



# Veterans Healthcare Policy Institute

## Strengthening Care for Veterans and the Nation

### **VHPI Analysis of VA's Market Assessments Used to Make Recommendations for VA Closures, Consolidations and Expansion**

March 2022

#### **Executive Summary:**

At the instruction of the MISSION Act of 2018, VA conducted market assessments of VA and private-sector capacity to care for American veterans across every geographic region. These assessments were used to form recommendations whether to close, consolidate or expand VA programs, services and medical facilities. The set of recommendations will become publicly available on March 14<sup>th</sup> and then turned over to an independent Asset and Infrastructure Review (AIR) Commission for deliberation.

The recommendations are extremely consequential as the basic integrity of the VA system of care depends on the data they generated.

VHPI, as well as distinguished experts that we've contacted, have reviewed the market assessments. We've found scores of major flaws and omissions, lapses that render them deeply inadequate as a tool to help VA leaders, the AIR Commission, and Congress make informed decisions about VA's future.

Key problems with the assessments include:

- The assessments use health care data that is five or more years old. This would be of concern in normal times but is doubly so in light of COVID-19, which has changed everything about provision of care in the VA and the broader American healthcare system. Despite this, the pandemic's effects are not at all accounted for.
- The assessments presume that the veteran population will decrease in perpetuity. They have not factored in impending new care eligibility (e.g., toxic burn pits), the EVEST Act (which automatically enrolls veterans leaving DOD into VA), or the possibility of another war (perhaps in Ukraine and Europe).
- The assessments ignore the substantial cost increase that occurs when care is provided in a fee-for-service private sector rather than an integrated not-for-profit system, like the VA.

- The assessments consider only private sector physical capacity and not provider availability (or willingness) to accept VA patients. In many regions, there are [far too few providers](#) to render health care for veterans if a VA downsizes.
- The assessments fail to provide private sector providers' proficiency in treating veteran-specific health conditions. In most regions, there are [few to no services](#) from professionals trained in evidence-based practices and trained to diagnose and treat veteran-specific healthcare problems.
- The assessments don't account for the direct impact of closing VA Emergency Departments (either by closing the entire hospital, the ED or associated medical units). Such closures could overwhelm other regional Eds and undermine VA's ability to fulfill its [Fourth Mission](#) to provide backup in local, regional or national emergencies such as COVID-19.
- The assessments don't assess the impact that closures of inpatient and outpatient services will have on medical school residency and fellowship training. VA facilities are the backbone of the entire national system of training doctors and all health care professionals.
- The assessments don't assess the impact that closures of inpatient and outpatient capacity on the VA's research mission.
- Despite VA's commitment that medical outcomes should drive decisions about where veterans receive their care, the assessments do not consider what is known about superior quality of care in the VA than the private sector.
- The assessments contain a multitude of data bits. But no formula is revealed for how that data is converted into local recommendations.

**Here, in more detail, are serious deficiencies in the regional market assessments. Answers to all of them are required before their usefulness can be assured.**

**Question about Data Collection Timing:**

1. Is five-year-old (in some instances seven-year-old) data useful for future planning? COVID-19 has changed everything we know about provision of care. Can VA provide information that accounts for recent seismic shifts?

**Questions about Private Sector Capacity:**

2. Have projections factored in the predicted physician shortages, especially in primary care, that our nation faces? A [report](#) by the American Association of Medical Colleges warns that by 2034, the U.S. will face serious shortages of primary care physicians of between 17,800 and 48,000 and a shortage across nonprimary care specialties of between 21,000 and 77,100. The delivery of health care to rural populations is a particular challenge. While 20% of the U.S. population is rural, only 12% of primary care providers (and only 8% of other specialties) are working in rural areas, and these provider numbers are declining. Sixty percent of counties – all rural – lack a single psychiatrist. Fifty-five percent, all rural, lack a psychologist or social worker.

3. Have assessments analyzed and utilized federal healthcare professional shortage area [data](#)? Should a facility close will there be at least 1 doctor per 3,500 citizens, as is the Health Professional Shortage Area (HPSA) cutoff?
4. Have assessments accounted for the [predicted](#) closures of rural civilian hospitals? A recent [report](#) predicted that over 500 rural hospitals are at immediate risk and another 400 of high risk of closure.
5. Have assessments surveyed community providers not currently in the VA's Community Care Network (CCN) to assess interest in accepting VA patients and VA payment structures?

**Questions about Private Sector Proficiency:**

6. What percent of local primary care providers are proficient in the rudiments of veteran-specific health conditions? What percent know 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? What percent of local providers have the necessary knowledge to recognize and treat combat-related injuries (e.g., gunshot, blast, and shrapnel injuries, heterotopic ossification, musculoskeletal injuries, spinal cord injury)?
7. What percent of primary care providers have the basic knowledge necessary to diagnose and treat PTSD, Military Sexual Trauma (MST) and Traumatic Brain Injury (TBI)?
8. What percent of providers have basic military cultural competency?
9. What percent of local mental health providers are proficient in providing evidence-based treatments for PTSD (e.g., Prolonged Exposure or Cognitive Processing Therapy)?
10. Are non-VA facilities held accountable to the same quality and training standards as VA staff?
11. 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?
12. When a VA facility is considered for closure, are its services readily available at private sector facilities from professionals trained in veteran specific healthcare problems? Here's a partial list of core veteran services offered in VA:

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 and Nursing Home 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

**Questions about Timeliness of Care:**

13. Would wait times increase for veterans and non-veterans at non-VA facilities? If a VA facility is closed, it seems reasonable to assume that there will be delays for outpatient, inpatient and emergency room care for veterans and non-veterans in the local area. At present, private sector average outpatient wait times for primary care, cardiology, and dermatology (though not orthopedics) are 68% longer than wait times at the VA.
14. VA's Access Standards ensure that a VA facility's wait times are monitored and enforced. Will there ever be expectations of timeliness for care of veterans in the CCN?

**Questions about Costs:**

The market assessments claim to provide "a high-level cost analysis." They compare three data points: internal VA cost to provide care to Veterans, potential cost to acquire the same care in the market at Medicare rates, and existing experience with purchase of non-VA care as applicable.

15. Has VA included in its calculations the aggregated costs associated with closing a VA facility or services and then issuing vouchers to all veterans newly eligible for the CCN? The closure of a VA facility and issuance of vouchers will incentivize other eligible veterans not currently cared for at a VA to take advantage of VA paying for the care and medications they receive in the community. How will this impact cost?
16. The VA pays approximately [half](#) the amount to purchase prescriptions as Medicare does. Has this been factored into the cost of closing a VA facility?
17. As a [recent ambulance study](#) showed, "acquiring the same care in the market at Medicare rates" costs as much as 21% more because the private sector utilizes and bills for more costly procedures under fee for service reimbursement. It is more costly to provide health care and procedures in the fee-for-service private sector, which has a built-in incentive to over-treat and [overbill](#). How has this been factored in to cost estimates?
18. Has there been consideration of the additional VA administrative staff that will be needed for oversight, patrolling for fraud and abuse, and reimbursement of veterans' private sector care in the entire affected region (as well as nationally) should the VA effectively become an insurer?

19. What is the total net cost associated with the all the VA closures and paying for more veteran health care in the private sector?

#### **Questions about VA Capacity:**

20. How is physician efficiency measured and what inputs went into making the assumptions about physician efficiency?
21. Market assessments base demand vs. supply by inserting FTE x productivity targets. Where were the figures for productivity targets obtained, especially for VAs affiliated with an academic institution?
22. How was it determined that primary care is over-resourced in a particular facility?

#### **Questions about the VA's Vital Training of America's Clinicians:**

23. If inpatient units and/or entire facilities that have academic affiliates are closed, what impact will this have on medical school residency and fellowship training? What impact will it have on other health professions that depend on the VA for training sites? If a VA facility were closed, required residency/fellowship rotations would not be available, core funding would be eliminated, leading to shrinkage and in some cases collapse of the local university residency training programs. The residency/fellowship programs housed at local VA's 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 would be curtailed for other trainees who rotate part or full time at VAs, such as medical and nursing students, psychologists, and trainees in more than 40 other health professions.
24. How would closure of inpatient units and associated reduction of medical school positions impact the number of health care professionals familiar with veterans' complex healthcare problems who enter a local community?
25. How would closure impact efforts at other VA facilities to recruit trained providers?

#### **Questions about Community Impacts:**

26. How will VA's fourth mission to serve as a safety net healthcare system be impacted by facility closures? How would closures impact local governments' ability to respond to emergencies both local and national as well as natural disasters? What will be the net reduction of ICU and inpatient beds, and ER facilities? Does that diminish the ability of the community to address the next pandemic or health crisis?
27. How will closing inpatient mental health beds impact veteran homelessness?
28. How will the elimination of VA facilities, which will lead to the curtailment of the identification of high-risk veterans and the number of suicide prevention coordinators, impact veteran suicide?

29. What will the impact of a facility closure be on healthcare disparities in the region?
30. How would layoffs affect the local economy? In rural areas, hospitals and health facilities are often one of [the largest employers](#) in a community, often providing up to 20% of employment and influencing the [vitality of communities](#). How will facility closures impact the rural economy? Given that veterans make up a third of VA employees, have there been efforts to predict and assure their ability to secure new employment, particularly in rural areas or for non-clinical staff?

### **Questions about Data Collection Methods:**

31. MISSION also states unequivocally that these assessments should identify gaps in furnishing such care or services at such Veterans Integrated Service Network or medical facility; (ii) identify how such gaps can be filled by— (I) entering into contracts or agreements with network providers under this section or with entities under other provisions of law; (II) making changes in the way such care and services are furnished at such Veterans Integrated Service Network or medical facility, including— (aa) extending hours of operation; (bb) adding personnel; or (cc) expanding space through the construction, leasing, or sharing of health care facilities. Have these factors been considered in decisions to close or consolidate facilities?
32. Market assessments assume that the veteran population will continue to decrease. Have they factored in the tens of thousands of new veterans who might soon become eligible for VA care because of toxic burn pit exposures, the EVEST act which automatically enrolls Veterans leaving DOD into VA, or the possibility of another war?
33. Even if the total number of current enrollees is going down, the number of Priority 1 enrollees - those that require the most care -- is going up. Priority group 1 veterans have more complex medical issues, may require greater care, and may have greater transportation challenges due to age or disability status. Are market assessments considering the level of care required for veterans?
34. The assessments note that “when there were discrepancies between data obtained from local sources and data obtained from national sources, national sources were used.” Why would one assume that national sources provide more accurate data? If market assessments are meant to look at local market conditions for each VISN/facility, why wouldn't local data be used?
35. For community care projections: “Validation of the data for this slide is not required.” Why is validation of community care projections not required?

### **Other Questions:**

36. VA has said it will build new hospitals and CBOCs and other facilities when it closes existing facilities. Will these facilities be closed before or after new facilities are built? The realization of promises to build new facilities depend on budget appropriations approved by Congress. Unless appropriations have already been allocated there is no guarantee a proposed new facility replacing one that has been closed will actually be built. No facility should be closed before a new facility is available to replace it.
37. Why do commercial assessments of mental health consider only psychiatry but not psychology and other mental health professionals? We know that the provision of mental health for

veterans depends heavily on psychologists, social workers and other clinicians, yet there is no assessment of their “reported capacity.”

38. How will the capacity of VA to conduct research that benefits veteran rehabilitation and health care and all Americans be impacted by closures? What lines of veteran-specific research will be shut down and not transferable elsewhere?
39. The VA 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, like PTSD and Agent Orange. Have the market assessment considered the impact on research when veterans’ care becomes scattered across the private sector?
40. Studies document that rural patients do better in systems that have well-established pathways they can utilize to access specialist care. Have private rural providers established such pathways?
41. Were alternative ideas for under-utilized facilities considered? For example: how can under-utilized facilities be expanded to include veterans with bad paper (OTH) discharges, veterans who are ineligible because of income qualifications or lack of proven service-connected disabilities? How could under-utilized facilities be used to care for veterans’ families or communities?
42. What will happen to “disruptive” veterans in the private sector? Currently, the VA is not permitted to “fire” disruptive patients, while private sector providers are given tutorials [in how to fire patients](#)

VHPI’s stable of experts is available to discuss these issues in greater depth and offer state-specific analysis. Those wishing to engage with our team should e-mail [ExecDirector@veteranspolicy.org](mailto:ExecDirector@veteranspolicy.org)

