STATEMENT FOR THE RECORD

House Committee on Veterans' Affairs

Health Subcommittee Legislative Hearing

January 13, 2026

from

Association of VA Nurse Anesthesiologists
Association of VA Psychologist Leaders
Association of VA Social Workers
National Association of VA Physicians and Dentists
Nurses Organization of Veterans Affairs
Veterans Healthcare Policy Institute

(All are independent organizations, not representing the Department of Veterans Affairs)

Chairman Miller-Meeks, Ranking Member Brownley, and distinguished members of the committee:

On behalf of our six organizations, we thank you for inviting us to submit a statement for the record for today's health subcommittee legislative hearing on improving the healthcare and services for veterans. Members of our organization are veterans, have family members who are veterans, had long careers dedicated to serving veterans, published papers on veterans' healthcare in peer-reviewed journals, presented testimony to your committee, and have served on President Trump's President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) task force.

In today's statement, we wish to convey our appreciation for your leadership and commitment to ensuring that veterans receive the highest level of healthcare within the Veterans Health Administration (VHA) and supplementary care in the private sector when it's both needed and authorized by the VHA.

We address our comments to five of the seven bills considered at today's hearing.

H.R. 2283 The RECOVER Act (Recognizing Community Organizations for Veteran Engagement and Recovery Act)

The RECOVER Act, a three-year pilot reintroduced by HVAC Chairman Rep. Mike Bost, would provide grants of up to $1.5 million ($60 million total) to non-profit mental health facilities serving veterans, prioritizing areas with large numbers of veterans at high risk of suicide. It would establish a parallel care system operating outside of, and disjointed from, the VA and the Veterans Community Care Program (VCCP), severely weakening the quality of services provided to veterans, as we detail below.

Undermines the Veterans Community Care Program

The RECOVER Act creates a parallel mental healthcare system that fundamentally conflicts with the existing VCCP operations and erode the MISSION Act's intention to create a single overarching, coordinated program by:

Introducing competing eligibility rules. For the past seven years, veterans needing mental health care qualified for services through the VCCP when VA cannot provide care within 20 days or 30 minutes of drive time. This bill would bypass the VA's authorization process entirely, allowing veterans to access VA-paid mental health care from grant recipients whenever they choose, ending the foundational principle of the VA as the authorizer and overseer of veterans' care,

The bill subverts the VA's established system for veterans' priority group eligibility and co-payments. Unlike the VA and VCCP, no veteran would have a co-payment.

Duplicating existing services. Unlike the Fox Grant program, which funds services unavailable through the VA, this bill duplicates mental health services delivered by the VA and VCCP.

Removing VA as the coordinator of care. The MISSION Act designated VA as the overall coordinator of care that is furnished in the community. Mental health care delivered through these grants circumvents that coordinated framework.

Reduces Quality and Evidence-Based Care Standards

Despite its stated goal of providing culturally competent, evidence-based care, the bill's requirements fall far short. At each grant-receiving facility, only *one* clinician—not all—must be trained in "culturally competent" veterans mental health care. No providers must be trained in evidence-based practices. In sharp contrast, VA clinicians have recognized expertise in military-related conditions such as PTSD and traumatic brain injury.

Furthermore, despite prioritizing the awarding of grants in areas where there are large numbers of veterans at high risk for suicide, the bill includes no requirement for suicide prevention training.

Fails to Improve Timely Delivery of Services

The bill establishes no concrete standards for timeliness of service. Grantees' wait times could be longer than those currently experienced with VA and VCCP services.

Pays Twice for the Same Care

The bill explicitly enables existing VCCP facilities to receive grant funding without any requirement to increase services—allowing providers to layer awards on top of the VA and insurance reimbursements that grant recipients already receive for delivered care.

Eliminates Oversight, Accountability and Adherence to Standards

The bill lacks crucial quality standards and facility accreditation requirements. Unlike VA facilities, grant recipients would not be required to obtain accreditation from The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities.

There is no mandate for semi-annual peer review, quality assurance standards integral to VA-delivered mental health care.

There is neither utilization review nor limits to the number of appointments per treatment episode.

Pre-post symptom improvement is not reported, and grants are not allocated based on successful outcomes.

Unlike VCCP providers, recipient facilities face no requirement to share health records with VA—a fundamental breakdown in care coordination that could leave a veteran's treatment fragmented and potentially compromised.

Undermines the network of the 300+ Vet Centers and 80 Mobile Vet Centers

These options exist to serve veterans who hesitate to seek mental health care at VA facilities—presumably one reason for the grants that subsidize private sector clinics.

Summary and Recommendation

This legislation would severely weaken VA's healthcare model and further diminish the VA's ability to provide veterans with high-quality mental health care. Changes to the delivery of veteran mental health care and suicide prevention cannot come at the expense of VA's integrated system, which—when properly staffed and funded—consistently succeeds in providing comprehensive, coordinated mental healthcare for our nation's veterans.

The more effective solution would be expanding VA's mental health workforce while maintaining its critical role coordinating care and leveraging community resources, rather than creating a parallel system with negligible oversight and lower standards of care.

Finally, this legislation could set a dangerous precedent, with veterans' mental health services being a test case for broad transformation of the VA from a provider of care provider to an insurance payer for care. That's not what the overwhelming number of veterans and prefer. The VA's central role in authorizing and coordinating veteran healthcare must be preserved while judiciously and effectively leveraging community resources within that framework.

Veterans Health Desert Reform Act of 2025

The Veterans Health Desert Reform Act of 2025 would establish a pilot program allowing three or more rural private sector facilities to provide hospital care and medical services to veterans outside of the Veterans Community Care Program (VCCP). Rather than protecting veterans, it could seriously compromise the healthcare access that most veterans currently depend on.

The VA MISSION Act of 2018 created a comprehensive private sector network through the VCCP, guaranteeing veterans emergency medical and psychiatric care, as well as walk-in urgent care, anywhere in the country. Veterans can also access private sector outpatient care if they would wait more than 20 to 28 days for an appointment or must drive more than 30 to 60 minutes to reach a VA facility. This new bill creates a parallel system that fundamentally conflicts with the existing VCCP structure in three critical ways.

First, it introduces competing eligibility rules that eliminate VA's role as authorizer of community care. Under VCCP, VA authorizes community care when veterans meet specific eligibility criteria. Under this bill, enrolled veterans could obtain VA-paid care at selected hospitals and their outpatient clinics simply by calling for an appointment or walking in, without any VA authorization.

This represents a dangerous departure from standard practice. Prior authorization is a routine feature of any insurance payer that pays for patient care and services. It offers critical protections to veterans who might otherwise receive unnecessary tests or procedures, or care that isn't based on scientific evidence. VA oversight also protects taxpayers from the fraudulent billing practices that are endemic in America's profit-driven healthcare system.

Second, this bill could duplicate services already available in the VA and VCCP—including in the same geographic locations. There's no stipulation that participating hospitals must be located more than a 60-minute drive from existing VA (or VCCP) facilities. Veterans might end up traveling longer distances than they currently experience with VA and VCCP services, defeating the bill's purported purpose of addressing health deserts.

Third, unlike VCCP providers, facilities face no requirement to share health records with VA. This represents a fundamental breakdown in care coordination that could leave a veteran’s treatment fragmented and potentially compromised.

Pilot programs are designed to start small before scaling up. This legislation would serve as a test case for arrangements that could eventually encompass far larger numbers of hospitals, representing another step in the accelerating privatization of VA's integrated healthcare system. As veterans shift their care to these facilities, funding follows. Declining patient volumes at VA facilities trigger budget cuts that force specialized programs to be scaled back or eliminated, ultimately depriving many veterans of the VA care they prefer and depend on.

We support a provision in the legislation that aligns healthcare reimbursement for veterans with rates paid for non-veteran patients. Financial incentives should never create a system where certain patients receive priority based on reimbursement disparities. However, this worthy reform can and should be accomplished within the existing VCCP framework, without creating a parallel system that undermines VA care and abandons the safeguards veterans need.

Recommendation

The VA's central role in authorizing and coordinating veteran healthcare must be preserved while effectively leveraging community resources within that framework. The existing VCCP already provides the structure needed to address access challenges in underserved areas. Rather than creating a competing parallel system, the bill should incentivize medical facilities not currently participating in VCCP to join that existing program.

Veterans Mental Health and Addiction Therapy Quality of Care Act H.R. 2426

The Veterans Mental Health and Addiction Therapy Quality of Care Act seeks to fulfill one of the VA MISSION Act of 2018's most important unmet promises: equipping veterans with the information they need to make informed healthcare choices and ensuring high-quality mental health care across both VHA facilities and the Veterans Community Care Program (VCCP). This is an inherently worthy objective. However, the bill as currently drafted risks undermining its own goals. Substantial revisions are needed to ensure it achieves its intended purpose.

The most fundamental flaw is the absence of any requirement for VA to modify its contracts with Third Party Administrators. Without contractual obligations, community care providers will have little incentive to assess patients' treatment progress. This means the intended comparison between VA and VCCP quality will collapse into a one-sided evaluation of VA care alone, completely defeating the bill's central intent.

Compounding this problem, the bill fails to authorize the VA or its designated evaluators to be able to access VCCP health care records. This creates a critical limitation: any comparison will be restricted to whatever records community providers happen to forward. Recent scientific studies and GAO reports reveal that only a fraction of initial records currently reach VA, with virtually nothing forwarded after initial treatment. The bill should explicitly require VCCP providers to submit both measurement data and veterans' complete health care records to VA for analysis, following the model established by the Fox Grant program.

The study design itself also needs clarification. The comparison must specifically contrast veterans treated in VA facilities with veterans treated through VCCP. As written, the bill could inadvertently compare VA patients with non-veterans in the private sector—an apples-to-oranges comparison that would yield far less meaningful results.

The bill should also specify the use of gold-standard outcome measurements that are widely accepted in the field. For PTSD, this means the PTSD Checklist. For depression, the PHQ-9. For substance use disorder, the Brief Addiction Monitor. These standardized instruments are essential for valid comparisons.

Several additional quality indicators are conspicuously absent from the current bill. There is no assessment of whether mental health and substance use providers have completed Department-accredited or other recognized training specific to the conditions they treat—a fundamental gap in any quality evaluation. Similarly, the bill includes no requirement to track how many

providers collect initial and follow-up data and enter it into the electronic health record. Provider peer review, another cornerstone of quality assurance, is entirely absent from the bill's requirements.

Wait times to commence treatment also need to be assessed.

Conducting a rigorous study of this complexity requires expertise that goes well beyond administrative capacity. The bill should designate that a scientific institution (such as the National Academies of the Sciences, Engineering, and Medicine) with demonstrated expertise in health outcomes evaluation oversee the study's design, methodology, measurement protocols, and analysis.

Finally, when evaluating the use of evidence-based practices in mental health and addiction therapy, the bill should reference the rigorously developed VA/DOD Clinical Practice Guidelines rather than the American Society of Addiction Medicine criteria.

With these revisions, the Veterans Mental Health and Addiction Therapy Quality of Care Act could fulfill its promise of empowering veterans with meaningful quality information. Without them, it risks creating an illusion of accountability while leaving veterans no better informed than they are today.

Veterans TBI Breakthrough Exploration of Adaptive Care Opportunities Nationwide Act of 2025 (BEACON Act of 2025)

The BEACON Act fundamentally undermines the VA's existing traumatic brain injury research and treatment infrastructure, particularly the VA Transitional Research Center for TBI and Stress Disorders (TRACTS). Rather than strengthening current programs and improving the lives of effected veterans, the legislation risks fragmenting and weakening the VA's coordinated efforts in this critical area.

The bill's stated purpose—to "increase research and development on integrated mTBI and mental health interventions outside the scope of traditional Department of Veterans Affairs pathways, interventions, programs, procedures, and pharmaceuticals"—appears designed to circumvent established clinical channels, potentially creating an alternative pathway for peer-based interventions that lack rigorous scientific validation.

This approach is unnecessary and counterproductive. The VA has already compiled extensive research on mild traumatic brain injury and its treatment. Veterans with mTBI currently have access to evidence-based psychotherapies that have been refined and improved over two decades of clinical practice. Creating a parallel treatment framework for mTBI ignores this substantial body of ongoing work and risks duplicating efforts and diverting needed resources.

Further, placing research grant administration outside the VA introduces organizational fragmentation and accountability gaps.

Data Driven Suicide Prevention and Outreach Act of 2025

The Data Driven Suicide Prevention and Outreach Act of 2025 would create a grant program to develop predictive models for evaluating suicide risk factors among veterans. While improving suicide prevention is undeniably critical, this legislation fundamentally duplicates the VA's existing big-data predictive analytics approach. Rather than strengthening the current program, it risks fragmenting and weakening the VA's efforts in this vital area.

Over the last decade, the VA has developed and refined a sophisticated suicide risk prediction algorithm and implemented the Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment (REACH VET) program. REACH VET identifies VA patients at extraordinarily high risk for suicide—specifically, the top 0.1% risk tier, patients predicted to die by suicide at a rate 30 times that of the overall VHA patient population. This risk identification is then provided to local REACH VET program coordinators, who inform the patient's clinicians so both can work proactively to enhance care.

The program has demonstrated tangible results. A 2021 study found that REACH VET was associated with more outpatient encounters, increased documentation of new suicide prevention safety plans, and fewer inpatient mental health admissions, emergency department visits, and documented non-fatal suicide attempts. While the study did not identify differences in suicide or all-cause mortality, these process improvements represent meaningful enhancements to care coordination and crisis response.

The bill's stated purpose—awarding grants to develop predictive models evaluating risk factors that contribute to veteran suicide—creates a parallel framework that ignores this substantial body of ongoing work. This approach is both unnecessary and counterproductive. Any algorithms developed through the grant program would be based on much smaller populations than the VA's comprehensive database, inherently reducing their predictive value.

Creating competing systems fragments resources and effort. Rather than paying twice for the same application of artificial intelligence and predictive analytics, Congress should invest in expanding, refining, and properly resourcing the existing REACH VET infrastructure. The VA's program already has the population-scale data, established clinical integration pathways, and demonstrated track record needed to identify at-risk veterans and connect them with enhanced care.

Thank you for the opportunity to offer our input on these important pieces of legislation.