Estimating Non-VA Costs

Mark Smith &

Todd H. Wagner

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Learning Objective

- It is common for veterans to use non-VA providers.
- At the end of the class, you will know the pros and cons of different methods for identify non-VA utilization and estimating non-VA costs

Non-VA Use is Common

- According to 1999 survey data, 73% of VA enrollees have alternative coverage
  - 53% have Medicare
  - 19% private without Medicare
  - 1% Medicaid without Medicare or private
- Among VA enrollees
  - Approximately 4 in 10 used VA exclusively
  - Two-thirds expect to use VA for primary care in the future

Shen Y et al. (2003) VHA Enrollees' Health Care Coverage and Use of Care. Medical Care Research and Review. 60(2) 253-267

Methods for Assessing Non-VA Utilization

- Existing datasets
  - Fee Basis
  - Sharing Agreements
- Primary data collection
  - Self-report

Fee Basis Data

Overview

- Pays for care at non-VA facilities when
  - it is the only source available, or
  - VA could save money
- Full range of services covered
- Nearly all outpatient care is pre-authorized; limited emergent care

Growth in Fee Basis

- Meteoric growth in last 10 years:
  - $556 million in FY2003, $3.1 billion in FY2009
  - 10-20% growth per year

- Examples of major spending areas
  - long-term care (community NHs)
  - kidney dialysis
  - radiology

8 Fee Basis Files per Fiscal Year

- Inpatient care
  - Hospital stays (facility or facility+physician)
  - Ancillary, physician (if billed separately)
- Outpatient care
  - Outpatient non-pharmacy
  - Payments to pharmacies
- Travel expenses
- Two vendor files (pharmacy, all other)
- Veterans with Fee Basis ID cards

Highlights of Clinical Data

- Outpatient
  - Date of service
  - 1 CPT procedure code
- Inpatient
  - Start and end dates of invoiced period (often different from overall admission & discharge)
  - Up to 5 surgery codes
  - Up to 5 ICD-9 diagnosis codes (*no decimal*)

Highlights of Financial Data

- Amount claimed
- Amount paid
  - often much less than amount claimed
- Many financial processing variables

Highlights of Vendor Data

- Vendor ID
- Address (city, state, zip)
- Related VA station number
- Payment totals by month

Records vs. Encounters

- LINENO refers to consecutive records for the same person

- Each row of data represents a service provided for a particular date (outpatient) or time period (inpatient)
  - TREATDTF: Inpatient start of invoice period
  - TREATDTO: Inpatient end of invoice period
  - TREATDT: Outpatient date of service

Records vs. Encounters

- Inpatient encounters
  - Locate all records for the same encounter using SCRSSN and treatment dates (TREATDTF, TREATDTO)
  - Use vendor ID to distinguish between contiguous stays over two or more locations, such as these:
    - transfer from NH to hospital or hospital to NH
    - transfer between hospitals
  - Concatenate inpatient records to estimate overall length of stay

Records vs. Encounters

- Outpatient services
  - Each billable procedure (CPT or HCPCS code) will have its own Fee Basis record
- Outpatient pharmacy
  - For prescriptions obtained from a pharmacy, Fee Basis files show only the total VA payment to the pharmacy for the month
  - Medications injected in a clinic should have a separate Fee Basis record with a “J code” (HCPCS code begins with letter ‘J’)

Overlap with Other Files

- A majority of stays in the PTF Non-VA Hospitalization (NVH) file also appear in the Fee Basis data.
  - The reverse is not true: most Fee Basis records are not in the Non-VA Hospitalization file.

- Monthly community nursing home (CNH) claims are recorded as outpatient services in DSS national data extracts (NDEs).

Notes

- Blank fields are common.
  - They can mean “not applicable” as well as “missing.”
- Each paid invoice has a separate record.
  - Example: an inpatient stay typically has one invoice (and therefore one record) for each calendar month.

Notes

- Records are typically processed within 30 days of invoicing, BUT
- Invoices may be sent LONG after services are rendered. THEREFORE
- To find all services in a fiscal year, look in the Fee Basis files in that year and the following 1-2 years.
- Search by
  - TREATDTF and TREATDTO for inpatient records
  - TREATDT for outpatient records

Cautions

- Watch for outliers: extremely long stays
- If a stay appears to end on September 30, check the October records
- Look over a long period (2+ years) to find all records pertaining to an inpatient stay

Sharing Agreements

- Sharing agreements are contracts with non-VA providers. They represent an alternative way of hiring non-VA services.

- Some care from sharing agreements is recorded in the Fee Basis files.
  - e.g., DoD hospitals in Alaska and Hawaii

Resources

- Fee Basis intranet web site
  - record of national Fee monthly calls
- HERC intranet web site
  - guidebook on Fee Basis data
  - technical report analyzing FY2003 data
- HERC customer service: herc@va.gov

Questions on Fee Basis Files?

Self-Report

Collecting Health Care Utilization

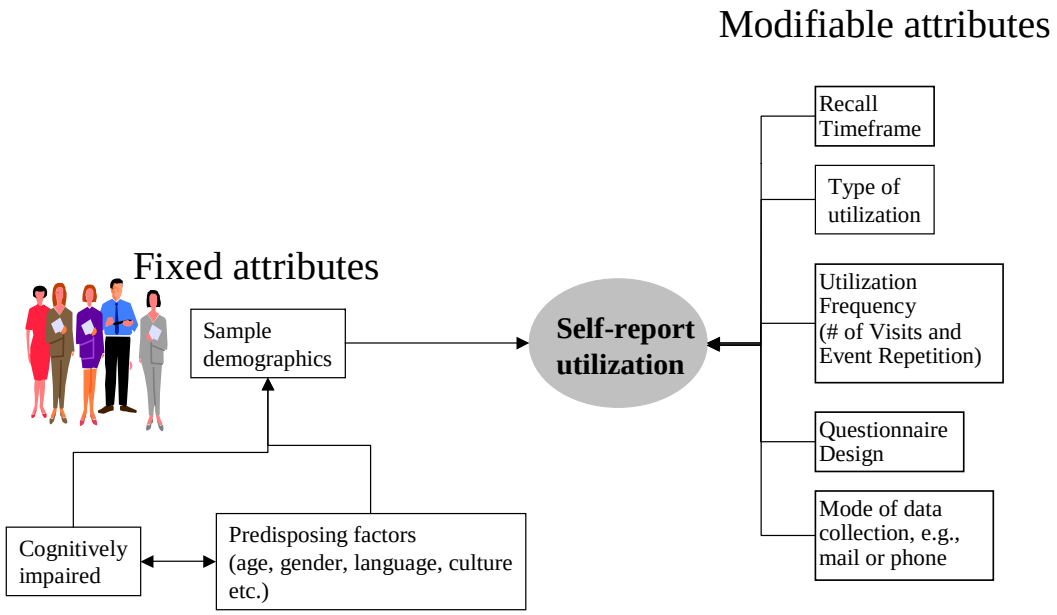
- Costly and time consuming
- No gold standard method
- Administrative data are incomplete / inaccurate
  - Limited benefits
  - Out-of-plan or out-of-pocket utilization
  - Capitated health plans

Poll

- During the past 12 months, how many times have you seen a doctor or other health care professional about your own health at a doctor's office, a clinic, or some other place? Do not include times you were hospitalized overnight, visits to hospital emergency rooms, home visits, or telephone calls.
- Responses
  - 0
  - 1
  - 2
  - 3
  - 4
  - 5
  - 6
  - 7+

What is Self-Report

- Cognitive process of recalling information



A. Bhandari and T. Wagner, "Self-reported utilization of health care services: improving measurement and accuracy," *Medical Care Research and Review* 63, no. 2 (2006): 217-235.

Fixed Attributes

- Process influenced by illnesses or disabilities (e.g., dementia or mental retardation)

- Older age is consistently correlated with poorer recall accuracy (spurious correlation)
  - Older adults more likely to under-report.

Recommendations

- Are respondents able to self-report?
  - Consider age and cognitive capacity
  - 14 is lower limit
  - Use cognitive screening tool, such as MMSE

Recall Timeframe and Frequency

- Time Frame
  - Longer recall times result in worse accuracy
  - Longer timeframes lead to telescoping and memory decay
- Frequency
  - Under-reporting is exacerbated with increased utilization
  - As the number of visits increase, people forget some

Recommendations

- Avoid recall timeframes greater than 12 months
- Shorter recall may be necessary for
  - Office visits (low salience)
  - Frequent users
- Consider two-timeframe method (i.e., 6-2)

Questionnaire Design

"How many times have you seen a physician in the past 6 months?"

- What is a "time?" What about multiple times on same day?
- What is a physician? Does a nurse count?
- Is "seen" literal? What about a phone consultation with prescription?
- What about care for someone else?

Design: wording

- Recall order
  - Chronological: go back a year and think forward
  - Reverse chronological: supposition: later events are the easiest to recall and helps recall previous events
  - Free recall
- Data are inconclusive; unclear whether this varies by gender or culture

Data Collection

- Modes: mail, telephone, Internet, and in-person data
  - No study has compared all four
  - Probing with memory aids can help improve accuracy
  - Stigma is important

Recommendations

- No standards exist and standards may not be possible
- Pretest: Dillman (2000)
- Placement in questionnaire might matter
- Phone, in person and some Internet surveys allow for memory aids
  - For example, landmark events

Response Scale

- Use counts
  - Include “your best estimate is fine”
- Avoid categories, which introduce biases and error in the statistical analysis
  - 0, 1-2, 3-5, 6+

Costs

- Self-reported costs are assumed poor
- Imputing costs from self-reports can introduce biases
- Analyze visits, not just costs
- Consider seeking billing data (discussed next)

Questions

Collecting Data from Non-VA Providers

Purpose

- Non-VA cost data needed to develop a full picture of patient spending.

- Many VA users under age 65 use non-VA services:
  - they have other insurance
  - they have a medical emergency

Overview of Method: Inpatient

- For each non-VA inpatient stay, ask for the following:
  - facility type (acute, nursing home, hospice, etc.)
  - facility name and location (at least city) → find zip code
  - admission and discharge dates
  - distance from patient's residence (or use patient's home zip code)
  - acute stays: days spent in ICU, whether surgery occurred*
  - primary cause/condition/purpose (e.g., MI; convalesce; give birth)

  *optional unless you will not collect a bill
- Obtain a signed release if you want information from the non-VA provider.

Overview of Method: Outpatient

- Note: not essential for cost, but may be needed for clinical outcomes.
- For each encounter ask the following:
  - provider type (physician office; dialysis clinic; dentist; etc)
  - provider name and location (at least city) → find zip code
  - distance from patient's residence (or use patient's home zip code)
  - service date
- Obtain a signed release if you want information from the non-VA provider.

Release of Information (ROI)

- The ROI authorizes the provider to release (disclose) information about the encounter to you.
- Key points about a ROI:
  - It is separate from the Informed Consent form.
  - It must be approved by the IRB.
  - It has many required elements. See VHA Handbook 1605.1, section 14.
  - A patient/representative cannot be forced or cajoled into signing it.

Necessary Elements: Highlights

- The ROI must contain the following:
  - Patient's name (a few providers require the SSN as well)
  - Description of information requested
  - Name of person/organization making the request
  - Name of person/organization to whom data will be disclosed/used
  - Description of purpose for disclosure/use
  - Expiration date for disclosure/use (can be "none" in certain cases)
  - Signature of patient or authorized representative
  - Statements about revocation, VA benefits being unrelated to request, and possibility of re-disclosure

After Obtaining the ROI

- Find fax and telephone numbers of non-VA provider.
- Call to find the person to whom info should be faxed.
- Fax cover letter and ROI.
- If it doesn’t come within a week, try again.

Alternative Sources of Cost Data

- VA: DSS NDEs, HERC average costs
- Medicare-funded stays using average cost per DRG (MS-DRG since FY08)
- Fee Basis data
- Other (published values; state or national averages)

Resources

- Process of gathering non-VA cost data
- HERC FAQ response I15

  http://www.herc.research.va.gov/resources/faq_i15.asp
- Requirements for valid ROI
- VHA Handbook 1605.1, section 14

  http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1423

Resources

- Estimating costs instead of finding actual costs
- See the following guidebooks on the HERC web site:
  - Fee Basis data
  - Microcosting methods (cost regression, other)
  - DSS National Data Extracts for inpatient and outpatient encounters
- HERC Average Cost data
- Go to HERC intranet site → Publications → Guidebooks

Questions?