Taking a Fresh Look: Reframing Veteran Health Care

Commission on Care
Washington, DC

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VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

Our Mission

…To care for those who shall have borne the battle, and for their widow and orphan.

-Abraham Lincoln

A Historical Perspective

1930 – Veterans Administration

1946 – Truman appoints Omar Bradley-20 million WWII Veterans-149 hospitals

1965 – Medicare/Medicaid enacted

1966 – Veteran Readjustment Benefits Act

Benefits to Veterans without service connected conditions

1973 – Congress authorized outpatient care for non-service connected conditions; CHAMPVA established

1980 – CHAMPVA expanded

1983 – Medicare Prospective Payment System (PPS)

1986 – Congress authorized VA to contract Veterans non-service connected care

1996 – Veterans Health Care Eligibility Reform Act

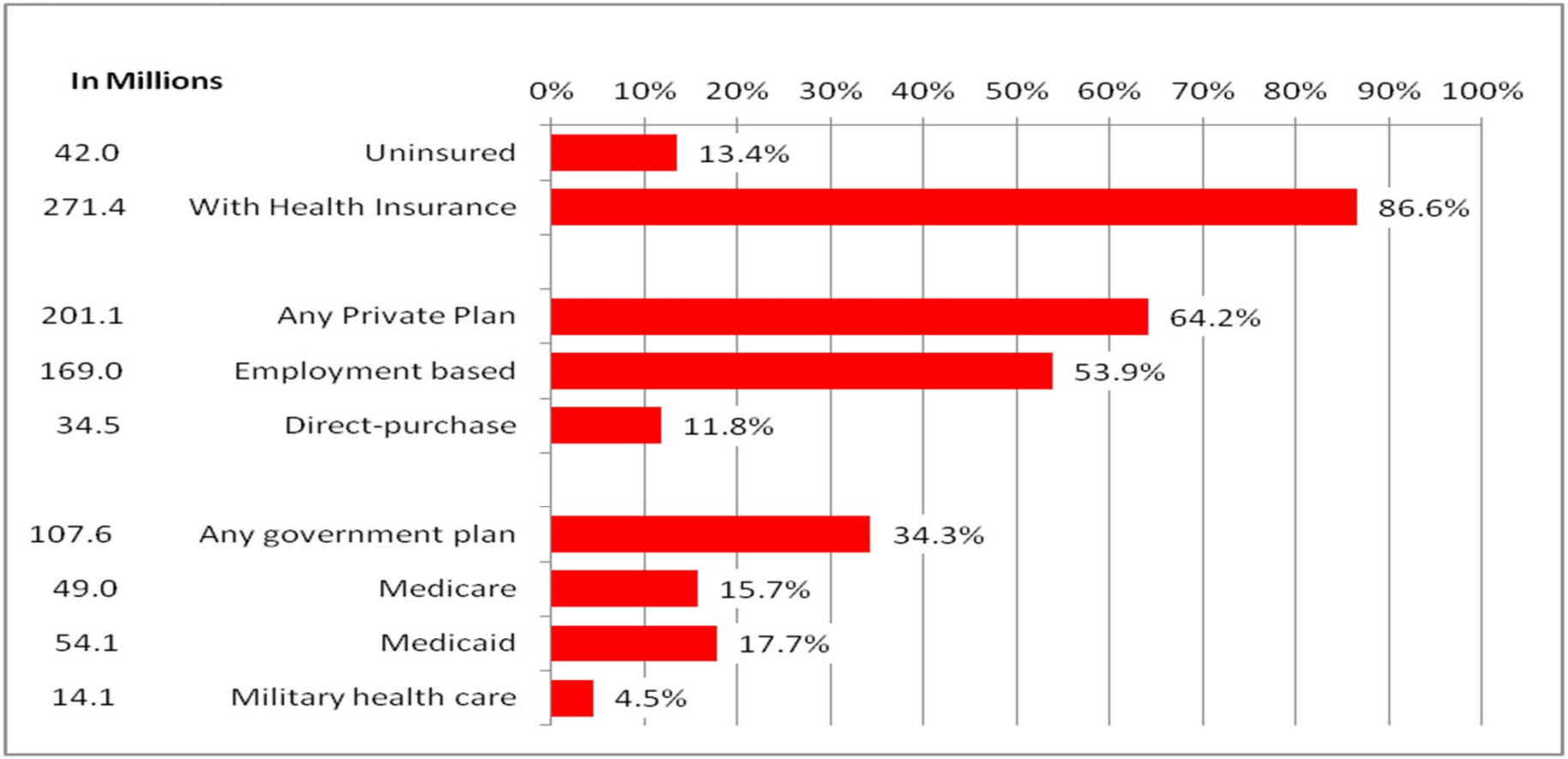
1999- Veterans Millennium Health Care and Benefits Act

2010 – Affordable Care Act

2014 – Veterans Access, Choice and Accountability Act

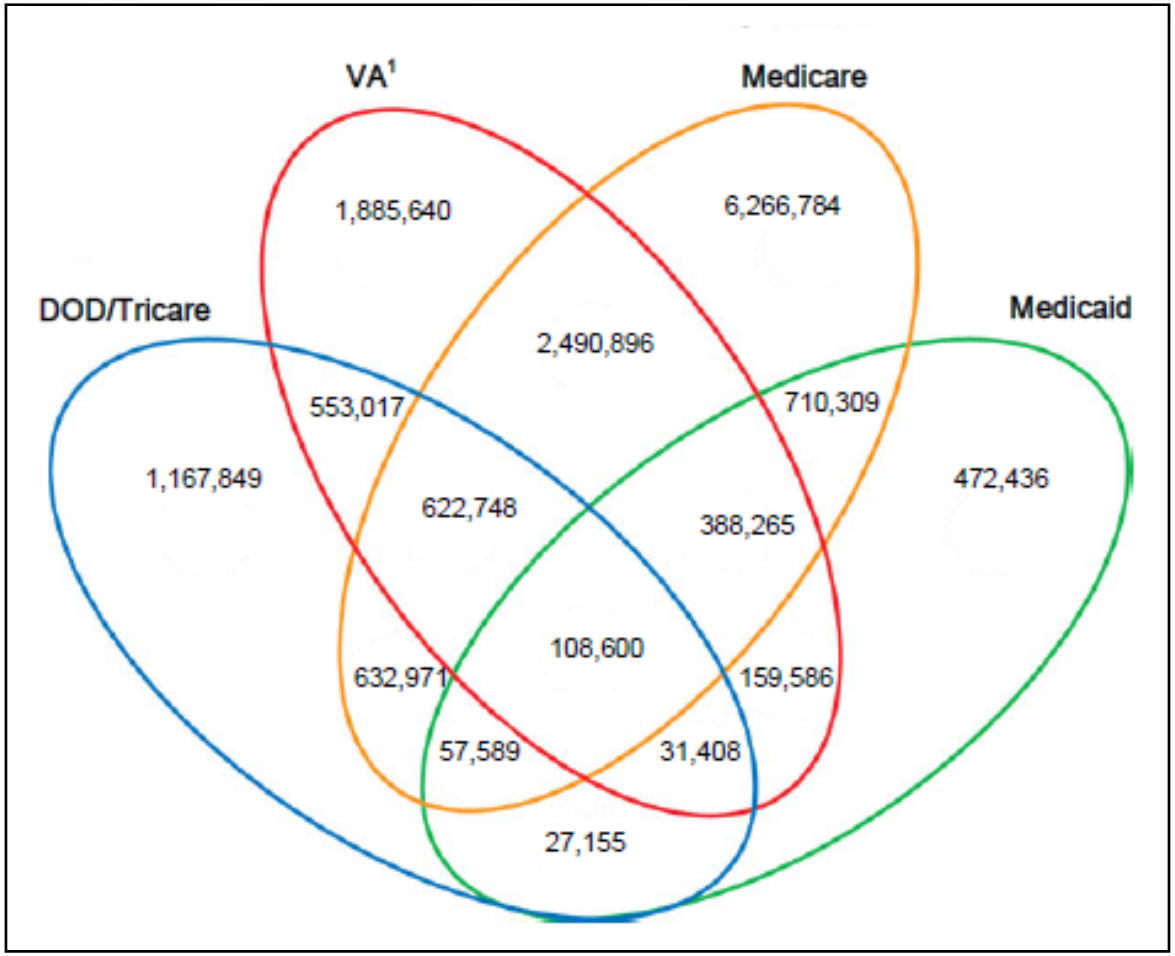
2015 – Surface Transportation and Veterans Health Care Choice Improvement Act

2013 US Population by Health Insurance Status



Source: Health Insurance Coverage in the United States 2013, U.S. Census Bureau

Health Care Programs Used By Veterans



Health Plan	ACS 2013
VA	6,240,160
TRICARE	3,201,337
MEDICARE	11,278,162
Medicaid	1,955,348
Private	6,173,312
Uninsured	1,329,080
Total Veterans	23,077,645

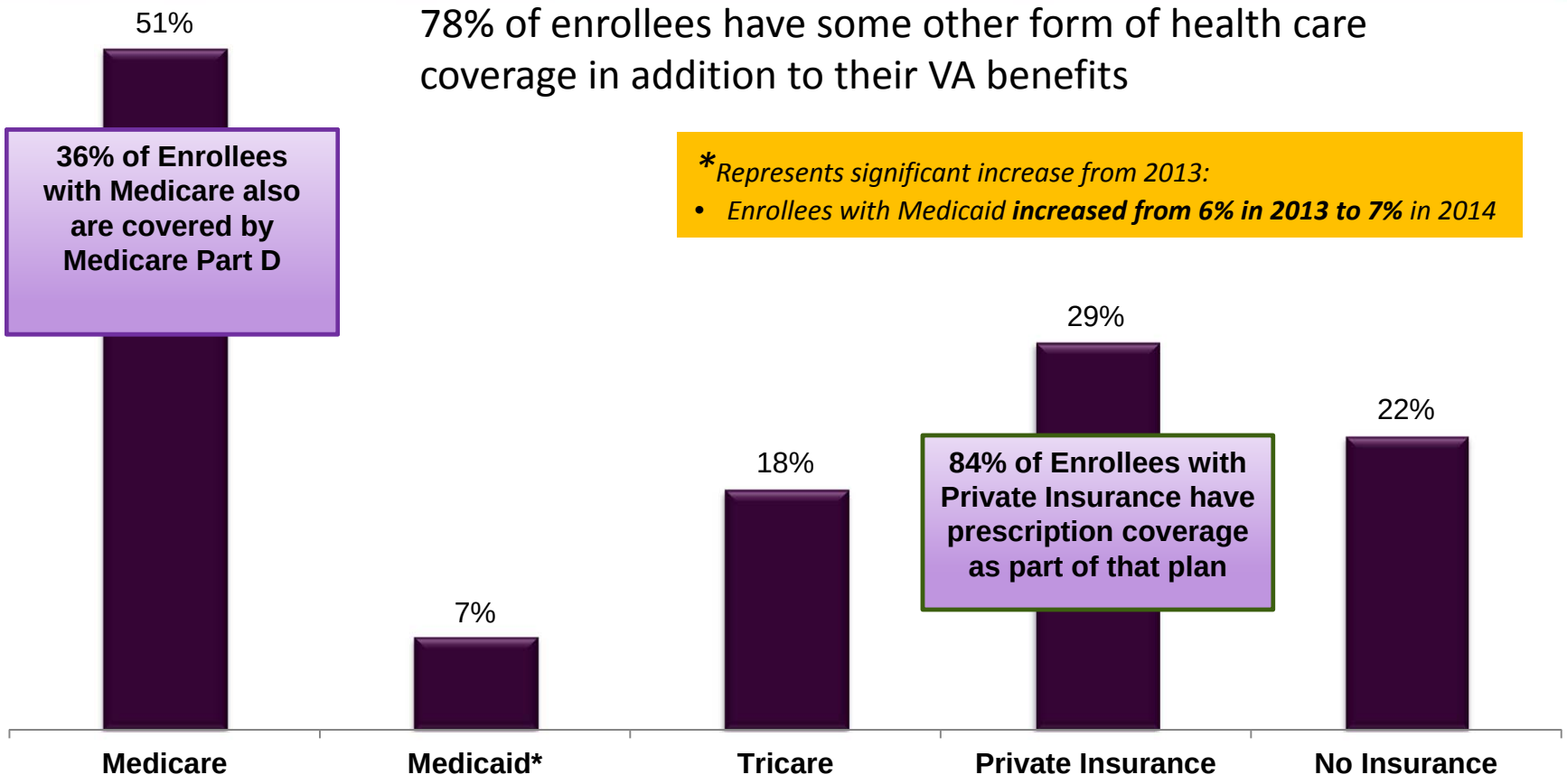
Source: 2013 American Community Survey

Other Health Insurance Coverage

78% of enrollees have some other form of health care coverage in addition to their VA benefits

**Represents significant increase from 2013:*

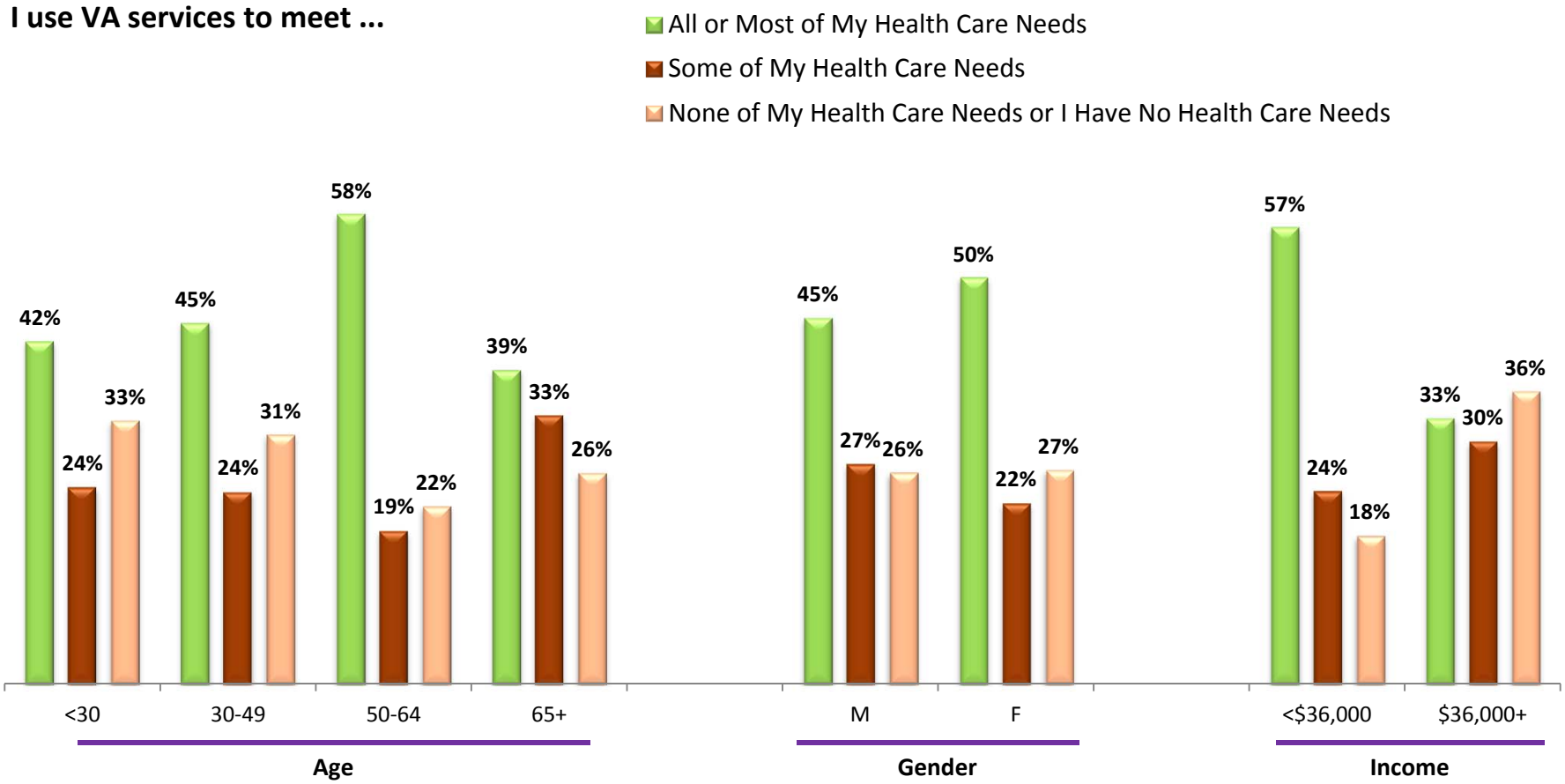
- *Enrollees with Medicaid **increased from 6% in 2013 to 7%** in 2014*



Source: 2014 Survey of Enrollees

Current Use of VA Health Care System

I use VA services to meet ...



Source: 2014 Survey of Enrollees

Strategic Drivers

- **Affordable Care Act**
  - Insurance Reform
  - Delivery System Reform
- **Veterans Choice Act**
  - Choice of Care Provider
  - Independent Assessments/Commission on Care
- **Evolving Veteran Enrollment, Utilization and Demographics**

Affordable Care Act

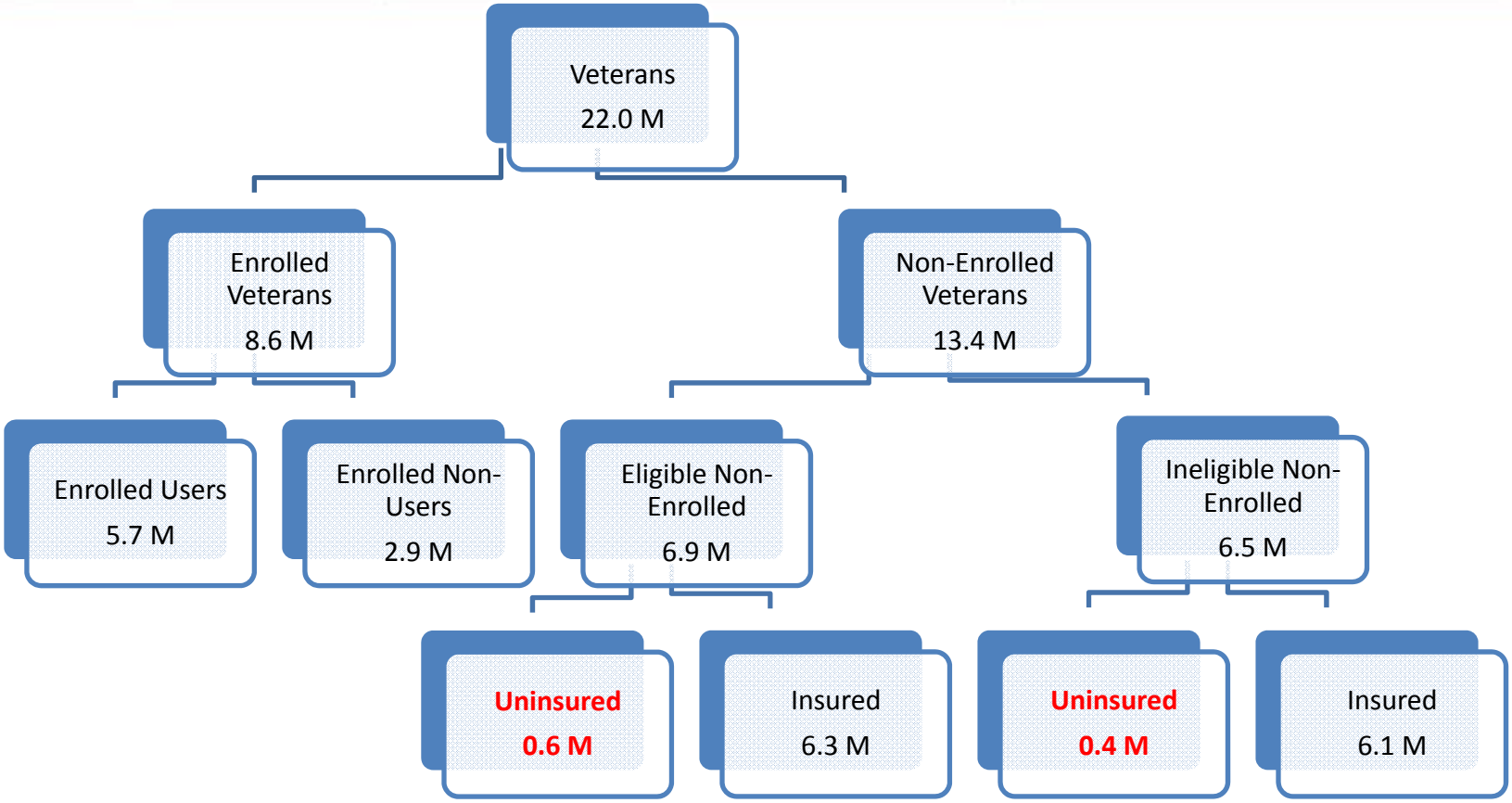
- By means of Insurance and Delivery System Reform, the Affordable Care Act seeks to improve health care in the United States by addressing:
  - Access
    - Opens avenues to insurance coverage
  - Quality
    - Institutes Value-Based Purchasing and cuts payment for services associated with medical errors or infections
  - Satisfaction
    - Expands measurement and use of patient satisfaction scores
  - Cost
    - Introduces mechanisms to reduce increases in cost of care over time

Affordable Care Act

Insurance Reform

- Medicaid Expansion: As of March 2015, 29 states including the District of Columbia either have or will extend Medicaid to all non-elderly low-income adults.
- Marketplace: As of March 2015, 34 states rely on the federal health insurance marketplace for 2015 enrollment. Three states have a federal/state sharing agreement.
- The Supreme Court ruled in June 2015 against a challenge to the tax credits provided in health care law in states without a state exchange, allowing these citizens and Veterans to retain tax credits to afford ACA.
- Impact on Veteran enrollment – estimated 33,000 Veterans enrolled due to ACA outreach and approximately 500 Veterans disenrolled.

2013 Veteran Population: Enrollment with VA Health Care and Health Insurance Coverage



Affordable Care Act

Delivery System Reform

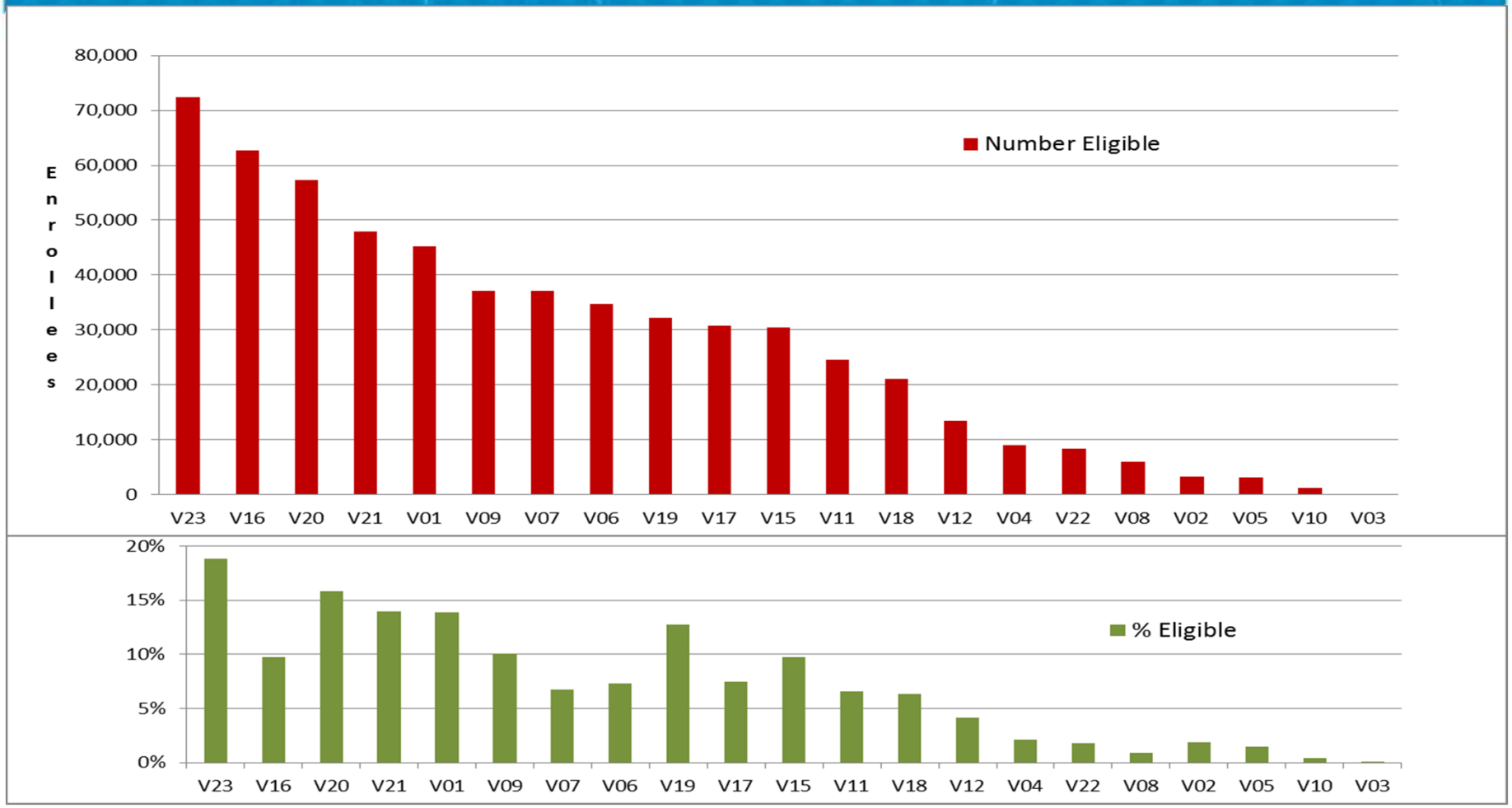
- ACA works to build a delivery system that:
  - Delivers better care;
  - Spends health care dollars more wisely; and
  - Results in healthier people
- Reforms from ACA introduce a variety of new payment models and organizational structures:
  - Accountable Care Organizations (ACO)
  - Value-Based Payment
  - Public-Private Partnerships via Health Care Payment Learning and Action Network
- Results of the transformation of the US health care system and movement to rewarding providers for quantity of care to quality of care.

Veterans Access, Choice, and Accountability Act

Section 101 Choice provisions

- By 2016, approximately 900,000 Veterans will be eligible to see practitioners in their communities using the Choice program based on the distance to a VA facility.
- Under the rule change from straight line distance to driving distance, up to 300,000 additional Veterans were made initially eligible to utilize the Choice program in 2015.
- Under the Choice Improvement Act, an additional 300,000 Veterans received a Choice card, as a result of the waiver of enrollment date. Approximately 30,000 of those became immediately eligible for Choice.

Impact of "40-Mile Rule" Change



Source: VHA/OPP Estimates of Enrollees and Patients Eligible for Choice Card Benefit, March 2015

Veterans Access, Choice, and Accountability Act

Section 201 – Independent Assessments

- 12 assessments
- Integrated Report was delivered on September 1st, 2015

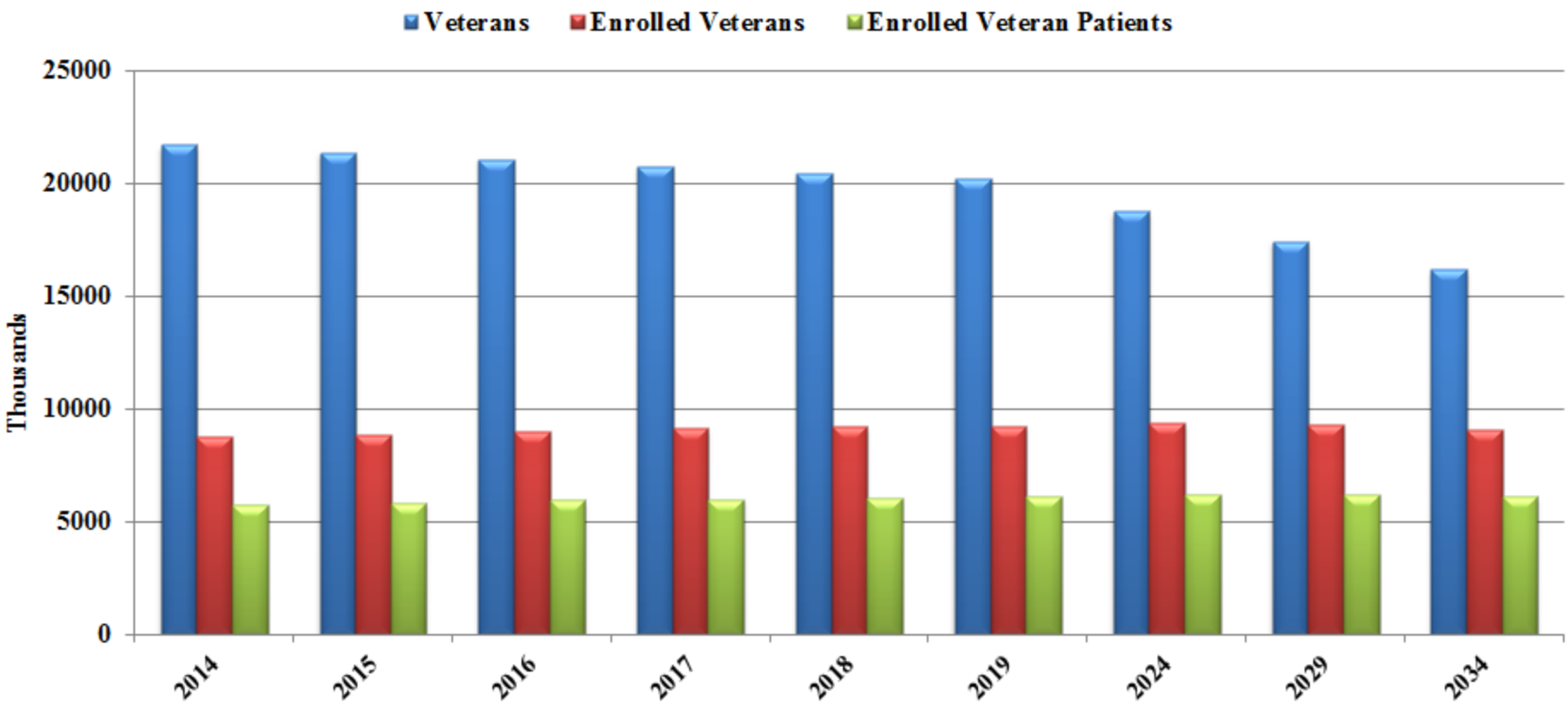
Section 202 – Commission on Care

To examine the access of Veterans to health care from VA and strategically examine how best to organize VHA, locate health care resources, and deliver health care to Veterans during the next 20 year period.

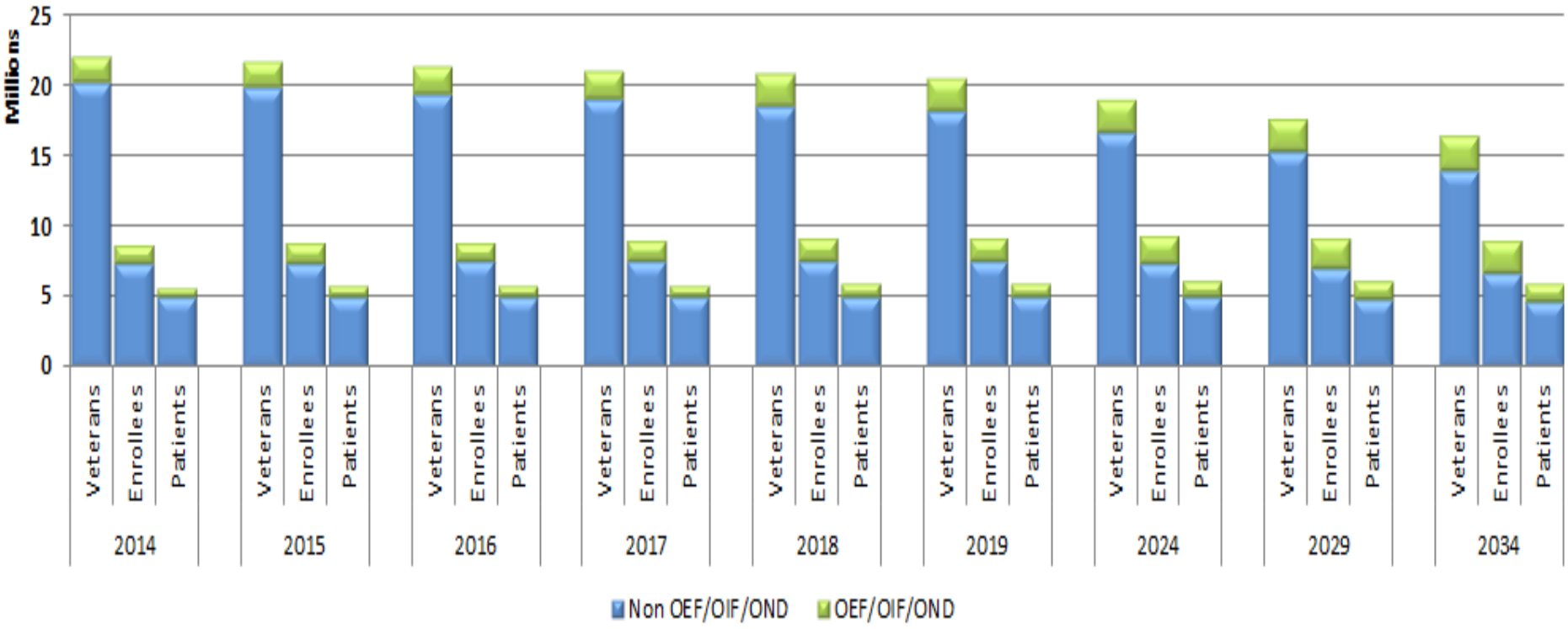
Evolving Veteran Enrollment, Utilization, and Demographics

- **Projected Enrollment and Utilization Changes**
  - Veteran Population Enrollment and Use of VA
  - Veteran Enrollment Changes
  - Veteran Utilization Change by VISN
- **Demographic Drivers of Enrollee Utilization of VA Health Care**
  - Key Findings of the Survey of Enrollees

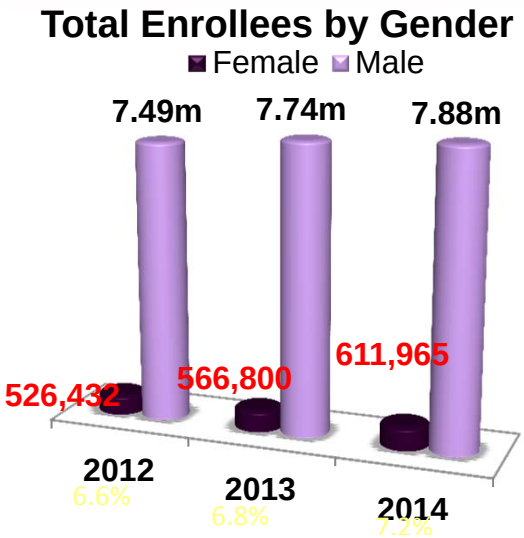
Veterans, Enrollees, and Patients FY 2014-2034

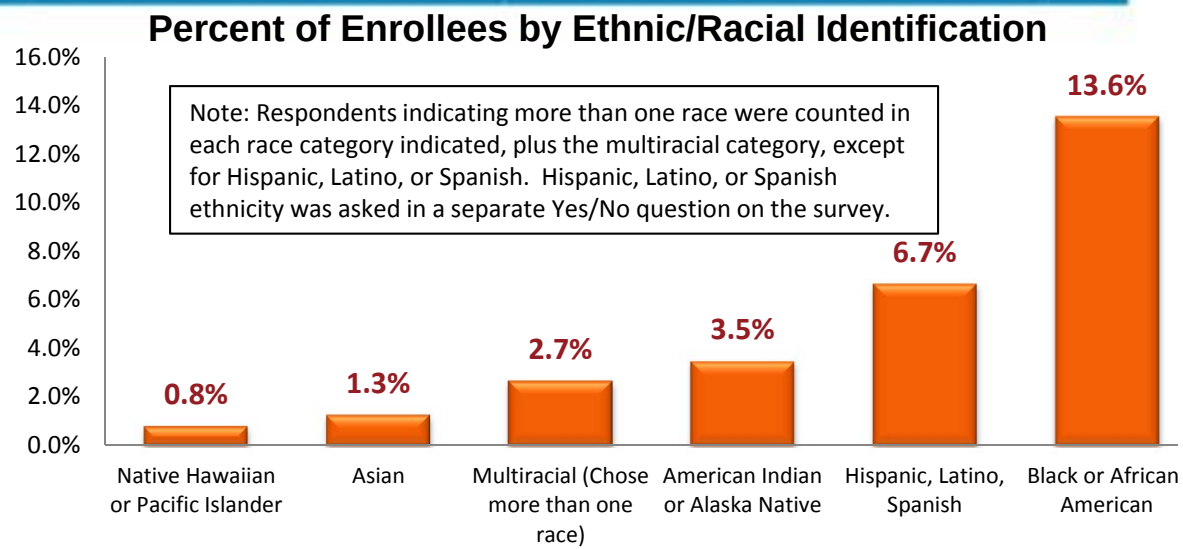


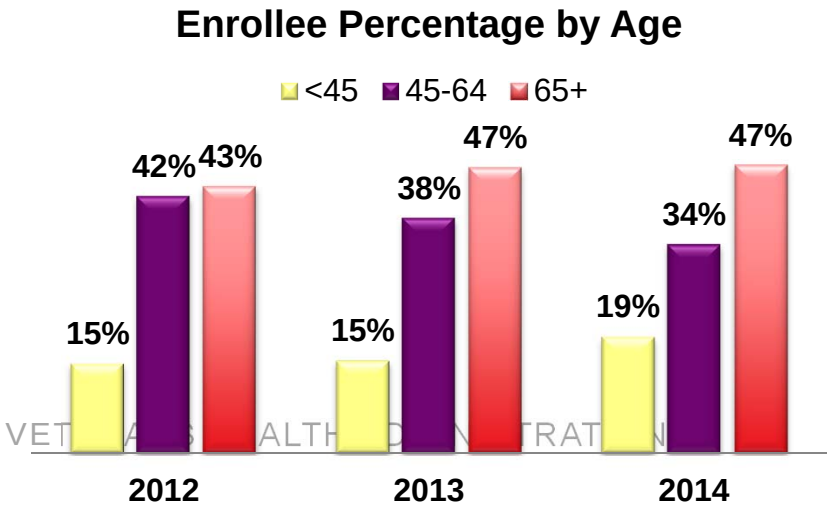
National Dynamics of Veteran Population, The Impact of OEF/OIF/OND: 2014-2034

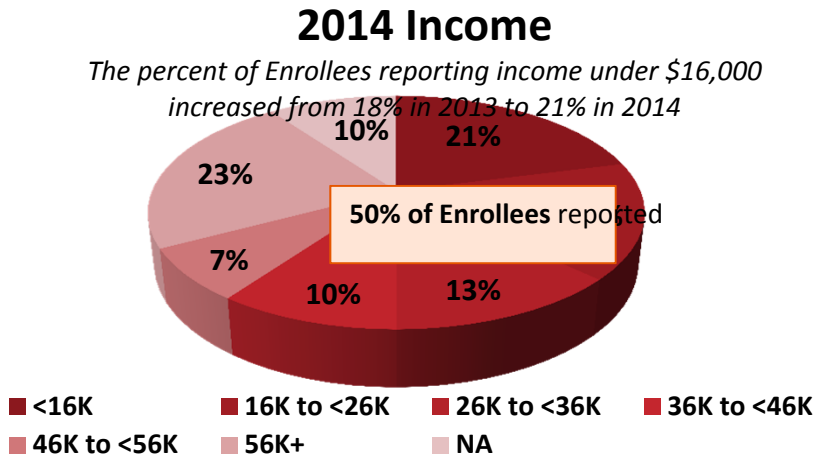


Current and Changing VA Health Care Enrollees' Demographics





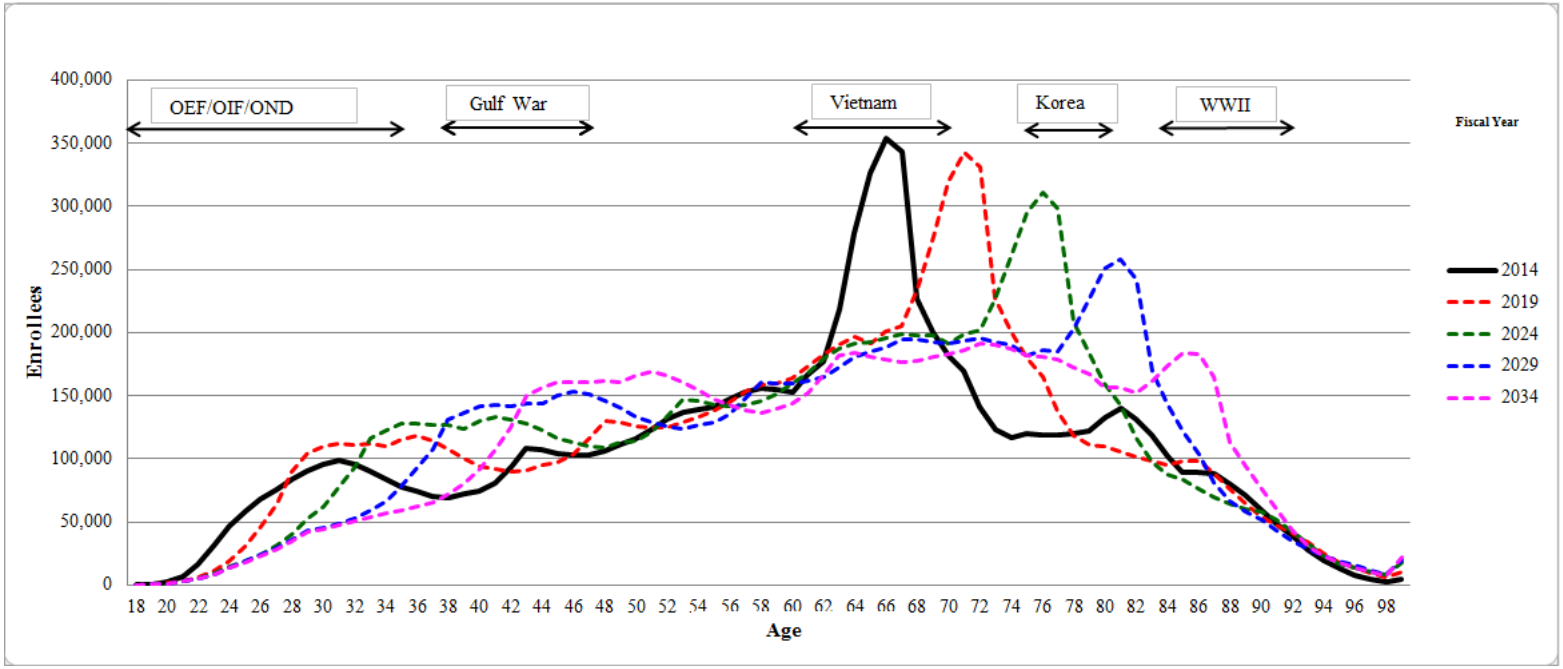




Key Enrollment Demographic Trends

- Within the enrollee population, two dynamic demographic trends are impacting the future cost of VA health care
  - Aging of the Vietnam Era enrollee population
  - Increasing number of enrollees being adjudicated by the Veterans Benefit Administration for service-connected disabilities, which increases the number of enrollees in Priorities 1, 2, and 3

Projected Enrollment By Age



Note: The period of service cohorts in the chart are defined by enrollee age in 2014 because enrollee level data on period of service is not available for all enrollees. Note, an enrollee may be in the age range for the cohort and not have served in the conflict, and the cohorts are not mutually exclusive.

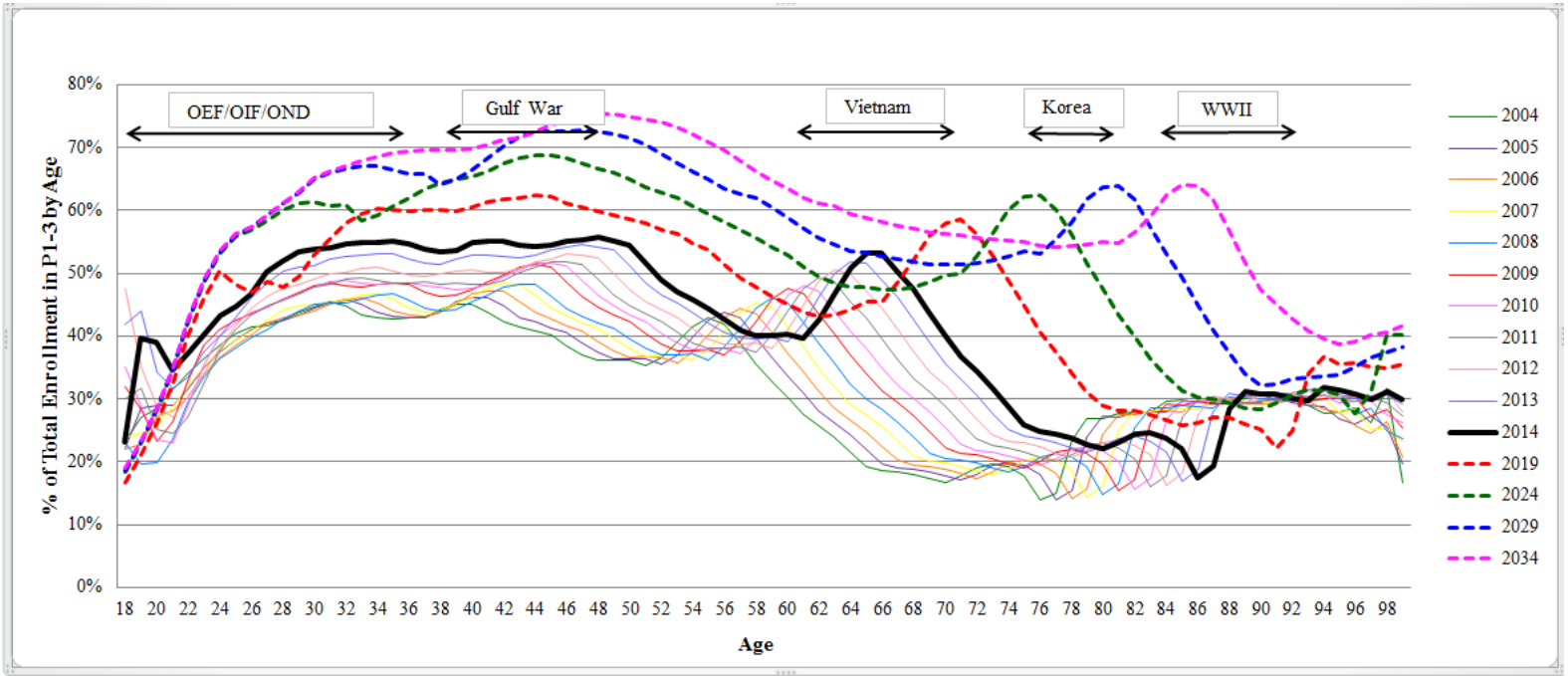
Enrollment Priority is Dynamic

- In recent experience, 40% of new enrollees transitioned to a different priority level within three years of enrolling
  - Enrollees transition between Priorities 5, 7, and 8 due to changes in income
  - Enrollees also transition into Priorities 1, 2, and 3 as a result of adjudication for service-connected disabilities by VBA
- The number and percentage of enrollees being adjudicated for service-connected disabilities has increased in recent years
  - The scope and definitions of service-connected conditions have broadened over time
  - Improved capture of service-connected conditions at the time of military separation
  - Enrollees continue to transition into higher priorities long after initial enrollment, continuing to achieve higher service-connected disability rating levels

Key Observations on Enrollee Service-Connected Disability Status

- Rates are very high at young ages soon after separation from the military
- Rates bump around the age of military retirement
- Younger enrollees already have higher rates of service-connected disability than the World War II generation
- Activity drops off significantly for enrollees older than Vietnam Era period of service
- The recent economic recession increased rates of transition into service-connected Priorities 1-3, with the greatest increase for Priority 3

Projected Growth in Priority 1-3, by Age



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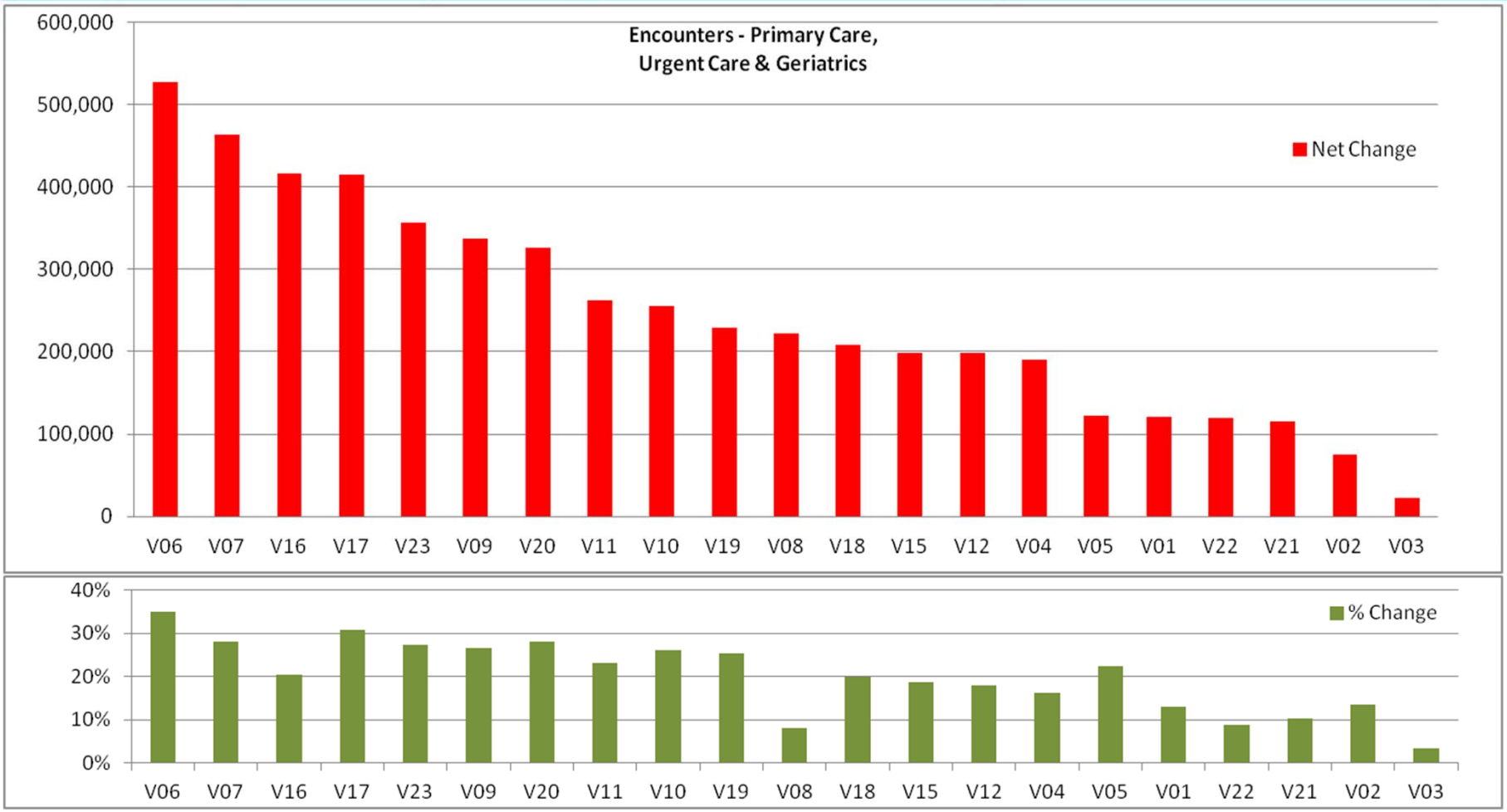
Priority Transitions
Implications for Demand for VA Health Care Services

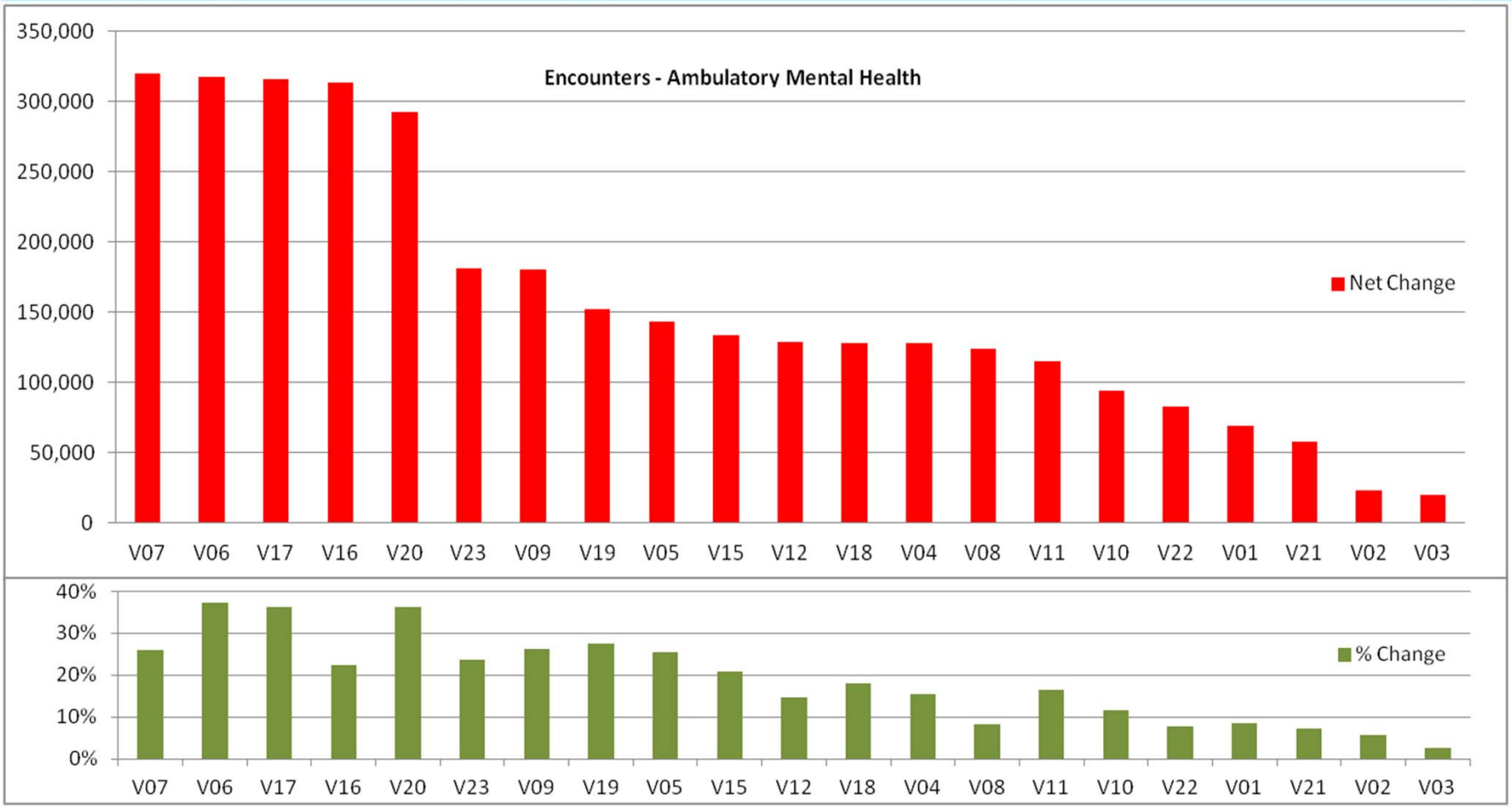
- Growth in Priorities 1 -3 is a key driver of demand for VA health care services
  - Enrollees are expected to increase their reliance to reflect the significantly higher reliance of enrollees in Priorities 1-3
  - Growth particularly impacts
    - Home and community based services
    - Short stay institutional long term services
    - Outpatient mental heath services
    - Inpatient acute mental health, medicine, and surgery
      - Although projections are declining in total due to other factors
    - Prosthetics
- Growth in Priority 1a (70% service connected or greater) is driving significant growth for services with special eligibility requirements
  - Dental
  - Long stay institutional long term services

National Ambulatory: Primary Care Clinic Stops: 2014-2024



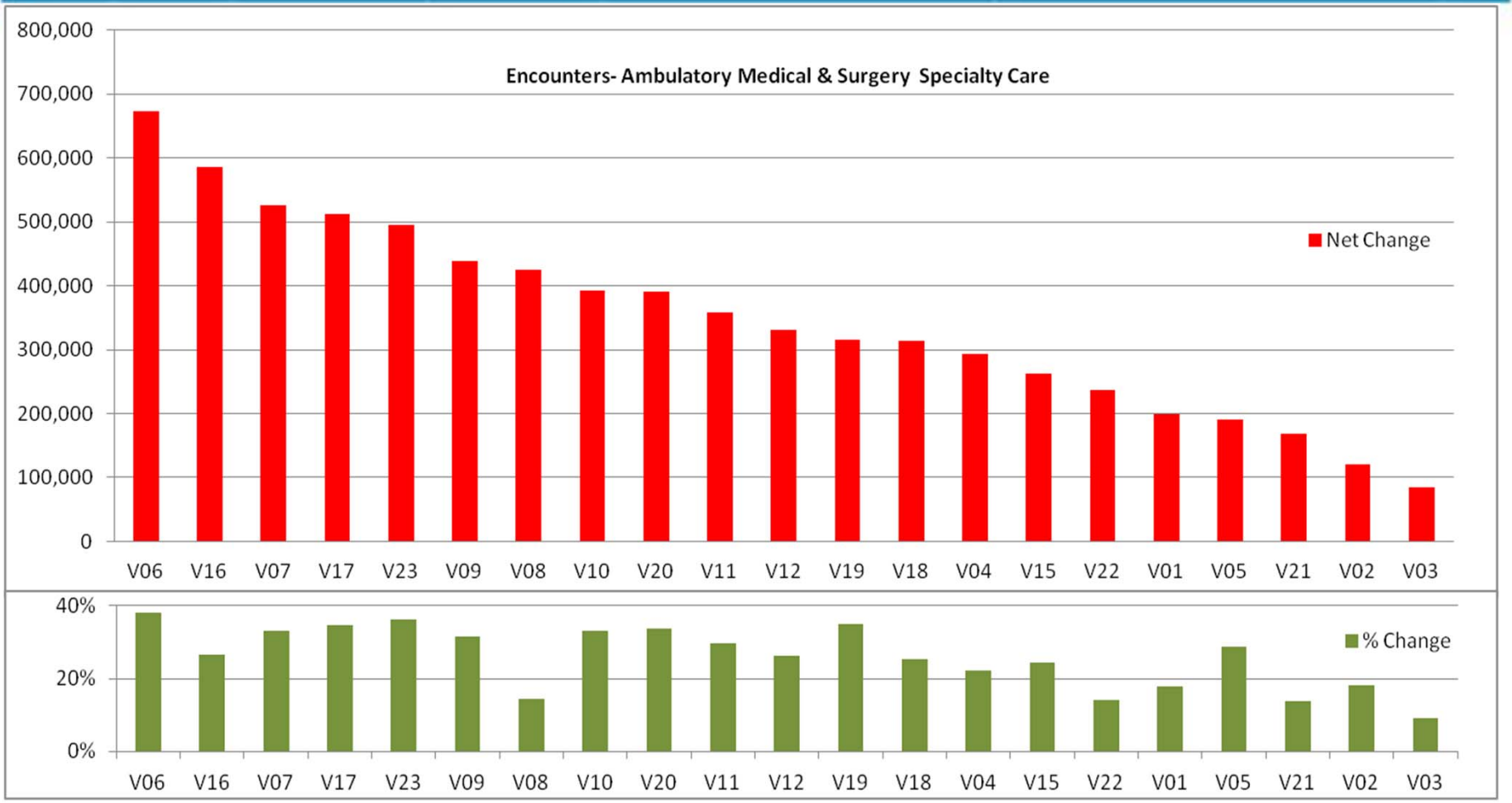
Source: Base Year 2014 Enrollee Health Care Projection Model

National Ambulatory Mental Health Programs Clinic Stops: 2014-2024



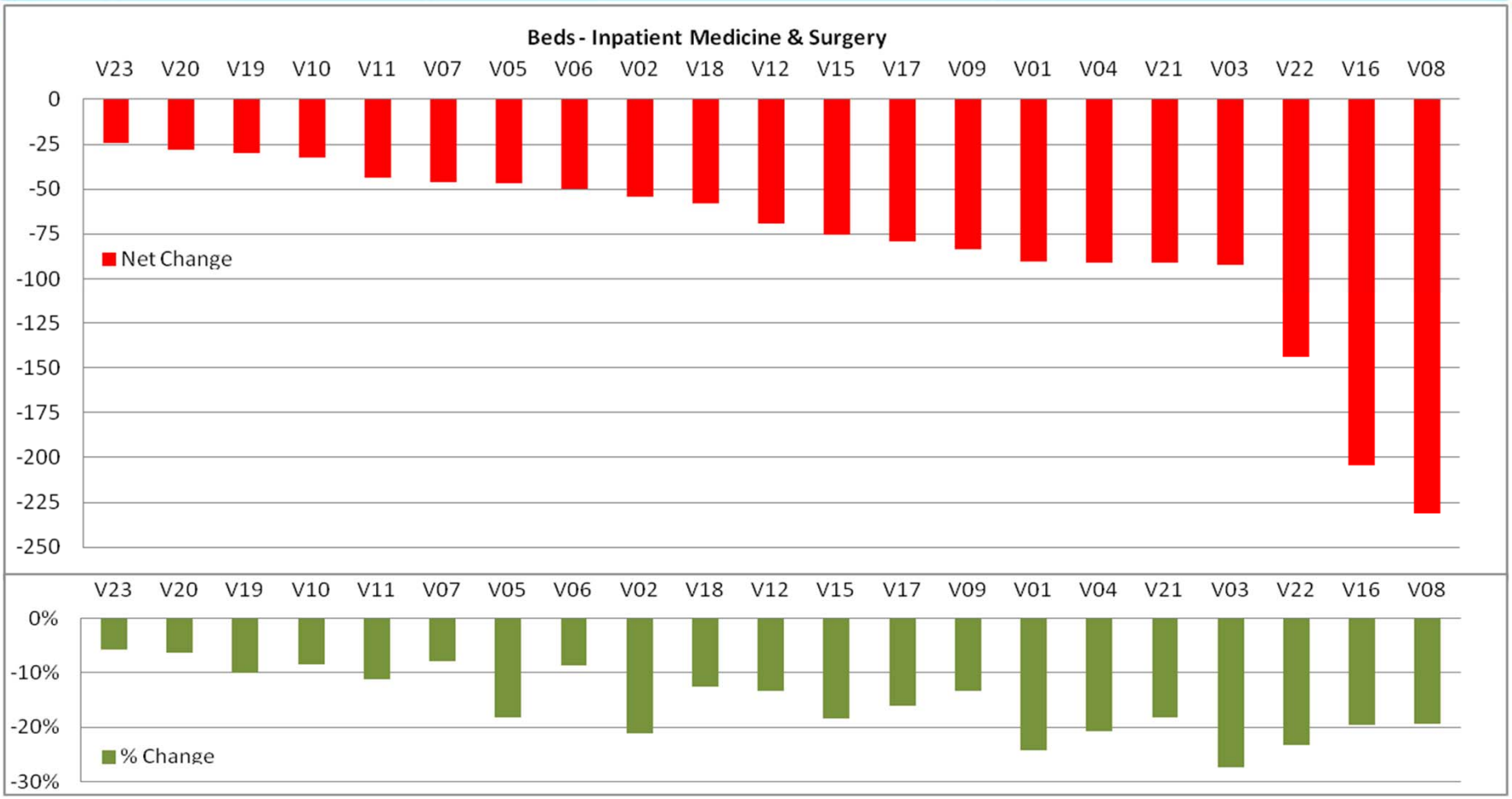
Source: Base Year 2014 Enrollee Health Care Projection Model

National Ambulatory Medical and Surgical Specialty Clinic Stops: 2014-2024



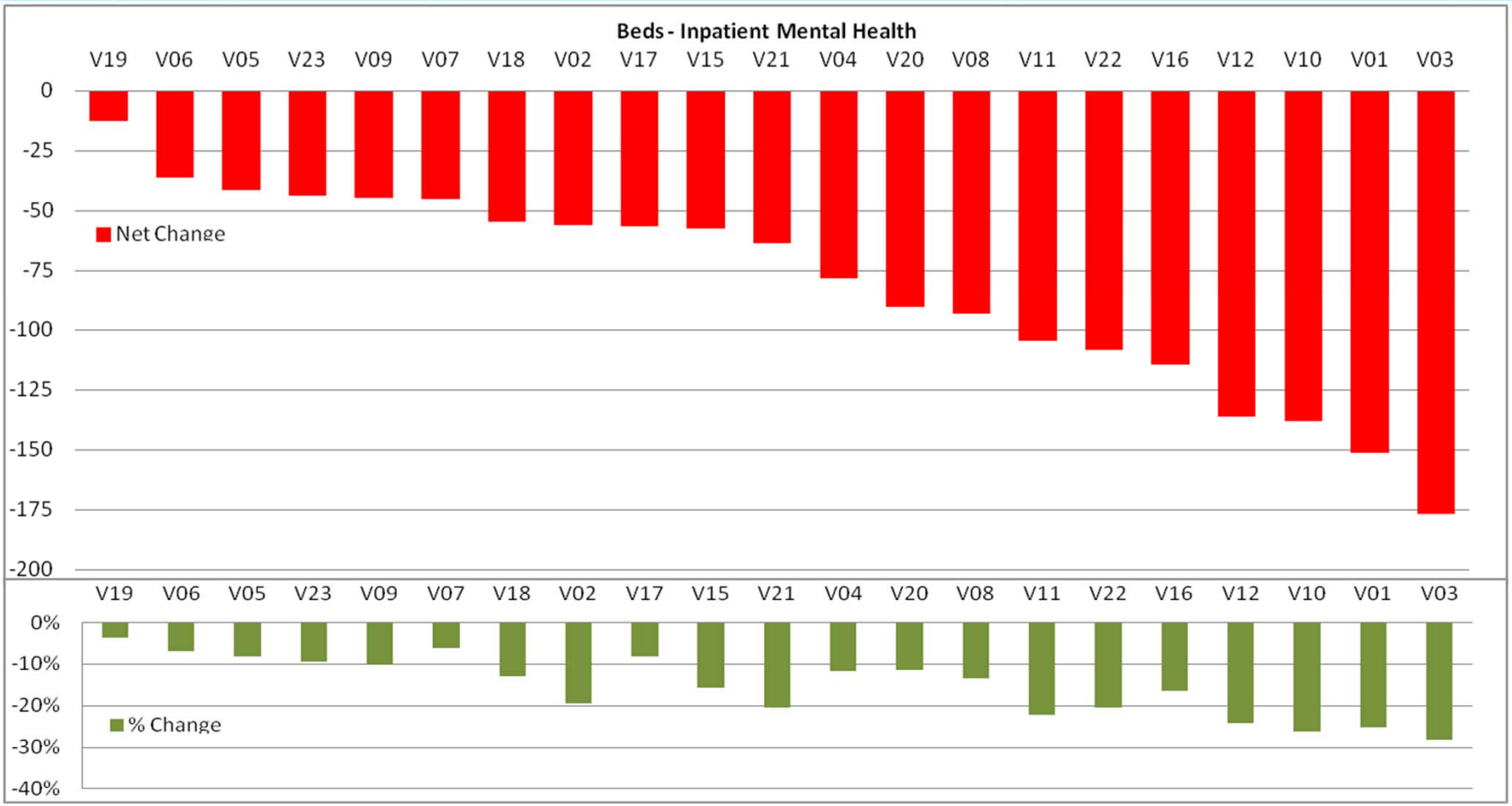
Source: Base Year 2014 Enrollee Health Care Projection Model

National Inpatient Medical/Surgical Utilization Change : 2014-2024



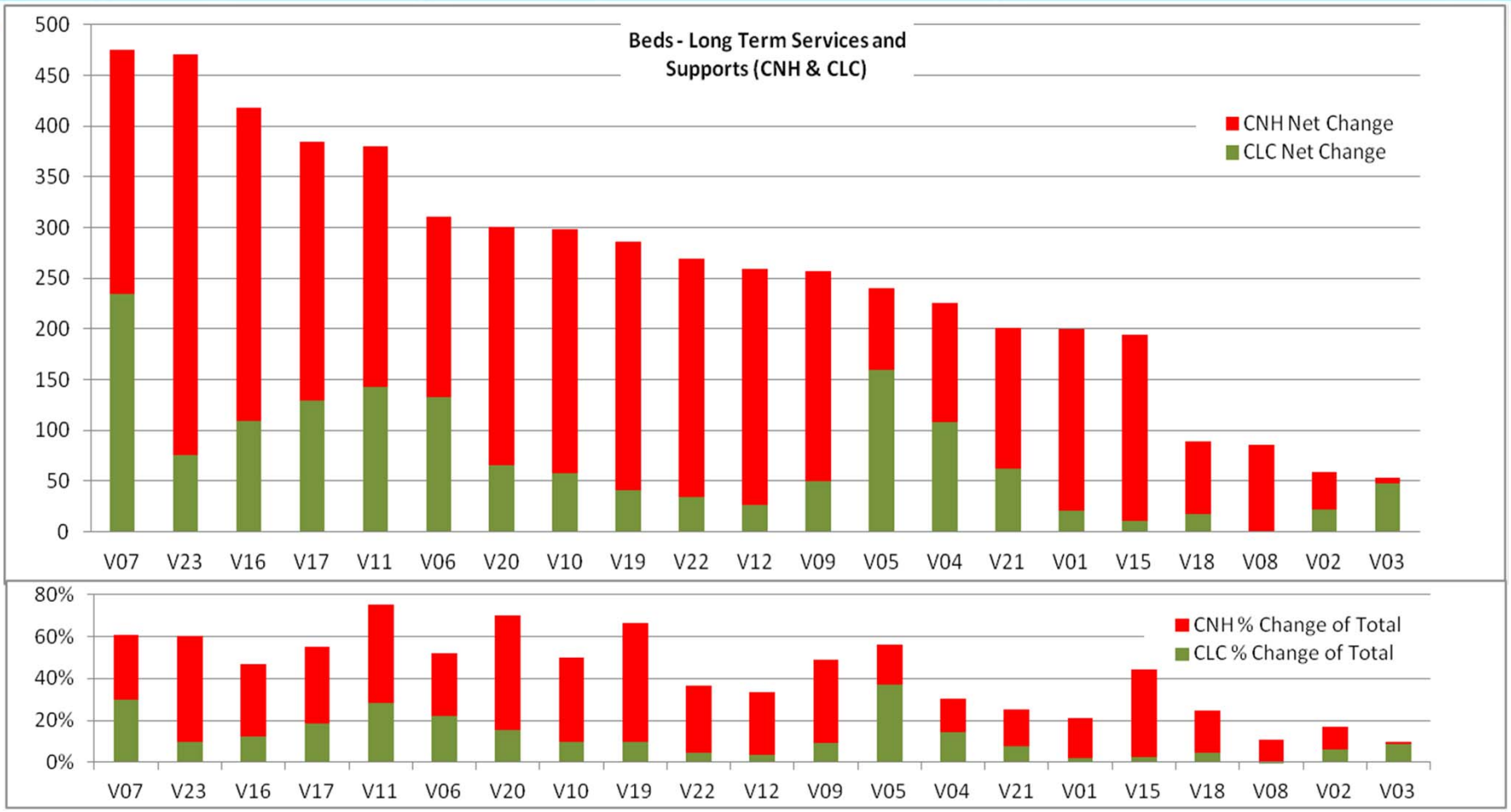
Source: Base Year 2014 Enrollee Health Care Projection Model

National Inpatient Mental Health and Residential Rehab Utilization Change: 2014-2024



Source: Base Year 2014 Enrollee Health Care Projection Model

National Long Stay Community Living Center (CLC) and Contract Nursing Home (CNH) Utilization Change : 2014-2024



Source: Base Year 2014 Enrollee Health Care Projection Model

VA Medical Care Obligations for Selected Medical Care Programs (dollars in millions)

Program	2014 Actual	2015 Current Budget Estimate	2016 Revised Request	2017 Advanced Appropriation Request	Percent Change 15 to 16	Percent Change 16 to 17
Ambulatory Care	$23,542	$23,598	$26,067	$27,099	10.46%	3.96%
Inpatient Care (Med/Surg and MH)	$10,806	$11,300	$11,717	$12,149	3.69%	3.69%
Mental Health (Outpt)	$6,676	$7,178	$7,455	$7,715	4.91%	3.49%
VA Community Living Center	$3,340	$3,376	$3,453	$3,622	2.28%	4.89%
Community Nursing Home	$721	$810	$845	$908	4.32%	7.46%
Total Obligations (All Programs)	**$57,530**	**$59,923**	**$63,129**	**$67,242**	**6.42%**	**6.52%**

Conclusions

- We have a moral obligation to ensure that every Veteran receives the best possible care, in the way that best meets their needs.
- Our service delivery structure must be flexible enough to adapt to changing demographics, utilization patterns, and Veteran expectations.
- Veterans have more choices for how they access health care services now than they have had in the past.
- The landscape of American health care is changing, and VA health care must change or risk failing in both our moral obligation and the competitive environment.

…To care for those who shall have borne the battle, and for their widow and orphan.

-Abraham Lincoln