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DEBATE-COMMENTARY

Editorial

Veterans Affairs Health Care—It is the Local Market

Health care systems in the United States face significant financial and regulatory pressure to balance access to care with appropriate utilization of potentially expensive services. As the nation's largest integrated delivery system, the Department of Veterans Affairs (VA) relies on Congressional appropriations and a fixed-cost business model for each medical center or outpatient clinic to provide health care to over 9 million veterans. In this issue of *HSR*, Hanchate and colleagues present an analysis for how external determinants (e.g., local unemployment) impact veterans' utilization of the VA system.

This study has several important findings. The authors report that VA utilization was sensitive to numerous external determinants. For many, such as increases in unemployment or the housing price index, absolute changes in utilization were small, but significant nonetheless. The largest change in utilization occurred in states that expanded Medicaid eligibility following passage of the Affordable Care Act. Here, aggregate VA utilization decreased by 9.1 percent among veterans' ages 18–64. No significant changes were observed in nonexpansion states. In response to external determinants such as the veterans' employment ratio, availability of employer-sponsored insurance, or the housing price index, they also found largely uniform decreases (or increases) in utilization for individual service categories. In other words, changes in utilization distributed somewhat evenly across inpatient care, pharmacy use, and VA payments to non-VA providers.

Predicting the future health care needs of any population is difficult. The authors appropriately highlight the complex and multifactorial decisions necessary for accurate, long-term policy planning. This study also demonstrates the interconnectedness of U.S. health care systems. It shows how changes in one safety net program directly impact others. While increases in the availability of

private insurance or Medicaid decreased utilization of the VA system, the opposite was also true. Regions that have limited options for coverage, or those with unfavorable local economies, rely more heavily on the VA.

The authors recommend that VA incorporate external determinants in subsequent funding calculations to more accurately match veterans' needs with limited taxpayer resources. Furthermore, they suggest merging VA discharge data with emerging all-payer registries' certain states is beginning to develop. This could serve as a tremendous resource for understanding long-term health care utilization patterns—especially for high-risk patient populations, such as veterans with disabilities or low socioeconomic status.

In 2015, VA began planning for the future in which high-performing networks leverage VA and private sector providers to meet veterans' needs in all regions of the country (Shulkin 2016). Congress recently passed the VA MISSION Act of 2018. This legislation is critical toward the formal implementation of high-performing networks (VA's Community Care Networks) and long-term strategies for balancing utilization of VA services with those in the private sector. It also has the potential to address many of the policy-relevant strategic opportunities discussed in the study by Hanchate and colleagues. Perhaps most relevant is the MISSION Act's explicit mandate that VA performs local market assessments at least every four years. Market evaluations will ensure that VA's local networks are responsive to external determinants (i.e., those used in the study) and other factors that reflect the capacity and quality of services.

This study highlights a clear need for better data. Within the context of certain limitations, the authors did a commendable job addressing the potential for bias from differences in beneficiaries' baseline health status. As individuals move between systems, it becomes increasingly difficult to distinguish new from existing comorbidities. Under this new legislation, VA will require a greater exchange of veterans' health care data with private sector providers. Key to this endeavor is ongoing efforts to improve the interoperability of electronic medical records. In addition, VA is advocating for veterans to have greater accessibility to their own health care data. Moving forward, it is also important for VA to partner with other public and private sector delivery systems to address specific gaps in knowledge. For example, the current methods to assess each regions' capacity to provide services are limited by a lack of

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accurate data on the specific locations of physicians, physician assistants, and nurse practitioners. Partnerships with public and private payers can improve this process and help ensure that local needs are met in an effective and responsible manner.

Veterans Affairs is also working to become a more responsive system. It is worth considering that, for certain external determinants, the magnitude of their effect could have been diminished by the fact that data in this study were aggregated at the state level. Local shifts in unemployment, housing prices, or the accessibility of primary care physicians may have a more dramatic impact on VA versus private sector utilization. Under the MISSION Act, VA will be able to more accurately evaluate local health care markets for access and quality. VA-specific resources should better reflect local demand. This is particularly important for the VA patient population. While approximately one in five Americans live in rural communities, that number is higher for veterans, where one in three live in areas with limited capacity. In some rural areas, there may be few incentives for private sector health systems to recruit providers and expand the scope of their own services. VA is also creating national provider agreements so that telemedicine services can be delivered to and from anywhere in the country. Expanding telemedicine and other virtual health technologies requires less local infrastructure and may be a more versatile strategy to address certain access issues. Finally, for a select number of service lines, VA also has the opportunity to use competition with local providers as a strategy to drive greater improvements in quality and efficiency.

It is important to consider that shifting utilization away from VA may have unintended consequences. VA is well-known to provide certain services with higher quality, or lower cost, than the private sector. For example, several prior studies found that VA care was associated with lower mortality following treatment of coronary artery disease and certain cancers. (Keating et al. 2011; Barnett et al. 2018) Another recent article in *JAMA* identified an increase in conservative management strategies for low-risk prostate cancer at VA medical centers. (Loeb et al. 2018) The latter example suggests that the integrated health care system model, and an absence of volume-based financial incentives, may promote more appropriate care in certain circumstances. External determinants that shift utilization from VA could result in more veterans receiving lower quality care. While patient preferences are also important, it is critical that policy makers continue to anchor policy goals on optimizing quality, safety, and access.

While other insurers or delivery systems focus on nearer-term needs and risks, VA is responsible for the entire lifespan of eligible veterans. As a result, VA has considerable interest in the longitudinal care of its high-risk populations. Veterans who are unemployed, have low socioeconomic status, or specific battlefield-related injuries stand to be impacted most by external determinants. For these individuals, rapid shifts in policy may lead to fragmentation of care and higher resource utilization. Funding VA based on year-to-year fluctuations in utilization may ignore the longer-term strategic advantages of a system built on a lifetime responsibility to its beneficiaries. Close attention to local market dynamics is and will be imperative to meet veterans' needs and assure that their care is consistently timely and high quality.

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Appendix SA1: Author Matrix.