

The Cost and Quality Implications of Dual Use of VA and Medicare Health Services

HSR&D Cyberseminar

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Overview

- VA-Medicare Dual Use: What it is; Why we care
- Research: What we know
 - The Basic Facts
 - Who Are Dual Users
 - Factors That Affect Dual Use
 - Consequences of Dual Use
- Policy Responses
 - Expand? Privatize?
 - Move to comprehensive model?
 - PACT
 - Improve gap model?
 - MyHealtheVet/Blue Button
 - NwHIN
- Future Research: The Affordable Care Act

Poll Question #1

- What is your primary role in VA?
 - student, trainee, or fellow
 - clinician
 - researcher
 - manager or policy-maker
 - other

VA-Medicare Dual Use: What it is; Why we care

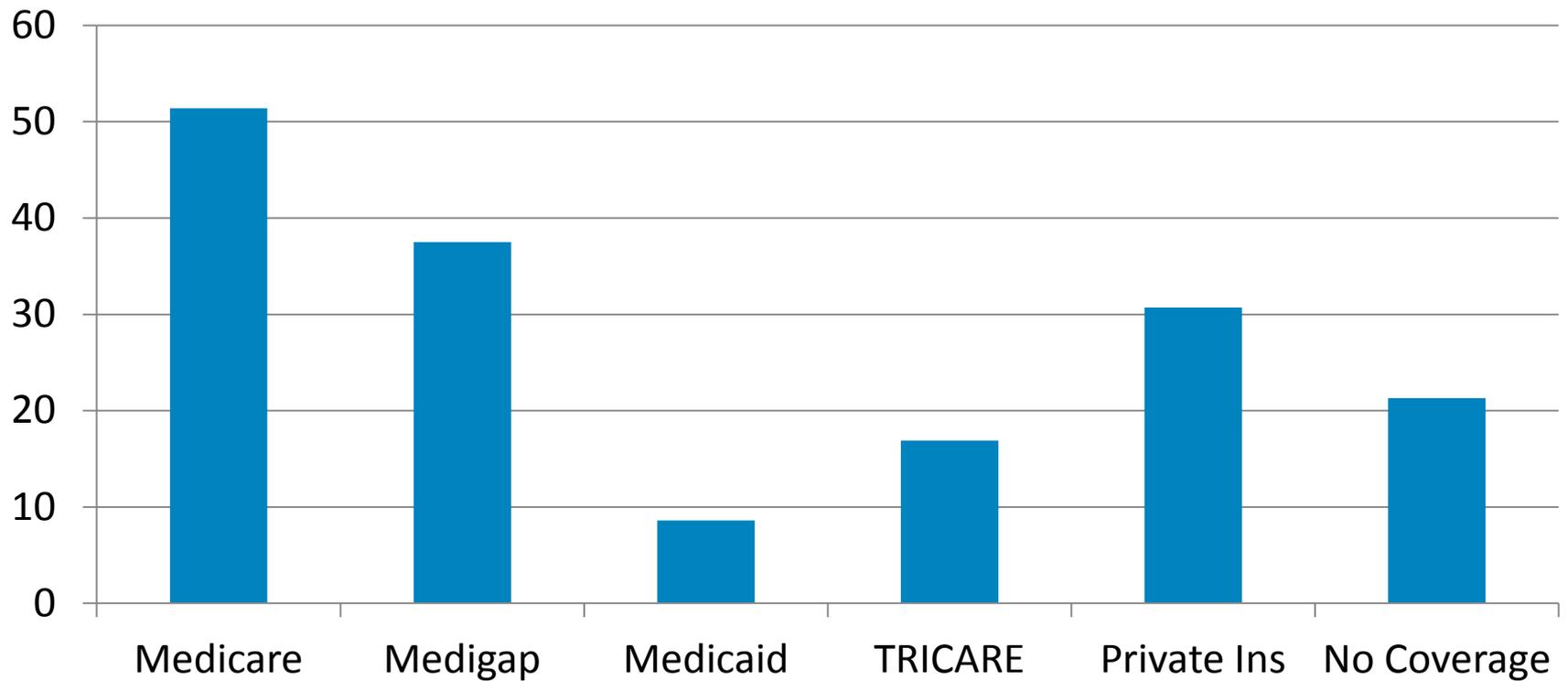
- Over half of VA enrollees are also enrolled in Medicare
- Most dual enrollees use mixtures of services from VA and Medicare
- This has cost and quality implications
- Cost
 - When VA resources are at capacity, many Veterans can obtain Medicare services
 - When VA improves access or quality, there is a reservoir of demand
- Quality
 - VA and Medicare provider networks do not overlap
 - Dual use implies transitions between providers
 - Coordination of care may suffer

VA-Medicare Dual Use: Some Basic Facts

- VA enrollees' other insurance
- Reliance on VA for outpatient care by type of Veteran
- VA and Medicare dual use by detailed service

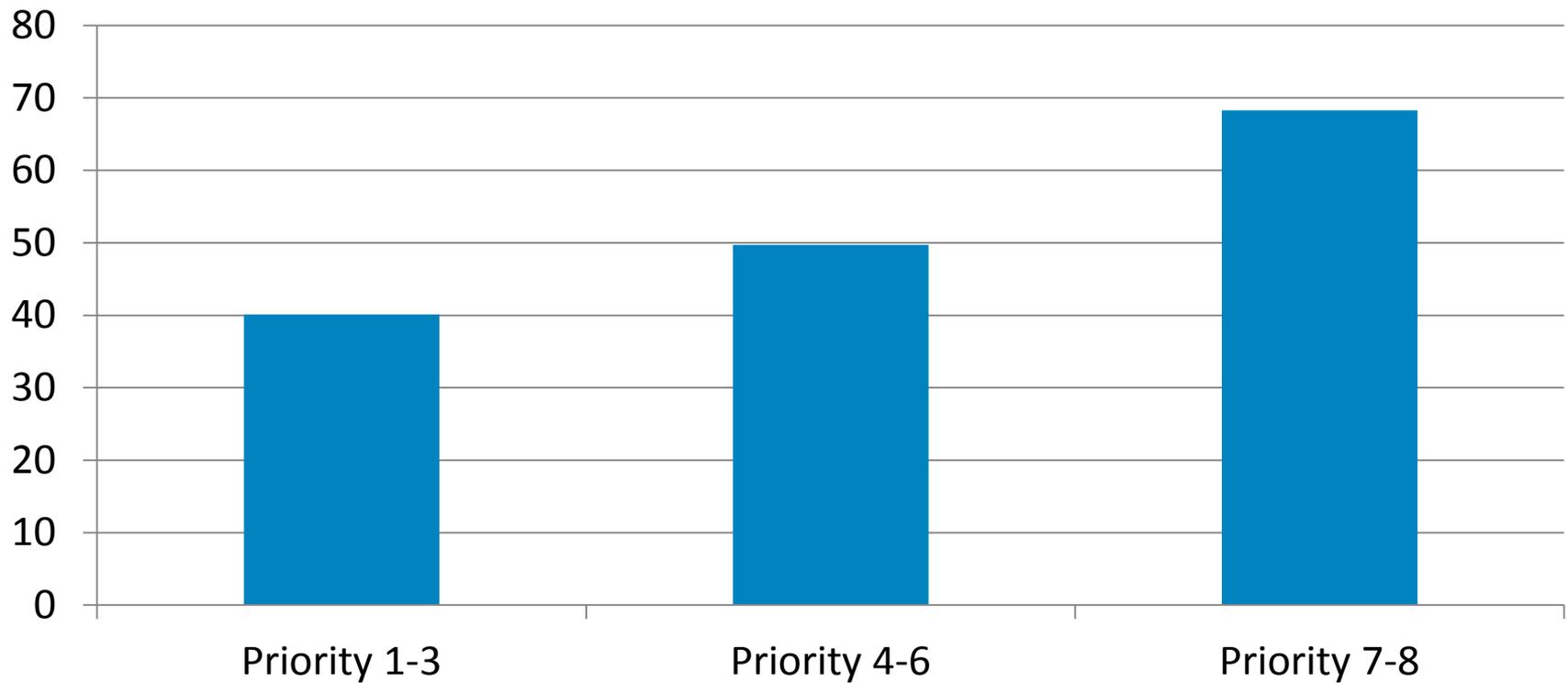
VA Enrollee's Other Insurance

% Enrollees

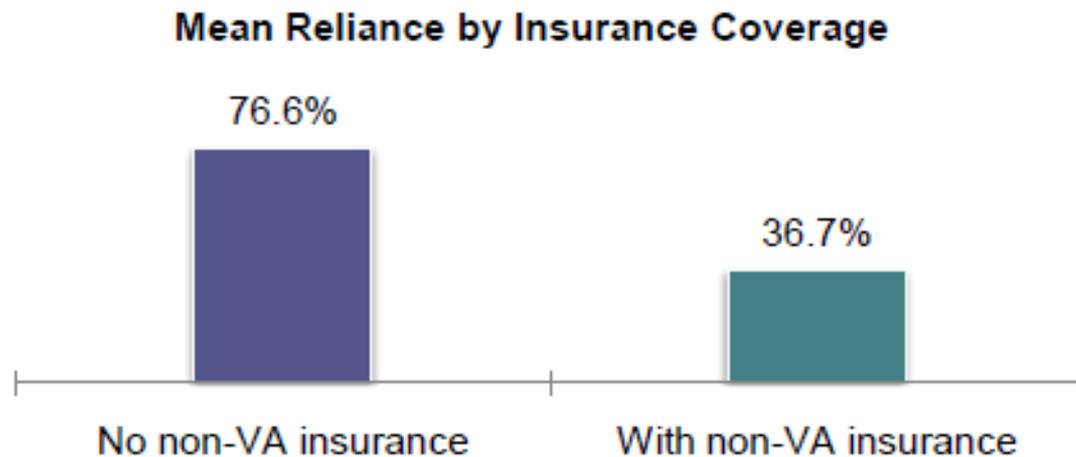


VA Enrollees with Any Medicare Coverage

% with Medicare



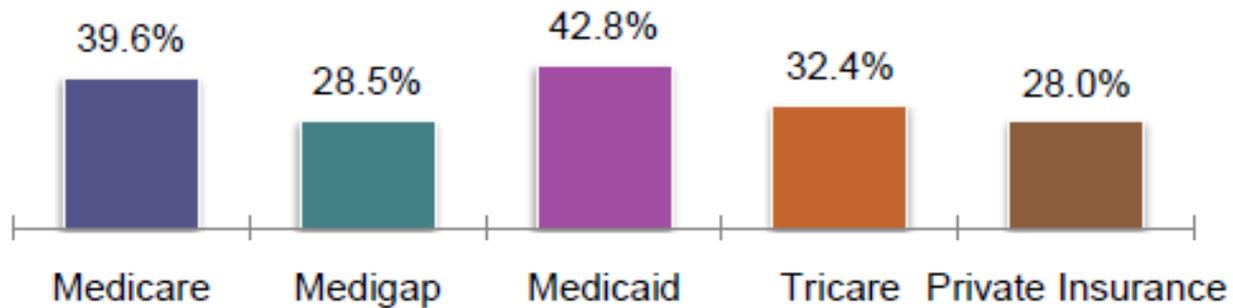
VA Reliance for Outpatient Care



Source: ADUSH 2010 Survey of Enrollees

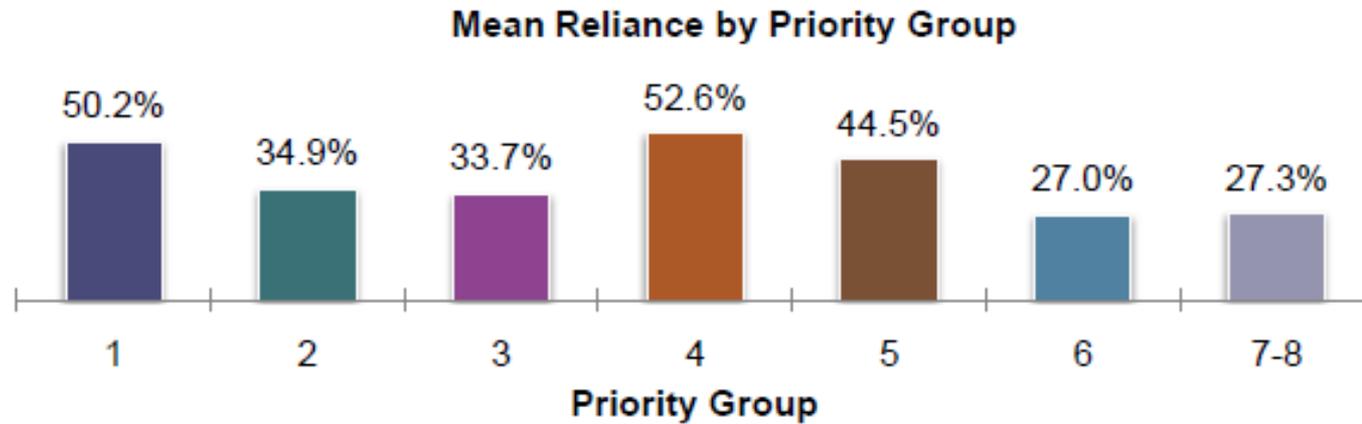
VA Reliance for Outpatient Care

Mean Reliance by Various Insurance Coverage



Source: ADUSH 2010 Survey of Enrollees

VA Reliance for Outpatient Care



Source: ADUSH 2010 Survey of Enrollees

VA Reliance for Outpatient Care

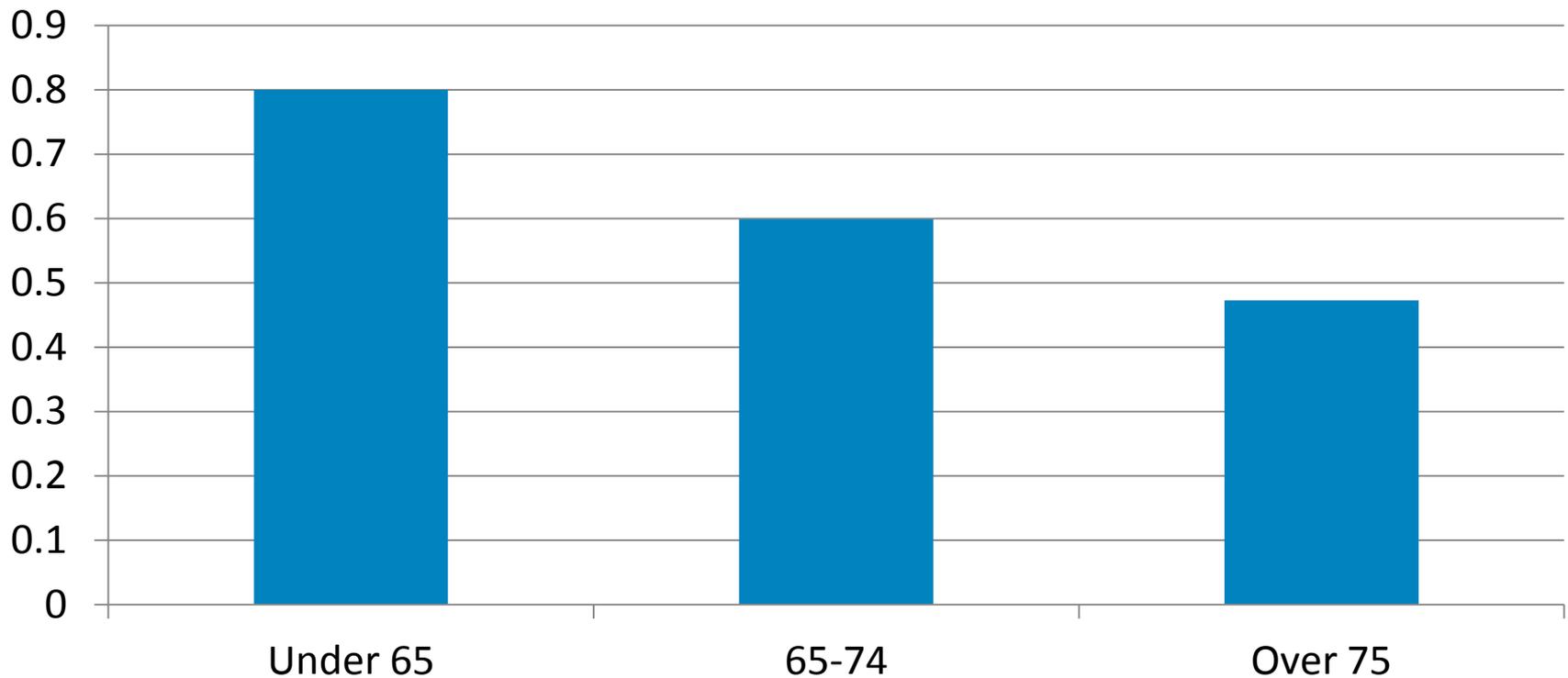
Mean Reliance by Income Group



Source: ADUSH 2010 Survey of Enrollees

VA Reliance for Outpatient Care

Mean Reliance by Age



VA-Medicare Dual Use by Service

Health Care Use by Veterans Enrolled in Both VHA and Medicare, by Type of Service, Fiscal Year 2005

(Percent)

Type of Service	No Use	Medicare Use Only	Both VHA and Medicare Use	VHA Use Only
Inpatient Hospital Care	76.2	19.2	1.2	3.4
Ambulatory Care	3.1	28.0	53.6	15.3
All Categories	3.0	28.1	53.9	15.0

Source: Congressional Budget Office based on data from the Department of Veterans Affairs.

Note: Data reflect the use of health care services by Medicare-eligible enrollees age 66 and older who have also been enrolled in the Veterans Health Administration (VHA) for one year or more.

Source: "Quality Initiatives Undertaken by the Veterans Health Administration," CBO, August 2009

VA-Medicare Dual Use by Inpatient Service

Health Care Use by Veterans Seeking Care from VHA, Medicare, or Both, by Detailed Health Service Category, Fiscal Year 2005

(Percent)

Type of Service	Medicare Use Only	Both Medicare and VHA Use	VHA Use Only	Probability of Use In Health Service Category (Percentage of Dual Enrollees)
Inpatient Hospital Care				
Medical	79	4	17	17
Surgical	87	1	13	11
Psychiatric	67	3	30	1
Substance abuse	63	4	34	*
Skilled nursing facility/ extended care facility (nonacute)	96	1	4	4
Overall Inpatient Hospital Care	81	5	14	24

Source: "Quality Initiatives Undertaken by the Veterans Health Administration," CBO, August 2009

VA-Medicare Dual Use by Outpatient Service

Ambulatory Care	Medicare	Medicare + VA	VA	Pr(use)
Allergy immunotherapy	94	1	6	1
Allergy testing	91	*	9	*
Anesthesia	92	*	8	15
Cardiovascular	72	8	20	52
Chiropractic	100	*	*	7
Consultations	72	5	23	37
Emergency room visits	77	5	17	30
Hearing/speech exams	26	3	71	11
Immunizations	48	4	49	56
Miscellaneous medical	67	12	21	71
Office/home/urgent care visits	30	48	23	94
Outpatient psychiatric	27	4	69	8
Outpatient substance abuse	10	1	89	*
Pathology	35	31	34	88
Physical exams	22	1	77	11
Physical medicine	39	3	58	14
Radiology	67	12	21	68
Surgery	73	8	19	65
Therapeutic injections	74	3	23	25
Vision exams	68	4	27	49

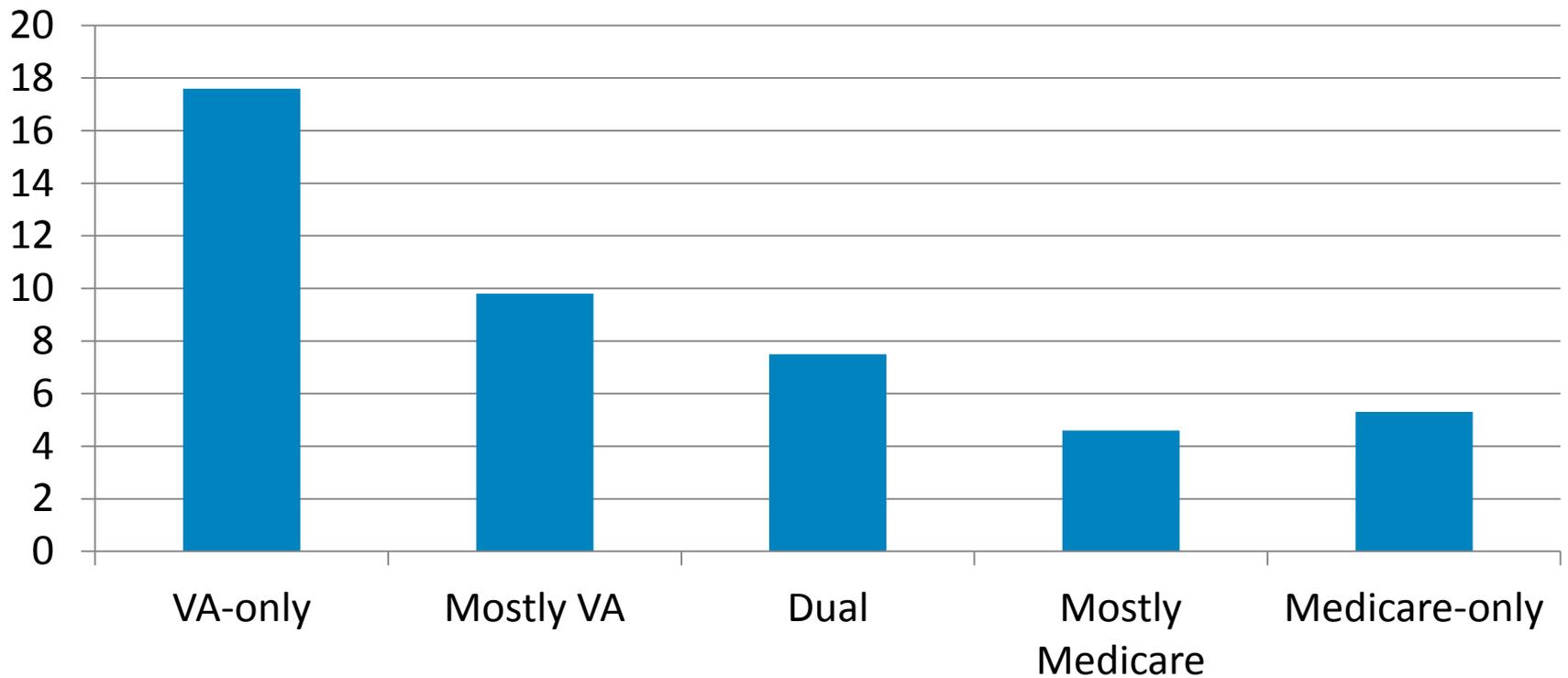
Source: "Quality Initiatives Undertaken by the Veterans Health Administration," CBO, August 2009

VA-Medicare Dual Use: The Basic Facts

- Half of VA enrollees have Medicare coverage
- VA reliance is about 40% for outpatient care, lower for inpatient care
- Inpatient demand is strongest for psychiatric and substance abuse care
- Outpatient demand is also strong for primary care and hearing/speech
- Demand is strongest from un/underinsured, high priority, lower income, under 65

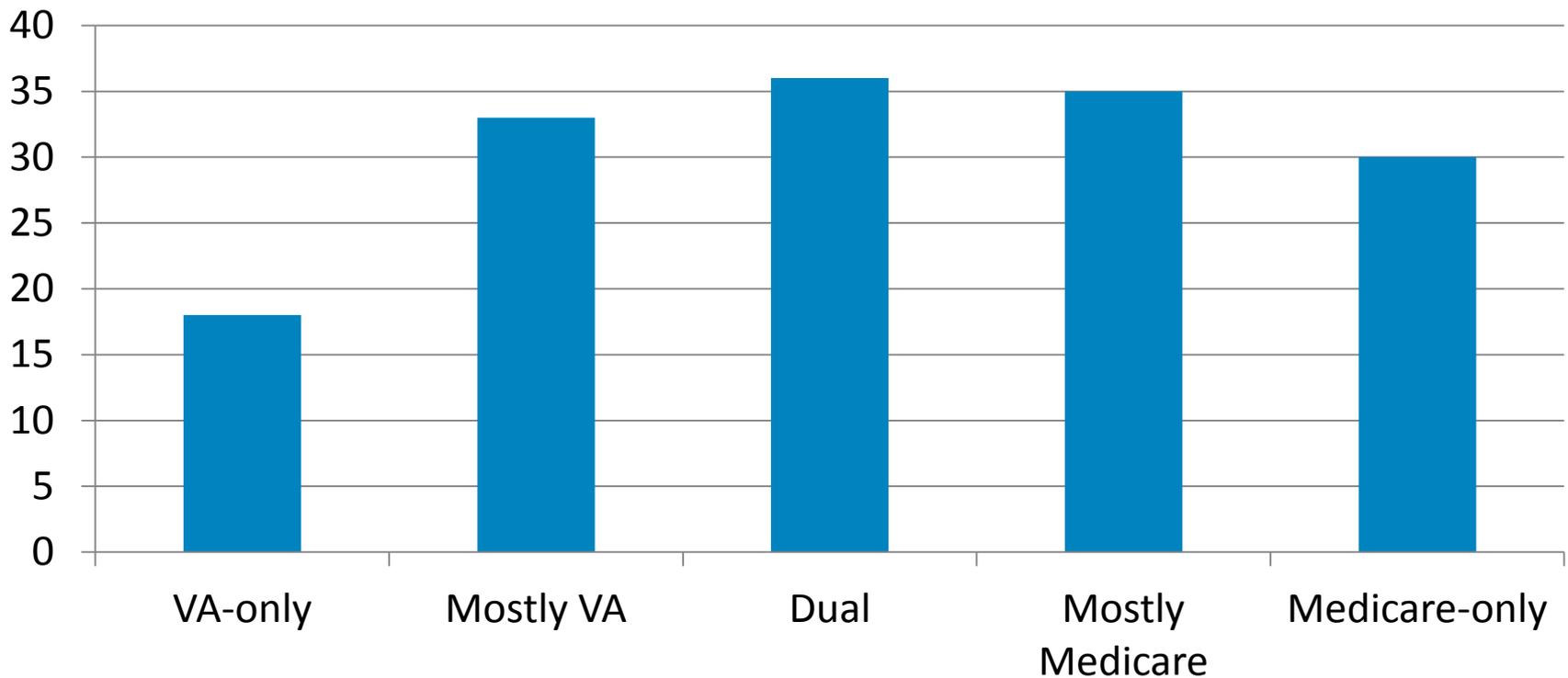
Who Are Dual Users?

% Black



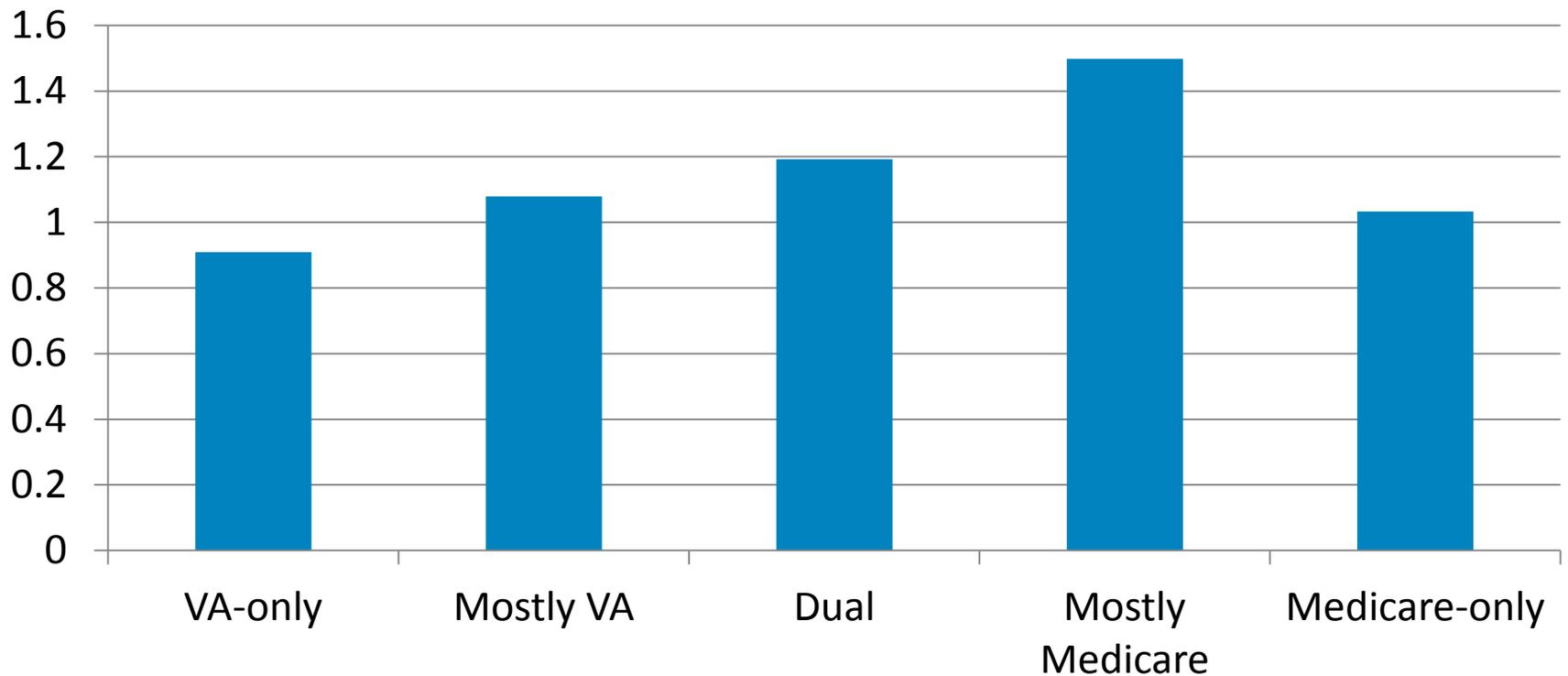
Who Are Dual Users?

Median Distance to VAMC



Who Are Dual Users?

Median Risk Score

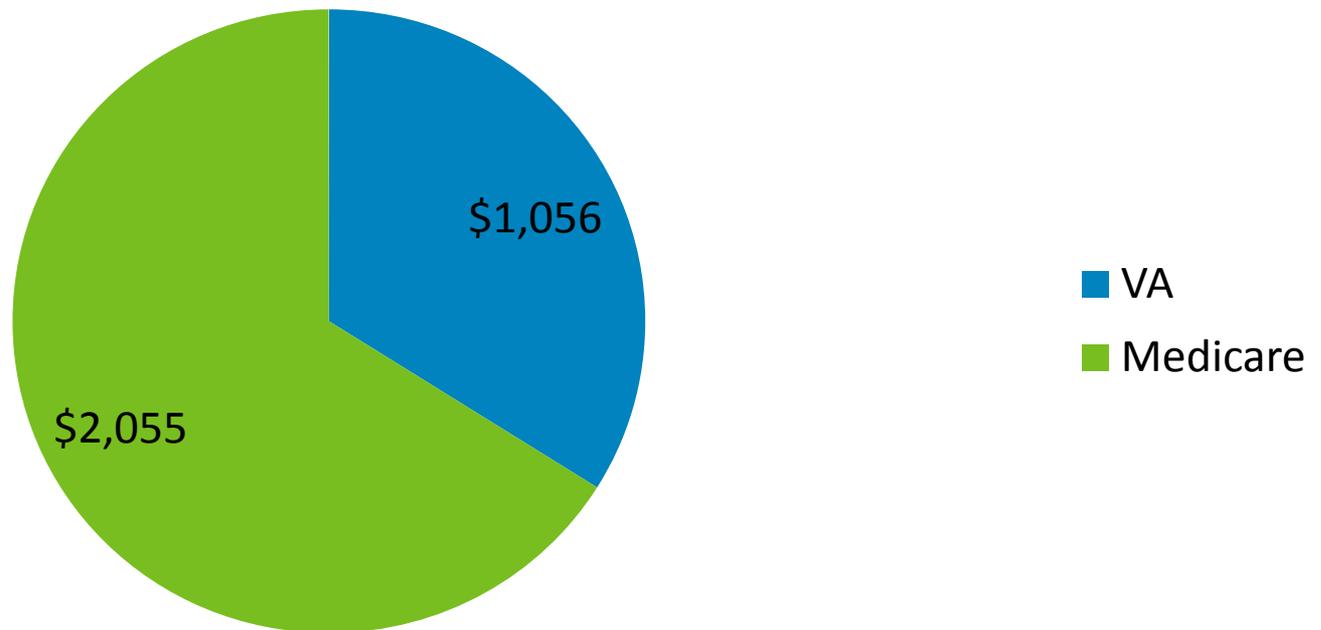


Factors That Affect Dual Use

- African-Americans and Veterans who live near VAMC are more likely to rely exclusively on VA
- As disease burden grows, Veterans rely more heavily on Medicare

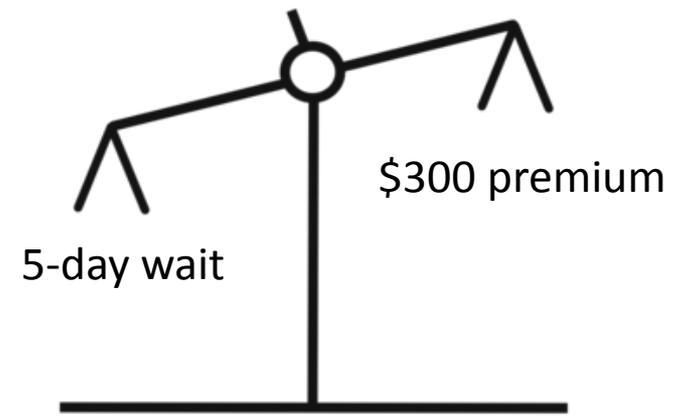
Consequences of Dual Use: VA Cost

Average Outpatient Cost, 1999



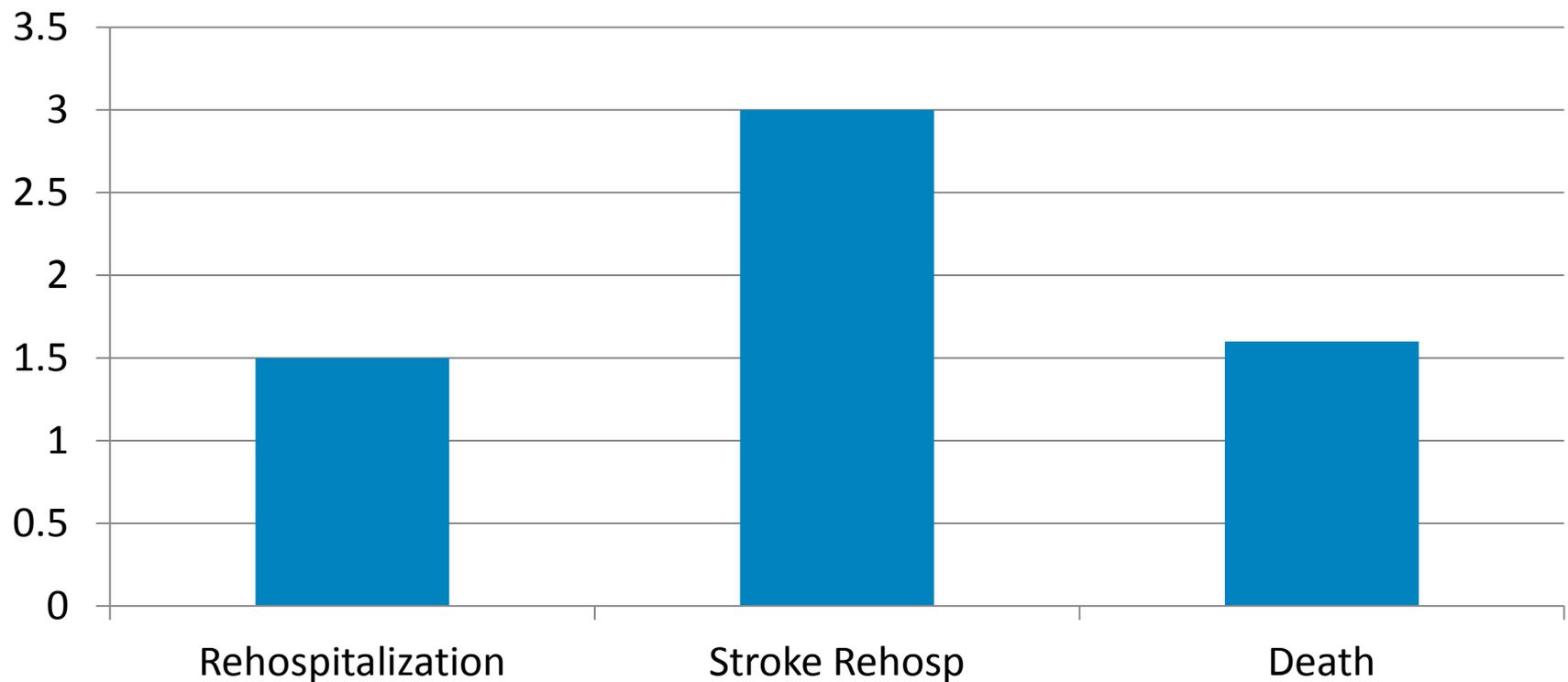
Consequences of Dual Use: Veteran's Cost

- Pizer and Prentice, Journal of Health Economics 2011, "Time is Money: Outpatient Waiting Times and Health Insurance Choices of Elderly Veterans in the United States"
- Study Medigap purchasing by Medicare-VA duals in Medicare Current Beneficiary Survey
- Link to VA administrative data on waiting times from appointment request to actual appointment
- 10% increase in VA wait time leads to 5% increase in demand for Medigap
- Representative Veteran indifferent between 5-day wait increase and \$300 annual premium increase



Consequences of Dual Use: Quality

VA-Medicare vs. VA-Only Stroke Patients (AORs)



Consequences of Dual Use: Quality

- Wow! Those are big effects of dual use
- Jia and colleagues controlled for demographics, length of stay, stroke type, comorbidity index, ICU days, stroke and TIA history, other variables
- But dual users may have been sicker in unmeasured ways
- Can we do a study that filters out effects of unobserved differences?

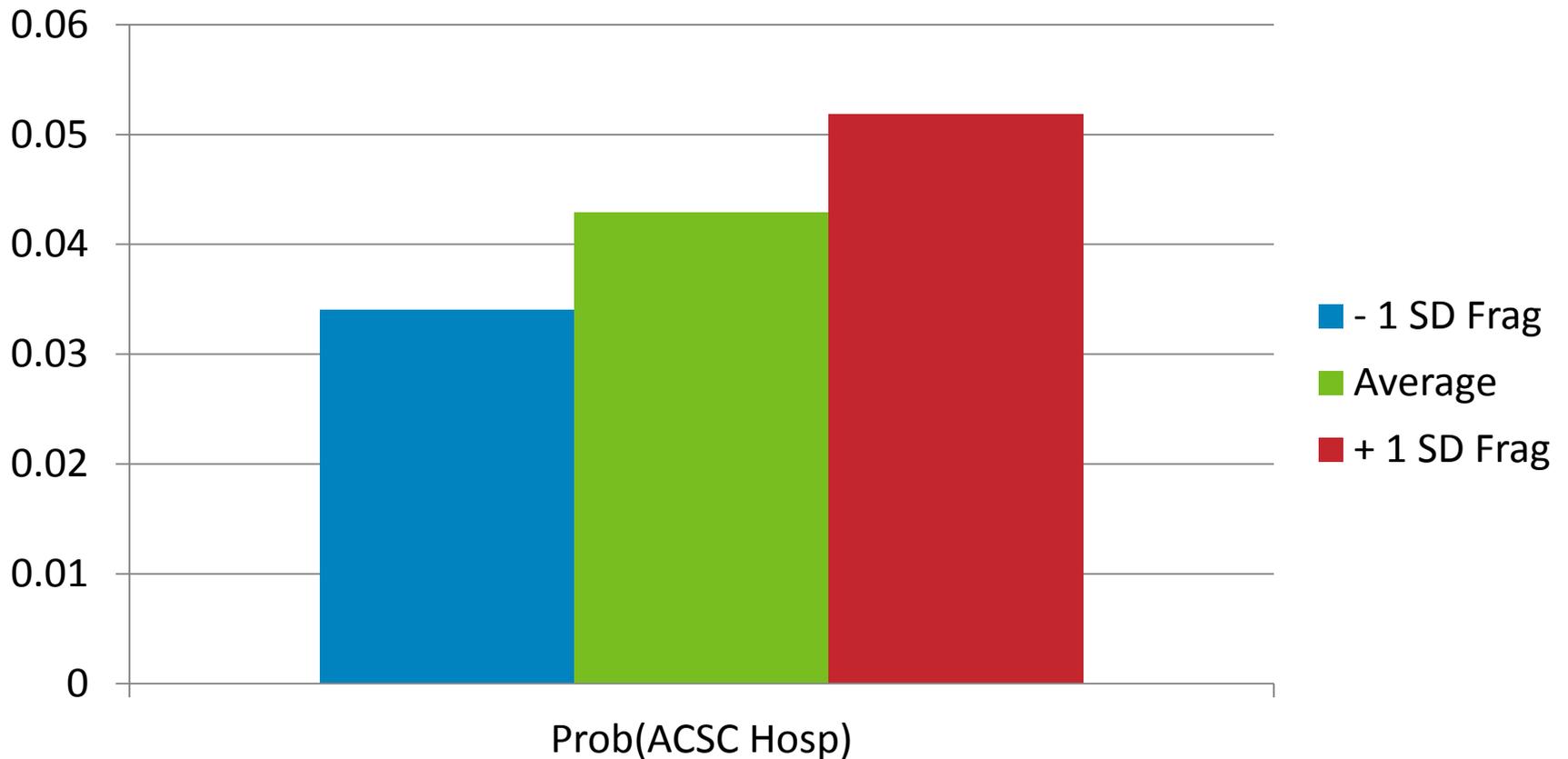
Brief Detour: How Instrumental Variables Work

- We have a question about a treatment
- Plan A: Run an experiment!
- Randomize into treatment; compare outcomes
- We can't
- Plan B: Build a statistical model of probability of treatment
- Find a variable that affects treatment probability, but not outcome (except thru Tx)
- Isolate variation in Tx that's due to quasi-random variable
- Measure only effect of quasi-random variation on outcome

Consequences Of Dual Use: Quality

- Pizer and Gardner, Inquiry 2011, “Is Fragmented Financing Bad For Your Health?”
- 288,000 observations on Veterans with VA and/or Medicare outpatient use
- Calculated “fragmentation of financing” = $1 - \max(\text{VA}\%, \text{Mcare}\%)$
 - VA or Mcare only => zero fragmentation
 - Max fragmentation is 0.5
- Outcome: Hospitalization for ambulatory care sensitive condition (AHRQ, 2001)
- Methodological challenge: Fragmentation and ACSC hospitalization jointly determined
- Solution: Use distance to VA as instrumental variable to predict fragmentation, then measure effect of predictable component only

Results: Fragmentation Moves Hospitalization Risk 20%



Implications

- Coordination problems between VA & Medicare are serious
- Effects on Veterans' health and budgets are significant
- Quality consequences are costly for both systems

Poll Question #2: Policy Responses

- What is the best policy response to dual use?
 - Expand VA services (VA absorbs Medicare services)
 - Privatize VA services (Medicare absorbs VA services)
 - Change to comprehensive model (e.g., PACT)
 - Improve VA-Non-VA coordination (e.g., MyHealthVet)

Policy Responses: Expand VA Services?

- Could VA provide comprehensive care to current enrollees?
 - Roughly double volume of outpatient care
 - Increase inpatient volume much more (4-5X?)
 - Increase prescription volume ← **This we could do!**
- If VA provided more comprehensive care, would demand for enrollment grow?

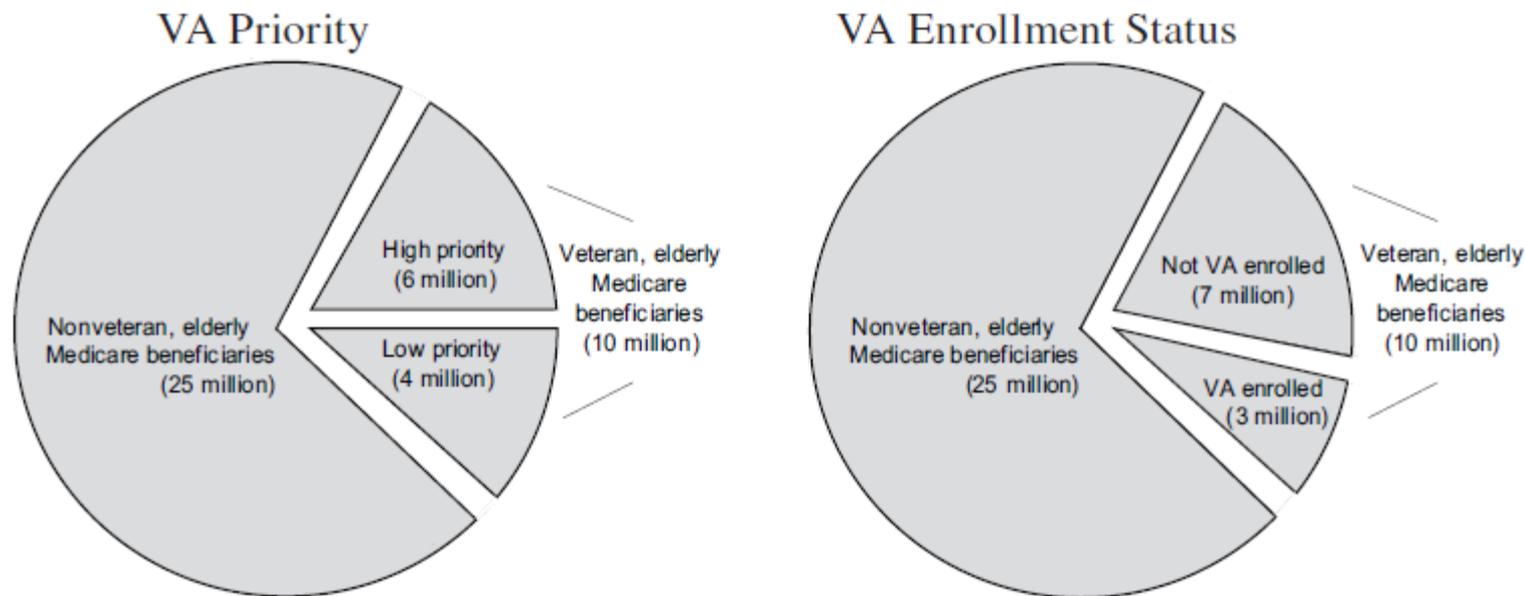


Figure 1 Elderly Medicare Beneficiaries^(a) in 2003 by Veterans Status and VA Priority^(b) and VA Enrollment Status. *Sources:* Authors' analysis of 2000 Census Data; United States Census Bureau (2007); United States Congressional Budget Office (2001).

(a) There were 41 million Medicare beneficiaries in 2003. These figures illustrate the 35 million of them who were elderly.

(b) Priority status imputed by authors using 2000 Census data. Low-priority veterans are those with priority status eight. High-priority veterans are those with any priority status number below eight.

Source: Frakt, Pizer, Hendricks, JHPPL 2008

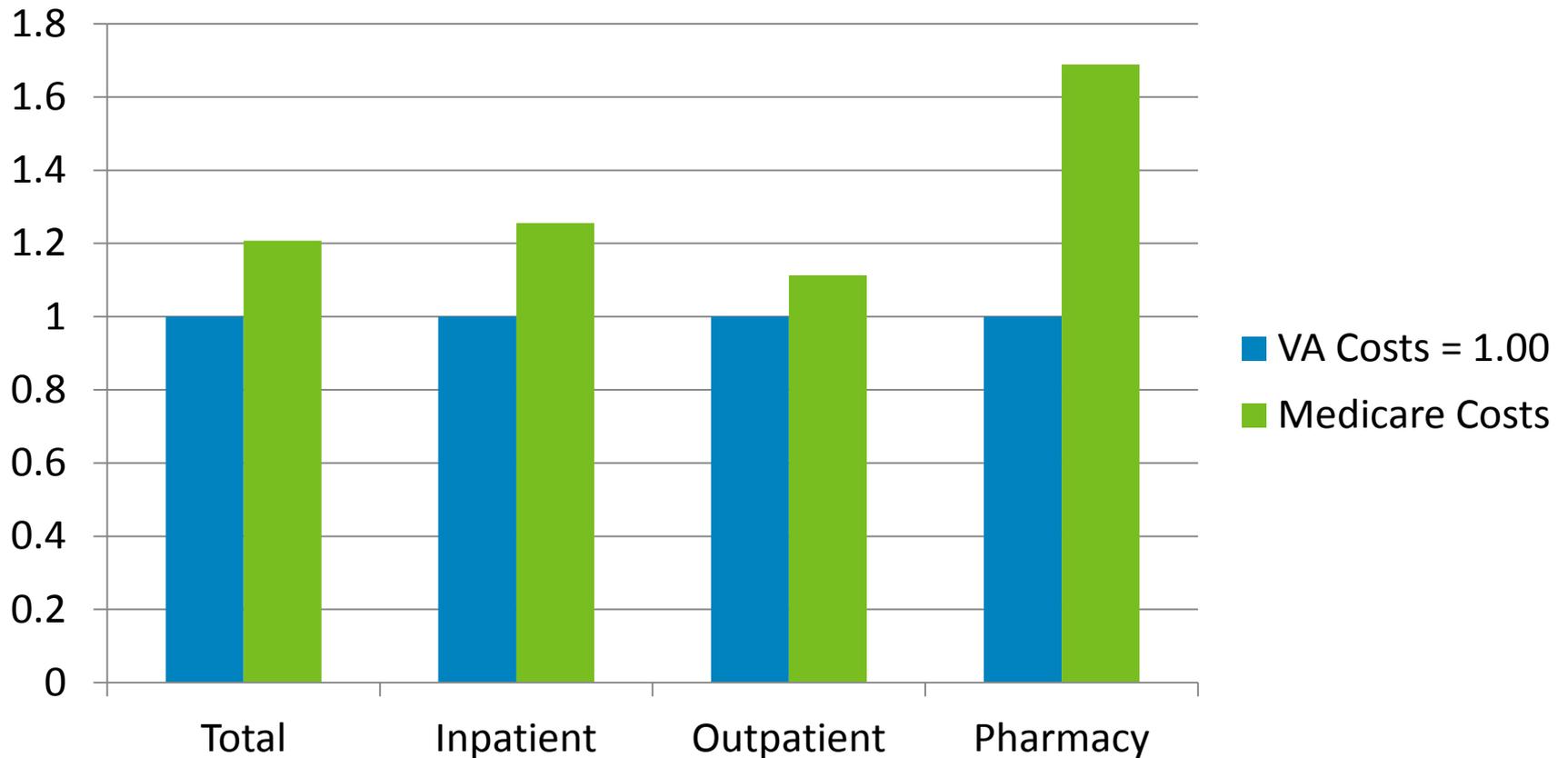
Policy Responses: Expand VA Services?

- Rate of VA capacity growth limits expansion
 - Exception: VA could offer a Medicare prescription drug plan (Frakt, Pizer, Hendricks 2008)
- Potential demand for VA care is vastly larger than likely capacity

Policy Responses: Privatize VA Services?

- If VA can't absorb Medicare utilization, should Medicare (or TRICARE) absorb VA?
 - Perennial question in Congress
- Nugent, Hendricks, Nugent, Render, MCCR 2004 “Value for Taxpayers’ Dollars: What VA Care Would Cost at Medicare Prices”
- Constructed Medicare prices for VA services delivered at 6 sites in 1999
- Used results to estimate Medicare costs for VA services nationwide

Policy Responses: Privatize VA Services?



Policy Responses: Privatize VA Services?

- Overall, Medicare prices were 20% higher than VA costs
- In 2003, it would have cost \$5 Billion more to provide VA services through Medicare, nationwide
- Clearly not an efficient solution to the problem
- Quality and access issues too (e.g., mental health services)

Policy Responses: Change to Comprehensive Model?

- Patient-Aligned Care Teams (PACT) designed to provide comprehensive care
- Improve coordination, communication
- PACT evaluation finding modest savings for <65, not for >65
 - <65 ACSC hosp and OP primary care were lower
 - >65 no change in ACSC hosp and OP primary care was higher
- PACT is costing about \$2 billion; hard to justify w/o savings for >65
- Is lack of savings for >65 because of increased VA reliance?
- Either way, VA primary care has to coordinate with non-VA specialty care



Policy Responses: Improve VA-Non-VA Coordination?

- Personal Health Record: MyHealtheVet
- Sharing clinical data through Nationwide Health Information Network (NwHIN)

Personal Health Record (PHR)

- MyHealthVet personal health record (PHR) designed to improve communication
- Veteran-provider (secure messaging)
- VA provider – Medicare provider?
- PHR interoperability still in infancy
- Blue Button is a first step
 - Burden on patient to print & carry
 - Very few actually do it
- Privacy vs. coordination
- Privacy is formidable concern, but battle is not over



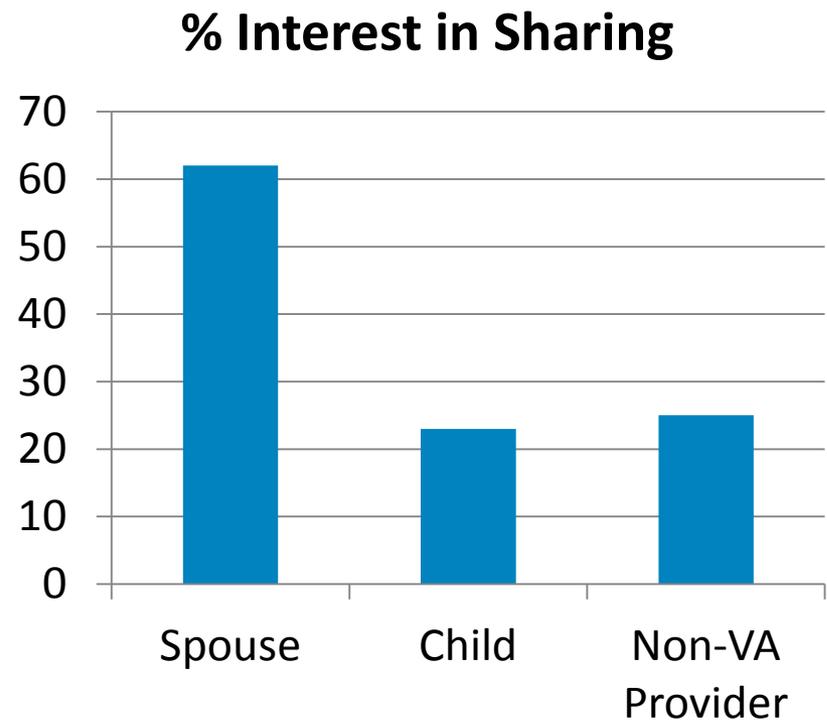
My Health, My Care: 24/7 ^{Online} Access to VA

Interoperable PHR: The Potential

Survey

- Zulman et al., Annals 2011, “Patient Interest in Sharing Personal Health Record Information”
- Web survey of 18,471 users of MyHealthVet
- Convenience sample; may not be representative

Results



Sharing the EMR: NwHIN and VLER Health

- Virtual Lifetime Electronic Record (VLER) started as VA-DOD data sharing in 2009
- VLER Health links VA and non-VA providers through local exchanges participating in Nationwide Health Information Network (NwHIN)
- 13 pilot sites as of March 2012 including: San Diego, Puget Sound, Minneapolis, Indianapolis, Buffalo
- Data elements include: allergies, medications, labs, vitals, immunizations, problems, encounters, procedures, other unstructured data including reports and notes

Challenges to EMR Sharing

- VA can plug into regional HIN, but it won't help if non-VA providers aren't plugged in yet
- Long-term VA HIN software development projects have suffered from OIT reorganization, budgetary changes, shifting priorities
- Will data sharing approval process be too burdensome for patients and clinicians on both sides to use?
 - As of May, 68,000 Veterans authorized VA to share, but community partner may also require authorization
 - Current HSR&D study of local exchange in Indianapolis (PI: Haggstrom)

Future Research: The Affordable Care Act

- ACA uses mostly federal funds to expand eligibility for Medicaid to 138% of Federal Poverty Line in states that opt in
- Currently 24 states likely to expand; 6 still considering
- In addition, individuals without employer-sponsored insurance will qualify for subsidized coverage through insurance exchanges
- VA enrollment qualifies as coverage
- Will there be more dual users?
 - VA enrollment might increase to comply with individual mandate
 - Dual use might increase due to Medicaid expansion and exchanges
- How will dual use be different under ACA?

Discussion

- Questions?
- Additional questions or comments: Steven.Pizer@va.gov