STATEMENT FOR THE RECORD

House Committee on Veterans' Affairs

Full Committee Legislative Hearing

February 25, 2025

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

On behalf of the Veterans Healthcare Policy Institute, we thank you for inviting us to submit a statement for the record for today's Full Committee Legislative Hearing on improving the care and services for veterans. Many members of our organization are veterans or have family members who are veterans. Many of us have had long careers serving veterans, published papers on veterans' healthcare in peer-reviewed journals, or presented testimony to your committee. In today's statement, we wish to convey our appreciation for your leadership and 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.

While today's hearing considers five bills, we limit our comments to only one of them—H.R. 740, the "Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025." We are concerned especially about Section 302 of the bill, which puts ideology before veterans, and in so doing, will imperil their ability to access the full range of health care and services through the VHA system. Modifications are recommended. Otherwise, it may be harmful to veterans because:

1. By granting veterans unfettered access to community care, large sums of funding will be diverted from the VHA to the private sector. This will drain VHA coffers, **forcing reductions of VHA staff, curtailment of in-house programs, and closures of inpatient units, emergency rooms, and entire facilities**.

2. By allowing veterans' access to private sector healthcare without VHA referral or pre-authorization, the VHA's foundational model of integrated healthcare will be replaced. **The VHA healthcare system will transform from its current primary role as a provider of healthcare into a payer for private sector care**.

3. In the name of offering more preference and choice, healthcare options will diminish for veterans. Draining VHA funds means that **veterans** – **especially service-connected veterans who depend on VHA as a provider of high-quality care that is tailored to their needs** – **will be denied that choice** when their preferred programs and facilities are defunded and close.

4. **This bill will make it difficult for the VHA to continue to collect data and conduct research on veterans' complex health conditions.** Every VHA patient and their electronic health record is available for analysis, which, for decades, has enabled researchers to make impressive big data breakthroughs on veterans' complex healthcare problems. Those innovations will fade if veterans' care becomes scattered across the private sector where there is no dependable way to study veterans. The bill will also jeopardize the critical role the VHA plays in the training of future healthcare professionals. Further, there will be fewer ER and inpatient beds so that the VHA will be unable to fulfill its Fourth Mission as backup for national emergencies.

Below, we elaborate on the ramifications of Section 302, as well as three other sections of important consequence.

Section 302: Modification of requirements for Center for Innovation for Care and Payment of the Department of Veterans Affairs and requirement for pilot program.

This section turbocharges the privatization of the VHA via a pilot program that dramatically alters how veterans access mental health and substance use disorder (SUD) care. It poses an irreversible threat to VHA's survival as an integrated healthcare system.

Veterans would be allowed to receive unfettered Veterans Community Care Program (VCCP) outpatient mental health or SUD care **without VHA referral and pre-authorization**. VHA's primary role would shift to paying invoices. Though initially a pilot program, the bill also mandates that after three-years, the VHA develop measures to make the program universal for all health conditions across the entire VHA.

A comprehensive report released last year by six healthcare experts warned that community care utilization was endangering 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. Section 302 worsens the very issues that concerned the report's

authors. By significantly expanding VCCP eligibility, it accelerates spending and threatens the long-term viability of the VHA.

Eliminating VHA are as the authorizer of care means that over time 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, such as lost limbs, traumatic brain injuries, or a variety of toxic exposures, which civilian providers are ill-equipped to recognize, much less treat.

A recent summary of research confirmed yet again that the quality of care veterans receive from the VHA is as good as or better than what they receive in the community. When the VHA is transformed from primarily providing integrated healthcare to an insurance payer for care, veterans will be deprived of high quality, patient-centered care delivered in a system that has amassed decades of expertise understanding, recognizing, and treating their complex health conditions. In this new insurance system, everything that is indispensable and unique to the VHA will fade–integrated and coordinated team-based care, comprehensive prevention screenings, wrap-around services, veteran-centric specialization, training of providers with veteran expertise, and research on veterans' conditions that helps all Americans. VHA social work connecting patients to veteran-specific follow-up resources for legal, transportation, home health, and housing services would wane. Bypassing VA oversight also eliminates traditional utilization review functions, which would make the care more expensive to taxpayers.

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. Between August 2022 and 2024, VHA experienced a 33% increase in enrollment over the previous two-year period. The PACT Act of 2022 alone contributed to an influx of 400,000 newly enrolled veterans with serious toxic exposure-related medical conditions.

Unfettered community care is hugely expensive, and as such, a **CBO score for this section, and others, is urgently needed.**

Section 103: Consideration of veteran preference for care, continuity of care, and need for caregiver or attendant.

This language, for the first time, would allow veterans the option to obtain care in the private sector if they express that's their "*preference*" and it's in their own best interest. The percent of VHA veterans potentially eligible for the VCCP will increase from ~33% to 100%. The extant standards of the VCCP eligibility standards – travel time to or wait time for a VHA appointment – would become moot.

This stipulation violates the core agreement that went into drafting the VA MISSION Act language. According to the Independent Budget's analysis of the MISSION Act at that time, the "best medical interest" criterion "is to be considered when a veteran's health and/or well-being would be compromised if they were not able to be seen in the community for the requested clinical service. When using this community care eligibility criteria, the ordering provider should include the following considerations: nature or simplicity of service; frequency of service; need for an attendant; and potential for improved continuity of care. '**Best medical interest' is not to be used solely based on convenience or preference of a veteran**" (bold emphasis added).

The proposed legislative language will predictably increase the proportion of VHA funds flowing to the VCCP. For all the reasons noted above, increased spending through the VCCP means that, over time, veterans will lose their preferred VHA options that are shuttered.

Many veterans deeply appreciate the convenience of being referred to community care close 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 of its members two months ago revealed "overwhelming support for VA to remain the primary deliverer of care for veterans." A prior VFW report involving 10,000 members found that 92% explicitly prefer that the VHA to be "fixed not dismantled."

A Veterans Healthcare Policy Institute report noted that many veterans who live in rural areas will have no choice of care providers should the VHA be turned into an insurance provider. This is due to 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. Last month, The Center for Healthcare Quality and Payment Reform reported that nearly 200 rural hospitals have folded, and over 700 more–a third of all rural hospitals in the country–are on the brink of collapse.

Section 202: Standardized process to determine eligibility of covered veterans for participation in certain mental health treatment programs.
and
Section 203: Improvements to Department of Veterans Affairs Mental Health Residential Rehabilitation Treatment Programs (RRTPs).
The VA MISSION Act of 2018 mandated uniform quality standards across VHA and VCCP providers, as outlined in Section 104 of § 1703C: "The Secretary shall establish standards for quality regarding hospital care, medical services, and extended care services furnished by the Department pursuant to this title, including through non-Department health care providers pursuant to section 1703 of this title." The phrase "Community Care is VA Care" captures this intended equivalency between these two settings–from provider training to preventative screenings to overall quality of care. Yet, despite this explicit requirement for parity between VA and VCCP services (including Residential Rehabilitation Treatment Programs (RRTPs)), that has not occurred.

The ACCESS Act takes an important step to address this gap. A key provision requires community RRTPs to obtain accreditation from either the Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC) – bringing them in line with VHA's operating RRTP standards. We strongly commend this important step that recognizes that there must be one, not two, standards of care.

That said, achieving true parity across both VHA and community RRTP settings requires additional requirements. Those include:

VHA and VCCP program requirement and certification of:

- A scientific peer-reviewed, evidence-basis for its treatment program
- Standardized ratios of licensed practitioners (LPs) to residents
- Semi-annual LP peer review quality assurance
- Mandatory VHA training for mental health and substance use disorder LPs: four hours in relevant patient population care and four hours in military culture
- Discharge planning commencement within first week after veterans are admitted to the program
- Mental health and substance use assessments for veterans at program entry, exit, and six-months post-discharge
- Submission of veterans' outcome data to VHA for analysis and public reporting on the Access to Care website

Further, this section has no mandated utilization review and approval once a veteran enters a VCCP RRTP. The default length of VCCP RRTP stays should not be 90 days, which this section tacitly abets. Regular utilization review by VHA and approval for extended care, as is standard medical practice, should be required.

Finally, the section’s requirement for real-time tracking and public reporting of RRTP wait times, for both VHA and community facilities, will empower veterans to make informed healthcare decisions. However, veterans also deserve transparent information about their providers' qualifications, training, and competency in addressing specific health concerns. We recommend that VHA gather and publicly share this information too.

Section 101: Codification of requirements for eligibility standards for access to community care from Department of Veterans Affairs.

Among its key provisions, this section would prohibit VHA from considering the availability of a telehealth appointment as satisfying the access standards.

We fully support giving veterans who prefer in-person care the option of in-person community care when VHA cannot meet access standards. However, for veterans who seek telehealth appointments, community care telehealth should only be offered if VHA

cannot provide telehealth care within the standard timeframe. Such an approach manages resources fairly and effectively.

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. 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 does not qualify as access, resulting in hundreds of thousands of 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 annually according to a VA's September 2022 "*Congressionally Mandated Report: Access to Care Standards."*

Our organization is happy to support legislation that encourages the judicious use of the private sector to "support, not supplant" VHA healthcare. We also back legislation that ensures VHA has robust resources needed to care for current and future cohorts of veterans.

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.