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Commentary

The Impact of the Affordable Care Act on VA's Dual Eligible Population

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The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively referred to as the Affordable Care Act (ACA)) represents comprehensive reform of the health care delivery system and is intended to expand access to coverage, control health care costs, and improve the health care delivery system. When fully implemented, ACA will provide some Veterans with new options for health care, such as purchasing private health insurance through the soon to be established health insurance marketplaces or from Medicaid if the Veteran resides in a state that expands Medicaid eligibility.

Dual Eligible Veterans

Dual eligible Veterans are those Veterans who are enrolled in VA health care as well as another health care program (i.e. Medicare, Medicaid, TRICARE, etc). Of the 6.5 million Veterans who received health care coverage under VA, Medicare, or Medicaid in fiscal year 2006 (which is the most recent data VA had), approximately one-third used more than one system of care. Veterans with dual and/or triple eligibility experience fragmented care, which diminishes continuity and coordination of care, resulting in more emergency department use, hospitalizations, diagnostic interventions, and adverse events.¹

ACA will not change Veterans' current eligibility for VA health care, covered benefits, or co-payments for services. However, ACA is expected to have an impact on the coordination of care for dual eligible

Veterans. As such, VA must understand its dual eligible Veterans in light of the changing health care environment. The ACA contains several provisions intended to improve care for dual eligible beneficiaries through better coordination of care, improved quality measures, and increased access to home and community-based long-term care services.^{2,3}

Initial Analyses and Findings

To better understand dual and triple eligibles among enrolled Veterans and to identify potential policy and program interventions for these Veterans, the VHA Office of Policy and Planning conducted several analyses. Medicare and Medicaid claims data from fiscal year 2006 was merged with VA utilization data to identify dual/triple system users. Based on their health care utilization in FY 2006, Veterans were classified into seven distinct user groups in order to compare the demographic characteristics, geographic distribution, and the morbidity/mortality of Veterans in these different user groups with a particular focus on those in the following dual/triple user groups: (1) VHA and Medicare; (2) VHA and Medicaid; and (3) VHA, Medicare, and Medicaid.

Demographic characteristics. Medicaid use was associated with being female and being of a younger age, on average, when compared to Medicare or VHA use. One-fifth of Medicaid only users were female compared to one-tenth of VA only users and one-twentieth of Medicare only users. Medicare users were older on average than individuals



Director's Letter

Change is good, but too much change can be disorienting and demoralizing. After almost two years of important, and I think necessary, changes in HSR&D—the initiation of CREATEs and the transition of our Centers to COINS—I am thrilled to have been appointed as the new Director of HSR&D to continue some of the initiatives begun under Seth Eisen. I hope over the next year, while continuing to consolidate the changes we have made, also to restore some of the stability that is necessary for an organization to function effectively and move ahead. I have described the changes we undertook in HSR&D as a “course correction” as opposed to an about-face, and the sailing analogies from my childhood with my grandfather on Buzzards Bay still seem apt. After changing course (“coming about”) in a sailboat, there is always that period where one waits for the sails to refill and for the boat to begin to move again. If I lost patience too soon, and started pulling the tiller one way or the other trying to find a slightly better breeze, I often found the boat dead in the water with the sail flapping in the wind. I am confident we are headed on a course that has aligned our research with the needs of the VA and Veterans and that will result in greater impact of our research. From five years in HSR&D I know I can trust the soundness of our research centers and all of our field investigators—our “boat” and “crew.” They will do the equivalent of trimming the sails and handling the occasional squall (IT anyone?). But I can already feel our “boat” beginning to pull through the water and pick up speed. Just keep an eye out for pirates.

David Atkins, M.D., M.P.H., Director, HSR&D

who used VHA and/or Medicaid. The average age for Medicare only users was 75.1 years compared to 56.2 years for VHA only and 49.8 years for Medicaid only. Medicare-Medicaid-VA triple users and Medicare-Medicaid dual users had the highest mortality rates (47.9 percent and 57.7 percent, respectively) of all the cohorts studied. VHA only users had the lowest reported mortality rate (10.7 percent).

Geographic distribution. In 2006, Medicare-VA users were concentrated in California, Texas, Pennsylvania, New York, Illinois, Ohio, North Carolina, Michigan, Missouri, Indiana, Georgia, and Tennessee. Medicaid-VA users were concentrated

in New York, Pennsylvania, Tennessee, Florida, and Ohio.

Diagnostic picture. Overall, diabetes mellitus was the most common diagnosis among Veterans with a prevalence of 24.2 percent. Heart disease was the second most common diagnostic category (22.3 percent), followed by lung disease (16.6 percent), neoplasms (14.0 percent), and vascular disorders (11.6 percent). Although prevalence rates varied among types of users (for example, the combined prevalence for Medicaid only users was 17.4 percent compared to 83.4 percent among users of all three systems), diabetes and heart disease were each among the five most prevalent diagnoses for all seven cohorts. The prevalence

of psychiatric and substance use disorders is higher among Veterans who use Medicaid and/or Medicare in addition to VHA services than those Veterans who used only VHA services.

Our findings indicate that Veterans who received care exclusively from VA had better health profiles than their dual or triple eligible users. Since VA serves a large number of dual and triple eligibles, this represents an opportunity for VA to enhance service delivery and improve care coordination for these socially and clinically complex patients.

There remain a number of unknowns regarding exactly how ACA will be implemented in terms of the health insurance marketplaces and Medicaid expansion. States are still deciding whether they will expand Medicaid eligibility but a number of states are indeed opting to expand and receive the additional federal funds for these newly eligible beneficiaries. Except for those individuals who, if otherwise eligible, seek the premium tax credit to defray the cost of insurance premiums, VA will continue to have a population of dual eligibles even after ACA is implemented in 2014. The VHA Office of Policy and Planning will continue its efforts to analyze the impact of ACA on VA's dual and triple eligible population in order to improve the quality and continuity of care for our Veterans.

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Response to Commentary

What We Need to Know about Dual Use

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As noted in the article by Pat Vandenberg et al., about a third of Veterans cared for by the VA also gets care outside of the VA, usually from private Medicare providers. Receiving care from two separate systems is not ideal in today's health care environment (for reasons described in other papers in this issue) but it represents the willing choice of those Veterans and is thus not likely to go away. We need to understand this population and the care they seek for a number of reasons: first, to ensure that their current and future needs are met; and, second, to predict future demands on VHA resources.

Patterns of Dual Use Care

The research we need to guide practice and policy falls into at least three general areas. The first area is to understand at a macro level the patterns of dual use so that we can better forecast the future needs of the population for which we care. As the analysis from the Office of Policy and Planning indicates, broad patterns of dual use are influenced by the age and gender mix of the Veteran population, their geographic distribution (rural vs. urban), their health care needs, and external factors such as the state of the economy and availability of insurance. All of these factors are changing, some dramatically. The demobilization of large numbers of active-duty military and impending reductions to the defense budget will create a large new cohort of Veterans, many of them living in rural areas. The implementation of the Affordable Care Act and Medicaid expansion may provide alternatives to VA care for many poorer Veterans.

Some forces will increase the number of eligible Veterans who seek care outside the VA (especially those that increase health care coverage options for Veterans) and some will decrease it (a slow economy with a population of Veterans whose needs are not well met in the private sector). We need to be able to forecast these trends more reliably or we will risk either building capacity we don't need or being unable to meet the demand that develops.

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Influences on Dual Users

The second area of research is understanding at a micro-level the factors that influence a dually-eligible Veteran to seek care in the VA but to turn outside of the VA for certain aspects of that care. There will always be Veterans who seek acute care at private hospitals because they live too far from the nearest VAMC. But other instances of dual use reflect preferences that are amenable to change, i.e. a decision that the private provider offers better access, convenience, experience of care, or technical quality. The substantial investment the VA is making to promote access in rural areas, expand telehealth, and improve specialty access may reduce the number of Veterans who seek out local specialists. At the same time, by better understanding the choices our Veterans are making and why, we will improve our decision making as to investments that would increase the proportion of times the patient chooses VA for their care.

Effects of Dual Use on Quality

A third critical area, which has been the emphasis of much of the limited research on dual use to date, is to examine the effects of dual use on quality. If Veterans receiving dual care had identical health outcomes to those getting all their care in the VA, the issue would be one simply of cost and convenience. Unfortunately, studies such as those by Pizer, et al. suggest dual use is associated with worse outcomes. While we can guess at reasons this might be so, we actually don't know the exact mechanisms by which dual use produces worse outcomes and, more importantly, how to mitigate them. Is it, as is often assumed, a result of poor communication and missed hand-offs as patients traverse two independent health systems? Or is it related to more complex factors of patient activation and engagement, which may be diminished by fragmented care? The answers matter because the solutions are different. To the extent that poor outcomes are a result of miscommunication between clinicians or with patients, interventions such as regional information exchanges, medication reconciliation, and the Blue Button feature of MyHealthVet may gradually improve things. But if the underlying problem is that a Veteran feels less connected to care, and thus less involved in effective self-management, because his or her clinicians are not all on one team, the solutions are much more challenging. A principal notion behind the VA investment in Patient Aligned Care Teams was to have a “medical home” that would coordinate comprehensive care. How does one recreate the benefits of “home” for a patient commuting between two residences?

One challenge for initiatives targeting these Veterans is that dual use can make the VA “business case” more complicated. If VA develops a successful program that improves coordination and reduces hospitalization in dual users, the savings may accrue to Medicare rather than to VA. There is no shortage of interesting questions for researchers to tackle and HSR&D is committed to building the knowledge needed to improve the care for this important and growing population. Moreover, the lessons we learn are likely to help us improve communication, coordination, and engagement for all of our patients.

Research Highlight

What are the Quality Consequences of Medicare-VA Dual Use?

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Over half of VA enrollees are dually enrolled in Medicare.¹ Veterans who are dual Medicare enrollees include about 40 percent of Veterans in the highest priority groups—those with service-connected disabilities—and higher percentages in lower priority groups. Dually-enrolled Veterans frequently obtain health services from VA and Medicare in the same year, typically relying on VA for less than 40 percent of their outpatient care. When they need inpatient care, these Veterans are more than four times as likely to rely on Medicare as they are to rely on VA.² These basic facts imply that VA costs are much lower than they would be if dual enrollees relied exclusively on VA for care. They also imply that the quality of VA care might be suffering because VA clinicians may have difficulty coordinating care and exchanging information with non-VA providers across the boundary between VA and non-VA networks.

To investigate the impact of dual use on quality of care, we combined VA utilization records with Medicare claims data and studied the relationship between fragmentation of care across the two systems and the likelihood of experiencing a hospitalization for an ambulatory care sensitive condition (ACSC).³ These hospitalizations have been widely used to assess the quality of outpatient care in geographic regions. Because inpatient admissions are costly, they are also an important measure of inefficient resource use.

Fragmentation Study

Our research database contained 288,000 observations on dually-enrolled Veterans with Medicare and/or VA outpatient use in 1999 and 2000. We counted outpatient visits in each system by six-month periods and then characterized the degree of fragmentation of care for each patient in each period as one minus the percentage of the patient's outpatient care provided by the VA or the percent-

age provided by Medicare, whichever was larger. This formula implies that a Veteran relying exclusively on either VA or Medicare would have a fragmentation measure equal to zero ($1-1=0$). The maximum degree of fragmentation possible is 0.5, arising if the Veteran evenly divided his or her outpatient visits between the two systems ($1-0.5=0.5$).

We related this measure of fragmentation to the probability of experiencing a hospitalization for an ACSC, as defined by the Agency for Healthcare Research and Quality. ACSC hospitalizations consist of 13 types of adult admissions thought to be potentially preventable through high quality outpatient care. The most common ACSC admissions in the VA population are those for congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), dehydration, urinary tract infection (UTI), long-term complications of diabetes, and pneumonia. We risk adjusted this relationship by controlling for the age and priority status of each Veteran as well as 30 co-morbidities defined by ICD-9-CM codes recorded in the period before measuring for fragmentation and outcomes.

This analysis was complicated by the fact that patient health or behavior that is unobservable to the researcher may affect fragmentation and ACSC hospitalization. For example, a patient with poor self-care skills might need frequent outpatient visits in both systems to address minor problems; this patient might also experience ACSC hospitalizations when more serious problems develop. In this example, fragmentation of care does not necessarily cause hospitalizations, instead, poor self-care causes both fragmentation and hospitalizations.

To address this methodological challenge, we used an instrumental variables statistical model constructed in two stages. The first

stage predicted the degree of fragmentation of care for each Veteran as a function of the distance between that Veteran's residence and the nearest VA Medical Center. The second stage estimated the relationship between the predictable component of fragmentation and the probability of ACSC hospitalization.

Results and Implications

Our estimates indicated that the degree of fragmentation of outpatient care between VA and Medicare had a strong and statistically significant effect on the probability of hospitalization for an ACSC. A one-standard deviation change in fragmentation was associated with a 20 percent change in hospitalization rates. The instrumental variables statistical technique allows us to infer a causal relationship more confidently than we could from a simpler observational design, but the inference is not as strong as it would be with a randomized experiment.

These results imply that VA and Medicare are spending substantial resources on inpatient care for Veterans who could be managed more efficiently and more effectively if their care were better coordinated. Several initiatives are currently being implemented by VA management to facilitate sharing of electronic medical records between VA and non-VA health plans and facilities. These efforts have the potential to reduce the harm from fragmentation. In addition, the reorganization of VA primary care to emphasize continuity and comprehensiveness of care from a patient-centered team has the potential to reduce fragmentation itself. With initiatives like these, VA managers have a rare opportunity to save money while simultaneously improving the quality of care for a particularly vulnerable population of Veterans.

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Research Highlight

Health Information Exchange in the VA

Michael Weiner, M.D., M.P.H. and David A. Haggstrom, M.D., M.A.S., both with HSR&D's Center of Excellence on Implementing Evidence-Based Practice, Richard L. Roudebush VA Medical Center, Indianapolis, Indiana

Although the VHA is a large integrated health care delivery system, no system of health care is closed. Many patients receive care or undergo procedures not only in the VA but in other medical institutions, such as academic medical centers, community-based hospital systems, free-standing clinics, laboratories, and pharmacies. In 2009, 50 percent of Veterans with Medicare Advantage received both VA and Medicare Advantage services. What happens when providers need information about care received by their patients in other institutions?

Health information exchange (HIE) enables information about patients to flow among a network of institutions with trust agreements and standards about how to share data. Under the Centers for Medicare & Medicaid Services (CMS) Stage 2 meaningful use requirements, eligible providers and hospitals must electronically transmit care summaries for at least 10 percent of their patient transfers or referrals. Providers may use standardized document formats, such as a Continuity of Care Document, to summarize a patient's status. Allergies, medications, plans of care, procedures, immunizations, notes, discharge summaries, and advance directives can all be exchanged using the eHealth Exchange, which is a set of national standards, services, and policies that enable secure HIE via the Internet. Health information organizations, which operate mostly at regional levels, oversee HIE, facilitate systems' interoperability and security, and ensure authorized purpose of use among those who access information. In 2009, the United States had about 88 operational health information organizations.

In 2009, President Obama announced the Virtual Lifetime Electronic Record (VLER) project, to aid the transition of patients and their administrative and medical records, starting with military service. VLER Health works with community partners in pursuing the interoperability of health information systems, including VA and DoD systems. More than a dozen VA medical centers have participated in a VLER HIE pilot that allows bi-directional exchange of health information about Veterans between the VA and its community partners in those cases when a patient is receiving care from both. Initial program sites include San Diego, Hampton, Puget Sound, Spokane, Altoona, Asheville, Buffalo, Charleston, Grand Junction, Indianapolis, Minneapolis, Richmond, and Salt Lake City; several of these pilot sites encompass both VA and DoD facilities. Through its graphical user interface, VistA Web makes information from the local VAMC, remote VA facilities, and partnering community-based facilities available to VA clinicians, for those Veterans who have consented to participate in this program. More than 68,000 Veterans have already authorized the VA to share their health information among VA and non-VA facilities. In some cases, the HIE partner requires its own additional consent from patients.

Evidence and Impact of HIE

What do we know about the impact of HIE on care? A study of 32,468 emergency encounters in Indiana showed that charges decreased by up to \$26 per encounter.¹ Another study of 25,952 patients in Tennessee showed that a city-based HIE could save more than \$1 million in a year, primarily due to a reduction in hospital admis-

sions.² Many patients are supportive of HIE: a 2012 New York survey showed that two-thirds are comfortable with automatic central data storage, and more than 90 percent indicated that a primary care doctor should have emergency access to records without permission.³ We also know that the usability of computer systems that display and manipulate HIE data for clinicians is likely linked with adoption and satisfaction with these systems.

Through an HSR&D IIR grant, investigators at the Richard L. Roudebush VA Medical Center are working with its facility's administration and the region's health information organization, the Indiana Health Information Exchange, to study outcomes of the VLER Health Initiative pilot in Indianapolis. This study aims to assess the proportion and predictors of health care received by Veterans outside the VA, to assess the impact of HIE upon quality of care received by Veterans, and to explore whether HIE is reducing health care costs for Veterans. Potential outcomes of HIE include improvements in the quality of ambulatory care, reductions in admission rates for ambulatory care-sensitive conditions, and reductions in other types of avoidable services.

HIE is technically achievable, and incremental implementation is recommended. HIE has shown early promise in improving important measures of health care, and the VA's program is now being studied. Care delivered across institutions is the reality in our mobile society. As the scope of HIE's activity grows nationwide, health services researchers should consider how to expand the evidence base to understand more fully how HIE can increase the value of health care delivered to Veterans.

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Research Highlight

Dual Use in Colon Cancer: What Have We Learned about Quality and Costs of Care?

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Approximately 175,000 patients receive cancer care each year from the VA health care system. Among some Veterans, including those who live in urban areas with many health care options or who have a high comorbidity burden, dual use of VA and Medicare services is substantial. Several recent studies suggest that patients might receive different and possibly duplicative cancer-related services in the two settings.¹

At the Center for Management of Complex Chronic Care based at the Hines VA Hospital, we have undertaken research on dual use of VA and Medicare in cancer. One study in particular focused on quality of care, survival, and costs in colon cancer (HSR&D IIR 03-196). The VA Information Resource Center (SDR-02-237) provided support for this study. We conducted a retrospective cohort study linking data from eight National Cancer Institute Surveillance, Epidemiology, End Result (SEER) programs and the VA Central Cancer Registry (VACCR) with VA and Medicare claims data on Veterans aged 66 or older with colon cancer. Forty eight percent of the cohort received their cancer care predominantly from the VA, 36 percent predominantly from Medicare, and 13 percent used both systems for substantial portions of their cancer care. Overall, we tracked care for 3,949 Veterans diagnosed with colon cancer through 2004 and examined surgery and chemotherapy use, survival, and costs.

Older Patients Receive Less Chemotherapy in Both Settings

In early work focused on colon cancer patients in California, we found similarities across those initially treated in VA settings compared to those initially treated in non-VA settings. However, we discovered that

older patients were not receiving adjuvant chemotherapy at the recommended rate. The 601 Veterans with stage I to III colon cancer treated at VA and non-VA facilities experienced similar colectomy rates and stage III patients had similar odds of receiving adjuvant chemotherapy. In both settings, older patients had lower odds of receiving chemotherapy than their younger counterparts, even when race and comorbidity were considered.²

Differences in Survival in Dual Use versus Predominantly Single System Setting

We found differences in survival between predominantly dual users and predominantly single system users. When we compared 3-year overall and cancer event-free survival (OS, EFS) among patients with non-metastatic colon cancer who were dual users with those who were predominantly single system (VA or Medicare fee-for-service (FFS)) users, VA and non-VA users (all stages) had reduced hazard of dying compared to dual users. For EFS, we found similar stage I outcomes, whereas stage II and III VA users, but not non-VA users, had improved EFS. Improved survival among VA and non-VA users compared to dual users raises questions about coordination of care and unmet needs.³

Higher Colon Cancer Costs among Dual Users

We found significantly higher mean colon cancer-related costs over the first year after diagnosis among those who were dual users compared to those who used predominantly VA services or Medicare services. The cost

of care for dual users of colon cancer treatment in our study was 14 percent greater than the cost for predominantly VA users, and 18 percent greater than that of predominantly Medicare users. The higher costs for dual users than for single-system users could reflect higher rates of fragmented and duplicative care among dual users. Furthermore, our research indicated higher costs among patients who were African American, had more comorbidities, were older, or had more advanced-stage disease.

Although VA patients can be reassured that care is consistent with recommended guidelines, our findings signal potential concerns among patients with colon cancer who are dual users. In particular, efforts should be focused on exploring the apparent underuse of adjuvant chemotherapy among older Veterans with colon cancer. Greater understanding about the mechanisms of dual use is also important to determine causal and temporal relationships with subsequent health care use. Further research is recommended to understand the contribution of the possible causes of treatment variation: differences in unmeasured health status, patient preferences, physician communication or bias, and variations in provider or system quality. Research that seeks to explore and examine alternative care coordination options for cancer patients and that includes evaluation of VA and non-VA providers and consideration of mechanisms to facilitate improved care coordination across systems may offer potential avenues to achieve improved outcomes and costs.

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Research Highlight

Changes in Outpatient Care-Seeking by Medicare-Eligible Veterans

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Medicare-eligible Veterans are unique in being able to obtain care from two public health insurance programs (VA and Medicare) depending on convenience, relative prices, health care needs, availability of services and other factors. A significant proportion of Medicare-eligible Veterans obtain outpatient or inpatient care in both systems, which can complicate continuity of care, care coordination, and medication management. Care that is fragmented due to dual use of VA and Medicare may result in under-use or over-use in services, which could adversely impact health outcomes of Veterans. Furthermore, VA performance metrics may be affected by missing non-VA services.

Numerous studies have examined age-eligible Veterans' use of inpatient services, but fewer studies have examined Veterans' use of outpatient care or how utilization patterns change over time. This article summarizes findings from an examination of changes in VA and Medicare outpatient utilization in fiscal years (FY) 2001 through 2004 from a nationally representative sample of Medicare-eligible Veterans who used the Veterans Administration's primary care services in FY2000.

VA Reliance by Type of Outpatient Care and Over Time

Medicare-eligible Veterans obtained more primary care from VA than from Medicare in 2001 through 2004, but they obtained more specialty care from Medicare than from VA.¹ These Veterans used much more specialty care than primary care, and their reliance on VA services declined consistently for both types of care. The number of VA primary care visits per person decreased from 2.4 in FY2001 to 1.9 in FY2004, whereas Medicare visits per person

increased over time from 1.3 in FY2001 to 1.6 in FY2004. The number of Medicare specialty care visits per person increased from 6.7 in FY2001 to 8.8 in FY2004, more than offsetting a modest decline in VA specialty care visits from 4.1 per person in FY2001 to 3.7 per person in FY2004. Medicare-eligible Veterans obtained most of their outpatient mental health services in VA in all years.

For these patients, VA primary care providers are essentially co-managing dual users of VA and Medicare services with non-VA primary care providers. However, VA and non-VA providers currently lack clinical information that is integrated across health systems in order to co-manage effectively. The complexity of care coordination among VA and non-VA providers could present additional challenges as VA's systemwide implementation of Patient Aligned Care Teams (PACT), a patient-centered medical home model, evolves to address the needs of these patients. Dual use also creates opportunities to develop and test care coordination initiatives within PACT.

VA Reliance Differs by Type of Veteran

There are important variations in VA reliance by Medicare eligibility (age or disability) and usual source of primary care in VA (community-based outpatient clinic (CBOC) or VA medical center (VAMC)). Age-eligible and disability-eligible Veterans sought primary care and mental health care most commonly in VA, but these Veterans most often sought specialty care in both systems.² Disability-eligible Veterans were more reliant on VA for primary care, specialty care, and mental health care than age-eligible Veterans throughout FY2001-2004. Greater VA reliance for primary care and spe-

cialty care visits by disability-eligible Veterans is most likely related to their greater health needs.

Veterans obtaining primary care at CBOCs used less VA primary care and specialty care over time than Veterans obtaining VAMC-based primary care, but used more primary care and specialty care covered by Medicare.³ By FY2004, many VAMC-based Veterans and most CBOC-based Veterans obtained at least some primary and specialty care outside the VA. Increasing access to VA primary care in community settings via CBOCs may unintentionally result in fragmented care arising from dual use of VA and Medicare services.

These analyses from 2001 through 2004 showed that reliance on VA outpatient care decreased over time for Veterans of all types, particularly for primary care and specialty care. Unsurprisingly, Veterans obtaining mental health care relied on VA for such care. Research is needed to improve our understanding of whether reliance on VA has changed since the introduction of Medicare Part D in 2006. Most research to date on dual use of VA and non-VA services focuses on age-eligible Veterans in the Medicare fee-for-service program; additional subgroups of Medicare-eligible Veterans merit further examination, including Medicare Advantage enrollees, disability-eligible Veterans, and Veterans enrolled in Medicaid. Future research also needs to assess the impact of PACT on processes and outcomes of care for Medicare-eligible Veterans.

The quality of research and subsequent policymaking related to dual users could be enhanced through a partnership between HSR&D and Operations; Operations is aware of the information gaps that need to be filled to improve decision-making, and HSR&D researchers have the measurement and methods expertise needed to fill these gaps.

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Bosworth Receives 2013 Under Secretary's Award for Outstanding Achievement in Health Services Research



Hayden B. Bosworth, Ph.D., will receive this year's Under Secretary's Award for Outstanding Achievement in Health Services Research. The highest honor for a VA health services researcher, the award recognizes work

that has met three key criteria: improved our understanding of factors that affect the health of Veterans and improved the quality of their care; contributed to the future of VA health services research by inspiring and training the next generation of investigators; and enhanced the visibility of VA research.

Dr. Bosworth's research focuses on three areas of significant importance to the care and health care of Veterans: 1) self-management in chronic care; 2) development of quality measurements to monitor and improve health care; and 3) trans-

lating research findings into clinical care practice. Over the past 15 years, his work has explored innovative approaches to improving outcomes for patients with chronic diseases, including hyperlipidemia, diabetes, osteoarthritis, and depression—all conditions that are prevalent among Veterans. His work has also helped to reduce health care disparities, particularly among individuals with low literacy, and under-represented groups such as African American and Women Veterans.

Dr. Bosworth serves as Associate Director of HSR&D's Center for Health Services Research in Primary Care in Durham, North Carolina, where he has also directed the local VA Office of Academic Affairs Ph.D. Post-Doctoral Fellowship program for the past 13 years. He is a developmental health psychologist and tenured Research Professor at the Duke University Medical Center, and is both a highly sought after mentor and prolific author.

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Translating research into quality health care for Veterans

Center for Information Dissemination and Education Resources
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Bosworth Receives 2013 Under Secretary's Award for Outstanding Achievement in Health Services Research



Hayden B. Bosworth, Ph.D., will receive this year's Under Secretary's Award for Outstanding Achievement in Health Services Research. The highest honor for a VA health services researcher, the award recognizes work

that has met three key criteria: improved our understanding of factors that affect the health of Veterans and improved the quality of their care; contributed to the future of VA health services research by inspiring and training the next generation of investigators; and enhanced the visibility of VA research.

Dr. Bosworth's research focuses on three areas of significant importance to the care and health care of Veterans: 1) self-management in chronic care; 2) development of quality measurements to monitor and improve health care; and 3) trans-

lating research findings into clinical care practice. Over the past 15 years, his work has explored innovative approaches to improving outcomes for patients with chronic diseases, including hyperlipidemia, diabetes, osteoarthritis, and depression—all conditions that are prevalent among Veterans. His work has also helped to reduce health care disparities, particularly among individuals with low literacy, and under-represented groups such as African American and Women Veterans.

Dr. Bosworth serves as Associate Director of HSR&D's Center for Health Services Research in Primary Care in Durham, North Carolina, where he has also directed the local VA Office of Academic Affairs Ph.D. Post-Doctoral Fellowship program for the past 13 years. He is a developmental health psychologist and tenured Research Professor at the Duke University Medical Center, and is both a highly sought after mentor and prolific author.

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