The Faces of Medicaid II: Recognizing the Care Needs of People with Multiple Chronic Conditions

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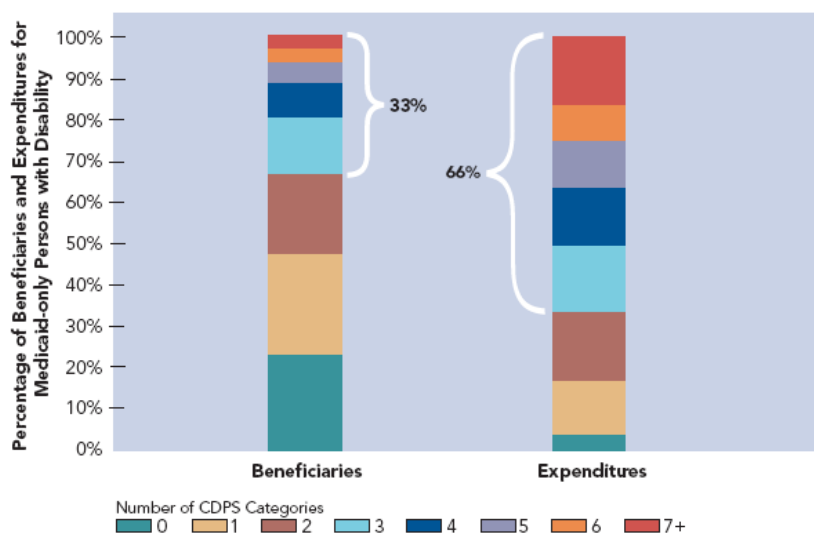
Executive Summary

In Medicaid, elderly and disabled beneficiaries make up only 25 percent of the population, but account for nearly 70 percent of all Medicaid spending. Most of these beneficiaries (many of whom have multiple chronic conditions) are stuck in the fragmented fee-for-service system, but would benefit greatly from integrated systems of care. As states look for ways to ease budget pressures, it is important that the health conditions of these high-cost beneficiaries are understood. Armed with this information states can make informed decisions about how to best manage care, thereby improving health outcomes, increasing quality of life, and reducing costs for this segment of high-need beneficiaries.

The Faces of Medicaid II answers the following questions:

- What is the prevalence of chronic conditions within the Medicaid population; and
- Are there patterns or clusterings of these conditions that could inform the development of more appropriate guidelines, care models, performance measurement systems, and reimbursement methodologies?

The data show that beneficiaries with three or more chronic conditions are responsible for a significant portion of Medicaid spending. This report sheds important light on how Medicaid stakeholders can rethink care management approaches for these beneficiaries. Traditional disease management programs that "silo" them into disease specific interventions do not address their multiple chronic conditions. By clearly identifying the complex needs of these beneficiaries, states, plans and providers can develop integrated and coordinated delivery systems that incorporate clinical care with behavioral and non-medical supportive services. Patients, health care providers, and taxpayers all stand to benefit when Medicaid tailors its care models to fit the needs of the population it serves.

Distribution of Beneficiaries and Expenditures for Medicaid-only Persons with Disability, by Number of CDPS (Diagnostic) Categories, 2002

Study Design

The Center for Health Care Strategies (CHCS) worked with Rick Kronick, PhD, and Todd Gilmer, PhD, nationally recognized experts in Medicaid disease prevalence from the University of California San Diego, to identify the most prevalent, complex and costly clusters of conditions and comorbidity patterns within the Medicaid population at a national level. The analysis used data from Medicaid Analytic eXtract system for 2002. Enrollees were analyzed separately according to the four major categories of eligibility: non-disabled children, non-disabled adults, people with disability, and the aged. Prevalence of chronic conditions was determined using diagnoses from the Chronic Illness and Disability Payment System (CDPS).

Key Findings

▪ Among high-cost beneficiaries virtually all have multiple chronic conditions. Within the most expensive 1% of beneficiaries in acute care spending, almost 83% had three or more chronic conditions, and over 60% had five or more chronic conditions.

▪ For Medicaid-only persons with disability, each additional chronic condition is associated, on average, with an increase in costs of approximately $700/month, or approximately $8,400 per year. There is evidence of "super-additivity" of costs (i.e., moving from seven to eight conditions adds more expenditures than moving from one to two conditions).

▪ Some pairs of diagnoses demonstrate strong correlations. For example, 68% of Medicaid-only disabled beneficiaries diagnosed with diabetes also have cardiovascular disease.

▪ The top most prevalent diagnostic pairs of diseases, or "dyads," among the highest cost 5% of patients are: cardiovascular-pulmonary (30.5%); cardiovascular-gastrointestinal (24.8%); cardiovascular-central nervous system (24.8%); central nervous system-pulmonary (23.8%) and pulmonary-gastrointestinal (23.8%).

▪ Within the 30 most common triads of diagnoses, 20 include cardiovascular disease, 12 each include pulmonary and skeletal and connective disease, 11 include psychiatric illness and central nervous system disorders, and eight include diabetes.

Implications

This analysis lays the groundwork for an examination of the clinically distinct conditions that make up high-cost clusters and should be the focus of integrated and coordinated care models. The findings also illustrate the need to refine existing performance measures and to develop new measures responsive to complex patients with multiple chronic conditions. Financing changes are necessary to best care for these beneficiaries, and incremental steps toward fully integrated funding streams may be the most effective way to reach this ultimate goal. Finally, the notable absence of evidence based care models for comorbid patients highlights the tremendous need to build a research agenda in this area.

Today, relatively little is known about how to best care for the millions of Medicaid beneficiaries living with multiple chronic conditions every day. This lack of knowledge, coupled with an over-reliance upon conventional disease-specific treatment guidelines, results in patients being treated as the sum of their individual conditions without regard to the impact of the conditions upon one another. Understanding the clusters and how conditions group into dyads or triads of these conditions could help consumers, family caregivers, purchasers, health plans, providers, and other stakeholders move from a piecemeal condition-based approach to a patient-centered, holistic approach.

Download the Full Report

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