STATEMENT OF

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A PROGRAM OF AMERICA'S WARRIOR PARTNERSHIP

FOR THE RECORD

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

WITH RESPECT TO

PENDING LEGISLATION

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Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, on behalf of Mission Roll Call, a non-partisan program of America's Warrior Partnership, and the roughly 1.4 million veterans and supporters who have opted-in to our digital advocacy network, thank you for the opportunity to provide their feedback through our remarks on pending legislation. While all the proposed bills are worthy of discussion and will have impacts on the veteran community, MRC's three main priorities are veteran suicide prevention, access to healthcare and benefits, and amplifying the voices of traditionally underserved populations. For this reason, in our testimony, MRC will focus on four specific bills on the docket for which we have polling data or learned in-person veteran experiences.

H.R. 3520, Veteran Care Improvement Act of 2023

MRC strongly supports this legislation as a necessity to ensure veterans receive timely access to quality care. The MISSION Act of 2018 was a bipartisan effort to improve accessibility to healthcare for veterans by streamlining the congealed process that existed via the CHOICE Act. Congress' intent with MISSION was clear: the VA must increase access to private doctors when the Veterans Health Administration couldn't provide care in a reasonable time and/or distance, or if access to an outside provider was in the best medical interest of the veteran.

In 2021, reports surfaced that VA administrators were overruling decisions by VA doctors and patients to keep veterans in the system, in some cases cutting off care entirely. The article confirmed what many veteran service organizations providing care coordination and casework already knew: that to protect VA's parochial interests, it was unnecessarily difficult for veterans to access care in the community when it was in their best medical interest. In 2022, 4 years after MISSION passed, Secretary McDonough testified community care now accounted for one-third

of VA's healthcare budget. As a result, the Secretary said the VA would look at changing access standards and use telehealth availability to determine wait times. In response, MRC conducted a poll on the issue, and with over 6,300 veteran responses across America, 81% said Congress should codify the access standards.

- Further, MRC asked questions on the more general veteran experience accessing community care. With an average of 6,200 responses across 7 unique polls:
  60% of veterans said their providers don't make them aware of this option after a delay in care;
- 37% said they had experienced a delay or postponement of any healthcare appointment at a VA facility;
- 71% said they were not referred to the community after a delay in mental health or other specialty care at a VA facility;
- 22% experienced problems scheduling the care once referred; 14% said their providers referred them to the community but the referral was later denied by the VA upon review;
- 21% said their providers scheduled them a telehealth to access their healthcare when they preferred in-person visits.

This data clearly indicates there is a problem simmering under the surface on this issue.

But this problem can be found in more than just statistics. During MRC's geographically and demographically diverse fact-finding tour last year, meeting with over 5,000 veterans individually in California, Texas, Florida, Alaska, Arizona, Idaho, Montana, and elsewhere, these problems were borne out in more than just statistics. While veterans who had good experiences at the VA mitigated their issues and went on living their lives productively, those with negative experiences accessing healthcare at VA facilities or with referrals to community care either gave up trying or were not shy to tell other veterans they should stay away from VA. These issues ranged from simple primary care appointments for things like allergies, to significant mental health issues. A few stark responses from veterans said they knew peers whose mental health spiraled after being frustratingly unable to access mental healthcare when and where they needed it. To the best of my knowledge, luckily none of these examples ended with a suicide attempt. But with less than 50% of the U.S. Census Bureau's estimated 17.4 million veterans in America enrolled in VA, and even less using it on a regular basis, making it harder to access healthcare when needed is counterproductive to the VA's interest, regardless where the care takes place.

As the VA is the largest health care system in the country and the second-largest federal agency behind the Department of Defense, it's understandable why officials sometimes make big decisions with respect to workforce recruitment and retention. However, Congress must ensure the agency keeps the veteran, not agency interests, as their North Star, and not defer or be unduly influenced by workforce considerations when those decisions could negatively impact the individual veterans' ability to seek healthcare. After all, the VA's core mission is to care for those who have borne the battle.

MRC is a successful program of America's Warrior Partnership, which has also supported a similar bill in the Senate, the Veteran's HEALTH Act. We hope the House and Senate can pass

both bills and come together on a bipartisan basis to pass this urgently needed legislation to protect veteran access to timely healthcare, whether that is in a VA facility or not.

H.R. 2768, PFC Joseph P. Dwyer Peer Support Program

MRC supports this legislation that would require the Secretary to establish a grant program to benefit eligible entities for the purposes of establishing peer-to-peer mental health programs for veterans.

Recently, MRC conducted a poll that asked if former service members with mental health challenges should be able to access the provider of their choice, regardless of whether the care was in a VA facility or in the community. With 7,200 responses, 94% said yes. With less than 50% of the estimated 17.4 million U.S. veterans enrolled in VA care, the Department must expand its use of grant funding to local organizations with touchpoints in the veteran community the VA simply does not have. Integrating local, non-governmental resources into a web of connectivity for veteran care is crucial in our fight against veteran suicide.

Successful peer-to-peer programs, whether through VA facilities like Vet Centers, community programs of America's Warrior Partnership across the country, resources like the Vets4Warriors line, or Boulder Crest Foundation events, show remarkable results where evidenced-based treatments fail. No one can better understand the struggles a veteran may be going through than another veteran. These resources provide confidential and free support through programs, case coordination, and conversations which help veterans in crisis or dealing with a non-crisis issue that may or may not be mental health related.

However, given the short window of applications for a similar grant program which negatively affected smaller organizations the program was intended to assist, MRC has concerns that if VA is not given a mandate to provide a reasonable window of time, history will repeat itself. The organizations on the ground doing this work must be laser-focused on programmatic activity and may not have a full-time employee whose job is to apply for grants and follow-up on government reporting requirements.

H.R. 1639, VA Zero Suicide Demonstration Project Act of 2023

MRC supports this legislation that would require the Secretary to establish a pilot program to institute the "Zero Suicide Initiative," which seeks to improve safety and suicide care for veterans at select VA facilities.

VA providers, generally, understand the unique traumas of veterans in crisis However, according to the VA's treatment decision guide for mental health issues, the effectiveness of evidenced-based treatments - talk therapy and pharmacology - have variable success rates of 53% and 40%, respectively. Providing VA clinicians with another resource to improve their

ability to handle veterans in crisis and refer them for "comprehensive assessment of suicidality" would bolster the VA's ability to refer and treat veterans with the appropriate resource they require, whether that is evidenced-based treatment or a more holistic approach to suicide prevention.

The VA is not going to counsel or prescribe its way out of a mental health crisis. Every veteran is different and needs a holistic approach.

H.R. 1774, VA Emergency Transportation Act

Under current law, VA only covers emergency travel to hospitals within their network. If a veteran seeks care for an emergent health issue at a non-VA facility, reimbursed by VA under current law and regulation, that veteran could still be hit with an expensive, surprise bill for ambulatory care. Given that acute financial stress is a major driver of suicide, MRC supports this legislation that would require the Secretary to reimburse veterans for the cost of emergency medical transportation to a healthcare facility. If a veteran requires care that the VA provides, either at a VA facility or community provider, it makes sense that the VA should cover the cost of that entire episode of care, from the moment a veteran requires assistance to complete convalescence.

Chairwoman Miller-Meeks, this concludes my testimony. Mission Roll Call would like to thank you and Ranking Member Brownley for the opportunity to testify on these important issues before this subcommittee. I am prepared to take any questions you or the subcommittee members may have.