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January 2017

IDA Document NS D-8235
Log: H 16-001181

INSTITUTE FOR DEFENSE ANALYSES
4850 Mark Center Drive
Alexandria, Virginia 22311-1882

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About This Publication
This work was conducted under the Institute for Defense Analyses (IDA) independent research program (C7156), "CRP Purch Priv Sec Care." The views, opinions, and findings should not be construed as representing the official position of either the Department of Defense or the sponsoring organization.

Acknowledgments
Thank you to Matthew S. Goldberg and Stanley A. Horowitz of IDA for performing technical review of this document.

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The Department of Veterans Affairs (VA) operates one of the largest healthcare delivery systems in the world. Organized around a large network of VA hospitals and clinics, the VA system relies almost exclusively on care it produces itself. A variety of factors, however, have placed the VA at the beginning of what will likely be a long-term fundamental transformation of its delivery structure away from its "brick-and-mortar" foundation towards a system that is more integrated with (and reliant upon) community-based—i.e., private sector—healthcare. Although there are many differences, the changes beginning to occur in the VA healthcare system share similarities with the transformation the Department of Defense (DoD) healthcare system undertook in the 1990s. This paper draws on the DoD experience to provide a set of principles that should guide the VA in its transformation. The paper further provides a range of options that the VA could consider that are informed by lessons from DoD (and other large federal programs purchasing healthcare).[1] DoD did many things well in its transition, but several large decisions that seemed appropriate to DoD at the time have ultimately caused significant challenges that DoD is now struggling to fix. By learning from and avoiding these pitfalls now, the VA's transformation offers a powerful opportunity to improve access and health outcomes for veterans while controlling cost.

A. History of TRICARE

In the late 1980s, as the Cold War was ending, the DoD healthcare system had 120 military hospitals and 250,000 medical personnel providing the majority of its beneficiary healthcare in-house—making it similar in size and organization to the current VA system. Its limited method of purchasing community-based care, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), was primarily for recruiters and others located far from military hospitals. By the 1990s, as large-scale post-Cold War rationalization of DoD infrastructure began, it had become clear that DoD healthcare was going to have to shift to a more integrated system with greater reliance on community-based care. The dominant method for purchasing care in the private sector at the time was

[1] This paper is focused on the purchase of community care and does not address other areas of lessons learned available from DoD, such as infrastructure planning and graduate medical education programs in an integrated system.

fee-for-service (FFS), in which doctors and other healthcare providers are paid for each service or procedure performed. FFS purchasing was also a simple approach for a system focused on purchasing wraparound or overflow care to augment its in-house facilities in the select markets and situations where it could not deliver all care itself. In this environment, the limited CHAMPUS system was transformed into the much larger TRICARE system, which today comprises three geographic regions (being reduced to two) that purchase community care through pass-through (e.g., no risk transfer) five-year FFS contracts, one per region. The initial contracts (T1, in DoD vernacular) were based on the FFS method of purchasing care, but also had a range of provisions that allowed alternatives (to FFS) for purchasing care, risk sharing between the government and the regional contractor, and contractor provision of ancillary services such as augmenting staff in military hospitals.

With two decades of experience (DoD is now completing its third round of contracts, called T3, and the next generation (T4) contracts have been awarded), the DoD transformation can teach us a great deal. Two particular trends are important to highlight for the purposes of informing the VA's transformation. The first is the movement away from FFS purchasing of healthcare in both the private and public sectors. The primary alternative to FFS when TRICARE was established was the staff model health maintenance organization (HMO). The two methods formed opposing poles, with various private sector insurers and other market participants ranging along the continuum between these poles. Modern healthcare no longer fits into this framework. There are few market participants at these poles and the continuum between them has been replaced by intense competition in a wide-ranging space of alternative value-based purchasing methods, including capitation, bundling, accountable care organizations, and many others. The healthcare sector discovered that the FFS model without risk bearing provided poor (and sometimes perverse) incentives for utilization management, care coordination, and promotion of health outcomes—in short, it was not a sustainable business model. In the public sector, the traditional FFS Medicare program (of which TRICARE is a variant) has already seen one-third of beneficiaries migrate to Medicare Advantage (which uses risk-based plans) and the Administration has set targets to have 50 percent of the FFS Medicare payments made through alternative (non-FFS) methods by 2018. The second important trend is that, although TRICARE started out with contracts that promoted a broader focus than just pass-through FFS purchasing of healthcare, over three generations of contracts, TRICARE devolved to just that. While the healthcare sector in general is moving away from the pass-through FFS model, TRICARE has narrowed to little else.

B. Lessons from TRICARE

The DoD experience identifies key principles that should guide VA decision makers as they transform the VA healthcare system over the coming years.

- **Pass-through FFS contracting for community-based care may be useful in select markets, but should not be the foundation for the new VA system**. In the select markets where robust VA capacity will continue to exist for an extended period of time and need for community-based care is limited to intermittent overflow demand for individual procedures, the TRICARE model may make sense. It may even be best for the VA to simply use the existing TRICARE contracts in these individual markets, and leveraging these contracts may be an efficient way for the VA to buy time as it fully develops its way forward. But the TRICARE experience over the last 20 years reveals that this should not be the foundation for the VA's new system or the VA will be setting itself up for the same challenges that DoD is now facing and will leave the VA fundamentally out of step with an ever-advancing healthcare sector. What made sense for DoD when most care was produced in military facilities and contracting was used for low levels of overflow care has become a poorly performing (limited access, high utilization and cost) system that is extremely challenging to reform. Avoiding this pathway now will be much easier than trying to transition away from it a decade from now, as DoD is currently facing.
- **Contracting for community-based care should, instead, be founded on purchasing a benefit for an individual with a risk-bearing contract**. A key lesson from the TRICARE experience is that the foundation for VA's transformation should not be built on the purchase of individual procedures; rather, it should be built on the purchase of a health benefit for the veteran. For individuals who are only eligible for care covering a certain condition or set of conditions, the benefit is thus defined by the set of conditions. For individuals eligible for a comprehensive benefit, this benefit would be a standard health plan or something similar. Contracting for the entire range of covered services is essential for ensuring that care is coordinated (for the covered services), utilization is managed, and health outcomes are promoted—the key outcomes of interest. In addition, the purchase of this benefit must transfer risk to the contractor. The healthcare sector is rapidly evolving, and a focus of the VA should be on the incentives being provided to the contractors to adopt and further innovate in their use of these value-based purchasing tools to promote the key outcomes of interest.
- **Cost control strategies should be based on total cost, not procedure costs**. One unfortunate impact of pass-through FFS contracting is that it focuses attention on per procedure costs while distracting attention from, and providing

few tools to manage, utilization and total cost. DoD's system is anchored in its use of Medicare reimbursement rates for procedures, and TRICARE often contracts for procedures at 20 percent or more below commercial rates. This has become an overriding focus in DoD and a primary measure by which reform alternatives are evaluated (e.g., a key evaluation criterion is often whether it raises per procedure rates). FFS models, however, incentivize increased utilization that may not be clinically necessary, and in DoD, utilization rates are 30–40 percent higher than demographically similar comparison groups. Despite paying less per procedure, DoD pays more per beneficiary.

The commercial healthcare sector is focused on total cost and the value received for the amount paid. To take a common example, a particular market may have several orthopedic surgeons performing total knee replacements. The best surgeons may charge higher rates for the surgery (there is higher demand for their services) but may also have lower costs for the entire episode of care (driven by lower failure rates, quicker healing rates, shorter physical therapy requirements, etc.). Private insurers will observe this difference and be willing to pay the higher surgical rate, incentivizing their patients to use the more expensive surgeons. This cannot be done in the TRICARE system; regardless of health outcomes and total cost, the surgeons with the lowest per procedure cost will be the only ones allowed. The focus on procedure rates drives other perverse results as well, e.g., narrow networks and poor access, and the VA will be more successful if it begins with and remains focused on the outcomes that matter.

- **"Winner-take-all" contracting should be avoided**. TRICARE uses winner-take-all (one successful contractor per region) five-year (often extended) contracts. The process by which TRICARE's contracts are awarded is complicated, prolonged, and characterized by protests and delays, increasing TRICARE's costs. More importantly, the lack of competition and the multi-year duration of contracts limits TRICARE's ability to innovate and keep pace with healthcare trends and advances. Most other public sector healthcare programs use competitive, annual (sometimes known as evergreen) contracts, e.g., Medicare Part C, Medicare Part D, and the Federal Employees Health Benefit Program (FEHBP). Large, multi-year, winner-take-all contracts can appear simple at first and may be attractive for this reason, but TRICARE experience demonstrates otherwise. Auctioning off extended (geographically and temporally) monopoly rights is not best practice in markets with well-defined and broadly traded commercial products. The VA should avoid TRICARE's contracting strategy and look to other federal programs for examples of how to successfully contract for community-based healthcare.

As the veteran population continues to change in size and location, and challenges with access remain, the pressure on the VA to modernize and transform its delivery system will grow. This transformation offers the VA an important opportunity to adopt best practices from the healthcare sector, improving access and health outcomes while controlling cost. Although the reasons and many of the details were different, DoD's transition in the 1990s was similar. DoD did many things well in that transition, but also made some key decisions about its approach that have not turned out well over time, leaving DoD with difficult challenges (limited access, high utilization and cost). The VA has the opportunity to learn from that transition to inform its decisions in this critical period, and provide for better outcomes on access and cost than DoD has achieved.

C. The VA Purchased Care System

The current VA purchased care system is primarily composed of the Patient-Centered Community Care (PC3) and the Veterans Choice program. Both programs were recently designed to be intermediate solutions to purchased care reform. Their similarities to the current TRICARE program make them similarly flawed as a long-term solution.

The VA rolled out the PC3 contracts in 2013. PC3 is a nationwide program by which veterans receive medical care outside the VA through a contractor's network of providers. The PC3 contracts are similar to the T4 TRICARE contracts. Both PC3 and T4 divide the United States into East and West regions and implement FFS contracts with a single carrier in each region. Both sets of contracts have an expected term of five years, comprising a year-long base period and four option years.

The Veterans Choice program began in 2014 as a result of the Veterans Choice Act. The two PC3 carriers are responsible for administering the Choice program in their respective regions. To join either the PC3 or the Choice program, the provider must contract with the sole carrier in their region. Thus, providers in the Choice program effectively form extensions of the PC3 networks. The contracts provide five-year regional monopolies on VA purchased care. This type of system may be appropriate as a short-term, low-usage solution, but as a major method of care provision, it leads to inflated costs and underserved beneficiaries. Observations of TRICARE over the past two decades provide direct evidence of this effect.

D. The Fundamental Problems

Basic economic principles help to explain the flaws in the designs of TRICARE, PC3, and the Choice program. In economics, the relationship between a government payer such as the VA and a healthcare contractor is called a principal-agent relationship. The VA is the principal who has contracted with an agent to produce a service (healthcare delivery, in this case). A challenge that arises in this situation is that the agent makes decisions (e.g., about how much costly effort to exert managing utilization of

beneficiaries), but does not experience the full consequences of the decisions (e.g., not receiving the cost savings that result from better utilization management). In other words, the agent may lack incentives to behave in a way that is optimal from the perspective of the principal.

For example, contractors decide whether to invest in activities that would reduce the likelihood of costly healthcare procedures. One such investment may be transportation services to medical appointments, which would facilitate preventive care and monitoring, reducing the likelihood of a major medical event that requires more costly procedures. TRICARE contractors do not make this investment. While beneficiaries would enjoy greater health and DoD would pay for fewer emergencies and expensive operations, the contractor would endure the cost of providing the transportation service without receiving any of the savings. Because the agent (contractor) bears the costs but not the benefits, the service is not provided.[2]

Consider another example—how contractors value the quality of providers in the PC3 network. Providers and facilities must meet minimum standards for quality set by the VA, but otherwise are allowed to enter into a subcontract with the carrier to provide care to veterans. PC3 providers are typically reimbursed at slightly less than Medicare rates. Under the FFS design, the VA simply reimburses the carrier for these costs in turn. Care from the highest-quality providers is more valuable to veterans and therefore to the VA, but those providers can command higher reimbursement rates and will not accept rates below Medicare (as in the orthopedic surgeon example provided on page 4). The network becomes composed of providers that accept the lowest rates regardless of quality (above the minimum VA threshold) and total cost of the episode of care. Veterans who prefer higher-quality community-based care cannot get it through the VA.

One potentially intuitive solution to this principal-agent problem is to explicitly impose the optimal actions on the agent in the contract terms. But to implement this, the principal would need to measure every action of the contractor, which is costly in some contexts and impossible in others, and know what the optimal action would be in every potential situation that could arise over the course of contract execution, a completely impossible task. The principal therefore suffers some combination of measurement costs, incomplete contract terms, and suboptimal decision-making.

Consider the issue of utilization management. In the TRICARE context, the contractor has little incentive to manage beneficiary utilization of healthcare services for

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[2] This example was taken from an interview with CareMore conducted in Las Vegas, NV, about things they actually do in their Medicare Advantage plans (which, as fully risk-bearing contracts, provide incentives to undertake these activities). Another example of a costly preventive effort taken by CareMore is providing electronic scales in the homes of patients at risk for congestive heart failure. The scales automatically provide the weights to CareMore and provide early warning of sudden weight gain.

improved outcomes and cost control. All care is paid for solely by DoD, but neither DoD nor the contractor exerts substantive effort to manage that care. Beneficiaries may request services that are not worth their cost, and providers may direct distorted patterns of care because of the arbitrary fee schedule they face. Correcting these problems would require costly effort by the contractor, but the contractor has no financial incentive to make these efforts. If the contractor is not rewarded for utilization management and care coordination efforts, it will not perform these activities. Instead it will allow all care and pass the bill to DoD. In the VA context, the staff of the local VA facility is tasked with determining whether a veteran needs a particular type of care. Making these determinations requires information and effort. From an economic perspective, for the staff to make these determinations optimally would require significant knowledge of the costs and benefits of the care requested. Even if obtaining this information is possible on the part of the VA, it is costly to do so. Every time a non-VA provider believes that a veteran requires additional treatment, the provider must communicate with the contractor, who must communicate with the VA, who must clinically review and decide whether to authorize the treatment.

The challenge in this example is that the optimal decisions will only be made with a combination of incentives and information. In the principal-agent problem, the principal possesses incentives, while the agent possesses information. To achieve a successful contract result, the agent must have both the incentives and information to make optimal decisions on behalf of the principal. It is also important to note that the principal-agent problem does not end when the contract is signed. Even a hypothetically perfect contract would need to be enforced and, again, properly aligning incentives is a more effective enforcement tool than micromanaging contract execution.

E. Criteria for Successful Purchased Care Contracts

The principal-agent problem is fundamental and pervasive in its influence on contractor behavior. Every decision that the contractor makes is made in the context of incentives and information available to the contractor. Every potential contractor decision that the VA chooses to address through prescriptive contract language extends and complicates the research, negotiation, document preparation, and enforcement processes. This amounts to treating the symptoms of the principal-agent problem. A successful contract addresses the cause of the problem, which is the discrepancy in incentives between the contractor and the VA.

Through purchased care, the VA seeks to improve outcomes and access while lowering cost. A successful contract that effectively deals with the principal-agent problem makes contractors willing and able to do the same. There are three primary factors influencing this alignment of incentives between the VA and the contractor:

- **Competition** makes contractors willing to improve outcomes.

Competition refers to the extent to which contractors must deliver value to maintain their customers (or "market share"). One element of competition is the number of contractors able to provide the service at a point in time in a specific geographic market. If beneficiaries have the opportunity to choose from among multiple contractors in a market, the contractors will be more competitive than in the "winner-take-all" arrangement of PC3 and TRICARE that allows only one contractor per market.

A second element of competition is who makes the selection among the contractors. A design that allows those most affected by the outcome (i.e., beneficiaries) to select their contractor at regular increments (e.g., annual open seasons) is more competitive than one in which a central authority (i.e., the VA) selects for all beneficiaries regardless of their individual circumstances and conditions.

In a competitive healthcare market, beneficiaries reward carriers they prefer with their business. When beneficiary preferences change over time, carriers are similarly rewarded for adapting to those changes. Contractors that fail to deliver what beneficiaries want lose their customers and either adapt or are driven out of business. In this way, competitive markets are self-correcting. The VA need not prescribe beneficiary preferences in contract language or even know what those preferences are. Competition channels beneficiaries to work with the VA (promoting better quality and lower cost) instead of the VA trying to force a solution on beneficiaries.

Like TRICARE, the PC3 and Choice programs lack competition because each beneficiary is limited to a single carrier in his or her region. Competition improves outcomes because beneficiaries choose carriers according to their preferences. Under PC3 and the Choice program, beneficiaries have no such mechanism for communicating their preferences.

- **Risk bearing** makes contractors willing to lower costs.

  Risk-bearing refers to the extent to which contractor compensation depends on costs. When contractors bear risk, they are rewarded for saving the VA money with a share of the savings. This directly aligns the budgetary incentives of the principal and agent. Contractors are given an incentive to evaluate their own operations using their own proprietary and otherwise exclusive information. The VA need not prescribe in a contract what measures it believes will be cost-saving or even know what those measures are.

  The PC3 and Choice programs lack risk-bearing contracts. The VA compensates the carrier for whatever costs the carrier pays to providers. This pass-through

design eliminates the carrier's incentive to limit costs. As noted previously, the carrier also lacks an incentive to manage utilization.

Although the first TRICARE contracts included risk-bearing mechanisms whereby DoD and the contractor would split cost savings or overruns, later iterations did away with these mechanisms. This was an attempt to simplify the contract terms by limiting the contractors' duties to administrative functions and having the costs of care pass through the contractors to DoD. This has likely increased the cost of healthcare to DoD, first because the contractors paid no share of the cost, and second because the contractors spent no effort to limit it.

- **Flexibility** makes contractors able to improve outcomes and lower costs.

  Flexibility refers to the extent to which the contractor is free to design agreements with providers and other subcontractors. When contractors are free to choose how they operate, they are empowered to fully employ the information they possess in order to choose optimally. Healthcare contractors derive their value from deep, up-to-date expertise in healthcare organization and provision, including knowledge specific to individual markets and circumstances. Through contract flexibility, the VA takes full advantage of this expertise in the service of its own goals. Conversely, to constrain the contractor's options with contract language is to constrain the value of this expertise. Lack of flexibility introduces the risk that the contractor would prefer to make a choice in the best interest of veterans, but is contractually prohibited from doing so.

  PC3 contractors have a small amount of flexibility in subcontracting. They must reimburse providers at less than Medicare rates, unless the provider is in a county with fewer than seven people per square mile. Choice program providers must be reimbursed at Medicare rates. The VA allows for purchased care to cover an "episode of care" that may comprise many appointments and procedures in multiple locations. The VA retains the discretion to decide on a case-by-case basis what constitutes an episode of care. The Veterans Choice Act originally limited an episode of care to no longer than 60 days from the date of the first appointment, but this limit was later amended to one year.

The absence of any of these criteria in a new purchased care system would diminish the achievement of VA goals in healthcare provision:

- Without competition, risk bearing could incentivize lowering the quality of the health benefit offered, e.g., consider a scenario in which a lone contractor is financially rewarded for restricting access and quality. In this scenario, the contractor faces no threat of another firm entering the market that might offer superior healthcare and thus lure away beneficiaries. The contractor can then

maximize profit by specializing in low-cost, low-quality care. Beneficiaries seeking care outside VA facilities would have to settle for the only choice they have.

- Without risk bearing, competition would lead to a "medical arms race," whereby contractors spare no expense in catering to beneficiaries because all of that expense is paid by the VA. In this scenario, contractors seek to impress beneficiaries with the most extravagantly skilled and equipped providers. Contractors specialize in high-cost, high-quality care. Beneficiaries overutilize and the VA pays for it entirely.
- Without flexibility, contractors cannot respond to their incentives no matter how closely those incentives are aligned with those of the VA. The optimal relationships with providers vary by geographic market, beneficiary population, and over time. There is no one-size-fits-all payment model, and to prescribe one in contract is to limit the ability of a contractor to improve outcomes and lower costs based on actual conditions in execution. Competition and risk-bearing contracts discipline this flexibility more effectively than contract micromanagement. If a new innovative tool provides value to beneficiaries greater than its cost, contractors that adopt it will gain market share and those that do not will be driven from the market. If the innovation is not worth its cost, contractors that adopt it will be driven from the market instead.

F. Other Government Healthcare Programs

The VA may look to other government healthcare programs as examples of these criteria being implemented. These include Medicare Part C (Medicare Advantage), Medicare Part D, and the FEHBP. Each program implements one-year flexible risk-bearing contracts with many competing carriers. Each year, each program has an open enrollment period of one to two months in which beneficiaries may change their health plans. Carriers have flexibility to tune the characteristics of their plans. Beneficiaries have the power to choose the plan that best serves their preferences. A bidding process with capitated payments causes cost overruns in a given year to fall on the carriers themselves. To maximize profit, carriers must cater their plans to beneficiaries while controlling outlays. This results in improved outcomes and lower costs.

Medicare Part C is an alternative to the original FFS provision of Medicare Parts A and B to individuals that are disabled or 65 or older. Medicare Part C plans submit bids to the Centers for Medicare and Medicaid Services (CMS). CMS determines geographically based benchmark amounts and compares them to the bids. If a bid is not less than its associated benchmark, CMS pays the benchmark and beneficiaries pay any difference. If a bid is less than its associated benchmark, CMS pays the benchmark minus 25 percent of

the difference, and the remaining 75 percent must pass through to beneficiaries in the form of additional benefits (e.g., vision and dental benefits) or reduced cost.

Medicare Part D, the Medicare prescription drug benefit, employs a similar bidding process for its plans. However, CMS pays 74.5 percent of the average of all bids rather than an administratively determined benchmark. Beneficiaries pay the difference between their plan's bid and the CMS subsidy. This means that, unlike Medicare Part C, there is no preset cap on the per-beneficiary cost of the program. Though this introduces some risk to the government payer, it serves the preferences of beneficiaries. Given a large number of bidders, each bid has a negligible effect on the average. This induces carriers to bid higher only to the extent that they believe beneficiaries are willing to pay more for what their plan offers. Carriers that offer the same benefit at a lower price attract beneficiaries, which exerts downward pressure on bids and, therefore, costs.

The FEHBP, which covers federal employees, annuitants, and their survivors, also uses an averaging methodology to determine the amount of government payment. Each year, each carrier sets premiums for their health plans. The Office of Personnel Management then calculates the average of those premiums, weighted by the previous year's enrollment. For those premiums greater than 96 percent of the average, the government pays 72 percent of the average. For those premiums less than 96 percent of the average, the government pays 75 percent of the premium. Beneficiaries pay the remainder of their respective premiums.

G. Challenges

VA faces multiple fundamental challenges in defining a new purchased care system. These are not new challenges. They entail decisions that must be made for any system of healthcare provision, including past and present operation of the VA. Some of these decisions are presently made for the VA on a case-by-case basis by local staff members. A new purchased care system might require standardization of VA policies for healthcare provision outside VA facilities. Some major policy challenges are as follows:

- **Defining plan eligibility**. VA purchased care programs have some ambiguous eligibility criteria, and those criteria that are unambiguous often induce inequality and perverse long-term incentives for veterans.

  As an example of such an unambiguous criterion, a veteran is eligible for the Choice program if the closest VA facility is greater than 40 miles of driving distance from the veteran's residence or the facility is unable to schedule an appointment within 30 days of the veteran's—or his or her physician's—desired appointment date. While this criterion is well-intentioned, it may have undesirable consequences. Consider a veteran who lives one mile from a non-VA medical facility that could treat her condition for the same cost as treatment

at the closest VA facility, which is 39 miles away. She is ineligible for the Choice program and drives to and from the VA facility for her care. If she lived 41 miles away instead, the VA would pay for her care at the non-VA facility. The veteran has an incentive to move farther away from the VA facility so that she will be eligible for the Choice program.

Other eligibility criteria are more ambiguous and rely on the discretion of the VA facility staff. A veteran is eligible for the Choice program if he or she "faces an unusual or excessive burden in traveling to a VA medical facility based on geographic challenges, environmental factors, or a medical condition" or if his or her "specific health care needs, including the nature and frequency of the care needed, warrants participation in the program."[3] PC3 eligibility is similarly ambiguous. A veteran is eligible for the PC3 program when the VA healthcare provider determines that the required care is not available at a nearby VA facility. The provider must decide what qualifies as "required" and "nearby." These criteria create inequality to the extent that VA healthcare providers vary in their knowledge and judgment.

The VA must decide on a set of purchased care eligibility criteria that are unambiguous, fair, and robust to variation in service availability. One such set of criteria is the set of priority groups that determine eligibility for VA healthcare. Priority groups are based primarily on the extent of service-connected disability, circumstances of former military service, and income. They make no reference to proximity to or capabilities of VA facilities. Except for disability rating, they require no judgment on the part of VA staff. Whether the VA uses the priority group system in its current form or an altered form, or designs a new system for determining eligibility, it is important that the criteria be based on objective and transparent measures.

- **Defining the basket of services**. The VA must decide what services will be available to veterans in the form of purchased care. Currently, this is the set of services that are not readily available at a nearby VA healthcare facility. This set varies temporally and geographically and therefore the non-VA health services available to each veteran vary as well. This set also depends on the provider's interpretation of availability.

  Even when the availability of required care at a nearby VA facility is unambiguous, this criterion creates geographic inequality due to variation across VA facilities. Each type of specialty care will be offered by some VA facilities

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[3] "Veterans Choice Program Eligibility Details, Updated December 1, 2015," http://www.va.gov/opa/choiceact/documents/FactSheets/Veterans-Choice-Program-Eligibility-Details.pdf.

and not others. Consider a veteran who lives near a VA facility, but needs a type of specialty care that the facility does not offer. The VA may use PC3 to pay for the veteran's specialty care at a non-VA facility. Suppose that the VA facility later hires a specialist that can provide the needed care. Regardless of the relative costs to the VA and benefits to the veteran, the veteran is now ineligible for the PC3 program. To continue receiving VA healthcare benefits, the veteran must change their provider to the VA specialist, which interrupts the continuity of their care.

The VA faces the challenge of settling on a definition of benefits that does not depend on when a veteran shows up or what market the veteran happens to live in. One option is for the VA to offer comprehensive coverage for veterans in non-VA facilities. Medicare Part C and the FEHBP illustrate possible methods of implementing comprehensive coverage. Another option would be to offer purchased care only for the treatment of service-connected disabilities. A third option would be to select a list of procedures, treatments, and medications that the VA would be willing to cover. The best option may be one, none, or some combination of these.

- **Defining cost shares**. The VA must decide how much of the cost of care will fall on beneficiaries. On one hand, only the two lowest of the eight priority groups currently pay copays for VA care. No VA beneficiaries pay premiums or deductibles. As the VA expands the use of purchased care, beneficiaries who do not pay at all for their care will lack an incentive to self-manage their utilization. This will increase costs to the VA beyond the value provided to veterans. On the other hand, charging veterans in the first six priority groups may be considered incompatible with the VA mission or incompatible for certain conditions.
- **Defining when the VA is a primary or secondary payer**. Many veterans are covered by health insurance from their employer or Medicare. The VA must decide in what cases they will be the primary payer for veterans with multiple sources of coverage. The VA is currently the primary payer for all PC3 care and all service-connected Choice program care. Choice program care that is not service-connected is billed first to any other insurance that covers the veteran. This offers a precedent for the VA as a secondary payer in some situations.

  Payment hierarchies may depend on many factors. For example, for a person who is 65 or older and covered by both Medicare and an employer health plan, Medicare is the primary payer only if the employer has fewer than 20 employees. If the person is disabled and under 65, the cutoff is 100 employees instead. Simplicity is important in determining sources of payment, but clarity is even more important. The primary and secondary payers in each case should be well-defined, no matter what combinations of coverage the beneficiary has.

- **Managing growth**. When DoD changed its system from being "brick-and-mortar"-based to being an integrated system available across the country, it created conditions that ultimately led to a dramatic increase in beneficiary participation. All retirees had been eligible to use the benefit, but less than half traditionally used it. The non-using beneficiaries came to be called "ghosts" and the two decades after DoD's transition saw a dramatic return of ghosts. (Over 80 percent of retirees now use the DoD benefit.) VA is in a very similar situation with an even larger "ghost" population of veterans potentially eligible for healthcare coverage who choose not to use it. The legislative expansion of VA benefits to community care and the new intensive enrollment of veterans as they leave military service have likely established an irreversible path of expanding use of VA (proportional to eligible population, at least) for the years to come. The choices made now on eligibility, benefit definition, cost-shares, and the level of integration with community-based care across the country will determine the extent to which these returning ghosts become active users of VA healthcare and the long-term cost of the system. It will be very important for policy makers to take this into account now as these major decisions are being made.

H. Conclusion

The VA purchased care system has changed in recent years and is likely to change in the near future. The present system is conspicuously similar to TRICARE, the system that DoD has used to purchase care for the past two decades. TRICARE is systematically flawed; quality is systematically harmed while cost is systematically inflated. The VA can do better, as evidenced by other government healthcare programs that better align payer and contractor incentives.

This paper begins to answer the questions of why and how the VA can improve. It describes TRICARE and VA purchased care, explains the flaws in their design, and characterizes a design that avoids these flaws. The paper then provides examples of other government healthcare programs that exhibit the preferred characteristics and notes some of the decisions that the VA leadership must make to reform purchased care. The VA is fortunate to have the past experiences and economic understanding of similar programs to guide these critical decisions.

Decision makers supporting the presidential transition and the new administration can use this information to guide their plans for VA reform. Planning should include a focus on the end state that is desired to prevent making decisions today that make future success harder. DoD's TRICARE experience shows how decisions that seem to make sense at the time of transition can, ultimately, lead to a program that is ineffective and

inefficient but hard to reform. A goal of decision makers today should be to avoid making these mistakes with reform of the VA.

Reference

"Veterans Choice Program Eligibility Details, Updated December 1, 2015," http://www.va.gov/opa/choiceact/documents/FactSheets/Veterans-Choice-Program-Eligibility-Details.pdf.

Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMS	Centers for Medicare and Medicaid Services
DoD	Department of Defense
FEHBP	Federal Employees Health Benefit Program
FFS	Fee-for-Service
HMO	Health Maintenance Organization
PC3	Patient-Centered Community Care
VA	Department of Veterans Affairs

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.

1. REPORT DATE *(DD-MM-YYYY)*	2. REPORT TYPE	3. DATES COVERED *(From - To)*
xx-01-2017	Final	Aug 2015 - Oct 2016

4. TITLE AND SUBTITLE

Purchasing Community-Based Care for Veterans: Lessons from the Department of Defense TRICARE Program

5a. CONTRACT NUMBER

HQ0034-14-D-0001

5b. GRANT NUMBER

5c. PROGRAM ELEMENT NUMBER

6. AUTHOR(S)

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5d. PROJECT NUMBER

5e. TASK NUMBER

CRP C7156

5f. WORK UNIT NUMBER

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)

Institute for Defense Analyses
4850 Mark Center Drive
Alexandria, VA 22311-1882

8. PERFORMING ORGANIZATION REPORT NUMBER

IDA Document NS D-8235
Log: H 16-001181

9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)

Institute for Defense Analyses
4850 Mark Center Drive
Alexandria, VA 22311-1882

10. SPONSOR/MONITOR'S ACRONYM(S)

IDA

11. SPONSOR/MONITOR'S REPORT NUMBER(S)

12. DISTRIBUTION/AVAILABILITY STATEMENT

Approved for public release; distribution is unlimited.

13. SUPPLEMENTARY NOTES

14. ABSTRACT

Veterans' healthcare is at the beginning of what will likely be a major transformation over the coming years. One element of this transformation will be an increased use of community-based care. The Department of Defense (DoD) went through a similar transformation 25 years ago that provides lessons learned to help make the change smoother and avoid pitfalls that DoD experienced. This paper reviews the DoD experience in expanding its use of private sector care, the challenges that have emerged within DoD based on the initial choices it made, and steps the Department of Veterans Affairs can take now to avoid these challenges.

15. SUBJECT TERMS

Veterans Affairs; Healthcare; Value-based purchasing; Private sector care

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			Whitley, John, E.
Unclassified	Unclassified	Unclassified	Same as Report	22	19b. TELEPHONE NUMBER *(Include area code)* (703) 575-6344

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Standard Form 298 (Rev. 8/98)
Prescribed by ANSI Std. Z39.18