Veterans Healthcare Policy Institute

Strengthening Care for Veterans and the Nation

In an Article on "Value-Based" Veterans Care, Vested Interests and Misinformation

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On March 30, the prestigious medical journal JAMA Network published an article entitled "Envisioning the Veterans Affairs Health Care System of the Future." While authored by two former VA officials, Baligh Yehia and Stephen Fihn, the piece does not present a blueprint for maintaining a robust public healthcare system dedicated to veterans' needs. Instead, it endorses the continuing stealth privatization of it.

Before the article even begins, the reader is confronted by a flagrant omission. While JAMA and other scientific journals request authors list any potential conflicts of interest, Fihn and Yehia declare only their past VA work.

This is all well and good for Fihn, who recently retired after 36 years serving as a VA physician and researcher. Yehia's story is, however, more complex. Also a physician, he served in the Obama and Trump administrations and was the VA's first Deputy Under Secretary for Health for Community Care. This role was created in the wake of the VA's wait-time scandal of 2014. In it, Yehia helped construct and oversee the department's "Community Care Network," which has outsourced millions of VA appointments to the private sector.

What Yehia neglects to mention is that he left the VA to serve as Senior Vice President and President of Ascension Medical Group, one of the biggest hospital networks in the country. This could be considered a clear conflict of interest.

In the midst of the 2014 scandal, lawmakers passed the Choice Act, which vastly expanded community care. During the drafting, passage, and wake of Choice, Ascension's lobbying activity and campaign contributions spiked. While Ascension spent less than $700,000 in

lobbying in 2013, their activity and spending has steadily increased, peaking at more than $3 million in lobbying over 2019 and 2020. In recent years, the corporation has also launched aggressive ad campaigns to woo veterans away from the VA. In 2016, Ascension spent thousands on TV, radio, and online ads telling veterans that they "have a choice in healthcare." One ad concludes, "You honored your oath, and so do we." In another, produced in 2019 for Veterans Day, a former servicemember raises a prosthetic arm and recites the oath of allegiance to the Constitution. Then a nurse and doctor, themselves veterans, pledge fealty to their patients as the physician's Hippocratic oath flashes across the screen. "Ascension is humbled to employ dedicated veterans and their families to provide care to those who need it most," a solemn female voice announces.

Yehia's failure to disclose his ties to Ascension is hardly the only problematic aspect of this article. Unfortunately, the piece contains many flawed arguments and half-truths. Yehia and Fihn claim, for example, that in the past, "many health systems sought to emulate the VA's success" but that "today, in many respects, the VA is once again trailing the private sector."

They present no evidence to substantiate this assertion, which is contradicted by studies making clear it is the private sector that trails the VA on many cost and quality measures. Studies have consistently reported that the VA delivers outcomes that are not only equal, but superior to those in the private sector. This is true for cancer care, diabetes management, suicide prevention, mental healthcare, end-stage renal disease and many other conditions. As we have noted at VHPI, the many benefits of the VA were recently confirmed by three economists connected with the National Bureau of Economic Research. Their analysis of over 400,000 ambulance calls explained that veterans who were taken to non-VA emergency rooms were twice as likely to die during or after an emergency than veterans who were taken to the VA. The economists attributed what they dubbed this "VA survival advantage" to models of better communication and coordinated care. To attain these benefits for their patients, the VA also spent 21% less than private sector hospitals.

It must also be noted that the VA has led the nation in best practices implemented during the Covid-19 pandemic. For instance, an article in NEMJ Catalyst reported that "the Veterans Health

Administration offers a blueprint for rapid expansion of telehealth services during the Covid-19 pandemic." Patients have also been safer in VHA nursing homes than those in the private sector or in some state-run veterans' homes, and the VA has delivered vaccines to patients and staff in a speedy, safe, and equitable manner.

Throughout the article, Yehia and Fihn present other troubling conclusions. They insist, for example, that the veteran population will quickly and consistently decline in numbers, and that Congress will not provide money to fund their many needs.

The decision to provide the resources the VA needs is, of course, a political one and thus depends not only on veteran need but on assertive advocacy and political action. Moreover, as history shows us, when veteran need increases, so does enrollment in the VHA and spending on veteran care. To cite just one example, between 2000 and 2018, declines in the veteran population did not lead to reduced demand for, and spending on, VHA services. Rather, this decline led to a 73% increase veteran use of the VHA as well as an almost 50% increase in spending on veteran care. This has occurred, in part, because newly recognized service-related conditions mean more veterans are eligible for VHA care. As veterans age, they also tend to seek out VA care not only for their service-related conditions but also for the problems associated with normal aging. This has been the trajectory of Vietnam-era veterans and will be true of those involved in our current Forever Wars. Even if the veteran population declines, more service-related conditions will be recognized, more veterans will age, and more will seek VA care.

The authors also assume that there will be no new additions to the veteran population due to the emergence of new conflicts. Yet if we have learned anything from American history, it's that this country gets itself into a war almost every twenty years. We cannot predict that America will not embark on another conflict or be pulled into one. Assuming that the veteran population will continue to decline is therefore unwise at best and folly at worse.

The authors laud the controversial follow-up to Choice: the VA MISSION Act of 2018. Their main concerns around VA outsourcing revolve around how private sector providers enrolled in

the Community Care Network are not treated well or paid in a timely manner. To remedy these issues, the authors believe that the VA should "accelerate the move to value-based care." They write:

> *For fiscal year 2021, Congress appropriated $18.5 billion for community care, representing 20% of the VHA's $90 billion budget. These services are purchased primarily through third-party networks and are reimbursed using a fee-for-service approach pegged to Medicare rates. Alternatively, the VA could follow the lead of the Centers for Medicare & Medicaid Services and major health care delivery organizations in adopting new payment mechanisms, such as bundled payments for clinically defined episodes of care."*

As the Centers for Medicare and Medicaid Services define it: "Value-based programs reward health care providers with incentive payments for the quality of care they give to people with Medicare." These programs promise better care for individuals and populations at a lower cost.

Value-based care is part of an effort to control America's escalating healthcare costs while improving its notoriously poor outcomes. This model often fails. As Alan Sager, professor of health policy and management at Boston University's School of Public Health explains, "Value-based care is the triumph of rhetoric over reality. It's a smoke screen for allowing U.S. healthcare businesses to continue to acquire more money to deliver less care to fewer people at greater cost."

Instead of producing higher quality at lower cost, value-based care has instead raised a raft of serious ethical and clinical issues. A recent report by the Lown Institute catalogued many of these problems, including penalties for "safety net hospitals and clinicians caring for poorer patients" and distressing health metrics, including around hospital infection rates. The article points to two recent studies published in JAMA that "have found that value-based payment programs not only penalize safety net hospitals, but specifically punishes hospitals and clinicians that care for more racial and ethnic minorities."

As one healthcare expert familiar with VA recently explained to me, value-based models do not work well in systems whose mission is to serve the poor and underserved. Nor do calculations of "value" consider the VA's mandate to conduct needed research, serve as a lynchpin of the

nation's healthcare professional education system, and fulfill its Fourth Mission of serving as a backup system in a national emergency like the recent Covid-19 pandemic.

Clearly the VA needs to exercise some sort of utilization review and quality control over the non-VA providers who always have – and always will – treat veterans who cannot access VA care. To ensure high quality care at an affordable cost, however, will also require reversing the dramatic outsourcing of patient care to the private sector.

This is not, however, the path the authors propose. To assure high quality care, Yehia and Finh argue, the VA should expand "core services, such as primary care, mental health care, and key subspecialties, particularly those unique to the care for veterans, while strategically partnering with federal and trusted community clinicians to provide other services using payment models that promote shared, measurable outcomes." To state this more clearly, the authors want to reduce the VA footprint, limit its services to the management of complex chronic conditions, and send many more veterans into the private sector for things like ER visits, colonoscopies, knee replacements, and the like.

"The proposal to rip acute inpatient and specialty care from the VA would create the mirror image of the fragmented, wasteful, and dangerously uncoordinated care for which Americans spend $4 trillion yearly." Alan Sager cautions. "This is perhaps the worst thing that could be done for patients – like most veterans who use the VA – who have multiple diagnoses and many chronic health problems." In this scenario, primary providers at the VA would have great difficulty integrating and coordinating care with private sector providers for whom care coordination is not a priority. "So," Sager warns, "everything's an ambulance run and a $4000 workup."

In the book "The Fragmentation of U.S Health Care," editor Einer Elhauge paints an equally stark picture of the consequences of the kind of care fragmentation that is the hallmark of the non-VA health care system. According to Elhauge, "the average Medicare beneficiary sees two physicians and five specialists a year…those with chronic illnesses see an average of thirteen physicians a year.…each focused on the discrete symptoms and/or body parts within their

jurisdiction." Add on coronary artery disease and "the numbers increase to ten physicians and six distinct practices." n the face of this dramatic escalation of providers and targeted conditions, few in the private sector, including Medicare, are willing to pay for the kind of care coordination that is routine in the VA.[i]

Some of the consequences for veterans shifted to the private sector were outlined in a September 2020 JAMA article, which noted:

> *Without well-defined mechanisms for 2-way flow of information, it is unclear how easier access to private sector care, potentially at the expense of increased fragmentation, could translate into safer higher-quality care, regardless of the cost implications. For example, in a recent study of nearly 280 000 Medicare-eligible veterans, 18.9% received 1 or more prescriptions from the VA and Medicare Part D concurrently and among these veterans, 49.7% had a potentially unsafe medication exposure… Specialty care outside the VHA could also lead to duplicative testing and delays for veterans returning to VA facilities for care or for those receiving dual VA and community care. The ability of VA clinicians to access notes, prescriptions, reports from imaging and other diagnostic studies, and pathology reports that occur in the community is also problematic.*

Yehia and Fihn also urge the VA to utilize "more widely accepted measures of quality, utilization, experience, and cost-effectiveness of care." Ironically, when Yehia worked at VA, he argued against making sure that private sector providers who sign up for the Veterans Community Care Network assure the quality of care they provide veterans by adhering to the VA's strict quality and wait-time measures and understanding military culture as well as veterans' complex service -related conditions.

As I reported in the American Prospect and The Hill in 2017, Yehia assured members of the Senate Committee on Veterans' Affairs that veterans would only be referred to "high-performing, integrated networks" in the private sector. When West Virginia Sen. Joe Manchin asked how the VA planned to ensure that all its outside providers had the necessary "skill sets" to care for patients with complex service-related conditions, Yehia informed him that free continuing medical education (CME) credits would be offered to all approved network

physicians. Manchin then demanded to know why such training would only be voluntary, not mandatory. Yehia insisted that the VA couldn't require such proofs of competency until private doctors and hospitals had a larger volume of veteran patients. "If you put a lot of burdens on the community providers and they're seeing a handful of veterans, they won't sign up," Yehia explained.

Unfortunately, Congress followed Yehia's poor advice. The Community Care Network has dramatically expanded, in some part because providers are not required to learn about veterans' complex conditions in order to receive payment for treating them. As Yehia and Fihn correctly explain, in 2021, 20% of the VHA's annual budget will be devoted to paying for private care. Rather than using taxpayer dollars to insource care and hire more staff and make needed infrastructure improvements, the VHA now will spend — in just one year — what it spent in three under the Choice program.

Hopefully, as the Biden administration and VA Secretary Denis McDonough move forward, they reject these recipes for stealth privatization and formulate a far more fact-based vision for the future of the VA healthcare system and the health and well-being of the veterans it serves.

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[i] Einer Elhauge, editor. The Fragmentation of U.S. Health Care: Causes and Solutions. (Oxford. Oxford University Press. 2010) p3.