



Summary

Beneficiaries who are super utilizers of services are a relatively small group of healthcare consumers, but have accounted for a disproportionate share of Medicaid spending in the U.S^{1,2}. Super-utilizers (SUs) beneficiaries in this study are defined as patients with more than 3 episodes of inpatient stays (IS) and more than 5 episodes of emergency-department visits (ED) within a year. This snapshot provides a profile of SUs in the District of Columbia’s (D.C.) Medicaid program regarding their utilization, cost and disease patterns, based on Medicaid claims. Our study showed that in fiscal year (FY) 2014, the average cost per SU among fee-for-service (FFS) beneficiaries is \$136,903, compared to \$16,455 for a FFS low-utilizer (LU); the average cost per SU among managed care organization (MCO) beneficiaries is \$117,867, compared to \$4,907 for an MCO LU.

Background

Improving public health, enhancing the quality of healthcare services, and reducing unnecessary costs are key priorities for District Medicaid policy makers. The Centers for Medicare & Medicaid Services (CMS) reported that 5% of Medicaid beneficiaries accounted for 54% of total Medicaid expenditures and top 1% of Medicaid beneficiaries accounted for 25% of total Medicaid expenditures, based on claims data from FY 2008³. Among this top 1% of Medicaid beneficiaries by total spending, 83% had at least three chronic conditions. Health care researchers have begun to focus on identifying the root causes of the disproportionately high costs and utilization among SU patients.

Methodology

DHCF researchers extracted claims data from the D.C. Medicaid Management Information System (MMIS). We used Medicaid claims with dates of payment in fiscal year (FY) 2014 to identify interactions between the number of IS and the number of ED. In our study design, we modified the analytic model developed by the Camden Coalition through adjusting the length of our study period and episode counts of IS and ED, to define SU beneficiaries as patients who had more than 3 episodes of IS and more than 5 episodes of ED within a year. Medicaid beneficiaries were classified into two groups based on different management and payment systems: FFS beneficiaries and MCO enrollees. The diagnosis analysis was conducted in FY 2015-2016 based on the primary diagnosis code, admitting diagnosis code, and diagnosis codes 1-13 from claims data in FY 2014. For the purpose of comparison, we also calculated the average cost per person among SU and LU beneficiaries. Low-utilizers are defined as patients with no more than 1 episode of IS and no more than 2 episodes of ED.

Results

Table 1 shows the number of beneficiaries, associated expenditures, and average cost per person among FFS beneficiaries and MCO enrollees. In FY 2014, all SU beneficiaries accounted for 0.3% of all beneficiaries, but 3.5% of all expenditures. FFS beneficiaries accounted for nearly 75% of all SU beneficiaries. Fee-for-service SU accounted for 0.8% of FFS beneficiaries, but 4.3% of FFS expenditures. Managed care organization SU accounted for only 0.1% of MCO enrollees, but 2.1% of MCO expenditures. Among FFS super-utilizers, the most common diagnosed symptoms/diseases were hypertension, end-stage renal disease (ESRD), and chest pain. Among MCO super-utilizers, the most common diagnosed symptoms/diseases were hypertension, chest pain, and symptoms involving the abdomen and pelvis.

Table 1. Utilization and expenditures of super-utilizers (SU) in FFS and MCO plans

	FFS beneficiaries	MCO enrollees	All SU beneficiaries
Number of people	250	92	342
Percentage of the FFS or MCO population (%)	0.8	0.1	0.3
Associated expenditure of the FFS or MCO population (%)	4.3	2.1	3.5
Total cost associated with these individuals (\$)	34,225,731	10,843,764	45,069,495
Average cost per person (\$)	136,903	117,867	131,782



Implications for Medicaid Program

Understanding the average cost and top diseases of SU beneficiaries can help address the following goals in healthcare program management and policy implementation: (1) to clearly identify system inefficiencies and their link to low-value care; (2) to help Medicaid beneficiaries who are not getting the preventive care they need; and (3) to develop an SU strategy for reducing preventable hospital visits by employing data-driven evidence, stakeholder engagement, and clinical redesign. Moreover, these study results can provide guidance with implementing multidisciplinary community-based care coordination, which can help SUs through primary care and community resources. To address these acute needs, DHCF launched a new Health Home program called My Health GPS on July 1, 2017. This new program will provide enhanced care coordination, increase access to primary care, and facilitate collaboration with social service programs. As a result, this new program plans to help Medicaid SU beneficiaries receive appropriate health care through care coordination services.

Conclusion

The utilization and expenditures of District Medicaid SU patients are not proportionally correlated. The average cost per person among SU patients is much higher compared to the rest of Medicaid beneficiaries. In addition, District Medicaid SU patients have multiple chronic diseases. DHCF researchers will continue studying the profile of SU beneficiaries regarding utilization, cost, and health conditions in the future.

Data Notes: Data was extracted by date of payment from the DC Government's MMIS in FY 2015-2016. All denied FFS claims were excluded for this analysis. For code strings or for more information about this snapshot, please contact the Division of Analytics and Policy Research at the DC Department of Health Care Finance at 202-442-5988.

References

1. Bodenheimer T. (2013). Strategies to Reduce Costs and Improve Care for High-utilizing Medicaid Patients: Reflections on Pioneering Programs, Policy Brief, October 2013.
https://www.anthem.com/provider/noapplication/f1/s0/t0/pw_e211389.pdf?refer=provider.%20Published%20Oct%202013
2. Emeche U. (2015). Is a Strategy Focused on Super-Utilizers Equal to the Task of Health Care System Transformation? Yes. *Annals of Family Medicine*, 13 (1), 6-7.
3. Mann C. (2013). Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality. In *CMCS Informational Bulletin*, Center for Medicare & Medicaid Services, Department of Health & Human Services, Baltimore, Maryland. Retrieved from <https://www.medicare.gov/federal-policy-guidance/downloads/cib-07-24-2013.pdf>
4. Brenner J. (2014). Exploring High-Utilizer Intervention Programs. Camden Coalition of Healthcare Providers. Retrieved from <https://www.camdenhealth.org/wp-content/uploads/2012/09/8-13-Open-House-Slides-All.pdf>