Testimony Before the U.S. House Subcommittee on Health of the Committee on Veterans Affairs

Hearing: "Right Time, Right Place, Right Treatment with VA Community Care"

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Chairman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, thank you for the opportunity to testify today.

It's an honor to speak on an issue that is both deeply personal and profoundly consequential.

My name is Meaghan Mobbs, and I sit before you as the Director for the Center of American Safety and Security at Independent Women. I am a combat veteran and former Army officer, as well as a clinical psychologist whose research has focused on trauma, transition stress, and post-military reintegration. I completed my internship in the VA system and currently teach under the Veterans Mental Health–Primary Care Training Initiative through the New York State Psychiatric Association. That program trains physicians and hospital-based clinicians across New York State to identify, treat, and appropriately refer veterans in civilian care settings—because, too often, providers fail to recognize the cultural and clinical complexities that define military and post-military life.

I've been on every side of this system: as a soldier, as a clinician, as an educator, and as someone who has walked beside my fellow veterans—men and women—struggling to navigate the bureaucracy meant to serve them.

In 2018, when President Donald Trump signed the bipartisan VA MISSION Act, it wasn't just legislation, it was a solemn promise: that what happened at the Phoenix VA, where veterans died waiting for care, would never happen again.[1]

The VA Community Care Program was born of that promise. It was built on the understanding that the VA, while indispensable, is not omnipresent.[2] That in too many places, at too many times, bureaucracy has stood where medical support should have. The Community Care Program was designed to bridge that gap.

It was a direct response to bureaucratic failure, not a detour around it. It put the focus where it belongs: on outcomes, not process; on veterans, not institutions.

The VA Community Care Program is not just helpful, it is essential. It is a critical tool that helps us uphold our moral and national obligation to veterans.

But that promise has not been fully realized.

The Reality We Face

In 2001, as America entered the Global War on Terror, the VA Hospital Administration received $20.9 billion in funding.[3] That same year, we lost 16.5 veterans a day to suicide.

In 2024, after nearly two decades of war and massive federal investment, the VA now receives $121 billion, a 479% increase.

And yet, at the end of last year, the VA reported the suicide rate at 17.6 veterans a day.[4] Of note, this figure is from 2022, as there is a significant data lag in veteran suicide statistics reporting.

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[1] Sen. Johnny Isakson. John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson. "VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act of 2018)." *115th Congress*, S. 2372. Introduced Feb. 5, 2018; enacted June 6, 2018 (Public Law No. 115-182). https://www.congress.gov/bill/115th-congress/senate-bill/2372/.

[2] Department of Veterans Affairs. "VA Makes It Easier for Veterans to Use Community Care." *Wilmington VA Medical Center*, May 19, 2025. https://www.va.gov/wilmington-health-care/news-releases/va-makes-it-easier-for-veterans-to-use-community-care/.

[3] Department of Veterans Affairs. "Administration Seeks Record VA Budget Increase." *VA News*, Feb. 7, 2000. https://news.va.gov/press-room/administration-seeks-record-va-budget-increase/.

[4] Department of Veterans Affairs. "VA Releases 2024 National Veteran Suicide Prevention Annual Report." *VA News*, Dec. 19, 2024. https://news.va.gov/137221/va-2024-suicide-prevention-annual-report/.

But these figures are more than just numbers. They serve as a stark reminder that money alone doesn't solve structural failure. It is increasingly apparent, we do not have a funding problem; we have a function problem. It is a system-design problem and a failure to adapt, to decentralize, and to meet veterans where they are.

It is a system that, despite its scale and sincerity, continues to force veterans to wait weeks or drive hours for care that should be available promptly and locally. And it's a system where decisions about who gets timely treatment are too often made by bureaucrats with a budget, not doctors with a diagnosis.

The Community Care Program was created to address that failure. It offers veterans an alternative path to care when the VA cannot meet their needs in a timely or appropriate manner. It is the answer to wait lists, distance barriers, specialty gaps, and overwhelmed facilities.

Today, roughly 40% of VA health care is delivered through community care.[5] Veterans are using it. They're satisfied with it. It's mostly working.

Community providers have stepped up, filling critical gaps in mental health, oncology, pain management, women's health, and substance use treatment. And in rural areas, especially, where VA facilities may be hours away, community care has become a lifeline.

But instead of expanding access, some VA administrators have worked to restrict it, undermining the law, the intent of the MISSION Act, and the trust of the veterans they serve..

Let me be specific. Last year at the Portland VA, a senior official admitted to oversight staff that they were deliberately trying to keep care "in-house," even when referrals were warranted.[6] In Buffalo, a veteran with cancer saw his radiation therapy referrals delayed, then canceled.[7] He died in pain. That is not a system error. That is systemic negligence.

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[5] Petra Rasmussen and Carrie M Farmer.. "The Promise and Challenges of VA Community Care: Veterans' Issues in Focus." *Rand Health Quarterly*, Jun. 16, 2023, Vol 10(3):9. https://pmc.ncbi.nlm.nih.gov/articles/PMC10273892/.

[6] Oregon Public Broadcasting. "Wyden: Roseburg VA Officials Admitted To 'Inappropriate Admissions' System." *OPB News,* Jun. 24, 2025. https://www.opb.org/news/article/roseburg-va-admissions-system-ron-wyden/

[7] Office of Healthcare Inspection. "Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA ..." *Department of Veterans Affairs Office of Inspector General,* Audit Report No. 23-03679-262. Sept. 27, 2024. https://www.vaoig.gov/sites/default/files/reports/2024-09/vaoig-23-03679-262.pdf

While VA has taken steps to improve the Veterans Community Care Program, key gaps in timeliness, oversight, and care coordination remain.

If we are serious about honoring the promise made to every man and woman who has served, we must get this right. And that begins with clarity of mission, guided by four principles: flexibility, accessibility, rapidity, and accountability.

Flexibility: Real Choice, Not Red Tape

Veterans do not live neatly within institutional boundaries. They live in rural towns, sprawling suburbs, and city centers. They manage jobs, raise families, and carry injuries—both visible and invisible. And they deserve a care system that reflects that complexity.

The Community Care Program allows them to seek care outside the VA when it is too far, too slow, or lacks the necessary capability. This is particularly critical for specialized services—such as orthopedics, trauma therapy, neurology, reproductive health, and substance use treatment.

The system must respond to the reality of the modern veteran, a population that is younger, more diverse, geographically dispersed, and managing complex civilian and military transitions. When a VA system goes two years without a full-time gynecologist, as was documented in a 2020 Inspector General report, that's not a scheduling issue; it's a failure of access and management.[8] And with 70% of women veterans preferring female providers for women-specific care, and 50% even for general care, flexibility becomes a clinical imperative.[9]

Accessibility: Geography Should Not Determine Health Outcomes

Let's be blunt: If a veteran has to drive three hours each way to get care, that's not access, that's denial of care.

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[8] Office of Healthcare Inspections. "Comprehensive Healthcare Inspection of the Alaska VA Healthcare System, Anchorage, Alaska." *Department of Veterans Affairs Office of Inspector Genera*l, Audit Report No. 19-06378-73, Jan. 23, 2020.
https://www.vaoig.gov/sites/default/files/reports/2020-01/VAOIG-19-06378-73.pdf.

[9] Kate L. Sheahan, Karen M. Golstein, Elizabeth M. Yano, et. al. "Women Veterans' Healthcare Needs, Utilization, and Preferences in Veterans Affairs Primary Care Settings." *Journal of General Internal Medicine*, Aug. 30, 2022, Vol. 37(Suppl 3):791-798.
https://link.springer.com/article/10.1007/s11606-022-07585-3

Only 55% of veterans live within 40 miles of a VA medical center. Just 26% live near a facility with full specialty care.[10] These numbers are even more dismal for veterans in rural communities, many of whom are older, sicker, and less mobile.

Community Care helps correct that. It allows veterans to seek treatment locally, reducing both the physical and financial burden of long-distance travel. That doesn't just improve health outcomes. It improves trust, adherence, and it keeps veterans engaged.

And with the veteran population shifting rapidly—2.2 million women veterans expected by 2025, nearly 18% of the total veteran population by 2040, and 43% of women VA users in 2020 from racial or ethnic minority backgrounds—it's no longer acceptable to offer a model built for the demographics of 50 years ago.[11]

Veterans deserve care where they live, not just where we've historically placed facilities.

Rapidity: Delayed Care is Denied Care

In that regard, veterans don't need care eventually, they need care now.

VA outpatient satisfaction ratings reached 91.8% in 2024, that is a number to be celebrated, but it also runs the risk of masking regional and categorical disparities.[12] It does not speak to the veteran experiencing PTSD symptoms today. It does not help the veteran with worsening chronic pain who's told to wait 28 days before seeing a specialist.

Under current rules, veterans are often forced to endure arbitrary thresholds before becoming eligible for Community Care—20-day waits and 60-minute drive times. These are numbers written on paper, not reflections of actual urgency.

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[10] Petra Rasmussen and Carrie M Farmer.. "The Promise and Challenges of VA Community Care: Veterans' Issues in Focus." *Rand Health Quarterly*, Jun. 16, 2023, Vol 10(3):9. https://pmc.ncbi.nlm.nih.gov/articles/PMC10273892/.

[11] U.S. Department of Veterans Affairs, Office of Women's Health. "Facts and Statistics." *Women Veterans Health Care*, accessed Jul. 10, 2025. https://www.womenshealth.va.gov/materials-and-resources/facts-and-statistics.asp.

[12] Department of Veterans Affairs. "Trust in VA Among Veteran Patients Rises to 91.8%, Up 6% Since 2018." *Wilmington VA Medical Center Press Release*, Apr. 17, 2024. https://www.va.gov/wilmington-health-care/news-releases/trust-in-va-among-veteran-patients-rises-to-918-up-6-since-2018/

I've worked with veterans denied certain types of mental health treatment or experienced significant delay in access to specialty mental health care. Others were turned away because they weren't sick enough. Still others were forced to partake in a type of therapeutic intervention at odds with their preferred course of treatment.

Many times these decisions were not meant to be negligent, but hyper process-oriented. Irrespective of intent, such moments are often perceived as administrative cruelty and institutional malaise. And it is costing well-being and lives.

Accountability: Structure Must Serve the Mission

I believe in oversight. And I believe that no system—public or private—should operate without guardrails. But accountability should be about ensuring quality and responsiveness, not erecting barriers that keep veterans out.

Despite ongoing efforts to improve the Veterans Community Care Program, the Department of Veterans Affairs continues to fall short in fully addressing longstanding structural and operational deficiencies.

These reforms are designed to ensure veterans can more easily obtain the health care that best fits their needs, whether within VA facilities or through qualified community providers.

Since 2018, the Government Accountability Office (GAO) has issued 27 recommendations to strengthen the program's performance, particularly in the areas of appointment scheduling, wait time monitoring, contract oversight, and network adequacy. As of early 2025, only nine of these recommendations have been fully implemented.[13] This sluggish pace of reform has tangible consequences for veterans who rely on community care when timely services are not available within the VA system.

A central and unresolved issue remains the lack of a clearly defined, enforceable standard for how quickly veterans must receive community care appointments. While the VA has implemented some mechanisms to track scheduling performance, it has not yet established comprehensive metrics aligned with those timeframes, leaving the system without meaningful accountability.

[13] Sharon M. Silas. "Veterans Health Care: Opportunities to Improve Access to Care Through the Veterans Community Care Program." *United States Government Accountability Office,* Feb. 12, 2025. https://files.gao.gov/reports/GAO-25-108101/index.html.

The VA's Referral Coordination Initiative, intended to streamline specialty care referrals, has likewise suffered from inconsistent implementation, unclear guidance, and inadequate performance metrics. These shortcomings create variability in veteran experience and undermine trust in the VA's ability to deliver timely, coordinated care across its network.

Equally concerning is the state of contract oversight and provider network adequacy. Although the VA has taken steps to improve data systems and oversight processes, critical vulnerabilities remain. The current methodology for assessing whether provider networks are adequate, particularly in the realm of specialty and mental health care, risks obscuring the extent to which veterans have real access to services. Without reforms to oversight processes and more accurate measurement tools, the VA risks misallocating resources and failing to ensure that community networks meet veterans' needs.

Finally, as the use of community care continues to grow, especially in behavioral health, the VA must prioritize seamless coordination between VA facilities and outside providers. Preliminary findings show that the majority of veterans who seek mental health services in the community continue to rely on the VA for ongoing care. This underscores the urgent need for standardized, reliable systems to ensure timely medical documentation exchange and continuity of treatment.

In light of all of these critical issues, I want to commend Secretary Collins on his recent announcement that the VA will expedite the implementation of the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act—enacted earlier this year—which addresses some of these concerns and includes critical provisions to expand and streamline veterans' access to the Community Care program.

Because let's be clear: It is not enough to offer a door, we must ensure that the door is open, functional, and leads somewhere worth going.

Conclusion

I completed my training in the VA system. I've referred patients there. I believe deeply in the VA and the essential mission it fulfills for our veterans. But no system,

no matter how well-intentioned, can serve every need, in every place, for every veteran.

That's why Community Care matters. It's not an indictment of the VA, it's an extension of the promise made. A veteran's health outcomes should not depend on geography, paperwork, or luck. They should depend on whether we've built a system that puts their needs first.

Veterans don't need more bureaucracy—they need choice, speed, and accountability.

Thank you for your time, your leadership, and your continued commitment to those who've served. I welcome your questions.