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MONOGRAPH 1 – MEDICARE COST SHIFTING FOR FALL INJURIES

This is the first of three Monographs addressing the cost shifts that occur when Medicare delays providing or fails to provide needed durable medical equipment and supplies (DME) to beneficiaries. This Monograph addresses Falls and Mobility DME. The 2nd and 3rd Monographs address Chronic Obstructive Pulmonary Disease (COPD) and supplemental oxygen therapy and Obstructive Sleep Apnea and Continuous Positive Airway Pressure (CPAP) equipment.

When Medicare implemented the DMEPOS[1] competitive bidding program, beneficiaries and case managers experienced significant difficulties and delays in obtaining medically necessary durable medical equipment and supplies. The number of DME suppliers has dropped dramatically since the institution of competitive bidding, exacerbating the problem. The inability to obtain or the delays in obtaining needed DME puts beneficiaries at a greater risk for medical complications that could have otherwise been avoided.

This risk can be quantified by understanding the direct impact of the failure to timely get the needed DME to a beneficiary. For example, the lack of mobility equipment results in fall-related injuries that require medical treatment; the lack of supplemental oxygen therapy results in untreated patients who suffer exacerbations from COPD and its comorbidities; the lack of CPAP equipment results in untreated patients who suffer from sleep apnea.

When these complications occur, Medicare ends up paying substantially more for treatment of those complications than it would have spent to pay for the needed DME. DME payments are covered under Medicare Part B. When costs are shifted from prevention to treatment, the increased payment burden is shifted for the most part to Medicare Part A, with much lesser amounts shifted to Medicare Parts C and D. Not surprisingly, after a complication, Medicare still often ends up paying under Part B for the DME it initially failed to provide.

[1] DMEPOS is an acronym for Durable Medical Equipment; Prosthetics; Orthotics; and Supplies

FALLS -

When Medicare fails to provide or delays in providing needed mobility DME, beneficiaries are at greater risk to fall and be injured. When a fall injury occurs, the cost of treating it is typically covered by Medicare Part A. Much lesser amounts are paid by Medicare Parts C (prescription drugs) and D (for Medicare Advantage users). Typically, Medicare also ends up paying for the mobility DME it initially failed to provide, under Part B. The cost to treat a fall injury dramatically exceeds the cost of the DME that could have avoided the fall in the first place.[2]

- In 2017, seniors fell 32.4 million times[3]
- 7.8 million of those falls resulted in injuries that required treatment of some sort[4]
- 3.6 million resulted in doctor/clinic visits[5]
- 3.1 million led to an emergency room trip[6]
- 900,000 were admitted to an acute care hospital[7]
- Countless others required visits to rehab therapists, home health care visits and stays in nursing care facilities

Treatment of these fall injuries comes at a substantial cost to Medicare.

- In 2017, Medicare payments for fall injury treatment totaled between $31.6[8] and $33.7[9] Billion, including at least:
    - $7.3 Billion in hospital payments[10]
    - $6.1 Billion in payments to physicians and other treatment providers[11]

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[2] Leitten, *The Case for Medicare Investment in DME – 2014 Update*, http://www.vgmdclink.com/uploads/Document-Library/d1306dfcd9db67830ba14d4cd5b3be8c.pdf

[3] *Cost of Falls Among Older Adults*, Centers for Disease Control (CDC), 2014 data updated for 2017 Medicare population https://www.cdc.gov/homeandrecreationalsafety/falls/fallcost.html

[4] Id. Some portion of those falls did not require medical treatment but did require restricted activity for at least one day.

[5] See Note 2.

[6] *Falls and Fall Injuries Among Adults Aged ≥65 Years — United States, 2014,* CDC Morbidity and Mortality Weekly Report (09/23/16) https://www.cdc.gov/mmwr/volumes/65/wr/mm6537a2.htm

[7] Id.

[8] Florence et al., *Medical Costs of Fatal and Nonfatal Falls in Older Adults,* Journal of American Geriatrics Society, Vol. 66, Issue 4, pp. 693-698 (2018) https://doi.org/10.1111/jgs.15304, data updated for 2017 Healthcare CPI

[9] See Note 2.

[10] See Note 8.

[11] Id.

- $228 Million in dental payments[12]
- $1.2 Billion in prescription drug payments[13]
- $16.6 Billion in other payments for home health care visits and stays in nursing care facilities[14]

With this information, the average cost shift that results each time a Medicare beneficiary sustains a fall injury because of a Medicare failure or delay can be determined. Three average cost shifts (mostly to Part A) are possible. First, the cost of fall injuries can be divided by the number of falls that require some form of treatment. This yields a cost shift in the range of between $4,139 and $4,315. This is the most conservative range, since a portion of the 7.8 million annual fall injuries did not require medical treatment but did require restricted activity for at least one day[15]. Those falls would not generate Medicare payments.

Another approach is to divide the cost of fall injuries by the number of ER visits that were triggered. This is the approach taken by the National Center for Injury Prevention and Control at the CDC.[16] This yields a cost shift in the range of between $10,091 and $10,787. This cost is higher than might be expected since it does not take into account falls that required only a doctor or clinic visit.

The most comprehensive approach is to divide the cost of fall injuries by the sum of doctor/clinic visits and ER visits. This best approximates the number of fall injuries that require medical treatment. It is likely that a beneficiary who falls will either visit a doctor or clinic or go directly to the ER (hospital admissions are generally a subset of ER visits). While there will be some overlap where beneficiaries do both, it should not significantly impact the outcomes. This approach yields a cost shift in the range of between $4,705 and $5,029.

"The expected cost shift in Medicare payments that results each time a Medicare beneficiary sustains a fall injury because Medicare fails to provide or delays in providing needed mobility DME is between $4,705 and $5,029."

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[12] Id.

[13] Id.

[14] Id.

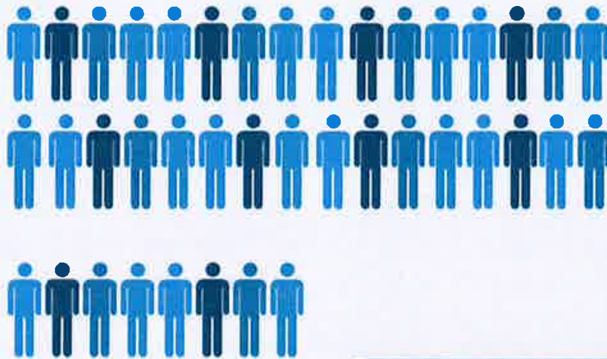
[15] See Note 4.

[16] Burns et al., *The direct costs of fatal and non-fatal falls among older adults - United States*, J Safety Res. Sep;58:99-103 (2016) https://www.ncbi.nlm.nih.gov/pubmed/27620939 (abstract only)

MEDICARE COST SHIFTING

MEDICARE COST SHIFTING WHEN DME IS DELAYED/NOT PROVIDED RESULTING IN A FALL

ANNUAL SENIOR FALLS: 32.4 MILLION[3]



SENIOR FALL INJURIES: 7.8 MILLION[4]

3.6 MILLION
SENIOR FALLS
DOCTOR VISITS[5]

3.1 MILLION
SENIOR FALLS
ER VISITS[6]

0.9 MILLION
SENIOR FALLS
HOSPITAL ADMISSIONS[7]

MEDICARE SPENDING FOR FALLS: $31.6 - 33.7 BILLION

$228 MILLION
MEDICARE DENTAL SPENDING[12]

$7.3 BILLION
MEDICARE HOSPITALS SPENDING[10]

$6.1 BILLION
MEDICARE PHYSICIANS & OTHER PROVIDERS SPENDING[11]

$1.2 BILLION
MEDICARE PERSCRIPTION DRUGS SPENDING[13]

$16.6 BILLION
MEDICARE OTHER SPENDING[14]

MEDICARE COST SHIFT PER BENEFICIARY FALL: $4,705 TO $5,029