URBAN INSTITUTE

Beyond Spend-down:

The prevalence and process of transition to Medicaid

Brenda Spillman and Timothy Waidmann

Using Administrative Data for Program Evaluation and Research

Nov. 30, 2016

Acknowledgment

The DHHS/Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, & Long-term Care Policy supported this work.

Full report is available at

http://aspe.hhs.gov/pdf-report/rates-and-timing-medicaid-enrollment-among-older-americans

Policy context

- Dually eligible older persons are a small minority of Medicaid enrollees but are disproportionately expensive
  - High costs primarily owing to need for long term services and supports (LTSS), particularly nursing home care
  - High LTSS costs are often associated with “spenddown” of assets and transition to Medicaid enrollment
- Policy themes related to Medicaid transitions
  - Some believe asset transfer to gain eligibility is widespread among middle class individuals who could pay for their own care
  - Others focus more on increasing affordable prefunding options to reduce need for “spend-down” to eligibility
- Age of existing estimates supported the need for updated analyses of the rate and process of transitions to Medicaid

Study aims and methods

- To provide new estimates of the rate and timing of Medicaid transitions, enabled by administrative data linked to a nationally representative survey cohort
  - Descriptive estimates of Medicaid at baseline and transitions over a 4-year follow-up
  - Probit model to estimate the relationship between baseline characteristics and probability of transition to Medicaid within a 4-year period
  - Survival model to estimate the relationship between time-variant factors (health spending and utilization, nursing home entry) and timing of transitions

Data

- Nationally representative cohort of Medicare enrollees age 65+ from the National Long Term Care Survey 2004 forms the baseline
  - Detailed interview respondents (n=~6,000) for overall estimates of Medicaid status
  - Community residing population age 65+ and not enrolled in Medicaid at baseline for transition estimates (n=~4,300)
- Linked administrative data allow longitudinal follow-up
  - Beneficiary and claims data for Medicare (2004-2009) and Medicaid (2004-2007)
  - Minimum data set (MDS) assessments to identify nursing home admissions after baseline
- State Medicaid program characteristics compiled from various published sources

Medicaid enrollment

- Transition measure is full benefit enrollment, not estimated eligibility
- Relies on data from 3 sources
  - Medicaid MAX files (2004-2007): Monthly Medicaid enrollment indicators
  - Medicare files (2004-2009):
    - Monthly Medicare “buy-in” indicators from beneficiary files 2004-09
    - Monthly duals eligibility indicator for 2006-08 from Medicare beneficiary files (derived from state Medicaid files)
- Decision rules for transition
  - Transition measure relies primarily on MAX indicators
  - Compared with MAX data, Medicare buy-in and duals indicators have few “false positives”, but about 20% “false negatives”
  - Continuous enrollment after transition assumed, based on MAX analyses

Descriptive findings

Overview of Medicaid enrollment, 2004

	Percent enrolled at baseline	Percent enrolling within 4 years
All Medicare aged	14	5
Disability		
None	10	3
Receiving no help	13	7
Help with IADLs only	21	10
Help with 1-2 ADLs	27	11
Help with 3+ ADLs	33	11
Institutional resident	63	7
Cognitive status		
Not impaired	12	4
Impaired	38	12

Community residents enrolling over 4 years: Place and timing of transition

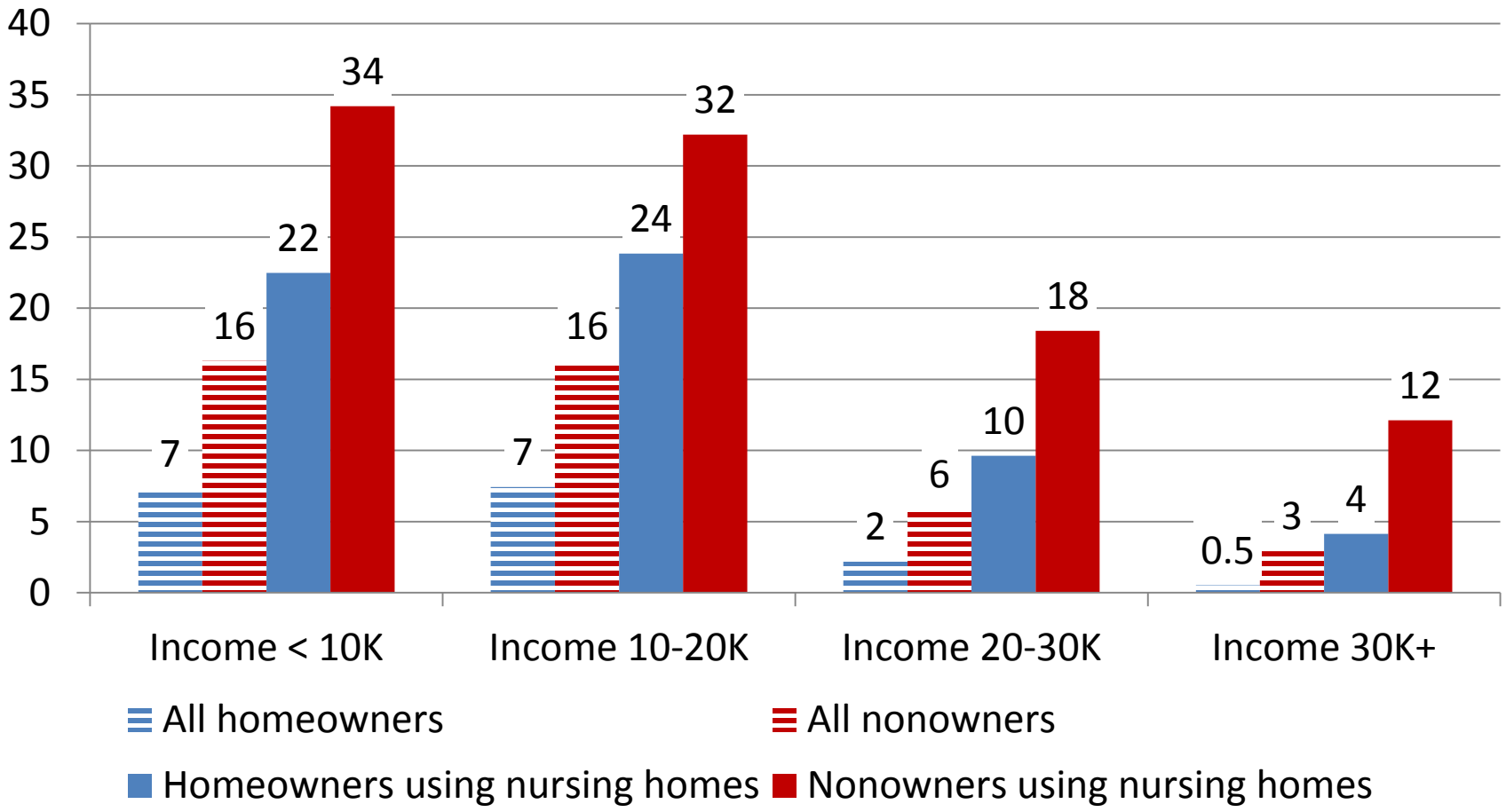
Place of transition	Percent of transitions	Mean time to transition (months)
All	100	21
Community	56	20
Nursing home		
At admission	10	19
After admission	34	23

Model results

Predictors of Medicaid transition over 4 years

	Marginal effect	
Nursing home entry during analysis period	0.081	**
Income < $10,000	0.064	**
Income $10,000 -<$20,000	0.055	**
Home value less than $75,000	0.024	**
Not a homeowner	0.021	**
Cognitively impaired	0.027	**
Help with 3+ ADLs	0.020	*
% of Medicaid LTSS spending in community >median	0.013	**
Medically needy program	0.012	**
Spousal protection income max AND resource >= 75th%ile	0.011	*
Community residential care	0.033	*
Retirement community/housing	0.028	**
Black, nonhispanic	0.062	**
Less than high school education	0.012	*

Predicted Medicaid transition rate over 4 years by income, home ownership, and nursing home use



Survival model: Relative hazard of transition in current month

Time varying characteristics	Relative hazard
Any short-stay nursing home use in month	**4.67** **
Any long-stay nursing home use in month	**30.12** **
Total Medicare spending in the last 6 months (log)	1.03
Inpatient stay in current month	**1.68** *
SNF stay in current month	0.86
Home health use in current month	0.95
Hospice use in current month	0.77
Outpatient use in current month	**1.58** **
Part B or DME use in current month	0.84

Summary of major findings

- 5% of community residents transition to Medicaid over 4 years
  - 56% percent of transitions occur in the community
  - 10% occur at nursing home admission, and 34% occur an average 9 months after admission
- Nursing home use is by far the greatest predictor of transition followed by low income & assets
  - Nearly 30% of the poor and near poor who used nursing homes transitioned vs about 6% of nonusers
  - Homeowners were less likely to transition, but even higher income homeowners were 8 times more likely to transition if they used nursing homes (4% vs 0.5% for nonusers).
- Findings were similar for monthly relative hazards of transition
  - 30-fold hazard for those in a long-stay nursing home episode; 5-fold for short stay
  - Inpatient and outpatient use also associated with 60-70% higher relative hazard
- More generous state eligibility standards and greater share of spending on HCBS were associated with higher risk and relative hazard

Study limitations

- We cannot observe changes over time in baseline characteristics
  - Functional status
  - Living arrangement, home ownership, informal care may change in response to functional changes or other events
- Financial information is limited to baseline income, home ownership, and home value at baseline
  - Home ownership, value correlated with other wealth accumulations, and may capture baseline economic status relative to others
  - Cannot capture “spenddown” and other changes in wealth, income
- We do not account for potential endogeneity of the nursing home entry decision and other unobservable factors

Implications for policy

- Current efforts and trends toward changing the locus of LTSS from nursing homes to community settings may be able to reduce the rate of transitions
- Increased Medicaid HCBS may increase transition rates modestly but have long-term beneficial effects on costs
- Policies to improve access to affordable prefunding might be able to bridge gaps between financial means and care needs for those with modest retirement income and resources
- Increased supports for informal caregivers may be able to reduce nursing home admissions and Medicaid transitions

Data policy implications

- Combination of survey and administrative data is a powerful tool for policy analysis, but has limitations
- Privacy of personal health information (PHI) presents particular challenges for such linkages (HIPAA rules)
  - Costs associated with data security measures
  - Combining geography (even state) with PHI is complicated or even prohibited
  - Developing successful data use requests for CMS data can be time consuming and costly, even under inter-agency agreements
- CMS (and some survey organizations) moving toward access only through virtual or physical data centers
  - Benefits in terms of reducing processing and security infrastructure required for research organizations
  - Access through data centers and storage still costly
  - New way of working for many researchers