Continuing the Discussion on Costs

February 26, 1999

In attendance: 33 people

1. INTRODUCTION

A. Agenda Review - Carol VanDeusen Lukas

1) Demakis review on progress since last year
2) Panel review of national databases by Barnett, Cowper, Hynes, Demakis
3) Evaluating VHA costs (Hendricks, Nugent)

Participants introduced themselves and shared their research interests.

B. Introduction - John Demakis

- Need to standardize methodology
- Report on progress of recommendations from last year
- Actions taken since last year:
    - Funding established to set up an economic resource center; one center was selected for a full proposal
    - Approved and funded a database center - VIReC
    - Papers & proceedings will be published in supplement of *Medical Care* in April 1999
    - RFA put out for research into cost methodology in VA to allow health economists to be PI in research projects
    - Expand role of health economists
    - Second meeting of health economists - this current meeting.
- VERA proposal is being considered/on hold
- Kizer considering doing project on Hepatitis C (similar to prior project on HIV)

Participant Comment: Ann Hendricks

- Medicaid data - she has experience working with SMRF (state Medicaid research files) which exists in 31 states. She had heard that as of next year, all states will have it. There is a question of whether data can be merged. If there is a letter of agreement with the agency, then there is no cost for using it (usual cost is $5K, $10K etc.). Although researchers don't use Medicaid data as often as Medicare, but it's still an important resource

2. REVIEW OF NATIONAL VA DATABASES

(Paul Barnett as Moderator)

A. Introduction to VIReC - Denise Hynes

- VIReC has 3 primary goals: disseminate database info to researchers; assess data content, availability, reliability, validity and accessibility; provide new infrastructure to support these activities

    - Update current "blue books" (i.e., books that describe existing databases)
    - Develop user manuals
    - Develop network of VA data experts
    - Provide ongoing evaluation to Scientific Review Board
    - Develop data consulting service
    - Provide liaison between research and information service

- 4 main service lines: customer service, web site, research, promotion & dissemination
    - Main tool is the internet; hope to make it more interactive by next year
- VIReC staff list & introduction & their specialties

- Web site: www.virec.research.med.va.gov

- Update on PBM (Patient level pharmaceutical use)

    - Pharmacy database will be ready in July, VIReC will have information on that
    - Can call Mike Valentino at PBM for more information
    - Currently research staff has no access to it
    - Data is extracted from individual local VISTA databases

B. Other VIReC Activities - Diane Cowper

- Report on Data summit in December 1998

    - Researchers were included as one of the "end-users"
    - Meeting participant agreed that change will only occur with upper mgmt "buy-in"

- VA Enrollment database

    - Data collected on all new enrollees since change in enrollment policy
    - Database updated monthly
    - Austin Automation Center will house the database

- National Patient Care Database

    - Housed at AAC
    - Outpatient data since 1996
    - Inpatient data will be migrated to NPCD
    - Access to production database will be limited to "super-users"
    - Need Austin accounts to get access to data "marts" of inpatient and outpatient data
    - There are 3 outpatient SAS files: visit file, procedure file, diagnosis file
    - A comprehensive listing of outpatient databases is available at VIReC website

Participant Comment: Bruce Ripley

- Enrollment database - there will be interim database available soon

Participant Comment: Anne Sales

- Question on billing for AAC usage: not sure how the money will be transferred or where it should come from

Participant Comment: Bruce Ripley

- Outpatient files credit workload from CBOCs to parent VA
- New SE file supposedly corrects that problem

Participant Comment: Ann Hendricks

- One of her programmers has noted that '98 data has more duplicates than ever, and she just wants everyone to be aware of this

Participant Comment: Ciaran Phibbs

- SE files & VISTA files are not the same, but there is no gold standard to establish which is more accurate

C. DSS - Paul Barnett

- Issues: (1) Need national extract; (2) Access; (3) Training; (4) Methods of validation

- There is an agreed-upon need for a national encounter-based extract of DSS data; there is a pilot extract for one site now, but it is unclear as to when it will become national

- Access policy

    - Currently still facility-based request
    - Possibility of establishing a super-user
    - Need to sign user data disclosure agreements (e.g., facilities do not want costs publicized because it would affect their ability to contract for services)

- Training

    - Pat Murphy will start setting up training for DSS usage
    - DSS has many training courses and materials, but not all are applicable to researchers

- DSS Access

- If obtain access to Austin, then can physically access all DSS data. However, permissions must be changed in Austin profile and by DSS site manager

D. Medicare - John Demakis

- There is a frequent need for Medicare data because of cooperative trials, etc.
- Explore possibility for centralized procedure to merge Medicare and VA data.
- Group including Garthwaite, Feussner, Paine, also Hynes & Cowper is coming up with proposal
- No barriers on VHA side because all are committed to it, however, seems to be resistance on Medicare side
- Possibility of using the AHCPR joint agreement with HCFA as a model

Participant comment: Anne Sales

- State of Washington now is merging Medicaid and Medicare data; is approaching VA about merging their data as well

3. <u>EVALUATING VA COSTS</u>

A. "Evaluating Cost for Veterans' healthcare": Presentation by Ann Hendricks & Gary Nugent

- Study research question: are the heath care service provided by VA facilities, over 1 FY, less costly than the same service would be purchased at fee-for-service or capitated rate?
- 6 sites were selected in AL, MI, NM, OH, RI, and WI
- Three phases:

  1) prepare for data collection
  Issues: Coding accuracy - need encoder to process ICD-code. This is common in private sector not at VA, which has limited capability to assess professional fees
  2) collect workload; need to be able to generate pseudo-bills
  3) conduct analyses

- Methods:

  - collect billable workload; through extraction
  - develop Medicare and other "bills" for workload; there are services that Medicare does not cover like pharmacy or dental, they needed to assess how much VA would have to pay if have to purchase it from private vendors; there are other services like domiciliary or spinal cord injury, no Medicare fee
  - Adjust CDR for capital & other costs; like overhead costs for VISNs, malpractice etc.; physician fee;
  - Compare CDR to total reimbursement

- Issues:

  - Acuity/severity of illness; are VA patients sicker than Medicare patients? Do VA patients have longer hospital stay?

- Use of multiple sources of care; will be a problem if go into capitation
    - VHA documentation
    - Different benefits

- The database from this study, when completed, will be available to researchers. It will be useful because it is an average across 6 sites

B. Discussion points:

- How good are databases for workload, billing and research?

    - Issues with professional MD costs & CPT encoder
    - Coder codes straight from doctor's documents, not just straight from number of days
    - Billed as MD consult even if visit is only from fellows
    - Other professional services encoder enters CPT codes
    - Has to manually extract these services out of the visit and enter the services separately

- Need to change databases to make them more usable

- Need better oversight and monitoring of databases because too many people are making changes to them

- Transfer DRGs / multiple DRGs for one single hospital stay - which DRG should be used for costing the visit?

- Problem with coding

    - Lack of coders because low pay grade
    - High error in doctor CPT code - approx. 50%, which is similar to the community rate (although it is not publicized)
    - Medicare experiences about 30% error in coding
    - Possibility for improvement : end hard cut-out date for submitting information because that is increasing errors due to shortage of time

- Issue with bundling & unbundling of services, and how to accurately cost them, e.g., labs, x-rays