Chairman Barrett and Ranking Member Budzinski:

Thank you for the invitation to participate in this hearing and to offer comments on providing world-class healthcare services to our veterans in Mid-Michigan. My name is Ben Frederick, and I serve as Associate Vice President of Advocacy, Government Relations and Business Development for Memorial Healthcare, a mid-sized independent rural hospital located in Owosso, Michigan.

Memorial Healthcare very much aligns with the mission of the committee from which this subcommittee derives, as the origins of our hospital were directly inspired by the Owosso community's desire to serve the veterans of Mid-Michigan following World War I. Our original 1921 edifice still stands as an ongoing memorial honoring those veterans and the many who have followed. In fact, our legal name remains "The Memorial Hospital," and our campus is home to Owosso's war memorial honoring those who perished in the War to End All Wars.

Our system CEO Brian Long sends his best regards to this committee and regrets being unable to address you personally. Mr. Long is himself a veteran of the United States Marine Corps, and many members of our leadership team and workforce are proud veterans of the United States military. The culture of Memorial has long included recognition of our team members who served, and a commitment to providing healthcare to the veterans who live within the communities we serve.

To that end, we flag a patient's veteran status during our intake process to ensure a ready connection with available services. We also strive to ensure veterans are aware of their benefits and are enrolled as participants in the Community Care Program.

One of our most solemn traditions is a "code honor," which marks the passing of a patient or long-term care resident at our facility.

Thank you, Chairman Barrett, for your efforts to ensure that the VA proactively notifies veterans of their option to receive care through community providers. Previously, veterans had to know to ask to use their hometown service providers. This simple change in how that conversation is initiated at the VA will drive convenience, timely care, and better outcomes – and ultimately yield savings to the VA system.

In 2025, we served over 400 veterans in our inpatient settings and 400 in outpatient care. Hundreds more were served with differing primary insurance. We are not satisfied with those totals, however, as they represent only a small portion of the estimated veteran population living in Shiawassee County.

As a community hospital in a rural region, our patients already face significant challenges that limit access to essential healthcare services. Our veterans carry the additional burden of wounds both seen and unseen, which can affect their willingness to seek care in the first place.

Research has also consistently shown that independent community hospitals deliver cost savings to patients. This reflects the continuous innovation occurring at health systems like Memorial as we work to provide world-class care while navigating the complexity of both reimbursement and regulation. Our competitive advantage is personalized patient care – the direct connection we establish with each individual in addressing their specific needs. From the first scheduling call through every follow-up contact, our team is engaged in a way that larger systems often cannot replicate.

From a fiscal sustainability standpoint, which is a particularly sensitive point for a rural hospital, we want to recognize the VA for its payment performance. Our operational team reports that, for patients who do receive care through us, subsequent denials are minimal and the overall record of paid claims is excellent.

Access to test results completed through the VA would also meaningfully improve care continuity. Currently, the patient is expected to ensure these results reach our practitioners – a gap that creates delays and the potential for duplicate testing and places an unnecessary burden on individuals who may already be managing complex health needs.

Taken together, the overarching concern I wish to bring to this committee on behalf of our team is the degree of self-advocacy veterans must exercise simply to remain connected with their own care. At every stage of the process, the burden falls on the veteran to initiate, follow up, and navigate a system that does not always communicate across its own components. Technology has an important role to play in reducing that burden.

The most immediate and pressing obstacle is the prior authorization process. An authorization is required at the outset for primary care services, and separate authorizations are then needed for any specialty or diagnostic referrals. Each is time-limited, and each requires the veteran to advocate proactively at every subsequent stage for a local option – primary care, diagnostics, and specialty. Memorial Healthcare is not able to assist veterans in navigating these authorizations as we do with other payer coverages, which results in delays, duplication of effort, and frustration as local providers struggle to stay integrated with VA care teams. There is not presently any communication with Memorial's scheduling team to ascertain our "next available" appointment when the VA is weighing the most timely option.

In closing, we deeply value the opportunity to honor every patient's choice of where to receive care – and we take particular pride in the trust our veterans have placed in us. We would welcome the chance to serve more of our local veterans, should they wish to choose Memorial as their local provider of record.

Thank you again to this committee for your focus on removing barriers to locally delivered care, and for the opportunity to share our perspective.

Reference Points for potential questions and summation:

Tech integration:

Memorial scheduling access: Currently, all professional visits are routed through Memorial's scheduling team for individualized follow-up. This aligns with an organization policy to ensure advance access to patient record information and other necessary context, particularly in the specialist vein before an appointment is confirmed. We are open to engaging with our employed providers and administrative team on this topic.

A significant concern with any direct scheduling integration is inadvertent disclosure of protected health information. Granting VA staff access to our Expanse scheduling system would expose the records of all scheduled patients – not just those with VA affiliation. There is no clear business justification for VA associates to have visibility into non-VA patient information, and that HIPAA exposure would need to be squarely addressed before any integration could move forward.

Assuming that HIPAA concerns were resolved, a second challenge is the training investment required. VA associates would need substantive onboarding in our Expanse system – not just a surface-level orientation.

- That would include understanding system limitations and scheduling guidelines; correctly capturing demographic, employment, and insurance information; entering prior authorization data in the right location for our billing department; uploading orders and referrals; and managing the effective dates, visit limitations, and end dates tied to each authorization. These are not simple tasks – they require a working knowledge of our workflows and the precision our billing process depends on.

There is also the matter of need-specific scheduling constraints. A procedure like an MRI with sedation, for instance, can only be scheduled in certain blocks because of our contracted anesthesia availability. This is a rural reality – and any integration would need to account for those capacity limitations, not simply open a generic scheduling portal.

- Beyond scheduling itself, our staff currently provides detailed preparation instructions to patients before any procedure that requires advance steps – walking them through what to do, what to bring, and how to find the right location. That patient education happens during intake and pre-appointment contact and is central to the personalized care experience we provide. Any hand-off to external staff would require that same level of thoroughness.

Memorial is not consulted when the VA is weighing referral options. We have no channel through which to communicate our availability or capacity, other than through the veteran directly asking. If a member of this committee is inclined to explore a remedy, one practical ask would be for the VA to establish a Secure File Transfer Protocol (SFTP) inbox that would allow their electronic health record system to push notifications of new orders, prior authorizations, referrals, and service approvals directly to community providers like us. That single step would dramatically improve communication and reduce the lag time that currently affects patient care.

Diagnostic Linkage: On the diagnostic side, when a veteran has completed testing through the VA, those results rarely make their way to us automatically. The veteran is expected to ensure the transfer of those records. In practice, this means our practitioners sometimes see patients without the foundational information they need – which leads to redundant testing, delayed diagnoses, and unnecessary cost. A structured result-sharing mechanism between VA and community providers would go a long way toward closing this gap.

Notes on Financials:

The most common reason for VA claim denials is expired authorization – specifically, when the visit limit or date constraint on a prior authorization has lapsed and services are rendered outside those parameters. Currently, there is no pathway to request retroactive approval for provider visits after that happens (though admissions, observations, and emergency visits have a 72-hour notification rule that provides some relief). A similar after-the-fact notification option for outpatient provider visits would be genuinely helpful. The combination of visit-count limits and date windows – say, four visits within six months not to exceed six months – creates ambiguity, and our teams and veterans sometimes miss one qualifier or the other.

On the contracting side, Memorial currently operates under single-case arrangements with the VA rather than any formal agreement, and both parties have expressed interest in changing that. The challenge is that we cannot accept a contracted fee schedule on behalf of our independent partners – pathology and radiology groups, for instance – who set their own rates and would need to be part of any negotiated arrangement. In approaching rural providers, this should be accounted for.

Memorial cannot initiate a referral on a veteran's behalf. If a veteran is seen at our facility and our providers determine that specialty care or additional diagnostics are warranted, the veteran must return to the VA to request that referral, and the VA then determines whether and how to proceed. We have no ability to advocate for the patient within the VA system nor speak to our readiness to provide timely care, which creates a gap in care coordination that falls squarely on the veteran to bridge.

The downstream consequence of that gap is redundant testing, delays, and in the case of our mid-Michigan veterans, a lot of unnecessary travel. Without seamless information sharing, veterans frequently undergo the same diagnostic work twice – once at the VA and again at a community provider who lacks access to the prior results. This is wasteful, burdensome for the patient, and entirely avoidable with better system integration.