

## STATEMENT FOR THE RECORD

### COMMITTEE ON VETERANS' AFFAIRS UNITED STATES HOUSE OF REPRESENTATIVES WITH RESPECT TO H.R. 3083, *The AIR Acceleration Act*

WASHINGTON, D.C.

June 19, 2019

Chairman Takano, Ranking Member Roe, and Members of the Committee:

The Veterans Healthcare Policy Institute (VHPI) would like to thank you for the opportunity to submit a statement on the record regarding H.R. 3083, *The AIR Acceleration Act*. We appreciate your bipartisan recognition that all Americans deserve to know their tax dollars are being used efficiently to ensure the highest quality and availability of veterans' health care.

We **strongly urge caution when reviewing *The AIR Acceleration Act (H.R. 3083)***, which would accelerate the timeline for the Asset and Infrastructure Review Commission. As we document in this analysis, there are harmful secondary consequences of a Veterans Health Administration (VA) facility closure that must be very thoroughly studied. Closure will likely increase overall costs and divert critical funds away from the national VA healthcare system. Beyond costs, shuttering any VA facility will erode the care of veterans, reduce the availability of clinicians with veteran-specific expertise, decimate healthcare education/research, harm local economies and diminish emergency preparedness.

#### Overview

Pub.L. 115-182, The VA MISSION Act of 2018, Sec. 202 established an Asset and Infrastructure Review (AIR) Commission to evaluate all VA facilities' utilization patterns and infrastructure needs, and recommend whether to close, replace, expand or repurpose them. Congress will have no authority to alter the final set of the Commission's recommendations. Instead, Congress may only approve or disapprove of the recommendations in their entirety, within a tight time frame. Because there will be no ability to walk back the Commission's proposals, it is critical that Commissioners and Members of Congress be thoroughly aware of the far-reaching repercussions of any recommended closures.

This document analyzes the severe economic, healthcare, training, and research consequences of a VA facility closure. As the nation debates the future of its largest and only publicly-funded, fully integrated healthcare system, it is critical to understand the vital role these medical centers play in their communities and the breadth and depth of the services they deliver to veterans.

Following is a summary of the major adverse consequences that **closing a VA facility will:**

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

1

2. **Diminish veterans’ access to veteran-specific, high quality, comprehensive and integrated care in their community,**
3. **Increase wait times for veterans and non-veterans at non-VA facilities,**
4. **Eliminate veterans’ choice if they prefer to receive their care in the VA,**
5. **Decimate residency and fellowship training programs at the affiliated medical and health professional schools,**
6. **Diminish the number of graduates who enter the local network of healthcare providers to treat veterans and the non-veteran public,**
7. **Impede efforts to recruit providers at other VA facilities,**
8. **Reduce VA research projects that benefits veteran rehabilitation and health care for all Americans,**
9. **Hamper local governments’ ability to respond to national emergencies and natural disasters.**
10. **Layoff employees, which would significantly impact the local economy. (Veterans make up a third of VA employees and many will find it difficult to secure employment).**

**SPECIFIC ADVERSE IMPACTS OF A VA FACILITY CLOSURE**

**1. Impact on the VA Budget**

Costs associated with closing a VA facility will be higher than keeping it open because:

- **The number of veterans whose care is financed by the VA will increase.** Of the approximately 19.6 million veterans, 32% were enrolled in the system and had some VA or Community Care paid by the VA last year; 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	
	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	32%	14%	54%	100%
Approximate total # of U.S. veterans	6.34M <sup>1</sup>	2.81M <sup>1</sup>	10.45M	19.60M <sup>1</sup>

<sup>1</sup>Vet Data Pocket Card<sup>1</sup>

For as long as a VA facility remains open, the VA pays for VA facility or community healthcare only for veterans in column A. But if a facility is closed, VA will automatically issue vouchers for the Veterans Community Care Program (VCCP) to all local veterans in columns A and B, plus to those veterans in column C who decide to enroll (because it is advantageous for these veterans to do so). According to a 2016 [report](#)<sup>2</sup>, the total systemic cost of a proposal to allow community care for veterans could increase usage and outlays nationally by \$96 to \$179 billion a year.

- **Health care procedures are more costly in the fee-for-service private sector**, which has a built-in incentive to over treat. One example is end of life care for veterans whose illnesses are terminal. VA's utilize more palliative and hospice care, while the private sector is more likely to use aggressive, expensive treatments, even if they are unlikely to significantly increase time and quality of life remaining.
- **Additional VA administrative staff will be needed for oversight and reimbursement of veterans' private sector care** in the entire affected region.

## **2. Impact on the Quality of Clinical Care Provided to Veterans**

If a VA facility were to close, **the overall quality, comprehensiveness and integration of care provided to veterans would decline.**

Independent [RAND](#)<sup>3</sup> and [Dartmouth](#)<sup>4</sup> analyses — among many others — continually affirm that the quality of VA's healthcare in regional markets is as good as, and in many instances superior to that of non-VA facilities.

VA healthcare settings provide the best (and arguably only) environment for providers and trainees 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 recognize which potential sources 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. [RAND's Ready or Not?](#)<sup>5</sup> study reported that a majority of private sector providers do not screen for specific health concerns that are common among veterans.

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.

[RAND's Ready to Serve](#)<sup>6</sup> study of therapists who treat PTSD and major depression found that compared to providers affiliated with the VA 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.”

VA social workers connect patients to veteran-specific follow up resources, including VA and other community resources that provide home health services, legal services, transportation, community living and housing. Such wrap-around services help mitigate homelessness and other social determinants of disease progression and prevalence of suicide. Veterans being discharged from the VCCP inpatient facilities to VCCP outpatient care would not receive the kind of VA expertise and systematic planning that links them to the array of veterans' resources they need.

As the [Commission on Care Final Report](#)<sup>2</sup> acknowledged: “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.” Compared to VA’s best practice integrated model, healthcare delivered in the community lacks integration or coordination of veterans’ care. The VA, as a unified system, has superior ability to implement and monitor adherence to assessment and treatment standards.

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

VA’s Access Standards ensure that VA facility’s wait times are monitored and enforced. There are no set expectations of timeliness for care of veterans in the Community Care Network.

If a VA facility is closed, 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.**

At present, private sector average outpatient wait times for primary care, cardiology, and dermatology (though not orthopedics) are [68% longer](#)<sup>8</sup> than wait times at the VA.

Our nation faces an intractable physician shortage, especially in primary care. A [report](#)<sup>9</sup> by the American Association of Medical Colleges warns that by 2030 the U.S. will be short 14,800 to 49,300 of needed 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 VA specializes and the private sector is drastically undersupplied, less than half of [geriatric fellowship positions](#)<sup>10</sup> even filled last year.

The delivery of health care to rural populations is a particular challenge. While 20% of the U.S. population is rural, only [12 % of PCPs are working in rural areas \(and only 8% of other specialties\)](#)<sup>11</sup>, and these provider numbers are actually declining. [Sixty percent of counties](#)<sup>12</sup> – all rural -- lack a single psychiatrist. Between 2010 and 2019, [95 rural hospitals closed](#)<sup>13</sup> and an additional 21% (=430) are at high risk of closing.

### **4. Impact on Veterans Having “Choice” for Where to Receive Healthcare**

Explicitly, the MISSION Act was developed to offer greater healthcare choices to veterans. **When a facility is closed, veterans who prefer to receive their care in the VA will no longer have that option.**

Forty-six percent of all veterans are enrolled in VA healthcare, and [17% utilize it as their primary source](#).<sup>14</sup> VA utilizers are more likely to be black, younger, female, unmarried, less educated and have a lower income.

Further, many veterans prefer to receive care in a VA facility because of the opportunity for peer contact. A third of VA employees are veterans. The VA 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 veterans and instill hope. Closure takes that away.

### **5. Impact on Training of Medical/Healthcare Professionals**

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.**

There are 135 allopathic medical schools and 30 osteopathic medical schools that are formally affiliated with VA's. 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 VAMCs, such as medical and nursing students, psychologists, and trainees in more than 40 other health professions.

### **6. Impact on the Number of Doctors and Other Healthcare Professionals Providing Healthcare in the Local Area**

Medical schools are a seedbed for training the next generations of doctors. Graduating residents tend to remain in their local area to live and work. A loss of hundreds of physician and other health care profession residency 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.**

### **7. Impact on Recruiting a Workforce Committed to Veterans**

Training programs are the single best mechanism for the recruitment of VA 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 VA employment. Roughly 60% of current VA physicians (and even higher percentages of some other professions) participated in VA training programs.

Closure of a facility means fewer residents, fellows, medical students and other health profession trainees would train at VA's. That will diminish this recruitment tool, and **VA's in other regions will be less able to attract physicians and other healthcare professionals committed to veterans.**

## **8. Impact on Research on Veterans**

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, posttraumatic stress disorder (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 VA would shut its lines of research that are unfeasible to transfer elsewhere.**

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. That will be impossible if veterans' care becomes scattered across the private sector in which communication is fragmented. Closure of any VA facility weakens the VA's ability to identify, diagnose and develop innovative treatments for the next PTSD or Agent Orange.

## **9. Impact on Readiness for 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. VAMCs are federal emergency response sites.

**In the event of 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 VA's routinely organize to track and assist veterans who are affected by such emergencies.

## **10. Impact on the Local Economy**

Each VA medical center has thousands, and smaller CBOCS have hundreds, of employees who 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 support roles, finding gainful employment will be difficult. Veterans on compensated work therapy will likely face insurmountable challenges. Any decision about closing a VA facility must also consider how job losses impact the local economy.

The Veterans Healthcare Policy Institute thanks the Committee for the opportunity to provide this statement for the record.

## **Authors:**



Contact:  
*ExecDirector@VeteransPolicy.org*  
*(202) 210-8879*

Russell B. Lemle, PhD, Senior Policy Analyst  
Suzanne Gordon, Senior Policy Analyst

**Contact:**

Brett W. Copeland, Executive Director [execdirector@veteranspolicy.org](mailto:execdirector@veteranspolicy.org)

## **Endnotes**

1. "Avery Dennison Template - VA.gov." <https://www.va.gov/vetdata/docs/pocketcards/fy2019q1.PDF>.
2. "Commission on Care - Amazon S3." [https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care\\_Final-Report\\_063016\\_FOR-WEB.pdf](https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf).
3. "Comparing Quality of Care in Veterans Affairs and Non ... - NCBI." 25 Apr. 2018, <https://www.ncbi.nlm.nih.gov/pubmed/29696561>.
4. "Veterans Health Administration Hospitals Outperform Non-Veterans ...." 19 Mar. 2019, <https://annals.org/aim/fullarticle/2718687/veterans-health-administration-hospitals-outperform-non-veterans-health-administration-hospitals>.
5. "Assessing the Capacity of New York State Health ... - RAND Corporation." 1 Mar. 2018, [https://www.rand.org/pubs/research\\_reports/R2298.html](https://www.rand.org/pubs/research_reports/R2298.html).
6. "Community-Based Provider Capacity to Deliver ... - RAND Corporation." 12 Nov. 2014, [https://www.rand.org/pubs/research\\_reports/R806.html](https://www.rand.org/pubs/research_reports/R806.html).
7. "Commission on Care - Amazon S3." [https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care\\_Final-Report\\_063016\\_FOR-WEB.pdf](https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf).
8. "Comparison of wait times for new patients between ... - JAMA Network." 18 Jan. 2019, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2720917>.
9. "New research shows increasing physician shortages in both primary ...." 11 Apr. 2018, [https://news.aamc.org/press-releases/article/workforce\\_report\\_shortage\\_04112018/](https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/).
10. "SAP Crystal Reports - 2017 SMS - NRMP." <http://www.nrmp.org/wp-content/uploads/2018/02/Results-and-Data-SMS-2018.pdf>.
11. "Rural America Faces Shortage of Physicians to Care for Rapidly Aging ...." <https://www.asaging.org/blog/rural-america-faces-shortage-physicians-care-rapidly-aging-population>.
12. "The Silent Shortage - New American Economy." [http://research.newamericaneconomy.org/wp-content/uploads/2017/10/NAE\\_PsychiatristShortage\\_V6-1.pdf](http://research.newamericaneconomy.org/wp-content/uploads/2017/10/NAE_PsychiatristShortage_V6-1.pdf).
13. "2019 healthcare outlook - Navigant." <https://www.navigant.com/-/media/www/site/insights/healthcare/2019/navigant2019healthcareoutlook.pdf>.
14. "US Veterans Who Do and Do Not Utilize Veterans Affairs ... - NCBI." 17 Jan. 2019, <https://www.ncbi.nlm.nih.gov/pubmed/30677266>.