Federal Register Document Number: 2021-02138
Request for Public Comment
For the Department of Veterans Affairs (VA) Secretary
in developing recommendations for the future of Veterans Health Administration (VHA) health care
pertaining to Criteria for Section 203 of the VA MISSION Act of 2018

Senior Policy Analysts of the Veterans Healthcare Policy Institute
Russell B. Lemle, PhD, Russell.lemle@veteranspolicy.org
Suzanne Gordon, Suzanne.gordon@veteranspolicy.org

Overview

The VA MISSION Act of 2018 Section 203 requires VA to establish criteria to be used by an Asset and Infrastructure Review (AIR) Commission regarding the modernization or realignment of facilities across the Veterans Health Administration (VHA) network. Beginning in 2022, the AIR Commission will evaluate all VHA facilities' utilization patterns and infrastructure needs and recommend whether to close, replace, expand or repurpose them. Congress will have no authority to alter the Commission's final set of recommendations. Instead, they must approve or deny the Commission's blueprint in their entirety. As such, the Commission will wield enormous power over the VHA's future footprint and effectiveness. It is therefore essential that commissioners and members of Congress be thoroughly aware of the far-reaching repercussions of its recommendations.

The aging infrastructures at some VHA facilities are in need of modernization that will be expensive. It is also the case that the veteran population is declining and relocating. However, those facts alone cannot be the basic consideration when it comes to decisions about shuttering a VHA facility. It is crucial to inquire whether closing a facility and issuing healthcare vouchers to all enrolled veterans in the region would cost even more in the long run than modernization. Further, what would happen to the provision of high-quality, comprehensive, coordinated care that veterans deserve? What would be the impact on the range of services, the length of wait times, training the next generation of providers with veteran-health expertise, conducting cutting edge research that benefits veterans and all patients, and serving as a backup system to other healthcare facilities in emergency moments?

This document analyzes how the closure of VHA facilities would jeopardize the government's commitment to care for veterans. Even in areas where veteran demographics have shifted it is highly unlikely that the veteran population, or the broader community, will be better served by closure of a facility. Unless strong safeguards are put in place, the AIR Commission may unintentionally cause severe economic, healthcare, training, and research harm to veterans, families, VHA employees and healthcare professionals in communities across America. Concerns over closings are particularly salient as the VHA continues to fulfill its Fourth Mission to serve as a backup to civilian facilities during the COVID-19 pandemic, whose effects will persist for many years.

Broadly summarized, the closure of any VHA facility will have the following impacts (which are elaborated further below): It will:

- **Increase overall costs and drain funds from remaining VHA facilities, ultimately eroding the provision of care throughout the system.**

- **Reduce the availability of veteran-specific, high quality, comprehensive and integrated care for veterans in a community**.

- **Increase wait times for veterans and civilians at non-VA facilities.**

- **Eliminate choice for the many veterans who prefer to receive their care in the VHA.**

- **Hinder veterans seeking VBA benefits.**

- **Decimate residency and fellowship training programs at the affiliated medical and health professional school, putting strain on the American system of healthcare professional training.**

- **Diminish the number of healthcare graduates who enter the local network of providers to treat veterans and civilians.**

- **Impede efforts to recruit providers at other VHA facilities.**

- **Reduce VA research that improves physical and mental health of veterans, as well as all Americans.**

- **Hamper the government's ability to respond to emergencies and natural disasters.**

- **Create financial hardship for laid-off employees, especially veteran employees, and adversely impact the local economy.**

AIR Commission Evaluation Criteria That We Recommend Be Assessed Before Any VHA Facility Is Considered for Closure

1. What is the number of anticipated enrolled veterans? Are aggregated costs associated with closing a VHA facility and issuing Veterans Community Care Program (VCCP) vouchers to all enrolled veterans lower than modernizing the facility and keeping it open?

2. When a VHA facility is considered for closure, are its services readily available at private sector facilities within a reasonable distance, in a coordinated care model, from professionals trained in evidence-based practices and trained to diagnose and treat veteran specific healthcare problems? Here's a partial list of services:

Addiction Services	Posttraumatic Stress Disorder Clinic Team
Audiology and Speech Pathology	Prosthetics
Bariatric Surgery	Returning Service Members
Blind Rehabilitation Center	Spinal Cord Injury Center
Integrated Mental Health & Primary Care	Suicide Prevention Coordinators
Compensated Work Therapy	Tribal Veterans Service Officers
Extended Care	Toxic Exposure clinics
Homeless Outreach & Assistance Coordinators	Veteran Service Organization Advocates
LGBT Care	Visual Impairment Services Team
Mental Health Care	Vocational Rehabilitation Services
Military Sexual Trauma	Whole Health Care

Polytrauma Center	Women's Veterans Care

3. What will be the projected impact on mortality, the management of chronic conditions and other healthcare outcomes if services for veterans are received in the private sector rather than the coordinated care that the VHA provides?

4. For primary care, and the most frequently utilized specialty care services, are wait times in the community shorter than wait times at a local VHA facility?

5. For the most common procedures and treatments, what is the cost of non-VHA care compared to VHA care?

6. If a VHA facility with an academic affiliation closes its inpatient units or the entire facility, will the university residency/fellowship training and other healthcare professionals training programs shrink and/or collapse? Will there be a reduction in the nationwide number of health profession trainees who have veteran-specific training?

7. What lines of veteran-specific research will be shut down and not transferable elsewhere? What research that benefits the entire population will be curtailed?

8. What will be the net reduction of ICU and inpatient beds, and ER facilities, and does that diminish the ability of the community to address the next pandemic or health crisis?

9. What will the impact of a facility closure be on healthcare disparities in the region?

Specific Adverse Impacts of a VHA Facility Closure

1. Impact on the VA Budget

Costs associated with closing a VHA facility are likely to be higher than modernizing it and keeping it open because:

- **The number of veterans whose healthcare is financed by the VA will significantly increase.** In FY20, of the total 19.54 million veterans, 33% were enrolled in the VHA system and had some VHA or non-VHA care paid by the VA, 14% were enrolled but did not have any care paid by the VA and remaining 54% were not enrolled for VA-paid care.

	A	B	C	
FY20	**Enrolled, some VA paid care in the last year**	**Enrolled, no VA paid care in the last year**	**Potentially eligible for VA paid care, but not enrolled**	**Total**
Approximate % of U.S. veterans	33%	14%	53%	100%
Total # of U.S. veterans	6.45M	2.71M	10.45M	19.54M

For as long as a VHA facility remains open, the VA pays for the care of veterans in column A either at VHA facilities or private sector care through the VCCP. Veterans in column B have the option of VA paid care, but for whatever reason, use other public/private coverage. Veterans in column C who need care must use their own public/private coverage. **If a facility is closed, VA will automatically issue**

VCCP healthcare vouchers to all local veterans in columns A and B. It is expected that most veterans in column B will utilize these vouchers, given the financial advantage of doing so. That will, on average, increase the percentage of veterans in that locale whose yearly care is paid by VA from 33% to potentially as high as 47%. That percentage will increase even further depending on how many veterans in column C decide to enroll in order to take advantage of the benefits. The Congressional Budget Office projected that providing this kind of VA-paid private care to veterans systematically would **cost an additional $500 billion over the next decade**, infinitely more than the $22 billion estimated that is needed to address poor infrastructure at VA facilities.

- **Health care procedures are more expensive in the fee-for-service private sector,** where care is not integrated and there are built-in incentives to overtreat. For example, a recent study of emergency care found VHA total spending, including government costs and patient out-of-pocket expenses, to be 21% less than identical care of veterans from non-VA providers.

- Further costs will accrue when a facility closes because **additional VHA staff will be needed to administer the oversight and reimbursement of private sector care** in the affected region.

- The shift in associated costs would be drawn from VHA's overall budget, **creating pressure toward further downsizing** or restrictions on veteran eligibility for VHA care.

2. Impact on the Quality and Outcomes of Clinical Care Provided to Veterans

If a VHA facility closes, **the quality, effectiveness, comprehensiveness and integration of care provided to veterans will decline.**

The VHA's core strength is in delivering comprehensive coordinated care to patients. The depth and breadth of care coordination in the VHA is unrivaled and impossible to produce in the private sector. Independent RAND and Dartmouth analyses — among many others — continually affirm that the quality, effectiveness and safety of VHA's healthcare is as good as, and in many instances superior to that of non-VA facilities. This is, in great part, due to its coordinated management of chronic conditions in a population that, as one RAND study states, "have a higher prevalence of chronic physical and mental conditions than other veterans….VHA providers handle a patient mix that differs from what most community providers typically see." Because of this care coordination in populations with high rates of chronic illness, the VHA has impressively reduced racial and economic disparities in its handling of COVID-19.

VHA healthcare settings provide the best (and arguably only) environment for providers and trainees to attain proficiency in treating veteran-specific issues. Veterans, whether or not they served in combat, are at higher risk for numerous conditions. Those in combat suffer from gunshot/blast/shrapnel injuries, Traumatic Brain Injury, heterotopic ossification and PTSD. Veterans also suffer from musculoskeletal injuries, spinal cord injuries, toxic exposures, Military Sexual Trauma (MST) and suicide. Not only do VHA trained personnel know how to treat these conditions, they recognize which potential sources of illness to investigate. For example, a non-VA practitioner is less likely to detect, explore or treat PTSD or MST as the cause of chronic insomnia or the impact of TBI on mood and decision-making. Non-VA practitioners will be less likely to be aware that conditions such as asthma, prostate cancer, or Type 2 diabetes may be the result of toxic exposures, including Agent Orange, contaminated water or burn-pits. Even if by chance they do detect such exposures, specific toxic exposure clinics for Agent Orange, Gulf War and burn pit veterans are not available in the private sector.

Private sector providers may, therefore, misdiagnose or ineffectively treat these critical conditions, order inappropriate diagnostic tests, and fail to collect information that registries need for veterans to qualify to

receive compensation. They will also fail to recognize patterns of illness that can help identify new conditions, health hazards and/ or toxic exposures.

RAND's Ready to Serve study of therapists who treat PTSD and major depression found that compared to providers affiliated with the VHA or DoD, "a psychotherapist selected from the community is unlikely to have the skills necessary to deliver high-quality mental health care to service members or veterans with these conditions." This and other studies confirm that private sector providers do not inquire whether patients are veterans or have any knowledge of military culture or military related health conditions. More disturbing is the fact that, when asked if they would like to gain greater knowledge and proficiency in treating veterans, the vast majority of providers say they would not.

The combination of culturally competent – and integrated — VHA services in a single location improves outcomes for veterans and their families. A VHA medical professional in a specialty clinic who identifies another condition for a veteran often quickly refers a veteran to another clinic in the same building. Specialized services like spinal cord injury programs, polytrauma, or blind rehabilitation programs depend on the availability of primary care providers, specialists, and other healthcare professionals trained in care coordination. This provides a unique level of diversity as well as economies of scale for expedited and coordinated care. Suicide prevention coordinators (available nowhere except within VHA facilities) assist with veterans who have recently contacted the Veterans Crisis Line and use big data predictive analytics to identify veterans with heightened potential risk. Prosthetic clinics provide critical services beyond replacement limbs, like canes, scooters, wheelchairs, and other mobility devices critical to veterans living full lives.

VHA expertise and systematic planning links veterans to the array of resources they need. VHA social workers connect patients to veteran-specific follow-up resources, including VA and other community programs that provide home health services, legal services, transportation, community living and housing. Such wrap-around services help mitigate substance abuse, homelessness and other social determinants of health that impact disease progression and prevalence of suicide. Homeless assistance (HUD/VASH) coordinators assist veterans often literally on the VHA medical facility doorstep or go out in search of veterans living on the streets. Justice Outreach coordinator assistance helps veterans with highly successful jail or prison diversion programs. Tribal Veterans Service Officers (TVSO) provide unique and culturally competent advocacy at local VHA facilities. VHA's coordination with IHS/THP in the delivery of rural healthcare for Native Veterans is absolutely essential.

The existing credentials, training, competency and performance standards that VHA requires of its own clinicians are not expected or required for providers who see veterans through the VCCP. A professional license is the only qualification, yet federal watchdogs have found that some unlicensed and dubious private sector clinicians are able to slip through the cracks into the VCCP.

A 2020 head-to-head comparison of VHA to non-VA care for ER patients found a 45% reduction in 28-day mortality when veterans were treated at a VHA. And, according to the researchers, "the veterans who benefit most from care at the VHA are more disadvantaged, with lower incomes, higher rates of minority status, and higher rates of mental health problems and substance abuse."

As the Commission on Care's Final Report stressed: "Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers." The VHA, as a unified system, has superior ability to implement and monitor adherence to assessment and treatment standards.

Simply put, the range — and outcomes — of comprehensive, integrated services at a VHA facility is not replicated in the private sector. VHA care is far different than the prevalent for-profit model that seeks financial reward for providing care on an episodic and transactional basis.

3. Impact on the Timeliness of Clinical Care Provided to Veterans

VHA's access standards ensure that VHA facility's wait times are monitored and enforced. There are no similar expectations of timeliness for appointments in the Veterans Community Care Program.

If a VHA facility is closed, veterans will struggle to get care in an overburdened and fragmented private sector healthcare system. **Delays for outpatient, inpatient and emergency room care for veterans and non-veterans in the local area will increase.** These delays may be heightened because of strains on the private sector healthcare system due to the COVID-19 pandemic.

A recent evaluation has reported the 29.8 day average wait time for private sector outpatient primary care, cardiology, and dermatology is 68% longer than the 17.7 day wait time at the VHA.

Another survey of primary-care doctors found that nearly a fifth had temporarily closed their practices due to the pandemic. Two in five had laid off or furloughed staff. Because of the coronavirus crisis, 20 to 40% of American hospitals today face serious financial difficulties and may not survive in their current form.

Our nation faces an intractable physician shortage in several care specialties, including primary care. A report by the American Association of Medical Colleges warns that, by 2030, the U.S. will be short 14,800 to 49,300 primary care doctors. Non-primary care medical specialties predict additional shortages of 33,800 to 72,700 physicians. In geriatric care, an area in which the VHA specializes and the private sector is drastically undersupplied, less than half of geriatric fellowship positions were even filled in 2018.

The delivery of health care to rural populations is a particular challenge. While 20% of the U.S. population is rural, (and 25% of the veteran population) only 9 % of physicians are working in rural areas and these provider numbers are actually declining. Sixty percent of counties – all rural – lack a single psychiatrist. According to another study, 65% of non-metropolitan counties lack a psychiatrist, 81% lack a psychiatric nurse practitioner, and 47% lack a psychologist. This is a crisis, and one that has especially impacted rural hospitals. Between 2005 and the 2014, 176 rural hospitals have closed, and the coronavirus pandemic is, according to some reports, threatening the financial stability and survival of one in four rural hospitals.

4. Impact on Veterans Having Choice for Where to Receive Healthcare

The MISSION Act was explicitly developed to offer greater healthcare choices to veterans. **When a facility is closed, veterans who prefer to receive their care at a VHA will no longer have that option.**

Another crucial resource lost when facilities close is access to peer specialists. The VHA has 1,100 peer specialists who are veterans in successful recovery from mental health challenges, integrated in mental health care programs and uniquely suited to engage fellow veterans and instill hope.

5. Impact on Veterans Seeking Benefits

In most cases, the veteran's first interaction with VA is a visit to the nearest VHA medical facility seeking medical care for a current condition. During their initial visit, the veteran quickly learns that, in order for to receive free VHA care, they must first apply for and be granted service connection by VBA. Furthermore, most newer veterans file VBA disability claims with multiple medical conditions during their first visit to a VHA facility.

Accredited Veteran Service Organizations (VSO) often staff VHA facility offices with trained full-time advocates. These staff improve access to VHA care and VBA benefits, especially to underserved areas and populations of veterans. Their assistive actions, all of which would be compromised if a VHA facility closes, include:

- Properly and promptly enrolling new veterans in VHA medical care.
- Receiving and then submitting evidence for a veteran's claim and/or appeal.
- Explaining and starting the VBA disability benefit claim process, answering questions about Compensation & Pensions exams, and figuring out claim appeals. This greatly expedites the claims process. Veterans who use a VSO for a claim usually receive more VBA benefits, faster. A quicker VBA claim decision opens the door to expedited VHA care. Treating the veteran sooner often saves money in the long run, especially for complex illnesses.
- Briefing veterans about the wide array of other VHA, VBA, NCA, and state benefits available for veterans and families.
- Referring veterans and families to local non-profits for services (food, cash, housing, support groups, etc.).
- Advising family members about health, disability, and burial benefits when a veteran is in crisis or passes away. Family members often visit the VSO office in a VHA facility because VHA facilities are "the face of VA" in the community.

6. Impact on Training of Medical/Healthcare Professionals

If a VHA facility with an academic affiliation closes, required residency/fellowship rotations will not be available and core funding will be eliminated, **leading to shrinkage and, in some cases, collapse of the local university residency training programs.**

There are 135 allopathic medical schools and 30 osteopathic medical schools that are formally affiliated with VHAs. The residency/fellowship programs housed at local VHAs include, but are not limited to: epilepsy, gastroenterology, geriatric medicine, hematology/oncology, infectious disease, hospice/palliative medicine, internal medicine, interventional cardiology, nephrology, neuromuscular medicine, nuclear medicine, ophthalmology, orthopedic surgery, pain otolaryngology, medicine, anatomic pathology, plastic surgery, psychiatry, psychosomatic medicine, pulmonary disease, radiology, rheumatology, sleep medicine, general surgery, thoracic surgery and urology.

In addition, education will be curtailed for other trainees who rotate part or full time at VHAs, such as medical and nursing students, psychologists and trainees in more than 40 other health professions.

7. Impact on the Number of Physicians and Other Healthcare Professionals Providing Healthcare in the Local Area

Medical and other healthcare professional schools are a seedbed for training the next generations of doctors. Graduating residents/trainees tend to remain in their local area to live and work. A loss of hundreds of physician and other health care profession trainee positions means that, year by year, there will be **incrementally fewer healthcare providers settling in the community to treat patients, including the very veterans being automatically placed in the VCCP**.

8. Impact on Recruiting a Workforce Committed to Veterans

Training programs are the single best mechanism for the recruitment of VHA health professionals, including those that relocate from other geographic areas. Positive experiences of treating veterans -- as well as being mentored by renowned experts -- in veterans' healthcare issues are, for a substantial number of trainees, the biggest determinant in their decision to seek VHA employment. Roughly 60% of current VHA physicians (and even higher percentages of some other professions) participated in VHA training programs.

Closure of an academic-affiliated facility means fewer residents, fellows, medical students and other health profession trainees will train inside VHA. That will diminish this recruitment tool, and **VHA facilities in other regions will be less able to attract physicians and other healthcare professionals committed to veterans.** This will significantly decrease the number of healthcare professionals with any understanding of veterans' complex conditions and make it increasingly difficult for veterans to get high quality care outside of the VHA.

9. <u>Impact on Research on Veterans</u>

Over the past 70 years, VA researchers and clinicians have worked together, along with scientists at academic institutions and the DoD, to develop innovative treatments that have benefited not only the nation's veterans, but also patients throughout the country and the world.

Take, for example, the San Francisco VA Medical Center, which has over 800 current research projects that would cease if the facility were closed. These include the study of basic neuroscience and neuroimaging of combat-related brain and spinal cord injuries, PTSD, fracture/ polytrauma, neurological combat-related injuries, rehabilitation after stroke and traumatic brain injury, Parkinson's disease, fracture repair, heterotopic ossification after polytrauma, prostate cancer, tinnitus, oncology, hypertension, stroke, cardiovascular disease, breast cancer, musculoskeletal disorders, hepatitis C, HIV, renal dialysis, epilepsy, cardiac surgery, mental health and substance use disorders. **Closure of a VHA facility will shut all of its lines of research. It is unlikely that this research will be transferred and conducted elsewhere.**

The VHA is unique in the American healthcare landscape because it has a stable population that can be followed over the long-term, enabling researchers to make big data breakthroughs on emerging veteran-specific healthcare problems. This work will be impossible if veterans' care becomes scattered across the private sector in which communication is fragmented. Closure of any VHA facility weakens the VHA's ability to identify, diagnose and develop innovative treatments for the next PTSD or Agent Orange. The VHA is currently doing this vital work for younger veterans who have been potentially sickened by exposure to so-called burn pits in the Middle East. Had the post-9/11 generation been funneled into a network of private hospitals that do not communicate with one another, the VHA may never have launched the ongoing work of collecting and studying data that has improved the care and benefits for those who have suffered from a variety of toxic exposures.

10. <u>Impact on Readiness for Emergencies</u>

The Fourth Mission of the VA is to support national, state, and local emergency management, public health, safety and homeland security efforts for veterans and non-veterans in the event of war, terrorism, national emergencies, and natural disasters. VA medical centers are federal emergency response sites. The VHA has responded far better to the COVID-19 pandemic than any other healthcare system in the United States. This is because it is a national system and its decisions are not based on fee-for-service reimbursements. It has also been able to shift and send staff to areas where the pandemic created the most need in the non-VA sector – whether it be to hard-hit hospitals or nursing homes. Since the ripple effects of the COVID-19 pandemic will last for years, so will the VA's Fourth Mission response to it.

In the event of the next emergency, closures of VHA facilities will mean that the VHA will not be available to help with more ICU and inpatient beds. It will have fewer ER facilities and staff that can be moved around the country or region to help. It will also be more difficult to set up the kind of command center that the VA's routinely organize to track and assist veterans who are affected by such emergencies.

11. Impact on the Local Economy

The employees at each VHA medical center and community-based outpatient center (CBOC) not only provide important care for veterans, but also generate revenue for the local economy. When a VAMC or CBOC is closed, those employees are laid off. For many of them, especially those in facility-support roles, finding good jobs with adequate benefits will be difficult. As one report on healthcare put it, "losing an employer of 150 people with good jobs is like losing a manufacturing plant. Hospitals are usually the largest, or second largest, employer in a community. That's something easy to lose sight of because we think of this from a health standpoint. But the effects are wide-ranging when a hospital closes."

One vital VHA-based program that is, for example, easily overlooked is the compensated work therapy program that enables veterans to quickly re-enter the work force -- would also be eliminated. Any decision about closing a VHA facility must consider how job losses impact the local economy as well as the insurmountable challenges employees face. It must not be forgotten that a third of all VA employees are veterans themselves.

Summary

The VA must establish AIR Commission criteria that will explicitly evaluate and take into account the severe consequences of a VHA facility closure. Closure should only be recommended if it can be shown to significantly save money while covering all enrolled veterans, offer the full array of services in the private sector whose quality is demonstrably as good or better than the VHA's, have shorter wait times, and have no adverse effects on availability of clinicians with veteran-specific expertise, healthcare education/research, local economies and emergency preparedness.

Finally, it should be said that decisions about closure must account for the honest truth that peace in this world is far too fleeting. When a VHA facility is shuttered, that locale loses forever the ability to provide VHA care to future generations of veterans.