KEEPING OUR PROMISE TO AMERICA'S VETERANS

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STATEMENT OF
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SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
DECEMBER 17, 2024

Chairwoman Miller-Meeks, Ranking Member Brownley and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to submit testimony for the record of this legislative hearing.

General Comments on VA Community Care Bills

The Subcommittee is considering four bills today (H.R. 10267, H.R. 214, H.R. 3176 and H.R. 5287) that would make significant changes to the Department of Veterans Affairs (VA) community care program and could significantly impact VA's ability to fulfill its mission of providing timely, high-quality, veteran-focused medical care and services to enrolled veterans. As such, it is important to understand the role of community care in VA's provision of comprehensive, specialized health care and supportive services to our nation's ill and injured veterans.

The VA health care system is a cornerstone in the lives of millions of service-disabled veterans, offering comprehensive primary care as well as world-class specialized programs tailored to their unique needs. While community care can and must remain a valuable supplement whenever VA is unable to offer timely, accessible, or high-quality care, it should not be used to supplant the VA's central role of providing and coordinating integrated care to enrolled veterans. The increasing use of and reliance on community care in recent years, however, poses critical challenges to this evidence-based model of care.

VA operates a comprehensive network of facilities with dedicated professionals designed to address the complex and multifaceted health issues faced by veterans, offering a level of expertise and continuity of care that most community providers do not consistently offer. However, the failure to expand VA's capacity to match the rising demand for care has resulted in an over-reliance on external providers. In an era of financial crises and fiscal restraint, a failure to properly manage VA's community care program risks stretching VA's financial resources too thin, thereby threatening the

sustainability of the whole system of care designed for the rehabilitation of our nation's ill and injured veterans.

The VA MISSION Act 2018 (P.L. 115-182) established a new process for integrating community care with VA's hospital care, medical services, and extended care services, to ensure that veterans receive the highest standards of care, regardless of the limitations or availability within the VA health care system. The legislation reflected a balanced compromise to expand access to non-VA care whenever and wherever necessary, while bolstering the VA direct care system to meet the rising demand for care by enrolled veterans.

The law established a new Veterans Community Care Program (VCCP), with designated wait time and travel distance access standards. The goal was for VA to maintain overall responsibility for the care of enrolled veterans by coordinating their care and by requiring community providers to meet the same quality and access standards as VA providers. Unfortunately, VA has never implemented the intended quality standards for non-VA providers, nor established a robust care coordination program for veterans receiving VA direct care services and care in the community.

The law also included major provisions to increase VA's internal capacity to provide care by improving the recruitment, hiring and retention of highly qualified clinicians, and by establishing a process to finally address the decades-long neglect of VA's health care infrastructure. While VA's workforce has been significantly increased over the past six years due to large funding increases from Congress, its health care infrastructure continues to be woefully neglected.

The MISSION Act also established an Asset and Infrastructure Review (AIR) process to modernize and realign the VA's medical infrastructure so that its medical facilities and services would be well-positioned to meet the needs of 21st-century veterans. Unfortunately, after several years of work by VA and the AIR Commission, the resultant recommendations were not acted upon by Congress and the process effectively ended. As a result, VA's hospital and health care infrastructure remains outdated, underfunded, and at risk.

Without adequate infrastructure and capacity to meet rising demand for care by veterans, VA has continued to increase utilization and reliance on community care, which has grown significantly faster than VA care. In 2022, VA's Under Secretary for Health commissioned a special "Red Team" to examine the role and impact of the rapidly growing use of community care and its impact on veterans health care. The Red Team was composed of a panel of nationally renowned health care experts with experience in the VA, Department of Defense (DOD), and private sector health care systems. Their report, titled "The Urgent Need to Address VHA Community Care Spending and Access Strategies," highlighted several critical issues regarding the Veterans Health Administration's (VHA) community care spending and access strategies. This independent review unanimously concluded that immediate action is

necessary to safeguard both VA's health care system and its community care program, and offered the following findings:

1. **Rising Costs**: The cost of referring veterans to non-VA providers (community care) has increased dramatically, reaching nearly $30 billion in FY 2023. This surge in costs threatens the funding needed to support the VA's direct care system.
2. **Quality and Timeliness**: There is a lack of real-time information about the quality and timeliness of community care. Research indicates that community care is often no more timely or of superior quality compared to VA-provided care, and in some cases, it is of lower quality.
3. **Increased Referrals**: The number of veterans referred to community care has increased significantly due to policy changes like the Veterans Choice Act and the VA MISSION Act.
4. **Budget Impact**: The rising costs of community care are projected to continue growing, which could decrease available funds for the VA's direct care system unless there are corresponding budget increases or reductions in VA programs.
5. **Urgent Action Needed**: The report emphasizes the urgent need for the VA to control community care utilization and costs to ensure the direct care system can continue to serve veterans effectively.

The report called for immediate action to address these issues and prevent potential mass closures of VA clinics or services, which could eliminate choices for veterans who prefer the VA direct care system. In their words, "roundtable members were in unanimous agreement that VA urgently needs to take action to control community care utilization and costs if the direct care system is to continue to be available to serve the diverse, specialized, and often highly complicated needs of veterans."

With this background and context, DAV offers the following comments about the four community care bills being considered by the Subcommittee today.

H.R. 10267, the Complete the Mission Act of 2024

The Complete the Mission Act of 2024, H.R. 10267, aims to expand the VCCP by increasing awareness of, access to, and utilization of the VCCP by enrolled veterans. The bill includes provisions to codify the VCCP's current access standards; publicize VA's average appointment wait times; and improve timely notification to veterans of their eligibility for community care, telehealth options, and reasons for denial of community care. The legislation would also require VA to pursue value-based reimbursement models for VCCP administrators, accelerate development of online self-service scheduling systems, and establish a new standardized process for eligibility and admission of veterans to residential rehabilitation treatment programs.

DAV appreciates the intent of the Complete the Mission Act to enhance veterans' access to timely, quality health care by eliminating barriers to community care programs. We also have concerns about VA's continuing inability to address longstanding problems with scheduling, care coordination, and continuity of care for veterans using both VA and community care network providers.

However, as discussed above, the MISSION Act was meticulously designed to not only improve veterans' access to community care, but was equally focused on expanding VA's internal capacity to provide direct care to millions of veterans, particularly disabled veterans who most often prefer VA over private sector care. While VA's staffing has risen significantly since enactment of the law, its inadequate, outdated physical and IT infrastructure and scheduling system continue to hamper its ability to satisfy veterans' demand for care.

We believe it is crucial to find a balance where the VA direct care system is strengthened as intended by the MISSION Act, while also implementing effective solutions to the VCCP's problems. We recognize that frustration with the VCCP has risen in recent years as the program has failed to eliminate access challenges for many veterans. However, some of the provisions in this legislation that are designed to limit VA's role in managing community care could actually exacerbate veterans' frustration by raising expectations without actually improving their access to care.

For example, codifying access standards will not improve veterans' access to care, lower wait times, improve quality, or produce better health outcomes. Investing in VA's health care infrastructure and staffing, however, would directly and measurably improve veterans' access to care. This is particularly true for veterans who live in rural and remote areas where VA is most likely to be a stable, long-term health care option for veterans because private sector medical facilities tend to close more often and without notice, regardless of the needs of veterans who live in those areas.

Investing in VA is also the surest way to produce better health outcomes for veteran patients, because studies continue to confirm that on average VA health care is equal to or better than private sector care. A robust VA health care system also provides vital research, medical provider training, and emergency preparedness for veterans and the nation, further justifying such investments.

We recognize the essential role that community care can and must play in providing timely access to medical services for veterans. Maintaining a strong and capable VA, while leveraging community care networks to fill in the gaps, can provide the best possible care for our veterans. This nuanced approach requires ongoing collaboration and thoughtful implementation of legislation and policies to ensure that veterans receive the highest standard of care. DAV is committed to working with all stakeholders to find this balance.

H.R. 214, the Veterans' True Choice Act of 2023

H.R. 214, the Veterans' True Choice Act of 2023, would allow veterans with service-connected disabilities rated at least 10% to enroll in the DOD TRICARE Select program; however, such veterans would no longer be eligible to enroll in or utilize any of the VA health care system's services. Veterans who are eligible for Medicare would not be able to enroll in the TRICARE Select program. The legislation would require VA to transfer funding from the VA health care system to DOD each time a veteran chooses to enroll in TRICARE Select under this legislation.

DAV has significant concerns about how this legislation would impact VA's ability to provide a full continuum of care to enrolled veterans, particularly disabled veterans who rely on the VA system. As resources are removed from the VA health care system as envisioned under this legislation, it is likely that VA would have to reduce the number and variety of direct care providers, including specialty providers, serving enrolled veterans, thus limiting their choices. As currently drafted, DAV would oppose this legislation.

H.R. 3176, the Veterans Health Care Freedom Act

H.R. 3176, the Veterans Health Care Freedom Act, would initially establish a pilot program in four Veterans Integrated Service Networks (VISNs) to eliminate the VA MISSION Act rules for access to non-VA care, which would become permanent for all VISNs after three years. This legislation would unravel the careful compromise that was reached in the MISSION Act to expand community care access while also strengthening the VA health care system.

Critically, the legislation mandates that all costs for community care must come out of the VA health care system, and that no new appropriations could be provided to VA to make up for that loss of funding. If enacted, it is likely that VA would have to reduce the number, location, and variety of its health care providers at hospitals and other medical facilities, thereby limiting choices for veterans who choose and rely on VA for most or all of their care, as is often the case with severely disabled and paralyzed veterans.

DAV has significant concerns that enactment of this legislation will reduce veterans' access to the VA health care system, weaken care coordination, and reduce the overall quality of care provided to veterans. For these reasons, DAV would oppose this legislation as currently drafted.

H.R. 5287, the Vet Access to Direct Primary Care Act

H.R. 5287, the Vet Access to Direct Primary Care Act, would require VA to create a five-year pilot program enabling veterans to receive primary care from non-VA providers through direct primary care (DPC) arrangements, to be paid for out of health accounts established by VA to cover fees, medical treatments, and medications. A

veteran who chooses to enter the pilot program would no longer be able to use VA for medical care services that are covered under a DPC arrangement.

DAV has significant concerns with this legislation, which could lower the overall quality of care provided to service-disabled veterans and weaken the overall VA direct care system that millions of veterans choose and rely on. The risk of fragmented care for veterans choosing the DPC option would be high because such arrangements are focused on primary care, and veterans would rely heavily on the VA's specialized care and would create challenges coordinating their overall health care. In addition, DPC providers may not meet the high standards set by the VA, potentially compromising the quality of care, particularly for veterans with chronic health issues and complex health history related to their military service.

Most critically, the legislation would move funding out of the VA health care system because the bill includes a prohibition on new appropriations to cover the costs of the pilot program. With fewer available resources, VA would have to make difficult choices about where to reduce or eliminate clinical providers, thereby limiting veterans' access to VA care. For these reasons, DAV would oppose this legislation as currently drafted.

Conclusion on VA Community Care Bills

In accordance with DAV Resolution No. 403, supporting strengthening and protecting the VA heath care system, it is imperative that the VA health care system continue to serve as the primary provider and coordinator of care for enrolled veterans. VA's Patient Aligned Care Team (PACT) model and its integrated approach to health care and wrap-around supportive services have consistently demonstrated superior outcomes in mental health integration, chronic disease management, and post-deployment care. These are areas where community care networks often fall short due to a lack of specialized knowledge and experience with veterans' unique needs. To effectively address the challenges veterans face to access timely, quality health care, we must focus on enhancing the VA's capacity and efficiency, while simultaneously fixing the longstanding systemic problems with VA's community care program. We look forward to working with the stakeholders to achieve these shared goals.

H.R. 6333, the Veterans Emergency Care Reimbursement Act

H.R. 6333, the Veterans Emergency Care Reimbursement Act, would enhance reimbursement for emergency treatment costs incurred by veterans by allowing more comprehensive reimbursement of amounts owed to third parties or for which veterans are responsible under their health plan contracts.

Currently, an enrolled veteran with no secondary health insurance can get their non-VA emergency room visits reimbursed, while an enrolled veteran with civilian health insurance has a different criterion. The veteran with civilian insurance is expected to file

a claim with their primary insurer and incur the cost of any copayment and deductible. This creates an inequity that should be remedied.

The bill broadens the scope of reimbursement claims to include various cost-sharing elements like copayments, deductibles, and coinsurance, even if previously rejected or denied by the VHA. It would also apply retroactively to reimbursement claims submitted on or after February 1, 2010.

DAV supports the Veterans Emergency Care Reimbursement Act, based on DAV Resolution No. 246, which calls for the elimination or reduction of VA and DOD copayments for service-connected veterans. Our nation's veterans should not be financially burdened by copayments for emergency treatments or any other health care treatment.

H.R. 8347, Improving Menopause Care for Veterans Act

H.R. 8347, the Improving Menopause Care for Veterans Act, mandates a comprehensive study by the Comptroller General on menopause care within the VA, evaluating services for perimenopause, genitourinary syndrome of menopause, and menopause. The study would review current care, training, diagnosis protocols, interdisciplinary care access, and educational initiatives. The goal is to ensure veterans receive comprehensive and effective menopause care, reflecting the unique needs of women veterans.

The issue of menopause and its impact on veterans is not well researched or clearly understood. This concern was highlighted in DAV's report, *Women Veterans: The Journey to Mental Wellness*. Although our report primarily addresses mental health and suicide risk, similar concerns apply to the physical well-being of women veterans during this stage of their reproductive life cycle.

DAV supports the Improving Menopause Care for Veterans Act, in accordance with DAV Resolution No. 39, which calls for support to enhance medical services and benefits for women veterans.

H.R. 8481, the Emergency Community Care Notification Time Adjustment Act of 2024

H.R. 8481, the Emergency Community Care Notification Time Adjustment Act of 2024, would provide our veterans with an extended deadline for submitting applications related to emergency treatment received in non-VA medical facilities.

The current deadlines for submitting applications for reimbursement or authorization of emergency care in non-VA facilities are often too stringent, adding unnecessary stress and financial burden to veterans already facing critical health challenges. The proposed extension to a minimum of 72 hours post-discharge is

practical and more appropriate. It recognizes the reality that during medical emergencies, veterans and their families are primarily focused on immediate care and recovery, rather than administrative requirements.

By providing a more flexible time frame, this bill would significantly reduce the administrative burden on both veterans and health care providers. This ensures that veterans receive the necessary care without the looming pressure of meeting unreasonable deadlines. Ensuring that emergency care is duly authorized and reimbursed under this Act will enhance trust between veterans, health care providers, and the VA. It sends a clear message that our nation is committed to the well-being of its veterans, respecting their sacrifices by easing the path to receiving critical care.

Veterans have faced unnecessary challenges due to the current stringent deadlines in place. This bill offers a compassionate solution, allowing them to focus on their health and recovery without the added worry of timely application submissions.

DAV supports H.R. 8481, in accordance with DAV Resolution No. 346, which calls for the improvement of urgent and emergency care benefits for service-connected veterans, which is a vital step towards better supporting our veterans in their times of need. It aligns with our national values of respect, gratitude, and commitment to those who have served.

H.R. 9924, the What Works for Preventing Veteran Suicide Act

H.R. 9924, the What Works for Preventing Veteran Suicide Act, would establish standard practices for a grant or pilot program administered through the VHA.

Specifically, the bill would require the VA Secretary to prescribe regulations that establish standard practices for any suicide prevention or mental health pilot or grant program carried out through the VHA. Standards must include: establishment of clear and measurable objectives; determination of information needed to properly evaluate the program; the identity of sources, methods, frequency and timing for collecting information; how information will be analyzed to evaluate program implementation and performance and identification of criteria that will be used to determine whether the program should be expanded, extended or made permanent.

The standard practices prescribed in regulations would apply to a grant or pilot program regardless of when it was established.

Given the higher rates of suicide among veterans, it is essential that VA pilot or grant programs focused on mental health and suicide prevention are properly evaluated by experts to determine if they are in fact effective for veteran patients. VHA subscribes to a whole health model of care and evidence-based treatments for mental conditions

common among veterans. This legislation would help to ensure a consistent set of standards are applied to evaluate new programs and initiatives for the purpose of determining what works and what does not.

DAV is pleased to support H.R. 9924, which is consistent with DAV Resolution No. 224, calling for improvements in VA mental health programs and suicide prevention initiatives.

H.R. 10012, to include eyeglass lens fittings in the category of medical services authorized to be furnished to veterans under the Veterans Community Care Program

H.R. 10012 would authorize the VA to include eyeglass lens fitting as part of VA's approved medical services for veterans using community care services. The bill would require VA to establish policies and procedures and to prescribe regulations so that veterans eligible to receive care in the community are able to schedule an appointment for a fitting for eyeglass lenses with a provider near their home.

Vision care and access to prescription eyeglasses are a part of a whole health model of care to which VA prescribes. If VHA is unable to provide a veteran with timely access to prescription eyeglass lens fitting and they are eligible for care through VA's Community Care Network, VA should be authorized to allow such services.

DAV supports H.R. 10012, which is consistent with DAV Resolution No. 18, which calls for veterans' access to comprehensive health care services to enrolled veterans. We further recommend the expansion of eye clinic services at the VA Community-Based Outpatient Clinics (CBOCs), mirroring the successful utilization of audiology services.

For many veterans, particularly those in rural or underserved areas, access to comprehensive eye care is limited. The proposed amendment addresses a significant gap in the services currently provided to our veterans by ensuring that eyeglass lens fittings are available and accessible through the Veterans Community Care Program.

Drawing from the successful model of including audiology departments at VA CBOCs, we can see the positive impact of providing specialized care in a community-based setting. Audiology services have proven to be highly effective in addressing the hearing needs of veterans, offering timely access to hearing assessments, hearing aids, and follow-up care. This model has not only improved health outcomes for veterans but also reduced the burden on larger VA medical centers.

We urge the Subcommittee to consider a similar approach for eye clinic services at CBOCs. By expanding eye care services at these VA facilities, veterans would

benefit from routine eye examinations, early detection and treatment of eye conditions, and timely access to prescription eyewear. This decentralized approach would ensure that veterans receive more timely and effective eye care close to their homes, promoting better health outcomes and overall satisfaction with their health care.

The expansion of these services would not only enhance the quality of care provided to veterans, but also reduce wait times and travel burdens. It would allow for more efficient and comprehensive care, much like the successes seen in delivery of audiology services.

Draft Bill, the Supporting Medical Students and VA Workforce Act

This draft bill, the Supporting Medical Students and VA Workforce Act, would offer a scholarship opportunity to a Public Health Service (PHS) officer to attend the F. Edward Hebert School of Medicine at the Uniformed Services University of the Health Sciences. This would be a scholarship opportunity between the VA, Health and Human Services (HHS) and the DOD.

Upon graduation and completing an initial residency, the PHS officer would be obliged to work full time at a VA medical facility for a period not to exceed 10 years. The PHS officer, the VA, HHS and DOD would establish a joint a contract specifying the details of the agreement, to include the length of service to the VA. Failure to complete the obligated period of service would result in the PHS officer reimbursing DOD and HHS twice the total amount of the tuition, salary, allowances, benefits and expenses paid by the VA.

The VA faces a growing demand for medical services, and this legislation directly addresses the need for an expanded, highly skilled medical workforce. By leveraging the expertise and resources of the VA, HHS, and DOD, this Act fosters a collaborative approach to enhance the quality of care provided to our veterans.

The program offers comprehensive medical education and training to PHS officers at the Uniformed Services University of the Health Sciences, equipping them with the knowledge and skills necessary to excel in the field of health care. In exchange for their education, PHS officers commit to serving at VA medical facilities, ensuring that our veterans receive care from dedicated and well-trained professionals. The partnership between VA, HHS, and DOD exemplifies a unified effort to address the health care needs of our veterans, promoting efficient use of resources and expertise across agencies.

DAV supports the Supporting Medical Students and VA Workforce Act, in accordance with DAV Resolution No. 196, which calls for effective recruitment, retention and development of the VA health care system workforce. This bill would provide

invaluable opportunities for medical education and professional growth and guarantee that our veterans receive the best possible care from a committed and proficient medical workforce.

This concludes our testimony on behalf of DAV (Disabled American Veterans). Again, we appreciate the opportunity to provide our position and comments on the bills being considered by the Committee.