Statement of Dr. Kyleanne Hunter

Chief Executive Officer

of

Iraq and Afghanistan Veterans Of America

before the

House Veterans Affairs Subcommittee on Health

July 15, 2025

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Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Committee, thank you for the opportunity to testify today. I come before you today as the CEO of Iraq and Afghanistan Veterans of America (IAVA), the leading voice of the post-9/11 generation of veterans. I am also a public policy researcher who for over a dozen years, has specialized in the physical and mental health care needs of military servicemembers and veterans, and as service-connected disabled veteran myself with complex mental and physical healthcare needs resulting from exposure related cancer, military sexual trauma, and injuries sustained during combat operations.

From all of these perspectives, I know the importance of ensuring that our veterans receive the most effective and highest quality healthcare, and that they receive it in a timely manner, so that they may continue to be of service to this nation out of uniform. I appreciate the commitment of this committee to ensuring that we receive the highest quality of care and that America keeps its promise to care for those who have borne the battle.

The topic of today's hearing - VA Community Care - is an important one, and one that has touched the lives of many post-9/11 veterans in some way. While the VA Community Care program has existed in some form since World War I, it has significantly expanded and changed in scope since the passage of the 2014 CHOICE and 2018 MISSION Acts. This legislation expanded eligibility and access to community care. The Congressional Budget Office (CBO) calculates that between 2014-2020, the number of veterans participating in community care increased by 1,000,000 (from 1.3-2.3 million veterans accessing community care), and the cost of community care has more than doubled (from $7.9-$16.9B).[1] More strikingly, community care costs jumped from approximately $14.9 billion in 2018[2] to $28.5 billion in 2023, with a projected 9.3% increase from FY 2023 to FY 2024.[3]

The most recent Department of Veterans Affairs (VA) budget reflects a significant and increasing allocation towards mandatory community care spending, shifting resources that could otherwise support direct care capabilities. Mandatory spending for community care is projected to rise from $6.74 billion in FY 2024 to $9.77 billion in FY 2025, contributing to an overall community care budget of $33.91 billion in FY 2024 and $40.94 billion in FY 2025.[4] This substantial increase in mandatory community care funding, while intended to expand veteran

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[1]Congressional Budget Office, *The Veterans Community Care Program: Background and Early Effects* (Washington, DC: Congressional Budget Office, October 2021), 12, https://www.cbo.gov/publication/57423.
[2] U.S. Government Accountability Office, *Estimating Resources Needed to Provide Community Care*, GAO-19-478 (Washington, DC: Government Accountability Office, June 2019), https://www.gao.gov/products/gao-19-478.
[3]U.S. Department of Veterans Affairs, *FY 2024 Budget in Brief*, Medical Community Care section (Washington, DC: Department of Veterans Affairs, March 2023), https://www.va.gov/budget/docs/summary/fy2024-va-budget-in-brief.pdf.
[4]U.S. Department of Veterans Affairs, *FY 2025 Budget in Brief* (Washington, DC: Department of Veterans Affairs, March 2024), https://www.va.gov/budget/docs/summary/fy2025-va-budget-in-brief.pdf.

access, raises concerns about its impact on the long-term viability and investment in the VA's integrated direct care system, particularly when juxtaposed with proposed increases in its construction budget.

The VA's proposed FY 2026 Military Construction (MilCon) related budget includes $3.0 billion for VA Construction programs, comprising base discretionary funding and additional support from the Recurring Expenses Transformational Fund.[5] Within this, major construction projects are slated for a significant proposed increase, from $961 million in FY 2025 to $1.87 billion in FY 2026.[6] This investment in infrastructure is critical for the VA's physical capacity; however, the ongoing and pronounced rise in mandatory community care spending at a higher cost to taxpayers continues to present a challenge. Evidence indicates that community care often incurs higher costs due to limited VA oversight and varied local market rates.[7] Reports highlight that this dramatic increase in community care expenses threatens direct care funding and could lead to a "downward spiral" for the VA's internal healthcare system.[8] For example, recent research found that veterans receiving community primary care for diabetes experienced worse quality of care and higher costs compared to those in VA primary care.[9] This dynamic suggests that while construction investments aim to bolster direct care capabilities, the escalating mandatory commitment to community care at potentially higher costs may erode the operational and financial capacity of the VA's core direct care mission over time.

Community care has, and can, provide positive outcomes for some patients,[10] but especially as we consider these rising costs, we need to be clear that the evidence does not bear out community care as a meaningful replacement for VA direct care. VA direct care provides better patient health outcomes, better coordinated and more timely services, and is frequently more cost-effective when compared to community care. Additionally, increased and more effective use of Community Based Outpatient Clinics (CBOCs) may fill in some service gaps for veterans

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[5] U.S. Department of Veterans Affairs, *FY 2026 Budget Submission* (Washington, DC: Department of Veterans Affairs, May 2025), https://department.va.gov/wp-content/uploads/2025/06/2026-Budget-in-Brief.pdf.

[6] U.S. Department of Veterans Affairs, *FY 2026 Budget Submission* (Washington, DC: Department of Veterans Affairs, May 2025), https://department.va.gov/wp-content/uploads/2025/06/2026-Budget-in-Brief.pdf

[7] Congressional Budget Office, *Veterans Community Care Program: costs and effects* (Washington, DC: Congressional Budget Office, October 2021), https://www.cbo.gov/publication/57257.

[8] Ken W. Kizer et al., *The Urgent Need to Address VHA Community Care Spending and Access Strategies: Red Team Executive Roundtable Report* (Washington, DC: U.S. Department of Veterans Affairs, March 30, 2024), https://veteranspolicy.org/wp-content/uploads/2024/05/Red-Team-Executive-Roundtable-Report.pdf.

[9] Yoon J, Chow A, Jiang H, Wong E, Chang ET. Comparing Quality, Costs, and Outcomes of VA and Community Primary Care for Patients with Diabetes. Journal of general internal medicine. 2024 Aug 5.

[10] Garvin, Lynn A., Marianne Pugatch, Deborah Gurewich, Jacquelyn N. Pendergast, and Christopher J. Miller. "Interorganizational care coordination of rural veterans by Veterans Affairs and community care programs: a systematic review." *Medical care* 59 (2021): S259-S269. doi: 10.1097/MLR.0000000000001542.

while ensuring that they receive the benefits of VA direct care. Each of these points will be expanded below.

Community Care is essential in limited situations

Community care must be understood as a critical component of the VA healthcare system, but one that plays an important role only in limited circumstances. To be eligible for community care, at least one of six eligibility requirements must be met:[11]

1. Veteran Health Administration (VHA) facilities do not offer the services that the veteran needs.
2. The veteran resides in a state or territory without a full-service VHA medical facility.
3. The veteran was eligible under provisions that applied before the VA MISSION Act was signed (i.e., they qualify under "grandfathered" eligibility for community care).
4. The care or services that the veteran needs do not meet the access standards for appointment wait times or drive times.
5. A VHA provider and the veteran agree that receiving care from an outside provider is in the veteran's best interest.
6. The care or services that the veteran needs do not meet designated quality standards.

Veterans who meet these requirements have benefited from increased access to care in a timely and high-quality manner. This is most evident for veterans who live in rural or remote areas, for whom it would be time-prohibitive to travel to a direct care facility[12] for primary care or preventative medicine. Community care allows them to attend necessary and regularly scheduled appointments in a manner that reduces disruptions to their lives and ensures access to healthcare.

Additionally, some specialty care has a narrow focus or serves a small population and is therefore not efficient or cost-effective for the VA to retain. For example, specialties such as oral and maxillofacial plastic surgery, ocular oncology, and vascular surgery, with the limited number of specialists across the US, the highly specialized equipment, and the limited number of cases requiring such specialty care, are ideal for community care. Labor and delivery services, as well as several assisted reproductive healthcare technologies, for which VA centers are not equipped, are other notable positive use cases of community care.

[11] Rasmussen, Petra, and Carrie M. Farmer. "The promise and challenges of VA community care: veterans' issues in focus." *Rand Health Quarterly* 10, no. 3 (2023): 9.

[12] For the purposes of this testimony, VA direct care facilities are defined as VA medical centers, VA clinics, VA Community Based Outpatient Clinics, and VA administered tele-health appointments.

VA Direct Care is essential for most needs of the post-9/11 veterans

Outside of the limited scope I just outlined, the truth is that the vast majority of the needs of the post 9/11 generation of veterans are best met by VA direct care. The post-9/11 generation is the most diverse and the fastest growing generation of veterans. Key policy changes, such as full desegregation of the military, the repeal of Don't Ask, Don't Tell, and the inclusion of women in ground combat units mean that the veteran population of today looks far different than that of even 25 years ago. Women, for example, are the fastest growing veteran population. PEW projections show that women, who made up less than 4% of the veteran population in 2000 will become nearly 20% of the veteran population by 2040 - a 5x increase.[13] Women veterans have uniquely *more* positive outcomes when using VA direct care as opposed to community care, both in terms of health outcomes and individual satisfaction.[14] Yet this population is also uniquely burdened by challenges in access to any care, at a time when the population needs it most.[15]

These same projections show that the proportion and number of veterans that served during war time will continue to rise over the next 25 years, due both to retirement or separation of those who served during the last years of America's longest war, and the passing of the previous generation of peacetime veterans. And we know that war veterans not only are more likely to have unique injuries that require long-term specialty care, but also need to be continually screened for cumulative exposure related injuries and illnesses, screenings that community providers may not be equipped to provide.[16]

The need for culturally competent veteran focused care is of more urgency as injuries sustained by service members in Iraq and Afghanistan are unique when compared to previous conflicts,

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[13] Katherine Schaeffer, "The Changing Face of America's Veteran Population," *Pew Research Center*, November 8, 2023, https://www.pewresearch.org/short-reads/2023/11/08/the-changing-face-of-americas-veteran-population/.

[14] Agnes C. Mog et al., "You Want People to Listen to You: Patient Experiences of Women's Healthcare within the Veterans Health Administration," *Health Services Research* 59, no. 6 (2024): e14324, https://doi.org/10.1111/1475-6773.14324.

[15] Tanya T. Olmos-Ochoa et al., "Challenges to Engaging Women Veterans in Quality Improvement From Patient Care to Policy: Women's Health Managers' Perspectives," *Women's Health Issues* 33, no. 2 (2023): 199–207, https://doi.org/10.1016/j.whi.2022.08.004.

[16] Daria L. Waszak and Aline M. Holmes, "The Unique Health Needs of Post-9/11 US Veterans," *Workplace Health & Safety* 65, no. 9 (2017): 430–44.
Evelyn T. Chang et al., "Use of General Primary Care, Specialized Primary Care, and Other Veterans Affairs Services Among High-Risk Veterans," *JAMA Network Open* 3, no. 6 (2020): e208120, https://doi.org/10.1001/jamanetworkopen.2020.8120.
L. D. VanTil et al., "Risk Screening of Veterans Throughout the Life Course," *Military Behavioral Health* 10, no. 1 (2022): 17–26, https://doi.org/10.1080/21635781.2021.2003378.

and these injuries often require specialized care and medical training not available outside of most VHA facilities.

- A 2023 analysis of combat-related injuries sustained in Iraq and Afghanistan found that over 75% of those whose injuries received an Injury Severity Score (ISS) of 9 or higher were accompanied by a significant blast event in conjunction with their traumatic event.[17] Blast events carry an increased risk of Traumatic Brain Injury (TBI), as well as sleep disruptions, hormonal changes, mental health changes, and increased risks of other neurological conditions. These conditions most often do not present acutely along with the trauma, but emerge in subsequent years, and significantly evolve in the way they present in patients.[18]
- Such complex injuries require not only specialized care, but specialized medical training to understand the cumulative and interactive impacts of the compound traumas and exposures on a given condition.[19]

Post-9/11 veterans are more likely to experience interrelated mental and physical health care conditions, and VA direct care providers are specially trained to understand the interrelated health care needs of combat veterans.

- Nearly a quarter of veterans have a formal post traumatic stress disorder diagnosis, and significantly more report symptoms even if not formally diagnosed.[20]
- Over 40% of female veterans report having experienced military sexual trauma (MST), and the number is slightly higher for those who have deployed to Iraq or Afghanistan.[21]

IAVA members have expressed their concerns about the ability of VA community care to meet the needs of the post-9/11 generation of veterans.

- In our most recent membership survey, only 31% of IAVA members who had experience with VA community care felt that their providers understood their medical needs.

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[17] E. W. D'Souza et al., "Combat Injury Profiles Among US Military Personnel Who Survived Serious Wounds in Iraq and Afghanistan: A Latent Class Analysis," *PLOS ONE* 17, no. 4 (2022): e0266588, https://doi.org/10.1371/journal.pone.0266588.

[18] Hilary Phipps et al., "Characteristics and Impact of U.S. Military Blast-Related Mild Traumatic Brain Injury: A Systematic Review," *Frontiers in Neurology* 11 (November 2, 2020): 559318, https://doi.org/10.3389/fneur.2020.559318.

[19] Bryann B. DeBeer et al., "The Association Between Toxic Exposures and Chronic Multisymptom Illness in Veterans of the Wars of Iraq and Afghanistan," *Journal of Occupational and Environmental Medicine* 59, no. 1 (2017): 54–60.
Jessica L. Morse et al., "Associations Among Environmental Exposures and Physical and Psychiatric Symptoms in a Care-Seeking Sample of US Military Veterans," *Military Medicine* 189, no. 7–8 (2024): e1397–e1402.

[20] U.S. Department of Veterans Affairs, *PTSD: National Center for PTSD Fact Sheet*, accessed July 11, 2025, https://www.ptsd.va.gov/understand/common/common_veterans.asp.

[21] Shannon K. Barth et al., "Military Sexual Trauma Among Recent Veterans: Correlates of Sexual Assault and Sexual Harassment," *American Journal of Preventive Medicine* 50, no. 1 (January 2016): 77–86, https://doi.org/10.1016/j.amepre.2015.06.012.

- Only 14% reported that they felt confident in the ability for the VA and community care providers to effectively coordinate care as a team.[22]

I am sure we all agree here that we can and must do better for our veterans. As I will outline below, VA direct care results in better patient outcomes, overall cost savings, and increased coordination in care that reduces brudens on patients and increases overall satisfaction. It is for these reasons that while we are discussing community care, we cannot do it at the expense of VA direct care. Indeed if we are to give veterans a choice, we must not remove their ability to choose VA.

Better Patient Outcomes

Care for the veteran should be the sole focus of the VA. Secretary Collins has repeatedly stated that he desires to put veterans back at the center of the VA. If he is to do this, he must invest in VA direct care, as the evidence is clear that VA direct care has better patient outcomes. I will discuss three distinct and essential areas in which VA direct care has far better patient outcomes than community care - patient wait times, overall health outcomes, and screenings for conditions caused by compound exposures and traumas.

Wait times

I would like to talk for a moment about something that comes up often when I'm having conversations with our generation of veterans, and has been at the center of community care discussions — wait times. This is not about convenience or hassle. Patient outcomes and wait times are connected. Prolonged wait times are associated with deteriorating health outcomes among multiple dimensions, particularly for primary and preventative care.[23] The VA waitlist scandals of 2014 led to a persistent culture of distrust in VA care and transparency.[24] In the intervening decade, the VA has made significant changes that have reduced wait times, improved overall quality of care as compared to non-VA care. The VA has also expanded access to physical and mental healthcare for veterans of all generations. By the end of Fiscal Year 24, 92% of veterans reported trusting that they would get the most timely and effective care from the VA.[25] However, one or two cases of dissatisfaction with wait times continue to dominate the conversation. While every case of dissatisfaction must be taken seriously, the data

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[22]Allison J. Pritchard, Stephanie Powell, and Tana Horr, *2022 IAVA Membership Survey* (New York: Iraq and Afghanistan Veterans of America and Syracuse University D'Aniello Institute for Veterans and Military Families, 2022).
[23] Astrid Reichert and Rowena Jacobs, "The Impact of Waiting Time on Patient Outcomes: Evidence from Early Intervention in Psychosis Services in England," *Health Economics* 27, no. 11 (2018): 1772–1787, https://doi.org/10.1002/hec.3800.
[24] Alyson L. Jones et al., "National Media Coverage of the Veterans Affairs Waitlist Scandal: Effects on Veterans' Distrust of the VA Health Care System," *Medical Care* 59, suppl. 3 (June 1, 2021): S322–S326, https://doi.org/10.1097/MLR.0000000000001551.
[25]U.S. Department of Veterans Affairs, *PACT Act Dashboard*, issue 42 (October 18, 2024), https://www.va.gov/resources/the-pact-act-and-your-va-benefits/#dashboard.

simply do not bear out that the VA is underperforming. As I was reminded many times during my doctoral training, the plural of anecdote is not data, and to provide the best quality care we must follow the data.

The VA does not have control over wait times for community care, and struggles to have effective and integrated coordination between direct and community care providers. And while wait times for both VA direct care and community care have on average decreased, by 2018 wait times for direct care, particularly for specialty care, were significantly less than wait times for that same care in the community.[26] Additional research on specialized veterans' needs found that at this point both wait times and outcomes were worse for community care than VA direct care across the country, and that for veterans in rural areas in many specialties there were no specialty care providers who had the ability to integrate records to coordinate with a VA primary care or Patient Aligned Care Teams.[27] This lack of integration extends beyond specific physical health specialties, with documented deficiencies in mental health care where community care has been associated with lower veteran satisfaction and higher suicide rates, partly due to community providers lacking military cultural competency and proper coordination of medication management or crisis planning.[28] Furthermore, for chronic conditions like diabetes, veterans receiving community primary care have demonstrated worse diabetes care quality and higher costs compared to those treated within the VA.[29] These coordination gaps are exacerbated by significant challenges in health record continuity, with VA Inspector General reports revealing instances of delayed cancer diagnoses due to community care staff failing to retrieve critical records and systemic issues with information exchange platforms leading to patient harm from

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[26] Deborah Gurewich, Michael Shwartz, Erin Beilstein-Wedel, Heather Davila, and Amy K. Rosen, "Did Access to Care Improve Since Passage of the Veterans Choice Act? Differences Between Rural and Urban Veterans," *Medical Care* 59, suppl. 3 (June 2021): S270–S278, https://doi.org/10.1097/MLR.0000000000001534.

[27] Bhavika Kaul, Denise M. Hynes, Alex Hickok, Connor Smith, Meike Niederhausen, Annette M. Totten, Mary A. Whooley, and Kathleen Sarmiento, "Does Community Outsourcing Improve Timeliness of Care for Veterans with Obstructive Sleep Apnea?" *Medical Care* 59, no. 2 (February 2021): 111–117, https://doi.org/10.1097/MLR.0000000000001446.

[28] U.S. Government Accountability Office, *VA Health Care: Management Attention Needed to Address Challenges with Community Care*, GAO-20-403 (Washington, DC: Government Accountability Office, 2020).
The American Legion, "EHRM, VA-DoD Interoperability and Quality of Care," 2023, https://www.legion.org/veteranshealthcare/258909/ehrm-va-dod-interoperability-and-quality-care.
Allison C. Weimer, Chad J. Miller, and Emily Smith, "Mental Health Care for Veterans in the Community: A Qualitative Study of Veterans' Perspectives," *Psychiatric Services* 72, no. 11 (2021): 1324–1331, https://doi.org/10.1176/appi.ps.202000683.

[29] Department of Veterans Affairs, Health Services Research & Development, "Briefs: Veterans with Diabetes Receiving Community Primary Care Had Worse Diabetes Care Quality and Higher Costs than Veterans Receiving VA Primary Care," 2022, https://www.hsrd.research.va.gov/research/briefs/22-02-brief.pdf.

missed diagnoses and unaddressed medical issues.[30]

Overall health outcomes

When compared to community care received in non-VA facilities, direct care received at the VA has markedly better patient outcomes. This includes a significantly lower post-surgical 28-day mortality rate, lower hospital readmission rates, and quicker post-hospitalization return to work rates.[31] When directly compared, the VA is also exceptionally better at screening for cancers and chronic respiratory and pulmonary diseases than VA-funded community care.[32] This is of particular importance for the post-9/11 generation, as exposure related cancers and chronic respiratory conditions are on the rise, and veterans face a higher instance rate of multiple chronic conditions than age matched civilians.[33]

Additionally, VA hospitals consistently outperform non-VA hospitals in CMS quality ratings, with 67% of VA facilities receiving 4 or 5 stars compared to 41% of non-VA hospitals, and VA patients report higher satisfaction across all 10 core HCAHPS metrics.[34] More critically, for our most vulnerable veterans, the disparity in outcomes is stark: a 2024 VA report revealed that the suicide rate for Veterans who received any VA-funded Community Care services was 50.9 per 100,000, significantly higher than the 41.3 per 100,000 for those receiving any VHA care.[35] Furthermore, studies show that older veterans (65+) hospitalized with COVID-19 in community

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[30] U.S. Department of Veterans Affairs, Office of Inspector General, *Delayed Diagnosis and Treatment for a Patient's Lung Cancer and Deficiencies in the Lung Cancer Screening Program at the VA Eastern Colorado Health Care System*, Report No. 22-00440-230 (Washington, DC: Department of Veterans Affairs, 2022).
U.S. Government Accountability Office, *VA Health Care: Management Attention Needed to Address Challenges with Community Care*, GAO-20-403 (Washington, DC: Government Accountability Office, 2020).

[31] Jungwon Yoon, Ciaran S. Phibbs, Melissa K. Ong, Megan E. Vanneman, Amy Chow, Angela Redd, Kenneth W. Kizer, Mayur P. Dizon, Edward Wong, and Yingjun Zhang, "Outcomes of Veterans Treated in Veterans Affairs Hospitals vs Non-Veterans Affairs Hospitals," *JAMA Network Open* 6, no. 12 (December 1, 2023): e2345898, https://doi.org/10.1001/jamanetworkopen.2023.45898.

[32] Elham A. Apaydin, Natalie M. Paige, Mekdes M. Begashaw, Jenny Larkin, Isomi M. Miake-Lye, and Paul G. Shekelle, "Veterans Health Administration (VA) vs. Non-VA Healthcare Quality: A Systematic Review," *Journal of General Internal Medicine* 38, no. 9 (July 2023): 2179–2188, https://doi.org/10.1007/s11606-023-08207-2.

[33] Peter Boersma, Robin A. Cohen, Carla E. Zelaya, and Eric Moy, "Multiple Chronic Conditions Among Veterans and Nonveterans: United States, 2015–2018," *National Health Statistics Reports*, no. 158 (April 7, 2021), https://www.cdc.gov/nchs/data/nhsr/nhsr158-508.pdf.

[34] A News, "VA Hospitals Outperform Non-VA Hospitals in Quality Ratings and Patient Satisfaction," accessed July 11, 2025, https://news.va.gov/98528/va-hospitals-outperform-non-va-hospitals-quality-ratings-patient-satisfaction/.

[35] VA Mental Health, "2024 National Veteran Suicide Prevention Annual Report, Part 1 of 2," accessed July 11, 2025, https://www.mentalhealth.va.gov/suicide_prevention/docs/National_Veteran_Suicide_Prevention_Annual_Report_2024_Part_1_of_2_FINAL.pdf.

facilities faced a 37% higher risk-adjusted mortality rate compared to those in VHA facilities,[36] and VA hospitals demonstrated a 20.1% lower adjusted 30-day mortality rate after emergency visits for veterans aged 65 or older, with even larger advantages for Black (-25.8%) and Hispanic (-22.7%) patients.[37] These findings underscore that while community care plays an essential role in expanding access, the integrated, specialized, and culturally competent care provided by VA facilities often leads to superior health outcomes, particularly for veterans with complex needs, mental health conditions, and those from minority or older demographics.[38]

Major medical association groups have submitted official statements to the record in previous oversight hearings on VA community care citing their concerns about the lack of quality standards present in community care.[39] In it, they highlight that the transparent quality standards required by section 1703 of the MISSION act have yet to be set, and that there is no enforcement mechanism to ensure that community care providers would be meeting the standards once they are. A lack of quality standards means that we are exposing our veterans to substandard care, resulting in worse outcomes. As a specific example, they note that the VA Inspector General found that there was no oversight provision or quality standard set for community care providers who were prescribing opioids to veterans, a population that experience higher levels of addiction risk factors than the general population.[40] The lack of screening oversight is a clear violation of VA contracts and in many instances state law, yet

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[36] *US Medicine*, "COVID Mortality Rates Higher for Older Veterans Hospitalized in the Community," accessed July 11, 2025, https://www.usmedicine.com/articles/covid-mortality-rates-higher-for-older-veterans-hospitalized-in-the-community/

[37] Kaveh Chan et al., "Mortality among US Veterans after Emergency Visits to Veterans Affairs and Other Hospitals: Retrospective Cohort Study," *BMJ* 376 (February 16, 2022): e068099, https://doi.org/10.1136/bmj-2021-068099.

[38] Megan E. Vanneman et al., "Experiences With VA-Purchased Community Care for US Veterans With Mental Health Conditions," *JAMA Network Open* 8, no. 5 (May 1, 2025): e2511548, https://doi.org/10.1001/jamanetworkopen.2025.11548.
journals.lww.com+8pmc.ncbi.nlm.nih.gov+8hsrd.research.va.gov+8

Megan E. Vanneman, Thomas H. Wagner, Michael Shwartz, Michelle Meterko, Jeffrey Francis, Charles L. Greenstone, and Amal K. Rosen, "Veterans' Experiences With Outpatient Care: Comparing The Veterans Affairs System With Community-Based Care," *Health Affairs* 39, no. 8 (August 2020): 1368–1376, https://doi.org/10.1377/hlthaff.2019.01375.

PMC, "Experiences With VA-Purchased Community Care for US Veterans With Mental Health Conditions," accessed July 11, 2025, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8905870/.

[39] American Psychological Association et al., *Multi-Organizational Statement for the Record*, Senate Committee on Veterans Affairs hearing on "Protecting Veteran Choice: Examining the VA Community Care Program," January 28, 2025.

[40] U.S. Department of Veterans Affairs Office of the Inspector General, *Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans*, report no. 22-00414-113 (Washington, DC: VA OIG, September 26, 2023), https://www.vaoig.gov/sites/default/files/reports/VAOIG-22-00414-113.pdf

there have been no moves to ensure quality standards are met, all while veterans are the ones who suffer.

Screening for delayed onset - PACT Act learnings

The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act, has been instrumental in codifying the recognition of delayed onset conditions and expanding eligibility and access to VA care for millions of veterans, leading to a surge in screenings and care for those who were exposed to burn pits, Agent Orange, and other harmful substances.[41] This means we are now actively identifying and treating illnesses that may have been silently developing for years. Given the unique, complex, and often multi-system nature of conditions arising from military cumulative exposures, the need for robust investment specifically in VA direct care is paramount. The VA's integrated system and specialized expertise in understanding military exposures are uniquely positioned to manage these intricate cases, which often do not fit neatly into community care models. There is still significant research that must be done to track the outcomes for these patients with complex needs, yet early research shows that VA teams are able to identify potential markers for exposure related conditions at a better rate than community providers.[42] As the demographic shift continues, with a larger proportion of veterans requiring extensive long-term and specialized care for both age-related and service-connected toxic exposure illnesses, the demand for VA services will only intensify, underscoring the urgent need for sustained and robust investment in the Veterans Health Administration's direct care capabilities to ensure we can meet the evolving healthcare needs of those who have so bravely served our country.

Lower cost

VA direct care doesn't just provide better patient outcomes; it ultimately provides cost savings to the US government. Recent analysis by the National Bureau of Economic Research found that for inpatient specialty services, VA direct care had a 21% overall cost savings to the

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[41]U.S. Department of Veterans Affairs, "The PACT Act and Your VA Benefits," accessed July 11, 2025, https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.
U.S. Department of Veterans Affairs, "In Two Years of the PACT Act, VA Has Delivered Benefits and Health Care to Millions of Toxic-Exposed Veterans and Their Survivors," *VA News*, August 9, 2024, https://news.va.gov/press-room/in-two-years-of-the-pact-act-va-has-delivered-benefits-and-health-care-to-milions-of-toxic-exposed-veterans-and-their-survivor/.

[42]Janeen H. Trembley et al., "Veterans Affairs Military Toxic Exposure Research Conference: Veteran-centric Approach and Community of Practice," *Military Medicine*, published online December 14, 2024, doi:10.1093/milmed/usae558.

government as compared to community care when adjusted for the 28-day cost of care average.[43]

More patients = more cost savings with direct care

As the veteran population ages, their need for access to specialty care will only increase. The PACT Act has shed a light on just how many more veterans may be needing this type of complex care. Over 6 million veterans have begun the screening process for toxic exposure, and over 4 million are enrolled in the planning process for VA care.[44] And as a result we have seen a rise in demand for VA care. In fiscal year 2023, the Department of Veterans Affairs delivered an impressive 116 million healthcare appointments to our veterans. This past fiscal year, 2024, we saw an even more significant increase, with the VA providing over 130 million healthcare appointments, marking a substantial 7% year-over-year rise.[45] This upward trend in "episodes of care" is not merely a statistic; it is a direct reflection of our aging veteran population, many of whom are facing complex, chronic health conditions that necessitate more frequent and comprehensive medical attention. Furthermore, a significant driver of this increased demand, and a profound challenge we must continue to address, stems from the long-term health consequences of toxic and cumulative environmental exposures during military service. As we know, conditions like respiratory illnesses, cancers, and other systemic disorders often manifest after considerable latency periods – sometimes decades – making the connection to service-related exposures difficult to ascertain.[46] However, as noted above, VA direct care providers are able to identify these conditions at a better rate than community care

[43] David C. Chan, David Card, and Lowell Taylor, "Is There a VA Advantage? Evidence from Dually Eligible Veterans," *American Economic Review* 113, no. 11 (November 2023): 3003–3043, https://doi.org/10.1257/aer.20211638.
[44] U.S. Department of Veterans Affairs, *PACT Act Performance Dashboard*, Issue 42 (October 18, 2024), accessed July 11, 2025, https://department.va.gov/pactdata/interactive-dashboard/.
[45] U.S. Department of Veterans Affairs, "VA Delivered All-Time Record Care and Benefits to Veterans in Fiscal Year 2024," *VA News*, October 26 2024, https://news.va.gov/press-room/va-delivered-all-time-record-care-and-benefits-to-veterans-in-fiscal-year-2024/.
U.S. Department of Veterans Affairs, *VHA 2024 Annual Report: VA Health Care—A Strong Foundation. A Healthy Future*, accessed July 11 2025, https://www.va.gov/health/docs/vha-annual-report-2024.pdf.

[46]Institute of Medicine (US) Committee to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides (Second Biennial Update), *Veterans and Agent Orange: Update 1998* (Washington, DC: National Academies Press, 1999), chap. 8, "Latency and Cancer Risk," https://www.ncbi.nlm.nih.gov/books/NBK230783/.
U.S. Department of Veterans Affairs, "Military Environmental Exposures Pocket Card," War Related Illness and Injury Study Center, accessed July 11, 2025, https://www.warrelatedillness.va.gov/WARRELATEDILLNESS/education/factsheets/Military-Environmental-Exposures-Pocket-Card.pdf.

providers. Earlier detection further reduces the cost of care.[47] As more patients seek complex care that is reliant on early detection, the cost savings from VA direct care will only increase.

Pricing standards

Community care charges for services such as imaging and lab testing are not standardized.[48] VA direct care gains efficiencies through using its own specialty equipment, and over time the cost per patient declines. However, community providers are not required to set standard pricing models, resulting in varying costs for specialty care which are beyond VA control.

Integrated care reduces costs

The VA direct care integrated, whole health approach to healthcare further reduces costs. In a side by side comparison with private sector care, VA patients who received direct care from a VA facility had a 12-24% year-over-year primary and preventative health care cost savings in every category except prescription drugs, where they have a 5% cost saving.[49] Additionally contributing to overall cost savings, veterans receiving direct care experienced some really staggering improved outcomes that also save costs— 43% fewer hospital admissions, 58% fewer days spent in the hospital, and 43% fewer outpatient surgical procedures than age, gender and preexisting condition matched peers who received private sector care.[50]

Effective Coordinated Care

VA care is unique in its ability to coordinate between primary care and specialists. The VA's Patient Aligned Care Teams integrate primary care, specialty care, mental health care, and other aspects of a veterans health and well-being (such as substance abuse counseling, and programs to access food and housing) in an integrated, veteran centered fashion.[51] The Patient Aligned Care Teams concept also has led to reduced wait times to see a provider, as care teams are integrated and in continual communication. The integrated scheduling and coordination further reduce burdens on the veteran for scheduling or managing their own care.

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[47] Rina Setyawati, Aldiana Astuti, Tyas Putri Utami, Saputra Adiwijaya, and Dadang Muhammad Hasyim, "The Importance of Early Detection in Disease Management," *Journal of World Future Medicine, Health and Nursing* 2, no. 1 (February 2024): 51–63, https://doi.org/10.55849/health.v2i1.692.
[48] Congressional Budget Office, *The Veterans Community Care Program: Background and Early Effects* (Washington, DC: Congressional Budget Office, October 26, 2021), https://www.cbo.gov/publication/57257.
[49] Wayne Jonas, *The Case for Delivering Whole-Person Care: High-Quality, Cost-Effective Health Care for Stronger Health Systems* (Santa Monica, CA: Samueli Foundation, February 2022), https://healingworksfoundation.org/wp-content/uploads/2022/02/Whole-Person-Business-Case2022.pdf.
[50] Ibid
[51] U.S. Department of Veterans Affairs, "Patient Care Services: Patient Aligned Care Team," accessed July 11, 2025, https://www.patientcare.va.gov/primarycare/PACT.asp#:~:text=A%20PACT%20uses%20a%20team,team%20may%20be%20called%20in.

Lack of coordination or integration of care can result in missed diagnoses, delays in treatment, and increased wait time for patients. Community care was meant to fill in gaps, not be the primary source of care.

Even when community care is used, the VA still should play a primary role in being the care coordinator and community care should only be accessed when the necessary conditions are met, not as a matter of convenience. As multiple independent agencies noted in their statement for the record earlier this year, the continued diversion of funds from VA direct care to private sector payments ultimately results in *fewer* healthcare options for veterans, while placing a higher burden on veterans to receive care because the essential coordinators are cut out of the loop.[52]

It comes down to this. The VA system was built with the veteran as its heart. Private sector medical care has been built on a system of profit maximization. These two systems may be at odds when it comes to veteran outcomes; their philosophies and models of care are that different. This is born out in the evidence. Recent studies found that community care providers frequently administered high-cost and medically unnecessary procedures to veterans in order to maximize the money received from the government.[53] This was done most often without coordination with the veteran's Patient Aligned Care Team, exposing the veteran to unnecessary treatment without medical benefit, while costing the government more money.

The importance of coordinating care and having providers with appropriate cultural competency and training is evident in patient satisfaction with community care. In surveys of patient satisfaction, veterans with complex cases, particularly those that involved a mental health diagnosis, reported significantly lower satisfaction with community care as compared to VA direct care.[54] This was most pronounced in their lack of satisfaction with the ability to communicate effectively with their provider about their medical needs, and the coordination between mental and physical healthcare.

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[52] American Psychological Association et al., *Multi-Organizational Statement for the Record*, Senate Committee on Veterans Affairs hearing on "Protecting Veteran Choice: Examining the VA Community Care Program," January 28, 2025.
[53] Brett A. Erickson, Ryan M. Hoffman, Jacob Wachsmuth, Vipul T. Packiam, and M. S. Vaughan-Sarrazin, "Location and Types of Treatment for Prostate Cancer After the Veterans Choice Program Implementation," *JAMA Network Open* 6, no. 10 (October 2023): e2338326, https://doi.org/10.1001/jamanetworkopen.2023.38326.
[54] Megan E. Vanneman et al., "Experiences With VA-Purchased Community Care for US Veterans With Mental Health Conditions," *JAMA Network Open* 8, no. 5 (May 1, 2025): e2511548, https://doi.org/10.1001/jamanetworkopen.2025.11548.

Community Based Outpatient Clinics - An opportunity for expanded care access worthy of investment

It has been well established that VA direct care is superior to community care on a number of dimensions. However, there remains the question of the need for care in areas where it is difficult for veterans to get to one of the 170 VA medical centers. VA run Community Based Outpatient Clinics (CBOCs) provide a viable option that should be expanded upon and invested in, yet they are too often misunderstood and misrepresented. CBOCs were established in the mid-1990s to expand direct VA primary care in areas geographically distinct from main VA hospitals.[55] CBOCs provide primary care, some preventative medicine service, mental health care, and may include regular visits from some specialists, primarily ophthalmology and geriatric medicine.[56] CBOCs were never intended to be specialty care providers or provide prolonged or extensive inpatient care. However, anecdotal complaints about the VA have often centered around the lack of specialty or inpatient services available at these locations.

It is important to differentiate the role of CBOCs in expanding access to care. While many CBOCs are strategically located in smaller towns and cities to bring VA services closer to Veterans, they typically serve areas with a certain population density that can support their operations. For Veterans residing in truly rural and remote locations, where the establishment of a CBOC may not be feasible due to geographic isolation or sparse population, community care often becomes the primary or only viable option for accessing necessary healthcare services, as outlined by the VA's own guidelines on community care eligibility for rural Veterans.[57]

CBOCs have provided vital care for veterans,[58] but can be further utilized to improve care, especially for the post-9/11 generation of veterans. The Independent Budget veterans service organizations (IBVSOs) highlight areas where the role of CBOCs is currently underutilized and can be significantly enhanced.[59] Better utilizing CBOCs may result in more veterans receiving

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[55] Michael K. Chapko et al., "Evaluation of the Department of Veterans Affairs Community-Based Outpatient Clinics," *Medical Care* 40, no. 7 (July 2002): 555–560, https://doi.org/10.1097/00005650-200207000-00001.

[56] Camilla B. Pimentel et al., "The Role of Department of Veterans Affairs Community-Based Outpatient Clinics in Enhancing Rural Access to Geriatrics Telemedicine Specialty Care," *Journal of the American Geriatrics Society* 72, no. 2 (February 2024): 520–528, https://doi.org/10.1111/jgs.18703

[57] U.S. Department of Veterans Affairs, "Community Care – Eligibility for Rural Veterans," accessed July 11, 2025, https://www.va.gov/communitycare/pubs/factsheets/eligibility-rural-veterans.pdf.

[58] Camilla B. Pimentel et al., "The Role of Department of Veterans Affairs Community-Based Outpatient Clinics in Enhancing Rural Access to Geriatrics Telemedicine Specialty Care," *Journal of the American Geriatrics Society* 72, no. 2 (February 2024): 520–528, https://doi.org/10.1111/jgs.18703.
Michael K. Chapko et al., "Evaluation of the Department of Veterans Affairs Community-Based Outpatient Clinics," *Medical Care* 40, no. 7 (July 2002): 555–560, https://doi.org/10.1097/00005650-200207000-00001.

[59]The Independent Budget veterans service organizations (Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars), *The Independent Budget: Fiscal Years 2026 and 2027 for the Department of Veterans Affairs* (Washington, DC: The Independent Budget veterans

the benefits of VA direct care, reduced costs to the government, and increased veteran patient satisfaction.

Recommendations for Better Utilizing CBOCs:

- **Expand Mental Health Staffing**: The IBVSOs recommend that VA aggressively recruit and retain mental health providers, care coordinators, and administrative support staff.[7] Specifically, they call for the addition of mental health providers in every VA medical center (VAMC) and CBOC. This aims to address the rising demand for mental health services, with an 8.7% growth in veterans enrolling in VHA care for mental health since the PACT Act, and ensure timely, high-quality mental health care within a competitive medical market. For FY 2026, the IBVSOs recommend adding 1,000 mental health personnel at an approximate cost of $154 million.

- **Increase Women's Health Capabilities**: To meet the needs of the growing population of women veterans, who represent more than 30% of the increase in enrolled veterans over the past five years, the IBVSOs recommend that there should be a women's primary care health provider at every CBOC. This is part of a broader recommendation for an overall investment of $190 million in FY 2026 to meet the current and future health care needs of this growing population, with $130 million allocated to Medical Services. The funding is intended to recruit and train more clinical providers with expertise in gender-specific care, addressing attrition, increasing demand for services, and improving access to care for women veterans.

- **Enhance Dental Care Capacity**: VA's current dental care program is constrained by the lack of clinical personnel and treatment space, which has driven up spending on community dental care contracts. To address this, the IBVSOs recommend appropriating an additional $75 million for minor construction to expand and modify treatment space in existing VA facilities, which would include CBOCs, and to support additional leased space. This aligns with the IBVSOs' broader recommendation in the Medical Services section to increase staffing in VA's currently authorized programs to expand dental care to all enrolled veterans.

- **Reinstate and Support Self-Service Kiosks for Transportation**: While not exclusively for CBOCs, the IBVSOs recommend that every VA health care facility and CBOC have at least one fully functioning kiosk. This would require an estimated $15 million in additional funding for VA's FY 2026 budget. The previous online and application-based system (BTSSS), introduced in 2020, has proven problematic for veterans and staff, with veterans using BTSSS for just 49% of all claims through mid-2022 and only 17% of claims automatically decided from February 2021 through July 2022. Reinstating accessible

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service organizations, February 2025), https://independentbudget.org/wp-content/uploads/2025/02/IB_FY26_27_D7_w.pdf

kiosks at CBOCs would enhance convenience and ensure veterans can easily file for reimbursement of travel expenses, thus better utilizing transportation support for accessing care at these local clinics.

By focusing on these targeted expansions and improvements, especially in staffing and infrastructure for primary care, mental health, and specific services like women's and dental care, CBOCs can more fully realize their designed role and reduce the current underutilization of their critical function in the VA healthcare system.

Conclusion

It should be clear now that while community care has a role in veteran health care, it cannot and should not replace the superior treatment veterans receive with VA direct care. Community care is best used as it was originally intended — in remote and rural areas where healthcare options are limited, and in locations where unique specialists and infrequently used equipment are required and would not be cost effective for the VA to directly own and maintain. For the majority of veterans healthcare needs, the evidence presented above indicates that VA direct care provides better care coordination, costs less, and leads to better patient outcomes.