Helen L. Smits, MD

Both the methods and the conclusion in this paper are worth a close look. Information from the Institutional Population Component of the 1987 National Medical Expenditure Survey has been painstakingly melded with Medicare claims data for the same people during the same period. Marrying information from survey research with claims data in this manner provides a far richer source of information than can be obtained from survey research alone or from claims analyzed separately. This paper, along with others in the same series from the same authors, provides us with illuminating insights into patterns of service use by institutionalized persons.

New Insight into the Plight of 'Dual Eligibles'

Their unique data enables the authors to estimate the magnitude of the use of hospital services by people who used nursing homes during 1987. Their conclusion is that a full 25 percent of all days of hospital care paid for by Medicare in the study year were for persons who also used nursing home services. Approximately half of them came to the hospital from nursing homes, both certified and uncertified; close to 70 percent of the entire group were transferred to a nursing home after their hospital stay.

Although the paper does not touch directly on Medicaid eligibility, many people who use both hospital and nursing home services in a single year can be presumed either to have been Medicaid-eligible before their acute hospital admission or very likely to reach such eligibility during a period of post-hospital residence in a nursing home. These "dual eligibles," entitled to both Medicare and Medicaid, are of particular concern in 1995 because the rapid change proposed by the current Congress in both programs is likely to affect the quality and the cost of care for these people in ways that are impossible to predict.

As the authors note, nursing homes have no incentive to avoid hospitalization and, under most State reimbursement systems, no way to recoup the increased cost of enhanced care for people with an acute illness. Hospitals have only a modest incentive to avoid nursing home transfers and no real way to guarantee that their post-discharge plans work out to the patients' benefit. Sharp separation of payment mechanisms into Medicare and State-based Medicaid and the fierce determination of both States and the Federal Government to minimize their own costs make it very difficult to redesign payment systems. The losers in this game are fragile patients and their physicians.

The authors' focus on institutionalized patients is a welcome one. We need to know as much as possible about the actual users of nursing homes and we need to look at ways to offer them care that is both cost effective and high quality. State Medicaid directors and Health Care Financing Administration staff members recently have agreed to study dual eligibles and look for solutions to the problems they present. Studies such as this one will move that effort along.

As we look for solutions, we need to keep in mind that the present system, while far from ideal, is greatly preferable to some of the alternatives now under consideration. Block grant proposals for Medicaid, which seem driven largely by beliefs about young users of welfare, will have a profound effect on nursing homes and nursing home users. Arbitrary limits on Medicaid growth will put tremendous pressure on States' ability to pay for nursing home care, increase the attractiveness of cost shifts to Medicare, and limit still further the ability of governmental payors to work together to find cost effective solutions. For the population studied here, changing the system the wrong way will lead to poorer care and escalating costs. We can only hope that fact is understood before radical restructuring of Medicaid takes place.

Dr. Smits is Deputy Administrator, Health Care Financing Administration, Washington, DC.

Tearsheet requests to Dr. Smits, HCFA, Room 314G, 200 Independence Ave., SW, Washington, DC 20201; tel. 202-690-5727; FAX 202-690-6262.