MULTIORGANIZATIONAL STATEMENT FOR THE RECORD

COMMITTEE ON VETERANS' AFFAIRS of the UNITED STATES SENATE

Full Committee Hearing to Consider Pending Legislation

July 12, 2023

by the

American Psychological Association
Association of VA Psychologist Leaders
Association of VA Social Workers
Association of Veterans Affairs Nurse Anesthetists
Military and Veterans Committee of the Group for the Advancement of Psychiatry
National Association of Veterans Affairs Optometrists
National Association of Veterans Affairs Physicians and Dentists
Nurses Organization of Veterans Affairs
Veterans Affairs Physician Assistant Association
Veterans Healthcare Policy Institute

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

Chairman Tester, Ranking Member Moran, 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 the U.S. Department of Veterans Affairs (VA) utilization of care in the community, prevention of veteran suicide and other veterans related bills. Many members of our organizations have published papers on these topics in peer-reviewed journals. Many of us have also had long careers serving veterans and have previously presented testimony to your committee. In today's statement, we want to convey our appreciation for your leadership and continuing commitment to ensuring that veterans receive the highest level of healthcare within the Veterans Health Administration (VHA) and supplementary care in the private sector when it's necessitated.

While there are 16 bills being considered today, we comment below on the seven most closely aligned with our expertise. Those are: S.1315 - Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act; Discussion Draft - Making Community Care Work for Veterans Act; S.928 - Not Just a Number Act; S.853 - VA Zero Suicide Demonstration Project Act; S.1545 - Veterans Health Care Freedom Act; S.1954 - Improving Whole Health for Veterans with Chronic Conditions Act; and S.449 - Veterans Patient Advocacy Act.

S.1315 - Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023

The budget implications for the long-term sustainability of VHA care loom large with this legislation. By design, the HEALTH Act will swiftly accelerate the outsourcing of veterans' care to the private sector and drain the VHA of funding needed for the provision of in-house care. It proposes a pilot access program that eradicates the core integrated health care model on which the VHA is based. These provisions will, in turn, cause a spiraling reduction in VHA staff and closure of programs/ clinics/facilities. The VHA would lose the ability to provide veterans with high-quality care that addresses their complex military-related conditions and, as numerous studies have documented, surpasses the private sector. We simply must preserve this level of care.

The bill's provisions are detrimental to veterans for the following reasons:

1. By allowing veterans access to private sector care because that is their "preference," major funding will be diverted from the VHA to the private sector. This will **force more reductions of VHA staff, curtailment of in-house programs, and closures of inpatient units, emergency rooms, and even entire facilities**. It will also make it nearly impossible to upgrade existing infrastructure needed to address the demand for services, particularly in the wake of the PACT Act.

2. By allowing veterans' access to private sector healthcare without any VHA referral, authorization, or oversight, the **VHA's carefully constructed model of integrated healthcare will be dismantled**. This bill would not only disassemble this model of care but rapidly expedite the **conversion of the VHA healthcare system from its current primary role as a provider of healthcare into a payer for private sector care**.

3. In the name of offering more choice, healthcare options would diminish for veterans. Draining VHA funds and closing programs/clinics/facilities means that **veterans – especially service-connected veterans who depend on VHA as a provider of high-quality care that is tailored to their needs – will be denied that choice**.

4. The bill's refusal to require transparency in the private sector – on wait times, care quality or provider training – means that policy makers and patients alike **will be denied information they need to make well-informed healthcare decisions.**

5. **This bill will make it difficult, if not impossible, for the VHA to continue to collect data and conduct research on veterans' complex health conditions.** Every VHA patient and their electronic medical record is available for analysis, which, for decades, has enabled researchers to make impressive big data breakthroughs on veterans' complex healthcare problems. Those innovations will fade if veterans' care becomes scattered across the disjointed private sector where there is no dependable way to study veterans. The bill will also jeopardize the critical role the VHA plays in the training of future healthcare professionals. Further, there will be fewer ER and inpatient beds so that VHA will be unable to fulfill its Fourth Mission as backup for national emergencies.

We draw these conclusions from specific sections of the bill:

Sec.103: This language, for the first time, would allow veterans the option to obtain care in the private sector if they contend that's their "*preference*" and it's in their own best interest. The percent of VHA veterans potentially eligible for the Veterans Community Care Program (VCCP) will increase from ~33% to 100%. The guardrails of the VCCP eligibility standards – travel time to or wait time for a VHA appointment – would essentially become moot.

This stipulation violates the intent of the VA MISSION Act. When MISSION passed, there was bi-partisan agreement that the VCCP was meant, in Senators' words, to "supplement, not supplant" VHA healthcare. A veteran would be offered the option of receiving healthcare outside of the VHA under six narrowly defined criterion. Legislators understood that veterans would get the option to choose whether to receive care in the private sector or the VHA if, and only if, they qualified under the six eligibility rules. This carefully constructed language was the firewall that ensured the long-term viability of the VHA healthcare system. The HEALTH Act would violate that core agreement.

The HEALTH Act will predictably accelerate the proportion of VHA funds flowing to the VCCP. As *U.S. Medicine* reported, "between FY 2017 and FY 2021, VA spending on community care rose from $10.1 billion to $21.8 billion – a 116% increase that does not factor in the costs of administering the program. At the same time, VA spending on healthcare in its own facilities grew 32%." By last year, VCCP's share of VHA's health services reached 44 percent -- and was still climbing. The proposed legislative language in this bill will vastly increase spending through the VCCP and threaten the viability of the VHA system.

The HEALTH Act will divert funds away from the VHA, forcing reductions of staff and in-house programs and closing entire facilities. As VA Secretary Denis McDonough predicted in September 2022, if use of private sector care continues to rapidly increase, "VA medical facilities, particularly those in rural areas, may not be able to sustain sufficient workload to operate in their current capacity." Closing programs/ facilities means that veterans – especially service-connected veterans who depend on VHA as a provider of care that is tailored to their needs – will no longer have that choice.

Independent RAND and Dartmouth analyses – among many others – continually affirm that the quality of VHA's healthcare in regional markets is as good as, and in many instances, superior to private options.

Siphoning VHA funds will also make it nearly impossible to upgrade existing infrastructure required to address the demand for services. That demand is continuing to grow - the PACT Act of 2022 has already contributed to an influx of a quarter million newly enrolled veterans with serious toxic exposure-related medical conditions.

This (and other) sections of the bill claim to reduce the wait-times for veterans accessing care. However, delays for outpatient, inpatient and emergency room care for veterans and non-veterans in a local area would increase. Today, the average VCCP wait times for primary care, mental health, and all other specialties are roughly 20% longer than wait times at the VHA. As millions more veterans flood the private sector, and/or if a VHA facility is downsized, veterans

and non-veterans alike will struggle to get care in an overburdened private sector healthcare system, which is still suffering from healthcare worker shortages in the wake of the Covid-19 pandemic.

Our nation faces an intractable physician shortage. A recent report by the American Association of Medical Colleges warns of an estimated shortfall by 2034 of between 17,800 to 48,000 primary care physicians and 21,000 to 77,100 non-primary care physicians. Another report projects a workforce shortage of approximately a million registered nurses by 2030. Most of our nation also suffers from severe shortages of mental health providers.

The delivery of health care to rural populations is a particular challenge. While 20% of the U.S. population is rural, only 12 percent of PCPs are working in rural areas (and only 8% of other specialties), and these provider numbers are declining. According to The Center for Healthcare Quality and Payment Reform between 2005 and 2019, 150 rural hospitals closed. In 2020, an additional 19 closed. In 2023, it was reported that another 600, or more than 30% of rural hospitals are at risk of closing.

Sec.206: This statute will accelerate the privatization of the VHA via a pilot program that will drastically modify the process by which veterans obtain mental health and substance use disorder (SUD) care.

Veterans would be allowed to receive outpatient mental health or SUD care in at least five private sector locations **without VHA referral, authorization, or oversight**. An enrolled veteran could simply make an appointment with any VCCP mental health or SUD provider for care for any duration. VHA's only role would be to pay the invoice.

Though this is initially a small-scale pilot program, the bill also mandates that the VHA "develop appropriate metrics and measures to assess and mitigate any barriers to extending the pilot program across the entire Veterans Health Administration." Subsequent legislation will create universal opportunities for veterans to select private sector providers. Within a few years, eligibility would likely expand so that all diagnoses, not just mental health and SUD, would be covered. All levels across the continuum of care, not just outpatient, would be added. Similarly, veterans throughout the country would be eligible, not just in a handful of locations.

Not only does this hasten the siphoning of funds out of VHA, but it will also transform the VHA from an integrated healthcare system, like Kaiser Permanente, to an insurance carrier, like Blue Cross/Shield or Aetna. In this new insurance system, everything that is indispensable and unique to the VHA will disappear – integrated and coordinated team-based care, comprehensive prevention screenings, wrap-around services, veteran-centric specialization, training of providers with veteran expertise, and research on veterans' conditions that also helps all patients. VHA social work connecting patients to veteran-specific follow-up resources for legal, transportation, home health, and housing services would fade. Even the Office of Inspector General's oversight of veterans' healthcare will be compromised, since its ability to access private sector health care records is limited.

The total cost of a proposal to create a system of unfettered community care was calculated when this idea was proposed, in 2016. At that time, it was estimated to be $96 to $179 billion yearly. Figures today would be even higher and, as such, **CBO scores for this and other sections are urgently needed.**

Sec.108: This section gives great latitude to the VCCP third-party administrators (TPAs) to offer extra pay to private sector providers to participate in the VCCP. Disturbingly, financial incentives are offered to providers to join the VCCP in the absence of any quality control over, or training requirements for, these providers. This statute will also lead to an escalation in funds being drained from VHA.

Sec.101: This statute jeopardizes veterans' timely access to VHA in-house care by explicitly depriving the VA Secretary of the ability to assess and revise eligibility access standards devised by former VA Secretary Robert Wilkie based on unsubstantiated drive time and wait time standards. Codifying these misguided standards into law will, along with other provisions in the bill, guarantee the increased outsourcing of VHA patients to the private sector.

Sect. 101 further promotes patient outsourcing by prohibiting the Secretary to reverse a troubling double standard governing the provision of the VHA's world class telehealth services. The Trump-era standards prohibited telehealth from being considered as access to care if offered by VHA while allowing VCCP telehealth to be furnished without any constraints. Arguing that this double standard should be reversed, VA Secretary Denis McDonough last year stated that this error unnecessarily redirects up to $1 billion annually to VCCP.

Under existing law, the VA has the authority to make changes so that telehealth appointments count as meeting timely access standards. The HEALTH Act would remove VA's authority to do so, even when telehealth is a veteran's chosen modality to receive care. To legislatively prohibit correcting this mistake harms veterans.

Sec.106: This statute removes VHA administrators' authority to override provider recommendations that a patient should be referred to private sector care because it is in the veteran's "best medical interest." This new stipulation is fixing a problem with a machete when a small scalpel is needed.

There are instances when "best medical interest" fits for a veteran who doesn't qualify for VCCP under the five other existing criteria. For example, a veteran might have to travel over a steep mountain pass in winter snow to the nearest VHA facility when there is an alternative in his/her hometown. But there are too many instances when this category is currently being misused. That's occurring when the provider's only justification for the "best medical interest" recommendation is that a veteran "prefers" non-VA care.

According to the Independent Budget's analysis of the MISSION Act, the "best medical interest" criterion "is to be considered when a veteran's health and/or well-being would be compromised if they were not able to be seen in the community for the requested clinical service. When using this community care eligibility criteria, the ordering provider should include the following considerations: nature or simplicity of service; frequency of service; need for an attendant; and

potential for improved continuity of care. '**Best medical interest' is not to be used solely based on convenience or preference of a veteran**" (bold emphasis added). When it is used as such, then VHA's administrative oversight is the appropriate response.

Going forward, VHA must retain – not lose -- the authority to have final say on whether external referrals meet explicit referral standards. Further, VHA employees making referrals to the VCCP need far better education about what does and does not constitute "best medical interest."

Sec.108 and related sections. The HEALTH Act ratifies unjustifiable double-standards by holding the VHA accountable while allowing the VCCP to operate with no significant oversight. Some examples:

- The timeliness and travel eligibility access standards apply to VHA, but not VCCP.
- The Inspector General is tasked with assessing the performance of the VHA, but not the VCCP, in delivering timely care.
- VHA, but not VCCP, is required to regularly publish wait-time information.
- Performance metrics will be implemented for VHA employees who are responsible for veterans accessing care. Similar metrics are not required for VCCP employees who have equivalent operational responsibilities.
- VHA providers are already mandated to take military cultural competency and other trainings like suicide prevention, and, in the wake of the PACT Act training in toxic exposures, as well as screen for a multitude of conditions. Trainings are one reason why the VHA has a better record of delivering higher quality mental and behavioral health services than the VCCP. Section 108 prohibits that any penalty be applied to VCCP providers who fail to take relevant trainings and gain even minimal expertise, The ethical and clinical consequences of this double standard are deeply worrisome.

Sec.205: This statue includes provisions to create new staffing models for the VHA, ignoring the fact that VHA already has them. What's needed instead is oversight and enforcement of existing VHA staffing standards to correct the wide variation in local VA health care system compliance.

In proposing new staffing models, this bill makes yet another error by explicitly trying to create staffing models that conform with private sector health care systems. To compare private sector staffing to the VHA neglects a critical fact: that VHA patients are far more complex than those seen in the private sector. VHA patients are 14 times more likely to have 5 or more medical conditions and 14 times more likely to have poor health status than the general population. Compared to the general civilian population, former service members have higher rates of depression, mental illness, suicidal thoughts, chronic disease, chronic pain and substance use disorder. Staffing models should also account for VHA's clinical environment, one that prioritizes genuine teamwork and time collaborating with providers and other staff.

Sec.108, 109 and 201: This language contains provisions that would force the VHA to change its model of healthcare delivery to one based on value-based care and reimbursement mechanisms. The guiding assumption behind these sections of the bill is that the VHA does not already deliver care that is person-centered, relationship-based, and recovery-focused, doesn't

provide good value for cost, and is not focused on "continuous innovation and quality improvement."

While there may be a need to revise the current iteration of the VERA resource allocation model and to reconsider various scheduling mechanisms that VHA leadership has launched, like "bookable hours," value-based care models do not address these problems, and in fact, would create many others.

Despite the claim that VBC is a proven and successful model of delivering healthcare, a body of scholarly literature concludes that it is more rhetoric than reality. According to a number of articles and analyses, including a 2021 article in *JAMA*, the vast majority of value-based models used by the Centers for Medicare and Medicaid Services (CMS) "do not show significant improvements in quality." The article goes on to point out that: "In many cases, national or regional benchmarks combined with adverse selection can make it appear as if participants have saved money when they in fact have not."

A chapter in a 2019 Report to Congress on Medicare stated that "the treatment effect of being in an ACO (one of the primary VBC models) does not show savings." In fact, these models often showed higher spending growth. The chapter added that ACO's use of wellness visits resulted in gaming the system through upcoding.

Most disturbing was a 2022 an article in the *New England Journal of Medicine.* It reported that value-based payment systems not only "failed to meaningfully reduce health care expenditures and improve quality" but "hampered the pursuit of health equity," and actually "perpetuated structural racism." The value-based model penalized health systems that cared for low-income patients, encouraged system gaming, and diverted funds from those providing direct care to patients toward investments in "external consultants."

One JAMA report found that "high-proportion Black hospitals were more likely than other hospitals to be penalized" by certain value-based models. Another study suggested that value - based models had resulted in decreased access to knee and hip replacement operations for adult Black patients. To impose unproven mechanisms, documented to negatively impact the kind of patients the VHA cares for could harm veteran patients.

An article last month assessing Value-Based Care that appeared in *JAMA Network* reiterated these concerns and added additional ones. Not only do financial incentives fail to improve quality, but the focus on cost also often comes at the expense of patient preferences which, not surprisingly, prioritize outcomes, experience, and safety over efficiency. The study went on to underscore the fact that Value-Based Models may penalize "smaller, rural, low volume, nonteaching hospitals that serve more deprived areas."

To impose unproven mechanisms, documented to negatively impact the kind of patients the VHA cares for, could harm veterans.

The Department of Veterans Affairs has long administered the most successful healthcare system in the country. As a recent summary of research yet again confirms, the quality of care delivered

by the VHA is as good as or better than the care veterans receive from VA-paid community care or the general public obtains through private care.

Our organizations are happy to support legislation that encourages the appropriate use of the private sector to "support, not supplant" VHA healthcare. We also back legislation that ensures VHA has robust resources needed to care for current and future cohorts of veterans. The HEALTH Act does neither.

Discussion Draft - Making Community Care Work for Veterans Act of 2023

The Making Community Care Work for Veterans Act of 2023 has several sections that contain some useful improvements but does not go far enough in addressing problems with the Veterans Community Care Program.

Sec.109 addresses a serious problem in the VCCP – that is the failure to require VCCP providers to provide VHA with data on the quality of the healthcare that they furnish. Despite the original MISSION Act mandate, VHA has never required third party administrators to collect or report such data. Lacking data, veterans have consistently been referred to care of completely unknown, and sometimes dubious, quality. That should never occur.

This section ostensibly fixes the gaping lack of data and accountability on VCCP's efficiency, effectiveness, quality, timeliness, and safety of care. But rather than requiring all VCCP providers to submit needed data during a veterans' treatment, the language exempts providers from submitting data if VHA deems that doing so *constitutes too heavy of a burden* on the provider's time and resources. This is too broad of an exemption. By its very nature, the collection of data is burdensome. To assure high quality veteran care and that VHA, as mandated, would coordinate with the VCCP, this kind of data collection cannot be exempted. By contrast, VHA is not exempt from data collection requirements, burdensome as they may be. Accountability and transparency should be mandatory for those who participate in VCCP and are paid to do so.

Not only does this provision provide too much latitude to providers, but it also fails to emphasize outcome data. The Institute of Medicine defines health care quality as "improvement of outcomes." Patients considering health care options benefit most from information about treatment effectiveness and symptom reduction.

This section also requires that a list of VCCP's "High-Performing Providers" (HPP) be published. This requirement could greatly benefit veterans if high performance was rigorously and transparently defined. Yet, as has been previously identified, serious problems with the HPP designation must be addressed and remedied: (a) A public reporting is needed of which specific measures comprise the HPP algorithms, (b) Calculating the HPP designation needs to be primarily based on outcome measures, which thus far has not occurred, (c) Behavioral and mental health conditions, which are intentionally "not included in HPP monitoring," must be included.

If all these problems are addressed and clearer legislative language is incorporated, only then is the bill's accompanying Sec.302 beneficial. That statute expands the data collected on VHA care quality. VHA already obtains and reports far more data than does VCCP about veterans' care. The gap must be closed, not widened.

Sec.110 would publish the "high compliance" of community care network providers that take VHA trainings (yet to be determined) and meet records timeliness goals. Public accounting of VCCP providers could potentially improve the program. However, as written, trainings that would lead to the high compliance designation are voluntary not mandatory.

VHA providers are mandated to take specified trainings, e.g., suicide prevention, lethal means safety, complex toxic exposures, and military culture. VCCP providers have no requirements. This continues to encourage lower standards in the community program.

Rather than making critical training and timely submission of records mandatory, this provision provides financial incentives to providers. A vast literature on the failure of financial incentives to enhance quality (noted above) demonstrates that such incentives rarely work. They will also increase the cost of VCCP care for what may be minor improvements in quality at best and none at worst.

Sec.111 prompts faster movement toward electronic interoperability between VHA and VCCP healthcare records. The utility of interoperability cannot be overstated. Care coordination for veterans receiving some of their care via VHA and some via VCCP is severely hampered by hard copy records.

Sec.201 would help VHA recruit and retain Medical Support Assistants (MSAs), whom the bill rightly describes as "the linchpin" to ensuring that veterans are scheduled for care in VHA or in the community in a timely manner. We support these efforts if they particularly target MSAs who work in offices supporting the delivery of VHA inhouse care, (not the scheduling of private sector care), where the major retention difficulties lie.

Sec.102 codifies into law the problematic Trump-era VCCP wait time and drive time access standards and makes it impossible for the VA Secretary to ever modify those standards. As Congress intended when it passed the MISSION Act, the VA Secretary is supposed to reassess whether the access standards to the VCCP need to be adjusted. One out of every three VHA patients now qualifies for VCCP based on drive time alone. Myriad evaluations of the VCCP have documented that it is a costly and flawed experiment that delivers care that is not only less timely but also dangerously fragmented and of lower quality than the VHA. It is essential that access standards be allowed to be continually reevaluated and revised in terms of the care the private sector delivers and the overall impact on veterans who depend on VHA for their care. This provision of the bill should be strongly opposed.

Sec.103 would allow VHA to designate telehealth appointments as meeting timely access standards, thus allegedly addressing the previous Administration's mistake that prohibited such designation.

But it then adds an extremely consequential – and system crushing -- qualification. Even when the VHA can provide telehealth within the 20/28-day wait time or 30/60-minute drive time access standard, a veteran would be allowed to indicate that his/her preference is to receive telehealth from the VCCP anyway.

As we note above, the VA MISSION Act was very clear that veterans would get the option to choose whether to receive care in the private sector or the VHA if and only if they already qualified under the six eligibility rules. This original carefully constructed language was the firewall that ensured the long-term viability of the VA healthcare system.

The Sec.103 statute has perilous implications. Veterans would be offered a VHA telehealth appointment when the access standard is met but are nonetheless given the option for telehealth in the VCCP. The predictable next step would be giving veterans the same "preference" option for in-person appointments. At that point, the firewall alluded to above will be completely broken.

Sec.303 modifies the standards for veterans accessing residential mental health or substance use disorder care in the private sector. The intention is laudable -- to ensure quick placement when a veteran is in urgent need of treatment for substance use, PTSD, or other mental health issues. The VHA has, at times, been too slow initiating such care.

The statute ensures diligent tracking of the timeliness of screening and treatment placement. But the opposite is true for the quality of care. There is not a single requirement (or even mention) pertaining to the essential elements of care – high-quality, evidence-based, measurement of outcomes, or prompt exchange of medical records.

Unregulated quality of care in the private sector that prioritizes profits is no trivial matter. To cite just one example, a year ago, two unscrupulous operators of addiction treatment facilities in Florida were convicted of a $112 million fraud scheme that included medically unnecessary services. In 2017, The New York Times also did a series of impressive articles exposing the unscrupulous practices of private sector addiction treatment programs.

The Office of Inspector General recently voiced the same concern. At an April 2023 HVAC hearing, Dr. Julie Kroviak, Principal Deputy Assistant Inspector General stated, "Our office has published reports related to community care detailing delays in diagnosis and treatment, lack of information sharing or miscommunication between providers, and significant quality of care concerns."

The statute must be amended to assure that quality standards are applied to VHA and non-VA providers. VHA should be mandated to do the following (which is supported by language in the MISSION Act and the Parker Gordon Fox Suicide Prevention Grant Program bills):

- create its own certification requirements for a facility participating in the Mental Health Residential Rehabilitation Treatment Program. The certification standard should include that there is:
    - scientific evidence for a program's treatment approach,

    - a standard ratio of licensed independent practitioners (LIPs) per resident,
    - semi-annual peer review quality assurance system,
    - treatment planning,
    - accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) or equivalent organization, and
    - forwarding of treatment records to VHA within 30 days of a veteran leaving residential care,
- recertify programs every three years,
- mandate the mental/behavioral health measures that are required in the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program be administered to every VA-paid veteran participant at the point of entry, exit, and six months (if reachable) following discharge from the program. Additional measures could be added at the VHA's discretion, for example, the Brief Addiction Monitor (BAM) or PTSD Checklist (PCL).
- require that the scores of veterans be sent to the VHA for data analysis and evaluation of each program. VA will provide technical assistance for testing administration,
- publish the program outcome data on VA's Access to Care website https://www.accesstocare.va.gov/,
- require mental health and substance use disorder LIPs to take a minimum of four hours of VA's TRAIN courses corresponding to the patient population they serve, and four hours on military culture.

The statutes' new referral, review and placement standards will add significant administrative burden and strain on VHA's health care budget absent new, dedicated resources for those purposes. The demands on VHA to screen and find a placement for "priority" referrals within a 72-hour window are considerable, and too rushed, especially for patients who have not already been recently evaluated. Adding "self-referrals" to the mix is certain to balloon the number of veterans needing evaluation. Funding for additional staff is essential. Plus, there must be assurance that supplemental medical center funding would go to increased staffing so that VHA can meet this tight review deadline mandate.

CBO score is urgently needed for this section.

Sec.104 removes VHA administrators' authority to override provider recommendations that a patient should be referred to private sector care because it is in the veteran's "best medical interest." As we explained in detail for Sec. 106 of the HEALTH Act, there are too many instances when providers' only justification for the "best medical interest" recommendation is that a veteran "prefers" non-VA care. Regulations are very clear that "best medical interest' is not to be used solely based on convenience or preference of a veteran." When it is used as such, then VHA's administrative oversight is the appropriate response.

As we indicated in our remarks for the HEALTH Act, VHA must retain – not lose -- the authority to have final say on whether external referrals meet explicit referral standards. Further, VHA employees making referrals to the VCCP need far better education about what does and does not constitute "best medical interest."

S.928 - Not Just a Number Act

We recognize the many benefits to this bill, which we enthusiastically support.

The bill would expand a key VHA document, the National Veteran Suicide Prevention Annual Report, to examine how veteran suicides correlate with the utilization of VA health care and benefits, such as the GI Bill, job training programs, and disability compensation. It calls for a study of the feasibility and advisability of creating a suicide prevention office separate from the Office of Mental Health – a review that has much merit.

Most importantly, it mandates that the report's findings be shared with the public. As such, it recognizes that publicizing and utilizing data are pivotal to forming policy that affects veterans' suicides.

That said, as has been written elsewhere, the Not Just a Number Act needs a simple amendment. While the bill requires the VHA to disclose its important suicide data, it doesn't disclose data generated by recipients of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. The program includes 80 non-profit, private, and government groups ranging from veterans' associations to social service agencies to tribal nations who are aiding VHA in the fight against veteran suicide in local communities. They are generating a treasure trove of invaluable information that could help policymakers, veterans, social scientists, public health officials, and others drive down the still distressing number of veteran suicides.

Yet most of that information is rolled up into aggregate numbers for the whole program. There is no way to determine whether a particular organization's services are effective. An amendment to the Not Just a Number Act should require the VHA to crunch those pre-post figures**,** itemize them for each grantee and place them in the public domain. Results should include items such as whether and how much scores on the five measures improve for veterans who complete the grantee's services.

S. 853 - VA Zero Suicide Demonstration Project Act

This bill requires the VA to establish a Zero Suicide Initiative pilot program for the purpose of improving safety and suicide care for veterans.

VHA is continuously endeavoring to decrease veteran suicides. Its' public health approach to suicide prevention is the national gold standard, guided by both the White House Strategy for Reducing Military and Veteran Suicide and VA National Strategy for Preventing Veteran Suicide (2018-2028) including both clinical and community-based strategies.

Examples of VHA clinical strategies:

- Veterans Crisis Line with follow-up consultations to VHA suicide prevention coordinators
- Suicide Prevention (SP) NOW Initiative (includes some community-based strategies as well)

- VA/DoD Clinical Practice Guidelines for the Assessment and Management of Patients at Risk for Suicide
- Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) predictive analytics program
- SP 2.0 Clinical Telehealth Program for Evidenced-Based Therapies
- VHA (internal) Suicide Prevention Demonstration Projects/Pilots
- Suicide Prevention in Emergency Departments (SPED)
- VHA Suicide Risk Management Consultation Program
- VHA Post-Traumatic Stress Disorder (PTSD) Consultation Program
- Required suicide prevention training that includes VA S.A.V.E. and VA Lethal Means Safety training

Examples of VA community-based suicide prevention strategies:

- VA Housing/Homeless Programs
- Suicide Prevention (SP) 2.0 Community-Based Interventions for Suicide Prevention
- Lethal Means Safety partnership with the American Foundation for Suicide Prevention and the National Shooting Sports Foundation
- Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program
- "Don't wait. Reach out" (donated media) and "Keep It Secure" (paid media) campaigns
- Governors' & Mayors' Challenges to prevent suicide among service members, veterans and their families
- Mission Daybreak Grand Challenge and related pilots (both clinical and community-based concepts)
- Distribution of cable gun locks and other outreach materials available across the country from both VHA suicide prevention coordinators and VHA community engagement and outreach coordinators

We are aware that the Zero Suicide Institute Curriculum has had promising results in the private sector, and we support further tests of its efficacy and cost effectiveness. In fact, the Manchester, NH VA already completed such a funded yearlong pilot. "There were no measurable improvements that could be directly attributed to the Zero Suicide processes (and some key performance indicators worsened)."The considerable costs for the Demonstration Project would likely divert resources from successful VHA suicide prevention efforts. We believe it is presently premature to implement it within the VHA without more specificity as to what aspects of the VHA's extensive safety and suicide prevention care for veterans that it aims to improve.

S.1545 - Veterans Health Care Freedom Act

The Veterans Health Care Freedom Act is an attempt to rapidly privatize the VHA. For three years, in a quarter of the country, all VHA-eligible veterans would be issued the option to obtain all hospital care, medical services and extended care services in the VCCP without VA authorization, referral or oversight. Once a veteran has a VCCP primary care provider, further specialty care would be referred to VCCP providers. There are no limits to utilization or over-utilization. VA's only role would be to pay the invoices.

The bill makes no attempt to hide its intention to completely replace the VHA integrated healthcare system from being a provider of healthcare into a payer for private sector care. Not only does the bill transform the VHA into just another insurer, but it does so at the expense of the stellar clinical care the VHA provides. The bill explicitly states that, "No additional funds are authorized to be appropriated to carry out this section and the amendments made by this section, and this section and the amendments made by this section shall be carried out using amounts otherwise made available to the Veterans Health Administration." This language assures that every dollar spent on private sector care is a dollar taken out of the VHA' inhouse, clinical care budget. The bill thus deprives veterans of high quality, patient-centered care delivered in a system that has amassed decades of expertise understanding, recognizing, and treating veterans' complex health conditions.

As we said above, our organizations are happy to support legislation that encourages the appropriate use of the private sector to judiciously "support, not supplant" VHA healthcare. We also back legislation that ensures VHA has robust resources needed to care for current and future cohorts of veterans. This bill does the exact opposite.

S.1954 - Improving Whole Health for Veterans with Chronic Conditions Act

We wholeheartedly support this much needed legislation to provide dental care to veterans who have diabetes and heart disease. The bill would set up a four-year pilot program to study the efficacy and cost of providing such care. The pilot would also offer loan reimbursement to dental professionals for participating in all four years of the program.

It is hard to overstate the need for such a program. According to VHA figures, over three million veterans suffer from diabetes and heart disease, yet only approximately 1.4 million of the total nine million enrolled veterans qualify for comprehensive dental care from the VHA. This gap has serious consequences for veterans as well as to efforts to contain VHA healthcare costs. Studies confirm the close links between diabetes and gum disease and the vicious spiral that can occur if patients with diabetes do not get proper dental care. Diabetes, for example, puts patients at great risk for gum disease, and gum disease makes it far harder to control diabetes. Gum disease also escalates the risk of strokes and heart attacks, cardiovascular disease, respiratory diseases such as pneumonia, progression of Alzheimer's disease and cancers such as kidney cancer and blood cancers. These are just a few of the devastating health problems that can occur from lack of dental care.

VHA dental care is also critical because, in many regions of the United States, the VHA may be the only provider of dental care for veterans. According to analyses done by the Rural Health Information Hub, the majority of counties in the nation have shortages – sometimes severe – of dental professionals. This is particularly true in rural and highly rural areas. By providing loan reimbursement to dental professionals, the VHA would deliver needed care to veterans and help attract more people into the profession, helping to ease the shortage of dental professionals in the nation.

Failing to provide appropriate dental care to veterans with diabetes and heart disease also has severe financial consequences. According to AIDPH and Care Quest estimates, providing dental care to only half of the enrolled veterans with diabetes or heart disease would save $3.4 billion a year in medical costs – almost 1.5 times the annual VHA budget for dental care. This legislation saves suffering, lives, and money.

Additionally, ensuring that VHA is the central provider of dental care would save tens of billions of dollars yearly, given the costs associated with VA-paid dental care in the community care program. VA needs a plan to quickly hire more dentists and dental staff, create larger dental clinics and fully support VA dentistry caring for these veterans before flooding the community system that has insufficient capacity to absorb them.

We enthusiastically support this legislation and urge Congress to quickly pass it as a benefit for veterans.

S.449 - Veterans Patient Advocacy Act

The importance of patient advocacy cannot be understated. Many of the issues being discussed today hinge on the quality of care that veterans receive within VHA as well as the clarity of information provided about those services. This bill would require the Office of Patient Advocacy within the VHA to ensure there are patient advocates (one patient advocate per 13,500 enrolled veterans) to listen to the veterans' concerns and offer advice on next steps.

It also provides those in highly rural areas access to a patient advocate, which is critically important as veterans in these areas often encounter difficulties and gaps in care. A patient advocate will be able to provide timely information, answers health care questions and coordinate next steps in that care.

We endorse VHA continuing to hire more support staff and patient advocates to provide veterans with a warm hand-off, so they receive the appropriate guidance that best fits their individual needs regarding the care and services within VHA.

We support what this bill affords veterans and look forward to reading the GAO report on implementation of this policy.

We thank you for the opportunity to provide our perspective on these essential matters.

Respectfully,

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