The Lincoln Declaration: a Letter of Concern about the Future of Veterans' Healthcare

Dear Secretary Collins, Inspector General, and Members of Congress,

On March 4, 1865—to an America torn by Civil War—Abraham Lincoln delivered a vision of national healing which remains inscribed at Veterans Affairs (VA) hospitals across the country:

> *"With malice toward none, with charity for all, with firmness in the right as God gives us to see the right, let us strive on to finish the work we are in, to bind up the nation's wounds,* ***to care for him who shall have borne the battle and for his widow and his orphan****, to do all which may achieve and cherish a just and lasting peace among ourselves and all nations."*

For 160 years, this vision has inspired VA healthcare workers to honor Lincoln's promise by serving those who served.

We are those healthcare workers: active and retired VA clinicians writing on personal time without use of government resources; faculty at VA affiliated medical schools; care providers across the nation who trained at VA and remain committed to its mission. We have offered our veterans lifesaving therapies and groundbreaking research; removed their cancers and repaired their hearts; seen them through crises and comforted them as they lay dying.

We are also veterans who receive care at the VA, caregivers who support them, and public servants whose work complements the other services VA provides to the nation: health education, research, and public health emergency response.

We write to raise urgent concerns about proposed policies which, in addition to ones already enacted, will undermine VA's healthcare system, overwhelm VA's budget, and negatively affect the lives of all veterans. We have witnessed these ongoing harms and can provide evidence and testimony of their impacts.

The rest of this letter presents three core concerns and seven evidence-based truths about veterans' healthcare. It offers three overarching policy recommendations to carry VA forward for the *next* 160 years. This healthy future requires growth and change. But as America's largest health professions educator and leading health services researcher, VA has a deep, rich culture of continuous improvement and innovation. This culture has made VA a respected model for cost-effective, integrated, patient-centered medicine and *the* system that the vast majority of veterans trust and prefer for their care.

We dedicate this letter those veterans, whose service we honor with our own, and to our future patients: the active-duty troops risking their lives and health to protect our nation and its constitution.

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Three Growing Risks to VA's Mission and Veterans' Healthcare

1. Workforce reductions without published objectives or impact assessments on veterans' healthcare access
2. Expansion of administrative authority into clinical decisions that are best made by veterans and their clinicians, and best guided by evidence, medical ethics, and the scientific method
3. Rapid growth of purchased (community) care that threatens to divert resources from VHA's high-value direct care and, over time, veterans' earned benefits.*

   * We support Community Care, which plays a valuable role in many veterans' treatment. At best, it reflects a mission-driven, public-private partnership—like those in VA's Academic Affiliations program—that are central to VA's past and future success. Our concern is ensuring that policy and spending decisions are driven by veterans' needs, not vendor incentives or market pressures.

Seven Evidence-Based Truths About VA History and Veterans Healthcare

- Over decades, the Veterans' Health Administration (VHA) has delivered equivalent or higher quality veterans' healthcare with lower cost and greater patient satisfaction when compared with non-VHA healthcare providers[1]
- Over the last 10 years, VA has outsourced a growing share of veterans' care—and health data systems—to external vendors who do not share VA's mission
- The main rationale for this shift—concern about excessive wait times causing delays in veterans' care—is inconsistent with available evidence on timely care and access in VHA and non-VHA healthcare settings[2]
- The result of this shift has been a rapid increase in VA spending on purchased healthcare services of uncertain quality and value and vulnerable to waste and abuse[3]
- The cost of Community Care is eroding VHA's high value, integrated internal systems and, with passage of the 2026 budget, will further erode its resources[4]
- If this trend continues, VHA facilities may be forced to close, and veterans may be forced into costlier, often overburdened community health systems ill-equipped to meet their specialized needs; as healthcare costs increase, veterans' benefits will be jeopardized[5]
- Service is the common thread uniting VHA's 4 missions: to provide veterans' healthcare, education, research, and emergency services *for the common good*. This thread not only "binds up the nation's wounds;" it binds America's medical, scientific, and military communities in a common patriotic enterprise. If VHA quality degrades, the damage to our cultural fabric may be difficult to repair.

Please see the appendix for evidence supporting these points.

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Policy Recommendations

1. **Contain VA Community Care Spending and Regulate Quality**
    a. **Hold CC funding at 2025 levels, pending investigation and reform**
        i. Investigate overbilling, overtreatment, waste, and abuse by examining CC spending trends on a per-provider, per-patient, and per-claim basis
        ii. **Reform Third Party Administrator (TPA) contracts**
            1. Decrease Administrative Fees to <15% (consistent with medical-loss-ratio standards)
            2. Investigate Potential Conflicts of Interest
                a. Examine referral patterns for disproportionate self-referrals from CCN 1-3's UnitedHealth-owned TPA (Optum Serve) to UnitedHealth-owned practice sites
                b. Require that oral prescriptions from CCN providers be issued through VHA's cost-effective Centralized Mail Order Pharmacy—NOT through OptumRx or private pharmacy benefits managers—and that injectables be given at VA infusion centers if drive-time allows
    b. **Refine Community Care eligibility standards**
        i. Hold CCN providers to the same wait time standard as VHA. If a CCN provider is unable to provide care sooner than VHA, that appointment should not be considered wait-time eligible
        ii. Include VHA telehealth appointments toward wait-time goals when clinically appropriate and preferred by the veteran
    c. **Amend the following bills which advance VHA privatization**
        i. **The Complete the Mission Act** - Extending wait/drive time eligibility to Mental Health Residential Rehabilitation Programs is unwise. These services' high costs, variable quality, and high fraud rate require close oversight from VHA clinicians.
        ii. **The Veterans ACCESS Act** - A pilot in this bill would allow unlimited mental health access—without VA authorization, referral or quality review—thereby draining VA funds and degrading care quality.

2. **Fully Staff and Fund VHA's Direct Care Services**
    a. **Staffing**
        i. Promptly backfill the positions of the 30,000 staff—including 827 doctors, 2300 nurses, 618 social workers, and 895 medical support assistants—whose jobs were vacated in 2025

ii. To facilitate hiring, reverse the 2017 HR modernization program, which decreased hiring capabilities of large VAMCs whose complex staff needs cannot be nimbly met with centralized HR services alone
iii. Freeze further "reorganizations"—e.g., elimination of VISNs or program offices—without Congressional approval.

b. Funding

i. Do not cut VHA's discretionary Medical Service budget

1. The proposed FY26 budget cuts some $12B from VHA's medical budget and diverts it toward Community Care
2. To support holistic veterans' healthcare, these funds must be restored to VHA's direct care budget as *discretionary funds*, not earmarked for conditions related to military toxic exposures.

3. Defer Healthcare Decisions to Clinicians, Patients, and Subject Matter Experts

a. Confirm a healthcare leader as Undersecretary of Health

i. VHA is the largest and most complex health system in the US.
ii. To retain staff confidence, the USH is ***statutorily mandated*** to have frontline medical experience and/or expertise running a large, well-regarded healthcare system

b. **Restore medical staff self-governance**

i. Medical staff bylaws are a core mechanism by which medical professionals safeguard the standards of the profession
ii. Longstanding guidelines from the American Medical Association and Joint Commission on Hospital Accreditation state that staff bylaws changes must be voted on by all medical staff
iii. Recent, unilateral changes to VA Medical staff bylaws must be reversed or put to a vote by VA Medical Center staff.

c. Ensure VHA clinical protocols follow evidence-based guidelines

i. VHA has long developed clinical practice guidelines derived from objective evidence synthesis by internal and external experts
ii. Recent, controversial CDC vaccination guidance raises concern that VA protocols—on vaccination, contraception, and other sensitive areas—may become politicized in a way that jeopardizes veteran-centered care
iii. Clinical practice guidelines in these areas—including medication formularies, patient education materials, electronic health record tools—must be crafted by VHA subject matter experts guided by respected, *independent* medical and health professional societies

d. **Restore scientific independence**

i. VHA's research mission depends upon open inquiry and peer review.
ii. Recent communications requiring administrative review of presentation slides and publication manuscripts undermines this mission and disrupts discoveries that benefit all Americans.
iii. VHA's commitment to scientific independence, consistent with VHA Handbook 0005, must be clearly restated

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Yours In Service,

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Appendix – Underlying Evidence

(1) VHA as Model for High-Value Healthcare

The VHA delivers perhaps the highest value healthcare in the nation. This is not our opinion. It is a fact supported by extensive research on the core components of healthcare value: quality and cost.

Quality: By any definition, in study after study, VHA's 170 hospitals and nearly 1200 clinics meet and usually exceed the quality of care provided elsewhere. Subjectively, over 90% of VA patients—on VA and independent surveys alike—report high trust in VHA and prefer it as their primary source of healthcare. Objectively, VA patients have better outcomes across a range of conditions when treatment occurs within VHA, and lower mortality when ambulances bring them to VHA emergency rooms. Various veteran subgroups also fare better under VHA care than their veteran counterparts—or the civilian public—fare with non-VHA providers. This is true both for "general medical populations" (like diabetic patients, who have fewer complications when treated at VHA clinics) and for highly complex ones including

- veterans with psychiatric conditions (whose suicide rates are lower when they receive VHA vs. non-VHA care)
- veterans on dialysis (who have lower mortality when their dialysis takes place within VHA)
- veterans experiencing homeless (of whom some 55% have been housed since 2008)
- veterans with Hepatitis C (of whom nearly 80% were cured, at VHA, by a forward-thinking campaign which leveraged upfront investment in expensive antivirals to stem downstream suffering from *more* expensive liver complications)

Cost: High-value preventive investments like Hep C eradication are a hallmark of VHA care. They are possible because VA's lifetime insurance coverage and capitated payment model promote cost-control measures for which private insurers and for-profit health systems lack incentive. Bulk drug pricing at steep discounts is another VHA practice which profit-driven pharmaceutical companies are incentivized to oppose; which Medicare part D plans are prohibited by law from negotiating; and which commercial pharmacy benefits managers (PBMs)—via opaque manufacturer rebates and formulary practices and vertical integration with insurers or dispensing pharmacies—untether from the free market.

For these reasons and more, cost-effectiveness research confirms that VHA care is generally less expensive as well as more effective. As above, this is true across multiple medical conditions, for studies comparing

- VHA patients vs. non-veterans (who tend to be less medically complex, and whose costs should be lower unless driven by something other than medical need)
- VHA care vs. veteran care funded by non-VA entities (e.g., Medicare, for dually enrolled veterans seen at non-VA hospitals).
- VHA-delivered care vs. VA-funded Community Care.

In a nation where healthcare expenditures, often taxpayer funded, approach 20% of Gross Domestic Product—and where dropping life expectancy is especially notable among the rural and working-class patients overrepresented among veterans—one might view VHA's high-value track record as a cause for celebration (if not a model for reform). Yet many VA and congressional leaders promote an alternate, false narrative in which VHA is a bloated, change-averse bureaucracy and the private sector is the solution.

(2) **Community Care Origin Story: Myth vs. Reality**

To support the narrative of VHA dysfunction, VHA critics cite "claims backlogs" and "wait times" as their areas of greatest concern. The first critique—backlogs in veterans' applications for service-related disability and healthcare benefits—has little to do with the Veterans Health Administration. Though largely outside the scope of this letter, these benefits share concerning echoes of a larger VA privatization trend and will receive brief mention in our next footnote.

The second critique—wait times for healthcare at VHA clinics—is inconsistent with evidence. Though VA leaders have repeatedly described these wait times as "going up" in recent years, VA's own website describes VHA wait times decreasing as of last analysis in early 2024 (to 17 and 22 days for mental health and primary care appointments, respectively). These wait times compare favorably with those the community.

Though not consistent with the evidence, concern about wait times *is* consistent with rhetoric surrounding a past VA scandal which Community Care growth was intended to remedy. To quote a member of Congress in July: "There is a reason the MISSION Act and Community Care exist. And the reason was because people were dying waiting for care at the VA." This quote references events still known throughout VA as the "2014 Wait Time Scandal," and it misrepresents those events as we understand them to have occurred:

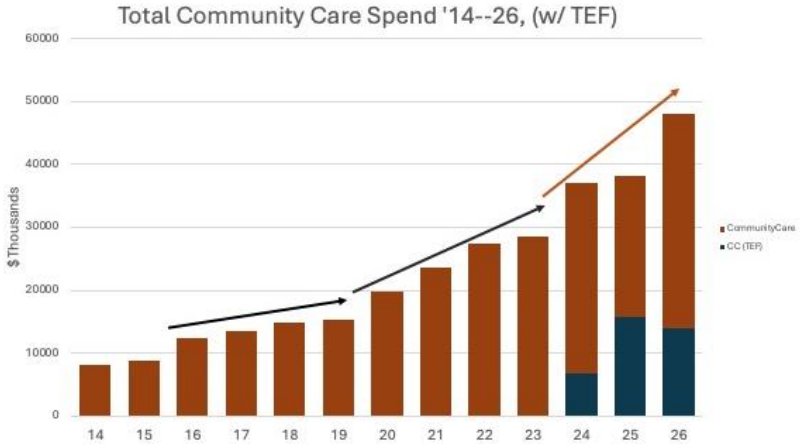
- In February 2014, a whistleblower alleged that some 40 veterans died while waiting for appointments at a VA medical center in the Southwest.
- In April, these allegations were announced before the House Veterans Affairs Committee
- During the same hearing, the Committee Chair shared a separate allegation that VHA schedulers had manipulated records to feign compliance with new 14-day wait time standards.
- In June, a national audit of all appointments scheduled in VHA in the previous year—some 6 million—showed 96% were scheduled within 30 days (VA's current wait-time standard for non-urgent care)
- In August, VA's Inspector General (IG) published an exhaustive report on the original whistleblower complaint—including manual reviews of some 3400 patients' charts from the southwestern VA
    - The report identified 6 veterans who had died while waiting for care, but that most were waiting for routine visits unrelated to their cause of death, and/or had severe chronic conditions whose trajectories would not have been altered by more timely treatment.
    - In all cases, investigators were "unable to conclusively assert that excessive delays caused the deaths of these veterans."
- In July 2014, one month before the IG report was released, Congress passed "emergency" legislation—the Veterans' Choice Act—which, for the next three years, broadly expanded VA's role as payor for purchased (community) healthcare services.
- In so doing, it "upended how VA has done business for the last 70 years." This statement was made by the CEO of the Concerned Veterans of America (CVA). The quote goes on to credit CVA for "exposing and driving the [wait time] crisis from the very beginning," and for being "central to [the Choice Act] in every aspect."
- Concerned Veterans for America was founded in 2011. Its main activities focused not on veterans' services but on 2012 electoral politics. Its main funding came not from veteran members but from a donor network organized by two brothers for whom "voucherizing" VHA had played a minor role in a larger anti-government agenda.
- The CEO's statement above was made at the brothers' donor summit in June 2014. It concludes: "Throughout [the Wait Time Scandal], CVA and its network partners intentionally broadened debate to include big government dysfunction in general, further fortifying new skepticism about what government run healthcare does."

(3) **The VA's Largest Sources of Waste and Abuse**

Over the last 10 years VA has funded two healthcare systems: the VHA's direct care system, and the Veterans Community Care Program. The results of this natural experiment are telling and unequivocal.

From 2014-2018, Community Care appropriations were time-limited and capped around $10 billion. Though private sector expenditures grew relatively slowly during that time, the program was rife with waste—most notably by the Third-Party Administrators. Some 25% of spending—around $1.9 billion—went not to veterans' outsourced healthcare, but to administrative fees charged by the two insurance companies who received single source contracts to build a Community Care provider network, schedule Community Care appointments, reimburse non-VA providers, and transfer medical records. Records retrieval from Community Care providers, though also outside the scope of this letter, remains a problem. (Its solution—replacing VHA's first-in-class, highly-rated, homegrown electronic health record with an unproven commercial product from healthcare-naive tech giant Oracle—via another no bid contract whose projected costs now approach $50B—may be a cure worse than the disease.)

Since 2018, Community Care spending has increased more dramatically, after passage of the VA MISSION Act. Short for "Maintaining Internal Systems while Strengthening Outside Network," the MISSION Act indefinitely extended the Choice Act's private sector funding stream, with no mechanism for cost containment (or quality control), and expanded eligibility criteria to all veterans living more than 30 minutes from their nearest VA (60% of all VA patients). Since then, Community Care referrals have increased modestly—mainly due to drive-time eligibility rather than long VHA wait times. Yet Community Care expenditures have risen dramatically from $14.8B in 2018 to an estimated $40.9B in Fiscal Year '25. This increase in per-referral and per-provider costs—which we hope VA investigation will further elucidate—suggests that some Community providers have become adept extracting the maximum amount of revenue per veteran.



Again, VA's Third-Party Administrators remain a major source of waste, and, in some cases, fraud and abuse. In 2024, VA's OIG found that United Health, which manages Community Care for Veterans the eastern Half of the US, had overcharged the VA by $783.4 million from FY2020- May 2024 for dental services provided by community care providers. (UH argued that VA's contract did not explicitly *prevent them* from charging the VHA more than they was reimbursing the community care provider.) United Health has also been implicated charging the government some $1.3B in premiums for Medicare Advantage plans targeted to Veterans whom it also receives administrative fees—averaging $318 per claim—for processing Community Care referrals. These referrals, in turn, often flow to private hospitals and clinics ***also*** owned by United Health. Insofar as United Health ***ALSO*** conducts a large proportion of Veterans Benefits Exams, it is possible that the taxpayer may pay this single company four times for the

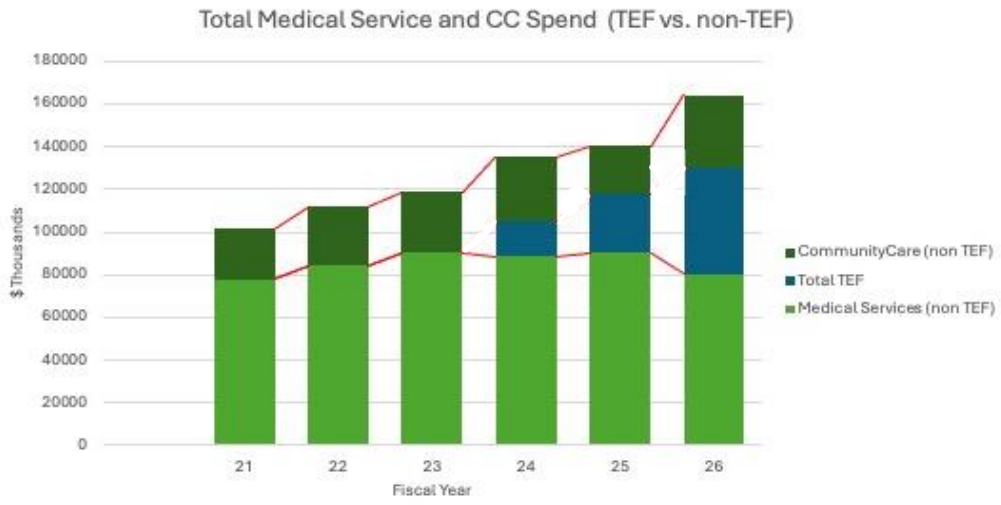
same veteran's care: first as a recipient of (unused) Medicare Advantage premiums; second to (impartially) vouch for that veteran's eligibility to receive taxpayer-funded VA care; third for directing that care (also impartially) to a provider in VA's community care network; and then delivering that care in a way that maximizes health and minimizes cost.

(4) **Avoiding the Downward Spiral: Impacts of Community Care Spending on VA Healthcare and Veterans' Benefits**

In early 2024, an independent panel—convened by VA to assess "trends and drivers of increasing community care spending"—determined that this spending posed an "existential threat" to VHA's hospitals and clinics. "With a fixed appropriated budget and escalating community care referrals…more of VHA's clinical care budget will have to be used to support the community care program. This could create a self-perpetuating cycle in which increased community care spending results in less direct care funding [and] direct care capacity, leading to increased community care reliance and a continuous 'downward spiral' for VHA's direct care system."

To healthcare scholars and frontline providers, the "downward spiral" scenario has long seemed intuitive. As Community Care costs rise, cuts to VHA's direct care budget would seem inevitable; should struggling VA Medical Centers and Clinics close, more-expensive Community Care (which is also generally less effective) would be the only remaining "choice" for veterans. As VA's medical budget swelled from this lower value care, cuts to veterans' benefits would be a worrisome possible next step. Indeed, the elimination of VA medical benefits for veterans in Priority Groups 7 and 8, who bravely served but do not have a compensable service connected disability, has been proposed by The Heritage Foundation.

These concerns have been dismissed by some in Congress. Yet the budget sent to Congress in June, and being reconciled between the chambers right now, shows that very downward spiral taking place starting in FY26. To offset an unprecedented $12 billion (50%) increase for Community Care spending—and a staggering 167% increase for costs related to Electronic Health Record outsourcing—this budget cuts some $12 billion (17%) from VHA's direct medical care budget. These cuts are hidden somewhat by inexplicably large growth in earmarked Toxic Exposure Fund (TEF). But the cuts are there.



This figure—17%--nearly exactly matches 15% target for the agency-wide reduction in force announced last March (and cancelled in June).

(5) It is deeply worrisome a 15% staff cut was entertained—and that significant staff reductions were pursued and achieved via buyouts and other means—in a VHA system already straining to meet demand AND operating with relatively high efficiency and low administrative overhead. In 2025, VA's Inspector

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General reported shortages in frontline staff—physicians, nurses, psychologists—at all 139 VA Medical Centers surveyed (out of 170 total). At the same time, VHA hospitals employed proportionally 25% fewer administrators than their private sector counterparts.

If it was unclear where a 15% staff cut might come from—or why it was needed at all—where veterans would go for healthcare was a mystery. One potential answer--"Community Care"—was promoted extensively in Project 2025, a document that has left its stamp on so much of government. (Its section on "Needed VHA Reforms" pertains nearly exclusively to "strengthening Community Care.") But this answer was implausible in America's current, often fragmented healthcare market. In August, a comprehensive 50-state analysis of healthcare services outside the VHA confirmed what we healthcare professionals knew intuitively. 89% of counties face primary care shortages; 61% of rural counties lack even a single psychiatrist; in short, the American healthcare market cannot absorb a large, rapid influx of complex veteran patients, let alone serve them with the expertise and high value they deserve and have come to expect from VHA.