Policy Analysis

Proposals for the Veterans Choice Program Redesign and their Impact on Veterans' Health Care

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July 10, 2017
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Background

Over the last decade, as the increasing demand for veterans' healthcare services outpaced the Veterans Health Administration (VA)'s capacity to meet it, excessive delays developed at some VA facilities. In 2014, Congress enacted the temporary Veterans Choice Program whose goal was to reduce delays by offering non-VA options to veterans who had to wait long or travel far for care. To date, over 1.6 million veterans have utilized the program.[1]

The demand for veterans' healthcare services is predicted to continue to climb during the next several years.[2] Services needed for recent returning veterans account for some of that increase. The bulk stems from the fact that more than 4 million of the approximately 9 million veterans currently enrolled in the Veterans Health Administration (VHA) are over the age of 65 with veterans over the age of 75 comprising the fastest growing sector of VHA enrollees. At least 2.6 million of veterans aged 65+ use VA health services and utilization continues to increase with age. Like all older adults, they consume healthcare resources out of proportion to their representation in the general population.

There are two basic ways to address VA's lack of capacity to meet this overall rising demand – bolster the VA by augmenting its number of clinicians and support staff, or purchase more services in the private sector. Those two options offset each other, since increases in Choice would be carved out of the VA.

As Congress deliberates Choice program redesign, policy makers should consider not only the plan's ability to remedy access problems, but also its broad impact. Congress must ensure that the next Choice program does not compromise VA's overall quality of health care – care that has been demonstrated, with geographic variations, to be at least equal to and often superior to non-VA care. Congress must ensure that the VA's innovative, integrated interprofessional care model is preserved. It must assure that the system for clinically training the majority of U.S. healthcare professionals is maintained. It must make sure that the VA is able to sustain its research mission that benefits not only veterans, but also every American. It must ensure that the private sector has the capacity to absorb an influx of veterans, which includes older, medically complex veterans, in a timely manner, and delivers excellent care. Given that non-VA care is more expensive than VA care, Congress must ensure that Choice is used judiciously so that there is no reduction in the level of services available to veterans. Finally, it must ensure that the VA is improved, not dismantled, because that's what veterans overwhelmingly prefer, and have been promised by administration and Congressional officials. Our analysis of major policy ideas for the next version of Choice concludes that only one proposal does all this.

Proposals for Veterans Choice Program Renewal

At least four ideas for modifying Choice have been proposed by policy makers and veterans' stakeholders. One – which we endorse – would fortify VA-delivered care and its management of the network of Choice providers. The other three concepts, although structured differently and still lacking specific details, would eliminate distance and wait time requirements, purchase far more care in the private sector, cut VA services and incrementally privatize veterans' healthcare.

The following are the four ideas, and their potential impact on veterans' healthcare if enacted:

1. Strengthen VA Delivered Care

The VA eliminates third party administrators and assumes direct management of high performing, integrated networks. Disparities between supply and demand are addressed first by resourcing VAs. External providers are

used only to fill in gaps that local VAs cannot provide. Eligibility for Choice is based on distance and wait time criteria that are convenient for the veteran.

Impact:

- Builds and strengthens the VA system for the long term.
  - Hires VA front line and support staff in locations where demand outstrips supply.
  - Increases VA appointment capacity.
  - Maintains quality assurance.
- Supplements care when needed.
  - Ensures that when timely, nearby VA care is not available, care is outsourced to the community.
- Is fiscally efficient.
  - Eliminating 3rd party administrative middlemen saves money and streamlines initiation of Choice care, when needed.
  - Hiring VA staff rather than purchasing more expensive private sector care reduces costs.
  - Gives VAs the ability to manage utilization and control expenses.
- Supports the comprehensive integrated care approach.
  - VA generalists treat veterans in primary care clinics and then walk them down the hall to meet with a behavioral health professional, pharmacist, social worker, nutritionist or other specialist.
  - The VA's coordinated, integrated care is not only more effective than the private sector's, it's far more convenient to veterans because everything is handled in one location.

2. Make Choice Cards Universal

Allow eligible veterans to seek unrestricted care from any outside, certified provider, without needing to obtain pre-authorization.

Impact:

- Fragments, diminishes and delays quality care.
  - Relies on community providers who are not vetted for quality and/or are less knowledgeable about veteran specific healthcare issues.
  - Increases wait times in the private sector for veterans as well as non-veterans. There aren't enough primary care, specialist, or mental health services in the community. By 2030, the U.S. will face a shortage of between 40,800 to 104,900 physicians.[3]
  - Because many physicians are unwilling to accept Choice payment rates,[4] veterans may have difficulty finding a qualified provider.
  - Creates uncoordinated administrative structures in which accountability is diminished.
  - Spreads treatment across the private sector, thereby reducing care coordination and integration. The Commission on Care Final Report[5] (page 28) recognized: "Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers."
  - The private sector virtually never screens for PTSD, MST or many other veteran problems, so many cases will be missed and untreated.
  - Suicide prevention programs in the community are generally far less comprehensive than in the VA.
- Leads to downsizing of VA delivered care.
  - Allows veterans to bypass the VA for services and send the bill to the VA for payment, even if the VA can provide prompt care that is closer and of higher quality. VA would cover the expenses of outsourced care by reducing their staff, programs, and services.
  - Allows eligible veterans who previously have been receiving care outside the VA using their own health insurance to send their bills directly to the VA for payment. That will further drain the VA budget.
  - Impairs VA's ability to continue to outperform the public sector, since funds are diverted to pay for Choice.
  - Secretary Shulkin's testimony at the June 7, 2017 Senate Committee on Veterans Affairs hearing affirmed: "Just giving veterans a card, a voucher, and let them go wherever they want to go… is appealing to some but it would lead to essentially the elimination of the VA system altogether. It would put veterans with very difficult problems out into the community with nobody to stand up for

them and to coordinate their care, and the expense of that system is estimated to be at the minimum $20 billion dollars more a year than we currently spend on VA healthcare."[6]

3. Limit the VA's Core Mission To Foundational Conditions

Redefine the VA's core mission as focusing on the treatment of foundational conditions, such as PTSD, traumatic brain injury, polytrauma, blindness, spinal cord injury, pain, limb loss and mental health. Outsource most of the remaining care to providers in the private sector.

Impact:

- Diminishes the quality and comprehensiveness of veterans' healthcare.
  - Outsourcing services to the private sector could mean many veterans may not receive high quality care. In study after study that contrasts private sector services to those of the VA, (including again in *Definitive Healthcare's* 2017 summary[7]), the quality of government-run VA care has been shown to be as good as and often better than private sector care. That's true across the spectrum, including for diabetes, heart disease, geriatric care, serious mental illness, PTSD, depression, safety practices, preventive care, surgical complications, infection control, hospital readmissions, hospital mortality and medication compliance. [8] [9] [10] [11] [12] [13] [14]
  - Private sector providers have less expertise in detecting and treating underlying conditions to which veterans are highly vulnerable. For example, a general practitioner is less likely to explore PTSD as the reason for chronic insomnia, the impact of traumatic brain injury on mood and decision-making, or that a particular condition – asthma induced by burn-pits or diabetes produced by Agent Orange exposure– is related to military service.
  - Many veterans have comorbid physical and mental health problems, which require integrated care. This is especially true of the large number of aging veterans.
- Increases wait times for veterans and non-veterans in the private sector.
  - As in #2, this plan leads to longer wait times in the private sector, which is already is struggling to keep up with demand. There aren't enough private sector doctors available to treat veterans or willing to accept Choice payment.
- Severely impacts poor, mentally ill and homeless veterans.
  - The VA has substantial programs that have had a significant impact on veteran homelessness. VA actively attempts to locate homeless veterans and ensure they are housed and cared for. The VA employs peer specialists who routinely reach out to veterans diagnosed with schizophrenia and other serious mental illness who have stopped showing up to appointments. Few private sector facilities offer the level of robust wrap-around psychosocial services that are standard in the VA.
- Reduces VA clinics and access for veterans who value and choose VA.
  - Major segments of VA healthcare would be outsourced to the private sector.

4. Allow Choice Eligibility Based On A Composite Community Standard Metric

Bases eligibility for Choice on a community standard metric, which will be a composite of patient satisfaction, wait time and quality measures. Where the composite score for a local VAMC non-foundational service line falls below that number, all veterans in that local clinic will automatically be eligible for Choice. Independent of whether VAMC service lines exceed that number, individual veterans can be granted Choice once they discuss VA and Choice options with their VA provider. Uses high-performing integrated networks for outsourced care.

Impact:

- Changes Choice eligibility to be based on a composite measure (comprised of wait time + patient satisfaction + quality metrics).
  Individual veteran level eligibility: Once veterans and their providers discuss and compare VA and community alternatives, veterans may be granted Choice. However:
  - Neither the VA's Access and Quality Tool website http://www.accesstocare.va.gov/ nor Medicare's Hospital Compare website https://www.medicare.gov/hospitalcompare/search.html have the data that veterans need to make informed decisions.
  - There is little data on effectiveness in reducing symptoms or functional deficits.
  - There is little data on outpatient care.
  - There is no data on community access.

Clinic level eligibility: When a VA non-foundational service line's composite score falls below their community's score, all veterans in that clinic will automatically be eligible for Choice for that service. However:
    - The algorithm to compute this composite metric has not been developed.
    - Comparing VA with community composite scores is misleading, since they are not apples-to-apples comparisons. Private sector statistics are based on non-veteran patients who, on average, are younger and have fewer medical and mental health conditions than do veterans.[15] [16]
- Increases costs and decreases productivity.
    - Reduces VA's ability to control costs if veterans have the prerogative to opt for private sector care even when the local VA is able to provide treatment that is less expensive, clinically superior, quicker and/or closer.
    - Requires VA providers to devote extra time mastering knowledge of private sector scores and going over those with patients. This decreases clinician productivity and increases wait times.
    - Is more expensive overall than the current VA system.
- Incrementally removes option of the VA for veterans seeking VA as their home.
    - There will be a steady flow of funds out of the VA and into private sector care. If funds that could have been used to make improvements are diverted to pay for Choice, VA facilities that lag behind will never be able to catch up. Even high performing VA's will falter when funds diminish.
    - Dozens of VA service lines are already identified as falling below the metric, qualifying all of the clinic veterans to be automatically eligible for Choice.
- Fragments care.
    - Encourages the VA to provide foundational services and outsource other services to the private sector.
    - Bi-directional, interoperable sharing of VA and private sector electronic medical records does not exist.
- Expands provider network where needed.
    - Aims to develop high-performing networks that link the private sector to the VA over time, although they are not yet available.

Analysis

Making significant, lasting improvements in the VA's ability to provide high quality care without serious delays is unquestionably the right thing to do. It honors the sacred obligation we owe to veterans, to care for those who have borne the battle. In our analysis, idea #1 optimally achieves what Choice was intended to do – remedy wait time delays by outsourcing care when the VA doesn't have prompt or existing services – without collateral damage to the unique advantages, superior quality, cost-effectiveness and integration within the VA healthcare system. It observes the guiding principle for healthcare systems and doctors, "first, do no harm."

In a fixed pot, every dollar spent on Choice would be subtracted from local VA budgets. Choice care is paid first and the VA makes do with what's left. Expansion of Choice inherent in ideas #2, 3 and 4 sets in motion a hollowing out, in which over time, local VAs will have less money, vacant positions won't be filled, medical services will be cut back and clinics closed. As the availability of VA's services diminish, more veterans will opt for or be placed into Choice, leading to more VA cuts in a vicious cycle. These models degrade the quality of options that already exist. They inexorably privatize veterans' healthcare, with the conversion occurring quickly in ideas #2 and 3, and gradually in idea #4. Idea #1 impedes privatization.

Idea #1 best supports the VA's integrated care model. The VA's one-stop approach facilitates the immediate identification and referral of a variety of problems, for example, when a veteran hints at feeling suicidal during an optometry appointment and is walked down the hall to a mental health clinician. It best supports the VA's holistic approach that incorporates the physical, psychological, social, and economic aspects of health and the impact these factors have on treatment compliance. Care provided in ideas #2 and 3, and to some degree in #4, is more fragmented, and limited to just the patient's chief complaint. Further, there is no ability at present to bi-directionally coordinate VA-community care via electronic medical records.

Idea #1 is the only one that assures continuity of the VA's 71-year-old statutory education mission. More than two-thirds of all U.S. doctors, not just VA doctors, receive their training at VA facilities. So do 40 other healthcare professions. Ideas #2, 3 and 4 lead to reductions in the number of VA attending supervisors, case volume, resident rotations and specialty training programs. A decline in VA training opportunities will be calamitous, given the shortages that already exist. There is no large-scale capacity in the private sector to train knowledge and skills of practitioners.

Idea #1 most effectively fosters groundbreaking research that has been the hallmark of the VA. More than 60% of VA researchers are clinicians, and their studies originate from daily interactions with veterans.[17] The VA has the largest integrated electronic medical record system in the world, uniquely enabling research questions to be pursued. Studies aimed at better understanding and treating veterans' conditions will be nearly impossible if care is scattered across the community.

Although ideas #1 and #4 are similar in some respects, there are key differences between them.

- #1 grants Choice options on a case-by-case circumstance. #4 does this too, but also grants Choice to large groups of veterans in identified clinics.
- #1 upholds the VA as a system treating a full complement of conditions. In #4, the VA emphasizes the provision of foundational services.
- While there have been important concerns raised about the use of distance and wait times to determine Choice eligibility in #1, these criteria allow the VA to manage Choice utilization and costs. The substitute composite metric in #4 is still unformed and untested.

The best information to date shows that community care is likely more expensive than VA's.[18] To offset added systemic costs for Choice care in plans #2, 3 and 4, it's likely that some current or future veterans would no longer be served, and/or charged higher deductibles and out of pocket expenses. Cutting benefits to disabled unemployable veterans to pay for Choice expansion was proposed in the original FY18 VA budget, although policy makers scrapped that idea recently and are now searching for a substitute.[19]

There is a myth that the only way the VA will be motivated to excel is if it is forced to compete with the private sector for its customers. This in spite of the reams of studies that show the VA -- without relying on market-based incentives -- already delivers care that is equal or superior to that provided in the private sector. The sense of mission to serve veterans is what motivates VA employees, and with convincing effect.

Ideas #2,3 and 4 contradict what veterans overwhelmingly want -- that the VA's clinical care and breadth of services be fixed and strengthened, not dismantled.[20] That's especially true for those veterans who use the VA.

We recommend other considerations for Choice redesign:

- Build VA capacity first.
  - Sustain budgets that assure all VA facilities have sufficient capability to provide comprehensive, high performing care. Such resources include staff, space and IT support. It would be a mistake to expand the Choice Program without first increasing the capacity for care at VA facilities where demand for services exceeds supply.
  - Enhance telehealth resources (in VA's FY18 budget request) so that veterans have expanded access to VA providers without needing to go outside the VA.
- Guarantee a high level of coordinated, integrated care.
  - Mandate that Choice providers/facilities be able to bi-directionally exchange electronic VA medical records before they are accepted into the Choice program.
  - Mandate that Choice providers engage in the same treatment recommendation process expected of VA providers, i.e. for them to understand what medical and mental health services are available at their local VAs and refer their veteran patients to the VA when the VA renders higher quality care.
- Strengthen the VA brand.
  - Include only high quality providers in the network. Choice should not mean that VA relies on partners simply because they are willing to accept payment, without adhering to the same high quality standards. Stipulate in Choice contracts that providers meet VA's elevated standards, use evidence-based treatments, have knowledge of military culture and competence in veteran-specific problems, engage in ongoing measurement of progress, and perform screenings, such as for PTSD, Military Sexual Trauma and Suicide Prevention.
  - Expand opportunities for the VA to publicize and advertise what it does well. The public remains grossly uninformed about its successes, innovations and overall superior quality.

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ENDNOTES

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