MULTIORGANIZATIONAL STATEMENT FOR THE RECORD

House Committee on Veterans' Affairs

Subcommittee on Health Legislative Hearing

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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
Nurses Organization of Veterans Affairs
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 the U.S. Department of Veterans Affairs (VA) utilization of care in the community and other veteran-related bills. Members of our organizations have published papers on these topics in peer-reviewed journals. Many of us have also had long careers serving veterans and have previously presented testimony to your committee. In today's statement, we want to convey our appreciation for your leadership and continuing commitment to ensuring that veterans receive the highest level of healthcare within the Veterans Health Administration (VHA) and supplementary care in the private sector when it's necessitated.

Of the 10 bills being considered, we focus our comments on four bills that share common goals. Those are: "Veterans Health Care Freedom Act" (H.R. 3176), "Complete the Mission Act" (H.R.10267), "Veterans Access to Direct Primary Care Act" (H.R. 5287) and "Veterans True Choice Act" (H.R. 214). Further below, we describe how each of these bills elicit serious concerns. However, first we wish to summarize their overarching implications.

1. Quality healthcare for our veterans is paramount. Studies consistently show that the quality and patient satisfaction with VHA care equals or exceeds that provided by non-VA facilities. Given this track record, shifting veterans from the VHA system to the private sector would **lower quality healthcare for veterans.**

These new bills disregard quality assurance, barely considering its importance at all.

2. Allowing veterans unfettered access to private sector healthcare without referral, authorization or oversight from the VHA will **dismantle the VHA's integrated healthcare system and convert its main role from being a direct provider of veterans' high-quality care to a payer of private sector care**.

3. Similarly, allowing private care based on a veteran's stated "preference" would divert money 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.

4. Under the banner of promising more freedom of choice, these changes would lead to fewer, not more, options for veterans. When VHA programs, units, clinics and facilities are closed after VHA funds are diverted to the private sector, **veterans who depend on the VHA – especially those with service-connected conditions – lose access to those care choices**. Although some healthcare policymakers argue that greater personal choice is unequivocally advantageous, the proposed change assents to a minority of veterans at the expense of the vast majority.

5. The bills' refusal to require private sector transparency around quality metrics, wait times, and provider training means that **veterans will be denied information they need to make informed health care decisions.**

6. These bills will make it **difficult for the VHA to continue to conduct research on veterans' complex health conditions.** Use of VHA electronic health records has, for decades, enabled researchers to make impressive big data breakthroughs on veterans' complex healthcare problems. Advances made possible by VA in diagnostic testing, disease management, rehabilitation, geriatrics, patient safety, and countless other areas benefit all Americans. Those innovations will fade if veterans' care becomes scattered across the disjointed private sector where there is no dependable way to study veterans and no national system in which to pilot and model the implementation of innovative treatments.

7. The actions contemplated **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 trained at a VA facility at some time. VHA is the largest single educator of psychiatrists and psychologists and 50% of all American Psychological Association-accredited postdoctoral psychology training programs are based in VA. The proposed bills will have jarring effects far beyond VA itself by constraining the development of a critically needed work force.

8. The proposed bills will quickly **degrade VHA's capacity to support its "Fourth Mission"** – assisting the nation in times of emergencies and disasters. The VHA has supported this assignment with direct patient clinical care, testing, education and training in response to natural disasters, pandemics, 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 given the national distribution of its facilities, the unique training and experience of its staff, and the exceptional integration of its services.

A March 2024 Red Team report by six independent healthcare experts raised the alarm about private sector spending. The Veterans Community Care Program (VCCP) has continued to expand at a relentless rate – referrals increase 15-20% year after year, and by 2022, its share of VHA health dollars reached 44%. The experts concluded that even if no additional changes are made to who is eligible to use private care, the VHA system's future is at risk due to this unsustainable growth.

Instead of prudently heeding these warnings, the proposed bills move in the exact opposite direction, exacerbating the issues the report sought to address. The bills widen eligibility and accelerate spending through the VCCP and endanger the viability of the VHA system.

The inescapable reality is that policies which pursue "choice at any cost" will actually diminish the choices available to veterans. It will also undercut the nation's readiness for war and disaster response and choke the nation's most productive pathway to develop new research and build the next generation of its clinical workforce. Current and future generations of veterans who rely on the VHA must never be abandoned.

Below, we examine how each bill impacts veterans' healthcare.

"Veterans Health Care Freedom Act" (H.R. 3176)

The "Veterans Health Care Freedom Act" would fundamentally upend how veterans receive healthcare by allowing them unfettered access to private sector care. The legislation establishes a three-year pilot program in a quarter of the country that will allow veterans to obtain hospital care, medical services, psychological services, and extended care in the VCCP, "regardless of wait times or drive times, and without needing to get permission from VA administrators." VHA would be removed from its authorization, referral and oversight functions, and its only role would be to pay the invoices. After the pilot period concludes, these health care options would cover *all* veterans nationwide.

The bill is transparent in its intention to replace the VHA integrated healthcare system from being a provider of world-class healthcare into a payer for private sector care. No other healthcare system or third-party payer functions without utilization review because they could not survive on that basis. Not only does the bill transform the VHA into an

insurance payer but it does so at the expense of the stellar clinical care the VHA provides.

The bill implements a draconian mechanism in which private sector expenses – for which there are no limits and no oversight -- are directly deducted from VHA hospital and clinic budgets. This assures that every dollar spent on private sector care is a dollar taken out of the VHA's inhouse budget, stipulating: "No additional funds are authorized to be appropriated to carry out this section, and this section shall be carried out using amounts otherwise made available to the Veterans Health Administration."

Diverting essential streams of VHA funding without the ability to seek supplemental allocations to make up the shortfall is unprecedented, and will force reductions of clinical and support personnel, programs, clinics, and hospitals. This will propel more veterans into the community, which will further drain money from VHA facilities, leading to more cutbacks.

In the name of health care "choice," millions of veterans will ***lose*** VHA choices. That's especially important for the 2.78 million men and women who rely exclusively on the VHA for all of their health care needs and the 1.56 million who use it for most of their care. 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 treat. They will be deprived of the freedom to choose the VHA when units and programs they depend on vanish.

Not only does this hasten the siphoning of funds out of VHA, but it will also transform the VHA from an integrated healthcare system to an insurance carrier, like Blue Cross/Shield or Aetna. In this new insurance system, all that is indispensable and unique to the VHA will disappear. This includes integrated and coordinated team-based care, comprehensive prevention screenings, wrap-around services, veteran-centric specialization, homelessness programs, enrollment in VA registries, and training of providers with veteran expertise, as well as research on veterans' conditions that also helps all patients. VHA social work connecting patients to veteran-specific follow-up resources for legal, transportation, home health, and housing services would fade. Even the Office of Inspector General's oversight of veterans' healthcare will be compromised, since its ability to access private sector health care records is limited.

The total cost of a proposal to create a system of unfettered community care was calculated when this idea was initially proposed, in 2016. At that time, it was estimated to be $96 to $179 billion yearly. Figures today would presumably be even higher and, as such, a **CBO score for this bill is urgently needed.**

"Complete the Mission Act of 2024" (H.R. 10267)

The MISSION Act's stated goal was unmistakable: to enhance veterans' access to high-quality healthcare, whether at VHA facilities or in their local communities when VHA

care wasn't quickly available or conveniently located. The strong focus on quality was crystal clear in its language - the word "quality" appeared 50 times, far more often than terms like "choice" or "community." By contrast, the "Complete the Mission Act," ignores healthcare quality. In the bill's 30 pages, the word "quality" is mentioned only once. The other three bills that push for more private options don't mention quality at all.

Four of the "Complete the Mission Act's" 12 sections increase the outsourcing of veterans' care to the private sector. As with the "Veterans Health Care Freedom Act," the budget implications for the long-term sustainability of VHA care loom large with these provisions. They will drain the VHA of funding and cause a spiraling reduction in VHA staff and closure of programs/clinics/ facilities. The VHA would lose the ability to fully provide veterans with high-quality care that addresses their complex military-related conditions. We must preserve this level of care.

Sec. 203. This section creates a three-year pilot program akin to the "Veterans Health Care Freedom Act" where in selected locations, the VHA would lose its role of pre-authorization and referral, and its sole function would be to reimburse for invoiced services**.**

Although it starts as a circumscribed program pertaining to outpatient mental health and substance use disorder services, the bill mandates that the VHA complete an assessment of how to "extend the pilot program across the entire Veterans Health Administration, including a plan, timeline, and required resources for such an extension." Within a few years, there would be universal opportunities for veterans to select private sector providers.

The bill **omits crucial VCCP quality standards** and facility accreditation requirements. It also fails to require a peer review quality assurance system. These standards are integral to VHA-delivered mental health care, highlighting a significant disparity in quality assurance between VHA and VCCP facilities.

The bill **fails to establish any standards for timeliness of service.** In an era of severe mental health professional shortages, veterans could potentially have even longer VCCP wait times than those currently experienced with VHA. It ignores the simple fact that the VHA generally provides more timely mental health services than are available in the community, and that VHA clinicians are more likely to have experience and specialized training in recognizing, diagnosing and treating problems such as posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI).

Changes to the delivery of veteran mental health care and suicide prevention cannot come at the expense of the integrity of VHA's integrated system which has been designed – and continually succeeds when well-staffed and fully-funded – to provide comprehensive, coordinated care for our nation's veterans. It's crucial to maintain the VHA's central role in authorizing veteran healthcare while effectively leveraging community resources.

A **CBO score for this section is urgently needed.**

Sec.101. This provision marks a consequential shift by considering a veteran's stated preference for community care as proof enough that it is in their "best medical interest." The MISSION Act standards for veterans to be eligible for community care – travel time or wait time for a VHA appointment – would become moot. Just like in the "Veterans Health Care Freedom Act," this change would expand private care eligibility from the current 33% of veterans to 100%.

When the MISSION Act passed six years ago, there was bi-partisan agreement that the VCCP was meant to "supplement, not supplant" VHA healthcare. A veteran would be offered the option of receiving healthcare outside of the VHA under six clearly defined criterion. Legislators understood that veterans would get the option to choose whether to receive care in the private sector if, and only if, they qualified under the six eligibility rules. The Independent Budget's analysis of the MISSION Act at the time affirmed the understanding that referral to the VCCP should not occur "solely based on convenience or preference of a veteran." The carefully constructed MISSION Act language was the guardrail that ensured the long-term viability of the VHA healthcare system. The Complete the MISSION Act would violate that core agreement.

Sec. 204. This section modifies the standards for veterans accessing residential mental health or substance use disorder care in the private sector. The intention is laudable -- to ensure quick placement when a veteran is in urgent need of intensive treatment for substance use, PTSD, or other mental health issues. Although it has recently made significant improvement, the VHA had, historically, been slow in initiating such care.

The statute provides rapid screening and treatment placement for acute situations. But the opposite is true for the quality of care, which was a core tenet of the MISSION Act. There is not a single requirement (or even any mention) pertaining to high-quality, evidence-based methods. This oversight is consequential because outcome data plays an indispensable role in healthcare decision-making. Veterans need information about treatment effectiveness and symptom improvement to make informed choices about their healthcare options. Additionally, this data helps the VA, Congress, and taxpayers evaluate which programs successfully improve veterans' lives and which don't. As the Institute of Medicine states, true healthcare quality is measured by "improvement of outcomes."

In a private sector that prioritizes profits over quality, failure to put VA comparative quality standards in place is no trivial matter. To cite just one example, recently two unscrupulous operators of addiction treatment facilities in Florida were convicted of a $112 million fraud scheme that included medically unnecessary services. In 2017, The New York Times also did a series of articles exposing the unscrupulous practices of private sector addiction treatment programs.

The Office of Inspector General recently voiced the same concern. At an April 2023 HVAC hearing, Dr. Julie Kroviak, Principal Deputy Assistant Inspector General stated,

“Our office has published reports related to community care detailing delays in diagnosis and treatment, lack of information sharing or miscommunication between providers, and significant quality of care concerns.”

The section must be amended so that the following quality assurances are added:

- VA shall create certification of non-Department and Department Residential Rehabilitation Treatment Programs (RRTPs). The certification standard shall ensure that each RRPT:
  - is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC),
  - bases its treatment approach on peer-reviewed scientific evidence,
  - meets a standard ratio of licensed practitioners (LPs) per resident,
  - formally reviews the quality of each LP’s work semi-annually,
  - develops initial treatment plan and begins planning for post-discharge housing and treatment within 5 days of admission into program.
- VA shall recertify programs every three years,
- VA shall develop and mandate mental health/SUD outcome measures to be administered by the RRTP to every referred veteran at the point of program entry, program exit, and at three months following discharge,
- VA shall require that measurement scores of all veterans referred to programs be sent to the VA for data analysis and evaluation of each program,
- VA shall publish each program’s outcome data on the VA’s Access to Care website https://www.accesstocare.va.gov/, and
- VA shall require mental health and substance use disorder LPs to take a minimum of four hours of courses corresponding to the patient population they serve, and four hours on military cultural competence.

Also, the existing language stipulates that a veteran who lives more than a 30-minute drive time from a VHA be eligible for community placements. Since distance is an important criterion for placement, this same 30-minute drive time criterion should be incorporated into non-VA facility referral decisions as well. The section must be modified to ensure drive time is evaluated uniformly as a placement factor, regardless of facility type.

A CBO score is urgently needed for this section.

Sec.105. This section would prohibit VHA from designating available telehealth appointments as meeting timely access standards. Even when the VHA can provide telehealth within the 20/28-day wait time or 30/60-minute drive time access standard, a veteran would be allowed to choose to receive telehealth from the VCCP anyway.

The VA MISSION Act established that veterans could only choose private sector care if they met specific eligibility requirements. However, when establishing these eligibility rules, the VA made a significant oversight: they did not include VA telehealth availability 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 VA has unnecessarily limited veterans' access to quality healthcare while wasting taxpayer money.

As this bill acknowledges, telehealth is a valid means of providing health care to veterans who prefer that option. The best action that Congress can take is to stipulate that both VHA telehealth care and in-person health care constitute "access to treatment." If implemented, this correction would save taxpayers a vast sum — up to 1.1 billion dollars yearly according to a VA report to Congress. The cost savings from this proposed correction is reason alone to implement it. Yet increased use of VHA telehealth care also means higher quality, quicker, and more convenient care for veterans. The language in this section explicitly prohibits that.

The VHA is the recognized world leader in providing telehealth care that is effective, timely, and veteran centric. Veterans across the country have access to telehealth services in more than 30 specialties. To ensure accessibility, the VA has established partnerships with major mobile broadband carriers so that veterans can receive telehealth care at home without additional charges. The VA project Accessing Telehealth through Local Area Stations (ATLAS) brings VHA telehealth to areas where existing internet infrastructure may not be adequate to support video telehealth. ATLAS is a collaboration with private organizations, including Veterans of Foreign Wars, The American Legion, and Walmart. The agency also provides tablets to veterans who might not have access to telehealth care, fostering higher access and patient satisfaction. The "Anywhere to Anywhere" VA Health Care initiative and telecare hubs eliminate geographic constraints, allowing clinicians to provide team-based services across county and state lines to veterans' homes and communities.

VHA telehealth is often used for mental health care, using the same evidence-based psychotherapies that VHA has championed and are superior to that available in the private sector. This advantage is largely due to VHA's rigorous training, consultation, case review, care delivery, measurement standards, and integrated care model. In a recent survey of veterans engaged in mental health care, 80% reported that VA 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 quickly and beneficially furnished by VHA clinicians.

Telehealth has been shown to be as clinically effective as in-person care. A review of 38 meta-analyses covering telehealth with 10 medical disciplines found that for all disciplines, telehealth was as effective, if not more so, than conventional care. And because the likelihood of not showing for telehealth appointments is lower than for in-person appointments, continuity of care is uninterrupted, and healthcare outcomes are improved.

There is no rational justification to allow VCCP fee-for-service providers to furnish care via telehealth when VHA could furnish that convenient modality of care within existing access standards.

In place of the proposed language in this section, Congress must end the double standard that has handicapped VHA from including telehealth availability in determinations of eligibility for community care. It will save the VA up to a billion dollars annually while ensuring that veterans have quicker access to better treatment.

Sec. 202. We support the concept of publishing wait times for care at VHA medical centers but have two significant concerns with stipulations in this section. First, the **publication requirement should extend to VCCP wait times** as well. Veterans need comparative VHA and VCCP wait time data to make informed decisions about their healthcare options.

Second, the proposed wait time metric "the period between the date of request for the appointment to the date on which the care was provided" requires revision. This definition is problematic because it artificially inflates wait times when delayed appointments are appropriate or requested by the veteran. For example, if a veteran chooses to schedule an initial appointment for two months later to accommodate personal travel, this would be recorded as a 60-day wait. Similarly, routine, non-urgent care at extended intervals (such as anticipated screenings such as cancer screenings, colonoscopy, or dementia screenings) would be recorded as long wait times of several months or even 365 days. We recommend modifying the wait time definition to a clinically indicated date to account for these types of circumstances so that metrics accurately reflect true delays in care delivery.

"Veterans Access to Direct Primary Care Act" (H.R. 5287)

The bill would establish Health Savings Accounts (HSAs) funded by the VA that veterans could use for private healthcare. Veterans electing these HSAs would be completely prohibited from accessing VA healthcare services.

This legislation would fundamentally undermine the VA healthcare system in several ways. It establishes a separate pathway for private care outside the existing VCCP, which directly contradicts the MISSION Act's goal of creating a single healthcare system for veterans coordinated by the VA. Furthermore, it has none of the crucial accountability measures that now apply to private sector providers who supplement VHA care. By explicitly diverting funds from the VHA's budget to support these HSAs, the Act would reduce the resources available for VHA facilities and services, with the significant erosion of the VHA system noted in the two bills above.

"Veterans' True Choice Act of 2023" (H.R. 214)

The proposal to allow service-connected disabled veterans to use TRICARE Select, funded by VHA's budget, has serious flaws. First, there is already evidence this approach doesn't work. The Department of Defense tried moving patients from military hospitals to TRICARE's private network and found that access to care decreased. Second, while this bill claims to expand veterans' choices, it restricts them by preventing the use of VHA facilities - even when VHA offers shorter wait times or specialized expertise in treating veteran-specific conditions. Third, TRICARE provider credentials are insufficient. Any licensed healthcare provider can become a TRICARE provider, but they are not required to demonstrate the specialized knowledge and cultural understanding that VHA professionals possess. A 2018 RAND study of New York State found that 92% of providers were accepting new patients yet only 2.3% met all criteria for effectively treating veterans.

The real impact of this bill would be to further drain money from the VHA system into private healthcare - continuing the pattern of weakening the VA healthcare system that we discussed earlier.

We also wish to comment on two other bills for which we have subject matter expertise.

"What Works for Preventing Veteran Suicide Act" (H.R. 9924)

We support this legislation's general aims. As we've testified before, community grants have lacked adequate measurement of programs' effectiveness in reducing suicide risk factors. This bill takes small steps to address this problem.

However, the legislation has important shortcomings. It doesn't require the evaluation of before-and-after outcome data. Veterans, Congress, the VA, and taxpayers need clear information about treatment effectiveness and symptom reduction. The VA has acknowledged the need for a standard in funding grantees, stating that "Having this screening occur at the beginning and again prior to services ending is important in evaluating the effectiveness of the services provided." Yet, this bill could still allow programs to simply report the number of veterans served.

Also, while grantees are supposed to receive continued funding based on demonstrated improvement in metrics, this bill lacks benchmarks for ending ineffective grants or pilot programs.

"Supporting Medical Students and VA Workforce Act" (Draft)

We support this bill that will increase the number of VHA medical providers working at the VHA whose medical education was funded by the VA.

We would, however, recommend a more detailed definition of the required service period. This would ensure that Public Health Service (PHS) officers understand upfront

their obligation to VHA. We would also suggest that this obligation be of sufficient length to bolster the VHA's long term physician staffing plans, while allowing the PHS officer to be sufficiently vested in VHA to consider retention once their PHS obligation is satisfied.

We thank you for the opportunity to provide our perspective on these essential matters.