**MULTIORGANIZATIONAL STATEMENT FOR THE RECORD**

House Committee on Veterans' Affairs

Hearing on

"Restoring Focus: Putting Veterans First in Community Care"

January 22, 2025

by the

American Psychological Association
Association of VA Psychologist Leaders
Association of VA Social Workers
National Association of Veterans Affairs Physicians and Dentists
National Association of Veterans' Research and Education Foundations
Veterans Affairs PA Association
Veterans Healthcare Policy Institute

(All are independent organizations, not representing the Department of Veterans Affairs)

Chairman Bost, Ranking Member Takano, and distinguished members of the committee:

On behalf of our organizations, we thank you for inviting us to submit a statement for the record for today's hearing on how the U.S. Department of Veterans Affairs (VA) can improve the care of veterans in the community. Many members of our organizations are veterans or have family members who are veterans. Many of us have had long careers serving veterans, have published papers on veterans' healthcare in peer-reviewed journals, or have previously presented testimony to your committee. In today's statement, we wish to convey our appreciation for your leadership and abiding commitment to ensuring that veterans receive the highest level of health care within the Veterans Health Administration (VHA) and supplementary care in the private sector when it's both needed and authorized by the VHA.

Problems in VHA scheduling and coordinating community care—a focus of the hearing—are real, and every veteran's experience deserves careful attention and efforts to rectify. There are stories from multiple vantage points, including veterans who received substandard care in the community. For example, we have a report of a Gulf War combat veteran who, after unusual sleep study results, was referred to a community cardiologist. The cardiologist recommended implanting a pacemaker and offered to perform the invasive procedure the next week. The self-referring and possibly

profit-motivated aspect raised doubts in the veteran's mind about whether a pacemaker was necessary, and a second opinion from another cardiologist confirmed that it was contraindicated. Consider also the Vietnam veteran who, despite indicating his strong preference to wait for VHA services, faced pressure from a scheduler to accept community care because the facility felt compelled to reduce its' average wait times. Or reflect on the Iraq War veteran in need of posttraumatic stress disorder treatment who did not feel understood by his community care clinician.

It is essential, however, that we not just listen to the individual stories brought to us, but take into account the aggregate data and research that represent the experiences of *all* our veterans. Information that encompasses the 9.1 million veterans enrolled in the VHA system is the strongest foundation upon which to base policy decisions and craft legislation. That is putting veterans first.

Our organizations support the need for supplemental community care options when access to VHA services is too delayed or too far away. We share the bipartisan goal of ensuring that the Veterans Community Care Program (VCCP) lives up to its promise—still unrealized—of delivering timely, high-quality care without the prospect of undermining VHA care. To help achieve this aim, we delineate significant challenges within the VCCP that merit thoughtful review and offer recommended improvements. These are:

1. Ensuring VCCP quality standards,
2. Ensuring VHA authorization for care is not bypassed,
3. Addressing the impact of VCCP usage on VHA staffing and exceptional veteran-centric care,
4. Ensuring the defined meaning of "veterans' health care choice" is applied,
5. Providing veterans with crucial information needed to make educated health care decisions,
6. Addressing the VCCP payment model that encourages unnecessary, costly overtreatment,
7. Addressing the deficiencies with health information sharing between the VA and VCCP,
8. Properly including telehealth in VHA access standards,
9. Protecting the VHA's 2nd, 3rd and 4th Missions by ensuring VHA is fully funded and staffed

**Ensuring VCCP quality standards**

The VA MISSION Act of 2018 established the VCCP with a laudable purpose: ensuring veterans could access high-quality healthcare, whether at VHA facilities or in their communities when VA care was not quickly available or conveniently located. The strong focus on quality was unmistakable. In its charter language, the word "quality" appears 50 times, far surpassing mentions of both "choice" and "community"—a point we'll explore further when discussing veterans' choice.

The quality of veterans' healthcare should always be the north star of Congressional policymaking, yet it has failed to set and enforce quality standards for contract providers. Study after study has found that veterans referred for care in the community have a higher likelihood of dying and are more likely to receive lower quality care than those treated at VHA facilities. Another study published earlier this month in *Health Affairs* found that the quality of care metrics of VCCP providers are substantially lower than those of other private sector clinicians, especially in primary care and mental health care. Given this track record of lower quality of healthcare and potential risks to veterans' health, it is imperative that Congress mandate **uniformity on quality and training metrics for VHA and VCCP providers and programs.**

## Ensuring VHA authorization for care is not bypassed

With increasing frequency in recent years, legislative proposals have sought to give veterans unfettered access to private healthcare, bypassing VHA referrals, authorization, and oversight entirely. Though they have not yet come to pass, we mention them here because enacting such legislation would fundamentally alter the VHA's core function. Instead of primarily serving as the provider of specialized, high-quality care for the unique health needs of veterans, the VHA would become more of a payer of private sector services. This would essentially **transform the VHA from a comprehensive healthcare system into an insurance company.** Notably, many Congressional proposals even omit traditional insurance company utilization review functions, which would make the care paid for even more risky to veterans.

## Addressing the impact of VCCP usage on VHA staffing and exceptional veteran-centric care

A comprehensive report last year by six healthcare experts raised serious concerns that community care utilization was endangering Congress's intent for the VCCP to supplement, not supplant, the VHA. VCCP care has been relentlessly increasing 15-20% year after year, and by 2022, its share of VHA health dollars reached 44%. The report concludes that even if no additional changes are made as to who is eligible to receive private sector care, the VHA system's future is at risk due to this unsustainable growth. It is incumbent upon the committee to ensure that new legislation doesn't further exacerbate the issues that the report raises. Should Congress further widen eligibility for the VCCP, it will accelerate spending and imperil the basic survival of the VHA system and thus, the continued availability of choice that so many on this committee have deemed essential to veterans.

Expanding VCCP eligibility, including by allowing the bypassing of VHA authorization, will intensify private sector referrals and divert funding from VHA facilities, **forcing staff reductions, curtailment of programs, and closures of inpatient units, emergency rooms, and entire facilities**. It would also prevent needed infrastructure upgrades despite growing demand for services.

If the VHA does not maintain its position as the sole authorizer of care, and receive sufficient funds to fully meet care demand, its indispensable integrated healthcare system specifically designed to serve veterans will be gradually dismantled. This includes coordinated team-based care, comprehensive prevention screenings, wrap-around legal and transportation services, homelessness programs, caregiving, and enrollment in VA registries. It includes veteran-centric care specialization that deftly address veterans' complex military-related conditions. (For example, VHA clinicians are more likely to have experience and specialized training in recognizing, diagnosing and treating problems such as posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), and exposure-related illnesses.)

As we elaborate further below, jeopardizing the VHA will also have a devastating impact on the training of our nation's healthcare workforce and deprive future clinicians of expertise in veterans' complex health conditions. Additionally, research on veterans' health conditions—research that also helps non-veterans—will also be compromised, as will the ability of the VHA to serve as the nation's healthcare safety net during public health emergencies. It also undermines VA's ability to support the military in time of war or terrorist attacks (a critical capacity in maintaining military readiness) or communities in times of natural disasters.

It is true that many veterans deeply appreciate the convenience of receiving authorized care closer to home rather than traveling long distances to VHA facilities. But when they are polled about preserving the VHA system, veterans' priorities are clear. A VFW survey last month of its members found "overwhelming support for VA to remain the primary deliverer of care for veterans." A prior VFW report of over 10,000 members found that 92% explicitly prefer that the VHA to be "fixed not dismantled." As a Veterans Healthcare Policy Institute report noted, and many studies confirm, many veterans who live in rural areas would have no choice of care providers should the VHA be turned into an insurance provider. This is because of a long-standing crisis in rural healthcare that now deprives rural residents of primary care, mental health care, as well as access to hospital, emergency, and pharmacy services.

## Ensuring the defined meaning of "veterans' health care choice" is applied

In the years since the passage of the VA MISSION Act of 2018, there has been a pervasive mischaracterization that the bill gave veterans the "choice to obtain their health care where and when they preferred." That was not the case. In the legislative language, a veteran would be offered the option of receiving healthcare outside of the VHA under six clearly defined criteria. Veterans could choose whether to exercise the option of private sector care **only after they first qualified under the eligibility rules and were authorized by VHA**. The Independent Budget's analysis of the MISSION Act affirmed the understanding at that time that eligibility for VCCP care should not occur "solely based on convenience or preference of a veteran." However, the critical phrases

“when eligible,” “when qualified” or “when authorized” are often dropped when alluding to veterans having the choice of where and when to receive their healthcare.

**Should the VHA be eliminated as the authorizer of care under the promise of more choice, there will be fewer, not more, options for veterans**. When VHA funds are diverted to the private sector, millions of **veterans who depend on the VHA—especially those with service-connected conditions who rely exclusively or near exclusively on the VHA for all their health care needs—will be deprived of the freedom to choose** the VHA when units and programs they depend on vanish. Many have catastrophic war-related ailments, like lost limbs, traumatic brain injuries, or a variety of toxic exposures, which civilian providers are ill-equipped to recognize, much less treat. Granting the option for unrestricted personal choice is not unequivocally advantageous; it comes at the expense of the majority of veterans, many of whom are in extreme need.

## Addressing the VCCP payment model that encourages unnecessary costly overtreatment

VCCP overtreatment and the overuse of expensive testing have been identified in recent scientific and governmental studies. One study scrutinized the care of veterans with prostate cancer. This is the most common cancer among veterans, particularly those who served in the Vietnam War, and were exposed to the carcinogenic herbicide Agent Orange which was used as a defoliant. The study, in the medical journal *JAMA*, tracked 10,000 veterans with newly diagnosed prostate cancer whose biopsies revealed “clinically insignificant” low-risk disease. The *JAMA* authors explained that the professionally recommended standard of care for these patients is what is called “watchful waiting.” Watchful waiting is the accepted standard because recommending aggressive testing and procedures does little good and can cause serious harm to patients whose tumors aren’t progressing. Complications of prostate surgery and radiation of include impotence, incontinence, hair loss, bowel problems, and even death. Despite these well-known problems, the *JAMA* study found that VCCP providers were twice as likely to provide veterans whose prostate cancer was deemed low risk with expensive, unwarranted, and potentially risky surgery or radiation.

Reviewing the use of imaging services in the VCCP for various other medical conditions, a 2021 Congressional Budget Office (CBO) analysis mirrored the findings of the *JAMA* study. When veterans were referred for imaging services, VCCP contractors used magnetic resonance imaging instead of less costly tests like computed tomography scans and X-rays. The CBO explained, “Some of those practice differences might stem from the cost control and incentive structures of VHA physicians and private sector providers. VHA does not control the amount or type of services veterans receive once they have been referred to outside providers for a particular episode of care.”

Excessive use of expensive and/or unnecessary procedures isn’t the only way that VCCP providers endanger veterans and extract resources from the VHA’s healthcare

system. Another is overcharging for services. One form of this is called “upcoding,” i.e., assigning an inaccurate billing code to a medical procedure to increase reimbursement. For example, a provider bills for a “Level 4” complex evaluation and management procedure even though the documented medical notes reveal only Level 3 elements were furnished.

The VA’s Office of Inspector General (OIG) found that, in FY 2020, “at least 37,900 providers of about 218,000 community care providers billed level 4 and level 5 evaluation and management services significantly more often than all other providers in their specialty—a potential flag for upcoding.” A separate 2021 OIG audit found that 76 percent of acupuncture claim treatments and 55 percent of chiropractic claim treatments were not supported by medical documentation. Another well-designed ambulance study found that non-VA hospitals were five times more likely to report high complexity (and more highly reimbursed) evaluation and management services than VHA facilities.

This pattern of overtreatment and fraudulent billing in the VCCP is hardly unexpected. VHA providers, all on salary, work in a mission-driven system that focuses on enhancing patient outcomes. VCCP providers are paid fees for discrete services and work in a system that emphasizes profit maximization. (Our first anecdote above speaks to this trend.)

Also, the rising cost of outsourced dental care has become financially unsustainable. Medical centers are spending anywhere from $25 to $80 million annually on community dental services alone. While some facilities carefully monitor community care referrals, others automatically refer all eligible veterans to outside providers without considering quality and cost. The situation is further complicated by community dentists who routinely propose treatment plans costing tens of thousands of dollars per veteran. The recently enacted Dole Act pilots, in two VISNs, a stringent review process of community dentist treatment plans, but the most cost-effective solution would be to expand the VHA's in-house dental staff. By providing these services directly, the VHA could deliver the same or better quality of care at a fraction of what is currently being spent on community providers.

## Providing veterans with crucial information needed to make educated health care decisions

Another issue in dire need of overhauling in the community care program is the lack of available information that veterans need to make informed health care decisions. Future community care legislation must require private sector transparency about comparative VHA-VCCP wait times and quality metrics.

Veterans also deserve easy access to information as to whether providers treating them have the training, education, and competence to address their specific health concerns. Yet, the directory that is available online doesn’t include all the providers in the network, and the listings lack any details about providers’ qualifications.

Further, third party administrators evaluate their providers and designate those delivering high-quality care as "High Performing Providers" (HPPs). However, this assessment ignores behavioral and mental health providers, despite the prevalence of mental health challenges that many veterans face. The evaluation system should expand to include mental health providers, and veterans should have direct access to HPP designations through the public directory.

**Addressing deficiencies with health information sharing between the VHA and VCCP**

For years, including last week, the OIG has documented "difficulties caused by community care providers failing to return medical documentation." When all the relevant healthcare information isn't properly shared between VHA and community providers, care becomes fragmented, and veterans are put at risk. VCCP mental health providers routinely submit requests for treatment reauthorization that lack clinical documentation needed to make decisions. To address these serious issues, Congress should **establish sanctions for failures to bi-directionally share information between the VHA and VCCP** in a timely manner.

**Properly including telehealth in VHA access standards**

When establishing the VA MISSION Act eligibility rules, the VHA made a significant oversight: they did not include the availability of VHA telehealth when calculating distance or wait times for care. We believe this was a shortsighted decision that has had serious negative consequences. By not considering telehealth options, the VHA has unnecessarily limited veterans' access to quality healthcare while wasting taxpayer money. Telehealth is a valid means of providing health care to veterans who prefer that option. In a survey of veterans engaged in mental health care, 80% reported that VHA virtual care via video and/or telephone is as helpful or more helpful than in-person services. And yet, because of existing regulations, VHA telemental health (TMH) does not qualify as access, resulting in hundreds of thousands of TMH visits being outsourced yearly to community practitioners that could be expeditiously and beneficially furnished by VHA clinicians. The best action that Congress can take is to stipulate that VHA telehealth care constitutes "access to treatment." If implemented, this correction would save taxpayers a vast sum—up to 1.1 billion dollars yearly according to a VA's September 2022 "*Congressionally Mandated Report: Access to Care Standards."*

**Protecting the VHA's 2nd, 3rd and 4th Missions by ensuring VHA is fully funded and staffed**

Congressional legislation on community care must attend to the impact on **the VA's vital role in researching veterans' complex health conditions.** For decades, VHA's electronic health records and access to VHA patients have enabled groundbreaking discoveries and treatments through large-scale data analysis of veterans' healthcare conditions. The VA's innovations in diagnostic testing, disease management, rehabilitation, geriatrics, patient safety, and numerous other fields have advanced healthcare for all Americans. The VHA has also proved invaluable and irreplaceable in its ability to study and compare the efficacy of different medications on patients' health This crucial research capability would disappear if veterans' care fragments across the private sector, where no unified system exists to study veterans' health outcomes or implement and evaluate innovative treatments systematically.

Congress should also be wary of expanding access to community care in a way that would **jeopardize the critical role the VHA plays in the training of future healthcare professionals across the nation.** More than 70% of all U.S. physicians train at a VHA facility early in their careers. At a time of dire mental health professional shortages, VHA is the largest single educator of psychiatrists and psychologists. Expanding care in the community will have jarring effects far beyond VHA itself by constraining the development of a critically needed work force.

Likewise, expanding care in the community that downsizes VHAs will **degrade VHA's capacity to support its "Fourth Mission:"**–assisting the nation in times of emergencies and disasters. The VHA has supported this mandated mission with direct patient clinical care, testing, education and training in response to natural disasters, pandemics (like COVID-19), and other crises. VHA also serves as the first fallback to the military health system in times of war. The VHA is uniquely suited to support these missions because of the national distribution of its facilities, the unique training and experience of its staff, and the exceptional integration of its services.

**Suggested solutions to improve the provision of community care.**

To strengthen use of community care, we propose these essential reforms:

1. The VHA and VCCP must operate under uniform quality standards and training requirements.
2. The VHA and VCCP should publicly disclose wait times, and provider directories must detail healthcare professionals' qualifications and quality metrics.
3. Predictive modeling capabilities to forecast how varying levels of VCCP utilization will impact VHA's operational capacity should be quickly developed.
4. The VHA's internal staffing should be expanded to fully meet demand.
5. The VHA should retain clear authority in determining community care eligibility.
6. It's crucial to reinforce the message that veterans' access to community care depends on first meeting established criteria.
7. Timely VHA telehealth should be recognized as meeting the access to care standard.

8. Timely health record sharing between VHA and community providers should be reinforced through meaningful penalties for non-compliance.
9. Rigorous monitoring must be implemented to identify and sanction community providers who engage in unnecessary testing, optional procedures, or fraudulent billing practices.

We respectfully thank you for the opportunity to provide our perspectives on these essential matters. We look forward to working with the committee to ensure that veterans can receive timely, high-quality compassionate care in the VHA and the community now and in the future.