CONGRESSIONAL TESTIMONY

STATEMENT FOR THE RECORD

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO PROVIDED TO

THE HOUSE COMMITTEE ON VETERANS' AFFAIRS HEALTH SUBCOMMITTEE LEGISLATIVE HEARING

DECEMBER 17, 2024

Chairman Miller Meeks, Ranking Member Brownley:

Thank you for inviting the American Federation of Government Employees to testify at today's Legislative Hearing. I am Mary-Jean "MJ" Burke, First Executive Vice President of AFGE's National Veterans Affairs Council, representing AFGE 306,000 employees across the Veterans' Health Administration (VHA), Veterans Benefits Administration (VBA), and the National Cemetery Administration (NCA). I also am a physical therapist at the Indianapolis VA in Indiana.

I came to the VA to practice in a setting where decisions are about patient care and are guided by clinical evidence not a corporate balance sheet. The degree of privatization of the VA threatens its integrated, holistic care model.

The VA is currently at a tipping point. According to the expert Red Team panel that VA convened earlier this year, referrals to private care "threaten funding needed to support VA's direct care system."[1] Forty-four percent of services that VA provides have now been diverted to privatized care, known as "Community Care."[2] Four of the bills the committee will consider today would radically accelerate privatization, ultimately leading veterans to lose the choice of the high-quality, integrated care delivery model that VA offers. Our members feel the effects of rapid privatization in the form of unpredictable staffing and closures of operating beds related to widespread VA facility budget problems that make it difficult to provide veterans with the care they deserve. VA has cited rapid privatization as one of the primary causes of the VHA budget shortfall. Referrals to private care have been rising at between 15-20 percent a year, a clearly unsustainable trend for the direct care system. [3]

Proponents of privatization say they are doing this in the name of veteran choice. However, approximately 92 percent of veterans have other options for health insurance; the majority have employer-sponsored coverage or access to private health care plans through Medicare.[4]

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[1] Kizer KW, Perlin JB, Guice K, Granger E, Friesen D, Safran DG. The Urgent Need to Address VHA Community Care Spending and Access Strategies – Red Team Executive Roundtable Report. March 30, 2024

[2]Statement of Miguel Lapuz, Acting Deputy Under Secretary for Health, Veterans Health Administration before the House Committee on Veterans' Affairs Subcommittee on Health, July 14, 2022

[3] Kizer KW, Perlin JB, Guice K, Granger E, Friesen D, Safran DG. The Urgent Need to Address VHA Community Care Spending and Access Strategies – Red Team Executive Roundtable Report. March 30, 2024

[4] Wagner TH, Schmidt A, Belli F, et al. Health Insurance Enrollment Among US Veterans, 2010-2021. *JAMA Netw Open*. 2024;7(8):e2430205. doi:10.1001/jamanetworkopen.2024.30205

Attempts to privatize the VA are too often rooted in ideological opposition to government-run health care and a desire to remove this option for those who want to use it.

A large body of research indicates that VA provides care that is as good and often better than private care. In a systemic review of quality and efficacy studies, VA dramatically outperformed private care defined as VA Community Care, private care provided to the general population, and private care veterans received outside VA through other insurance. VA did better than private care on all or most outcomes in 18 of the reviewed studies on the quality/safety of non-surgical care. The VA performed as well as Community Care or there was a mixed result in nine studies. Private care only outperformed VA on all or most outcomes in four studies. For surgical care, VA did as well or better in most studies included in the review.[5]

If we want VA to continue to provide veterans with high-quality care, we must reverse privatization rather than accelerate it. For this reason, AFGE opposes or has concerns about the following bills that are a subject of this hearing:

H.R. 3176, "Veterans Health Care Freedom Act"

H.R. 3176 creates a three-year pilot program allowing veterans to obtain hospital care, medical services, psychological services, and extended care bypassing VA authorization and the need to meet access standards. No health care system could survive if it is forced to pay for whatever out-of-network provider a member wishes to see and still provide services on demand to its enrollees. This will inevitably lead to service closures and create more limited options for veterans who wish to have their care at the VA. AFGE opposes this effort to transform VA from

[5] Shekelle P, Maggard-Gibbons M, Blegen M, et al. VA versus Non-VA Quality of Care: A Living Systematic Review. Washington, DC: Evidence Synthesis Program, Health Systems Research Office of Research and Development, Department of Veterans Affairs. VA ESP Project #05-226; 2024.

an integrated delivery system to a mere payer of care. VA's value resides in its evidenced-based, holistic, veteran-centered care model. VA's leading mental health model exemplifies this approach, providing integrated outpatient mental health care through the Behavioral Health Interdisciplinary Program (BHIP). BHIP teams comprise psychologists, psychiatrists, psychiatric nurses, social workers, peer support specialists, and administrative staff. Team members work collaboratively to set treatment goals and manage veteran care. One study evaluated 7 process measures and found VA's scores were superior on all by more than 30 percent.[6]

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

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 barred from accessing VA healthcare services. This bill would undermine VA's role coordinating care for veterans and would siphon resources from the VA. For these reasons, AFGE opposes H.R. 5287.

Complete the Mission Act (No bill number)

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

This section codifies the current access standards which unnecessarily promote privatization. For primary care, mental health care, or non-institutional extended care, VA must be able to provide an appointment within a 30-minute drive time, and not later than 20 days from the date

[6] Watkins, Katherine E., et al. The Quality of Medication Treatment for Mental Disorders in the Department of Veterans Affairs and in Private-Sector Plans. Psychiatric Services, Https://psychiatryonline.org/doi/full/10.1176/appi.ps.201400537, vol. 67, no. 4, American Psychiatric Publishing, Apr. 2016, pp. 391–396, doi:10.1176/appi.ps.201400537. April 01, 2016.

the request or the veteran would have the option for community care. For specialty care, the appointment must be within 60-minute drive time, and not later than 28 days from the date of the request or the veteran would have the option for community care. The standards prohibit the Secretary from counting VA telehealth in determining whether VA meets wait-time and drive-time access standards. AFGE believes that access and quality standards should be equalized for VA and non-VA care. Also, one-size-fits-all access standards are problematic. VA leaders believe that the 28-day wait time for specialty care is too long for some specialties like oncology and too short for some stable patients who may prefer to book appointments further out. Specialty-specific access standards should be developed. Most troubling is the fact that community providers are not held to the same timeliness or quality standards as the VA, once care is sent out.

Sec. 103. Consideration under Veterans Community Care Program of veteran preference for care and need for caregiver or attendant.

This section modifies 38 USC 1703(d)(2) to make veteran preference to go to a private provider a criterion for what constitutes best medical interest.

AFGE opposes broad bans on VA authority to review community care referrals. A physician is often unwilling to challenge a veteran who may want to go out of network even when it is not in the patient's best medical interest. This provision directly weakens VA's ability to coordinate care. Further, no healthcare network can afford to cover any services outside its network that its members desire while simultaneously meeting obligations to directly provide services on-demand for all its members. All viable healthcare networks need to be able to reasonably limit outside referrals to effectively coordinate care, avoid unnecessary or ineffective treatments, and manage costs.

We believe VA should update its training to make sure the language defined by Congress for Best Medical Interest is implemented appropriately.

Sec. 104. Notification of denial of request for care under Veterans Community Care Program. This section puts a 2-day written notification requirement to inform veterans of community care denial. AFGE appreciates the desire to ensure that veterans receive timely notification of denial for a referral to private care. AFGE would prefer to see minimum scheduling efforts and communications methods be aligned to what VA does internally to ensure that there are adequate attempts to notify a veteran.

Sec. 203**.** This section creates a three-year pilot program in at least five locations where veterans could access outpatient mental health and substance use services. AFGE opposes this provision as it would circumvent VA's ability to coordinate care and is unsustainable for the VA in the long term.

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

H.R. 214 would allow veterans to choose TRICARE and require VA to pay for it. Veterans would not be allowed to use VHA facilities. This would starve VA of financing and move people to a network where VA could not coordinate care for veterans. As a result, AFGE opposes H.R. 214.

H.R. 8481, "Emergency Community Care Notification Time Adjustment Act"

This bill would change the time period that community care providers would have to notify VA that they're providing emergency services to eligible veterans from within 72 hours of the start of an episode of care, to until 72 hours after discharge. This would allow a private emergency provider to provide care for an unlimited number of days and notify the VA only 72 hours after

discharge leaving VA responsible for whatever the cost of the care. With studies showing that private emergency care is often of lower quality and given the expense (see discussion below under H.R. 6333) this bill would create unsustainable costs for VA. AFGE therefore opposes. AFGE supports the following bills:

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

We support efforts to create standards for grant programs aimed at reducing suicide risk.

H. R. 6333, "Veterans Emergency Care Reimbursement Act of 2023"

H.R. 6333 amends 38 USC 1725(c)(4)(D) to cap the amount under which a veteran can be reimbursed by VA for co-pays owed to a third party and excludes deductibles and coinsurance from the limitation.

The VA has historically reimbursed veterans without insurance for emergency care expenses. But VA has denied reimbursement for emergency care to veterans with other forms of health insurance obligating them to pay deductibles and coinsurance which can cost thousands of dollars.

AFGE supports H.R. 6333 as it would insulate veterans with other sources of income from costly out-of-pocket fees for emergency care. However, emergency care remains the largest out-of-network expenditure for VA at 30 percent. Attempts to reduce out-of-pocket costs and deductibles for non-VA care should be coupled with policies such as intensive case management for frequent users of emergency care to reduce unnecessary use. In addition, VA should be more intentional about the use of costly private emergency care that in many cases produces poorer outcomes than VA care. One study found that veterans taken by ambulance to VA hospitals had a

20.1% lower mortality rate within 30 days of arrival than those taken to non-VA hospitals.[7] The VA should build upon efforts to identify frequent emergency department users and hold Community Care third party administrators accountable for reducing unnecessary emergency care use. The VA has implemented policies to address overuse of emergency room care, such as embedding emergency personnel in Clinical Contact Centers and using Critical Resource Hubs to triage patients. It is our opinion that VA and Congress should be evaluating clinical outcomes, costs associated with those outcomes and veteran satisfaction when creating policies related emergency care and all VA care. It should be noted that VA must grapple with the challenges of veterans in rural areas who live far from their nearest hospital, which may skew overall outcomes for emergency care. Congress can help by funding comparative studies on alternative emergency care models, including rural care. Access to urgent care services could be improved by addressing limitations in strategic alignment plans.

Discussion Draft, "Supporting Medical Students and VA Workforce Act"

AFGE supports this legislation, which creates a joint scholarship program under which the Secretary of Veterans Affairs pays for medical education of an officer of the commissioned corps of the Public Health Service at the Uniformed Services University in return for a period of obligated service by such officer at a medical facility of the Department of Veterans Affairs.

Thank you for giving AFGE the opportunity to present its view about these bills, and we look forward to further dialogue with the Committee.

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[7] Chan, David, et al. Mortality among US veterans after emergency visits to Veterans Affairs and other hospitals: retrospective cohort study*BMJ* 2022; 376 doi: https://doi.org/10.1136/bmj-2021-068099 Feb. 16 2022