

June 29, 2016

Commissioner Michael Blecker

This letter explains my decision not to sign the Report of the Commission on Care.

This report recommends many changes to the organization, operation, and direction of the VA's health care services that are necessary to ensure our society fulfills its commitments to those who served it in uniform. I agree with the Commission's recommendations that relate to Clinical Operations, Facility and Capital Assets, Governance, Health Care Equity, Information Technology, Supply Chain and Workforce management. These recommendations will strengthen veteran health care and I hope they are adopted promptly.

However I cannot agree to the Commission's first and most significant recommendation, establishment of a proposed "VHA Care System." Given the design of this proposed new delivery model, the adoption of this proposal would threaten the survival of our nation's veteran-centered health care system as a choice for the millions of veterans who rely on it. Although this is only one of many recommendations in the Report, this single recommendation risks undermining rather than strengthening our veteran-centered health care system, and I cannot agree to it.

The "VHA Care System" would undermine veteran-specific care for millions of veterans

I believe that veteran health care services are best provided by an effective, efficient Veteran's Health Administration. Not every veteran needs or wants veteran-centered care. But for those who do there is no substitute. My priority is to ensure that veteran-centered care is accessible and effective for the veterans who rely on it.

I do not believe that the Commission Report's "VHA Care System" achieves this. Key elements of the proposed new system will result in the degradation or atrophy of important health services that the VA provides with high quality, to high demand, at low unit cost, and with a unique degree of military and veteran competency. This will happen because of two design choices proposed for the "VHA Care System": first, it does not assure the preservation of effective care coordination, and the primary care services that are essential to effective care coordination, within the VHA; second, it does not ensure that objective, evidence-based, locally-determined criteria are used to decide when services are best provided through the VA or through community partners. Instead, the VHA Care System recommends choice for all enrolled patients, and for the range of services to include primary care, care coordination and referral. The Commission's insistence on making "choice" a core element of its plan will, according to the Commission's economists, likely divert 40% of the VHA's service base. I believe that this would threaten the viability of VA care for the millions of veterans who rely on it. In its design, the "VHA Care

System” has prioritized users’ access to the private health care system above all else: above cost, above quality, above preserving the choice of comprehensive veteran-specific care for those who need it.

Furthermore, I do not believe that the proposed structure would preserve the qualities that even the VHA’s strongest detractors acknowledge are unique and valuable VHA capacities. First among them is the VHA’s integration of primary, behavioral, and mental health care. The Report recognizes how this is essential to effective mental health care, and how the VHA’s unmatched services in this area should be a model for other providers. Yet the “VHA Care System” design separates mental health care (VHA-provided) from primary care and care coordination, thereby undermining rather than reinforcing this essential competency. Similarly, the VHA’s leadership in diagnosing, treating, monitoring and researching complex chronic conditions associated with military service, including environmental hazards associated with herbicides or service in Southwest Asia, relies upon close integration of primary care and specialized internal medicine. The “VHA Care System” would fragment specialist from primary care and remove them from a care coordination context with high awareness of the special medical correlates of military service. It is highly likely that a “VHA Care System” as proposed would never have even recognized the existence of Gulf War Syndrome or cancers associated with service in Camp Lejeune. That is not a veteran health care system worth serving for.

Finally, we must confront the fact that the proposed design costs substantially more than alternative proposals, and at the high end of the range, those costs are staggering in magnitude. In any case, the projected cost increases associated with this design surely call into question how Congress could meet those new costs while also providing needed funding for the investments the Commission proposes for VHA, particularly for new IT systems and much-needed facility modernization. The Report suggests that these increased costs could be offset by reducing the number of veterans eligible for VA health care, reducing the range of services offered in the VHA Medical Benefits Package, or increasing veterans’ out-of-pocket costs. It is alarming to me that we would even consider reducing veteran benefits in order to pay for more expensive health care options. This is not responsible stewardship of veteran health care, in my view.

The Commission has designed a health care system that is optimized for people who do not rely on veteran-specific health care. That should not be our highest priority. Our highest priority should be meeting the needs of the many veterans who need veteran-specific care, for clinical reasons or for personal reasons. When I enlisted I was not promised a PPO, and I do not want to see the VHA converted into one now. I was promised that the nation would take responsibility for the medical and health consequences of military service. We must design our veteran health care system for those who need it most, not for those who want it least. The proposed VHA Care System does not do so.

The “VHA Care System” design was not based on the facts before the Commission

The Commission agreed at the outset that our recommendations would be data-driven. But I see no evidence that the proposed “VHA Care System” design is supported by or drew on the facts available to

the Commission. Here are the primary facts presented to the Commission that were not adequately incorporated into the Recommendation.

VHA provides higher quality care than outside providers. The Independent Assessments found that VHA provides better clinical outcomes than outside providers, according to most measures. The Commission was provided with a supplementary literature review of some 75 recent studies that confirmed this. Care quality can be inconsistent, due in part to operational and administrative problems, and these must be remedied. But outside care is also inconsistent, also due to operational and administrative problems, and the bottom line is that outside providers generally provide lower quality care as a result. The Commission never explains why expanding reliance on lower-quality health care options will improve veteran health care.

Veterans want more VHA care, not less. The present crisis in veteran health care is primarily a demand problem: veterans want more health care from the VHA than it is able to provide. This is true even though most users of VHA health care have other health insurance options, according to the Independent Assessments. And it is most true for the veterans who need it most: the Independent Assessments showed that the sicker a veteran is, the more likely he or she is to prefer VHA care over outside care. There are some areas where legacy VHA infrastructure exceeds demand, and the Committee recommends a sensible response to this. But the tragic and unacceptable reports of delayed health care are not coming from those areas, they are coming from places where people want more VHA care than is available. The Commission does not explain why its response to excess demand for VHA care should be a reduction in supply of VHA care.

A reduction in VHA care services would reduce choice, not expand it. The Independent Assessments found that most users of VHA health care have other health care options, yet they are choosing VHA anyway for at least some of their care. These are not people who want a new health insurance option to pay the same doctors they can access through Medicare or their employer-provided insurance plan; these are people who want the veteran-specific health care that the VHA offers. Most have choices, and they are choosing the VHA. A “VHA Care System” that explicitly or predictably reduced the scope of veteran-specific health care would deprive them of this choice.

VHA care is probably cheaper than outside care. The question of how the VHA’s unit costs compare with outside providers has been one of the thorniest that the Commission faced. The Independent Assessments were unable to reach a conclusion on this question. Other analysts such as the CBO have also noted the difficulty in comparing costs. Certainly, an important Recommendation requires that VHA publish unit costs. Nevertheless, the CBO concluded that the best information available shows that overall VHA costs are about 20% lower than Medicare, which is itself lower than typical insurance rates. Staunch advocates for VA privatization such as Concerned Veterans for America have acknowledged that VA care is cheaper than outside care, and Commission economists had presented models that reflected this. However, at the Commission’s final meeting Commission economists presented analysis that for the first time showed VHA costs above Medicare costs, citing a data source that had not been analyzed in the Independent Assessments or discussed with the Commission. I recognize that the

Commission staff operated under time and information constraints, but the Commission Recommendation should not rely on such important information with so little support.

Reasonable alternatives for VHA reform were not adopted

I did not join the Commission in order to defend the status quo, and I do not do so now. There clearly exists a crisis in veteran health care access, as well as important operational problems at the VA that must be addressed. I endorse all of the Recommendations in the report other than the VHA Care System, and I would like to see the VHA care delivery system changed in ways that can strengthen the system for those who rely on it.

But I do not feel that I have to prove my seriousness by offering to sacrifice effective veteran health care. Some have suggested that our response is not “bold” or “transformative” unless we consider radical options like cutting eligibility, reducing eligible services, or raising veterans’ out-of-pocket costs. I reject these possibilities not because I am timid but because they are bad ideas. Our veteran health care system deserves better than this sort of Civil-War-era medicine where every injury gets treated with an amputation.

To me, the facts provided in the Independent Assessments and presented to the Commission paint a clear picture of how community care can play an essential role in supplementing VHA care. Where VHA care is available, it is a high-quality, cost-effective way to provide veteran-specific care; where given services are not available, access to community providers should be easy, efficient, and seamless. Care coordination and primary care should always be available and provided through VHA, and those providers should operate seamlessly with specialists both inside and outside the VHA as demand requires.

There are several different variations on this, and I would have supported any one of them. For example, one idea involves local assessments of demand and supply to identify exactly which services are best provided in the community, and building partnerships with community care providers to do so seamlessly. This is being piloted in El Paso, Texas under the leadership of a Congressman Beto O’Rourke, and Undersecretary Shulkin has proposed a nation-wide plan that effectively reproduces this. A different idea has been to define clear access criteria and make outside referral automatic if those criteria are not met, effectively making Choice Act authorities streamlined and permanent. These were presented to or discussed in the Commission, or have been available in public discussion on this issue, but the Commission has not adopt them.

I mention these here briefly simply to show that reasonable, practical, effective solutions are available to address the access problem. I also point out that a key element of the VHA Care System design proposed in the Commission report was adopted at our last meeting and with little discussion. Until only a few weeks ago, “veteran choice” was offered as an “aspirational goal,” but in a troubling reversal was adopted as a virtual centerpiece of the VHA Care System design. I do not believe that the decision to adopt “veteran choice” was in any sense data-driven or reflects careful attention to the facts before

the Commission, and the range of evidence-based, tested approaches that might better solve the problem.

In raising these concerns, I speak as a Commissioner, a veteran, and a lifelong advocate for community-based veteran support services. I was working with veterans in need when the VHA was not the comprehensive, integrated, wrap-around provider of veteran-centered health care that it is now, and I do not want to see us move backward. When I joined the Commission I stated at one of our public meetings that I would not sign the report if I thought it would hurt veterans. The recommendation that redesigns the Veterans Health Care Delivery System by outsourcing the choice of primary care providers will do just that – hurt veterans. The bottom line is that the Commission has adopted a dangerous idea. And it has failed the most fundamental principle owed veterans who rely on VA health care, the principle that we should “do no harm.”



Michael Blecker
Swords to Plowshares, Executive Director
U.S. Army Veteran, 1967-1970