Title: Estimating Variation in Productivity Across State Medicaid Programs: Evidence from Dual-Eligibles (Part 2)

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Key Findings and Policy Implications

This paper examines the variation in institutional long-term care utilization across states with different Medicaid program provisions. It focuses on people who are dually eligible and enrolled in both Medicare and Medicaid; and uses national administrative enrollment and claims data from both programs. The paper finds that:

- There is substantial variation in utilization of institutional long-term care across states. In Connecticut and Indiana, almost 20 percent of dual-eligible enrollees have an episode of institutional long-term care in any given year, while fewer than 5 percent of dual-eligibles have an episode in Oregon, Vermont, and Alaska.

- The variation is even larger when accounting for the duration of care episodes. In Connecticut and Indiana, the average dual-eligible enrollee uses around 60 days of institutional long-term care per year; while in Oregon, Vermont, and Alaska, dual-eligibles use fewer than 10 days per year.

- By looking at people who move from one state to another, we estimate that 40 to 45 percent of the cross-state variation in long-term care utilization is causal, with the remaining variation stemming from differences in enrollee composition. The relative attribution to causal versus compositional influences is similar for various measures of utilization, suggesting an important role for program design.

- The relationship between causal impacts on spending and causal impacts on utilization are weak. For example, moving to a state with a 10 percent higher state spending effect leads to an increase in the probability of using any institutional long-term care during the year by only 0.06 percentage points, or 0.7 percent of the baseline level of use.

While the findings suggest a clear causal impact of state Medicaid policy on costs and utilization, the weak relationship between these effects point to a more nuanced story of how different states prioritize institutional long-term care versus home and community-based services.