Medicaid Per Capita Costs for Persons with Disabilities

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The Menges Group

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Summary

- Persons with disabilities represented 11% of non-dual eligible Medicaid beneficiaries and accounted for 45% of non-duals' Medicaid expenditures during 2010.
  - Average annual costs per disabled recipient were $18,258
- Wide cost variation exists among states
- Cost, usage, and coverage continuity of this subgroup create important care coordination opportunities for SSI non-duals
  - Nationally, 78% of 2010 expenditures for this subgroup occurred via the traditional fee-for-service payment model
  - Care coordination program for SSI non-duals must be carefully designed and tailored to each beneficiary's unique needs and circumstances

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Medicaid Costs Per Eligible Per Month by State for Persons with Disabilities, 2010 -- 30 States with Highest Per Capita Costs

State	2010 Costs Per Eligible Per Month, Disabled Beneficiaries (non-dual eligibles)	State PEPM Cost as % of USA PEPM Cost	State Rank (1 = Highest PEPM Cost)
Alaska	$2,921	192%	1
Connecticut	$2,624	172%	2
Minnesota	$2,546	167%	3
North Dakota	$2,460	162%	4
District of Columbia	$2,437	160%	5
Wyoming	$2,155	142%	6
New York	$2,110	139%	7
Maryland	$2,102	138%	8
Arizona	$2,011	132%	9
Delaware	$2,001	132%	10
Nebraska	$1,995	131%	11
Utah	$1,968	129%	12
New Jersey	$1,925	126%	13
Iowa	$1,912	126%	14
Vermont	$1,877	123%	15

State	2010 Costs Per Eligible Per Month, Disabled Beneficiaries (non-dual eligibles)	State PEPM Cost as % of USA PEPM Cost	State Rank (1 = Highest PEPM Cost)
South Dakota	$1,811	119%	16
Idaho	$1,801	118%	17
Ohio	$1,767	116%	18
New Hampshire	$1,710	112%	19
Virginia	$1,698	112%	20
Hawaii	$1,672	110%	21
North Carolina	$1,650	108%	22
Indiana	$1,614	106%	23
Oregon	$1,596	105%	24
Massachusetts	$1,588	104%	25
Tennessee	$1,584	104%	26
Colorado	$1,565	103%	27
Nevada	$1,561	103%	28
Missouri	$1,545	102%	29
Montana	$1,543	101%	30

Dual eligibles excluded in above figures. Source of tabulations is CMS MSIS data sets.

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Medicaid Costs Per Eligible Per Month by State for Persons with Disabilities, 2010 – 20 States with Lowest Per Capita Costs

State	2010 Costs Per Eligible Per Month, Disabled Beneficiaries (non-dual eligibles)	State PEPM Cost as % of USA PEPM Cost	State Rank (1 = Highest PEPM Cost)
Kansas	$1,537	101%	31
Illinois	$1,534	101%	32
Michigan	$1,455	96%	33
California	$1,431	94%	34
Texas	$1,394	92%	35
Oklahoma	$1,393	92%	36
South Carolina	$1,389	91%	37
Pennsylvania	$1,342	88%	38
Washington	$1,307	86%	39
Louisiana	$1,285	84%	40

State	2010 Costs Per Eligible Per Month, Disabled Beneficiaries (non-dual eligibles)	State PEPM Cost as % of USA PEPM Cost	State Rank (1 = Highest PEPM Cost)
Rhode Island	$1,275	84%	41
Florida	$1,259	83%	42
Wisconsin	$1,255	82%	43
Arkansas	$1,208	79%	44
New Mexico	$1,179	78%	45
Georgia	$1,138	75%	46
Kentucky	$1,135	75%	47
West Virginia	$1,067	70%	48
Mississippi	$1,019	67%	49
Maine	$872	57%	50
Alabama	$804	53%	51
USA Total	**$1,522**	**100%**	

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Greater Use of Care Coordination is Needed for Disabled Beneficiaries

- 22.1% of nationwide spending for disabled non-duals was paid via capitation during 2010 (versus 50.2% for TANF)
- Disabled subgroup has many attributes that are more conducive to use of care coordination than TANF
  - SSI subgroup exhibits very high per capita costs
  - High usage rate in areas that well-designed interventions are likely to impact (e.g., inpatient hospital, pharmacy)
  - SSI inpatient costs are driven by chronic conditions where a future claims costs trajectory can be significantly affected, whereas TANF costs are driven by pregnancies
  - SSI subgroups have relatively stable and lasting Medicaid eligibility

Effective Care Coordination for SSI Beneficiaries Requires a Tailored Approach

- "Whole person" focus that integrates attention to multiple conditions
  - SSI non-duals have very high prevalence of behavioral health conditions
  - Many persons with disabilities have a complex mix of comorbidities
- Individually tailored model that addresses each person's unique needs and circumstances
  - Comprehensive assessment of clinical needs, strengths & limitations, family and housing dynamics, social support, communication avenues, etc.
  - Individualized plan of care and care coordination team
  - Appropriate ongoing modifications to initial plan of care