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VA LONG-TERM CARE PATIENTS' MEDICARE AND MEDICAID EXPENDITURES

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ABSTRACT

Backgrounds: Three quarters of VA long-term care patients rely to some extent on the national Medicare and Medicaid programs. This Data Brief documents the extent to which VA long-term care patients receive services from all three programs.

Methods: Average VA budget amounts and Medicare and Medicaid reimbursements (including patient liabilities) except those for outpatient pharmacy are described here for 1998-2000 (for VA), 1998-2001 (Medicare) and 1999 (Medicaid). Expenditures are attributed to the year in which the services were delivered. Medicare and Medicaid enrollees were identified from the program denominator or eligibility files using a finder file including all VA patients from 1995 through 2001. The programs' long-term care files included all VA patients with such care in the study years.

Results: More than 2/3 of VA long-term care patients were enrolled in Medicare in each of the study years. One patient out of seven was enrolled in Medicaid in 1999. Most of those latter patients were also enrolled in Medicare. Only 1.7% of all VA long-term care patients also had both Medicare and Medicaid long-term care.

Medicare and Medicaid together account for about one-sixth ($940 million out of $5.6 billion) of total expenditures for medical care for VA long-term care patients under these three systems. Medicare covered the majority ($654 million) of these expenditures. For long-term care, almost 90% was provided through VA.

Half of Medicare expenditures were for acute inpatient services. About 25% were for nursing home, home health or hospice. For Medicaid, almost two-thirds of payments were for non-acute care, generally nursing homes.

The reliance of VA long-term care patients on Medicare and Medicaid differs according to the VA programs they use. Community nursing home and Geriatric Evaluation and Management inpatients rely most heavily on Medicare. Community nursing home patients are more often enrolled in Medicaid than are patients in other VA programs.

Conclusions: For long-term care services, VA and Medicaid services appear to be relatively complementary in that about a third of the dual enrollees use long-term care under both systems in a given year. Only one in five of VA long-term care patients enrolled in Medicare had Medicare long-term care in the same year.

It also seems clear that those using multiple systems are sicker patients, on average. Those using two or more systems have higher per patient total medical care expenditures than do those who use only one system. This higher spending is not only because spending amounts are being added from two or more systems. For VA long-term care patients who also use Medicare services, even per capita VA spending alone is a little higher than for those VA long-term care patients who use only VA services.

BACKGROUND

VA long-term care patients receive substantial amounts of VA medical services (Hendricks et al. 2005). Average per patient VA expenditures for long-term care were over $12,000 in each of the fiscal years (FY) 1998-2001; average total VA expenditures (which include acute care and outpatient pharmacy expenses) for these patients were $29,000 or more per patient per year. Aggregate expenditures for VA long-term care rose from $1.8 billion in FY1998 to $2.3 billion in FY2001 and amounts for non-long-term care VA services for long-term care patients exceeded $2.6 billion. The annual total aggregate was over $4.6 billion in FY1999, for example.

Three quarters of these VA patients also rely to a greater or lesser extent on two national programs: Medicare and Medicaid. Sometimes these Medicare or Medicaid services substitute for VA services. At other times, Medicare or Medicaid services supplement VA long-term care services. In calendar year (CY) 1999, expenditures for Medicare services for VA long-term care patients (including amounts paid by third parties or the patients themselves, sometimes through supplemental insurance) approached $700 million. Expenditures for Medicaid services for these patients were nearly $150 million in that year (the most recent year available for this analysis).

VA long-term care patients' reliance on these services and the combinations in which these services are used by VA long-term care patients are the subjects of this Data Brief. Two-thirds of VA long-term care patients are enrolled in Medicare, and approximately 60% of that two-thirds use Medicare services in a given year. One out of seven VA long-term care patients is enrolled in Medicaid. The overlap between these two types of enrollment represents 10% of VA long-term care patients.

This Data Brief describes the extent to which VA long-term care patients receive services from these three programs as measured by expenditures. About 17% of all medical expenditures identified here for VA long-term care patients are made under Medicare or Medicaid, but that does not mean that these services are minor. This Data Brief provides the first integrated and extensive look at the reliance on these services by this vulnerable VA patient population. It considers what kinds of services they receive (particularly long-term care) from these systems and how the use of these multiple systems varies according to the type of VA long-term care services the patients receive.

METHODS

This Data Brief presents average dollars budgeted through VA and average dollars reimbursed through the Medicare and Medicaid programs, except for outpatient pharmacy, which is excluded from both the VA and Medicaid amounts. The methods are descriptive. The evaluation team valued the VA services that patients received in each of four years (FY1998-FY2001), summed the dollar amounts and averaged them by type of care and category of patient. For Medicare, the team used files of all paid claims for CY1998 through CY2001. For Medicaid, the files of paid claims and enrollment are available only for CY1999 for this analysis. Thus, for the combination of all three systems – VA, Medicare

and Medicaid – the evaluation team had data only for 1999. The timing of the use of services in that year is not exactly synchronized between the VA fiscal year and the Centers for Medicaid and Medicare Services (CMS) calendar year, but this makes only a minor difference in the findings.

For simplicity, the Results subsection emphasizes CY1999, the common year for the available Medicare and Medicaid data. Except where noted, patterns for Medicare data are relatively stable across the years. Where results are not shown, they are available from the authors.

Data Sources:

VA Utilization and Costs VA utilization came from the national automated datasets maintained at the Austin Automation Center. For all VA services other than outpatient prescription drugs and contracted care recorded in the "fee" files, the cost estimates are the VA national hypothetical budget amounts compiled and calculated by the Health Economics Resource Center (HERC)[1].

The datasets for contracted long-term care are especially important because they are the only source of patient-level information about VA disbursed amounts for contracted long-term care. The amounts are attributed here to the fiscal year in which the services were delivered, which is sometimes earlier than the fiscal year in which VA payment was made. Cross-validation of VA's two files for contract nursing home care suggests that about one third of all such stays do not appear in the files for contract disbursements, however. This lack of payment record leads to understatement of contract expenditures.

Medicare Utilization data for the Medicare program came from six standard analytic files: Inpatient, Physician/Supplier, Institutional Outpatient, Skilled Nursing Facility, Home Health, Hospice, and Durable Medical Equipment. Medicare inpatient data for CY1998-CY1999 were taken from the MEDPAR files for those years. Inpatient data for CY2000-CY2001 came from the Inpatient standard analytic file. Medicare enrollment was identified for CY1998-CY2001 from Denominator files using a finder file that included all VA long-term care patients between FY1995 and FY2001 (identified from automated VA inpatient, extended care, outpatient, and fee basis utilization data available at the Austin Automation Center). The long-term care files (Skilled Nursing Facility, Home Health, and Hospice) for CY1998-CY1999 include all VA patients who had such care financed through the Medicare system in the years listed.

If a patient was enrolled for either Part A or Part B for one or more months in a given calendar year, as shown by monthly indicators in the Denominator files, that patient was counted as enrolled in Medicare for that calendar year. Medicare HMO enrollment is

[1] Health Economics Resource Center estimates were selected primarily because they were available for the baseline year, FY1998, as well as subsequent years. For a complete description of Health Economics Resource Center's methods for estimating costs, see the user's guides available at the Health Economics Resource Center website: www.herc.research.med.va.gov.

similarly shown by a set of specific monthly indicators in the Denominator files and was used to identify patients enrolled for at least one month.

Spending was assigned to the calendar year in which a service was delivered, regardless of when CMS actually paid Medicare's share. When the base record indicates a payment, an analyst can determine service delivery by the 'claim from' and 'claim thru' dates. For a small number of institutional claims, the 'claim thru' date was later than either the Medicare benefit exhaustion date or the 'covered level care thru date.' The earliest date among these three was used to apportion payments to the appropriate calendar year. The CMS amounts were taken from specific variables in the datasets that indicate the total amount that CMS paid on the claim, usually labeled 'claim payment amount.' This measure typically excludes what CMS calls 'pass through amounts.' The analysis counted payments, not charges. What this section refers to as 'patient payments' are the deductible and co-payment amounts for which patients are liable, as determined by CMS and recorded on the claim record, whether or not the patient actually paid those amounts. Third party liabilities are similarly indicated liabilities in the Medicare claim records, regardless of what the parties actually paid.

For institutional claims (Inpatient, Outpatient, Skilled Nursing Facility, Home Health and Hospice), all expenditure information came from the base record only. For Physician/Supplier and Durable Medical Equipment claims, Medicare payments, third party liability and patient deductible amounts came from the base record. Patient co-payment amounts came from the line item detail records. The dates of service for the specific detail record determined the calendar year to which these co-payments were assigned.

Medicaid Data came from Medicaid Statistical Information System files. States submit claims data to CMS quarterly, usually within two months of the close of the calendar quarter. Submission of enrollment data has a slightly different schedule. Enrollment data came from files that cover CY1999, the first year Medicaid Statistical Information System submissions were required for all states. Only Hawaii and West Virginia did not have data in these Medicaid Statistical Information System claims. The claims data were taken from submissions for all quarters for CY1999 and CY2000 and the first quarter of CY2001. This approach comprises the most complete set of records for services delivered in CY1999 possible until more Medicaid Statistical Information System datasets become available. Claim records are submitted to Medicaid Statistical Information System based on the date Medicaid paid the claim, not the date the service is delivered. This report includes only the Medicaid expenditures for services delivered in CY1999. When dates of service for a claim crossed calendar years, the analytic team apportioned the Medicaid amounts paid to the respective calendar years in proportion to the number of service days that fell in the calendar year.

For Medicaid enrollment and Medicaid long-term care utilization, the Medicaid files were matched (by Social Security Number) against a list that included more than 7 million VA patients over the period from FY1995 thru FY2001. For Medicaid utilization other than long-term care, the match was against a list of all VA patients who received VA long-term care in those same fiscal years.

Key Terms In the discussion of results, it is convenient to use shorthand for specific key concepts. This subsection describes some convenient shorthand expressions.

- Total expenditures for Medicare services = CMS payments + patient liability + third party liability
- Medicare outlays = CMS payments only
- Total government outlays = VA expenditures + Medicare outlays + Medicaid outlays
- Total expenditures = total government outlays + patient liabilities + third party liabilities under Medicare

Like Medicare, VA imposes copayments on some patients for some services. For individual patients, those copayments are not easily identified from VA cost data. The VA budgeting and expenditure allocation process ensures that reflected in total VA expenditures recorded in the Cost Distribution Report. The measure of 'total expenditures' is thus the most consistent treatment of all three payment systems – VA, Medicare and Medicaid – because it includes all government and patient liabilities for all three systems.

The Medicaid files contain a field for third-party liabilities, but the amounts reported are very small, and the documentation is not clear about exactly what these amounts include and whether the inclusion rules can be consistent from state to state. For these reasons, the discussion of results excludes Medicaid-reported third-party liabilities.

'Reliance' on a particular source of funding for medical services can be expressed in many ways. Here the term 'reliance' refers specifically to the share of expenditures for medical services that is accounted for by a program. The degree of reliance can be thought to have two components. The first component is 'extent of reliance' the fraction of the population with some positive expenditure in a given system (VA, Medicare or Medicaid). The second component is 'intensity of reliance' the average expenditure in a given system for those patients in the population with some positive expenditure in the system. This terminology is a convenient way to distinguish those factors that determine who or how many patients rely on a given system (or certain types of utilization within that system) and those factors that determine by how much patients who use the system rely on it. As these two sets of factors are often distinct, separating them can aid understanding.

RESULTS

Overview:

The Medicare and Medicaid programs, separately and in combination, are important for a large majority of VA long-term care patients. The importance is evident just from enrollment of VA long-term care patients in these programs (Table 1). Three-quarters of all VA long-term care patients were enrolled in one or both of these programs in 1999. More than two-thirds of VA long-term care patients were enrolled in Medicare in each of the three years for which we have data. One patient out of seven was enrolled in Medicaid in CY1999. Most (two-thirds) of those VA long-term care patients who were Medicaid enrolled were also enrolled in Medicare.

Table 1. VA Long-Term Care Patients in FY1999 by Medicare and Medicaid in CY1999

	Medicare Only	Both Medicare and Medicaid	Medicaid Only	Total with Either
Enrolled in	59.9%	10.1%	4.4%	74.4%
Received Long-Term Care Under…	13.4%	1.7%	3.4%	18.5%

The percentages of patients using Medicare or Medicaid long-term care services were lower than the percentages enrolled. Some enrollees do not use any Medicare or Medicaid services in a given year and others use only non-long-term care services. Of all VA long-term care patients, 18.5% had either Medicare or Medicaid long-term care; 81.5% had neither. Most of the long-term care overlap was between VA and Medicare (skilled nursing facility or home health). The overlap among all three long-term care programs was very small: only 1.7% of all VA long-term care patients also had both Medicare and Medicaid long-term care in 1999.

Medicare and Medicaid together account for about one-sixth (16.8%) of the total expenditures for medical care for VA long-term care patients under these three systems (Table 2). The dominance of VA expenditures is to be expected because the patients were identified initially from their participation in VA long-term care programs, but one-sixth of total expenditures is a significant amount ($940 million).

Table 2. Total Expenditures for VA Long-Term Care Patients, FY or CY1999

System	Expenditures ($ Mil)	Percent of Total
VA (FY1999)	4,666.0	83.2
Medicare (CY1999)	654.2	11.7
Medicaid (CY1999)	284.6	5.1
Total Expenditures	5,604.8	100.0

VA expenditures are dominant for these patients' long-term care (Table 3). About 85% of all program expenditures for long-term care were provided through VA. The remainder is a split between Medicare (6.3%) and Medicaid (8.0%) in proportions that reflect the relatively smaller long-term care benefit under Medicare compared to Medicaid.

Table 3. Total Long-Term Care Expenditures for VA Long-Term Care Patients, FY or CY1999

System	Long-Term Care Expenditure ($ Mil)	Percent of Long-Term Care $
VA (FY1999)	1,949.2	85.7
Medicare (CY1999)	142.2	6.3
Medicaid (CY1999)	181.6	8.0
Total Expenditure	2,273.0	100

Medicare Enrollment and Utilization by VA Long-Term Care Patients

Of all VA long-term care patients, about 70% were Medicare enrolled in each of the study years (Table 4). This proportion is higher than the self-reported rate of 53% for all VA enrollees in 1999 (Shen et al. 2003). The percentage of VA long-term care patients in Medicare HMOs rose slightly, from 6.7% of all VA long-term care patients in CY1998 to 8.7% in CY2001.

Table 4. Of All VA Long-Term Care Patients, the Percentage Who … by FY/CY

	1998	1999	2000	2001
Are Medicare Enrolled	69.0	70.5	71.4	72.4
Are in a Medicare HMO	6.7	8.1	8.9	8.7
Have Medicare Payments for Care	40.2	41.4	41.7	41.9

The proportion of all VA long-term care patients with Medicare utilization was about 41% in each year, growing slightly from CY1998 to CY2001. This proportion translates into a rate of 58% (e.g., 40.2/69) of dually enrolled VA long-term care patients with Medicare claims in a year. Utilization for those in Medicare HMOs is not included in these claims. As a result, the growth in Medicare HMO enrollment might be expected to reduce the percentage of patients with fee-for-service utilization. The fact that this decline did not occur may simply reflect the increasing age of this VA subpopulation. Older patients tend to use more care.

This count of VA long-term care patients includes those in VA domiciliaries, who are younger on average than other VA long-term care patients. For example, 90% of domiciliary patients are 64 years of age or younger, compared to only 29% of other VA long-term care patients. Greater age implies greater use of Medicare services by non-domiciliary long-term care patients. The data support that expectation. The share of VA long-term care patients with some Medicare spending is higher when domiciliary-only patients are excluded, 46.8% in CY1999 compared to 41.4% for all VA long-term care patients (not shown). Results for all years are similar and are available from the authors.

Of long-term care patients enrolled in Medicare, about 3/5 were originally entitled to Medicare because of age, with most of the rest entitled because of disability (Table 5). The share with disability declined steadily (1 to 2 percentage points per year), which mirrors the growth in those who qualify by age.

Table 5. Of All VA Long-Term Care Patients Enrolled in Medicare, Original Reason for Entitlement, Calendar Year

	1998	1999	2000	2001
Age	59.8%	61.1%	63.2%	64.0%
Disability	39.6	38.3	36.2	35.5
ESRD[a]	0.3	0.3	0.3	0.2
Disability + ESRD	0.3	0.3	0.3	0.3

[a] ESRD = End Stage Renal Disease

For Medicare expenditures, the split among the categories of payers (the Medicare program, patients, and third-party payers) was almost identical in each of the calendar years (Table 6). Medicare outlays accounted for 86% of the total expenditures for Medicare services for these VA patients (almost $600 million in 2000). The patients (or their supplemental insurance policies) paid for about 13% (~$100 million); third parties paid for 1.5% ($10 to 13 million).

Table 6. Total Medicare Expenditures for VA Long-Term Care Patients, by Year, ($ millions)

	1998	1999	2000	2001	% Change 1998-2001
Medicare outlays	544.1	551.7	592.3	639.7	17.6
Medicare patient liability	79.4	91.6	95.6	106.0	33.5
Third-party liability	9.8	10.9	10.7	12.8	30.6
Total expenditures for Medicare services	633.3	654.2	698.6	758.5	19.8

Total Medicare outlays for VA long-term care patients grew 17.6% from 1998 to 2001, but patient deductibles and co-payments for this care grew by more than 30%. VA expenditures for these same patients (which includes any VA patient co-payments for non-long-term care during this period) increased by 22.5%, with VA's non-long-term care expenditures increasing slightly less and long-term care expenditures slightly more (not shown).

Medicare+Choice HMOs The amounts in Tables 2, 3 and 6 include all Medicare spending reported in claims files for the respective calendar years, but patient utilization and payments for HMO enrollees are not reported in claims data. To approximate total Medicare spending for VA long-term care patients who are in Medicare HMOs, we calculated an average monthly per capita payment for HMO membership for CY1999. For 6,965,780 enrollees, Medicare paid $38.424 billion (U.S. Dept of HHS, 2002). Assuming each managed care enrollee had 10 months enrollment, the average payment per patient per month was $552. This assumption of an average 10 months enrollment is based on the averages for VA's long-term care enrollees, whose average months of HMO enrollment (conditional on enrollment of at least 1 month during the year) ranged from about 9.5 in CY1997 to 10.2 in CY2000.

For Medicare enrollees among VA long-term care patients, the number of person-months in Medicare HMOs totaled 123,199 in CY1999. Evaluated at $552 per person-month, the Medicare payment was approximately $68.0 million, or just over 12% of Medicare's fee-for-service expenditures of $551.7 million for all VA long-term care patients in CY1999. This estimate is intended only as a rough approximation, but it raises total expenditures for VA long-term care patients by more than 1% and Medicare's share of the cost for these patients from 10.4% to 11.7% of the total (excluding patient payments and third-party liabilities).

VA and Medicare Expenditures per VA Long-Term Care Patient Each year (1998-2001) Medicare fee-for-service outlays were about $5,300 per Medicare-enrolled VA long-

term care patient excluding the Medicare+Choice enrollees (Table 7). Patient payments averaged an additional $778 to $896. Third party payers also added about $100 per patient. The total payment for Medicare fee-for-service care was thus about $6,300 per Medicare patient not in an HMO for any part of the calendar year.

Table 7. Medicare Expenditure Per Patient, VA Long-Term Care Patients

Not Enrolled in HMO				
	CY1998	**CY1999**	**CY2000**	**CY2001**
Total Expenditure	$ 6,207	$ 6,066	$ 6,306	$ 6,407
Medicare Outlay	5,333	5,113	5,346	5,402
Patient Liability	778	853	866	896
Third-Party Liability	96	101	94	109

Non-HMO Enrollees With Medicare Utilization				
	CY1998	**CY1999**	**CY2000**	**CY2001**
Total Expenditure	$ 9,858	$ 9,444	$ 9,606	$ 10,200
Medicare Outlay	8,469	7,965	8,145	8,600
Patient Liability	1,236	1,322	1,314	1,426
Third-Party Liability	153	157	147	174

Because only about 3/5 of Medicare-enrolled VA long-term care patients have any Medicare fee-for-service utilization in the calendar year, the average Medicare expenditure for patients with any Medicare fee for service care in that year is actually more than $7,900. Patient payments averaged between $1,200 and $1,400; third-party liabilities stayed effectively constant at about $150 per patient per year until 2001, when they averaged $174.

Medicare Expenditure By Type of Care The largest share of Medicare expenditures, almost half in each year, was accounted for by inpatient acute care services (Table 8). The next largest shares (from 10% to 20% for each category of spending in each calendar year) were attributable to physician/supplier services, home health and skilled nursing facility.

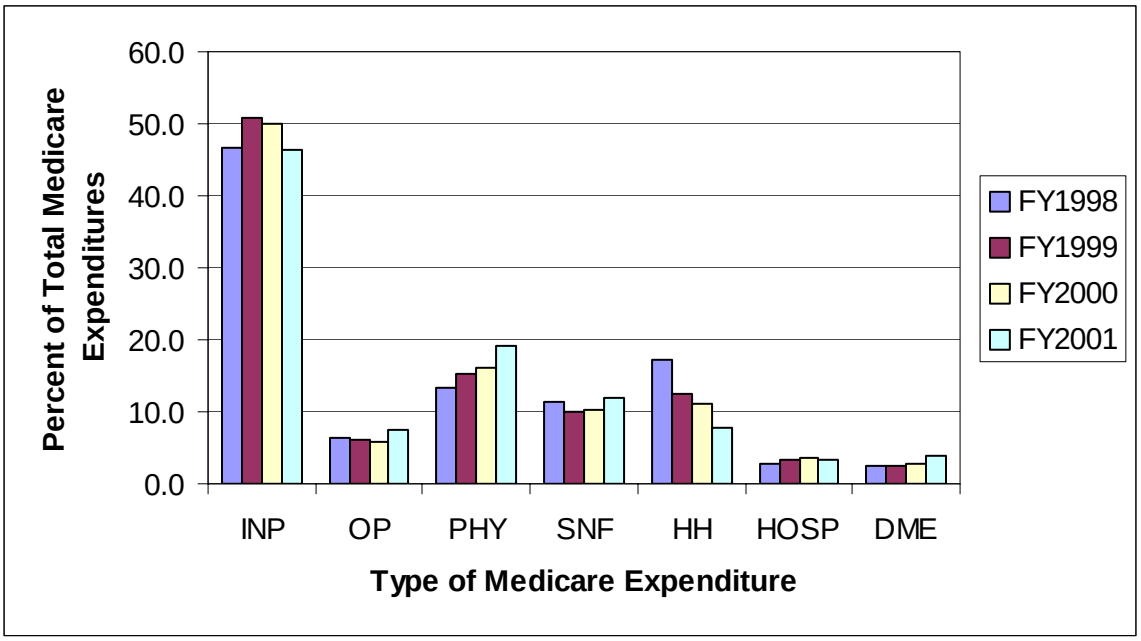
Table 8. Medicare Outlays By Type of Claim, CY1999, $ millions*

Type of Claim	Medicare Outlays*	%
Inpatient	280.5	50.8
Outpatient	33.3	6.0
Physician/Supplier	81.2	14.7
Skilled Nursing Facility	55.3	10.0
Home Health	68.2	12.4
Hospice	18.7	3.4
Durable Medical Equipment	14.5	2.6
Total	$ 551.7	100.0

*Excludes patient payments and third-party liabilities.

The distribution of expenditures shifts over these four years from home health to physician/supplier (Figure 1). Home health accounted for 17.1% ($93.1 million) in CY1998, but only 7.9% ($65.8 million) in CY2001 (see Frakt and Zhu, 2004, for a discussion of changes in payments that may relate to this decision). Physician/supplier expenditures rose from 13.3% ($72.3 million) in CY1998 to 19.1% ($96.1 million) in CY2001. Skilled Nursing Facility expenditures stayed relatively stable over the period.

Figure 1. Distribution of Medicare Expenditures for VA Long-Term Care Patients, CY1998-CY2000, by Type of Expenditure



Because of the reduction in home health outlays following changes in eligibility and reduced payment rates introduced by the Balanced Budget Act of 1997, the share of Medicare outlays accounted for by all other types of services increased over this period. The actual dollar outlays for these categories of service usually increased, but outlays for outpatient services were flat, at around $34 million each year, until 2001.

The fastest rising category of Medicare expenditure was for hospice care, with an increase of nearly 30% between CY1998 and CY1999. However, total hospice outlays were a small proportion of total Medicare outlays (less than 4%, even after the rapid increase). Among the categories accounting for larger shares of total Medicare outlays, the fastest growing were physician/supplier outlays, increasing by more than 12% in each year. Inpatient spending grew by more than 5% each year.

Medicaid Enrollment and Utilization by VA Long-Term Care Patients

The assessment of VA long-term care patients' use of Medicaid services uses many of the same measures as the description of utilization of Medicare services. The major differences

are that there was a much smaller share of VA patients enrolled in Medicaid than in Medicare and that only one year of Medicaid data was available for making comparisons (CY1999). In addition, Medicaid files are organized by only three types of services: inpatient, long-term care and other.

Of all VA long-term care patients in FY1999, 14.5% were enrolled in Medicaid in CY1999. This contrasts with about 6.5% of all VA patients who were enrolled in Medicaid in CY1999. The proportion of all VA long-term care patients with Medicaid utilization was 11.4% (not shown). This proportion means that 78.6% (11.4/14.5) of VA long-term care patients enrolled in Medicaid had Medicaid claims that year. This proportion is greater than that for VA long-term care patients also enrolled in Medicare (60%; see Table 4).

The average Medicaid expenditures per patient with any Medicaid expenditures was $14,542, of which almost two-thirds ($9,280) was for long-term care, a tenth ($1,498) was inpatient care, and a quarter ($3,764) was for outpatient services (Table 9).

Table 9. Aggregate and Average Medicaid Expenditures for VA Long-Term Care Patients, CY1999

	Total $ Millions	Mean $	%
Inpatient	29.3	1,498	10.3
Other	73.7	3,764	25.9
Long-Term Care	181.6	9,280	63.8
Total	284.6	14,542	100%

The 14.5% of VA long-term care patients enrolled in Medicaid have slightly lower than average VA long-term care expenditures, as they account for only 10.7% of total VA long-term care expenditures in FY1999 (not shown). They have slightly higher than average non-long-term care VA expenditures, accounting for 16.7% of VA non-long-term care expenditures for care among VA long-term care patients. There is also considerable overlap between Medicare and Medicaid enrolled patients; 10.1% of VA long-term care patients in FY1999 were enrolled in both Medicare and Medicaid in CY1999. These Medicaid-enrolled patients accounted for 27.2% of Medicare expenditures by VA long-term care patients in CY1999 (not shown).

Accounting for All Public Long-Term Care for VA Patients

The results presented above refer to enrollments and expenditures only for VA long-term care patients in 1999. Other VA patients in that year were also long-term care patients in Medicare or Medicaid, but not through VA programs. Table 10 presents the counts of these patients according to the source of their long-term care. These counts exclude veterans who were enrolled in VA in 1999 but who received no VA health care services in that year.

Of the 3.0 million VA patients in 1999, 275,000 received some publicly-funded long-term care in that year. The largest number, 130,407 or 47.5%, received such care only through

VA programs. Another 101,210 (36.9%) received only Medicare-financed skilled nursing or home care. Only 3.3% relied exclusively on Medicaid for their long-term care. Of the 11.4% who received long-term care services from two programs, about $^{2}/_{3}$ used both the VA and Medicare programs.

Table 10. VA Patients by Source of Publicly-Funded Long-Term Care, 1999*

Total Number in 1999	**274,528**	**100%**
Source of Long-Term Care		
VA Only	130,407	47.5
Medicare Only	101,210	36.9
Medicaid Only	9,181	3.3
Any 2 of 3 Programs		11.4
VA+Medicare	21,769	7.9
VA+Medicaid	4,851	1.8
Medicare+Medicaid	4,663	1.7
All 3 Programs	2,447	0.9

* Includes patients with any VA utilization in FY1999 who received long-term care under VA or Medicare or Medicaid.

Future analyses need to focus on the total costs and patterns of care for these VA patients who receive long-term care under the Medicare and Medicaid programs. Such analyses can guide policymakers in understanding patients' choices about their care. Future work can also highlight where the public programs need more co-ordination.

Reliance on Medicare and Medicaid Across VA Long-Term Care Programs

The primary measure of patients' reliance on Medicare or Medicaid in this subsection is the share of total expenditure that is accounted for by outlays of either program. Because few VA long-term care patients use both of the other programs, these results are presented first only for Medicare reliance and then only for Medicaid reliance.

Medicare Reliance There is considerable variation in Medicare reliance across VA long-term care programs. The programs that rely least heavily on Medicare are the domiciliary programs, both inpatient and outpatient. Medicare outlays for patients in these programs generally make up less than 5% of total VA and Medicare expenditure for these patients each year. This low reliance reflects the low Medicare enrollment rates (20.8% and 17.4%) for these programs (Table 11).

VA nursing home patients were the next program group with the least reliance on Medicare outlays, with only about 7% of total expenditures from Medicare in each year. Patients in this program have the highest average VA expenditures of any program, however, and 7% of those high expenditures represents a considerable total amount of services. Over 3/4 of these patients are Medicare enrollees, however.

Table 11. Reliance on Medicare By VA Long-Term Care Program, CY1999

	Reliance Measured by:	
VA Long-Term Care Program	**% of Medicare Enrolled**	**Medicare Outlays as % of VA + Medicare**
VA Nursing Home	77.1	7.0
Contract Community Nursing Home	77.6	12.2
Geriatric Evaluation and Management inpatient	84.8	13.1
Home Based Primary Care	77.4	15.7
Adult Day Healthcare	84.4	17.6
Geriatric Evaluation and Management outpatient/Alzheimer	87.4	25.1
Domiciliary inpatient	20.8	2.5
Domiciliary outpatient	17.4	4.7
Fee Long-Term Care Home Health	65.6	9.3
Community Residential Care	69.7	11.8

For most other programs, the reliance on Medicare outlays is between 12% and 18% and enrollment is 2/3 or greater. Patients in adult day healthcare and geriatric clinics (including the Alzheimer/dementia clinic) have the largest share of their total expenditures accounted for by Medicare. For adult day healthcare, the share is around 20% each year; for geriatric clinics, it is over 25%. These reliance indicators are relatively stable across the three years as are the enrollments (not shown).

Medicare expenditures for fee-for-service care understate total Medicare expenditures by omitting expenditures for HMO enrollment. Because the extent of HMO enrollment varies among VA long-term care programs, understatement of expenditures also varies. However, a sensitivity analysis (not shown) using months of HMO enrollment indicates that the relative importance of Medicare expenditures among VA programs is not much affected by the omission of HMO participant fees. The discussion of program-by-program differences would not be changed appreciably by more exact figures for HMO participant fees.

VA long-term care patients who have Medicare inpatient care in CY1999 average $10,000 to $14,000 for Medicare acute inpatient care (Table 12) and this amount is almost half their total Medicare expenditure (Table 8).

Comparing Medicare utilization of patients in VA and contract community nursing home programs is instructive. The proportions enrolled in Medicare in 1999 were roughly equal (77.1% and 77.6%), but Medicare expenditures comprised 12.2% of all VA and Medicare expenses for contract community nursing home patients that year compared to only 7.0% for patients in VA nursing facilities (Table 11). This greater reliance was not due to greater average expenditures by category of care (Table 12). Indeed, among those with any Medicare claims, the contract community nursing home patients had lower average Medicare expenditures in each category except one (skilled nursing facility).

Table 12. Average Medicare Expenditures by VA Long-Term Care Program, CY1999*

	VANH	CNH	FLHH	GINP	HBPC	ADH	GERC	DINP	DOUTP	CRC
INP	$ 13,010	$ 12,381	$ 11,070	$ 12,776	$ 14,041	$ 10,982	$ 11,493	$ 10,790	$ 13,622	$ 12,838
OP	906	848	869	819	966	894	767	939	1,015	1,314
PHY	1,436	1,335	1,220	1,422	1,521	1,269	1,383	1,406	1,811	1,467
SNF	7,050	7,732	5,969	7,087	7,666	7,278	7,194	5,533	7,389	8,093
HH	3,471	2,941	3,901	3,548	4,212	2,982	3,574	1,867	2,119	3,295
HOSP	5,467	4,964	4,804	4,456	5,797	4,967	6,321	5,237	0	4,109
DME	885	869	1,229	927	1,235	752	933	1,087	525	1,064

* Average expenditure is per patient with any expenditure in the listed Medicare category.
VANH = VA Nursing Home; CNH = Contract Community Nursing Home; FLHH = Fee Based Long-Term Care Home Health; GINP = Geriatric Evaluation and Management inpatient; HBPC = Home Based Primary Care; ADH = Adult Day Healthcare; GERC = Geriatric Evaluation and Management outpatient/Alzheimer; DINP = Domiciliary Inpatient; DOUTP = Domiciliary Outpatient; CRC = Community Residential Care; INP = Inpatient; OP = Outpatient; PHY = Physician; SNF = Skilled Nursing Facility; HH = Home Health; HOSP = Hospice; DME = Durable Medical Equipment

The difference in reliance comes from greater use of the Medicare by contract community nursing home patients. More than three of every five contract community nursing home patients have Medicare expenditures in CY1999 (not shown). Two of five VA nursing homes patients have such claims. Indeed, contract community nursing home patients were almost twice as likely as VA nursing home patients to have skilled nursing facility services under Medicare. In part, this higher percentage with skilled nursing facility utilization may be attributable to the higher percentage with Medicare inpatient care (21% versus 15%, not shown).

Home based primary care and Geriatric Evaluation and Management inpatient program participants were the most likely to use Medicare home health services. For patients in the Geriatric Evaluation and Management inpatient program, the Medicare home health services may be helping them recover at home from acute inpatient episodes of care.[2] Participants in these programs were also (by a small margin) least likely to be using Medicare institutional outpatient or physician/supplier services. Despite the similarity in the reliance on Medicare for total expenditures in these Medicare categories, Geriatric Evaluation and Management inpatients are more likely to have Medicare claims. The fact that the reliance percentage is similar but with fewer home based primary care patients with Medicare claims suggests that home based primary care patients with Medicare have higher utilization expenditures.

[2] Readers must keep in mind that the identification of program participation is made for the full year, as is identification of Medicare expenditures. When we say that a patient, who at some time during FY1999 was a Geriatric Evaluation and Management inpatient, has Medicare home health expenditures in CY1999, we are NOT saying that those Medicare expenditures were incurred over the time period for which the patient was a Geriatric Evaluation and Management inpatient.

Fee-basis home health and home based primary care patients have the most intense reliance on Medicare durable medical equipment services, with averages of over $1,200 per year per patient using durable medical equipment services. Adult day health patients have the lowest intensity of reliance for durable medical equipment, with an average of less than $760 per patient per year in CY1998 and CY1999 (Table 12). The same two programs, fee-basis home health and home based primary care, also have the most intense reliance on Medicare home health services, having consistently higher average Medicare expenditures per patient than do other VA long-term care programs. By far, the least intense reliance on Medicare home health services is by domiciliary inpatient participants.

Home based primary care participants also tend to have the most intense reliance on Medicare inpatient services, with average expenditures over $14,000 per patient. This intensive reliance is important because 15% or more of patients in this VA long-term care program have some Medicare inpatient expenditures in any one year.

Reliance on Medicaid Services Variation across VA long-term care programs in the importance of Medicaid services is substantial. Contract community nursing home and domiciliary outpatient programs have by far the largest proportion of Medicaid enrollees: 29.3% and 26.1% respectively (Table 13). The next highest program is Geriatric Evaluation and Management inpatient, with 16.4% enrolled in Medicaid. The lowest rates of Medicaid enrollment are for the Geriatric Evaluation and Management outpatient programs (9.4%) and Fee-basis home health (11.5%).

Table 13. Reliance on Medicaid By VA Long-Term Care Program, CY1999

VA Long-Term Care Program	% Medicaid Enrolled	Medicaid $ as % VA + Medicaid $
VA Nursing Home	13.1	4.5
Contract Community Nursing Home	29.3	13.9
Geriatric Evaluation and Management inpatient	16.4	4.8
Home Based Primary Care	13.7	4.9
Adult Day Healthcare	13.0	7.9
Geriatric Evaluation and Management outpatient/Alzheimer	9.4	8.1
Domiciliary inpatient	14.5	2.1
Domiciliary outpatient	26.1	5.8
Fee Long-Term Care Home Health	11.5	4.3
Community Residential Care	16.0	4.9
Total	**14.5**	**5.7**

The rate of Medicaid enrollment is more than twice as high among contract community nursing home patients as among VA nursing home patients (29% vs. 13%). This heavier reliance on Medicaid by patients in contract community nursing home is consistent with the view that VA personnel try to move these patients into Medicaid nursing home beds.

As measured by the percentage of all VA plus Medicaid expenditures, VA long-term care patients appear not to be very reliant on this public program. Overall, Medicaid expenditures accounted for only 5.7% of the combined program expenditures for VA long-term care patients in 1999 (Table 13). By this measure, domiciliary patients were least reliant (2.1%) and contract community nursing home patients were most reliant on Medicaid (13.9%).

Medicaid files distinguish only three major types of claims; long-term care, inpatient, and other. Home health and skilled nursing facility services are both included in long-term care, for example. Table 14 presents, by VA long-term care program, the percentage of all Medicaid expenditures for VA patients accounted for by these three major types of care. Domiciliary inpatient and outpatient programs have by far the lowest reliance on Medicaid long-term care expenditures: less than 10%. The next lowest program is Fee-basis home health, for which only 31% of Medicaid expenditures are long-term care. For all other programs, Medicaid long-term care expenditures account for at least half of all Medicaid expenditures. For patients in contract community nursing home programs, they are 81.6%.

Table 14. Distribution of Medicaid Expenditures by VA Long-Term Care Program, CY1999

	% of Medicaid Expenditures for:		
	Long-Term Care	**Inpatient**	**Other**
VA Nursing Home	73.5	7.9	18.6
Fee Based Contract Community Nursing Home	81.6	4.6	13.7
Fee Based Long-Term Care Home Health	30.9	17.3	51.9
Geriatric Evaluation and Management inpatient	69.9	11.1	19.0
Home Based Primary Care	48.3	11.8	39.8
Adult Day Healthcare	60.0	1.2	31.8
Community Residential Care	52.3	10.8	36.9
Domiciliary Inpatient	8.5	42.1	49.4
Geriatric Evaluation and Management outpatient/Alzheimer	66.1	4.6	29.3
Domiciliary Outpatient	4.8	36.0	59.2
All VA Long-Term Care	70.5	7.7	21.8

There is considerable similarity in the intensity of Medicaid expenditures across programs. For most VA long-term care programs, when Medicaid long-term care services are received, the average patient's Medicaid long-term care expenditures are between $15,000 and $23,000 (Table 15). For two programs, the average Medicaid long-term care expenditures are about $11,000 per patient with positive Medicaid long-term care expenditures. Expenditures for Medicaid inpatient services show greater variation in intensity. Two programs (domiciliary inpatient and outpatient) have average Medicaid inpatient expenditures of $13,000 or higher when Medicaid inpatient expenditures are present. Just as

with Medicare services, when domiciliary patients get Medicaid treatment outside VA, that treatment is heavily weighted toward inpatient care. Four other programs have average Medicaid inpatient expenditures of between $6,000 and $9,000 for their patients who receive Medicaid inpatient services. Other Medicaid services are used by many more dual enrollees than inpatient or long-term care services are. The average Medicaid expenditures for these other services are lower than for either long-term care or inpatient care, ranging from $5,000 to $6,600.

Table 15. Medicaid Claims and Average Outlays by VA Long-Term Care Program, CY1999*

	% with Claim for Medicaid:				Medicaid Outlays for:		
	Any services	Inpatient services	LTC	Other services	Inpatient	LTC	Other
VANH	17.5	2.8	11.1	15.3	8,613	19,961	3,649
FCNH	26.1	4.1	20.3	22.7	6,502	23,261	3,488
FLHH	9.4	1.8	2.5	8.8	11,063	14,190	6,652
GEM INP	14.4	2.7	8.8	12.9	9,104	17,630	3,270
HBPC	11.4	1.7	4.0	10.5	10,040	17,486	5,503
ADH	11.6	1.1	5.5	10.4	12,262	18,155	5,076
DOM INP	10.7	1.7	0.5	10.5	14,470	10,841	2,804
GERC/GALZ	7.2	0.9	3.2	6.5	5,144	21,224	4,646
DOM OP	20.9	3.4	0.6	20.6	13,036	11,241	3,214
CRC	12.1	1.7	3.1	11.6	6,417	17,547	3,287

* Average outlay is per patient with any Medicaid cost in the listed category.
LTC = long-term care; VANH = VA Nursing Home; FCNH = Fee Based Contract Community Nursing Home; FLHH = Fee Based Long-Term Care Home Health; GEM INP = Geriatric Evaluation and Management inpatient; HBPC = Home Based Primary Care; ADH = Adult Day Healthcare; DOM INP = Domiciliary Inpatient; GERC/GALZ = Geriatric Evaluation and Management outpatient/Alzheimer; DOM OP = Domiciliary Outpatient; CRC = Community Residential Care

SUMMARY/CONCLUSIONS

Both Medicare and Medicaid programs play important roles in providing medical services for VA long-term care patients.

- Almost 70% of VA long-term care patients are enrolled in Medicare; 14.5%, in Medicaid.
- About 40% of VA long-term care patients have some Medicare fee-for-service utilization; about 11% have some Medicaid utilization.
- Medicare services account for 10% to 12% of medical services for VA long-term care patients.
- Medicaid services accounted for 5% of medical services for VA long-term care patients.

The reliance of VA long-term care patients on these two systems of medical care financing differs in important ways, according to the VA long-term care programs in which the patients participate. Community nursing home and Geriatric Evaluation and Management inpatient participants rely most heavily on Medicare, with more than half their participants using Medicare services. Next are home based primary care, Geriatric Evaluation and Management outpatient, and adult day healthcare. The programs least likely to use Medicare services are also those with the lowest enrollment rates, domiciliary programs. Even after controlling for the lower enrollment rates, the rate of use of Medicare is lower for domiciliary patients (about 1/3 versus 1/2 or more for other programs). Community nursing home patients are more often enrolled in Medicaid than are patients in other VA long-term care programs. Domiciliary patients, who are least likely to be enrolled in Medicare among VA long-term care patients, are almost as likely to be enrolled in Medicaid as are contract community nursing home patients.

The patterns of dual system spending suggest that certain kinds of Medicare or Medicaid spending are often substituted for VA spending, others are complementary to VA spending. For example, VA home based primary care services and Medicare home health services appear to be complementary. Geriatric Evaluation and Management outpatient and Medicare outpatient services tend to be substitutes. Similarly, Medicare and VA inpatient services often appear to be substitutes. The high Medicaid enrollment and use rates for domiciliary patients suggest that Medicaid services are complementing VA services in very different ways than do Medicare services. The low rate (1.5%) of patients who have long-term care services under all three systems suggests that there is a good deal of substitution among the systems in long-term care care. Most VA long-term care patients get their long-term care services from one (or sometimes two) systems, seldom from all three. Finally, although domiciliary patients seldom use Medicare services, when they do use those services, they have very high Medicare average spending.

For long-term care services, VA and Medicaid services appear to be relatively complementary in that about a third of the dual enrollees use long-term care under both systems in a given year. Only one in five of VA long-term care patients enrolled in Medicare had Medicare long-term care in the same year.

It also seems clear that those using multiple systems are sicker patients, on average. Those using two or more systems have higher per patient total medical care expenditures than do those who use only one system. This higher spending is not only because spending amounts are being added from two or more systems. For VA long-term care patients who also use Medicare services, even per capita VA spending alone is a little higher than for those VA long-term care patients who only use VA services.

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