

Estimating Costs for Veterans Health, Part 3

Gideon Lukens, PhD, Commission on Care

Jamie Taber, PhD, Commission on Care

April 18, 2016

Agenda

1. Introduction and Outline of Presentation
2. Description of the Scenario
3. Nurse Navigators/Care Managers
4. “Other than Honorable” Discharges
5. Community Delivered Services Scenario
Estimates

Description of the Scenario

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Scenario

- This scenario would expand Care in the Community for certain types of care. At least initially, all care currently being provided by the VA would continue to be provided by the VA. In addition, expanded Care in the Community also called Community Delivered Services (CDS) will be provided by an integrated network consisting of providers (medical practitioners including physicians, mid-level practitioners and therapists and hospitals and clinics) that are vetted by the VA. CDS will be focused on tertiary and quaternary care. They will not include primary care, special emphasis care, and some types of specialty care. This network of providers will be coordinated and vetted by the VA and would vary by community. In order to make the flow of service both appropriate and smooth in operation, there will be navigators who will help guide veterans to the best and most appropriate providers inside and outside of the VA.

Nurse Navigators/ Care Managers

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VHA Patient Aligned Care Team

Replaces episodic care based on illness and patient complaints with coordinated care and a long term healing relationship



Takes collective responsibility for patient care



Is responsible for providing all the patient's health care needs



Arranges for appropriate care with other specialties

THE PRIMARY CARE TEAM

Patient Aligned Care Teams Mission

Improved Teamwork, Work Design,
Maximizing Team Function & Roles

Improving Care Coordination &
Focusing on Critical Transitions of
Care (Inpatient to Outpatient, PC to
Specialty, VA to Non-VA)

Pt Centered Care

Improving Access to Care: Visits
with Provider, Team Members, &
Non Face to Face Care (telephone,
My HealtheVet, Secure Msg)

Improving Chronic Illness and
Health Promotion/Disease
Prevention

Expanded Team Members

Clinical Pharmacy Specialist: ± 3 panels
Clinical Pharmacy anticoagulation: ± 5 panels
Social Work: ± 2 panels
Nutrition: ± 5 panels
Case Managers
Trainees
Integrated Behavioral Health
Psychologist ± 3 panels
Social Worker ± 5 panels
Care Manager ± 5 panels
Psychiatrist ± 10 panels

Expanded Team Members

For each parent facility
HPDP Program Manager: **1 FTE**
Health Behavior Coordinator: **1 FTE**
My HealtheVet Coordinator: **1 FTE**

Core Teamlet: assigned to 1 panel (±1200 patients)

- **Provider: 1 FTE**
- **RN Care Mgr: 1 FTE**
- **Clinical Associate (LPN, MA, or Health Tech): 1 FTE**
- **Clerk: 1 FTE**

Monitored via Primary Care Utilization Data

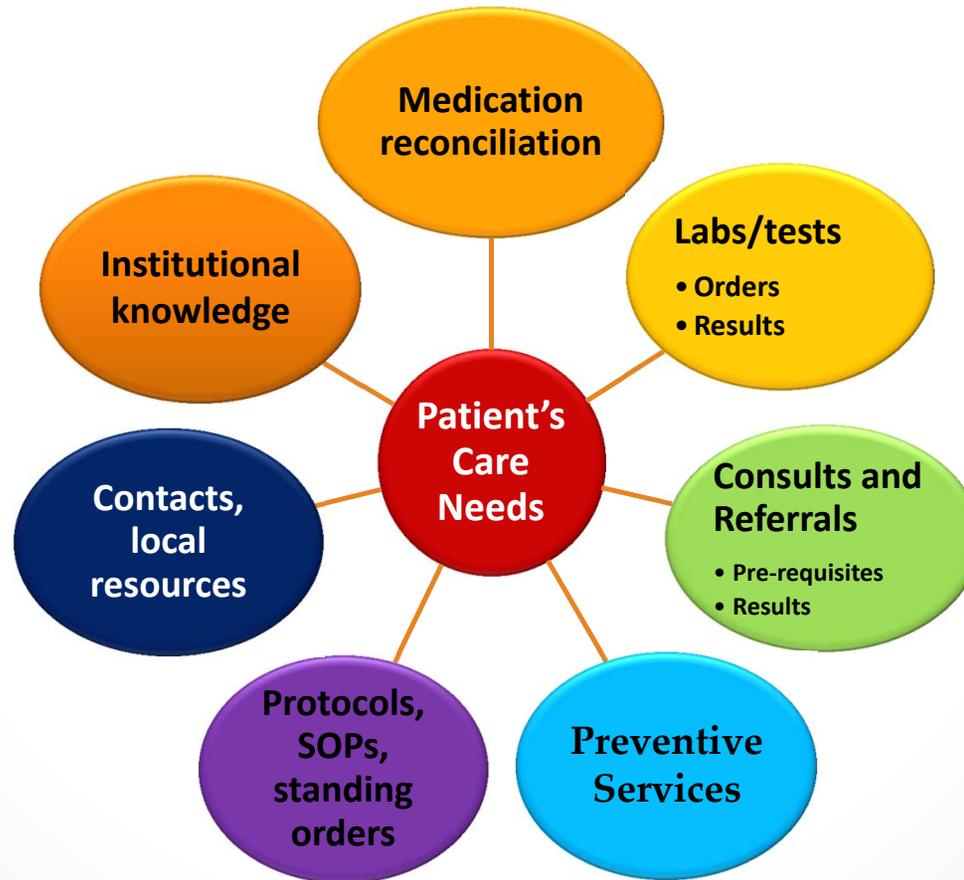
Panel size adjusted (modeled) based on staffing, acuity, etc

Patient

The Patient's Primary Care Team

Care Management

Making sure the right things get done at the right time

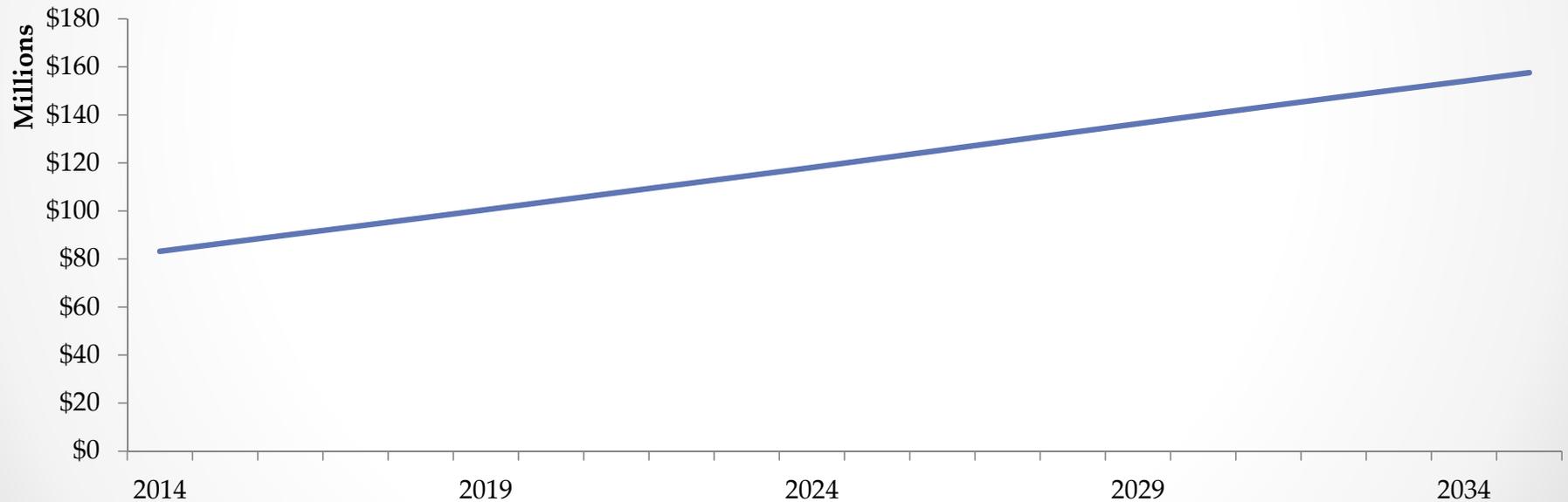


Cost Estimate for Additional Care Managers

- Care Managers who guide patients to choose care in and out of the community are already part of the PACT team.
- But if they are doing additional work (more coordination with community providers), VA may need to hire additional Care Managers.
- Assume:
 - Recommended panel size (FY14) = 1,200
 - 1 additional RN Care Manager per 5 panels
 - Average total compensation of \$94.4k (FY14)
 - 882 FTE in 2014, growing with projected patient population through 2034
 - Compensation inflated at EHCPM personnel inflation trend

Cost Estimate for Additional Care Managers

Cost of One Additional RN Care Coordinator per 6,000 Patients



“Other than Honorable” Discharges

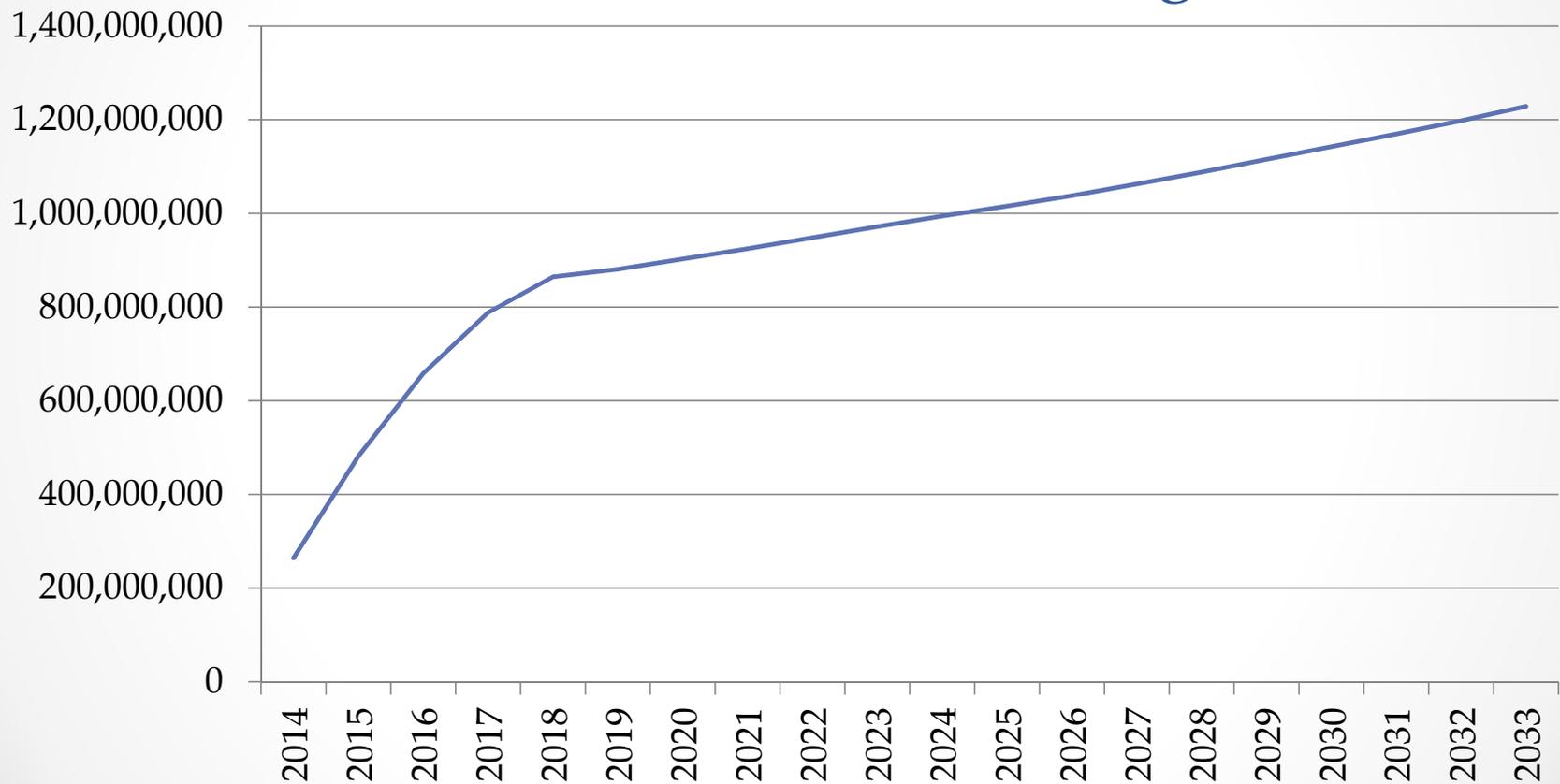
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“Other than Honorable” Discharges

Assumptions:

- We assume all people with an “Other than Honorable” discharge are initially made eligible for VHA care.
- We assume that 73 percent of veterans with an “Other than Honorable” discharge are eligible for VA care based on income and disability criteria, consistent with the rest of the Veteran population.
- Over a period of 5 years, their cases are examined, and 50% are positively adjudicated [note: 50% is a guess.]
- The number of eligible Veterans with an “Other than Honorable” discharge who enroll increases over the first 5 years as they become aware of the new policy. It increases to 52% (consistent with other veterans).
- Costs per patient are similar to other veterans of the same age.

Projected Costs of Covering those with an “Other than Honorable” Discharge



Community Delivered Services (CDS) Scenario Estimates

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Unit Costs

- 33 out of 75 health service categories (47% of all expenditures) are eligible for choice into CDS networks
- Community care priced at Medicare Allowable unit costs
 - Medicare Allowable rates matched to VA health service categories
 - Exception: benefits not covered by Medicare use historic care in the community costs
 - e.g. Dental, long-term services and supports, hearing aid services
- Veterans choose to receive 50% all eligible care in the CDS networks
- Shift to CDS networks phased in over 5 years

Unit Costs

- Unit costs broken down into seven components
 - direct salary; indirect salary; staff contract; direct non-personnel; indirect non-personnel; equipment; national overhead
 - Unit cost shares vary considerably by health services category
 - This data combines VA facility and care in the community
- For care shifting from the VA into the CDS networks, assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remains in VA facilities
- Resources not included in unit costs – buildings, NRM – implicitly assumed to remain in VA
- Phased in over 5 years to allow incremental adjustment of resources concurrent with changes in reliance, enrollment, and shifts in CDS networks

Reliance and Enrollment

- Approximately 52% of eligible Veterans have enrolled in VA health care
- Enrolled veterans receive, on average, 34% of health care through the VA
- Improving access, choice and/or quality of services likely to induce more reliance and enrollment
 - This increases VA's Budgetary costs
 - Not necessarily an "economic cost", since more benefits are being provided
- Assume a range of reliance increases for services delivered in CDS networks: 10%, 35%, and 50%
- Assume a range of enrollment increases: 0%, 5%, and 10%
- Phased in over 5 years

Caveats

- Estimates don't include savings/costs of reducing or repurposing infrastructure
- Impacts on VA's teaching, research, and emergency preparedness missions are not considered
- Medicare Allowable rates assumed to provide veterans with adequate access in CDS networks
- For care priced at historic community rates, national average rates are representative of future rates
- Unit costs for services remaining in VA facilities effectively increase by assuming equipment and national overhead costs are fully retained
- Other than equipment and national overhead, the costs of care shifting to CDS networks is phased out of VA facilities concurrently with other effects in the model
- Reliance increases occur only for services shifting to CDS network; no spillovers
- New enrollees have same costs as existing enrollees
- Hires of RN Care Managers are the only additional administrative cost

Projected Costs of CDS Scenario

