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The Veterans Community Care Program: Background and Early Effects

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The Veterans Health Administration (VHA), part of the Department of Veterans Affairs (VA), provides health care to eligible veterans using a combination of VHA and non-VHA providers and facilities. Until a few years ago, VHA generally allowed patients to seek community care (that is, it referred patients to outside providers) on an exception basis.[1] In recent years, however, major legislative and VA-led changes to VHA's policies have increased opportunities for veterans to seek community care at VHA's expense. Currently, the Veterans Community Care Program (VCCP) allows veterans to see outside providers on the basis of several factors, including the local availability of VHA care and the circumstances of individual veterans. In this report, the Congressional Budget Office examines some of the effects of VCCP.

Between 2014 and 2019, about two million veterans, or almost one-quarter of VHA enrollees, were authorized to use community care under VCCP's predecessor, the Veterans Choice Program. The VA MISSION Act (Public Law 115-182), which was enacted in 2018, created VCCP to replace the Veterans Choice Program as well as most agreements that VA medical centers had with local private providers; it also consolidated other community care programs. The MISSION Act diverges from previous VA policy that used community providers as a last resort. Now, eligible veterans may choose community care even if a VHA provider is available as long as they meet specific requirements.

In examining the effects of VA's changing policies toward community care, CBO determined that since 2014, the number of veterans using community care has increased and average wait times in VHA facilities have declined and remained generally below those in the private sector. CBO estimates that VHA's costs for community care grew from $7.9 billion in 2014 to $17.6 billion in 2021. (All dollar values are expressed in 2021 dollars unless otherwise stated.)

In addition, CBO found that prioritizing veterans' access to community providers may affect other aspects of patient care and VHA's ability to deliver it: It is more difficult for VHA to coordinate care outside of its own facilities, and VHA has little control over the quality of care that veterans receive from community providers. Finally, increasing access to community care may reduce utilization of VHA facilities that have sufficient capacity, which could lead to higher costs per veteran if VHA cannot close or consolidate them.

What is the Veterans Community Care Program?

VCCP permits veterans who meet specific requirements to see outside health care providers who are paid by VHA. Although VHA has always used community providers for veterans under certain circumstances, the legislation that created VCCP consolidated and replaced many of VHA's existing community care agreements with one program and expanded the number of veterans eligible to seek care outside of VHA facilities.

VHA Health Care Services

VHA operates a direct care network of 170 medical centers and more than 1,000 outpatient clinics, rehabilitation

1. The use of outside providers has been known by many names and has fallen under many VHA programs; in this report all such care, including long-term care, is referred to as community care unless otherwise indicated.

Notes: In discussing the Veterans Health Administration's costs for community care, this report cites data provided by VHA regarding obligations recorded by that agency for such care. Legislation provides agencies with the authority (called budget authority) to spend money for their programs; then, those agencies make commitments (called obligations) to spend that money; and lastly, the Treasury spends the money as outlays to fulfill those obligations. In any given year, obligations and outlays tend to be similar because most obligations result in outlays during the same fiscal year. To remove the effects of inflation, dollar values are adjusted with the gross domestic product price index from the Bureau of Economic Analysis. All dollar values are expressed in 2021 dollars unless otherwise stated.

facilities, and nursing homes. Services include inpatient, outpatient, and specialty care; pharmaceuticals; and auxiliary social support, such as programs for the homeless and stipends for caregivers.

The amount of care and services VHA can provide is determined by funding that the Congress appropriates each year. Given that budgetary constraint, VHA calculates how many veterans it can serve using a system of priority groups. When veterans first apply for care, they are assigned to one of eight priority groups (with 1 denoting the highest) on the basis of a number of factors, including service-connected disabilities and income.[2] (Service-connected disabilities are medical conditions that develop or worsen during a service member's time in the military; they are determined by VA.) Depending on their assignment, some veterans receive free care, some have minimal cost sharing for treatment or pharmaceuticals, and some are not permitted to enroll; that is, not all veterans are eligible for VHA services.

Of the 9.2 million veterans enrolled with VHA in 2020, about 6.2 million actually sought care from VHA that year (760,000 nonveteran patients were also treated).[3] Most veterans do not rely on VHA for all their medical treatment: Many have additional insurance and receive a large amount of health care from other sources, particularly Medicare. VHA projects that spending will average $14,750 per veteran patient in 2021 and that enrollment will remain relatively steady until 2023, when mortality in the enrollee population is expected to surpass new enrollment.

Development of the Veterans Community Care Program

Community care has been used to supplement VA-provided health care for veterans since World War I, but eligibility requirements have evolved. In the 1920s, when VA mainly provided inpatient services, the Congress authorized contracting with outside providers in certain circumstances. For instance, VA paid for some outpatient care to treat veterans with service-connected disabilities. In 1957, female veterans and all veterans living in U.S. territories were made eligible to seek community care, and in 1979, veterans who were receiving a VA pension or who were housebound also qualified. Some services (such as dialysis) were authorized for community care when VA medical centers were far away from where patients lived or the centers were very busy; other services (such as obstetrics) were authorized because VA medical centers did not provide them.

In 1989, VA was reorganized and VHA was established shortly thereafter to administer health care for veterans, both in VHA facilities and in the community when necessary. VHA agreements for community care mainly operated at the local level.[4] That care was paid for on a fee-basis arrangement, whereby providers (such as community private hospitals and home health care services) submitted bills to the local VHA facility, which then authorized payment of the expense from a central payment center.

Veterans' access to community care has expanded significantly since 2014 (see Figure 1). In the spring of that year, accusations surfaced about long wait times for outpatient appointments and unscrupulous management practices at several VA medical centers. In response to those accusations, lawmakers enacted legislation requiring VHA to provide access to health care in the community for veterans who could not be seen in a timely manner or who lived far from a VHA facility. The Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146), enacted in August of that year, established the Veterans Choice Program, a temporary benefit that allowed eligible veterans to see non-VHA providers. Lawmakers appropriated $10 billion (in nominal dollars) over three years to treat veterans in the community if they were unable to schedule appointments at VHA facilities within VA's goals for wait times (30 days) or if they had to drive long distances to the nearest VHA facility (more than 40 miles). The act required VHA to begin allowing more veterans to seek community care within 12 weeks of enactment.

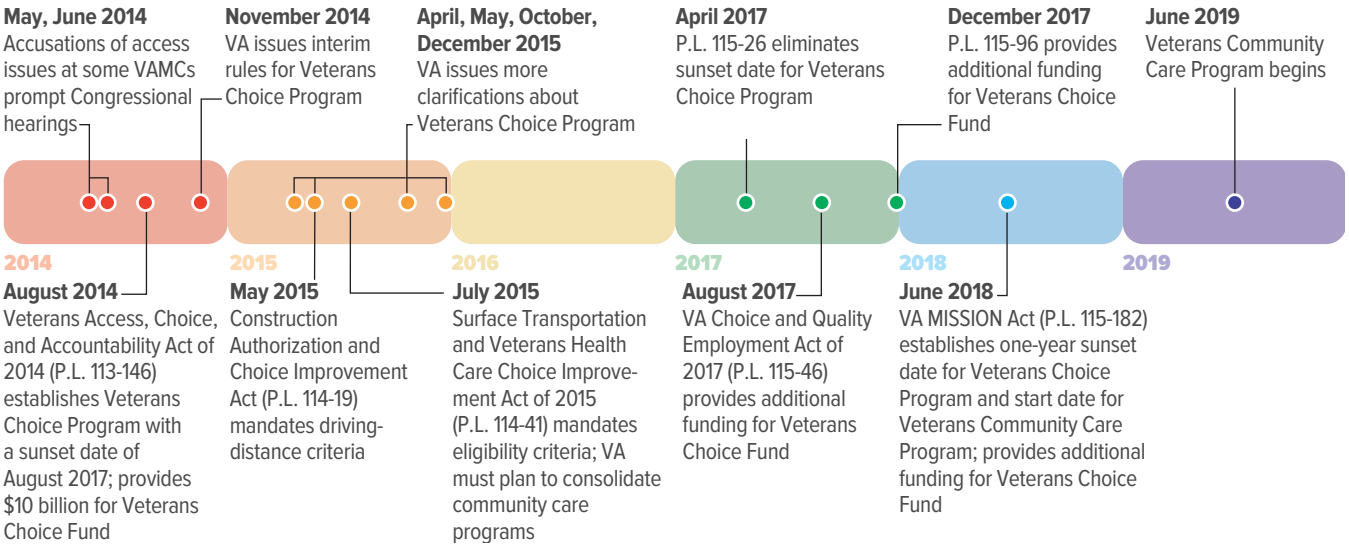
2. The highest-priority groups, groups 1 to 3, are veterans who have service-connected disabilities. Priority group 4 consists of veterans who are housebound or catastrophically disabled. Priority group 5 contains lower-income veterans. Priority group 6 includes special populations, such as certain combat veterans discharged from the military within five years of applying for VA health care. The lowest-priority groups, groups 7 and 8, contain higher-income veterans with no compensable service-connected disabilities (enrollment in priority group 8 has been partially restricted since 2003). For a full description, see Department of Veterans Affairs, "Health Benefits" (April 23, 2019), https://go.usa.gov/x6mVW.

3. About one-third of enrollees do not seek treatment from VHA in a given year. Nonveteran patients include active-duty military and reservists, certain surviving spouses and family members of veterans, and employees receiving care, such as occupational immunizations.

4. For more detail on the history of VHA's use of outside providers, see Sidath Viranga Panangala and others, *VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act; P.L. 115-182)*, Report R45390, version 2 (Congressional Research Service, November 1, 2018), https://go.usa.gov/x6mVd.

Figure 1.

Recent Legislation and Agency Rules Affecting Veterans' Community Care



Data source: Congressional Budget Office.

VA = Department of Veterans Affairs; VAMCs = Veterans Affairs Medical Centers.

Additionally, the act provided $5 billion (in nominal dollars) for VHA to hire more medical staff and expand its in-house capabilities over several years.[5] In the following months and into 2015, clarifications and revisions were made to the Veterans Choice Program by VHA, which issued and implemented rules for the program, and by the Congress in subsequent legislation.

In 2017, a new Congress and Presidential Administration significantly changed VHA's policy of using community care as a last resort. Under the new policy, veterans who meet broad criteria can choose whether to seek care from VHA or in the community. In April, while VHA was developing a new program, lawmakers eliminated the August expiration date for the Veterans Choice Program, and in December, they provided additional funds for the program. Meanwhile, VHA continued developing plans to consolidate most community care contracts and to ultimately replace the Veterans Choice Program. VHA crafted new eligibility criteria for receiving care in the community that were based largely on timely access to services and clinical need, which gave veterans more options to seek treatment for particular medical conditions outside VHA facilities.

In the spring of 2018, various health care provisions were combined into a single piece of legislation, the VA MISSION Act, which was signed into law on June 6.[6] That act created VCCP, a permanent program providing medical and long-term care services through non-VHA health care providers.[7] The act altered the legal framework around many local agreements and other community care programs.[8] VHA now uses contractors to develop and administer regional networks of community care providers that furnish medical care and related services

5. See Congressional Budget Office, letter to the Honorable Bernie Sanders providing an estimate for H.R. 3230, the Veterans Access, Choice, and Accountability Act of 2014 (July 29, 2014), www.cbo.gov/publication/45601.

6. In September 2018, some changes and technical amendments were made under the Department of Veterans Affairs Expiring Authorities Act of 2018 (P.L. 115-251).

7. For a detailed description of the VA MISSION Act, see Sidath Viranga Panangala and others, *VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act; P.L. 115-182),* Report R45390, version 2 (Congressional Research Service, November 1, 2018), https://go.usa.gov/x6mVd.

8. The act left in place several statutory provisions, including those governing care provided by the Department of Defense and by the Indian Health Service (the federal health care provider for Native Americans).

to enrolled veterans.[9] Those providers are predominantly, but not exclusively, participants in the Medicare program.

How Do Veterans Qualify for the Veterans Community Care Program?

Veterans qualify for VCCP under one or more criteria that are based on their situation or VHA's in-house capabilities. VHA also introduced new access standards for wait and drive times; the latter markedly increased the number of veterans eligible for community care. Theoretically, under VCCP, every enrolled veteran could be eligible for community care in certain circumstances.

Eligibility for Community Care

The 2018 legislation provided general conditions under which VHA is required to provide community care but left some criteria to the discretion of the VA Secretary. Because the program is new, implementation of VCCP is still evolving. As of 2021, veterans qualify for community care under one or more of the following six criteria:

- The veteran requires care or services that VHA facilities do not offer.
- The veteran resides in one of the three states or one of the four territories without a full-service VHA medical facility.[10]
- The veteran previously qualified for community care with the Veterans Choice Program under certain provisions.
- VHA facilities do not offer the care or service that meet VA-designated access standards regarding wait time for appointments or drive time to facilities.
- VHA facilities do not offer the care or service that meet VA-designated quality standards.
- The veteran and VHA provider agree that it is in the best interest of the veteran to receive care from outside providers.

VHA authorizes use of community providers for what is called an episode of care, or a course of treatment for a specific medical problem during a set time period. In other words, community care is approved for treating—in part or entirely—a particular medical condition, and that approval does not authorize a veteran to receive subsequent care from outside providers. In general, VHA staff need to approve community care before the first visit, except for emergency and urgent care visits.[11] Appointments with approved providers (those participating in Medicare and Medicaid programs and federal providers, such as the Department of Defense) may be made by the veteran, VHA, or the contractors who administer the community care networks. As of 2020, approximately 1.7 million community providers had joined VHA's regional networks, and most of them agree to the rates Medicare pays its providers.[12]

Access Standards

Under the authorities established in the MISSION Act, VHA introduced new standards for wait and drive times for VCCP eligibility, which have expanded the number of veterans eligible for community care and will probably have large effects on the scope and costs of the program. The new drive-time standards are the same as those used for Tricare Prime, the HMO-style health care program administered by the Department of Defense (DoD). DoD has relied heavily on community providers to treat beneficiaries other than active-duty personnel for many decades; by contrast, VHA has traditionally delivered most care directly.

Although lowering wait and drive times was the impetus for expanding veterans' access to community care, community care providers do not have to meet the access standards that apply to VHA. Although VA tries to ensure that its contractors build and maintain adequate networks using access standards similar to VHA's, VHA officials have acknowledged that once eligible veterans choose community care, VHA has no control over how

9. VHA may also enter into supplemental contracts, known as Veterans Care Agreements, if care cannot be delivered in VHA facilities, through VCCP community networks, or by using other statutory authorities. For example, VHA contracts with State Veterans Homes, which are facilities owned and operated by state governments, to provide nursing home, domiciliary, or adult day care services.

10. The states are Alaska, Hawaii, and portions of New Hampshire; the territories are Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and the U.S. Virgin Islands.

11. Veterans who disagree with authorization decisions may use VHA's internal clinical decision appeals process. Emergency care is covered under a separate authority from VCCP.

12. Providers are organized into six geographic regions managed by contractors; veterans may see only those providers who are part of the VHA network. When care or services are not payable under Medicare rates, are payable under Medicare but with no established pricing at the national or local level, or are provided in a highly rural area, payment rates may be established by the VA Secretary.

long private providers make veterans wait for an appointment.[13] As a result, VHA has no specified goal for the maximum wait time for a veteran to obtain community care. Similarly, qualifying veterans may choose a private provider farther away than a closer VHA facility.

Wait Times for Appointments. The Veterans Choice Program wait standard (that is, the maximum number of days a veteran could wait) was defined as not more than 30 days for a new appointment. Under VCCP, VHA has shortened the standard to 20 days for primary care, mental health care, and noninstitutional extended care services (such as geriatric evaluations, adult day health care, and respite care). The standard for specialty care is 28 days. Those standards do not apply in cases in which a veteran agrees to wait longer after consulting with the VHA provider.

Under the Veterans Choice Program, about half of veterans using community care qualified on the basis of long wait times at VHA facilities. However, the decrease in wait times at those facilities since 2014 makes it less likely that veterans will qualify for VCCP on that basis. VHA operates a website where patients can check the average wait time at specific VHA facilities, and it regularly posts detailed historical access information, including average wait times based on outpatient appointment information from its scheduling system.[14] Measuring actual wait times may be difficult for most health care providers, and despite improvement in recent years, outside audits in 2020 and earlier years concluded that VHA still experienced some problems in measuring wait times and scheduling veterans' appointments.[15]

Drive Time. Under the Veterans Choice Program, veterans qualified for community care if they had to drive a distance of more than 40 miles to the closest VHA facility.[16] Under VCCP, the driving standard is based on time rather than distance: Veterans qualify for community care if they have to drive an average of more than 30 minutes to the nearest VHA facility for primary care, mental health care, or noninstitutional extended care services; for specialty care, the drive-time standard increases to no more than 60 minutes.

Unlike the criterion for wait times, the criterion for drive times has not been systematically evaluated.[17] Under the Veterans Choice Program, relatively few veterans (about 250,000 patients) qualified under the driving-distance standard. Under VCCP, drive time will probably be the most common condition under which veterans may access community care. According to VHA data provided to CBO, at least 2 million veterans (about one-quarter of all enrollees and 1 in 3 patients) were eligible for VCCP on the basis of drive time in 2020. Most of those 2 million veterans probably live in rural areas. VHA allocates resources to serve those rural veterans by constructing VHA facilities in areas with limited access to care—which tend to be sparsely populated—and by offering numerous programs through its Office of Rural Health. Even so, many of those areas are so remote that no providers, VHA or otherwise, could be reached within 30 minutes.

How Has Access to Care Been Affected?

Many veterans may find it easier to access care than they did in 2014 because the number of veterans using community care has increased and average wait times in VHA facilities have decreased.

In 2014, about 1.3 million veterans were authorized to use outside care under previous community care agreements. By 2020, that number had grown by more than 75 percent to 2.3 million veterans. (More veterans were

13. See Government Accountability Office, *Veterans Community Care Program: Improvements Needed to Help Ensure Timely Access to Care,* GAO-20-643 (September 2020), www.gao.gov/products/gao-20-643.

14. See Department of Veterans Affairs, "Average Wait Times at Individual Facilities" (accessed June 21, 2021), https://go.usa.gov/x6mvT, and "Veterans Health Administration, Patient Access Data" (accessed June 21, 2021), www.va.gov/health/access-audit.asp.

15. See Testimony of Debra A. Draper, Director, Health Care, Government Accountability Office, before the House Committee on Veterans Affairs, *Veterans Health Care: Opportunities Remain to Improve Appointment Scheduling Within VA and Through Community Care*, GAO-19-687 (July 24, 2019), www.gao.gov/products/gao-19-687t.

16. Veterans who had to travel by air, boat, or ferry, or who otherwise faced an unusual or excessive burden in accessing VHA facilities were exempt from the 40-mile distance requirement.

17. A single study examined driving distances under the Veterans Choice Program for cataract surgery; it found that some veterans drove farther than the closest private sector provider but that others who chose direct care used the closest VHA facility, suggesting that there are other reasons besides driving distance that affect where veterans seek care. See Warren B. P. Pettey and others, "Comparing Driving Miles for Department of Veterans Affairs-Delivered Versus Department of Veterans Affairs-Purchased Cataract Surgery," *Medical Care*, vol. 59 (June 2021), pp. 307–313, https://tinyurl.com/fbhcsy9b.

authorized to use community care than did so, but VHA did not provide CBO with data on use.) Over those same years, the number of VHA enrollees increased by just 2 percent. The long-term trend for VHA's patient load is down: The number of veterans in the United States has fallen from 30 million in 1980 to fewer than 20 million in 2021.

VHA facilities have, on average, shorter wait times than those in the private sector.[18] Recent research has found that VHA wait times for primary care and several specialties have improved since 2014 and that average wait times for VHA providers are now the same or shorter than those for outside providers.[19] That is true for veterans living in urban areas as well as those in rural ones.[20]

Recent studies have concluded that many VHA facilities with longer wait times are located in regions that also have long waits for community care, and VHA administrative data support those findings.[21] For instance, certain VHA facilities in the South and parts of Texas reflect the scarcity of private-sector providers in those areas, leading to heavier reliance—as measured by the share of all health care received—on VHA. (Even when private providers exist in an area, their participation in VCCP is not mandated or otherwise guaranteed.)

During the 2020–2021 coronavirus pandemic, certain restrictions regarding telehealth were waived so that veterans had access to community providers while offices and clinics were closed. VHA officials have said that use of telehealth depended on community providers' telehealth capabilities, veterans' preferences, and the type of care needed. Use of telehealth within VHA was extensive during much of 2020.[22]

How Has Spending on Community Care Changed?

VHA's spending on community care has grown sharply in recent years, in terms of both dollars spent and its share of VHA's total spending. In 2014, community care for veterans accounted for $7.9 billion, or about 12 percent of VHA's budget. By 2021, the cost of community care programs had more than doubled to $17.6 billion and accounted for about 20 percent of VHA's budget, CBO estimates. VA was appropriated $89.8 billion in 2021 for medical care (of which direct clinical services are only part); that was about 40 percent of the department's funding for all programs.[23] (All of those dollar values are expressed in 2021 dollars.)

Historical Spending and Funding Requests for Community Care

Growth in VHA's recent spending on community care can be considered over two periods: The growth in the first was a result of the temporary program (Veterans Choice Program), and the increase in the second was a result of VCCP. In the first period, 2014 to 2019, VHA's annual costs for community care—for both health care and long-term care—rose significantly, starting with a 33 percent increase in 2015, the first year the Veterans Choice Program was put into place (see Table 1). As that program matured, growth in costs moderated. By 2018, those

18. See statement of Theresa Boyd, Assistant Deputy Under Secretary for Health, Department of Veterans Affairs, before the Senate Committee on Veterans Affairs (May 22, 2019), https://tinyurl.com/yj9rbk87 (PDF, 317 KB).

19. In 2017, overall average wait times for new appointments in VHA facilities (17.7 days) were shorter than those for appointments in the private sector (29.8 days). See Madeline Penn and others, "Comparison of Wait Times for New Patients Between the Private Sector and United States Department of Veterans Affairs Medical Centers," *JAMA Network Open*, vol. 2, no. 1 (2019), https://dx.doi.org/10.1001/jamanetworkopen.2018.7096; and Kevin N. Griffith, Nambi J. Ndugga, and Steven D. Pizer, "Appointment Wait Times for Specialty Care in Veterans Health Administration Facilities vs Community Medical Centers," *JAMA Network Open*, vol. 3, no. 8 (2020), https://dx.doi.org/10.1001/jamanetworkopen.2020.14313.

20. See Deborah Gurewich and others, "Did Access to Care Improve Since Passage of the Veterans Choice Act?: Differences Between Rural and Urban Veterans," *Medical Care*, vol. 59 (June 2021), pp. S270–S278, https://tinyurl.com/v5fus64r.

21. See Kevin N. Griffith, Nambi J. Ndugga, and Steven D. Pizer, "Appointment Wait Times for Specialty Care in Veterans Health Administration Facilities vs Community Medical Centers," *JAMA Network Open*, vol. 3, no. 8 (2020), https://dx.doi.org/10.1001/jamanetworkopen.2020.14313.

22. For more detail regarding VHA's efforts with community providers during the coronavirus pandemic, see Government Accountability Office, *Veterans Community Care Program: VA Took Action on Veterans' Access to Care, But COVID-19 Highlighted Continued Scheduling Challenges,* GAO-21-476 (June 2021), www.gao.gov/products/gao-21-476.

23. That amount excludes emergency funding that VHA received in March 2020 as part of the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136): $14.4 billion for direct care and related medical support and $2.1 billion for increased community care, which translates to an average of an additional $2,700 per veteran patient. In March 2021, VA received an additional $17.1 billion as part of the American Rescue Plan Act of 2021 (P.L. 117-2); most of that funding was allotted to VHA programs, including $4 billion specifically for VCCP.

Table 1.

VA's Costs for Community Care for Veterans, Fiscal Years 2014 to 2023

Billions of 2021 Dollars

								Estimated	Revised Request	Advance Request
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Costs for Health Care Paid From VHA's Appropriations	4.9	4.2	5.1	4.3	4.9	7.4	12.1	12.8	17.2	18.0
Costs for Health Care Paid From Veterans Choice Fund	0	2.7	2.1	4.5	3.0	1.8	0.8	0.1	0	0
Subtotal, health care	4.9	6.9	7.2	8.8	8.0	9.2	13.0	12.9	17.3	18.0
Costs for Long-Term Services and Supports Paid From VHA's Appropriations	3.0	2.8	3.5	3.1	3.3	3.6	3.9	4.7	5.5	5.8
Costs for Long-Term Services and Supports Paid From Veterans Choice Fund	0	0.7	0.1	0.6	0.8	0.4	0	0	0	0
Subtotal, long-term services and supports	3.0	3.6	3.5	3.7	4.0	4.0	3.9	4.7	5.5	5.8
Total	**7.9**	**10.5**	**10.7**	**12.5**	**12.0**	**13.2**	**16.9**	**17.6**	**22.7**	**23.9**
Memorandum:										
Number of Veterans Authorized for Community Care (Millions)	1.3	1.4	1.6	1.6	1.8	2.1	2.3	n.a.	n.a.	n.a.
Number of Veteran Patients (Millions)	6.0	6.0	6.1	6.1	6.2	6.3	6.2	6.3	6.3	6.4
Number of Enrolled Veterans (Millions)	9.1	9.0	9.0	9.1	9.2	9.2	9.2	9.2	9.2	9.2

Data source: Congressional Budget Office, using data from the Department of Veterans Affairs. See www.cbo.gov/publication/57257#data.

Community care comprises health care (inpatient, outpatient, dental, mental health, prosthetics, and rehabilitation services) and long-term services and support (community nursing homes and noninstitutional care, and state facilities and programs).

VHA pays for other programs using community care funds that are not included here, such as those for caregivers and for the Camp Lejeune Family Member Program.

Amounts do not include adjustments from audits, accounting changes, or additional Congressional funding in 2016. Those amounts total approximately $3 billion from 2014 to 2021. Emergency funding in March 2020 and 2021 for the coronavirus pandemic is also excluded.

VA = Department of Veterans Affairs; VHA = Veterans Health Administration; n.a. = not applicable.

costs had risen by an additional 14 percent. Long-term services and supports (predominantly nursing home care) accounted for about 30 percent of all community care costs and experienced less growth than costs of health care.[24]

In the second period, beginning in 2020, costs for community care and requests for future funding jumped further when VCCP was implemented. For 2023, VHA's advance request for community care is $23.9 billion (in 2021 dollars), three times the costs in 2014 and double the amount in 2018.[25] That growth contrasts sharply with VHA enrollment: Over the 2014–2021 period, the number of veteran patients increased by only 3 percent.

24. CBO's estimates of VHA's costs for community care reflect only obligations for health care and long-term care, not for other programs such as those for caregivers and Camp Lejeune families. The estimates also exclude hepatitis C treatment and information technology costs that were partially paid from the Veterans Choice Fund, which was set up under the Veterans Choice Program and provided with mandatory funding to carry out VA's requirements to furnish hospital care and medical services through agreements with specified non-VA providers. CBO estimates that the fund financed $17.7 billion of community care from 2015 to 2021. Some funds remain in the Veterans Choice Fund, and they can be used for VCCP.

25. Each year, VHA receives a regular appropriation for the upcoming fiscal year and an advance appropriation for the following year. None of the amounts include additional funding for community care that the Congress provided for the coronavirus pandemic. In May 2018, CBO estimated that VCCP would cost $21.4 billion in nominal dollars from 2019 through 2023. CBO's estimate for all provisions of the MISSION Act was $46.5 billion in nominal dollars, subject to future appropriations. See Congressional Budget Office, cost estimate for H.R. 5674, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (May 14, 2018), www.cbo.gov/publication/53871.

Future Spending for Community Care

Because the amount of care VHA provides is determined by how much funding the Congress appropriates for VA each year, the Congress directly controls future spending. (For the other major VA programs, such as veterans' disability compensation, lawmakers set eligibility and benefit amounts but do not directly control the costs.) VHA's budget requests will depend in part on veterans' choices about whether to pursue care outside of VHA and the costs for non-VHA providers. Increased pressure on spending could result in larger budget requests or in VHA's moving resources away from other programs to fund community care.

There may be pressure for increased spending because VHA has limited ability in the near term to control the use of community care once a veteran has been approved to seek it and because community care may be more expensive than care in VHA facilities. Cost comparisons of VHA's direct care to purchased care are rare, and much of the existing research is outdated. A recent study, however, confirmed earlier findings that VHA care cost less than comparable services from Medicare providers and that VHA patients had better health outcomes.[26]

Different practice patterns by outside providers could also put upward pressure on spending. Some of those practice differences might stem from the cost control and incentive structures of VHA physicians and private-sector providers; VHA does not control the amount or type of services veterans receive once they have been referred to outside providers for a particular episode of care. VHA officials reported that higher-than-estimated spending for community care in 2017 and 2018 was driven, in part, by local practice patterns, such as use of magnetic resonance imaging instead of less costly tests like computed tomography scans and x-rays.

Conversely, the cost of community care would be less if, for example, outside clinicians provided fewer referrals for other health care or tertiary services than VHA providers. Private-sector providers may also be more efficient or see more patients per day. Also, use of community providers could free up space in busy VA medical centers, allowing VHA to avoid making expensive capital investments to expand those facilities or build new ones.

Pressure for increased spending for VCCP could be a challenge for future VA budgets, particularly because VA's spending has grown significantly faster than economywide inflation over the past two decades.[27] If veterans increased their reliance on VHA for their health care and chose to seek community care, paying for that care could lead to more rapid spending growth.[28] If VA did not receive enough funding to accommodate that growth, the VA Secretary could tighten access to community care or rescind enrollment for veterans in lower priority groups to provide care for those in higher priority groups (as required under current law). The Congress could also legislate more restrictive access criteria for use of community care or reduce spending for other programs, both defense and nondefense.

What Are Other Effects of the Veterans Community Care Program?

Providing more access to community providers has made it easier for veterans to use outside care, but other outcomes are mixed.[29] In its 2021 budget submission, VA stated that its goal is to "provide high-quality, timely, veteran-centric care in line with veterans' preferences and clinical needs."[30] However, conflicts often exist between quality, timeliness, patients' preferences, clinical needs, and cost. The MISSION Act introduced requirements that may remain outside the agency's control or that are

26. For an overview of those older studies comparing VHA to outside providers, see Congressional Budget Office, *Comparing the Costs of the Veterans' Health Care System With Private-Sector Costs* (December 2014), www.cbo.gov/publication/49763. In 2020, researchers examining outcomes in emergency rooms found that veterans taken by ambulance to VHA hospitals had better survival rates and overall lower spending than veterans taken to hospitals that accept Medicare patients. See David C. Chan, David Card, and Lowell Taylor, "Is There a VA Advantage? Evidence From Dually Eligible Veterans" (presentation given at Department of Veterans Affairs, Health Services Research & Development, Cyberseminars, November 2020), https://go.usa.gov/x6mfm.

27. For a discussion of VA's spending since 2000, see Congressional Budget Office, *Possible Higher Spending Paths for Veterans' Benefits* (December 2018), www.cbo.gov/publication/54881, and *Potential Costs of Veterans' Health Care* (October 2010) www.cbo.gov/publication/21773.

28. VHA reports that enrollees rely on the agency for about one-third of their health care (excluding long-term care). Limited evidence—mainly from the department's budget requests—suggests that reliance on VHA is growing; the agency expects further increases as a result of the MISSION Act.

29. For an overview of VA's research on veterans' use of community care—predominantly under the Veterans Choice Program—and how VHA facilities interact with community care providers, see the dedicated issue of *Medical Care*, vol. 59 (June 2021), https://tinyurl.com/3n22ps8u.

30. See Department of Veterans Affairs, Office of Budget, *Medical Programs and Information Technology Programs,* vol. 2 of *FY 2021 Budget Submission* (February 2020), p. VHA-2, www.va.gov/budget/products.asp.

conflicting. For example, contracts with outside providers that require screening for mental health, reporting quality measures, and sharing patient records for payment could seem onerous, which may result in fewer providers joining the network of community providers. Because VCCP is new, its effects on use of community care, cost, and other metrics are generally unknown. Nonetheless, research indicates that coordinating care among health care systems is difficult. Monitoring the quality of care provided by every non-VHA provider may be impractical. Increased use of outside providers may also lead to an underutilization of existing VHA facilities.

Coordination of Care

Care coordination involves organizing patient care activities and sharing information among all providers for safer and more effective treatment. Research indicates that such coordination is particularly important for patients with chronic conditions or multiple conditions. Among veterans, those medical and psychological conditions include cancer, chronic obstructive pulmonary disease, posttraumatic stress disorder, and suicide risk.

Evidence shows that coordination of care between VHA and other providers has been uneven.[31] As of June 2020, very few community providers had signed up to use VHA's software system to manage referrals and share information.[32] Researchers have found that both VHA and non-VHA providers have expressed frustration with communication, methods of sharing medical information, and variations in how care is delivered. Many of those issues were experienced under the Veterans Choice Program. Providers also expressed frustration with delayed payments. Because of those experiences, community providers in certain areas are unwilling to participate in the new VCCP.[33]

The risks of poorly coordinated care include repeated or unnecessary tests, inconsistent medical instructions, and uneven transitions across providers. VHA offers training to community providers about several health care needs common to veterans. In most cases, that training is optional, however, and many community providers may not be aware of those needs.[34] Additionally, once a veteran is approved for community care for an episode of care, VHA may be unable to retain that patient for in-house treatment and could therefore lose the ability to coordinate the patient's treatment to achieve the best outcomes. Still, future coordination of care could improve if outside providers took advantage of VHA's electronic health care records and new programs and if they developed standing relationships with their local VHA facilities.

Quality of Community Care Providers

Community care providers in VHA's network must meet credentialling standards—they must provide evidence of licensure, education, and training—but the quality of many of those providers is unknown. (Health care quality encompasses many aspects of patient care, but in general, quality indicates how well medical services improve health outcomes.)[35] A long literature, including several recent studies, has consistently found that VHA generally delivers high quality care that is as good as or better than that offered by outside providers.[36]

31. See Megan E. Vanneman and others, "Veterans' Experiences With Outpatient Care: Comparing the Veterans Affairs System With Community-Based Care," *Health Affairs*, vol. 39, no. 8 (August 2020), pp. 168–176, http://dx.doi.org/10.1377/hlthaff.2019.01375; and Kristin M. Mattocks and others, "Recommendations for the Evaluation of Cross-System Care Coordination From the VA State-of-the-Art Working Group on VA/Non-VA Care," *Journal of General Internal Medicine*, vol. 34 (May 2019), pp. S18–S23, http://dx.doi.org/10.1007/s11606-019-04972-1.

32. VHA expects that, when fully implemented, that software system, the HealthShare Referral Manager, will also manage authorizations between VHA and community providers. But community providers are not required to use the HealthShare Referral Manager.

33. See Kristen M. Mattocks and others, "Understanding VA's Use of and Relationships With Community Care Providers Under the MISSION Act," *Medical Care*, vol. 59 (June 2021), pp. S252–S258, https://tinyurl.com/hfrk384f.

34. VHA requires providers who can prescribe opioids to complete that training.

35. The National Academy of Medicine defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." See Agency for Health Care Research and Quality, "Understanding Quality Measurement" (June 2020), https://go.usa.gov/xMS4e.

36. See Stephen W. Waldo and others, "Outcomes Among Patients Undergoing Elective Percutaneous Coronary Intervention at Veterans Affairs and Community Care Hospitals," *Journal of the American College of Cardiology*, vol. 76, no. 9 (September 1, 2020), pp. 1112–1116, http://dx.doi.org/10.1016/j.jacc.2020.05.086; Paul G. Barnett and others, "Comparison of Accessibility, Cost, and Quality of Elective Coronary Revascularization Between Veterans Affairs and Community Care Hospitals," *JAMA Cardiology*, vol. 3, no. 2 (January 3, 2018), pp. 133–141, http://dx.doi.org/10.1001/jamacardio.2017.4843; and Rebecca Anhang Price and others, "Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings," *Journal of General Internal Medicine*, vol. 33, no. 10 (April 25, 2018), pp.1631–1638, http://dx.doi.org/10.1007/s11606-018-4433-7.

The MISSION Act requires VHA to establish and monitor the quality of outside providers. Health care systems construct and measure multiple dimensions of patient care, but no single national system of quality reporting exists in the United States. Therefore, in general, any measures that VHA receives are not standardized. Additionally, participants in VHA's network are not required to report VHA's quality measures, and providers' quality varies. The quality of many discrete services, like kidney dialysis or monitoring of cholesterol levels, are probably similar across providers, whereas more complicated, clinician-intense treatments, like mental health care and occupational therapy, probably differ substantially.

VHA has several new initiatives to assess the quality of care from outside providers. Some monitoring may be accomplished through accreditation, a process by which standards are set and providers are reviewed to make sure they meet those standards. Accreditation from outside entities is common. Medicare providers must be certified by the state in which they practice, but outside accreditation for them is voluntary. VHA also hosts a website (www.accesstocare.va.gov/) that provides quality comparisons for its own facilities and some non-VHA providers using information from the Centers for Medicare & Medicaid Services and others. Certain measures, such as mortality rates and adherence to safety protocols, are easy to document. But other dimensions of health care quality are hard to assess: Patient satisfaction, for instance, probably has little to do with the clinical quality of care provided.[37] And although VHA can promote its services and veteran-focused care, veterans may prioritize convenience even if that results in lower quality than VHA provides.

Utilization of VHA Facilities

In certain parts of the country, VHA faces imbalances between the size and location of its medical facilities and the number of veterans living in those states. According to VHA, increasing veterans' access to community care will expand capacity and efficiency in some of its medical centers; it may also allow VHA to avoid the high capital costs of building new facilities. But in other places, increasing access to outside providers could reduce veterans' use of facilities that have sufficient capacity today, which could lead to higher costs per veteran patient if VHA cannot close or consolidate those facilities.

Improved Patient Flow in Areas With Insufficient Capacity. During the late 1990s and 2000s, VHA invested heavily in infrastructure as it shifted from primarily acting as an inpatient provider to offering more outpatient and broad-based care for any veteran who enrolled. Most VHA hospitals and large outpatient clinics are in states east of the Mississippi River that have traditionally been densely populated by veterans, such as Pennsylvania, Ohio, and Illinois. Since then, however, many older veterans from the Northeast or Midwest—colder and often more expensive areas of the country—spend part of the year in or have retired to states in the Southeast and Southwest. As a result, some states have a large number of VHA facilities relative to the number of enrollees and others have fewer than average (see Figure 2). For example, New York has the same number of VHA hospitals and clinics as Florida but less than half the enrollees. Likewise, Massachusetts has twice the number of VHA facilities that Nevada has but only 10 percent more enrollees. There may be shorter waits in places like Hartford, Connecticut, than in locations farther south, like New Mexico and western Alabama. However, CBO determined that geographic region and longer wait times do not directly correlate because wait times are influenced by many factors, including how facilities are managed.

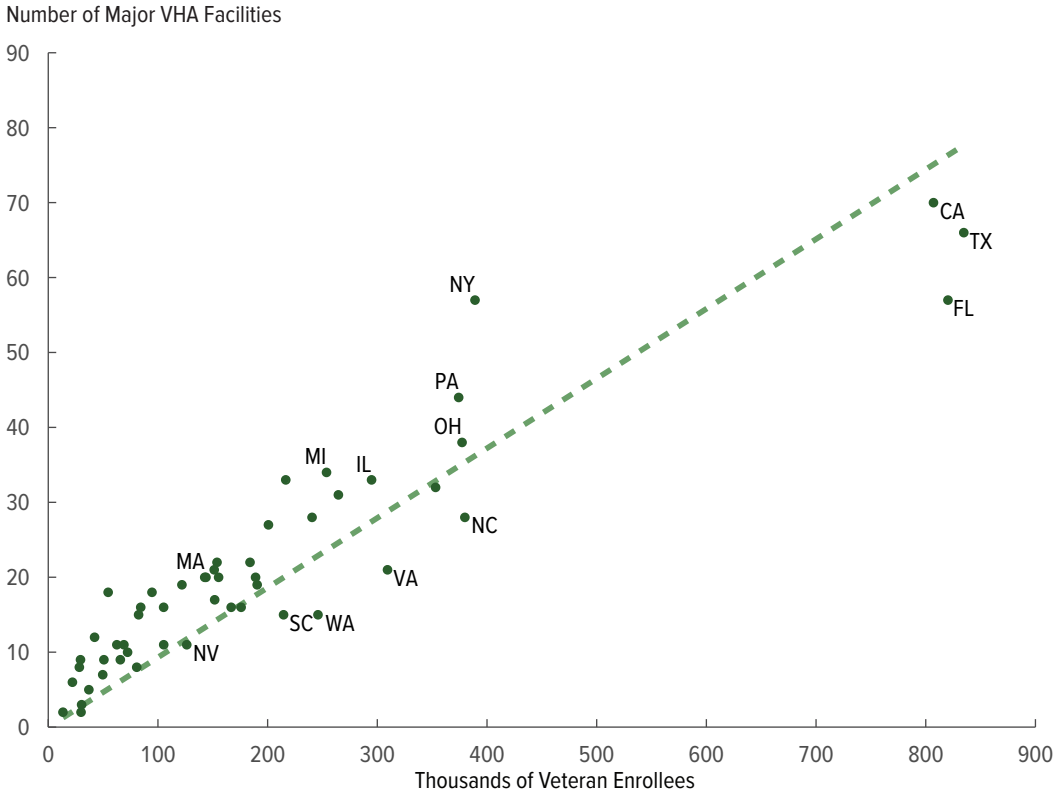
If VHA was able to rely on the private sector to treat veterans in areas of the country where delays occurred, it could ensure timely care for veterans in existing VHA hospitals and clinics. Moreover, VHA would save money by not making costly investments in new or larger facilities, equipment, and personnel in an era when the nation's population of veterans is shrinking. That also applies to VHA facilities that experience seasonal variation in appointment volume. However, in places where there are few private providers, access to community care may only have a small effect.

Reduced Use of VHA Facilities in Areas With Sufficient Capacity. More widespread access to outside providers could lead to fewer veterans seeking care at VHA's medical facilities that are meeting patients' needs

37. Although many health care providers use patient satisfaction surveys, research indicates that mortality rates and other technical quality measures are unrelated to patient satisfaction. See Cristobal Young and Xinxiang Chen, "Patients as Consumers in the Market for Medicine: The Halo Effect of Hospitality," *Social Forces*, vol. 99, no. 2 (December 2020), pp. 504–531, https://dx.doi.org/10.1093/sf/soaa007; and Joshua J. Fenton and others, "The Cost of Satisfaction: A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality," *Archives of Internal Medicine*, vol. 172, no. 5 (March 2012), pp. 405–411, https://dx.doi.org/10.1001/archinternmed.2011.1662.

Figure 2.

Number of VHA Facilities and Number of Veteran Enrollees in Each State in Fiscal Year 2019



On average, states had 8,500 veteran enrollees for each of their facilities in fiscal year 2019 (as shown by the dotted line). But the variation among states was significant. Those below the trend line had more veterans per facility than the nationwide average; states above it had fewer. For example, New York had about the same number of facilities as Florida but less than half the enrollees.

Data source: Congressional Budget Office, using data from the Department of Veterans Affairs. See www.cbo.gov/publication/57257#data.

Facility refers to a VA medical center; a large, freestanding outpatient clinic; or a community-based outpatient facility.

VA = Department of Veterans Affairs; VHA = Veterans Health Administration.

and operating at or under capacity. In those cases, the average cost for the remaining patients would increase because some of the facility costs are fixed. That is, maintaining existing hospitals and tertiary facilities entails high fixed costs regardless of how many veterans use them. Even when clinical staff can be relocated, buildings cannot be. Under VCCP, VHA cannot compel veterans who qualify for community care to use its facilities.

To address the underutilization that may result, the MISSION Act requires VA to develop criteria for selecting which of its facilities to modernize or dispose of to better meet the health care needs of veterans; that Asset and Infrastructure Review is set to begin in 2022. But if attempts to close underutilized VHA facilities were not successful, increased use of non-VHA providers could mean that VHA maintained expensive hospitals and tertiary facilities that served few veterans. If all current facilities remained open, some would need significant modernization, which tends to be both lengthy and costly; justifying those investments could be difficult for facilities that experienced a decline in use. If veterans' reliance on VHA increased or there were changes in other factors—such as overall economic conditions or VA policy—the underutilization of VHA facilities may be less.

This report was prepared at the request of the Ranking Member of the Senate Committee on Veterans' Affairs. In keeping with the Congressional Budget Office's mandate to provide objective, impartial analysis, the report makes no recommendations.

Elizabeth Bass prepared the report with guidance from David Mosher and Edward G. Keating. Heidi Golding and John Kerman (formerly of CBO) contributed to the analysis. Ann E. Futrell, David Newman, and Rebecca Sachs offered feedback on the draft, and Ron Gecan provided comments on the figures and table.

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Jeffrey Kling and Robert Sunshine reviewed the report. Caitlin Verboon edited it, and R. L. Rebach created the graphics and pepared the report for publication. This report is available on CBO's website at www.cbo.gov/publication/57257.

CBO seeks feedback to make its work as useful as possible. Please send any comments to communications@cbo.gov.

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Director