Testimony for the Record
Submitted to the
**U.S. House of Representatives Committee on Veterans Affairs**
for the Hearing
**"Community Care Network Next Generation: One Trillion Dollars of Oversight."**
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The Veterans Community Care Program (VCCP) and the proposed expanded Community Care Network (CCN) Next Generation represent a shift of funding from direct care provided by Veterans Health Administration (VHA) clinicians to care in the private sector that results in worse or no better patient outcomes at higher costs, partially due to the actions of the private insurance companies chosen as stewards of the program.

The proposed expansion of the use of private medical care for veterans poses a serious risk to their health and the financial well-being of the VHA. The accelerating shift from public sector care delivered at the VHA to care in private facilities is based on assumptions not supported by the evidence that the private health care sector, specifically private insurers, can provide better care more efficiently than the public sector and that private companies chosen as contractors for the VCCP will prioritize veterans over the desire of their shareholders to increase profits.

This mirrors the trend in other federal health care programs where taxpayer dollars are paid to private corporations to administer these previously trusted public health programs. The results have included decreased trust in public health programs, poor patient experiences, and increased profit for private corporations. Instead of increasing funding for private contractors and care, the Department of Veterans Affairs (VA) should invest in expanding VHA facilities, hiring more staff, and utilizing the traditional Medicare program to process the small amount of claims for veterans who need highly specialized care only found in the private sector.

**How the VCCP currently operates**

The current VCCP was authorized and established by the VA MISSION Act, which was passed by Congress in 2018. Prior to this, the VHA was in the midst of both increasing veterans' access to care outside the VA and increasing their capacity for direct care through hiring more medical staff under the Choice Act.[1] After passage of the VA MISSION Act, the VHA contracted with TriWest Healthcare Alliance and OptumServe to develop networks of providers outside the VA that veterans could see and to process claims and payments to those providers. The VA has released a Request for Proposals for prospective contractors for the next iteration of the VCCP called the CCN Next Generation. These contracts represent an expansion of the VCCP with a total cost of up to $1 trillion dollars over the next ten years. The continuation and expansion of the VCCP is predicated on the assumptions that the private sector provides better medical care than the public sector and that the private sector provides care more efficiently than the public sector.

[1]Congressional Budget Office, "Funding for Department of Veterans Affairs Health Care," December 2023, https://www.cbo.gov/publication/57583#_idTextAnchor003.

**Private contractors have financial incentives that conflict with the goal of high quality care for lower costs when administering public health programs**

The performance record of private companies administering the VCCP demonstrates concerning profit-maximization practices that pose financial risks to the VA and taxpayers. A prominent example of such behavior was identified by the VA Office of Inspector General (OIG) in its February 2025 report, which found that OptumServe and TriWest billed the VHA nearly $1 billion more for dental services delivered by community care providers between FY2020 and May 2024 than they reimbursed the providers. Specifically, when a veteran received dental care from a CCN provider, OptumServe or TriWest charged the VHA in excess of the reimbursement paid to the provider and retained the difference. Although this overbilling was enabled by a contractual gap that did not explicitly prohibit charging the VHA more than the amount reimbursed to providers, this raises concerns about whether contractor motivations align with VA's mission in a public-private partnership.

In another example of profit maximization behavior by private companies involved in the VA and other federal health programs, Medicare Advantage (MA) plans that enroll veterans collect the full capitated payment from the government for the expected medical costs of that enrollee. However, veterans eligible for care at the VA rarely or never use any Medicare services. Companies administering MA plans not only fail to report this trend to the government, they have begun actively advertising their plans to veterans. In 2023, there were nearly 200 veteran MA affinity plans, many of which exclude prescription drug coverage, which experts conclude is to specifically attract veterans who use VHA care.[2] This results in immense wasteful spending with the federal government paying over $1.3 billion in 2020 to private insurers running MA plans for VHA enrollees who did not use any Medicare services in that year.[3] In the context of VCCP contractors, UnitedHealth Group, the parent company of VCCP contractor OptumServe and MA provider UnitedHealthcare is duplicatively billing the government by requiring payment for a VHA enrollee who has a United MA plan and uses VCCP. Not only is this extracting additional revenue from the government, it raises serious questions about alignment with the VA's interests and stewardship of taxpayer dollars.

Unfortunately, this profit maximization behavior appears in other federal health programs, such as MA. Multiple independent researchers and government organizations, including the Committee for a Responsible Federal Budget and the Medicare Payment Advisory Commission, have identified that insurance corporations running MA plans receive roughly $84 billion in overpayments every year.[4,5] These excessive payments result from well-documented financial

[2]Susan H. Busch et al., "Medicare Advantage Plans That Target Veterans," JAMA Health Forum, 2024, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2831837.
[3]Richard G. Frank et al., "Medicare Advantage and VA Enrollees' Use of Services," Health Affairs, 2024, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.00302.
[4]Committee for a Responsible Federal Budget, "Medicare Advantage Will Be Overpaid by $1.2 Trillion," 2024, https://www.crfb.org/blogs/medicare-advantage-will-be-overpaid-12-trillion.
[5]Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2025,

behaviors like upcoding, or adding more diagnosis codes to an enrollee's chart to make them appear sicker thus garnering a higher payment from the government, and favorable selection, or the enrollment of healthier people into MA plans due to obstacles to care in those plans. Private insurers have built extensive tools to capture as much money from the government as possible in the MA program including data mining and chart reviews to find diagnoses doctors did not make for a patient, sending providers to seniors' homes to ask questions and uncover new diagnoses (which the seniors are then never treated for), and paying physicians to add more codes to charts.[6]

In MA, companies administering the plans have erected barriers to care to aid in maximizing their revenue and profits. The most frequent obstacle is prior authorization, in which insurers require a request to be submitted to them, reviewed by insurance employees, and approved before certain services prescribed by the patient's provider are delivered. Differences in prior authorization requirements further illustrate how financial incentives shape program design. In traditional Medicare, which has no profit motive, 52 outpatient medical services and durable medical equipment products require prior authorization and the decisions made on these authorization requests are more than 98 percent accurate.[7,8] In contrast, MA plans require prior authorization for hundreds, sometimes over one thousand medical services and tests, and over 80 percent of the decisions MA plans make are overturned once appealed.[9] As prior authorization has become an obstacle for needed care, many patients and providers have called on insurance companies to remove this barrier. However, prior authorizations are a profit maximization behavior, and companies have not stopped it. In fact, in 2022 CVS "'de-prioritized' a plan to reduce the overall volume of prior authorizations, concluding that the impact on lost savings to the company was 'too large to move forward.'"[10]

Finally, private companies that receive federal and state tax dollars for Affordable Care Act (ACA) premium subsidies and to administer Medicare, Medicaid, and VHA have recently raised their premiums and often push for higher payment from the government citing increased medical costs. At the same time, these companies spend billions of dollars on repurchasing stock, which enriches shareholders and increases executive compensation packages. Specifically, the seven largest for-profit insurers, including UnitedHealth Group which owns VCCP contractor

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https://www.medpac.gov/wp-content/uploads/2025/03/March_2025_MedPAC_Report_Press_Release_SEC.pdf.

[6]Charles E. Grassley, "How UnitedHealth Group Puts the Risk in Medicare Advantage Risk Adjustment," January 2026, https://www.grassley.senate.gov/news/news-releases/grassley-report-details-unitedhealths-record-of-appearing-to-game-the-medicare-advantage-system-turning-risk-adjustment-into-its-own-business

[7]Centers for Medicare & Medicaid Services, "Outpatient Department Services That Require Prior Authorization," 2023, https://www.cms.gov/files/document/opd-services-require-prior-authorization.pdf.

[8]Centers for Medicare & Medicaid Services, "Pre-Claim Review Program Statistics FY 2023," 2023, https://www.cms.gov/files/document/pre-claim-review-program-statistics-document-fy-23.pdf.

[9]Meredith Freed et al., "Nearly 50 Million Prior Authorization Requests Were Sent to Medicare Advantage Insurers in 2023," KFF, 2024, https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/.

[10]U.S. Senate Permanent Subcommittee on Investigations, "Medicare Advantage Prior Authorization and Denials," Majority Staff Report, October 17, 2024, https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf.

OptumServe, spent $146 billion repurchasing their own stock from 2014-2024 while raising ACA plan premiums by almost 100% during that time.[11]

**Evidence does not show superior care in the private sector compared to the VA**

Medical care provided by the VA results in better patient outcomes in many situations compared to care received at private facilities and hospitals. For example, a peer-reviewed medical research paper found a 46% reduction in 28-day mortality for senior veterans experiencing medical emergencies who were treated at VA medical centers compared to those treated at private medical facilities.[12] Another study showed that veterans in the intensive care unit (ICU) at VA medical centers had lower rates of mortality than veterans in the ICU at hospitals in the CCN.[13] In surgical settings, researchers found that patients undergoing surgery at VA medical centers had a 40% lower adjusted risk of mortality than in the private sector.[14] There are many other studies that find similar trends when comparing VA care to private sector care.

The VA Health Systems Research and Development Service (HSRD) maintains a systemic review of VA versus non-VA Quality of Care, which is updated periodically and takes into account all relevant studies comparing VA and private sector care. In the last public update in October 2024, the VA found that "most published studies of comparisons of quality of care show that veterans getting care from VA get the same or better quality care than veterans getting community care or the general public getting non-VA care." Additionally, the VA researchers state that they "did not identify any study that found that patient experience was better in community care."[15] Additionally, many providers such as mental health providers are not trained and do not have military cultural competency to provide the mental health care that many veterans need.[16]

In addition to worse patient outcomes in many situations, the VCCP exhibited issues maintaining adequate CCNs for veterans to get the care they needed. In 2024, the OIG determined that the two VCCP contractors, OptumServe and TriWest, failed to maintain adequate provider networks to meet veterans' community care needs. The OIG could only verify that OptumServe and TriWest had substantively discussed CCN network adequacy requirements, as was required by their contracts, with three of the 172 VA medical centers nationwide. Moreover, VA facility staff

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[11]Healthcare Uncovered, "Where Do Our Health Insurance Premiums Really Go?," 2024, https://healthcareuncovered.substack.com/p/where-do-our-health-insurance-premiums.
[12]David C. Chan et al., "Outcomes for Veterans Treated in VA Versus Non-VA Hospitals," Journal of General Internal Medicine, 2024, https://pmc.ncbi.nlm.nih.gov/articles/PMC11735001/.
[13]JAMA Health Forum, "ICU Outcomes at VA and Community Hospitals," 2024, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2842406
[14]JAMA Surgery, "Surgical Outcomes in VA vs Private Sector," 2022, https://jamanetwork.com/journals/jamasurgery/fullarticle/2787614.
[15]VA Health Services Research & Development, "Systematic Review of VA Versus Non-VA Quality of Care," October 2024, https://www.hsrd.research.va.gov/publications/esp/quality-of-care-review.pdf.
[16]Rajeev Ramchand et al., "Mental Health Care for Veterans: Barriers and Cultural Competence," RAND Corporation, 2015, https://www.rand.org/content/dam/rand/pubs/research_reports/RR800/RR806/RAND_RR806.pdf.

reported that many providers listed in the CCN database were not, in practice, accepting VA patients. These deficiencies persisted despite contractual requirements obligating OptumServe and TriWest to "always maintain a network of providers and practitioners that will extend across the entirety of each CCN region and must always be sufficient in numbers and types of providers." VHA facility leadership and staff further reported that OptumServe and TriWest frequently denied requests to expand network capacity, asserting that sufficient access already existed; assertions based on inaccurate provider network data that the contractors had not corrected.[17]

As a larger shift from veterans receiving direct care at the VA to care in the private sector is being proposed, it is imperative to consider the wealth of research that demonstrates that at best, patient care is equivalent in the private sector and at worst, patient outcomes are significantly worse in the private sector than the VA. Further, it is imperative to review the performance of the first iteration of VCCP contracts in which the contractors failed to maintain adequate provider networks for veterans.

**Evidence suggests that the VA and other public programs administer care more efficiently than the private sector**

Misconceptions about the efficiency of the public sector, specifically when dealing with health care, have led many to believe that the private sector provides and administers health care with greater efficiency compared to the public sector, when the opposite is true. Within the VA, there is ample evidence that VA medical centers provide more efficient care than private facilities. One of the most important considerations when proposing an expansion of veterans using private providers is the comparison of wait times for appointments in the VA versus private providers. Research funded by the VA HRSD found that when looking at wait times at the Veterans Integrated Service Network (VISN) level, wait times were shorter for VA than for community care.[18] Another study comparing wait times in the VA versus the VCCP for cardiology, gastroenterology, orthopedics, and urology, high volume services for the VCCP, found that mean wait times for appointments at the VA were lower than those for appointments with community providers.[19]

When examining the value of care provided at VA medical centers compared to CCN providers, private providers are more frequently providing both low-value and more expensive care, specifically, when treating "clinically insignificant" low-risk prostate cancer. Medical organization guidelines advise treating this diagnosis with attentive surveillance rather than

[17]Department of Veterans Affairs, Office of Inspector General, "Provider Network Deficiencies in the Veterans Community Care Program," Report 23-00876-74, April 2024, https://www.vaoig.gov/sites/default/files/reports/2024-04/vaoig-23-00876-74.pdf.
[18]VA HSRD, "Wait Times for New Patient Appointments in VA Versus Community Care," HSRD Publication Brief, 2024, https://www.hsrd.research.va.gov/research/citations/pubbriefs/articles.cfm?RecordID=1183.
[19]Michael J. O'Shea et al., "Comparison of Wait Times in VA and Community Care," JAMA Network Open, 2020, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2769826.

aggressive treatments such as surgery. Researchers found that CCN providers were twice as likely to treat these patients with unnecessary and risky surgeries for their cancer than providers at the VA. Providers at the VA pursued the lower-cost, higher-value treatment plan of active surveillance.[20] Similarly, another study found that treatment costs over 28 days for senior veterans treated at a VA medical center during an emergency were 21% lower than for veterans treated in private facilities.[21] In addition, veterans treated at VA facilities were more likely to receive low cost follow-up treatment such as phone calls.

The VA operates with lower administrative overhead than the private health care sector. Data analysis demonstrated that the VHA staff includes significantly less employees in administrative roles compared to the private health care sector. If the private sector were able to use the same efficient staffing pattern as the VHA, there would be nearly one million fewer administrative personnel needed, which would significantly reduce overhead costs.[22] This increased efficiency compared to private health care is also seen in Medicare with the administrative costs for traditional Medicare ten times lower than those for private health insurance.[23] The ability of the VA to provide care to veterans quicker and at a lower cost is an important consideration when debating expanding veterans' use of private sector care.

**Increasing funding for the VCCP decreases funding for the VHA which provides crucial support to the U.S. health care system**

The proposed increase in funding for care in the private sector was paired with a proposed 17.4% decrease in the budget for direct medical care at the VHA. This defunding of the VHA will have effects far beyond care for veterans. The VHA provides immense structural support to the U.S. health care system that often goes unnoticed. Part of the VA's mission, known as the fourth mission is to "improve the nation's preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to Veterans, as well as to support national, state, and local emergency management, public health, safety and homeland security efforts." During the COVID-19 pandemic, the VA fulfilled this fourth mission by providing over 1 million pieces of personal protective equipment, caring for over 600 non-veteran patients, and sending personnel to over 50 states and territories.[24] Reducing funding for the VHA will reduce their capacity to serve as the backstop for the U.S. health care system and ensure the health of all Americans during times of crisis.

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[20]JAMA Network Open, "Management of Low-Risk Prostate Cancer in VA and Community Care," 2023, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2810875.
[21]See note 12 above
[22]JAMA Network Open, "Administrative Staffing in VA Versus Private Sector Health Systems," 2024, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2814055.
[23]Karen Davis and Amber Willink, "Comparing Apples with Oranges: Administrative Expenses in Medicare Systems," American Journal of Managed Care, 2017, https://www.ajmc.com/view/comparing-apples-with-oranges-administrative-expenses-and-finances-in-medicare-systems.
[24]Department of Veterans Affairs, "VA's Fourth Mission and COVID-19 Response," 2020, https://www.va.gov/health/coronavirus/statesupport.asp.

Another core mission of the VA is to educate medical professionals. The VA has trained almost 70% of physicians in the U.S. at one of their medical centers or clinics. Each year, the VA trains over 120,000 physicians, nurses, psychologists, dentists and other health professionals making it the largest trainer of health care professionals in the country.[25] As shortages of health care professionals plague the country, decreasing funding for the largest trainer of medical professionals would greatly exacerbate the shortage.

The VA is also a major medical research hub making discoveries and developments that benefit veterans and the general public. The first laboratory to study cancer tumors was at the Hines VA Hospital in 1932. A VA researcher at the Los Angeles VA Medical Center built the prototype for what would become the CT scanner, a core diagnostic tool in modern medicine. The first successful liver transplant was performed in 1967 at the Denver VA Medical Center. The Million Veterans Program is run by the VA which uses blood samples to examine how health and wellness for veterans is affected by genetics, lifestyle, and military experiences.[26] These examples only scratch the surface of the significant research that the VA has done. This research capacity would be in jeopardy with decreased funding for medical care.

**Expanding the VCCP with CCN Next Generation without changes scales known failures in the system**

The proposed contracts of up to $1 trillion for the CCN Next Generation initiative run the risk of replicating and amplifying the inefficiencies and poor performance of the private sector outlined above. Specifically, expanding the amount of care veterans get from private providers could decrease quality and outcomes those veterans have based on the research demonstrating that the VA provides higher quality care and better outcomes. Additionally, as funding is increased for VCCP, funding for direct care is decreased which will inhibit the ability for veterans to get the higher quality care offered by the VA.

Increasing the amount of care the veterans get in the private sector will also increase their wait times for appointments, as is demonstrated by studies that found longer wait times for primary and specialty care providers in private facilities compared to the VA. The increased funding for VCCP will not act to lower wait times for veterans in the private sector because the funding from VCCP is very small relative to the size of the private health care market. However, if the money from VCCP were reinvested into increasing VHA's direct care capacity, it would have a much larger impact in decreasing the already shorter VA wait times.

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[25]Department of Veterans Affairs, "VA Medical School Partnerships Benefit Veterans," 2019, https://news.va.gov/56543/va-medical-school-partnerships-benefit-veterans/.
[26]Department of Veterans Affairs, "The Million Veteran Program," 2024, https://new.express.adobe.com/webpage/D4t5eyV6RNiow.

Initiating new contracts with private companies to administer the VCCP before identifying how to prevent the profit maximizing pattern of behaviors that those companies have exhibited in the first round of VCCP contracts, as well as in other federal health care programs, poses the risk of more tax dollars being misused by these contractors. Though it is unrealistic to expect zero tax dollars will be misused in contracting relationships, it is reasonable to attempt to remove any possibility of that happening and the proposed CCN Next Generation initiative leaves the door wide open for gaming and misuse of taxpayer dollars.

The safeguards against contractor bad actions in the current documents supporting the CCN Next Generation request for proposals do not adequately safeguard the VHA. For example, the contracts require contractors to report suspected conflicts of interest. However, as insurance companies more frequently consolidate with medical providers, there is an inherent conflict of interest created when asking a prospective contractor to create a provider network that serves the needs of the veterans and schedule appointments with private providers. In this case, an insurer that is the contractor for this program would likely be creating a network from providers they own and do not own and also scheduling patients with providers they own and do not own. This creates the potential for steering veterans to providers that the contractor owns, rather than the best provider for them. This differential treatment of affiliated providers and non-affiliated providers has already been uncovered in the commercial market.[27] This issue could get a foothold in the VCCP based on the current request for proposals, and potentially already has since OptumServe, a current VCCP contractor owns significant medical providers and has a record treating affiliated providers differently than non-affiliated providers.[28]

In addition to amplifying existing problems with the VCCP contractors, the proposal for CCN Next Generation will import new problems from the current Medicare and MA programs into VCCP. In the attachments in the RFP labeled "Attachment 1 - CCN Next Gen - Medical East TOPR PWS" and "Attachment 1 - CCN Next Gen - Medical West TOPR PWS" the VA describes requirements for contractors in CCN Next Generation to implement four "value based care" models, including the lower extremity joint replacement (LEJR) advanced payment model.[29] Value based care models have the potential to provide promising results, if conducted under the right conditions, including operating in a not-for-profit health care system and being fully provider led. Under the wrong circumstances, these models can lead to rationing care and profiteering. The VCCP contractors required to implement value based care models, who are likely to be private corporations, will be operating with opposing objectives to 1) increase profits for shareholders, and often secondary to that objective 2) provide quality care at lower costs.

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[27]Erin C. Fuse Brown et al., "Differential Treatment of Affiliated and Non-Affiliated Providers," Health Affairs, 2025, https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00155.
[28]Ibid.
[29]Department of Veterans Affairs, "CCN Next Generation Request for Proposals," SAM.gov, 2025, https://sam.gov/workspace/contract/opp/7b2734002e4048bfa2ac4cc5b0479930/view.

Most value based care models have failed to save money and the most prominent, the Medicare Shared Savings Program (MSSP) led to an increase in government spending.[30,31]

Aside from failing to save money, value based care models often include capitated payments, or lump sum payments for all the care a person may need in a definite time frame or for a particular condition. Research shows that capitated payments in these settings can lead to rationing of needed medical care. For example, in primary care, full capitation of payments for a patient can lead to rationing of care for preventive services.[32] Rationing of care is also a risk in capitation payments for specific conditions or procedures, like the proposed VCCP LEJR model, potentially leading to providing less care or avoiding caring for sicker patients in the absence of risk scoring, which has its own flaws.[33] Finally, in the MA program where insurers are paid a lump sum for all care an enrollee may need in a year, care is rationed by limiting the providers patients can see and delaying and denying needed medical care.[34,35] Introducing value based care models with capitation, like the LEJR model, without addressing the trend of care rationing in these models poses immense risk to the health of veterans across the country.

Many value based care models utilize risk adjustment, including the LEJR model that the request for proposals requires contractors to implement in VCCP. Risk adjustment works by assigning a risk score to each patient based on their health status and then adjusting the payment made to contractors based on that risk score. For example, a person with average health would receive a risk score of 1. A person who has a chronic illness would be assigned a higher risk score, say 1.2. The payment a contractor receives for this patient would be the baseline price multiplied by 1.2, resulting in a 20 percent increase in payment. This method, required by the LEJR model and many other value based care models, replicates the risk scoring from the MA program and imports it into the VCCP. This is an alarming development seeing as risk scoring in MA has been manipulated by private companies to extract taxpayer dollars they did not earn. This manipulation of the risk scoring system in MA is projected to cost the federal government an extra $600 billion from 2025-2034.[36] Replicating this broken risk scoring system in the VCCP poses an existential risk to the fiscal solvency of the VHA. Further, the document titled

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[30]Health Affairs Forefront, "All Do Win? Why Beating Benchmarks Doesn't Mean ACOs Are Reducing Costs," 2023, https://www.healthaffairs.org/content/forefront/all-do-win-why-beating-benchmarks-doesn-t-mean-acos-reducing-costs.
[31]JAMA Health Forum, "Performance of Accountable Care Organizations in the Medicare Shared Savings Program," 2024, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2812611.
[32]Urban Institute, "Primary Care Capitation: Payment Reform in Primary Care," 2016, https://www.urban.org/sites/default/files/2016/06/13/02_primary_care_capitation_2.pdf.
[33]Urban Institute, "Bundled Episode Payments in Health Care," 2016, https://www.urban.org/sites/default/files/2016/05/03/06_bundled_episode_payments.pdf.
[34]KFF, "Medicare Advantage Enrollees' Access to Physicians," 2023, https://www.kff.org/medicare/medicare-advantage-enrollees-have-access-to-about-half-of-the-physicians-available-to-traditional-medicare-beneficiaries/.
[35]Office of Inspector General, HHS, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns," 2022, https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/.
[36]Committee for a Responsible Federal Budget, "Medicare Advantage Will Be Overpaid by $1.2 Trillion," 2024, https://www.crfb.org/blogs/medicare-advantage-will-be-overpaid-12-trillion.

"Attachment W Lower Extremity Joint Replacement LEJR Bundled Payment Model" states that in the LEJR model "participating providers may earn up to 50% of the total savings pool generated when actual episode costs fall below the risk adjusted episode costs" creating a major incentive to ration care and increase risk scores to increase savings.

**CCN Next Generation reflects broader trends toward privatized administration of public health programs**

The increasing amount of tax dollars and patient care being outsourced from the VHA to the private sector mirrors a larger trend in public health programs. Enrollment in private MA plans has grown from 19% of Medicare beneficiaries in 2007 to 54% in 2025.[37] Additionally, the Center for Medicare and Medicaid Innovation recently announced the Wasteful and Inappropriate Service Reduction (WISeR) Model which will contract with private companies currently involved in administering prior authorization in MA plans to expand prior authorization in traditional Medicare.[38] Finally, over recent decades, many states have contracted with private insurers to manage their Medicaid programs. Research found that using private companies to administer the Medicaid program rather than their governments costs the federal government and state governments a total of $77 billion in 2023.[39] The rapidly spreading pattern of outsourcing federal health programs to private companies comes with the promise of better care and lower costs. However, in reality it results in higher costs, worse care, and taxpayer-funded profits for corporations.

**Policy recommendations**

**Re-invest the money proposed for CCN Next Generation into expanding the VHA's capacity**

The original goal of the VCCP, to increase access and decrease travel and wait times for veterans, is more easily attainable through other means than spending $1 trillion on private contractors. Instead of $1 trillion for VCCP, the VA should invest most of that money into expanding the capacity of the VHA by building more VA medical centers and hiring more medical staff. To put into perspective the magnitude of money being shifted from the VHA to these private contractors, take the fact that the amount of money set aside for the VCCP could fund the building of roughly 500 new VA medical centers.[40] VHA does not need that many new medical centers. However, I recommend a bold goal of doubling the number of VA medical

[37]KFF, "Medicare Advantage Enrollment Update and Key Trends," 2025, https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/.
[38]Centers for Medicare & Medicaid Services, "Wasteful and Inappropriate Service Reduction (WISeR) Model," 2024, https://www.cms.gov/priorities/innovation/innovation-models/wiser.
[39]Physicians for a National Health Program, "The Medicaid Managed Care Privatization Blueprint," 2025, https://pnhp.org/system/assets/uploads/2025/08/MedicaidBlueprintFinal.pdf.
[40]Healthcare Facilities Today, "New VA Center Is One of World's Most Expensive," 2022, https://www.healthcarefacilitiestoday.com/posts/New-VA-Center-Is-One-of-Worlds-Most-Expensive--26631.

centers over the next ten years and modernizing the existing VA buildings which would leave roughly $600 billion from the original funding for hiring additional medical staff and for any care veterans need to receive in the community because it is truly specialized or they live in a particularly remote area. Reinvesting money into expanding the capacity of the VHA has provided positive results. For example, researchers found that access to VA care increased from 2014 to 2017 and surpassed access in private facilities in three out of four specialties studied.[41] During the same time period, Congress had appropriated $5 billion for the VHA to expand capacity and hire more staff.[42] Investing in the VHA has shown proven results and should be continued.

**Use traditional Medicare to process claims for veterans who need care in the private sector**

Veterans will likely continue to need specialized care in certain situations, just as some complex diseases in those with private insurance require specialized care. The VCCP should address this need while also safeguarding veterans and taxpayer dollars by using the traditional Medicare infrastructure to administer the VCCP. Rather than utilizing private contractors with demonstrated histories of being poor stewards of the well-being of patients and funding, the VHA should enable all veterans who receive a referral from the VHA to see any provider who accepts Medicare. That provider would then send the claim to Medicare which would pay it and then request reimbursement from the VHA. This policy would capitalize on the efficient, proven structure of the Medicare program. Additionally, the VCCP bases many of its payments to providers on Medicare rates so it would not require increased reimbursements to physicians and would decrease the overhead spending from private contractors. Finally, Medicare is trusted and viewed favorably by 94% of enrollees suggesting that veterans would have positive experiences under this administration of community care.[43]

[41]Michael J. O'Shea et al., "Appointment Wait Times for Specialty Care in the Veterans Health Administration and the Private Sector," JAMA Network Open, 2019, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2720917.
[42]Congressional Budget Office, "Funding for Department of Veterans Affairs Health Care," 2018, https://www.cbo.gov/publication/57583#_idTextAnchor003.
[43]KFF, "Public Attitudes Toward Medicare and Medicaid," 2025, https://www.kff.org/health-costs/kff-health-tracking-poll-public-weighs-health-care-spending-and-other-priorities-for-incoming-administration/.