S. HRG. 119–7

PROTECTING VETERAN CHOICE: EXAMINING VA'S COMMUNITY CARE PROGRAM

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

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TUESDAY, JANUARY 28, 2025

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:30 a.m., in Room SR–418, Russell Senate Office Building, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present: Senators Moran, Boozman, Cassidy, Tillis, Sullivan, Blackburn, Cramer, Tuberville, Banks, Sheehy, Blumenthal, Hassan, King, Duckworth, Gallego, and Slotkin.

OPENING STATEMENT OF HON. JERRY MORAN, CHAIRMAN, U.S. SENATOR FROM KANSAS

Chairman MORAN. The Senate Committee on Veteran's Affairs will come to order. We welcome our witnesses. We are here today to discuss what I consider hugely important, a hugely important role that community care plays in providing timely high-quality care to our Nation's veterans. I represent a rural state, and during my time as a Member of the House of Representatives, I represented a congressional district approximately the size of the State of Illinois. There was no, and is no VA hospital included in that geographic territory. And so, I bring this perspective of long distance and long amounts of time for veterans to access care.

I've heard countless stories from veterans in Kansas and across the country who live in faraway places from the VA facilities about those challenges. In the absence of VA's community care program, these veterans would not be able to use the VA healthcare benefits they earned. The same can be said for veterans who face long wait times at the VA, veterans who require a service that the local VA doesn't offer, or veterans who have unique needs that are best served through community care.

The MISSION Act was created so that the VA could more seamlessly care for those veterans. However, seven years after the MISSION Act was signed into law, it is still not fully living up to its promise. I have heard from veterans nationwide who've suffered as a result, especially over the last year, as VA acted to discourage and restrict the use of community care under the MISSION Act. Some of those veterans who've suffered the most are those with mental health conditions and addiction.

This morning, we will hear from veterans' family members, we'll hear from veterans and advocates about how they encountered barriers at the VA, which limited veterans access to potentially lifesaving care and put their lives at risk. One of those veterans is Eric Golnick, who will testify today about waiting more than a year to be connected to a counselor after asking the VA for help in the midst of a personal crisis. Another one of those veterans is Paige Marg's husband, Charlie. Paige will testify today about how her and Charlie repeated requests for inpatient care were denied by the VA after Charlie attempted suicide in the parking lot of a VA clinic.

VA leaders and advocates have repeatedly said that suicide prevention is one of their top VA's priorities. If that is indeed true, stories like the ones Eric and Paige will share, and the countless others that this Committee has heard from, veterans and their loved ones, should not be happening, and cannot be allowed to continue.

As chair of this Committee, I'm committed to making certain that they do not. That is why I'm introducing legislation today with Chairman Bost, my counterpart in the House, to strengthen the MISSION Act and give veterans like Eric and Charlie an improved pathway to care in the VA's direct care system and in the community. And I hope this will be a bipartisan effort.

The VA healthcare system is an invaluable resource for veterans, but it will only remain so if it stops failing those who need it the most. I yield to the Ranking Member, Senator Blumenthal, for his opening remarks.

OPENING STATEMENT OF HON. RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you, Mr. Chairman. This cause must be bipartisan and it must be immediate. There is no question about the need to speed, streamline, and safeguard access to community care and referrals to the kind of providers that are necessary to prevent the tragedies or near tragedies such as your husband, Charlie, suffered, Ms. Marg.

I believe, strongly, that these two systems, private and VA, must be complementary, not competitive. And overriding all of this debate is the need for more providers, more doctors, more nurses, more psychiatrists, and social workers who can provide the kind of care that our veterans need. And, obviously, the VA should not be in competition with communities for the numbers of scarce providers, skilled professionals who are necessary to provide this care.

But we're here on a morning when all of these programs are in severe and urgent jeopardy. The Trump administration has announced, illegally, that it will freeze federal aid for programs that are immensely important to veterans. This freeze on federal aid will hurt veterans by pausing funding for critical programs that millions of veterans and their families rely on. We're talking about homeless veterans, funding for veterans' nursing homes across the country, suicide prevention programs, many of the programs that we will be discussing today and the efforts to streamline speed and safeguard access to community programs. Reimbursement for those providers who need it to make community care work, frozen.

We are deterring and discouraging that kind of community care right now in real time, and I urge all the Members of the Committee, I urge my colleagues to oppose this measure to make their views known. I call on veterans and their organizations across the country to make their views known because these funds must be freed immediately or else veterans will be betrayed.

There's nothing woke or Marxist about working to end veteran suicide or delivering our veterans the benefits they've earned and deserve. And I will put in the record later today a list of programs. It's going to be probably about two pages long. I have a tentative list here that will be adversely impacted by this freeze on funding.

[The list referred to appears on page 73 of the Appendix.]

It is also, by the way, unsustainable legally. It violates the Impoundment Act. These funds have been lawfully appropriated under bills passed by the Congress and signed by the President, and no member of the executive branch, including the President, has the lawful power to simply stop them.

I am concerned also about the action to dismiss the Inspector General. I'm going to be circulating a letter to my colleagues that would in fact protest to the President, the firing of the VA's Inspector General, Mike Missal, who has worked for many years under both Republican and Democratic administrations to call out and stop waste, fraud, and abuse. He's done it in a very bipartisan, or actually, non-political way, aggressively and effectively.

And the question for all of us is why this measure of firing the inspector general of the VA was done at this moment when, in fact, he has been the bulwark against waste, fraud, and abuse in the VA as have inspectors general across the executive branch.

I believe strongly that the private sector healthcare system and the VA are complementary, and one route to care should never come at the expense of the other. I fear that's what's happening today. The erosion of VA direct care is a real threat. And I say erosion because it could happen gradually, not all of a sudden, but if it happens, it may well be irreparable.

I am hopeful that we will restore the inspector general, that we will make sure that the funding for the VA system and other programs will be unfrozen, and that we will work together in a bipartisan way to speed and assure the referral system under the kind of legislation that the Chairman has proposed.

There was an effort last session, and I supported it to legislate in this area. I'm hope hopeful that his measure is one that we can all support. I know last session he offered the Veterans' Health Act. I assume that this measure is similar to it. Senator Tester offered the Making Community Care Work for Veterans Act. I feel some combination of these measures is viable and achievable, and I'm hopeful that we can reach a bipartisan effort. Thank you, Mr. Chairman.

Chairman MORAN. Thank you, Senator Blumenthal. I would indicate just a couple of things for all of our Members. It's my understanding that the Department of Veterans Affairs leadership is meeting later this morning with OMB to learn details of this issue of impounding or withholding funding. And I would say that in both instances, both the inspector general and this issue, one of the

best things that we can do is get Congressman Collins confirmed, and in a position to represent the Department of Veterans Affairs in these matters. And that is apparently taking place this week.

I'll now call on our witness panel. Let me introduce them. Eric Golnick, a Navy veteran and an advocate for mental health and suicide prevention for veterans and first responders. Paige Marg, a veteran spouse with firsthand experience in navigating the VA healthcare system on behalf of her Air Force veteran husband, Charlie. Jim Lorraine, the President and Chief Executive Officer of America's Warrior Partnership. Naomi Mathis, the Assistant National Legislative Director for Disabled American Veterans, and John Eaton, the Vice President for Complex Care for the Wounded Warrior Project.

Thank you-all for being here this morning. More importantly, thank you for all you do in care of veterans, and your care and concern for your loved ones. Mr. Golnick, we'll recognize you first, and you are recognized for five minutes.

STATEMENT OF ERIC GOLNICK, VETERAN

Mr. GOLNICK. Chairman Moran, Ranking Member Blumenthal, and distinguished Members of the Senate Veterans' Affairs Committee. Thank you for the opportunity today to testify on the critical issues of improving access to care through the VA's Community Care Program. My name is Eric Golnick, I'm a U.S. Navy veteran and I've dedicated my life to supporting the health and well-being of veterans and first responders.

The VA is an essential resource for millions of veterans. Community care under the MISSION Act is meant to complement, not replace the VA services, ensuring veterans receive the right care at the right time. I am going to begin by sharing a personal story to show you why this is so important to me.

After leaving the military, I sought mental health care through the VA. I was fortunate to see a psychiatrist relatively quickly, but it took over a year to see a therapist. The lack of therapy meant I was only addressing part of the problem. This came to a head over the holidays a few years ago, and without the support of friends and fellow veterans, some of who are in this room, I may not be here today.

For someone with a mental health or substance use disorder, the window to intervene is often just days. For veterans, timely access to this care is a matter of life and death. My experience reflects the systemic barriers many veterans face with in accessing timely care. That's what inspired me to co-found Forge Health in 2016. We addressed urgent mental health and substance use needs for veterans and first responders, working closely with the VA to help those who couldn't find adequate care.

The collaboration showcased the potential of how these relationships could work with the community, but it also highlighted the potential challenges. Some VAMCs and VISNs fostered strong partnerships. However, inconsistent implementation across the system resulted in delays highlighting need for clear standardized practices to ensure veterans receive timely and consistent care.

While the MISSION Act has expanded options for veterans, many don't know about these options. Unclear eligibility require-

ments often lead to delays or denial even for those who meet the access standards. One veteran, after being told he couldn't continue care, that he developed a therapeutic relationship with a clinician for over a year, told me, "I'm done. I give up. Before this year, I had been through four clinicians in less than six months."

When transitioning from VA to community care, many veterans face disruptions caused by poor communication and unclear processes. For example, a marine veteran I worked with struggling with severe post-traumatic stress was referred to community care, but waited months due to administrative delays. During that time, his condition worsened and he attempted suicide with a firearm.

Some VA employees hesitate to refer veterans to community care, fearing it could negatively impact their budgets. This can create barriers forcing veterans to choose between systemic concerns and urgent care needs. The MISSION Act was designed to ensure timely high-quality care, whether through the VA or through community providers. Veterans and not funding structures should remain the top priority in the care of veterans.

To address these challenges, the VA should enhance its efforts to educate veterans about their options under the MISSION Act. Clear communications during VA appointments, proactive outreach campaigns, and partnerships with VSOs can ensure veterans are fully informed about their rights and choices.

The referral and approval process should be streamlined. Simplifying and automating these procedures can reduce delays, alleviating administrative burdens, and help veterans access care more efficiently. This includes ensuring that community providers, TPAs, and VISNs are all in transparent and constant communication.

For rural and underserved areas, community care should act as a force multiplier and not a replacement for VA services, helping the VA fill and address critical service gaps. Telehealth is also a powerful tool for bridging these service gaps in these rural and underserved areas by providing immediate access to care. However, challenges such as limited broadband access could make this option unworkable. It's also crucial for some veterans, especially when you're talking about mental health, to have the option to see an in-person provider, especially if you're processing trauma.

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee, the VA has made progress in improving care for veterans, but significant challenges remain. By addressing these barriers and building on the foundation of the MISSION Act, we can ensure that all veterans receive timely high-quality care they deserve.

It's our responsibility to ensure no veteran is left behind. By fostering collaboration and prioritizing veterans' needs, we can fulfill our promise to those who served. Every delay risks veterans' well-being, and their life. As one veteran told me, "I shouldn't have to fight this hard to get help."

Thank you again for the opportunity to testify. I look forward to your questions, and working together to improve the care for our Nation's veterans.

[The prepared statement of Mr. Golnick appears on page 39 of the Appendix.]

Chairman MORAN. Thank you for your testimony and for your service. Ms. Marg.

STATEMENT OF PAIGE MARG, VETERAN SPOUSE

Ms. MARG. Good morning, Chairman Moran, Ranking Member Blumenthal and the Members of the Committee. Thank you for the invitation to speak at today's hearing. My name is Paige Marg, and I am the wife of Charles Marg. I'm not here to talk about the life of my husband in the past tense, but I'm here to tell you how Charlie was saved.

Countless times, the VA and Community Care Program could have provided impactful mental health counseling, resources, and residential treatment, but failed again and again. I met my husband 27 years ago. We've been married for 23 years. In this time, I have seen my husband change dramatically from a pivotal deployment that he went on.

In October 2012, Charlie deployed from Germany to Guantanamo Bay, Cuba for eight months. To this day, I'm not sure what happened on that deployment, but whatever did happen permanently and profoundly changed my husband.

In August 2013, while still on active duty, Charlie attempted suicide and was hospitalized at Landstuhl Regional Medical Center. It was then that he disclosed that he attempted suicide twice on deployment. His doctors told us that he could not have PTSD because he was not deployed to a combat zone. He was diagnosed with major depressive disorder and anxiety, and was medically retired in July 2015.

We moved back to San Antonio, and Charlie enrolled in the VA Heart of Texas Health Care Network. He was connected to a VA psychiatrist who only supported his mental health journey through medication. Counseling is not part of these quarterly appointments. Charlie has repeatedly requested counseling referrals from the VA psychiatrist, and the cycle that includes the Community Care Program failed Charlie again and again.

He would wait six to eight weeks for the referral to be processed to see a community care provider. In each of the nine times that he went through this process, he's never been granted more than 12 visits with a counselor, even when he needed them more. And in each cycle, he saw a different provider and he spent time retelling his story and building rapport.

In February 2023, Charlie went to see his VA psychiatrist to request immediate mental health support as he was in crisis. We were told to go outside of the VA to seek care, and we were given a list of local providers who accepted TRICARE. The earliest appointment that we could find was 30 days .

On March 1, 2023, My husband sat in his truck in the VA clinic parking lot and attempted to overdose on his medication. I found him in his truck, drenched in sweat, crying, and incoherent. He was transported to a local hospital. When he was released, he was referred again to the VA community care system for counseling, and was seen for 12 visits before he was released from care again. His medication was adjusted multiple times over the next six months.

Toward the end of this period, Charlie went missing and was found by the police in the ER waiting room at Audie Murphy VA Hospital. He was held on an emergency detention order and admitted to the psychiatric ward for 36 hours. For several reasons, I asked if he could be sent to a residential program and was told that no option like that existed through the VA.

At his follow-up appointment, I explained the last few years of navigating fragmented community care counseling, and that these 12 session appointments were not adequate support, and that a longer-term solution was needed for him. I again requested that he needed to be put in a residential treatment program. A referral was submitted for residential treatment to the Community Care Program.

Charlie's psychiatrist called and told him that the referral was denied and suggested that he reach out to TRICARE Wounded Warrior Project or another veterans service organization to get the care covered. Wounded Warrior Project's Complex Case Coordination Program assigned a case manager, and within three days, paid for his flight to Tucson, Arizona, secured a bed for him at Sierra Tucson and paid for six weeks of residential inpatient treatment.

Sierra Tucson is in the VA's Community Care network, and the VA should have covered this expense, but failed to support Charlie again. While he was there, all of his medications were changed and reset, he received intensive counseling treatment for his nightmares, and was diagnosed with PTSD.

Since he returned home, Charlie has avoided the VA for mental health support because he did not want to go through the familiar cycle of fragmented care again. Instead, he has sought outside support through local nonprofits. Charlie is currently attending counseling appointments through the local vet center in San Antonio. Wounded Warrior Project saved his life by getting him connected to care that he desperately needed for years that over and over again the VA fell short on.

It's heartbreaking to see your spouse become a shell of a person, to repeatedly ask for help, to maintain prescription compliancy for more than a decade, and to not miss appointments, only to be discarded from the entity that should be providing treatment and care that he earned through his military service and sacrifice.

The obtuse, heartless interactions with the VA over and over, are why veterans do not seek care. It's why veterans suffer in silence. How many veterans need to commit suicide for the VA to prioritize long-term mental health care? How long do veterans have to wait for mental health care? How many veterans are getting lost in giving up in the community care system that do not have someone to advocate and fight for them? We need the VA to be better.

Thank you for the opportunity to share Charlie's story.

[The prepared statement of Ms. Marg appears on page 41 of the Appendix.]

Chairman MORAN. Ms. Marg, thank you for your—must be difficult testimony, but very compelling and valuable to me and the Members of this Committee. Mr. Lorraine.

STATEMENT OF JIM LORRAINE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICA'S WARRIOR PARTNERSHIP

Mr. LORRAINE. Chairman Moran, Ranking Member Blumenthal, and Members of the Committee, I'm honored to testify today regarding veteran access to healthcare, specifically care in the community.

The ability to make our own decisions is a foundational American freedom. I've always told my Army-serving son, that a successful career should give him the choices throughout life. I remained in the military through retirement because I love service, but I also did it to ensure I had choices, especially, managing my healthcare through TRICARE or the VA, something my father, a World War II veteran never had the option.

AWP believes veterans have a choice in managing healthcare they've earned. Providing veterans with healthcare choices of where, when, and most importantly, the continuity of care they seek is not only the right thing to do, but it's also affordable and effective.

AWP operates at a community level by building proactive relationships with veterans. Our mission is to partner with communities to holistically improve the quality of life of their veterans and their families, thereby reducing veteran suicide. Community care is a vital tool for veterans, particularly those who don't trust the VA and who don't utilize the VA facilities due the factors like distance, time, and continuity.

While we recognize the VA's crucial role in veteran care, AWP always sides with the veteran. We have supported empowering veterans to make their own healthcare decisions, and community care is one of the most popular and in-demand options. The MISSION Act and community care enabled veterans the opportunity to access outside VA facilities has been overwhelming.

Community care helps veterans regain the trust in the system, especially given that almost half of the 17.6 million veterans in the United States are unknown to the VA. At AWP, nearly 9,000 veterans contacted us in 2024, over 4,000 needing assistance most often related to healthcare. These 4,000-plus represented 6,000 cases—issues—392 related to mental health. Of those 392, 329 had suicidal ideations within 30 days of contacting us.

The most common theme we see is a struggle to access care. Even for veterans familiar with the system, navigating the VA can be frustrating. Confusion, long wait times, and canceled appointments, erode trust in the system. Though it's popular, full implementation of the MISSION Act has yet be to be realized.

In the past years, the VA has continued to deny community care referrals, continue to expand VA hospitals, continue to hire more employees, often competing with the private providers for talented medical professionals in the community. We must get this right.

Mr. Chairman, as you said during Mr. Collins' confirmation, America's national security is dependent on an all-volunteer military force and the VA that is successful in helping service members thrive as veterans is key to bolstering recruitment and keeping the Nation safe. We agree 100 percent and feel that the VA is not a social service department, it's a national security entity.

Despite some opposition and clear data, and data is clear, veterans are voting with their feet to seek care outside the VA. The department should trust and empower veterans by allowing them to choose their care providers. After all, who knows what's best for the veteran; the government or the veteran?

In my experience, both my wife, who's a veteran—service-connected disabled veteran, and I, have faced challenges accessing care in the VA. After years of frustration, we seek our care through TRICARE and Medicare because it provides us with so many other choices.

Community care is essential. Veterans should be able to choose their providers who meets their needs the best. AWP has put forward several recommendations for improving care. Codifying the access standards. Congress should codify the existing access standards for the community to ensure the veterans have guaranteed access to timely healthcare.

Eliminate the referrals for veteran health, substance abuse, and TBI care. I add TBI care because it's essential. Need for these services is often urgent, as Ms. Marg said, and referrals delay needed help. Further, TBI assessment and care have been neglected because of their similarities to post-traumatic stress disorder symptoms. We must include TBI services when discussing mental health and substance abuse. We also feel that we need to educate veterans on community care options, and allow veterans the preference for community care, and allow veterans to utilize TRICARE Select.

Community care is essential to improving veterans access to healthcare. We must continue to improve the system by empowering veterans, not restricting them. Together, we can do better. Thank you, sir.

[The prepared statement of Mr. Lorraine appears on page 47 of the Appendix.]

Chairman MORAN. Thank you, sir. Ms. Mathis, welcome.

STATEMENT OF NAOMI MATHIS, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Ms. MATHIS. Chairman Moran, Ranking Member Blumenthal, and Members of the Committee, over the past decade, due to increased demand for services, VA's reliance on purchase medical care services has risen significantly. While the use of community care has grown, many veterans have encountered barriers to accessing that care.

DAV supported the VA MISSION Act, which aimed to improve veterans access to timely, high quality and veteran focused care. Importantly, this support was based on maintaining a fundamental set of principles. Unfortunately, there are reports from some veterans indicating that they have been denied eligibility and access to the veteran Community Care Program.

The access standards enacted in the MISSION Act are clear, and VA is responsible for educating its employees on the law and veterans' rights to access community care when VA cannot provide needed care in a timely manner or due to distance from a VA facility. In cases where it is determined to be in the best medical interest of the veteran.

We also continue to hear about delays in scheduling community care appointments once a referral has been made. Due to the lack of an interoperable health record system, VA struggles with transmitting patient records to community providers and integrating those records into the patient's VHA electronic health record.

Additionally, community providers report complications with transmitting healthcare information and test results back to VA. There are also complaints from veterans regarding billing issues associated with referrals to community care.

VA must find an effective solution to ensure that patient records are transferred in a timely manner and provide community care providers the tools and procedures for transferring records back to VHA. VA should also require the return of patient records to VHA before payments for services rendered are made. Finally, VHA must ensure veterans are not erroneously billed and burdened with resolving billing issues related to community referrals.

A bipartisan issue and VA's top clinical priority is suicide prevention. Yet it does not mandate community care providers to meet the same training and quality standards as VA direct care providers.

DAV recommends VA amend its contracts with these providers and require clinicians who treat veterans to be trained in military culture, suicide prevention, lethal means safety counseling, and trauma-informed care. Accessing mental health and substance use disorder care is essential in preventing veteran suicide. And we made recommendations in our testimony to ensure quality services are provided to veterans referred to the community.

Women veterans are also significant users of community care. They're referred to the community for all maternity care, and oftentimes, for other basic gender-specific or specialty reproductive health services.

Although we want to see fixes to improve access to services in the community, we strongly believe that investing in VA's comprehensive, veteran-focused, evidence-based care model is likely to produce better health outcomes for veteran patients and ensure quality of care. It is essential to maintain VA as the primary provider and coordinator of veterans' healthcare. A bipartisan position supported by current and past VA secretaries and undersecretaries of health.

A robust VA healthcare system also provides vital research, essential clinical provider training, and emergency preparedness for veterans and the Nation. The failure to adequately fund, maintain, and expand VA's direct care infrastructure, and increased staffing levels to meet rising specialty care demand has led to unsustainable growth in community care, threatening the long-term viability of the entire VA healthcare system. Likewise, an improperly managed veteran Community Care Program has resulted in some veterans receiving substandard care.

In closing, Congress and VA must work together to resolve existing issues impacting veterans' healthcare. Improvements need to be made expeditiously to ensure veteran patients receive quality, timely care. Most important is to maintain a veteran-focused healthcare system for service-disabled veterans who rely exclusively on VHA for their healthcare needs. Ensuring VA specialized

care and services remain available is part of honoring the commitment to those who served.

Mr. Chairman, we look forward to working with you and the Committee. This concludes my formal statement.

[The prepared statement of Ms. Mathis appears on page 57 of the Appendix.]

Chairman MORAN. Ms. Mathis, thank you for your testimony, and thank you for DAV's continued presence before Members of this Committee and the Committee when we're meeting. Thank you for your testimony. And, Mr. Eaton.

STATEMENT OF JOHN EATON, VICE PRESIDENT FOR COMPLEX CARE, WOUNDED WARRIOR PROJECT

Mr. EATON. Thank you, Chairman Moran, Ranking Member Blumenthal, and distinguished Committee Members for this opportunity to speak with you.

Since 2003, Wounded Warrior Project has been working to transform the way America's injured Post-9/11 veterans are empowered, employed, and engaged in their communities. Over the past 20 years, our programs and services have matured to a point where we can now engage with each individual based on their unique needs.

Part of our process for helping warriors is learning more about their journey to Wounded Warrior Project, and some of these veterans have used VA for mental health care, others have not. Using VA is not a prerequisite to accessing our free programs and services, nor is it a requirement to keep engaging with us. But as a majority of warriors we serve use VA and nearly half report using VA for mental health care, we often learn about what that care has looked like for those who come seeking mental health care and support from us.

For some, wait times are still an issue. Despite efforts to expedite access through the VA MISSION Act, many warriors have reported wait times of several weeks to months before being provided with a mental health appointment. This is typically when a veteran or their family reaches out to organizations like ours for help. We have relationship with direct care providers and can help triage veterans into care sooner in many cases. And while the VA has its community care network for a similar purpose, we've learned that some warriors still wait for care well beyond 20 days after being referred to a community provider.

For some of these same warriors and others, we hear a frustration with provider turnover at the VA. It can take time to develop the kind of trust and rapport with a counselor that is critical to effective care. But when VA mental health providers leave the VA system, their patients are left to start over.

This can be an agonizing process for some, particularly those who struggle to tell their story. And even as some veterans are referred into the community, an enduring relationship with a community-based provider isn't always possible as VA workloads adjust and authorizations for external care lapse after a course of treatment.

While these stories are not common, the challenge that we've seen firsthand is accessing care through VA's Mental Health Resi-

dential Rehabilitation and Treatment Programs, or RRTPs. VA's Mental Health RRTPs provide residential rehabilitative and clinical care to eligible veterans who have a wide range of symptoms, illness, or rehabilitative care needs.

To be clear, the VA provides inpatient acute stabilization for veterans in crisis or suffering from severe mental illness. Our RRTPs serve as a step down to that acute stabilization and a more intense treatment option for those veterans in needs of substance abuse, PTSD care, and dual diagnosis treatment, for example, in a residential setting.

RRTPs serve as small but high-need, high-risk population of veterans. Approximately, 32,000 veterans received RRTP treatment at the VA or in the community in 2023. By contrast, nearly 2 million veterans received individual or group mental health treatment in a VA over that same period. And despite the logical association between RRTP and mental health care, the access standards contemplated by the VA MISSION Act and memorialized in the Code of Federal Regulations do not in practice extend to mental health or substance use disorder care provided in a residential setting.

This becomes a problem even more pronounced when we're working directly with high-risk warriors for placement at the VA or in the community. Stated most simply, we've encountered VA providers who have stopped making referrals to RRTP care in the community, even when there's no firm idea of when that care will be available in the VA direct care system.

And when this happens, we will pay for that faster connection to community-based, military-competent care paid by donor dollars and with almost no opportunity to secure any reimbursement from the VA. We're proud to step in at this point, but we know we only see a small percentage of the veterans who are seeking this critical level of care.

In totality, many veterans are not accessing care they need when they're ready to receive it. Delays in finding appropriate care in a timely manner not only fail to capitalize on the veteran's desire to change their life circumstances, but in some cases, cause further damage to their mental and physical health, declines in their family and social relationships, and even involvement with the justice system.

To mitigate the risk associated with unpredictable RRTP access and ensure consistent VA help throughout the enterprise, we believe the MISSION Act access standards must apply to the delivery of residential programs. We want and need the VA to be successful in this. Simply put, the VA is our most critical partner in connecting veterans to the residential rehabilitative care that they need.

In closing, we thank the Committee and its distinguished Members for this opportunity to share our perspective on VA community care. We're eager to support your efforts and to keep our promise to our Nation's veterans. And I look forward to your questions.

[The prepared statement of Mr. Eaton appears on page 65 of the Appendix.]

Chairman MORAN. Mr. Eaton, thank you. Ms. Marg, I want to highlight really the testimony, maybe between you and Mr. Eaton.

You indicated that on numerous occasions, the care that your husband needed was denied by the VA, and the suggestion was that you seek care through TRICARE, or through a private organization——

Ms. MARG. That's correct.

Chairman MORAN [continuing]. Not-for-profit?

Ms. MARG. That's correct.

Chairman MORAN. And that's despite the fact that Charlie had a 70 percent service-connected disability from the VA?

Ms. MARG. Correct. And his rating has actually increased. So, he's 70 percent, but he is rated as IU, for individual unemployability. So, he is actually at 100 percent right now.

Chairman MORAN. And what was the reason that the VA made that recommendation that you seek care elsewhere? How did they explain that?

Ms. MARG. At his follow-up visit, after the second suicide attempt, the nurse practitioner told us that the VA did not do long-term mental health well. And she turned around her computer screen and pulled up psychologytoday.com and told us to search and filter for which providers take TRICARE and to connect to a provider like that. The only explanation was they just don't do long-term mental health well.

Chairman MORAN. Is it true, Mr. Eaton, that the VA could refer Charlie to the same place that TRICARE would be paying for?

Mr. EATON. Yes, sir.

Chairman MORAN. Under Community Care, under the MISSION Act?

Mr. EATON. Yes, sir. The location that Ms. Marg highlighted is a member of the Community Care Network and would be eligible for a referral.

Chairman MORAN. And that caught my attention, that where you have helped find a place for Ms. Marg's husband, Charlie, is also—would be eligible for the VA to refer to in Community Care.

Mr. EATON. Yes, sir.

Chairman MORAN. How do you explain that?

Mr. EATON. Well, I think without clear defined access standards, the VA's left to other alternatives to find that level of care. It goes back to education, but also really clear, whenever a veteran is met with ambiguity in this critical time you can imagine the different barriers they have to face in accessing care. And so, we need clear standards that are dispersed across the entire VA that outline what veterans' options are and what their rights are in this case.

Ms. MARG. Can I add something to his statement?

Chairman MORAN. Oh, please.

Ms. MARG. So, when my husband went to Sierra Tucson, they actually have a program just for veterans. It's a Red, White, and Blue Program. My husband was there with other veterans, and was housed with veterans. Other veterans there had the VA pay for their care there. And so, it really seems very hit or miss as to what the provider understands and knows what the process is as to what kind of care they actually get connected with.

Chairman MORAN. That is a really a partial answer to my follow-up question with you again, is, do you know of other veterans,

other veteran families that have experienced similar circumstances, or are you just a one-case circumstance?

Ms. MARG. No, sir. There are other veteran families.

Chairman MORAN. Mr. Golnick, you were nodding your head.

Mr. GOLNICK. Yes, Senator. We saw this a lot in Forge where—what's the old saying? "If you've seen one VA, you've seen one VA." Unfortunately, like I had mentioned my testimony, some VISNs and VAMCs had a great education on community care, others didn't. And when that ambiguity came in with others, that's where people started—unfortunately, what happened with your husband, you're getting into those things and it's not necessarily something that is standardized across the system. So, that really is the bigger issue.

Chairman MORAN. My impression, and you can correct me if I'm wrong, that often the treatment at the VA, if you remain there for the kind of treatment you need for the circumstances that Charlie and Mr. Golnick both needed is often opioid prescription. Is that true?

Mr. GOLNICK. Senator, it's in some cases, right? In some cases it is. A lot of it can be severely and persistent mental illness that the VA works a lot, SPMI. But, yes, that is a lot of the times the case.

Chairman MORAN. I don't know whether I made my question clear, at least for the point I wanted to make is—there are programs that don't involve opioid treatment, but the VA's tendency is to utilize opioids as a treatment. Is that true?

Mr. GOLNICK. In a lot of cases, sir, yes. They're looking for a——

Chairman MORAN. You've already answered my question, but I wasn't sure.

Mr. GOLNICK. Yes, sir.

Chairman MORAN. Anybody want to add anything to what I ask? And if not, we'll go on to send it to the Ranking Member. Mr. Lorraine?

Mr. LORRAINE. Thank you, sir. I think the other point that that's being missed is that the ability to do case coordination at a national level to understand where the resources are. WWP has figured it out and they've got a great group of people that do complex case coordination. We work closely with them, but I think that's the absence. If there is care out there, it's just a matter of—if you know about it, you know about it, but you have to know somebody to know about it, and you need somebody who can navigate the system that way——

Chairman MORAN. Thank you.

Mr. LORRAINE [continuing]. And sometimes it's outside.

Chairman MORAN. Senator Blumenthal.

Senator BLUMENTHAL. Thanks, Mr. Chairman. What I hear is a common theme; veterans should have choices, care should be timely, and it should be high quality. The most skilled professionals in the world ought to be available right away, especially in cases of mental health crisis such as you experienced in your husband, Ms. Marg.

And the best laws in the world demand accountability. The VA must be held accountable, and one of the best means of holding it accountable is an effective inspector general. Would you agree, Mr. Eaton?

Mr. EATON. Yes, sir.

Senator BLUMENTHAL. Firing an inspector general sends a message on accountability, and it should be accountability not only for the VA, but also for dollars spent on community care. Would you agree with that, Mr. Eaton?

Mr. EATON. I believe so, yes, sir.

Senator BLUMENTHAL. And right now, the inspector general is barred from that kind of accountability when dollars are spent in community care, and they're scarce dollars. We can't afford to waste them. Whatever we think about the VA, at least there are means of tracking and record keeping there that often is unavailable when dollars are spent on community care. We spend a lot of time talking about VA facilities; wait times, for example. That data is transparent. It can be recorded, tracked, and acted upon, but that's not true in the private sector.

Mr. Eaton, would you agree that there needs to be accountability in both the private sector and the VA?

Mr. EATON. I think when you consider access standards, what we've heard from veterans is even if they receive a Community Care Network referral, they could be waiting perhaps longer than they would within the VA system, that 20-day mark. And so, I think there's certainly opportunity to identify how we can ensure streamlined care throughout VA's entire integrated system, which includes the Community Care Network.

Senator BLUMENTHAL. That point is absolutely critical. That the wait times for community care actually may be longer in some instances, and we need to guarantee, again, the two systems have to be complementary, not competitive, that veterans are not delayed in the care they receive because care delayed can be cared denied, as Charlie's example shows so dramatically and graphically. And I want to thank you, by the way, Paige, for being here today. I know it's not an easy task to be here, and thank you for telling us, being the voice of Charlie's story.

I want to talk about the hiring freeze. The hiring freeze was going to apparently deny positions being filled in VA facilities across the country; doctors, nurses, attendants, technicians, the people who provide direct care. The administration may have walked back on that hiring freeze. In so far as VA facilities are concerned, we are still unsure and clearly the hiring freeze still applies to essential core functions the VA provides.

And I'm going to ask you again, Mr. Eaton, because your organization was so instrumental in providing care for Charlie, and your organization, Ms. Mathis, provides services for veterans, thousands of them across the country. Isn't this hiring freeze having a detrimental effect on the VA?

Mr. EATON. Thank you, Senator, for the question. As we are teams analyzing the details of the freeze, looking at the exemptions, we note that critical roles like psychologists, social worker, marriage, family therapist, and licensed mental health counselors, as of now are listed as exemptions. And so, we're going to continue to work closely with warriors to hear their experience throughout the system so that we can step in if and when there's an area for us to offer support.

Senator BLUMENTHAL. But if there are insufficient exemptions, it will have a deleterious effect. I assume you would agree?

Mr. EATON. Yes. The capacity and timeliness for care is definitely tied to provider capacity.

Senator BLUMENTHAL. And the freeze on funding, that affects vital programs including suicide prevention program. Just to give you one example, Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program provides grants to community-based suicide prevention resource meet the needs of veterans. You're familiar with it, Mr. Lorraine?

Mr. LORRAINE. Yes, sir.

Senator BLUMENTHAL. Including Easter Seals, for example, in New London, Windham Counties in my State of Connecticut. That program now is frozen——

Mr. LORRAINE. Yes, sir.

Senator BLUMENTHAL [continuing]. In terms of funding. That's a bad decision. Would you agree?

Mr. LORRAINE. I think it freezes our ability. We connect to 235 veterans a week through the Fox Grant. That's 235 veterans I can't connect to.

Senator BLUMENTHAL. Thank you. My time has expired. I have quite a few more questions, and I hope the Chairman will give us a second round.

Chairman MORAN. Senator Cassidy.

HON. BILL CASSIDY,
U.S. SENATOR FROM LOUISIANA

Senator CASSIDY. Thank you. Mr. Golnick, maybe three years ago, we had testimony that VA was giving people iPads, and allowing telemental health, and also setting up satellite offices, for example, in a rural area in the back of a Walmart. So, it would be as if you're going to the pharmacy, but instead you slip back there and it would preserve—you know, you weren't going to the psychiatrist with a stigma that might be there, but rather very discreet.

As I read each of your testimony, I didn't see any reference to that, so I'll throw that open, but I'll start with you. What about this telemental health program? Are you familiar with it?

Mr. GOLNICK. I am, Senator. Yes, again, I think there are lots of good options getting out there. And again, I'm not anti-telehealth. I think that veterans should have the opportunity to be able to have the choice between seeing an in-person provider versus a telemedicine care, if that's the only option available.

Senator CASSIDY. Well, I only mention that because the rule aspect of it. I mean, this is obviously a way to—so someone doesn't have to drive an hour to get in and fighting traffic and maybe miss the appointment. I'm a physician. And by the way, Ms. Mathis, do anybody else have any experience with the telehealth and is it effective?

Because, obviously, one issue here is the lack of providers, and this was portrayed to us, us as a way that maybe extra providers across the country would be able to provide services someplace else and therefore give some continuity of care and address that need. Yes, ma'am.

Ms. MATHIS. Yes, sir. We agree telehealth is an excellent option. I think, though, when it comes to license portability, there becomes an issue.

Senator CASSIDY. No, for the VA I'm told——

Ms. MATHIS. For VA that's not an issue.

Senator CASSIDY. Not an issue, correct.

Ms. MATHIS. But if you're talking about——

Senator CASSIDY. But be specific about the VA right now.

Ms. MATHIS. Yes, sir. Telemental health is a very good option, complementary with in person.

Senator CASSIDY. And so, is that being fully used and or is it fully effective? I guess that's because a lot of what we have here is a shortage of providers and therefore requiring long wait times and/or referral. Yes, ma'am.

Ms. MARG. So, my husband has utilized telehealth before in some of his referrals to community care. Personally, for him, he would rather choose to see somebody in person, given the opportunity, especially when he's talking about his mental health struggles.

Senator CASSIDY. Again, I'm a physician, so when there's so much churn and that churn has been a feature of the discussions about mental health in the VA for some time, it's telling me something's wrong. Now, it could be that the salaries are less, but then why would you take the job in the first place? Or it could be that the administration is so frustrating that people just don't want to spend the rest of their life in this sort of a situation.

Now, you're on the outside looking in, perhaps, but you may have special insights. Any ideas as regards why there is so much churn among providers?

Mr. GOLNICK. In terms of them getting into the VA, or?

Senator CASSIDY. No, the providers. One of the things I read said, "They provide us with this constant turnover. When you're trying to get that rapport, and then six months later you have somebody else, and then six months later you have somebody else." And we've seen previous statistics in which there's a lot of hiring, but there's a lot of departures. And so, I'm trying to—and there's a pattern there, and it's disruptive of the patient-physician relationship or the provider-patient relationship. Do we have any insight as to what might be causing that churn? Jim?

Mr. LORRAINE. Yes, sir. One of the things that we see, it's not just a churn about leaving the VA, it's a churn about leaving, moving within the VA, also. I think, continuity, and I mentioned it in my testimony, continuity is really critical. And I think whether when we talk about telehealth, seeing a patient face-to-face as a provider, myself, seeing a patient face-to-face can't be replaced by telehealth. It can be augmented and enhanced by telemedicine——

Senator CASSIDY. I accept that.

Mr. LORRAINE [continuing]. But in terms of the churn, you're moving within an enormous VA system. They just don't—it's not just leaving the system. It's leaving the facility that you're in.

Senator CASSIDY. So, they may go from Des Moines, Iowa to New Orleans, Louisiana?

Mr. LORRAINE. Or move within the facility to another area, yes, sir.

Senator CASSIDY. Okay. But then, obviously, theoretically you've systems that would limit that?

Mr. LORRAINE. But you'd lose your continuity. It's a churn. It's a churn from the individual's level out. It's a churn.

Senator CASSIDY. Okay. Well, I thank you-all for your testimony.

Chairman MORAN. Senator Gallego.

HON. RUBEN GALLEGO,
U.S. SENATOR FROM ARIZONA

Senator GALLEGO. Thank you, Mr. Chairman. Thank you, everyone, for being here today, and for your service to your country whether by direct service or as a family of a service member. The testimony today illustrates the ways in which bureaucracy's failing our veterans, especially when it comes to veterans seeking mental health care.

Personally, I have my personal experience with this. When I first got back from the war, I actually tried to go right to my VA, and my ask for services for PTSD was rejected because my paperwork hadn't caught up. And then continued to try to get help as well as many of my other guys that I serve with, and avoided therapy for almost 12 years after that. And luckily, and now in and have been, but a lot of us missed some opportunities, I think, to really put ourselves in the right path because of VA bureaucracy back in the day.

And this is 2005, 2007 timeframe. So, this is, as I say, this is very personal to me. And even now, I still talk to my brothers in arms who are now also going through different levels of therapy and/or rehabilitation. So, thank you for the testimony you guys are providing because this is, obviously, important.

As well as also, I am disappointed that we didn't get someone from the VA to come and talk because they could have brought us a very good firsthand experience about really what effective contracting looks like, as well as asking the Government Accountability Office about their assessment of the program last year. And I think that would've been a very good perspective, because we really need to look at this holistically. And for us, veterans that use services get PTSD services or other services, we know the best way to deal with anything of this nature is holistically.

So, Mr. Golnick, thank you for sharing your experience seeking mental health care through the VA, and for the work you're doing with Forge Health—did I say that correctly?

Mr. GOLNICK. Yes, sir.

Senator GALLEGO. Okay. Just want to make sure. English is my second language, so sometimes I mess up things. I've also had the experience of seeking care, as I said, and dealing with the trauma of being told that you can't get help. And it's too common of a story among us veterans. It's our responsibility to ensure that veterans have access to timely high-quality healthcare.

And in your testimony, you said that like the men that I was able to help catch in the first months really of trauma were the ones we were able to recuperate and put on a good path. And those that weren't has been a very long trial out. You mentioned the collaboration between Forge Health and VA showcase potential VA community partnerships, but also highlight some of these ongoing challenges.

Can you speak more specifically about what you saw in terms of inconsistent implementation, and what solutions you would recommend be implemented to address these issues in particular?

Mr. GOLNICK. Yes, Senator, thank you for your question. I think, again, going back to what I had mentioned previously, there are some VISNs and some VAMCs that are very collaborative and work well within the system if there's delays, and there are some where they were basically told not to refer out no matter what the case was, right? So, I think the standard, how we fix this, in my personal opinion, is to figure out a way to standardize those standards across the system to where every VISN, every VAMC has the same exact standards on how they're going to refer out the number of people they're going to refer out.

I understand that community care costs money, but there's—you know, again, Senator, when you have a veteran and you don't catch them in time, and then they end up going to the emergency room.

Senator GALLEGO. Becomes more expensive,

Mr. GOLNICK. It becomes way more expensive, right? So, how do we go upstream to prevent that? And so, I think that standardized practice across the VISN and across the VAMC really is an important piece.

Senator GALLEGO. Some of that is like tech, but some of it's just like SOPs as if we used to do the military. No matter what unit you were, you did the SOP. So, actually, you didn't have to have massive retraining, and there was at least uniformity across.

Mr. GOLNICK. And, unfortunately, you saw it from the VAMC where the providers or the people that were referring out would say, "Hey, I'm trying to refer. I understand this veteran needs that care." But the VISN is telling us no.

Senator GALLEGO. Got it. And Naomi—did I say that correctly? Great organization that I really appreciate Disabled American Veterans. They actually helped me get my VA disability rating. So, thank you so much.

But I wanted to follow-up on that. Are there currently any standards in place to ensure that community care providers are adequately trained to treat these types of conditions, in your opinion? And also, have you seen any specific instances where the lack of veteran-specific training standards have negatively impacted the quality of veteran care, at least from people that have been sharing with members, constituents of the DAV or other organizations?

Ms. MATHIS. Thank you for that question, Senator. Correct. There is a lack of training in community care. Currently, community care providers are only required to have opioid abuse treatment training, and this is as far as compared to direct care. So, there's a difference between what the direct care providers are required to have and the community care providers. And so, this is why we believe that if you strengthen the VA direct care, that then you would have better health outcomes.

Senator GALLEGO. And so, community care—and I apologize, Chair—but so community care, sometimes there may be a veteran that goes, but only ends up getting some treatment specifically for opioids, but not, for example, trauma, deep trauma, or anything else of that nature. So, there's probably a mismatch at that point. And what you're saying is there's probably a better investment in

direct care, or potentially maybe also doing community care, hyping up community care, making them more accessible to traditional PTSD?

Ms. MATHIS. Where they would understand military culture.

Senator GALLEGO. Yes.

Ms. MATHIS. Right. And so, that's really where that opportunity is missed. Is you might have a veteran that presents before a community care provider and they don't understand military culture, and they're missing the cues where this patient might actually be suicidal.

Senator GALLEGO. Thank you. Thank you, Mr. Chairman.

Chairman MORAN. Excellent. Senator Tuberville.

HON. TOMMY TUBERVILLE,
U.S. SENATOR FROM ALABAMA

Senator TUBERVILLE. Thank you, Mr. Chairman. Ms. Marg, I apologize for what's happened to your husband. I had a couple friends who went through the same situation. Terrible outcome. Even some were arrested at the VA for not having appointment and run off the property. It's a terrible mess. How do you communicate with other service members or family that come to you and asks you about your husband's problem? I mean, what's that conversation like?

Ms. MARG. I'll tell them that any story that they've heard about the VA is true. When I've heard other people's stories, when I first heard them, I was surprised and shocked that, like, this must be a one-off situation. But my husband has been medically retired since 2015, and it seems like every step along the way, it is just such a struggle.

There's been many times where my husband has just felt that he is done, and I tell him he is not. And we just keep fighting. And sometimes it takes going to an outside entity to get help, which I'm incredibly thankful that it exists, but that's ridiculous.

Senator TUBERVILLE. Ms. Mathis, I heard you say something in your opening statement. Are we still having problems getting information from the DoD to the VA?

Ms. MATHIS. Yes, sir. There is no interoperable.

Senator TUBERVILLE. And we've spent billions of dollars doing that. Billions, not millions, but billions. I wonder why we need a new IG. I wonder why we need to freeze the funds. We find out what the hell's going on. It's embarrassing. Absolutely embarrassing. I mean, the biggest healthcare system in the world and second largest budget in our country, and we can't figure out how to get information from one entity to another. But you know what? I've talked to people who said they could do it, but we won't go to those people. For some reason, we keep going to the same people. Any follow-up?

Ms. MATHIS. Senator, I think that's something that VA needs to really get a handle on, which is the records issue and the Electronic Health Records System. I believe, and I, I probably misspoke, I believe that VA, DoD, are probably easier to speak to each other. But when you talk about community care and VA, is where you have the rub, is where you have the issue. Records are

not coming back into VA from community care, and they're not going out.

Say for a mammogram. If I go for a mammogram for three years in a row, I go to the same provider, right? And then VA sends me, I don't know, maybe to another provider. That provider that is going to look at that radiograph needs to see the previous other images, not just the report. And so, then the onus is on the veteran to transfer those records and those images from one provider to the next, or from the provider to VA. And so, that's where they really need to need to have an interoperable system. A system that talks to each other.

Senator TUBERVILLE. So, we have the same problem in the DAV, just as bad as we do in the VA of information coming back and forth, that was the disabled veteran.

Ms. MATHIS. In DAV?

Senator TUBERVILLE. Yes, the same problem, informationwise, exchanging of the information from one entity to another.

Ms. MATHIS. You mean from VA?

Senator TUBERVILLE. Yes.

Ms. MATHIS. Oh, from VA to DoD. They've actually worked on that with Cerner and with Oracle. But it's really the issue is from community to entity.

Senator TUBERVILLE. Okay. Thank you, Mr. Chairman.

Chairman MORAN. Thank you, Senator Tuberville. Senator Duckworth.

HON. TAMMY DUCKWORTH,
U.S. SENATOR FROM ILLINOIS

Senator DUCKWORTH. Thank you, Mr. Chairman. And I want to welcome our witnesses for being here. Family members are caregivers. And thank you, Ms. Marg for your standing by your husband. As far as DAV, you hold my power of attorney as well. Says something. And Mr. Eaton, there might be a conflict of interest. I think I was the first female patient to receive a care pack, one of the backpacks that Wounded Warrior Project handed out at Walter Reed. I think I was one of the first 10 you ever handed out. Unfortunately, it had jockey shorts, socks, and a shaving kit.

[Laughter.]

Senator DUCKWORTH. None of which I could use, but my husband thanks you for them. The kits are much better now because now with the presence of women, they took my advice and readjusted, so. But certainly, Wounded Warrior Project was there for me very early on.

I do want to take a moment to bring attention to that outrageous EO that President Donald Trump signed last night. And my colleague, Senator Blumenthal, touched on briefly that this EO will pause all federal grants effective 5 p.m. Eastern Standard Time today.

We are in a hearing room full of policymakers and citizens dedicated to the welfare of our Nation's veterans, but let me tell you what this means for you or your loved ones who receive care from VA. This EO will pause critical and life-changing VA grants, including those that aid in VA's mission, ranging from community-based suicide prevention efforts, to rural veterans' telehealth, ac-

cess and transportation services, to hiring and retention of nurses at State Veterans Homes, to especially adapted housing, assistive technology, and so much more.

It is sadly ironic that we are here today to discuss expanding access to care for veterans. Meanwhile, the Trump administration is actively preparing to restrict their access to care in just a few hours' time. What happens then, in the meantime, to veterans who rely on these grants for suicide prevention resources? What happens to rural veterans who rely on VA transportation services to travel to their VA medical center? What happens to veterans who rely on these grants to live independently?

This EO, which is illegal, by the way, creates chaos and threatens the stability of these programs that, in many cases offer, lifelines to people who sacrifice for their country. Congress alone has the power of the purse, and Trump unilaterally freezing billions of dollars of federal grants and loans that Congress already approved is unconstitutional and will hurt millions of people across this country. I hope that my Republican colleagues and the courts have the spine to stand up to Trump in the face of this cruel, chaotic, and unconstitutional order that hurts everyday Americans, including veterans.

I could not agree more with the frustrations that have been described with trying to access care through VA, within VA itself, as well as through community care. I have both. I get care in the community because the VA cannot provide me care, for example, with the extremely advanced prosthetic devices that I use. I should have the right, and I do have the right to choose the prosthetist who provides me with that care.

It's very ironic because the VA provides care for my left leg, but my prosthetist in the community provides care for my right leg. So, it's really important to me that they talk to each other, because otherwise, it makes it very difficult to walk.

And, Ms. Mathis, I think you're touching on this communication piece is critically important. When I went from DoD to VA, I was given a CD-ROM. I had to wait 90 days to go talk to VA, at which point, I went and saw a physician assistant whose job it was to determine whether or not I was still an amputee.

It was a waste of his time. It was a waste of my time. He wanted to be taking care of veterans, and yet he had to go through this rigmarole. To this day, there is still lack of good transferring of information from the DoD to the VA. It is also compounded when you go to community care. I do think that we need to do much more to allow veterans to make their own decisions.

And Mr. Golnick, I appreciate that you brought attention to this very issue in you witness testimony about veterans being able to make the decisions. In your opinion, how should VA be ensuring that veterans are getting the information they need to make appropriate decisions about their care, including the choice to receive direct care at VA?

Because VA needs to be your medical center home. I think you should go to VA, that's your medical center home. And they look at you and they go, okay, you're an Iraq veteran. We're going to take care of your mental health. But also, you may have respiratory illnesses. You need to be informed. And then, if you want

to go to community to get the care, that should be made seamless. Can you speak to that?

Mr. GOLNICK. Yes, Senator. I do think it's an education thing. And I think on the ground level, and I'm sure you've seen both of you, have seen this before, where the clinicians at the ground level, at VA, they want to do the right thing. They want to get veterans into care immediately. They want to get the care that they need. I think where it gets gunked up is when it gets up to a different level, right? So, it starts going up to the VISN level. They're putting the referral in.

But in terms of educating, I think there needs to be an education across the VA system of, hey, these are your options. These are the things that are out there. Here's what we can provide. Here's what we can't provide, or it's going to take too long, and here's how you get there. And this is the process to do it. So, I think there really needs to be an education on the ground level, and I think it needs to go all the way up to the VISN level.

Senator DUCKWORTH. Thank you. Thank you, Mr. Chairman.

Chairman MORAN. Thank you, Senator Duckworth. Let me indicate there's a vote at noon and we have less flexibility than we used to have in enrolling the timeframe. So, I'm going to try to keep everybody to their five minutes. Senator Blackburn.

HON. MARSHA BLACKBURN,
U.S. SENATOR FROM TENNESSEE

Senator BLACKBURN. Thank you, Mr. Chairman. I appreciate what Senator Tuberville said, and Senator Duckworth just alluded to this; that it is very difficult for the veteran to get their records.

And I think one of the things we should look at is who owns those records. It would be so much more helpful if the veteran himself controlled those records. If individually, we owned our healthcare records, every one of us. And then that way, you wouldn't have the problem that you're talking about, Ms. Mathis. The veteran would be in charge of their records, and would be able to take it whether they're in community care, whether they're in TRICARE.

Because we have seen just an inordinate amount of waste in trying to build the Electronic Health Records. Whether it is Cerner, Epic, Oracle, it is like they can't figure this out. In Nashville, Tennessee, we've got a lot of health IT innovators. They can figure this out. And one way to do it is to let individuals, not the doctor, not the insurance company, not an agency, own their healthcare records.

I also want to say, I find it very sad that for many of our vets, Tunnel to Towers and Wounded Warrior are the people that can help them get help, because the VA can't figure out how to do their job. They're still working remote. They do not show up. It takes forever. That's why there are 956,000 claims in the queue, and nearly 300,000 over 120 days. And veterans cannot get a response from these people.

I know a lot of it is because of the union that is there at the VA that is stifling access to this care and benefits. And I find it just something that should not be tolerated. And it's frustrating to the veterans that we're trying to serve. And it's why community care

is so vitally important. And Ms. Marg, thank you for speaking to that.

Mr. Golnick, I want to come to you and thank you for your service, and thank you for what you're doing with Forge in trying to solve a problem, because the VA has thrown up barriers to healthcare. And you're trying to get around that and improve access. So, I want you to give like a 1, 2, 3 point. What could this Committee require the VA to do to improve that access?

Mr. GOLNICK. Thank you, Senator. And just to be clear I am a co-founder of Forge. I've stepped down from full-time with them, so that's why I'm representing myself. But I will say there are things, and to your point, Senator, I think there's a lot of friction points that are preventing veterans from getting access to care, especially when you're talking about mental health, right?

I think what this Committee could do is work with the VA to ensure that they're educating veterans. That the VA is educating veterans on what their options are. Number two would be the administrative side of this. Ensure that the access standards are codified so people that within VA system know, okay, if X, then Y, right? I think that's as simple as that.

And then I think ensuring that there's some oversight on certain VAs and certain VISNs in terms of that care being—making sure that that care of the veteran is the true North Star. It's not what their local budget is. It's not anything else. Care of veterans should be the true North star of all care decisions.

Senator BLACKBURN. I agree with that. And putting the veteran at the center. That's why I've got this VA Health Care Freedom Act that would remove those obstacles, and really put the criteria in the MISSION Act for eligibility for community care, and give full choice to veterans in select regions. Let's roll this out as a pilot project and then put it on a four-year path to fully implement it so a veteran can go get what they need when they need it, where they need it. Show their VA card, and the VA gets the bill, not the veteran. And that would solve this and this enormous backlog that we have. Give the veteran the choice, put them at the center of this. Thank you, Mr. Chairman.

Chairman MORAN. Senator Blackburn, thank you. Senator King.

HON. ANGUS S. KING, JR.,
U.S. SENATOR FROM MAINE

Senator KING. Thank you, Mr. Chairman. In answer to Senator Tuberville's questions, I think the beginning of this electronic medical records problem started with a no bid contract about five years ago, six years ago, that was extended by the last administration. And I still don't understand why we don't go out to the market, whether—I'm sorry you mentioned Epic, Senator. Because Epic is a successful medical records system that I've observed in my system——

Senator BLACKBURN. All running slow.

Senator KING. Well, okay. In any case, it seems to me, in order to analyze the issue of the relationship between VA direct care and community care, we need more data. We know exactly the VA wait times and all those kinds of things. We don't have that kind of data in terms of the private sector. I know in the private sector in

Maine, it's pretty hard to get an appointment particularly with a specialist.

So, I think in order to make policy here, Mr. Chairman, we need some, we need some information. We need to have cost comparisons. We need to have time comparisons, wait times. So, I—everybody's nodding, but that won't show up in the record. Could somebody say yes?

[Laughter.]

Senator KING. "Yes, Senator, you're right."

Ms. MATHIS. Yes, Senator, I wholeheartedly agree. There is no data coming back out of the community back into VA. And there is no sort of accountability either when the records don't show up back to VA. So, you have a provider, a primary care provider, say at VA, that may have sent a patient out to the community for specialized care, and the information when the patient comes back to VA, the information is not coming back. Therefore, that provider is not able to provide an accurate treatment plan for that patient.

Senator KING. So, we know we don't have a handle on cost, quality, or time. Is that correct?

Ms. MATHIS. Correct, Senator.

Senator KING. And, by the way, when we're talking about the time of VA's responsibility on backlogs, a staff freeze isn't going to help that problem. If there are fewer people to answer the phone, fewer people to process claims, that's only going to exacerbate the problem, not, not make it any better.

And I note that the administration the other day appeared to walk back part of the hiring freeze with regard to direct care providers, but to leave a hiring freeze in effect that has fewer people responding, processing claims, and those kinds of things, that's in effect, a denial of benefits itself. Is it not, Mr. Eaton?

Mr. EATON. Yes. I think the big focus area, and that's where we come in, and Senator Duckworth mentioned in terms of the backpack. You know, in 2003, we started providing backpacks to the first injured, ill, and wounded Warriors coming back from Iraq and Afghanistan. And we made a promise. And so, we'll continue that promise that we'll be there for their needs for a lifetime.

And so, we're doing that today in times where there's changes throughout the system that we can be a constant, to support them and remove barriers to increasing access to care.

Senator KING. And I think one other factor we need to talk about when we're talking about private sector is that there are huge shortages in the private sector. My major hospital, one of my major hospitals in Maine is down something like 800 nurses. And so, it's not enough to say, oh, the community can take care of it when, indeed, there are shortages in the community in terms of CNAs, nurses, psychiatrists, psychologists.

And I think we need to recognize that there's no simple answer to this. To me, the answer is better coordination, better data, and understanding the results that we want for our veterans. That's really the goal. Is that correct?

Mr. GOLNICK. Yes, Senator, absolutely. And to your point, even the private sector, a lot of the commercial payers aren't even collecting this data because it makes them look bad if the wait times

are too long or any of this other stuff. So, it really needs to be complementary.

Senator KING. I just want to be sure we're comparing apples to apples when we're deciding policy here, and that we don't move toward a policy that in the real world, doesn't necessarily improve things for the veterans. And I'm just concerned that we not hollow out the VA capacity and then say, "oh, look, the VA's not doing very well," when we've made it impossible for them to do it, to do the work that they've been charged to do.

So, I appreciate you-all joining us here today, and look forward to continuing to work with you because I think this is an issue that needs attention. Thank you. Thank you, Mr. Chairman.

Chairman MORAN. Senator, thank you. The Elizabeth Dole Act that we passed and became law requires significant data collection regarding community care. So, maybe we'll have some information that we can make that analysis. I also would point out that I've argued with the VA about when the wait time starts, and they want to start the wait time when the appointment is made, not when the veterans ask for the appointment. But I don't need to get——

Senator KING. You ought start with the call.

Chairman MORAN. Yes.

Senator KING. Thank you.

Chairman MORAN. Senator Cramer.

HON. KEVIN CRAMER,
U.S. SENATOR FROM NORTH DAKOTA

Senator CRAMER. Thank you, Chairman. Thank you to all of you for being here, and for your testimony, and for your service. So, a couple of things come to mind. Well, one of the things with regard to Senator King's comments about shortage of workforce, that's a real problem. That's a problem in healthcare. It's a problem in manufacturing. It's a problem in everything. But it is particularly challenging in healthcare.

Which is why the CMS rule, the staffing rule, is so awful because it literally, literally provides less opportunity because it runs the risk of shutting down healthcare providers simply because they don't have a 24-hour day, 7 day a week RN. And I would submit to you that access is not just about the quality of the care, it's about access, period, if the alternative is none.

And so, while standards are important, I would also submit that I don't share some of my friends' view that it shouldn't be competitive. I think the best way to improve care is competition. Whether it's competition between the private sector and the public sector, or two private sectors or two public sector agencies. A little bit of competition is fine.

I agree, I don't want to gut the VA's direct care system. There are unique things about the VA that I know several of my veterans—I have a veteran who would drive 300 miles to Fargo every day before he would see a local provider, particularly for counseling. All of that said, whether there are all kinds of barriers to community care, a lot of it is the bureaucracy itself. I mean, even in North Dakota where we have a quite a cooperative VA hospital in Fargo, we hear many, many stories of roadblocks being put up

to community care. They check all the boxes except one, or you know, they only check 99 out of the 100 boxes, therefore null.

I just think we need to make it—I agree with what Senator Blackburn said. If we put the choice in the hands of the veteran, the market will determine where they go. The type of care they get will determine where they go, how long the wait is will determine where they go.

So, a little bit about North Dakota. We have one VA center. It's in Fargo. That's right on the Red River. I mean, literally on the—it's on the shores of the Red River, which is the barrier, the border to Minnesota. That means if you're in Williston, or Dickinson, or Beach, you might be 400 miles away from the VA hospital.

We have eight CBOCs, I think it is. And we have 37 critical access hospitals. Critical access care hospitals are there on purpose, and it has to do with access, right? And they're reimbursement by CMS particular formula. And we have veterans, and by the way, I think it's just a handful of those CBOCs are in the same community as a critical access hospital.

What I'd like to see us do, and I've got a proposal to do this, and you'll be hearing more about it eventually, and if training's required, I'm all for it. But for many of these critical access hospitals, their margins are this thin. They're barely hanging in there. And two, or three, more patients, or five more patients in the community might be what keeps that hospital open. And if it's 50 miles to the next hospital or 350 miles to the VA hospital, that critical access hospital might be the only provider that could save a veteran.

I'd like to make this automatic. No doubt, smart people can figure out the records thing. I don't know why it's taking as long as they can. And maybe I'll start with you, Mr. Lorraine. Is that plausible? Am I somewhere in the ballpark of a possible solution in a very, very rural place?

Mr. LORRAINE. Yes, sir. I know I've been to Minot, I know how rural and out there it is.

Senator CRAMER. That's one of our biggest cities.

[Laughter.]

Mr. LORRAINE. But, you know, one of the things that I spoke about was continuity of care. And not only continuity care is a healthcare provider, I want the family there, I want the physical therapist nearby, I want the staff that does this. And we talk a lot about mental health and substance abuse, but it's really more than that. We're talking about access to healthcare, right? So, it's surgery. How many total knees are done in this location versus this location.

So, the answer is we need to look at what's the best long-term outcome for a veteran in terms of getting their care. It may be the VA that's in their community. But it may be your local hospital that the family can be present, the physical therapist is there, the staff is invested. And it's all one. Thank you.

Senator CRAMER. I'd just rather have it easy rather than confusing, and then likely, a denial for community care. Thank you.

Chairman MORAN. Senator Hassan.

HON. MARGARET WOOD HASSAN,
U.S. SENATOR FROM NEW HAMPSHIRE

Senator HASSAN. Well, thank you, Chairman and Ranking Member Blumenthal, and thanks to all of our witnesses for being here today. Whether you've served, been an advocate for veterans, or both, we really appreciate your support for and commitment to our veterans and to our Nation.

I appreciate that this hearing is focused on community care. It's a really important component of providing care to our veterans, especially in a state like New Hampshire, which doesn't have a full-service VA hospital of its own. It matters that we get this right and that we ensure that veterans who qualify for community care really get prompt access to it, understanding as Senator King has pointed out that access in the private community care system is challenging for private citizens as well right now.

But before I get to any questions, I want to take a moment to discuss what are illegal and unconstitutional acts by this administration because of the way they affect the very issues we are talking about today. As Senator Duckworth referenced, the administration last night ordered a full halt on a whole lot of federal funds, including some states are now locked out of Medicaid funds. Community care in rural areas that Senator Cramer was just talking about won't exist if hospitals don't exist. And they are very dependent on Medicaid.

But the administration appears to be halting that funding as it is halting critical funding today for veterans in rural areas that depend on it. The administration also took an illegal act when it decided to unilaterally try to fire inspectors general contrary to law, and this is really troubling for a lot of reasons.

But just for example, the VA inspector general's office just released a report last fall on community care scheduling delays in the VA health service. But the administration is unilaterally, contrary to law, decided to fire all of these inspectors general. The report that that inspector general did concluded that leaders had failed to focus on the patient, respond to staff concerns, and get to the root cause of concerns regarding delayed scheduling of urgent consults.

This type of work holding government accountable and making sure that our system operates as efficiently as it can is at the heart of what independent, Senate-confirmed inspectors general do. So, that's why I am really concerned by President Trump's illegal firing of at least 17 inspectors general over the weekend, including VA Inspector General, Michael Missal, who was confirmed to that position with unanimous consent by the United States Senate.

The letter to these inspectors general said that priorities were changing. That's what the Donald Trump administration said. What greater priority is there to ensure that taxpayer dollars are used? Well, it is in the interest of every American that these public servants be able to investigate waste, fraud, and abuse without political interference, and be able to stand up to powerful interests without fear of losing their jobs. We owe that to our country and especially to our veterans.

Now, I have time for a couple of questions. I want to start, Mr. Eaton, with you. In your written testimony, you discussed some of the obstacles veterans encounter when seeking mental health care,

and in particular, identified that more providers are needed regardless of whether they are in the community or in the VA system.

Mr. Eaton, can you please speak to the need for veterans to have access to steady, high quality mental health treatment, and how increasing the number of mental health providers could support that?

Mr. EATON. Thank you for the question, Senator. When you think about an effective care team, and we understand that, first of all, the personal journey that it takes to get to that first appointment, building a relationship, rapport and telling your story is incredibly meaningful to building that relationship.

And so, as VA employees or even community care network employees are transitioning, really it leaves the veteran to navigate that system, again, on their own. And so, as we've highlighted here today, not only a veteran issue, but also just as civilians, in general, mental health is a shortage area. And so, looking at ways to incentivize providers create environments where practicing medicine and mental health is a thriving environment, is really important, as we're helping to buildup a system to support veterans.

Senator HASSAN. Well, I appreciate that. Thank you very much. Ms. Mathis, community care provides a chance to receive timely quality care close to home for many veterans who don't live near VA facilities. This is especially true for rural veterans and veterans who live in states like New Hampshire that don't have a full-service VA hospital.

Ms. Mathis, could you please discuss the importance of ensuring timely access to local care for rural veterans, and the role that community care plays in ensuring that veterans get the care that they need and deserve?

Ms. MATHIS. Absolutely. Thank you for that question, Senator. As outlined in the MISSION Act, it should be complementary, the two. We believe that access to community care is essential, especially in a rural community where you're fighting with the community to get specialized care. And so, yes, absolutely, access is critically important and really could be lifesaving.

Senator HASSAN. Thank you very much. Thank you, Mr. Chair.

Chairman MORAN. Senator Banks.

HON. JIM BANKS,
U.S. SENATOR FROM INDIANA

Senator BANKS. Thank you, Mr. Chairman. Mr. Golnick, healthcare organizations get more frustrating and impersonal the bigger they get. I think we all agree about that. And the Veterans Health Administration is the largest hospital system in the country. Why do you think the VA is so bureaucratic, and what can Congress do to change that culture?

Mr. GOLNICK. Senator, that's a tough question. Every large healthcare system is frustrating, right? There's a lot of—there are a lot of things that are structurally in place that I think are important things, that are safety. You know, especially when you're talking about mental health, right? Like, accreditations, certain things. Clinicians should have a certain criterion.

Again, I don't think it's on the clinical side that we're seeing the issues where I see the issues are when you get up into the administrative, right? I think the processes that are in place right now be-

tween VA into community care and back and forth, what my colleague from DAV has been talking about, that's really where I think there could be some good work done in codifying those access standards so that everybody in this bureaucracy—you know, I look at things as a naval officer, right? They always said the instructions are written in blood, right? Because there needs to be a very clear line that shows okay, if X then Y. And we don't see that a lot in a lot of these places because there's no standardization.

Senator BANKS. Yes. As a Navy officer, you understand culture, though. So, how do we change the culture, and what can I do, Members of the Congress do to force that culture to change?

Mr. GOLNICK. I think the ability to ensure that the leadership at VA—I've talked to some VAMC directors in my time where they said, you know, I give directives not orders, right? So, sometimes things are just not followed, right? So, I think there needs to be, you know, in order to change that culture, I think really streamlining and codifying things in a more clear manner, and having an SOP. And having those things in place is going to ensure that people are following the letter of those instructions.

Senator BANKS. Mr. Lorraine, we hear a lot about community care being too expensive. It accounts for about 40 percent of veterans healthcare, and it makes up about 25 percent of the VHA budget. That sounds like a pretty good deal to me. Isn't it?

Mr. LORRAINE. Yes, it is. But I don't think we've given enough chance to the community care to measure the long-term impact of local, meaningful, well-rounded healthcare. The other thing, if I can just add to the question that you asked Eric, in my opinion, the veteran needs to be the center of the universe for the VA, not the VA, the center of the universe for the veteran.

Senator BANKS. Amen. Well put. The VA added 120,000 employees over the last decade, and I support giving the VA the resources it needs to take care of our veterans. But there are only so many doctors and nurses to hire. How do you think the department can deliver more healthcare with the personnel that it already has?

Mr. LORRAINE. You know, I think there needs to be, not managed healthcare, but coordinated care. Coordinated care. Somebody needs to take responsibility for the veteran and connect them to private organizations like WWP, public healthcare providers that are in the Community Care Network and the VA. To look for the best opportunity, but to unify, to coordinate the care for the best outcome. It doesn't just need to be in the VA.

Senator BANKS. Mr. Eaton, we want VHA care and community care to complement each other, not compete as they have over the last decade. What VA policies need to change to make that happen?

Mr. EATON. Thank you for the question, sir. I would say, again, we've hit on throughout today; standard access across the board. We think about VHA as the largest integrated health network. That's their direct care, but also the Community Care Network. And these are cultivated networks created in partnership with third-party administrators that have been found to offer high-quality, veteran-centric care. And so, having the same standards and then care coordinated throughout the entire system, not thought about as two separate would be really a great first step.

Senator BANKS. The VA has 120 residential mental health rehab facilities, and veterans in crisis are waiting about three weeks to get placed. It takes the VA three to five years to lease a new facility. Do you think the VA could ever open enough residential rehab facilities to fully meet the veterans' needs?

Mr. EATON. I think if we take a step back, that's why the Community Care Network exists, right? To really complement the VA in areas where there's gaps, higher demand, and where veterans' needs are most sought. And so, I think if we take a step back and look at all inputs from both footprint from the VA, as well as the Community Care Network, we'll have all the data points to make an informed decision.

Senator BANKS. Thank you. I yield back

Chairman MORAN. Senator Banks, thanks. We're not doing another round because if somebody else walks in the door, I'm in trouble on the time. But Senator Blumenthal has a couple of questions, and I have a couple of questions, then we're going to wrap this up.

A vote was expected at noon. We no longer have the flexibility because we're attempting to enforce the votes only lasting 15 minutes. And we used to be able to do this much differently, but we cannot. So, Senator Blumenthal,

Senator BLUMENTHAL. Thanks, Mr. Chairman. I have a few questions which I think are answerable by yes or no because what I'm hearing is, as Mr. Lorraine said so well, veteran ought to be the center of the universe. Veterans' choices should be respected, veterans' decisions should be informed so that the veterans' medical interest is put first.

And an informed decision can't be made by a veteran based on an ad that he/she sees on television saying, go get this drug. You know, anybody watching TV these days, you are deluged by ads that depict certain drugs as cure-alls. A veteran shouldn't be permitted to go into the community and just say, "Give me this opioid." I assume all of you would agree?

Ms. MATHIS. I would agree with that, Senator.

Senator BLUMENTHAL. And I'm taking the absence of a disagreement as a yes. Let me pose another question to you real quickly. My fear, as I said at the very beginning, is that there will be an erosion, a starving of the VA because the attempt to shift care to the community without veterans having choices will mean less investment in the VA system and Connecticut.

We're rebuilding our VA facility in West Haven. It will provide for a new surgical suite, new parking, new care facilities, particularly for women. That kind of investment will make VA care better than it is now. I assume all of you would agree that we need to make those capital investments in VA facilities across the country, and maybe build facilities in parts of Kansas that right now don't have any. Would you-all agree?

Mr. LORRAINE. I disagree, sir.

Senator BLUMENTHAL. I'm sorry?

Mr. LORRAINE. I disagree.

Senator BLUMENTHAL. Tell me why?

Mr. LORRAINE. I don't think that we can build enough VA facilities to meet the needs of every veteran in the United States. I

think that there needs to be a merge between good VA facilities and none. I don't mean to use up your time.

Senator BLUMENTHAL. And you are absolutely right. And if I was unclear, I'm not saying that VA facilities should be built for every veteran. We need some community care, no question about it. But the VA facilities that exist right now serving veterans in Connecticut or Kansas, should be the gold standard. They ought to be top flight. They ought to give veterans the best care possible. Would you agree with that point?

Mr. LORRAINE. 100 percent.

Senator BLUMENTHAL. Thank you. Let me just conclude by saying this conversation seems a little bit surreal this morning. Because I'm hearing from—I'm getting emails from healthcare groups in Connecticut whose funds have been frozen. These are suicide prevention, they're addiction treatment, their payrolls are halted, their budgets are in danger. We're talking here about community care potentially decimated. There's chaos and confusion as a result of this freezing of funds.

You know, in my prior life as Attorney General in the State of Connecticut, I would be in court saying that this action is illegal, it's unconstitutional. Congress has the power of the purse. It's a seizure of that power, monarchical and autocratic, and it's a violation of the Impoundment Control Act.

But put aside the legalities, it is potentially devastating to healthcare for veterans. The Fox Suicide Prevention Program that was mentioned is just one of literally tens, maybe hundreds, of programs that are in peril right now. And so, I call on my colleagues to join in protesting and opposing. Once again, I ask veterans to rise up and say, please, Mr. President, clarify that you are not going to make veterans the victims of this illegal policy.

And the same point I would make as to the firing of inspectors general, accountability for community care as well as veterans care. Let's put veterans care, first and foremost, including holding accountable the VA. The VA ought to have its feet to the fire. As Michael Missal has done as inspector general, he saved $40 billion. That's a rough estimate. And there was a mention of the electronics record program.

There was a provision that would've provided more accountability for the electronic records program. Apparently, it was deleted at the last moment. I think we can include it in whatever legislation we pass. I'm fully in favor of making sure that standards and criteria are applied, and that they eliminate wait times, whether at the VA or in community care.

Mr. Chairman, I really appreciate your leadership. I know you made reference to the importance of inspectors general when we had a hearing recently. I think this cause can be bipartisan and that the hiring freeze, as Mr. Eaton said so well, can be clarified so that it doesn't affect the VA and our veterans' care. Thank you, Mr. Chairman.

Chairman MORAN. Thank you, Ranking Member. There are five minutes left in the vote, but I still have questions. So, we're about done. Mr. Eaton and Mr. Mr. Lorraine, both the Wounded Warrior Project and American Warrior Partnership, indicate they've seen trends over the last year indicating pressures from VA administra-

tors on VA providers to not place referrals. Would one or both of you explain what you've seen?

Mr. EATON. Yes, sir. Thank you for the question. What we're hearing, again, from clinicians is really that pressure from an administrator perspective to minimize referrals out and even a referral decision being made at the administrative level versus a clinical level.

And so, this could mean that instead of going out into the community a longer wait time for care within the VA, it could also result in a different level of care than initially indicated. So, whether individual counseling could be shifted into a group setting which is really not aligned with what the veteran was looking for or what his clinician recommended his or her.

Chairman MORAN. And that, I mean, just for me to point out what I think is obvious, that can very well be contrary to what's in the best interest of the veteran patient. And who, but the VA, including their administrators, ought to be the most interested in the quality, and not only the timeliness, but the quality of the care a veteran receives.

I spoke about this, and it bothers me because for my involvement in veterans' issues, for as long as I've been in Congress, I sometimes can get individual cases altered, fix a problem for a veteran. But it doesn't seem like when I do that it fixes the problem for the system for every other veteran who's experiencing the same thing.

I highlighted it on the Senate floor. The veteran in my hometown who was receiving cancer treatment. 60 treatments, he was receiving them in the community at the authorization of the VA. He had 59 treatments of the 60 he needed, and the VA called him back to the VA hospital for the 60th care treatment.

The other example is the constant—I mean, I've indicated so many times that what I think I know is based upon what I hear from veterans. What we call casework, is part of that. The number of times, for example, that chiropractic care has been recalled back out of the community. So, you have a veteran who's been receiving chiropractic care with the same chiropractor for months and years, but the VA says, no, that's no longer permissible. Community care will not cover your visit to a chiropractor, come back to the VA.

Those decisions can't be being made based upon what's in the best interest of the healthcare and well-being of the veteran. I mean, I was involved in the creation of the MISSION Act. One of the components by which a person can be referred to the, to community care is what's in the best interest of the veteran. And we intentionally defined "best interest of the veteran" to be determined by the veteran and his or her provider, not an administrator at the VA, so that the decision is made on the best healthcare interest of the veteran, not on the financial well-being or the caseload of the VA.

I mean, I'm all interested in seeing that the law is complied with. And that's what I have spent so much time in trying to convince, in recent months, the VA to utilize the MISSION Act in the way that it was not only intended, but in many instances, actually written. So, we're trying to get the law to be the law at the VA.

And I appreciate the testimony that we heard today. And I think there's a takeaway for me, and I hope others, that this is particu-

larly important, Mr. Golnick and Ms. Marg, when it comes to mental health, suicide ideation. All the care for veteran matters, but there are certain things in which the timeliness, and the consistency, and the personal nature of the care determines the outcome and whether there's success.

And so, I take your testimony very seriously with a renewed interest in trying to be a better advocate for not just community care or the MISSION Act, but community care and the MISSION Act as it may save a life and improve the quality of life of veterans who can't get what they need within the VA. I wanted to talk about residential treatment in the length of time, but I don't have the time. But that has captured my attention as well. What can the Department of Veterans do to provide more longer-term care for veterans?

I'm going to conclude the hearing. It's concluded with this expression of gratitude for all of your presentations and your willingness to visit with us, and we'll try to be a Committee that listens to those who tell us what the challenges are and respond appropriately.

Each Member of our Committee has five legislative days in which to revise and extend their remarks, what we all said. And I ask any Senator who'd like to submit a question to you, to do so in a timely manner. And we'd like for you to respond for the record following today's hearing in a timely manner as well.

With that, this hearing is adjourned.

[Whereupon, at 12:19 p.m., the hearing was adjourned.]

A P P E N D I X

Prepared Statements

Testimony of Eric Golnick
Before the Senate Committee on Veterans' Affairs
Oversight Hearing: "Protecting Veteran Choice: Examining VA's Community Care Program"

Chairman Moran, Ranking Member Blumenthal, and distinguished members of the Senate Veterans Affairs Committee:

Thank you for the opportunity to testify today on the critical issue of improving access to care through the Department of Veterans Affairs' (VA) Community Care Program. My name is Eric Golnick, and I am a U.S. Navy veteran who has dedicated my life to supporting the health and well-being of veterans and first responders. The VA is an essential resource for millions of veterans. Community care under the MISSION Act is meant to complement, not replace, the VA's services, ensuring veterans receive the right care at the right time.

Let me begin by sharing a personal story to illustrate why this issue is so important to me. After leaving the military, I sought mental health care through the VA. While I was fortunate to see a psychiatrist relatively quickly, it took over a year to connect with a therapist. The lack of therapy meant I was only addressing part of the problem. This came to a head over the holidays a few years ago, a particularly difficult time for veterans. Without the support of friends and fellow veterans, I may not be here today.

For someone with a mental health or substance use disorder, the window to intervene is often just days. For veterans, timely access to this care is a matter of life and death.

My experience reflects the systemic barriers many veterans face in accessing timely care, which inspired me to co-found Forge Health in 2016. We addressed urgent mental health and substance use needs for veterans and first responders, working closely with the VA to help those unable to find adequate support. This collaboration showcased the potential of VA-community partnerships, while highlighting the ongoing challenges.

Some VAMCs and VISNs fostered strong partnerships. However, inconsistent implementation of community care across the system resulted in delays, highlighting the need for clear, standardized practices to ensure veterans receive timely and consistent access to care.

Challenges Veterans Face

While the MISSION Act has expanded options for veterans, significant gaps in awareness and accessibility persist. Many veterans remain unaware of community care options, and unclear eligibility requirements often lead to delays or denials, despite meeting access standards. One veteran, after being told he couldn't continue care with a clinician he had developed a strong therapeutic relationship with over the course of a year, said, 'I'm done. I give up. Before this year, I was bounced between four clinicians in less than six months.'

When transitioning from VA to community care, many veterans face disruptions caused by poor communication and unclear processes. One Marine Corps veteran I worked with, struggling with

post-traumatic stress, was referred to community care but waited months due to administrative delays. During that time, his condition worsened to the point of a suicide attempt.

Some VA employees hesitate to refer veterans to community care, fearing it could negatively impact their budgets. This creates a barrier, forcing veterans to choose between systemic concerns and urgent care needs. The MISSION Act was designed to ensure timely, high-quality care, whether through the VA or community providers. Veterans, not funding structures, must remain the top priority in care decisions.

Opportunities for Improvement

To address these challenges, the VA should enhance its efforts to educate veterans about their options under the MISSION Act. Clear communication during VA appointments, proactive outreach campaigns, and partnerships with VSOs can ensure veterans are fully informed about their rights and choices.

The referral and approval process also needs significant streamlining. Simplifying and automating these procedures can reduce delays, alleviate administrative burdens, and allow veterans to access care more efficiently. This includes ensuring that communication between VAMCs, VISNs, and community providers is consistent, transparent, and structured.

For rural and underserved areas, it is critical to address gaps in services that the VA might struggle to fill. Community care should serve as a force multiplier to the VA, enabling it to meet veterans' needs without diminishing the critical services that only the VA can provide.

Telehealth is a powerful tool for bridging service gaps, especially in rural or underserved areas, by providing immediate access to care. However, challenges such as limited broadband access can make this option unworkable. It's also crucial that veterans have the choice to see an in-person provider in the community if telehealth is their only VA option.

Closing Statement

Chairman Moran, Ranking Member Blumenthal, and members of the Committee, the VA has made progress in improving care for veterans, but significant challenges remain. By addressing these barriers and building on the foundation of the MISSION Act, we can ensure all veterans receive the timely, high-quality care they deserve.

It is our shared responsibility to ensure that no veteran is left behind. By prioritizing veterans' needs and fostering collaboration, we can fulfill our promise to those who have served. Every delay and missed opportunity to provide care puts a veteran's well-being—and life—at risk. I remember a veteran telling me, "I shouldn't have to fight this hard to get help." No veteran should have to fight for the care they've earned.

Thank you again for the opportunity to testify. I look forward to your questions and to working together to improve care for our nation's veterans.

United States Senate
Committee on Veterans' Affairs

Oversight Hearing:
"Protecting Veteran Choice: Examining VA's Community Care Program"

Statement for the Record
Submitted by:
Paige Marg

January 28, 2025

Thank you, Chairman Moran, Ranking Member Blumenthal, and committee members for this opportunity to provide a statement for the record of today's hearing to examine VA's Community Care Program. Any care that a veteran seeks is important, and I would like to express that the void of long-term mental health support and care has led to a situation where impactful care is out of reach.

My name is Paige Marg, and I am the daughter of a retired soldier and the wife of a medically retired airman, and I am from San Antonio, TX. I met my husband Charles (Charlie) when I was 15 and we have been married for 23 years. I spent the first half of my career as a DoD civilian supporting overseas family resiliency initiatives and have spent the last 12 years working for a non-profit veteran service organization. I have never worn a uniform, but I have made it a priority to find a way to support military families and veterans.

I am here to be a voice for my husband's experience navigating the Community Care Program for mental health support. There is a need for this process to be developed further, particularly for veterans in a mental health crisis state and for whom long-term care is warranted. My husband's story of mental health struggles stemming from his service are unique, but sadly familiar in the veteran community.

Guantanamo Bay, Cuba
Charlie joined the Air Force in January 2000 for what was initially going to be four years and was medically retired in July 2015. In 2012-2013, my husband was deployed from Germany to Guantanamo Bay for eight months, and while deployed he attempted suicide twice and attempted a third time when he came home to Germany. He was hospitalized at Landstuhl Regional Medical Center. Prior to his deployment, Charlie had never attempted suicide throughout the 12 years of his previous military career and did not suffer from depression or anxiety.

In seeking care through Ramstein mental health clinic, a DoD facility in Germany, he and I were told that he could not have PTSD by his doctor because he was not deployed to a combat location. I advocated for him at the clinic that my husband never had mental

health problems prior to this deployment. Suddenly crowded spaces, having to make decisions – even minor ones, small changes in schedules, having people behind him when he was sitting – led to anxiety attacks with physical reactions. He additionally began developing OCD ritualistic habits to try and control what he could when he felt so much was out of his control. Charlie was instead diagnosed with Major Depressive Disorder and anxiety. Charlie lost his SCI clearance due to the attempt and the medication dosage he was prescribed and was no longer allowed to do his job. In 2014 a medical evaluation board process was initiated. Through this period Charlie's mental health continued to decline and his doctors stated that he would need care and medication for the rest of his life more than likely.

Return to the United States
In July 2015, Charlie was medically retired with a 70% mental health rating. We came home to San Antonio, Texas, as both of our parents retired here, and we needed family support.

Charlie enrolled in the VA Heart of Texas Health Care Network with the intention that the VA would be his primary care service. His experience in trying to get connected to mental health services since retiring has been nothing short of frustrating, demoralizing and the lack of care and concern for him as a person and veteran is evident in the responses that we have received from many VA Heart of Texas Health Care Network healthcare professionals over the years.

Charlie reached out and was assigned a VA psychiatrist for continuity of his mental health prescriptions and he requested counseling. Since 2015, Charlie has been passed and shuffled through the VA mental health system and has been referred several times to Community Care for counseling. The VA Heart of Texas Health Care Network has failed him repeatedly – lack of continuity of care, employees who simply blame and cite red tape as an excuse for lack of care, pointing the finger at other VA departments, pushing community-based resources that were either not viable options or had space for additional patients.

Since retirement, he has received no long term and consistent mental health support. As a veteran who was medically retired at a 70% rating for mental health alone, I do not understand why there was not any kind of transition plan made for him to continue to receive care when he left active duty.

Community Care Referral Process
He has requested counseling from his prescriber, a VA psychiatrist who he sees quarterly that only prescribes his medication but does not offer counseling appointments. His VA psychiatrist will put in a counseling referral to VA counseling services. VA counseling services will come back in 7-10 days that they do not have appointments within the 30-day window. From that point the referral is passed to Community Care, and it generally takes another 7-10 days for Charlie to be contacted from the outside agency. When he is

contacted by the Community Care provider, they will set up and appointment, but this is generally 25 days or more out from the date of the call. The referral to Community Care initially grants 6 visits and another 6 can be added on by the Community Care provider. In the 9 times that he has been through this process since 2018, he has never been granted an extension past 12 weeks and has never seen the same provider for more than one course of care. Many times, he has been 'cured' and released from counseling in the 7–9-week time frame. There have been times too that the extension paperwork was not processed through the VA in a timely fashion, and we have paid out of pocket for visits above the initial 6 that were granted.

In February 2023, Charlie was intensely struggling with his mental health and reached out to his VA psychiatrist for help and counseling. He was able to get a quick turnaround appointment, and I attended with him. He was given a 4-page photocopied document that listed many local therapists that took Tricare. She explained that the VA was backed up and was told he would probably be able to get an appointment through one of these providers quicker if he went through Tricare than the VA, and a follow up appointment was made for March 1, 2023. I held on to this paper as a Hail Mary of hope that someone on these pages would be able to help him; however, I was infuriated and frustrated that this was the level of care that he was receiving. While we do pay and have Tricare, getting pointed to another list of resources, to attempt to navigate with another healthcare system, without Tricare knowledgeable of his mental health history, treatment or current state, is not a well-functioning VA should work.

I called many of the numbers, only to be told that these providers were no longer able to take new patients, or the intake process would take time, up to 30-45 days for him to be seen. I explained over and over that this was an emergent situation but was told by the potential provider's office staff that they were not set up for crisis counseling/therapy. I was not able to find him an option that could see him before his March 1, 2023, appointment.

Suicide Attempt – March 2023

On March 1, 2023, my husband sat in his truck in the North West San Antonio VA Clinic parking lot and attempted to overdose. I kept trying to connect with him on his phone, but he would not answer, and I had an uneasy feeling and left work and went to where I could track his phone. I found him in his truck where he had crushed up about 75 propranolol pills in water and had drunk about 2/3 of it. He was drenched in sweat, crying, and not making sense.

I got him inside the VA, let staff know the situation, an ambulance was called, and he spent several days in a local hospital in the ICU and then in a ward, and then transferred to Audie Murphy where he stayed a couple of days.

When he was released and was referred again to the VA Community Care system for counseling and was seen the 12 visits before he was released from care again. From March 2023 – October 2023 his medication was adjusted and increased multiple times.

Suicide Attempt – October 2023
Emergency Room
On October 4, 2023, my husband left home with no communication and turned off his location services. His best friend reached out that he had had a strange call from him, Charlie told him that he loved him and that he would be out of pocket for a while and hung up. I tried to find him, and when I could not, I reached out to the police, and the police connected with our phone carrier to ping his phone.

We found him in the waiting room of VA Audie Murphy hospital's emergency room. He had not checked in but had been sitting in the waiting room for hours at that point. He disclosed to the police that he wanted to hurt himself but did not have a plan. He was crying and kept repeating that he was so tired of being broken and tired of trying to get help and he wanted to be done with everything. The police filled out the Emergency Detention paperwork and he was processed through the ER and admitted to the psychiatric ward in the early morning on October 5, 2023. I heard from a patient coordinator on the 5th and was told that my husband was very withdrawn and not speaking to anyone and that he would more than likely be kept through the weekend.

Post-Discharge Plan
On October 6, 2023, I heard from one of his doctors at Audie Murphy that he would be discharged that day. I questioned if this was the best plan, especially since the day before he was not speaking to anyone.

I asked what the plan was for follow up care because this was his second hospitalization and suicide attempt in seven months, and we needed a plan in place that was better than what was put in place before because it was not effective. I asked if there was a residential/in patient program that he could be referred to. I was questioned by his doctor on what I meant by a residential program, and I explained my request and was told that the VA did not have anything like that.

I pleaded and admittedly cried to the doctor that a different plan was needed for him after discharge because he needed long term care and support. I was told that he had a safe plan and that if he was feeling bad again, he could always return there. I pressed again that he needed a better plan than to come back to an emergency detention hold and was told to follow up with his doctor. He was discharged on October 6, 2023, and I picked him up and took him home.

Follow up visit
His follow up appointment was on October 10, 2023, and was seen by a Nurse Practitioner at the North West San Antonio VA Clinic. I explained the last few years of navigating

fragmented Community Care counseling and that a longer-term solution was needed for him because this was his second suicide attempt in the same calendar year and to keep repeating the same cycle and expect a different result.

The Nurse Practitioner stated that the VA system did not provide long term counseling and the VA "didn't do mental health well", turned her computer screen towards us, and pulled up www.psychologytoday.com and said to use the website to search for therapists that would accept Tricare.

I requested again for a residential treatment program for him and explained that I had connected with Wounded Warrior Project (WWP) Complex Critical Care team and that there were facilities in the community care referral system that he could go to. We were offered a pamphlet for the STAR program, an outpatient option for two weeks that was local and that she would pass the request for the referral to Dr. Gerardi.

Residential Treatment Referral Request
From October 10-18, 2023, we waited on a decision by the VA on the referral for a residential program within the VA Community Care network and the referral was supported by his VA psychiatrist. On October 18, 2023, Charlie's VA psychiatrist called him to let him know that the referral was declined and to see if Tricare, WWP, or another veteran service organization will pay for the care. The despair and rage that I felt that day when we received the call for the VA, further cemented the feelings and their lack of care, compassion and disregard for my husband and his life. I am not sure what else a person has to do to show they are in crisis, are desperate for help and attempt to take their own life twice in less than a year.

At that point we reached out to WWP and WWP paid for his flight to Tucson and secured a bed for him at Sierra Tucson, in Saddlebrook, Arizona. Charlie flew out on October 21, 2023. WWP paid for his care at Sierra Tucson after the VA again denied the request and subsequent extension request.

South Texas Veterans Health Care System's High- Risk List
On October 24, 2023, the VA sent a letter to Charlie to inform him that he was removed from the South Texas Veterans Health Care System's High-Risk List (HRL) for suicide by his Mental Health/Suicide Prevention team. This was 18 days from his Emergency Detention hold at Audie Murphy VA Hospital, 6 days after his doctor told him to go to outside VA resources for support, and 3 days after he arrived at an inpatient residential treatment facility that the VA denied the referral for. The form letter thanked him for the opportunity to serve him and encouraged him to continue to participate in the health care they offer.

They thanked him. For wanting to kill himself. So that they could have the opportunity to serve him.

Sierra Tucson
Charlie received care at Sierra Tucson and came home December 5, 2023. There his medication was completely reset, he finally received treatment for nightmares, received intensive counseling and was diagnosed with PTSD. When he returned home, WWP and Sierra Tucson connected him with an outpatient daily program through Laurel Ridge.

2024
Charlie has sought counseling through Endeavors and is currently going to counseling through the Vet Center in San Antonio. He attempted to utilize the VA Community Care network but was told that all that was available for him was the same 6 session referral that could be extended by the Community Care Provider if warranted.

It is heartbreaking to see your spouse become a shell of a person, to request over and over for help, to take all his medications and maintain medicine compliancy for more than a decade, to not miss appointments and to be discarded from the entity that should be providing treatment and care that he earned through his military service and sacrifice.

I am incredibly thankful for Wounded Warrior Project, that they helped us navigate getting him care and funded my husband's care – but they shouldn't have to. Charlie earned this care with his service, and his struggles are directly connected to his military service. I have tirelessly worked to become his advocate and at times his voice when he was too tired to fight for himself. I always worry that there will be a day that comes that I will not be there to save him, that I didn't do enough for him, that I didn't fight hard enough for him.

The obtuse, heartless interactions with the VA over and over are why veterans do not seek care. It is why veterans suffer in silence. And it is ultimately why veterans kill themselves because the entity that is supposed to help them shows them again and again that they do not matter. How many veterans need to commit suicide for the VA to prioritize long term mental health? How many veterans are getting lost and giving up in the Community Care system that do not have someone to advocate and fight for them?

Thank you to the Committee members for the opportunity to share Charlie's story. I hope that by sharing his struggles in obtaining care through the Community Care Program with you, his story will save another veteran's life.

Written Testimony:

Mr. Jim Lorraine, Lt. Col., USAF (ret)
President & CEO
America's Warrior Partnership (AWP)

U.S. Senate Committee on Veterans Affairs
January 28, 2025
10:00 am, Russell Senate Office Bldg., Room 418

Oversight Hearing

"Protecting Veteran Choice: Examining VA's Community Care Program."

Chairman Moran, Ranking Member Blumenthal, Honorable Members of the Committee.

I am honored today to testify to the Committee regarding veterans' access to health care, specifically care in the community. And at AWP, that's where we operate: in the community.

Life is about choices. Hopelessness dwells on the lack of choices. I've told my Army-serving son that a successful career should give him choices throughout life. I say this because I remained in the military, doing my job and serving the Nation I love, to give myself and my family choices. One of the greatest choices gained from my military career is my ability to manage my healthcare through TRICARE or the VA, something my father, who was a World War II veteran, never had.

At AWP, we believe all veterans should have a choice in managing the healthcare they've earned. We believe providing veterans with the choice of where, when, and who they receive their healthcare is not only the right thing to do but also more affordable and effective than our current approach.

AWP's mission is to partner with communities. We find and build relationships with veterans, connect them with trusted partners and resources, and collectively succeed by improving veterans' quality of life and, in turn, reducing veteran suicide. Our community integration model with a "one-size-fits-one" approach to helping veterans is designed to build trust through a relationship with the veteran and their families. Our work at AWP is perfectly suited to discuss many of the issues this Committee is discussing today.

Community care is a successful tool and resource we can offer veterans, most of whom come to us through referral or outreach. And it is especially helpful for many veterans who don't fully trust the VA or don't want to utilize VA facilities due to distance, time factors, or continuity of care concerns.

AWP will always side with the veteran. This does not mean being against the VA, but rather in favor of veterans. We have always supported empowering veterans to make their own decisions and take charge of their own care. We consider the VA to be one of our closest partners, and they take great care of many of the veterans we are in

touch with or refer to the VA. But the ability to have veterans choose their path forward and have options has been a game-changer.

For the past several years, the Mission Act and community care have remained popular and in-demand. Requests from veterans for care in the community continue to increase. The number of appointments scheduled through community care has dramatically increased.

Regardless of the politics surrounding community care, it is without a doubt a vital tool in bringing veterans back to get care. As I have pointed out many times in previous statements and testimony, only half of the nation's 17 million+ veterans are known to the VA. At AWP, we find veterans that need help. Many of them have lost confidence in the VA. Community care helps change that discussion.

We must get this right. Mr. Chairman, as you said during Mr. Collins's confirmation hearing, "America's national security is dependent on an all-volunteer military, and a VA that is successful in helping service members thrive as veterans is key to bolstering recruitment and keeping our nation safe." We agree 100%. The VA is not a social services department but a national security entity.

In 2024, AWP had nearly 8,800 veterans contact us and our community branches. Over 4,100 of them needed help. From there, nearly 6,247 new cases representing multiple issues were opened for these veterans. Of those cases, a majority involved some type of challenge relating to access to health care. 392 were related to mental health. And 329 screened positive for suicidal ideations in the past 30 days before they contacted AWP (representing nearly 8% of all those screened).

In short, access to VA care is a challenge. And the use of community care is very high and remains a popular option.

Every year at AWP, we put out a "Community Survey" of veterans in the community across the nation. And the results have been remarkably consistent. The vast majority of America's veterans are successful and doing well, seeking only opportunities to volunteer and give back, connect to other veterans, or receive slight assistance on the edges.

However, a recurring theme among all veterans is the constant struggle for access to care. Even for those who are experienced, or high-functioning and successful, or know the system – access to VA health care remains a challenge.

And it's a challenge because veterans are NOT empowered to control their own health care. Their decisions are made by and for the VA itself, not the veterans.

The confusion, conflict, tension, and stress developed from trying to navigate a system with few choices have a negative impact on veterans' trust and confidence in the VA. Waiting on hold to schedule calls, being transferred repeatedly, waiting for your appointment, having appointments canceled, waiting again, additional phone calls … it adds up. It grinds away patience. It eats away at hope. It numbs veterans to the possibility that getting help for their medical conditions is reachable.

Finally, through the incredible work of Congress, the CHOICE Act and then the MISSION Act were signed into law. And veterans have voted with their feet, and used the opportunity to receive care outside of the VA.

Although the Biden Administration partially implemented the program and guided it through a pandemic and dramatic VA expansion of authorities with the PACT Act, it still has not reached its full potential.

In fact, in recent House testimony, many groups – including those representing government employees - have outright opposed the law and opposed its expansion. They called it "privatization." They see it as an existential threat to the existing VA model.

However, at its core, supporting veterans' choice and community care comes down to simple questions: Have veterans earned the right to choose? And do you trust veterans?

Do policymakers, VA employees, health care providers, and American citizens believe veterans should be trusted to make their own decisions regarding their health care? I think the data on community care usage where veterans are voting with their feet to seek care outside the VA is a testament to how the VA should provide care.

Community care is VA care.

In other words, do you believe veterans should be empowered, or does the government know best?

Over the past several years, the VA has shown their answer. In that time, the VA has increased hiring and brought specialists in-house rather than letting these medical professionals flourish in the community. This is directly at odds with the intent of the Mission Act. And directly at odds with the millions of veterans who voted with their feet and requested community care referrals.

For a combat-related hand disability, my VA provider prescribed an MRI to confirm a diagnosis. For a week, I called my local VA to set up an appointment, only to have the phone picked up and hung up without a word being said. When I inquired to the VA medical center director, I was told the MRI scheduler had been on vacation for a week. I was never offered community care, and when I pressed to get a non-urgent referral outside the VA or seek service from a TRICARE provider, I was denied. It has been months and I'm still awaiting an MRI.

VA can absolutely help coordinate care, track records, and manage everything- but it does not need to provide all the treatments and solutions to everything. Further, the contracts it holds with major providers need to be more of a partnership in the veteran's best interests, rather than a one-direction transaction.

While some veterans enjoy their local VA facilities and utilize them regularly, how many are fully aware of the options available to them under the MISSION Act? Many of the veterans who call AWP do not know they are eligible for a community care referral and are unaware of their potential choices.

The VA has made significant progress over the past 25 years since the start of the Global War on Terror, but improvements are still needed. As veteran demographics change, community care must remain a key tool and be expanded. It benefits not only those within the VA system but also those outside it who may not want or trust traditional VA services.

The VA's role is to care for veterans, while Congress determines how that is done. It's not the VA's job to expand into every community or reduce access to community care. Nor should it compete with private hospitals and centers, many of which are federally subsidized, particularly in rural areas, while also vying for limited medical professionals.

Community care also benefits the community itself. In the past several years, the number of employees at the VA has dramatically increased. At the same time, our nation continues to suffer from a shortage of medical workers. For every nurse and doctor the VA hires, it removes that medical professional from the community.

There is no better evidence of this than a quick look at VA medical specialists. Both Congress and VSO's broadly agree that there is a core set of functions where the VA must absolutely invest in medical professionals, such as those related audiology, mental health, prosthetics, etc – where there is an exceptional demand from veterans. However, the discussion sours when the topic turns to lower-density specializations, such as obstetrics, where the use of these specialized medical professionals is not in demand by veterans nearly as much as the civilian population.

For those types of specialists, bringing them into the VA doesn't make sense. Many veterans feel more comfortable getting referred to community care, where they can build a relationship with the same medical professional during every visit. It's not a secret that the most experienced and knowledgeable experts in the medical field are often in the private sector. There they can do similar procedures multiple times daily, become subject matter experts, and have a financial incentive to be the best. While there are exceptional doctors at the VA that are experts, why should the VA compete to bring them in house?

Keeping these specialists in the community, along with countless other doctors, nurses and medical professionals, would buoy local communities by allowing civilians to access their work as well, and supplement the small practices across the nation that struggle with staffing shortages. The billions of dollars that have been spent on expansions of Community Based Outreach Clinic's (CBOC's) are better spent ensuring that every community has a doctor and specialists within their area. Let's focus should be on building relationships between the doctors and veterans, and getting ahead of issues, while also reducing drive times and wait times.

But instead of sending tax dollars back to every community across nation, those federal dollars are going to government run hospitals instead.

These are real issues that affect many of our nation's current and future veterans. It's the responsibility of policymakers to help ensure the VA is planning for the future while also offering the best care for all veterans today. Whether that involves another "Asset and Infrastructure Review (AIR) Commission" is up to policymakers. But until that happens, Congress should have a serious look at all VA-related construction projects and renovations, and weigh if they are essential before a longer-term strategy is in place.

With that in mind, below is a list of recommendations AWP has put forward for the Committee regarding community care:

1. **Codify the access standards.**

AWP is proud to support the "Complete the MISSION Act" in the House, and the ACCESS Act in the Senate, both of which codify the existing access standards. It is vital that the measure for community care eligibility is no longer left to regulatory guidance. Congress must pass minimum standards into the US Code and guarantee a minimal level of criteria for care. The 20 days or 30-minute drive time for primary care, and 28 days or 60-minutes for specialty care, are the current VA standards. But they should not be the goal. These should be the maximum wait, and goals set to half that standard. The VA must strive to do better. By comparison, the standard for TRICARE is 7-days for primary care, and no longer than 28 days for specialty care (while the driving time standards remain the same.) By codifying the access standards for community care, Congress is stating in no uncertain terms that the ability for veterans to choose their care in the community is here to stay… permanently.

We feel continuity of care should also be a factor in considering community care. Continuity of care has long been recognized for improved patient-provider

relationships, better health outcomes, coordinated care, patient satisfaction, and as an outcome, cost-effectiveness.

2. **Eliminate referrals for veterans seeking help for mental health, substance abuse, and Traumatic Brain Injury (TBI) care – and make it priority admission at VA**

Referrals are generally required for all community care, but it can also require considerable time to schedule. For mental health, substance abuse, and TBI care – the need is often urgent. Time is of the essence.

Accordingly, Congress should allow veterans to access outpatient mental health, substance abuse, and TBI services through health care providers without a referral. This is a big step and would take care of veterans at a vital and vulnerable moment.

If at any time a veteran feels like they require those services, they could go to the approved list of health care providers without additional steps, and it must include residential rehabilitation treatment programs (RRTP).

It is well known that the VA does not have enough space or staff for all outpatient mental health or substance abuse service requests. But the community has space and programs, and for several years the referral process was easy and worked well.

However, in April, both AWP and our partners abruptly saw a surge in denials for care in these areas. The result was thousands of veterans left without help, and given wait times in excess of 6+ months for a bed at a VA program. Generally, there is a "magic 48hr window" to get someone into treatment for substance abuse after they ask for help. If that period of time is missed, that relationship and trust is broken, and statistically are unlikely to seek assistance in the near future.

Subsequently, we and our partners have lost touch with many of these veterans who asked us for help. They were suffering. And mental health and substance abuse are two leading factors in suicide.

In addition, Traumatic Brain Injury (TBI) services should be available without referral as well. Often, the symptoms of TBI express themselves as post-traumatic stress and are then labeled as a mental health issue. However, they are physical wounds of the brain and need to be treated differently, and carefully. It is our belief that several programs and providers across the nation who offer TBI services should be added to

the approved list of providers who do not need a referral. There is a growing demand for this type of service from veterans across the nation. In fact, our partners at the Avalon Action Network have an 8-month waiting list at all their facilities across the nation.

3. **Educate Veterans about community care options**

Despite the popularity of the MISSION Act and community care, many veterans are still unaware of their eligibility under the law, or what it means to them. Education is paramount to ensuring veterans make the best choice for their care. This education to veterans must be more than just an email or letter stating they are eligible; it must clearly and simply lay out what options or choices are available, how to make those decisions, what it means for them, etc.

4. **Veterans' preference in community care**

The next step to ensure the success of the MISSION Act is to empower veterans by allowing them to state their preference for when, where, how, and who they seek hospital care, medical services, or extended care services. Currently, the VA decides whether veterans can use community care based on availability at the VA facility and time/distance. This would allow veterans to unequivocally state that they prefer to see someone in community care.

While it may seem small, it raises the ability of veterans to receive primary or specialty care in the community at a place they prefer. This could be due to location or the ability to see the same medical professional again. Continuity of care is incredibly important in the medical field. And if a veteran can see the same doctor or specialist for their concerns, they can build a relationship and improve health care outcomes.

5. **Allow Veterans the opportunity to utilize TRICARE Select instead of VA care**

While some legislation has previously been introduced on this topic, including The Veterans' True Choice Act of 2024 (H.R. 214), the idea behind the legislation would be a big win for veterans. H.R. 214 would allow veterans in Priority Groups 1-3 with a service-connected disability the choice to use TRICARE Select (with no copays) instead of VA furnished healthcare. For the veterans who chose TRICARE Select, the VA would reimburse the Department of Defense (DOD) for the cost, and the veteran

would be ineligible for concurrent VA health care. For those veterans who are also eligible for Medicare, H.R. 214 would authorize TRICARE for Life.

TRICARE Select has been a successful program within the DOD for many years. This program has been widely revered by servicemembers and veterans already. Giving military servicemembers and retirees the ability to use the military health system and/or community providers for primary care and specialty care (without referral) when/where it is best for them has proven to be a win for everyone. While some have claimed that moving eligible members to TRICARE Select and out of the military health system has not worked, the evidence points to the contrary, with tens of thousands of appointments booked and a consistent flow of new TRICARE Select members.

This policy/legislation would be a win for veterans and dramatically alter how health care is delivered. While proper oversight will continue to be needed, the DOD has implemented significant safeguards to ensure proper reimbursements and member outcomes.

Improving all veteran's trust and confidence in the VA is a national security imperative. Community care has been an essential resource, but its full potential has been questioned. In response, let veterans choose. Loosen the referral restrictions and put veterans in charge of the care they want. Let's enable veterans, not restrict them. Together, we can do better.

Members of the Committee, we look forward to our continued work together and would like to thank each of you for all your hard work and dedication to those who served in our nation's armed forces.

KEEPING OUR PROMISE TO AMERICA'S VETERANS

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STATEMENT OF
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BEFORE THE SENATE COMMITTEE ON VETERANS' AFFAIRS
JANUARY 28, 2025

Chairman Moran, Ranking Member Blumenthal and Members of the Committee:

On behalf of DAV's (Disabled American Veterans) nearly 1 million members, thank you for inviting us to provide testimony for this important hearing, *Protecting Veteran Choice: Examining VA's Community Care Program*.

DAV members are wartime service-disabled veterans who were wounded, injured, or made ill during their military service. They utilize Department of Veterans Affairs (VA) Veterans Health Administration (VHA) services at high rates and many prefer and depend on the Veterans Health Care System for all or most of their care.

Through VHA, the VA operates the largest integrated health care system in the country, with 171 medical centers and 1,113 outpatient clinics, serving 9.2 million veterans. Over the past decade, due to increased demand for services, VA's reliance on purchased medical care services from its community providers has risen dramatically. While the use of community care has increased, many veterans have experienced barriers to accessing that care—especially rural veterans, those with post-deployment mental health challenges, and at risk for suicide, and traditionally underserved veteran populations.

Challenges and Barriers to Accessing Community Care

Eligibility for Community Care

Like most veterans service organizations (VSOs), DAV strongly supported the VA MISSION Act (Public Law 118-182) after working for several years with this Committee, your counterparts in the House, VA leaders, and other stakeholders. The resulting legislation was a carefully crafted compromise to improve veterans' access to timely, high-quality, and veteran-focused care. Our support, however, was predicated on maintaining a fundamental set of principles underlying the VA MISSION Act to ensure that veterans' health outcomes would be improved:

- VA would continue to be the primary provider and coordinator of veterans' care;
- VA's internal capacity to provide care would be expanded through investments in staffing, infrastructure, and IT in order to meet the rising demand for care by enrolled veterans, particularly disabled veterans;
- Veterans who would otherwise have to wait too long or travel too far to get necessary care from VA should have swift and seamless access to high-quality community care options; and
- Community care providers would have to meet the same access AND quality standards, as well as training and certification requirements, as VA clinicians.

The above principles were designed to achieve that goal by balancing the need for greater access to timely care with the imperative of providing high-quality and veteran-focused care and services.

Unfortunately, there are reports from some veterans indicating they have been denied eligibility and access to the Veterans Community Care Program (VCCP). The access standards enacted in the MISSION Act are clear and VA is responsible for educating its employees on the law and veterans' right to access community care when VA cannot provide needed care in a timely manner or due to distance from a VA facility and in cases where it is determined to be in the best medical interest of the veteran. The focus, first and foremost, must be on getting veterans the care they need—period. Administrative burdens that appear to be causing barriers to care must be acknowledged, addressed and resolved by VA.

Coordination of Care and Timely Receipt of Patient Records

Given the number of veterans who utilize both direct and community care services, the coordination of that care is extremely important. Integrated care for veterans with complex medical histories is essential for quality care and positive health outcomes. Unfortunately, we continue to hear from veterans about delays in scheduling community care appointments once a referral has been made. Because VA does not have a fully operational bi-directional health records system in place, it struggles with seamlessly transmitting patient records to community providers, and return of those records for integration into the patient's VHA electronic health record. For example, it can take several weeks once a veteran has been referred to the community to arrange for the veteran's patient files to be sent to the patient or provider's office and to set up an appointment. In some cases, VHA mails the records to the patient for them to hand carry to the community care appointment. Conversely, there are also reports of delays in getting records transferred back to VA once the appointment or episode of care is complete. Veterans have reported that some VA facilities still rely on fax machines to transmit critical information from a veteran's community care visit with a specialist and that health information may not get conveyed to their primary care clinician at VHA for months or in some cases not at all. Community care providers also report problems and complications with transmitting health care information and test results back to VA for their veteran patients. There are also complaints from veterans regarding billing issues associated with referrals to care in the community.

VHA policy requires staff to import all community care documents in the patient's electronic health record within five business days of receipt. However, an Office of Inspector General (OIG) report (23-01739-26), *Care in the Community Inspection of VA Desert Pacific Healthcare Network and Selected VA Medical Centers of VISN 22*, found that Albuquerque, Los Angeles, Loma Linda, and San Diego medical facility managers reported having a significant backlog of scanned community care documents, with some dating back to 2019. The OIG noted, "failing to promptly scan incoming medical documentation from community care providers could negatively affect care coordination and quality of care monitoring. Therefore, it is critical that staff receive and scan these documents in patients' electronic health records in a timely manner." In a survey sent to those same facility leaders within the VISN, 92% reported delays receiving community provider medical documentation, and a staggering 73% reported appointment delays negatively affecting patient outcomes. This is unacceptable.

These concerns are similar to those raised in another OIG report (23-03679-262) of VA Western New York Healthcare System in Buffalo. The OIG substantiated that community care staff's delays in scheduling patients' radiation therapy and neurosurgery appointments resulted in delays in care, and in some cases, either caused or increased the risk of patient harm.

It is important to emphasize that delays in treatment can have detrimental effects not only on patients' physical health but also on their mental well-being. When medical care is postponed, patients may experience a worsening of their condition, leading to more severe physical symptoms and serious complications that could have been prevented with timely intervention. Additionally, the stress and anxiety caused by waiting for medical care can exacerbate mental health issues, potentially leading to depression, increased stress levels, and a sense of helplessness. This is particularly critical for veterans, who may already be dealing with complex health issues related to their military service, including mental health disorders such as post-traumatic stress disorder (PTSD), cancer due to toxic exposures and other serious physical injuries. Ensuring timely access to this care is essential for maintaining both the physical and mental health of veterans, and any delay could have serious implications for their overall well-being.

DAV recommends that VHA get to the root of the problem with records transfers and find an effective solution to ensure that patient records are transferred in a timely manner to community care providers. Likewise, VHA must provide community care providers in its network the tools and an effective standard operating procedure for transfer of records back to VHA until a fully functional bi-directional electronic health record solution is realized. VA should also include a mandate in its next generation third-party administrator (TPA) contracts that will require return of patient records to VHA before payments for services rendered will be made. Finally, VHA must improve its standard operating procedure for payment of VCCP services to ensure veterans are not erroneously billed and face the burden of trying to resolve billing issues related to community care referrals.

Improving VCCP provider training for mental health care and suicide prevention

Training health care professionals—including physicians—is one of the VA's four statutory missions. Since 1946, VHA has worked with academic institutions to provide high-quality, state-of-the-art health care to America's veterans; train new health professionals; and advance health care practices and medical innovation.

With more than 9 million enrolled veterans, VHA serves individuals whose lived military experiences are foreign to many civilian health care professionals. Essentially, disabled veterans are served by a system designed for them that has advocates and providers who know military culture, the unique health challenges veterans face and the language they use.

VA's number one clinical priority has been preventing veteran suicide, but despite significant efforts, as well as a plethora of new programs and services dedicated to achieving this goal we have only seen limited progress over the years. One area where VHA believes specific intervention can be effective is in lethal means safety counseling. According to VA's most recent National Suicide Prevention Annual Report, 72% of veterans who took their life by suicide did so using a firearm. While the VA prioritizes mandatory training for its providers in lethal-means safety counseling for at-risk veterans, it does not require community care providers to be trained in such prevention efforts. This intervention—highlighting safe storage practices and creating time and distance to pause and reflect during a mental health crisis can save lives. All providers seeing veteran patients should be mandated to take this training.

The VA also trains its providers in trauma-informed care practices to address the specific needs of veterans with known trauma histories—this should also be a training requirement for community care network providers. A RAND study, Ready to Serve notes, a provider's lack of cultural competence in veteran-related health care issues is a complication to providing care. VHA providers specialize in understanding the specific needs of their patient population.

In-line with our 2025 critical policy priorities, DAV strongly recommends that the VA should amend its contracts with community care providers to require those who treat veterans to be trained in military culture, suicide prevention and lethal-means safety counseling. Alternatively, Congress could and should mandate such training. Additionally, the VA should require all community network providers to be trained in trauma-informed care practices used by VHA providers to address the specific needs of veterans with known trauma histories.

Timely access to mental health services and substance use disorder treatment

Timely access to mental health care and supportive services is essential for at-risk veterans and those suffering with PTSD, depression and suicidal ideation. Access

to specialty services, such as substance use disorder (SUD) treatment is also critical for veterans with co-occurring mental health and substance-use conditions.

VA has one of the country's premier SUD programs, providing comprehensive, high-quality evidence-based therapies and treatments. However, there are many challenges to adequately fund and staff this specialized programming, which is particularly concerning for the 4.7 million rural veterans in the United States, 58% of whom are enrolled in VHA. It is clear that, due to these challenges and barriers, rural veterans are less likely to receive the gold standard of care for SUD.

Additionally, VHA has a veteran patient population with a high rate of suicide and military sexual trauma (MST) compared to their civilian peers. According to the latest VHA Annual Suicide Prevention Report—from 2021 to 2022, the suicide rate rose by 37.8% for male veteran VHA users who disclosed a history of MST compared to a 1.8% increase for those without a history of MST. Recognizing that many survivors of sexual trauma do not disclose their experiences unless asked directly, it is VHA policy that all former service members seen for health care are screened for MST. VA's national monitoring data show that about 1 in 3 women and 1 in 50 men respond yes to having experienced MST when screened by their VA health care provider.

The VA's Mental Health Residential Rehabilitation Treatment Program (RRTP) mission is to provide state-of-the-art, high-quality residential treatment services for veterans with co-occurring mental health and substance use disorders, medical concerns, and/or psychosocial issues such as homelessness and unemployment. This includes 24/7 nursing coverage and support for medication compliance and administration. In addition, VA's SUD treatment programs focus on a whole health model of care and provide alternatives to traditional medicine such as meditation, yoga, acupuncture and tai chi.

While DAV strongly believes the VA's integrated, whole-health model of care and specialized wraparound support services provide veterans the type of comprehensive care and support they need for recovery, some veterans may need to receive these specialized services in the community due to long wait times or availability to access such services. Unfortunately, there is an absence of quality standards for VA-contracted clinicians who provide residential mental health and substance use disorder care.

For these reasons DAV recommends Congress and/or the VHA:

- Require mental health/substance use disorder-licensed independent practitioners who want to treat veterans to take a minimum of four hours of VHA TRAIN courses corresponding to the patient population they serve, four hours on military culture and two hours of suicide prevention and lethal-means safety counseling.
- Require licensed independent practitioners in residential care facilities to take VHA TRAIN courses in MST.
- Create VA certification requirements for private facilities participating in the Mental Health Residential Rehabilitation Treatment Program. The certification standard should include:

- ❖ Scientific evidence for a program's treatment approach;
- ❖ A standard ratio of licensed independent practitioners per resident;
- ❖ A semiannual peer review quality assurance system;
- ❖ Treatment planning;
- ❖ Accreditation by the Commission on Accreditation of Rehabilitation Facilities or an equivalent organization;
- ❖ Requirement for forwarding treatment records to the VA within 30 days of a veteran leaving a community residential care program; and
- ❖ Recertification of residential rehabilitation programs every three years.

- Mandate that mental/behavioral health outcome measures be administered to every VA-paid veteran participant at the point of entry, exit and follow up with VHA following discharge from the residential program.
- Require that the mental/behavioral health outcome scores of veterans be sent to VHA for data analysis and evaluation of each program.
- Publish program outcome data on the VA's Access to Care website with health care access and quality information about VA facilities.

Care Coordination Critical for Women Veterans

Women are the fastest-growing demographic of veterans—with over 650,000 now using VA health care services. Women veterans using VA care have high rates of service-connected disabilities, many have medically complex health histories and use specialty care—such as mental health and substance use disorder services at higher rates.

Women veterans are also high users of community care. Gaps in gender-specific care and specialized programming in some locations regularly require women veterans to be referred out to the community to receive needed care. Women veterans are referred to the community for all maternity care, and at times for other gender-specific or reproductive health services; in fact, some VA health care facilities don't provide any specialty gender-specific care, instead exclusively using its VCCP providers to meet patient needs. VHA also requires maternity care coordinators as a resource for pregnant veterans because of known pregnancy-related risks associated with post-traumatic stress and other mental health conditions common among veterans, as well as postpartum depression.

DAV recommends that VHA ensure maternity care coordinators have adequate allocated time to track and manage veterans with complex health histories, especially those utilizing community care services.

Conclusion

The Committee noted in the invitation for this hearing concerns from veterans and stakeholders about existing barriers to care through VA's CCN and "an inability of veteran patients to more freely choose where, when and how to use the VA health care services they have earned through their military service." As previously noted, Congress expanded the ability of veterans to receive care from community health care providers, through the Veterans Community Care Network established under the VA MISSION Act of 2018, and eligibility requirements for community care are clearly defined.

To that end, VA must ensure its employees are properly trained, understand the law and eligibility rules and set forth effective operating procedures for community care referrals. We urge Congress and VA to work together to resolve existing issues that act as barriers to accessing timely care both in VA and through its community care network and have offered a number of recommendations to the Committee for doing so.

A veteran's access to care should be the priority—whether in VA's direct care system or in the VCCP. Veterans should not be burdened with bureaucracy and experience delays in accessing needed care. To eliminate barriers, VA must ensure appropriate staffing levels to meet demand for direct care services and Congress must address long-standing staffing, IT, funding and infrastructure needs to accommodate timely, quality, modern health care delivery. VA must ensure appropriate staffing levels in its community care offices to manage the volume of referrals coming in and assign care coordinators as part of those teams to assist veterans with critical care needs, such as urgent cancer screening, approval of more complex treatment plans and authorizations needed to meet a veteran's unique care needs.

However, in considering changes to VCCP, DAV's primary focus is on whether proposed changes would result in better health outcomes for veteran patients, particularly disabled veterans. The principles we noted earlier in our statement were designed to achieve that goal by balancing the need for greater access to care with the *imperative* of providing high-quality and veteran-focused care.

While we agree that veterans must have options whenever and wherever VA is unable to provide timely, accessible, and high-quality care, research continues to show that the quality of care provided by VA is better than or equal to quality of care provided in the private sector on average and in some cases superior. Additionally, in VHA's 2024 Annual Report—it reported record breaking trust and satisfaction levels reported from veterans using VA services. Trust in VA outpatient care was 92% reflecting increased reliance on VA care.

Given VA's comprehensive, veteran-focused, evidence-based care model, investing in VA is the most likely way to produce better health outcomes for veteran patients and ensure quality of care. VHA clinicians are more likely to have experience with diagnosing and treating veterans with PTSD, traumatic brain injury, and toxic exposure illnesses. In our opinion, it is essential to maintain VA as the primary provider and coordinator of veterans' health care, a position supported by current and past VA Secretaries and Under Secretaries of Health serving in administrations of both political

parties. A robust VA health care system also provides vital research, essential clinical provider training, and emergency preparedness for veterans and the nation, further justifying such investments.

Unfortunately, the decades-long failure to properly fund, maintain and expand the VA's direct care infrastructure and increase staffing levels to meet rising demand for specialty care by veterans has led to an unsustainable growth in community care and related costs, threatening the long-term viability of the entire VA health care system. More importantly, an improperly managed VCCP has resulted in some veterans falling through the cracks and receiving a substandard level of care.

In closing, veteran patients deserve better and for improvements to be made expeditiously. Veterans need to know that Congress and VA are committed to working together to find solutions and resolve these existing issues that are negatively impacting some veterans health and well-being. At the same time, we ask the Committee to be mindful about the importance of a veteran-focused health care system to service-disabled veterans—many who rely exclusively on VHA for all of their health care needs. They have chosen VA and a system tailored to help them recover from catastrophic war-related wounds, injuries and illnesses so they can live full and meaningful lives with dignity and respect. We want to ensure they and future generations of service-disabled veterans do not lose the option of receiving VA's specialized care and services. A strong and viable health care system is part of keeping our promise to those who served.

Mr. Chairman, DAV appreciates your attention to this issue and we look forward in the year ahead to working with you and the Committee to improve care for our nation's veterans. This concludes my formal statement and I look forward to answering questions from the Committee.

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WOUNDED WARRIOR PROJECT

Statement of:
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Submitted for the Oversight Hearing:
"PROTECTING VETERAN CHOICE: EXAMINING VA'S COMMUNITY CARE PROGRAM"
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

January 28, 2025

Chairman Moran, Ranking Member Blumenthal, and distinguished members of the Senate Committee on Veterans' Affairs – thank you for inviting Wounded Warrior Project (WWP) to submit this written statement for record of today's hearing on the Department of Veterans Affairs' community care program. We share your commitment to ensuring that veterans receive high quality care in a timely manner, and we are grateful for your attention to this topic in the earliest days of the 119th Congress.

For over 20 years WWP has been dedicated to a mission to honor and empower wounded warriors. In addition to our advocacy before Congress, we offer more than a dozen direct service programs focused on connection, independence, and wellness in every spectrum of a warrior's life. Our organization has grown alongside the warriors we serve, and we strive to tailor our programming to the evolving needs of a post-9/11 generation of warriors that has become increasingly diverse. More than 225,000 veterans are currently registered and being served in various ways across the United States.

In this context, assisting warriors with their mental health challenges has consistently been our largest programming investment over the past several years. In Fiscal Year 2023, WWP spent more than $93 million in mental and brain health programs – an investment consistent with the fact that more than 7 in 10 respondents to our 2022 Annual Warrior Survey self-reported at least one mental health condition, and nearly the same amount (66.3%) reported visiting a professional in the past 12 months to help with issues such as stress, emotional, alcohol, drug, or family problems.[1]

As diagnoses of post-traumatic stress disorder (PTSD), depression, and anxiety have consistently ranked among the top five most self-reported conditions across previous editions of our Annual Warrior Survey, our Mental Health Continuum of Support has matured over the last decade and now allows us to engage each individual based on their unique needs. WWP helps support warriors by providing accessible and innovative solutions to mental health support

[1] WWP's 2022 Annual Warrior Survey can be viewed at https://www.woundedwarriorproject.org/mission/annual-warrior-survey.

including four programs focused specifically on mental health: WWP Talk, Project Odyssey, Complex Case Coordination, and WWP's Warrior Care Network – a partnership with four world-renowned academic medical centers providing veterans and Service members first-class treatment for PTSD, traumatic brain injury (TBI), military sexual trauma (MST), and other related conditions. Each of these programs are designed to support and empower post-9/11 veterans and their families in building resilience and overcoming any mental health challenges. Through these programs in Fiscal Year 2024 alone, WWP provided warriors and their family members with over 68,000 hours of treatment for mental health conditions.

Of course, WWP believes that no one organization can meet the needs of all wounded, injured, or ill veterans alone. Partnerships with and investments in other military and veteran support organizations help guide collaboration that allows WWP to amplify the effects of our efforts. For purposes of today's hearing however, we will focus on our largest and most significant partner in meeting the needs of post-9/11 wounded warriors: the U.S. Department of Veterans Affairs (VA). The perspectives that follow are intended to identify and discuss what we believe to be among the most critical areas of concern related to accessing mental health care in the community.

Access to Residential Rehabilitation Treatment Programs

Congress delivered a significant victory for veterans across the country by passing the *Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act* (P.L. 118-210); however, WWP and other leading veteran service organizations were discouraged by the omission of a provision to define an access to care standard for VA's mental health residential rehabilitation treatment programs (RRTPs). While VA has made strides to address access barriers in recent months, WWP remains firmly committed to finding a legislative solution to ensure that veterans can receive this critical, and in some cases, life-saving treatment.

VA's mental health RRTP provides residential rehabilitative and clinical care to eligible veterans who have a wide range of problems, illnesses, or rehabilitative care needs. To be clear, VA provides inpatient acute stabilization for veterans in crisis – a service expanded by the *Veterans COMPACT Act* (P.L. 116-214 § 201). RRTPs serve as the step down to those acute stabilizations and as a more intense treatment option for those veterans in need of substance use, PTSD, and dual diagnosis treatment, for example, in a residential setting. RRTPs serve a small but high-need, high-risk population of veterans – approximately 32,000 veterans received RRTP treatment at VA or in the community in 2023.[2] By contrast, 1.96 million veterans received individual or group mental health treatment in a VA setting in 2023.[3]

Despite the logical association between RRTP and mental health care, the access standards contemplated by the *VA MISSION Act* (P.L. 115-182 § 104) and memorialized in the Code of Federal Regulations (38 C.F.R. § 17.4040) do not, in practice, extend to mental or substance use disorder care provided in a residential setting. VA has maintained adherence to access standards for this type of care through VHA Directive 1162.02, which establishes a

[2] JENNIFER BURDEN, U.S. DEP'T OF VET. AFFAIRS, PARTNERSHIP STAKEHOLDER MEETING JANUARY 2024: MENTAL HEALTH RESIDENTIAL REHABILITATION TREATMENT PROGRAM (digital slide deck) (2024).
[3] U.S. DEP'T OF VET. AFFAIRS, FISCAL YEAR 2025 BUDGET SUBMISSION, Medical Programs and Information Technology Programs at VHA-109, https://www.va.gov/opa/docs/remediation-required/management/fy2025-va-budget-volume-ii.pdf (last visited January 23, 2025).

priority admission standard of 72 hours and, for all other cases, 30 days before a veteran must be offered (not necessarily provided) alternative residential treatment or another level of care that meets the veteran's needs and preferences at the time of screening.

Due to this approach, veterans seeking mental or substance use disorder care provided in a residential setting are not subject to the access standard protections assigned under law. VA is not required to inform these veterans of their expected wait time. *See* P.L. 117-328, Div. U, § 122. Veterans are not guaranteed the soonest possible starting time before a community referral must be made. *See* P.L. 117-328, Div. U, § 121; 38 U.S.C. § 1703(d)(4). The access standards used are not applicable to community care network providers who receive referrals for these veterans' care. *See* P.L. 117-328, Div. U, § 125; 38 U.S.C. § 1703B(f).

Most importantly, if appropriate community-based providers are identified and available to provide treatment, veterans waiting beyond VHA's policy-backed access standards have no dependable, consistent recourse to be referred for that care. In May 2024, VA presented data indicating that around 1,600 veterans are pending admission to RRTPs on any given day.[4] And while statistics about declining wait times (average time from referral to admission was 21.8 days during Q2 FY 2024) are encouraging, there remains significant variability across programs and Veteran Integrated Service Networks (VISNs).

For these reasons, WWP strongly encourages Congress to continue its pursuit of a legislative solution to address RRTP access. During this process, we encourage consideration of certain key facts. First, at the end of September 2023, VA operated 120 mental health RRTP facilities across the entire country.[5] Second, RRTP facilities may offer one or more of five discrete services: domiciliary substance use disorder programs (72 locations), domiciliary PTSD programs (43 locations), general domiciliary programs (53 locations), domiciliary care for homeless veterans (43 locations), and compensated work therapy – transitional residence (39 locations).[6] As illustrated here, not all VA RRTP access points provide the same level of services and may not appropriately match a veteran's care needs. VA's 2022 Asset and Infrastructure Review (AIR) Report offers a close approximation of VA's RRTP facility footprint and generally illustrates that VA's RRTP services are not widely available in every state.[7]

Finally, VA's third-party administrators of the Community Care Network are charged with sourcing needed RRTP options across the country to meet the demand. These organizations meet the appropriate care standards, and many provide specific military and first responder programs. While similar market assessments for community-based RRTP services are not included in the AIR Report, more detailed information about where community-based RRTPs are located can help inform future policy decisions. For example, we encourage careful review of the potential long-term impact on RRTP care supply if VA must adhere to a distance-based access standard for this critical but not abundant variety of care.

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[4] JENNIFER BURDEN, U.S. DEP'T OF VET. AFFAIRS, MAY 2024 PRESENTATION AT THE 27TH ANNUAL VA PSYCHOLOGY LEADERSHIP CONFERENCE (digital slide deck) (2024).
[5] U.S. DEP'T OF VET. AFFAIRS, FISCAL YEAR 2025 BUDGET SUBMISSION, Medical Programs and Information Technology Programs at VHA-131, https://www.va.gov/opa/docs/remediation-required/management/fy2025-va-budget-volume-ii.pdf (last visited January 23, 2025).
[6] BURDEN at footnote 3.
[7] U.S. DEP'T OF VET. AFFAIRS, VA RECOMMENDATIONS TO THE AIR COMMISSION – VOLUME II APPENDICES: THE MARKEY ASSESSMENTS, https://www.va.gov/AIRCOMMISSIONREPORT/Appendices.asp (last visited January 23, 2025).

General Observations on Access to Community Care Through VA

Wounded Warrior Project has built our organization around providing care and support to post-9/11 wounded, ill, and injured veterans and Service members in many forms, including mental health care. In FY 24 (October 1, 2023, to September 30, 2024), WWP provided over 19,000 warriors and family members with mental health services – and were connected to support, on average, in 3.5 days. Some of these veterans have used VA for mental health care, others have not – using VA is not a pre-requisite to accessing WWP's free programs and services. However, for some warriors, VA experiences are a driver of engagement with WWP. Common themes are discussed in more detail below:

Culture of CCN referrals at VA: WWP has observed trends indicating downward pressure from VA administrators on VA providers to not place referrals outside of VA direct care. Even when placed, referrals are being denied by administrators. Accordingly, we generally cosign the Senator Moran-led letter to Secretary McDonough on July 25, 2024, which commented, "[i]n line with these examples from veterans, VA whistleblowers have disclosed the establishment of burdensome processes to have VA medical center leaders highly scrutinize community care referrals in an effort to recapture care in VA medical facilities."

Long wait times for VA mental health care: Despite efforts to expedite access through the *VA MISSION Act*, many warriors have reported wait times of several weeks to months before being provided with a mental health appointment. That is typically when a veteran – or their family – reaches out to organizations like WWP for help. WWP has contractual relationships with direct care providers and can help triage veterans into care sooner in many cases. If we are unsuccessful at helping a warrior get into VA care quickly, WWP pays a premium for that faster connection to military competent care, paid from donor-dollars, and with almost no opportunity to secure any reimbursement from the veteran's existing benefits.

Community-based care referrals do not guarantee faster access: Once authorized for care in the community, veterans may still experience longer than desired wait times. For example, a WWP warrior recently moved and began pursuing care through their new VA Medical Center (VAMC). The VAMC referred the veteran to community-based care because it did not have enough staff to provide a timely appointment. After VA placed the referral, the veteran did not receive any information about the provider's name, location, or what services would be provided. It took several months for the veteran to be seen by the community-based provider and the veteran did not have any information to help advocate for more timely care.

In this context, WWP recognizes that we simply need more providers in the field regardless of whether they choose to practice at VA or in the community. To that end, we supported several bills in the 118th Congress that will help develop and sustain a mental health workforce that can begin to close the gap with demand for services. For example, the *Mental Health Professionals Workforce Shortage Loan Repayment Act* (S. 462, H.R. 4933) would authorize the federal government to repay up to $250,000 in eligible student loan repayment for mental health professionals who provide substance use disorder care in mental health shortage areas. Similarly, the *Better Mental Health Care, Lower-Cost Drugs, and Extenders Act* (S.

3430) would provide incentives under Medicare and Medicaid to health care providers to provide mental health and substance use disorder treatment in health professional shortage areas.

Mental health provider turnover (VA and community): Veterans have consistently reported churn in their assigned VA mental health care providers. In the often-personal mental health context, frustration with turnover is amplified as veterans are forced to restart care with a new provider and redevelop trust, rapport, and familiarity with symptoms and back story. However, we also hear about community-based providers accepting referrals with knowledge that they will not be able to deliver care over a longer-term period. In those scenarios, a veteran will receive a limited amount of care only to be referred back to VA before a course of treatment is completed.

Ineffective treatment at VA: For mental health specifically, warriors may be assigned a psychiatrist for medication management, but with no additional referral to a provider who can deliver evidence-based psychotherapy. This is contrary to a best practice to maximize treatment outcomes, which is to concurrently receive psychopharmacology and evidence-based psychotherapy. In addition, some veterans have approached VA with requests to receive a specific variety of care in the community – for example, individual counseling – only to have that request denied upon a VA decision that it can offer comparable care directly. When that care is of a different nature, like group therapy, it can leave the veteran feeling unheard and invalidated. Often times the type of care the veteran is hoping to receive is not conducive, and potentially counterintuitive, to be provided in a group setting.

Community-based provider billing: While the community care network's third-party administrators have shared encouraging statistics on their pace of paying providers, veterans have relayed to WWP that some providers complain that they are not receiving prompt payment. When some veterans receive provider complaints of this nature, it may have one of several effects. The provider may cease the veteran's treatment until payment is received. Veterans may experience stress related to the responsibility that follows receiving a bill for unpaid care in the community, even if that responsibility is just working with VA to reconcile and pay the balance. Some veterans have also suggested that they would stop seeking the care out of concern they will be presented with more bills or may stop seeking care because they feel that the care is being provided as a charity.

CONCLUSION

Wounded Warrior Project thanks the Committee and its distinguished members for inviting our organization to submit this statement. We are grateful for your attention and efforts towards addressing the critical issues surrounding the delivery of health care to veterans around the country. We look forward to continuing to work with you on these issues and are standing by to assist in any way we can towards our shared goals of serving those that have served this country.

Submission for the Record

Department of Veterans Affairs Programs and Grants Potentially at Risk due to OMB Funding Pause

- State Veterans Home Construction Grant Program
- State Veterans Homes Domiciliary Care
- State Veterans Homes Nursing Home Care
- VA Homeless Providers Grant and Per Diem (GPD) Program
- State Veterans Homes Adult Day Health Care
- Post-9/11 Veterans Educational Assistance
- Life Insurance for Veterans
- Montgomery GI Bill Selected Reserve
- VA Supportive Services for Veteran Families (SSVF) Program
- Adaptive Sports Grant Programs
- Veterans Transportation Program
- Paralympics Monthly Assistance Allowance Program
- Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
- Specially Adapted Housing Assistive Technology Grant Program
- Payments to States for Programs to Promote the Hiring and Retention of Nurses at State Veterans Homes
- Research and Development
- Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program
- Legal Services for Veterans Grant Programs
- Suicide Mortality Review Cooperative Agreements
- Veteran and Spouse Transitional Assistance Grant Program
- Automobiles and Adaptive Equipment
- Burial Expenses Allowance
- Veteran Pensions
- Pensions for Surviving Spouses
- Specially Adapted Housing
- VA Compensation for Service-Connected Disabilities
- Dependency and Indemnity Compensation
- Housing Guaranteed and Insured Loans
- Veteran Readiness and Employment
- Survivors and Dependents Educations Assistance
- Veterans Housing Direct Loans
- Post-Vietnam Veterans' Education Assistance
- All-Volunteer Force Education Assistance
- Vocational and Educational Counseling
- Native American Direct Loan Program
- Monthly Allowance for Children of Vietnam Veterans Born with Spina Bifida

- Vocational Training and Rehabilitation Benefits for Children of Vietnam Veterans Born with Spina Bifida
- Veteran Rapid Retraining Assistance Program
- National Cemeteries
- Procurement of Headstones and Markers
- Veterans Cemetery Grants Program
- Veterans Legacy Grants Program
- VA Casket or Urn Allowance Program
- VA Outer Burial Receptacle Allowance Program

Non-VA Programs and Grants Directly Impacting Veterans Potentially at Risk due to OMB Funding Pause

- Department of Agriculture's Enhancing Agricultural Opportunities for Military Veterans Program
- Department of Agriculture's Assistance for Socially Disadvantaged and Veteran Farmers
- Department of Justice's Veterans Treatment Court Discretionary Grant Program
- Department of Labor's Homeless Veterans' Reintegration Program
- Department of Labor's Jobs for Veterans State Grants
- Small Business Administration's Veterans Outreach Program

Questions for the Record

Senator Dan Sullivan
Questions for the Record
Senate Veterans' Affairs Committee
Protecting Veteran Choice: Examining VA's Community Care Program
Tuesday, January 28, 2025

Questions for Jim Lorraine, America's Warrior Partnership

1. I appreciated your testimony, and your recognition of the very positive impact the MISSION Act has had on how veterans receive community care. Yet, despite the popularity and demand for community care, the program been a target for partisan politics – especially within the VA. The recommendations of the VA's 'red team' demonstrate this quite clearly, claiming that community care presents "an existential conundrum for VA."

Can you speak to how you've seen community care weaponized? Are there specific policies Congress can put in place that will codify access for our veterans?

Reply from Jim Lorraine, President and CEO of America's Warrior Partnership.

America's Warrior Partnership (AWP) remains steadfast in our support for the MISSION Act and the principles it upholds, chief among them, empowering veterans with timely access to high-quality care in their own communities. Since its enactment, the MISSION Act has enabled thousands of veterans to receive life-saving services closer to home, especially in underserved and rural areas where VA capacity is limited or unavailable.

Unfortunately, we have witnessed the growing politicization of community care. These barriers—delayed referrals, restrictive interpretations of eligibility, and inconsistent provider reimbursements—have diminished the potential of a program that reduces barriers to care.

As a nation, we must safeguard community care as a permanent, reliable option for all veterans. We support legislation that codifies access standards, ensures timely referrals and reimbursements, enhances transparency, and protects a veteran's right to choose care that best meets their needs.

Veteran care should never be a political debate. It should be a national promise, honored through policy, protected through oversight, and upheld by unwavering commitment. Community care is not a threat to the VA; it is a vital complement to its mission. Preserving that balance is essential to truly serving all who served.

2. While formal Community Care is focused on providers in the community, I would be remiss if I did not mention the great work America's Warrior Partnership is doing in Alaska, and the value of community organizations like yours. Local community partners, with boots on the ground, are

critical for meeting the needs of veterans which may fall outside the traditional scope of VA services. My legislation, the *LINC VA Act*, which I plan on reintroducing, would help support organizations that connect veterans with resources on a "one-size-fits-one" basis, as you put it. In Alaska, this can mean delivering firewood or plowing a driveway – things not typically thought of that are, nonetheless, vital to the veterans' well-being.

Can you speak the importance of partnering with community providers outside of the VA? Additionally, would you support the *LINC VA Act*, and do you think this approach would be revolutionary in the VA?

Reply from Jim Lorraine, President and CEO of America's Warrior Partnership.

Partnering with community providers is essential to ensuring that veterans receive timely, personalized, and comprehensive care, particularly in areas where VA resources are limited or veterans face barriers to access. Many veterans either live far from VA facilities, face long wait times or have unique cultural or medical needs that community providers are better positioned to address. These partnerships expand the reach of care, reduce gaps in service, and enable a more holistic approach that addresses not only physical and mental health, but life issues such as economic instability, housing, employment, or substance use.

America's Warrior Partnership (AWP) has seen firsthand how local providers can serve as the connective tissue between federal systems and the veteran. When we work with trusted community partners, we meet veterans where they are, often before they reach a point of crisis, and build relationships rooted in trust, not bureaucracy. Empowering communities strengthens the whole ecosystem of veteran care.

The LINC VA Act (Leveraging Integrated Networks in Communities for Veterans Act) is a good step forward. The legislation recognizes that successful care coordination happens locally, and that integrating community providers into the VA's broader network is not a compromise; it's an upgrade. There are three points that must be addressed for the broad success of a community coordination program. First, this program should be technology agnostic, as almost all service programs utilize different systems. Second, funding is needed to properly coordinate across government and non-government programs, and lastly, the leading organization requires the authority to act within the community across government and non-government programs to ensure a holistic, integrated approach to addressing veterans' complex and basic needs.

Statements for the Record

American Association of
NURSE ANESTHESIOLOGY

Written Statement for the Record by:

Janet Setnor, MSN, CRNA, Col. (Ret), USAFR, NC,
President
American Association of Nurse Anesthesiology

Senate Veterans Affairs Committee
"Protecting Veteran Choice: Examining VA's Community Care Program"

412 Russel Senate Office Building
Washington, DC 20510

January 28, 2025

Background on AANA and CRNAs

Chairman Moran, Ranking Member Blumenthal, and Members of the committee, thank you for the opportunity to offer this statement for the record. The American Association of Nurse Anesthesiology (AANA) is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists, with membership that includes more than 65,000 CRNAs and student nurse anesthetists representing over 88 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who provide anesthesia, as well as acute, chronic, and interventional pain management services. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. CRNAs are highly trained and skilled anesthesia providers who have full practice authority in the Army, the Navy, and the Air Force, as well as the Indian Health Service. CRNAs are the primary provider of anesthesia on the battlefield, including in forward surgical hospitals.

AANA applauds the Committee's continued oversight of the ways the Department of Veterans Affairs (VA) provides quality care and services for our nation's veterans. This hearing is an important opportunity to address inefficient models of care within the VA health system that can lead to veterans seeking and receiving care in the community. The VA has unnecessarily restrictive practice models for anesthesia that intentionally underutilize CRNAs, driving up costs for taxpayers, increasing wait times for veterans, and creating significant inefficiencies and unnecessary redundancies in the system. This was readily apparent at the Hampton, Virginia VA Medical Center (VAMC), where a lack of physician anesthesiologists meant that CRNAs were not allowed to provide anesthesia despite being trained and educated to do so. This directly led to unnecessary delays in care, diversion to other facilities, and wasted money and resources.[1] We also applaud the Trump Administration for their leadership on reducing barriers to care for APRNs, including CRNAs, both by temporarily removing supervision requirements for CRNAs, as well as putting out a report that called for allowing all APRNs to work to the top of their training, which we strongly encourage the VA to follow.

Many of the veterans who turn to community care live in rural and underserved areas. According to data from the VA, there are 4.4 million veterans living in rural areas, and a higher percentage of rural veterans are enrolled in the VA health system than those in urban areas.[2] Additionally, veterans in rural areas are more likely to experience difficulty in accessing care, with longer waits and greater distances to care. In these areas, veterans who opt to utilize community care are far more likely to receive anesthesia from a CRNA. CRNAs make up approximately 80% of rural anesthesia providers and are the sole provider of anesthesia in nearly 100% of rural hospitals.[3] Despite the fact that veterans who are sent out into the community for care are more likely to receive anesthesia from a CRNA, the VA health system itself utilizes an unnecessarily

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[1] https://veterans.house.gov/news/documentsingle.aspx?DocumentID=6424
[2] Department of Veterans Affairs. *Rural Veteran Health Care Challenges.* Office of Rural Health. https://www.ruralhealth.va.gov/aboutus/ruralvets.asp
[3] https://www.aana.com/about-us/about-crnas/

restrictive anesthesia model that significantly contributes to veterans being forced to seek care outside of the VA health system in the first place because it is so inefficient.

The continued requirement of physician supervision of CRNAs within the VA is a persistent roadblock to the delivery of healthcare to our veterans. The practice is costly and dangerous, as it means veterans will see their care delayed or cancelled when an anesthesiologist is not available, despite the VA health system having ample CRNAs who are ready and able to provide care. This model of care is also incongruent with the vast majority of state laws, which do not require physician supervision of CRNA services, and runs counter to the preponderance of peer-reviewed evidence on CRNA safety, which shows that CRNAs can practice independently without any safety concerns. In fact, numerous studies have shown that patient health outcomes are identical when anesthesia services are performed by CRNAs versus physician anesthesiologists. CRNAs possess the education and training to provide care to all patients, even those with complex medical conditions.

To better provide the care that our veterans have earned and deserve, the VA health system must remove costly, unnecessary barriers to care. The VA health system could realize considerable cost savings and improved wait times, all without sacrificing healthcare quality, by allowing CRNAs full practice authority at all VA health facilities. This would allow a considerable number of veterans to receive care within the VA health system should they so choose. Otherwise, the VA health system will continue to face fiscal shortfalls in coming years and our veterans will be forced out into community care in ever greater numbers.

The Important Voice of Nurses

The voice of nurses is critical to our healthcare system and to finding solutions that work for patients. Too often, the thoughts and opinions of the nation's more than four million nurses are forgotten in the halls of Congress. For the twenty-third year in a row, nurses remain the most trusted professional in the country.[4] Given the role that nurses play on the front lines of patient care, their consistent role in interacting with patients, and the incredible public trust they have garnered because of that service, it's important that we learn from them, and we encourage the utilization of nurses as expert witnesses and helpful resources for hearings such as this. We hope the Committee will engage with nurses as we work together toward our common goal of ensuring that all veterans have access to healthcare.

VA Unnecessarily Creating Delays and Inefficiencies

The goal of Community Care is to expand access to healthcare for veterans and lower or eliminate barriers to care. This has long been a policy priority for the AANA in both veterans' healthcare and in our broader healthcare system. Too often, outdated and inefficient barriers to care have made accessing healthcare difficult for patients. Community Care plays a significant role in ensuring that veterans have access to timely care.

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[4] Saad, Lydia. (January 13, 2025). *Americans' Ratings of U.S. Professions Stay Historically Low.* https://news.gallup.com/poll/655106/americans-ratings-professions-stay-historically-low.aspx

The VA must get out of its own way when it comes to providing timely access to care. The VA health system continues to utilize incredibly inefficient anesthesia models that increase waits times for veterans, increase costs to taxpayers, and harm veterans' health by delaying or denying care. In too many cases, the VA health system uses 1:1 and 1:2 supervision ratios, wherein a physician anesthesiologist, making close to $400,000 a year, supervises a single CRNA on a single case at a time.[5] This is a comically inefficient use of taxpayer money and healthcare resources. Such supervision models continue to lead to the VA unnecessarily delaying care and forcing veterans to seek care outside of the VA health system, even if that is their preferred provider. These same models of care are rare in the private sector, and veterans who seek community care will almost certainly receive care from a far less restrictive anesthesia model, one that allows CRNAs to work far more independently and efficiently than the VA health system currently does.

We have seen firsthand at the Hampton VAMC the damage that the VA health system's inefficient anesthesia models can cause. The facility previously employed just one physician anesthesiologist and had canceled or delayed care when that physician was unavailable. The VA was therefore paying multiple CRNAs at the Hampton VAMC, who were not being allowed to provide care when the physician anesthesiologist was not present, despite being fully capable of doing so. Not only was this a waste of taxpayer dollars, but an affront to our veterans. The Hampton VAMC, due to this misguided policy, had to divert patients to other facilities and borrow physician anesthesiologists from other Veteran Integrated Services Networks (VISNs), furthering the inefficiency of care already guaranteed by the artificial limits to CRNAs' scope of practice at the VA.

As VISN 6 leadership has admitted, they are forced to contract with outside anesthesia providers, unnecessarily increasing costs for care at a time the VHA is facing budget shortfalls. The VISN 6 leadership also mentioned that they are working with the Department of Defense to recruit active-duty providers in the region. This is ironic as active-duty CRNAs, under the rules of the Defense Health Agency, enjoy full practice authority everywhere, including when they practice within the state of Virginia. The current anesthesia models within the VA health system are untenable for our veterans, and it is the result of a misguided policy employed by both the VA in general and the Hampton VAMC specifically, and represents a broken promise made by the VA nearly a decade ago.

Community Care and CRNAs

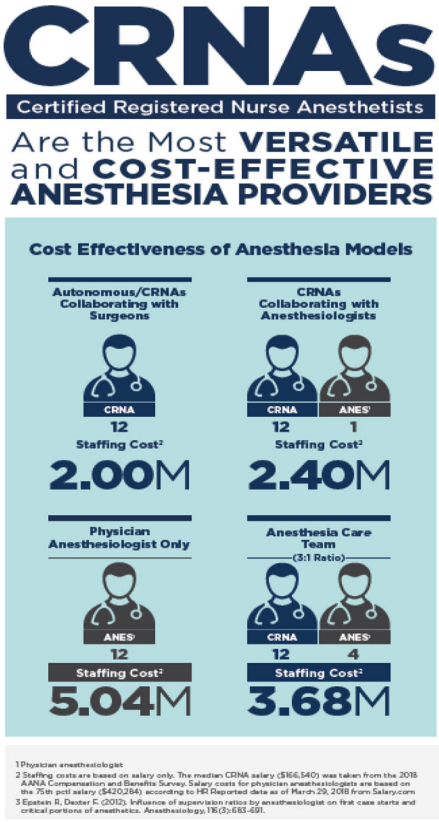
The AANA strongly believes that the VA should move to grant CRNAs full practice authority to increase access to care, so that every veteran who wants to access care within the VA can do so, especially with the increasing number of veterans eligible for care under the PACT Act. For those who cannot access care within the VA system, Community Care represents an option that will help to increase access and improve timeliness of care. Yet, a major disconnect occurs between the VA and all other practice environments. While the VA utilizes overly strict supervision models that impede access to care without any corresponding increase in outcomes,

[5] https://www.va.gov/OHRM/Pay/2021/PhysicianDentist/PayTables_20210103.pdf

the majority of states do not require these supervision models. The VA even quixotically uses these restrictive and inefficient models when they are in conflict with state requirements.

Currently, only seven states have supervision requirements for CRNAs in their Nurse Practice Act, Board of Nursing rules, or their equivalent, and twenty-five states have opted out of Medicare's supervision requirements for CRNA services. The trend of states opting out of supervision requirements for CRNAs has accelerated recently, with eight states opting out just in the last five years. This represents an ongoing, bipartisan trend towards increasing access to care and removing administrative burdens that harm patients.

When we meet veterans where they are to provide care, it is often CRNAs who are providing that anesthesia, particularly in the rural and underserved communities that are most reliant on community care. If CRNA led anesthesia care is good enough for Community Care, and is good enough for the Defense Health Agency and every branch of the military, why isn't it good enough for the VA health system? While there are legitimate concerns that sending more care out into the community created budgetary issues for the VA, the delivery of anesthesia is one area where the private sector has moved to be more efficient. It is time to bring the VA in line with the rest of the country by allowing CRNAs to provide high-quality, timely care. They must be granted full practice authority within the VA if we are to live up to our promise to care for our veterans.



Comparing various methods of anesthesia delivery, an autonomous CRNA collaborating with a surgeon is the most cost-effective model for anesthesia delivery. Current trends in the QZ modifier, which is utilized when a CRNA is billing for anesthesia without supervision, have shown a steady increase in the utilization of this billing modifier, implying an increase in CRNA autonomous practice. The anesthesia care team model, of 1:3 supervision is one of the most expensive anesthesia delivery models possible. Allowing for autonomous practice by CRNAs allows facilities the flexibility to choose a model that meets their needs and helps to keep costs down. Unfortunately, the VA health system is known for significant waste in their anesthesia delivery models, including the utilization of the highest cost 1:1 supervision model, and incurring millions of dollars in costs due to outside anesthesia contracts. Veterans and taxpayers deserve better than VA's inefficient anesthesia delivery models.

Independent Recommendations and Clinical Data

While the VA continues to utilize inefficient models and waste taxpayer dollars while simultaneously harming veterans' access to care, they have made it clear multiple times that they do not see evidence that CRNA independent practice provides outcomes any different than other, more restrictive anesthesia models. On the contrary, the VA has supported CRNA independent practice as equally safe as our anesthesiologists' colleagues, stating in a 2016 rule, "'over 900 CRNAs provide every type of anesthesia care, as well as chronic pain management services, for our Veterans in the VHA. The safety of CRNA services has long been recognized by the VHA and underscored by peer-reviewed scientific studies, including a major study published in Health Affairs which found that '"anesthesia care by CRNAs was equally safe with or without physician supervision.' VA agrees with these comments."[6] Additionally, the VA agreed in their materials published with this rule that "anesthesia care by CRNAs was equally safe with or without physician supervision."[7]

The evidence is overwhelming that CRNA independent practice is just as safe as the anesthesia care provided under supervision or by our physician anesthesiologists colleagues. In a study that the VA commissioned from Temple University, it was found that "studies have found that CRNAs who had an expanded scope of practice did not have worse patient outcomes, complications, or mortality when compared to anesthesiologists."[8] A peer reviewed study published in the Journal of Medicare Care in 2016 looked at anesthesia related complications for CRNA only, anesthesiologist only, and a team-based approach and found there were no differences in complication rates based on delivery model.[9] This corroborates an earlier peer reviewed study published in Health Affairs in 2010 that looked at the differences in outcomes in states that had opted out of Medicare's supervision requirement for CRNAs were no different than outcomes in states that maintained supervision.[10] A comprehensive review completed by the Cochrane Library in 2014 further reinforced these finding, when it reviewed the literature on anesthesia staffing and found that there could be no definitive statement can be made about the superiority of anesthesia delivery models.

During his first Presidency, the Trump Administration released a report on "Reforming America's Healthcare System Through Choice and Competition" that included recommendations to "allow all healthcare providers to practice to the top of their licensure, utilizing their full skill sets".[11] President Trump also put in place policy during the Public Health Emergency to

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[6] "Advanced Practice Registered Nurses" (A rule by the Veterans Affairs Department, 2016). https://www.federalregister.gov/documents/2016/12/14/2016-29950/advanced-practice-registered-nurses

[7] Department of Veterans Affairs, op. cit.

[8] Baumle, op. cit.

[9] "Scope of Practice Laws and Anesthesia Complications" (Negrusa, Hogan, Warner, Schroeder, and Pang, 2016). https://journals.lww.com/lww-medicalcare/abstract/2016/10000/scope_of_practice_laws_and_anesthesia.4.aspx

[10] "No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians" (Dulisse and Cromwell, 2010). https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2008.0966?journalCode=hlthaff

[11] Department of Health and Human Services. (December 3, 2018). *Reforming America's Healthcare System Through Choice and Competition.* https://public3.pagefreezer.com/browse/HHS.gov/31-12-2020T08:51/https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html

temporarily waive the supervision requirement for CRNA services. The VA Health system needs to continue in this vein. The situation will become even more dire in the coming years, both within the VA and in Community Care as the Association of American Medical Colleges predicts as shortage of specialty physicians, including anesthesiologists, of between 10,300 and 35,600 by 2034.[12] The combined physician shortage and nursing shortage makes clear that we can no longer rely on outdated anesthesia models that are already untenable, and will become increasingly dangerous with a growing and aging veteran population. It is imperative that all qualified anesthesia providers, including CRNAs and our physician anesthesiologists' colleagues, need to be providing direct patient care-especially to ensure that our veterans have the timely access to care they deserve, either at the VA or through Community Care. Veterans and taxpayers can no longer afford to pay healthcare providers to stand around and provide unnecessary supervision when they could be, and should be, providing actual patient care. Not only is this the right thing to do for veterans, but it aligns with the Department of Government Efficiency's goal of removing administrative burdens and more efficiently using taxpayer funds.

Conclusion

The VA continues to create its own problems with its woefully outdated anesthesia models that hurt veterans and taxpayers equally. The VA needs to make changes now. We applaud the work of your committee and the vision that that Trump administration has laid out to remove barriers to APRNs and to increase competition and choice within the healthcare system. We believe this will benefit veterans at every level and save American taxpayers money. We hope to be helpful partners in your work to provide our veterans with the highest quality care possible.

[12] Heise, Stuart. (June 11, 2021). *AAMC Report Reinforces Mounting Physician Shortage.* https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage

Statement for Senate Veteran's Affairs Committee Hearing: "Protecting Veteran Choice: Examining VA's Community Care Program"

Tom Sauer
Founder & CEO, Miramar Health

Chairman Moran, Members of the Senate Committee,

My name is Tom Sauer; I'm a former enlisted Marine infantryman, US Naval Academy graduate, and former Navy EOD Officer. Today, I'm the Founder and CEO of Miramar Health, a mental health and addiction treatment company exclusively serving America's Veterans through the VA MISSION Act.

At Miramar Health, we provide Veterans with the treatment and support they need to rebuild their lives and recover from addiction.

Today, I am urging the committee to address an exceptionally pressing, time-sensitive issue: Veterans' access to Community Care for Residential Rehabilitation Treatment Programs (RRTPs) under the MISSION Act is being compromised, and it's time for new VA leadership and Congress to take urgent action.

The MISSION Act was passed under the 115th Congress and signed into law by President Trump with the promise of providing Veterans with timely, high-quality care by allowing Veterans to seek care within the community when the VA is unable to meet their needs.

Yet, in the VA Desert Pacific Healthcare Network (VISN 22) and across most of our nation, it is treated as a last resort, *or not an option at all*. Veterans are routinely denied the care they need, and these denials have deadly consequences. This is not just an administrative failure; it's a failure to protect those who served our country.

One example (attached) of many I can personally attest to is Luis, a Marine Corps Veteran who sought treatment at Miramar Health for his alcohol addiction in 2024. Luis had been struggling for years but found hope and a path forward at Miramar. He was making progress—committed to his recovery and benefiting from the treatment we provide. But when it came time for him to continue his care after a brief relapse, the VA denied his request to stay at Miramar because a bed would be available at the domicillary several weeks later.

Despite his success in our program, the VA refused to allow him to remain at Miramar Health, and Luis was denied a treatment program that was working for him. This decision had devastating consequences – Luis tragically took his own life ten days later. His story isn't an isolated case. This is happening to Veterans across the country—Veterans who are being denied access to the care they need because the VA refuses to follow the law.

The MISSION Act was meant to ensure that Veterans have access to care when they need it, whether it's through the VA or through the community care, because community care is VA care. system. But in far too many cases, Veterans explicitly denied this option. The denial of community care is not only a violation of the law—it's a violation of the promise we made to Veterans when they joined. These Veterans, who have already sacrificed so much for our country, are being forced to navigate a broken system that refuses to help them when they need it most.

We cannot continue to stand by and let this happen. Veterans like Luis deserve the care that works for them, whether that care comes from the VA or from a trusted community provider. If the VA is not able to immediately meet a Veteran's needs, the system must allow that Veteran to seek care outside the VA system—without delay, without obstacle, and without denial. This is especially true when it comes to addiction, mental health, and suicide. Community care is not an alternative to VA care—it is an essential extension of the VA's mission to serve Veterans where and when they need it.

The refusal of care through community providers isn't just about access to treatment. It's about the impact these decisions have on the lives of Veterans. Veterans are suffering and dying because of these denials, and the system is failing them. Luis's case is a tragic reminder that when we fail to provide timely access to care, the consequences can be fatal.

I'm here today to ask this Committee to urge new VA leadership, especially Secretary Collins, to end this practice on **Day One**. I know I'm preaching to the choir here, but the MISSION Act is not optional—it's the law, and it's time the VA followed it. The MISSION Act must be fully implemented, and that means Veterans should not be denied care just because it's easier for the VA to keep them in-house at the risk of the Veteran's life. The law is clear: when the VA cannot *immediately* provide the care a Veteran needs, they must allow Veterans to seek care with a qualified community partner.

We also support future legislation that strengthens the MISSION Act's access standards and increases access to RRTPs for Veterans who are struggling with addiction (SUD) and mental health issues. These programs are vital to Veterans' recovery, and the system must ensure that Veterans can access them in a timely manner. No Veteran should have to wait weeks or months for care, and no Veteran should be forced to leave a treatment program that's working just because the VA refuses to refer them to community care.

The time for action is now. We've seen the damage that is done when Veterans are denied access to the care they need. We cannot wait any longer. I urge this Committee to take immediate steps to ensure VA complies with the MISSION Act and puts Veterans' health and well-being first. The lives of our Veterans are on the line, and we can't afford to wait for another tragedy to highlight the failure of this system.

Thank you for your time and attention to this critical issue. I look forward to working with the Committee to ensure that the MISSION Act is appropriately followed.

Sincerely,

Tom Sauer
Founder, Miramar Health

Luis T West Los Angeles VA Medical Center Case Study

Luis T's Story Line

To Whom It May Concern,

I am Luis [redacted], a United States Marine Corps Veteran. I enlisted in August of 1999 and ended my active-duty service in May of 2007. I have been struggling with alcohol addiction for years and on December 1, 2023, I decided to go to the West Los Angeles Veterans Affairs Emergency Room and commit to detoxifying my body of alcohol. I spoke with a social worker and decided to go to an outsource mental health organization called Miramar Health, located in Orange County in California. I found out later that this organization has multiple homes to address the different stages of detoxification and recovery.

My experience at Miramar was great from the start. The staff and nurses there were very welcoming, understanding, and empathetic. While I was hesitant for years to attend any kind of rehabilitation center, the staff at Miramar began to change my view and mindset towards recovery. While I was against attending group meetings, the staff at Miramar helped to change my approach towards attending groups. I began to find it therapeutic. I began to let go and commit and it felt great.

I was only approved to be in the detoxification house for 7-10 days, but I stayed an extra day due to what is called a "Domiciliary Interview " for the West Los Angeles Veterans Affairs. After the interview, I was told that space was available for their inpatient program. I decided to voluntarily go, since they would no longer fund my recovery through Miramar Health.

I spent about 2 months at the domiciliary and successfully attended all my group meetings. I attended 12 step meetings and SMART recovery sessions as well. I maximized my access to all the resources I felt would benefit me in regard to my recovery. I attribute this mindset to the staff at Miramar Health for setting me up to do the work I needed to move forward.

Unfortunately, I relapsed about 2 weeks later and I quickly got myself to a point where I was already having heavy alcohol withdrawal symptoms. Being a middle school music teacher, it was difficult to get through the rest of the school year while dealing with withdrawal symptoms. I would miss work and would have to go to the emergency room several times at the West Los Angeles Veterans Affairs Medical Center several days for detoxification and would return to work.

After the school year ended, I checked myself back into the emergency room at the West Los Angeles Veterans Affairs Medical Center, under the direction of my primary doctor at the Sepulveda Ambulatory Care Center in North Hills, California. My doctor wanted me to go through a detoxification program at an outsourced location. Due to my previous positive experience at Miramar Health, I immediately requested to go back through their program upon speaking with the social worker at the emergency room. I was sent for later that same day and returned to the same detoxification house through Miramar Health located in Santa Ana, California.

While I was not in the greatest state, most of the staff at Miramar Health remembered me and I felt like I simply continued where I left off in my recovery, but with a few setbacks – of course. I immediately began to feel that sense of community and began to really communicate with nearly everyone on shift at Miramar. Everyone that I spoke with had something to offer, whether it was a simple "hello," asking how I was doing, to offering advice, and with certain staff – breaking

ground to learn more about myself and to pay more attention to self-care. This immediately began to make the experience at Miramar Health even better than the first time. I received therapy immediately.

It was unfortunate that, while I was seeking formal therapy this entire time through the Veterans Affairs, I had to wait three months for an intake for Trauma Recovery Services offered through the Sepulveda Veterans Affairs. Back when I was at the domiciliary, I received very minimal one-on-one therapy and had to wait for my appointments due to the large number of patients at the domiciliary.

I began to become more hopeful during my second stay at Miramar Health and stated that I would like to extend my recovery program to thirty days and move on to their next step in recovery which was residential treatment. I was moved to the residential treatment house while awaiting my next domiciliary interview, which the West Los Angeles Veterans Affairs again required. While being there, we had an organized, but flexible schedule that consisted of daily groups, physical activities, house chores, and 12-step meetings. I was very welcomed by the new staff and immediately felt the sense of a supportive community all over again.

I was told that even though I had requested to stay at Miramar Health, that if after 30 days they did not have any space available at the domiciliary, they would allow me to continue with the program at Miramar Health.

The day after my domiciliary interview, which was Tuesday June 25, 2024, I was told that the West Los Angeles Veterans Affairs decided to deny my request for an extension and informed the administration staff at Miramar Health that they had adequate space at the domiciliary so that I could continue my recovery there. I was devastated to learn the news.

The positive experience that I had been having at Miramar Health was already a better experience than the one I had at the domiciliary. I couldn't understand the decision-making process after I had advocated for myself during my domiciliary interview to stay at Miramar Health.

I was informed by my roommate that the Veterans Affairs had a "Patient Advocacy" office where I could file a complaint. When I did my research, I found that the West Los Angeles Veterans Affairs changed the title to "Patient Experience." I called their office several times and it was a while before anyone got back to me. On Thursday, June 27, 2024, a representative from the Patient Experience Office called and I explained to her my situation. She informed me that, after looking at my file and request, that no decision had been made yet regarding my request to extend my stay at Miramar. She informed me that she would elevate this situation to her supervisors and that a staff member that is involved with the decision-making process would get back to me within seven business days of the filing of the request. She said that the request was filed on Tuesday, June 25, 2024.

Luis T West Los Angeles VA Medical Center Case Study

Upon further research, I have come across "Public Law No: 115-182 (06/06/2018) VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 or the VA MISSION Act of 2018" and I wanted to point out certain sections within this public law:

1. TITLE I—CARING FOR OUR VETERANS:

. Subtitle A--Developing an Integrated High-Performing Network –

. SEC. 101. ESTABLISHMENT OF VETERANS COMMUNITY CARE PROGRAM.

. (a) ESTABLISHMENT OF PROGRAM - (1) IN GENERAL.— Section 1703 is amended to read as follows: ''§ 1703. Veterans Community Care Program"

. '(2) The Secretary shall coordinate the furnishing of hospital care, medical services, and extended care services under this section to covered veterans, including coordination of, at a minimum, the following:.

. ''(B) Ensuring continuity of care and services.

. ''(D) Ensuring that covered veterans do not experience a lapse in care resulting from errors or

delays by the Department or its contractors or an unusual or excessive burden in accessing hospital care, medical services, or extended care services.

I would like to point out part B and part D in that the VA's decision of not letting me continue with Miramar Health for my recovery causes both a pause in the continuity of my care and lapse in care in that I would have had to uproot my progress and start all over in my residential program at the domiciliary.

. "(d) CONDITIONS UNDER WHICH CARE IS REQUIRED TO BE FURNISHED THROUGH NON-DEPARTMENT PROVIDERS.

. (1) The Secretary shall, subject to the availability of appropriations, furnish hospital care, medical services, and extended care services to a covered veteran through health care providers specified in subsection (c) if—

. "(E) the covered veteran and the covered veteran's referring clinician agree that furnishing care and services through a non-Department entity or provider would be in the best medical interest of the covered veteran based upon criteria developed by the Secretary.

Luis T West Los Angeles VA Medical Center Case Study

Upon my doctor's order to do my alcohol detoxification at a community care facility, it would only make sense that if I were transferred to a residential part of this community program, that I stay with this program, especially if the continuity and evidence of progress was recorded and consistently tracked.

I feel that we as veterans, as men and women who have devoted our time and have given so much - resulting in physical, mental, emotional, and social consequences, deserve to have a major say in deciding what treatment plan works best for us. I am highly disappointed and frustrated that I must go through this process simply to, what I feel like is, plead to the West Los Angeles Veterans Affairs to allow me to stay with Miramar Health because I feel like it is the right recovery plan for me at this time. I do not deserve this, nor do any other fellow brother/sister veterans either.

Thank you for your attention to this matter.

Respectfully,

Luis[redacted]
Staff Sergeant, United States Marine Corps
1999 - 2007

Luis T's Timeline

- 6/14/24 Admit from West LA VA for detox
- 6/17/24- Luis declined interview at the DOM and requested to discharge home after detox
- 6/19/24- Luis decided he did want RTC and understood that he had to interview the DOM (per West LA VA process) to be considered for CCN residential services
- 6/20/24- DOM consult form submitted to DOM Admission and Gilad per their process requesting consult appt
- 6/21/24- Email and call to the DOM stating he was set to discharge today and needed DOM consult - Dr. Nikola Alenkin was filling in for Gilad who was out on vacation and apologized for the oversight and stated he didn't have time to interview Veteran until Monday.
- 6/21/24- submitted RFS for RRTP (RTC) extensions
- 6/22-6/24- Miramar Health provided scholarship awaiting DOM consult as Veteran was motivated for treatment and most likely wouldn't have remained sober without 24/7 support.
- 6/24/24- Luis had DOM consult and stated he didn't want to leave Miramar for DOM treatment despite there being beds available. The interviewer stated that she agreed it

would be disruptive to his progress and stated she, [redacted], would push for CCN referral to Miramar.

- 6/25/24- Email from [redacted] stating he was denied. (see cut and paste below)

  Hi Miramar Team,
  RE: Mr. [redacted]
  Dom screener attempted to advocate for him but CITC declined to approve an RTC stay as the dom has beds. Veteran did tell the screener that if he was not approved for CITC RRTP then he will discharge and follow-up with outpatient treatment as he was not interested in the dom. Please check in with him one last time and advise us if he is still declining the dom.
  Thank you,
  [redacted] ***LCSW***
  [redacted]
  Domiciliary Residential Rehabilitation & Treatment Program
  11301 Wilshire Boulevard
  [redacted]
  Los Angeles, CA 90073
  [redacted]

- 6/25/24- Veteran discharge to home.

For Questions regarding any aspects of this case, please contact any of the following:

- Brendan Dowling: 949-403-0162
- Andrea Dressler: 949-202-6907

Paralyzed Veterans of America

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www.PVA.org

501(C)(3) Veterans Non-Profit

STATEMENT FOR THE RECORD
PARALYZED VETERANS OF AMERICA
FOR THE
SENATE VETERANS' AFFAIRS COMMITTEE

ON

"PROTECTING VETERAN CHOICE: EXAMINING VA'S COMMUNITY CARE PROGRAM"

JANUARY 28, 2025

Chairman Moran, Ranking Member Blumenthal, and members of the committee, we appreciate the opportunity to discuss the role that the Department of Veterans Affairs' (VA) Community Care Network (CCN) plays in meeting the needs of veterans with spinal cord injuries and disorders (SCI/D). For nearly 80 years, Paralyzed Veterans of America (PVA) has served as the lead voice on a number of issues that affect severely disabled veterans. Throughout the decades, we have championed critical changes within the department and educated legislators as they have developed important policies that impact the lives of paralyzed veterans.

The SCI/D system of care is the crown jewel of the VA's health care system. It is unequaled in the care it provides for the tens of thousands of veterans with SCI/Ds. Protecting access to this system for paralyzed veterans is PVA's number one priority. This system is the difference between life and death for our members and we view its existence as tied to that of our own welfare. It's because of this system of care that veterans are able to live in their own homes, travel, work, volunteer, and otherwise contribute to society.

Access to proper medical care is the cornerstone of health for veterans with SCI/Ds. However, none of VA's 25 SCI/D centers are operating at full capacity, primarily due to personnel shortfalls. We remain deeply concerned about the effect inadequate funding and staffing has had on the VA SCI/D system. Many beds were closed in the past two years and remain inaccessible to SCI/D veterans simply because VA does not have proper staffing. Critical support, such as respite care, is not available to their caretakers, pushing many of them to their breaking points. Supportive care like rehabilitation and recreational therapies that help veterans maintain independence and contribute to their health and wellbeing have been reduced or eliminated altogether. Even if robust funding is available, critical

vacancies at VA's SCI/D centers can take too long to fill because of the department's burdensome internal hiring processes. We call on Congress to ensure that care and benefits for veterans with catastrophic disabilities are properly funded, managed, and available when needed for veterans, their families, caregivers, and survivors.

General Views on the VA MISSION Act and Community Care

PVA supported the passage of the VA MISSION Act of 2018 (P.L. 115-182), which reformed VA's ability to provide timely access to care and modernize its health care infrastructure. Of particular importance to PVA were the bill's provisions that increased the VA's internal capacity to provide care by improving the recruitment, hiring, and retention of highly qualified clinicians; expanded eligibility for VA's Program of Comprehensive Assistance for Family Caregivers; and established a process to address the department's aging health care infrastructure.

While the MISSION Act also allowed greater numbers of veterans to receive care in the community, it was never intended to replace or undermine VA's direct care system. While community care may be a desirable and viable option for some veterans, it cannot fully meet the needs of those with catastrophic disabilities. We believe that a strong VA health care system is one in which the VA is the main provider and coordinator of veterans' care, with support from community care as required to address veterans' needs.

Although we do not believe codifying access standards would improve veterans' access to care, lower wait times, improve quality, or produce better health outcomes, particularly for veterans with catastrophic disabilities, we do not oppose formalizing the access standards for care received in the community. We also believe VA should notify veterans of their eligibility for care under the Veterans Community Care Program and consider veterans' preferences in regard to how, when, and where they prefer to receive their health care, and whether the request requires the assistance of a caregiver. Furthermore, the Veterans Health Administration (VHA) does not have a good process to inform veterans that their requests for community care have been denied. VHA should be directed to establish one and should provide denials in writing, not just for community care, but all other decisions that affect veterans' access to care.

VA should also establish an interactive, online self-service module to allow veterans to request and track their appointments and their referrals for VA community care, and publicize average wait times for care at VA medical centers to help veterans determine the better point of service to receive their care. Furthermore, as health care delivery evolves, we believe veterans should be afforded access to telehealth options. We support requirements for VA to better inform veterans about telehealth appointment availability.

We continue, however, to have significant reservations with the application of value-based reimbursement models to VA care, regardless of where it is delivered. In value-based care, health care providers are reimbursed based on the quality of care they provide, rather than the number of services they perform. Complex health issues like SCI/Ds do not fit neatly into such models and could have unintended consequences for veterans with these conditions. We are unable to support the use of such models in VA or CCN care until there is straightforward evidence that the care veterans with SCI/Ds might receive, and/or their access to it, would not be impaired through the use of such models.

The Role of Community Care for Veterans with SCI/Ds

The overwhelming majority of veterans with SCI/Ds choose to receive their care at VA facilities. Properly caring for veterans with SCI/Ds requires sharp assessment, time- and labor-intensive physical skills, and genuine empathy. Those working in the SCI/Ds field must possess unique attributes and skills. All clinical providers working with the SCI/D population are required to have increased education and knowledge focused on health promotion and prevention of complications related to SCI/Ds. This includes the prevention and treatment of pressure injuries, aspiration pneumonia, urinary tract infections, bowel impactions, sepsis, and limb contractures. Unlike the VA, few facilities in the private sector have the highly trained personnel on staff to properly care for SCI/D patients. A few private sector health care facilities do a good job of providing acute SCI/D recovery care, but only VA is able to provide the full, lifelong continuum of services for veterans with SCI/Ds that has increased average lifespans by decades.

Logistically, it takes tremendous effort to transfer a veteran from their home to a medical facility and return them to their residence safely. Literally everything—grooming, dressing, feeding, prepping for transport, loading/unloading, and transferring the patient to the exam room table/chair takes extra time. VA's SCI/D centers were intended to help alleviate the burden of accessing care for paralyzed veterans by offering the full complement of service lines they need in a single location. This is why PVA continues to place tremendous emphasis on preserving and strengthening VA's specialized systems of care.

Aside from certain types of benign care, e.g., lab work, our member's experience with community care tends to differ from other veterans. Those being referred to the private sector wonder why their VA Medical Center or SCI/D center can't provide the care they need in house. Community care is the only choice they are given, and this situation exists simply because VA has been allowed to leave critical vacancies unfilled year after year.

There is also a great likelihood their experience with a civilian provider will be inadequate. For example, female PVA members have been referred to private facilities with aging imaging equipment forcing them to remain in their chairs for their mammograms. The net result was insufficient films that had to be repeated. Similar problems have occurred when members are referred into the community for

ophthalmology and optometry. Even if exam rooms are wheelchair accessible, the equipment to assess the patient often is not, and the offices frequently lack the equipment to safely transfer the patient to the exam chair.

Another veteran was referred outside of VA for needed dental care. It was an aging facility and the exam rooms were too small for him to get close to the dental equipment. They ended up treating him in his chair over a period of many months for care that could have been completed at a fully accessible VA facility in 1-2 visits. Conversely, a different veteran who encountered a similar situation at a VA facility was denied the choice of seeking care in the community. Her situation was a bit more extreme, because she needed the front tooth fixed that she uses to operate her wheelchair. Frustrated, her and her husband ended up procuring private dental insurance and paying nearly $8,000 out of their own pockets for what should have been service-connected care.

The VA exists to ensure that veterans can receive the care they need; so, the department alone bears the responsibility to treat, heal, and rehabilitate the men and women who served in our military and suffered injury or disease as a result. We have stated on multiple occasions before this committee that care delivered in the community is an essential component of VA's health care system. But it is simply that, a component. Those seeking to push a greater share of VA care into the private sector beyond that needed to meet veterans' needs threaten to undermine the VA system—the same system where more than 90 percent of veterans say they want to receive their care. The choice of these veterans to receive their care through VA should not be washed away. Congress must take the steps necessary to ensure that VA's direct care system is not weakened to the point where care in the community becomes the only choice for catastrophically disabled veterans.

Improving Access to Residential Rehabilitation Treatment Programs

Given the high rates of mental health conditions and substance use disorders (SUD) within the veteran population, it is critical that all veterans needing inpatient residential care can access it in a timely manner. VA's residential rehabilitation treatment program (RRTP), provides comprehensive treatment and rehabilitation services to veterans with mental health conditions like posttraumatic stress disorder (PTSD), depression, and SUDs. RRTP takes a whole health approach to address challenges these veterans may experience, including medical concerns and social needs such as employment and housing. RRTP services are provided 24/7 in a structured, supportive, and comfortable residential environment.

Bills introduced in the previous Congress sought to standardized the process VA uses to determine RRTP eligibility, including the ability to access such care in the community. PVA is supportive of these efforts and would like to continue working with Congress on potential solutions. This includes making SUD residential treatment available to veterans with SCI/Ds.

Having a history of mental illness or substance abuse; current mental illness, other than depression; and current abuse of alcohol or illegal substances are also risk factors for depression among the SCI/D community. SUDs are prevalent and associated with poor outcomes in individuals with SCI/Ds, with 14 percent of individuals with SCI/Ds reporting significant alcohol-related problems and 19.3 percent reporting heavy drinking. We are not aware of any VA or private sector facility offering this level of care for veterans with SCI/Ds who have other nursing needs, such as regular bowel and bladder care, at this time. Since VA is the leader in care for veterans with SCI/Ds, we believe it is in the best interest of our members that VA develop national procedures and protocols related to providing mental health and SUD inpatient care for veterans with SCI/Ds and that information on VA inpatient care for these veterans be tracked and reported.

Title 38 Protections for Community Care

PVA remains deeply concerned about the exclusion of protections for injuries that occur as a result of community care. 38 U.S.C. § 1151 protects veterans in the event that medical malpractice occurs in a VA facility and some additional disability is incurred or health care problems arise by providing clinical appeal rights, no-cost accredited representation, and congressional oversight and public accountability. However, if medical malpractice occurs during community care, the veteran must pursue standard legal remedies, and is not privy to VA's non-adversarial process. If these veterans prevail on a claim, they are limited to monetary damages instead of enjoying the other ancillary benefits available under Title 38 intended to make them whole again. Congress must ensure that veterans who receive care in the community retain current protections unique to VA health care under 38 U.S.C. § 1151.

We appreciate this opportunity to relay our views on VA's health care system, including access to community care. We would be happy to answer any questions you may have.

MULTIORGANIZATIONAL STATEMENT FOR THE RECORD

Senate Committee on Veterans' Affairs

Hearing on

"Protecting Veteran Choice: Examining VA's Community Care Program"

January 28, 2025

by the

American Psychological Association
Association of VA Anesthesiologists
Association of VA Psychologist Leaders
Association of VA Social Workers
National Association of Veterans Affairs Physicians and Dentists
National Association of Veterans' Research and Education Foundations
Nurses Organization of Veterans Affairs
Veterans Affairs PA Association
Veterans Healthcare Policy Institute

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

Chairman Moran, Ranking Member Blumenthal, and distinguished members of the committee:

On behalf of our organizations, we thank you for inviting us to submit a statement for the record for today's hearing on how the U.S. Department of Veterans Affairs (VA) can improve the care of veterans in the community. Many members of our organizations are veterans or have family members who are veterans. Many of us have had long careers serving veterans, published papers on veterans' healthcare in peer-reviewed journals, or previously presented testimony to your committee. In today's statement, we wish to convey our appreciation for your leadership and abiding commitment to ensuring that veterans receive the highest level of health care within the Veterans Health Administration (VHA) and supplementary care in the private sector when it's both needed and authorized by the VHA.

Problems in VHA scheduling and coordinating community care—a focus of the hearing—are real, and every veteran's experience deserves careful attention and efforts to rectify. There are stories from multiple vantage points, including veterans who received substandard care in the community. For example, we have a report of a Gulf War combat veteran who, after unusual sleep study results, was referred to a community cardiologist. The cardiologist recommended implanting a pacemaker and offered to perform the invasive procedure the next week. The self-referring and possibly profit-motivated aspect raised doubts in the veteran's mind about whether a pacemaker

was necessary, and a second opinion from another cardiologist confirmed that it was contraindicated. Consider also the Vietnam veteran who, despite indicating his strong preference to wait for VHA services, faced pressure from a scheduler to accept community care because the facility felt compelled to reduce its' average wait times. Or reflect on the Iraq War veteran in need of posttraumatic stress disorder treatment who did not feel understood by his community care clinician.

It is essential, however, that we not just listen to the individual stories brought to us, but take into account the aggregate data and research that represent the experiences of *all* our veterans. Information that encompasses the 9.1 million veterans enrolled in the VHA system is the strongest foundation upon which to base policy decisions and craft legislation.

Our organizations support the need for supplemental community care options when access to VHA services is too delayed or too distant. We share the bipartisan goal of ensuring that the Veterans Community Care Program (VCCP) fulfills its promise—still unrealized—of delivering timely, high-quality care without the prospect of undermining VHA care. To help achieve this aim, we delineate significant challenges within the VCCP that merit thoughtful review and offer recommended improvements. These are:

1. Ensuring VCCP quality standards,
2. Ensuring VHA authorization for care is not bypassed,
3. Assessing the impact of VCCP usage on VHA staffing and exceptional veteran-centric care,
4. Ensuring the defined meaning of "veterans' health care choice" is applied,
5. Providing veterans with crucial information needed to make educated health care decisions,
6. Addressing the VCCP payment model that encourages unnecessary, costly overtreatment,
7. Addressing the deficiencies with health information sharing between the VA and VCCP,
8. Properly integrating telehealth into VHA access standards,
9. Protecting the VHA's 2nd, 3rd and 4th Missions by ensuring VHA is fully funded and staffed.

Ensuring VCCP quality standards

The VA MISSION Act of 2018 established the VCCP with a laudable purpose: ensuring veterans could access high-quality healthcare, whether at VHA facilities or with their communities when VA care was not readily available or conveniently located. The strong focus on quality was unmistakable. In its charter language, the word "quality" appears 50 times, far surpassing mentions of both "choice" and "community"—a point we'll explore further when discussing veterans' choice.

The MISSION Act required that a single, uniform body of quality standards be applied to care furnished by both VHA and VCCP providers. Sec. 104 of § 1703C. Standards for quality states: *"The Secretary shall establish standards for quality regarding hospital care, medical services, and extended care services furnished by the Department pursuant to this title, including through non-Department health care providers pursuant to section 1703 of this title."* Such parity has yet to be applied.

The failure to set and enforce VCCP quality standards has translated into lower quality of healthcare and potential risks to veterans' health. Study after study has found that veterans referred for care in the community have a higher likelihood of dying and are more likely to receive inferior care compared to those treated at VHA facilities. Another study published earlier this month in *Health Affairs* found that the quality of care metrics of VCCP providers are substantially lower than those of other private sector clinicians, especially in primary care and mental health care.

Controlled substance monitoring is a case in point. VHA facilities maintain over 98% compliance with state database checks before prescribing opioids - a critical safeguard against overdose deaths. By contrast, when the VA Office of Inspector General (OIG) reviewed VCCP prescriber records, only a minority included such inquiries. These were clear violations of provider contracts, and in many cases, state law. Yet, both Congress and the VHA refuse to stipulate and enforce contract providers abiding by the lifesaving quality standards that are enforced across VA services.

Or regard Residential Rehabilitation Treatment Programs (RRTPs). The benchmark that represents basic quality is accreditation by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities. Every one of VHA's RRTPs meets this standard. VCCP programs have never been required to do so.

Another crucial example is suicide prevention training. The last two VA National Veterans Suicide Prevention Annual Reports found that veterans treated solely by VCCP providers were more likely to die by suicide than if their care was furnished from the VHA. The VHA mandates its entire clinical workforce take a suicide prevention training (mental health professionals must do so yearly). But without VCCP requirements to do the same, only a tiny fraction of contract providers have completed trainings in how to identify and mitigate risk.

The quality of veterans' healthcare should always remain the north star of policymaking. It is imperative that Congress enforce **uniformity on all quality and training metrics for VHA and VCCP providers and programs.**

Ensuring VHA authorization for care is not bypassed

With increasing frequency in recent years, legislative proposals have sought to grant veterans unfettered access to private healthcare, bypassing VHA referrals,

authorization, and oversight entirely. Though they have not yet come to pass, we mention them here because enacting such legislation would fundamentally alter the VHA's core function. Instead of primarily serving as the provider of specialized, high-quality care for the unique health needs of veterans, the VHA would shift to functioning more of a payer of private sector services. This would essentially **transform the VHA from a comprehensive healthcare system into an insurance company.** Notably, many Congressional proposals even eliminate traditional insurance company utilization review functions, which would make the care paid for even more risky to veterans.

Accessing the impact of VCCP usage on VHA staffing and exceptional veteran-centric care

A comprehensive report released last year by six healthcare experts raised serious concerns that community care utilization was endangering Congress's intent for the VCCP to supplement, not supplant, the VHA. VCCP care has been relentlessly increasing 15-20% year after year, and by 2022, its share of VHA health dollars reached 44%. The report concludes that even if no additional changes are made as to who is eligible to receive private sector care, the VHA system's future is at risk due to this unsustainable growth. It is incumbent upon the committee to ensure that new legislation doesn't further exacerbate the issues that the report raises. Should Congress further expand eligibility for the VCCP, it will accelerate spending and imperil the very survival of the VHA system and thus, the continued availability of choice that so many on this committee have deemed essential to veterans.

Expanding VCCP eligibility, including by allowing the bypassing of VHA authorization, will intensify private sector referrals and divert funding from VHA facilities, **forcing staff reductions, curtailment of programs, and result in closures of inpatient units, emergency rooms, and entire facilities**. It would also hinder needed infrastructure upgrades despite growing demand for services.

If the VHA does not maintain its position as the sole authorizer of care, and receive sufficient funds to fully meet care demand, its indispensable integrated healthcare system specifically designed to serve veterans will be gradually dismantled. This includes coordinated team-based care, comprehensive preventive screenings, wrap-around legal and transportation services, homelessness programs, caregiving, and enrollment in VA registries. It includes veteran-centric care specialization that deftly address veterans' complex military-related conditions. (For instance, VHA clinicians are more likely to have experience and specialized training in recognizing, diagnosing and treating problems such as posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), and exposure-related illnesses.)

As we elaborate further below, jeopardizing the VHA will also have a devastating impact on the training of our nation's healthcare workforce and deprive future clinicians of expertise in veterans' complex health conditions. Additionally, research on veterans' health conditions—research that also helps non-veterans—will also be compromised,

as will the ability of the VHA to serve as the nation's healthcare safety net during public health emergencies. It also undermines VA's ability to support the military in time of war or terrorist attacks (a critical capacity in maintaining military readiness) or communities in times of natural disasters.

It is true that many veterans deeply appreciate the convenience of receiving authorized care closer to home rather than traveling long distances to VHA facilities. But when they are polled about preserving the VHA system, veterans' priorities are clear. A VFW survey last month of its members revealed "overwhelming support for VA to remain the primary deliverer of care for veterans." A prior VFW report involving 10,000 members found that 92% explicitly prefer that the VHA to be "fixed not dismantled." As a Veterans Healthcare Policy Institute report noted, and many studies confirm, many veterans who live in rural areas would have no choice of care providers should the VHA be turned into an insurance provider. This is due to a long-standing crisis in rural healthcare that now deprives rural residents of primary care, mental health care, as well as access to hospital, emergency, and pharmacy services.

Ensuring the defined meaning of "veterans' health care choice" is applied

In the years since the passage of the VA MISSION Act of 2018, there has been a pervasive mischaracterization that the bill gave veterans the "choice to obtain their health care where and when they preferred." That is not accurate. According to the legislative language, a veteran would be offered the option of receiving healthcare outside of the VHA under six clearly defined criteria. Veterans could choose whether to utilize the option of private sector care **only after they first qualified under the eligibility rules and were authorized by VHA**. The Independent Budget's analysis of the MISSION Act affirmed the understanding at that time that eligibility for VCCP care should not occur "solely based on convenience or preference of a veteran." However, the critical phrases "when eligible," "when qualified" or "when authorized" are often dropped when alluding to veterans having the choice of where and when to receive their healthcare.

Should the VHA be eliminated as the authorizer of care under the promise of more choice, there will be fewer, not more, options for veterans. When VHA funds are diverted to the private sector, millions of **veterans who depend on the VHA—especially those with service-connected conditions who rely exclusively or near exclusively on the VHA for all their health care needs—will be deprived of the freedom to choose** the VHA when units and programs they depend on vanish. Many have catastrophic war-related ailments, such as lost limbs, traumatic brain injuries, or a variety of toxic exposures, which civilian providers are ill-equipped to recognize, much less treat. Granting the option for unrestricted personal choice is not unequivocally advantageous; it comes at the expense of the majority of veterans, many of whom are in critical need.

Addressing the VCCP payment model that encourages unnecessary costly overtreatment

VCCP overtreatment and the overuse of expensive testing have been identified in recent scientific and governmental studies. One study scrutinized the care of veterans with prostate cancer. This is the most common cancer among veterans, particularly those who served in the Vietnam War, and were exposed to the carcinogenic herbicide Agent Orange which was used as a defoliant. The study, in the medical journal *JAMA*, followed 10,000 veterans with newly diagnosed prostate cancer whose biopsies revealed "clinically insignificant" low-risk disease. The *JAMA* authors explained that the professionally recommended standard of care for these patients is what is called "watchful waiting." Watchful waiting is the accepted standard because recommending aggressive testing and procedures does little good and can cause serious harm to patients whose tumors aren't progressing. Complications arising from prostate surgery and radiation of include impotence, incontinence, hair loss, bowel problems, and even death. Despite these well-known problems, the *JAMA* study found that VCCP providers were twice as likely to provide veterans whose prostate cancer was deemed low risk with expensive, unwarranted, and potentially risky surgery or radiation.

Reviewing the use of imaging services in the VCCP for various other medical conditions, a 2021 Congressional Budget Office (CBO) analysis mirrored the findings of the *JAMA* study. When veterans were referred for imaging services, VCCP contractors used magnetic resonance imaging instead of less costly tests like computed tomography scans and X-rays. The CBO explained, "Some of those practice differences might stem from the cost control and incentive structures of VHA physicians and private sector providers. VHA does not control the amount or type of services veterans receive once they have been referred to outside providers for a particular episode of care."

Last week's OIG "Care in the Community" report documented instances in which veterans referred to the VCCP "received additional services or procedures not requested."

Excessive use of expensive and/or unnecessary procedures isn't the only way that VCCP providers endanger veterans and drain resources from the VHA's healthcare system. Another is overcharging for services. One form of this is called "upcoding," i.e., assigning an inaccurate billing code to a medical procedure to increase reimbursement. For example, a provider bills for a "Level 4" complex evaluation and management procedure even though the documented medical notes reveal only Level 3 elements were furnished.

The OIG has also found that, in FY 2020, "at least 37,900 providers of about 218,000 community care providers billed level 4 and level 5 evaluation and management services significantly more often than all other providers in their specialty—a potential flag for upcoding." A separate 2021 OIG audit found that 76 percent of acupuncture claim treatments and 55 percent of chiropractic claim treatments were not supported by medical documentation. Another well-designed ambulance study found that non-VA

hospitals were five times more likely to report high complexity (and more highly reimbursed) evaluation and management services than VHA facilities.

This pattern of overtreatment and fraudulent billing in the VCCP is hardly unexpected. VHA providers, all on salary, work in a mission-driven system that focuses on improving patient outcomes. VCCP providers are compensated based on fees for discrete services and work in an environment that emphasizes profit maximization. (Our first anecdote above speaks to this trend.)

Also, the rising cost of outsourced dental care has become financially unsustainable. Medical centers are spending anywhere from $25 million to $80 million annually on community dental services alone. While some facilities carefully monitor community care referrals, others automatically refer all eligible veterans to outside providers without considering quality and cost. The situation is further complicated by community dentists who routinely propose treatment plans costing tens of thousands of dollars per veteran. The recently enacted Dole Act pilots, in two VISNs, a stringent review process of community dentist treatment plans, but the most cost-effective solution would be to expand the VHA's in-house dental staff. By providing these services directly, the VHA could deliver the same or better quality of care at a fraction of what is currently being spent on community providers.

Providing veterans with crucial information needed to make educated health care decisions

Another issue in dire need of overhauling in the community care program is the lack of accessible information that veterans need to make informed health care decisions. Future community care legislation must require private sector transparency about comparative VHA-VCCP wait times and quality metrics.

Veterans should be provided information about concerns with the quality of VCCP services. One way this could be improved is to make publicly available the complaints and grievances that third-party administrators are required by contract to forward to VHA within 48 hours.

Veterans also deserve easy access to verification as to whether providers treating them have the training, education, and competence to address their specific health concerns. However, the online directory doesn’t include all the providers in the network, and the listings lack any details about providers’ qualifications.

Further, third party administrators evaluate their providers and designate those delivering high-quality care as "High Performing Providers" (HPPs). However, this assessment ignores behavioral and mental health providers, despite the prevalence of mental health challenges that many veterans face. The evaluation system should expand to include mental health providers, and veterans should have direct access to HPP designations through the public directory.

Addressing deficiencies with health information sharing between the VHA and VCCP

For years, including twice again in the last two weeks, the OIG has documented "difficulties caused by community care providers failing to return medical documentation." When all the relevant healthcare information isn't properly shared between VHA and community providers, care becomes fragmented, and veterans are put at risk. VCCP mental health providers routinely submit requests for treatment reauthorization that lack clinical documentation needed to make decisions. To address these serious issues, Congress should **establish sanctions for failures to bi-directionally share information between the VHA and VCCP** in a timely manner.

Properly integrating telehealth into VHA access standards

When establishing the VA MISSION Act eligibility rules, the VHA made a significant oversight: they did not include the availability of VHA telehealth when calculating distance or wait times for care. We believe this was a shortsighted decision that has had serious negative consequences. By not considering telehealth options, the VHA has unnecessarily limited veterans' access to quality healthcare while wasting taxpayer money. Telehealth is a valid means of providing health care to veterans who prefer that option. In a survey of veterans engaged in mental health care, 80% reported that VHA virtual care via video and/or telephone is as helpful or more helpful than in-person services. And yet, because of existing regulations, VHA telemental health (TMH) does not qualify as access, resulting in hundreds of thousands of TMH visits being outsourced yearly to community practitioners that could be expeditiously and beneficially furnished by VHA clinicians. The best action that Congress can take is to stipulate that VHA telehealth care constitutes "access to treatment." If implemented, this correction would save taxpayers a vast sum—up to 1.1 billion dollars annually according to a VA's September 2022 "*Congressionally Mandated Report: Access to Care Standards."*

Protecting the VHA's 2nd, 3rd and 4th Missions by ensuring VHA is fully funded and staffed

Congressional legislation on community care must attend to the impact on **the VA's vital role in researching veterans' complex health conditions.** For decades, VHA's electronic health records and access to VHA patients have enabled groundbreaking discoveries and treatments through large-scale data analysis of veterans' healthcare conditions. The VA's innovations in diagnostic testing, disease management, rehabilitation, geriatrics, patient safety, and numerous other fields have advanced healthcare for all Americans. The VHA has also proved invaluable and irreplaceable in

its ability to study and compare the efficacy of different medications on patients' health This crucial research capability would disappear if veterans' care fragments across the private sector, where no unified system exists to study veterans' health outcomes or implement and evaluate innovative treatments systematically.

Congress should also be wary of expanding access to community care in a way that would **jeopardize the critical role the VHA plays in the training of future healthcare professionals across the nation.** More than 70% of all U.S. physicians train at a VHA facility early in their careers. At a time of dire mental health professional shortages, VHA is the largest single educator of psychiatrists and psychologists. Expanding care in the community will have jarring effects far beyond VHA itself by constraining the development of a critically needed work force.

Likewise, expanding care in the community that downsizes VHAs will **degrade VHA's capacity to support its "Fourth Mission:"**–assisting the nation in times of emergencies and disasters. The VHA has supported this mandated mission with direct patient clinical care, testing, education and training in response to natural disasters, pandemics (like COVID-19), and other crises. VHA also serves as the first fallback to the military health system in times of war. The VHA is uniquely suited to support these missions because of the national distribution of its facilities, the unique training and experience of its staff, and the exceptional integration of its services.

Suggested solutions to improve the provision of community care.

To strengthen use of community care, we propose these essential reforms:

1. The VHA and VCCP must operate under uniform quality standards and training requirements.
2. The VHA and VCCP should publicly disclose wait times, and accessible provider directories must detail healthcare professionals' qualifications and quality metrics.
3. Predictive modeling capabilities to forecast how varying levels of VCCP utilization will impact VHA's operational capacity should be quickly developed.
4. The VHA's internal staffing should be expanded to fully meet demand.
5. The VHA should retain clear authority in determining community care eligibility.
6. It's crucial to reinforce the message that veterans' access to community care depends on first meeting established criteria.
7. Timely VHA telehealth should be recognized as meeting the access to care standard.
8. Timely health record sharing between VHA and community providers should be reinforced through meaningful penalties for non-compliance.
9. Rigorous monitoring must be implemented to identify and sanction community providers who engage in unnecessary testing, optional or unauthorized procedures, or fraudulent billing practices.

We respectfully thank you for the opportunity to provide our perspectives on these essential matters. We look forward to working with the committee to ensure that veterans can receive timely, high-quality compassionate care in the VHA and the community now and in the future.

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