The Health Care Costs of Financial Exploitation in Maine

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The Health Care Costs of Elder Financial Exploitation in Maine

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Introduction

Elder financial exploitation (EFE), defined as the illegal or improper use of the property or resources of an incapacitated or dependent adult for another’s profit or advantage, takes myriad forms such as scams perpetrated by strangers or frauds perpetrated by trusted advisors. Most often however, EFE involves family members or friends who take or divert money or property for their own use. The loss of resources can lead to an older adult’s inability to meet their own needs for food, shelter, or health care and increase their reliance on public programs, which often pay for these services for vulnerable adults.

This study sought to determine the Medicare and Medicaid costs experienced by dual eligible older adults in Maine for whom Maine Adult Protective Services (APS) substantiated allegations of EFE and to compare them to those of Maine’s general older population. The analysis is an important step forward in estimating the medical costs associated with elder abuse.

Research Questions

1. What is the socioeconomic and health status profile of victims of EFE; how do they compare to the general older population in Maine?2. Does the health care cost/use profile of victims of EFE change pre & post APS investigation; how does this compare to matched controls?3. Does health care use and cost differ from that of the general population by type of utilization, i.e. by inpatient, outpatient, LTSS, and prescription services?

Data Sources and Study Design

- The primary sources of data for this study are Medicare summary enrollment, cost, use, and chronic and disabling conditions data files; Maine Medicaid administrative claims; and Maine Adult Protective Services Information System (MAPFISI) data. All three data sources were limited to Maine adults age 60 and older over years 2006-2014.
- Dual eligible adults with APS investigations of EFE in 2007-2012 were matched with a set of non-APS controls. We established a 4-year study period for each APS adult: 1 pre-APS event year; the APS event year; and 2 years following the APS event year. Propensity scores facilitated matching each APS-EFE adult to 2 non-APS controls using nearest kernel techniques. Members were matched using age, gender, number and type of chronic conditions, payer (i.e. dual eligible), and urban/rural residence based on Rural-Urban Commuting Area codes.
- Using a quasi-experimental design, difference in differences logistic models and generalized linear models addressed the impact of financial exploitation on the probability of incurring costs and levels of inpatient, outpatient, long term services and supports (LTSS), and prescription expenditures, respectively.

Results

Table 2. Characteristics of APS-EFE and Non-APS Sample Populations

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>APS-EFE</th>
<th>Non-APS</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (Avg. years)</td>
<td>74.8</td>
<td>74.8</td>
<td>0.54</td>
</tr>
<tr>
<td>Less than 75 years</td>
<td>40.5</td>
<td>54.8</td>
<td></td>
</tr>
<tr>
<td>75 to 84 years</td>
<td>38.9</td>
<td>30.4</td>
<td>0.004</td>
</tr>
<tr>
<td>85 and older</td>
<td>19.6</td>
<td>14.9</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>66.4</td>
<td>63.8</td>
<td>0.54</td>
</tr>
</tbody>
</table>

Table 3. Total 4-year Medicare and Medicaid costs above matched controls for 131 dual eligible older adults with substantiated elder financial exploitation

<table>
<thead>
<tr>
<th>Per member/year costs above expected PMPM in the presence of substantiated abuse</th>
<th>Per member/anual cost (PMPM*12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,705</td>
<td>$20,460</td>
</tr>
<tr>
<td>$1,851</td>
<td>$22,212</td>
</tr>
<tr>
<td>$578</td>
<td>$6,936</td>
</tr>
<tr>
<td>$708</td>
<td>$8,496</td>
</tr>
</tbody>
</table>

Summary of Results

A higher proportion of the APS-EFE group lived in rural areas compared to the non-APS comparison pool (47% vs. 44%). Geographic isolation can lead to greater dependence on others for daily needs and provide opportunities for exploitation to occur.

The APS-EFE population represent a more vulnerable, clinically complex set of patients; they had a higher number of chronic conditions, were more likely to have been diagnosed with Alzheimer’s Disease and other dementia, asthma, heart disease, cancer, depression, diabetes, chronic kidney disease, and stroke than the general elderly population.

The APS-EFE group had higher total costs than matched controls across the 4-year study period. While annual costs for both groups increased over time, difference in differences generalized linear model showed the interaction between Years 2-4 and baseline to be significantly higher for the APS-EFE group (p <0.05). Strikingly, the APS-EFE group were nearly twice as likely to be hospitalized (p=0.003) and for those who were, hospitalization costs were an estimated $797 higher than controls (p=0.04).

Compared to matched controls, the APS-EFE group had higher costs over the 4-year study period of nearly $3.7 million, 2006-2014.

Conclusion

Elder financial exploitation may result in significant public burden on Medicare and Medicaid, shouldered by taxpayers. Efforts to detect, investigate, prosecute, and mitigate this abuse will benefit not only the victims, but also the financial stewardship of these public programs.

Acknowledgements

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