The Urgent Need to Address VHA Community Care Spending and Access Strategies

"Red Team" Executive Roundtable Report

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2. Key Findings in Brief

1. Referring Veterans enrolled in the Veterans Affairs (VA) Health System to non-VA providers (aka 'community care' or 'out of network care') is an important strategy for serving Veterans when needed services are not readily available in VA's direct care system.[a] However, the costs of such referrals have risen dramatically in recent years (to nearly $30 billion in FY 2023) and may now threaten funding needed to support VA's direct care system. Real time information about the timeliness and quality of community care is generally not available, and research data show that community care is often no more timely nor of superior quality to the care offered by the VA. In many instances it has been shown to be of lower quality. Roundtable members were in unanimous agreement that VA urgently needs to take action to control community care utilization and costs if the direct care system is to continue to be available to serve the diverse, specialized, and often highly complicated health care needs of Veterans.

2. Referral of Veterans enrolled in the VA Health System to community care providers is not a new phenomenon, but the number of Veterans referred for community care has markedly increased in recent years consequent to policy changes effected by the Veterans Access, Choice and Accountability Act of 2014 (Choice Act) and the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act). In FY 2022, more than 40% of enrolled Veterans were provided care through the Veterans Community Care Program (VCCP). Community care referrals have risen on average by 15-20% per year in recent years.

3. Commensurate with the increased numbers of Veterans being referred to community providers, the cost of the VCCP has dramatically increased, rising from $14.8 billion in FY 2018 to $28.5 billion in FY 2023.[1]The VCCP's costs are projected to continue to grow year over year – e.g., there was a 19% increase in costs from FY 2023 to FY 2024.[1] These rising costs decrease available funds for VHA's direct care system absent corresponding increases in VHA's budget or reductions in the number of VHA provided programs, facilities, or number of Veterans served.

4. VHA has a stated goal of providing Veterans with "the soonest and best care," but the VCCP has insufficient information to know whether referrals to community providers will result in the Veteran receiving either the soonest or the best care, recognizing that the soonest care often does not equate to the best care. Private sector outpatient providers are not required to make access (e.g., wait time) and quality of care data publicly available, nor are contracted providers required to report these data to VHA. Variable performance data are available for community hospitals, and, when available, this information is not always easily accessible and understandable to patients. Additionally, VCCP Community Care Network (CCN) providers are not required to demonstrate competency in diagnosing and treating the complex care needs of Veterans nor in understanding military culture, which is often critical to providing quality care for Veterans.

[a] Veterans Affairs (VA) and Veterans Health Administration (VHA), the subcabinet agency that manages the VA Health System, are used interchangeably in this report.

5. When referring community care eligible Veterans to non-VHA providers, the VCCP has an implicit obligation to inform the Veteran about the pros and cons of such a referral – i.e., of providing information that allows the Veteran to make an informed choice about receiving care in the community or in the VHA direct care system. However, at present, the VCCP generally does not provide Veterans with quality of care or timeliness data that would allow them to make truly informed choices about where they receive care.

   Numerous research studies have shown that care provided by the VA's direct care system is comparable to or of superior quality to that provided by private sector providers and may have other advantages from coordination and continuity of care perspectives; however, little has been done to translate such research findings into messaging that can be used to inform Veterans or VHA staff about the pros and cons of choosing community or VA care. For example, a recently published study showed that women Veterans receiving non-cardiac surgery at VA hospitals had half the risk of postoperative death compared to surgeries performed in the community and that postoperative complications were more safely managed when surgery occurred in VA hospitals. If such information were provided to the Veteran, it could influence her choice of providers.

   Community care referrals are generally managed by mid-level administrative personnel without clinician involvement. These administrative personnel are not prepared by training or other background to meaningfully engage with Veterans about clinical issues that may be relevant to their choice of providers.

6. The amount of care referred to community care providers by individual VA Medical Centers (VAMCs) and within different Veterans Integrated Service Networks (VISNs) varies widely, but there is limited understanding of what accounts for the variability. There is little insight into whether some VAMCs and VISNs are employing practices that would retain care within the VHA direct care system and/or better control costs while maintaining fidelity to the intent of the MISSION Act.

7. The VCCP has recently initiated certain practices that promise to increase accessibility to VHA's direct care system and better manage out-of-network care. The opportunity exists to employ additional practices that would likely reduce programmatic costs while still providing Veterans meeting eligibility criteria with community care choices. A number of these practices are highlighted in the body of this report.

8. The largest category of out-of-network care (by expenditure and volume) is for emergency services. The VCCP has recently begun to utilize practices used by well-regarded private health plans to identify high vulnerability patients that would benefit from intensive case management, care navigation, and/or other methods that might lesson the need for unscheduled emergent care. These methods need to be systematized. Additional opportunities exist to utilize advanced data analytics (e.g., machine learning/artificial intelligence) to further help in this regard. Numerous options for addressing out of network emergency care and other areas of high community care spend are detailed in the body of this report.

9. Analogous to the Centers for Medicare and Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (CMMI), the VHA has a Center for Care and Payment Innovation (CCPI); however, the CCPI does not appear to be actively involved in testing new models of care that could make VHA direct care services more accessible or that could more cost-effectively utilize community care providers.

10. Anecdotal reports indicate that referral of increased numbers of Veterans to community care providers is adversely impacting some of VHA's graduate medical education and other training programs, as well as some research activities. In so far as health professional training and research are statutorily required missions of the VHA and these missions have substantial tangible benefits for the American population writ large (i.e., not just for Veterans and the VA Health System), the impact of growth of the VCCP on VHA's educational and research missions needs to be better understood.

11. The VA Health System is the only national health care system in the U.S., and it has a statutorily directed mission of providing backup to the Military Health System and the private sector during national public health emergencies or other specified national security circumstance. This is colloquially referred to as VHA's "fourth mission." The importance of the VA Health System as a backup to the private sector was well demonstrated during the height of the COVID-19 pandemic. It is not known how growth of the VCCP has impacted the ability of the VHA to carry out its fourth mission or how continued growth might affect it in the future.

12. Increasing numbers of Veterans referred to community providers and rising costs of the VCCP threaten to materially erode the VA's direct care system creating a potential unintended consequence of eliminating choice for the millions of Veterans who prefer to use the VHA direct care system for all or part of their medical care needs. This is especially concerning in so far as the available evidence indicates that the VCCP has achieved mixed results in facilitating Veterans gain more timely access to high quality care. There are many actions the VCCP could take to address these issues while concomitantly providing eligible Veterans with timely access to high quality care and a choice of providers. The Roundtable members believe that addressing this matter should be an urgent priority for VA/VHA leadership.

3. Background and Context for the "Red Team" Executive Roundtable[b]

Referral of Veterans enrolled in the VA Health System to non-VHA providers in the community (i.e., 'community care' or 'out of network care') is not a new phenomenon, although historically such referrals were made infrequently and for few reasons.[2,3] Until recently, these referrals were arranged for and managed by local VA medical centers (VAMCs) and the costs were included

[b] "Red Team" is a colloquial term often utilized by the Department of Defense, intelligence agencies, and other entities to refer to a small group of persons authorized and organized to review and recommend options for actions that should be taken to address a problematic situation, focusing especially on what would work in a real-world operational environment.

as part of a medical center's clinical care budget. As part of the VA Health System transformation of the late 1990s, VHA was given greater flexibility to refer Veterans to community care providers by the Veterans Eligibility Reform Act of 1996.[3] This catalyzed modest growth in the numbers of Veterans referred to community care providers in subsequent years.

More recently, consequent to policy changes effected by the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) and the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act), the number of enrolled Veterans referred to community care providers has markedly increased. To manage and provide system-wide oversight of community care a national Veterans Community Care Program (VCCP) office was established within VHA headquarters (aka Veterans Affairs Central Office or VACO). Third Party Administrators (TPAs) were contracted with to regionally manage the VCCP's Commu Care Network (CCN) of private providers and work with the VAMCs and VISNs on communi care referrals.

In FY 2022, more than 40% of enrolled Veterans were provided care through the VCCP. The number of such referrals has grown at a rate of 15-20% per year in recent years. The cost of the VCCP increased from $14.8 billion in FY2018 to $28.5 billion in FY2023, increasing 19% from FY 2023 to FY 2024.[1] Costs are projected to continue to grow rapidly unless steps are taken to increase the accessibility of VHA's direct care system and community care referrals are more cost-effectively managed.

VHA has a stated commitment of ensuring every Veteran receives the "soonest and best care," recognizing that the soonest care may not necessarily be the best care. For example, a research study published in 2023 found that offering Veterans the option to receive care in the community sometimes improved timeliness, but the quality of care often was not equivalent to VHA care.[6] Numerous other research studies published in peer-reviewed journals have shown care provided in the VHA direct care system is generally of equal or superior quality and often more readily accessible compared to private sector providers.[2-24]

To ensure Veterans have access to the highest quality care, VHA has continued efforts to improve its service offerings and enhance Veteran access to the direct care system. However, the increasing numbers of Veterans referred for community care and the resultant increased cost of the VCCP threaten funding for VHA's direct care system. Substantially increased funding will likely be required to meet the costs of the VCCP if current trends continue. Absent such funding, options include eliminating Veteran facing programs or closing facilities. Since so many of health care costs are fixed costs, the ability to incrementally reduce spending is limited.

To independently assess the trends and drivers of increasing community care spending, VHA's Under Secretary for Health (USH), Dr. Shereef Elnahal, convened a panel of nationally recognized health care experts to participate in a "Red Team" Executive Roundtable on January 9-10, 2024.[c] The Red Team was asked to analyze VCCP utilization and cost data, identify data gaps, assess reported VCCP cost control management strategies being utilized or considered for implementation, and recommend additional opportunities for the VCCP to cost-effectively

[c] One expert originally planning to participate in the Roundtable (Dr. Kavita Patel) had an unavoidable conflict at the last minute and did not participate in the review.

manage the program while continuing to ensure Veterans meeting eligibility criteria have a choice of providers. All data considered by the Red Team were provided by the VHA or came from peer-reviewed publications. No independent data verification or analysis was performed by the Red Team; such was beyond the scope of what it was asked to do. As briefly detailed in this report, Roundtable members agreed that the growing cost of the VCCP is an exigent matter that urgently needs to be addressed by VA/VHA leadership, and it offered a number of observations on existing trends and recommendations for cost-effectively managing the VCCP and enhancing the accessibility of VHA's direct care system.

4. Observations from the Executive Roundtable

A compilation of the Red Team's observations and feedback are briefly detailed below:

Select observations related to VHA access and quality

- VHA generally provides accessible and high-quality care in its direct care system.[2-24] As with all large health systems, regrettable situations do occur that highlight opportunities for improvement. Additionally, as the nation's only national health system, the VHA is often challenged by the specific circumstances of the highly diverse environments in which it operates.

- Numerous research studies have shown that VHA's quality of care is comparable to and often better than care provided by private sector providers.[2-18] For example, in a large study of hospitalizations for VHA enrollees discharged between January 1, 2012, and December 31, 2017, researchers found there was a significantly lower probability of 30-day mortality in older heart failure patients and younger and older stroke patients treated at VHA facilities compared to community hospitals.[6] Additionally, Veterans treated at VHA facilities had a lower probability of readmission when treated for gastrointestinal hemorrhage, heart failure, pneumonia, and stroke or after coronary artery bypass surgery.

- While VHA closely monitors quality of care in its direct care system, information about the quality of care provided by community care providers is much less available. Quality management, social support, and multidisciplinary patient care teams are intrinsic to almost all VA hospitals, but such practices vary in community hospitals. This variability likely affects outcomes in diverse ways, both measurable and unmeasurable. Private sector outpatient providers are not required to make access (e.g., wait time) and quality of care data publicly available, nor are contracted providers required to report these data to VHA. Variable performance data are available for community hospitals, and, when available, this information is not always easily accessible or understandable to patients. Additionally, VCCP Community Care Network (CCN) providers are not required to demonstrate an understanding of military culture nor competency in diagnosing and treating the diverse, specialized, and often highly complicated health care needs of Veterans or knowing which military service-related conditions may be eligible for disability compensation. Limited transparency of community care quality makes it difficult to ensure Veterans receive the highest quality care when they are referred to community

care providers. Said differently, while VHA has a stated goal of providing Veterans with "the soonest and best care," insufficient information is available to the VCCP to know where referrals to community providers will result in the Veteran receiving either the soonest or the best care, recognizing that the soonest care often does not equate to the best care.

- When referring Veterans to community care providers, the VCCP has an implicit obligation to inform the Veteran about the pros and cons of such a referral – i.e., of providing information that allows the Veteran to make an informed choice about receiving care in the community versus in the VHA direct care system. However, at present, the VCCP generally does not provide Veterans with timeliness and/or quality of care information that would help them make truly informed choices about where they receive care. As noted above, this may be due to such data not being available, although substantial amounts of data are available that could help a Veteran make an informed choice of provider.

  Numerous research studies have shown that care provided by the VA direct care system is of comparable and often superior quality to that provided by private sector providers and may have other advantages from coordination and continuity of care perspectives.[24] However, little has been done to translate these research findings into messaging that can be used to help community care eligible Veterans make informed choices about where they choose to receive care. For example, a recently published study showed that women Veterans receiving non-cardiac surgery at VA hospitals had half the risk of postoperative death compared to surgeries performed in the community and that postoperative complications were more safely managed when surgery occurred in VA hospitals.[4] If such information were provided to the Veteran, it might affect her choice of provider.

  In addition, community care referrals are generally managed by mid-level administrative personnel without clinician involvement. These administrative personnel are not prepared by training or other background to meaningfully engage with Veterans about clinical issues that may be relevant to their choice of providers.

- Veterans enrolled in the VA Health System are an especially complex patient population with health care needs that are both similar and different from those of nonveterans. For example, compared to large private health systems, VHA enrollees have higher disease acuity and higher rates of behavioral health conditions (e.g., posttraumatic stress disorder, substance use disorders, suicide) and past exposure to environmental toxins, . These conditions are often associated with benefits not available to non-Veterans. For example, Veterans may be at risk for certain kinds of cancers as a result of toxic exposures during their military service that makes them eligible for disability pensions. Community care providers generally are not well-versed in military culture and lack knowledge and understanding about Veterans' unique experiences such as military sexual trauma or little knowledge about how to successfully manage posttraumatic stress disorder. While VHA makes training available to community care providers to increase their military/veteran cultural competency and their familiarity with health care

issues common among veterans, only a small proportion of community care providers have completed this training. VA has no authority to require that they do so.

- A large majority of Veterans report an exceptional experience with the care provided by VHA, and studies have shown experience of care and trust scores are higher than for community care providers. As with the most highly regarded private health systems, regrettable situations do occur that highlight opportunities for improvement.

- While access to care varies across the VA Health System, in many locations and specialties access is better in VHA than for community care providers.[19-24] However, based on statutorily specified eligibility criteria, some Veterans may be eligible for referrals to community care providers even if wait times or drive times for VA care are better than for the community care providers.

Select observations and feedback related to overall community care trends

Continued increases in community care spend at the rate of 15-20% per year may not be sustainable and challenge future investments in the VHA direct care system and/or existing programs. With a fixed appropriated budget and escalating community care referrals (which must be paid), more of VHA's clinical care budget will have to be earmarked to support the community care program. This would generate a continuous cycle and "downward spiral" where less direct care funding negatively impacts direct care system capacity, thus leading to increased community care reliance, continuing the cycle.

In FY 2023, the primary reasons for Veterans seeking non-emergent specialty care in the community were due to drive time (50%), services unavailable (26%), and wait time (5%). However, it is not known how many Veterans eligible for community care under drive time or wait time criteria had to travel further or wait longer to receive care in the community. There are numerous anecdotal reports and some research data about this being the case. A directed inquiry to better understand this matter is warranted.

Select observations and feedback related to community care spend by category of care

- Emergency care spend accounts for ~30% of total community care spend.

- Geriatrics and Extended Care accounts for ~20% of community care spend. This category of spend has increased significantly in recent years, being driven by expenditures for homemaker/home health aides (which increased by over 40% from FY2021 to FY 2023), community nursing homes and skilled nursing facilities.

- Oncology spend accounts for ~5% of community care spend; this is driven by pharmaceutical costs. Community infusion centers generally charge a substantially higher price for pharmaceuticals (compared to VHA's costs for the same drugs) when Veterans receive infusions in the community.

- Mental Health spend accounts for ~5% of community care spend. This has significantly increased over the past four fiscal years.

- Orthopedic spend accounts for ~4% of community care spend. Notable shifts have been seen in the percent of major surgical procedures performed in the community versus the direct care system (e.g., hip, knee, and shoulder replacements).

- With the above information in mind, it was further acknowledged that the amount of care referred to community care providers, and the associated expenditures, by individual VA Medical Centers (VAMCs) and within different Veterans Integrated Service Networks (VISNs) varies widely. However, there is a limited understanding of what accounts for this variability and whether some VAMCs and VISNs are employing practices that make VHA direct care more accessible or otherwise better control community care costs while maintaining fidelity to the intent of the MISSION Act.

Select observations and feedback related to existing VHA initiatives

VHA is pursuing a number of initiatives designed to improve access and quality of care within the direct care system and has had demonstrable success with several of these initiatives. For example, "Access Sprints" have improved new patient volumes by over 10% in recent months for primary care and select specialties. Other promising initiatives include Referral Coordination, Tele-Emergency Care, and Tele-Oncology. Successful recently launched programs should be expeditiously scaled and deployed systemwide (e.g., Referral Coordination Initiative, Tele-Oncology Initiative). Such efforts need to be continuously evaluated to ensure they are meeting their goals in VHA's many different operating environments.

5. Recommendations from Executive Roundtable

In addition to what is presented in Section 4, Roundtable members offered several additional recommendations for VHA based on the information shared with it. These include the following:

- **Build an "attraction strategy" focused on quality and backed by a robust communications campaign and leadership accountability.** Abundant data shows that VHA often outperforms private sector hospitals in quality of care, but there is a difference between showcasing that in academic articles and making it visible to Veterans, VHA staff, community care providers, external stakeholders, and the media. VHA should leverage its quality of care and patient satisfaction ratings with a sense of pride and build a sense of trust around attracting Veterans to the direct care system. This includes educating all levels of staff in this regard and creating a culture around working together to implement the strategy and communication plan. VA/VHA leadership should make this a top organizational priority, supported by a culture of accountability for results at all levels. A data backed approach should be taken to help provide increased transparency and accountability (e.g., sharing referral data back to all providers on a routine basis).

- **Continue proposals to revise drive and wait time standards.** Existing eligibility criteria can lead Veterans to receive care from community providers that is a longer drive time or appointment

wait time than what VHA could have offered.[19-24] These criteria could be revised to ensure referrals to the community are only made when it is actually a more accessible or otherwise better option. In addition, alternative options for assessing and measuring access to care (i.e., alternative to or in addition to wait times and drive times) should be considered. In addition, wait time criteria could be modified to include the availability of clinically appropriate telehealth appointments within VHA. VHA estimates potential cost savings of $424M to $1.14B by reducing instances where Veterans drive a greater distance to receive services from community care providers when comparable, timely VHA services are available within the same or shorter drive distance.

- **Report the quality and value of the Community Care Network (CCN).** Changes to the way VHA manages the CCN could improve the efficiency and effectiveness of the network, including the incorporation of quality and value standards. Value based contracts including quality metrics, and in line with CMS value-based care models, could be used to incentivize CCN providers to deliver higher quality of care. Episode payment bundles with quality bonuses could be used for episodic care and outcome-based incentives could be used for chronic care treatment or other services. Financial incentives, such as co-pay waivers, could be used to encourage Veterans to stay within direct care, especially where VHA care is of demonstrable higher quality. VHA telehealth offered before and after major procedures, combined with financial support for patient travel, could also encourage Veterans to utilize VHA direct care. Functional assessments prior to referral could also be used to anticipate when significant procedures will be necessary (e.g., joint replacements) and guide referrals to the highest quality source. TPA contracts could also be modified to require more involvement in directing Veterans to the direct care system when medically optimal; and especially for repatriation of Veterans admitted from an emergency department visit. Using evidence-based standards to compare quality of care, including the necessity of procedures, could help ensure all Veterans receive services that meet specified quality standards. The TRICARE national monitoring contract could be used as a model for establishing contractual terms and conditions for data sharing and monitoring. As VHA rethinks the next generation of the CCN, they could review leading practices from TRICARE and private sector systems, including data reporting requirements and national quality monitoring.

- **Reconsider use of Standard Episode of Care (SEOC) referral authorizations and more closely monitor the services utilized under a SEOC.** When a Veteran is referred to a community provider the services authorized by that referral are specified in what is known as a standard episode of care (SEOC). The SEOC is a set of clinically related health care services for a given medical condition (diagnosis and/or procedure) that are authorized to be provided during a specified period of time not to exceed one year. The SEOCs are quite open-ended as far as the amount and nature of the services provided as long as the services fall under what is specified in the SEOC. The VCCP provides little oversight over the provision of these services. For example, if a Veteran is referred for possible knee replacement surgery, the SEOC will typically authorize whatever imaging or other diagnostic studies, whatever number of physical therapy sessions, or whatever other interventions are relevant to this condition, including the surgery, without any assessment of whether a service (e.g., physical therapy) is medically warranted. Likewise, if a Veteran is referred for 20 massage therapy or chiropractic visits for low back pain, the VCCP does not monitor the patient's condition to see if the Veteran is benefitting from such treatments or whether all 20 sessions are appropriate. Consistent with the practices of well managed private health plans, VCCP could more closely monitor and assess what services are authorized by the SEOC and for how long and otherwise more closely manage utilization.

- **Consider expanding partnerships with academic health systems given overlapping missions.** Many VAMCs are located in immediate or close proximity to prestigious academic health systems. These organizations not only offer specialized services which may be needed for high acuity referrals, but they also have similar educational and research missions as VHA. Expanded partnerships could be mutually beneficial. When referrals to community providers are needed, if there were priority partnerships with many of these academic health systems, it could help ensure Veterans are receiving high quality care, help advance the training and teaching missions across the organizations, and support value-based care models with enhanced care continuity between both systems.

- **Standardize Referral Coordination Teams across the enterprise.** VHA has a centralized model for clinical and administrative teams known as Referral Coordination Teams (RCTs) that discuss care options with Veterans and empower them to choose the best care. However, RCTs are not implemented across the enterprise in a standardized manner. VHA has the capacity for more care, but just having capacity is not enough. VHA needs to guide Veterans to VHA direct care based on quality to sustain VHA capacity. RCTs should direct Veterans to the "right" community providers based on quality in addition to access (timeliness and distance). Tiering providers or creating a narrower network could help in this regard. Before a patient is referred to the community, RCTs can also conduct functional status appropriate screenings to confirm whether the patient will benefit from a specific procedure or if a telehealth visit within VHA is a viable alternative to driving to or waiting for an in-person visit. VHA also has an opportunity to better leverage tools or technology to help Veterans navigate care, including viewing their next available appointments across VHA and community care on an app.

- **Enhance real-time data and analytic capabilities to better understand drivers of community care spend and develop mitigating initiatives.** Given the magnitude of community care spend, it is critical for VHA to have a robust understanding of the drivers of the community care spend and have sufficient data to make strategic and operational decisions. A key part of this would be to better understand the fully loaded unit cost of care in the direct care system versus the community care system. This information could help VHA understand how much it could inves help attract and retain Veterans in the direct care system when that is their first choice. In addition, these financial insights could help inform where opportunities may exist for VHA to expand service offerings in areas where limited services exist across VHA (e.g., Geriatrics an Extended Care). In addition, a more robust understanding of the type of Veterans who use community care (e.g., age, length of time in VHA system, urban vs. rural, gender, etc), could enhance initiative design to meet Veterans' needs, and predictive analytics could be used to help intervene in advance of Veterans choosing to go to the community. The VCCP also has an opportunity to employ advanced data analysis methods (e.g., machine learning/artificial intelligence) that would further help in this regard. These methods may materially help the VCCP more cost-effectively manage the program.

- **Continue to enhance initiatives designed to mitigate Emergency Care spend.** Given Emergency Care is the largest category of community care spend, continued focus in this area should be a top priority.[25] Additional efforts the VCCP could take in this regard include:
    - **Continue tele-emergency care expansion so that it is available in every VISN.** Incorporate into the robust communication campaign to ensure all stakeholders (internal and external) are aware of the key attributes of the program and how to access Tele-EC. VHA estimates that 50% of Veterans who have been ended up in community hospital emergency departments could have their care need resolved through Tele-EC. VHA's

cost analysis estimates a 17% reduction in community care emergency visits and $248-490 in savings per Tele-EC visit, or $44.6M to $88.2M in total annual savings before accounting for Tele-EC costs. Annual savings after Tele-EC costs are estimated at $6.1M to $49.7M. Currently, Tele-EC is not consistently offered across the system. Tele-EC must be standardized nationally to fully realize its benefits.

- **Revert to VHA as a Secondary Payer**. There should be a change in current payment policy to make VHA the secondary payer for nonservice-connected community emergency care and associated inpatient hospital claims. In this case, a Veteran's other health insurance would serve as the primary payer and VHA would cover any additional out-of-pocket costs to negate the financial impact on the Veteran; however, the Veteran would still be required to pay their VHA copay for nonservice-connected emergency care. VHA would remain the primary payer for service-connected care. This payment reform could result in an annual $1.73B cost avoidance.
- **Enable more repatriation.** Because 84% of VHA's community emergency care spending is attributed to inpatient care, VHA has a significant opportunity to manage costs through repatriation when that is the best option for a Veteran. VHA could better leverage its TPAs to inform VHA when patients require inpatient admission or a high dollar procedure that could be accommodated via direct care.
- **Deploy a consistent intensive case management approach to Veterans with a high likelihood of ED visits or inpatient admissions.** VHA can leverage its Patient Aligned Care Teams (PACTs) to provide intensive case management for vulnerable and high use populations. PCPs, NPs, and PAs familiar with the Veteran are the best persons to direct them to the right care setting and to provide the best and soonest follow up care. Maintaining care and care decisions within the PACTs would likely have the additional benefit of improving care coordination.
- **Execute a concerted communication campaign to broadly communicate how to obtain the best care when urgent or emergency care is needed.** This could include a wide variety of communication methods, ranging from ensuring all VISN and VAMC websites have this type of information prominently displayed on their landing page and use of such things refrigerator magnets or information cards clearly outlining all options to get emergency care within VHA that are provided to Veterans at each visit.

- **Evaluate opportunities to offer more Geriatrics and Extended Care services within VHA.** Since Geriatrics and Extended Care is the second biggest category of community care spend, VHA should conduct financial analyses to determine which types of services could be offered within VHA at a higher quality and lower cost. At present, nearly all of this care is directed to the community since VHA does not have many offerings in these areas. This is ironic given VHA's historic role in developing the medical specialty of geriatrics. If VHA were to expand offerings in these areas, it could also serve as a pipeline of future clinicians for VHA, and if VHA were to offer more home-based care services they may be better able to maintain continuity of care for Veterans and identify when Veterans are in need of early intervention to prevent inpatient admissions. In addition, VHA should consider options for how Medicare or Medicaid programs could help assist with providing home health coverage.
- **Continue to enhance initiatives designed to mitigate Oncology spend.** Oncology represents the third largest category of community care spend, and additional efforts to scale initiatives in this area should be prioritized. These include:
  - **Continue Tele-Oncology expansion.** Tele-Oncology is a proven strategy for providing oncology care and is widely used by leading private sector cancer care providers. VHA could materially increase its tele-oncology care. This holds great promise for providing

Veterans with the best care for their type of cancer regardless of where they live, while concomitantly reducing the need for and cost of referrals within the CCN.

- **Continue to expand infusion centers through Close to Me (CTM) infusion services.** This service is currently available at 20 Community Based Outpatient Clinics (CBOCs) with an additional 20 scheduled to open services by the end of FY24. This program should be expeditiously expanded.
- **Consider referral terms for oncology services in the community.** Renegotiate the referral duration for oncology care to community care providers. This can include a collaborative approach to community oncologists where a care plan is identified in the community but managed in whole or in part by VHA.
- **Contract with TPAs to leverage VHA's pharmaceutical pricing.** VHA should consider requiring contracts with community infusion centers to obtain specialty pharmaceuticals from a VA pharmacy whenever feasible and to limit the amount of markup by the community infusion center.
- **Explore innovative partnerships with DoD.** If functionally combined, VHA and DoD would make up the largest health system in the United States by far. Combining resources to increase purchasing power or otherwise leverage their combined assets could increase accessibility of care and decrease costs.

- **Continue to enhance initiatives designed to mitigate Mental Health spend.** Mental Health represents the fourth largest category of community care expenditures. Additional efforts to scale initiatives in this area should be prioritized; these include:
  - **Enhance granularity of data.** Better understand the breakdown of demographics and conditions of Veterans using community mental health services, including outpatient and residential rehabilitation treatment programs.
  - **Build internal capacity and infrastructure.** Build internal bed capacity; increase training and hiring of VHA mental health professionals; and expand telehealth and tele-mental health capabilities to internalize more mental health care at lower costs. VHA could relatively quickly operationalize multiple overlapping and mutually reinforcing strategies to expand it mental health care workforce.
  - **Compare quality of mental health care in the community.** Explore use of evidence-supported and measurement-based care in the community and how outcomes compare to VHA. Leverage quality data to empower and encourage Veterans to choose VHA for their mental health care. Explore options to include quality measurement in CCN contracts and/or create narrow networks of providers to ensure quality of care.
- **Continue to enhance initiatives designed to mitigate Orthopedic and Cardiology spend.** Orthopedic and cardiology are specialties with relatively higher amounts of community care spending. Additional efforts to scale value-based care initiatives in these areas should be prioritized. These include:
  - **Enhanced referral coordination for orthopedic and cardiology services.** Having a PCP in place to work with Veterans to understand their care options would help ensure all procedures are the best therapeutic options for patients. In addition, more robust in network sports medical and physical therapy services could help mitigate the need for some orthopedic surgeries.
  - **Revise prior-authorization criteria**. VHA has a broad standardized episode of care where the Veteran is referred out for a whole episode of care (see prior comment about SEOCs). The Veteran may go to a community provider for physical therapy, and from there, imaging and other services are considered an episode, which normally requires three to six months of care. Through enhanced referral coordination, Veterans can be

repatriated back to VHA for their continued care versus staying in the community where quality and effectiveness are difficult to measure

- **Analyze impact of ambulatory surgical centers (ASCs) on access and patient preference.** While many community providers continue to expand their ASC footprint, it may increase the preference for Veterans to seek care in the community for these services given the proximity of care to their home and the convenience of having surgeries in an outpatient setting. VHA should evaluate the differential cost of providing this procedural care in the direct care system versus in the community to inform how much of an investment may be warranted. Additionally, this could be another area where stronger partnerships with specific community care providers (e.g., its affiliated academic health systems) could be a cost-effective strategy.

- **Utilize VHA's Center for Care and Payment Innovation (CCPI) to rapidly test new models of care.** Analogous to the Centers for Medicare and Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (CMMI), the VHA has a Center for Care and Payment Innovation; however, the CCPI does not appear to be actively involved in testing new models of care that might increase accessibility of VHA's direct care services or more cost-effectively utilize community care providers. A concerted effort should be made to more effectively utilize this resource.

6. Other Areas of Concern

- Anecdotal reports indicate that referral of increased numbers of Veterans to community care providers is adversely impacting some of VHA's graduate medical education and other training programs, as well as some research activities. In so far as health professional training and research are statutorily required missions of the VA and have substantial tangible benefits for the American population writ large (i.e., not just for Veterans and the VA Health System), the impact of growth of the VCCP on VHA's educational and research missions needs to be better understood. Directed inquiries by appropriate bodies should be made into this matter.

- The VA Health System is the only national health care system in the U.S. and has a statutorily directed mission of providing backup to the Military Health System and the private sector in times of national public health emergency or other specified national security circumstance. This is colloquially referred to as VHA's "fourth mission." The importance of the VA Health System as a backup to the private sector was well demonstrated during the COVID-19 pandemic It is not known how growth of the VCCP has impacted VHA's ability to carry out its fourth mission, and a directed inquiry shou be made into this matter by an appropriate entity.

- There is a limited pool of health care companies that understand both the Military He System and Veterans Affairs Health System and how to partner with them to maximize access, quality, and choice while at the same time controlling costs. As the timing of issuing a final Request For Proposal (RFP) and awarding a contract on the next generation of the CCN program, it will be important to ensure that potential TPAs have the requisite capabilities to serve the Veteran community.

7. Conclusion

After reviewing extensive data and peer reviewed journal articles about the current state of VHA direct and community care programs, and after discussing the data and research findings with VHA leaders, the Red Team concludes that continued rapid growth of the VCCP presents VA/VHA leadership with an existential conundrum. The increasing numbers of Veterans being referred for community care and VCCP's rapidly rising costs are eroding VHA's direct care system and are likely having untoward ripple effects in VHA's other missions of health professional training, research, and emergency response. The intent of the Choice and MISSION Acts were to give Veterans timely access to high quality health care through greater choice about where they receive care; however, as discussed in this report it is not demonstrably evident that the primary goal of these legislative measures is being consistently and cost-effectively achieved. Also, in so far as the rising costs of the VCCP threaten funding for and erosion of the VHA direct care system this creates the potential unintended consequence of reducing or eliminating choices for high quality care for the millions of Veterans who prefer to use the VA direct care system for all or part of their medical care needs. Roundtable members do not believe that this was the intent of Congress when enacting the Choice and MISSION Acts. Roundtable members agree that VHA generally provides high quality and timely care and applauds VHA's demonstrably successful efforts to improve access and quality for Veterans within the direct care system. It urges the USH to systematize initiatives such as "access sprints," referral coordination, tele-emergency care, and tele-oncology. Roundtable members also called out multiple additional opportunities to manage the growth and cost of the VCCP, some of which may require legislative support but in the long term may be most helpful in cost-effectively managing the VCCP.

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Additional Materials Provided for Review

- VHA Business Line Review: Highlighting Community Care Spending and Access Strategies, VHA, 2023.
- VHA, Veterans Health Administration Overview, 2024.
- Community Care and Access Strategies Red Team Executive Roundtable, VHA, 2024.
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