of data on duals who are 20 years old. We believe that their inclusion has an insubstantial effect on the results shown.

## DATA NOTES: ESTIMATES OF MEDICAID-MEDICARE SHARES OF EXPENDITURES

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- The data presented in this report is based on 2008 claims data for Medicaid and Medicare, and shows a Medicaid share in combined total spending of 51 percent.
- This estimate of 51 percent reflects neither the inclusion of the out-of-pocket costs paid for by Medicaid nor the program changes that have occurred since 2008. (We do not have an estimate of that amount.) A projection of the Medicaid share of total spending beyond 2008 would likely show a Medicaid share that is higher than 51 percent.
- Most notably, the state's financial contribution to the implementation of Medicare Part D in 2006 was not reflected in the 2008 data that were used in this report. The estimates of expenditures in this report were based on fee-for-service claims, and did not include "clawback" payments, by which states contribute to Medicare for Part D coverage.
- Other projections, including those provided by the state in its March 18, 2011 Request for Information (RFI) suggest that the Medicaid share could be as high as 67 percent of the combined spending total in 2011. This projection was derived from per capita spending estimates of dual eligibles reported by the Medicare Payment Advisory Council (MedPAC) for 2005 and reflected Medicaid's full responsibility for pharmacy at that time.

## DATA NOTES: DEFINING DIAGNOSTIC CATEGORIES AND OTHER DIAGNOSES

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- The data presented in this report relied upon three major diagnostic categories to describe the health status of the population: physical illness and disability; behavioral health diagnoses; and developmental disability. Each major category is defined by many diagnoses. The selection of diagnoses and their definition by ICD9 codes were made by JEN Associates and is not now publicly available.
- The behavioral health category is defined by diagnoses such as depression, schizophrenia, substance abuse and many others. These diagnoses are specified by ICD9 codes, which are routinely recorded on health care claims submitted by hospitals, physicians and others. The diagnosis of schizophrenia, for example, is defined as all ICD9 codes beginning with the three-digit code 295 for “schizophrenic disorders.” The diagnosis of depression includes codes for manic and depressive disorders, bipolar disorders, as well as other codes for neurotic disorders.
- The developmental disability category includes diagnoses of mental retardation, cerebral palsy, spina bifida, varied congenital anomalies and other conditions.
- The physical illness and disability category includes a very wide range of diagnoses from many different body systems.
- Readers should bear in mind that the diagnostic information comes from illnesses and symptoms reported in claims for physician services and hospital stays. These diagnoses do not necessarily tell us the reasons for beneficiaries’ disabilities or the full range of their health problems. Multiple years of claims data would improve our understanding of the health status of duals. Use of a publicly available diagnostic classification system would also facilitate sharing of more detailed data for policy and planning purposes.

## DATA NOTES: DEFINING DUALS RESIDING IN THE COMMUNITY WITH HIGH AND LOW LEVELS OF SUPPORT SERVICES

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- Duals living in the community were categorized into two groups: those who were considered to be “Duals Receiving High Level Support Services in the Community” and those who were considered to be “Duals Receiving No or Low Level of Support Services in the Community.”
- Duals were identified as “High Support” if they had been living in a nursing facility sometime within the past three months, if they had used home and community-based waiver services designed to keep individuals at risk of institutionalization living in the community, or if they had received a high level of Medicare or Medicaid home health services. This was determined by the indicators included in the data set used for this report, which identified certain duals as “nursing-home certifiable (NHC),” a category developed originally for older individuals whose level of need for support in activities of daily living made them eligible for nursing home care. Home and Community Based Services (HCBS) waiver programs available in Massachusetts for duals include one for elders (age 60+) at risk of nursing facility placement and one for adults with developmental disability at risk of institutionalization.
- This method could be improved upon for purposes of service planning. Because of spending limits on waiver programs, we suspect that some dual eligibles with significant levels of need for support services do not receive them; as a result, the classification “duals residing in the community who received a high level of support services” may not include some duals with significant needs for support services.

## DATA NOTES: BEHAVIORAL HEALTH SERVICES

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- In this report, we could not fully examine the use of behavioral health services used by duals ages 21–64, because of the limitations of the data.
- We examined the outpatient data for behavioral health and found that spending on these services represented only 2 percent of all Medicaid and Medicare spending. It is important to note that the outpatient facility data is only one piece of the total spending on non-inpatient behavioral health care for duals.
- A more accurate estimate of total spending on behavioral health services in 2008 would have to include spending for practitioners and physicians who deliver behavioral health services. That data was not available for this report, however.
- Further analysis of the use of behavioral health services by duals would be very helpful to the discussion of service integration, given the significant numbers of duals diagnosed with a behavioral health condition.



# DEFINITIONS: MEDICAID SERVICE AND SPENDING CATEGORIES

## SERVICE CATEGORIES FOR THE MEDICAID PROGRAM

MAJOR CATEGORY	SUB CATEGORY	DESCRIPTION
Inpatient	Inpatient Acute	All hospital charges associated with a short stay provider
Inpatient	Inpatient Non-Acute	All hospital charges associated with a non-short stay provider
Long-Term Care (LTC)—Institutional	Other LTC Facility	All Intermediate Care Facility payments
Long-Term Care (LTC)—Institutional	Nursing Home	All Nursing Home services
Long-Term Care (LTC)—Institutional	Skilled Nursing Facility	All Skilled Nursing Facility services
Outpatient	Outpatient Hospital & Clinic	Selected Outpatient Hospital charges for use of facilities
Outpatient	Outpatient Mental Health/Substance Abuse (MH/SA)	All charges from outpatient mental health/substance abuse providers
Long-Term Support Services	Adult Day Health	Adult Day Health services
Long-Term Support Services	Waiver Services	Elderly HCBS and DD Medicaid waiver services
Long-Term Support Services	Home Health Care	All Home Health services including Personal Care Attendant (PCA) services
Long-Term Support Services	Hospice	All charges from Hospice providers
All Providers	Physicians	Physician services, including the professional component of Outpatient Hospital visits
All Providers	Other Practitioners	Non-physician professional charges, incl. the professional component of Outpatient Hospital visits
Pharmacy	Pharmacy/Non-Part D	Retail pharmacy claims covered by Medicaid
All Other	Lab/Rad/Testing/Transportation/Ambulance	Radiology and diagnostic testing services, transportation, ambulance services
All Other	Supplies/Durable Medical Equipment (DME)	Medical supplies and DME
Miscellaneous	Miscellaneous	Unclassifiable payments
Out-of-Pocket Payments <sup>1</sup>	Out-of-Pocket Payments	Cross-Over payments
	Out-of-Pocket Payments	Capitated Payments: HMO and other provider capitation payments
	Out-of-Pocket Payments	Premium Payments: State Medicare buy-in payments
	Out-of-Pocket Payments	Medicaid Coinsurance: Medicaid Coinsurance payments
	TPL Collections	Medicaid Third Party Liability (TPL): TPL payments made for Medicaid services

NOTE: 1. Out-of-pocket payments are excluded from this report.

# DEFINITIONS: MEDICARE SERVICE AND SPENDING CATEGORIES

## SERVICE CATEGORIES FOR THE MEDICARE PROGRAM

MAJOR CATEGORY	SUB CATEGORY	DESCRIPTION
Inpatient	Inpatient Acute	All hospital charges associated with a short stay provider
Inpatient	Inpatient Non-Acute	All hospital charges associated with a non-short stay provider
Long-Term Care (LTC) — Institutional	Skilled Nursing Facility	All Skilled Nursing Facility services
Outpatient	Outpatient Hospital & Clinic	Selected Outpatient Hospital charges for use of facilities
Outpatient	Outpatient Mental Health/Substance Abuse (MH/SA)	All charges from outpatient mental health/substance abuse providers
Long-Term Support Services	Home Health Care	All Home Health services
Long-Term Support Services	Hospice	All charges from Hospice providers
All Providers	Physicians	Physician services, including the professional component of Outpatient Hospital visits
All Providers	Other Practitioners	Non-physician professional charges, including the professional component of Outpatient Hospital visits
Pharmacy	Pharmacy/Non-Part D	Retail pharmacy claims covered by Medicaid
All Other	Lab/Rad/Testing/Transportation/Ambulance	Radiology and diagnostic testing services, transportation, ambulance services
All Other	Supplies/Durable Medical Equipment (DME)	Medical supplies and DME
Miscellaneous	Miscellaneous	Unclassifiable charges
Out-of-Pocket Payments <sup>1</sup>	Out-of-Pocket Payments	Medicare Deductible payments
	Out-of-Pocket Payments	Medicare Copayments
	TPL Collections	Medicaid Third Party Liability (TPL): TPL payments made for Medicaid services

NOTE: 1. Out-of-pocket payments are excluded from this report.