

Retaining Effective and Sound Programs for Excellent Care and Treatment (RESPECT) for Veterans



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Abbreviations

CAMH	CMS Alliance to Modernize Healthcare
CBO	Congressional Budget Office
CMS	Centers for Medicare & Medicaid Services
DO	Doctor of Osteopathy
GAO	Government Accountability Office
HEDIS	Healthcare Effectiveness Data and Information Set
MD	Medical doctor
MISSION	Maintaining Internal Systems and Strengthening Integrated Outside Networks Act
NASEM	National Academies of Sciences, Engineering, and Medicine
NCVAS	National Center for Veterans Analysis and Statistics
OMHSP	Office of Mental Health and Suicide Prevention
PTSD	Post-traumatic stress disorder
TBI	Traumatic brain injury
USC	United States Code
VA	Department of Veterans Affairs
VCCP	Veteran Community Care Program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Networks

Executive Summary: The Increasing Threat of Privatization

Over the past five years, the Veterans Health Administration (VHA) has been the subject of much debate in Congress, which has resulted in the increasing privatization of the health care services it provides to veterans.¹ This slow march towards outsourcing the VHA's health care services to private health care providers has not received the same scrutiny and assessment as the VHA's own health services have received, and private-sector health care threatens to undermine the very health care that veterans are entitled to under the VHA.

As veterans are a unique population with health needs that require the specialized care provided by the VHA, this move to provide veterans care in the private sector threatens their very lives. Therefore, to protect veterans, the VHA should expand its own capacity where needed and use the private sector only as an interim measure.

The Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) was a relatively minor step toward privatization. It became law amid concerns about long waits for veterans to receive health care through the VHA. It allowed veterans to receive care in the private sector if they lived more than 40 miles from the nearest VHA facility or could not get an appointment within 30 days (Sec. 101(b)).² To better understand how to meet veterans' health needs, the Choice Act required a set of 12 independent assessments—Assessments A to L—by private-sector organizations (Sec. 201(a)(1)(A)-(L)). It also required one of these organizations to create a report that integrates these assessments (Sec. 201(d)) and a report undertaken by a 15-person commission called the Commission on Care (Commission) (Sec. 202(b)(3)(B)). This paper draws on these assessments as well as other scientific studies and medical literature.

1 The Department of Veterans Affairs (VA) is composed of three organizations. The Veterans Health Administration, the Veterans Benefits Administration, and the National Cemetery Administration (VA 2009). For clarity, this paper will use "VHA" rather than "VA" when discussing veterans' health care and related services managed by the VHA and "VA" when discussing issues that encompass more than one of the three organizations that constitute it. Quoted materials that use "VA" when referring to the medical centers and other VHA facilities will be left unchanged.

2 The 30-day time frame is based on the veteran's preferred date or the date recommended by a physician.

With the passage of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act), we now stand on the verge of massive privatization under the Veterans Community Care Program (VCCP). As veterans are a unique population with health needs that require the specialized care provided by the VHA (Eibner et al. 2015:168; Tanielian et al. 2018:1, 19, 36, 40-41), this move to provide veterans care in the private sector threatens their very lives. Therefore, to protect veterans, the VHA should expand its own capacity where needed and use the private sector only as an interim measure.

Veterans' Unique Health Care Needs

Veterans have greater health needs, and different care requirements than the civilian population. Assessment A, required by the Choice Act, examined the unique health care needs of the VHA population currently and as projected in future years (Eibner et al. 2015). This assessment found that the health care needs of the veteran population differ substantially from those of civilians. First, in part because it trends older, the veteran population as a whole has greater health needs than the civilian population (id. at 168). Veterans who actually enroll with the VHA, slightly less than half of the total veteran population, tend to have even greater health needs than both veterans overall and the civilian population—in particular, higher rates of chronic conditions (id. at 83-115). Second, veterans, and especially VHA enrollees, have service-related disabilities and conditions that require specialized treatment, particularly those who have seen combat (id. at 168).

Yet, despite veterans' greater health needs, their service-related disabilities, and their service to our country, health care for veterans is provided, by statute, "only to the extent and in the amount provided in advance in appropriations Acts for such purposes" (38 U.S.C. 1710). To manage this uncertainty in funding, the VHA bases eligibility for care on eight priority groups ranging from those with the highest priority, veterans with service-

connected disabilities that are 50 percent or more disabling or who are unemployable from a service-connected condition, to priority group 8, veterans with income above specified limits or who were enrolled as of specific dates (VHA 2018a; Wang et al. 2019:4). The use of these priority groups explains, at least in part, the reason that the VHA patient population has greater medical, psychological, and economic needs than veterans who do not use the VHA and even greater needs than the U.S. population as a whole.

The VHA performs exceptionally well in suicide prevention and treating the post-traumatic stress disorder (PTSD) and depression experienced by many veterans

The VHA Outperforms the Private Sector on Quality, Access, and Cost

Multiple studies have confirmed that the VHA outperforms the private sector in quality, access, and cost in both inpatient and outpatient care.³ Examining well-established measures of hospital quality, VHA hospitals performed the same or significantly better than non-VHA hospitals on all measures of patient mortality and patient safety, and 12 out of 14 effectiveness measures (Price et al. 2018: 1, 3-6). Other studies confirm that VHA outperforms the private sector in outpatient care as well, particularly in preventive care and treating chronic health conditions (O’Hanlon et al. 2017:117, citing Trivedi et al. 2011; Price et al. 2018:2).

Providing quality mental health care is a key concern at the VHA as 33 percent of all VHA enrollees have a mental health condition (Eibner et al. 2015:168). Under contract from the U.S. Department of Veterans Affairs, the National Academies of Sciences, Engineering, and Medicine (NASEM) appointed mental health experts to assess the “quality, capacity, and access” of VHA mental health services (2018:15). They concluded that the VHA performs as well as or better than the private sector (id. at 326). The VHA performs exceptionally well in suicide prevention and treating the post-traumatic stress disorder (PTSD) and depression experienced by many veterans (Gordon 2018:159, 191-93; Lemle 2014:18).

Although the Choice Act was prompted by claims that veterans were suffering detrimental health effects from lengthy appointment wait times, RAND research team Hussey et al., tasked with assessing the VHA’s capability to provide timely and geographically-accessible care, found that the problem had limited scope and that the VHA generally outperforms the private sector on timely access (2015:154-67). Studies of 15 major metropolitan markets across the United States conducted in 2014 and 2017 found that the VHA compared favorably, typically exceeding the private sector in providing timely primary and specialty care (Hussey et al. 2015:154-67; Merritt Hawkins 2014 and 2017). More recently, RAND analysts Farmer and Tanielian testified before Congress that the VHA’s “average wait times were 4.2 days from the preferred date for primary care, 5.5 days for mental health care, and 10.4 days for specialty care” (2019:3, citing VA 2019a).

To compare the VHA to the private sector regarding geographic accessibility, Hussey et al. used travel times to hospitals for fee-for-service Medicare enrollees as a proxy for the length of time that veterans might have to travel to access care in the private sector (2015:142). In most cases, Medicare enrollees living in the same network service areas as VHA enrollees were traveling farther to access a private hospital than veterans would have to drive to a VHA hospital in the same area. In a few cases veterans had had to travel about five to 15 minutes longer (id. at 143). Veterans who lived farther than 40 miles of driving distance to a VHA facility also had very limited access to non-VHA physicians, complex care, and specialized hospital services from non-VHA facilities (id. at 137-49).

Lastly, the VHA excels when it comes to containing costs. An overwhelming majority of studies confirm that the VHA has lower costs compared to Medicare payment rates (Hussey et al. 2015:51, citing Hendricks, Whitford, and G. Nugent 2003a and Hendricks, Whitford, and L. Nugent 2003b; G. Nugent et al. 2003; G. Nugent et al. 2004; Render et al. 2003a; Render et al. 2003b; Roselle et al. 2003), particularly for outpatient pharmaceutical and rehabilitation services (Nugent et al. 2004:501-02). Had the studies compared the cost of providing care through the VHA versus the private sector at commercial insurance rates, estimated cost savings would have been significantly higher (CBO 2014:5-6, citing CMS 2012:66-67). Importantly, veterans also save money using VHA health care as it has no premiums or deductibles and cost-sharing, when required, is generally more affordable than commercial health insurance (CBO 2014:3; Hussey et al. 2015:167-70).

3 Price et al. used the Agency for Healthcare Research and Quality’s Patient Safety Indicators, CMS’ 30-day risk-standardized mortality and readmission measures, and the Joint Commission’s ORYX measures for inpatient safety and effectiveness.

The Commission on Care Misses the Mark

The Choice Act tasked the 15-person Commission on Care⁴ (Commission) with evaluating and assessing veterans' access to health care through the VHA and producing a report⁵ with its recommendations for legislation or regulations to improve their access (Sec. 202(b)(3)(B)). Although the Commission's report recommends creating an expanded health care network that would increase the use of private-sector providers (2016:23), it also recognizes that contracting care out to the private sector may have "unintended consequences" (id. at 33). It flags two issues in particular: [1] that health care for veterans might supplant care for Medicare and Medicaid patients in underserved communities (ibid.) and [2] that increased consolidation of health care markets may require the VHA to pay higher prices in the private sector (ibid., citing Cutler and Scott). The Commission further states that "[s]uch circumstances underscore the importance of VHA retaining the option of building its own capacity" (id. at 33).

By its own admission, however, the cost estimates for the Commission's recommended option for expanding private-sector care is based on a model with severe limitations (id. at 173-74). The Commission's model uses little or no data on VHA capacity, local community capacity, enrollment numbers, reliance on VHA care,⁶ and administrative costs (ibid.). Moreover, the Commission's estimates for its recommended option would shift 40 percent of care from the VHA to the private sector, leaving many VHA facilities underutilized and ripe for closure (id. at 177). Given the limited data underpinning its recommendation coupled with the overall superior performance of the VHA compared to the private sector, it would be extremely irresponsible for Congress to move forward on the Commission's recommendation. Rather, building VHA capacity through targeted improvements where needed would be the best and most prudent approach.

The MISSION Act's Regulatory Double Standard

The regulations promulgated for the VCCP, established by the MISSION Act, have tightened access standards for the VHA but fail to hold the private sector accountable to the same standards. The regulations establish separate access standards for primary care, mental health care, and non-

institutional extended care services, on the one hand, and specialty care, on the other (VA 2019c:26310 to be codified at 38 CFR 17.4040). Under the access standards, veterans are eligible to seek care in the private sector for primary care, mental health care, and non-institutional extended care services, if VHA appointments are not available within 20 days of the request date and 30 minutes' average driving time from the veteran's home and for specialty care, if VHA appointments are not within 28 days of the request date and 60 minutes' average driving time from the veteran's home (ibid.).

Studies of 15 major metropolitan markets across the United States conducted in 2014 and 2017 found that the VHA compared favorably, typically exceeding the private sector in providing timely primary and specialty care.

Private providers are not held to the same access or eligibility standards as VHA providers. The eligibility standard for the private sector to provide care to veterans does not specify access standards, but merely states the VHA will *consider* the wait time for an appointment and the distance from the covered veteran's home (id. at 26309 to be codified at 38 CFR 17.4030). In discussing comments on the proposed rule, the VA unequivocally declares that non-VHA providers will not be held to the same wait time and geographic accessibility standards as VHA providers (id. at 26293). Furthermore, the VA clarifies that a requirement to consider a provider's qualifications "to furnish the hospital care, medical services, or extended care services" will consist of collecting information regarding licensing and credentialing rather than meeting competency or quality standards (id. at 26309 to be codified at 38 CFR 17.4030).

4 The president and members in the House of Representatives and the Senate, from both major parties, each appoint three Commission members for a total of 15 voting members.

5 The Choice Act requires the Commission to create both an interim and a final report in Section 202(b)(3). This paper considers only the final report.

6 This draws on the notion of "reliance," defined as "the share of health care services that VA patients receive from VA versus from other sources" (Eibner et al. 2015:57).

Conclusion

Congress created the VHA with the “primary function ... to provide a complete medical and hospital service for the medical care and treatment of veterans” (CMS Alliance to Modernize Healthcare 2015:23, citing 38 U.S.C. 7301). With limited exceptions, the VHA meets this statutory function. Moreover, it generally provides eligible veterans excellent health care in a timely manner. As discussed above, the VHA meets or exceeds care in the private sector on access, quality, and cost. Therefore, Congress should focus on remedying the exceptions rather than expanding use of private-sector providers.

Yet, the VHA faces a dilemma between its mission, “Honor America’s Veterans by providing exceptional health care that improves their health and well-being” and providing care insofar as appropriated funding allows (id. at 23). The law that created the VHA requires that hospital care and medical services be provided to veterans but simultaneously limits the provision of these services “to the extent and in the amount provided in advance in appropriations Acts for such purposes” (ibid., citing 38 U.S.C. 1710). To resolve this dilemma, Congress must mandate a dedicated financing mechanism and a comprehensive package of benefits that ensures our veterans get the health care they need and deserve.

Furthermore, Congress and the relevant administrative agencies must ensure all the following requirements are met. First, before expanding care in the private sector, they should require the same assessments of the private sector that the Choice Act required of the VHA. Second, the private sector must be held accountable to the same health care quality, access, and competency standards and reporting requirements. Third, private-sector care should be expanded only if the VHA cannot provide the health care needed in a timely and geographically accessible way and the private sector has the capability and capacity to do so.⁷ Finally—as care in the private sector would almost certainly cost more than that provided by the VHA and, thus, fewer veterans would be able to receive treatment in the private sector than at the VHA for the same budget allocation—capacity in the VHA must be expanded and care should be provided in the private sector only until the VHA has the capacity to do so.

⁷ Note that both the Choice Act and the MISSION Act allow veterans to seek care outside the VHA irrespective of whether the private sector can provide the needed health care in a more timely or accessible manner.

I. Introduction

Congress created the Veterans Health Administration (VHA)⁸ with the “primary function ... to provide a complete medical and hospital service for the medical care and treatment of veterans” (38 U.S.C. 7301). With limited exceptions, the VHA meets this statutory function. Yet, the VHA faces a dilemma between its mission, “Honor America’s Veterans by providing exceptional health care that improves their health and well-being,” and the limits that appropriated funding levels impose on its work (CMS Alliance to Modernize Healthcare (CAMH) 2015:23). By law, the VHA must provide hospital care and medical services to veterans but the law simultaneously limits the provision of these services “to the extent and in the amount provided in advance in appropriations Acts for such purposes” (38 U.S.C. 1710). The law forces the VHA to work within the budget allotted by Congress, regardless of the demand put on VHA services. CAMH acknowledges the role of politics in VHA budgeting:

... Congress appropriates VA’s budget as a nondefense discretionary program; thus, congressional priorities can influence both the level of money available and the way VA can spend the money once allocated. Funding for other large federal health programs differs in important ways. (ibid.)

For example, Medicare, our largest federal health program, differs from the VHA in that it has a dedicated financing mechanism and provides a congressionally mandated package of benefits.

The tension between the VHA’s mission and the limits set by congressional appropriations must be recognized as a fundamental background condition as we examine the move to privatize the VHA. This move was prompted by concerns about veterans’ access to health care. Congress addressed these concerns in two steps—first, by passing the Veterans Access, Choice, and Accountability Act of

2014 (Choice Act), which President Obama then signed into law, and second, by passing the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act), which President Trump signed into law.

The Choice Act expanded use of private-sector health care providers⁹ and facilities for the limited number of veterans who live more than 40 miles from the nearest VHA facility or who could not get an appointment within 30 days (Sec. 101(b)).¹⁰ It required a set of 12 independent assessments—Assessments A to L—by private-sector organizations (Sec. 201(a)(1)(A)-(L)). It also required that one of these private-sector organizations create a report that integrates the 12 assessments (Sec. 201(d)) and a report¹¹ undertaken by the 15-person Commission on Care (Commission) (Sec. 202(b)(3)(B)). Drawing selectively on these assessments and the Commission’s report,¹² the MISSION Act took the Choice Act’s privatization further by consolidating and expanding the use of non-VHA providers under the new Veterans Community Care Program (VCCP) (Title I, Subtitle A) and establishing a process for closing VHA facilities (Title II, Subtitle A). Justification for shifting care to the private sector requires not only showing that the VHA is deficient, but also that the private sector can address the deficiency. Specifically, shifting care to the private sector makes sense only if both of the following hold: [1] the VHA is unable to provide quality health care within established geographic and timely access standards and [2] there are local hospitals, clinics, and qualified clinicians that are able to provide the specialized health care that veterans need in a more timely or geographically accessible way than can be provided by the VHA. Unfortunately, neither the Choice Act nor the MISSION Act required a robust and thorough assessment of private-sector providers. To ensure our veterans get the care they need, Congress must move quickly to remedy this.

8 The Department of Veterans Affairs is composed of three organizations. The Veterans Health Administration (VHA) which operates the health care system, the Veterans Benefits Administration (VBA) which “supplies compensation and vocational assistance to disabled veterans”, and the National Cemetery Administration (NCA) which manages veteran burials and memorials (VA 2009). For clarity, this paper will use “VHA” rather than “VA” when discussing veterans’ health care and related services managed by the VHA and “VA” when discussing issues that encompass more than one of the three organizations that constitute. Quoted materials that use “VA” when referring to the medical centers and other VHA facilities will be left unchanged.

9 References to “provider,” or “providers” typically includes medical groups, hospitals, and health care facilities in addition to individual health care practitioners.

10 The VHA standard of timeliness under the Choice Act used the number of days from either the veteran’s preferred date or the date recommended by a physician. Thus, the assessments required by the Choice Act used this standard. As will be discussed below, this standard changed under the MISSION Act.

11 The Choice Act requires the Commission to create both an interim and a final report (Sec. 202(b)(3)). This paper considers only the final report.

12 According to analysis by staff with the Congressional Research Service, the creation of the MISSION Act’s Asset and Infrastructure Review Commission draws on the Choice Act’s assessments and Commission on Care report (Panangala, et al. 2018:31-32).

This paper compares care provided by the VHA with care available in the private sector based on the assessments and reports required by the Choice Act as well as scientific studies and medical literature. Although an in-depth analysis of the private sector is needed, available evidence shows that the private sector cannot provide the specialized care veterans require. The first section begins by discussing the demographics and health status of veterans as compared to the U.S. population as whole. It then examines the priority groups that the VHA uses to determine veteran eligibility to receive care through the system. The second section provides an overview of the VHA and examines how it performs in terms of quality, access, and cost compared to the private sector. The third section considers whether the private sector has both sufficient understanding of veteran and military experience and the clinical expertise to meet veterans' unique needs. Next, the paper critically examines the flawed model used by the Commission to estimate costs of various options for providing care and its preferred option, a combination of VHA and private providers that uses narrow networks to control costs. In section five, it considers how the implementation of the MISSION Act through the rulemaking process unfairly holds the private sector and the VHA to different standards. The paper concludes with a call for Congress to expand care through the VHA rather than the private sector wherever possible; to hold the private sector accountable to the same health care quality, access standards, and reporting requirements as the VHA when it is necessary to use it; and to ensure that the VHA has sufficient funds to provide veterans needed care.

II. Veteran Population

Veterans have greater health needs, and different care requirements than the civilian population. Assessment A, as mandated by the Choice Act, addresses: “Current and projected demographics and unique health care needs of the patient population served by the Department” (Sec. 201(a)(1)(A)). The RAND Corporation carried out the assessment. RAND analysts Eibner et al. remark at the beginning of their report as follows: “Meeting the needs of this population

Examining veteran demographics, health status, and the VHA enrollee priority system makes clear that the VHA cares for patients with unique needs. These patients are among the veterans who have given the most to our nation at tremendous sacrifice to their very bodies and mental health. Many of them also have great economic need.

requires a clear understanding of Veterans’ distinctive characteristics in comparison with non-Veterans, in terms of both their demographic and health characteristics ...” (2015:2). Examining veteran demographics, health status, and the VHA enrollee priority system makes clear that the VHA cares for patients with unique needs. These patients are among the veterans who have given the most to our nation at tremendous sacrifice to their very bodies and mental health. Many of them also have great economic need.

Demographics

According to the National Center for Veterans Analysis and Statistics (NCVAS),¹³ as of 2018, there are approximately 19.6 million U.S. veterans (2016:Table 1L). NCVAS reports that most veterans, 73 percent, are 50 years of age and older. It reports further, as shown in Figure 1, that the youngest age bracket, 17 to 29, is smallest at 5.0 percent; the number of veterans increases steadily from ages 30 to 79 from 10.2 percent to 20.1 percent; and then drops significantly for those 80 and older to 14.6 percent. The age distribution reflects the large number of living Vietnam War veterans—6.5 million (NCVAS 2016:Table 2L)—who served

Figure 1. Age Distribution of Veteran Population

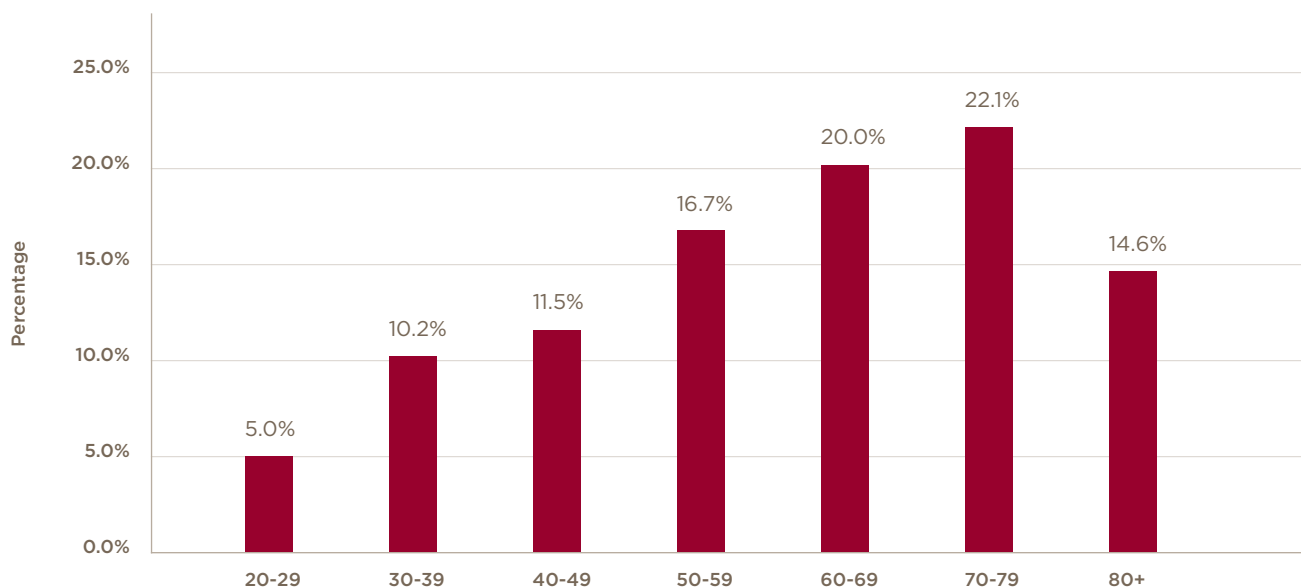


Chart based on data from NCVAS (2016:Table 1L)

13 The NCVAS 2016 data are projections for September 30 of the relevant year “[u]sing the best available Veteran data at the end of FY2015 as the base population” (NCVAS 2016).

Figure 2. Racial Breakdown of Veteran Population

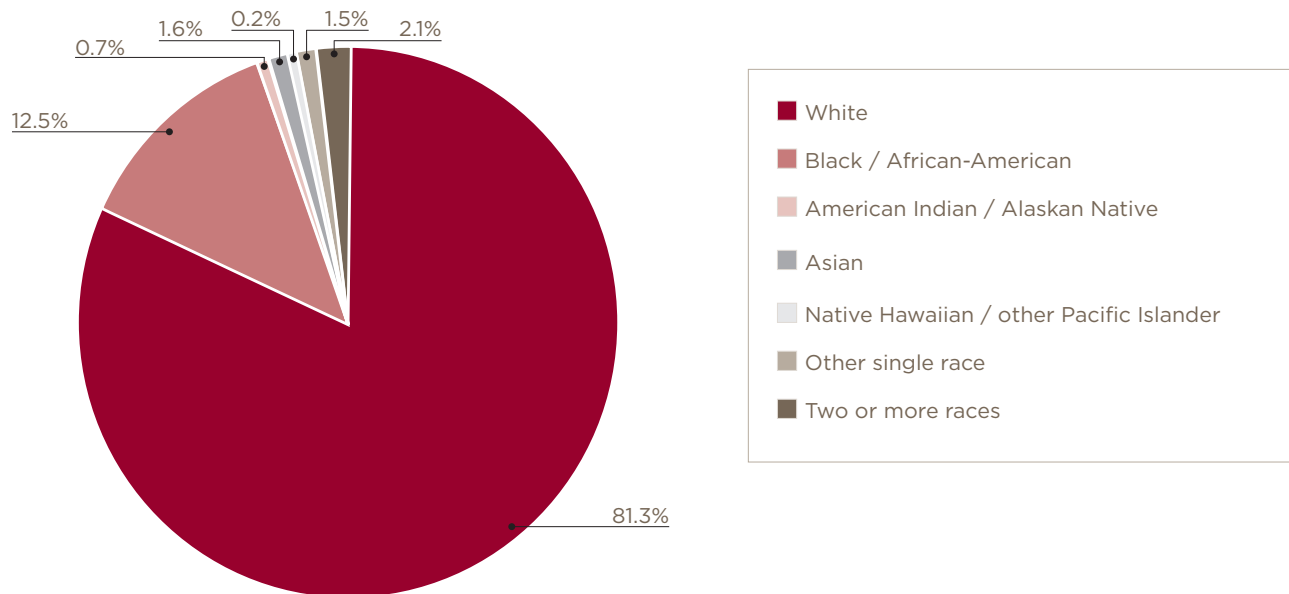


Chart based on data from NCVAS 2016; Table 3L

from August 1964 to April 1975 (NCVAS 2019:43). As one would expect, older veterans tend to have greater health needs than younger veterans. However, the nearly 1.5 million veterans who served in Operation Enduring Freedom, Operation Iraqi Freedom, or Operation New Dawn (OEF/OIF/OND),¹⁴ constituting 17.8 percent of VHA enrollees, are an important exception (Wang et al. 2019:26). These veterans are more likely to be under 45 years of age and are also more likely to have service-connected disabilities of 50 percent or higher (Wang et al. 2019:26; Huang et al. 2018:12). Women veterans and veterans from racial/ethnic minorities tend to be younger than the population of white, non-Hispanic men, reflecting changes since the shift to an all-volunteer military (Bialik 2017).

The NCVAS data show that while a large majority of veterans are men, there is a small but growing percentage of veterans who are women that currently stands at 9 percent (2016:Table 3L). According to these data, the racial/ethnic breakdown among the veteran population is primarily white at 81.3 percent, with 12.5 percent black/African American, 2.1 percent multi-racial, 1.6 percent

Asian, 1.5 percent other single race, 0.7 percent American Indian/Alaska Native, 0.2 percent native Hawaiian/other Pacific Islander, and 7.5 percent Hispanic/Latino of any race. Figure 2 shows the current racial breakdown. However, the NCVAS projects the veteran population will become more racially and ethnically diverse over time.

Health Status

Assessment A found that veterans' health status¹⁵ is significantly worse compared to non-veterans (Eibner et al. 2015:83-115). Moreover, it found that health status gets progressively worse as we move from veterans who are not enrolled in the VHA, to those who are enrolled in the VHA but not using its health care services, and finally to enrollees actually using VHA health care services.¹⁶ It is crucial to understand these differences when considering whether to expand the use of the private sector in providing veterans' health care (id. at 87). Assessment A describes some of the key differences between VHA patients and non-VHA private-sector patients:

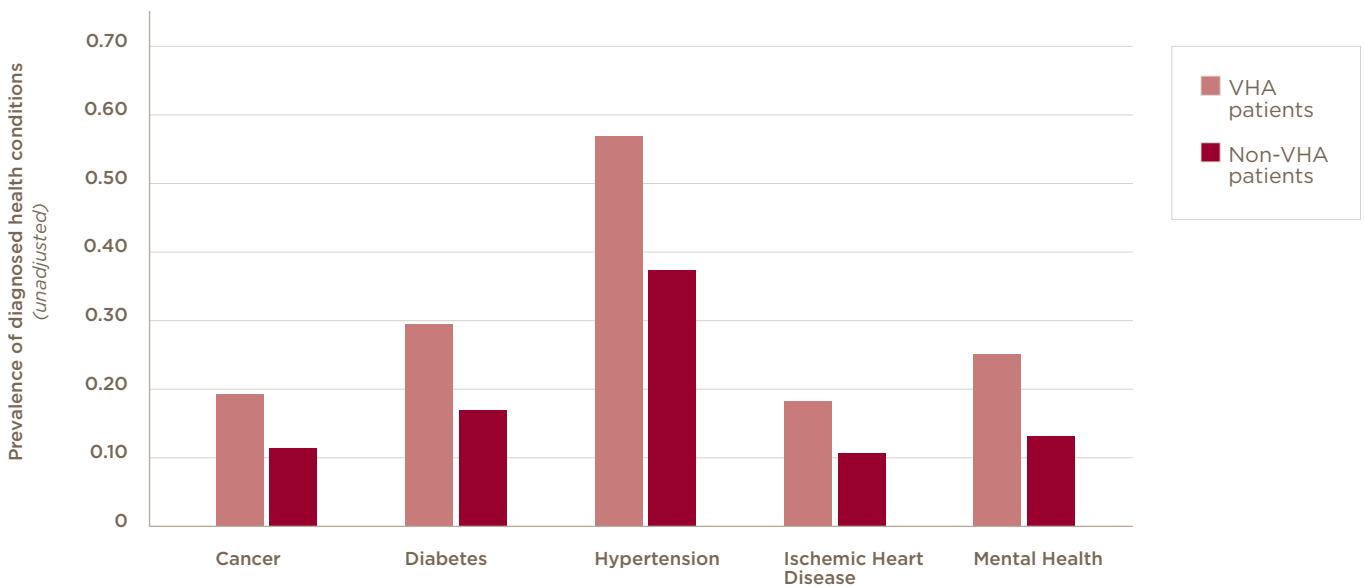
14 Operation Enduring Freedom took place in Afghanistan October 2001 – December 2014, Operation Iraqi Freedom took place in Iraq March 2003 – November 2011, and Operation New Dawn took place in Iraq September 2010 – December 2011 (VA 2015).

15 The U.S. Office of Disease Prevention and Health Promotion includes these factors, among others, in determining health status:

- » Physically and mentally unhealthy days
- » Self-assessed health status
- » Limitation of activity
- » Chronic disease prevalence

16 The eligibility priority system is responsible to some degree for these differences. This is discussed below.

Figure 3. Unadjusted Prevalence of Diagnosed High-Prevalence Health Conditions Among Veterans, by VHA Patient Status¹⁷



Source: Assessment A, Eibner et al. (2015:98) citing RAND analysis of MEPS, 2006-2012

Reflecting VA patients' older age, the diagnosed prevalence of common chronic conditions (e.g., diabetes, cancer) is two to three times higher among Veterans than among non-Veterans. Thirty-three percent of all patients seen at VA have a mental health condition, and 8 percent have [post-traumatic stress disorder]. When combined with the otherwise rare conditions related to combat—amputation, [traumatic brain injury], blindness, and severe burns—and the vulnerable circumstances of some patients, VA handles a patient mix that is uniquely different from what community providers are used to. (id. at 168)

Farmer et al. also include spinal cord injuries on their list of conditions that are far more prevalent among VHA patients than the U.S. population as a whole (2016:4).

More specifically, Assessment A found that veterans have a higher prevalence of chronic physical conditions such as cancer, chronic obstructive pulmonary disease (COPD), diabetes, gastroesophageal reflux disease (GERD), and hearing loss than non-veterans, in part because of demographic differences such as being an older, mostly male population (Eibner et al. 2015:87-89). Although it found that the differences are smaller when

adjusted for demographics, the difference in prevalence rates between veterans and non-veterans persisted (ibid.). Perhaps surprisingly, veterans have a slightly lower prevalence rate of mental health issues than non-veterans prior to adjusting for demographic differences except in the case of post-traumatic stress disorder (PTSD) (id. at 88). After adjusting for demographic differences, veterans have a somewhat higher prevalence of mental health issues and an exceptionally higher incidence of PTSD at 13.5 times the rate of non-veterans (id. at 88-89). Finally, as shown in Figure 3, among conditions that are highly prevalent among veterans as a whole, veterans who are VHA patients are more likely to be diagnosed with cancer, diabetes, hypertension (high blood pressure), ischemic heart disease (coronary heart disease), and mental health conditions than veterans who are not VHA patients (id. at 98).

VHA enrollees also differ substantially from the overall veteran population in reporting lower socioeconomic status (Huang et al. 2018:69, citing Houston et al. 2013). VHA enrollees had much higher unemployment rates¹⁸ (Huang et al. 2018:xv, 26, citing Bureau of Labor Statistics 2018), lower incomes¹⁹ (Huang et al. 2018:69), and lower levels of education (ibid.)—all correlated with lower health

¹⁷ This chart is modified slightly from Eibner et al. (2015:98).

¹⁸ This excludes the 57 percent who are retired or who are not part of the labor force for another reason (Huang et al. 2018:24).

¹⁹ Nearly half of survey respondents (47 percent) reported household income below \$35,000 with 15 percent under \$15,000 (Huang et al. 2018:17).

status (Office of Disease Prevention and Health Promotion 2018). The “2018 Survey of Veteran Enrollees’ Health and Use of Health Care” (Wang et al. 2019) found that enrollees face significant economic challenges. Enrollees experienced high rates of unemployment at 8.0 percent (id. at xii) and low annual household income levels with 44.7 percent earning less than \$35,000 and 13.7 percent earning less than \$15,000 (id. at 14-15). Although enrollees tend to be older, the percentage of enrollees under the age of 45 has increased from 15.1 percent in 2013 to 20.7 percent in 2018 (Huang et al. 2018:15; Wang et al. 2019:13). Eibner et al. found that the portion of patients under age 35 had tripled over the previous 10 years (2015:xxii-xxiv). Finally, nearly half of enrollees (47.8 percent) had combat experience (Wang et al. 2019:9).

Turning to utilization, the 2018 survey found that some veterans use the VHA to supplement care that the private sector is not providing or cannot provide as cost-effectively (Wang et al. 2019:xviii, 47, 109, 114). For example, 43.3 percent of survey respondents relied on the VHA for all prescription drugs in the prior 30-day period (id. at 47).²⁰ However, a significant portion of veterans (28.7 percent) rely exclusively on the VHA for all of their health care (id. at 112). Those who use the VHA for at least some of their health care tend to be older than veterans who do not use the VHA at all (id. at 113). Yet those younger than 30 receive the highest percentage of their care from the VHA while those over 65 receive the lowest percentage from the VHA (Eibner et al. 2015:xxiv). In addition, women veterans are far more likely than men to use the VHA as their sole source of health care with 18.9 percent of women, compared to 11.4 percent of men, receiving all their care through the VHA (NCVAS 2019:29). Others with a greater reliance on VHA care are those who have lower incomes, live in rural areas, belong to racial and ethnic minority groups, lack another source of insurance coverage, or report poorer health status (Eibner et al. 2015:78; Farmer et al. 2016:4; Huang et al. 2018:6; Wang et al. 2019:112-14).

Finally, OEF/OIF/OND veterans will constitute an increasingly larger portion of VHA enrollees. The 2018 survey data show that OEF/OIF/OND veterans make up 17.8 percent of VHA enrollees (Wang et al. 2019:26). This is up from 12 percent in 2014 and is expected to reach approximately 19 percent by 2024 (Farmer et al. 2016:5). With 96 percent having served in a combat zone (Wang et al. 2019:26), these veterans are almost twice as likely to have a service-connected disability than all other veteran groups (VA 2018a:41) and make up a disproportionate share of VHA enrollees with a service-connected disability

that is 50 percent or more disabling (Wang et al. 2019:11). In addition, OEF/OIF/OND veterans are among the youngest VHA enrollees with an average age of 40 years old (Wang et al. 2019:26). Given their age, they can be expected to need VHA services for decades to come.

Priority Groups

Part of the reason that VHA patients have greater health care needs than the veteran population overall is rooted in the VHA’s priority group system. Veterans are not entitled outright to receive health care through the VHA but are eligible for health care only to the degree that Congress deigns to fund it (38 U.S.C. 1710). To manage its perennial underfunding, the VHA has implemented a complex system of priority groups regarding who will receive care. The priority groups include veterans in the following categories:²¹

- » **Priority Group 1:** Veterans with service-connected disabilities that are 50 percent or more disabling or are unemployable because of a service-connected condition;
- » **Priority Group 2:** Veterans with service-connected disabilities that are 30 percent or 40 percent disabling;
- » **Priority Group 3:** Veterans with service-connected disabilities that are 10 percent or 20 percent disabling, former prisoners of war, and Purple Heart recipients;
- » **Priority Group 4:** Veterans with catastrophic disabilities that are not related to service;
- » **Priority Group 5:** Veterans with disabilities not connected to service or with service-connected disabilities that are VA-rated at 0 percent and who meet income limits based on resident location; who receive a VA pension; or are eligible for Medicaid;
- » **Priority Group 6:** Veterans with service-connected disabilities that are VA-rated at 0 percent, have served in various conflicts, or experienced specific exposures;
- » **Priority Group 6 enhanced eligibility:** Veterans currently enrolled and new enrollees who served in combat situations after November 11, 1998 and veterans discharged on or after January 28, 2003 are eligible for priority group 6 for five years after

20 Legislation limits the prices the VHA pays for prescription drugs. In addition, the VHA requires low, or no copayments for prescription drugs, making it more affordable than many commercial insurance plans.

21 This is not an exhaustive list of the priority group criteria. See VHA 2018a and Huang et al. 2018 for additional information.

discharge (unless they qualify for a higher priority group);²²

- » **Priority Group 7:** Veterans who are below income limits that are adjusted based on resident location (requires copayments); and
- » **Priority Group 8:** Veterans who are above income limits that are adjusted based on resident location (requires copayments). (VHA 2018a; Wang et al. 2019:4)

The criteria for the priority groups, together with the health-related socioeconomic factors discussed above, shed light on why the health status of the VHA enrollee population is worse than for veterans as a whole. Enrollees in priority groups 1 and 2, and to a lesser degree group 3, have significant service-connected disabilities. Priority groups 4 through 6 also face significant health challenges, particularly those in priority group 4 who have catastrophic disabilities.

22 They may be assigned to a lower group based on their income after the five-year period ends.

III. About the VHA

The VHA provides health care and social support services to eligible veterans through the largest integrated health network in the United States. Serving more than 9 million enrollees, the VHA encompasses 1,250 health care facilities, including 172 medical centers and 1,069 outpatient sites (VHA 2018b). Divided into 18 administrative areas called Veterans Integrated Service Networks (VISNs), the VHA cares for veterans in all 50 states, four territories (American Samoa, Guam, Puerto Rico, and Virgin Islands), and the Philippines (VHA 2017). In addition, the VHA trains a majority of all medical, nursing, and other health care practitioners and performs extensive medical research on both combat-related health conditions and health issues that affect the U.S. population at large (VA 2018b). Finally, the VHA offers support on a contingent basis to the U.S. Department of Defense and the U.S. Department of Health and Human Services in wartime and during national emergencies (VA 2017:134).

As part of the larger VA system, the VHA is able to connect veterans to the many resources available to them through the VBA including education; vocational rehabilitation, job training and employment services; work therapy for veterans with mental illness or physical disabilities; and housing services.

Integrated Health Care Delivery System

The VHA provides a continuum of care designed to meet the unique needs of veterans that includes primary and specialty care, inpatient care, preventive services, urgent care, and pharmacy services. Moreover, it integrates mental and physical health care across this continuum—from primary care that deals effectively with the chronic conditions while also remaining sensitive to the mental health issues facing so many veterans through specialized care for treating combat-related mental and physical issues such as PTSD, traumatic brain injury, blindness

rehabilitation, and prosthetics (Gordon 2018:201-38). In addition, the VHA provides residential rehabilitation treatment programs for veterans with psychiatric problems or substance use disorders as well as domiciliary care for homeless veterans (Burden 2017:12).

Integrating health care and social supports and services is far more effective in improving the lives and health of veterans than addressing health care needs alone, particularly when it includes providing benefits to the family as a whole. The VHA's holistic approach not only provides integrated care for mental and physical health problems but also addresses the social determinants of health (Gordon 2018:266, 285). These include housing status and living arrangements, employment status and income, and social supports and services (id. at 239-40). In addition, family benefits include health care coverage, respite care, and financial support from the VHA for many family members caring for veterans injured in the line of duty (VHA 2018c).²³ As part of the larger VA system, the VHA is able to connect veterans to the many resources available to them through the VBA including education; vocational rehabilitation, job training and employment services; work therapy for veterans with mental illness or physical disabilities; and housing services (VBA 2018). Finally, the ability to provide additional resources extends beyond the VA into other branches of the federal government. For example, the VA collaborates with the U.S. Department of Housing and Urban Development to provide rental assistance vouchers to homeless veterans and their families (Gordon 2018:187; Homeless Veterans 2018).²⁴

Quality

Despite differences in health status between veterans enrolled with the VHA, on the one hand, and both veterans who are not enrolled with the VHA and civilian populations, on the other, numerous studies have found that the VHA provides excellent care to veterans overall and frequently outperforms the private sector. As detailed above, patients who enter the VHA system tend to be less healthy and diagnosed with more medical conditions than veterans treated in private facilities. There are even greater differences in health and comorbidities when compared

23 Section 162 of the MISSION Act expanded this program to caregivers of veterans injured in the line of duty while serving in the armed forces on or before May 7, 1975. Prior to this, the benefit was only provided to caregivers of veterans injured on or after September 11, 2001.

24 See Suzanne Gordon's book (2018) *Wounds of War: How the VA Delivers Health, Healing, and Hope to the Nation's Veterans* for a rich, in-depth discussion of how the VHA integrates health care across the continuum, and in the context of both the broad social determinants of health, and the experiences and needs of veterans in their day-to-day lives.

to non-veteran patients (Agha et al. 2000; Eibner et al. 2015:xxv, 78, 87-88, 168; Farmer et al. 2016:4; Huang et al. 2018:6).

The most recent systematic review of published studies, O’Hanlon et al., compared the quality of care provided in VHA facilities to the quality of care in non-VHA facilities with respect to safety and effectiveness (2017:118). In examining 34 articles on safety and 24 articles on effectiveness, it concluded that in the vast majority of studies, 42 out of 58, VHA facilities performed as well or better than non-VHA facilities. Four studies showed mixed performance with only 12 of 58 studies showing worse performance. In comparing VHA facilities to non-VHA facilities on safety, 22 of 34 studies found that the VHA performed the same or better. In particular, VHA facilities performed similarly or better than non-VHA facilities in most studies that compared morbidity and mortality. Most studies comparing the effectiveness of VHA and non-VHA facilities, 20 of 24, found that the VHA had “the same or better quality of care” as non-VHA facilities.

Inpatient Care

In an article drawn directly from Choice Act Assessment B,²⁵ RAND analysts Price et al. reported that, based on well-established measures of hospital quality,²⁶ VHA hospitals performed the same or significantly better than non-VHA hospitals on all three measures of patient mortality, all six measures of patient safety, and 12 of 14 effectiveness measures (2018:1, 3-6).²⁷ Although VHA hospitals fell short on three readmission measures (id. at 1, 3-4), a study by Nuti et al. noted that the “absolute differences between these outcomes at VA and non-VA hospitals were small” (2016:591). Finally, Price et al. found that the performance of both VHA and non-VHA hospitals varied from hospital to hospital, but that variation was far greater in non-VHA hospitals (2018:1, 3-4, 6). Moreover, they noted that “variations in performance across regions and VA facilities may be inevitable because of differences in patient characteristics” (id. at 6).

In analyzing safety measures, O’Hanlon et al. considered studies that addressed injury and illness related to

medical care such as post-surgery complications and rates of mortality and morbidity (2017:107). Most studies they reviewed comparing mortality and postoperative morbidity rates at VHA facilities to non-VHA facilities found that VHA facilities were generally as good as non-VHA facilities and in some cases better (ibid.). Numerous studies demonstrated that the VHA stands out in terms of safety and effectiveness when it comes to cancer treatment (O’Hanlon et al. 2017:109, citing Keating et al. 2010, Keating et al. 2011, and Landrum et al. 2012; and 111, citing Trivedi et al. 2011). For example, the survival rates for male VHA patients over the age of 65 with colon and non-small-cell lung cancer exceeded the survival rate for similar fee-for-service Medicare beneficiaries (O’Hanlon et al. 2017:109, citing Landrum et al. 2012). In addition, Landrum et al. found that the survival rate for VHA patients with rectal cancer, small-cell lung cancer, one form of lymphoma, and multiple myeloma was similar to that of fee-for-service Medicare patients (ibid.).

Outpatient Care

Reviewing studies that examined effectiveness of care, O’Hanlon et al. found that VHA facilities performed well in the outpatient setting, particularly in preventive care and chronic disease management (2017:117). For example, studies demonstrated that diabetic veterans receiving health care and education through the VHA were more likely to receive recommended care such as foot and eye examinations than veterans treated outside the VHA (O’Hanlon et al. 2017:117, citing Lynch, Strom, and Egede 2010). VHA patients were also more likely to receive recommended preventive care such as cancer screenings and vaccines than civilian and veteran patients treated outside the VHA (O’Hanlon et al. 2017:117, citing Chi, Reiber, and Neuzil 2006; Keyhani et al. 2007; Lynch et al. 2010; and Trivedi and Grebla 2011). Finally, a study using the Healthcare Effectiveness Data and Information Set²⁸ (HEDIS) to compare VHA patients to Medicare Advantage patients found VHA patients received more effective care than non-veterans based on 10 of 11 quality measures in the first study year and all 12 quality measures in the second study year assessing diabetes, cardiovascular, and

25 The Choice Act calls for Assessment B to address: “Current and projected health care capabilities and resources of the Department, including hospital care, medical services, and other health care furnished by non- Department facilities under contract with the Department, to provide timely and accessible care to veterans” (Sec. 201(a)(1)(B)). RAND Corporation analysts Hussey et al. carried out Assessment B. Their work will be discussed below in examining access.

26 Price et al. used the Agency for Healthcare Research and Quality’s Patient Safety Indicators, CMS’ 30-day risk-standardized mortality and readmission measures, and the Joint Commission’s ORYX measures for inpatient safety and effectiveness.

27 Price et al. used the Agency for Healthcare Research and Quality’s Patient Safety Indicators, CMS’ 30-day risk-standardized mortality and readmission measures, and the Joint Commission’s ORYX measures for inpatient safety and effectiveness.

28 According to the National Committee for Quality Assurance: “The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 92 measures across six domains of care.”

cancer screening care, with rate differences ranging from 4.3 percentage points ... for cholesterol testing in coronary heart disease to 30.8 ... for colorectal cancer screening. (O’Hanlon et al. 2017:117, citing Trivedi et al. 2011)

Similarly, another study found that VHA patients were diagnosed with colon and rectal cancers earlier and given care that was similar to or better than care received by fee-for-service Medicare beneficiaries (O’Hanlon et al. 2017:109, citing Keating et al. 2011). Price et al., also using HEDIS data, found that the VHA provides exceptional care in outpatient settings (2018:2). Specifically, they observed: “The performance of VA facilities was significantly better than commercial HMOs and Medicaid HMOs for all 16 outpatient effectiveness measures and for Medicare HMOs, it was significantly better for 14 measures and did not differ for two measures” (ibid.).

The VHA excels in treating the PTSD and depression experienced by so many veterans. VHA’s integration of mental health and primary care enables providers to identify veterans with symptoms of depression and PTSD who otherwise may have been undiagnosed.

Mental Health Care

Addressing the need for veteran mental health services is crucial. As noted above, 33 percent of VHA enrollees have a mental health condition (Eibner et al. 2015:168). Under contract from the U.S. Department of Veterans Affairs, the National Academies of Sciences, Engineering, and Medicine (NASEM) appointed a committee of experts to assess the “quality, capacity, and access” of mental health services available to veterans as well as any barriers to accessing these services (2018:15). As mandated by the National Defense Authorization Act of 2013, NASEM focused on meeting the needs of veterans who served in OEF/OIF/OND (id. at ix, 321).

Based on extensive research that included a literature review, VHA site visits across the United States, and a veteran survey (id. at 321), the committee concluded that the VA provides mental health care that is generally of comparable or superior quality to mental health care that is provided in the private and non-VA public sectors and that it has multiple centers of excellence in various aspects of mental health care. (id. at 326)

Although the committee also remarked that there was variability in quality and access in the VHA, they noted that these problems are also found in the private sector and non-VHA public settings (22, citing American Hospital Association 2016; The Commonwealth Fund 2013; Merritt Hawkins 2014; Sundararaman 2009 and 326, citing The Commonwealth Fund 2013; Merritt Hawkins 2014; O’Hanlon et al. 2017). Finally, the committee noted that, in many communities, private-sector and non-VHA public sector providers are unable to meet the needs of current residents (id. at 7, 328). This is not surprising given that more than one in three U.S. residents live in a mental health professional shortage area.²⁹ The shortage of mental health professionals suggests that it would be difficult to expand veterans’ options for VHA care through the private sector.

More importantly, VHA mental health providers are more familiar with military culture and are more likely to have the necessary clinical skills for treating veterans than mental health providers in the private sector. For example, two recent studies of pharmaceutical treatments for mental health disorders comparing the VHA to the private sector found the VHA performance to be far superior in prescribing appropriate medications (Lemle 2014:20, citing Barry, Bowe and Suneja 2016; Watkins et al. 2015). VHA patients with “serious mental illness” have a greater life expectancy and fewer inpatient days than similar patients in the U.S. population as a whole (Lemle 2014:18). This is particularly significant as veterans who use VHA services have twice the incidence of mental health issues than veterans who do not use the VHA (Lemle 2018:18, citing Farmer et al. 2016).

Suicide prevention is a key concern for the VHA. The VA’s Office of Mental Health and Suicide Prevention (OMHSP) reported that in 2015 an average of 20.6 veterans committed suicide each day (2018:5, 14). The office also found that veterans had an age-adjusted suicide rate more than twice that of non-veteran adults (id. at 5). Moreover, between 2001 and 2014, age-adjusted rates of suicide for veterans who did not use the VHA system increased by 38.4 percent overall and by 81.6 percent for women veterans, while rates for VHA patients increased by only 5.4 percent overall and dropped 2.6 percent for women (OMHSP 2017:21). Finally, the suicide rate for VHA patients with either a diagnosed mental health or substance use issue decreased by 25 percent (Lemle 2018:18, citing the OMHSP 2016).

The reason VHA patients have lower suicide rates derives from the VHA’s holistic approach to suicide prevention and the familiarity of its providers with military and veteran culture. Notably, unlike care in the private sector, the VHA provides suicide prevention training to staff at every level

29 Health professional shortage areas are discussed in greater detail in the section on access below.

including even those who do not provide direct care to veterans such as clerks and transport workers (Gordon 2018:191-193). Moreover, all VHA medical centers have at least one suicide prevention coordinator as part of the care team for patients identified as at risk for suicide (id. at 191, 194-195). Psychologist Russell Lemle, who leads the VA-Community Care Workgroup for the Association of VA Psychologist Leaders, describes some of the key features of the VHA suicide prevention program:

For veterans in VHA care who are at risk for suicide, mental health policies include regular screening, follow-ups to missed appointments, and safety planning. For high-risk veterans, suicide prevention policies also involve a medical record flagging and monitoring system with mandatory mental health appointments. (2014:18)

The VHA excels in treating the PTSD and depression experienced by so many veterans. VHA's integration of mental health and primary care enables providers to identify veterans with symptoms of depression and PTSD who otherwise may have been undiagnosed (Gordon 2018:91-96). For example, in 2015 nearly half a million veterans were diagnosed with depression by their primary care provider (id. at 96). In addition, the VHA has developed two treatment methods, prolonged exposure therapy and cognitive processing therapy, known as the "gold-standard treatments for PTSD" (id. at 159). Finally, the VA's National Center on PTSD is a world-class research and education center housing a comprehensive database on PTSD research that serves as a resource for providers in the VHA and in private practice (ibid.).

Access

In addition to understanding how the VHA and private sector compare on quality, it is crucial to understand how they compare on access. The Choice Act required an assessment of VHA wait times and geographic accessibility, Assessment B, which was conducted by RAND analysts Hussey et al. (2015). The discussion below uses the analysis by Hussey et al. as well as other materials to demonstrate that, on the whole, access to providers in the VHA is as good as or better than the private sector.

Wait Times

According to Hussey et al., there is no single national standard for wait times in the private sector (2015:155) and there is limited data overall (Hussey et al. 2015:162; Farmer and Tanielian 2019:10, citing the Government Accountability Office 2018).³⁰ However, for new patient appointments, Hussey et al. were able to find comparable data for the private sector and the VHA. It demonstrated that the VHA generally outperforms the private sector on timeliness in providing appointments for new patients (2015:162). Thus, although the Choice Act was prompted by claims that veterans were suffering detrimental health effects from lengthy wait times, the available data imply that the problem has limited scope.

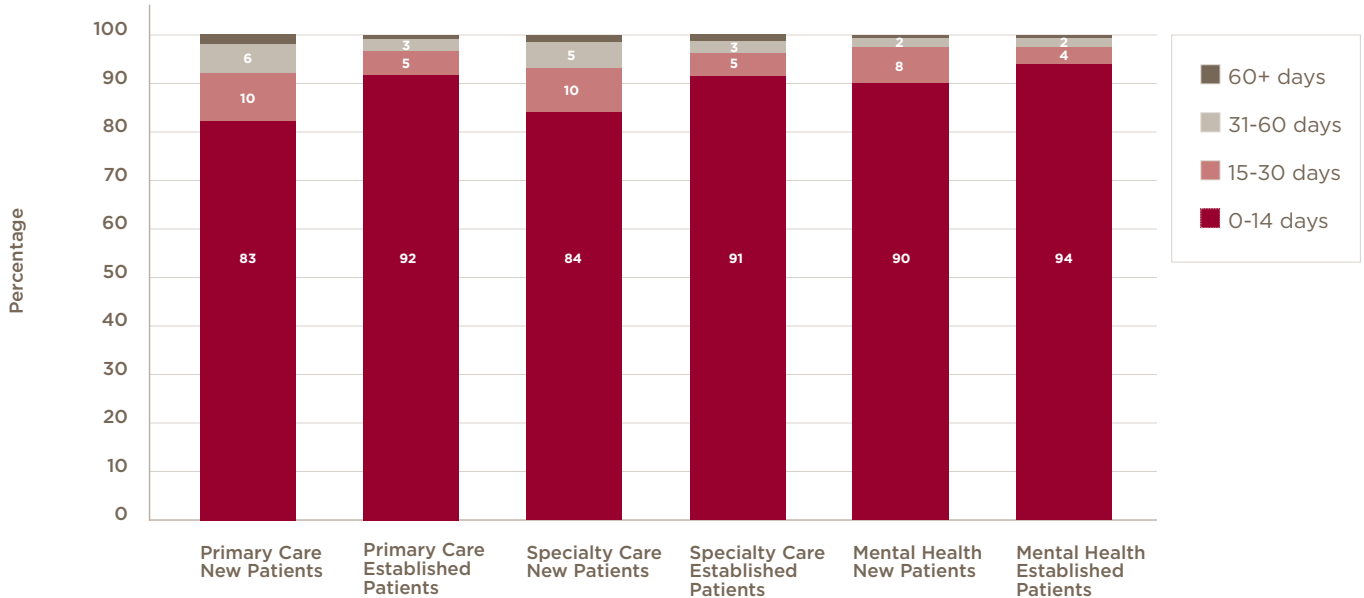
The first study Hussey et al. reviewed, covering 15 major metropolitan markets across the United States, found that the average wait time for new patients to see a family physician in the private sector was 19.5 days on average from first call to appointment date with a range of five to 66 days overall depending on the metropolitan area (Hussey et al. 2015:163, citing Merritt Hawkins 2014). Average wait times for specialty care ranged from a low of 10 days for orthopedic surgery to a high of 29 days for dermatology (ibid.).

Next, Hussey et al. reviewed a 2013 study by the Massachusetts Medical Society that found that wait times in the private sector were longer than at the VHA (ibid.). It reported average wait times of 39 days for family medicine and 50 days for internal medicine, with specialty appointments ranging from 22 for orthopedic surgery to 37 days for obstetrics and gynecology (ibid.). In addition, the study found that only 45 percent of internal medicine physicians and 51 percent of family medicine physicians in Massachusetts were accepting new patients at all (ibid.).

In contrast, VHA wait times in the first half of FY 2015 were considerably shorter than in non-VHA facilities. VHA wait times across all facilities averaged 6.5 days for both primary care and specialty care and 3.5 days for mental health care (id. at 158). Primary care wait times ranged from less than a day to 41 days, specialty care wait times ranged from less than a day to 22 days, and mental health care wait times ranged from less than a day to 12 days (id. at 160). Remarkable on the significance of the comparison, Hussey et al. stated: "VA facilities do not have the option of turning away new patients, and so might be reasonably expected to have longer wait times" (id. at 163). Figure 4 shows that 93 to 95 percent of appointments nationwide were completed within 30 days of the preferred date and 83 to 94 percent were completed in 14 days or less.

30 As discussed below, implementing the MISSION Act without fully assessing the private sector may result in little improvement for veterans and increased costs for the VHA.

Figure 4. Percentage of VA Appointments Completed Within 0-14, 15-30, 31-60, and 61+ Days of Preferred Date, First Half of FY 2015³¹



Source: Hussey et al. (2015:159) citing their analysis of VA wait-time data for the first half of FY 2015 obtained from the VHA Support Service Center by The MITRE Corporation.

A new Merritt Hawkins survey of the same 15 metropolitan areas above found that compared to 2014, average wait times in 2017 for new patient appointments in the private sector for family medicine (primary care) increased 50 percent to 29.3 days (2017:11) and that average wait times for private-sector care increased for the other specialties surveyed as well (id. at 12). A recent study published in the *Journal of the American Medical Association* by Penn et al., comparing the Merritt Hawkins to VHA data on primary care, dermatology, cardiology, and orthopedics found that, in most cases, wait times at VHA facilities were shorter than in the private sector (2019:1). New patient primary care appointments in the VHA had a wait time of just under 18 days compared to the private sector wait time of nearly 30 days (id. at 4). In 2017, VHA facilities had shorter average wait times in cardiology at 15.3 days compared to 22.8 days in the private sector and in dermatology at 15.6 days compared to 32.6 days in the private sector (id. at 5). Although the study found that VHA facilities had longer wait times for orthopedics at 20.9 days compared to 12.4 days in the private sector, it noted that VHA wait times are improving in all four areas while wait times in the private sector remain stagnant (id. at 6-7).

Finally, in an April 10, 2019 hearing before the U.S. Senate Committee on Veterans' Affairs, RAND analysts Farmer and Tanielian testified: "Since our 2015 study, VA has continued to assess and publish wait times for appointments. As of

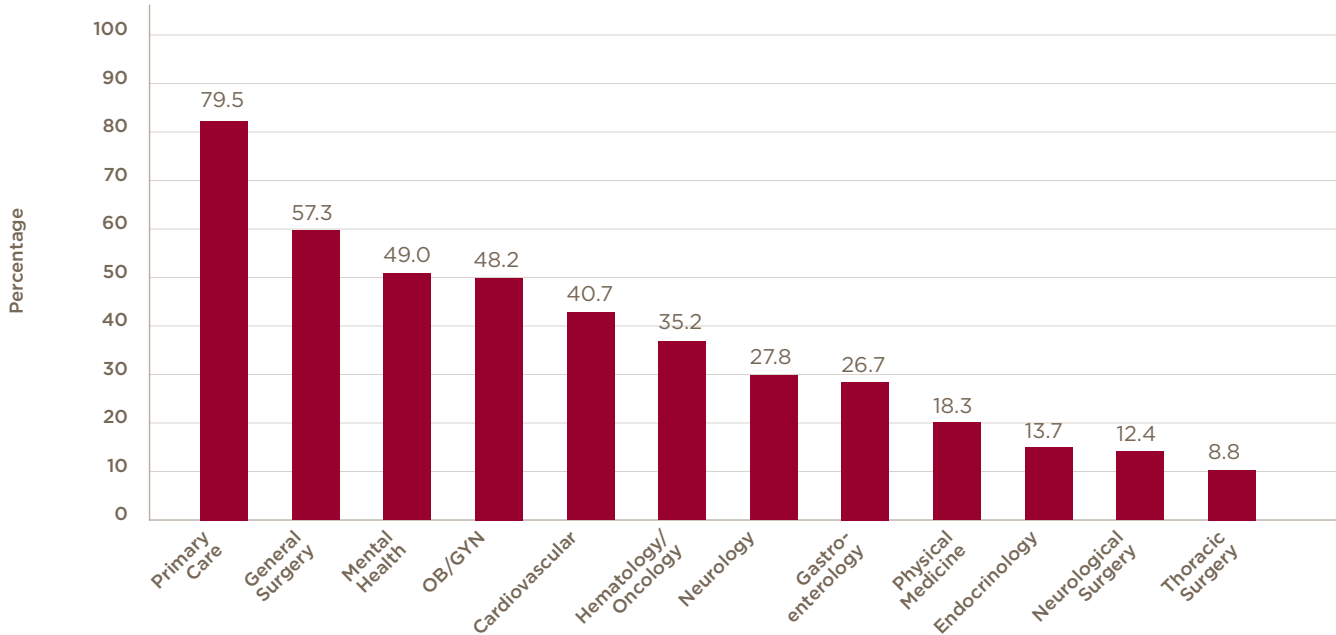
March 2019, 93 percent of VA appointments were within 30 days of the preferred date, and average wait times were 4.2 days from the preferred date for primary care, 5.5 days for mental health care, and 10.4 days for specialty care" (3, citing VA 2019a). Clearly, the VHA outperforms the private sector overall on timely appointments.

Distance/Geographic Accessibility

Measuring accessibility based on driving distance or travel time will not solve the lack of providers, whether VHA or non-VHA, for veterans in rural or medically underserved areas. As the Commission notes in its final report, some of the issues facing the VHA "reflect large-scale problems in the U.S. health system in general, such as acute shortages of primary care doctors and lack of health care capacity in poor and rural areas" (2016:2). The most recent data on health professional shortage areas (HPSAs) reported by the U.S. Health Resources and Services Administration (HRSA) demonstrates that this problem persists. HPSAs are primarily rural and low-income urban areas but also include specific population groups within a geographic area such as "low income, migrant farmworkers, and other groups" (HRSA 2016). The magnitude of this problem should not be underestimated. According to HRSA, there are 6,418 primary care HPSAs with a population of 75.4 million; 5,304 dental HPSAs with a population of 53.9 million; and

31 This chart is taken directly from Hussey et al. (2015:159).

Figure 5. Geographic Access to Non-VA Physicians Among Enrollees Residing More Than 40 Miles from VA Medical Facilities, by Specialty, 2013³³



Source: Hussey et al. citing their analysis of SK&A Office-Based Physician Database, VA Site Tracking System, and VA Planning Systems Support Group Enrollee file (2015:153).

4,592 mental health HPSAs with a population of 111.7 million (2019:2). This amounts to nearly 1 in 4 U.S. residents living in a primary care shortage area, more than 1 in 6 living in a dental shortage area, and more than 1 in 3 living in a mental health shortage area. According to HRSA, 13,758 primary care practitioners, 6,100 mental health practitioners, and 9,527 dentists are needed to remove the shortage designation (ibid.). Hospital closures also have affected access in the private sector. Rural hospitals have been hit particularly hard with 108 closures since 2010 (Sheps Center for Health Services Research 2019a). In addition, out of 2,129 rural hospitals analyzed, 196 have a high risk of financial distress and 361 have a mid-high risk which suggests that there may be additional closures in the offing (Sheps Center for Health Services Research 2019b:1).

In examining geographic accessibility in the VHA, Hussey et al. used travel times to hospitals for fee-for-service Medicare enrollees as a proxy for the times that veterans might have to drive to access care in the private sector (2015:142). The Medicare fee-for-service program has an open provider network and “almost all” health care practitioners participate in the program, potentially making it an even broader network than veterans would have with expanded private-sector care under the new VCCP (ibid.). Average estimated travel time for Medicare enrollees was 61 minutes

with estimates for Medicare enrollees living in the VHA VISN areas ranging from 32 to 85 minutes (id. at 142-43). In 15 out of 21 cases,³² Medicare enrollees were driving farther to access a hospital in the private sector than veterans would have to drive to a VHA hospital within their VISN (id. at 143). On the balance, one VISN had virtually no difference, two were less than five minutes longer, and two were between 10 and 15 minutes longer (ibid.).

Additionally, in many cases, veterans who live more than 40 miles from a VHA facility have difficulty accessing non-VHA hospital services as well (id. at 137-49). These veterans are more likely to have difficulty accessing academic and teaching hospitals, specialized hospital services, and complex care from non-VHA facilities (ibid.). Hussey et al. found that veterans who lived more than 40 miles from a VHA facility also had difficulty accessing physician services (id. at 149-52). According to their assessment, more than half the enrollees who live farther than 40 miles from a VHA medical facility live more than 40 miles from a non-VHA physician in 12 major specialty areas except primary care and general surgery (id. at 151). Figure 5 shows that VHA enrollee access to non-VHA physicians begins at under 9 percent for a thoracic surgeon and ranges from 12.4 to 49 percent for 10 other specialties (id. at 153).

32 There are now 18 VISNs because some areas have been combined or otherwise realigned.

33 This chart is taken directly from Hussey et al. (2015:153).

More recently, in its 2018 report on community-based providers available to VHA enrollees under the Choice program, the Government Accountability Office (GAO) found that private-sector provider networks frequently failed to have sufficient providers to meet veteran care needs (3).³⁴ At times, inadequate private-sector provider networks under the Choice program have forced its third-party administrators (TPAs) to send patients back to VHA facilities because they were unable to provide appointments to veterans (id. at 44). Forming adequate provider networks was particularly problematic in rural areas (id. at 57). Among the managers from the sample of six VHA medical centers, three “said that key community providers—including large academic medical centers—have refused to join the TPAs networks or dropped out of the networks after joining them, often because the TPAs had not paid them in a timely manner for the services they provided” (ibid.).

The findings of Hussey et al. and the GAO demonstrate that allowing veterans to seek care in the private sector will not be a panacea for the issues facing the VHA because private-sector providers also have accessibility issues which are often more problematic than those facing the VHA. Rather, the solution lies in filling VHA vacancies.

“Since our 2015 study, VA has continued to assess and publish wait times for appointments. As of March 2019, 93 percent of VA appointments were within 30 days of the preferred date, and average wait times were 4.2 days from the preferred date for primary care, 5.5 days for mental health care, and 10.4 days for specialty care.”

VHA Vacancies

In considering both wait times and geographic accessibility, it is crucial to consider the role that VHA vacancies play. According to Assessment B:

Increasing the number of physicians and other licensed independent practitioners was viewed as a critical or very important way to reduce clinically meaningful delays in patient care by approximately 94 percent of sites (46 of 51 sites) reporting

patient delays in obtaining a new primary care appointment on the 2015 Survey of VA Resources and Capabilities. (Hussey et al. 2015:259)

The VA Office of Inspector General found that the main reasons for vacancies were an insufficient number of qualified applicants, low salary, high turnover rates, and geographical issues such as areas with a competitive job market and rural areas that have a shortage of candidates (2018:13). *USA Today* reported in 2015 that there were nearly 41,000 vacancies for doctors, nurses, assistants, and intake staff (Hoyer). The *Washington Post* reported that staffing shortages at the VHA were exacerbated by a federal hiring freeze imposed by President Donald Trump when he took office in January 2017 (Wax-Thibodeaux 2018). Although clinical personnel were exempt from the freeze, the shortages among human resources staff made it difficult to process applicants in a timely manner (ibid.). After the freeze ended, shortages remained in the VA’s human resources department that continued to limit its ability to process job candidates effectively (ibid.). Data for the second quarter of fiscal year 2019 show that vacancies remain very high (Office of Human Resources and Administration 2019). VHA medical and dental vacancies stand at 25,936 with total VHA vacancies of 44,413. The VHA should address the issues identified by the VA Office of Inspector General to improve hiring and retention of health care practitioners. Building staffing capacity should be the primary response to rectifying access shortcomings, not shifting care to the private sector.

Cost

In 2014, the Congressional Budget Office (CBO) examined the cost of care in the VHA compared to the cost of care in the private sector. It noted that as an integrated system, the VHA should be able to deliver lower cost and higher quality care than is typically provided in the private sector (CBO 2014:9-10). The CBO identified cost-saving aspects of integrated care that included these features:

- » Comprehensive medical records are accessible to all providers and in all care locations, providing better information on which to make clinical decisions and making it easier to avoid delivering duplicative or potentially conflicting services [and]
- » Collaboration among doctors and coordination of care among locations should be easier for both doctors and patients when the care is all provided “under one roof” (id. at 10).

34 Note that the GAO report data was not comprehensive but was based on a “non-generalizable” sample of 196 appointment referrals to private-sector providers from six of 170 VHA medical centers (30, 67) and a “non-generalizable” sample of 5,000 appointment referrals provided by the VHA (70).

In analyzing the cost of health care provided by the VHA compared to the private sector, the CBO singled out one study, Nugent et al. 2004, that it described as “careful and comprehensive” (id. at 4). The CBO described the study’s findings regarding a sample of six VHA facilities as follows:

- » The full range of services that VHA provided in 1999 would have cost about 21 percent more if those services had been delivered through the private sector at Medicare’s payment rates.
- » Inpatient care (excluding costs for nursing homes and rehabilitation facilities) would have cost about 16 percent more if it had been purchased at Medicare’s rates.
- » The outpatient care provided by VHA would have cost about 11 percent more if it had been provided at Medicare’s prices.
- » Prescription drugs would have cost about 70 percent more using a combination of Medicaid’s and Medicare’s payment methods. That difference alone accounted for almost half of the net difference in overall costs.³⁵ (id. at 5)

The CBO reported that the study found some differences between costs for particular types of care in the six VHA facilities examined and the VHA system as a whole, though both showed significant savings compared to Medicare rates (ibid.).³⁶ Turning to the original study, Nugent et al. found that the cost for the VHA system as a whole at Medicare rates, based on a conservative estimate, would have been 17 to 20 percent higher than actual spending by the VHA (2004:506). Specifically, medical costs for the VHA system in fiscal year 1999 were \$18.8 billion, compared to an estimated \$22 billion that would have been paid at Medicare rates (id. at 503). Outpatient pharmaceutical and rehabilitation services showed the greatest difference, costing 69 percent and 70 percent more, respectively, at Medicare rates than what the VHA paid (id. at 501-02).

An overwhelming majority of studies confirm that the VHA has lower costs compared to Medicare payment rates (Hussey et al. 2015:51, citing Hendricks, Whitford,

and G. Nugent 2003a and Hendricks, Whitford, and L. Nugent 2003b; G. Nugent et al. 2003; G. Nugent et al. 2004; Render et al. 2003a; Render et al. 2003b; Roselle et al. 2003).³⁷ This is particularly significant given that Medicare rates for physicians and hospitals generally are lower than rates paid by private insurance plans. More specifically, Medicare rates average about 20 percent less for physicians and 30 percent less for hospitals (CBO 2014:5-6, citing CMS 2012:66-67). Thus, had the studies compared the cost of providing care through the VHA versus the private sector at commercial insurance rates, VHA’s estimated cost savings would have been significantly higher.

More recent studies have found even greater differences in prices between Medicare rates and average private-sector rates paid by commercial insurers. For example, a CBO working paper that examined three major insurers’ claims data for 20 common services found that the commercial insurers’ fee-for-service rates were higher than Medicare fee-for-service rates for all 20 services (Pelech 2018:13). Physician payments in the private sector averaged from 11 percent higher than Medicare rates for an established patient office visit to more than 200 percent higher for an MRI, though prices varied both within and across geographic areas (ibid.). This same paper, citing a 2017 Medicare Payment Advisory Committee report, stated that private-sector prices averaged approximately 28 percent higher than Medicare fee-for-service prices (id. at 4). According to a second CBO working paper, the gap in prices for private-sector hospitals paid by commercial insurers versus Medicare fee-for-service was even larger than the difference for physicians—with commercial insurers paying 89 percent higher rates for inpatient services than Medicare fee-for-service rates (Maeda and Nelson 2017:1).

It’s critical to note that Medicare rates fall between commercial rates, which are higher, and VHA rates, which are lower, as the Commission predicted that the VHA likely would have to pay commercial rates to some VCCP providers, particularly in highly consolidated markets (2016:33, citing Cutler and Scott). Thus, the cost of care at commercial rates could be far higher than care provided

35 Legislation caps the maximum price that the VHA pays for a drug at either the best commercial price net of certain discounts and rebates or the average price paid by pharmacies minus a large statutory discount, whichever is lower. In addition, the VHA receives discounts when drug prices rise faster than general inflation. (CBO 2014:7). Medicare is prohibited by law from negotiating drug prices.

36 The CBO noted that inpatient services would have cost 10 percent less at Medicare rates in the VHA system as a whole than in the six-facility sample while outpatient rates would have cost 30 percent more (2014:5). Researchers from the study discussed by the CBO explained the differences as follows: We believe that this represents costs that VA facilities assigned to this account that could not be directly linked with health services (e.g., the cost of subacute care imbedded in acute inpatient hospitalizations) that could be priced in the private sector. In the microstudy, some services could be identified in additional records or files that were unavailable at the national level, which relied on the computer files at VA’s automated data repository in Austin, Texas. (Nugent et al. 2004:504)

37 The CBO cites a single study, Weeks et al. 2009, that found the VHA would cost more than the private sector. However, it describes the methodology used in the study as “relatively weak” because, among other things, “[t]he study relied on survey data rather than detailed reviews of administrative data and medical charts ...” (2014:6).

through the VHA. The VA's interim final rule on Veteran Care Agreements fulfilled this prediction by allowing higher rates under the VCCP than Medicare pays "when VA determines, based on patient needs, market analyses, health care provider qualifications, or other factors, that it is not practicable to limit payment for services to the[se] rates" (2019:21681 to be codified at 84 C.F.R. 17.4120). Additionally, the VHA may pay higher rates than Medicare pays for hospitals under an all-payer agreement with the CMS, in "highly rural areas," and Alaska (*id.* at 21680-81 to be codified at 84 C.F.R. 17.4120).

Finally, veterans also see significant savings on health care costs through the VHA. The VHA has no premiums or deductibles and cost-sharing, when required, is generally more affordable than commercial health insurance (CBO 2014:3; Hussey et al. 2015:169-70). The CBO found that in 2013 VHA enrollees spent an average of \$100 total in copayments, amounting to about 2 percent of the costs of their care (2014:3). Enrollees in Medicare Part B, which covers physician services, paid approximately \$100 per month plus approximately 20 percent of the costs for their care (*ibid.*). In addition, the VHA's lower out-of-pocket costs may prove more cost effective as higher out-of-pocket costs discourage individuals from seeking preventive care, filling prescriptions and/or taking their medication as prescribed (*ibid.*). In turn, this may lead to higher health care costs overall as individuals wait until a medical situation has escalated before seeking treatment (*ibid.*). This is particularly true for low-income individuals, the elderly, and those with chronic conditions—a substantial portion of the population receiving care through the VHA (*ibid.*).

IV. Health Care in the Private Sector

The sections above have discussed the unique needs of veterans and the specialized care that the VHA provides as well as the broad resources available through the VA that go beyond simply providing health care. In order to better compare and understand the level of care available in the private sector, this section considers cultural competency and clinical expertise in the private sector as compared to the VHA.

The CBO report discussed above notes that “the VHA system is designed to serve a unique patient population: former members of the armed forces who served on active duty” (2014:2). Tanielian et al. concur, stating:

Veterans are a unique population of men and women who have served their country, many facing extraordinary health risks during their deployments. Because many veterans have served on overseas missions, including in combat, veterans with health issues related to their military service are a clinically complex and potentially vulnerable population.

Service-connected health issues include mental and physical health problems caused by disease, events, or injuries incurred or aggravated during active military service. (2018:1)

Understanding veterans’ unique needs—including those of veterans who have never seen combat—is crucial to assessing the private sector’s ability to care for veterans.

Cultural Competency

Cultural competency, defined here as “the degree to which providers are sensitive to the unique needs and relevant issues of concern within the veteran population” (Tanielian et al. 2014:2), is crucial in providing care to a vulnerable population such as veterans eligible for care through the VHA (Tanielian et al. 2018:19, 36, 40-41). According to the VA, and borne out by the studies discussed below, the lack of cultural competency³⁸ creates significant problems for veterans who receive care in the private sector: “Not having a clear understanding of the Veteran experience also results in poorly designed support mechanisms for Veterans by external VA providers” (2018:38-39). The VA attributes the problem to Americans’ nearly universal lack of experience with the military or veterans. This lack of experience prevents private-sector health care providers from referring veterans back to the VA to receive the broad range of

critical services available to them only through the VHA and the VBA (Vest, Kulak, and Homish 2018:3-4).

In performing Assessment B, RAND analysts Hussey et al. found that veterans and VHA staff both identified cultural affinity and understanding as critical to their care:

Some Veterans prefer to seek VA care because it provides them an opportunity to spend time with other Veterans. The sense of camaraderie that Veterans feel among other Veterans at VA facilities was one of the top 20 themes that RAND identified in analysis of online Yelp reviews of those facilities. Additionally, in interviews, administrators and health care workers emphasized the importance of Veterans receiving care from providers who understood their experience, and of VA’s provision of services that provide a sense of a community for Veterans, such as events to welcome home returning service members. As of 2014, over half (55 percent) of Veterans responding to the Survey of Enrollees reported that they either completely agreed or agreed that Veterans like them like to go to VA because they like to talk to other Veterans. (2015:170)

Moreover, in addition to the VHA’s exclusive focus on caring for veterans and facilities where all the patients are veterans, many VHA practitioners are themselves veterans. In 2016, 33 percent of VA employees were veterans (Shane III 2016). Finally, although cultural competency is important to health care overall, it is especially important in mental health treatment as its success depends upon building a therapeutic relationship between the provider and patient (Tanielian et al. 2014:2). Furthermore, research has shown that a lack of understanding on the part of the health care provider may be a factor in whether veterans seek out or continue mental health treatment (Tanielian et al. 2018:41, citing Weiss, Coll, and Metal 2011).

This section considers three recent studies about veteran and military cultural competency, all of which demonstrate that private-sector providers lack the cultural competency necessary to provide veterans care effectively. The first study, a 2011 report contracted by the VA with researchers at the Medical University of South Carolina at Charleston, surveyed mental health and primary care providers in Connecticut, Maryland, North Carolina, Pennsylvania, and Virginia (Kilpatrick et al. 23). It found that most private sector providers had little knowledge or experience with

38 The VA does not use the phrase “cultural competency” in the document cited, though the context makes clear that that is at least a major part of the problem.

veterans or the military even though a third of the providers had received part of their training in a VHA hospital. However, few of them (12 percent) had been employed by the VHA and the vast majority (84 percent) had never served in the military (id. at 6).

The second, an in-depth RAND study by Tanielian et al. published in 2014, examined private-sector readiness by surveying more than 500 behavioral health providers. The survey included at least 125 providers in each of four categories ranging from master's level counselors and social workers to psychologists with doctorates and psychiatrists with medical degrees (id. at 3) and had broad geographic representation of private-sector providers from across the United States including Hawaii, Alaska, and Puerto Rico (id. at 10). Researchers evaluated 22 variables related to cultural competency that covered the level of familiarity with veteran and military culture, comfort working with veterans, and self-reported treatment proficiency (id. at 5). High cultural competency required meeting thresholds for 15 out of 22 variables (id. at 6); only 19 percent met the criteria (id. at 11).

Finally, a 2018 study sponsored by the New York State Health Foundation and conducted by RAND analysts Tanielian et al. examined whether private-sector health care providers in New York State were able to provide accessible, high-quality care to veteran patients. Familiarity with military culture was one of seven “components of readiness” considered (8). The criterion for cultural competency required participants to be familiar with more than 50 percent of 10 listed indicators (id. at 19). Participants performed somewhat better than the two previous studies, yet only 30 percent of these private-sector providers met the criterion (ibid.). Moreover, among the approximately 87 percent of private-sector providers who had no formal training in military and veteran culture, fewer than half were interested in receiving such training (19, 46).

In sum, all three studies demonstrate a lack of military and veteran cultural competency in the private sector. This, particularly in light of the lack of interest in improving cultural competency found in the third study, suggests that shifting care to the private sector will undermine veterans' health care outcomes, given its importance to providing them effective health care.

Clinical Expertise

The VHA's clinical expertise and ability to provide specialized care to veterans is discussed at length above. This section considers the clinical aspects of care in the studies just discussed regarding cultural competency, which also demonstrate that private-sector providers

often lack the clinical expertise necessary to treat health conditions that disproportionately affect veterans compared to civilians. Kilpatrick, et al. found that fewer than half of private-sector providers (47 percent) screened for patient or family military service (2011:7). In examining knowledge about best practices for six different conditions related to military service—PTSD, traumatic brain injury (TBI), depression, substance abuse or dependence, family stress and problems with relationships, and suicide—they found that 50 percent or more of these non-VHA practitioners were knowledgeable about “treatments for depression (61%), suicide (52%), and family stress and relationship problems (50%)” but “[f]ewer than half of providers said they were knowledgeable about best practice treatments for PTSD (45%), substance abuse/dependence (42%), and TBI (24%)” (id. at 12). The lack of private sector provider clinical expertise in service-related health conditions is particularly problematic with respect to PTSD and TBI which, as discussed above, are far more prevalent among veterans than non-veterans—especially those with recent military deployments.

Tanielian et al. considered “capacity and inclination to deliver clinically appropriate, evidence-based care” of non-VHA practitioners, in addition to cultural competency, with a focus on major depressive disorder and PTSD (2014:2). Non-VHA practitioners scored better in clinical aspects of treatment than they did with cultural competency but still fell short. The study found that 35 percent of these providers were capable of providing appropriate care based on their training with just under 30 percent actually providing evidence-based care often or always (id. at 17-18). Only 13 percent of the private-sector providers met the “readiness criteria” for both culturally competent and clinically appropriate care (ibid.).

Lastly, consider the New York study by Tanielian et al. in 2018. Two components out of seven analyzed were directly related to clinical expertise: [1] “[p]repared to deal with conditions common among veterans” and [2] “[p]rovides high-quality care to their patients” (id. at 8). Criteria for the first component required the provider to be “somewhat or well prepared to manage care for patients with more than one-half of the listed common concerns” and the second was based on the degree to which the provider “reported using clinical practice guidelines” (ibid.). Almost two-thirds of private-sector providers were able to treat common conditions among veterans (id. at 27). For example, among medical doctors (MDs) or doctors of osteopathy (DOs), 61 percent reported being somewhat or well prepared to care for patients with traumatic brain injuries (id. at 33) — considered the “signature wound” of veterans who have served in Iraq and Afghanistan (Bagalman 2015:1; Health Services Research and Development 2017). The non-

VHA providers performed better with respect to using clinical practice guidelines, with 70 percent reporting that “they often or always used clinical practice guidelines” in determining treatment (Tanielian et al. 2018:34). Yet fewer than half of all these providers, including MDs and DOs (48 percent), screened for conditions common among veterans in their examinations (Tanielian et al. 2018:27, 30, 43). Only 20 percent of all private-sector providers, and just under 12 percent of MDs and DOs, asked their patients about their current or previous military status (id. at 30, 40). In the final analysis, only 2.3 percent of the non-VHA providers met all seven components for readiness (id. at 42).³⁹

³⁹ In brief, the seven components used were: currently accepting new patients, prepared to deal with conditions common among veterans, provides high-quality care to their patients, screens for other conditions common among veterans, accommodates patients with disabilities, familiar with military culture, and screens patients to determine whether they are current or former members of the armed forces or family members of such a person.

V. The Commission on Care’s Recommended Option

As noted above, Section 202 of the Choice Act established the Commission on Care. The Choice Act enumerated the Commission’s duties as follows: [1] to “undertake a comprehensive evaluation and assessment of access to health care at the Department of Veterans Affairs,” [2] in so doing, to “evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201,” and [3] to issue an interim and a final report on its findings as well as “such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration” (ibid.). The Commission’s final report recommends dramatically expanding the VHA’s use of the private sector (2016:4, 24, 27).⁴⁰ Instead of the VHA system in place in 2014, its “recommended option,” an expanded health care network for veterans that would increase the use of private-sector providers called the VHA Care System, “provides an integrated network of VHA, [Department of Defense] and other federally funded providers, and community providers, credentialed by VHA” (id. at 30). The Commission would restrict what it calls “special-emphasis care” to the VHA which includes “prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health and homeless care” (id. at 177, note 671).

Managing care is often a euphemism for outright denial of care ... Using narrow networks will put our veterans in the same problematic position facing many people who get their care through the private sector today, such as difficulty finding a provider accepting new patients or long wait times to see the provider and surprise medical bills when a provider is not in network.

The Commission presents low, middle, and high cost estimates for its recommended option, which the Commission assumes would use “well-managed, narrow networks” (id. at 178). “Well-managed” care, in this context, refers to restricting the types of care that are provided and the conditions under which they are provided through strict guidelines to limit costs. For example, care can be restricted by creating barriers such as requiring preauthorization for tests and treatments and requiring a referral to see a specialist. *Managing care* is often a euphemism for outright denial of care. The “narrowness” of a network refers to the number of primary care providers and specialists it has relative to the number of people enrolled in the network—the narrower the network, the fewer providers it has. Narrow networks may constrain costs by limiting the number of providers in high-cost specialties, excluding cutting-edge treatment centers, and other measures. Using narrow networks will put our veterans in the same problematic position facing many people who get their care through the private sector today, such as difficulty finding a provider accepting new patients or long wait times to see the provider and surprise medical bills when a provider is not in network.

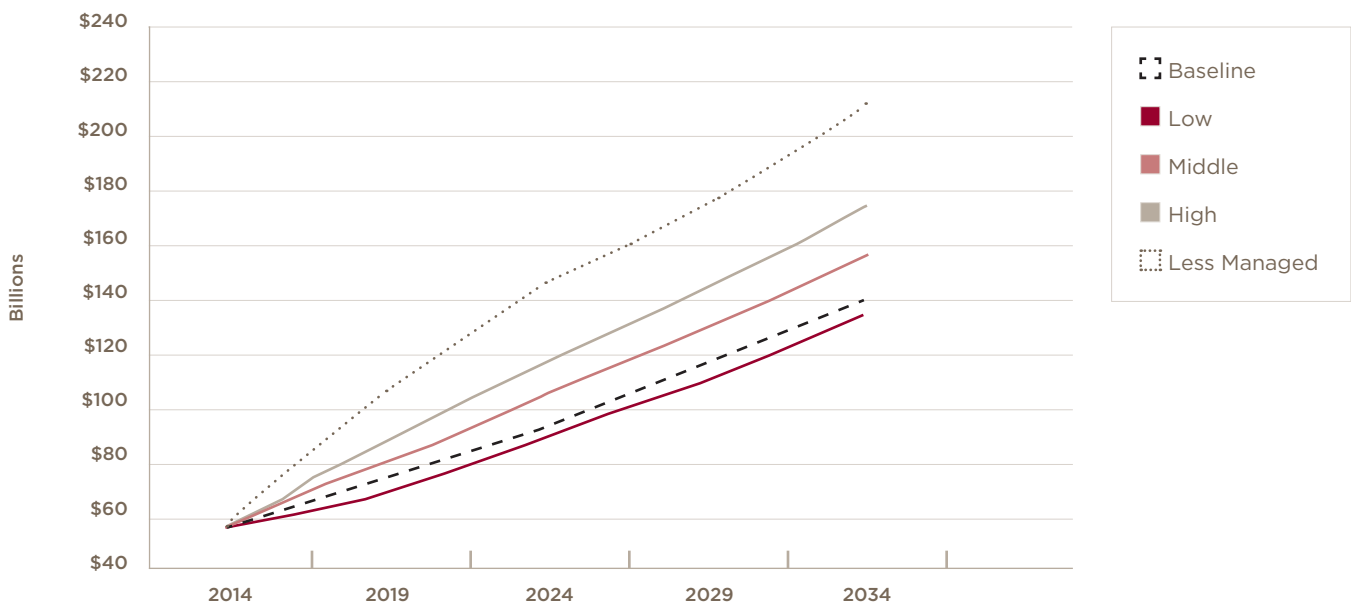
For 2019, the Commission’s cost estimates are, respectively, \$65 billion, \$76 billion, and \$85 billion. These estimates are compared to what the cost of the VHA program in place in 2014 would cost in 2019 based on estimated cost projections—\$71 billion. All but the low estimate of \$65 billion would exceed the projected cost of the current program (id. at 179).⁴¹ The Commission provides an estimate of \$106 billion for a “less-managed, broader network” noting that the costs could be considerably higher than the previous estimates if the VHA fails in “tightly managing the network” (id. at 178). These estimates represent cost changes relative to the 2014 VHA baseline that range from a decrease of 8 percent to increases of 7 percent, 20 percent, and almost 50 percent depending on how narrow the network of providers is (id. at 178-79). Figure 6 charts the low, medium, and high estimates for the recommended option as well as the cost of a “less managed” option (id. at 178).

Problematically, the estimates do not include most of the costs of the “administrative burden of expanded community care” (id. at 175). Administrative costs include hiring additional VHA staff to handle referrals, paying

40 All references attributed to the Commission are from its final report.

41 The actual cost of the 2014 VHA program was \$53 billion. This serves as a baseline figure to which various options for changing the program are compared.

Figure 6. Projected Costs of Recommended Option⁴³



Source: Hussey et al. citing their analysis of SK&A Office-Based Physician Database, VA Site Tracking System, and VA Planning Systems Support Group Enrollee file (2015:153).

contractors to manage the private networks, and other overhead costs that reduce the amount of money available to provide actual health care to veterans. The Commission acknowledges that “[t]hese additional, nonmodeled administrative costs could be substantial” (id. at 177).⁴²

Yet, as the Commission admits, the model for deriving these estimates has severe limitations (id. at 173-74). Due to these limitations, as well as uncertainty regarding potential changes to the U.S. health care system over time, the Commission notes the cost estimates become less dependable as they are projected into the future (id. at 174). Thus, it urges the reader to focus on the 2019 estimates in comparing the recommended option to the other options modeled (ibid.).

Looking at the Commission’s cost estimates in greater detail, we find that, beyond the lack of accounting for administrative costs, four additional critical components are not modeled at all or are based on very little data. These critical components include VHA capacity, local community capacity, enrollment, and reliance (id. at 173-74).⁴⁴ Regarding the first two, the Commission acknowledges that its model does not consider capacity

in the VHA or in local communities (ibid.). Given that the Choice Act established the Commission on Care to make recommendations to improve veterans’ access to care, determining capacity should be a central feature of any cost modeling. The failure of the Commission to accurately estimate the costs of an expanded private-sector provider network for veteran care once again demonstrates the need to perform the same assessments of the private sector that the Choice Act required of the VHA and then incorporate the data for both the private sector and the VHA into its model.

Accurately modeling the next two components, enrollment and reliance, is central to creating solid cost estimates as well as ensuring veterans’ access to care. The issue here is a lack of data regarding the number of veterans likely to enroll in the newly-created VHA Care System and how much of their care these enrolled veterans would seek within the system rather than outside of it—referred to as veteran “reliance” on the VHA Care System (id. at 176). At the time of the Commission’s report, 52 percent of eligible veterans were enrolled in the VHA and, on average, the enrollees relied on the VHA for a third of their care and received the balance of their care elsewhere (ibid.). The

⁴² There are additional costs that are not included in the model discussed in Appendix A of the Commission’s report, many of which are highly technical.

⁴³ This chart is taken directly from Commission on Care (2016:178).

⁴⁴ This draws on the notion of “reliance,” defined as “the share of health care services that VA patients receive from VA versus from other sources” (Eibner et al. 2015:57).

Commission admits that it cannot accurately quantify how enrollment and reliance would change and is “confident” only about the direction of change (ibid.). Both enrollment and reliance would increase (or decrease) based on how much choice in providers was afforded to patients as well as the providers’ accessibility (ibid.). Similarly, greater cost sharing and requiring a referral to see a specialist would reduce enrollment and reliance (ibid.). The model’s shortcomings affect not only the cost estimates, but also the viability of using the private sector. Unless the VHA cannot provide care to veterans in a particular area and the private sector can do so with the clinical expertise and cultural competency needed to provide high quality care, cost estimates are meaningless.

The Commission estimates that, based on 2014 data, 68 percent of health care provided at the VHA would have been eligible for care by private-sector providers participating in the new recommended network (id. at 177). Furthermore, it assumes that 60 percent of the eligible care actually would shift from the VHA to the private sector (ibid.). Sixty percent of eligible care amounts to more than 40 percent of the care provided by the VHA. If these estimates are accurate, 40 percent of current VHA care would be privatized. As the Commission sees it, the costs of this care would come from the VA budget: “For care shifting into the CDS networks [private sector], we assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities” (id. at 31). As modeled by the Commission, care shifting into a private-sector network would siphon large numbers of patients from VHA facilities, leaving them underutilized. This movement of patients from VHA facilities into the private sector would then be used to justify reducing funding or closing these facilities.

Yet, despite calling for a massive expansion into the private sector, the Commission recognizes that shifting care to the private sector may have “unintended consequences” (id. at 33). It flags two issues specifically: [1] that health care for veterans might supplant care for Medicare and Medicaid patients in underserved communities (33) and [2] that increased consolidation of health care markets may require the VHA to pay higher prices in the private sector (ibid., citing Cutler and Scott). As the MISSION Act and related regulations allow provider reimbursement rates that are higher than Medicare (Sec. 101(a)(1); VA 2019b 21680-81), the VCCP may create a financial incentive to prioritize veterans over Medicare and Medicaid patients. Though the issue of veterans seeking private-sector care supplanting Medicare and Medicaid patients may be an “unintended consequence” of the VCCP, it clearly is foreseeable.

Importantly, the Commission further states that “[s]uch circumstances underscore the importance of VHA retaining the option of building its own capacity” (ibid.). As Veteran

Service Organization leaders Garry J. Augustine et al. put it, the private sector should “fill gaps and expand access,” not replace VHA services (2016:1). To do otherwise is likely to weaken the VHA by reducing its use and, under the MISSION Act, result in the closure of its facilities. In addition, as the Commission acknowledges, many access issues are not unique to the VHA but are part of larger issues facing the United States as a whole (id. at 2). These nationwide access issues include long wait times for specialty care, a shortage of primary care and mental health care providers (particularly in low-income and rural areas), clinician burnout, and hospital closures. Thus, shifting veteran care from the VHA to the private sector cannot solve these issues and may make things worse for those Medicare and Medicaid patients currently receiving private-sector care.

VI. The MISSION Act's Regulatory Double Standard

The regulations promulgated for the new VCCP, established by the MISSION Act, have tightened access standards for VHA facilities but fail to hold the private sector accountable to the same standards. However, privatization makes sense only if both of the following hold: [1] the VHA is unable to provide quality health care within established geographic and timely access standards and [2] there are local hospitals, clinics, and qualified clinicians that are able to provide the specialized health care that veterans need in a more timely or geographically accessible way than can be provided by the VHA. Failing to meet both these conditions recklessly throws open the doors to privatized veteran care.

The new access standards for the VHA, promulgated as part of the VCCP, are as follows:

1. Primary care, mental health care, and non-institutional extended care services. VA cannot schedule an appointment for the covered veteran with a VA health care provider for the required care or service: (i) Within 30 minutes average driving time of the veteran's residence; and (ii) Within 20 days of the date of request unless a later date has been agreed to by the veteran in consultation with the VA health care provider.

2. Specialty care. VA cannot schedule an appointment for the covered veteran with a VA health care provider for the required care or service: (i) Within 60 minutes average driving time of the veteran's residence; and (ii) Within 28 days of the date of request unless a later date has been agreed to by the veteran in consultation with the VA health care provider. (VA 2019c:26310 to be codified at 38 CFR 17.4040)

The regulations reduce wait time eligibility for VHA providers from 30 days to 20 days for primary care, mental health care, and non-institutional extended care services and from 30 days to 28 days for specialty care. Yet, no wait time requirements are similarly imposed on private-

sector providers before veterans can seek care outside the VHA. Although stated in terms of driving time, the regulations also reduce the geographic distance limit, in most cases,⁴⁵ for a veteran to be eligible to receive care in the private sector.

These new standards thus make it easier for veterans to access care outside the VHA while failing to hold the private sector accountable. Whereas the VHA is held to appointment time and geographic access standards, non-VHA providers are not. Instead, the regulations merely state that the VA will consider the following in determining whether non-VHA providers are accessible:

1. The length of time the covered veteran would have to wait to receive hospital care, medical services, or extended care services from the entity or provider;
2. The qualifications of the entity or provider to furnish the hospital care, medical services, or extended care services from the entity or provider; and
3. The distance between the covered veteran's residence and the entity or provider. (id. at 26309 to be codified at 38 CFR 17.4030)

In discussing comments on the proposed rule, the VA unequivocally states that, regarding (1) and (3), non-VHA providers will not be held to the same wait time and geographic accessibility standards as VHA providers (id. at 26293), but that the "VA will determine accessibility by considering [those] factors" (id. at 26309, emphasis added).

Furthermore, in its explanation of the final VCCP access regulations, the VA clarifies that (2) refers to collecting licensing and credentialing information rather than regulating competency or quality standards. The VA states in the Federal Register:

⁴⁵ The Choice Act based geographic distance on miles rather than driving time and required that a veteran live farther than 40 miles from a VHA facility to receive care in the private sector. Thus a 30-minute travel time is a shorter distance for those whose average speed traveling to a VHA provider would be less than 80 miles per hour as this is how fast someone would have to travel for a 40-mile drive to be under 30 minutes. For those seeking specialty care, whether eligibility for private-sector care is less stringent under the new regulation than under the Choice Act will depend on what their average driving speed would be over a time period of 60 minutes. For those whose average speed to a VHA provider would be less than 40 miles per hour, the 60-minute driving time means that living a shorter distance from a VHA provider would make them eligible to see a non-VHA provider while the distance will increase for those whose average speed to a VHA provider would be more than 40 miles per hour. For those whose average speed to a VHA provider is less than 40 miles per hour the 60-minute driving time means a shorter distance will enable them to seek non-VHA providers while the distance will increase for those whose average speed to a VHA provider would be more than 40 miles per hour.

Although not part of the proposed rule, VA is establishing competency standards and requirements for the provision of care by non-VA providers in clinical areas where VA has developed special expertise, in accordance with section 133 of the MISSION Act. We are not regulating these standards to permit flexibility, as such standards are based on clinical practice and can be subject to change. VA's contracts, agreements, or other arrangements will impose requirements to meet these competency standards. (id. at 26292)

The VA claims that it cannot regulate competency standards even in areas where they have special expertise such as “post-traumatic stress disorder, military sexual trauma-related conditions, and traumatic brain injuries” because they need to maintain “flexibility” (MISSION Act 2018:Sec. 133 (a)). Yet, in fact, they could regulate these and other clinical practice areas by stating that non-VHA providers must meet the same standards as VHA providers—this would build in the flexibility they claim to need as clinical practice changes while at the same time holding all providers to the same standards. Instead, competency standards in specialty areas are relegated to nebulous “contracts, agreements, or other arrangements” (VA 2019c:26292). Furthermore, there is no mention of competency standards in any other clinical area. Thus, private providers under the VCCP are not held to the same access or eligibility standards as VHA providers.

VII. Conclusion

The private sector should be subject to the same quality, access, and competency standards and ongoing reporting requirements as the VHA when providing care to veterans. Insofar as Congress and the administrative agencies implement the MISSION Act without requiring that the private sector face the same scrutiny that the Choice Act required of the VHA, it is acting irresponsibly. That means that the evaluation of the private sector should include the same 12 reports that the Choice Act requires of the VHA and the independent assessment that integrates the reports. In recent congressional testimony, RAND analysts Farmer and Tanielian stated: “To our knowledge, there has been no systematic analysis of the timeliness or quality of care that veterans receive through VA community care programs” (2019:10). As discussed above, the 2018 Government Accountability Office report, the 2016 Commission on Care report, and reports by RAND analysts (Farmer and Tanielian 2019; Hussey et al. 2015) all agree that there is a lack of data about private-sector capacity and accessibility. Without comprehensive data, shifting more care from the VHA to the private sector is unconscionable.

As care in the private sector would almost certainly cost more than that provided by the VHA, fewer veterans would be able to receive treatment in the private sector than at the VHA for the same budget allocation. In the face of the uncertainties in the Commission’s cost modeling and the effect of privatization on veterans’ access to care through the Commission’s recommended “VHA Care System,” we must examine the private sector more closely. Given the likelihood that providing care in the private sector will cost more than providing care through the VHA, addressing issues of access through increased use of the private sector will lead to inferior care at greater cost. Ultimately, shifting veteran care to the private sector will require either additional funding to provide the same level of care or a reduction in the care provided.

Given their commitment to serve our country, we must in turn commit to providing veterans with the care they need. Where needed, capacity should be improved within the VHA. Expansion into the private sector should be pursued only if the VHA cannot provide the health care needed in a timely and geographically accessible way, and the private sector has the capability and capacity to do so.⁴⁶ Rather than spending more money for care in the private sector, as the Commission’s recommended option would require, the private sector should serve only as a temporary measure.

In sum, Congress must rectify the tension between the federal mandate to provide broad health care benefits and the lack of a congressional commitment to funding them. To this end, Congress must limit the private sector to a supplementary role and hold it to the same standards as the VHA, appropriate sufficient funding for the VHA to improve its capacity, and provide a dedicated funding stream that ensures that veterans get the health care they need and deserve.

⁴⁶ Note that both the Choice Act and the MISSION Act allow veterans to seek care outside the VHA irrespective of whether the private sector can provide the needed health care in a more timely or accessible manner.

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