Partnered Evidence-Based Policy Resource Center

POLICY BRIEF

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Cost, Quality, and Access of Fee-For-Service Purchased Care vs. VHA Care for Veterans

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Through the Choice Act,[1] the VHA expanded its role as a purchaser of care, alongside its more familiar role as a provider. Under the Act, the VHA purchases non-VHA care at fee-for-service (FFS) or Traditional Medicare (TM) prices for Veterans living too far from or waiting too long for care at a VHA facility. Further expansion of purchased care invites an opportunity for the VHA to reconsider not just for whom to offer it, but how to pay for it.

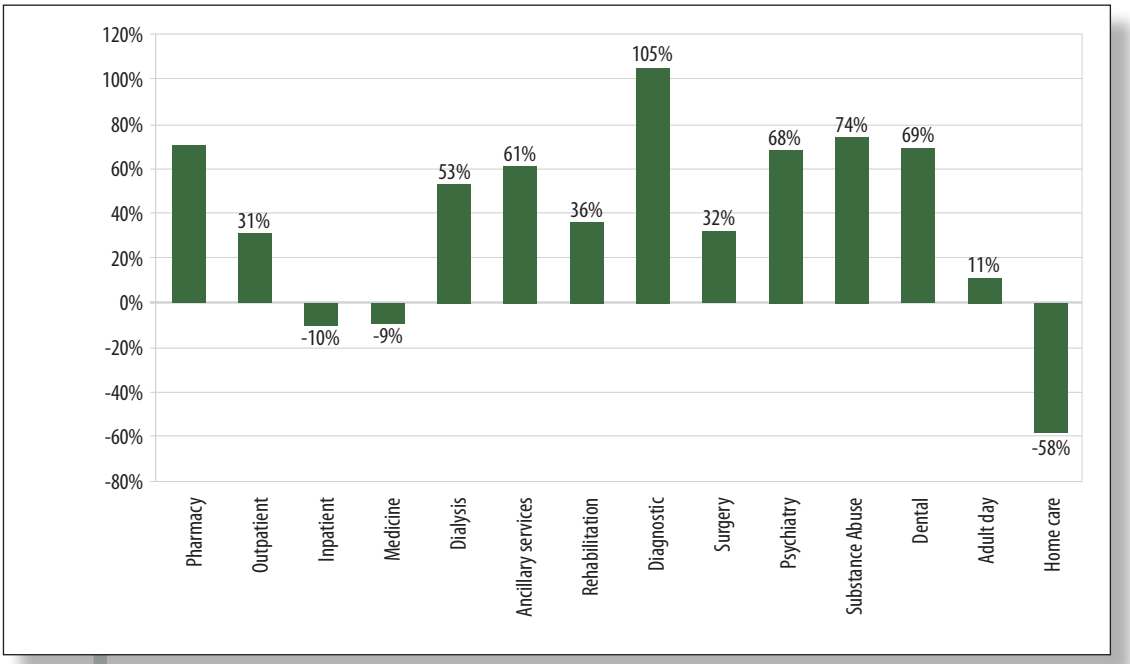
Published evidence can help us understand the impact on cost and quality of different ways to pay for healthcare. This policy brief explores the cost and quality of FFS-purchased care relative to VHA care.

Cost of Care

Because cost is the product of price and volume, we address those two components separately in this section.

"Price" for Services. Published studies infer the prices of different services provided by the VHA from cost accounting methods, permitting a comparison to TM's FFS prices, at least for services provided by both systems. For outpatient services and prescription drugs, VHA prices are below those of TM. For inpatient care, they are higher. Phibbs et al. (2003) estimated that VHA's prices of certain outpatient services—such as dialysis, rehabilitation, surgery, diagnostic testing, and psychiatry—are about 24-51% lower than TM's.[2] Nugent et al. (2004) estimated that VHA outpatient care would cost 30% more at TM prices, pharmacy services would cost 70% more, and inpatient care (excluding nursing homes and rehabilitation facilities) would cost 10% less.[3] Frakt, Pizer, and Feldman (2012) argued that the VHA pays substantially less for prescription drugs, relative to Medicare Part D plans, in part because it has the ability to exclude costly—but not more effective—drugs from its national formulary.[4]

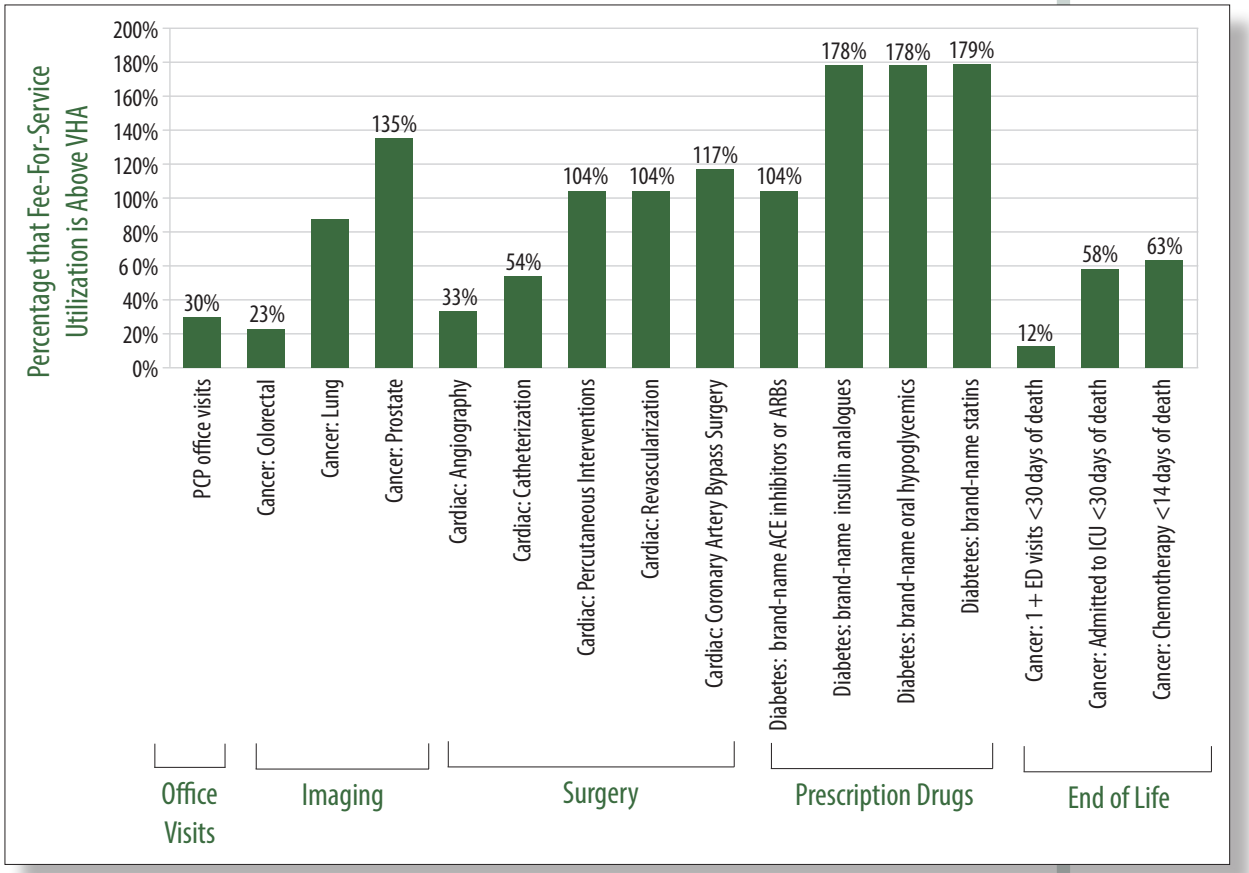
Figure 1: Price Markup: Fee-for-Service Percentage Above VHA



Published studies compare VHA and TM prices for certain services at a given point in time, providing a simplistic estimate of how prices might change if the VHA were to purchase care like TM does. To improve the estimate, we should consider three issues. First, a large portion of VHA-provided services are not covered by TM, such as dental services (Phibbs et al. 2003). VHA would need to negotiate its own fees per service without having the TM reference point. Second, with recent wars, the case mix of and thus services needed by today's Veterans may be different from Veterans' services at the time of these studies. The proportion of care accounted for by prescriptions, outpatient services, and inpatient services will influence how prices will affect overall cost. Third, the VHA has substantially fewer beneficiaries than TM. With so many beneficiaries, TM has the market power to establish lower prices and still have providers treat its beneficiaries. The VHA may have more difficulty in negotiating prices as low as TM and still have Veterans be treated in a timely manner and by high-quality providers.

Volume of Care. Previous studies have shown that purchasing care via fee-for-service contracts encourages providers to deliver more services, increasing spending without necessarily improving outcomes. In particular, studies have shown that patients covered by TM received 30% to over 100% more services than comparable patients in the VHA, depending on the service (see Figure 2). Most recently, McWilliams et al. (2014) found that patients covered by TM who had certain cancers received on average 92% more imaging services than similar patients covered by the VHA.[5] Fee-for-service payment can incentivize providers to spend more hours seeing patients.[6] This could reduce wait times and improve access. These volume effects will increase cost.

Figure 2. Utilization Markup: Fee-For-Service Percentage Above VHA



Quality of and Access to Care

Quality. Purchasing care from community providers via a FFS system could negatively impact quality of care, depending on a patient's condition. Studies have shown that patients with certain types of conditions who are treated at the VHA have better health outcomes and experience higher quality care than those treated by TM-paid providers and providers in other non-VHA settings.[7] Fee-for-service systems incentivize providers to spend less time per patient.[8] In addition, switching from the current VHA system to a TM-like system may worsen the coordination of care. Veterans would shift from a relatively centralized team of providers to decentralized, independent providers.[9] However, a few studies have indicated that in some areas, community hospitals have more up-to-date technology than VHA hospitals, which could improve Veteran health outcomes for conditions that require such technology.[10]

Access. As mentioned previously, FFS payment can incentivize providers to see more patients, potentially improving access. However, there may be limited supply of the types of providers that Veterans need, unless the VHA is willing to pay more to attract providers to enter the market. Veterans have a higher use of mental health services, PTSD treatment, and long term care. Phibbs et al. (2003) found that approximately 20% of the procedures performed in the VHA were not covered by TM and potentially other health plans.

Conclusion

In sum, the evidence suggests that if the VHA transitioned to a FFS system, it should expect cost to increase and quality (of certain services) to worsen, though access could improve. Fee-for-service, however, is not the only way to purchase care. Risk-based and value-based contracting are purchasing methods designed to reward and penalize providers based on patient health care cost and/or health outcome metrics. These approaches were promoted by the Patient Protection and Affordable Care Act of 2010.[11] Please see PEPReC Policy Brief 2016 Vol. 1, No. 3 for more information.

Endnotes

[1]Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146).

[2] Phibbs, C., Bhandari, A., Yu, W., Barnett, P. (Supplement to September 2003) Estimating the Costs of VA Ambulatory Care. Medical Care Research and Review, 60, p. 354-73.

[3] Nugent, G.N., Hendricks A.M., Nugent, L., Render, M.L., 2004. Value for taxpayers' dollars: what VHA care would cost at Medicare prices. Medical Care Research and Review, 61 (4), p. 495-508.

[4] Frakt, A., Pizer, S., and Feldman, R., 2012. Should Medicare adopt the Veterans Health Administration formulary? Health Economics. 21(5), p. 485-95.

[5] McWilliams, M.J., Dalton, J.B., Landrum, M.B., Frakt, A.B., Pizer, S.D., and Keating, N.L., 2014. Annals of Internal Medicine, 161 (1), p.794-802.

[6] Ferrall, C., Gregory, A., and Tholl, W., 1998. Endogenous work hours and practice patterns of Canadian physicians. Canadian Journal of Economics, 31(1), p. 1-27.

[7] Trivedi, A.M. et al. (2011) Systematic Review: Comparison of the Quality of Medical Care in Veterans Affairs and Non-Veterans Affairs Settings. Medical Care, 49(1), pp. 76–88.

[8] Longman, P., 2013. Best Care Anywhere: Why VA Health Care Is Better Than Yours. Department of Veterans Affairs, VHA Facility Quality and Safety Report, Fiscal Year 2012 Data, p. 12–17.

[9] Asch, S.M., McGlynn, E.A., Hogan M.M., Hayward R.A., Shekelle P., Rubenstein L., 2004. Comparison of Quality of Care for Patients In the Veterans Health Administration and Patients in a National Sample. Annals of Internal Medicine, 141, pp. 938-45.

[10] Landrum M.B., Keating N.L., Lamont E.B., Bozeman S.R., Krasnow S.H., Shulman L., 2012. Survival of older patients with cancer in the Veterans Health Administration versus fee-for-service Medicare. Journal of Clinical Oncology, 30(1), p. 1072-9.

[11] Kerr E.A., Gerzoff R.B., Krein S.L., Selby J.V., Piette J.D., Curb J.D., 2004. Diabetes care quality in the Veterans Affairs Health Care System and Commercial Managed Care: the TRIAD study. Annals of Internal Medicine, 141, p.272-81.

Figure Citations

Fig. 1: *Note:* The outpatient services estimate excludes pharmacy and prosthetics. *Definition:* VHA: Veterans Health Administration. *Sources (from left to right)*: Nugent et al. (2004) produced the pharmacy and inpatient estimates in the figure. Phibbs et al. (2003) produced the outpatient services estimate and estimates for specific outpatient service categories.

Fig. 2: *Definitions:* VHA: Veterans Health Administration. PCP: primary care physician. ACE: angiotensin converting enzyme. ARBs: angiotensin receptor blockers. ED: emergency department. ICU: intensive care unit. *Sources (from left to right):* Hickson, Altemeier, and Perrin (1987) produced the estimate for office visits. McWilliams et al. (2014) produced the estimates for cancer imaging. Petersen et al. (2003) produced the estimates for angiography. Landrum et al. (2004) produced the estimates for cardiac surgery. Gellad et al. (2013) produced the estimates for brand-name prescription drug use. Keating et al. (2010) produced estimates for end of life services.

About PEPReC Policy Briefs

This evidence-based policy brief is written by the Partnered Evidence-based Policy Resource Center (PEPRec) staff to inform policymakers and VHA managers about the evidence regarding determinants of demand for VHA care within the broader health system and economy. PEPReC, the Partnered Evidence-based Policy Resource Center, is a QUERI-funded resource center that collaborates with operational partners to design and execute randomized evaluations of VHA initiatives, develops and refines performance metrics, and writes evidence-based policy briefs.

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