BREAKING DOWN BARRIERS: GETTING VETERANS ACCESS TO LIFESAVING CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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C O N T E N T S

TUESDAY, MARCH 25, 2025

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TUESDAY, MARCH 25, 2025

SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The subcommittee met, pursuant to notice, at 3:20 p.m., in room 360, Cannon House Office Building, Hon. Mariannette Miller-Meeks [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meeks, Brownley, Dexter, and Morrison.

Also present: Representative Carter.

OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. Subcommittee on Health will now come to order. Before I begin my remarks, I would like to highlight some numbers. First, $20.9 billion. That is the amount the Veterans Health Administration (VHA) received in 2001 at the onset of the global war on terror. In that same year, an estimated 16 to 17 veterans took their own lives every single day.

Second, $121 billion. That is the amount the VHA received in 2024 after nearly two decades of war and an entire generation of veterans now relying on the system billed to care for them. 17, that is the number of veterans our Nation loses to suicide every single day in 2024. That number could be higher as the U.S. Department of Veterans Affairs (VA) does not include veterans who lose their lives to overdoses in its official suicide statistics.

The numbers tell a clear story. VA's problem is not a lack of resources. VA's problem is not a lack of funding. VA's problem is not a lack of staffing. VA's problem is not that Congress has failed to provide what it needs to care for those who have served.

Since the beginning of the global war on terror, VA's budget has increased an incredible 479 percent. Yet, the number of veterans we lose every day has remained approximately the same, and these are just to suicides that we know about or that the VA counts. Some seem to believe that the solution is straightforward. Continue to invest in VA staffing, expand services, grow the system, but the number do not lie. If the money alone could solve this problem, it would have been solved long ago.

No, the VA does not have a resource problem. It has an access and a process problem. It is a blatant failure of the VA to adapt to the needs of the very people it was created to serve. VA's current

processes are not designed to provide veterans care when and where they need it. Instead, veterans are left waiting, navigating delays, bureaucratic red tape, and systemic inefficiencies that create barriers rather than breaking them down. Well, I believe that Congress and the VA has taken some necessary steps to increase access, it is not enough.

We continue to hear from veterans who are turned away from the lifesaving care that they need. Some are denied residential treatment because they had not previously sought VA care as if a veteran in crisis should have predicted their need for help years in advance. Others are told they cannot access community care unless a VA facility fails to meet a 20-day threshold, forcing them to wait even when immediate alternative options exist. Some are simply lost in the system, bounced from program to program expected to navigate a maze of bureaucracy while struggling with the very mental health conditions that make the process overwhelming.

In one particular case, a veteran suffered from severe alcohol withdrawal who was seeking admission into a residential rehabilitation treatment program (RRTP) in the community was outright denied because the VA stated they had a bed available 100 miles away. Had the leadership at that community facility not stepped up, the VA would have effectively forced that veteran into homelessness.

That is why I support Chairman Bost's Veterans Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act, which takes long overdue steps toward fixing these issues. The Veterans ACCESS Act recognizes that the goal should be to protect veterans, not VA bureaucracy. It cuts through VA's arbitrary restrictions by allowing more veterans to seek the care they desperately need in the community when the VA cannot provide it.

VA claims that there is no wrong door for veterans seeking care. Yet, we continue to hear about doors locked, doors hidden, and doors that simply do not exist. It is time we stop making excuses and start making changes, real changes and putting veterans first.

Today, we will hear firsthand from those who can speak to these process failures, and those that can help us fix them. The cost of inaction is too high. Thank you all for being here. I look forward to today's discussion. With that, I yield to Ranking Member Brownley for any opening remarks she may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Madam Chair. I would like to first say that we cannot have a hearing discussing veterans' access to mental healthcare without also acknowledging the very real impacts that the Trump Administration's chaotic and haphazard actions are causing both to VA's mental health workforce and to the mental health many veterans who rely on VA for their healthcare, their support system, and their livelihoods.

Veterans are scared. Scared that their VA mental health providers who are being forced to report to work in person at facilities that do not have room for them will decide that providing care in an environment that does not ensure veteran privacy is not worth it and will resign from the VA.

They are scared that the very support staff who make it possible for VA providers to focus on care and putting veterans first will be fired, leaving clinicians less able to focus on their care. They are scared that the outside research and agencies that help improve VA care will be shut down weakening VA's ability to provide world class care.

Unexpected VA staffing shortages are already affecting veterans in my district. Just last Thursday, I held a roundtable for veterans to share the impacts they are experiencing related to workforce cuts at VA. In a very concerning way I heard that at a local vet center that serves many of the veterans in my district, there is only one provider left to offer care.

Typically, vet centers employ at least four or five providers. Because of this severe staffing shortage and VA's failure to fill these critical vacancies, the vet center now can only offer group therapy, which is not clinically appropriate for every veteran.

Workforce shortages and cuts at VA should not be what determines how and where veterans receive care. If the Trump Administration moves forward with its plan to further cut its workforce by up to 83,000 employees, I fear this problem will only get worse and veterans have less choice than ever before. This context leads me to today's hearing topic.

The Department of Government Efficiency (DOGE) cuts in the Trump Administration's workforce actions are already directly impacting the programs we are discussing today. My staff has heard of at least one researcher who was fired from VA's Center for Substance and Addiction Treatment and Education, the center responsible for developing best clinical practices for substance use disorders.

The Trump Administration has also taken an aim at the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, or SAMHSA, where cuts of up to 50 percent of the workforce is expected.

SAMHSA oversees 988, the national suicide and crisis line which routs calls directly to the veterans crisis line through 988, press 1. Although SAMHSA's programs do not directly serve veterans, cutting its workforce will undoubtedly have ripple effects across any provider of substance use disorder treatment.

I agree with my colleagues across the aisle that we must ensure that any veteran who is ready to seek assistance can get that treatment. I do not agree that the answer is to cut existing workforce at VA, but other essential services and research, and just throw the doors open to community providers because VA has not developed a fee schedule for residential rehabilitation treatment programs.

Community providers who treat veterans can effectively set their own rates, and VA will reimburse them at rates far higher than the industry norms. These providers has a vested financial interest in treating veterans, a population that they admit in their own statements that they have not been able to access because so many already receive care at VA.

Worse still there is a serious lack of oversight over community providers. There is no guarantee that veterans receiving care in the community will get better, more timely access to care, and we do not know if they do because VA does not track that. When veterans

do access care at residential treatment facilities in the community, we have no way of knowing the level of treatment or support that they are getting.

We do not know if veterans are receiving care from providers who understand what it means to be a veteran and can establish a rapport with their patients. We do not know if they are being referred back to VA care in a timely manner as VA is in the best position to coordinate their overall care beyond treatment for their substance use disorder, which is often just one aspect of their overall healthcare needs.

Unfortunately because VA has not developed a fee schedule for resident rehabilitation treatment, there is also no way to ensure that VA is overpaying for these services. In fact, we have heard of some community residential treatment centers charging VA up to $6,000 a day for one veteran's care. It simply will not be sustainable for VA to continue paying for these services at these rates.

I have said before, we must find a balance between community care and VA direct care. In my opinion, we have not found that balance when it comes to residential rehabilitation treatment facilities, and I look forward to hearing from our VA witnesses on how we can work together to get closer to that balance. I thank our witnesses for being here today. With that, I will yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley. I would now like to introduce the panel 1 witnesses. Testifying before us today we have Ms. Missy Jarrott, mother of Navy Veteran Landon Holcomb, excuse me. Mr. Michael Urban, Army veteran and licensed clinical social worker, and Dr. Shankar Yalamanchili, Chief Executive Officer (CEO) of River Region Psychiatry Association (RRPA). Ms. Jarrott, you are now recognized for 5 minutes to deliver your testimony.

STATEMENT OF MISSY JARROTT

Ms. JARROTT. Honorable Chairwoman and Ranking Member Brownley, and all of the members attending today. I have Landon sitting right beside me, right here. If you will notice that infectious smile that I am about to mention.

If soldiers are going to die it needs to be at the attempt of an enemy, not a lack of effort and unorganized antics by the VA. The VA is killing our soldiers. My son Landon, who served as a air traffic controller Navy veteran, Naval Air Station (NAS) Jacksonville, 7 years ago was struggling to find mental health in a system that completely failed him.

Like many veterans, he reached out to the VA for help and support. His first consultation with a provider was on December 4, 2023. However, the VA did not provide a follow-up visit until April 10, 2024. Landon had scheduled events between this timeframe. However, unfortunately the VA canceled multiple visits denying him the chance to see a provider who specialized in medicine management.

Landon tried and tried to keep his head up, that the VA would follow through. He was experiencing anxiety, insomnia, restlessness, and mood swings. Landon knew that he needed a mood stabilizer. "Mom, I am struggling." After four unsuccessful months, he

began to unravel with all of the canceled appointments. He became hopeless in the system. He was very emotional.

On April 10, he visited the Savannah VA mental health team who determined that he was not under distress. How do you determine mental health when symptoms are invisible? Landon said the visit was a checklist, and he explained that he had been asking for a psychiatrist, medicine management. He was hoping for a better outcome and knew that this meant another delay in getting the help he critically needed.

Those that smile the brightest might be fighting a war within. Landon was fighting. He came by to see me after this visit. At this point, family and friends became involved in searching for a psychiatrist and to no avail. We took it upon ourselves to call a psychiatrist in the Savannah, Bluffton, and Hilton Head, South Carolina areas. They did not accept military insurance, take new patients, or charged $300 an hour. More stress.

Landon made numerous call himself. "Hey Mom. I was calling you back. I was on my scooter. I was at the gym. I tried to call. I have also been out for some therapy groups, in Savannah, and the people over here at Social Empire. I have made a lot of phone calls this morning. I am going to get a workout in. Call me back when you want to. All right, love you. Bye."

That call, that voicemail, was the Monday before he died. On April 19, he received a call from the Charleston VA for a Zoom appointment scheduled for May 3. He did not make that appointment and passed away on May 2. The unthinkable happened. Landon was found in the restroom of a restaurant on Hilton Head Island. He had fentanyl in his system. To numb his pain, he thought he was taking oxys. Landon did not plan to leave us. He was not suicidal. The hopelessness of canceled appointments, feeling abandoned, and not taken seriously and the emotional spiraling ended his life.

Landon was buried at the Beaufort National Cemetery in South Carolina with US Naval honors on May 13. He leaves behind two beautiful teenagers, a loving family, and many loving friends. He was a true patriot who loved his country. Help just did not come soon enough.

Mental health is real. It cannot wait. All Landon asked for was a mental health appointment for medicine management. He raised his hand over and over again. In memory of my 39-year-old son could light up the room with his infectious smile let his voice, I am sorry, be heard from heaven above.

On behalf of the veterans who struggle every day, let us be reminded to never leave a soldier behind. These are our children. This is why I am here today. How many more testimoneys is it going to take for change? How many? May God bless our military serving all over the world, and may God bless our veterans and all our military families.

[THE PREPARED STATEMENT OF MISSY JARROTT APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you very much, Ms. Jarrott. Mr. Urban, you are now recognized for 5 minutes to present your testimony.

STATEMENT OF MICHAEL URBAN

Mr. URBAN. Good afternoon, members of the committee. I am honored to share my personal story and experiences with the Department of Veterans Affairs medical system.

In 2003, after serving 4 years as a paratrooper in the 82d Airborne, I was medically discharged following an accident during a jump. The subsequent 13 surgeries led to a regimen of heavy opioid use, a path all too familiar to many veterans.

In 2004, I began receiving care at the Philadelphia VA Medical Center. In my journey, I have experienced firsthand the challenges of accessing care within the VA system. When I sought help in 2004, I faced a wait time of two to 3 months for a bed. I have had multiple stays in VA RRTPs where I have witnessed practices that now as a clinician I know not to be best practices.

In 2014, I had the opportunity to receive treatment outside the VA system, which provided a transformative experience. Since December 2, 2014, I have maintained sobriety and achieved numerous personal and professional milestones all attributed to the quality care I received.

Community providers are required to operate following American Society of Addiction Medicine (ASAM), a standard of care which is much higher than that of VA. A standard in which I encourage VA to adopt. Office of Inspector General (OIG) has applied and referenced this standard during investigation into the deaths of veterans related to the lack of alcohol detoxification standards.

In 2021, 2022, 2023, and 2024, how many years, or yet better, how many more veterans must die before VA follows a standard? In 2020, during the pandemic I developed a program for veterans affected by lockdown treating approximately 200 veterans from Veterans Integrated Service Network (VISN) 4 and under 6 months. This experience highlighted the potential for collaboration between VA and community providers, but also revealed inconsistent practices across different VA facilities. In 2021, I joined a national provider to develop a veteran program at 18 facilities expanding my presence from local to national. This afforded me a unique glimpse of the entire VA system.

Over the past 4 years, I have visited over 75 Veterans Affairs Medical Centers (VAMCs), numerous Community-Based Outpatient Clinics (CBOCs) and vet centers. I had the privilege to address VA service gaps not only at our 18 facilities, but by opening facilities in Alaska, Denver, virtual services for rural veterans in developing an eating disorder program specifically for veterans.

Through my extensive interactions with veterans, veteran advocates and VA employees across the country I have consistently encountered growing challenges in accessing community care for mental health. We have observed a decline in a veteran's ability to receive this essential care, and this problem is not confined to a specific region.

I have witnessed it in VA medical centers from Florida to Alaska. Unfortunately, the situation has deteriorated since last March. At Brockton VA, I worked with a veteran who was denied entry into RRTP due to past behavior. He then requested community care, but was denied without reason.

At Hines, a veteran was told drive time standards do not apply to his RRTP needs. In Houston, veterans are restricted to facilities only approved by the chief limiting their choices. In Denver, veterans are all forced to travel out of State for VA care when it is available locally in the community.

In Portland VA, social workers confirmed, "We do not use community care," referring veterans to Medicare-accepted providers instead. In Philadelphia, veterans were denied community care due to the chief who told me, "I cannot send veterans to the community as it will not allow me to justify my budget next year."

The issues faced by veterans in accessing community care are systemic and widespread. These challenges include VA has often failed to provide written explanations for denying community care, the interpretation of access standards, obtaining a consult and referral for substance abuse and mental health have become complex and time consuming, requests for services for veterans hospitalized in the community are not processed promptly leading to prolonged delays and discharge without necessary care. 5, ignoring the best medical interest standard.

Administrators often prioritize VA interest over decisions made by the veteran and provider. I have personally witnessed the struggles of homelessness and addictive veterans in almost every State. Many of them prefer not to seek care at the VA due to the barriers that they face, instead opting for Medicaid or community resources.

This raises a question. Why should veterans who are entitled to VA services rely on Medicaid when VA is specifically funded to support them? VA has a tagline: "Choose VA." Well, I must tell you. It is not much of a choice when VA employees are the ones making the choice.

During the pandemic, we demonstrated that community and VA can effectively collaborate to address challenges faced by veterans. By working together, we can better tackle these issues and provide more comprehensive support. It has become an "us versus them" mentality, and the ones who suffer are my fellow veterans.

Instead of creating barriers, VA should focus on removing them particularly for those seeking mental health treatment. Each year, VA releases statistics on veteran suicide which remains almost unchanged despite VA's significant investments and initiatives like increased outreach. While outreach is crucial, it is insufficient when a veteran in crisis in met with very limited options such as being placed on an acute psych ward or the police. Being confined in such a setting can feel punitive rather than supportive for those seeking help.

It is time for us to prioritize improving access to care and the appropriate levels of care from the moment a veteran requests it rather than subjecting them to a bureaucratic nightmare, or worse a literal one. By doing so, we can ensure that veterans receive timely and effective support when they need it most. Whether it be at VA or in the community, we need timely access to care and we only get there by working together.

[THE PREPARED STATEMENT OF MICHAEL URBAN APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Urban. Dr. Yalamanchili, you are now recognized for 5 minutes to present your testimony.

STATEMENT OF SHANKAR YALAMANCHILI

Mr. YALAMANCHILI. Thank you. Good afternoon, Chairman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee. Thank you for the opportunity to testify today. I am honored and privileged to be here and serve our country.

I am here to be a resource to our country, and our veterans and the VA. My name is Dr. Yalamanchili, though many know me as Dr. Chili, and I am a board certified psychiatrist with over 20 years of experience. I currently serve as the founder and medical director of River Region Psychiatry Association, soon to be Ally Psychiatry, a multi-state behavioral health enterprise.

Our mission is simple. To improve access to high quality mental healthcare for those who need it most, close to where they live, while reducing cost and increasing efficiency. Our practice roots started in, and we continue providing care in rural communities. As our future name suggests, we want to be an ally to everyone that seeks help.

After beginning my psychiatric career in the VA hospitals of Montgomery and Tuskegee in 2005, I became increasingly frustrated with the inefficiencies that prevented veterans from getting timely care. I later moved to community health centers where I worked to improve operations.

However, I quickly saw how widespread financial mismanagement, systemic inefficiencies, and fragmented care there really were, contributing to rising costs and poor outcomes not only for patients, but for the healthcare system as a whole.

Today, I stand before you to offer a proven scalable solution that has already improved mental health access for thousands of patients, and one that has the potential to save our Nation, I believe, at least $1 billion annually in healthcare costs.

At RRPA and Ally Psychiatry, we have built a care model that delivers patient-centered technology driven here across both inpatient and outpatient settings. In 2024 alone, our 68 physicians and 157 advanced practice providers served over 115,000 outpatients and completed over 400,000 patient visits.

Our inpatient services are located in hospitals, jails, residential treatment centers ensuring care is accessible across a variety of environments. With this expansive footprint, our model delivers care at approximately 25 percent lower per patient cost than the traditional VA or hospital systems.

Moreover, we consistently outperform national benchmarks achieving a 20 percent increase in emergency department throughput, 25 percent reduction in inpatient long-term stay, and 15 percent reduction in avoidable readmissions for behavioral health patients.

Our providers average 1,000 more patient encounters a year more than full time employees at the VA who often see eight to ten patients a day on a 4-day work week. With our care model, 100 RRPA providers working in the VA system could enable 100,000 more patient visits annually while reducing costs up to 20 to 30 percent, which is what we have seen in our current partnerships.

There are real challenges in accessing care at the VA. Despite the best intentions of both providers and administrators, in 2023 a Government Accountability Office (GAO) report found that vet-

erans often wait 30 days or more for routine mental health appointments, even longer in rural areas where sometimes wait times exceed 60 days.

Community Care Network meant to expand access, but it often fails to meet the needs of veterans with chronic mental health conditions, providing only episodic care with limited continuity. Many of these issues are due in part to staffing shortages.

For example, the VA OIG report reported that over 61 facilities had severe psychology shortages, and 47 facilities have severe psychiatry shortages in 2023. This means that the providers that are there often cannot handle the current caseloads.

Patients are not seen in a timely manner, and providers suffer burnout. Delayed care, as we hear, can lead to worsening mental health conditions, higher rates of hospitalizations, and increased emergency room use all of which endanger patients while seeing raised costs.

The VA has a challenge to hire full time psychiatrists, nurse practitioners, and physician assistants. They are competing with the private market and hospital systems. When needed, contracting with practices like mine would allow the VA to save on hiring, training, long term benefit costs and infrastructure costs. It will enable the VA to scale staff based on need and have access to specialized expertise very quickly. They can do all of this while enhancing patient access and care.

There are numerous ways that the VA can do this. There are models that I have outlined in written testimony. I believe that allowing increased public/private partnerships to address chronic care needs in a common sense a first step, particularly as this is an area where the current Community Care Network falls short.

Under this model, for example, private partners would contract the VA for services as needed when there are staffing issues, lag in patient wait time, or lack of VA resources. Private partners would be required to integrate with the VA self-electronic medical records to ensure seamless information in sharing and collaboration with the VA teams. This allows for continuity of care, greater providers availability, and reduced wait times, especially for veterans in rural or underserved areas.

A private practice such as mine, I have more flexibility to work with local clinics and provide greater telemedicine options. Therefore, we can eliminate typical access barriers and to lower the cost, deliver the most appropriate cost-effective care. In emergencies, we can quickly get the veteran to the best level of care in a very short time.

In closing, the VA needs support in closing access gaps and reducing wait times for mental health care. Our model at RRPA and Ally Psychiatry demonstrates that a partnership with private providers can expand capacity, improve patient outcomes, and reduce costs. This permanent public/private partnership model is a win-win for veterans, taxpayers, and our Nation. Our success so far is based on a collaborative model to improve outcomes, and we ask for the same. Thank you.

[THE PREPARED STATEMENT OF SHANKAR YALAMANCHILI APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Yalamanchili. In accordance with Committee Rule 5E, I ask unanimous consent that Representative Carter from Georgia be permitted to participate in today's subcommittee hearing. Without objection, so ordered.

As is my typical practice, I will reserve my time until all other members have had a chance to ask their questions. I now recognize Ranking Member Brownley for 5 minutes for any questions she might have.

Ms. BROWNLEY. Thank you, Madam Chair. Mr. Urban, since you mentioned having been employed by a national provider of substance, excuse me, substance use disorder treatment starting in February 2021, the majority of my questions I think are going to be toward you.

First I believe the company you work for starting in February 2021 was Banyon Treatment Recovery, LLC. Is that correct?

Mr. URBAN. Yes, ma'am.

Ms. BROWNLEY. Pardon me.

Mr. URBAN. Yes, ma'am.

Ms. BROWNLEY. Thank you. In your written testimony, you mention VA having cut reimbursement rates to this provider by 90 percent for virtual care, and by 60 percent of her residential treatment and detox. What rates was Banyon charging VA daily?

Mr. URBAN. Ma'am, I could not answer that because I was not in billing.

Ms. BROWNLEY. You were not in the building?

Mr. URBAN. Billing.

Ms. BROWNLEY. In the billing.

Mr. URBAN. I do not take part in billing. I just build the programs and operate.

Ms. BROWNLEY. You have no idea how the VA's rates compare to other payer's rates?

Mr. URBAN. I do. Their initial rates were, I do not know who set them, but they were not educated.

Ms. BROWNLEY. They were not what?

Mr. URBAN. They were not educated. The rate fee that I did see was far beyond what anybody should have been reimbursed, but that was the VA schedule. We had nothing to do with that.

Ms. BROWNLEY. Well, VA does not have a schedule.

Mr. URBAN. They do, ma'am. I can forward it to you.

Ms. BROWNLEY. There is no established fee schedule for community providers in this kind of treatment.

Mr. URBAN. Ma'am, there is one in Alaska because that is why we ask for a fee waiver that you—that the VA just put out in 2025.

Ms. BROWNLEY. That might be the VA hospital in Alaska that does that, but not VA Central. Anyway, so I guess you do not know if your rates were higher or lower, about the same?

Mr. URBAN. No, ma'am. I said originally when I first saw the rates they were beyond what anybody should have been paying.

Ms. BROWNLEY. You are saying you are paying a lot less—excuse me, charging a lot less?

Mr. URBAN. No. What VA was reimbursing based on their fee schedule was beyond what any commercial insurance pays. The rates are now in line due to most of the rate cuts. Now they have

went so far that rural veterans and veterans in Alaska, you cannot sustain operations because they just cut them.

Ms. BROWNLEY. You seem to know a lot about their rates, but you do not know what Banyon was charging?

Mr. URBAN. I am not in the department.

Ms. BROWNLEY. I know, but you do not seem to know a lot about, you know, where the rates were, where they are now but yet do not have any idea what the number is.

Mr. URBAN. I do not, ma'am, because what I am told is these rates are getting cut. If we do not figure this out, you will not sustain treating veterans. My job is to build programs and operate them. I get told the budget and whatever it is they set for that facility. I am not in the internal billing.

Ms. BROWNLEY. Okay. Just for the record, I disagree the VA does not have a fee schedule for community providers, period. Full stop. In your bio it says in your current role as a consultant that you develop business strategies and train teams on outreach to the veteran and military populations. Can you elaborate on exactly what that means?

Mr. URBAN. Yes, ma'am. I train organizations who would like to work with veterans on veteran language, how the VA operates, how it functions, and how to collaborate. We have created systems to collaborate effectively with the VA.

Ms. BROWNLEY. Develop business strategies. What does that look like?

Mr. URBAN. That means teaching them how they can reach veterans in the community who need resources. In Alaska right, the villages where none of the VA employees will go, I train the company to go to the villages and find veterans and bring them back.

Ms. BROWNLEY. Okay. It just, honestly it sounds like to me that it says you are helping treatment facilities like the one you used to work for more effectively targeting veterans to receive care at the facilities who you have worked with, which also brings along a dedicated revenue stream in the form of VA reimbursements. Does a financial incentive to treat veterans exist in the facilities like Banyon?

Mr. URBAN. I mean, it is a job. It would be the same as if you worked at the VA. You have an interest in keeping veterans in the VA. Would you in the private sector?

Ms. BROWNLEY. I am talking about incentives, about how many people you can bring into the facility, et cetera.

Mr. URBAN. Not where I have worked. No, ma'am.

Ms. BROWNLEY. Okay. I will just say I think, you know, the providers in this industry seem to have, to me, a profit motive to serve veterans. VA's mission is to honor the promises we have made to our veterans and ethically care for their whole health after they serve our country. Their motivation is to provide world class care to veterans. It is clear to me that through the actions of your past employers and your own actions as a consultant that your motives are very different. With that, I will yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley. The Chair now recognizes Dr. Dexter for 5 minutes for any questions she may have.

Ms. DEXTER. Thank you, Madam Chair. First, thank to our panel for coming in. Ms. Jarrott, I am so sorry for the loss of your son, and thank you for your courage coming to share his story with us. It means a great deal. Having taken care of many patients unfortunately like your son as a critical care doctor, what I can say for certain is that he is not unfortunately alone, and we are failing not just our veterans, but everyone in our community across this country. This is a tragic reality that we are all facing.

I also know having been both a VA and community provider that community standard as Mr. Urban talked about is actually not superior in many areas to the Veterans Administration care. I know we are failing everyone broadly. To be clear, what we do not know with these policies, and this is just for the record, we do not have any ability to compare when we refer someone whether or not they will get community care faster than they will get in the VA, or if it is better quality.

On that quality note, Mr. Urban, I wanted to first thank you for your service to our country and for sharing your story as well with substance use disorder, and your desire which is clear to help our veterans deal with that. I just your intentions are good and that you share in this committee's commitment to ensuring our veterans receive the highest quality of care.

What I read in preparing for today's hearing, similar to what I think on my Ranking Member, we are trying to get to is that we are concerned about the reimbursement that does not have a fee schedule. I know that different areas may have different policies. That we are paying as much as $6,000 a day for inpatient care for some of this treatment. Mr. Urban, does that seem consistent with community levels of reimbursement in your experience?

Mr. URBAN. Currently, or when they started?

Ms. DEXTER. $6,000 a day reimbursement.

Mr. URBAN. It is absolutely insane. I said that in my last statement.

Ms. DEXTER. Yes.

Mr. URBAN. No one should be paying that amount of money.

Ms. DEXTER. I agree. I think what foundationally I would usurp is that before we pass any such policy as this, we should have a fee schedule. We need to have control over what we are paying to the community because there is waste, fraud, and abuse that is potentially going to be a risk with this without better control. We also should know how long it should take for someone to be expecting treatment if they are sent to the community, and whether it is sooner than the VA. Those things I wanted to establish.

I also understand that you were the manager. You were not in charge of running these facilities necessarily. Is that correct, Mr. Urban?

Mr. URBAN. Correct, ma'am.

Ms. DEXTER. Okay. There clearly were many issues at both Banyon Treatment and Recovery, as well as is it correct that you worked at the Livengrin Foundation in 2019 through 2021?

Mr. URBAN. Yes, ma'am.

Ms. DEXTER. Okay. Also at Sobriety Solutions from June 2018 to May 2020?

Mr. URBAN. Yes, they were not community providers though.

Ms. DEXTER. None of those are providing——

Mr. URBAN. Just Livengrin.

Ms. DEXTER. Okay, thank you for that clarification. The thing I wanted to offer is there could be community care in different areas of the community. That may be a reflective experience that these facilities each had improper safety—well, I will say to Banyon there were improper safety measures at one of their facilities that led to a permanent paralysis of a patient who fell from the fourth floor roof. That there were nurses who had wages that were revoked. That the New Jersey Commission of Investigation found that Banyon was engaged in patient brokering and the practice of paying for referrals.

I am not asserting that this is your practice by any means. What I do want to suggest is that there is incentive for waste, fraud, and abuse when we do not have clear expectations for community care and the quality of that care. Even when providers have the best interest, that you may not have control of that. Is that a fair assertion, Mr. Urban?

Mr. URBAN. Yes, ma'am.

Ms. DEXTER. Thank you. For the committee what I wanted to establish is that even for someone who clearly cares for the wellness of our veterans and is a veteran who has suffered with substance use disorder and wants to serve, it is challenging to maintain high levels of care. Our veterans deserve to have that highest quality, most effective care. We know that that is provided within the Veterans Administration.

Until we have a fee schedule that is established and disincentives waste, fraud, and abuse, I would assert that we should not be considering further exploration of expansion of this. Thank you.

Ms. MILLER-MEEKS. The gentlewoman yields. The Chair now recognizes Representative Carter for 5 minutes.

Mr. CARTER. Thank you, Madam Chair. Thank you for holding this hearing. I appreciate this very much, and thank you for allowing me to waive on. I also want to thank the witnesses, particularly my constituent, Ms. Jarrott.

Thank you for being here. Your courage is an inspiration to all of us, and I want you to know how much we appreciate this. I know this is not easy for you, and you have been up here—it is the second time you have been up here, I think, in less than a month, and we appreciate that very much.

I know that I say I know. I can only imagine what it is like to lose a son. I cannot even go there. I want you to know that you have made a purpose of making sure that you are advocating for necessary changes that, and reforms to the VA, that would raise awareness about the dangers of illicit fentanyl poisoning. As you know, I am a pharmacist, and I am very familiar with fentanyl, and I am very familiar with the illicit use of it.

I want to tell you, Madam Chair, members of the committee, first class, as you have heard, first class Landon Holcomb exemplified what it meant to be and to serve his country. He was born in Savannah, Georgia on April 22, 1985, and he was a proud veteran, and he was a patriot of this great nation.

He served as an air traffic controller in Jacksonville, Florida. He was a father to two children. They are now teenagers. He passed

away on May 2, 2024, due to fentanyl poisoning. Poisoning, not addiction. No. Poisoning.

He was a veteran who was experiencing mental health issues like many of our veterans do once they get out of the service. Like many of our veterans he reached out to the VA, but unfortunately the VA's response was not adequate, and it was unsuccessful from preventing the tragedy from occurring. Under the previous administration, the VA canceled multiple visits and denied Mr. Holcomb a chance to see a healthcare provider during a time of need.

Ms. Jarrott, do you believe that had your son been able to receive care from qualified providers in the community without delay, do you believe it would have changed the outcome?

Ms. JARROTT. Yes, he would be with us today. What we experienced with him and the emotions to the point here I let the committee hear his voicemail, which was Monday prior to passing away on Thursday, went to work Tuesday, went to work Wednesday, called Thursday morning to talk to his brother and myself, and who was vacationing from Colorado in Savannah. We all had plans.

After it was around 5:22 p.m. he walked into a restaurant as I said on the Island. They found him 45 minutes later. They worked on him 20 minutes. Of course, the telephone call, receiving the call, and you know I will never forget it. You know, grieving, it is always going to be there. I question as to whether I was going to come back up here. Thanks for Congresswoman Miller-Meeks, I received an invitation to come back.

Giving back I guess I could call this a way for me to give back, maybe in Landon's memory, a veteran's memory, veterans out there like I said are waiting. I sit here, and I listen. I sat through your, you know, your previous meeting. I sit here listening, going back and forth about what should be covered in benefits under the VA. I am thinking, why is this even an issue?

In the private health sector under private plans, we cover bariatrics. We cover the therapy you are talking about, and you are still talking about it. Preventative care has been there 100 percent down the line. We even cover vitamins in our plan. Preventative care is all about providing those tools and resources to keep people healthy, and that includes veterans and their dependence as well.

I am like therapy. In 2019 under the Trump Administration, he passed the right to try. Yet, you are sitting here talking about are we going to cover this or that? Well, a veteran has the same right as we do to try psychedelics, to try cancer treatments, and to try therapy programs. If I am wrong, let me know. In my mind, I was thinking right to try is out there. Why is it a question? Why cannot they do it if they want to do it, and they make that decision as to whether they want to have it or not based on whatever they know.

Under the VA I cannot imagine. I just realized you talking about there is not a fee schedule. How do you operate without a fee schedule? I mean, networks operate, doctors operate with fee schedules. When you are in a network, the whole reason you have a network is because doctors are looking for you to steer patients to them, which reduces fees.

A network, okay so there is networks. You have the community care group. By the way, when I went to our zip code in Savannah

here is your VA website, va.gov, and you can go across and you can review benefits, resources, tools, mental health. I went to the mental health site, and I typed in—you can search a provider by the zip code or city.

I typed in our zip code in Savannah, Georgia, the facility type which is required. It comes up, community providers in VA's network, service type required. You can type in chiropractic or optometrist. I typed psychiatrist. It pulled up, we could not find that. Please try another service.

Mr. CARTER. Ms. Jarrott, wait. I am sorry, we have already gone over.

Ms. JARROTT. Yes.

Mr. CARTER. The Chair has been very indulgent.

Ms. JARROTT. Yes.

Mr. CARTER. Again, I want to thank you for being here.

Ms. JARROTT. Yes.

Mr. CARTER. I want to thank you for your courage and your advocacy. You have made it your purpose to bring this to the attention to all of us, and we appreciate that very much and God bless you.

Ms. JARROTT. Well, thank you, Congressman. I appreciate it.

Mr. CARTER. Absolutely.

Ms. JARROTT. Thank you for the invitation.

Mr. CARTER. I thank you for your indulgence, all the committee.

Ms. MILLER-MEEKS. The gentleman yields. Thank you very much, Representative Carter. Ms. Jarrott, thank you for your bravery and being here. I guess I just have a simple question. Your son was denied and delayed numerous appointments.

Ms. JARROTT. Right.

Ms. MILLER-MEEKS. The initial appointments were months apart when he received one visit. Did anyone at the VA ever explain your family's right to access community care or offer you alternative treatment options when VA programs were not available?

Ms. JARROTT. To my knowledge, no.

Ms. MILLER-MEEKS. Yes. You know, today we have heard that, you know, veterans should have the highest quality, most effective care. Do you think that your son, through the VA, had the highest quality most effective care?

Ms. JARROTT. Congresswoman, Landon lived in Colorado, so he accessed the VA in Colorado. There was not a problem there. He said, "Mom, it is state-of-the-art." He lived in Asheville, North Carolina. He was pleased with the facility there, okay, the VA there. As a matter of fact, he made a comment. He said, "Mom, if I were back in Asheville, you know, I would have gotten in sooner." Okay. He moved south to be near family, his daughter, et cetera.

What I am saying is what he saw, there are inconsistencies between the centers, and they are not—there is not coordination of care.

Ms. MILLER-MEEKS. Precisely, which is why we have community care.

Ms. JARROTT. Right.

Ms. MILLER-MEEKS. Because of the inconsistencies and lack of care, do you believe that no care is better than care in the community? Mr. Urban, is no care better than care in the community?

Mr. URBAN. Absolutely not.

Ms. MILLER-MEEKS. Dr. Chili, is no care better than care in the community?

Mr. YALAMANCHILI. No, ma'am.

Ms. MILLER-MEEKS. How cost effective is it if people die waiting for care at the VA? Dr. Chili, you noted the practices like yours achieve significant cost savings up to 30 percent while expanding patient capacity. That does not sound like you are driven by a profit motive to me. Can you provide more detail on how these savings are realized without compromising care quality, particularly within the VA system's regulatory framework?

Mr. YALAMANCHILI. One of our philosophies is that, you know, we went to school with the community at large, actually families and universities that have given us a unique skill to treat patients. With that we kind of, in the group anyway, we think that how many people can we reach? How many people can we touch? How many people can we help?

In that model we set up our schedules in such a way that there is gradience in schedule where new patients require more time, patients in crisis require more time, patients that are midway through the treatment require a little bit less, patients that are stable require less. We collaborate between the providers and the therapist to see if how things are flowing and getting either better or worse. If patients need to come back sooner, we bring them back in sooner. If we need to see them more frequently, we see them more frequently.

With this is kind of a matrix of how we see patients I think we are able to see more patients in a given day. At the end of the day it is the same cost, right? Then when you look at how much is—you know, let us say if we are spending whatever amount of money, but then we are seeing more patients then your per patient cost comes down.

Ms. MILLER-MEEKS. Thank you. Mr. Urban, given your story and both your written and verbal testimony, it seems to me like your experience at the VA or lack of care, inconsistent care, difficulty accessing care is really propelled you into the profession you now hold. Based upon your experience, what is the single most consequential policy failure that prevents veterans from receiving timely residential substance use disorder treatment through the VA.

Mr. URBAN. I think the time it gets access to care. If you read VHA Directive 1016.01, it says you know you have 7 days to complete a screening from when someone asks for help. 7 days? Good luck. Do you know how long it took me to get to those 7 days before I was finally offered a bed 2 months away?

I mean, I think the access to care and how long it takes to get care and the different—I do not want to say schemes. Different ways VAs have set up the process delays care, like, and every VA is different in the way you want to get a mental health referral to treatment and people just give up. They just say, I do not care. I will go to Medicaid, or I will use a community resource as opposed to get timely access.

I am not opposed to getting care at the VA. Like, it should not take a month, 2 months. As far as standards, we cannot compare

apples to apples when VA makes its own standard, and ASAM is what the industry follows.

Ms. MILLER-MEEKS. Let me address that. What clinical standards, such as ASAM criteria, do you believe the VA should be required to adopt nationally to ensure consistent levels of care for substance use disorder treatment? If, Dr. Chili, you have input please provide that as well.

Mr. URBAN. I think it should be utilizing ASAM because it dictates the level of care someone should get at. It dictates the intensity of care. It dictates the services, the staffing ratios. It lays everything out in places somewhat appropriately as opposed to this, "Well, we have a bed in the acute psych ward. We will put you there until an RRT"—like that is the difference.

Ms. MILLER-MEEKS. If I can allow you to redeem yourself, and I know I am going overtime. Mr. Urban, is what drives you to do what you do a profit?

Mr. URBAN. No, ma'am. I do not want someone waiting two to 3 months for a bed.

Ms. MILLER-MEEKS. Dr. Chili, given what you do and the model that you have created, is profit the reason why you do what you do?

Mr. YALAMANCHILI. No, ma'am.

Ms. MILLER-MEEKS. Thank you very much. On behalf of the subcommittee, I want to thank you all for your testimony and for joining us today. You are now excused. We will wait for a moment while the second panel comes to the table.

[Recess.]

Ms. MILLER-MEEKS. I would now like to introduce the panel 2 witnesses testifying before us today. Dr. Maria D. Llorente, Acting Assistant Under Secretary for Health for Integrated Veteran Care at the Veterans Health Administration who is accompanied by Dr. Ilse Wiechers, Deputy Director, Office of Mental Health at the Veterans Health Administration. If I mispronounced your name, please feel free to correct me. Dr. Llorente, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF MARIA LLORENTE

Ms. LLORENTE. Before I start my oral testimony, I just want to acknowledge and thank the first panel for sharing their very personal stories, particularly of one such devastating loss. It really does take a lot of courage, and I want to thank them for advocating for other veterans.

Chairwoman Miller-Meeks, Ranking Member Brownley, and other members of this subcommittee, my name is Maria Llorente, and I was recently appointed as the Acting Assistant Under Secretary for Health for Integrated Veteran Care. It is been my privilege to work as a VA psychiatrist, being board certified in adult and geriatric psychiatry and addiction medicine for the past 30 years.

I take care of veterans with mental health and substance use disorders, and it is an honor to serve veterans who have made such significant sacrifices for our country. Thank you for the opportunity today to discuss the provision of residential substance use disorder, or SUD treatment through VA's mental health residential rehabili-

tation treatment programs, or MH RRTP and community care residential treatment programs.

Joining me here today is Dr. Ilse Wiechers, Deputy Director, Office of Mental Health, Veterans Health Administration, also a geriatric psychiatrist and provider.

Prior to the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, one of my prior roles as the associate chief of staff for mental health at a VA medical center experienced firsthand the challenges our veterans faced related to access for residential treatment programs. The facility where I worked did not have its own residential treatment program, so we had to refer veterans to other facilities that did. The demand for this lifesaving care often exceeded the supply of available beds, and this delay in care increased the risk of relapse and worse health outcomes.

Offering our veterans access to residential treatment through community care address this concern. This allowed us to seamlessly transition the veteran into residential care when indicated. Timely access to residential treatment programs enhances overall outcomes, so that the veteran was more likely to engage in mental health services and treatment, and maintain sobriety.

MH RRTPs provide care within specialized SUD programs, referred to as Domiciliary SUD programs, as well as across the full MH RRTP continuum, which includes programs for the treatment of post traumatic stress disorder, general mental health concerns, and services for homeless veterans.

These programs have evolved over time to better meet the needs of veterans. For example, in 2012 as part of the first culture of safety standdown, VA introduced Naloxone as a critical tool to prevent overdose deaths. The passage of the VA Mission Act of 2018 expanded access to community care, furthering transforming veteran care. This law expanded access to eligible veterans who can elect to receive care in the community in certain situations.

In October 2020, VA developed the MH RRTP's standardized episode of care which made it easier for VA to order residential treatment in the community. This has led to significant growth in the number of community programs providing residential treatment and the number of veterans receiving this care.

To help maintain high quality care for veterans, VA requires that residential community care providers maintain appropriate credentials, such as by the Commission on Accreditation of Rehabilitation Facilities or by the Joint Commission.

As of March 2025, there are over 260 MH RRTP's across 125 locations providing more than 6,600 operational beds. In fiscal year 1924, approximately 32,000 veterans used MH RRTP care with 97 percent diagnosed with SUD, and over 92 percent with co-occurring SUD and mental health diagnoses. During the first quarter of the current fiscal year, 70 percent of veterans were admitted to VA domiciliary care within 20 days.

Increasing access to community care is a significant component of VA's strategy to ensure that veterans have access to the care they need. On average, veterans must travel 150 minutes or more

to receive this specialized care, whether through VA or through community care.

For VA to continue to meet the growing need for MH RRTP care, we acknowledge that changes are needed to VA's current access standards. As a result, VA was proud to support the Veterans Access Act of 2025 before the full House Committee on Veterans Affairs on February 25, 2025, while ensuring the offsets or additional appropriations were provided.

We are committed to working with Congress and other stakeholders to reduce barriers, improve access to the care veterans have earned. We want to thank the committee for its continued oversight, and we would be happy to answer any questions you or other members of the subcommittee may have. Thank you.

[THE PREPARED STATEMENT OF MARIA LLORENTE APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Llorente. As my typical practice, I will reserve my time until all the other members had a chance to ask their questions. I now recognize Ranking Member Brownley for 5 minutes for any questions she may have.

Ms. BROWNLEY. Thank you, Madam Chair. Dr. Wiechers, can you tell me how many mental health providers have resigned or retired earlier than expected since January 20, 2025?

Ms. WIECHERS. I do not have those numbers in front of me for the national set of numbers. No, I do not.

Ms. BROWNLEY. You know how many.

Ms. WIECHERS. No.

Ms. BROWNLEY. You just do not have those—that information with you.

Ms. WIECHERS. I do not. I do not have that number. It is not under the purview of my office.

Ms. BROWNLEY. Who is purview is it?

Ms. WIECHERS. It would be some information that we would have at a facility in a VISN level. I would have to dig in to get those numbers for you. I do not have those numbers available to me right now.

Ms. BROWNLEY. Okay. I presume by your answer that mental health providers who accepted the so-called fork in the road offer, you have the same answer for that as well? You do not know the numbers and it is not under your purview.

Ms. WIECHERS. Correct.

Ms. BROWNLEY. Okay. Dr. Llorente, as you probably gather from my questioning in the first panel, you know, I am very concerned that VA has not developed a fee schedule for residential treatment facilities. You are currently reimbursing these providers at much higher rates than industry norms. On average, VA has been paying $3,000 per day for this type of care. Some providers are getting paid as much as $6,000 a day, far more than the average cost of care per day in an Intensive Care Unit (ICU).

I understand that the VA has been looking for sometime to establish this fee scheduled and bring its payment rates more inline with industry norms. I also understand that VA will have to modify its contracts with TriWest and Optum in order to implement a new fee schedule. Can you tell me what the status of this effort is? When will you have this fee schedule in place?

Ms. LLORENTE. Yes, ma'am. I am very appreciative actually that you asked those questions. It is my understanding that in December, this past December, TriWest did establish a policy with respect to reimbursements for RRTPs that are within their network. I believe that that was in part with what the first panelist was referencing. Because those payments are now per diem rather than multiple line items, it did make differences with respect to the providers in that network.

In addition to that with respect to Intensive Outpatient Programs (IOPs) and Partial Hospitalization Programs (PHPs), those fees are now in keeping with Centers for Medicare and Medicaid Services (CMS) standards. With respect to Optum, I would have to take that question back in order to provide you with a more accurate status update.

Ms. BROWNLEY. Okay. If I understand you correctly you are saying that the schedule that the previous witness was referring to was possibly a schedule that was—my understanding is that it might be a percentage of a cost that is charged or, you know, a percentage of what the rate would be rather than, here is the rate for this specific, you know, for an hour of care, this specific care. It is not explicit and sort of complete for everything that possibly these residential providers would provide.

Ms. LLORENTE. My understanding is it is per diem.

Ms. BROWNLEY. Okay.

Ms. LLORENTE. As opposed to multiple billings.

Ms. BROWNLEY. Okay.

Ms. LLORENTE. I can get you the details, ma'am.

Ms. BROWNLEY. Okay. Are residential treatment providers qualified to provide emergency stabilization care for veterans experiencing acute suicidal crisis under the authority provided by the Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act?

Ms. LLORENTE. It would have to depend upon the residential facility itself. Standalone residential treatment programs, no. If the residential treatment program is part of a healthcare system that includes an emergency room department with 24/7 coverage then it could.

Ms. BROWNLEY. Okay. For standalone providers that do not have hospitals or emergency care, the answer is no, correct?

Ms. LLORENTE. That is my understanding, yes.

Ms. BROWNLEY. Is it true that VA has detected a pattern of certain community providers admitting veterans for residential rehabilitation treatment without VA authorization, and then attempting to bill VA for this care under the COMPACT Act?

Ms. LLORENTE. I personally do not have detailed information of what you are referencing.

Ms. BROWNLEY. Okay.

Ms. LLORENTE. I am more than happy to inquire and get information back to you.

Ms. BROWNLEY. Okay. I will just say that your predecessor told both the House and Senate committee staff that that was occurring.

Ms. LLORENTE. That is entirely possible, ma'am.

Ms. BROWNLEY. Okay.

Ms. LLORENTE. I just do not have firsthand knowledge.

Ms. BROWNLEY. The Office of Inspector General also issued this fraud alert in December 2024 requesting the public's help in stopping scams involving substance use disorder treatments. Specifically the OIG warned quote, "Certain drug and alcohol rehabilitation facilities or treatment centers are attempting to exploit veterans with substance use disorders for profit through various unethical and illegal practices."

Do you know what the VA is doing to remove bad actors like these from the community care program?

Ms. LLORENTE. Yes, ma'am, several different things. The first is when we do identify concerns with respect to those types of practices, we often will reach out to the OIG, request an investigation to describe the nature of the concerns that we have identified. At the same time, we will also notify the Third Party Administrator (TPA) if that particular provider is within one of our networks.

Based on my understanding of how the contracts work, the TPA will then conduct an investigation based on the results of those investigations. Then, there is typically a back and forth with the VA. When findings are substantiated, then those types of providers could be removed from our network.

Ms. BROWNLEY. Okay. It is my understanding that the OIG is still investigating some of these issues. You might get some results in the near future. I yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley. The Chair now recognizes Dr. Dexter for 5 minutes.

Ms. DEXTER. Thank you so much, Madam Chair. Thank you again to our panel for being here. I share my Republican colleagues' concerns about the veterans access to wait—access to care and the wait times they are facing for mental healthcare, substance use disorder treatment, and residential rehabilitation treatment programs.

As I shared previously, this is not a specific problem to our Veterans Administration facilities. This is a community wide problem. In fact, in my district we continue to have far too few care providers and far too long of delays, and that is not improving. It is getting worse.

I think it feels like magical thinking when we offer proposals to codify additional community care access standards when it is abundantly clear that there is not the capacity in the community to accept our veterans and get them the urgent care that they need.

I will just state that I believe in controlling the controllables. We cannot control outside of the VA, but we can control what we are doing within the VA. As Ranking Member Brownley pointed out earlier, the VA does not have a set fee schedule. That needs to be changed. Clearly paying $6,000 a day is egregious and a waste of taxpayer dollars.

I also think it is not exactly shocking that while referrals to inpatient care, including residential treatment, made up about 13 percent of the VA's total behavioral health referrals to community care providers in Fiscal Year 2021 through 2023. Those referrals at 13 percent made up nearly 3/4 of the total expenditures for behavioral community care referrals.

We have a problem. I think we can agree on that. I will just state for the record that Dr. Llorente is nodding her head.

Ms. LLORENTE. Yes, ma'am, agreed.

Ms. DEXTER. I will just ask you. Do you also agree that we should be seeking to ensure that veterans are getting proven high quality care in all instances as much as possible?

Ms. LLORENTE. Yes, ma'am. There is no question about that. Veterans deserve the very best care, and we are very proud that we are able to demonstrate with studies and research that VA delivers that care. Unfortunately, not every VA has that care available, and that is where community care can fill a gap.

Ms. DEXTER. Exactly. I absolutely agree that we need to make sure that they have that care. I think accreditation requirements into community care contracts is important. For instance, there is this mind blowing case in South Florida of a community care provider that employed patient recruiters to give illegal drugs prior to admission to ensure that patients were admitted for detox services, which were the most expensive. Obviously, none of us want our taxpayer dollars used at the harm—doing harm to our veterans.

Community care standards, fee schedule. I also just wanted to ask Dr. Llorente, can you confirm that in late January President Trump fired the VA's Inspector General Mike Missal?

Ms. LLORENTE. That is what I read in the news, yes, ma'am.

Ms. DEXTER. Yes. We have been talking about the Inspector General's office and the importance that they play in investigating some of these things. Would you agree that not having an inspector general impedes our ability to do that?

Ms. LLORENTE. I do not know if I can fully agree with that because we continue to engage with the Inspector General's office. We continue to participate in investigation inquiries, in audits. We receive reports and findings, and really engage very collaboratively with the Inspector General's office. That work has continued.

Ms. DEXTER. I am so happy to hear that it is continuing, and I think it is probably a short term reality that until there is some upper level director—in my experience, when there is no captain things kind of derail over time. That is not a question. You do not have to make a position on that.

I just want to bring us back to acknowledging that the larger context that we are all here to do is make sure our veterans are getting the best care possible. Our administration has fired veteran staff. It has removed the inspector general. We are here talking about spending less money in our budgets for the veterans, and we are wasting a lot of that on unnecessary expenditures that we have the ability to control.

I just hope before this committee sends anything to the floor that my colleagues and I can work together to address this head on and ensure the administration is allowing us to inspect things, but also that we are making sure that our veterans have access to the best possible care, and that our policies reflect that. Thank you, Madam Chair. I yield back.

Ms. MILLER-MEEKS. Thank you, Ms. Dexter. The Chair now recognizes Dr. Morrison for 5 minutes for any questions she might have.

Ms. MORRISON. Thank you, Madam Chair. I appreciate the discussion brought forward in this hearing about the importance of access to treatment for substance use disorders. It is imperative that we care that the care that we offer our veterans comes from providers with a demonstrated ability to deliver high quality evidence-based care.

My experience is one of the millions of physicians that has trained in a VA facility gave me a firsthand introduction to the uniquely specialized care that the VA is able to offer our veterans. Achieving the goal of quality while preserving the specialized care VA offers requires intentional investment in VHA facilities that provide substance use disorder care and continual reflection on how providers are meeting veteran needs.

For over 150 years, VA has been committed to providing residential care for veterans in need of additional structure and support. In 2022, VHA served over 300,000 veterans with substance use disorder diagnoses. Thank you, Doctors, both of you for being here today.

In the spirit of understanding the progress VA's made in substance use disorder treatment, I have a couple of pretty straightforward questions for you, and they really are just yes or no questions.

The first one, has utilization of residential substance use disorder treatment programs increased over time?

Ms. LLORENTE. Just to clarify, in direct care, community care, both?

Ms. MORRISON. Both.

Ms. LLORENTE. Short answer is yes.

Ms. MORRISON. Would you agree, Doctor?

Ms. LLORENTE. Absolutely, yes.

Ms. MORRISON. Okay, thank you. Next question is, has increased capacity in VA's substance use disorder treatment programs led to improvements in your ability to provide the intensive medical treatment veterans, especially underserved groups, increasingly need?

Ms. LLORENTE. I would like to ask Dr. Wiechers to answer that question.

Ms. WIECHERS. Sure.

Ms. MORRISON. Yes or no.

Ms. WIECHERS. Yes.

Ms. MORRISON. Okay, thank you. Then, last question. Would you characterize the educational training and staffing level requirements within VA's substance use disorder treatment programs to be consistent across your program sites?

Ms. WIECHERS. Yes.

Ms. MORRISON. Okay, thank you very much. VA's commitment to developing a cohesive continuum care is indispensable to achieving successful outcomes for veterans that find themselves at various stages of treatment for substance use disorders.

I urge my colleagues to recognize the importance of supporting the residential substance use disorder treatment infrastructure within VHA, investing in expanded VA program capacity, and standing against tactics that would undercut treating our veterans

with the dignity they so rightfully deserve. Thank you, Madam Chair. I yield back.

Ms. MILLER-MEEKS. Thank you. The Chair now recognizes herself for 5 minutes. I would also urge my colleagues to recognize the care that comes in the community. The reason why the MISSION Act exists is because patients were not getting care. Veterans were not getting care. They were not getting access. They were waiting. They were dying. They were committing suicide. They were overdosing. They were dying of fentanyl poisoning.

As a matter of fact, in this very hearing room when we had a hearing on residential care and substance use disorder, prior VA officials admitted that they did not think that residential care or substance use disorder residential care fell under the MISSION Act. It did not matter if the patient waited 30 days, 100 days, or a year. They still were not going to refer them to community care because they did not feel it was under that—fell under the MISSION Act. This is the VA's own words.

Dr. Llorente, and I am an ophthalmologist. Not only have I worked at VA facilities, not only was my uncle—you know, six of the eight kids in my family are veterans. My father is. My husband is. My grandfathers are. My uncle was in a residential facility at the VA for his entire life when his ship went down in the Pacific in World War II. I have done substance use disorder and helped to change policies at the State level.

When a veteran is assessed needing urgent residential care, how long do you think they should wait? Are you confident that every VA facility applies this same timeline and criteria to get that veteran placed, or referred to the community without delay?

Ms. LLORENTE. Thank you very much for that question. First let me say that the national policy is very clear and is applicable across the country. The fact that there is variability, and a lack of standardization is a problem. There is no question about that.

Ms. MILLER-MEEKS. If the standard is present, then that means the culture is not permitting the standard to be met. Because the committee continues to hear that policies governing residential treatment and community care referrals are interpreted differently depending on where a veteran seeks care, how is the VA going to ensure that policies are followed uniformly?

Ms. LLORENTE. Thank you very much. The Secretary has initiated a review.

Ms. MILLER-MEEKS. This would be Secretary Collins?

Ms. LLORENTE. Yes, ma'am, has initiated review of policies, directives, staffing, organization, structure of multiple aspects of the direct care system, as well as multiple aspects of the community care system.

In order to be able to begin to answer the questions that you are asking in general, and these are generalities, when you have policy and it is just not being carried out, there are common reasons for that. Some common reasons is that a policy may not be clearly written. The policy may have broad subject to interpretation features. It may be that we have simply not adequately trained the frontline staff.

There are a whole list of other reasons in between those things. Those are the things that we need to address because those are

interfering with our ability to provide the access that veterans needs to have. It is creating barriers, and in some cases it may be creating additional administrative steps.

Ms. MILLER-MEEKS. Dr. Llorente, as I mentioned, we have programs like the Gordon Fox Parker Suicide Prevention Grant Program. We have buddy systems within our veteran service organizations that help veterans to navigate some of these things.

I realize that you are a recent addition, although you have cared and done mental health and substance use for a long time. How do programs like the Gordon Parker Fox Suicide Prevention Grant Program help veterans access mental healthcare services?

Ms. LLORENTE. Is that a question you might be able to take Dr. Wiechers?

Ms. WIECHERS. Sure. The Fox Grant Program provides grants to community organizations for helping to engage veterans that do not engage directly with our VA health system. It really helps to fill that gap in providing access out in the community. There are partners out in the community helping engage veterans to reduce their risk for suicide.

They can also grant—participants can also access care through VA when they have become part of one of the programs with the grantee.

Ms. MILLER-MEEKS. Let me just say that, you know, I think that our VA healthcare system, although I do not utilize it as a veteran, nor does my husband, I want to save that for the veterans who have most in need and need that access to care.

Nonetheless I think, you know, our Veterans Administration, our hospitals, our programs do a very good job, but they are not always there. It is those gaps that we are trying to fill and these partnerships, whether they be in the private sector in other avenues that we are trying to make sure veterans have access to care.

I think we all want the same thing. I think to continually denigrate a provider that is outside the VA, just like continually denigrate the VA itself, both of those attitudes are inappropriate and wrong because as we have already said, we want the highest quality, most effective care.

Sometimes that is at the VA hospital. Sometimes that is in the community because if you cannot get access to care, it does not matter how high the quality is. It does not matter how effective the program is. If you cannot get access care, you have no care. Given that I am in a rural area, our veterans like to have access to care when and where they can get it.

With that, Ranking Member Brownley, would you like to make any closing remarks?

Ms. BROWNLEY. I would. I would indeed. Thank you very much. I would just like to say that I agree with my colleagues across the aisle that we must ensure that any veteran who is ready to seek assistance can be treated unequivocally.

I am worried that treatment will not be available with the clinicians who have either been fired or cannot be recruited. We are already understaffed. We need a fee schedule, so the community providers will conform to industry norms. We need to weed out bad actors and not fire very capable employees within the VA.

For the record one more time, I will say I support community care and community care is a critical partner to VA. We have got to get it right. I will yield back.

Ms. MILLER-MEEKS. Thank you very much. I am again going to remind this committee as we did several weeks ago that over the 4-years of the previous administration, there was an increase of $126 billion to the VA, an increase of 80,000 employees, 57 of those full time, 23,000 part time. That as we have heard from Secretary Collins, healthcare workers were exempt.

With that, I would like to thank everyone for their participation in today's hearing, and for the great discussions we have had on this important topic. I would especially like to thank our witnesses and Ms. Jarrott for her very moving testimony today, and for having the courage to come forward. I want to thank both of our witnesses from the VA, some of whom may be new to this process for being here today as well.

Today's hearing reinforced what we have heard time and time again. While there may be very good care to excellent care at the VA, veterans do not struggle because the VA lacks funding or resources. They struggle because they continue to fall through the cracks of a bureaucratic system that is bogged down in inefficient processes and inconsistent standards.

Veterans in crisis cannot afford to wait. I know this firsthand and personally. I look forward to working with Secretary Collins and the VA to break down barriers preventing our veterans from accessing the lifesaving care that they so desperately need in their moments of crisis, be it at a VA or be it in a community.

The complete written statements of today's witnesses will be entered into the hearing record. I ask unanimous consent that all members have five legislative days to revise and extend their remarks, and include extraneous material. Hearing no objection, so ordered.

I think the members and the witnesses for their attendance and participation today. This hearing is adjourned.

[Whereupon, at 4:45 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Missy Jarrott

I'm Missy Jarrott, of Savannah, Georgia, and the Mother of Landon Holcomb, who tragically lost his life 10 months ago. I'm very grateful for your invitation to share my son's story which is condensed due to limited time.

Thank you Chairwoman, Miller-Meeks, and Ranking Member Brownley, and all of the members attending today.

"If soldiers are going to die, it needs to be at the attempt of an enemy, NOT a lack of effort and unorganized antics by the VA. The VA is killing our soldiers"

My son, Landon, who served as an Air Traffic Controller Navy Veteran (NAS Jacksonville) several years ago, was struggling to find mental health help in a system that completely failed him. Like many Veterans, he reached out to the VA for help and support. His first consultation with a Provider was on December 4, 2023, however the VA did not provide a follow-up visit until April 10, 2024. Landon had scheduled visits between this timeframe, however, unfortunately, the VA canceled multiple visits denying him the chance to see a Provider who specialized in medicine management. Landon tried and tried to keep his head up that the VA would follow through. He was experiencing anxiety, insomnia, restlessness and mood swings. Landon knew that he needed a mood stabilizer. "Mom, I'm struggling." After four unsuccessful months, he began to unravel with all of the canceled appointments. He became hopeless in the System. He was very emotional. On April 10, he visited the Savannah VA Mental Health team who determined that he wasn't under distress. Landon said the visit was a "checklist", and he explained that he had been asking for a psychiatrist (medicine management). He was hoping for a better outcome and knew that this meant another delay in getting the help he critically needed.

"Those that smile the brightest might be fighting a war within". Landon was fighting.

He came by to see me after this visit. At this point, family and friends became involved in searching for a psychiatrist and to no avail. We took it upon ourselves to call psychiatrists in the Savannah, Bluffton and Hilton Head SC areas. They did not accept military insurance, take new patients or charged $300/hr. More stress. Landon made numerous calls himself. (Play **VOICEMAIL** here) On April 19, he received a call from the Charleston VA for a Zoom appt. scheduled for May 3. He did not make that appointment and passed away on May 2. **The unthinkable happened.** Landon was found in the restroom of a restaurant on Hilton Head Island. He had fentanyl in his system. To numb his pain, he thought he was taking oxys. Landon did not plan to leave us! He was not suicidal. The hopelessness of canceled appointments, feeling abandoned and not taken seriously and the emotional spiraling ended his life.

Landon was buried at the Beaufort National Cemetery in SC with U.S. Naval Honors on May 13. He leaves behind two beautiful teenagers, a loving family and many loving friends. He was a True Patriot who loved his country. Help just didn't come soon enough. Mental health is real. It can't wait! *All Landon asked for was a mental health appointment for medicine management. He raised his hand over and over.*

In memory of my 39 year old son who could "light up a room with his infectious smile", let his voice "be heard from Heaven above" and on behalf of the Veterans who struggle every day....let's be reminded to "Never leave a soldier behind". These are our children. This is why I'm here today.

How many more testimoneys is it going to take "for change". How many?

May God bless our military serving all over the world and may God bless our Veterans and all military families.

July 23, 2024

Dear Members of Congress,

As the mother of a U. S. Navy Air Traffic Controller Veteran, I am writing to let you know how the VA system failed my amazing 39 year old son, Landon, who passed away on May 2. I hesitated to write this letter, however, I can only feel that my son's death should serve as a Voice so that you are aware that our Veterans are not getting the mental health care appointments they desperately need in a crisis. Waiting times of 2-3 months is heartbreaking. Landon's "**cry for help**" was not taken seriously. He turned to the VA for help. He became hopeless.

In December 2023, Landon realized that he was experiencing mood swings, insomnia, and restlessness. He reached out to his Primary Care Physician (VA Beaufort SC) to schedule a mental health appointment. Landon had moved to Hilton Head Island on November 1, 2023. Three months passed and still no mental health appointment to treat the symptoms. **Appointments were canceled by the VA over and over again.** Landon knew that he needed a mood stabilizer.

Family and friends began to search for help outside the VA network in the Savannah, Bluffton and Hilton Head area. Local Psychiatrists were not taking new patients or there was a three week wait. Help couldn't wait much longer. Finally, Landon was encouraged to go to the Hilton Head Hospital ER in the hopes of getting a referral from the ER doctor to a Provider for a mental health appointment. He received a referral to an out-of-network mental health center located on Hilton Head Island. After one counseling assessment that same week, he was told he would have to wait approximately three more weeks to be able to see a psychiatrist. He told the out-of-network counselor that he was only there because he could not get an appointment at the VA. This is noted in the counselor's notes and in his medical records. As he got in the car to go home, he held his head down and began to cry…."**Mom, I'm struggling.**"

Landon made his own phone calls searching for an appointment on Monday, April 29, before he died. He left me a voicemail which sounded normal and that he was still in hopes of finding a Provider. However, later that week, we realized that he was extremely distressed, so his hysterical girlfriend and myself each called 911. I pleaded on the call for the Beaufort Co. Sheriffs Department to "call an ambulance and to please take him somewhere". It didn't happen. Officers went to his villa, and we were told that Landon answered the door and said that he was fine and going to the gym. In addition, we were told that they couldn't do anything because it wasn't an active overdose. Two 911 calls within minutes, and nothing was done. The Officers didn't realize that there was a "mental war that Landon was fighting within". A mother's frantic plea on the 911 call to take him somewhere may have saved his life that day. **The unthinkable happened!** Three hours later, Landon was found dead in the restroom of a restaurant less than a mile from where he lived on the island. He found street drugs that afternoon in search for a way to temporarily numb his pain. There was **fentanyl** in his system. **Landon did not plan to leave us!** I'm still in disbelief.

Landon was a bodybuilder and didn't miss a day at the gym, trained young men, worked in the restaurant industry and nutrition industry on the island, and people flocked to him because of his phenomenal personality and infectious smile. To this day, the local gym displays Landon's picture in memory of his perseverance to fitness and for the positive impact that he made on other members.

All Landon ever asked for was a mental health appointment. **He was counting on help from the very government that he served.** Landon served in The Navy several years ago, and if you're unaware, an Air Traffic Controller position is one of the most stressful jobs in the country. He would work 8-9 hrs in the Control Tower, and then study at home reading FAA regulations. Landon graduated top of his class in ATC School in Pensacola. As a newlywed with a baby, I onced asked him, "Landon, why do you have to study after leaving the Base", and he replied, "Mom, I'm responsible for landing multi-million airplanes carrying our soldiers!" **He was a true Patriot who loved his job and more importantly, loved his country and always "stood up to defend our flag"! Landon "walked the talk" throughout his short life.** It

saddens me every day that all he asked for was a mental health appointment and it never happened. ***We lost a young hero.***

Since Landon's death, we learned that the VA Savannah has a hiring freeze. Why didn't Landon (we) know about the freeze? Is this a reason why so many Veterans are waiting and struggling? There's no communication. And, after reading the 2023 Mental Health Parity Act, there isn't any accountability for Wait Times. This Act is solely for the general public and private healthcare plans. The VA (on their website) states there is supposed to only be a 20-day wait time for appointments. **We know this is not happening.** There are thousands of Veteran stories. And, the VA's 2018 MISSION Act commitment must do more but it appears there has been no uphill progress the past couple of years. In addition, Veteran benefits should be the same for all Veterans whether they served two months, three years or ten years. ***Every day is a sacrifice. Every day when our soldiers wear the uniform, they immediately become targets. Please think about that!*** At present, only 20 year or active duty military can receive Tri-Care. Landon only received the general VA health care benefit. Our family and friends were willing to join together to help financially pay the $250-$300 per hour session for a psychiatrist for Landon.

Landon had a big heart! Landon loved life! Landon was humble! Landon was a Leader! Landon loved fishing, whitewater rafting, hiking, skiing and mountain biking! Landon loved football! Landon loved good music! Landon loved weightlifting! Landon loved his family! Landon was a Christian! Landon loved real people! He would have only wanted you to know how he looked to the VA and became discouraged and lost hope in the system that he was depending on. The hopelessness of canceled appointments, feeling abandoned and not taken seriously and the emotional spiraling ended his life. He planned to live and expected to come out of that restroom and thought he was only taking oxys—yet, **fentanyl** was in his system. This is all so devastating and heartbreaking for our family. ***America must win the war on mental health and on fentanyl.***

I'm asking for your consideration: ***to pass Legislation for Wait Times to a minimum of 7 days for*** **mental** ***health appointments; to ensure VA accountability with no exceptions****;* ***to allow*** *Tri-Care benefits to every Veteran regardless of tenure;* ***to include*** *out-of-network benefits coverage for psychiatrists, psychologists, licensed therapists, licensed social workers as if they were In-Network;* ***to revise*** *locations and limit travel distance for Veterans (ex: Savannah Veterans are required to travel two hours to Charleston, SC, for specialty and mental health care appointments);* ***to have ability*** *to access local hospitals and community facilities. Claims* ***to be processed*** *as if utilizing In-Network benefits;* ***to involve*** *community healthcare management coalitions and local Veterans groups in collaboration efforts to better serve ALL Veterans and dependents; private insurance groups such as United, Aetna, CIGNA and Blue Cross mandatory to accept all military benefits;* ***to eliminate*** *a hiring freeze at all VA clinics;* ***to hold*** *the VA responsible for notifying every member of* ***Congress of hiring status for the VA Clinic located in their District****.*

Landon Holcomb was born in Savannah, Georgia, April 22, 1985. He was buried at the Beaufort National Cemetery in South Carolina with U. S. Navy Honors on May 13, 2024. He leaves behind two beautiful teenagers, a loving family and many loving friends. Help just didn't come soon enough. **Speaking on behalf of Landon for all Veterans, please hear Landon's Voice, "Mental health cannot wait!"**

An emotional and very proud former Navy Mother whose goal is to ask Congress **to save the lives of Veterans who are waiting in line**, and who are deserving of the utmost **respect** and **compassion** for their service! Sadly, there are so many who feel that they have been forgotten. **In Landon's memory, I pray that you will please "prioritize" mental health and hear the "cries for help" across America.**

May God bless our military and our Veterans! Thank you Congress for your service!

Respectfully,

Missy Jarrott

Enclosure: *Picture(s)*

Prepared Statement of Michael Urban

Table of Contents

Introduction

I am honored to share my personal story and experiences with the Department of Veterans Affairs (VA) system. In 2003, after serving four years as a paratrooper in the 82nd Airborne, I was medically discharged following an accident during a jump. The subsequent surgeries led to a regimen of heavy opioid use—a path all too familiar to many veterans. Upon leaving the military, I was not informed about the VA or its services. It wasn't until my loved ones intervened due to my addiction that I discovered the VA. In 2004, I began receiving care at the Philadelphia VA Medical Center.

I share this background to frame my testimony, which will draw from my experiences as a VA consumer, Licensed Clinical Social Worker (LCSW), an individual in recovery from substance use disorder, and a community care provider. I believe my diverse perspectives uniquely qualify me to address the current challenges facing VA community care and mental health services.

When I sought help from the VA in 2004, prior to the MISSION Act, I was given a wait time of two to three months for a bed. Today, the VA typically offers a date range of under thirty days. This does not mean the date won't be changed multiple times to a later date. One could say not much has changed in that regard. However, receiving a potential time frame without any guaranteed admission date is devastating when you finally muster the courage to ask for help. I have had multiple stays in VA RRTP facilities over the course of my ten years trying to get sober. During one of these stays, a doctor advised me that saying, "I want to hurt myself," would expedite getting a bed. This practice placed me on the acute psychiatric floor until a bed became available. My stay lasted over three weeks because no beds were available, and I was warned that leaving would jeopardize my chance of getting into the RRTP. Although I knew I didn't belong on a psychiatric floor, I was surprised to find many fellow veterans with substance use disorders similarly confined, waiting for an indefinite period. This practice continues today, raising questions about whether the VA is truly meeting the needs of veterans or merely fulfilling administrative requirements. The next ten years were spent struggling with my addiction as well as trying to get care from an ever-changing complex system.

In 2014, while pursuing my Master of Social Work (MSW), I was enrolled in Vocational Rehabilitation (chapter 31) and my university required VA to purchase commercial insurance for me. They informed VA that having only VA coverage was not sufficient coverage by their standards. I needed SUD treatment and having this insurance allowed me to enter a private treatment facility for opioid addiction, marking my first experience outside of the VA system. The difference was profound. For the first time, I felt genuinely cared for, and the treatment I received was vastly superior to what I had experienced within the VA. I underwent a comprehensive program which included the full continuum of care. This included detoxification, residential care, partial hospitalization (PHP), and intensive outpatient (IOP) services, which took approximately six months to complete. Since December 2, 2014, I have maintained sobriety and achieved numerous personal and professional milestones, including completing my MSW, getting married, becoming a father, earning my LCSW licensure, establishing myself as a community care provider, and a developer of MH/SUD programs around the country. These accomplishments are directly attributed to the quality of care I received outside the VA system.

Becoming a Community Care Provider

In 2020, as the COVID-19 pandemic led to lockdowns and VA facility closures, I was working at a treatment facility outside of Philadelphia. Recognizing the need for continued support, I requested permission to develop a program specifically for veterans affected by the lockdowns. From May 2020 to February 2021, I had the privilege of treating approximately 200 veterans through community care and primarily from VISN 4. During this period, I established relationships with several dedicated VA providers. Together, we developed policies and procedures to meet the evolving needs of our shared veterans, ensuring they received necessary services. While most VAMC providers were collaborative, I was surprised to find that my home VA in Philadelphia was less cooperative. This experience highlighted both the potential for effective collaboration between VA and community providers and the challenges that can arise from inconsistent practices across different VA facilities.

In February 2021, I was approached by a national provider of substance use disorder (SUD) and mental health (MH) services to join their team. They asked me to develop veteran-specific programming at eighteen of their facilities, which provided an opportunity to expand my reach and apply the lessons learned from my previous program on a larger scale. This role also allowed me to engage with VA on a broader level, gaining a deeper understanding of how the entire system operates. Through this experience, I have been able to observe firsthand the complexities and challenges of coordinating care between VA facilities and community providers.

Over the past four years, I have had the opportunity to visit over seventy-five VA Medical Centers (VAMCs), numerous Community-Based Outpatient Clinics (CBOCs), and Vet Centers. Through these visits, I have interacted with a wide range of VA employees, from entry-level positions to executive roles. What I have observed is a significant disconnect between the policies and directives issued by VA Central Office and the realities on the ground at individual facilities. The saying "if you've been to one VA, you've been to one VA" holds true, as each facility operates with its own unique culture and practices. This variability highlights the need for more consistent implementation of policies and standards in mental health across the VA system to ensure that veterans receive uniform quality of care.

During my travels, I identified several areas where the VA lacked adequate services and worked to address these gaps. For instance, I found that there was limited substance use disorder (SUD) treatment available in Alaska, so I established a facility there. Similarly, upon discovering Eastern Colorado lacked SUD treatment options for veterans, I opened a facility in that region as well. Additionally, I developed and implemented an eating disorder program specifically for veterans in Philadelphia.

When VAMCs reached out to me about providing virtual therapy for rural veterans, I was able to meet their needs by establishing programs that served hundreds of veterans. However, when VA decided to cut reimbursement rates for virtual care by 90%, we were forced to close these programs, which had been serving over 800 veterans.

In Alaska, our program was poised to expand services, as there were no detox or residential facilities available in the state. However, the VA cut rates by 60%, and despite our request for a fee waiver, they further reduced the rates. This decision seems counterintuitive, as our services could have supported VA by providing detoxification services necessary for veterans to be admitted into the Domiciliary. I am currently working with a new organization to

bring these essential services to Alaska, and we will figure out how to make it work as our veterans need care.

Community Care Access Across the Country

Through my interactions with veterans and advocates across the country, I have consistently heard about the same challenges. One of the most pressing issues is access to community care for mental health has become increasingly inaccessible. We have witnessed a decline in veterans' ability to receive necessary care, particularly for services not offered by the VA. This problem is not isolated to a specific region; I have observed it in VAMCs from Florida to Alaska. Unfortunately, the situation has worsened following a directive issued last March which limited community care. Since then, I have seen veterans who, like me, sought help but suffered due to inadequate care, with some tragic outcomes. I have documented these experiences in a journal, which is included in Appendix A.

The community care process is intended to be straightforward and veteran-focused, but my personal experience highlights the complexities and frustrations that many veterans face. Last year, I met with my doctor on January 6, 2024, and we decided that I should see a community care provider for dermatology. The consult was placed that day, but it took over four months and forty-four interactions with the VA to get approval. These interactions included two congressional calls, four White House complaint calls, an email to VA Central Office, two handwritten letters to the director of the Philadelphia VA, and numerous interactions with the patient advocate.

The most disheartening aspect was the dismissiveness of the patient advocacy team. When I requested that they follow **VHA Directive 1041**, which outlines the community care appeals process through patient advocacy, they told me it "doesn't apply to our office." Eventually, I received approval for my consult, and I received calls from VISN leadership apologizing for the mistake. However, this raises serious concerns: What if this had been a mental health consult? How many veterans would go to such lengths to resolve their issues? How can a veteran feel supported when their patient advocate seems to be working against them? *(See Appendix B)*

As I have traveled across the country, I have consistently encountered similar issues with community care. For instance, in Massachusetts, I worked with a veteran who was denied entry into a VA Residential Rehabilitation Treatment Program (RRTP) due to past behavior. He then requested community care but was denied without being given a reason. He submitted an appeal through patient advocacy, as the VA was not offering him the necessary services. Unfortunately, the denial was upheld in writing, citing that the VA knew he could obtain a scholarship elsewhere, which they used as justification for not approving community care. I find this rationale puzzling, as it does not seem to be a valid basis for denying community care. I have documentation of this denial, but I would need to obtain a release from the veteran to share it publicly.

In Illinois, I worked with a veteran who resided more than two hours from the Hines VA and required substance use treatment. Fortunately, there was a community care facility located just ten minutes from his home, which was particularly beneficial given the rural nature of the area. Despite meeting the drive time access standard, when he requested that his provider submit a consult for community care, he was informed that this standard did not apply to his Residential

Rehabilitation Treatment Program (RRTP) needs. The veteran appealed this decision but was denied in writing. This case highlights the inconsistencies in applying community care standards and the challenges veterans face in accessing necessary care.

In Texas, I worked with a veteran who was affiliated with the Houston VA. Despite qualifying for a community care consult, he was informed that approval would be contingent on his choosing from list of community care facilities who the Chief of Mental health approved. The veteran submitted an appeal and contacted the White House complaint line. Subsequently, he received a call from the chief of psychiatry, who stated that he could only attend one of three pre-approved locations, as the chief "he was in charge" of what facilities could be used. This same message was conveyed to me via email. We reported this issue to Optum and VA Central Office but were told that they could not control local practices and could only attempt to educate leadership. This experience highlights the lack of continuity in community care process in some regions, where veterans' choices are severely limited by local VA leadership.

In Colorado, we have worked with numerous veterans and non-profit organizations, as there is no VA Residential Rehabilitation Treatment Program (RRTP) available in eastern Colorado. Many veterans in need of RRTP services were told by the Denver VA that they would have to travel to North Dakota or other out-of-state locations to receive care within the VA system. Most VA social workers in Denver will confirm that these services are not offered locally. Given this lack of availability, it seems reasonable that all veterans in need should qualify for community care. What happens to veterans who cannot or will not leave the state? When we inquired about detox services with leadership at the Denver VA, they listed only outpatient options. Upon further questioning, they ceased communication with us. This experience highlights the systemic issues in accessing necessary care and the complete ignorance of the MISSION act.

In Portland, we have worked with numerous veterans who have been consistently told by VA social workers that "we don't use community care." This is particularly concerning given that the Portland VA routinely reports mental health care visits exceeding thirty days on their tracking website. Instead of using community care, most veterans are referred to community providers who accept Medicaid. These providers often operate in large open bay shelters, which can be inappropriate for veterans with a history of Military Sexual Trauma (MST), as they may not feel safe in such environments. If veterans do not feel secure where they are receiving care, the effectiveness of that care is significantly compromised. Furthermore, many veterans are informed that a consult will not even be placed, further limiting their access to necessary services. This practice highlights systemic issues in how community care is utilized and the need for more comprehensive support for veterans.

In Philadelphia, we have encountered numerous veterans who are consistently denied community care. The typical justification provided is that veterans can be accommodated at the Coatesville VA, which is over an hour away from most parts of the city. However, when we have met with the chief of psychiatry, he explains "I cannot send to the community as I won't be able to justify my budget next year". He has cited the MISSION Act, stating that veterans who live within sixty minutes of any VA facility, even if that VA doesn't have the service they won't qualify for community care. According to him, "In the Northeast, where VA clinics are abundant, this disqualifies veterans from receiving community care". It is puzzling that proximity to a VA facility that does not offer the necessary services would be used as a reason to

deny community care. This practice highlights the need for more flexible and service-oriented policies that prioritize veterans' needs over administrative constraints.

In southern California, I have worked with veterans who request community care and are denied. If they are approved, they are only allowed to choose a place within that VA's catchment area. We had veterans from the Long Beach VAMC who wanted to attend a facility in the Loma Linda VAMC catchment, and they were denied due to it being in another VAMC's catchment. This practice also occurs in the Chicago area.

Across the country, I have engaged with Veterans Courts established to support veterans involved in the justice system. One of the primary frustrations these courts face is securing timely access to necessary care for veterans, rather than seeing them remain incarcerated. Communities are coming together to support veterans in need, but a significant barrier remains veterans who rely solely on VA care often struggle to access it in a timely manner. I have met with numerous district attorneys, public defenders, probation officers, and court social workers, all of whom express frustration with the lack of timely access to care for these veterans. The Veterans Justice Outreach (VJO) program is intended to serve as a bridge to facilitate access to care, but it appears that VJOs are often constrained in their ability to secure community care, further exacerbating the challenges faced by veterans in need.

In conclusion, the challenges faced by veterans in accessing community care are widespread and systemic. Across the country, veterans encounter inconsistent application of community care standards, lack of transparency in denial decisions, and restrictive practices that limit their choices. The experiences in Massachusetts, Illinois, Texas, Colorado, Portland, southern California, and Philadelphia illustrate these issues, from being denied community care without clear reasons to facing barriers due to VA facility proximity or "budget" constraints. To address these challenges, it is essential to adopt standardized criteria, such as the ASAM Criteria, to ensure consistency and coordination between VA and community providers. Additionally, streamlining the referral process, educating, and empowering patient advocates, and prioritizing veterans' needs over administrative constraints are crucial steps toward improving access to necessary care. By implementing these reforms, we can ensure that veterans receive timely and effective support, aligning with the principle of acting in their best medical interest.

Community Care Issues

The examples provided are just a few among many (see Appendix A for additional details), and they illustrate that these issues are not confined to a single VA Medical Center (VAMC) or Veterans Integrated Service Network (VISN). Instead, there is a systemic problem with the use of community care, with as many reasons for denial as there are VAMCs. The following list highlights common challenges in accessing community care:

1. **Lack of Written Denials**: In almost every case, VAMCs do not provide written explanations for denying community care, often citing vague reasons.
2. **Discretionary Mental Health Access**: The interpretation of community care access for mental health varies widely among VA facilities, often at the discretion of the Chief of Mental Health.

3. **Patient Advocate Limitations**: Many patient advocates lack knowledge of relevant directives, such as VHA Directive 1041, and find their efforts to assist veterans thwarted by systemic barriers.
4. **Misinterpretation of Residential Care Definitions**: VA providers often define Residential Rehabilitation Treatment Programs (RRTPs) as "extended care," which is used as a rationale for denial based on exclusionary criteria. What is interesting about this point is the definition of residential care in **VHA Handbook 1006.02** states,

Residential care is distinct from VA outpatient, inpatient (acute and psychiatry, medicine, rehabilitation, and surgery beds), and institutional extended care (CLCs).

5. **Process of obtaining a consult:** referral for SUD and MH care through the VA is often arduous, particularly for individuals who are already in a fragile state. This complexity can be attributed to several factors including:
    - **Initial Consult Request**: Many VAMCs require veterans to first see their primary care provider or mental health provider to request a consult. This initial step can delay the process and may not always result in a consult being placed.
    - **Approval Process**: In some cases, the consult is sent to the chief for approval, which can further prolong the process. This bottleneck can lead to significant delays, as the chief may not have the time or resources to review every case promptly.

VA RRTP Application Requirement: Some VAMCs mandate that veterans first apply to the local VA Residential Rehabilitation Treatment Program (RRTP). If the veteran qualifies for VA RRTP but no beds are available locally or within the VISN, the consult may then be sent to the chief for approval. This step can add weeks to the process and may lead to veterans being denied access to community care if they do not meet RRTP criteria. Regarding admission to an RRTP, **VHA directive 1162.02 states** "*Screening with an admission decision must be completed within 7 business days of the referral*". While this is the directive we have seen it take even longer than this just to get a decision.

Admission Review Teams:
Some VAMCs have teams that review potential admissions, but these teams typically meet only once or twice a week. This infrequent review can cause significant delays in the approval process.

Referral to Non-VA Services:
If veterans do not qualify for admission to RRTP, their consults often go unaddressed. In many cases, veterans are referred to seek services through local non-profits or enroll in Medicaid, which may not provide the specialized care they need.

Community Care Approval:
If a consult is approved, it is sent to community care, and a nurse will contact the veteran. While community care nurses often honor veterans' requests for specific facilities only if they align with local VAMC and VISN guidance, many VAMCs have established restrictive rules regarding where veterans can receive community care. This entire process can take anywhere from a week to four weeks to complete, and most VAMCs do not count this time toward MISSION Act access standards. Instead, they may set a clinically indicated date (CID) later,

which technically allows them to remain in compliance with MISSION Act standards but does not reflect the actual date of the veteran's request.

Hospitalized veterans:
When a veteran is hospitalized for substance or mental health-related issues in the community, most Requests for Services (RFS) related to this hospitalization are not processed in a timely manner and often go unconsidered. Technically, these requests should be approved promptly, as the referring provider oversees the veteran's care. However, many VAMCs fail to honor these requests, instead requiring veterans to apply to a VA Residential Rehabilitation Treatment Program (RRTP), which can take several weeks. Community hospitals often lack the capacity to keep a veteran in a bed for an extended period awaiting a VA decision. As a result, many community hospitals have stopped attempting to coordinate with the VA due to the prolonged wait times. This raises a critical question: How many veterans could have been ready to receive care but were instead discharged back to the streets, awaiting an uncertain date for a VA RRTP bed? This situation underscores the need for more efficient processing of RFS to ensure timely access to necessary care.

Best Medical Interest:
A concerning issue is that the "best medical interest of the veteran" access standard is often disregarded. In many cases, providers are willing to write a consult but will inform veterans upfront that it will likely be denied. This practice suggests that the VA's decision-making process prioritizes administrative considerations over the medical needs of veterans. It is crucial that the VA ensures that all decisions regarding community care are made with the veteran's best medical interest in mind, rather than being influenced by factors such as budget constraints or availability of VA services. By ignoring this standard, the VA may inadvertently create barriers to care, which can have serious consequences for veterans seeking timely and effective treatment.

COMPACT Act:
This process needs to be refined as it is not clear to most providers how to work with these veterans and be compensated. Currently private organizations can admit these veterans and it typically takes two to three weeks to find out if the stay will be covered. Organizations cannot function on the hopes and wishes they will be paid. Many providers have issues with veterans who need detox from a substance which could be causing the suicidal ideations, but these veterans are denied in most cases.

Emergent care:
Veterans often present to providers in need of emergent care for alcohol or benzodiazepine withdrawals, but coordinating care with the VA is frequently challenging. According to the Optum CCN provider manual pg.26, "*if a veteran seeks care from a behavioral health provider without a valid referral, the provider must contact the veteran's VA Medical Center to obtain a referral*". However, when we call the local VA, we are directed to the national reporting number. After calling this number, we are given a verification number but often do not receive notification about care approval for weeks. This delay can be critical for patients in need of immediate care. We have collaborated with the directors of VA finance, who process these claims, but they have been unable to identify the root cause of these issues. This lack of timely coordination can lead to significant delays in providing necessary care, highlighting the need for more efficient processes to support veterans in crisis.

In conclusion, the challenges faced by veterans in accessing care through the VA system are starkly contrasted with the streamlined processes available in the private sector. While veterans often encounter lengthy delays and bureaucratic hurdles, the private sector allows individuals to contact a facility, complete an assessment, and arrange for admission on the same day, with transportation sometimes provided. This efficiency highlights the importance of timely action when someone seeks help, as delays can lead to missed opportunities and potentially permanent consequences. The VA must adopt more responsive and efficient practices to ensure that veterans receive the care they need promptly. By doing so, the VA can better align with the principle of acting in the best medical interest of the veteran, ensuring that those who have served receive the timely and effective support they deserve.

Solutions to Community Care Access

As we have discussed, numerous challenges hinder veterans' access to substance use disorder (SUD) and mental health (MH) community care. To address these issues, I propose the following solutions:

1. **Documentation of Denials**: The VA should be required to provide written explanations for denying community care. For instance, when using the DST system to determine drive times, which differ from commercial tools like Google Maps, the VA should provide supporting evidence if a veteran does not meet the drive time standards. Unfortunately, such documentation is rarely provided. It is essential that VA cannot deny community care without clear, documented justification.
2. **Clear Guidance on SUD/MH Access Standards**: There is a need for clear criteria regarding SUD and MH access standards. Adopting the American Society of Addiction Medicine (ASAM) standards would facilitate communication between VA and community providers, ensuring consistency in care delivery. I will discuss this further in the next section.
3. **Appeals Process for Denials**: Pending legislation aims to establish an appeals process for community care denials. However, the issue is not the process itself but rather ensuring that VA staff understand the policies and procedures. Updating the current process to require documentation of initial denials would be beneficial.
4. **Expanded Authorization for Community Care**: Allowing professionals beyond physicians to approve community care authorizations could streamline the process. Currently, the system is often bottlenecked by physicians who may not be fully familiar with a veteran's case. Permitting social workers to approve care, given their familiarity with veterans and existing groundwork, could alleviate backlogs and ensure timely access to necessary care.
5. **Streamlined Process for Mental Health Consults**: A streamlined process for mental health consults requiring Residential Rehabilitation Treatment Programs (RRTPs) is essential. Veterans, their families, advocates, and providers should be able to request RRTPs efficiently. Assessments for these time-sensitive requests should be completed within twenty-four hours.
6. **Efficient Processing of Requests for Services (RFS)**: RFS should be processed through a national notification number rather than local VA facilities. This is crucial for time-

sensitive requests from community hospitals, where delays can be significant. Veterans should have priority access to available beds, whether in the community or VA system, to prevent unnecessary delays and discharges.

7. **Upholding the "Best Medical Interest" Principle**: It is vital to honor the principle of acting in the "best medical interest of the veteran." Decisions made collaboratively between providers and veterans should not be overridden. This includes respecting the professional judgment of social workers, psychologists, and other licensed mental health providers who often have a deeper understanding of veterans' needs.

8. **Emergent Care**: Not every mental health emergency occurs during VA operating hours or near a VA facility, making it unsafe for veterans who are intoxicated, experiencing withdrawals, or in a mental health crisis to travel to a VA facility. Many veterans are reluctant to visit an emergency room due to concerns about being placed on a psychiatric unit. In contrast, community care can offer facilities located where veterans live, with most providing 24/7 admissions. It is essential that the VA adopts a uniform process for handling these situations, removing decision-making from local VA facilities, which often view these decisions as budget issues rather than prioritizing veterans' immediate needs. By doing so, we can ensure that veterans receive timely and appropriate care without unnecessary barriers.

By implementing these solutions, we can improve veterans' access to community care and ensure Veterans receive timely, effective support tailored to their individual needs. VA states, "choose VA", well it's not much of a choice when VA is truly in charge of your choice. The above solutions can do just that which is create choice for veterans.

VA's standard of care for SUD

As a clinician and community care provider who oversees facilities across the country, I would like to highlight concerns regarding communication challenges between the VA and community care providers. These issues stem from differences in standards of care, which hinder effective collaboration and coordination between these entities.

Adoption of ASAM Standards:

The VA has not adopted the American Society of Addiction Medicine (ASAM) standards, despite these being widely recognized and required for community care providers. The ASAM Criteria provide a comprehensive assessment tool that determines the appropriate level of care, specifies minimum treatment hours, and outlines staffing ratios. The VA's reluctance to adopt these standards, citing them as "*they serve as thorough, multidimensional assessments for providers and patients who want to do them"* They found them to be *"long and burdensome for providers to complete and evidence lacking."* (VA/DOD Clinical Practivce guideline for the mangement of substance use disorders, 2021) is puzzling given their widespread use and recognition in addiction treatment. If we want to see an increase in success rates of our veterans, it starts with the proper assessment. "Long and burdensome" should not be terms used when dealing with the lives of anyone let alone veterans.

ASAM Criteria Overview:

The ASAM Criteria are developed by the American Society of Addiction Medicine, a professional medical society dedicated to improving addiction treatment quality. These criteria involve a multidimensional assessment of six dimensions: acute intoxication and/or withdrawal

potential, biomedical conditions, emotional/behavioral/cognitive conditions, readiness to change, relapse potential, and recovery environment. ASAM's guidelines are developed using rigorous methodologies, combining scientific evidence and clinical expertise to establish best practices in addiction treatment.

Benefits of ASAM Criteria:

1. **Comprehensive Assessment**: The ASAM Criteria offer a holistic assessment that evaluates six key dimensions, ensuring treatment plans are individualized and address the full spectrum of a veteran's needs.
2. **Evidence-Based Outcomes**: Research indicates that the ASAM Criteria effectively match patients with the appropriate level of care, leading to improved retention rates and outcomes. Studies have shown that ASAM implementation can increase retention in residential treatment settings.
3. **Standardization and Consistency**: Adopting ASAM would align VA treatment standards with those used by community care providers, ensuring consistency and continuity of care for veterans receiving treatment both within and outside the VA system. This standardization supports seamless transitions between different levels of care and providers.
4. **Widely Recognized and Utilized**: The ASAM Criteria are widely recognized as a standard for addiction treatment, with many states requiring their use for assessments and level of care determinations. The Centers for Medicare and Medicaid Services (CMS) has identified the ASAM criteria as evidence-based treatment guidelines.
5. **Improved Placement in Care**: Adopting the ASAM Criteria would enable better placement of veterans in the appropriate level of care. Currently, veterans are often screened for substance use disorders but not placed in the correct level of care.
6. **Community Care Provider Requirements**: Community care providers are required to adhere to ASAM standards to be part of the CCN network. For veterans in residential levels of care, adherence to these standards is crucial for ensuring consistent and effective treatment.

As per the Optum provider manual which community care providers must follow it states *"The ASAM Criteria was not written for health plans or insurance coverage but was written to improve assessment and outcomes-driven treatment and recovery services. It is used to match patients to appropriate types and levels of care. It defines specific levels of care within SUD services that comprise the care and evaluation within the six dimensions to determine patient placement*". Why is community care held to one standard and VA gets to make its own? If VA was truly the leader in this type of care wouldn't the rest of the industry, follow suit?

By adopting the ASAM Criteria, VA can enhance treatment outcomes, improve collaboration with community providers, and ultimately better serve the complex needs of veterans. This standardization would facilitate more effective communication and coordination between the VA and community care providers, ensuring that veterans receive timely and appropriate care.

Lack of Standards Lead to Negative Outcomes:

In an OIG report from 04Jan2024 titled *VHA Needs more written guidance to better manage inpatient management of alcohol withdrawal*,[1] it was found that approximately 4% of all acute admissions in VA during the years 2020 and 2021 were due to alcohol withdrawal. A survey of 30 VHA healthcare systems by the Office of Inspector General (OIG) revealed that 87% of these facilities lacked written guidance on consulting a substance use disorder (SUD) specialist for managing alcohol withdrawal. It also noted 57% of these systems lacked any guidance on how to determine the appropriate level of care for these veterans. The OIG published reports in 2021, 2022, and 2023 highlighting incidents related to inadequate alcohol withdrawal management, all of which resulted in the death of a veteran. Notably, these reports utilized guidance from the American Society of Addiction Medicine (ASAM) in examining the issues and making recommendations. VHA's response to the OIG report was to concur with the need for written guidance on the management of alcohol withdrawal and asked the local level to provide this guidance. Why not use the industry standard which is accepted and utilized everywhere but VA? These reports outline three veterans who died due to the issues discussed how many veterans could we have lost that we don't know about?

Lack of Standards on the use of Ambulatory Detoxification:

Since VA does not use ASAM criteria, the judgment of who is appropriate for ambulatory detoxification and who is not seems subjective. This was evidenced in all three OIG investigations. According to **VHA directive 1160.06**, "**Management of Admission for Veterans in Acute Withdrawal**," it states, "*Although alcohol and drug withdrawal can often be safely and effectively managed on an outpatient basis, medically monitored inpatient withdrawal management must be available, as needed, for Veterans evaluated to be at risk for moderate to severe withdrawal from alcohol, sedative/hypnotics, or opioids.*" In practice, we have observed veterans visiting the "mental health same day access clinics" for SUD and being provided ambulatory detoxification medication, which is essentially "the management of detoxification on an outpatient basis." Technically, the VA is meeting the veteran's need and fulfilling its requirement to provide this level of care. However, the question remains: Is the VA truly meeting the needs of these veterans in a meaningful way or the needs of the VA?

a. Ambulatory detoxification is best suited for individuals experiencing mild to moderate withdrawal symptoms and having a strong support system at home. This approach is ideal for those requiring flexibility in their treatment schedule and capable of managing symptoms without 24-hour medical supervision. It is particularly suited for individuals with stable mental and physical health, without severe medical conditions or co-occurring mental health issues. However, how can we ensure that veterans have these necessary supports if a comprehensive assessment is not conducted when they present for care? In my experience, I have encountered veterans who consume large amounts of alcohol daily, such as a half-gallon of vodka, and are offered ambulatory detox medications while being placed in outpatient care until a bed becomes available at a VA RRTP. This practice is perplexing because it suggests that the veteran requires residential care, yet they are sent home due to unavailability, highlighting a disconnect between the level of care needed and the care provided. Also based on the above criteria a veteran discharged to a shelter would not be a good fit but it happens all too often.

Lack of Consistency in Continuum of Care:

In appendix F section C of the ***VA/DOD SUD/MH practice guidelines***, veterans who took part in a focus group around VA care "expressed frustration in the lack of coordination and inadequate transitions between inpatient and outpatient treatment settings. Participants reported they had to initiate care and there was a significant time lag in access to outpatient services. ". Participants noted a significant difficulty in transitioning to an outpatient level of care. Participants noted a lack of information from providers as well as a lack of a clearly defined plan.

As stated in my personal journey I was able to take part in a full continuum of care which greatly aided my recovery. RRTP is just a starting point in someone's journey. Research published by the National Institute on Drug Abuse (NIDA) indicates that "individuals who remain in treatment for 90 days or longer have better outcomes, including lower relapse rates, compared to those with shorter treatment durations". This length of stay does not all need to be at the RRTP level of care. There should be a step down to partial hospitalization (PHP) or intensive outpatient (IOP) or outpatient (OP).

1. **VA Continuum of Care: VHA directive 1160.04** defines VA continuum as,

b. The continuum of care for provision of SUD services using a stepped care model.

includes:

(1) ***Level 0.*** *Foundational services including self-care.*

(2) ***Level 1.*** *Interventions in primary care, non-specialty SUD care and general*

mental health clinics.

(3) ***Level 2.*** *Specialty SUD outpatient services, intensive outpatient SUD programs, Opioid Treatment Programs, residential rehabilitation, and acute inpatient services.*

2. **Community Care Continuum of Care:** The following is the standard community care must follow,

ASAM Levels of Care

a. **ASAM Level 0.5**: Early Intervention
   - Assessment and education for those at risk of substance abuse.

b. **ASAM Level 1.0**: Outpatient Services
   - Less than 9 hours per week; for mild disorders or transitioning from intensive programs.

c. **ASAM Level 2.1**: Intensive Outpatient Services
   - 9-20 hours per week; for moderate disorders requiring structured support.

d. **ASAM Level 2.5**: Partial Hospitalization
   - At least 20 hours per week; daily structure for routine living skills.

e. **ASAM Level 3.1**: Clinically Managed Low-Intensity Residential
    - 5 hours or fewer of treatment per week; for relapse management in a group home setting.

f. **ASAM Level 3.5**: Clinically Managed Medium-Intensity Residential
    - For individuals with cognitive function issues; slower-paced treatment.

g. **ASAM Level 3.7**: Clinically Managed High-Intensity Residential
    - 24-hour oversight for those at risk of severe withdrawal or harm.

h. **ASAM Level 4**: Medically Managed Intensive Inpatient
    - 24-hour medical and nursing care in a hospital setting for severe cases.

Comparison:

- **ASAM is More Comprehensive**: ASAM provides a detailed and structured framework that ensures consistency and continuity of care. It is widely recognized and adopted by community providers, which facilitates better coordination and outcomes.
- **ASAM Offers Better Standardization**: The ASAM Criteria are evidence-based and provide clear guidelines for each level of care, ensuring that patients receive appropriate treatment based on their needs.
- **VA Model Lacks Specificity**: The VA's stepped care model, while accessible, lacks the specificity and structure of ASAM, potentially leading to variability in care quality across different facilities.

In summary, ASAM offers a more comprehensive, standardized, and effective framework for substance use disorder treatment compared to the VA's continuum of care. ASAM's detailed criteria and evidence-based outcomes make it a superior choice for ensuring that patients receive the appropriate level of care.

The VA's Intensive Outpatient Programs (IOPs) often fail to meet the standards outlined in **VHA Directive 116.01**, which requires a minimum of nine hours of programming per week. During my visits to various VA Medical Centers (VAMCs) across the country, I have found that only a few meets these standards. Most VAMCs lack nighttime IOP options, leaving a significant portion of the veteran population without access to care. Veterans who work or attend school and require evening services are frequently denied community care consults. VA denies because they offer IOPs, even though these services are often inadequate or not when they can attend. For instance, VA Philadelphia's response to inquiries about their IOP schedule is typically that they have an IOP which offers a one-hour group session five days a week, which is often unrelated to substance use disorder (SUD) treatment. This schedule doesn't even meet VA standards. This is not an isolated case; many VAMCs claim to offer IOPs but, upon closer examination, it becomes clear that they have pieced together services to appear compliant. This practice denies veterans the comprehensive care they need and can lead to further barriers in accessing community care.

Closing Remarks

In conclusion, the challenges faced by veterans in accessing community care are widespread and systemic. Through my personal experiences and interactions with veterans across the country, inconsistent application of community care standards, lack of transparency in denial decisions, and restrictive practices hinder timely access to necessary care. The experiences in Massachusetts, Illinois, Texas, Colorado, Portland, Southern California, and Philadelphia highlight these issues, from being denied community care without clear reasons to facing barriers due to VA's fear of losing veterans to the community. This is a systemic problem and one which is costing veterans their life.

To address these challenges, it is essential to adopt standardized criteria, such as the ASAM Criteria, to ensure consistency and coordination between VA and community providers. Additionally, streamlining the referral process, empowering patient advocates, and prioritizing veterans' needs over administrative constraints are crucial steps toward improving access to necessary care. By implementing these reforms, we can ensure that veterans receive timely and effective support, aligning with the principle of acting in their best medical interest. Our fellow veterans need our help, and this should be a team effort not a battle to justify budgets.

I urge policymakers to consider these recommendations and work toward creating a more responsive and veteran-centered community care system. By doing so, we can honor our commitment to those who have served by providing them with the care they deserve.

Appendix A

The documentation in this section only covers into early 2023. Unfortunately, any documentation afterwards is unretrievable as I no longer work at the organization whose network I had been using. I can assure you the issues outlined here are the same today if not worse.

2021

- **May 2021**: Philadelphia VA is one of the most difficult facilities to deal with. Dr. Oslin, the Chief of Mental Health, is notorious for not signing consults. He told me on a call, "We need to keep our veterans with us, or we will lose resources." After an email from Mary Beckett in Dr. Upton's office about utilizing community care correctly, Dr. Oslin called me to discuss how to help veterans. However, he frequently denied community care consults, which were sometimes approved after I called him.
- **June 2021**: Danville VA - I received a call from Dr. Stephanie Erickson from the Danville VA. She was upset that our team had been calling to help veterans get referrals for the community. I explained to her our team understands the criteria for getting a referral and we explain this to the veterans as well. We have been spoken to several SWs who work for Danville and have said they have "difficulty getting care for their veterans and it's even more difficult for a community referral". I was also told by Dr. Erickson "we don't need your help and all of our veterans will be served here". I also met with several SWs and they expressed their struggle with getting veterans in this region care. They stated, "leadership won't send out as it will cost them jobs in our VA".
- **July 2021**: Hines VA - I have spoken with several providers there, the main one being Erin Magano who is the director of the homeless program. We have a facility in the outer reaches of the Hines VA's area which they would like to use. We have been cleared by their CC department but have yet to get a referral. I had been asked by Erin to connect her with other VA social workers who have gotten auths. I am assuming here but based on the conversations with her and others they want to send veterans to the community but cannot get the auths approved.
- **July 2021**: Togus ME - This veteran did admit to us but only after the following situation: His Psychiatrist Dr. McIntyre at the Togus VA in ME submitted the consult twice, and community care says he is eligible for a community care referral, but they refuse to send him out of their region. They sent the veteran to TX in November. The Chief is refusing to send him out of the region.
- **July 2021**: Houston - We had a veteran request to come to our facility which is part of the CCN but was told we "weren't on the approved list". Apparently, Houston has a list which comes out every Monday of who providers are allowed to refer to.
- **July 2021**: New Orleans- we have had several veterans request services but were unable to get authorizations for them. The patient advocate at this facility was super helpful but as of now none of the leadership has responded. We know the veterans in this area are sent to Arkansas or Biloxi for substance use care. The Patient Advocate stated, "it's almost

impossible to get a veteran a referral here". Haven't had much more interaction to know the validity of this.

- **August 2021**: Boston, MA - An email chain from the Jamaica Plains VAMC discussing community care referrals and wait times for SARRTP.
- **September 2021**: West Palm Beach VA - Initially had a waiting list and did not send veterans out, but later began sending them towards the end of the year.
- **Fall 2021**: Danville VA - There was a dispute regarding a veteran who was asked to pay for his own ticket to travel for treatment.
- **October 2021**: Syracuse VA - They typically sent us 10-15 veterans a month but were later directed to keep as much in-house by sending to other VA's.
- **November 2021**: Togus ME - The veteran was sent to TX for care.
- **December 2021**:
    - **12 December 2021**: Brockton, MA - Any veteran who needs residential MH or SUD must first be interviewed by that VA's program. If and only if they are approved to get services, will they be put on a list. If the wait list is more than 30 days then they will get a CCN referral. If the team does not feel they would be accepted into their program, then they will not get a referral. The providers are fed up and echoed it's the admin who calls the shots.
    - **16 December 2021**: Coatesville is the local SUD/MH hub for this region and has been closed for almost two weeks now. Wilmington VA has sent us sixteen veterans for inpatient SUD care. Philadelphia is much larger and has sent three outpatient who need inpatient care but won't auth inpatient. The other SUD/MH hub Lebanon has closed as well.
    - **23 December 2021**: Coatesville VA was not accepting referrals for the SUD program due to COVID until at least January 5, 2022. Veterans were placed on psychiatric units until SUD beds became available.

2022

- **January 2022**:
    - **Update on Syracuse VA -** They asked us to stop providing care which the veterans like. They said they are having a difficult time getting veterans to engage in VA care because the food is "too good" especially serving them ice cream. They asked if we could stop that. They also asked if we could "stop allowing them to smoke" since veterans don't like that the VA won't allow them to smoke. They also asked if we could not allow them to see what else we offer as the veterans push back against using VA after seeing us. The focus of the call was that veterans don't want to utilize VA care and we are making it "hard for them to compete".
    - **Update on medication issues** - After meeting with the new undersecretary of care in the community (Dr. Flynn), we were able to resolve the issue with injectable

medications like Vivitrol. However, the problem with CVS filling prescriptions persists.

- **Brockton, MA** - The attachments are regarding a veteran from the Brockton, MA VAMC. This veteran requested treatment for SUD and was denied. His SW contacted me and asked if we could help. I asked why he was denied care and she told me he had been a behavior problem in the past and due to this he was not appropriate for their facility. He requested a consult for CCN which was denied. He then submitted this appeal on 19 January 2022 but because the PA didn't log it until 21 January 2022 the time did not start on his appeal. For some reason, his providers supervisor told them they he had a scholarship to our facility if he was denied. They denied him a consult because we offered him a scholarship. I was told by the SW the administration was angry the veteran had "found the law" and put such a request together.
- **20Jan2022-** I was able to connect with the wife of one of the veterans I had been helping who ended up committing suicide. She would be more than happy to share her husband's story with you. He was a Vietnam veteran. The VA had sent him to our facility for substance use disorder but upon arrival it was evident he needed mental health treatment as well as urology. We tried to get him to urology when he was with us, but they would not give a community consult. They originally kept him in the acute psychiatric unit for a few weeks (so technically they were meeting his needs by the VA's definition). Acute needs should not last weeks. They denied his CCN request for urology which was a big contributor to his decline in mental health. His wife's name is (redacted), and her number is (redacted). She asked if someone could call after 430 EST.

We brought him back to the VA to get mental health treatment. After we dropped him off and the VA knew he needed care they left him alone and he fled the VA. The VA initially tried to blame our facility, but his wife had gone up to get him. She met another veteran's wife who was present for her husband being brought in and handed off to VA providers. This contradicted everything the VA told us and his wife. I am working on getting you some more veterans to speak with as well.

- **February 2022**:
  - **2 February 2022**: Met with the Long Beach VA team. They were very open to utilizing our services but did tell us about their procedure. First, a veteran must request treatment and be approved by their SUD program. Once they are approved, the consult is then sent to a committee which determines if they will give approval or not. From the sounds of it, the providers are not part of this committee.
  - **3 February 2022**: Met with the Hines VA who have sent us some eating disorder and mental health veterans. Most providers are unfamiliar with the process of submitting consults as they are not always approved. It was unclear but it sounded like Dr. Nutter was the gatekeeper who would or wouldn't be approve consults. Providers did tell us they are always instructed to search the entire VISN first and then if no care can be found then search other VISNs and if no care can be found there then a consult can be placed.

- **9 February 2022**: This veteran (Redacted) requested a CC referral due to being over an hour from the facility. He was denied and he wrote an appeal letter which was subsequently denied. It took well over two weeks to get a response as well. The VA failed to meet the required three-day response period as well. They did put their own date on it, but he has the initial email. I gave the veteran a free month of treatment at our facility which is close to home.

- **March 2022**:
  - **2 March 2022**: We just got a call from a veteran and his wife who has been trying to get him substance use treatment. The veterans VA provider has expressed her concern as the Hines VA has a full inpatient unit and a full outpatient unit. The only option they can provide him is the acute psychiatric unit at this time. The VA provider, the veteran, and his wife know this is not what he needs. The provider is going to try and place a consult but is unsure as "our (Hines) facility doesn't allow us to refer out". I have connected her with providers who have done eating disorder referrals to help her out.

- **April 2022**:
  - **15 April 2022**: Coatesville VA - A veteran was deemed better suited for our facility, but the VA team could not submit a consult due to computer issues. They suggested we scholarship the veteran instead. When asked why they wouldn't refer out if they couldn't provide the best care, they stated that they do provide care but it wouldn't be ideal for the veteran, and thus they cannot refer out.
  - **13 April 2022**: Seattle VA - A coworker has been working with the director of SUD at the Seattle VA. She was informed they will only give a CCN referral after a veteran has attempted the Seattle VA's program three times and failed. They told her this is the only way someone would be considered for a CCN referral for SUD and even then, it's not guaranteed she will allow them to go to the community.

29April2022

- We had a veteran (Redacted) from the Philadelphia VA be admitted to the Philly VA hospital(23April2022) for alcohol detox complications. He was there for a few days and then discharged home. He had an appointment four days after discharge and asked for SUD treatment and they told him he would be put on the wait list. He asked for a consult to the community, and they told him "no". He almost died from drinking, asked for help, and was sent home. This veteran was readmitted this weekend (30May2022) due to him drinking again while he awaits the VA to send him somewhere. If they would just provide the care when he needs, he wouldn't have to continue to be seen in the emergency room. (05May2022) Veteran was found in the street seizing from alcohol use and again needs to go back to the VA.

- **May 2022**:
  - **5 May 2022**: Houston VA – (redacted) a veteran, was referred to us by a nonprofit program that struggled to find good CCN-approved facilities. They work very closely with the Houston VA and are looking to start utilizing our location to provide services

for veterans. A Dr. Nair at the VA submitted the consult for (redacted) to come to us for services but, at that VA they have created a "special approved list" that provides 10 facilities in which the VA can use for services, and we haven't made it on that list.

- **June 2022**:
  - **8 June 2022**: Hines VA - We have two veterans through the Hines VA. One needs SUD care and has been referred through veteran's court. The Hines VA will not give an auth and has told them it's a 5-6 week wait list for VA RRTP. They offered him to go to Milwaukee which is over four hours away.**10 June 2022**: I was finally able to get consults placed for both veterans after emailing Dr. Flynn the undersecretary of care in the community who then contacted the national patient advocate team.
  - **18 June 2022**: Lyons VA - Veteran (redacted)-he reported he was approved for CC and requested to attend our facility. I spoke to PT and the VA wanted to only send him to Sunrise in NJ. He really wanted to come here but the VA wouldn't allow it. He has intake on Monday at Sunrise.
  - **22 June 2022**: Biloxi VA - Providers have reported the VA has taken the ability of providers to recommend levels of care for veterans requiring MH/SUD treatment. They now have a separate team who has worked with the veteran to make a recommendation which does not always seem to be as beneficial to the veteran.
- **October 2022**:
  - **15 October 2022**: Lyons VA has been sending us veterans but as of recently they have been instructed to search the entire VISN and surrounding VISNs before sending to the community.
  - **20 October 2022**: Veterans in the panhandle of Florida are being sent to Arkansas for SUD treatment.

3 January 2023

- **Tuskegee (AL)**: Met with the community care department, including one of the leads and several nurses, and the patient advocate. The sentiment at this facility with the CC team is they have "no issue placing and getting consults done. The issue is with getting the doctors to sign the consults. They always have some reason as to why they cannot sign the consult". This department struggles with the delays and pushback the doctors give them when trying to get a veteran care in the community. This department also does the authorizations for Montgomery as well.
- **Montgomery**: Met with a social worker (a veteran herself) in the SUD/MH section. She told us she is booked three months out for individual sessions. She says they place community care consults and then it's up to getting a doctor to sign it. The overall sentiment is they can't keep people (employees) because they are "overworked and have a lack of support from VA". The VA system is "not conducive to providing consistent MH care which is integral to providing quality care". She is unable to see veterans on a weekly

basis which at least in the beginning of mental health care would be the standard of care (Very far from "world class care").

- **Birmingham**: They moved all mental health to a new building. The patient advocate here was helpful and connected us with the directors of the facility, and we are still waiting to hear back from them.
- **North Dakota**: Spoke to the Patient Advocate and head of social work at Fargo. They said they rarely refer to community care providers. When someone requires residential MH or SUD, they send them to the St. Cloud (MN) or Black Hills VA(SD). St. Cloud is a three-hour commute, and the Black Hills, which is in Hot Springs, is a seven-hour drive.

4 January 2023

- **Black Hills**: Has a Dom onsite. They will only refer for specialty programs which they cannot treat.

5 January 2023

- **Hines**: Met with the chief of mental health (Thomase Nutter) and chief of social work (Joe Adder) who were very open to speaking with us. We have worked with them on eating disorder veterans, and they were very open to sending eating disorder veterans to us. We met to discuss how we have SUD services in their area and a treatment center in two areas they cover which are a 90-minute drive from this VA. Dr. Nutter was very open that they cannot send veterans out due to drive time because they have a residential program (12 beds) and SUD residential treatment is "not covered under CCN as it is domiciliary care". (Considering we offer outpatient services near where the veteran lives, you would think that would qualify) The VISN has been pressuring the chief to open back up to double occupancy rooms, but they do not have the staff and are concerned with COVID. They also said they send to other VA providers anywhere in the country before sending out. This is a sentiment which is echoed over and over to keep veterans in VA healthcare. This VA had an eating disorder team at it, but they all left and there is no one left to treat these veterans.
- **Jesse Brown**: I was invited by the Community outreach team to meet and do a tour of the VAMC. The clinicians we met with were very welcoming and open to collaboration with outside providers. The eating disorder team was very happy to meet with us and had a veteran who would need our services. We spent about two hours speaking with several MH providers. One of the areas of frustration seems to be the "higher ups" decisions to not always provide the appropriate level of care for the veterans. There is a lot of putting people into outpatient levels of care rather than sending them to inpatient or a community provider who can meet those needs. They didn't come out and say this, but during the conversations, these were some of the comments made. Most were careful with their wording, but it was the lower peer support veterans who were more vocal with their frustrations in the "old way of thinking".

- **Sheridan**: The patient advocate was not available but spoke to people at the front desks in social work and mental health. Both said they have enough services internally and if they need a higher level of care, they use Black Hills VA for residential use when needed, which is a four-hour drive.
- **Cheyenne**: Spoke to the Veteran Experience Officer in the patient advocate office. They do refer to Black Hills but won't utilize the CCN. They were standoffish and said they couldn't provide much information as they cannot show favoritism towards one provider.

6 January 2023

- **Danville VAMC**: Met with (Josh Friant) to discuss utilizing community care and the services they need for veterans. He said he has seen a change since the last director left. He stated he has had to advocate for at least twelve veterans in the last seven months to get community care consults pushed through. Veterans presented for help, and they had over a 30-day wait list for care in their facility. The veterans were never offered community care until they met with him. He said they have 15 beds, and they are always filled. He was very open to working with us but is aware of the administrators throwing up roadblocks in using community care. He is a veteran himself and very passionate but has echoed frustrations with the VA and the politics involved in getting fellow veterans the services they need.
- **Indianapolis VAMC**: Mental health facility seemed empty, but was able to speak with the person who checks clients in. He said he was familiar with community care and was asking what services we have to offer. He said the MH clinic is always backed up for therapy and currently is booked through April. He said they have a lot of veterans who show up who "need care but can't get it".. Still haven't heard from the chief or get a response from an email.

9 January 2023

- **Palo Alto VAMC**: Was not able to directly speak with anyone, but staff was happy to give me the director's name, phone numbers, and emails.
- **San Jose**: Was able to meet with the program services administrator who met with us to discuss our services. She gave us her email and was willing to send the email to the staff. (She did forward an email with me attached to the entire CBOC).
- **Fremont**: Small CBOC and gave us the director's name to connect with.
- **Oakland**: Mental health was in another building, and there were no MH providers we could connect with.
- **San Francisco**: Went to behavioral health in the main hospital, and there was only one SW, and we were told the rest work remotely. We then went to building 8, the behavioral health building. It was interesting as they are expanding the building, but on all three floors, there was a total of one clinician working. There were more than forty offices with

names but no one working there. We spoke to the front desk, and they said, "providers only come in once a week and there is no set schedule; it is whenever they want to come in".

10 January 2023

- **Livermore CBOC**: Met with Sean Gibson (MH treatment coordinator) who was interested in the services we offered, especially eating disorders. He told me they just had a meeting about the lack of these services within the VA.
- **Previous Meeting with Dr. Dominguez**: He was not open to our services at first and said they are "not allowed to send to community care and have to keep it within the VA". They don't send veterans to detox but rather prescribe them "ambulatory detox" at home. After a veteran detoxes at home, they can go to Menlo Park DOM and receive OP services.
- **Modesto CBOC**: Spoke with the front desk who said they would take my card, but they are not allowed to discuss what services they offer.
- **Fresno VAMC**: Met with Ed, the assistant executive director of the hospital, who then called in the director of the mental health service line. We discussed our services, and they informed us they are going to "stop utilizing the CCN for SUD as they will be keeping everything in house". They informed me they are at "50% staffing for SUD but will be onboarding and be at 70% capacity soon". They use one CCN program right now but will be stopping once they have all the staff they need. They agreed they don't have eating disorder resources and would pass my information along for those services.

11 January 2023

- **Sacramento VAMC**: We have been doing most of this system's telehealth services. They do send about 15-20 veterans a month to CCN provider Akua for residential SUD and MH. We spoke with the nurse manager who has said they "have a need for an eating disorder program" which we do have. They took our information and said they would like to set up a meeting.
- **Mclean CBOC**: Met with the CCN patient advocate who took our information and sent us to social work. They have referred people in the past and don't have any issues with using CCN.
- **Mare Island CBOC**: Met with the patient advocate who told us they do send veterans to the community when they need help. He did tell us MH services at their facility are "horrible and they get a lot of complaints because none of the providers come in". They told me the psychiatrists don't do video appointments but just phone sessions with the veterans, and veterans hate those sessions. Met with the BH nurse who took our information and echoed the sentiment of the PA.

13 January 2023

- **Albuquerque**: Met with community care workers and the supervisor of the department. They were very open to having a meeting with us about our services and what we offer. They have offered to set us up with the CCN behavioral health nurse. They told us they do send many veterans to the community for SUD and MH. They do get many calls from veterans requesting CC because they have long wait lists. They do have a need for eating disorders as well.

17 January 2023

- **Prescott VAMC**: Met with Jason Ramos, the chief of the domiciliary, to discuss our services. He informed us they have 160 beds and don't normally have a wait list or a need to send to the community for SUD. We discussed how he has been getting veterans from all around the country to his program and has been asked to expand his bed count. They do need resources for eating disorders which he has tried to use us in the past. They also provide telehealth and follow-up care, which seems to be the most comprehensive of any VA I have been to. This is only domiciliary care, which is not residential. One thing which does not add up here is they say they have staffing issues and have 160 beds. On the list of providers, there was only eight psychologists who provide care. If this is true, then there is no way they should have 160 clients. Following ASAM staffing standards, you shouldn't have more than 8-12 people on a case load in residential treatment, which would limit this facility to 96 veterans they could serve.
- **Phoenix VAMC**: Met with James Cox, who was the director of the MICU. We discussed how this VA only has domiciliary care and not residential services for SUD. We discussed how a veteran must prove through multiple failures at lower levels of care before they will even be considered for the domiciliary at this facility. We discussed how this VA will not send any veterans out of state as this is what has come down from above. We discussed how there are more than a few veterans falling through the cracks at this VA and not getting the care they need due to resistance in sending to the community. This VA does not have a detox either and he believes they send them to the psychiatric ward for a 72-hour detox. This is not sufficient time for an appropriate detox. I have noticed more than a few of these facilities don't technically offer residential services anymore. What they do is offer "the dom" which they reside at and then get services which are technically outpatient. This allows them to circumvent standards of how many veterans a clinician can have on their caseload. There has been a switch to saying they have domiciliary care and not residential. Technically, the Phoenix VA does not offer residential SUD treatment, and any veteran requesting these services should qualify for a CCN referral.

Appendix B

6 January 2023

- Saw pulmonology for my yearly appointment and it was suggested I see dermatology. I requested a community care consult, and he told me I would have to speak with dermatology when they called. Doctor placed the consult on 6 January 2023.

27 January 2023

- I was contacted by the dermatology scheduler who said they had an appointment on 27 February 2023. I asked for a community care consult to be placed due to the appointment wait time as well as the distance as I live 60 minutes from the facility. The scheduler told me I did not qualify, and she would not request a consult be placed. She informed me "we go by the PID date, and your doctor gave us a PID of 1 March 2023, so we have until 1 April 2023 to get you an appointment". I told her that I still qualified under the distance, and she told me that's "not true since we can get you an appointment in 30 days none of the other criteria matter". I became angry and so did she and she began yelling and telling me "You don't know what you're talking about". (I was not very nice in return). She wouldn't give me her name and hung up on me.
- I immediately received a call back from a Denise Johnson who said she was a supervisor. She wanted to see how she could help me. I told her "I would like a community care consult be placed" and she reiterated what the first woman told me "we go by the PID date and since we can get you in within that time you cannot have a consult placed". She asked me "what will make you happy" and I told her if she could "please get me in writing exactly why I was being denied this request"? I was informed she would need to ask her supervisor and would call me back later in the day or tomorrow.

30 January 2023

- I emailed my primary clinic requesting a community care consult be placed.
- I emailed the patient advocate (for some reason whenever I send a message to the patient advocate appealing my decision or asking about community care they disappear from my sent box within 48 hours) I left a voicemail from patient advocate.

3 February 2023

- I heard back from my primary care that they placed a community care consult for this appointment.

6 February 2023

- I received a call from the nurse in dermatology who informed my "consult was denied because we can give you an appointment within 30 days". I asked who denied the consult and he would not tell me.
- Called patient advocate and emailed.

7 February 2023

- I emailed the provider of dermatology who told me she understands my frustration, but community care said, "based on your address you don't qualify". I confirmed the address, and she was using an address I haven't lived at in 10-15 years. I was confused as I get all my mail from VBA, VHA, Philly VAMC to my current address.
- I called the patient advocate left a message and emailed.
- I called the national VHA hotline in DC and filed a complaint, Case Number: 09467772
- Spoke with the local congressional rep and filled out paperwork for them to get involved.

8 February 2023

- Heard back from dermatology who resubmitted my consult to community care as she said "it appears based on your updated address you do qualify for a community care referral".
- Called patient advocate left VM and emailed.
- I called the national nursing line and told them what was going on. The nurse was very helpful and said "I am sorry this is happening unfortunately the Philadelphia VA is notorious for not answering the phone, returning calls, or emails. Whose numbers do you need, and I will give you their direct lines, so you don't get stuck in a main mailbox".

9 February 2023

- Received a call from the patient advocate who said, "I received your file from the main VHA complaint line and wanted to confirm that you do qualify for community care, and I will make sure the consult is placed".

15 February 2023

- I called the patient advocate back and this time she told me "Looks like your consult was denied after we reviewed it again. Based on the software we use you don't meet the time requirement. Someone from CC was supposed to call you to explain.". I informed her they haven't and that I would like this in writing so I could appeal it. She took my email and I have yet to hear from her.

28 February 2023

- I called the patient advocate and spoke with Judy who told me Carol was assigned to my case. I was told she would call me back in 10 mins and an hour later I got a message that Carol would connect with me at some point....
- I am filing another complaint with the main VHA hotline to get my denial in writing so I can follow VHA policy to appeal to the VISN. VA hotline 9616278

1 March 2023

- Spoke with Carol S that she is forwarding my concern to CC and will get me the denial in writing. I asked if she needed a copy of the VHA policy and she laughed and said, "I won't say anything to incriminate myself".

3 March 2023

- VA responds with written letter (see attached). They essentially said because I refused an appointment it was my fault "drive time and wait time standards could not be met".

5 March 2023

- My response to the VA letter:

Mrs. Belton,

Thank you for getting back to me. I would appreciate if we could get some clarity on the reason, they are denying me. In this letter it states that "4. VA cannot provide care within certain designated access standards Does not meet criteria as DST (decision support tool built in CPRS) indicates veteran is less than 60 mins drive time and appointments are available at the VA less than 28 days. Veteran has refused multiple appointment date options. In this situation, VA is unable to schedule an appointment that is within both average driving time standards and wait time standards. "

First, I was asking for a community care referral based on drive time which is why I was unwilling to accept an appointment. This is a right afforded me by congress and it has taken two months for VA to reply with rationalization for not providing a CCN referral. I am unsure how my refusal for an appointment takes the onus off VA to not meet the drive time standard? Whether I accept an appointment or not has a bearing on drive time.

I would like a printout of VA DST showing I do not live within the drive time requirements. Using google maps and other civilian maps show the drive time ranges between 85 and 50 mins. The average I have found is 67 minutes utilizing civilian technology. Therefore, I would request that you please include what your system shows as well as a printout. If VA is going to deny me a right afforded me by law, you should be able to provide clear documentation. Please let me know if you cannot do this and why so that I may proceed with my appeal to the VISN level. Thank you again for your time and consideration.

6 March 2023

- Spoke with patient advocate who told me I need to speak with Renee Tucker the manager of CC. The patient advocate told me that is who would need to help me get that information.
- Called and left VM for Renee Tucker. (2158235800 x209390)

7 March 2023

- Called and left VM for Renee Tucker

10 March 2023

- Called and left VM for Renee Tucker

13 March 2023

- Spoke with someone in the patient advocates office who apologized and said she would message Mrs. Tucker to call me ASAP. No one called me.

14 March 2023

- Called patient advocate and no one will answer.
- Emailed the former Undersecretary of CC who then forwarded me to Shaterri Brown who contacted VHA15 for review.

15 March 2023

- Called VHA hotline again and filed another complaint VHA case number- 09739517. I requested to please have my denial with the printout of the DST so I could appeal to the VISN.

20 March 2023

- Received a reply from Shaterri Brown from VISN 4

Good afternoon!

Sharing the update below from VISN 4 Veteran Experience Office.

"This is a VA Hotline Case that was entered on 3/15/2023 with the Request being created on 3/16/2023 under General. The Service Line of Community Care has the Request assigned to them, per National Policy they have 5-7 business days to respond to a general case, leaving the Service Line 5 more days to respond to the Case. "

We will continue to provide updates as they become available.

Thanks!

28 March 2023

- I emailed Shaterri as it was past seven days and still no response....

29 March 2023

- I received this response from Shaterri

Good Afternoon,
Our VISN 4 partners have informed us that a new dermatology consult was created today for you by your Primary Care Provider. Any additional concerns regarding this consult can be addressed by his PACT Team using MHV Secure Messages or by calling (215) 823-4280 Option 5. Furthermore, the team provided Mr. Thompson's contact information in the event further assistance is needed.
POC: Iain W. Thompson, MPH | Supervisor Patient Representative, Veteran Experience Office | office: 215-823-5803
Our office is closing out this inquiry. If you have additional questions regarding this matter, please feel free to reach out to Mr. Thompson directly. Thank you for bringing this matter to our attention.

29 March 2023

- I received a call from Mr. Thompson stating that "after learning of some new information a new consult will be placed and you will be hearing from dermatology". I informed him if this one is denied I would be more than happy to file an appeal in accordance with VHA directive 1041 section 4 and in accordance with procedures in section 5. Once this appeal is

filed, I would like to have the denial in writing per the policy with the printout from the DTS. He told me I could contact him through messaging or his phone number. I informed him that I sent multiple messages to his office in the past and that they keep disappearing. I informed him this has happened multiple times and that all my other messages have been answered by other providers.

29 March 2023

- Congressional response was finally given and signed by the director. This stated, "I did not qualify for CC and my consult would be denied".

4 April 2023

- Scheduler called me to schedule an appointment for the end of June. When I said I wanted a CC referral she told me I could come in tomorrow and therefore don't qualify.

5 April 2023

- Called and left VM for Ian and sent email.

6 April 2023

- Spoke with CC who told me they have never had a consult for me and that they don't approve or deny consults and cannot give me anything in writing.
- Called PA who told me Iain would call me. She told me VHA directive 1041 does not apply to their office and they don't have to give me anything in writing. She told me I do not qualify for CC based on the schedule they have. I asked for it in writing which she would not give me.

10 April 2023

- PA Carol called me back and said a consult had been placed and that VHA directive 1041 does not apply to their office, and they would not discuss it any further.
- Called VHA hotline again. She stated it would best to check back in and ask the next person to escalate it to the VISN level next if it is not resolved.
- Emailed Shaterri Brown

Good morning,
I am back to square one with this issue. Mr. Thompson called me one day and assured me he would be my POC. I have called and emailed him and no response. The scheduler called me and offered me an appointment at the end of June or the next day. I told them I was out of state and couldn't make it the next day. She told me that I didn't qualify for CC since they could get me in the next day and refused the appointment. The patient advocate also told me VHA directive 1041 doesn't apply to them, and CC must provide me a denial in writing. CC told me they don't approve or deny any consults and that the someone else would have to do this for me. I informed that VHD directive 1041 covers CC appeals and states their office is responsible for this, but they said I was wrong and would not discuss it anymore. I had to call the patient advocates office since last Tuesday before anyone even got back to me. I have no idea where to go from here as I am following VHA policy and VA is not doing the same. I would appreciate any guidance on

this as I am stuck and just want to follow the rules to get the services I should be getting. Thank you for your time and assistance with this matter.

11 April 2023

- Mr. Thompson called me to apologize for the delay in getting back to me. He confirmed that a CC consult has never been placed for me and he will work on it. He asked if "we can get you in within thirty days would that be good for you". I asked him "if an organization had treated you the way the VA has treated me would you come in"? His response was "No I wouldn't and that's why I have private insurance and don't use the VA". We discussed the drive time and how he knows where I live and agreed it should be in the drive time access standard. He agreed this "need to end and we need to get you the care you deserve". He told me he would get to work on it and get back to me.

14 April 2023

- Was called by someone in CC who told me my CC consult was approved and a scheduler would call me in a few days to get me scheduled. I informed them I knew where I wanted to go and they told me to "get the NPI and have it ready" when they call back.

18 April 2023

- Called CC and spoke with Adele who was very helpful. She said she would get this assigned to the lead of the green team and let them know my preference. She said someone would reach out to me to get me scheduled.

19 April 2023

- CC called me and we called the place I want to go and have an appointment on 20 April a block from my house.

References

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https://www.vacommunitycare.com/doc/ccnProvManual/ccnPrManual
VHA Directive 1160.04, VHA programs for Veterans with Substance Use Disorders

VHA Directive 1160.02, Mental Health Residential Rehabilitation Treatment Program

VHA Directive 1006.02 VHA site classifications and Definitions
(VA/DOD Clinical Practivce guideline for the mangement of substance use disorders, 2021)

Prepared Statement of Shankar Yalamanchili

Good afternoon. Chairman Bost, Ranking Member Takano and distinguished members of the Subcommittee Thank you for having me here to testify this morning. I am honored and privileged to be here and serve the country. I am Dr. Shankar Yalamanchili, my friends and colleagues call me Dr. Chili. I'm a psychiatrist with over 20 years of experience in working to improve mental healthcare efficiency and accessibility. I'm testifying here today to discuss how we can improve patient care while increasing efficiencies in mental health services in Veteran's Affairs Hospitals by allowing the VA to contract with private physician groups, when appropriate.

After completing my residency and fellowship in psychiatry, I began working at the Veterans' Affairs (VA) hospitals in Montgomery and Tuskegee in 2005. While working there, I became frustrated with the inefficiencies that were interfering with my ability to treat patients, so I transitioned to Community Mental Health Centers. These centers allowed me the flexibility to improve operations, although financial mismanagement later destabilized the system. Through my experience in both systems, I recognize the national scale of these financial and efficiency issues and the effect on proper patient care. This led me to create sustainable solutions that would improve patient care while making the system more efficient.

Today, I lead River Region Psychiatry Associates (RRPA), a multi-state psychiatric practice designed to bring care directly to patients where they live, rather than having to travel long distances. At RRPA and our owned outpatient delivery system, Ally Psychiatry, we emphasize a holistic approach that focuses on treating patients' underlying issues and thoughtfully incorporating families, when necessary, to develop manageable and successful treatment plans. In 2024, Ally Psychiatry now operates in 51 clinics across nine states, employs 68 physicians, over 150 nurse practitioners and physicians, which allows us to see over 115,000 patients.

RRPA's inpatient presence spans 55 inpatient facility locations across 7 states (specifically Alabama, Tennessee, Missouri, Georgia, Mississippi, South Carolina, and North Carolina), in hospitals, emergency departments, jails, community health centers and more. In 2024, RRPA managed more than 1,000 inpatient facility beds, served more than 48,000 patients (about twice the seating capacity of Madison Square Garden), and completed more than 400,000 patients (about half the population of Delaware) visits/encounters.

Our doctors also provide the highest qualities of care. We provide professional ethics and new innovation training, we have high standards for different levels of care (intake, crisis treatments, and then stable patient continuing care) and we believe in holistic care that uses the newest technology and engages families, rather than simply prescribing unnecessary medications. We also rigorously comply with all of the State and Federal regulations and standards. If we are not providing excellent patient care, we won't succeed.

Unfortunately, the one area where we are not able to expand our patient care and services is where it is needed the most – VA hospitals. It is critical for U.S. veterans to have stable and qualified healthcare providers. An estimated 41 percent of veterans are in need of mental health care programs every year, and the VA provided over 1.7 million Veterans mental health services in 2024. Mental health issues and suicide among veterans are prevalent and complicated problems to sufficiently address, but we need to be more proactive and provide consistent treatment. Roughly 17 veterans die by suicide each day, according to a 2022 report by the VA and fewer than 50 percent of returning veterans in need receive any mental health treatment.

Mental health services are just one area where patients are struggling to receive timely and consistent care. In general, VA hospital average wait times can be anywhere from a few days to a few months for needed care, and then appointments are often canceled at the last minute. Congress and the Administration recognized the need for more providers and they implemented the CHOICE Program, now VCCP, which provides opportunities for veterans to seek care from private, non-VA or Department of Defense doctors through "community care" providers. This allows veterans who need services not offered by the VA automatically or veterans who live in a State without a full-service VA facility, such as New Hampshire, Alaska, or Hawaii. However, the current system does not allow VA hospitals to contract directly with private physician practice organizations to address situations where veterans are underserved or forced into the lengthy waits by the VA due to staffing shortages and physician availability. Additionally, while the Community Care Network's (CCN) intended benefit of faster care, more access, and patient choice, are often undermined by red tape, payment issues, and poor coordination. Veterans end up waiting longer, juggling providers, or getting denied care, while private doctors are frustrated and leave the network. As the Committee heard yesterday, there can also be

issues with consistency in patient data between community care and the VA. By allowing VA hospitals to partner with physician staffing groups, they will be able to provide enhanced access to consistent, reliable, and continuing quality care for our veterans and consistency in patient data. This will, in turn, extend availability from big cities, and provide some relief to CCN networks, to bring these critical services to the smaller rural communities in a timelier manner.

Improving the health and well-being of our veterans who have served this Nation requires a collaboration between public and non-profit mental health providers. It is imperative that we increase the availability of mental health services and professionals for all veterans, and I believe that practices like mine can help achieve this. This includes encouraging more community-based services AND allowing private physician groups to provide services to the VA.

In addition to the long wait times due in large part to shortage of key staff at the VA, which result in delays in care, there are also high overhead expenses. While the VA has met their own hiring initiatives designed to increase the number of inpatient and outpatient mental health providers, they continue to face challenges in hiring adequate mental health staff to meet the full demand for services (GAO, 2015). The GAO cites pay disparities with the private sector, competition between VA medical centers (VAMCs) to fill positions, lengthy hiring processes, a lack of space for new hires, a lack of sufficient support staff, and a nationwide shortage of mental health professionals as reasons why the vacancies are going unfilled. Practices like mine can help solve these issues.

When comparing the current state of the VA mental health workforce with private enterprise health groups, significant improvement in both patient care and efficiency is seen. For example, private health groups can staff a VA hospital so that twice as many patients can be seen, and that there are doctors available Monday-Friday, with weekend availability, and on-call 24 hours a day. Importantly, when hospitals contract the doctors out, there is a decreased per-patient cost of treatment while maintaining quality, value-based care and a decrease in the overall infrastructure costs while working with existing VA best practices and meeting VA quality metrics. In my practices, we use all the tools at our disposal. We evaluate patients using assessment tools in addition to talking to patients and their loved ones and previous providers because understanding past failures is essential to therapy going forward. We utilize community resources including religious institutions and groups such as AA, Alzheimer's foundation, and disease specific associations, and we empower patients to sustain lifelong stability with focus being able to get back to work and relationships. No one's disability should define them. Finally, all of the doctors in our practices train and collaborate with each other.

We must improve where and how our veterans receive care and ensure that it is scalable, affordable, and patient centered. While veterans Community Care Programs may work well for very specific, targeted treatments over short durations of time, the gap remains for the sustainable and chronic care treatment model, which requires a higher level of continuity of care than can currently be offered through Community Care Networks, especially in the mental health space.

To decrease cost to taxpayers, and improve efficiency and access to care, we propose that the VA **ALSO** contract with local private enterprise providers who can see VA patients in their clinics. The existing Community Care Network model is designed to meet episodic (time-limited) problems and short-term needs. While important, this leaves a gap specific to chronic care, which requires a higher level of continuity of treatment than can currently be offered through Community Care Networks. That is why we also propose a permanent public/private partnership that utilizes the resources of the VA with defined support from private enterprise (e.g., private practices). Support models can be tailored to meet the needs of individual VA facilities and communities.

This is not without precedence. There are currently two pilot projects underway in three states that could serve as models for a program. First, there is a VA-Private Telehealth Partnership Pilot in rural Montana and Alaska where VA facilities are sparse. Under this project, funded through the VA Office of Rural Health (ORH) grants and CARES Act telehealth expansion funds, the VA contracted with private telepsychiatry groups to deliver care via VA-provided telehealth platforms. The result has been that Veterans were seen faster and often in non-clinical community settings (like local libraries or community centers) with VA-trained facilitators. Wait times went from 60+ days to under 14 days for mental health appointments and there was high satisfaction among veterans, especially those hesitant to visit VA clinics due to stigma.

In Texas, under a State grant, several private psychiatric groups were brought into VA's Community Care Network, but the difference was they received dedicated liaisons and fast-track credentialing from the VA. A shared portal was created for

scheduling and communication, avoiding usual CCN bottlenecks. This resulted in 80 percent faster referral-to-appointment time compared to standard CCN clinics and providers stayed in the network longer due to faster reimbursement and reduced paperwork.

I can also envision a model where the VA continues to manage robust inpatient services, while then transitioning veteran's outpatient care to an identified partner who has established a care network in that market/region. To ensure a seamless care transition, the partner practice would utilize the VA's EMR while managing the patient's care. This will allow for seamless patient health information management including collaborating with VA care management teams.

It would also be possible to have the private enterprise partner provide facility enterprise coverage for the VA community. This potential solution would make access to care easier and improves the quality of care for the veteran community while driving down the cost of that care as funded by the taxpayer and increasing its all-around value. VA contracting with local, private providers who can safely, securely, provide quality service based on VA quality measures in areas where there are provider shortages could be game changing for vulnerable Veterans. We will see our valued veterans in our clinics closest to their homes along with the rest of the community. Utilizing our existing efficient practices in place we can see a thousand more encounters per provider per year. This could be a $50,000 reduction, on average, in cost per provider per year, in my opinion.

The public/private partnership model is mutually beneficial to both physicians and patients. These models I presented could reduce costs by 20 percent–30 percent while expanding patient capacity by the same margin and outperforming traditional VA and community mental health systems. At RRPA, we have found that when hospitals contract with us, there is also a 20 percent reduction in emergency department visits, a 25 percent decrease in inpatient length of stay, and a 15 percent reduction in readmittance. As a private company, we're not successful if the patient care and efficiencies don't make a meaningful difference.

We strongly support the VA's mission to best serve veterans who have borne the battle with honor, and it would be our privilege to help improve their mental health care.

Prepared Statement of Maria Llorente

Chairwoman Miller-Meeks, Ranking Member Brownley, and other Members of the Subcommittee. Thank you for the opportunity today to discuss the provision of residential substance use disorder (SUD) treatment through VA's Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) and community care residential treatment programs. Joining me here today is Dr. Ilse Wiechers, Deputy Director, Office of Mental Health, VHA.

Introduction

VA's MH RRTPs are a critical component of VA's broader efforts to address the needs of Veterans with substance use concerns. The MH RRTPs provide care within specialized SUD residential programs, referred to as Domiciliary SUD programs, as well as across the full MH RRTP continuum, which includes programs for the treatment of posttraumatic stress disorder, general mental health concerns, and services for homeless Veterans. In fact, more than 95 percent of Veterans served within the MH RRTPs have a SUD diagnosis, and all programs provide treatment for SUD either as the primary treatment or concurrently with other services.

Innovation has been a priority within MH RRTPs, focused on ensuring the provision of high-quality care that is responsive to Veterans' needs. For example, in 2012, MH RRTPs moved quickly to implement procedures to prevent fatal overdoses with the first Culture of Safety Stand Down launched in November 2012 and the introduction of naloxone as a critical tool. VA also established clear expectations to support access to life-saving medications for the treatment of opioid use disorder.

The enactment of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act of 2018) (P.L. 115–182) further transformed the landscape of Veteran care by expanding access to community care options. This law expanded access to eligible Veterans to elect to receive care in the community in certain situations. In October 2020, VA developed the MH RRTP Standardized Episode of Care, which made it easier for VA to order residential treatment in the community. This has led to significant growth in the number of community programs providing residential treatment and the number of Veterans

receiving this care. To help maintain high quality care for Veterans, VA requires residential community care providers to maintain appropriate credentials, such as by Commission on Accreditation of Rehabilitation Facilities or by Joint Commission.

Improvements in MH RRTP

In the past few years, VA has expanded MH RRTP care. As of March 25, 2025, there are more than 260 MH RRTPs across 125 locations of care, with more than 6,600 operational beds. These programs provide integrated, concurrent treatment for co-occurring SUD and mental health treatment needs, ensuring comprehensive care for Veterans. During Fiscal Year (FY) 2024, around 32,000 Veterans utilized VA's MH RRTP care with just over 25,000 receiving care at a VA-operated facility and the remaining Veterans receiving care from community providers.

During Fiscal Year 2024, 97 percent of Veterans served across all MH RRTPs, had an SUD diagnosis, and more than 92 percent had a co-occurring SUD and mental health diagnosis. Recognizing the importance of ensuring access to residential SUD treatment, VA has increased access through the addition of new Domiciliary SUD programs with four programs opening in 2024 and additional programs expected to open this year. VA's commitment to providing timely access to care is evident and has been a priority focus area over the last several years. During the first quarter of Fiscal Year 2025, 70 percent of Veterans were admitted to VA Domiciliary care within 20 days. The average wait time for Veteran admission for VA MH RRTP in Fiscal Year 2024 was 17.1 days.

VA also emphasizes the critical role of community care in expanding access to residential treatment. When Veterans are eligible and elect to receive such care, referrals to community providers help address gaps in specialized residential treatment programs that may not be available within VA. By leveraging both VA's continuum of programs within regions and programs in the community, VA ensures that Veterans can access residential treatment as close to home as possible. On average, Veterans must travel 150 minutes or more to receive this specialized care, whether through VA or community care.

Leveraging Community Care to Maximize Access

Increasing access to community care is a significant component of VA's strategy to ensure Veterans have access to the care they need. The VA MISSION Act of 2018, its implementing regulations, and subsequent laws and policies have facilitated this expansion by allowing eligible Veterans to receive care in the community. For VA to continue to meet the growing need for MH RRTP care, we acknowledge that changes are needed to VA's current access standards. As a result, VA was proud to support the Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025 before the full House Committee on Veterans' Affairs on February 25, 2025, while ensuring the offsets or additional appropriations are provided. We are committed to working with Congress and other stakeholders to reduce barriers and improve access to the care Veterans have earned.

Conclusion

We want to thank the Committee for its continued oversight. This concludes my statement. We would be happy to answer any questions you or other Members of the Subcommittee may have.

STATEMENTS FOR THE RECORD

Prepared Statement of American Academy of Physician Associates

Dear Chairman Bost, Ranking Member Takano, Subcommittee Chairwoman Miller-Meeks, Subcommittee Ranking Member Brownley, and Members of the Committee:

On behalf of the more than 168,000 physician associates/physician assistants (PAs) throughout the United States and the more than 2,500 PAs currently employed full-time by the U.S. Department of Veterans Affairs (VA), the American Academy of Physician Associates (AAPA) thanks the Committee for your commitment to ensuring veterans have timely access to urgent mental health care, substance use disorder treatment, and residential rehabilitation treatment programs. AAPA appreciates the opportunity to submit comments for the record on the Committee's March 25 hearing on Breaking Down Barriers: Getting Veterans ACCESS to Lifesaving Care.

PAs are licensed clinicians who practice medicine in every specialty and setting at the VA, and throughout America. PAs diagnose illness, develop and manage treatment plans, manage their own patient panels, and often serve as a patient's primary healthcare provider. PAs practice medicine in every State, the District of Columbia, and all U.S. territories. Scope of practice for PAs is determined by their education and experience, State law, facility policy, and the needs of patients. Studies reinforce that PAs provide high-quality care, and patients have consistently indicated high-levels of satisfaction with PAs, comparable with care delivered by physicians.[1] Patients have also already demonstrated confidence and trust in the PA profession by indicating the type of health professional who provides care is less important than when they obtain access to quality care.[2] The VA is also the largest employer of PAs.

PAs at the VA are critical to the Committee's work toward better access to care. We agree with the goals of the Veterans' Assuring Critical Care Expansions to Support Servicemembers Act of 2025 (ACCESS Act) to reduce bureaucratic barriers to access to care for veterans, and with Chairwoman Miller-Meeks's emphasis on VA's goal of there being "no wrong door" at the VA for veterans seeking care.

However, language in the ACCESS Act may inadvertently overlook the importance of the increased access to care PAs can provide. Specifically, Section 203, Improvements to Department of Veterans Affairs Mental Health Residential Rehabilitation Treatment Program, includes the following among the assessments of providers' quality of care delivered required of the Secretary of the VA:

- (3) the ratio of **licensed independent practitioners** per resident;
- (4) the rate of completion of training on military cultural competence by **licensed independent practitioners...**

AAPA recommends that "licensed independent practitioners" be replaced with "licensed practitioners" to ensure that these assessments of quality do not inadvertently exclude PAs. In other contexts, some hospital administrators and personnel have been confused as to whether PAs were included among those professionals who authorized to order certain care due to the word "independent" appearing in regulatory language. However, the term "licensed independent practitioner" is a phrase that is not used in the Social Security Act or commonly used in any Federal statute. "Independence" is not a measure of a healthcare professional's educational preparation, competency, or ability to provide quality medical care. Eliminating this term, which has limited the ability of PAs to deliver needed care to patients, supports patient access to care, moves further toward a team-based

[1] Hooker RS, Moloney-Johns AJ, McFarland MM. Patient satisfaction with physician assistant/associate care: an international scoping review. *Hum Resour Health*. 2019 Dec 27;17(1):104.

[2] Dill MJ, Pankow S, Erikson C, Shipman S. Survey Shows Consumers Open To A Greater Role For Physician Assistants And Nurse Practitioners. *Health Affairs*. 2013 Jun; 32 (6).

healthcare delivery model and recognizes the need to fully utilize the healthcare workforce.

In fact, the Centers for Medicare and Medicaid Services (CMS) removed this confusing language in a 2019 regulation which also prompted the Joint Commission to make the same change to conform with CMS.[3]

AAPA thanks the committee for the opportunity to submit this recommendation and for your ongoing dedication to the health of our Nation's veterans. We are committed to working with Congress to advance our shared mission of improving access to health care for veterans. If we can be of assistance on this or any issue, please do not hesitate to contact Tate Heuer, AAPA Vice President, Federal Advocacy, at theuer@aapa.org.

[3] AAPA. Joint Commission Removes "Licensed Independent Practitioner" Term from Restraint and Seclusion Standards. 2020.

Prepared Statement of National Association for Behavioral Healthcare

National Association for Behavioral Healthcare

Access. Care. Recovery.

NABH Statement for the Record:
Breaking Down Barriers: Providing Veterans ACCESS to Lifesaving Care
U.S. House Subcommittee on Health Oversight Hearing
March 25, 2025

The National Association for Behavioral Healthcare (NABH) applauds the House Veterans Affairs Committee's continued focus on improving access to timely and appropriate behavioral healthcare, specifically treatment for substance use disorder, serious mental illness, and suicide-prevention for America's veterans by introducing the *Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025.* NABH supports the U.S. Veterans Affairs Department's (VA) renewed commitment to removing barriers to care through the Community Care Network (CCN). We are encouraged by the continued congressional oversight of the VA, and we advocate for empowering veterans with information they need to make decisions about their healthcare.

NABH represents behavioral healthcare providers along the full behavioral healthcare spectrum of care in all settings, including inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as medication assisted treatment centers and other facility-based outpatient programs for children, adolescents, adults, and older adults in 49 states and Washington, DC. NABH is proud to represent behavioral healthcare providers who are dedicated to treating our nation's veterans. We share our members' concern that VA gatekeepers have erected barriers to veterans seeking behavioral healthcare services guaranteed to them through the *Mission Act of 2018* through a culture of denying and delaying coverage.

NABH staff has engaged with the House Veterans' Affairs Committee and is pleased with Committee's continued focus and engagement with the Trump administration to ensure both the *MISSION Act of 2018* and the *Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (*Dole Act), (P.L. 118-210) – which became law on Jan. 2, 2025 – are implemented fully. We also strongly urge Congress to pass the *Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025*, which will 1) codify current community care access standards as the minimum access standards; 2) expand them to include all extended care services, including mental health residential rehabilitation; and 3) require the VA to ensure that veterans are screened for mental health residential rehabilitation treatment programs within 48 hours of the time the veteran or his or her provider requests admittance, among numerous other important provisions.

Our nation's veterans' behavioral healthcare needs are critical. Veterans have disproportionately high levels of behavioral healthcare need relative to the general population. According to both the VA and the National Institute of Mental Health, for the years 2022-2021 (which is the most up-to-date reporting) the suicide rate among veterans was 57.3% higher than the general population. The VA reported that 6,407 veterans died by suicide in 2022, with the highest rates among men (22 times higher than women) and recent veterans between the ages of 18 and 34. While many veterans have undiagnosed needs, 43% have been diagnosed with a mental health and/or substance use disorder.

Among those who died from suicide that year, 39% were diagnosed with depression, 26% with anxiety, 25% with Post Traumatic Stress Disorder (PTSD), 20% with alcohol use disorder, 9% with cannabis use

disorder, 8% with bipolar disorder, 4% with personality disorder, 4% with opioid use disorder, 4% with psychotic disorders,3% with ADHD, and 3% with schizophrenia. According to the National Institute on Drug Abuse (NIDA), more than one in ten veterans have been diagnosed with a substance use disorder, which is slightly higher than the general population.

The Community Care Network gives veterans expanded choice in their healthcare, and supplements complex cases and long wait times. In 2022, Congress passed the *PACT Act*, which led to more veterans than ever qualifying for VA coverage. The *MISSION Act* requires the VA offer care in the community to veterans who need care when wait times for mental healthcare appointment exceed 20 days or longer than 28 days for a Specialty appointment (or if the drive time to a primary or mental healthcare appointment is longer than 30 minutes). This is because delays in care can be deadly, particularly for suicidal patients. According to the VA, it operates "about 250 programs at around 120 residential rehab sites across the country with enough beds to accommodate more than 6,500 Veterans." This is not nearly enough programs to meet the need for services. And the VA acknowledges this fact. During a House Veterans' Affairs Committee hearing on Sept. 10, 2024, then-Under Secretary of Veterans Affairs for Health Shereef Elnahal, M.D., M.B.A. said the VA does rely on its community care partners to provide care in certain areas because "We simply do not have the institutional capacity."

In early 2023, NABH members who provide care to veterans through the Community Care Program sounded the alarm to NABH staff that VA gatekeepers increasingly denied clinically appropriate and timely care to veterans receiving behavioral healthcare services. Members noticed a pattern of delayed care that exceeded the amount of time the *Mission Act of 2018* promises them. Veterans who need residential treatment services have faced waiting times for services that far exceed the 28-day limit for specialty care, making them eligible to seek community care services. And while different VA VISNs and regions operate independently, this situation is not confined to any particular geographic region. VA referrals to providers in the CCN are down more than 80% – a fact multiple NABH members have corroborated. In fact, some markets appear to have ceased third-party referrals altogether.

Under the CCN contracts, VA requires contractors to meet two primary network adequacy standards for specialty care, which includes mental health. These standards establish limits on how long veterans should have to travel to, or wait for, an appointment. VA uses claims data to assess contractor performance against these standards. GAO found that VA's methodology excludes certain claims if the claims do not meet the applicable standard, such as when veterans prefer a specific provider or appointment day or time. In contrast, VA includes these claims if it meets the standard. As a result, VA's methodology may result in an incomplete, and potentially misleading, assessment of network adequacy. This poses a risk to VA's ability to fully assess the extent to which its CCNs can meet veterans' healthcare needs adequately.

For example, some VA patients have reported they were told to switch enrollment from one VA to another to receive care- a process that itself can take months. In addition, the VA has escalated the administrative burden required to make a third-party referral, not only for third-party providers, but for VA Medical Centers and for patients. And if a veteran refuses to travel away from home to receive care, his or her chart is often marked as "declining care." Consequently, their names to no appear on VA waiting lists.

Waiting times can have life-changing impacts. For instance, one of our members shared a story about a veteran who received care for substance use disorder in one of this member's facilities. The clinicians recommended the veteran stay longer to complete treatment; however, the VA denied the longer stay, and, after nearly a month, located a bed in a VA-operated facility. The wait for that facility was fewer than 28 days, but in total that veteran waited for appropriate treatment for much longer than the *MISSION Act* dictates. One day before this veteran was scheduled for admission to a VA facility, the veteran received a DUI.

NABH supports the bills the House Veterans' Affairs Health Subcommittee marked up on March 25 and the provisions in the *ACCESS Act*. We also offer the following suggestions to increase transparency in the system and remove barriers to behavioral healthcare services:

- VA transparency: waiting times and reports on residential rehabilitation services should be public, providing data for veterans to make informed decisions. Performance metrics should be public and should be checked quarterly to ensure there are no hidden wait lists.
- VA lacks comprehensive information on the factors that contribute to scheduling challenges, which could include network adequacy difficulty identifying a community provider. This is because VA does not ensure that facility staff members do not give a reason when they encounter scheduling delays or are unable to schedule an appointment. Having this information would help the VA determine whether an insufficient number of providers could be affecting veterans' access to community care. It could also help the VA take targeted actions, including actions to strengthen the CCN, if appropriate.
- VA standardized screening processes should be implemented as soon as possible. A potential way to prioritize access is to use criteria from the American Society of Addiction Medicine.
- Assess the extent to which CCNs are adequate to meet veterans' needs, including for mental healthcare.
- Given the high demand for mental health and substance use disorder treatment, residential treatment, and the insufficient amount of VA treatment facilities, special provisions must be made. Veterans are often waiting more than 48 days for life saving treatment.
- Community Care: If A VA program bed is not available within the allocated timeframe (48 hours for priority, 20 days for routine), veterans should have the choice to seek care outside the VA, and they should understand they are entitled to timely and appropriate care. The veteran should have recourse either to challenge the VA's denial and understand what their options are outside the VA.
- Homeless veterans often have no access to transportation, especially in rural areas, so care in the community may be the most viable option. Veterans with limited access to transportation or experiencing homelessness should be considered a priority.
- We support federal efforts to ensure that veterans receive care from high-performing community clinicians.
- VA facilities administer comprehensive training to VA staff about the *MISSION Act* and what the law provides for America's veterans.

Thank you for the opportunity to offer our recommendations to improve transparency in the VA healthcare system and remove barriers to care for veterans seeking residential and inpatient behavioral healthcare treatment. We appreciate the Committee's continued focus on this issue and commitment to our nation's veterans.

Shawn Coughlin
NABH President and CEO