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PART I
Introduction and Methods

This report is divided into three main parts. Each part is composed of several sections, which together address a common topic.

Broadly, this report summarizes the findings of a congressionally mandated study of U.S. Department of Veterans Affairs (VA) purchased care, responding specifically to three basic questions posed by Congress:

- What authorities and mechanisms does VA have to purchase care?
- Does VA have the appropriate authorities and mechanisms to purchase care?
- Should VA have the authority to purchase care through the completion of episodes of care?

In answering these research questions, we undertook an extensive investigation of VA's current authorities and mechanisms for purchasing care, as well as of potential changes and alternative models that stakeholders and policy-makers might consider in the future. Parts II and III of this report deal with the current landscape and future possibilities for VA purchased care, respectively.

Part I of this report offers an introduction to our assessment task and to our methods of research and analysis in carrying out this study. We provide here an overview of the broader context of our research and mandate, including how purchased care fits into the larger health care mission, organization, and recent history of VA. We also discuss the message, audience, and purpose of this report.

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CHAPTER ONE

Introduction

One of VA's core functions involves providing health care services to eligible Veterans. Although VA has traditionally carried out this role primarily by operating a national network of hospitals and other facilities, the agency also administers a purchased care function, through which it pays for health care services from outside providers. VA purchased care evolved primarily to address situations in which VA's direct-care resources were unable to offer needed services. Although purchased care has accounted for only a small fraction of VA's health care budget over the past decade, that fraction is growing. In the wake of the recent crisis in access to care at VA facilities, stakeholders and policy-makers are now revisiting the role and performance of VA purchased care. Specifically, they are considering whether modifications to VA's purchased care approach might be desirable, given broader goals of expanding access to care, enhancing trusted partnerships, and improving VA operations to deliver seamless and integrated support.

The Veterans Access, Choice, and Accountability Act of 2014 (Veterans Choice Act) and the assessment mandate for this report were passed into law in the summer of 2014. According to some commentators, the act was a congressional response to misconduct and mismanagement in the VA health care system, in which delayed access to services was allegedly associated with the deaths of dozens of Veterans and falsified wait-time data collected at the VA medical center (VAMC) in Phoenix, Arizona.

The access crisis in Phoenix and other parts of the country led Congress to require a series of corrective actions under the Veterans Choice Act. Perhaps most notably, the legislation established the new Choice program, an initiative to increase access to purchased care for eligible Veterans who met new enrollment, wait-time, and driving-distance criteria. Another major provision of the Veterans Choice Act served to reorganize payment authority and budgeting for purchased care, shifting responsibility from VAMCs to the Veterans Health Administration's (VHA's) Chief Business Office. Both measures under the act reflect policy-makers' view of purchased care as an important tool for ensuring comprehensive access to medical services by Veterans.

1.1. Objective of This Report

Pursuant to Section 201(a)(1)(C) of the Veterans Choice Act, Congress mandated an independent assessment of VA specifically to address "[t]he authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities, including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care."

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The first clause of the assessment mandate broadly addresses the legal and policy contours under which VA is empowered to provide health care services at non-VA facilities. We interpreted the phrase *health care at non-Department facilities* as synonymous with *purchased care*—or actions taken by VA to pay for outside medical services for Veteran beneficiaries, rather than providing service directly through VA-employed or VA-contracted providers and at VA-owned or VA-contracted facilities.[1] Although the language of the Veterans Choice Act mandate could be interpreted more broadly to encompass other aspects of VA practice related to the delivery of health care services, such as facility leasing, the primary focus of this assessment is on purchasing health care for Veterans from non-VA sources and on the authorities and mechanisms that support this practice.

The second clause of the assessment mandate asks whether the VA Secretary should have the authority to furnish health care services at non-VA facilities through the completion of *episodes of care*. At present, VA has established a patchwork of policies, programs, and mechanisms to furnish health care at non-VA facilities. Thus, for this assessment, we were asked to assess the various elements of the purchased care system and to envision what the array of laws, programs, and policies might look like in the future. The language of the Veterans Choice Act mandate asks a forward-looking, normative question about VA authority and implicitly invites comment on an array of potential policy changes to the VA purchased care landscape. The mandate also invites specific comment on episodes of care and their relationship to other aspects of VA authority and purchased care in practice.

One additional aspect of the assessment mandate deserves particular note: the focus on authorities and mechanisms. We interpreted *authorities* to refer to the statutory and regulatory framework that empowers VA to purchase care, while we interpreted *mechanisms* to refer to uncodified VA policies and to the actual practice by which VA carries out its purchased care activity. In essence, the mandate involved addressing several basic research questions about purchased care:

1. What authorities and mechanisms does VA have to purchase care?
2. Does the Secretary have the appropriate authorities and mechanisms to purchase care?
3. Should the Secretary have the authority to purchase care through the completion of episodes of care?

1.2. Historical Evolution of VA Purchased Care

The landscape of VA purchased care authorities is complex, largely because the act of purchasing medical services is inherently complicated. Purchasing care minimally involves screening Veterans to determine when outside referrals for services may be appropriate, initiating those referrals, and establishing contractual relationships with outside providers. It also involves defining the scope of authorization for outside care in specific situations, monitoring the services provided, sharing records appropriately and coordinating care with non-VA providers,

[1] Note that *purchased care*, as we define it here, may also include actions taken by VA to obtain services from outside care providers at non-VA facilities without directly paying for them, as through strategic resource-sharing arrangements between VA and the U.S. Department of Defense (DoD). With this being said, much of our focus is specifically on VA's role and authority as a payer for outside services. Hence, we use *purchased care* as an umbrella term in describing the scope of this assessment.

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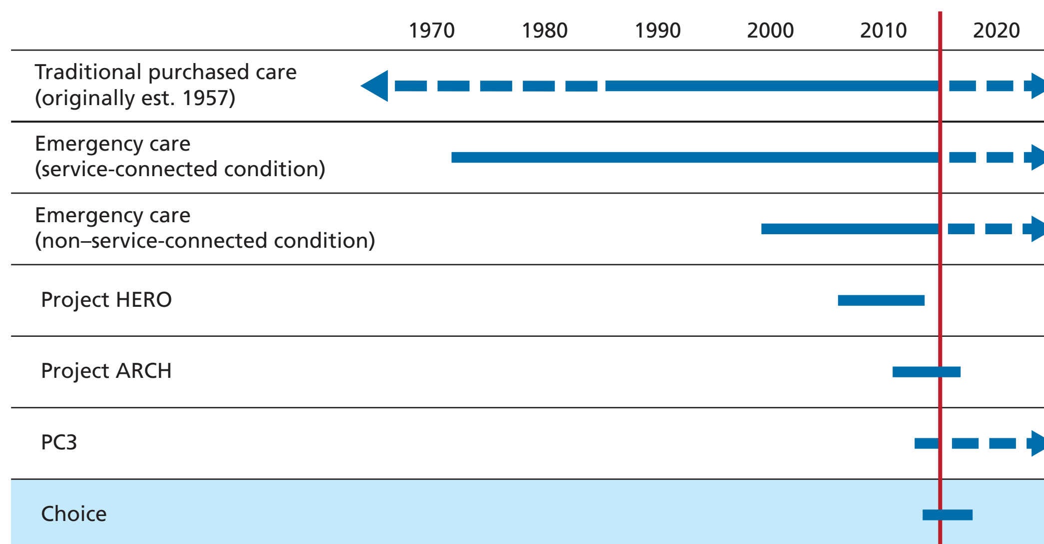
and paying claims for outside services. VA purchased care does not involve just a single function and mechanism, but rather a whole series of interlocking ones. For the system to operate effectively, all the parts must work together efficiently and consistently.

As shown in Figure 1-1, VA has had the core statutory authority to purchase care for decades. We characterize this authority, originally established by what is currently 38 U.S.C. 1703 and programs enacted thereunder, as *traditional purchased care*. Over the years, VA has purchased inpatient and outpatient services through a mix of individual authorizations and contracts with outside providers at external facilities. As with health care services provided through VA directly, purchased care has evolved to cover both service-connected conditions and non–service-connected conditions. There was a similar expansion in coverage with regard to the purchase of or reimbursement for emergency care services. In part as a response to the recent conflicts in Iraq and Afghanistan, VA has been compelled to apply and refine its purchased care tools to meet increased demand. For example, in 2001, Project HERO (Healthcare Effectiveness Through Resource Optimization) was instituted as a pilot program designed to enhance the coordination of care delivered by both VA and external providers. Project ARCH (Access Received Closer to Home) was originally fielded as a pilot program to increase the coordination and cost-effectiveness of care provided to rural Veterans, and the pilot was continued under the Veterans Choice Act. PC3 (Patient-Centered Community Care, sometimes referred to as PCCC) was subsequently created to further expand access and was based on lessons learned from the prior pilot programs.

Each of the multiple VA purchased care programs and initiatives that exist today has different criteria for Veteran and provider eligibility, different guidelines for VA discretion to

Figure 1-1
Timeline of VA Purchased Care Mechanism Development



NOTES: Dashed arrows indicate mechanisms established prior to the start of the figure's timeline or anticipated to continue indefinitely. The vertical red line indicates when this analysis took place (2015).
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furnish care,[2] and different rules governing payment. Table 1-1 compares four primary mechanisms involved in providing purchased care.

Unsurprisingly, the multiplicity of mechanisms and programs in purchased care has sometimes created confusion and inefficiency. Although a single purchased care provider might deliver care through more than one of these mechanisms, the corresponding reimbursement rates, requirements for record sharing, and other conditions of participation vary by mechanism.

Individual Veterans may be eligible to receive purchased care through multiple mechanisms. For Veterans and VA staff, determining the appropriate route to access purchased care is sometimes difficult. Referring VAMCs must select from among these options according to one or more goals, including optimizing ease of access, lowering costs, leveraging preexisting contractual relationships with providers, and optimizing Veteran choice.

As of this writing (in summer 2015), about 10 percent of VA's annual health care budget went to purchased care. VHA's Chief Business Office estimated that purchased care costs in fiscal year (FY) 2014 totaled $5.6 billion, after steady and significant increases year after year (Figure 1-2; VA, 2014c). Other VA sources have provided different estimates of purchased care expenditures during this time frame, with VA Deputy Secretary Sloan Gibson testifying before the Senate Veterans' Affairs Committee on May 12, 2015, that VA had spent more than $8.5 billion on purchased care in FY 2014 (Exploring the Implementation and Future of the Veterans Choice Program, 2015). The difference in these estimates is likely because Deputy Secretary Gibson included Civilian Health and Medical Program of Veterans Affairs (CHAMPVA) costs in his totals. Using another metric of purchased care utilization, Deputy Secretary Gibson noted that Veterans completed 55.04 million appointments at VA facili-

Table 1-1
VA Purchased Care Rules for Eligibility, VA Discretion, Providers, and Payment

Feature	Traditional VA Purchased Care	ARCH	PC3	Choice
Eligibility	VA not able to furnish necessary care (per 38 U.S.C. 1703)	Driving time to VA facilities (pilot sites only)	VA not able to furnish necessary care	Wait time, geographic distance to VA facilities
Does corresponding authority *permit* or *compel* VA to furnish care at non-VA facilities?	"may"	"shall"	"may"	"shall"
Providers	Contract/ agreement	Network	Network	Medicare-eligible[a]
Typical reimbursement rate	VA fee schedule, Medicare rate, or contracted rate	% of or full Medicare rate	% of Medicare rate	% of Medicare rate

[a] Health care providers from DoD, the Indian Health Service (IHS), and federally qualified health centers (FQHCs) would also be qualified under Choice.

[2] Some VA authorities specify that VA *shall* furnish care, while others specify that VA *may* furnish care. In this context, *shall* represents VA authority and a congressional mandate to provide or pay for the care required, as long as the eligibility criteria are met. *May* implies greater discretion on VA's part, in that VA has the authority to furnish the necessary care but not a specific mandate to do so.

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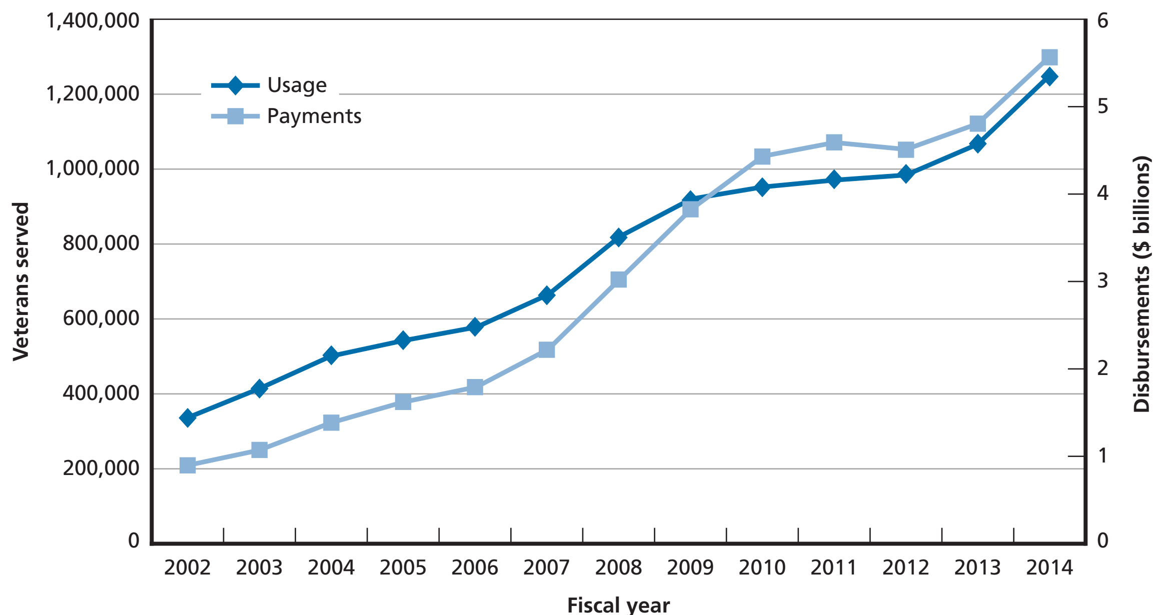
Figure 1-2
Growth in VA Purchased Care, FYs 2002–2014



SOURCE: Data obtained through a request to the VHA Chief Business Office, May 12, 2015, and originally derived from VA Central Office fee payment files.
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ties and 16.2 million appointments in the community (through purchased care) in FY 2014 (Exploring the Implementation and Future of the Veterans Choice Program, 2015).

Rising expenditures over the past decade reflect only one of the ways in which purchased care has evolved. The research for this assessment began in November 2014. Since that time, there have been major changes to VA's authorities and mechanisms for purchasing care. For example, as required by the Veterans Choice Act, VA mailed "Choice Cards" to Veterans to seek care in the community, reorganized the VHA Chief Business Office, and consolidated the purchased care budget. In addition, in April 2015, VA promulgated a revised regulation that changed its interpretation of the access standard used to determine Veterans' eligibility for the Choice program from a geodesic line to driving distance using the fastest route (VA, 2015d).[3] This roughly doubled the number of Veterans eligible to receive care in the community under the Choice program (Exploring the Implementation and Future of the Veterans Choice Program, 2015).

This assessment represents the status of VA purchased care as of early in 2015. There were many changes to the purchased care landscape that were implemented, planned, or proposed while we were writing this report. The changes to the Veterans Choice Act mentioned above were just a few examples. Throughout this report, we have attempted to incorporate and address the most recent developments in purchased care authority and mechanisms as of May 2015.

[3] We discuss this change in more detail in Chapter Three of this report.

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1.3. Overview of VA Purchased Care Funding

Beyond the programs and mechanisms of VA purchased care, it is also helpful to recognize that purchased care is bounded by some basic features of VA's structure as an agency. Perhaps most important, VA health benefits are notably *not* a legal entitlement or a benefit to which Veterans are automatically entitled and for which the government must pay. Rather, Veterans may obtain VA health care services according to a priority scheme for eligibility established by Congress.[4] In addition, VA's capacity to provide health care benefits is limited by its annual appropriations allocated by Congress.[5] As such, VA's health care mission involves not only providing health care services with "integrity, commitment, advocacy, respect, and excellence"[6] but also doing so while simultaneously keeping expenditures under a restrictive resource ceiling.

This basic funding reality for VA's health care operations is central to understanding purchased care. One historical implication is that dollars spent on purchased care by local VA facilities have sometimes been viewed as a direct offset to funding available for other local health care purposes. From this perspective, purchased care may sometimes involve a resourcing trade-off against strengthening the capacity of VA's own provider facilities. While this is beyond the focus of this report to address in depth,[7] for stakeholders concerned with VA health care more broadly, the potential for a resourcing trade-off between VA direct care and purchased care is an important consideration for the future.

Another implication of VA's funding constraint is that some of the basic features of purchased care are implicitly tied to limiting spending. Such features include eligibility and authorization requirements for purchased care, Veteran copays, requirements for outside provider reimbursement rates, and restrictions on who can participate as an outside provider.[8] Collectively, these have the effect of giving VA more control and influence in restricting purchased care expenditures. Achieving an optimal balance between access and quality on one hand and cost control on the other presents a fundamental challenge for VA in purchased care.

The discretion to purchase care has traditionally resided with VA rather than Veterans. This has changed somewhat under the new Choice program, which confers more power on eligible Veterans to elect to pursue purchased care, as well as a direct mandate for VA to pay for that care when wait-time or driving-distance criteria are met. Together, these features of the Choice program are likely to enhance access, but with the implicit trade-off of reducing VA control over related expenditures.[9] Here again, purchased care involves striking a balance between the competing aims of enhancing Veteran choice and access and containing related costs.

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[4] We describe the priority scheme for enrollment for health care benefits in Appendix E of this report.

[5] As we discuss in Chapter Three, funding for purchased care in particular shifted somewhat with the Veterans Choice Act, which established a specific reserve of $10 billion to cover costs associated with the Choice program established by the act.

[6] These are the five core values articulated by VA as an implicit part of its mission statement (VA, 2014b).

[7] Note that a separately mandated assessment under the Veterans Choice Act addressed issues of VA health care capacity and focuses more directly on this particular issue (see RAND Health, 2015b).

[8] We discuss these features in more detail in Chapters Three, Four, and Seven of this report.

[9] Regarding the latter point, it is noteworthy that the Veterans Choice Act established a $10 billion funding pool for benefits under the Choice program. Thus, although the congressional mandate for Choice program benefits has the effect of reducing VA's control over costs, the budget mechanism and additional resourcing serve to balance that.

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All of these considerations spotlight the importance of VA's funding context in shaping the operation of purchased care. Purchased care fulfills a limited function within VA's health care mission, and it does so primarily through discretionary funding from Congress. Recent changes to purchased care under the Veterans Choice Act invite some reflection on this context and on how changes to the context might influence the balance between access, choice, and cost containment in the future.

1.4. Scope of This Report

The contents of this report adhere closely to the assessment mandate posed by Congress in Section 201(a)(1)(C) of the Veterans Choice Act. To address components of that mandate, we undertook a broad investigation of VA purchased care authorities, policies, and mechanisms.

Authorities and *mechanisms* are terms drawn directly from the assessment mandate in Section 201(a)(1)(C) of the Veterans Choice Act. We interpreted each of these terms in accordance with its plain meaning and in view of the act's objectives. Here again, *authorities* refers broadly to federal law, the powers and responsibilities delegated by Congress to the Secretary, and formal rule-making undertaken by the Secretary, consistent therewith. *Mechanisms*, by contrast, is a less formal term. We construed mechanisms to include (uncodified) VA programs and initiatives, VA guidance documents and policies, and VA operating practices for furnishing purchased care. Generally speaking, mechanisms are not formally codified by law and regulation, but they nevertheless reflect VA practice and VA's efforts to furnish purchased care consistent with the framework established by formal authorities. Both concepts are central to understanding the landscape of VA purchased care.

Although we describe laws and regulations pertaining to VA purchased care in detail in Chapters Three and Four of this report, it is important to emphasize that this report is not intended to offer an academic review of the law or a legal treatise.[10] Rather, this report was written for a broader policy audience (including Congress and VA, as well as other interested stakeholder groups) and in direct response to the assessment mandate in Section 201(a)(1)(C) of the Veterans Choice Act. VA purchased care is a complicated topic, and a discussion of the statutory and policy issues surrounding VA purchased care requires an understanding of the legal framework that defines it. However, the law also reflects an underlying set of policy objectives and economic relationships that are the substance of purchased care, both as it exists today and as policy-makers might choose to refashion it in the future. This report aims to speak to this broader policy context, not just the legal aspects of it.

It is equally important to highlight what is beyond the scope of this report. As we noted earlier, the assessment mandate of Section 201(a)(1)(C) refers to the phrase "care at non-Department facilities." For the purposes of this report, we interpret this phrase as being largely synonymous with purchased care. However, the same phrase could be interpreted in other

[10] It is also important to emphasize that this report does not offer formal legal advice to VA or to Congress. Formal legal advice can only be given by licensed attorneys operating within the scope of their professional practice in response to legal consultation sought by a client. The RAND Corporation is not a law firm and is unable to give formal legal advice. If the sponsors of this report would like to receive legal advice, they would need to consult internally with their own counsels or seek assistance from an independent law firm.

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ways. VA facility leasing, for example, involves "care at non-Department facilities."[11] Likewise, it could also include VA's relationship with DoD to provide health care services to Veterans. Although we do touch on the latter topic in some parts of this report, we do not address it at length. VA and DoD have a unique, long-standing collaborative relationship that has been the subject of intense scrutiny and comment elsewhere (see, for example, Military Compensation and Retirement Modernization Commission, 2015).

More generally, VA purchased care authorities and policy are closely tied to many other aspects of VA's health care mission, structure, and operations. For example, the types of health care services purchased by VA are implicitly determined by the contours of the agency's health care benefit, since the latter defines the services that Veterans may be eligible to receive. Likewise, Veterans' ability to obtain purchased care services is contingent on initial eligibility to receive VHA benefits. Other examples of collateral features that have some relevance to purchased care include the anatomy of VA's national infrastructure of health care facilities, the structural and command relationship between VA's local facilities and its regional and national administrative offices, and the composition and evolution of VA's internal provider capabilities. We do not address these ancillary aspects of VA in much detail in this report, though they do shape the VA purchased care landscape in various ways. Some of these topics were addressed by other mandated assessments under the Veterans Choice Act.

One additional scoping note deserves particular mention here. Veterans' eligibility for health benefits, broadly construed, is outside the scope of this report to address. However, VA's purchased care authority does involve an important interaction with Veteran eligibility: the Secretary's discretion to purchase services when VA facilities are unable to provide those services directly versus the Secretary's obligation to provide care to specific categories of Veterans as designated by statute.[12] In Chapter Three of this report, we discuss the tension between these two basic authority provisions and the implications for actual practice in VA purchased care.

1.5. Organization of This Report

This report is organized into three parts. Part I includes this introductory chapter and an overview of our study methods (Chapter Two). Part II focuses broadly on authorities and mechanisms for VA purchased care and includes sections on these authorities and mechanisms prior to and since the passage of the Veterans Choice Act (Chapter Three) and in practice (Chapter Four), along with a discussion of procurement and episodes of care (Chapter Five) to help frame a strategy for VA purchased care going forward. The report concludes with Part III, which examines potential reforms to VA purchased care practice (Chapter Six) and alternative government payer models (Chapter Seven); it also presents our overall conclusions and recommendations (Chapter Eight). This report includes five technical appendixes providing additional background and detail on rates of VA purchased care utilization and authorizations (Appendix A); statutory and regulatory authorities for the provision of VA purchased care (Appendix B); characteristics of the policy documents received through our request for data on VA purchased care in practice at the local level (Appendix C); pertinent questions included

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[11] VA facility leasing is a focus of other assessment mandates in the Veterans Choice Act in Section 201(a)(1)(K) and (a)(2)(B) (see McKinsey, 2015b, and RAND Health, 2015b).

[12] We refer here to 38 U.S.C. 1703 and 1710, respectively. See the discussion in Chapter Three of this report.

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in the 2015 Survey of VA Capabilities and Resources that was fielded to all VAMCs, as well as data on responses to those questions (Appendix D); and information on VA health benefits and priority groups, to provide a fuller picture of the context in which VA purchased care mechanisms operate (Appendix E).

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