DOI: 10.1111/1475-6773.14162

RESEARCH ARTICLE

HSR Health Services Research

Payer shifting after expansions in access to private care among veterans

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Funding information
Health Services Research and Development

Abstract

Objective: To investigate whether expanded access to Veterans Affairs (VA)-purchased care increased overall utilization or induced a shift from other payers to VA for emergency care among VA enrollees.

Data Sources and Study Setting: This study included all emergency department (ED) encounters in 2019 from hospitals in the state of New York.

Study Design: We conducted a difference-in-differences analysis comparing VA enrollees to the general population before and after the implementation of the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act in June 2019.

Data Collection/Extraction Methods: We included all ED visits with individuals aged 30 or older at the time of the encounter. Individuals were considered eligible for the policy change if they were enrolled with VA at the beginning of 2019.

Principal Findings: Of the 5,577,199 ED visits in the sample, 4.9% ($n = 253{,}799$) were made by VA enrollees. Of these, 44.9% of visits were paid by Medicare, 32.8% occurred in VA facilities, and 7% were paid by private health insurance. There was a 6.4% (2.91 percentage points; std. error = 0.18; $p < 0.01$) decrease in the proportion of ED visits paid by Medicare among VA enrollees relative to the general population after the implementation of the MISSION Act in June 2019. This decrease was larger for ED visits with a subsequent inpatient admission (−8.4%; 4.87 percentage points; std. error = 0.33; $p < 0.01$). There was no statistically significant change in the total volume of ED visits (0.06%; std. error = 0.08; $p = 0.45$).

Conclusions: Leveraging a novel dataset, we demonstrate that MISSION Act implementation coincided with a shift in the financing of non-VA ED visits from Medicare to VA without any increase in overall ED utilization. These findings have important implications for VA health care financing and delivery.

KEYWORDS
emergency care, insurance, medicare, veterans health, veterans health services

What is known on this topic

- Recent policy changes in the Veterans Health Administration (VA) greatly increased access to care purchased from community-based providers.

- Costs of VA-purchased care have increased dramatically, with emergency care by far the largest contributor.
- Historically, assessing the demand for care among the population VA serves has been challenging as most veterans who use VA care have other sources of coverage, such as Medicare or private insurance, and rely on those other sources of care for some of their health care needs.

What this study adds

- This study includes data from outside the VA to form a complete census of emergency department (ED) utilization for VA enrollees as well as the general population.
- We found that ED visits made by VA enrollees were less likely to be paid by Medicare relative to the general population after expanded access to purchased care, with no change in overall utilization.
- The results strongly suggest the expanded access to purchased care is shifting the fiscal burden from other insurance programs to VA.

1 | INTRODUCTION

The US Department of Veterans Affairs (VA) has long partnered with the non-VA health care community to provide certain outpatient, inpatient, and emergency care services to VA enrollees. Historically, this was provided through the VA's fee-based Patient-Centered Community Care programs and then through the Veterans Choice Act of 2014. Through the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, VA substantially expanded its role overall as a purchaser of care with greatly increased opportunities for Veterans to receive care outside VA with community-based providers, hereafter referred to as "VA-purchased care." The MISSION Act established new, permanent funding for VA-purchased care along with consolidating and streamlining existing programs.[1]

The number of veterans utilizing VA-purchased care has increased over time and these expansions have been immensely costly to VA. Most recently, VA-purchased care utilization and expenditures are growing at a faster rate than care delivered within VA facilities.[2] In 2014, VA-purchased care for Veterans accounted for $7.9 billion, or about 12% of VA's health care budget. By 2022, the cost of VA-purchased care programs had more than doubled to $23.4 billion and accounted for about 25% of VA's health care budget.[3,4] While VA has always purchased a portion of care utilized by enrollees, previous issues with access to care—including a scandal involving secret wait lists, overzealous denials of emergency care at non-VA hospitals, and a lack of funding for purchased care—led Congress to continue increasing VA-purchased care access, culminating with the MISSION Act.[5,6] The purpose of these policy changes was to ensure adequate, timely access to care for VA enrollees.

Data limitations have made it difficult to demonstrate whether expansions in VA-purchased care have had their intended effect. Previous research has demonstrated that distance to VA is associated with VA reliance, VA wait times for outpatient appointments are on par with the private sector, and there is qualitative evidence of improved access to care for some enrollees.[7–11] However, other metrics of access are often difficult to measure when care outside VA is considered.[5] The vast majority of VA enrollees do not rely on VA for all of their medical treatment, and data from VA's survey of enrollees indicates that over 80% of VA enrollees have some other form of health insurance.[12,13] Because VA does not observe the full choice set of VA enrollees, prior studies evaluating expansions in VA-purchased care are limited in observing only care that is VA-provided (care provided directly by VA at VA facilities) and VA-purchased (care paid for by VA at non-VA facilities). Absent from these analyses is a third category of care, non-VA care (care at non-VA facilities that is neither paid nor provided by the VA). Without this data, it is difficult to assess whether expansions in VA-purchased care have resulted in greater access to care that was otherwise delayed or foregone, or if access remains unchanged and costs are merely shifted from other health insurance to VA.

Because VA lacks the ability to track VA enrollees' utilization when VA is neither the payer nor the provider, there is currently no peer-reviewed evidence of how these policy changes affect the payer mix. In an effort to close this knowledge gap, we leverage a novel dataset to determine if recent expansions in VA-purchased care resulted in changes in emergency care utilization. Emergency care is an important context to study this phenomenon for two reasons. First, emergency care is by far the single largest contributor to VA-purchased care spending, comprising over one-third of the total purchased care budget while all other clinical service areas constitute less than 5% of that budget.[4] Even though VA enrollees have always been eligible for emergency care when immediate medical attention is needed, emergency care-related expenditures are growing exponentially, having increased 46% since 2020.[14] Second, policy changes associated with the MISSION Act made it easier for patients to receive emergency care at non-VA facilities and have the costs covered by VA. The most significant of these policy changes were streamlining claims submissions by implementing centralized notification—making it easier for VA enrollees to notify VA about their visit to a non-VA emergency department (ED)—and vastly reducing the proportion of visits that VA would reimburse at lower than

Medicare rates, previously used when VA was not notified of the visit within 72 h and the facility was not in the VA-purchased care network. The MISSION Act significantly expanded the VA network of community hospitals, meaning far more encounters would then be reimbursed at Medicare rates. More details—and a brief history of VA-purchased care—are provided in the supplement.

We examined how both payer mix and total utilization were affected by the implementation of the MISSION Act in June 2019. Specifically, we assessed whether increased access to VA-purchased care afforded by this policy increased total ED utilization—indicating an increase in access to care afforded by the policy change—or induced shifts in the payer mix for VA enrollees seeking emergency care.

2 | METHODS

2.1 | Data sources, sample, and linkage

Non-VA ED and inpatient encounters occurring in the calendar year 2019 were identified for all New York state residents 18 years and older using the New York Statewide Planning and Research Cooperative System (SPARCS) state inpatient and ED databases. SPARCS is an all-payer data reporting system that collects information on patient characteristics, payer information, and diagnoses for ED and inpatient stays. This data is collected from all short-term, acute care New York hospitals except VA hospitals. *VA-provided ED and inpatient encounters* in the state of New York during the same period were identified using the VA Corporate Data Warehouse (CDW), a database of VA records that contains information from VA electronic medical records.

Our Veteran enrollee sample was derived from VA enrollment files and included individuals enrolled in VA care and residing in New York state during the study period. We linked these individuals to SPARCS data using patient name, date of birth, and partial social security number. We limit our analysis to ED visits and inpatient stays originating in the ED. Thus, our final dataset included all VA-provided ED encounters, VA-purchased ED encounters, and non-VA ED encounters for VA enrollees. Our non-Veteran, or general population, the sample was derived from SPARCS data and included non-Veteran, New York state residents during the study period. Finally, we limited the dataset to individuals 30 years or older to partially account for the age differences between VA enrollees and the general population, with the contrasting age distributions shown in Supplementary Figure 2.

2.2 | Analytic approach

We conducted a difference-in-differences analysis in which we compared the payers of emergency care between VA enrollees and the general population before and after the MISSION Act's implementation on June 6, 2019. Because access to VA-purchased care was not randomly assigned, we examined potential policy-induced changes in the payer mix using the general population as an ideal comparison group: these individuals live in the same geographic location and use the same non-VA facilities as VA enrollees, but are unaffected by VA policy changes. Hence, there is little risk of bias from selection into treatment or compositional change with this approach.

We identified the primary payer of each ED encounter and categorized payers into seven groups: Medicaid, Medicare (which includes both traditional fee-for-service Medicare as well as Medicare Advantage), Private, Uninsured/Self-pay, VA Community Care (VA-purchased care), VA Provided, or Other (which includes Workers Compensation, among others). All groups are mutually exclusive. While it is possible that some encounters may have had multiple payers—such as Medicare with private wraparound coverage—we focus on the primary payer both due to the fact the primary payer is responsible for the majority of the claim and because regulations prohibit VA from acting as a secondary payer to another federal program.

For our primary difference-in-differences approach, regression estimates provide the change in the probability that an ED encounter with a VA enrollee was paid from a given source before and after the policy change relative to the general population. To explain how rapidly, and to what degree, the policy changes resulted in a change in the primary payer mix, we also conducted this analysis as an event study analysis—in which we considered each month to be a separate time period. Both models relied on the assumption that if not for VA-purchased care expansion, trends in the payer mix would have been similar across VA enrollees and the general population. We demonstrate evidence of parallel trends before the policy was implemented in our main results. Regression models were adjusted for patient age, month of the year, and whether the patient was admitted. In sensitivity analyses, additional covariates were included, without significant differences in results (see Supplementary Table 4).

Finally, to show changes in utilization, we estimated the same differences-in-differences model examining the probability that any given ED encounter was made by a VA enrollee as the outcome. We also estimated the change in the count of ED encounters for VA enrollees over time relative to the period just before the policy change (May 2019). For all specifications, we also conducted subgroup analyses stratifying by whether patients were admitted or discharged following the ED encounter. Full regression specifications are available in supplemental materials.

3 | RESULTS

In 2019, 5,577,199 ED encounters were made by patients aged 30 years or older. 30% of these ED encounters resulted in hospital admission, while 70% resulted in discharge. 4.6% of all ED encounters were made by VA enrollees, and of these encounters, 32.7% of encounters occurred at VA facilities. The majority of VA enrollees were male (94.5%) and white (75.1%). Characteristics of ED encounters made for the full sample are shown in Supplementary Table 1, and characteristics of ED encounters for VA enrollees and the general population are presented in Supplementary Table 2.

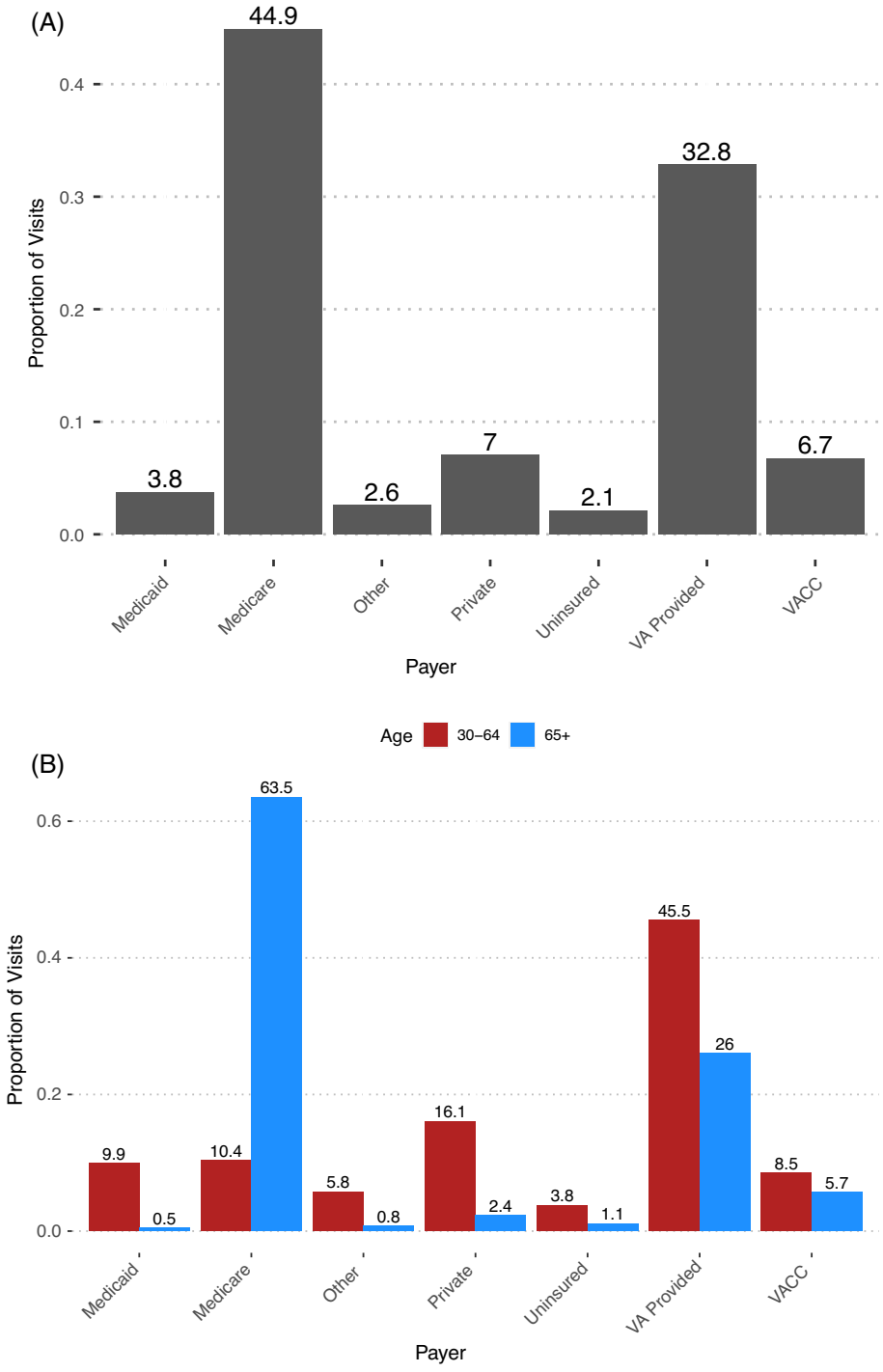

FIGURE 1 Proportion of emergency department (ED) visits by insurance type and age group for Veterans Affairs (VA) enrollees. Payer mix for all ED visits for VA enrollees in New York in 2019 (a) and split out by individuals aged 30–64 and 65+ at the time of visit (b). Payer categories are mutually exclusive, with proportions shown within each age group. *Medicare* includes both fee-for-service Medicare and Medicare Advantage. [Color figure can be viewed at wileyonlinelibrary.com]

Figure 1 shows the primary payer mix for ED encounters made by VA enrollees. Among VA enrollees of all ages, Medicare was the dominant payer (45%) of ED encounters. For those aged 65 and older, the majority (63.5%) of encounters are paid by Medicare. In this population, just over a quarter of encounters occur at VA facilities, and 5.7% are VA-purchased care encounters. Less than 5% of encounters are primarily paid by Medicaid, private insurance, self-pay/uninsured, or other insurance. In contrast, among Veterans under 65, 44.9% of ED encounters occur at VA facilities. After VA, private insurance is the most common payer (15.8%), followed by Medicaid (9.9%), Medicare (9.9%), and VA-purchased care (8.6%). Figure 2 plots the estimates of our primary model over time. Each point represents the difference in the probability that an ED encounter is paid by Medicare between VA enrollees and the general population in each month, with estimates relative to May 2019 just before the MISSION Act was implemented. Prior to implementation, there was no significant difference in the likelihood that an ED encounter would be paid for by Medicare. However, there is an immediate shift downward after the law's implementation, meaning ED visits for VA enrollees were less likely to be paid by Medicare relative to the general population. This is true for both

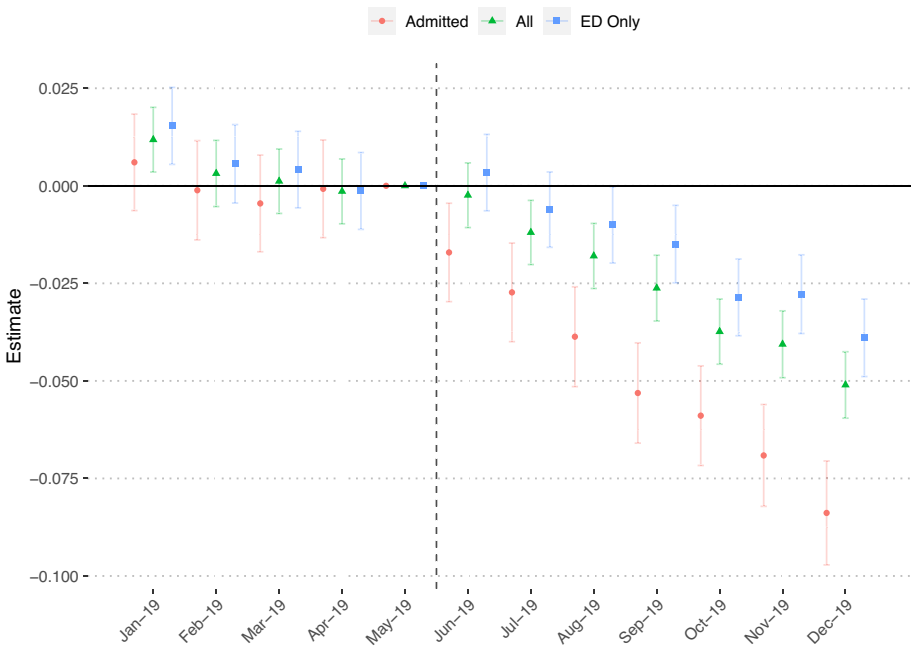

FIGURE 2 Difference in probability of having Medicare as the payer of an emergency department (ED) visit for Veterans Affairs (VA) enrollees compared to all other individuals by month, all ED visits, and visits with and without a subsequent admission. Event study figure showing the difference in probability that Medicare pays for an ED visit between VA enrollees and all others by month. The dashed line represents the implementation of the MISSION Act in June 2019. Estimates are relative to May 2019, just before the law was implemented. All ED visits are shown in green, visits with a subsequent admission in pink, and visits without a subsequent admission in blue. [Color figure can be viewed at wileyonlinelibrary.com]

TABLE 1 Regression estimates of changes in the payer mix after the implementation of the MISSION Act in June 2019.

	Medicare as payer	Medicare as payer, ED Only	Medicare as payer, admitted	Private payer	Private payer, ED only	Private payer, admitted	VACC as payer	VACC as payer, ED only	VACC as payer, admitted
All									
Estimate	−2.91	−2.18	−4.87	−0.37	−0.49	−0.06	1.69	0.93	3.34
SE	(0.18)	(0.21)	(0.33)	(0.11)	(0.00)	(0.16)	(0.10)	(0.12)	(0.19)
Mean in May 2019	45.31	39.70	57.92	6.70	8.09	3.58	6.12	5.98	6.42
% Change	−6.42	−5.49	−8.41	−5.52	−6.06	−1.68	27.61	15.55	52.02
Over 65									
Estimate	−3.08	−2.35	−4.62	0.20	0.26	0.22	1.95	0.99	3.54
SE	(0.23)	(0.31)	(0.38)	(0.08)	(0.02)	(0.10)	(0.12)	(0.14)	(0.21)
Mean in May 2019	64.06	60.96	69.24	2.19	2.63	1.18	5.11	4.84	5.54
% Change	−4.81	−3.85	−6.67	9.13	9.89	18.64	38.16	20.45	63.90
Under 65 (age 30–64)									
Estimate	−1.79	−1.52	−3.95	−0.86	−0.98	−0.98	0.98	0.64	2.52
SE	(0.20)	(0.21)	(0.56)	(0.26)	(0.29)	(0.58)	(0.19)	(0.20)	(0.51)
Mean in May 2019	10.65	9.53	15.58	15.23	15.85	12.54	7.98	7.58	9.71
% Change	−16.81	−15.95	−25.35	−5.65	−6.18	−7.81	12.28	8.44	25.95

Note: Regression estimates from a differences-in-differences model that gives the percentage point changes in the proportion of visits for VA enrollees paid by a specified payer after the implementation of the MISSION Act in June 2019. Estimates are shown with the proportion paid by that payer in May 2019 for VA enrollees. The final three columns give estimates of a regression with only VA enrollees relative to May 2019, as the general population is not eligible for VA community care (VACC) as a payer.

Abbreviations: ED, emergency department; MISSION, Maintaining Internal Systems and Strengthening Integrated Outside Networks; VA, Veterans Affairs.

ED encounters with and without subsequent inpatient admission. Point estimates for this figure are shown in Supplementary Table 5 and unadjusted time trends of payers for both Veterans and the general population are available in Supplementary Figure 1.

Table 1 presents regression estimates from the differences-in-differences analysis. The proportion of ED encounters paid by Medicare fell 2.9 percentage points for VA enrollees relative to the general population (std. error = 0.18; $p < 0.01$). 45.3% of all ED encounters

for VA enrollees were paid by Medicare just before the MISSION Act, translating into a 6.4% drop in the proportion of Medicare-paid visits. This effect is stronger for ED encounters with a subsequent inpatient admission, where there was an 8.4% drop in the proportion of visits paid by Medicare for Veterans relative to the general population (point estimate −4.87; std. error = 0.33; $p < 0.01$). The bottom panel of Table 1 shows similar estimates for the over-65 population, emphasizing both that Medicare is the dominant payer and that older Veterans constitute a majority of the sample (see Supplementary Table 2). The proportion of ED encounters paid by private insurance also decreases, although not for ED encounters with subsequent inpatient admission. The estimate for all VA enrollees is −0.37 percentage points (std. error = 0.11; $p < 0.01$), signifying a 5.5% decrease from the 6.7% of encounters paid by private insurance for VA enrollees before the policy change. The effect on private insurance was larger for those under 65, although also not statistically significant for ED encounters with a subsequent admission.

Table 1 also shows the increase in the proportion of ED encounters paid by VA-purchased care. This specification lacks a general population control group, as non-Veterans are not eligible for VA-purchased care programs and payment. However, it is useful as evidence that the drop in the proportion of encounters paid by Medicare coincided with an increase in the proportion of visits paid by VA-purchased care. Accordingly, there was a 27.6% increase in the proportion of encounters with VA-purchased care as the payer after June 2019 (point estimate 1.69; std. error = 0.1; proportion paid by VA-purchased care 6.12% in May 2019; $p < 0.01$). This increase is more than 50% when examining ED encounters with a subsequent inpatient admission (point estimate 3.34, std. error = 0.19; proportion paid by VA-purchased care 6.42% in May 2019; $p < 0.01$).

Figure 3 shows the change in the count of VA enrollee ED encounters relative to May 2019. There is no change in overall ED utilization following the implementation of the MISSION Act, regardless of disposition. Table 2 shows estimates of the percentage point change in the proportion of all encounters with VA enrollees. These estimates are not statistically significant (0.06; std. error = 0.08; $p = 0.45$).

TABLE 2 Regression estimates of changes in ED utilization after the implementation of the MISSION Act in June 2019.

	All ED visits	ED only	Admitted
All			
Estimate	0.06	0.14	−0.17
SE	(0.08)	(0.09)	(0.15)
Mean in May 2019	3.60	3.45	4.00
% Change	1.66	4.20	−4.21
Over 65			
Estimate	0.05	0.11	−0.09
SE	(0.20)	(0.28)	(0.27)
Mean in May 2019	8.96	10.20	7.38
% Change	0.54	1.08	−1.19
Under 65 (Age 30–64)			
Estimate	0.06	0.16	−0.24
SE	(0.07)	(0.08)	(0.14)
Mean in May 2019	2.15	2.28	1.72
% Change	3.06	6.98	−14.2

Note: Regression estimates from a differences-in-differences model that gives the percentage point changes in the probability that an ED visit is with a veterans affairs enrollee after the implementation of the MISSION Act in June 2019.

Abbreviations: ED, emergency department; MISSION, Maintaining Internal Systems and Strengthening Integrated Outside Networks; VA, Veterans Affairs.

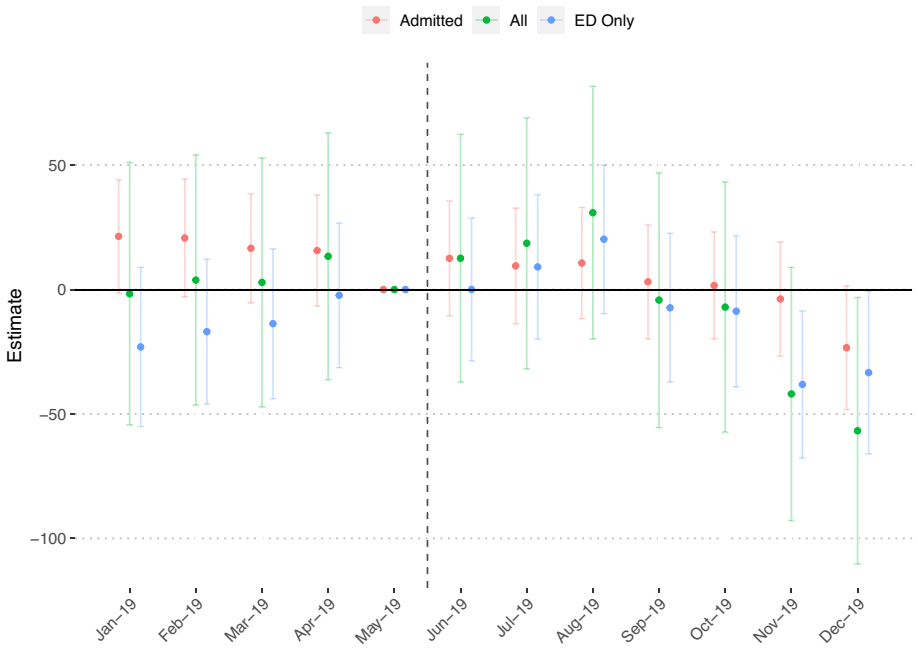

FIGURE 3 Change in the count of emergency department visits for Veterans Affairs (VA) enrollees relative to May 2019. Event study figure showing the difference in the count of all emergency department (ED) encounters for VA enrollees at all providers by month. The dashed line represents the implementation of the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act in June 2019. Estimates are relative to May 2019, just before the law was implemented. All emergency department visits are shown in green, visits with a subsequent admission in pink, and visits without a subsequent admission in blue. [Color figure can be viewed at wileyonlinelibrary.com]

4 | DISCUSSION

The MISSION Act-related changes in provider networks, notification processes, and reimbursement rates have simplified the process of approving and paying for VA-purchased emergency care. Leveraging a novel dataset, our results show these changes were associated with an immediate and striking shift in who pays for emergency care for VA enrollees—with a shift toward VA as the primary payer of emergency care. This effect is most pronounced for the costliest ED encounters—those that result in an inpatient admission.

The extent to which this phenomenon is patient- or provider-driven is unclear and should be addressed in future work. While data on billing decisions are not observed, hospital incentives to favor a particular payer when presented with a choice may depend on several factors. VA enrollees are encouraged by VA to go to the nearest ED when life or health is in danger, and VA takes on the role of the insurer by paying the claim sent by the non-VA hospital after the fact. Historically, however, VA had been slow to process ED claims, had high rates of denied claims, and often paid 70% of Medicare rates.[15] In an effort to address these shortcomings, implementation of the MISSION Act resulted in several changes to VA's emergency care policies. These policy changes include expanding VA's network of community EDs, streamlining claims submissions by implementing centralized notification, improving medical claims adjudication, and new payment authorities that increased reimbursement rates from VA to community hospitals with most claims now paid at 100% of Medicare rates. Higher and more expedient payments from VA may incentivize providers to bill VA for emergency care as opposed to Medicare or another insurance provider. While no research to date has shown that providers have modified billing practices in accordance with changes in VA policies, previous research has shown that providers are extremely sensitive to government payment changes in Medicare and Medicaid, both in their willingness to accept patients and in their coding and billing practices.[16–18]

VA is prohibited from sharing costs with Medicare and other federally-funded insurance programs. This is problematic given that Medicare is by far the most common source of health insurance for Veterans—a reflection of the Veteran population where the modal enrollee is just under 65.[13] Patient financial responsibility varies substantially depending on the payer. If a Medicare-enrolled Veteran seeks emergency care in a non-VA facility and requires inpatient hospitalization, they face a minimum out-of-pocket cost of $1566 in 2022 if Medicare is the payer, and $0 for the same service if VA is the payer. This difference can quickly compound with repeated hospitalizations, post-acute care, and/or associated medications, all of which are either free or substantially less costly when VA is the payer. These differences in cost-sharing also exist with private health insurance—where the average inpatient coinsurance amount is 20%—and Medicare Advantage, which typically imposes a daily copayment that can add up to larger out-of-pocket costs than traditional Medicare for longer stays.[19,20] Thus, for the patient, there is a consequential incentive for VA to be the payer when afforded a choice.

4.1 | Policy implications

Regardless of the cause, the large increase in spending on VA-purchased emergency care has prompted VA officials to explore options to control the growth in expenses. The stated intent of the MISSION Act was to create a high-performing, integrated network of VA and community-based providers who seamlessly provide Veterans with high-value care while increasing access to care. Our results suggest that rather than increasing access to acute care, these policy changes have only resulted in a substitution of primary payers for the same care. While our analysis is limited to emergency care and limited in geography, it is possible that similar shifts in the payer mix are occurring nationwide and in other outpatient services, and warrants future investigation.

There are several paths forward for policymakers. First and perhaps most simply, Congress could choose to adjust future funding allocations to VA to ensure the budget can accommodate payer shifting. This solution would allow Veterans to seek care at the location that is most convenient for them. The obvious drawback is that this may result in substantial increases in fiscal spending.[3] This analysis indicates that there is still substantial room for growth of VA-purchased care, as more individuals may shift away from Medicare and private payers and to VA-purchased care in the future.

Second, if VA does not receive enough funding to accommodate growth in VA-purchased care costs, Congress could legislate more restrictive access criteria for use of VA-purchased care or rescind enrollment for Veterans in lower priority groups. Specific to emergency care, VA could choose to scale back benefits for VA-purchased emergency care by including more stringent eligibility requirements, implementing copays commensurate with Medicare, or transferring patients back to VA facilities before inpatient admission. VA may also choose to institute requirements that improve communication between non-VA facilities and VA providers. However, this approach could result in unintended delays or avoidance of medical care and is likely to be unpopular among patients and policymakers. VA may also expand primary care, urgent care, and/or improve and expand virtual telehealth centers that are currently in operation, but we note that our results indicate total VA and non-VA emergency visit volume did not change during the study period, meaning this approach would have to impact total ED utilization.[21]

Finally, Congress could choose to bring down the fiscal wall between Medicare and VA, as has been proposed in the past and has been the topic of recent lawsuits against VA.[22–24] Cost-sharing could take many forms, but perhaps the most straightforward approach would be to assign Medicare as the primary payer as is currently standard in the Military Health System. If results from this analysis are indicative of the entire VA population, then a substantial portion of VA-purchased emergency care is provided to Medicare-enrolled Veterans. Our data show that 65% of ED encounters made by Veterans 65 and older, and an additional 10% of ED encounters made by those under 65, were paid for by Medicare. With 4.5% of VA enrollees living in New York, extrapolating to the national VA population would result in $9.4 billion per year that could be shared between VA and Medicare (using a mean estimate payer cost of $2410 from SPARCS data).

This is a relatively small portion of Medicare's $830 billion budget. If payer shifting is also happening in service areas outside of the ED, our results underestimate the extent of this phenomenon. In this case, policy changes that improve cooperation between VA and Medicare could benefit both agencies and their beneficiaries.

4.2 | Limitations

In addition to the issues in pinpointing the drivers of our results discussed above, the primary limitation of this study is that it is limited to ED care. This setting choice was selected both because emergency care is the single largest contributor to VA-purchased care spending and because of data limitations. The SPARCS data provides data for all ED and inpatient care but does not currently include outpatient care data. Future research may examine whether our findings are generalizable to other outpatient services as data become available.

Second, the data in this manuscript are limited to encounters in the state of New York. While New York is a populous state, it is not necessarily representative of all VA enrollees. Supplementary Table 3 shows differences between Veterans in New York state and those residing elsewhere during the study period. VA enrollees in New York are more likely to be older, male, and live in an urban area. They are also less likely to have high VA disability ratings and have lower Elixhauser comorbidity scores. However, previous work has shown that enrollees in other states have similar distributions of payers for inpatient care.[12]

Finally, this observational study relies on the assumptions of any difference-in-differences analysis. This includes the parallel trends assumption that the VA enrollee and general population groups do not have time-varying differences other than the effects of the policy change. We provide evidence of the validity of this assumption with the event study analysis, and we are not aware of any New York-specific laws implemented in 2019 that would have affected VA enrollees and the general population differently in terms of payment sources for emergency care. To our knowledge, there was no physical change in VA ED capacity (e.g., opening or closing an ED) during the study period. We also provide evidence that there was no change in an operational capacity in VA EDs in Supplementary Table 6, which shows that ED volumes, door-to-triage time, and door-to-provider time all remained stable throughout the study period. The MISSION Act also included increased access to non-VA urgent care to VA enrollees, but early research indicated this benefit was not used widely at first.[25] Further, increased use of the urgent care benefit in place of VA and non-VA EDs would only bias estimates upward if the increase siphoned from VA EDs more than non-VA EDs, which seems unlikely given the payer mix shown in Figure 1. However, how these policy changes affected the mix between ED and urgent care should be investigated in future work.

5 | CONCLUSIONS

The VA has undergone a major transformation in the way that care is delivered to Veterans with an increasing rate of reliance on VA-purchased care. While new changes have simplified the process of approving and paying for VA-purchased emergency care, these changes have resulted in a substantial shift in the payer mix for ED visits made by VA enrollees in non-VA settings. Policymakers and VA should articulate a clear strategy for how pricing and payment policy reforms can be leveraged to ensure the fiscal solvency of the VA community care program.

ACKNOWLEDGMENTS

The data used to produce this publication was provided by the New York State Department of Health (NYSDOH). However, the conclusions derived and views expressed herein are those of the author(s) and do not reflect the conclusions or views of NYSDOH. NYSDOH, its employees, officers, and agents make no representation, warranty or guarantee as to the accuracy, completeness, currency, or suitability of the information provided here. Funding is provided by the US Department of Veterans Affairs Health Services and Research Development Service and the Office of Integrated Veteran Care. The funders had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Rose L, Tran D, Wu S, Dalton A, Kirsh S, Vashi A. Payer shifting after expansions in access to private care among veterans. *Health Serv Res*. 2023;58(6):1189-1197. doi:10.1111/1475-6773.14162