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MEETING TRANSCRIPT

UNDERSTANDING CHRONIC CONDITIONS AMONG CALIFORNIANS WITH ORIGINAL MEDICARE

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Speakers:

- Anastasia Dodson
- Nils Franco
- Dr. Carla Perissinotto

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See the transcript below.

(DHCS)

Understanding Chronic Conditions among Californians with Original Medicare

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>> ANASTASIA DODSON: Welcome, everyone. I'm here at the California Department of Health care services. Welcome to the webinar. This webinar is for anyone. We are glad you are here. Whether you are someone with Medicare. You want to learn more about Medicare. You work at a health plan or a provider's office. You work with older adults or you just have a passion for these issues. Thank you for joining. You may be a researcher, maybe working for a foundation. We are glad for everyone here on this webinar today. And very excited to be talking about this topic here at DHCS. We have an office of Medicare innovation and integration. We are partnering with the Scan foundation. Thanks for their support for ATI who has done the excellent analysis. Welcome, and we will dive right in. So, my name is Anastasia Dodson, I work in the Department of Health care services. We are a state agency that administers Medi-Cal and we are joined by -- will do a little bit more detailed instructions. That's talk about the housekeeping. All of you are muted upon entry. So that we don't get the background noise. This webinar is being recorded. And will be posted on the DHCS website. To access the chat, you can click on the chat button on the lower right corner of your screen. And you will see a little picture of that on the right hand side of the screen right there. On the slides. And we are trying to only take questions via chat for the webinar. But, if we need more clarification, we can take you off mute, if you raise your hand. The button to raise your hand is at the bottom right of the screen next to the emoji icon. And for anyone who needs live closed captioning for today's webinar, we have a link for assistance. So please look at the chat for that link or you can also use the CC button, which again is at the bottom. The agenda is posted on the DHCS website on the slides

as well as the chart book will be posted there shortly and you can see the link DHCS.ca.gov and then there is a few more was there and then OMII and that will get you to the page on the agenda. And again we will post the slides and a larger chart book. All right, next slide. So, what are we going to cover today? We have a wonderful analysis of chronic conditions among Californians with original Medicare. And we are going to take the topic into two sections, so we can have a Q&A in the first section and then Q&A in the second section. So, the first section is about what chronic conditions are most prevalent and what are the demographic and geographic differences. And again this is the data analysis. Analysis of California's with original Medicare and the data is from 2021. So, I will go through that first section, do some Q&A and discuss with Doctor P., and the second section will be behavioral health regional data and dual eligibles. And the chart book itself which is even more about all of this is going to be posted shortly. Same with the slides. One more thing about the data and what information is available. The California health and human services agency has what is called "open data portal" and in the coming weeks, we are going to be posting even more data files related to what you will see today. So, a lot of the slides are looking at the statewide level. But, for anything that you may be interested in here on a regional level, Los Angeles, Orange County, San Joaquin County, Sacramento area, the data specific to those regions is also going to be posted on the data portal. So, this is the beginning of the conversation. And over the next few weeks we will be posting more information and so, we hope that these documents are in your consciousness and available for discussion. Today will be a great discussion, because this is really important data to get published. Next slide. So, we are very pleased to have Nils Franco, analyst 80 advisory ATI is a research and advisory service that works to transform the delivery of services that promote the health and well-being of any individuals with complex health and social needs. We are also pleased to have Doctor Carla P. who is a physician professor in the division of Geriatrics --. And then one more reminder before we dive into the data and information. So, if you have a consumer question, if you have Medicare and you have a question about Medicare whether it is about health plans or concerns about anything else. Your local high Office is available to help. There's a 1800 number on the screen that you can call and find your local high Office. You can also go to the California Department of aging website. Find services in your county. And again HICAP Help 1-800-603-4227. I will hand it off to you. Thank you so much.

>> SPEAKER: I am honored to be here with each of you today to discuss the chronic condition and our most experienced by Caltrans with original Medicare and will go into some of these terms like. I am an analyst at ATI advisory. Insights I will share with you today are from a chart book prepared by ATI advisory for the office of Medicare innovation and integration that will be published shortly. In the next few weeks there will be an open data set and will show you some of the insights today that will be from that data set. We have a packed schedule. Let's turn to the agenda of topics of this segment. Briefly, the topics I will cover in the first half of the webinar includes an overview of the Medicare program and how Medicare intersects with Medi-Cal. And we will look at the top ten most common chronic conditions and then deep dive into the differences in the prevalence of these conditions and total spending by the Californians with original Medicare who have these conditions. We will look at differences in terms of

demographic like age, gender, race and ethnicity and by rural urban geography. We will review some Medicare topics and terms. On the next slide, we have reviewed Medicare and dual eligibility terms starting with Medicare. Some Medicare is the federal program that covers healthcare for about 7 million Californians today. And about 6 million that you see in that larger circle on the right, in 2021. So, in 2021 is the study period for today's data about chronic conditions. Medicare covers specific groups of people across the US. People age 65 or older, people with long-term disabilities and people with end-stage renal disease. Among others. Original Medicare, this second -- is the Medicare program where the government -- health insurers sent you a Medicare card and pays healthcare providers directly in California about half of the Medicare beneficiaries 3 million have original --. Other entity like employer administers Medicare benefits for people who choose to enroll in their Medicare advantage health insurance plan. So, today's analysis is going to focus on the original Medicare program and the population who have that coverage. On the next slide we will talk about how this intersects with Medi-Cal. Which is the Medicaid program in California. And that program may also cover Medicare beneficiaries. When that happens, we call the individual who has both benefits of full dual beneficiary in this analysis. A Medi-Cal is a programmer primarily serves people with low income, but other populations as well. And that brings us to our new fold dual beneficiaries label and one thing that you see in the Medicare data here is that plenty of Medicare beneficiaries enter Medi-Cal each year. And when someone with Medicare gained Medi-Cal coverage during a year, such as 2021, we call them " New dual beneficiary. " So in this trouble, that would be someone who entered organic medical coverage during that year of 2021. And had Medicare throughout that year. So, why does this population matter --, we get to segment of two presentations -- indicators of the medical and financial -- that may proceed. Cool enrollment and so will find interesting chronic conditions dynamic for those two populations with full dual benefits. Those are the key terms. We will just have sort of a wrap up and view all of the populations in 2021. Next slide. We have 6 million California Medicare beneficiaries. 3 million on the left-hand side of original Medicare. And the remainder Medicare advantage. Original Medicare covers those folks and then we got a separate circle on the right-hand side. 1.5 million Californians have full dual benefits. Both Medicare and Medi-Cal. And of those 819,000 also have original Medicare. So, they are in the population that were able to look at today in the study. And in the middle will be a topic that we will bring up in segment two of this presentation. Now that we have done this table setting I will start sharing the chronic conditions data. And primarily we will talk about original Medicare, but I want to pause here that we are doing that because comparable analytics were not possible for the Medicare advantage population. So, original Medicare data allowed us to look into these questions. But, it is worth noting that while we focus on original Medicare here, the Californians who have Medicare advantage also live with chronic conditions that may warrant attention. And so, the next slide, we will start looking at our findings and the data we looked at. We will talk about the top ten most common chronic conditions among Californians with original Medicare. But, let's first talk about the data source. So, the analyzed selection of 38 chronic conditions identified in Medicare data by the national chronic conditions warehouse or CCW. This study used that data source for 2021. And we looked at original Medicare beneficiaries who ended 2021 with one, two, or three years of having continuous

enrollment in original Medicare. So, that is consistent with how CCW requires audible use of data for use and identifying chronic conditions. Note that these definitions look for chronic condition diagnosis. So, that means that -- diagnoses may affect the detection of chronic condition. And that is a chronic limitation of this type of analysis that applies to this study as well. So, that is someplace setting and we will get into that summary of the findings here. So, let's start with a quick comparison between California and rest of the US. Among original Medicare beneficiaries, Californians were less likely than the rest of the US to have eight of the top ten most common conditions that we will talk about in the next slides. And I think we are one slide too far. If we can go back one slide. There we go. So that is that first bullet that Californians with original Medicare have a lower likelihood of having these conditions than the national population with original Medicare. That is one key finding. Now, the second bullet is that among, in California, the top ten most common conditions range from chronic kidney disease with the prevalence of 18% to high blood pressure with the prevalence of 63% among Californians with original decay. And after calculating how may conditions each person had, this is the third bullet. We found that more than half of Californians with original Medicare had for Californian chronic conditions. So in other words the typical Californian with original Medicare had four diagnosed conditions at of --. We found that the top ten most conditions were generally more common in urban areas compared to other areas and we found that they were generally more common at older ages. Now, we also saw relatedly variation in the prevalence of these ten most common chronic conditions by gender or sex and by race, ethnicity as well. But, we will share that to you soon, but no sex or race or ethnicity group was considered leasing high prevalence across the 10 conditions. So it varied from condition to condition in a way that was not true for age group. Or geographically and we will look at that in a second. Medicare spending correlates with out-of-pocket spending. Medicare spending was generally higher among certain groups and we will look into that as well. Total Medicare spending for people with conditions was generally how for men than women in urban areas than in some rural and rural areas that age is under 65 compared to those 65 or older and also among --. Now if you think about Medicare spending and includes things like hospital stays or ER visits which may be covered by Medicare and these often expensive experiences for the individual reflect or may reflect the Medi-Cal complexity that people are managing with their chronic conditions. So, you will see that spending information on the following pages. On the next slide we have the top 10 most common chronic conditions. And here we have high blood pressure, experienced by 63% of the Californians with the original Medicare in 2021. High cholesterol, similarly 62%. And then going down the list there is a big drop out after that with arthritis affecting 33% of Californians with original Medicare. Diabetes, 28%. Cataracts, 24%. And so forth with anemia, chronic pain/fatigue. Hypothyroidism. Coronary higher disease which you will see abbreviated as CHD. And chronic kidney disease abbreviated with CKD. And those 10 conditions are the most common that we identified among Californians with original Medicare. Now on the right-hand side you see the number of times more Medicare spending, those with the condition experienced during the year compared to the statewide Medicare spending on average through the original Medicare population. Which was $14,525. To interpret this briefly, among people with anemia, Medicare spending was much higher on average than statewide Medi-Cal spending overall 2.6

times the average Medicare spending experienced by people with anemia compared with those overall with Medicare in the state. On the next slide we will look at series of analysis over the next few slides by demographic group and geography. Let's walk through these charts. Look at the prevalence bars on the left with the name of the conditions. That is an example among Californians with original Medicare, 46% of those younger than 65, which is the top dark blue bar, you can see it on the bottom right corner. 46% of those younger than 65 have a high blood pressure compared to the 80%, 85 or older, which is that yellow bar, that fourth bar at the bottom.

>> SPEAKER: Sorry. This is Anastasia. I will interrupt you on the spending, the Medicare spending. The example on anemia. It may be helpful for folks if you can remind them that even though someone with anemia is a chronic condition may have that larger spending, it counts for all of their Medicare spending not just the spending related to the anemia, is that right?

>> SPEAKER: That is right. This is the total Medicare spending experience by the population represented by the bar. If we went to the prior slide that in EMEA and that represents the total Medicare spending Californians with original Medicare who have anemia in the year. And their Medicare spending overall. Not just the Medicare spending that is caused by anemia and related care. Their overall Medicare spending. Which may be associated with other conditions as well. It is 2.6 times the statewide average for Californians with original Medicare. And that is a really important point. So, thank you Anastasia. Going back to the age group comparisons here. It is going to be the same story where the spending comparisons are the total Medicare spending for that population. So, focusing for now on the prevalence side on the left-hand side. We see that the populations with older ages live with many of these conditions more often than younger populations with original Medicare. This may be the result of conditions accumulating as people age. And on the spending side, on the right we have the average total original Medicare spending for each age group compared to the spending for all ages with the condition. So, as an example interpretation here, the first bar shows that 1.5 times that you see there for those younger than 65 for high blood pressure. So, what does that mean? That means that among Californians with original Medicare and you live with high blood pressure, the average Medicare spending per person per year for those younger than 65 is 1.5 times the overall average, where that means for Californians with original Medicare who live with high blood pressure at any age. Going down the list here we can see a consistent theme were those who are under 65 or those who are 85 or older experience higher average Medicare spending compared to those in the age range of 65 through 84. Next slide, please. Now that we have introduced the meaning of these slides, and the ability to make comparisons in this way. The next slides are going to be about age group, sex, geography, race and ethnicity. Here we have the 6 tent most common conditions, the next five most common split between age groups. So, this is a continuation from the prior -- you will note that those are 85 or older experience in anemia coronary heart disease, that is CHD and chronic kidney disease, that is CKD. Twice as often or more as compared to those who are ages 65 to 74. So we are comparing here the yellow bar at the bottom for condition compared to the lighter blue bar, the second bar for each condition. You will note that those who are younger than 65 experience chronic pain or chronic fatigue more often than the rest of

the age groups. Medicare spending on the right hand side is distinctly higher for under age 65 among populations living with coronary heart disease and chronic kidney disease. Next slide please. So, now we have a comparison by sex or gender, and there is not much of a difference in prevalence are some conditions here. But, you will see particularly high prevalence of arthritis among female beneficiaries compared to the male beneficiaries. And mail beneficiaries experience slightly high average Medicare spending compared to the female beneficiaries with the same conditions. So, here is a comparison I want to draw your attention to and interbred is arthritis where we see 38% prevalence among female Californians with original Medicare compared to 27% lower percent prevalence among male beneficiaries with original Medicare in California. Next slide please. The next five most common conditions are here again split by sex for the Californians with original Medicare. And where we see female beneficiaries more living with chronic pain or chronic fatigue and hypothyroidism, coronary heart disease is more commonly experienced by male beneficiaries. So, that is the CHD condition on the left-hand side. The only condition for which male-female beneficiaries have higher rates of spending compared to the male beneficiaries with the same condition is coronary heart disease. And so, the difference here is not very large, but you can see the blue bar here for CHD is slightly larger than the yellow bar. Which represents the relative spending for female beneficiaries compared to the male beneficiaries. Next light please. So, here we have now in comparison by geography, and of the ten most common conditions, urban residents are more likely than rural residents to have each condition. On this slide the most notable difference is diabetes prevalence with 20% of urban Californians with original Medicare having diabetes, 20%. Compared to 24% of semi rural residents and 22% of rule residents. Counteracts prevalence is fairly consistent between urban areas, semi rural areas and rural areas in contrast. So, this provides an opportunity and you will see in the chart book that we will publish to really deep dive in condition into how the frequency or prevalence of these conditions varies by rural or urban areas or may not, right? As you see for cataracts, for instance with the relatively small difference in general the Medicare spending for people with each condition is higher among urban residents than rural residents, which may have reflect some mix of hire utilization of Medicare or higher care prices are more complex care needs. Something that might be investigated in the future. You will see a persistent trend from prior one looking at the next five most common chronic conditions and split again by urban rural geographic. So the most notable difference in prevalence here is anemia affecting one of four rural residents, 24% compared to one in six urban residents, 17% chronic pain or chronic fatigue is the only condition where it is more prevalent in some rural areas -- similar prevalence between geographies and contrast for instance to anemia where there is some differences between urban areas and more rural areas in the state. So, with that is the geography analysis. And on the next slide will have condition prevalence and spending by race and ethnicity for the four most common conditions. And then we will go into the next three and the next three. So, for the four most common conditions shown here, for example for high cholesterol about two and three Black beneficiaries -- compared to just one Hispanic beneficiaries or American Indian or Alaska native beneficiaries abbreviated AI -- in the bottom right. 9% of Asian beneficiaries and Hispanic beneficiaries have diabetes. Whereas lower percentages for example of white beneficiaries have diabetes at 22%. Like beneficiaries experience the highest Medicare

spending compared to the overall average for each condition. Across this and also the next two slides. So on the next slide we will look at the fifth through the seventh most common conditions. Moving down the list. Split by race and ethnicity. What we see again is variation but there is variation there is no consistent across the conditions. Each condition seems to have its own unique pattern of racial and ethnic differences and prevalence, which may want further research and discussion. For example, cataracts are most common among white and Asian beneficiaries at -- is most common among Black beneficiaries that have 30%. Chronic brain or chronic fatigue marked as --. Here we have the eighth through 10th most common conditions split by race and ethnicity. For example, hypothyroidism and coronary heart disease are most prevalent among Black beneficiaries where CHD means coronary heart disease. Now the important thing here is that we are seeing a unique pattern conditions by condition of racial and ethnic differences in prevalence, but a consistent higher spending among higher Medicare spending among beneficiaries which correspond or correlates with out-of-pocket exposure to higher out-of-pocket costs make, along with higher Medicare spending for these populations of Californians with original Medicare who are living with these conditions. So, I think with that we can move to questions and to the next segments of these slides. I will hand it back to Anastasia here, thank you all so much.

>> SPEAKER: Thank you so much, Nils, very important data to look at. And let's go back to the questions. We are going to first of all let me open it up. Anyone who wants to ask a question or raise a thought on any of this, you can type into the chat. Also, you can raise your hand if there is something that is more in-depth where you want to come off mute. But, I will ask Doctor P. You have any initial thoughts on this data? What is the most interesting implications?

>> SPEAKER: I want to congratulate the team on such an incredible reporting of results. I can imagine the amount of work. I think there is a couple of things to be celebrated. -- Medicare beneficiaries and so is with better -- prevention. I will not put on my cynical hat and I will put on my hope for the future have. My cynical hat is that so much of this data is dependent on what clinicians physicians and nurse practitioners and -- are writing in electronic records and charts. We have a long way to go in accuracy and completeness. And I think we will see some of that in the data you will present. I do have some questions in terms of some of the rural and urban areas and concentration of academic medical centers. And how we are doing as clinicians it is actually appropriately identifying and coding. To be frank, sometimes because our electronic medical records are so overburdened, it may be for example that as a clinician I write coronary heart disease but I don't write separate hyperlipidemia or cholesterol problems. So, there are some nuances just to tease out in the future. Move into the future, what this means is we still have Medicare beneficiaries whether they are traditional Medicare or Medicare advantage order was that have that are living with multiple medical problems. What is that important? It is important because we have our workforce that can care for this complexity. As a clinician and as a geriatrician I can't think of my older adults as only with coronary heart disease -- hypertension. As we emerge from this pandemic where we know there has been a lot of burnout in clinicians, what is our primary workforce doing? how are we training our geriatric education? So, that is where I think there is a lot of feature discussion and similarly with care ordination

what we would love to see on subsequent analysis is of these folks with multiple chronic conditions. Are they saved multiple special -- what does the care coordination look like? Are these impacting people's ability to cope? Get adequate care? And what are the other modifiable things we could be doing to address some of these conditions? So, I will pause there. There may be some questions in the chat. I can go on and on. Maybe that is a little bit of an overview of how I'd look at this incredible data and how we move forward.

>> SPEAKER: Wonderful. Great thoughts. It is just like a conversation that could go on and I think it will and it has been for months and years and going forward too. Today just all of this data. Nils, There are a couple of questions from Michelle in the chat. Around prevalence and spending and overlap and condition. And another question about why CMS is using high cholesterol, hyperlipidemia. How did we ask --

>> SPEAKER: Happy to address the questions. So, the chart book will go into further detail about typical number of co-occurring chronic conditions for the individuals who live with each condition profile. So, each of these top ten most common conditions you will see that many co-occurring product conditions are typical for the individuals who have that chronic condition. So, for example number one for the most common condition is high blood pressure as you saw in the profile it will be published in the chart book coming out soon. You will be able to see the numbers of co-occurrence chronic conditions for the typical California with the original Medicare who has high blood pressure and we are really excited to show that. One thing that is important, and for example, we highlighted higher Medicare spending for the population who have anemia, right? And there may be co-occurring chronic conditions that are driving the higher spending. So not just the anemia and we wanted to capture the total Medicare. And so, there is overlap and contribution of other complexities and conditions for these individuals that is captured in the overall average Medicare spending that we are presenting. We want to be very clear about that is also consistent with the data that CMS the centers of Medicare and decayed services publishes about the chronic conditions and the Medicare populations as well on the topic about the labels here we have full description of how we converted labels into the true conditions that CMS is identifying using diagnosis. So, for example CMS is identifying hyperlipidemia which is a bigger category than high cholesterol, necessarily. But, we use labels what CMS in their infographics for public facing materials. So, we are calling it higher cholesterol to be more public facing consistent with what CMS does. But, we are actually measuring hyperlipidemia. And so, hypertension as opposed to high blood pressure, for example, hyperlipidemia is opposed to high cholesterol so that will be cleared in the chapbook.

>> SPEAKER: Great. I really encourage anyone who is part of the audience today to chime in the chat. I know, Nils, thank you for the great description of how the numbers work and the definitions for CMS. If anyone else who maybe does not have any kind of technical background once to chime in, your comments are welcome. About again having multiple chronic conditions and how that works navigating across different providers, different specialists. We are certainly not going to solve everything or make everything sort of more streamlined just with this webinar. But, we do want to keep both the numbers and people in mind as we are going through the data here. So, with that

we are right on time to move to the next section. But again, anyone can feel free to chime in the chat. Whether it is questions or the thoughts about how this data could be used in the future, different webinars, different analysis. Nils, I will hand it back to you.

AKER: Okay. Thank you. So, on the next slide will just briefly transition to segment two. And thank you Anastasia and thank you Doctor Perissinotta. In this segment will provide some further and analytic detail on the topics in the next slide. So, to topics primary cognitive and behavioral conditions. And dual beneficiaries who have both original Medicare and Medi-Cal on the next slide. We also show you a map and -- we are using covered California regions which are consistent with other materials from the Department of healthcare access and information. So, on the next slide with a quick note about the methods and then the top line findings from our data. So, note that the methods here are the same as before. And as we move into the top line findings. We looked at Alzheimer's disease and dementia. That is ADRD. And drug use disorders and depressive disorders as three cognitive and overall health conditions of interest that are measured by CMS and the chronic conditions warehouse. For the first ADRD, we found that while 8% of Californians with original Medicare live with the condition, Alzheimer's disease and related dementia both conditions had 214% higher Medicare spending per person compared to the state average of Medicare spending. Which was again $14,525 and so, 214% higher than the average Medicare spending for the population with ADR D. And we will go over it in the future slide. California region with interesting variation in future slide moving to drug use disorders here, 4% on the next slide of Californians with original Medicare. Drug use disorders with Medicare spending again it was hundred 61% higher for people with drug use disorders as compared to the state average drug use disorder our brain disorder where the recurrent use of drugs causes impairment affecting health disability and life responsibly. And you will see some important analytics in the next slide. Moving into depressive disorder, which includes depression and bipolar disorder among others 18% or about one in five Californians with original Medicare had this condition and individuals with depressive disorders likewise experience 17% higher Medicare spending compared to the statewide average in --. Across these conditions, the cognitive and behavioral health conditions cognitive and behavioral health conditions the prevalence very between one and 25 to one and five but Medicare spending -- Medicare spending out-of-pocket spending and the same that it can correlate, but does not necessarily without a pocket spending. There are instead the spending that Medicare is making on behalf of the individual. Now on the next slide we looked at dual beneficiaries. Who have both the federal original Medicare program and the state administered Medi-Cal program. Full double beneficiaries, those with Medicare and Medi-Cal who we discussed earlier, experienced many conditions more often than other beneficiaries and had higher Medicare spending than other beneficiaries. We will deep dive into the conditions of these two groups of beneficiaries who have Medi-Cal benefits as well, experience or are diagnosed as of 2021. And will find some surprising conditions that were especially common among these two groups. Now again, new dual beneficiaries are Californians with original Medicare who started 2021, having Medicare only and not having Medi-Cal. By the end of 2021 had Medi-Cal coverage and had full dual benefits in both programs. On the next slide we will jump back to these cognitive and behavioral conditions. ADRD, Alzheimer's disease and related dementia at the top here affecting a percent of the population. And this is

mislabeled here. And having a spending of 3.1 times the average statewide Medicare spending per person here. A $14,525. Again, ADRD prevalence, 8%. And depressive disorder is 18%. So those are mislabeled on the left-hand side. Only on the left-hand side. Depressive disorders were diagnosed among 80% of the Californians with the original Medicare. And the average spending for the present disorders was 2.2 times the state Medicare spending. Drug use disorders again had for prevalence and this was average spending with the drug use disorder was 2.6 times the state Medicare spending on average. Now on the next slide we have for the demographic differences for these three cognitive and behavioral health conditions. There is a lot here. And we don't have to read through all of this. But, among our findings about cognitive and behavioral health conditions, among Californians with the original Medicare we found that one in four live with ADRD ages 85 or older. And one in three live with depressive disorders under the age of 65. 13% live with drug use disorder ages younger than 65, which is more than three times the overall prevalence, which again is 4%. American Indian or Alaskan native beneficiaries and Black beneficiaries have higher rates of living with drug use disorder. Now in the next slide we will turn to the differences by gender and rural urban geography, and here we are going to have small differences in prevalence for these different demographic groups and will express this in terms of percentage difference on the next slide. So, we found higher rates of ADRD among women and urban areas. And we found higher rates of depressive disorders among women as well and lastly we found higher rates of drug use disorder in spending rural areas and compared to the urban areas. Now here's an example of the region mapping on the next slide we are looking at ADRD prevalence rates by covered Californians region. So note that the region covering much of the northern California such as Mendocino or Jefferson -- while in contrast prevalence is higher and higher than 11% in Los Angeles County, and again statewide average for this condition ADRD leads as embers disease and related dementia is a percent. So, Los Angeles County is higher than 11%. Moving into the next slide moving differences between dual beneficiaries, those are people baffled Medi-Cal benefits in addition to the original Medicare. And Medicare only beneficiaries who do not have Medi-Cal benefits. You can see the prevalence and relative spending for full dual beneficiaries as the yellow third bar at the bottom of each condition grew. And Medicare only beneficiaries in the dark blue middle bar for each condition. The conditions showed that the five with first the biggest difference between full double beneficiaries and Medicare only beneficiaries also affect more than 5% of dual beneficiaries. So, one in 20. Looking at the bottom condition, 27% of full dual beneficiaries live with depressive disorders compared to the 14% of Medicare only beneficiaries. The adjacent 1.9 times that you can see right next to the 27% and 14%, it means that the prevalence of depressive disorders for full dual beneficiaries is 1.9 times that for Medicare only beneficiaries. These conditions are notably associated with high spending. These are drug use disorders, Pneumonia -- this is higher Medicare spending and we are talking about total spending, not just the spending attributable to the condition. On the next slide we have a similar chart. That will show the five conditions that are especially common among new dual beneficiaries. And that affect more than 5% of these beneficiaries. New full dual beneficiaries are those who entered Medi-Cal during the year of 2021. And the comparison is with Californians with the original Medicare overall. So, for example we see that pressure and Chronicle there is affect what percent of new

full know dual beneficiaries, which is the top.5 times the prevalence overall. We see that new full dual beneficiaries expense remarkably higher Medicare spending compared to the overall populations with the same condition. This is particularly notable here, because of these conditions is associated with very high Medicare spending overall. Not just for full dual beneficiaries. A new full dual beneficiaries may be entering Medi-Cal as a result of impact of their savings and their disposable income due to the high medical spending. So, these findings highlight a frequent will of conditions that are associated with high medical costs in the time before Medicare beneficiaries entered Medi-Cal and that is notable and that wraps up our analysis of full dual beneficiaries as well as cognitive and behavioral health conditions. With some regional mapping. So, with that we'll turn into the summary of what we have learned across these two segments. So, the top ten most common conditions on the next slide, the top ten most common conditions among Californians with original Medicare, had prevalence rates that range from 18% are chronic kidney disease to 63% for high blood pressure. The prevalence of each condition vary by age, gender, aggravate and race and ethnicity. And the total Medicare spending for individuals who experience each condition varied widely. So, for example we saw those who had anemia, they had 2.6 times the total Medicare spending on average, per person compared to the Californians with original Medicare. Medicare spending correlates with out-of-pocket costs that are faced by individuals. Many conditions such as drug disorders and dementia, Alzheimer's disease and related dementia for example here are especially common among full dual beneficiaries and new full dual beneficiaries. You can find additional detail in an upcoming chart book from the California Department of Health care services at this website. And then under the coming weeks will have additional data from the study up on the open data portal that we mentioned and you will find that by searching the -- we are really excited to have shared with you and we are excited --. I know this was a lot of data all at once across both prevalence spending. Behavioral and cognitive conditions and also for the conditions that are specially, for dual beneficiaries with both Medicare and Medi-Cal. So, thank you so much and with that I will hand it back to Anastasia and we will move the questions and discussions.

>> SPEAKER: Thanks so much, Nil. If we could, take up that topic of spending. I think it would be awful for the audience to walk through. Why did we choose spending as a metric? Is it because it is kind of the best way for us to look at sort of the intensity of care and services that people are getting. There could be considerations, and care is a national program. We are all part of the same country we have the same interest seeing how does Medicare spends its funds. But I think that proxy for utilization is something especially interesting. So, do you have any thoughts on that? Not to speak for them, how do we generally think of that spending is a tool?

SPEAKER: I think it is a really valuable question. I want to start with, there is nothing more important than the individual experience of a chronic condition and experiences of managing it well and living helpfully as healthy as possible with the condition. The medical system and medical expenses that person experience will encounter during their time with a chronic condition will vary and so, there is one expense of a person. For example, Alzheimer's disease and related dementia. But, I think that trends and averages do tell a story about the kind of experiences encountered

by a typical California --. That may be associated with hospital stay. It may be associated with nursing facilities. These are experiences that take a person out of the normal environment and also associated with high spending and costs. Not only to the federal government, but most important each of the individual. Next question to say, What portion of this is being driven by hospital utilization or a nursing facility utilization. An understanding that it kind of drivers of Medicare spending. But, as an overall kind of index of a combination of prices and the kind of care experiences that a person requires. Do the combination of all of the health care needs and conditions we choose to include it and this is modeled after the centers of Medicare and Medicaid services, similarly publishes total Medicare spending by chronic condition. So, really good question. I think future data analytic, it look into utilization and kind of services that people are requiring by condition and then also there may be entities or organizations in the state. Such as the hospital or such as health insurer or provider led organization. They may be accountable for managing both individual experience and the chronic condition for population and also managing the Medicare spending. For example it might be accountable care organization. And those organizations may be interested in, where are we seeing the highest spending? And where can we invest in preventive activities to bring down that spending to the individual experience with a chronic condition or avoiding that chronic condition altogether.

>> SPEAKER: Doctor P. I know you had some thoughts on Alzheimer's disease and related dementia. But, before we get into that, what does tracking spending mean and how do we take that into context?

>> SPEAKER: I think it is really important. From the perspective of our people getting the right people of care. From a health system perspective. Who are the costly people and why? There is an important part which is also, our people getting the services that you need? And you wonder sometimes with some of the regional variations and urban and rural, was an access issue? Is it the type of service available? Is it the spending appropriate or not? And I think as Nil said about some of the conditions that occur that may be encountered during the hospitalization is huge. You know, I will say from personal experiences as -- who provides home-based care, we know that home-based care often gives people the right care at the right time at the right place. And often is more cost effective. But, how do you think about scaling some of these things at a more state level?

>> SPEAKER: Absolutely. Did you want to share some thoughts about Alzheimer's disease and related dementia figures?

>> SPEAKER: Yeah. I will say that I was a little bit surprised that it was " only 8% " and I recognize that thought all aggregated, which is all Medicare beneficiaries because it certainly you think about the prevalence rates nationwide they vary. Depending on the age groups, the highest age group being those over 85 where you are most likely to see -- I think California was a little bit lower. I know that again from my personal experience as a clinician and also someone who has done research in this area, we under diagnosed dementia all the time I have done some smaller studies at UCSF, looking at what percentage of people -- age group actually have dementia on a problem --. Why is

this important again? It is important because you want to know who is suffering from dementia because of the increase Medicare spending, and also because of the burden of illness and we know from -- perspective once someone has diagnostic dementia. Often we have to rethink how we manage those other chronic conditions. I am very intrigued about the map in LA, I am like what is going on with this diagnosis is in LA? I don't think everyone has dementia in LA. Across the state as you know, dementia -- which is really focused on educating the primary care clinicians that are really about diagnosing and providing the right support services. And then on the national landscape are the new guide models, which are the new payment models thinking about those of us who are carrying Medi-Cal.

>> SPEAKER: That is a great plug for the guide model. In thinking about that team-based care as well people with dementia.

>> SPEAKER: Exactly right.

>> SPEAKER: Cruz Who has control of the slides. Can we go back to the slide that I think is talking about people who are newly eligible for Medi-Cal. Let's see.

>> SPEAKER: I think it is, I think it might be ten slides past here. Under the future.

>> SPEAKER: Cruz Go forward on that site, please.

>> SPEAKER: It is coming up, two more after here. There we go. One more.

>> SPEAKER: Okay. Yeah. And so, what do we see in the data and what do we think it might be telling us. Some of it we may not know for sure. But, looking at this, I have been thinking about the journey that people make. Is it that they are the only half Medicare. And then they have some kind of acute event like a stroke. I think of pressure and chronic ulcers are not necessarily acute. But, some kind of event that they have hospitalization. And then for economic reasons oh I need Medi-Cal because that is going to help me with my co-pay the coinsurance for this hospital stay. Or and or some people wonder, well, most other states and California now we still have some asset limits, but we want as of January 1, 2024. We talk about the spend down population, excuse me, people may not be at the income level or they may be just above the income level for Medi-Cal. But, they may also have some assets and as they spend those assets they become eligible for Medi-Cal and maybe they need Medi-Cal to help cover skilled nursing facility. But it is hard to tell from this data which population we are talking about. Maybe Alzheimer's Disease and related dementia population. That could be we had our ML TSS and dual webinar back in August. We looked at the people with -- because who are in a skilled nursing facility. The vast majority there is a fair number of people with Medi-Cal and skilled nursing facilities who have a very low share of costs. So it doesn't always tell us one story. Nils Do you have any thoughts about the past that you may BC the folks that are displayed on this slide or other data that we might want to look at to unpack a little bit more.

>> SPEAKER: I think it is a really important line of inquiry and I think that every individual's journey through the medical system or with a chronic condition looking for a

diagnosis or getting one unexpectedly. And then through the care that they need as a consequence of that. Which may include not just medical care but also long-term services and support. Like in-home aid. Those experiences are really varied, but may have commonalities for these individuals who are experiencing whatever pressures are leading up to entering Medi-Cal and gaining Medi-Cal coverage which is also associated with becoming eligible. Which involves at the end of the day a lower income or lower assets or total wealth before 2024, at least. That asset question will be an important part of it especially for 2021 as we see in the data. For long-term services and support needs are going to be one part of it. The medical care expenses and long-term services and support expenses may be a part of it. But all of this is an open question. And we are really excited to share this data with you and we think this is a novel way to look at it. But, as you hint at Anastasia, this is a journey that every person is going down and it is really a continuum of experiences. It is something that happens over time per person. Where they may need one type of care, and then develop more and need a different type of care or additional types of care as they continue on. Just to kind of hit at this slides meaning here, as we look at stroke and tragic ischemic attack, which is the last condition category here at the bottom. Average per person here spending by Medicare for stroke or transient ischemic attack patients, people who experienced it during the year is $47,000, right? And then for the people who entered Medi-Cal during the year, the averages $97,000. 2.1 times different. On the right-hand side at the very bottom, it is an enormous amount of spending for a condition that is already associated with very high spending. But, the individuals who are entering Medi-Cal during a given year are seeing distinctly high spending for conditions that are already associated with really high medical costs, really high medical care utilization. So, those are the things to look into. And this hence and piques our interest but does not address the final question in total. So, I think this is a call to action or call for further investigation.

>> SPEAKER: Do you have any other thoughts on this? What happens with the patients now?

>> SPEAKER: Here is my very high level is that our dual beneficiaries, whether they are initiating or more have an intersection of very high unmet social determinants of health or problems in socially determined of health -- and he goes back to what I actually said at the beginning of this. That where we are moving forward for California and older Americans is what is our workforce in terms of interdisciplinary teams and how we care coordinate because there are risks and -- initial missed opportunities when we do not coordinate. And that is a multi-factorial approach in terms of making sure our electronic medical records talk to each other. Making sure that we explain things while the patient adults and -- dual eligible people are quite sick or at risk of significant complications. And it is upon us to really do right by them. I think that also means that at a large level reimbursement models both for Medicaid or Medi-Cal here in California there is a shortage of providers more and more who want to see unfortunately Medi-Cal patients is that differently when they are duly eligible, yes. But I think there is more room for us to continue these discussions at the state level.

>> SPEAKER: That is a great point, and I think as we look at the targeted rating increase on that Medi-Cal side. How does that translate over to the dual eligibles? We will try to unpack that more next year.

>> SPEAKER: And I think we are seeing examples where things have gone well, for example we see huge changes in hospice access and the provision of how hospice care for medical beneficiaries. And so, if you take some of those models to see how we can translate this to other conditions. And not just the last six months of life, but more to this is always great things about researchers.

>> SPEAKER: That is great. Okay so, we have two questions in the chat. One is about accountable care organizations and the acronym for those are ACO's they are the type of provider led organization that Medicare, original Medicare contracts with to kind of wrap the whole -- care for the person for the patient, but it is not the same as Medicare advantage. And there is not affirmative enrollment supplements. Is there anything else you would like to add about ACO's?

>> SPEAKER: I will just share in the chat helpful explainer overviewing in California from the OMI website and this includes counts of -- of the year. 2021. For California by ACO type. There are within Medicare programs there are different types of ACO's some of which are more recent than others and you can learn about each of those types in that brief fact sheet that have shared in the chat.

>> SPEAKER: Thank you. Let's take a look at the next question in the chat. Not necessarily a question for Nils, but if you something you want to chime in as well. The question is: Who at the state is looking at the data from the original Medicare and Medicare part C and is that the data combined and analyzed so that practicing clinicians don't have to think about their Medi-Cal Medicare eligible patients populations and buckets or original Medicare versus Medicare advantage. So, good question. The state's version of -- pay or claims database that is administered. There are I'm not sure if my team may have the link to put in to the chat. HCAI They have the webpage now that is combine both the original Medicare and Medicare advantage data. Individuals chronic conditions across both sets of data. There are some limits, the data set is not complete for all years. And we don't want to confuse ourselves what is in the data set and the ATI slides. There is a lot of great work being done that is really a think the beginning and much more to come on the efforts to combine the data. And again, we have this data. Now, what do we do with it? How do we think about helping clinicians planning for our overall healthcare delivery system, there is a lot to think about.

>> SPEAKER: I will add to that. I graduated a while ago. I am not sure what is being taught these days. But very little unless you have a specific focus on public health did we learn as physicians payment models. In some ways that allows you to be agnostic to payment as a trainee. And just learning how to take care of people. But if you move into the private practice whether it is on your own or in an academic institution or a community health setting. It is a little bit hard to expect that clinicians to understand all of this, however, understanding the big pocket buckets and understanding what the quality metrics were looking at and what are the different types and --. I think there is a

translation issue which is why these talks are so great. How do we move from this payment here is the data, here is the clinician and putting all of them together too.

>> SPEAKER: Great point. And also a great point about quality measures. If we have different payment systems focusing on different quality measures. How can the clinicians figure out, okay what should I especially focus on? Do I have to know what health insurance my patient knows to know what I focus on?

>> SPEAKER: And we expect our electronic records to do this and not just my brain which is overstretched so often. Let me think about the things I really want to think about as a nation. Which I'm supposed to do that. That is not a good bang for your buck.

>> SPEAKER: Right, we have a lot of smart people here in California, such as yourself. So I will keep working together and talk about to look for improvements. We are close to wrapping up. Again I am glad we did this HKI topic that came up. They are doing great work. And right after this webinar I am going to the meeting with them. We are talking to ourselves within the administration here in Sacramento. And really glad to be talking with you all of you as well. And folding in researchers, clinician leaders, so grateful for both of you to be on this webinar today. Again, the folks that are on this call, very across and who are in the health system. We have the ability of HICAP. -- and then we will publish hopefully this week. And thank you for the scan foundation. Thank you Nils and the ATI team, thank you Doctor Perissinotto for this great webinar, great presentation. And we will go to the next slide. Oh, that is it. Okay. Thank you everyone very much. Have a good day. This is the end of the webinar.