Healthcare Utilization and Expansions in Access to Community Care

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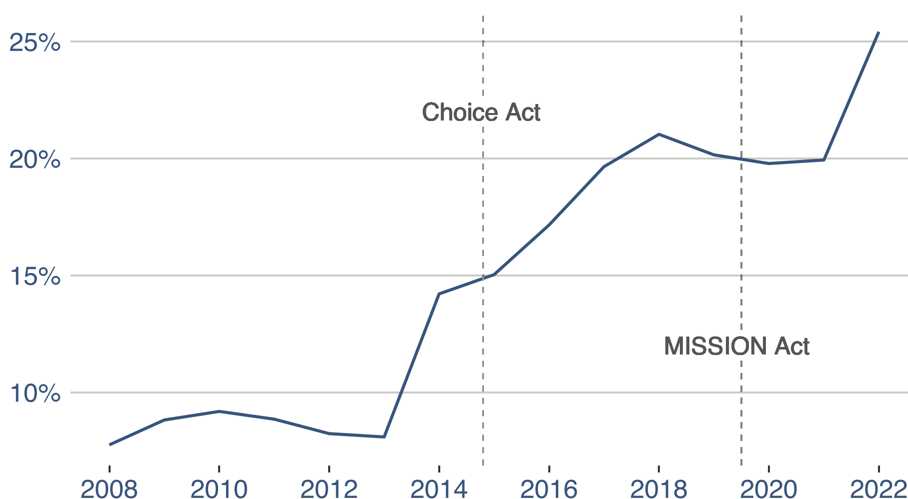
Policies implemented because of the Choice Act of 2014 and the MISSION Act of 2018 substantially increased the amount of healthcare that VA purchases from non-VA providers. However, identifying the effect of these policies on utilization, patient outcomes, and clinical care has not been straightforward. Individuals who use community care are often different from those who use VA exclusively – in ways that are both observed and unobserved. Thus, it is difficult to know if any changes over time in patient behavior and outcomes are due to these policy changes, or to other factors such as the aging Vietnam Veteran cohort, the increase in the number of OEF/OIF/OND Veteran enrollees, policy changes outside VA such as the Affordable Care Act, or the COVID-19 pandemic.

What we know with certainty is that the cost of community care has increased dramatically over the last decade. Community care now consumes more than 25 percent of the total VHA budget (see Figure 1) and shows little sign of slowing down. A recent study found that this trend accelerated during the COVID-19 pandemic, with VA-provided care slower to rebound than VA community care.[1] However, it is unclear how much of this acceleration is due to differences between the VA healthcare system and non-VA community care, and the implementation of the MISSION Act just nine months before the start of the pandemic.

To distinguish the effect of VA policies on access to community care, our study examined a specific feature of the Choice Act that helps alleviate concerns about unobserved differences among community care and VA users. Among other provisions, the law permits VA enrollees to access community care if they live more than 40 miles from a VA facility. This policy allowed us to compare enrollees around the 40-mile threshold, some of whom were granted easier access to community care. While it is not possible to randomly assign VA enrollees to be eligible for community care, this study design approximates randomization because of the arbitrary threshold. Our study found that being eligible for community care increased community care utilization by 25 percent in 2015-2018.[2] Perhaps more importantly, we also found that VA-provided care did not decrease, meaning that combined VA paid and provided care increased by 3 percent. These changes were not associated with any changes in mortality. A study using similar methods examining surgical procedures also found large increases in community care utilization, but no differences in short-term mortality or readmissions.[3]

Figure 1. Purchasing More Care: Community Care as a Proportion of VHA's Budget



Key Points

- Community care accounts for more than 25 percent of the total VHA budget.
- Results from the author's study indicate that being eligible for community care increased community care utilization by 25 percent in 2015-2018, and, more importantly, VA-provided care did not decrease.
- These findings show that expanding access to community care increases community care utilization, but not simply as a substitute for VA-provided care.

The significance of these findings is that expanding access to community care increases community care utilization, but not simply as a substitute for VA-provided care. The reason for this is not clear. As previously stated, community care users are different from VA-only users, and a large portion of enrollees use both community and VA care. Complicating matters further, it has long been known that many VA enrollees have other forms of health insurance. Yet, VA has long been blind to utilization outside of what it pays for or provides. Yoon et al. (2022) solved this by linking VA data with all-payer inpatient databases from several states.[4] This paper showed a positive association between the Choice Act and VA community care hospitalizations, but no association with changes in mortality. Perhaps more importantly, this paper showed definitively that VA is not the primary provider of inpatient services for VA enrollees. From 2012-2017, Medicare covered more hospitalizations (54 percent) than any other payer, including VA.

The significance of these findings is that much of VA's expansion of community care can be thought of as VA expansion *as an insurance provider*. Because VA is required to pay Medicare rates, VA community care providers

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So, I think it will be a real struggle going forward because you talked about how an individual Veteran makes a decision about who he or she goes to see when we can't compare quality of care between provider A and provider B versus the group of providers associated with that VA station.

Dr. Miguel Lapuz (IVC): These are excellent points and let us know how we can help you get there.

Dr. David Atkins (HSR&D): To wrap things up, is there anything we can do to facilitate this partnership or make communication easier between our offices (IVC and HSR&D)?

Dr. Miguel Lapuz (IVC): We already had a discussion with the leadership and stakeholders regarding changing the regulations and in one area, telehealth, we're likely going to be changing the regulations regarding community care eligibility. That is making telehealth a qualifier for VA services. So, in other words, if we can offer telehealth in a particular clinical situation and we are within the MISSION Act wait and drive times, then the appointment would count with regard to the eligibilities. People are going to be asking how effective telehealth is in VA as a substitute for in-person care, and what are the clinics in which telehealth is better in comparison to in-person care? I think that's a fair question and I think that that's one area that we need to be able to respond to.

Dr. David Atkins (HSR&D): That's an important question, and we have been working with our colleagues in the Office of Connected Care to examine some of those questions, including outcomes of virtual care and how to classify those.

Dr. Kristin Mattocks (CREEK): We appreciate your talking with us today and we will share this information with our HSR&D colleagues. We look forward to continued collaboration.

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point of contact. Second, most participants thought information about healthcare options would ideally be provided by VA, yet many questioned the feasibility of any single entity providing comprehensive, nationwide information about non-VA healthcare options. Third, participants generally trusted fellow Veterans to deliver information and to triage Veterans to professionals with specific VA or non-VA care expertise. However, focus group participants perceived the delivery of accurate and consistent information as more important than its source. Fourth, participants felt that those delivering information should be empathetic and have extensive knowledge of local VA and community resources. Fifth, participants felt that an informational support program would need to accommodate a range of Veteran needs, including the needs of those Veterans already in VA and moving to a new location, those being discharged from active duty, those not enrolled in VA, those with a negative perception of VA, Veterans living in a rural area, those enrolled in higher education, those willing and able to access technology, or those experiencing homelessness. Sixth, many Veterans may not be aware they are eligible for VA benefits; such Veterans would benefit from a multi-faceted outreach strategy tailored to local communities and Veteran subgroups.

Veterans' Decision-making about VA and Non-VA Healthcare

In the second phase of our research, we used our qualitative findings to develop and refine new survey measures of: Veterans' reasons for using VA care, non-VA care, or both; reasons for choosing the VA facility they use for most of their care; sources of information they used to choose between getting healthcare in VA or outside VA; and the importance of having particular types of information to facilitate that choice. We then combined these new measures with existing items into a survey that will measure Veterans' use of and decision-making about VA and non-VA care; and perceptions of the timeliness, affordability, quality, and patient-centeredness of their healthcare. In November 2022, we administered this survey to a nationally representative sample of 3,000 Veterans who are part of Ipsos KnowledgePanel®. In addition to the new survey measures we developed, products of this phase will soon include national estimates of factors associated with Veterans' use of VA care, non-VA care, or both; reasons Veterans choose VA care, non-VA care, or both for different types of healthcare services; and Veterans' views of different types of information to help them choose between getting healthcare inside or outside the VA system.

Partnering with Veterans and VA leaders to Translate Findings into Policy and Practice

In the third and final phase of our research, we will engage both Veterans and VA operational leaders to identify actionable strategies to inform Veterans' decision-making and ways in which policies and programs could reflect Veterans' preferences for and experiences with using VA and non-VA healthcare. Using a combination of deliberation and design methods, we will share key qualitative and survey findings with separate virtual groups of Veterans and VA leaders from across the United States. We will then guide participants through a collaborative process in which they will identify, prioritize, and begin to design programs and policies that could support Veteran decision-making about use of VA and non-VA care.

To maximize the benefits of VA and non-VA healthcare options, Veterans need information and support that they can trust, that they will value, and that will be useful to their healthcare decision-making. Our multiphase research will yield opportunities to better inform Veterans' healthcare decisions to help them access the services they need and deserve.

References

1. Kullgren JT, Fagerlin A, Kerr EA. "Completing the MISSION: a Blueprint for Helping Veterans Make the Most of New Choices," *Journal of General Internal Medicine* 2020; 35(5):1567-70.

2. West AN, Charlton ME, Vaughan-Sarrazin M. "Dual Use of VA and non-VA Hospitals by Veterans with Multiple Hospitalizations," *BMC Health Services Research* 2015; 15(1):431.

3. The Veterans Community Care Program: Background and Early Effects | Congressional Budget Office. Published October 26, 2021. Accessed October 24, 2022. https://www.cbo.gov/publication/57583

Innovation Update

Development of a New Measure to Assess the Adequacy of VA Outpatient Provider Options

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Delivering timely, accessible, high-quality healthcare to Veterans is a top VA priority, reiterated in VA's Fiscal Year 2022-2028 Strategic Plan. Consistent with this goal, Veterans have the choice of receiving care from outpatient provider options at over 900 VA facilities nation-wide. Eligible Veterans also have the choice of care options available through the Veterans Community Care Program (VCCP).

To date, the adequacy of provider options available to Veterans has been captured using objective measures such as appointment wait times and driving distance. However, these measures, when used to inform decision-making, are frequently considered in isolation and ignore other factors that influence Veterans' desired choice of provider. For example, Fortney et al. (2011) demonstrate that provider access is determined by a wider set of considerations, including financial, cultural, and digital.[1] This prior research also points to the importance of how dimensions of access are perceived in Veterans' choice of provider. Additionally, theory indicates that the attributes of providers such as gender concordance and clinical quality influence provider selection.

Research currently being conducted as part of a VA HSR&D merit award study titled "Measuring the Value of Improving Access to Community Care" seeks to address existing limitations in the measurement of access to VA provider options. Within this project, our study team at the Seattle-Denver Center of Innovation is developing econometric methods that measure the value of access to outpatient provider options within VA and through VCCP from the perspective of Veterans. These econometric methods measure Veterans' revealed preferences for provider attributes (e.g., travel time, wait time, gender concordance, clinical quality) and use VA administrative data to observe the tradeoffs that Veterans make when choosing providers. By understanding tradeoffs between indirect costs (e.g., travel costs, opportunity costs of time) and other provider attributes, our econometric models estimate an overall monetary value that Veterans derive from the provider options available in their local market area. The advantage of the proposed methods is the ability to measure Veterans' perceived value simultaneously across multiple provider attributes into a single, easily interpretable, composite access measure. Early results from this study were presented at the 2022 AcademyHealth Annual Research Meeting in Washington, DC.

The new approach to measuring access to provider options in this study will yield insights in at least two areas. First, model estimates will identify how much weight is placed on different provider attributes inherent in Veterans' choice of provider and will describe differences in these preference weights by geographical region. Second, products from this study represent a potential approach for VA and non-VA stakeholders to compare the desirability of provider options to an enrollee population, which can inform areas where provider networks are potentially inadequate and require more options. For VA, this may include greater use of community providers through VCCP. To enable this, simulation models are currently being developed to allow stakeholders the ability to examine access under "what-if" scenarios, such as the addition of providers with specific attributes in user specified locations.

Reference

1. Fortney JC, Burgess JF, Jr., Bosworth HB, Booth BM, Kaboli PJ. "A Re-conceptualization of Access for 21st Century Healthcare," *Journal of General Internal Medicine* 2011; 26 Suppl 2:639-64.

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In another analysis of the MISSION Act urgent care benefit, the ACE team found the following:[3]

- From June 2019 to February 2020, 138,305 Veterans made 175,821 community UC visits, costing VA $23,273,792.
- The program's reach increased over time but only 2 percent of potentially eligible Veterans utilized the UC benefit during this period.
- Being younger, female, and living farther from a VA ED/UC center was associated with greater UC benefit use.
- Upper respiratory infections were the most common reason for community UC use.

Future work by the ACE team will examine predictors of VA and CC ED use, and factors that can help identify differences in the quality of ED care received by Veterans in the community versus VA.

Accessing emergency care is challenging for Veterans who use VA for healthcare, in part because the VA ED footprint is limited. As an increasing number of Veterans are treated in community EDs, it is vitally important that we better understand the access, quality, safety, and cost implications associated with this shift. The confluence of operational partner needs and HSR&D priorities makes this an ideal time for interested VA researchers to engage in this high priority area.

*ACE Team: Anita Vashi MD, MPH, MHS; Tracy Urech, MPH; Diem Tran, PhD; Liam Rose, PhD; Andrea Nevedal, PhD; Steven Asch MD, MPH; Todd Wagner, PhD; Derek Boothroyd, PhD; Aaron Dalton, MA, MSW; Winnie Wu, MPH; Lena Schoemaker, MS

References

1. Department of Veterans Affairs. Veterans Health Administration. Care Optimization in the Emergency Department (CO-ED) Guidebook. February 2022.
2. Nevedal AL, et al. "Veterans' Experiences with Accessing Community Emergency Care," *Military Medicine* 2021 May 24: online ahead of print.
3. Vashi AA, Urech T, Wu S, et al. "Community Urgent Care Use Following Implementation of the Veterans Affairs Maintaining Internal Systems and Strengthening Integrated Outside Networks Act," *Medical Care* 2021; 59(6 Suppl 3):S314-21.

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and Medicare providers are generally one and the same. The same is also true for providers that accept TRICARE and private insurance. Thus, an important open question remains: to what degree have the expansions in community care increased access to care for VA enrollees, rather than simply providing a new option for paying for the same care?

As researchers, we still have a long way to go to answer this puzzle. Many studies limit their cohort to Veterans dually enrolled in VA and traditional Medicare, because VA's data partnership with CMS allows researchers to capture patient utilization more fully. But Medicare Advantage is fast approaching 50 percent of all Medicare enrollment, and data delays and limitations have hindered examinations of this population. Moreover, such study cohorts ignore the use of TRICARE and employer-provided insurance, both of which are common among Veterans under 65. As community care becomes an increasing part of the VA landscape, it is crucial that researchers continue to find ways to examine the full set of choices Veterans face when deciding where to receive care.

References

1. Rose L, Tran LD, Asch SM, Vashi A. "Assessment of Changes in US Veterans Health Administration Care Delivery Methods During the COVID-19 Pandemic," *JAMA Network Open* 2021; 4(10):e2129139.
2. Rose L, et al. "Association of Expanded Health Care Networks with Utilization Among Veterans Affairs Enrollees," *JAMA Network Open* 2021; 4(10):e2131141.
3. Graham LA, et al. "Expansion of the Veterans Health Administration Network and Surgical Outcomes," *JAMA Surgery* 2022 Dec 1;157(12):1115-1123.
4. Yoon J, Kizer KW, Ong MK, et al. "Health Care Access Expansions and Use of Veterans Affairs and Other Hospitals by Veterans," *JAMA Health Forum* 2022; 3(6):e221409.

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