



*Veterans Healthcare Policy Institute  
Strengthening Care for Veterans and the Nation*

## **The HEALTH Act Jeopardizes the Best Care Anywhere:**

### **Analysis of S. 1315 - The Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023**

June 16, 2023

#### **Executive Summary**

The Department of Veterans Affairs (VA) has long administered the most successful healthcare system in the country. As a recent [summary of research](#) yet again confirms, the quality of care delivered by the Veterans Health Administration (VHA) is as good as or better than the care veterans receive from VA-paid community care or the general public obtains through private care.

Quite distressingly, however, the VHA is straining to maintain its workforce and programs. That's the result of dramatic outsourcing of patient care initiated under the VA MISSION Act of 2018. In 2022, [44%](#) of health services were being delivered in the private sector through the Veterans Community Care Program (VCCP).

Recently, Senators Jerry Moran (R-KS) and Kyrsten Sinema (I-AZ) introduced legislation – the [Veterans HEALTH Act of 2023](#) -- that would swiftly accelerate the massive outflow of resources and patients by providing veterans with unaccountable, unfettered access to private sector care. In the name of offering veterans with more choice, a so-called “veteran preference” option would ultimately lead to disassembly of the VHA, denying veterans the choice of the VHA as a provider of high-quality care that is tailored to their needs. In truth, **the Veterans HEALTH Act poses the gravest threat to veterans’ health and well-being in decades. It must not pass.**

The bill’s provisions are harmful to veterans for the following reasons:

1. By allowing veterans access to private sector care because that is their “preference,” major funding will be diverted from the VHA to the private sector. This will **force more**

**reductions of VHA staff, curtailment of in-house programs, and closures of inpatient units, emergency rooms, and even entire facilities.** It will also make it nearly impossible to upgrade existing infrastructure needed to address the demand for services, particularly in the wake of the PACT Act.

2. By allowing veterans' access to private sector healthcare without any VHA referral, authorization, or oversight, the **VHA's carefully constructed model of integrated healthcare will break.** The model today produces outcomes that are far superior to those produced by a fragmented private sector system. This bill would not only dismantle this model of care but rapidly expedite the **conversion of the VHA healthcare system from its current primary role as a provider of healthcare into a payer for private sector care.**
3. Under the guise of offering "choice," healthcare options would diminish for veterans. Draining VHA funds and closing programs/ facilities means that **veterans -- especially those like Service-Connected veterans who depend on VHA -- will no longer have that choice.**
4. The bill's refusal to require transparency in the private sector – on wait times, care quality or provider training – means that policy makers and patients alike **will be denied information they need to make well-informed healthcare decisions.**
5. **This bill will make it difficult, if not impossible, for the VHA to continue to collect data and conduct research on veterans' complex health conditions.** It will also jeopardize the critical role the VHA plays in the training of future healthcare professionals, in conducting research on veterans' complex conditions, as well as its ability to fulfill its Fourth Mission as backup for national emergencies.

### **Specific Statutory Analyses of the HEALTH Act**

**Giving unlimited access to veterans who prefer private sector care will increase overall costs and drain funds from VHA facilities, ultimately eroding the availability of care throughout the system.**

**Section 103:** This language, for the first time, would provide veterans with the ability to seek care in the private sector even when high-quality care is readily available in the VHA. All a veteran would need to do is indicate his/her "preference" for where, when, and how to obtain their care. The guardrails of VCCP eligibility standards – travel time to or wait time for a VHA appointment – would become moot.

This stipulation violates the spirit of the VA MISSION Act. When MISSION passed, there was bipartisan agreement that the VCCP was intended, in [legislators' words](#) to "supplement, not supplant" VA healthcare. That meant a veteran would be offered the option of receiving healthcare outside of the VHA under six narrowly defined criterion (including extensive delays

for, or long travel times to, an appointment.) Legislators understood that veterans would get the option to choose whether to receive care in the private sector or the VHA only after they qualified under the six eligibility rules. This carefully constructed language was the firewall that ensured the long-term viability of the VA healthcare system. The HEALTH Act would betray that core agreement.

The HEALTH Act will divert funds away from the VHA, forcing reductions of staff and in-house programs and closing entire facilities. As VA Secretary Denis McDonough predicted in September 2022, if use of private sector care continues to rapidly increase, “VA medical facilities, particularly those in rural areas, may not be able to sustain sufficient workload to operate in their current capacity.” Siphoning VHA funds will also make it nearly impossible to upgrade existing infrastructure required to address the demand for services. That demand is continuing to grow - the PACT Act of 2022 has already contributed to an influx of a quarter million newly enrolled veterans with serious toxic exposure-related medical conditions.

If VHA programs, units, or facilities close, access to veteran-specific, high-quality, comprehensive, and integrated care would decline. Independent [RAND](#) and [Dartmouth](#) analyses — [among many others](#) — continually affirm that the quality of VHA’s healthcare in regional markets is as good as, and in many instances, superior to private options. For example, a veteran is far [more likely to survive](#) if treated in a VHA rather than a private sector emergency room.

VA healthcare settings provide the best (and arguably only) environment for providers to attain proficiency in treating veteran-specific issues. Veterans are at higher risk for particular conditions, including combat-related injuries (e.g., gunshot, blast, and shrapnel injuries), traumatic brain injury, heterotopic ossification, musculoskeletal injuries, spinal cord injury, toxic exposures, PTSD, military sexual trauma, and suicide.

Not only do VA-trained personnel know how to treat these conditions, they also recognize which potential sources of that condition to investigate. A non-VA practitioner is less likely to explore PTSD as the cause of chronic insomnia or the impact of traumatic brain injury on mood and decision-making. Non-VA practitioners would be less likely to 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. Given their failure to understand veterans’ complex health conditions, private sector providers are less likely to provide evidence-based treatments for them.

[RAND’s Ready to Serve](#) study of therapists who treat PTSD and major depression found that, when compared with 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.” Private sector providers’ ignorance of a plethora of veteran health conditions may lead them to misdiagnose or ineffectively treat these critical conditions, as well as to order inappropriate diagnostic tests and prescribe unproductive treatments. This will not only compromise the health of millions of veterans, but

also reproduce the kind of spiraling healthcare costs that characterizes the private healthcare sector.

Private sector providers may also fail to conduct critical screenings that are routine inside the VHA. Another [RAND's study – "Ready or Not?"](#)— found that most private sector providers do not screen for specific health concerns that are common among veterans, like sleep-related problems, pain-related concerns, suicide risk, and unhealthy alcohol use.

Scattering veterans across disconnected and fragmented healthcare institutions will deprive the VHA of the ability to chart the occurrence and gather further information about known conditions and recognize newly acquired military-related healthcare conditions so that they can be researched and effectively treated. Private sector providers unaware of current veteran health conditions will also fail to collect information that registries need for veterans to qualify to receive compensation. They may even fail to notify veterans that they are eligible for compensation.

CBO scores on the veteran preference provision of the bill are urgently needed.

**The HEALTH Act's Trojan Horse pilot mental health care program will also accelerate the privatization of the VHA and transform it from an integrated healthcare system to an insurance carrier.**

**Section 206:** This statute will accelerate the privatization of the VHA via a Trojan Horse pilot program that will drastically modify the process by which veterans obtain mental health and substance use disorder care.

Veterans would be allowed to receive outpatient mental health or substance use disorder (SUD) care in at least five private sector locations **without VHA referral, authorization, or oversight**. An enrolled veteran could simply make an appointment with any VCCP mental health or SUD outpatient provider for care at any level and for any duration. VHA's only role would be to pay the invoice.

Though this pilot is initially small-scale, the bill also mandates that the VHA "develop appropriate metrics and measures to assess and mitigate any barriers to extending the pilot program across the entire Veterans Health Administration." Subsequent legislation will create universal opportunities for veterans to select private sector providers. Within a few years, eligibility would likely expand so that all diagnoses, not just mental health and SUD, could be covered. All levels across the continuum of care, not just outpatient, could be added. Similarly, veterans throughout the country could be eligible, not just in a handful of locations.

Not only does this hasten the siphoning of funds out of VHA, but it will also transform the VHA from an integrated healthcare system, like Kaiser Permanente, to an insurance carrier, like Blue Cross/Shield or Aetna. In this new insurance system, everything that is indispensable and

unique to the VHA will be gone -- integrated and coordinated care, comprehensive preventive screenings, wrap-around services, veteran-centric specialization, training of providers with veteran expertise, and research on veterans' conditions that also helps all patients. Even the Office of Inspector General's oversight of veterans' healthcare will be curtailed, since its ability to access private sector health care records is limited.

The total systemic cost of a proposal to allow unfettered community care was [calculated](#) when this idea was first proposed, in 2016. At that time, it was estimated to be \$96 to \$179 billion every year. Figures today would be even higher.

CBO scores on this provision of the bill are urgently needed.

### **The HEALTH Act's incentives to VCCP providers will also balloon VCCP costs.**

**Section 108:** This section gives great latitude to the third-party administrators (TPAs) of the VCCP to offer extra pay to private sector providers to participate in the VCCP. Disturbingly, financial incentives are offered to providers to join the VCCP in the absence of any quality control over, or training requirements for, these providers. This statute will lead to an escalation in funds being drained from VHA, diverting in-house resources and leading to more program/facility closures.

CBO scores on this provision of the bill are also urgently needed.

### **The HEALTH Act deprives the VA of the ability to revise misguided telehealth access standards.**

**Section 101:** This statute jeopardizes veterans' timely access to VHA in-house care by explicitly depriving the VA Secretary of the ability to reverse a double standard regarding the VHA's world class telehealth services. The Trump-era standards prohibited telehealth from being considered as access to care if offered by VHA while allowing VCCP telehealth to be furnished without any constraints. Arguing that this double standard should be reversed, VA Secretary Denis McDonough last year [stated](#) that this error unnecessarily redirects up to \$1 billion annually to VCCP.

Under existing law, the VA has the authority to make changes so that telehealth appointments count as meeting timely access standards. The HEALTH Act would remove VA's authority to do so, even when telehealth is a veteran's chosen modality to receive care. **To legislatively prohibit correcting this mistake harms veterans.**

A far better legislative fix would ensure that VHA-delivered telehealth shall count as meeting access standards, but that no veteran would be required to accept a telehealth appointment, either in the VHA or VCCP, when they want to see their provider in-person.

### **The HEALTH Act will increase wait times for veterans and non-veterans at non-VA facilities.**

For years, lawmakers have passed outsourcing laws in an attempt to reduce wait times. The HEALTH Act claims to address this issue, too, though it will **severely increase wait times** for veterans and non-veterans at private facilities.

VHA's access standards ensure that VHA facility's wait times are monitored and enforced. In the HEALTH Act, there are no VCCP wait-time standards.

As more veterans flood the private sector, and/or if a VHA facility is downsized, veterans will struggle to get care in an overburdened private sector healthcare system. Delays for outpatient, inpatient and emergency room care for veterans and non-veterans in the local area would increase. Today, the average VCCP wait times for primary care, mental health, and all other specialties are roughly [20% longer](#) than wait times at the VA.

Our nation faces an intractable physician shortage. A [report](#) by the American Association of Medical Colleges warns of an estimated shortfall by 2034 of between 17,800 to 48,000 primary care physicians and 21,000 to 77,100 non-primary care physicians.

The delivery of health care to rural populations is a particular challenge. While 20% of the U.S. population is rural, only 12 percent of PCPs are working in rural areas (and only 8% of other specialties), and these provider numbers are declining. Sixty percent of American counties – all rural -- lack a single psychiatrist. According to [The Center for Healthcare Quality and Payment Reform](#) between 2005 and 2019, 150 rural hospitals closed. In 2020, an additional 19 closed. In 2023, it was reported that another 600, or more than 30% of rural hospitals are at risk closing.

### **The HEALTH Act strips VHA's authority to enforce VCCP eligibility standards.**

**Section 106:** This statute removes VHA administrators' authority to override provider recommendations that a patient should be referred to private sector care because it is in the veteran's "best medical interest."

This new stipulation is fixing a problem with a machete when a small scalpel is needed. There are instances when "best medical interest" fits for a veteran who doesn't qualify for VCCP under the five other existing criteria.

For example, a veteran might have to travel over a steep mountain pass in winter snow to the nearest VHA facility when there is an alternative in his/her hometown. But there are too many instances when this category is currently being misused. That's occurring when the provider's only justification for the "best medical interest" recommendation is that a veteran "prefers" non-VA care. According to the MISSION Act, the VHA's administrative denial is the appropriate

response. Going forward, VHA must retain – not lose -- the authority to have final say on whether external referrals meet explicit referral standards. Further, VHA employees making referrals to the VCCP need better education about what does and does not constitute “best medical interest.”

**The HEALTH Act imposition of a Value-Based Care (VBC) model on the VHA is a risky experiment.**

**Sections 108, 109 and 201:** This language contains provisions that would force the VHA to change its model of healthcare delivery to one based on value-based care and reimbursement mechanisms.

As the bill reads, it aims to “transform the current health care delivery model of the Department of Veterans Affairs into one that is person-centered, relationship-based, and recovery-focused, and to support that transformation with a system that is value-based and incentivized for continuous innovation and quality improvement.” It advocates the need for “the [VHA to] adopt a value-based model to align with delivering whole health care.”

The guiding assumption behind these sections of the bill is that the VHA does not already deliver any of the above, doesn’t provide good value for cost, and is not focused on “continuous innovation and quality improvement.”

And yet, the bill contains no information to back up this argument. It doesn’t define the current VHA model of healthcare but nonetheless states it must be transformed. Indeed, the bill ignores the fact that the VHA already uses gold standard mechanisms to assure that it delivers high quality care at a lower cost. Its stellar outcomes are repeatedly documented. VHA is a recognized world leader in whole health care. While there may be a need to revise the current iteration of the VERA resource allocation model and to reconsider various scheduling mechanisms VA leadership has launched, like “bookable hours,” value-based care models do not address these problems but instead would create many others.

Despite the claim that VBC is a proven and successful model of delivering healthcare, a body of scholarly literature concludes that it is more rhetoric than reality. According to a number of articles and analyses, including a 2021 article [in JAMA](#), the vast majority of value-based models used by the Centers for Medicare and Medicaid Services (CMS) “do not show significant improvements in quality.” The article goes on to point out that, “In many cases, national or regional benchmarks combined with adverse selection can make it appear as if participants have saved money when they in fact have not.”

Another article titled [“value-based care: a good idea, many caveats,”](#) looked at the international implementation of value-based Care and concluded that “this model has proven to be insufficient to suppress price inflation, endangering the sustainability of health systems.”

A chapter in a [2019 Report to Congress on Medicare](#) stated that “the treatment effect of being in an ACO (one of the primary VBC models) does not show savings.” In fact, these models often showed higher spending growth. The chapter added that ACO’s use of wellness visits resulted in gaming the system through upcoding.

Most disturbing was [an article](#) that appeared in 2022 in the *New England Journal of Medicine*. It reported that value-based Payment systems not only “failed to meaningfully reduce health care expenditures and improve quality” but “hampered the pursuit of health equity,” and actually “perpetuated structural racism.” The value-based model penalized health systems that cared for low-income patients, encouraged system gaming, and diverted funds from those providing direct care to patients toward investments in “external consultants.”

One JAMA [report](#) found that “high-proportion Black hospitals were more likely than other hospitals to be penalized” by certain value-based models. Another [study](#) suggested that value-based models had resulted in decreased access to knee and hip replacement operations for adult Black patients. To impose unproven mechanisms, documented to negatively impact the kind of patients the VHA cares for could harm veteran patients.

**Section.201:** This statute mandates the establishment of a working group to make specific VBC recommendations. The allocation of members mirrors the process used during the establishment of the MISSION Act’s disastrous and discredited Asset and Infrastructure Review Commission and is similarly tilted heavily to healthcare industry representatives with a large stake in VHA privatization.

### **The HEALTH Act imposes potentially problematic staffing models.**

**Section 205:** This statute includes provisions to create new staffing models for the VHA, ignoring the fact that VHA already has them. What’s needed instead is oversight and enforcement of existing VHA staffing standards to correct the wide variation in local VA health care system compliance.

Plus, according to the bill’s language, staffing models would be constructed to assure “timely access to care.” While increasing VHA staffing to adequately meet demand is essential, this measuring stick ignores the issues of quality and safety. Staffing models must account for those as well.

In proposing new staffing models, this bill makes yet another mistake by explicitly trying to create ones that conform with private sector health care systems. To compare private sector staffing to the VHA neglects a critical fact: that VHA patients are far more complex than those seen in the private sector. VHA patients are 14 times more likely to have 5 or [more medical conditions](#) and 14 times more likely to have poor health status than the general population. Compared to the general civilian population, former service members have [higher rates](#) of depression, mental illness, suicidal thoughts, chronic disease, chronic pain and substance use



disorder. Staffing models should also account for VHA's clinical environment, one that prioritizes genuine teamwork and time collaborating with providers and other staff.

Staffing models that are not grounded in an understanding of the complexity of VHA patients and the myriad duties of VHA staff will fail veterans.

**The HEALTH Act also ratifies unjustifiable double-standards by holding the VHA accountable while allowing the VCCP to operate with no significant oversight. Some examples:**

- The timeliness and travel eligibility access standards apply to VHA, but not VCCP.
- The Inspector General is tasked with assessing the performance of the VHA, but not the VCCP, in delivering care in a timely manner.
- VHA, but not VCCP, is required to regularly publish information on wait times.
- Performance metrics will be implemented for VHA employees who are responsible for veterans accessing care. Similar metrics are not required for VCCP employees who have equivalent operational responsibilities.
- VHA providers are already mandated to take military cultural competency and other trainings like suicide prevention, and screen for a multitude of conditions. That's why it has a record of delivering higher quality mental and behavioral health services than the VCCP. Section 108 prohibits that any penalty be applied to VCCP providers who fail to take relevant trainings and gain even minimal expertise.

**The HEALTH Act creates downstream harms to research of veteran-centric conditions, training of healthcare professionals, and national emergency backup.**

**Research:** Every VHA patient and their electronic medical record is available for analysis, which has enabled researchers for decades to make impressive big data breakthroughs on veterans' complex healthcare problems. Those innovations will fade if veterans' care becomes scattered across the fragmented private sector where there is no dependable way to study veterans,

**Education:** The bill will jeopardize VHA's central role in training the nation's future healthcare professionals as well as the. Seventy percent of physicians gain part or all their training at VHAs.

If VA inpatient units downsize or close, required residency/fellowship rotations will not be available, core funding will be eliminated, leading to shrinkage 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 will 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.

**Backup for National Emergencies.** 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. VHA medical centers are federal emergency response sites.

If the HEALTH Act is passed and there is an emergency, there will be fewer ER and inpatient beds. It will also be more difficult to set up the kind of command center that the VHA's routinely organize to track and assist veterans who are affected by such emergencies.

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### **Conclusion:**

The HEALTH Act of 2023 will increase the outsourcing of veterans' care to the private sector and drain the VHA of needed funding for the provision of in-house care. This will, in turn, cause a spiraling reduction in VHA staff and closure of programs/clinics. It creates a Trojan Horse pilot program that upends the entire integrated health care model on which VHA is based.

VHA would lose its capacity to provide coordinated care and thus shelter veterans from the dangerous fragmentation that is endemic in the rest of American healthcare. Under the guise of providing veterans with more choice, the VHA option would be decimated. The "HEALTH" that would result from this legislation would be to the bottom line of private sector interests, like private equity firms, for-profit providers, and healthcare consultants.

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