Visiting Nurse Association Health Group White Paper:

Will Home Care Payment Cuts Lead to Higher Government Health Spending? Medicare Home Care Expenditures Correlate with Lower Medicaid Spending on Elder Care

Steven H. Landers MD, MPH (steven.landers@vnahg.org)

Visiting Nurse Association Health Group, Red Bank, NJ

Elizabeth Madigan RN, PhD

Case Western Reserve University Frances Payne Bolton School of Nursing, Cleveland, OH

Bruce Leff, MD

Johns Hopkins University School of Medicine, Baltimore, MD

Abstract

The aging United States population portends an increasing need for home and community based care. Recent legislation and policies have targeted Medicare home care for reimbursement cuts. We considered whether lower home care spending could lead to higher overall expenses from unnecessary hospitalization and institutionalization. We performed exploratory correlations of state level Medicare home care spending with state level Medicaid spending for 2007 for dually eligible beneficiaries and found a strong correlation between higher Medicare home care and lower overall Medicaid spending on dually eligible beneficiaries.

Background

Medicare covers a range of home care products and services that support the recovery, independence, and comfort of beneficiaries with serious illness in their private homes. Three of the most notable covered home care services are home health, durable medical equipment, and hospice. Hospice crosses venues, but the private home is the most common locus of care.[1] The United States population is aging with a substantial burden of chronic illness, a trend that heralds an increasing need for home-based care;[2] especially, in light of patient preferences for care at home[3] and that in-home care can be less expensive than facility care.[4] However, it is difficult to measure fully the value of home care in a fragmented system where costs and benefits may be unevenly distributed among the Medicare and Medicaid programs and where perverse incentives between these programs exist. The Affordable Care Act of 2010, ñhealth reform law,ò decreases Medicare home care reimbursement. This reduction was preceded by The Medicare Modernization Act of 2003 which enacted ñcompetitive biddingò to cut home medical equipment reimbursements. There have also been further recommendations for home care cuts by the Medicare Payment Advisory Commission (MedPAC). These cuts came in response to analyses suggesting high profits, inappropriate utilization, regional variation, and fraud and abuse in the Medicare program.[5-6] In light of these issues home care became an easy target for legislators looking for ñoffsetsò to expand coverage for the uninsured and other new initiatives.

However, if Medicare home health keeps beneficiaries out of costly facilities such as hospitals and nursing homes these reductions could lead to higher healthcare expenditures if there is an associated decline in home care access and quality. A previous analysis of regional variation in Medicare spending concluded that regions with higher overall Medicare spending also have higher Medicare home care spending.[7] The hypothesis that more spending on home care is associated with lower Medicare costs was not supported. However, looking at Medicare in isolation limits our ability to draw strong inferences because of the exclusion of Medicaid spending. The purpose of this study was to explore the relationship between state level Medicaid spending for dually-eligible older adults and Medicare home care spending. We hypothesize that at the state level, lower levels of Medicare home care spending are associated with higher Medicaid spending on dual eligible patients.

Methods

Medicare state level spending data for 2007 were obtained from the Dartmouth Atlas.[8] Medicaid data were obtained from Medicaid Statistical Information System (MSIS).[9] Data obtained from Dartmouth Atlas are adjusted and based on a 5% random sample of traditional Medicare enrollees age 65-99. The MSIS data represents fiscal year 2007 for all dual eligible enrollees age 65 and older. Forty nine U.S. states and the District of Columbia were included; Arizona was excluded because most of their long term care spending is not captured by MSIS.[10] A series of Spearman correlations were performed. Total Medicare home care reimbursements were defined as the sum of home health agency, home medical equipment, and hospice reimbursements.

Results

The associations between state level Medicare home care and Medicaid expenses for dual eligibles are in the **Table** and the **Figure.** State by state Medicare home care expenditures correlated negatively with Medicaid expenditures. Higher levels of Medicare home care expenditures in a given state are associated with lower Medicaid expenditures. The strongest relationship to lower state per capita Medicaid expenses was seen where home care composed a higher percentage of overall Medicare expenses.

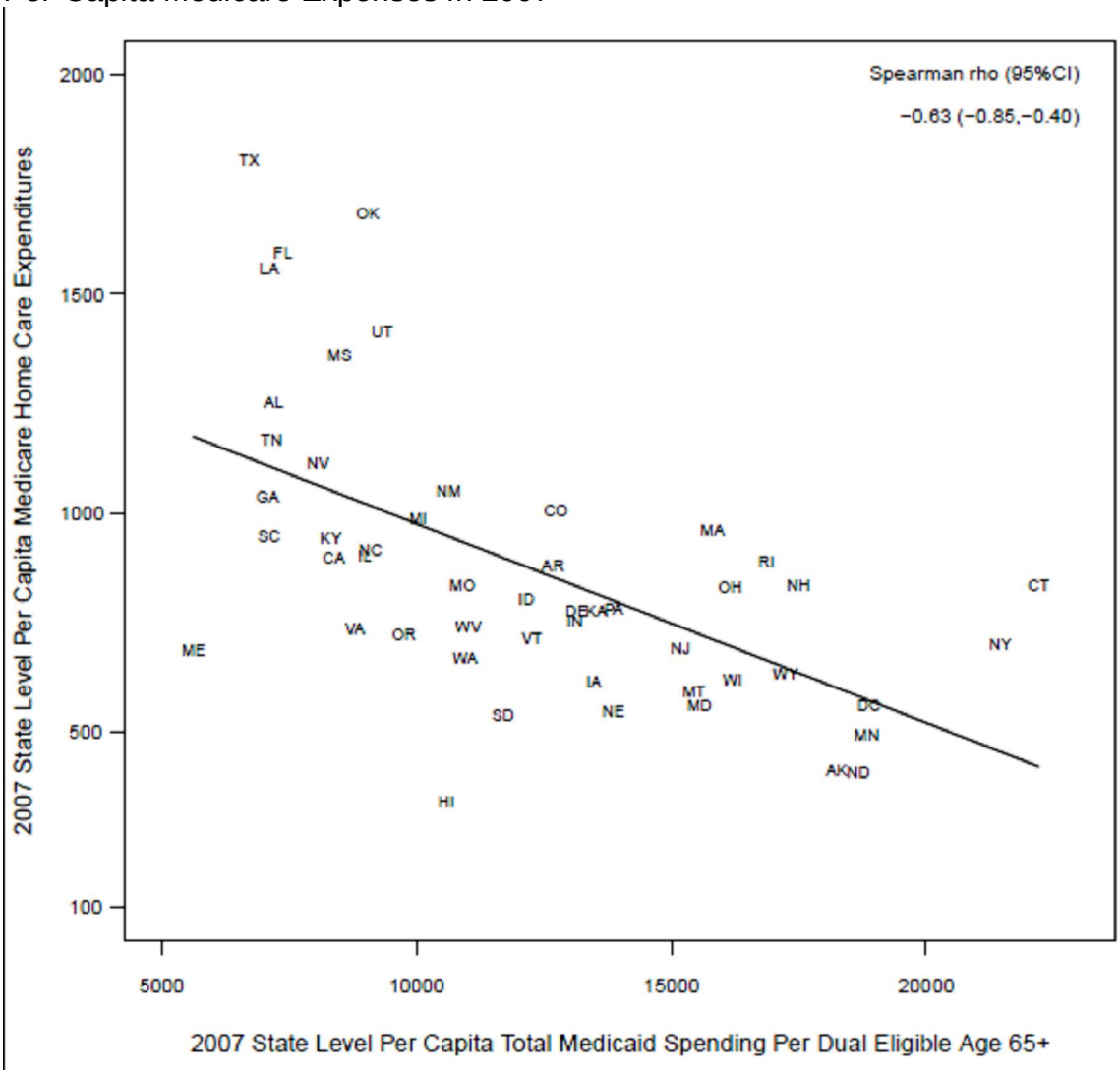
Table . Correlation of State Per-Capita Medicaid Expenses per Dual Eligible 65+ and State Per-Capita Medicare Expenses in 2007

	Medicaid Total		**Medicaid Nursing Facility**	
	Spearman rho (95% CI)	**P value**	**Spearman rho (95% CI)**	**P value**
Medicare Spending				
Home Health	-0.52 (-0.77,-0.27)	<.001	-0.42 (-0.68,-0.15)	.003
Hospice	-0.50 (-0.76,-0.25)	<.001	-0.43 (-0.69,-0.17)	.002
Durable Medical Equipment	-0.55 (-0.80,-0.31)	<.001	-0.41 (-0.67,-0.14)	.003
Total Home Care	-0.63 (-0.85,-0.40)	<.001	-0.50 (-0.75,-0.24)	<.001
Home Care as Percentage of All Medicare	-0.69 (-0.90,-0.48)	<.001	-0.59 (-0.82,-0.35)	<.001

Discussion

State by state variation in Medicare home care expenditures correlated with variation in Medicaid expenditures. Higher levels of Medicare home care expenditures in a given state correlate with lower Medicaid expenditures. Since Medicaid long term care expenses are substantial, these trends may indicate the recent home care payment cuts could potentially lead to higher spending on Medicaid and not result in anticipated savings in government health care spending. This study was meant to be hypothesis generating and the correlations we found do not confirm a direct causal relationship, however the data suggest that policymakers should consider the possibility that changes in either Medicare home care expenditures or total Medicaid expenditures may be associated with changes in the other program. There are several important limitations to our study. First, Medicare and Medicaid policy implementation and changes at the state level are complex; state to state variation in expenditures may also result from local issues and Medicaid rules. Second, the study design is prone to ecologic fallacy. Third, there is not precise overlap of the populations for which we obtained the Medicare and Medicaid data and both data sources are subject to error. A complete multi-variate analysis including individual claims level data and other demographic, geographic, and ecological factors should be performed. Nonetheless, policymakers should consider that higher Medicare home care expenditures correlate with lower Medicaid expenditures when developing and implementing changes to Medicare intended to increase value for the public health care dollar.

Figure. Correlation of State Per-Capita Medicaid Expenses per Dual Eligible 65+ and State Per-Capita Medicare Expenses in 2007



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