

**ENSURING VETERANS' TIMELY ACCESS TO  
CARE IN VA AND THE COMMUNITY**

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**HEARING**

BEFORE THE

**COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE**

ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

—————  
SEPTEMBER 21, 2022  
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## **ENSURING VETERANS' TIMELY ACCESS TO CARE IN VA AND THE COMMUNITY**

**WEDNESDAY, SEPTEMBER 21, 2022**

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

The Committee met, pursuant to notice, at 3 p.m., in Room SR-418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

Present: Senators Tester, Sanders, Brown, Blumenthal, Hirono, Sinema, Hassan, Moran, Boozman, Cassidy, Rounds, Sullivan, Blackburn, Cramer, and Tuberville.

### **OPENING STATEMENT OF CHAIRMAN TESTER**

Chairman TESTER. The Committee will come to order.

First of all, I just want to say thank you. This is a really important hearing this afternoon and I want to thank the Secretary for taking time out of his day to be here on the first panel.

We have got a second panel up that we will talk about a little later that is also going to be critically important for us to listen to and get input from.

Studies have consistently shown the quality of care at VA is often comparable to or better than care provided in the private sector. I have said before, and I will say it again, VA can outsource the work when it makes sense but it cannot outsource the responsibility for taking care of our veterans. Whether they receive care in the VA or care in the community, they are responsible for both.

As we begin today's conversation on VA wait times, I want to make sure we are continuing to emphasize that veterans deserve top-notch care whether they are seen in a VA facility or in the private sector. The Department is accountable for making sure that is exactly what they receive, quality care.

Community care has always been a part of the VA and it is time we treat both the Department and the private sector the same on a lot of fronts, including ensuring veterans are covered for medical injuries received when they go into the community for services.

Right now, if a veteran is harmed while receiving services through Community Care Program, they are not eligible to file an 1151 claim through the VA, which would allow them to receive compensation for a new disability or the worsening of an old one because of medical mistakes. I think we can all agree that is not right. Whether at VA or the community, vets need to be treated the same.

If problems are occurring at the VA we have an Office of Inspector General and Government Accountability Office to tell us what is going wrong and how to fix it. We have none of those protections for vets when they go in the community.

Another concern I have heard over and over is that private sector providers are not giving medical records back to the VA after appointments. The VA has a responsibility for coordinating care which, in my book, includes getting a record of care that takes place in the community. VA needs to do a better job of getting those records back so the Department providers are better informed about what treatments their patients are getting in the community.

In this very room a few months ago we held a hearing on quality measures and discussed holding community care providers to the same quality standards that we hold the VA. We need to have that same discussion today on wait time requirements. Private sector providers who treat veterans in the community should have to meet the same wait time rules as the VA. It makes no sense to develop access standards VA is required to meet and then give veterans the option for community care where they may have to wait longer than if they had stayed with the VA.

The VA must ensure veterans are receiving timely options for private sector care and quickly connecting veterans with community care when they need it. The Department must improve its internal process for referrals so veterans receive faster access to the community.

The bottom line is veterans deserve to know how long they need to expect to wait for health care in the VA and in the private sector.

We know challenges remain on how VA calculates wait times and we know VA does not always get this right. But I hope that after today's hearing, we can walk away with a better idea of how to address these concerns. For care in the community, VA does not have readily available data and that is a failure and something that we need to help the VA fix.

On Friday, the Department released a congressionally mandated report regarding access standards as required by the VA Mission Act. I expect us to get into that a bit today but, for now, I want to focus on one item in particular. That report states that the VA is rapidly approaching a point where one-half of all care available in both settings is provided through community care. It also notes operational leaders are concerned by the potential of a spiral effect in some areas where workload and talent are shifting to outside of the VA.

Given that statement, I want to know what your plan is, Mr. Secretary, for avoiding both those outcomes.

Finally, I am open to hearing recommendations for how to improve community care. Look, we are all here working for the veteran. Veterans deserve programs that work. But the only solution cannot be just sending more folks into the community.

With that, is he close? Unclear.

Just so you guys know, we are in the middle of two votes. And so, if people get up and leave, do not take that personally.

With that, because Senator Moran is somewhere in transit, I am going to turn it over to you, Secretary McDonough, a man that I really do not have to introduce because he has been very generous with his time to this Committee and we very much appreciate that.

Secretary MCDONOUGH. Thank you.

Chairman TESTER. And also, in a different hearing this morning, I appreciate the staff that were sent over, Remy, Elnahal, and others, because they did a very nice job at the hearing, too.

So Mr. Secretary, I will turn it over to you.

## PANEL I

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### STATEMENT OF THE HONORABLE DENIS R. MCDONOUGH

Secretary MCDONOUGH. Chairman and members of the Committee, thank you very much for your unwavering support of veterans and thanks for this opportunity to testify today.

At VA, we come to work every day to ensure access to timely world-class care for America's veterans, ensuring that they receive, as you have just said, the best possible care wherever they access that care, at the VA or in the community.

I am talking about veterans like Amanda Barbosa. I first met Amanda at the U.S. Capitol earlier last month. One of those tough vets who spent nights on the steps of the Capitol until the PACT Act was passed. Amanda has been through a lot.

At what she remembers as the lowest point in her life, she came to the VA clinic at Fort Benning, Georgia and, she said, "VA saved my life and turned it around completely."

Today, Amanda is thriving and she has devoted herself to saving other veterans' lives. Veterans like her husband, Raphael, a Marine vet and an Army vet exposed to toxins during three deployments to Afghanistan, Iraq and Kuwait. Just two years after he was honorably discharged, he was diagnosed with cancer and Amanda, caring for him, helped him file his VA claim. Three weeks later, they had a decision, 100 percent service connection.

Amanda says that experience made her a stronger, better advocate for others. As she sees it, it is her great privilege to stand with other vets and their families to help save lives. That is what we want to do at VA, stand with vets, be their advocates, ensure they have access to the world-class care and the timely benefits that they, their families' caregivers and survivors have earned. And I know that that is what this Committee also wants.

Since President Biden took office, VA has delivered more care to more vets than at any other time in our Nation's history. More care to more vets than at any other time in our Nation's history. And when it comes to providing world-class health care to veterans and their families, study after study shows that we are delivering better health outcomes for veterans than the private sector, which is why vets now have trust scores for outpatient VA care averaging above 90 percent during the past year.

Notably, in 2021, we had a record 33 million completed appointments in the community. We are not where we need to be on timely scheduling of those appointments, but as we have seen this

record volume we are making steady progress in reducing wait times.

We have needed to fix the way we measure and publish wait times for veterans since before I arrived at VA. So in July, working with VSOs, with you and your staffs, and having listened to the IG and GAO, we updated the website so that the average wait times better align with what veterans experience when they make their own appointments and give veterans localized information that allows them to choose the care that is best for them.

We also recently, and finally, completed the CMR, the Congressionally Mandated Report, on access to care standards.

At the end of my last appearance in this room, I said to Senator Moran that I was considering changing the access criteria for community care. But on reflection, and after close consultation with our new, excellent Under Secretary for Health Dr. Shereef Elnahal, I have reconsidered.

VA is proposing no immediate changes to the current designated access standards. However, we are planning to propose incorporating VA telehealth availability into determinations regarding eligibility. I know this will require careful consideration and that is why we will welcome public and congressional input on the proposal when we make it. Telehealth is part of the evolving ways in which care is delivered and it improves our ability to provide that care.

Ensuring veterans receive timely access to world-class care, including each of those 33 million appointments in the community, is influenced by many factors in addition to those access standards including the enduring impact of COVID and the pandemic on how health care is delivered; the state of VA infrastructure, which I heard from our experts in Des Moines last week, too often impacts their decision as to whether a veteran can receive care at that VA facility; our sometimes too slow internal handling of referrals to the community; and the health care employee shortages that plague not just VA but all of health care and thus, impact what care is available in the community and in the VA direct care system.

We are overcoming each of these challenges, often with your help, including through the passage of the PACT Act which gave us new workforce authorities and important new infrastructure opportunities to advance one of our top priorities, which is getting more veterans into VA care because, as I have said, study after study shows vets in VA care do better.

So with your help, we will continue to deliver for veterans like Amanda and Raphael and millions of others and giving them the very best because that is what they deserve, and nothing less.

Again, thanks for this opportunity, Mr. Chairman, to testify, members of the Committee. I look very much forward to the questions.

[The prepared statement of Secretary McDonough appears on page 47 of the Appendix.]

Chairman TESTER. Thank you for your testimony, Secretary McDonough. I will cede my time to Senator Hassan.

**SENATOR MARGARET WOOD HASSAN**

Senator HASSAN. Thank you, very much, Mr. Chair. And thanks to you and the Ranking Member for this hearing.

And Mr. Secretary, thank you for being here and please extend my thanks to everybody who works at the VA, critical work for people we all care about deeply.

I want to start with a question about mental health access. Many veterans suffer from mental health crises and the VA needs to provide appropriate and time sensitive care. The VA has taken important steps, such as a nationwide crisis line that helps connect veterans with the care that they need. However, there are still problems with providing timely access to timely mental health care.

According to the VA's website, the current wait time for a new patient to get a mental health appointment at the VA Medical Center in Manchester, New Hampshire is 22 days. This delay in accessing care can put veterans at unnecessary risk and discourage them from seeking help in the future. What is the VA doing to lower mental health wait times and ensure that veterans get the quality care that they need as soon as possible?

Secretary MCDONOUGH. Thanks very much, Senator.

Keep in mind that the wait times on the website, which we updated in July with your help, do not include emergent or emergency care. So importantly, things like the Veteran Crisis Line, things like walk-in service at the vet centers, and even walk-in service at our CBOCs or health care centers including VA Medical Centers, means that especially during the pendency of the pandemic, have met or exceeded the two-day requirement that we seek, for example, for emergency care for Medicare.

Senator HASSAN. Okay.

Secretary MCDONOUGH. So we are meeting emergency care and urgent care requirements, one.

Two, it is true that first-time patients have a harder and longer time getting into care. There is a certain degree of that that is logic, meaning your first visit to your provider in any system is going to be more and extra paperwork.

Senator HASSAN. Right.

Secretary MCDONOUGH. So the fact is then that once you are an established patient, you have a rapport and a relationship with your provider, those subsequent appointments are much easier.

Senator HASSAN. Right.

Secretary MCDONOUGH. But the third thing is we, as I said in my opening testimony, suffer from something that the rest of the health care industry suffers from, which is a shortage of mental health care providers.

So we are increasing our ability to smooth out the providers we have in the country. So through telehealth we can get a psychologist with extra time in his allotment to provide care by telehealth into New Hampshire or into rural areas. So national clinical resource hubs are critically important, telehealth generally, and then training of additional providers.

Lastly, we published on Monday of this week, grant support to community providers and community organizations made possible by this Committee, each of you, that allow us to support organizations in local communities—including in New Hampshire—where

they know their veterans best, so they can provide care and support to those vets.

Senator HASSAN. Well, I appreciate that. And I think the thing that I would like to follow up with you and your team on is the statistics about emergent appointments versus less urgent appointments. I think in the mental health space, that can be a particularly hard judgment to make, for the veteran in particular.

Secretary MCDONOUGH. Correct.

Senator HASSAN. So it would be good if we could speed up these times for first visits, just making sure that people know that when they reach out with a mental health challenge they can see somebody quickly, is going to be really important.

Secretary MCDONOUGH. Yes.

Senator HASSAN. So I would look forward to following up with you on that.

In the remaining time I have, let me turn to the Solid Start Act.

Secretary MCDONOUGH. Yes.

Senator HASSAN. The Senate recently passed my bipartisan bill that strengthens the Solid Start Program through which, as you know, the VA contacts every veteran after they leave active duty to help connect them to the VA programs and benefits.

Solid Start supports newly separated veterans who are less likely to know of and use the VA benefits that they have earned. Do you support codifying the Solid Start Program to ensure that the VA and Congress continue to support this valuable program?

Secretary MCDONOUGH. We support your bill, yes.

Senator HASSAN. Thank you.

And how does the VA use feedback that it gathers from the Solid Start Program to better allocate resources and provide newly separated veterans with timely health care.

Secretary MCDONOUGH. It gives us an opportunity to get a relationship with those vets and obviously the feedback loop for us is we identify where vets are and therefore where we need additional resources to provide care.

And most importantly, it gives vets a better understanding of what is available to them.

Senator HASSAN. Well, I thank you for your support of the bill and look forward to working with you on it.

Thank you again, Mr. Chairman.

Secretary MCDONOUGH. I think I missed the two most important points in reaction to your first question.

One, if you are the best determiner of whether you are in an urgent or an emergency situation is the veterans himself or herself.

Senator HASSAN. Yes.

Secretary MCDONOUGH. And so I urge any veteran or family member who feels they are in an emergency situation to dial 988, press 1, and we will get them seen that day through the Veteran Crisis Line. One.

Two, as I did in my opening comments, I commit to doing a better job on reducing those wait times. I think we are making progress but let nobody mistake me for saying that we are doing enough. We will continue to do better on this.

Senator HASSAN. I appreciate that and just a quick comment. Every veteran I talk to in New Hampshire, this is their number

one concern for themselves and/or for their peers. I look forward to continuing to work with you on it.

Thank you.

Secretary MCDONOUGH. Great, thank you.

Chairman TESTER. Senator Moran for his opening statement, and then we will go to Senator Tuberville.

#### **OPENING STATEMENT OF SENATOR MORAN**

Senator MORAN. Chairman, thank you.

I was trying to cast the second vote to make this more convenient for you, but I failed. The first vote is still ongoing.

Mr. Secretary, I am sorry I missed what you had to say.

I thank the Chairman for this hearing today and I thank the witnesses for being with us. This is a topic I care a lot about, as are the topics of almost all of our hearings. But we have been fully engaged in the Mission Act and the timing of this determination is important to me because I think it is important to veterans.

The Veterans Health Administration role is to make certain that service-disabled veterans receive world-class health care in a timely fashion. In most cases, that care is going to be delivered, is delivered by the Department of Veterans Affairs in VA facilities, by VA health care providers.

The Mission Act allows enrolled veterans the choice to receive care from community network providers when (1) they are or their doctors think it is in their best interest; (2) the VA does not provide the service or does not provide it in insufficient quality; or (3) when a veteran would have to wait a long time or travel too far to receive care at a VA facility.

World-class health care, whether it is in the VA facility or from a community network provider means nothing if a veteran cannot have access to timely care. Measuring that access and the number of days it takes to get a veteran into that care is essential for the VHA to meet its mission, for veterans to know when they qualify for health care outside the VA, and ultimately is the way that our country meets its obligations to veterans.

How the VA measures the number of days it takes is an important component to meeting our obligations and it must be done in a transparent way that takes each step into account, from the veteran calling their provider to the scheduler entering the appointment, to the veteran showing up at the VA facility to actually receive the care.

The VA's decision to change how it reports average wait times by using a different start date than the one used for measuring wait times for community care eligibility is concerning and leads to confusion and was not the intent of the Mission Act. It is also a way for the VA to mislead on the average wait time it takes for a veteran to see a doctor. This is unacceptable.

My view is that a wait time begins when a veteran requests care from the VA, not at any later point. I anticipate hearing from our witnesses today on how the VA is measuring these wait times. Perhaps there is something the Secretary or others will say to dissuade me of my concerns, but it seems to me to be very straightforward. Wait time is when you call and ask for an appointment, you complain to the person on the phone saying "these are my

symptoms and I need to see a doctor.” That is when the time should begin. And I hope that turns out to be the case.

Mr. Secretary, thank you for your presence today and I will save my questions until others have had a chance to ask.

Chairman TESTER. Senator Tuberville.

#### SENATOR TOMMY TUBERVILLE

Senator TUBERVILLE. Thank you, Mr. Chairman. Thank you, Mr. Secretary, for being here today and your hard work.

Those are great numbers, by the way, that you read off earlier. That is encouraging. We have got a lot of people in my State that need help but are getting help. So thank you for that and I hope they continue.

As you know, many veterans suffer from sleep apnea due to medical conditions they manage as a result of their service. CPAP machines used to aid veterans’ sleep apnea have been in short supply since the pandemic—I think you know that—due to chip shortage and a global recall on CPAPs.

I understand there are some devices that are available that do not require a chip and could be available to veterans today. We are having a huge problem in our State.

Would you consider it an ethical violation of the VA if the VA provider was not provided the CPAP if they knew it was available? And have you heard any problems with this?

Secretary MCDONOUGH. I have heard a lot of frustration, especially with the recall and the complications that that is creating for us. I have heard personally from a lot of vets and then obviously I am getting updates on a regular basis on this.

So as to the question of an ethical concern, I am not sure I understand the question precisely, but—

Senator TUBERVILLE. Well, some of these do not need chips. And we do have available devices that are available that are—

Secretary MCDONOUGH. Let me take and get that. I will be happy to talk to your or your team afterwards and we will make sure we dig into that. If there is a clinically proven available option, then we will do it.

Senator TUBERVILLE. Thank you, thank you.

On an unrelated topic of this hearing, I want to bring this up. I want to take a minute to let you know I am strongly opposed to the recent interim final rule that permits the VA to provide abortion services in every State, even in those States who have prohibited abortion.

For nearly two weeks now the VA has authorized medical facilities to provide abortion services to enrolled veterans and certain dependants. At this time, do you know, has a VA medical facility performed an abortion since this has started in the last two weeks? Do you know if there has been one?

Secretary MCDONOUGH. I am told that there has been one, yes.

Senator TUBERVILLE. The interim final rule is silent on abortion restrictions after a certain point in pregnancy. Does the VA have a plan on the abortion procedures up until the birth of a child? How long do we go on this? What is the rules and limitations that you know of?

Secretary MCDONOUGH. Thanks for the question, very much.



This is obviously an issue that we came to based on one very simple principle which is the health and safety of our veteran patients, of our pregnant veteran patients. We have created an exception to the exclusion of providing either abortion counseling or abortion services in four cases: rape, incest, the life of the veteran, or the health of the veteran.

Those, it is spelled out in the interim final rule, how we will come to those conclusions. As it relates to the health of the mother, of the veteran, that will be determined in consultation with the veteran's health care provider.

Senator TUBERVILLE. How many are you considering, with all of your facts and figures, how many abortions do you think we will have in the first year? Is there any number that we came up with?

Secretary MCDONOUGH. You know, I think the regular—as we prepared the regulation, I think we had to make some estimates for what that would result in terms of budget. I do not have that at my fingertips.

My own view, we provide health care to 300,000 women veterans of child-bearing age. My hope is that no one would ever have to face the health or life-threatening, let alone rape or incest, results to have this service. But because of the importance of ensuring the health and safety of those veteran patients, we have determined that we needed to do this.

Senator TUBERVILLE. Do we have the proper equipment, that you know of, in all facilities to perform abortions?

Secretary MCDONOUGH. We are going through those training steps now and making sure that—obviously, these are all things that we could not do prior to the interim final rule because it was prohibited. So we are going through those steps now.

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

Secretary MCDONOUGH. Thank you, Coach.

Senator MORAN [presiding]. Senator Hirono, I am told that Senator Brown was here first but you have a scheduling conflict and the Chairman told me to recognize you and Senator Brown has been reasonably polite.

Senator BROWN. Reasonably.

#### **SENATOR MAZIE HIRONO**

Senator HIRONO. Thank you very much, Senator Brown, and thank you, Mr. Chairman.

I would like to follow up on the issue of your interim final rule. The Supreme Court's decision in overturning Roe has created fear and chaos throughout the country, including for the 300,000 or so female veterans you just mentioned of child-bearing age. Many of them live in States where abortion is no longer available.

So the VA's decision to provide abortion services in the instances of rape, incest, and the life or health of the mother will save lives. There is absolutely no question that this interim rule will save lives.

This is something that I called on the VA to do, to come up with this interim rule.

So the Alabama Attorney General has already said that he will prosecute any provider, anybody who provides these services. And

I would expect other Republican attorneys general in the States where abortion is not provided to follow suit.

Mr. Secretary, what legal protections do Federal employees of VA have under the interim final rule?

Secretary MCDONOUGH. Thank you for the question, Senator. I just reiterate the principle that led us to take this step is veteran patient safety. We take that very, very seriously. Every health decision we make flows from that principle.

As it relates to your specific question, VA requested and has received now, just in the last couple of hours, an opinion from the Justice Department's Office of Legal Counsel concluding that VA's interim final rule on access to reproductive health services is a lawful exercise of VA's authority.

The OLC opinion further concludes that States may not impose criminal or civil liability on VA employees, including doctors, nurses, administrative staff who provide or facilitate abortions or related services in a manner authorized by Federal law, including the IFR.

As that opinion, I am told, explains the Supremacy Clause of the U.S. Constitution bars State officials from penalizing VA employees from performing their Federal functions whether through criminal prosecution, license revocation proceedings, or civil litigation.

So I think this OLC opinion makes very clear the protections that are afforded VA providers.

Senator HIRONO. That is good to hear because there is no question, as I mentioned, that the Supreme Court's decision has created a lot of fear among doctors, and the professionals—doctors, nurses, and others—as to what kind of reproductive services they can provide. And it is really important that as far as the VA is concerned, in terms of their legal posture, that they are able to provide these kinds of services without being dragged into court by State attorneys general.

Thank you very much for your—I really appreciate the VA, in the context of this environment of chaos and fear as a result of the Roe decision, that you have stepped forward to provide these services for the hundreds of thousands of veterans who are of child-bearing age.

I also appreciate your comments about the Department's plans to focus on challenges veterans are facing in different parts of the country, including Hawaii. Hawaii's unique geography creates significant challenges for veterans when it comes to accessing care through both the VA and in the community, especially given Hawaii's current shortage of health care workers.

So veterans living in a more rural community, neighbor island veterans, not those living on Oahu, still sometimes have to wait months to get treated in the community on the island in which they live when traveling to a VA facility on Oahu, for example, could significant reduce their wait times.

If a veteran referred to community care can be treated much sooner at a VA facility, does the Department provide reimbursement for travel to get such treatment?

Secretary MCDONOUGH. We do have beneficiary travel. This is an issue of particular importance, I know, to you in your State, to Senator Moran in his, Senator Tester in his, Senator Rounds in his,

given those big geographic expanses. The rules on that are governed by established practice and, in some cases, statute.

But yes, we do provide reimbursement for travel. Not in every case, but in many cases.

Senator HIRONO. So are these individual case-by-case determinations? Because I would think that if there is an emergency then it is more likely that you would pay for such travel. But if it is not an emergency but let us say it is to alleviate pain, would that be considered reimbursable travel?

Secretary MCDONOUGH. I think what would be useful, and I know Senator Sullivan in particular on this question of emergent transportation reimbursement is also obviously—given the situation similar to yours geographically.

We have certain authorities now, emergency authorities, that allow us to cover certain emergency proceedings and procedures related to the fact of the pandemic. When those emergency authorities go away, we will have to look at those and establish that.

But as it relates—rather than me trying to go through the individual aegis here, I know we will be spending some time together and we will figure out—

Senator HIRONO. I appreciate that very much.

Secretary MCDONOUGH. We will be happy to dig into those questions with you.

Senator HIRONO. By the way, Mr. Chairman, I am really glad that—thank you for agreeing to let the Secretary come to Hawaii, but it is not just because we have a lovely State, because when the Secretary comes he will be working every moment. He will not be lying around in the sun, right?

Secretary MCDONOUGH. I arrive in the morning and I leave in the afternoon, I am told.

Senator MORAN. I am only curious at what season the Secretary is visiting.

Senator HIRONO. Well, he is coming. We are glad.

Thank you.

Senator MORAN. Senator Rounds.

#### SENATOR MIKE ROUNDS

Senator ROUNDS. Thank you, Mr. Chairman.

Secretary McDonough, first of all, let me begin by saying thank you for the amount of time that you have taken to work on the challenges we found at the Sioux Falls VA facility. I can tell you that there have been improvements there, but your interest in helping the veterans there was greatly appreciated and noticed. And my team there has made it very clear that they appreciated the opportunity to participate with you in those meetings.

I hope you found it interesting and perhaps—

Secretary MCDONOUGH. Very much so. Very much so.

Senator ROUNDS. The challenges that are there, you helped to alleviate some of them.

I would like to share with you, and as you know, I have had real concerns about the implementation of care in the community, in part because I really do not believe that the VA, by itself, has the resources to take care of all of the needs of all of our veterans, and in some cases the needs of the veterans would be better served

closer to home, using the physician of their choice, or in some cases simply because the VA does not have all the resources necessary on a timely basis to meet that.

What I would like to share with you, with regard to care in the community, from one of my team members who has been working with veterans since you were there, this is his message, and I think it is self-explanatory, but then we can kind of discuss where we go from here.

“In the past six months, care in the community at the Sioux Falls VA has hired approximately seven additional employees to assist in the call center. This solved the problem of call wait times and call drops. Now veterans wait only minutes or seconds to have their calls answered, a huge improvement over the one-hour-plus wait times many had been experiencing.

“But this seems to be where the process comes to another halt. The call center verifies the veteran’s demographics and notes the veteran’s preference for care providers. After this has been accomplished, the veteran will be transferred to a scheduler in order to schedule that appointment with an in-network provider of their choice.

“In many cases, if not the majority of cases, there is not a scheduler available to take that next step to schedule the appointment. When that happens, the veteran is told that his or her preference for care is listed and that he or she will be contacted by a scheduler when they are available. Currently it can take up to two months for the veteran to receive a callback to schedule that appointment, unless it is an urgent or STAT situation.

“The issue of timely and appropriate care has not been resolved, and the actual scheduling wait times have not improved and are simply not acceptable. The veteran is not receiving the same standard of care as civilians in the community.”

And based upon that message, I guess what I am asking is, I recognize that you are trying to work through the issues within the VA to get a clear and concise measurement, but the bottom line is care in the community should be available, and right now it appears there is still a huge amount of pressure within the VA itself to keep as many veterans as possible within the VA system, and that even if their preference is to go to the care in the community program they are really being restricted. And I am just curious, are you finding that still to be the case within the VA?

Secretary MCDONOUGH. Yes. Senator, thanks very much, and I was thrilled to be in Sioux Falls. I really appreciated the time there. Your team was great, and I am glad to hear there is some progress.

What I hear when I listen to what you are reading there is I hear, one, the waiting two months to get a call back from a scheduler is unacceptable, one. Two is we submitted in a report last Friday, I said in my opening comments, that these periods during which we spend as much time talking to ourselves about scheduling a veteran in the community as it actually ends up taking to schedule the appointment in the community is not acceptable. And so we are working through what we call our work flows on that, and we will get those right.

Third, what I also hear in there is—well, I could be wrong. Your team knows it better than anything—but there is still a shortage of people, the MSAs, we call them, the schedulers. This is one of the hardest jobs to fill right now in the system. It has to do with wage grade and a lot of other things. But that is part of the issue, which brings me to the fourth thing to respond to your question.

I do not think anybody—look, the good news is that the IG is looking at this too. You and I have had a back-and-forth on the Referral Coordination Initiative. They are looking at that, and we will see what they come back with, and I am eager to find out what they come back with.

Are there individuals who are refusing to move people into the community? Maybe. That is not what I experience. But let me just say this, because the evidence I have on this, I was with Rob McDivitt last week in Des Moines. He told me fiscal year 2018 he spent, in VISN 23, we spent, on you all's behalf, \$700 million in care in the community. This year, fiscal year 2022, which ends in two weeks, VISN 22 will spend \$1.3 billion.

Senator ROUNDS. Mr. Secretary, I think that points out the veterans really do want to use care in the community, and I think your message, in your opening statement, your written statement, that the use of VA direct care is growing, but use of community care is growing faster. Third, the growing use of VA care is not uniform across the country. It is clear. I think in rural areas, where it is closer to home, you may very well find out that the care in the community is perhaps growing faster. I just simply want to point out, long term—

Secretary MCDONOUGH. I think that is fair, and I think that is probably a good thing.

Senator ROUNDS [continuing]. We should focus on what the veteran wants, and if I could—and I am over time—if there is any possibility that once a veteran has been cleared rather than having the VA schedule it, why not give them an authorization, tell them who the providers are that are accepted, and allow that veteran to access their provider directly, and save that whole 30 to 60 additional days?

Secretary MCDONOUGH. So we have a couple of pilots where we are testing different scheduling options, and we will be happy to brief you on those.

Senator ROUNDS. Thank you. Thank you very much, and thank you, Mr. Chairman.

Senator MORAN. Senator Brown.

#### **SENATOR SHERROD BROWN**

Senator BROWN. Thank you, Senator Moran. I echo Chair Tester's opening statements about your accessibility and your reasonableness and your responsiveness, and thank you both for what you have done for all of us and what you have done for veterans in Ohio.

Before I turn to the hearing topic I want to reiterate my concerns. We have talked about it before and I want to do it publicly, about the Oracle-Cerner electronic health record. Your team in Columbus is doing amazing work. I have been there. I have talked to them.

Yet the concerns keep mounting and employees are stretched thin. You know all that. We need to find answers to the pharmacy and scheduling concerns in the system. Latency issues all could affect patient safety and veteran satisfaction. I implore you and Deputy Remy and the whole team to stop the rollout until all the concerns are addressed.

Secretary MCDONOUGH. I know you and Dr. Elnahal had a good conversation after he was in Columbus. I think he was shocked to find the challenges there to be even starker than he had feared, notwithstanding the conversations that we have had with you and others on the ground.

Deputy Secretary Remy said again this morning, in the Appropriations Committee, that we are committed to not moving forward until we have clarity on the deployment checklist and confidence that this is not going to negatively impact veteran safety. And so we will stay on top of that. But the frustration I hear from you, that we Shereef heard directly from the providers when he was in Columbus two Fridays ago, we are very worried.

Senator BROWN. We will continue this.

In the congressionally mandated report released on Friday, VA said if the balance of care provided in the community continues on its current upward trajectory we anticipate that certain VA medical facilities, particularly those in rural areas, including one you visited in Ohio, may not be able to sustain sufficient workload to operate at the current capacity. Obviously, that includes the PACT Act.

Joy Ilem highlighted that concern in her testimony, and I appreciate that, and I have done a number, as many on this Committee have, I have personally a number of roundtables with veterans in all parts of the State, and so has Anna, Andrew, and my staff. We must focus on strengthening VA and attracting medical and administrative personnel especially to rural parts, to care for our veterans. Section 901 of the PACT Act requires a national rural recruitment and hiring plan.

I urge you to consult with local VSOs and community stakeholders and union representatives, local veterans, and those who support them, who provide valuable insight into how to best address that. Will you ensure—just a simple yes, I think, will be fine—will you ensure that rural voices are heard during this process and commit to regular updating us?

Secretary MCDONOUGH. Simply yes.

Senator BROWN. Thank you. Increasing staff in rural areas will help bring down wait times within VA. We know that.

My last question, Mr. Chair, a consistent refrain at veterans roundtables we hear about is VA doctors. Veterans will often say—and you know this, and I want particularly people on the other side of the aisle to hear this—“VA doctors understand me in a way that community doctors do not.” “VA doctors understand me,” veterans tell me all the time, “in ways that community doctors do not. They know what I am going through. They know how to provide me with the care I need.”

That is what I hear. I think that is what you hear. Veterans rely on VA for consistent care by well-trained professionals. Many of the providers are veterans themselves. Getting that care in the community is much less likely. And this is especially true with respect to

mental health. I think we are going to hear that more and more as patients come in through the PACT Act.

When this Committee drafted the MISSION Act, Senator Blumenthal and I worked with the veterans community, specifically DAV, to draft Section 133. It stipulates that VA establish competency standards for community care clinicians treating PTSD, MST, and TBI. I want to again emphasize how important that is, as there are people on this Committee that want to privatize far too many VA services. Senator Sanders, when he was chair, fought back against that, as Senator Tester has. A lot of us have.

My question about this is what steps are you taking to ensure community care providers meet the same rigorous training that VA clinicians receive?

Secretary MCDONOUGH. Yes, well thank you very much. We obviously have the quality standards that we also have to meet. We reported on those earlier this summer. So we have not only the access standards but the quality standards, and we take those very seriously and we report to you on those. That is one step we take.

Second is you have given us additional authorities and training requirements to make sure that we are training the network providers, to ensure that they have best available data and best available practice as it relates to interacting with vets, that they are providing culturally competent care.

And third is, this is not anecdotal, right. I mean, we have had study after study, I referenced several in my opening statement, that show vets in our care do better in terms of outcomes, and that is a real driving force for us. There are times when we do not have the care, when it takes too long, that we obviously facilitate that care in the community.

The thing we really need from our community providers is their help, as the CBO reported last October, their help in making this care much more integrated, by getting those records back to us, by working with us in a more coordinated fashion so that our providers, who do know vets best, can help integrate that care.

Chairman TESTER [presiding]. Senator Boozman, I want to thank Senator Boozman for the great hearing this morning on electronic health records.

#### **SENATOR JOHN BOOZMAN**

Senator BOOZMAN. We did have a really good hearing this morning. Thank you for participating and being such a big part of it. Your team did a great job, Mr. Secretary. I get my dates—we are so busy running around here that I thought the hearing was—I had forgotten that the hearing was today. I told them that if you got hurt in the ballgame tonight it was not an excuse for you not showing up tomorrow, but here you are this afternoon. Good luck. When I see the Capitol Police I tell them to be nice to you and not to hurt you too bad.

Secretary MCDONOUGH. I appreciate that very much.

Senator BOOZMAN. That is good.

I want to talk to you about, you know, scheduling, because it really is a real consideration. As you know, we had an incident in Fayetteville, and that was really more of a leadership problem than

a scheduling problem, but it was a scheduling problem too. We had a veteran that developed cancer, recommended to have surgery. That was in March. There were two or three referrals back and forth. Again, it was just a total mess and did not wind up getting the surgery until September 29th, which was not good, okay, and everybody agrees it was not good and just a complete failure.

But the problem is we have not had a head of the hospital for 18 months, and it really does make a difference. The staff in Fayetteville does a very, very good job. They are very talented. As I talk to veterans they are very pleased with everything that goes on. This, to me, it is a leadership problem. So what I need is for you to work hard to get us somebody on board, somebody good.

The other part of that is I know that these are big jobs, and when you compare the job there compared to what they do in the private sector there is no comparison pay. I mean, they do it because they are called to do this, and we have got to deal with that. But regardless, I would like for you to commit to helping us out there.

And the other thing, too, is to put in place, to make sure that this same thing does not happen someplace else with this system, within the safeguard that if somebody is not getting scheduled. It is one thing to not be scheduled for an elective procedure or something like that, but something like this, that truly is a life-and-death situation, we have got to have the safeguards in place where it just simply cannot happen.

Secretary MCDONOUGH. Senator, I agree 100 percent, one. Two, my heart breaks for that veteran's family and for his loved ones.

I talked, just this afternoon, and talked to her last night and talked to her again this afternoon, with Skye McDougall, who is our network director. I know she is in touch with your team on a regular basis. She also briefed all the legislative staff in and around the Fayetteville region last week about two changes we have made. One is daily administrative review of cases, weekly clinical review of these cases, and then—three changes—regular discussions with those veterans who are awaiting those procedures. This, I think, is going to end up being a best practice, so we will keep working that across the system.

But you are also right that it is a leadership challenge. Skye McDougall briefed your team last week that she had narrowed the director job down to two people. She told me a couple of hours ago that she has made a selection for who that person will be, the permanent director of Fayetteville. We now have to run through some traps in OPM and otherwise, but I will stay on top of that and make sure that gets done.

Senator BOOZMAN. Very good. We appreciate that very much.

One thing, in order to solve a problem you really have to understand it, and I know that there has been some problems with calculating wait time calculations. The IG was critical of how we were doing that. I would like for you to comment on that. But again, that is so important, not to be critical but if we do not know exactly what the wait times are, you know, how do you deal with it?

The other thing, and I know it is a problem because I am out and about as much as anybody, as are the rest of the Committee here, but we hear that from so many people. One of the problems



that we have got, and VA needs to help us with this, is that the VA compensation is based on Medicare. Medicare is scheduled to get a 4 percent cut this year. You know, every year for the last few years we are dealing with this, and as a result it is really difficult.

I have been in offices of friends where they are on the phone. You know, these are very respected people in the community. They are in the private sector and they need to find somebody that will accept a new Medicare patient because they are starting to limit there.

So it all goes together and it is something that we have got to work on, as a whole. Can you comment on that real quickly before the Chairman gavel me down?

Secretary MCDONOUGH. I know how tough he is.

Two things. One is I hear you on reimbursement rates, and I will obviously take and work that. I do want to say that I am proud of the fact that we have made great improvements over the course of the last 18 months on timeliness of our payment. That does not mean that there are not Arkansas doctors who—

Senator BOOZMAN. I agree, and I am not really hearing that like I used to.

Secretary MCDONOUGH. So we are working on timeliness. We will work on rate of reimbursement. So I hear you on that.

On the time, this has been a burr in our collective saddle since I got in this job. We updated the website, which average time across the whole system, which we want to make more usable for veterans so that it is more representative of their experience. Individual determinations of eligibility are going to continue to be made on a case-by-case basis. But we want to get the most accurate, illustrative data available to veterans through the website. We did that in consultation with the IG, the GAO, with your staffs, with VSOs. It is not perfect but it is getting better.

And I guess I would just say this, one proof point, which is uniformly the numbers went up on the wait times. So again, in response to an earlier question, if we are trying to stop community care we are doing a bad job, and if we are trying to hide wait times we are doing a bad job, because our updated website just made them look longer, not shorter.

So I have no interest in hiding the facts from you. Most importantly, I have no interest in hiding the facts from the vets. We will continue to work with your teams on this. If there is a better way to do this with the data, we are all ears. It is a nettlesome problem. It is not impossible. But the bottom line is let us also not mistake the averages on the website for the individual referrals and the individual eligibility determinations, which will continue to be made on a case-by-case basis.

Senator BOOZMAN. Thank you very much. Good luck tonight.

Secretary MCDONOUGH. Thank you.

Chairman TESTER. Senator Sanders.

#### **SENATOR BERNARD SANDERS**

Senator SANDERS. Thank you, Mr. Chairman, and my apologies, Mr. Secretary, for missing your opening remarks. I will read them. And thanks very much for coming to Vermont. I hope you enjoyed your day there.

Throughout the pandemic VA has been offering more and more telehealth appointments, and my understanding is that veterans feel pretty good about that. However, these appointments do not count toward VA access standards, which is what we are discussing today. Clearly if a veteran is able to receive the care they need via telehealth there is no reason that should not count toward VA meeting those requirements. My understanding, Mr. Secretary, is you have the authority to make this change. Will you commit to implement this regulatory change by the end of the year?

Secretary MCDONOUGH. I want to be careful on how I say this because I am told by the lawyers that the verbs I use here are really important. I intend to carefully consider and propose such a change, and I will make sure that we work with everybody on this Committee to make sure that they have an opportunity to comment on it and that the public has an opportunity to comment on it.

Senator SANDERS. Do I hear you saying, though, you intend to go forward to make this change?

Secretary MCDONOUGH. I intend to propose a change.

Senator SANDERS. You intend to propose.

Secretary MCDONOUGH. Right.

Senator SANDERS. All right. I am not a lawyer. I do not know exactly what that means.

Secretary MCDONOUGH. As I said in my opening statement, we are providing more and more care by telehealth. A lot of vets like it. Some do not. We want to be able to update the access standards in this way. We are going to do it consistent with the law and consistent with getting good public input on it, which, by the way is not—well, so, that is surely my intention.

Senator SANDERS. Okay. In a VA report on access to care issued last Friday, VA stated, I quote, “VA should allow both telehealth and in-person care to satisfy the wait time standard for VA access to care,” end quote. It went on to say, quote, “Only when VA cannot meet demand to include using telehealth should it use community providers,” end quote.

How are you prioritizing in-house care over private sector care?

Secretary MCDONOUGH. Well, the bottom line, as I have said now a couple of different times, is we believe, and studies show, that vets in the direct care system do better. And so as a general matter, you know, Senator Rounds said it earlier that 33 million have completed appointments in 2021, speaks to veteran demand, partially. They also speak to provider vacancy. They also speak to aging facilities. They also speak to, as you and I have discussed, to stringent eligibility priority groupings. They also speak to limited access in rural areas.

And so by using the authorities you have given us in the PACT Act to hire and to keep professionals, by using the authority you gave us to get these 31 new leases done, we are continuing to make VA the most attractive option. But there are going to be places where a veteran wants to choose otherwise, and telehealth is a good example of that. If a vet says, “You know what? I prefer to wait an extra six weeks to get direct care in the direct care system, in person, rather than get telehealth,” well, we are going to make that happen.

Senator SANDERS. That makes sense.

All right. Let me ask you a question, and I do not know if you have the information on this. You know, a lot of the debate, there is a lot of agreement in this Committee, and there is some disagreement. It is my view that the private health care system in this country is the most expensive in the entire world, that the outcomes are not necessarily all that great compared to other countries.

Do you have numbers—and I know it is hard to come up with this stuff, but everything being equal, the same procedure being done within the VA as opposed to being done in the private sector, which is more expensive? My assumption is the private sector health care is more expensive. Is that correct or not?

Secretary MCDONOUGH. We have a section in the congressionally mandated report on this issue. I have had a back-and-forth extended with Senator Moran on this question. I think that when you take into account all of the requirements that VA meets in terms of the provision of care, I think that we are very, very competitive. But I will be more than happy to give you—

Senator SANDERS. But do we have anything more than just—look, the United States—

Secretary MCDONOUGH. We do. We do, but I do not—

Senator SANDERS [continuing]. The United States spends twice as much as almost any other country on health care. One would assume that if we do not have a UnitedHealth making, I would assume, billions of dollars administering the program, and all the other things that take place in the private sector, VA would provide less expensive health care. But do we have numbers on that, or is that just an assumption?

Secretary MCDONOUGH. I think it is an assumption, one, but I also know that there are numbers on this, and I would be happy to get you those. I just do not have them at my fingertips.

Senator SANDERS. Okay. When we talk about, you know, sometimes people think, well, it takes me a while to get into the VA but gee, I just get on the phone and I go into the community health care and in five minutes I have an appointment with a doctor. Clearly that is not the case. Do we have any information as to how long it takes veterans to get an appointment in the private sector?

Secretary MCDONOUGH. It is very difficult to get that information because nobody else maintains information like that. And so we have tried that. We have had this ongoing back-and-forth with the Chairman, with the Ranking Member, on this question, to try to get some apples-to-apples so that veterans are best informed. But it is hard enough for us to do that with the data in our own system. We have not yet figured out how to do that in the private system.

Senator SANDERS. All right. I believe that when we spend health care dollars they should go to doctors and medicine and the provision of health care, not to bureaucracy. As I understand it, and correct me if I am wrong, UnitedHealth is the major administrator in getting veterans to community health care. Is that correct?

Secretary MCDONOUGH. We have two—

Senator SANDERS. Two, right. Optum is the other one.

Secretary MCDONOUGH. Yes, Optum and TriWest. Optum is related to UnitedHealthcare—third-party administrator.

Senator SANDERS. How much do we spend—

Senator SULLIVAN. Are we going to have a debate on health care or are we going to go to the other Senators?

Senator SANDERS. Let me just finish up.

Senator SULLIVAN. We are going kind of long.

Senator SANDERS. No, we are not. This is not any longer than other people have gone.

Just a question. Do we know how much money we spend to those two companies in administering health care?

Secretary MCDONOUGH. It is knowable. I do not have it with me.

Senator SANDERS. Could you get me that as well?

Secretary MCDONOUGH. Yes.

Senator SANDERS. Okay. Thank you.

Chairman TESTER. Senator Sullivan.

Senator SULLIVAN. Mr. Chairman, I am going to pass my time right now to Senator Blackburn.

#### SENATOR MARSHA BLACKBURN

Senator BLACKBURN. Thank you, Mr. Chairman, and thank you to Senator Sullivan for this, and thanks for coming back to us. We appreciate.

Secretary MCDONOUGH. Thank you for having me.

Senator BLACKBURN. You know, one of the things that Senator Tuberville and I have worked on is legislation we have introduced with a three-year pilot program that would allow veterans to go directly into facilities in their community and really kind of take the referral process from VA out of this. It is frustrating to people. There are so many frustrations with how the VA is working and running the Community Care Program.

And in June you indicated to us that the VA might propose changes to the current access standards, because Community Care was costing too much. And in your recent report, which was late, about three months late—

Secretary MCDONOUGH. Yes, ma'am.

Senator BLACKBURN [continuing]. You stated that you would not propose immediate changes to the current access standards. So that is good, but however, what concerns me is that you go on to state that you are planning to incorporate VA telehealth into the access standard eligibility criteria. And the concern is this might be a way that the VA would manipulate the numbers and prevent veterans from seeking care outside the VA.

So if a veteran wants an in-person visit but the VA can provide a telehealth visit within the wait time eligibility category, will that veteran be allowed access to an in-person visit in the community?

Secretary MCDONOUGH. Yes, thanks, Senator. I am not aware of anybody who wants to manipulate the data or obfuscate anything. When we make a proposal on the inclusion of telehealth we will make sure that we do this with plenty of time and transparency for public comment, obviously from you, from veterans in Tennessee, from veterans across the country, and we will obviously carefully consider those.

Senator BLACKBURN. Telehealth can be a wonderful tool, but we do have veterans that prefer—

Secretary MCDONOUGH. Definitely.

Senator BLACKBURN [continuing]. An in-person.

Secretary MCDONOUGH. Definitely.

Senator BLACKBURN. So that is of concern.

Let us talk about the PACT Act because we are very concerned about that. Now one of the questions that has come to us is veterans have been receiving treatment from a provider in community care, outside the VA. Will the VA force that veteran to then come into the VA to receive care if they are covered in that PACT Act addition, or are they going to allow them to stay with the provider where they have established that relationship?

Secretary MCDONOUGH. There is nothing in the PACT Act that would force any changes in existing referrals and existing relationships with doctors.

Senator BLACKBURN. Okay.

Secretary MCDONOUGH. I am not sure I understand the question precisely, but—

Senator BLACKBURN. Well, we have got some veterans who have chosen community care and they are there, but they are also going to be given additional services because of the PACT Act. And what they are wanting to do is stay with what they have.

Let me ask you something.

Secretary MCDONOUGH. Well, they would obviously continue to work that out with their primary care provider and the VA, and they would work that through their referral process and their relationship with their doc.

Senator BLACKBURN. Let us talk about wait times because why has the VA chosen not to calculate wait times based on the date of request as required by the Veterans Community Care Program regulation?

Secretary MCDONOUGH. We have not made that choice, so I am not sure what you are referring to.

Senator BLACKBURN. Okay. Well, you all are—

Secretary MCDONOUGH. For new patient appointments with a referral the average wait time is calculated starting when the consult is entered by the provider to the date that the appointment is completed.

Senator BLACKBURN. Okay. All right.

Secretary MCDONOUGH. For a new patient without a referral, the average wait time starts with the earliest recorded date in the process of receiving care.

Senator BLACKBURN. Okay.

Secretary MCDONOUGH. For established patients, the calculation is made from the moment that that veteran, with his provider, determine, hey, I would like to have you come back in six months, or I would like to have you come back in three months.

So that is the way we do it. I think you might be referring to the way the calculations were made on the website, which I have committed to the Senator from Kansas the first time I appeared here, I would change, because that happened before I got here.

So if that is what you are referring to, that has changed as of July.

Senator BLACKBURN. As of July. Okay. Thank you, and I will submit one to you for the record.

Secretary MCDONOUGH. Thank you very much.

Senator BLACKBURN. Thank you.

Chairman TESTER. Thank you. Senator Blumenthal.

**SENATOR RICHARD BLUMENTHAL**

Senator BLUMENTHAL. Thanks, Mr. Chairman. Thanks for having the hearing, and thank you for being here, Mr. Secretary, and your impressive work on all of these issues—

Secretary MCDONOUGH. Thanks.

Senator BLUMENTHAL [continuing]. At the VA. I would just like to join your comments at the outset of your testimony on the performance of the VA staff, employees, docs, nurses. As you said, they have deferred time off as well as retirement, out of their sense of dedication. This has been an extraordinarily demanding time as I have seen in Connecticut, but it has also brought forth the very best in the VA health care system. They have performed with tremendous courage and skill and strength, so thank you.

In that connection, is the VA continuing to provide vaccinations and boosters to veterans who want them—

Secretary MCDONOUGH. Yep.

Senator BLUMENTHAL [continuing]. And I hope encouraging them to seek them.

Secretary MCDONOUGH. Yes, and encouraging vets, so when they come in to get both the bivalent, the new, updated vaccine, along with flu, while we are very worried about flu this season. So yes, we are doing that.

Senator BLUMENTHAL. And the VA folks themselves, are they getting boosters?

Secretary MCDONOUGH. Yes. Yes. So same thing, that we continue to offer boosters, including the new bivalent, updated booster to the workforce.

Senator BLUMENTHAL. On the PACT Act, thank you to you for your support for it. Obviously, the champions, Senator Tester, deserves a ton of credit, along with Senator Moran, and I have been proud to help in that effort.

I am concerned about getting the word out, telling veterans about the availability of this care, the changes in policy. As much as we like to think that the world is riveted on what we do in this building, there are a lot of folks who, frankly, do not know about it. And I am concerned that they may not be availing themselves of the care that they could get.

So I have been doing the best I can to hold meetings and forums around the State of Connecticut, but obviously that is a limited effort. I wonder if the VA has planned outreach in that regard.

Secretary MCDONOUGH. We do. Importantly, I think you all, in the PACT Act, gave us additional authority and additional funding to increase communications around the PACT Act.

I agree with you, by the way. I think applications or claims filed are up about 20 percent since the President signed the bill into law.

Senator BLUMENTHAL. That is great news.

Secretary MCDONOUGH. That is good news, but I had kind of hoped it might even be higher. So we are trying to ascertain whether there is any confusion about the PACT Act and the claims process. We are constantly looking at that.

We are also working right now with the appropriators to get clearance on the \$500 million toxic exposure fund to allow us to begin the effort on implementing this act. That is a fund expressly for toxic exposure and not for anything else. So we are working to make sure that the appropriators understand our plan on that. That will then unlock the comm's effort.

Importantly, I hope our veterans understand that the effective date of August 10, 2022, which is the date the President signed the bill into law, that is the effective date for all 23 conditions in the bill, but vets have to file within the first year to make that effective date available to them. So we are really urging them to file so that they get that August 10, 2022, effective date, meaning that benefits paid out will be paid out starting that date.

Senator BLUMENTHAL. That is very important, very important. And likewise, on Agent Orange, the coverage of hypertension—  
Secretary MCDONOUGH. Correct.

Senator BLUMENTHAL [continuing]. That is the effective date as well.

Secretary MCDONOUGH. Exactly. So Agent Orange does not wait until fiscal year 2027, which was an option under the law. The President urged us to move that up to August 10, 2022, which we have now done. So the Agent Orange-exposed Vietnam vets now suffering from hypertension should also make their claims filed.

Senator BLUMENTHAL. I am just about out of time, you will be happy to know, because my next questions were going to be about the New Haven hospital. But I will follow up, if it is okay with you.

Secretary MCDONOUGH. I know we are going to spend time there together here in the next couple months, so I am looking forward to that.

Senator BLUMENTHAL. Great. Thank you very much, Mr. Secretary.

Chairman TESTER. Senator Moran has not asked his questions yet, and since he has got a commitment here we are going to go to Senator Moran.

Secretary MCDONOUGH. Is that commitment still that there will be easy questions?

Senator MORAN. You handle them all so adeptly, Secretary.

I walked in from voting as you were concluding your answers to Senator Blackburn, and I wanted to follow up a bit because it is the second topic at least that you were talking about then that I am interested in.

The website has said this. "Measuring wait times from the date the appointment was requested until the date the appointment is completed is the most accurate measure for veterans because it is the actual average number of days veterans have waited for an appointment," end quote.

The answer that I heard is we have changed our words on our website to reflect what we now do, which makes sense. You would want to say what you do. But I do not understand the justification for not using what I have to think is the common meaning of "wait time."

If I call the doctor and I want an appointment, my wait time starts from the moment I ask the receptionist to schedule me an

appointment, not the moment that the decision is made, well, we will schedule Jerry for August 31st.

Secretary MCDONOUGH. Yes.

Senator MORAN. And this is a bit in response to Senator Rounds' questions. A reason that I worry about this is for the same reason he suggested he is worried. I worry that there is a bias. I lived with this with Choice, which there is a bias against Community Care. And so every time you do something, the VA does something, it sends me another message that I am worried. We were so intentful in the MISSION language to try to overcome the capabilities of the Department of Veterans Affairs to undo Community Care. And so you get me on these questions because I see them as an effort to undermine the plan.

Secretary MCDONOUGH. And look, that comes through, and it has come through in every one of our interactions in this room and every one of our interactions on the phone and every one of our interactions in person, and I get that. And I will keep arguing that nobody is trying to limit a veteran's access to best available care.

I will tell you, my view is I want all the vets we can keep in the system to stay in the system, but that is not my call.

But let me just say the following. Let me just give you one data point, which was in my opening statement. In 2021, 33 million completed appointments in the Community Care system. That is a big number. Now, you are automatically thinking of, yes, well, relative to what, and all that stuff, and I get that. But this is a function of a lot of things, not just veteran preference, although veteran preference is one of them. We do not have enough nurses and docs. We have talked about this in both of your States. We have pent-up demand for care, so we cannot schedule appointments because we still have a lot of care that is getting worked. We do not have enough MSAs, which is exactly what Senator Rounds talked about.

So let me just give you three examples of how we calculate wait times and make sure that we are talking about the same thing, at least.

New patient appointments with a referral, the average wait time is calculated starting when the consult is entered by the provider to the date that the appointment is completed. This calculation is new on the website, and the starting point now includes a date that is earlier than previously measured. Okay? The date that the provider puts the referral into the system to the date that the care is provided.

For new patient appointments without a referral, that average wait time starts with the earliest recorded date in the process of receiving care, usually the date that the scheduler talks to the veteran.

Senator MORAN. The scheduler is not the first point of contact with the veteran. Is that true?

Secretary MCDONOUGH. No, because we do not have a referral, right?

Senator MORAN. Right.

Secretary MCDONOUGH. So that is the second calculation. This did not change between the old system developed by the team before I got there and our new system, because it is really hard for us to figure out when else to press start on the gun.



Senator MORAN. And is there no ability, Mr. Secretary, to press start on the gun when the veteran asks for an appointment, walks in the door——

Secretary MCDONOUGH. I asked the same question——

Senator MORAN [continuing]. Sends an email.

Secretary MCDONOUGH [continuing]. Yes, I asked the same question today and I have asked the same question each time after I talk to you, and we are looking for that, and where we can establish that we use it. But oftentimes the clearest indication of the start, without a referral, is that moment.

Senator MORAN. Let me see if I can summarize. You will be pleased to know that I have to leave here before I get a chance to continue this conversation. But let me sum up what I think you are telling me is, in your view, there is no or little bias against Community Care. We are not trying to game the system by the point in which we determine “wait times.” It is only that we do not have the data. We do not have the information when someone calls, walks in the door, or sends an email saying, “I need help from the VA.” Is that a summary of what you are telling me?

Secretary MCDONOUGH. That is a summary of what I am telling you. I would add to the summary the following. We are also constantly looking at how we measure this. You know, we spent 18 months to get this update in July. We will keep updating it. We update it with new data every day, and we will keep doing that.

But I also want to not mistake the average wait time on the website, which is meant to explain to the veteran, here is what you should expect, generally speaking. Let us not mistake that from the individual determination as to whether that veteran qualifies for the referral. He works that out with his provider.

And so the third thing I would say is the IG is looking at this, which I am really glad about. I want everybody to look at this because I am not like the world’s most effective manager, but if I am trying to stop guys from going into the community and we have set a new record the last two years for completed appointments in the community, then I am really a bad manager.

Senator MORAN. I will conclude. I just would highlight I do not want there to be false information provided to Congress to the veteran——

Secretary MCDONOUGH. You and me both.

Senator MORAN [continuing]. For either the setting in Community Care or the wait times for an appointment or a procedure at the VA. They are the same to me.

Secretary MCDONOUGH. Yes.

Senator MORAN. And I just want to be able to compare those wait times, and I certainly do not want the wait time to be shortened as a method by which it reduces the availability of the usage of Community Care. I want there to be a fair understanding of the facts, and the shot being not based upon——this just seems so out of character. A beginning point time is when I ask for an appointment, and we cannot get there, and it must be the VA does not have the——at least that is what you are telling me is the VA does not have the capability to do what I think is just the straightforward way of answering this question.

Secretary MCDONOUGH. I wish I had a better answer for you than that, but that is the answer. And if somebody has a better way for us to do that then I am all ears.

Senator MORAN. We will be calling the Inspector General.  
Chairman TESTER. Senator Sullivan.

#### SENATOR DAN SULLIVAN

Senator SULLIVAN. Thank you, Mr. Chairman, and I know Senator Moran has to leave, but maybe a quick follow-up. I do not want to see bias in Community Care either. Congress passed the MISSION Act to increase access to community care where wait times were too long.

There was a recent article. I would like you to comment. Maybe Senator Moran wants to hear this too, that the VA recently removed the MISSION Act website and is redirecting veterans toward a page called "Choose VA."

Mr. Chairman, I would like to submit this for the record.

Chairman TESTER. Without objection.

[The article submitted by Senator Sullivan appears on page 89 of the Appendix.]

Senator SULLIVAN. "Biden's VA undermining the law that gives veterans access to private health." So is that true, and then why did you do it, if it is true? And we are doing wait times and everything—that seems like blatant bias if you did that. So is that true, and why did you do it?

Secretary MCDONOUGH. We have an Office of Integrated Veteran Care now, so veterans—

Senator SULLIVAN. But you removed MISSION Act, which talks about Community Care, completely off your website, and now it just says "Choose VA." That is the replacement? What is that? Maybe it is not true. Maybe the Fox News—

Secretary MCDONOUGH. Should I answer the question or not?

Senator SULLIVAN. Yes, try to answer it.

Secretary MCDONOUGH. We have an Office of Integrated Veteran Care. It used to be we had an Office of Community Care and an Office of Access to Care, where we would force veterans to decide which one they should choose. You know what I want them to have? Access to care, timely access to world-class care, so they should go to one office. And it used to be that people on your side of the aisle—

Senator SULLIVAN. No, no. Do not do "your side of the aisle." I am getting ready to ask you some questions on your side of the aisle. You know, look, I used to be a big fan of yours. The way you worked the PACT Act stuff, you are starting to become partisan, and this agency should not be partisan.

Secretary MCDONOUGH. We just—

Senator SULLIVAN. And I have been on this Committee way longer than you have. I have been focused on veterans' issues way longer than you have, and I do not want "your side of the aisle" stuff. That is not the way this Committee works. You started doing that during the PACT Act, your CNN appearance, your misinformation about the Toomey Amendment. You need to tone it down, Mr. Secretary. That is not going to help veterans.

So take the “your side of the aisle” back. We all want care for our veterans.

Secretary MCDONOUGH. I take it back.

Senator SULLIVAN. And I have enjoyed working with you, but you are the one who is starting to get partisan, and I am not appreciating it.

Secretary MCDONOUGH. I take it back. We are trying to reduce the overhead of having two offices that provide the same service, which is access to care. So rather than make vets have to choose which of those offices they go to, we have been working for the last 18 months on a plan that was put in place by the clinicians before I arrived at VA to have one place that those decisions are made.

And we have been talking to you guys about this since I arrived on the job, and we will continue to talk to you about it.

Senator SULLIVAN. Well, if there is oversight on this Committee, which you are seeing it—we all care about our veterans. My State has got more veterans per capita than any State in the country, and if certain members are starting to think that there is a bias with regard to Community Care, which was a bipartisan bill on the MISSION Act, I think you need to listen to it.

Secretary MCDONOUGH. I am listening to you and that is why I am coming to your State. That is why I am spending time on this question. That is why I am here today. That is why I will continue to listen to you.

Senator SULLIVAN. Okay. Let me turn to—I was going to go into all the details of the PACT Act, the Toomey Amendment, but I just think your statement on CNN after you and I talked over the weekend, I tried to connect you with Senator Toomey so we could have a good, bipartisan understanding, and the fact that you went on national TV and said this is an artificial cap on spending, on veterans, it is risk rationing care.

Look, I can submit a million things for the record. That just was not accurate, and I do not think it was helpful. It was more partisan talking points from the White House. I think you are better than that. I have appreciated working with you on that. So just take that as a point. At least one Senator that was not impressed, and to be honest, was disappointed.

Let me turn to one final issue. I just met with a recent group of Alaska Natives. They mentioned that the Native American Direct Loan Program, which is about Native veteran housing, there has been no Alaska Native who has qualified for a loan since the program started in 1992.

Now, this relates to the issues of trust land, but the point of the program is to get Native American veterans help on housing through the VA, and my constituents, for almost 40 years, having gotten one loan. They are some of the most patriotic Americans. The GAO came out, as you probably know, with a report saying, hey, this is wrong. You cannot exclude Alaska Natives from a really important program.

So can I get your commitment to work with me, like the GAO said, to fix this? There is nobody on this Committee that wants to discriminate against an entire set of Native Americans who, by the way, Alaska Natives and Lower 48 Indians serve at higher rates in the military than any other ethnic group in the country. This

might be an oversight, but we need to fix this. My Alaska Native veterans do not need to be treated like this. Can I get your commitment on that, Mr. Secretary?

Secretary MCDONOUGH. You have my commitment on this. I have worked closely with Senator Rounds on this.

Senator SULLIVAN. No, I am aware of what you are working on.

Secretary MCDONOUGH. Yes. I am frustrated to hear that. He has had the same experience, and obviously South Dakota has a major Native population. You know, it is in the ones, the numbers of mortgages that we have gotten done through this program. So yes, it is something that we can do much, much better.

Senator SULLIVAN. Thank you. Thank you, Mr. Chairman.

Chairman TESTER. Senator Cassidy.

#### SENATOR BILL CASSIDY

Senator CASSIDY. Hello, Mr. Secretary.

Secretary MCDONOUGH. Senator.

Senator CASSIDY. Mr. Secretary, I will also echo some disappointments. When we first met I expressed to you how, in previous administrations, not of presidents but of secretaries, it had been very difficult to have transparency with the VA, and you assured me that was not going to be the case under your watch. And as a physician I have, you know, at least a little bit of an ability to look at productivity numbers to get a sense of what those productivity numbers are. I just know how a well-run clinic goes.

So my staff requested information regarding veterans health care in the Community Care center, and we were told to submit a Freedom of Information Act. This is Congress. This is the VA Committee, which is supposed to be providing oversight, and we were told to submit a FOIA.

It kind of took things to a new level because I once told you of an episode where we had requested something and we got it six months later and it was off point. We requested it and it came back six months later and it was off point. And it was just a rope-a-dope in terms of getting this information. That actually looks good relative to being asked to get a FOIA. I do not know how to say that is such disrespect for the institution of Congress.

Secretary MCDONOUGH. I will take it and I will dig into it.

Senator CASSIDY. It just blows my mind. And I am sorry to be so frustrated, but I am representing people, and when those people feel as if the VA is doing nothing but hiding, it is not me. It is the people I represent, the veterans I represent, who are really being offended.

So just to say that. And if we could have a point person that we could contact, and that is accountable to you, and I can call you up and say, "Denis, we had a great meeting, man. What is going on?" and you could ride herd over this person—because I suspect you did not know about this. But it is being made by somebody who does not want to give us information.

So if we could have that, and your staff could relate to Christian—raise your hand, man—then I would appreciate that sort of workarround on something which is wrong.

Secretary MCDONOUGH. Fair enough.

Senator CASSIDY. Secondly, kind of related to the same. On April 12th, our office sent a letter to you regarding the ineffectiveness of the VA's Opioid Safety Initiative and asked what barriers Congress should remove in order to better public-private partnerships to increase veterans' access to testing and treatment. There was an August 21 report in Washington Post, which kind of motivated this, which showed that after the introduction of the Opioid Safety Initiative suicides among veterans in rural areas increased by 75 percent and increased in the urban area by 30 percent.

We have not heard back from a letter that we sent on April 12th about a program which the Washington Post is reporting was at least associated, temporally—we do not know causally—with a 75 percent increase in veteran suicide in rural areas. I do not know. Any comment?

Secretary MCDONOUGH. No. I will get to the bottom of it.

Senator CASSIDY. Okay. And again, I am sorry to seem as agitated as Senator Sullivan, but you can imagine when I come to my staff and I say, hey, man, I am all excited about this. We put something together, worked really hard on it, we send it off, and we have a FOIA request.

The next issue is—and again, I have always enjoyed our interactions so I am sorry for the unpleasantness of this. Again, I am a physician, and I know there are certain productivity measures. They are just a way a well-functioning outfit should work. It is my concern that in some places that there are a lot of folks employed but not as many patients being seen. Frankly, I think there are some facilities the VA would choose to close because of lack of adequate patient volume. I actually see that as important and you have my support, depending on where it is.

But the point being is that we should expect a certain amount of patients seen per provider in order to just have a well-functioning clinic, even to keep up clinical skills.

This is the GAO report, and I am sure you are familiar with it, reported in 2017, that VA did not maintain an accurate count of physicians providing care in the VA, hindering the ability to ensure the appropriate number of the clinical workforce—I would say the appropriate number of people being seen per physician—and also lacked data on the number of contract physicians providing care in the VA because its personnel databases and workforce planning tools did not include contractors.

Now I do not know how many contractors you are, but contractors are a pretty important part. Have you all corrected that? Because one thing I want to know is patient volume per provider. And so has that been updated, and what is going on?

Secretary MCDONOUGH. It sounds like a—I heard you say 2017, the GAO report. Is that right? So I assume it has been updated, but let me take and find that out. But what we do is we track average daily census in our facilities, which obviously helps us make sure that we are tracking, most importantly, patient safety, which is obviously derivative of whether our docs, our nurses, our specialists are getting adequate rounds, adequate time on target. And so I would be happy to work through that with you.

But I assuming, from a 2017 GAO report, we have done that, but let me take that.

Senator CASSIDY. Well, I will finish by saying the reason I asked is one thing we have asked for is datasets so that we can actually look at this data ourselves, and, of course, we have not heard back. But on the other hand, if what we are receiving does not take into account contractors it would unfairly portray. And I am absolutely not doing this to go after the VA. I am doing this to gain understanding. But if I have to be aware of the limitations of the data, which we would hope to receive before we do that.

Secretary MCDONOUGH. Okay.

Senator CASSIDY. So if they could have that codicil or that addendum to that, I would appreciate it.

Secretary MCDONOUGH. Got it.

Senator CASSIDY. Thank you.

Chairman TESTER. Thank you, Senator Cassidy. Before I go to Senator Sinema I just want to say that I would be just as frustrated as you with a FOIA request back. I would hope that, because I have done this with everybody from Wilkie to this Secretary, that if there was something that came up like that you guys could get hold of them immediately and say, "Hey, this is unacceptable."

I do not know what the rules around FOIA are, but I get your point, and when we ask questions we need to get answers.

Senator Sinema.

#### **SENATOR KYRSTEN SINEMA**

Senator SINEMA. Thank you, Mr. Chairman, and thank you to Ranking Member Moran for holding this hearing.

Wait times are of particular concern to me, given the Phoenix VA's history, as you are aware, Secretary. Veterans in Arizona and around the Nation deserve access to timely care without a loss of quality. But with more veterans entering the VA health care system every day we need to ensure we have a plan in place to take care of them. No one should slip through the system and no one should be left behind. You and I have spoken about this numerous times, and thanks again for being here today. I appreciate it.

So Secretary McDonough, during the COVID-19 pandemic the use of telehealth increased nationwide. What lessons did we learn that we could use from that timeframe to improve both the quality and accessibility of health care and decrease wait times for veterans?

Secretary MCDONOUGH. Yes. Let me say two things. One is that I was recently in Boise, Idaho, where I visited the Clinical Resource Hub. What we do in Clinical Resource Hubs, which we have within VISNs, so within your VISN, within your region in Arizona, but then we also have across the country, allows us to smooth out providers. We have a lot of providers in different places. We have too few in other places.

So by using these Clinical Resource Hubs we can connect providers to veterans who are not getting timely access, irrespective of where they are.

I have told the story before about meeting a veteran in Kansas who was getting coverage from a psychiatrist in New York City. In Boise, that Clinical Resource Hub is giving coverage to veterans throughout that VISN, so into the Upper Northwest. That is a real-

ly important capability we have, and we find that veterans—not every veteran but a lot of veterans—have really appreciated it. That is point one.

Point two. That requires us to be able to, for example, prescribe controlled substances across borders. So one thing that we are really worried about is when the national emergency related to the pandemic ends, whenever that may be, the emergency authority our clinicians now have to prescribe across State lines goes away. So we need some statutory relief there, because this ability to provide care through Clinical Resource Hubs into lightly populated areas where we have a lot of vets but we do not have enough providers, that prescribing authority goes away with the pandemic national emergency.

So those are two things, the good and the bad, that are lessons learned from this experience, that I hope we can get you guys' help. We have been talking with the Committee now on this for a while, in the House and the Senate, so I think we are just about there. But that is something that we could use as a very clear lesson learned from the pandemic, that I would like to see continue apace here, because it gets to this big question of access, wait times, and then the full suite of care, including, where necessary, pharmaceutical prescriptions.

Senator SINEMA. I appreciate that answer. Mr. Chair, I just want to say that I would be more than happy to work on this issue. In particular the ability to have psychiatrists prescribe psychotropic medication for veterans who live in underserved areas where they cannot get access to the mental health services they need in a physical setting would be very important. So I would be very interested in helping solve that issue.

I know that in Arizona, for sure, we have got veterans who sometimes have trouble getting access to timely care for the mental health services they need, and of course, a loss or an interruption of psychotropic medication can be deadly for veterans.

Secretary MCDONOUGH. Deadly. Yes.

Senator SINEMA. Thank you. So my next question, Secretary, is I have heard that Community Care referrals to rural areas may not be able to sustain the anticipated trajectory of need as it increases upwards. What do you feel is the most important aspect to focus on to alleviate this issue and ensure timely access to quality care?

Secretary MCDONOUGH. I think two things. One is we have to use the authorities that you have given us in the PACT Act to hire and keep the clinicians that we have, and hire the clinicians that we need. But that is in the direct care system, so that is the first thing we have to do.

The second thing we have to do is really focus on network adequacy. And this is where I have had this conversation with folks in this room, including with Senator Moran. We are a better payer now in the Community Care networks than we have been. I am proud of that fact. We should now expect better performance from our third-party administrators too on maintaining a healthy, high-quality network, so that we are not in a position, in certain rural areas, where we do not have access to high-quality providers.

So this is a rub for us, but this is highly doable, and we are surely investing enough in the Community Care Program to make that happen.

Senator SINEMA. Mr. Chair, I see my time has expired. Might I ask one follow-up question?

Chairman TESTER. Yes. Senator Cramer is going to be very patient. Go ahead. Go ahead. Ask one more.

Senator SINEMA. I owe you one, Kevin.

Thank you, Secretary. Telehealth, including ATLAS pods, have been discussed as a potential solution, but we are not seeing high utilization rates at many ATLAS pods—

Secretary MCDONOUGH. We are not.

Senator SINEMA [continuing]. Including the one at Wickenburg, Arizona, which we fought so hard to get.

Secretary MCDONOUGH. I know.

Senator SINEMA. What can be done to improve the ATLAS program so that we are meeting the need and increasing utilization of these pods?

Secretary MCDONOUGH. It is a good question, and, you know, I have had this conversation with other members of the Committee too, and we are talking through our Office of Mental Health with our partners in this program, to see what more we could do. So I do not have a specific brief with me on that but I would be happy to follow up with you on that. I know this is a conversation you and I have been having on the ATLAS program itself. So let me follow up with you and give you a sense of where those conversations are with our partners.

Senator SINEMA. I appreciate that. Thank you, Mr. Chair, and Senator Cramer, thank you for your patience.

Chairman TESTER. Senator Cramer.

#### **SENATOR KEVIN CRAMER**

Senator CRAMER. It is my pleasure to wait. I like to hear.

Thank you, Mr. Secretary, for being here.

Secretary MCDONOUGH. Nice to see you, Senator.

Senator CRAMER. Nice to see you. I am going to highlight a specific situation to illustrate the point, and then hopefully we can have maybe an early discussion of solutions. Let us put it that way.

Secretary MCDONOUGH. Okay.

Senator CRAMER. So I have a staff person who actually is stuck in one of these ruts between the VA and Community Care. Roughly four months ago, she was told that it would take five months to get an appointment for the particular specific service she needed. Of course, obviously, well outside the 28 days to qualify.

Secretary MCDONOUGH. Right.

Senator CRAMER. So in hopes of not having to wait five months, which, by the way, in and of itself is a ridiculous proposition, but believe me, I know the challenges the VA and all of health care is having, pretty much every industry is having these days. So without passing judgment from me on that. She, of course, then sought third-party care, or community care.

She got approval from the VA, of course, to pursue the community care, but what she got caught up in is the authorization system, the movement of information from the VA to the third-party



administrator, back and forth, back and forth, which became very frustrating. As I said, this was four months ago.

And one of the more concerning issues for me is there is this pointing of the finger back and forth between the two entities. We sent it, we did not receive it. We faxed it, we did not get it. We faxed it, we did not get it. Now I suppose they could both be right, but right now I have a staff person who is neither getting the care and at the same time sort of anxious about, where is all my personal health care information that keeps getting faxed?

Now I would like to say this is the only one that I have had to deal with, but I have constituents that have had very similar situations where days turned into weeks, turned into months.

And just sort of listening to what I have listened to today, I am afraid the VA, like every bureaucracy around here, if we do not prescribe, in law, precisely what they have to do, and write into law precisely what they are prohibited from doing, they will do whatever they want to do. And I do not think that is necessarily your fault. In fact, largely I think it is more likely a reaction from the bureaucracy itself as opposed to the leadership, the political leadership itself.

I do not see a lot of incentive for you to be part of any of these problems, but at the same time I have told some people, actually, some of the other politicians in your agency before—I voted for them—I know you mean what you say and I guarantee you, you will find it harder to do than you think. “Oh, no, no. I am going to fight like hell.” No, you are going to, and they are going to win.

So I want to be part of the solution. First of all, I do worry about the personal information going back and forth on a fax machine.

Secretary MCDONOUGH. Yes.

Senator CRAMER. But a lot of us are from rural States. You are hearing a lot of the rural issues. The access issue is particularly relevant to them.

I am thinking out loud with you a little bit here now. Would it be possible that in a State like Montana, Alaska, North Dakota, where we have a lot of critical access hospitals, which are critical access because they are so far from other places, they are hospitals that run on very small margins, have very small populations but they are still necessary, you know, is there a way that we could work on something where at least we could simplify it for those people in those very remote, rural places and maybe just make a critical access hospital an extension of the VA?

I know it has got to be more complicated than that. I tend to simplify complicated things, because I am a simple person, but I just want to find a solution.

Secretary MCDONOUGH. Look, I visited a facility like that with Senator Moran in Kansas, and we do a lot of business in that facility for veterans in Kansas. And so I think there is a way to make this work. So I am open to having that conversation. Maybe it is because I understand your accent, but it seems like something that we could do some work on, one.

Two is I also worry about your staff member, and I am confident, if she is comfortable talking to our Office of Community Care, I am confident we can get that worked out.

Senator CRAMER. I am sure she would be, and I would appreciate that.

Secretary MCDONOUGH. So we will track that down.

Senator CRAMER. Well, I appreciate that and we will follow up on that. And I have had other people that have helped in similar situations, where when I make the inquiry it gets solved. But every time I do that it bothers me because I think of how many people do not know me? You know, most people know me in North Dakota, just like everyone knows Senator Tester in Montana. But there are some people who do not think to call their Senator to get help.

Secretary MCDONOUGH. That is right and you do not want to have to have that special pleading.

Senator CRAMER. That is right. Thank you. Thank you, Mr. Chairman.

Chairman TESTER. Thank you, Senator Cramer.

Look, you have been at this for an hour and 45 minutes. I put my questions in for the record to save the pain, and then you can answer them in a timely manner. But I just want to say thank you very much for being here.

Secretary MCDONOUGH. Thank you.

Chairman TESTER. Thank you for fielding the questions. I will tell you that I think it is important that people are passionate, but I apologize. It kind of got out of control here for a bit.

Secretary MCDONOUGH. I am sure—

Chairman TESTER. No, that is my call. I should have handled it, and I am sorry.

Secretary MCDONOUGH. It is my fault. I will follow up with Senator Sullivan. It was inappropriate what I said.

Chairman TESTER. But thank you. I will release you now, and we will get to our second panel.

Secretary MCDONOUGH. Thank you, Mr. Chairman.

Chairman TESTER. Yes. And, look, one of the problems with being on a second panel after an hour and a half with the Secretary is that everybody burns out and goes home. They will be watching this and reading this verbally. But I do want to introduce the second panel, and I do want to very much thank them for being here.

First, I want to introduce Dr. Carrie Farmer, who is Co-Director of the Epstein Family Veterans Policy Research Institute, which is a mouthful, and Senior Policy Researcher for the RAND Corporation.

Thank you for being here, Carrie.

Joy Ilem, who is no stranger to this Committee, she is National Legislative Director of the Disabled American Veterans.

Welcome back, Joy.

And finally, Darin Selnick, who was Senior Advisor to the Secretary of Veterans Affairs during the Trump administration.

Thank you for being here, Darin.

So, Dr. Farmer, we will go with your testimony, and look, we like you to keep within five minutes but know your whole testimony will be a part of the record.

**PANEL II**

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**STATEMENT OF CARRIE FARMER**

Ms. FARMER. Great. Thank you. Good afternoon, Chairman Tester and members of the Committee that may be listening to this later. Thank you for your invitation to testify today.

I am a senior policy researcher at the nonprofit, nonpartisan RAND Corporation where I co-direct the RAND Epstein Family Veterans Policy Research Institute. I am a health services researcher by training, and my research is focused on military and veteran health care, including health care provided by the U.S. Department of Veterans Affairs.

VA provides health care to nearly 7 million veterans every year, both through care delivered in VA facilities and through the Community Care Program, where care is paid for by VA and delivered by the private sector. Since 2014, over 3 million veterans have used VA Community Care, but whether this has resulted in more timely, high-quality care for veterans is not well understood. There is no single, accepted measure of timely care, nor are there any national standards for how long is too long for a patient to wait for a health care appointment. By and large, no U.S. health care system other than VA publically reports their data on wait times, so making comparisons is difficult.

VA publically reports wait time information at the facility level on its Access to Care website. VA updates this data daily, so any veteran looking for information about care local to them has up-to-date information about how long they should expect to wait for an appointment. Using my own location as an example, I was able to find out that the average wait time for a new mental health care appointment at my closest VA medical center was 34 days, but there was no wait for an appointment at a local VA clinic. This kind of information simply does not exist outside VA.

There is little available data about how VA wait times compare to non-VA wait times, but what does exist suggests that VA's wait times may be comparable or shorter. A study just released last month by Merritt Hawkins examined physician wait times in 15 major metropolitan areas. I estimated average VA wait times in these metropolitan areas using the data from the Access to Care website and compared them to the Merritt Hawkins data. I found that in many parts of the country and for some types of care veterans may face a shorter wait time for care from VA than an average person getting care from the private sector.

Data also suggests that veterans have shorter wait times for care from a VA facility than from Community Care. Though VA provides detailed information on how long veterans should expect to wait for an appointment at a VA facility, VA does not publically report wait times for VA Community Care.

In a recent analysis, VA researchers examined referrals for new patient appointments for VA-delivered care and VA Community Care. The analysis included over 22 million appointments for primary care, mental health care, and specialty care. For each type of care, wait times for VA-delivered care were shorter than VA

Community Care, and these findings persisted in different parts of the country.

It is critical that discussions about veterans' access to care always consider care quality. An appointment available tomorrow that provides poor care could be worse than waiting for good care. As prior RAND research has demonstrated, VA typically provides care that is equal to, or better than, the private sector. While VA tracks and reports on dozens of quality measures and makes much of these data publically available, equivalent data are not available for VA Community Care. VA does not publically report or, to my knowledge, assess quality measures for VA Community Care.

Better data about the timeliness and quality of VA Community Care is needed. I have three recommendations for how Congress and VA could improve available data.

First, VA should publically report average wait times for VA Community Care appointments using the same data and methodology used to report average wait times for VA-delivered care.

Second, VA should make use of existing data to systematically monitor and publically report the quality of community care. For example, VA could use community care claims-type data to construct quality measures for veterans receiving care in the community.

Third, the third-party administrators responsible for managing the Community Care network routinely collect information about network providers that is not shared with VA because it is not required by contract. VA should explore contract changes that would facilitate additional information sharing and new data collection about network providers and the quality of care they provide.

In conclusion, concerns about veterans' access to timely, high-quality care have been longstanding. To truly improve veterans' care, however, additional data and analysis on the timeliness and quality of VA Community Care and how that compares to VA-delivered care are required.

Thank you for inviting me to speak with you today on this important topic, and I look forward to any questions you may have.

[The prepared statement of Ms. Farmer appears on page 54 of the Appendix.]

Chairman TESTER. Thank you for your testimony.  
Joy?

#### **STATEMENT OF JOY ILEM**

Ms. ILEM. Thank you, Chairman Tester. I am pleased to be here this afternoon on behalf of DAV to present our testimony on VA health care wait times, access standards, and ways to improve the quality of care veterans receive.

Assuring timely access to high-quality, veteran-focused medical care has been, and will remain, a top priority for DAV and our members. However, any discussion of timeliness must be linked directly to the quality of that care because timely access to low-quality care is no more acceptable than delayed access to high-quality care.

While access to community care to meeting the needs of our Nation's ill and injured veterans, one consequence of VA's current ac-

cess standards is an increased shift of veterans and funding from VA to community providers. According to a recent RAND report, since 2014, the number of veterans authorized to receive community care and the cost to provide that care has doubled.

VA's recent report on access to care standards noted, "If the balance of care provided in the community continues on its current upward trajectory, certain VA medical facilities, particularly those in rural areas, may not be able to sustain a sufficient workload to operate in their current capacity."

VA also warned of a potential for this spiral effect in some areas where workload and talent are shifting externally and, thus, threaten to harm VA's training, research, and emergency preparedness missions.

Mr. Chairman, maintaining a comprehensive system of care for service-disabled veterans is essential, and new research confirms that VA health care outperforms the private sector for quality, cost, and timeliness. The Journal of the American Medical Association, or JAMA, just published a study which found that VA wait times were lower than community care providers for primary care, mental health, and specialty care.

Importantly, according to the JAMA study, areas with high wait times for community care are not expected to benefit from liberalized access and, instead, suggested it would take more creative policies "such as physician relocation incentives, telehealth, or mobile deployment units," to expand access and reduce wait times for veterans in underserved areas. This is critical in rural areas, particularly those with longer wait times—with longer VA wait times, such as VISN 15, which includes Kansas. VA and Congress must work with the Office of Rural Health on developing unique solutions for these areas.

In terms of cost, RAND found indications community care may be more expensive than VHA-delivered care and that VHA-delivered care costs less than comparable care from Medicaid providers and produced better outcomes.

Research also continues to confirm that the quality of care provided by VA is equal to, or better than, the private sector. One reason for that, RAND reported, was VA clinicians are well versed in veteran culture and the conditions that are prevalent among veterans and only a small portion of community providers ever complete training offered by VA.

Mr. Chairman, to improve timeliness and quality, DAV recommends that VA continue a full continuum of care in as many locations as possible and remain the primary provider and coordinator of veterans care. Community care providers must meet the same quality, competency, and training requirements as VA providers. VA must develop a scheduling system that shows real-time available appointments in both the VA and community as well as comparable timeliness and quality metrics, and VA needs to increase funding and develop innovative models to expand access for rural veterans.

Mr. Chairman, VA has struggled for decades to expand its capacity to meet the ever rising demand for care, often resulting in these excess wait times for veterans. While the use of wait time standards to allow veterans to use community care can help address

some of the access problems, research indicates that the best way to reduce wait times is by investing in the VA system that millions choose and rely on.

With its world-class, evidenced care, cutting-edge research, medical education, national emergency roles, VA is an irreplaceable system that we must continue to strengthen and sustain for our ill and injured veterans now and in the future.

Mr. Chairman, that concludes my statement, and I am happy to answer any questions you may have.

[The prepared statement of Ms. Ilem appears on page 67 of the Appendix.]

Chairman TESTER. Thank you for your statement.  
Darin?

#### **STATEMENT OF DARIN SELNICK**

Mr. SELNICK. Chairman Tester, I appreciate the opportunity to testify in today's hearing on addressing health care wait times at the Department of Veterans Affairs and in the community. My testimony today reflects my own personal expertise as former Senior Advisor to both VA Secretaries Shulkin and Wilkie and as Veterans Affairs Advisor at the White House Domestic Policy Council.

The VA facility wait times are inaccurate and misleading and can lead to delayed care for veterans, causing negative health consequences or even death as happened in the Phoenix VA Medical scandal in 2014. The VA MISSION Act was a promise that this would never happen again, but that promise is being broken.

First, VA announced in October '21, they were decommissioning and closing the Office of Community Care. Plus, VA shut down the MISSION Act website, making it harder for veterans to access information regarding their health care options and community care eligibility.

Last June, the VA Secretary implied that he wanted to roll back VA access standards. He said demand for health care has increased more intensely for care in the community than for care in the direct system and told Senators, "My hunch is that we should change access standards."

Why would VA want to restrict community care? The answer came from Acting Deputy Under Secretary for Health LaPuz in his HVAC testimony: If care provided in the community continues on its current upward trajectory, certain VA medical facilities may not be able to sustain sufficient workload to operate in their current capacity.

VA's problems with providing accurate wait times came to light with the AFP Foundation FOIA documents. Key findings included, one, denying community care referrals based on clinical appropriateness, two, waiving wait time access standards without veterans' consent, three, overriding providers and veterans on deciding "best medical interest," four, using "patient indicated date" to misrepresent wait times, and five, neglecting to advise veterans of their community care eligibility.

The problem with VA's calculation of average wait times is they do not follow the VCCP regulation, which states, VA cannot sched-

ule an appointment within 20 to 28 days of the date of request, unless a later date has been agreed to by the veteran.

Inaccurate wait times deny veterans their eligibility for community care. This includes a new wait time method submitted to the Federal Register on July 25th which has two main problems.

First, VA is incorrectly dividing veteran patients into new patient and established patient categories and using different types of start dates. All patients should have their wait times calculated the same way to ensure consistent and accurate wait times.

Here are two examples:

Billings, Montana. Mental health. New patient, 76 days. Existing patient, 10 days.

Eisenhower Medical Center, Kansas. Mental health. New patient, 51 days. Existing patient, 14 days.

Second, the start date and end date measures are inaccurate and should not be used as they artificially shorten wait times. Here is why:

Earliest recorded date in the scheduling system to the date it is scheduled to occur. There is often a delay in recording the date, and a scheduled appointment may be canceled and rescheduled by the VA.

Second, from the date agreed upon between the veteran and provider for future care. Date agreed upon is only to be used for follow-up appointments after it is agreed by the veteran that the date of request does not work.

And, Third Next Available Appointment. The problem with using TNAA is that is a theoretical appointment, not a real appointment with a start and end date.

The correct way to calculate average wait times is to start with the date of request and end with the date the appointment is completed.

For community care wait times, VA is not following the 2019 Community Care policy of processing requests in two business days and, instead, is adding additional steps through the referral coordination initiative. The solution is to go back to following the 2019 policy.

VA's review of access standards. Although VA says it is not changing access standards, it is instead proposing a "Trojan horse," incorporating telehealth availability into determinations regarding eligibility based on the designated access standards. VA rejected this in 2019 because it can be used to game the system and is a way to gut access standards and reduce community care eligibility.

Here are three recommendations to improve VA wait times:

First, pass the GHAPS Act with the existing access standards included. This will provide veterans with a guarantee and certainty on their ability to choose community care when facility wait times are too long.

Second, follow the VCCP regulation for average wait times. Start at date of request and end on the date care is received. VA should withdraw its Federal Register submission on calculation of average wait times.

Third, educate all veterans and staff on the requirements of the MISSION Act and VCCP regulation per Section 121.

In conclusion, as VA goes forward, it must change its culture and become veteran-centric. As General Omar Bradley said, “We are dealing with veterans, not procedures; with their problems, not ours.”

I look forward to working with the Chairman and Ranking Member and all members of this Committee to achieving what is best for veterans. I am happy to answer any questions. Thank you.

[The prepared statement of Mr. Selnick appears on page 75 of the Appendix.]

Chairman TESTER. Thank you for your statement, and I want to thank you all for your statements.

I am going to start with you, Ms. Ilem. You heard my earlier statement on the Department rapidly approaching the point where one-half of all care available in both settings is provided through community care. What is your take on that? Are you concerned by that statistic?

Ms. ILEM. I think it is concerning. You know, I think the Secretary well stated, you know, that we are really seeing this increase in community care, and while veterans may need access to community care, that has always been part of what, you know, VA has provided. You know, they are trying to look at a good balance across the system in terms of, you know, maintaining the ability to provide veterans the best-quality, high-quality, you know, care available. They know that the outcomes are better in VA care. You know, they should be resourced and the vacancies filled and having the ability, to the best of their ability, to provide that care whenever veterans—you know, whenever they can.

And I think I noted in my statement, you know, particularly in rural areas it is a concern, you know, if it is going to be negatively impacted for VA to have the ability to provide that care, especially for service-disabled veterans.

Chairman TESTER. I think in your statement—correct me if I am wrong—you talked about that while timeliness is important quality of care is really important also.

Ms. ILEM. Absolutely.

Chairman TESTER. So in addition to quality of care and timeliness, what are other factors that Congress should be considering when evaluating VA’s versus community health care’s performances?

Ms. ILEM. So I think the virtues of VA health care are its integrated health care system, you know, its focus on the veteran, especially those with service-related disabilities, you know, the special disabilities for blindness, spinal cord injury, mental health services. Having a system that is focused on them, research is focused on them, I think is critical, especially for those veterans who are going to need the system for the long term, for the remainder of their lives, and expect—you know, they are satisfied with that care. They tell us they like that care because the ability of providers to really focus on their needs, spend the time with them that they need. They have complex health conditions that require unique attention.

And while we need access to care in the community when VA cannot provide that care, we do not know as much about the qual-



ity of care. That has been noted several times here today. The research shows, you know, VA is providing good, high-quality care. So their ability to continue to do that in every place that they can is important for service-disabled veterans and to have a system that meets their unique needs for the long run.

Chairman TESTER. Thank you.

Dr. Farmer, you work for the RAND Corporation. I read and listened to your testimony. As you could tell, there is a bit of a scrap here on community care versus VA care. Do you have a dog in this fight?

Ms. FARMER. Absolutely not. We are not affiliated with VA in any way. We are a nonpartisan organization that just believes in the research and the data.

Chairman TESTER. Okay. You hit on a point in your testimony that I think is pretty key, actually, and that is getting down to the information we need to make an honest evaluation. I think the VA is the only medical system in the country that reports wait time, and it does so daily, and it also does it at the facility level.

Your comparison using Merritt Hawkins survey data is the sort of information that veterans should be presented with when they are making choices about where they need to get care or where they should—you know, so it is their choice, so they are making it with reasonable information.

So what should VA keep in mind if it moves forward with comparing in-house and community care timeliness numbers so that veterans would know?

Ms. FARMER. Well, first, there is just not data on the timeliness of community care, so I really encourage VA to identify how that might be possible, to publically report the data in the same way that the data is currently available for care delivered by VA facilities.

I acknowledge that there is nuance to that. It may be difficult in certain parts of the country. The number of visits may not make sense to add together, and so it may have to happen at the VISN level or some—but I do believe there is some way to report this information in a way that can help dispel what I think is a myth, that getting care in the community is going to be faster than getting care from a VA facility.

Chairman TESTER. Okay. Well, look, I just want to thank you all. I want to thank all the witnesses for being here. I appreciate your patience waiting.

This Committee is going to continue to work so that veterans receive quality care in a timely manner.

We will keep the record open for a week, and with that, this hearing is adjourned. Thank you.

[Whereupon, at 5:08 p.m., the Committee was adjourned.]



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**A P P E N D I X**

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## **Prepared Statements**

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**STATEMENT OF THE HONORABLE DENIS MCDONOUGH  
SECRETARY OF VETERANS AFFAIRS  
DEPARTMENT OF VETERANS AFFAIRS (VA)  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
ON VETERANS ACCESS TO CARE**

**SEPTEMBER 21, 2022**

Introduction

Good afternoon, Chairman Tester, Ranking Member Moran and members of the Committee. Thank you for inviting me here today to discuss how VA is responding to what we are hearing from Veterans about accessing the timely, world-class, care they have earned through their service and sacrifices for our country. The Veterans Health Administration's (VHA) approximately 380,000 employees, one third of whom are Veterans, come to work every day with one goal in mind: to serve Veterans, their families, caregivers and survivors as well as they have served our country. The President has called this a sacred obligation with a mission that unites us all. For us, Veterans are our mission.

Our employees prove daily that we will face any challenge and go to any length, including during the worst pandemic in more than 100 years, to ensure Veterans receive the care and services they have earned and deserve. Despite the strain of the pandemic, VA employees worked tirelessly to ensure that Veterans received care, deferring time off and retirement out of their own sense of dedication, and this passion continues today. A recent study in The Lancet Regional Health found that our employees succeeded,<sup>1</sup> and that VA's strategy likely saved Veteran lives. Importantly, we know that some Veterans chose to defer routine care during the pandemic, and we continue to stand ready to help Veterans meet their individual health goals.

Hailing from communities across the Nation, the population of Veterans VA serves is unique with rich diversity, seniority in age, health challenges specific to military service and a high percentage of Veterans choosing to live in rural areas, among other factors. This requires VA to be exceptionally proactive and innovative to ensure meaningful access and outcomes for each Veteran in our care. Furthermore, the population we serve continues to evolve, with record numbers of women Veterans enrolling in VHA health care, and VA's work with Congress on military environmental exposures enables more Veterans to seek care for health concerns incurred during military service. We must cultivate a thriving health care system for current and future generations of Veterans across both direct and community care.

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<sup>1</sup> Available online: <https://www.sciencedirect.com/science/article/pii/S2667193X21000892#bib0011>.

Impact of the VA MISSION Act on the Balance of Care between VA and the Community

Since the Veterans Community Care Program established by the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act) was implemented in June 2019, VA has observed several trends in how Veterans are accessing VA care and the extent to which they rely on it. While this analysis has been challenged due to confounding factors such as the impact of the Coronavirus Disease 2019 pandemic, there are several important takeaways that we have learned since this program was implemented.

Our analysis shows that the VA MISSION Act perpetuated and, in some cases accelerated, trends that have been observed over the last decade. First, while total enrollment has remained relatively stable, Veteran reliance on VA (direct care and community care) overall has been growing. Second, the use of VA direct care is growing, but use of community care is growing faster. Third, the growing use of VA care is not uniform across the country.

To put the growth of community care into perspective, community care accounted for 23% of the total workload, by relative value units (RVUs) of VA care in fiscal year 2018. Three years later, in fiscal year 2021, community care RVUs grew to 35% of the total workload. As RVUs represent a metric most relevant to costs, our community care spending has increased accordingly.

Additionally, when examining the balance of care VA provides as a function of outpatient appointments, VA community care represented approximately 24.8% of total Veteran appointments immediately prior to the implementation of the VA MISSION Act. Thus far in Pandemic Year 3, that figure is 27.9% (Table 1). Additionally, as shown below, 40.2% of all outpatient specialty care appointments provided to Veterans in Pandemic Year 3 are occurring in the community.

*Table 1: Veteran Balance of Care by Outpatient Appointment Type .*

	Direct Care Appointments				Community Care Appointments			
	All	Mental Health	Primary Care	Specialty Care and All Other	All	Mental Health	Primary Care	Specialty Care and All Other
<i>Pre-Mission (Jun 2018 - May 2019)</i>	89,209,415 (75.2%)	19,611,882 (96.1%)	21,496,129 (98.8%)	48,101,404 (62.9%)	29,442,003 (24.8%)	788,731 (3.9%)	255,327 (1.2%)	28,397,945 (37.1%)
<i>Pre-Pandemic (Jun 2019 - Feb 2020)</i>	66,688,731 (73.0%)	14,560,899 (95.1%)	16,319,135 (98.9%)	35,808,580 (60.1%)	24,725,998 (27.0%)	751,785 (4.9%)	188,360 (1.1%)	23,785,853 (39.9%)
<i>Pandemic Year 1 (Mar 2020 - Feb 2021)</i>	76,964,279 (71.5%)	16,052,971 (93.4%)	22,006,014 (98.9%)	38,905,292 (57.0%)	30,706,490 (28.5%)	1,126,561 (6.6%)	241,954 (1.1%)	29,337,975 (43.0%)
<i>Pandemic Year 2 (Mar 2021 - Feb 2022)</i>	85,281,354 (70.6%)	16,113,457 (94.1%)	22,817,396 (99.0%)	46,350,501 (57.5%)	35,463,648 (29.4%)	1,011,810 (5.9%)	219,589 (1.0%)	34,232,249 (42.5%)
<i>Pandemic Year 3 (Mar 2022 - Aug 2022)</i>	41,926,995 (72.1%)	8,196,845 (93.4%)	10,584,500 (99.0%)	23,145,650 (59.8%)	16,261,706 (27.9%)	583,405 (6.6%)	105,927 (1.0%)	15,572,374 (40.2%)

*Note: Table 1 demonstrates appointments delivered. A single Veteran may have multiple appointments of various types in a given year.*



Timeliness Trends after the VA MISSION Act and the Pandemic

It is important to note that the VA MISSION Act provided six eligibility criteria for when covered Veterans can elect to receive care in the community. Included in these criteria are designated access standards established by VA that incorporate average drive times and wait times. We have completed the required triennial access review and continue to evaluate the impact of the designated access standards on Veterans' access to care on an ongoing basis.

With this context in mind, Veterans' access to care is central to our mission and a top priority, whether or not Veterans receive that care in VA or in the community. Current Veteran Outpatient Trust levels are currently 90% nationally; however, we remain focused on initiatives to bolster staffing and recruitment, improve our workflows and technology and strengthen support for our VA clinicians and staff members to ensure we earn each Veteran's trust each day.

Within eight months of implementation of the VA MISSION Act and initial publication of the current, designated access standards, the COVID-19 pandemic took hold. This served as a significant confounder in determining the specific impacts of the VA MISSION Act. Initially, during the first 2 years of the pandemic, Veterans experienced decreased wait times for direct primary care and mental health services beginning in March 2020. This was largely the result of deferred primary and mental health care due to necessary curtailments in VA services to address the pandemic when care was not deemed necessary, Veterans choosing to postpone elective care, and increased use of virtual care options in lieu of in-person care.

Currently, VA is experiencing similar trends to those seen in health care across America, including increasing volumes of appointments due to the return of Veterans who previously delayed or deferred care needs; growing health care demands across the Veteran population; recruitment and retention challenges due to an increasingly competitive job market; and COVID-19's continuing impact on staffing levels as case rates ebb and flow across the United States. As a result of factors such as these, we have seen average wait times grow slightly in our direct care system in the past year.

Table 2: Veteran average wait times for new patient appointments for VA's direct care system.

	Average Wait Times for New Patient Appt in Direct Care (in days)			
	All	Mental Health	Primary Care	Specialty Care and All Other
<i>Pre-Mission (Jun 2018 - May 2019)</i>	23.6	13.2	21.1	24.7
<i>Pre-Pandemic (COVID-19) (Jun 2019 - Feb 2020)</i>	23.8	13.3	19.9	25.0
<i>Pandemic Year 1 (Mar 2020 - Feb 2021)</i>	22.1	11.0	14.0	24.4
<i>Pandemic Year 2 (Mar 2021 - Feb 2022)</i>	24.8	16.2	17.8	26.1
<i>Pandemic Year 3 (Mar 2022 - Aug 2022)</i>	27.9	19.2	23.6	28.9

Table 2 above displays the average wait times for new patient appointments in VA's direct care system over the same time periods as Table 1. Veterans are considered a new patient if they have not been seen by a provider or a clinical service at the same medical center for the same, or a related, health care need in the past 3 years. For new patient appointments with a referral, the referral date is the starting point used for measuring average wait times, and the end point is the date care is received. For new patient appointments without a referral, the average wait time starts with the earliest consistently-recorded date in the process of receiving care (typically the scheduler works with a Veteran to coordinate a future appointment) to the date care is received.

Table 3: Veteran average wait times for new patients for community care.

	Average Wait Times for New Patients in Community Care (in days)			
	All	Mental Health	Primary Care	Specialty Care and All Other
<i>Pre-Mission (Jun 2018 - May 2019)</i>	41.2	41.2	41.0	41.2
<i>Pre-Pandemic (COVID-19) (Jun 2019 - Feb 2020)</i>	39.4	41.7	42.9	39.3
<i>Pandemic Year 1 (Mar 2020 - Feb 2021)</i>	39.9	37.9	46.5	39.8
<i>Pandemic Year 2 (Mar 2021 - Feb 2022)</i>	39.6	42.2	45.2	39.4
<i>Pandemic Year 3 (Mar 2022 - Aug 2022)</i>	36.3	34.2	44.3	36.3

Table 3 above represents the average wait time for new patient referrals in community care. In the data above, the referral date is the starting point used for measuring average wait times, and the end point is the date of the scheduled appointment or the date it is scheduled to occur if not yet completed. When looking at the national average for community care wait times in Table 3, they have improved slightly in recent years.

It is important to note that average wait times for both direct VA care and community care will vary based on the type of care and geographic location. Additionally, due to data limitations, it is not possible to directly compare wait times between VA and community care. The average wait times do not include wait times for facilities that have implemented our new Electronic Health Record (EHR). For sites using the new EHR, VA now has the capability to measure the Third Next Available Appointment (TNAA) in a manner like others in the health care industry.

#### Targeting Access Initiatives to Unique Challenges in the Direct Care and Community Care Systems

VA understands the importance of listening to Veterans and gathering feedback from front-line field staff who engage with Veterans daily, as this information helps refine our access strategy. Local site visits by our Integrated Veteran Care team have shed light on unique, root cause challenges in both the direct care system and for community care. We have identified the longest parts of each process, affording us insights that have directed the efforts of VA's Office of Integrated Veteran Care.

Veterans are scheduled for care faster in the direct care system, but they often wait longer between the date they received their confirmed appointment and their actual appointment date. Our site visits have surfaced a few primary reasons for this: first, Veterans have been catching up on previously deferred or delayed care because of the pandemic, on top of baseline demand. Secondly, staffing challenges have been significant in the context of increased competition in the labor market. Third, we are navigating a competitive health care recruiting environment as well as the need to onboard new hires much more rapidly. Fourth, there is a continual need to ensure that our physical and virtual infrastructure best allows us to meet the access needs of Veterans. All of this has made clear that increasing the accessibility and availability of appointments would be the most impactful actions to improve access in the direct care system.

In addition to increased staffing, we are also focused on optimizing clinical productivity. In the coming months, providers will be expected to utilize 80% of their bookable clinical time with limited exceptions and with standardized appointment lengths for each service to ensure that we are optimizing available clinic time and consistently accommodating as many Veterans as possible.

We have created a roadmap to ensure all necessary steps are taken for successful implementation and are targeting full implementation prior to the end of the

calendar year. VHA directives and guidebooks are being updated to reflect the new standards. Across the system, VHA facilities have started implementing the standards, and preliminary results are promising with improvements in wait times for Veterans in certain areas. It is important to note that clinical work is a team effort and, to fully achieve the promise of this effort, we will need to ensure that we recruit and retain the employees necessary to support our clinicians in meeting these productivity goals.

The ability to expand health care access through telehealth services also continues to be a priority focus for increasing available appointments in the direct care system. Being able to meet specialty care needs through telehealth appointments increases access and availability across VA, especially when VA providers can provide care across State lines. VA is reinvesting in telehealth more broadly to reliably allow providers from across regions, and in some cases, across the country, to offer more appointments to Veterans in any given location.

In contrast to our direct care system, our analyses have revealed that the process for scheduling care in the community is often longer than the duration of time a Veteran waits between receiving a confirmed appointment and the date of their actual appointment. Various workflow, staffing and system challenges make the appointment process challenging for community care staff, including a lack of direct visibility into community care appointment availability. Therefore, we currently have a task force of experts reviewing our scheduling processes to identify opportunities for significant system improvements.

We also continue to closely monitor the performance of our Community Care Network (CCN) and the availability of community providers working with our third-party administrators to build capacity and address gaps. Today, CCN lessons learned from the last few years are being incorporated as we prepare for the next generation of CCN contracts timed for the fall of 2023.

#### Targeting our Access Initiatives Locally, with VISN and National Support

Finally, it is important to note that unique challenges that are specific to certain facilities and regions often account for some of the most significant barriers to access to care. We continue to place a focus on these challenges daily and are using lessons learned as we work to improve access to care across the country. VA remains committed to ensuring that feedback from Veterans and our frontline employees is central to driving improvements and innovations in how we deliver access to care for Veterans. In addition, we remain committed to leveraging the expertise and support at all levels of VA to ensure we are providing the assistance necessary to address Veteran access needs in every part of the country.

#### Conclusion

In conclusion, I want to reiterate how important this forum is for us at VA to not only share the actions we are taking to ensure Veterans have access to the timely,

world-class health care they rightly deserve, but also to listen and learn from each of you here today as partners in our mission. With that in mind, I look forward to answering any questions you or other members of the Committee may have today. Thank you.

## Wait Times for Veterans Scheduling Health Care Appointments

### Challenges with Available Data on the Timeliness and Quality of VA Community Care

Carrie M. Farmer

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Testimony presented before the U.S. Senate Committee on Veterans' Affairs on September 21, 2022



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*Wait Times for Veterans Scheduling Health Care Appointments: Challenges with Available Data on the Timeliness and Quality of VA Community Care*

Testimony of Carrie M. Farmer<sup>1</sup>  
The RAND Corporation<sup>2</sup>

Before the Committee on Veterans' Affairs  
United States Senate

September 21, 2022

Chairman Tester, Ranking Member Moran, and members of the committee, thank you for your invitation to testify today. My name is Dr. Carrie Farmer. I am a senior policy researcher at the nonprofit, nonpartisan RAND Corporation, where I codirect the RAND Epstein Family Veterans Policy Research Institute. I am a health services researcher by training, and my research is focused on military and veteran health care, including care provided by the U.S. Department of Veterans Affairs (VA).

Over my 13-year career as a policy researcher at RAND, I have been immersed in rigorous research on how to improve veterans' access to high-quality care, both from VA and from non-VA providers. In 2015, I led an independent analysis of the health care delivered by VA, required by the Veterans Access, Choice, and Accountability Act of 2014 ("Choice Act"). The Choice Act and the independent assessment it required were driven by concerns over reports that veterans were facing long wait times to receive health care at VA facilities. Our analysis revealed that although there was significant variability depending on VA facility, over 90 percent of VA appointments were completed within 30 days of veterans' preferred date for care, for both new

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<sup>1</sup> The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of the RAND Corporation or any of the sponsors of its research.

<sup>2</sup> The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest. RAND's mission is enabled through its core values of quality and objectivity and its commitment to integrity and ethical behavior. RAND subjects its research publications to a robust and exacting quality-assurance process; avoids financial and other conflicts of interest through staff training, project screening, and a policy of mandatory disclosure; and pursues transparency through the open publication of research findings and recommendations, disclosure of the source of funding of published research, and policies to ensure intellectual independence. This testimony is not a research publication, but witnesses affiliated with RAND routinely draw on relevant research conducted in the organization.



patients and established patients, in both primary care and specialty care.<sup>3</sup> Although this result suggested that problems with timely care were perhaps not widespread, our analysis also found that only 55 percent of veteran patients reported that they were always able to get a routine appointment as soon as they needed one. Over half of VA medical center directors reported that some veterans faced clinically meaningful delays in care.<sup>4</sup>

In part to address deficiencies in veterans' access to timely care, VA and Congress established new efforts to shorten patient wait times. VA's efforts were driven largely by changes to staffing and scheduling and through the implementation of VA Community Care, a key aspect of the Choice Act that expanded veterans' access to private-sector care paid for by VA. While VA has enabled veterans to access care from non-VA providers throughout its history, the passage of the Choice Act, and subsequently the MISSION Act in 2018, established a permanent entitlement for veterans unable to access care from a VA facility to receive care from non-VA providers, paid for by VA.<sup>5</sup>

Over 3 million veterans have received non-VA care through the VA Community Care program since 2014,<sup>6</sup> and VA has estimated that 44 percent of all care available from both VA facilities and VA Community Care is now provided by non-VA providers.<sup>7</sup> However, whether this expansion of VA Community Care has resulted in more-timely care for veterans is not well understood, and concerns about veterans' access to care have persisted.<sup>8</sup>

In this testimony, I discuss what we know about veterans' access to timely, high-quality health care. First, I will provide a brief overview of how timeliness of care is assessed. Next, I will discuss VA's approach to measuring and reporting appointment wait times. I will describe how wait times for VA appointments compare with wait times for non-VA appointments, noting that VA is the only health system in the country that publicly reports wait times. Because very limited data are available on the timeliness and quality of VA Community Care, I will

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<sup>3</sup> Carrie Farmer, Susan Hosek, Christine Eibner, Heather Krull, David Adamson, Ernesto Amaral, Philip Armour, Trinidad Beleche, Olena Bogdan, Kristine Brown, et al., *Balancing Demand and Supply for Veterans' Health Care: A Summary of Three RAND Assessments Conducted Under the Veterans Choice Act*, Santa Monica, Calif.: RAND Corporation, RR-1165/4-RC, 2016, [https://www.rand.org/pubs/research\\_reports/RR1165z4.html](https://www.rand.org/pubs/research_reports/RR1165z4.html).

<sup>4</sup> Peter Hussey, Jeanne Ringel, Carrie Farmer, Melissa Bauman, Kristin Leuschner, Mary Vaiana, Susan Hosek, Sarah MacCarthy, Katherine Watkins, Sangeeta Ahluwalia, et al., *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*, Santa Monica, Calif.: RAND Corporation, RR-1165/2-VA, 2015, [https://www.rand.org/pubs/research\\_reports/RR1165z2.html](https://www.rand.org/pubs/research_reports/RR1165z2.html). RAND's 2015 Survey of VA Resources and Capabilities was fielded to 141 VA medical center chiefs of staff to ask about delays in care for both new and existing patient appointments, reasons for delays, issues affecting provider and system efficiency, and recruitment and retention of clinical personnel.

<sup>5</sup> Congressional Budget Office, *The Veterans Community Care Program: Background and Early Effects*, Washington, D.C., October 2021.

<sup>6</sup> LaPuz, Miguel, Acting Deputy Under Secretary of Veterans Affairs for Health, statement before the U.S. House of Representatives, Committee on Veterans' Affairs, Subcommittee on Health, July 14, 2022.

<sup>7</sup> LaPuz, 2022.

<sup>8</sup> Petra Rasmussen and Carrie M. Farmer, *The Promise and Challenges of VA Community Care: Veterans' Issues in Focus*, Santa Monica, Calif.: RAND Corporation, PE-A1363-5, 2022, <https://www.rand.org/pubs/perspectives/PEA1363-5.html>.

recommend several approaches to improve data collection and reporting that could help veterans make better-informed decisions about their health care.

### Wait Time Measures and Other Timeliness Metrics

There is no single, accepted measure of timely care, nor are there any national standards for how long is too long for a patient to wait for a health care appointment.<sup>9</sup> Wait times for care can be assessed in several ways, each of which captures a slightly different aspect of health care appointment scheduling. VA has historically used a measure of timeliness that assesses the time between when the veteran wants the appointment to occur and the date of the appointment. This metric allows for flexibility for clinical appropriateness—for example, an appointment for follow-up care may not need to occur for another three months. It also allows for veteran preference—for example, a veteran might be unavailable for a period of time and would prefer the appointment to be scheduled at a later date. Last month, VA changed its wait time measurement for *new* patient appointments to be the difference in days between the first time a referral for care is entered into the scheduling system and the date the appointment is completed.<sup>10</sup> For existing patient appointments, wait times continue to take into account provider and patient agreement on when the appointment should occur.

An alternative to this approach is a simple measure of the number of days between now and the next available appointment. A second alternative, which VA recently adopted as part of its transition to a new electronic health record and will eventually roll out VA-wide, considers that, in many instances, the next available appointment may be open because of a last-minute cancellation and therefore does not accurately represent appointment availability. In this alternative, wait time is a measure of the number of days between now and the third next available appointment. The *third next available appointment* metric is used by other health care systems, including the Military Health System,<sup>11</sup> and could enable “apples to apples” comparisons between VA and other health systems that report these data.

While appointment wait times have been a focus, veterans’ own self-reported experiences of getting timely care are equally important to assess. Like other health systems in the United States, VA regularly collects and reports on patient experience using Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, which are the national gold standard for assessing patient experience. CAHPS surveys ask a series of questions about how often the patient was able to get an appointment as soon as they needed one. These questions, along with other related questions, are analytically combined into an overall metric of “access,” which VA publicly reports at the facility level in comparison with national and regional benchmarks.

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<sup>9</sup> Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, Washington, D.C.: The National Academies Press, 2015.

<sup>10</sup> U.S. Department of Veterans Affairs, “Calculation of Average Wait Time for New and Established Patients,” *Federal Register*, Vol. 87, No. 141, July 25, 2022, pp. 44191–44192.

<sup>11</sup> Defense Health Agency, Analytics and Evaluation Division, *Evaluation of the TRICARE Program: Fiscal Year 2021 Report to Congress: Access, Cost, and Quality Data Through Fiscal Year 2020*, Washington, D.C.: U.S. Department of Defense, 2021.

## VA Is the Only Health System in the United States that Publicly Reports Appointment Wait Times

By and large, no U.S. health care system other than VA publicly reports its data on wait times, so making comparisons is difficult. Those that do report data on wait times do so infrequently and in aggregate across the entire health system or health plan. For example, in its annual report to Congress, the Defense Health Agency (DHA) reports aggregate information on the timeliness of care in the Military Health System: the average number of days to the third next available appointment for acute and future primary care and the average number of days from scheduling to appointment for specialty care.<sup>12</sup> DHA reports these data in aggregate across the fiscal year, both for care delivered in military treatment facilities and for care delivered by providers who work outside military settings but participate in the TRICARE network. The state of California requires health plans to collect and report data on timely access to care, assessed by whether appointments were available within a set of standard time frames. Each year, the California Department of Managed Health Care reports these data in aggregate per plan as the percentage of providers within each health plan who had appointments available within the standard time frame.<sup>13</sup>

VA publicly reports wait time information at the facility level on its Access to Care website. VA updates these data daily, so any veteran looking for information about care local to them has up-to-date information about how long they should expect to wait for an appointment. Using my own location as an example, I was easily able to find out that the average wait time for a new neurology appointment in Pittsburgh, Pennsylvania, as of September 5, 2022, was 13 days. For individual mental health care, the average wait time for a new patient appointment at the local VA medical center was 34 days, but there was no wait for an appointment at a local VA community-based outpatient clinic. This kind of information simply does not exist outside VA.

## Wait Times for VA-Delivered Health Care Are Often Shorter than for Non-VA Care in the Private Sector

As noted earlier, very little public data exist about wait times for health care outside VA. A just-released study by Merritt Hawkins reported on physician appointment wait times in 15 major metropolitan areas.<sup>14</sup> In spring 2022, using a secret shopper approach, researchers called physician offices and attempted to make a new patient appointment for a nonurgent condition. Merritt Hawkins found that, in general, wait times in these metropolitan areas have increased significantly since the survey was last conducted, in 2017: Average wait times were 34.5 days for a dermatologist appointment (up 7 percent since 2017), 26.6 days for a cardiologist (up 26

<sup>12</sup> Defense Health Agency, Analytics and Evaluation Division, 2021.

<sup>13</sup> California Department of Managed Health Care, *Timely Access Report: Measurement Year 2020*, Sacramento, Calif., 2022.

<sup>14</sup> Merritt Hawkins, *2022 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates*, Dallas, Tex.: AMN Healthcare, 2022.

percent), and 16.9 days for an orthopedic surgeon (up 48 percent). On the other hand, wait time for a new appointment with a family physician was 20.6 days, a 30-percent reduction from 2017.

To understand how wait times in the private sector compare with VA's wait times, I used the real-time data from VA's Access to Care website to estimate average wait times in each of the metropolitan areas covered in the Merritt Hawkins survey. I note that how wait times are calculated are different; the Merritt Hawkins study uses a *first-available appointment* measure, and VA measures *average time from referral to appointment completion*.<sup>15</sup> We should expect the Merritt Hawkins *first available appointment* metric to generally produce shorter wait times, since VA's *average time from referral to care* metric includes the time it takes for a scheduler to work with a veteran to schedule care. In many cases, the scheduled VA appointment is not the next available appointment—for example, if the veteran is unavailable or unable to attend during that particular time slot.

With the caveat about differences in methodology, Table 1 compares average new patient appointment wait time for specialty care (dermatology, cardiology, and orthopedic surgery) between VA and non-VA providers in the 15 metropolitan areas included in the Merritt Hawkins survey. For the VA data in this comparison, I used the VA Access to Care website to identify average wait time for a new patient appointment in each of the three specialty areas, using a radius of 25 miles from each metropolitan area.<sup>16</sup>

**Table 1. Average Wait Time, in Days, for a New Patient Appointment from VA and Non-VA Providers**

Metropolitan Area	Dermatology		Cardiology		Orthopedics	
	VA	Non-VA	VA	Non-VA	VA	Non-VA
Portland, OR	53	84	40	49	33	28
Washington, DC	0	12	32	36	20	5
Denver, CO	14	27	49	33	31	14
Miami, FL	1	45	30	32	26	13
Boston, MA	4	50	36	29	17	15
Philadelphia, PA	1	9	62	29	50	10
Seattle, WA	26	45	63	29	43	21

<sup>15</sup> Specifically, VA measures the average time from referral to appointment completion or the date the appointment is scheduled to occur if it has not yet been completed. In the absence of a referral, the wait time measurement starts with "the earliest recorded date in the process of receiving care - typically the date a scheduler works with a Veteran to coordinate a future appointment" (Access to Care, "Same-Day Healthcare Services and Other Options at VA Facilities Search," webpage, U.S. Department of Veterans Affairs, <https://www.accesstocare.va.gov/PWT/SameDayService>).

<sup>16</sup> I selected 25 miles as a radius to capture both major VA medical centers and VA clinics providing specialty care in a given metropolitan area.

Metropolitan Area	Dermatology		Cardiology		Orthopedics	
	VA	Non-VA	VA	Non-VA	VA	Non-VA
New York, NY	<b>13</b>	23	<b>22</b>	28	19	8
Atlanta, GA	<b>10</b>	26	85	26	29	8
Houston, TX	<b>23</b>	25	32	23	18	11
Los Angeles, CA	25	15	28	22	42	31
Minneapolis, MN	<b>0</b>	72	35	20	26	16
San Diego, CA	42	22	29	17	<b>33</b>	55
Detroit, MI	59	29	58	13	24	10
Dallas, TX	39	34	35	13	<b>23</b>	28

SOURCES: Data on average wait time from VA providers collected from VA's Access to Care website on September 5, 2022 (Access to Care, homepage, U.S. Department of Veterans Affairs, undated, <https://www.accesstocare.va.gov>). Data on average wait time from non-VA providers are from Merritt Hawkins, 2022.

NOTE: Bold type indicates that VA wait time is shorter than non-VA wait time.

These data suggest that, in many parts of the country and for some types of care, veterans may face a shorter wait time for care from VA than an average person would face getting care from the private sector. This is especially notable because we would expect wait times for the next available appointment (the Merritt Hawkins approach) to generally be shorter than wait times calculated as the time from the referral to the completed appointment (the VA approach). For example, in Portland, Oregon, wait times are consistently shorter for VA care than for private-sector care. But the reverse is true in other metropolitan areas, such as Detroit, where VA wait times appear to be longer, even when we consider differences in methodology. Across 11 of the 15 metropolitan areas I looked at, average wait times for a new patient appointment for cardiology seem to be longer for VA than in the private sector. In Philadelphia, Seattle, Atlanta, and Detroit, veterans have to wait almost double the time to seek care at VA than in the community.

While this is an imperfect review, there are no other sources of data that I am aware of that allow this kind of comparison between VA's timeliness and that of the private sector, and this kind of information is both useful and important. My simple example has a very short shelf life, though; while the VA data are continuously updated, the Merritt Hawkins data are six months old at this point, so already the availability of private-sector health care may have changed. Furthermore, the Merritt Hawkins survey is conducted only every five years; includes only these 15 metropolitan areas; and does not include some types of care that are especially important for veterans, such as mental health care. Without ongoing, comparable data on wait times in the private sector, it is extremely difficult to interpret VA's published wait times as a measure of VA's performance.

## Wait Times Are Often Shorter for VA-Delivered Care than for VA Community Care

Although VA provides detailed information on how long veterans should expect to wait for an appointment at a VA facility, it does not publicly report wait times for VA Community Care appointments—care in the community that is paid for by VA. The limited existing evidence, conducted by VA researchers who have access to detailed appointment data, suggests that veterans may wait longer for VA Community Care than for care from a VA facility. Some of the added wait time for VA Community Care appointments is due to the requirement that veterans first receive approval from VA before receiving Community Care.<sup>17</sup> Most studies on the differences between VA-delivered care and VA Community Care have focused on differences in the timeliness of a particular type of care or medical procedure. In one recent study, veterans with hepatitis C who were referred to VA Community Care waited 42 days for treatment, compared with 29 days for veterans receiving care from VA.<sup>18</sup> In another study, veterans with sleep apnea waited an average of 252 days between testing and therapy in a VA Community Care setting, compared with 129 days in a VA facility.<sup>19</sup> A third study found no difference between VA-delivered care and VA Community Care in wait times for a colonoscopy.<sup>20</sup>

The most-recent comprehensive analysis of timeliness of VA-delivered care compared with VA Community Care was just published in *JAMA Network Open* in August 2022.<sup>21</sup> In this analysis, researchers examined referrals for new patient appointments for VA-delivered care and VA Community Care between 2018 and 2021. They calculated wait time as the time between when the veteran received approval for VA Community Care and when the appointment was completed. By calculating wait time from the date of approval, the researchers were able to set aside any added delay due to the approval process to enable a direct comparison of wait times for VA-delivered care and VA Community Care. The analysis included more than 22 million appointments for nearly 5 million unique veterans, and the researchers examined appointments for primary care, mental health care, and specialty care. Table 2 shows the study’s findings of mean wait times for each of these types of appointments for both VA-delivered care and VA

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<sup>17</sup> Kevin N. Griffith, Nambi J. Ndugga, and Steven D. Pizer, “Appointment Wait Times for Specialty Care in Veterans Health Administration Facilities vs Community Medical Centers,” *JAMA Network Open*, Vol. 3, No. 8, August 26, 2020; U.S. Government Accountability Office, *Veterans Community Care Program: Improvements Needed to Help Ensure Timely Access to Care*, Washington, D.C., September 2020.

<sup>18</sup> Daniel Chao, Hema Buddha, Chitra Damodaran, Linda Tran, Richard Strong, and Christian S. Jackson, “Outcomes Comparison of the Veterans’ Choice Program with the Veterans Affairs Health Care System for Hepatitis C Treatment,” *Federal Practitioner*, Vol. 37, Supp. 3, June 2020.

<sup>19</sup> Bhavika Kaul, Denise M. Hynes, Alex Hickok, Connor Smith, Meike Niederhausen, Annette M. Totten, Mary A. Whooley, and Kathleen Sarmiento, “Does Community Outsourcing Improve Timeliness of Care for Veterans with Obstructive Sleep Apnea?” *Medical Care*, Vol. 59, No. 2, February 2021.

<sup>20</sup> Jeffrey M. Dueker and Asif Khalid, “Performance of the Veterans Choice Program for Improving Access to Colonoscopy at a Tertiary VA Facility,” *Federal Practitioner*, Vol. 37, No. 5, May 2020.

<sup>21</sup> Yevgeniy Feyman, Daniel A. Asfaw, and Kevin N. Griffith, “Geographic Variation in Appointment Wait Times for US Military Veterans,” *JAMA Network Open*, Vol. 5, No. 8, August 25, 2022.

Community Care. For each type of care, wait times were shorter for VA-delivered care than for VA Community Care. (All differences were statistically significant.)

**Table 2. Mean Wait Times, in Days, for VA-Delivered Care and VA Community Care New Patient Appointments**

Type of Care	VA-Delivered Care	VA Community Care
Primary care	28	35
Mental health care	35	40
Specialty care	36	41

SOURCE: Feyman, Asfaw, and Griffith, 2022.

The authors examined whether these findings persisted in different parts of the country. They found that, overwhelmingly, wait times for VA-delivered care were shorter than for VA Community Care in nearly every region of the country. VA is organized regionally into 18 Veterans Integrated Services Networks (VISNs). For primary care, wait times were shorter for VA-delivered care than for VA Community Care in 15 of 18 VISNs; for mental health care, wait times for VA-delivered care were shorter in 16 of 18 VISNs; and, for specialty care, wait times for VA-delivered care were shorter in 17 of 18 VISNs.

Although the wait time data suggest that there are shorter wait times for VA-delivered care than for VA Community Care, veterans may not always perceive this to be the case. VA collects information on veterans' experiences with Community Care through its Survey of Healthcare Experience of Patients (SHEP)—Community Care and through its annual Survey of Veteran Enrollees' Health and Use of Health Care. In the 2021 Survey of Enrollees, 23 percent of respondents reported having received VA Community Care.<sup>22</sup> Veterans reported slightly better experiences with getting appointments from VA Community Care compared with VA-delivered care—81.4 percent of enrollees reported that, “most of the time,” or “always/nearly always,” it was easy to get appointments within a reasonable time with VA Community Care, compared with 77.7 percent who reported this for VA-delivered care.

### Quality Matters as Much as Timeliness

Although most of my testimony has focused on timeliness, it is critical that discussions about veterans' access to care always consider care quality. An appointment available tomorrow that provides poor care could be worse than waiting for good care. As prior RAND research has demonstrated, VA typically provides care that is equal to or better than care from the private

<sup>22</sup> Z. Joan Wang, Pavan Dhanireddy, Cynthia Prince, Michael Larsen, Michael Schimpf, and Gerald Pearman, 2021 *Survey of Veteran Enrollees' Health and Use of Health Care*, Monterey, Calif.: Advanced Survey Design, 2021.

sector.<sup>23</sup> However, we know very little about how VA-delivered care compares with VA Community Care.

VA tracks and reports on dozens of quality performance measures and makes much of the data publicly available through its Access to Care website.<sup>24</sup> The website includes facility-level data on standardized performance measures, such as the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS measures are developed by the National Committee for Quality Assurance to assess health care quality and are widely used throughout the country. HEDIS measures and other measures included on the website allow veterans to compare the quality of care at their local VA facility with that of non-VA providers in their community, as required by the MISSION Act.<sup>25</sup> VA makes additional data available on its “Open Data” website, which includes quarterly reports on VA medical center performance on VA’s Strategic Analytics for Improvement and Learning Value Model (SAIL).<sup>26</sup> SAIL data include selected performance measures on hospital readmission rates, sepsis management, employee satisfaction, suicide risk screening rates, and other quality metrics.

Equivalent data are not available for VA Community Care. VA does not publicly report, or, to my knowledge, collect, quality and performance measures for VA Community Care. Studies by VA researchers who have access to data on VA Community Care have provided some limited insights into the quality of VA Community Care. In one recent analysis, VA researchers found that veterans who received total knee arthroplasties at a VA facility had lower odds of readmission than those whose surgeries had been performed by a VA Community Care provider.<sup>27</sup> Another analysis of complications following cataract surgery found no significant differences between VA-delivered care and VA Community Care.<sup>28</sup> Researchers who used the SHEP survey to analyze veterans’ experiences with care found that veterans’ satisfaction with

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<sup>23</sup> Claire O’Hanlon, Christina Huang, Elizabeth Sloss, Rebecca Anhang Price, Peter Hussey, Carrie Farmer, and Courtney Gidengil, “Comparing VA and Non-VA Quality of Care: A Systematic Review,” *Journal of General Internal Medicine*, Vol. 32, No. 1, January 2017; Rebecca Anhang Price, Elizabeth M. Sloss, Matthew Cefalu, Carrie M. Farmer, and Peter S. Hussey, “Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings,” *Journal of General Internal Medicine*, Vol. 33, No. 10, October 2018.

<sup>24</sup> Access to Care, homepage, U.S. Department of Veterans Affairs, undated, <https://www.accesstocare.va.gov>.

<sup>25</sup> Access to Care, “How Does Care Compare in VA and Other Facilities in My Area?” webpage, U.S. Department of Veterans Affairs, undated, <https://www.accesstocare.va.gov/Healthcare/QualityOfCare/>

<sup>26</sup> U.S. Department of Veterans Affairs, “SAIL FY2022 Hospital Performance – All Facilities,” data set, last updated August 22, 2022, <https://www.data.va.gov/dataset/SAIL-FY2022-Hospital-Performance-All-Facilities/rc4s-93qz>.

<sup>27</sup> Amy K. Rosen, Erin E. Beilstein-Wedel, Alex H. S. Harris, Michael Shwartz, Megan E. Vanneman, Todd H. Wagner, and Nicholas J. Giori, “Comparing Postoperative Readmission Rates Between Veterans Receiving Total Knee Arthroplasty in the Veterans Health Administration Versus Community Care,” *Medical Care*, Vol. 60, No. 2, February 2022.

<sup>28</sup> Amy K. Rosen, Megan E. Vanneman, William J. O’Brien, Suzann Pershing, Todd H. Wagner, Erin Beilstein-Wedel, Jeanie Lo, Qi Chen, Glenn C. Cockerham, and Michael Shwartz, “Comparing Cataract Surgery Complication Rates in Veterans Receiving VA and Community Care,” *Health Services Research*, Vol. 55, No. 5, October 2020.



their communication with care providers, care coordination, and provider rating scores were higher for VA-delivered care than for VA Community Care.<sup>29</sup>

### VA Should Improve Data on Timeliness and Quality of VA Community Care

Better data about the timeliness and quality of VA Community Care are needed to enable veterans to make decisions about where to receive care and to enable VA to better plan for care delivery. There are likely some types of care and some locations where it will be faster for a veteran to receive care from VA Community Care Network providers than from VA providers, but this is not always or even often the case. Accurate information about wait times for both VA-delivered care and VA Community Care would ensure that veterans are able to get the care they need, when and where they need it.

Similarly, comprehensive analysis of the quality of VA Community Care compared with that of VA-delivered care is essential to ensure that veterans receive high-quality care, regardless of where it is provided. Our own analysis of health care providers in New York found that fewer than 5 percent of non-VA providers were prepared to treat veterans.<sup>30</sup> VA requires its providers to complete training on such topics as military cultural competence, suicide risk screening, and evidence-based treatments for mental health conditions and offers this training to Community Care providers through the VHA TRAIN website.<sup>31</sup> However, few Community Care providers complete this training.<sup>32</sup> Better data, analysis, and public reporting of the quality and performance of Community Care are needed.

I have several specific suggestions for how to improve data on the timeliness and quality of VA Community Care. First, VA should publicly report average wait times for VA Community Care appointments, using the same data and methodology used to report average wait times for VA-delivered care. These data should already exist, since they are collected by VA as part of the appointment scheduling process, but they are not publicly reported. There might be some types of care or geographic locations where the volume of VA Community Care appointments is too low to reliably report average wait times. If this is the case, VA could determine a volume threshold (e.g., a certain number of appointments per month) for public reporting.

Second, VA should make use of existing data to systematically monitor and publicly report the quality of care provided in the community. VA could use Community Care Network claims-

<sup>29</sup> Megan E. Vanneman, Todd H. Wagner, Michael Shwartz, Mark Meterko, Joseph Francis, Clinton L. Greenstone, and Amy K. Rosen, "Veterans' Experiences with Outpatient Care: Comparing the Veterans Affairs System with Community-Based Care," *Health Affairs*, Vol. 39, No. 8, August 2020.

<sup>30</sup> Terri Tanielian, Coreen Farris, Caroline Batka, Carrie M. Farmer, Eric Robinson, Charles C. Engel, Michael William Robbins, and Lisa H. Jaycox, *Ready to Serve: Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families*, Santa Monica, Calif.: RAND Corporation, RR-806-UNHF, 2014, [https://www.rand.org/pubs/research\\_reports/RR806.html](https://www.rand.org/pubs/research_reports/RR806.html).

<sup>31</sup> U.S. Department of Veterans Affairs, "VHA TRAIN," webpage, last updated June 9, 2021, [https://www.va.gov/EMPLOYEEEDUCATION/ees\\_vha\\_train.asp](https://www.va.gov/EMPLOYEEEDUCATION/ees_vha_train.asp).

<sup>32</sup> Carrie M. Farmer, Sierra Smucker, Natalie Ernecoff, and Hamad Al-Ibrahim, *Recommended Standards for Delivering High-Quality Care to Veterans with Invisible Wounds*, Santa Monica, Calif.: RAND Corporation, RR-A1728-1, 2022, [https://www.rand.org/pubs/research\\_reports/RRA1728-1.html](https://www.rand.org/pubs/research_reports/RRA1728-1.html).

type data to construct quality measures for veterans receiving care in the community. To do this, it would need to consider the types of care frequently provided by VA Community Care providers and identify appropriate existing claims-based quality measures, such as those used by the Centers for Medicare & Medicaid Services.<sup>33</sup> There may be lessons to be learned from the Department of Defense, which publishes quality measures, including some HEDIS measures, for care received at military treatment facilities and for non-DoD care paid for by DoD through the TRICARE network.<sup>34</sup> Providing aggregate information about the quality of VA Community Care at the VISN (or another) level using existing standardized quality measures would allow for comparisons with VA-delivered care.

Third, the third-party administrators (TPAs) responsible for managing the Community Care Network routinely collect information about network providers that is not shared with VA because such information-sharing is not required by contract. VA should explore contract changes that would facilitate additional information-sharing and new data collection about network providers and the quality of care they provide. For example, VA could require TPAs to report whether network mental health providers have received training and certifications in evidence-based psychotherapies, if this is information they have already collected for other payers.

## Conclusion

Concerns about veterans' access to timely, high-quality care have been long-standing. Limited available data suggest that veterans' wait times for care from VA facilities are usually shorter than wait times for VA Community Care. VA wait times seem to be similar to those in the private sector, although they may be longer for some types of specialty care, but data are even more limited, and the use of different metrics makes comparisons challenging. VA is the only health system in the country that makes detailed information about wait times available, and this is commendable, for it provides veterans with needed information to make decisions about where to receive care and what to expect. To truly improve veterans' care, however, additional data and analysis on the timeliness and quality of VA Community Care, and how it compares with VA-delivered care, are required.

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<sup>33</sup> Quality Payment Program, "Quality Performance Category: Traditional MIPS Requirements," webpage, U.S. Centers for Medicare & Medicaid Services, last updated August 30, 2022, <https://qpp.cms.gov/mips/quality-requirements>.

<sup>34</sup> Defense Health Agency, Analytics and Evaluation Division, 2021.



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**STATEMENT OF  
 JOY J. ILEM  
 DAV NATIONAL LEGISLATIVE DIRECTOR  
 COMMITTEE ON VETERANS' AFFAIRS  
 UNITED STATES SENATE  
 SEPTEMBER 21, 2022**

Chairman Tester, Ranking Member Moran, and members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at today's hearing examining health care wait times at the Department of Veterans Affairs (VA) and in the community. As you know, DAV is a non-profit veterans service organization comprised of more than one million wartime service-disabled veterans. For more than a century, DAV has been dedicated to a single purpose: empowering our nation's heroes and their families by helping to provide the resources they need and ensuring our nation keeps the promises made to them.

Mr. Chairman, the vast majority of DAV members choose and rely heavily on the VA health care system for some or all of their medical needs, particularly those with serious injuries, illnesses, and disabilities. Assuring timely access to high quality, veteran-focused medical care has been and remains a top priority for DAV and our members.

Today's hearing will examine how VA measures wait times and how that information is presented to veterans. In addition, it is critical to understand how VA uses wait time data to improve health care delivery for the veterans it serves. However, we note that timeliness is just one aspect that determines whether veterans receive the best care possible. Timely access to low quality care is no more acceptable than delayed access to high quality care. Therefore, any discussion of timeliness must be linked directly to the quality of that care. While VA must continually strive to accurately measure and report wait time data, how that data is used by VA is crucial to improve both access and quality of care.

**Methodology for Measuring Wait Times**

Over the past decade, VA has measured medical wait times several different ways, including using the provider's clinically indicated date, the veteran's preferred date, the date of the appointment request and the date the appointment is created in VA's scheduling system. Though all of these data points may have shortcomings, each can provide useful information about the timeliness of VA care as long as it is honestly, consistently, and transparently measured and presented.

In July, VA revised its methodology once again, and will now measure average wait times for new patients from the earliest recorded date in the scheduling system until the appointment is completed, or to the date it is scheduled to occur if not yet completed. For established patients, wait times will be measured from the date agreed upon by the veteran and their provider. VA health care sites that have implemented the new electronic health record (EHR) system will employ a different metric called Third Next Available Appointment (TNAA), which measures the number of days between today and the third-next appointment available in VA's scheduling system. TNAA is used by some private sector health systems and according to VA is considered a more consistent and reliable predictor of when veterans would be able to schedule appointments in the future.

#### **Purpose of Measuring Wait Times**

The main purpose of measuring and calculating average wait times has traditionally been to allow veterans and VA to assess the performance of the VA health care system. When average wait times are unacceptably high or rising, it is an indication of inadequate capacity and resources, increased demand for care, administrative breakdowns, or a combination of these and other factors. With this information, veterans can make better informed decisions about their options and use of VA health care. For VA and Congress, average wait times help to determine future policies and funding levels for the VA health care system. In addition, since 2014, wait times have been used as an access standard to determine when enrolled veterans could opt to use non-VA community care, which has had troubling consequences for veterans and the VA health care system.

#### **Evolution of Wait Times and Access Standards**

For decades, VA has struggled to ensure that all enrolled veterans could access their care in a timely manner. In 2010, then-VA Secretary Eric Shinseki established a 14-day wait time goal in order to attack a growing backlog of VA health care appointments. However, as veterans increasingly were turning to VA for their care, the funding and resources necessary to meet this rising demand was falling farther behind. Ultimately, this longstanding and systemic mismatch between resources and demand led to serious access problems.

In 2014, persistent long wait times, as well as the uncovering of "secret" waiting lists at some VA facilities, resulted in Congress approving the Veterans Access, Choice and Accountability Act ("Choice Act") to expand access to non-VA community care. The Choice Act created access to care standards that would determine when veterans could "choose" to receive care from non-VA community providers as part of the new Veterans Choice Program (VCP). Veterans who would be required to wait 30 days or longer for a VA appointment, or who would have to travel 40 miles or more to a VA facility for an appointment, were eligible for community care in the Choice program.

Within just a couple years, it became clear that the Choice program had fundamental flaws and would need significant changes to be effective. In 2018, Congress passed the VA MISSION Act (Public Law 115-182), which reorganized VA's community care programs and mandated the establishment of new access standards. In 2019, VA proposed and adopted new access standards that are still in use today. Instead of a 30-day wait time standard for all care, VA now has two different wait time standards: 20 days for primary and mental health care, and 28 days for specialty care. Instead of a travel time access standard, VA now uses drive times: 30 minutes for primary and mental health care, and 60 minutes for specialty care.

The adoption and implementation of these new access standards, as well as the impact of the COVID-19 pandemic, have significantly shifted veterans and funding from the VA health care system to private community providers. According to a recent RAND report<sup>1</sup> that summarized research on VA community care, since 2014, the number of veterans authorized to receive community care almost doubled and the cost to provide that care has more than doubled, now consuming about one-quarter of VA's overall health care budget.

In VA's "*Congressionally Mandated Report: Access to Care Standards*," released last week, VA reported that more than one-third of all appointments are fulfilled through community care.<sup>2</sup> VA concluded that, "...if the balance of care provided in the community continues on its current upward trajectory, we anticipate that certain VA medical facilities, particularly those in rural areas, may not be able to sustain sufficient workload to operate in their current capacity." Further, VA reported that, "Operational leaders already note concern for the potential of a 'spiral effect' in some areas, where workload and talent are shifting externally and thus threaten to harm VA's training, research and emergency preparedness missions."

If this trend continues, it could endanger the ability of VA to sustain the critical mass required to provide a full continuum of care to all veterans who choose and rely on VA for their care. This shift is especially concerning because new research discussed below confirms that VA health care on average outperforms private sector care for quality, cost as well as timeliness. Therefore, wait times and wait time access standards must be evaluated and implemented in the overall context of how they will lead to better health care outcomes and a stronger VA health care system.

### **New Research Finds VA Has Shorter Wait Times**

The *Journal of the American Medical Association* (JAMA) also recently published the results of a comprehensive new study entitled, "Geographic Variation in

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<sup>1</sup> RAND: "The Promise and Challenges of VA Community Care"; Petra Rasmussen, Carrie Farmer; August 2022; [www.rand.org/pubs/perspectives/PEA1363-5.html](http://www.rand.org/pubs/perspectives/PEA1363-5.html)

<sup>2</sup> VA: *Congressionally Mandated Report: Access to Care Standards*; September 2022;

Appointment Wait Times for US Military Veterans,”<sup>3</sup> which found that VA medical wait times were lower than community care providers in almost every part of the country. The study looked at over 22 million appointments for almost 5 million veterans between January 2018 to June 2021 and found that wait times at VA facilities were less than community care providers. The average wait for veterans seeking primary care at VA was 27.9 days, compared to 34.8 days in VA’s community care network. For mental health care, VA’s average wait was 34.6 days compared to 40.4 days in the community; and for specialty care, the VA average was 35.9 days compared to 40.6 days. The study also found that VA not only had shorter average wait times nationally, but within most regions of the country as well. Overall, 15 of VA’s 18 regional Veterans Integrated Service Networks (VISNs) had shorter average primary care wait times; 16 of 18 VISNs had shorter average mental health care wait times; and 17 of 18 VISNs had shorter average specialty care wait times.

According to the study’s authors, “... areas with high-wait times for community care are not expected to benefit from liberalized access...” to VA’s community care networks. The RAND report similarly concluded that private sector care was no more timely than VA care, and that further expansion of community care was “...unlikely to completely address the challenges some veterans face in receiving timely care.” Instead, the JAMA study suggested that it would take more creative policies, “...such as physician relocation incentives, telehealth, or mobile deployment units...” to expand access and reduce wait times for veterans in underserved areas.

This is especially important in highly rural areas of the country, particularly those that have longer wait times at VHA compared to community providers, including VISN 15 (Kansas, Missouri) and VISN 17 (Texas.) In order to close these access gaps, VHA will have to strengthen the Office of Rural Health and increase funding for rural programs, as well as develop innovative means of reaching veterans where they live.

### **Studies Also Find VA Care May Be Less Expensive**

Studies also suggest that VA offers more timely access than community care providers at a lower cost. RAND’s report found that, “... there are some indications that community care may be more expensive than VHA-delivered care...” and that “... VHA-delivered care costs less than comparable care from Medicare providers and produced better outcomes.”

Further evidence supporting this cost advantage was reported by the VA Information Resource Center (VIREC) at a briefing conducted last week. According to VIREC, the accounting methodology used by VA to measure the cost of “purchased” community care is “often incomplete and underestimated.” For example, cost comparisons regularly ignore Third Party Administrator fees charged for managing the community provider networks, as well as the costs borne by VA to coordinate veterans’ care through the Integrated Veterans Care office and its predecessors. Further,

<sup>3</sup> JAMA: “Geographic Variation in Appointment Wait Times for US Military Veterans”, Yevgeniy Feyman, Daniel Asfaw, Kevin Griffith; August 25, 2022; [jamanetwork.com/journals/jamanetworkopen/fullarticle/JAM](https://jamanetwork.com/journals/jamanetworkopen/fullarticle/JAM)

according to VIREC, VA primary care providers are expected to coordinate the care for veterans using community care providers, adding additional burden and cost on VA, whereas private sector providers do not coordinate care veterans receive in community care networks.

### **Studies Confirm That VA Provides Higher Quality Care**

Scientific research and studies continue to consistently and regularly find that the quality of care provided by VA on average is better than the private sector. For example, two recent studies by Stanford economists published in the *British Medical Journal* (BMJ)<sup>4</sup> and by the National Bureau of Economic Research (NBER)<sup>5</sup> both found that veterans who received emergency room care in non-VA hospitals were twice as likely to die within 30 days compared to those who were treated in VA hospitals.

The RAND report outlined several critical advantages of VA-provided health care compared to community care to help explain why VA consistently produces better outcomes for veterans. VA is an integrated health care system and care coordination is a core element of its success. As RAND notes, "The complexity of the VHA patient population makes care coordination critical for improving patient outcomes and decreasing costs." In addition, VA providers are better trained and more experienced at treating veterans suffering from illnesses, injuries, and conditions more prevalent in former military service members. RAND's analysis found that enrolled veterans, "...are a complex patient population with health care needs that differ from those of the nonveteran population, including higher rates of posttraumatic stress disorder, exposure to environmental toxins, and suicide."

RAND reported that VA clinicians are, "... well-versed in veteran culture and the conditions that are prevalent among veterans. Community care providers may not have substantial experience caring for veterans and may not even realize that a given patient is a veteran." Furthermore, RAND stated that VA makes, "...training available to community care providers to help increase their military/veteran cultural competency, familiarity with health care issues that are common among veterans, and aspects of specialized care. However, only a small proportion of community care providers have completed this training."

Mr. Chairman, wait time metrics and wait time access standards are important tools to help provide veterans timely access to care. However, timeliness without quality will not lead to better health outcomes for veterans. Any efforts or initiatives to improve timeliness must be inextricably linked to quality.

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<sup>4</sup> BMJ: "Mortality among US veterans after emergency visits to Veterans Affairs and other hospitals: retrospective cohort study"; David Chan, Kaveh Danesh. Et.al.; February 16, 2022; <https://www.bmj.com/content/376/bmj-2021-068099>

<sup>5</sup> NBER: "Is There a VA Advantage? Evidence from Dually Eligible Veterans"; David Chan, David Card, Lowell Taylor; February 2022; [www.nber.org/papers/w29765](http://www.nber.org/papers/w29765)

Independent research continues to find that on average, VA provides better quality care, access, and timeliness, and does so at a lower cost compared to the private sector. The best way to reduce wait times is not by expanding veterans' access to non-VA care, but instead by increasing the capacity of the VA health care system. While there will always remain a need for community care to fill gaps whenever and wherever VA is unable to provide timely or quality care, VA must remain the coordinator and primary provider of care for enrolled veterans to ensure the best health outcomes.

To help accomplish these goals, DAV makes the following **Recommendations**:

1. **VA must complete development and implementation of a universal electronic scheduling system that allows schedulers and veterans to see all VA and non-VA community care appointment options at the same time.** When VA is unable to meet its wait time standard, thereby triggering access to the VCN, veterans must be able to review the community care appointment options in real time before deciding where to seek their care.
2. **VA must provide comparable timeliness metrics for VA and CCN providers that empower veterans to make fully informed decisions about their health care options.** The VA MISSION Act specifically required community care providers to meet the same access standards as VA (see 38 USC, 1703B); however, VA has not implemented this requirement. Congress must take action to ensure VA complies with the letter and spirit of the law.
3. **VA must ensure comparable quality metrics are available and integrated into VA's scheduling system to inform veterans as they make decisions on their care options.** As discussed above, quicker access to lower quality care does not lead to better health care outcomes. Veterans must be able to compare standardized safety and quality metrics when reviewing VA and non-VA care options.
4. **VA must mandate that CCN providers meet the same quality, competency, and training requirements as VA providers.** Veterans must be assured that CCN providers are being held to the same standards as VA providers. Mandating compliance with the VA MISSION Act (see 38 USC 1703C(a)(1)) is essential to assuring quality care.
5. **VA must work with HHS, other federal agencies, and private entities to develop uniform health care access and quality metrics for all health care providers.** The lack of transparency by private sector providers concerning wait times and quality has limited VA's ability to provide veterans with meaningful and accurate comparisons between VA and CCN providers. Greater federal leadership and congressional intervention will be necessary to ensure the availability of data and metrics necessary to allow veterans to compare VA and private health care providers when making decisions about health care options.



6. **VA must remain the care coordinator for all enrolled veterans, whether using VA or CCN providers, and must expand its capacity to do so.** One of the cornerstones of the VA health care system, and a leading factor in quality care, is comprehensive care coordination. Private sector providers do not manage or coordinate other providers; therefore, it is essential that VA continue to fill this role, regardless of whether or how much care a veteran receives from non-VA providers.
7. **VA must continue to provide a full continuum of care in as many locations and facilities as possible, thereby remaining the primary provider of care for enrolled veterans, particularly those with severe disabilities and injuries.** Veterans have repeatedly indicated their preference for receiving their care from VA providers, and surveys continue to show higher trust and satisfaction with VA compared to community providers. In addition, as VA's report notes, "...fragmentation in the experience of health care is inherently at odds with quality."
8. **VA must maintain adequate surge capacity to fulfill its 4th mission responsibilities during times of war, national disasters, or public health emergencies, while simultaneously providing timely and accessible care to all enrolled veterans.** As we have learned during the COVID-19 pandemic, there is little or no surge capacity in the private sector. Even if the national shortage of health care personnel improves in the future, only the government can afford to maintain excess capacity. In order to maintain timeliness during times of crisis, VA must rely on itself to maintain adequate surge capacity.
9. **VA must continue to study and assess the expanded use of virtual health begun during the pandemic, focusing on quality and efficacy.** The sudden need for social distancing in 2020 dramatically accelerated VA's use of virtual health care delivery. VA must now determine the safety and efficacy of virtual care for the specific types of medical care it offers. Virtual health care has tremendous potential to expand access to timely, high-quality VA care, but only if and when it is shown to be as safe and effective as traditional hands-on care.
10. **VA must continue to develop innovative models of expanding access to care in rural and remote regions of the country, and increase funding for such initiatives.** In addition to expanding the role of virtual health care delivery, VA must devote additional resources and focus to close the access gaps that exist in rural and remote regions of the country. Veterans live disproportionately in rural areas, and VA must develop and implement new and different strategies to meet the unique health care needs of this population.

Mr. Chairman, assuring veterans timely access to care is a critical element of providing the best health outcomes to the men and women who served. However, timeliness without quality does not lead to better health care outcomes. It remains critical that Congress and VA work to expand access, lower wait times and improve quality. Mounting evidence shows that the best way to accomplish this is by strengthening and sustaining the VA health care system, which provides high-quality,

veteran-centered care to millions of veterans. This is absolutely essential for those who choose and rely on VA, particularly service disabled veterans, who have earned the right to get all or most of their care at VA.

That concludes my testimony, and I would be pleased to respond to any questions members of the Committee may have.

*Statement of*

**Darin Selnick,**

**Former Senior Advisor to the Secretary Department of Veteran Affairs**

*before the*

**Senate Veterans Affairs Committee**

*concerning*

**Wait times in Veterans Health Administration facilities and in the  
Community**

September 21, 2022

Thank you Chairman Tester, Ranking Member Moran, and Members of the Committee. I appreciate the opportunity to testify at today's hearing on addressing health care wait times at the Department of Veterans Affairs (VA) and in the community. Your leadership on this issue is critical to ensure that health care wait times measurements are accurate and properly reported, as required by the VA MISSION Act and the VA Veterans Community Care Program (VCCP) regulation, so that veterans can be properly notified when they are eligible for community care and truly make an informed choice between VA and community care ensuring them the timely, convenient and quality health care they deserve.

In the interest of full disclosure, I am a Senior Advisor to Concerned Veterans for America (CVA), but my testimony today reflects only my own personal expertise, analysis, and observations. In no way does my testimony reflect, nor are they representative of CVA or any other organization. The views I present here today are entirely my own. My expertise on this subject comes from my years of experience working both at the VA and the White House Domestic Policy Council in helping to create and implement the VA MISSION Act and the VA VCCP regulation, as the former Senior Advisor to both VA Secretaries David Shulkin and Secretary Robert Wilkie, and as Veterans Affairs Advisor at the White House Domestic Policy Council.

### **Background on VA wait times**

So why are VA facility wait times being accurate and consistent important? They are important due to average wait times being a barometer for veterans on how long it might take them to get their health care appointments, and they are what determines eligibility for community care. This is to ensure veterans do not receive delayed care. In a 2020 study published in JAMA, "among those

reporting delayed care, more than half (57%) said they experienced negative health consequences as a result.”<sup>1</sup>

VA wait times are part of the bigger VA health care picture of providing timely quality care for veterans. If VA facility wait times are inaccurate and inconsistent it can lead to delayed care for veterans, causing negative health consequences or even death, as happened in the Phoenix VA Medical Center scandal in 2014. In creating the VA MISSION Act in 2018, we were determined that the Phoenix 2014 scandal would never happen again and that through access standards with a wait time trigger, no veteran would ever have to wait too long to access quality care either at VA or through the community. The VA MISSION Act created that promise, but that promise is being broken today as evidenced by the complaints of veterans, FOIA documents, VA OIG and GAO reports.

In September 2020, the VA [Inspector General reported](#) nearly 20 million VA appointments cancelled or delayed during the pandemic, denying millions of veterans’ access to critical care.<sup>2</sup> Moreover, there is [evidence that suggests](#) a potential trend of the VA using improper wait time calculations to limit access to community care under the VA MISSION Act access standards.<sup>3</sup> Documents obtained through a [Freedom of Information Act lawsuit](#) filed by the Americans for Prosperity (AFP) Foundation on July 20, 2021 confirm and expand upon concerns outlined by the Government Accountability Office.<sup>4</sup>

The VA announced in October 2021 that they were [decommissioning](#) and closing the Office of Community Care as well as shutting down the VA MISSION Act website ([missionact.va.gov](https://missionact.va.gov)).<sup>5</sup> This action by the VA came as many veterans are still learning about their health care options and made it harder for veterans to access information regarding their options and eligibility.

In a June 14, 2022, hearing at the Senate Veterans’ Affairs Committee, VA Secretary Denis McDonough implied that he wanted to roll back VA access standards. When asked about access standards, [McDonough replied](#) that demand for health care “has increased more intensively for care in the community than for care in the direct system and told senators “my hunch is that we

<sup>1</sup> Mary G. Findling, Robert J. Blendon, and John M. Benson, “[Delayed Care with Harmful Health Consequences—Reported Experiences from National Surveys During Coronavirus Disease 2019](#),” *JAMA Health Forum*, 1, no. 12 (December 2020). <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2774358>

<sup>2</sup> Department of Veterans Affairs Office of the Inspector General, *Veterans Health Administration: Appointment Management During the COVID-19 Pandemic*, Report #20-02794-218. Daniel Morris, et. al. September 1, 2020. <https://www.va.gov/oig/pubs/VAOIG-20-02794-218.pdf>

<sup>3</sup> Walt Buteau, “Critics claim VA ‘cooking the books’ in calculating veteran wait times,” *WFLA.com*, April 28, 2021. <https://www.wfla.com/8-on-your-side/critics-claim-va-cooking-the-books-in-calculating-veteran-wait-times/>

<sup>4</sup> “Records confirm VA’s inaccurate wait time numbers,” *Americans for Prosperity Foundation*, October 1, 2021. <https://americansforprosperity.org/records-confirm-va-inaccurate-wait-time-numbers/>

<sup>5</sup> Department of Veterans Affairs Office of Public and Intergovernmental Affairs, PRESS STATEMENT: VA embarks on process to design new model to deliver seamless integrated care, October 5, 2021. <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5724>

should change access standards.”<sup>6</sup> Changing access standards to limit community care would only make wait times longer.

I am often asked, “why would VA want to restrict community care?” The answer came from Acting Deputy Undersecretary for Health Miguel LaPuz in his [written testimony](#) to the House Veterans’ Affairs Committee on July 14, 2022. LaPuz said, “Operational leaders already note concern for the potential of a “spiral effect” in some areas, where workload and talent are shifting externally and thus threaten to harm VA’s training, research, and emergency preparedness missions.”<sup>7</sup> He then states “if the balance of care provided in the community continues on its current upward trajectory, we anticipate that certain VA medical facilities, particularly those in rural areas, may not be able to sustain sufficient workload to operate in their current capacity.”<sup>8</sup>

In other words, VA is more concerned with maintaining its facilities and staff, rather than ensuring veterans receive timely care, whether inside or outside VA.

VA’s problems with providing accurate wait time measurements have been brought to light recently by the AFP Foundation FOIA documents, VA OIG memo and the GAO report. The AFP Foundation FOIA documents revealed how VA is undermining the VA MISSION Act, access standards, wait times and eligibility for community care.<sup>9</sup>

Some of the FOIA key findings which are included in attachment 1:

1. Failing to follow the VA MISSION Act eligibility requirements and denying community care
  - Denying community care referrals based on clinical appropriateness requirement
  - Waiving wait time access standards without veterans’ consent
  - Granting administrators, instead of providers and veterans, the final decision-making authority on “Best Medical Interest” eligibility
  - Using “Patient Indicated Date” to misrepresent wait times

<sup>6</sup> “Review of the Fiscal Year 2023 Budget and 2024 Advance Appropriations Requests for the Department of Veterans Affairs,” *United States Senate Committee on Veterans Affairs*, June 14, 2022. <https://www.veterans.senate.gov/2022/6/review-of-the-fiscal-year-2023-budget-and-2024-advance-appropriations-requests-for-the-department-of-veterans-affairs>

<sup>7</sup> “Statement of Miguel Lapuz, M.D., Acting Deputy Undersecretary for Health, Veterans Health Administration, Department of Veterans Affairs,” *United States House Committee on Veterans Affairs - Subcommittee on Health*, July 14, 2022. <https://docs.house.gov/meetings/VR/VR03/20220714/114988/HHRG-117-VR03-Wstate-LaPuzM-20220714-U1.pdf>

<sup>8</sup> *Ibid.*

<sup>9</sup> “More evidence the VA is improperly delaying or denying community care to eligible veterans,” *Americans for Prosperity Foundation*, January 28, 2022. <https://americansforprosperity.org/va-denying-delaying-care/>; “VA Wait-Time FOIA Requests and Subsequent Lawsuit,” *Americans for Prosperity Foundation*, July 2021; [https://americansforprosperityfoundation.org/wp-content/uploads/2021/07/AFP\\_VA-Wait-Times-FOIA-Suit.pdf](https://americansforprosperityfoundation.org/wp-content/uploads/2021/07/AFP_VA-Wait-Times-FOIA-Suit.pdf) “Records confirm VA’s inaccurate wait time numbers,” *AFPF*.

2. Canceling and rescheduling of appointments without agreement of the veteran or offering community care
3. Inadequate documentation of when veterans opt-out of community care
4. Using cost to determine administration of community care program
5. Neglecting to advise veterans of their options and actively dissuading use of community care

The VA OIG in its April 7, 2022, [memo](#) stated, “the start date used to calculate wait times posted on the second website for new patients was not consistent with the method for calculating wait times described in the Federal Register and the VHA scheduling directive. VHA’s published wait time data have not always followed VHA policy and may be misleading. The inconsistent use of start dates for calculating wait times can be misleading and may result in inaccurate reporting”.<sup>10</sup>

The GAO stated in a June 30, 2022, [letter](#) to Secretary McDonough, “Until VHA improves the reliability of its medical appointment wait time measures, VHA is less equipped to identify areas that need improvement and mitigate problems that contribute to longer wait times.”<sup>11</sup>

Unfortunately, VA has not learned from its past mistakes and instead of fixing its wait times measurements and reporting has implemented new wait time calculations and reporting that are still flawed and inaccurate.

### **Evaluation of VA’s wait time measurement, including any planned changes**

As the AFP Foundation FOIA documents have shown, VA’s past and current wait time measurements are flawed, inaccurate, and deceptive.

The problem with VA’s past and current calculation of average wait times and reporting is that they do not follow the VA MISSION Act law and the Veterans Community Care Program (VCCP) regulation, which were designed to ensure consistent and accurate wait times, both for reporting and for the purpose of eligibility determinations for community care.

The wait time designated access standards listed in the [VCCP regulation](#) are as follows: “VA cannot schedule an appointment for the covered veteran with a VA health care provider for the required care or service... Within 20/28 days of the date of request unless a later date has been agreed to by the veteran in consultation with the VA health care provider.”<sup>12</sup> You will notice there is no distinction between new or existing patients.

<sup>10</sup> Department of Veterans Affairs Office of the Inspector General, *Concerns with Consistency and Transparency in the Calculation and Disclosure of Patient Wait Time Data*, Memo #21-02761-125. R. James Mitchell, et. al. April 7, 2020. <https://www.va.gov/oig/pubs/VAOIG-21-02761-125.pdf>

<sup>11</sup> U.S. Comptroller General Gene L. Dodaro to Veterans Affairs Secretary Denis McDonough, “Priority Open Recommendations: Department of Veterans Affairs,” *U.S. Government Accountability Office*, June 30, 2022. <https://www.gao.gov/assets/gao-22-105630.pdf>

<sup>12</sup> “Veterans Community Care Program,” Department of Veterans Affairs, *Federal Register*, 84 FR 26278 (2019). <https://www.federalregister.gov/documents/2019/06/05/2019-11575/veterans-community-care-program>

SEC. 101 of the VA MISSION Act states that VA care is required to be furnished through non-department providers if VA “is not able to furnish such care or services in a manner that complies with designated access standards”.<sup>13</sup> Inaccurate wait times measurements deny veterans their eligibility for community care through the designated access standards. It also hinders what is required by SEC 103, “provide veterans...with relevant comparative information that is clear, useful, and timely, so that covered veterans can make informed decisions regarding their health care.”<sup>14</sup>

#### **Problems with VA’s measurement of wait times**

VA has never calculated accurate and consistent wait times. This includes VA’s new method for calculating average wait time for new and established patients, which was submitted to the federal register for comment on July 25<sup>th</sup>, 2022, “[Calculation of Average Wait Time for New and Established Patients](#),” and is now published on the VA Access and Quality in VA Healthcare website, [www.accesstocare.va.gov](http://www.accesstocare.va.gov).<sup>15</sup> The new way VA is calculating average wait times although better than the previous way, is still incorrect, misleading and artificially makes wait times to appear shorter than they truly are and they should not be used.

**First** – VA is incorrectly dividing veteran patients into new patient and established patient appointment categories and establishing different types of start dates. There is no reason to calculate wait times differently for new or established patients. All patients should have their wait times calculated the same way to ensure consistent and accurate wait times. That is what we did in the VCCP regulation. To show how wait times are artificially shorted let’s look at two examples of state wait times using new versus existing patients in Montana and Kansas.<sup>16</sup>

#### **Montana - Billings**

Primary Care Average Wait Time: New Patients - 33 Days, Existing Patients - 4 Days  
Mental Health Average Wait Time: New Patients - 76 days, Existing Patients - 10 days

#### **Kansas - Eisenhower VAMC**

Primary Care Average Wait Time: New Patients - 42 Days, Existing Patients - 6 Days  
Mental Health Average Wait Time: New Patients - 51 days, Existing Patients - 14 days

**Second** – VA’s new listed methods of calculating average wait times from start to end date are not in line with the VCCP regulation, inaccurate, and should not be used. These new methods include:

- Earliest recorded date in the scheduling, to the date the appointment is completed, or the date it is scheduled to occur if it is not yet completed. *This artificially shortens the wait times at the start date and at the end date. There is often a delay in recording the date and a scheduled appointment may be cancelled and rescheduled by the VA.*

<sup>13</sup> [38 U.S.C. § 1703\(d\)\(D\)](#)

<sup>14</sup> 38 U.S.C. § 1703B(b)

<sup>15</sup> “Calculation of Average Wait Time for New and Established Patients,” Department of Veterans Affairs, *Federal Register*, 87 FR 44192 (2022). <https://www.federalregister.gov/documents/2019/06/05/2019-11575/veterans-community-care-program>

<sup>16</sup> Data collected from “Average Wait Times at Individual Facilities” at [AccessToCare.VA.gov](http://AccessToCare.VA.gov) as of September 14, 2022.

- Earliest recorded date in the process of receiving care, typically the date a scheduler works with a veteran to coordinate a future appointment, and it ends on the date care is received or the date it is scheduled to occur if not yet completed. *This artificially shortens the wait times at the start date and at the end date. There is often a delay in recording the date and a scheduled appointment may be cancelled and rescheduled by the VA*
- From the date agreed upon between a veteran and provider for future care and ends on the date care is received, or the date that care is scheduled to occur if it has not yet occurred. *This artificially shortens the wait times at the start date and at the end date. Date agreed upon is only to be used for follow up appointments after it is agreed by the veteran that date of request does work. This was a tactic used pre-VA MISSION Act to artificially lower wait times. Scheduled appointment may be cancelled and rescheduled by the VA so they are not accurate as an end date.*
- Third Next Available Appointment (TNAA), which is a measure of appointment availability that displays the number of days between today's date and the date of the third-next appointment available in VA's scheduling system. *This is an improper use of an industry metric, typically used for internal administration, and considerable debate exists on its effectiveness, particularly as a tool for patients.<sup>17</sup> The problem with VA using TNAA is that it is a theoretical appointment, not a real appointment with a start and end date.*

#### **The correct way to calculate VA average wait times**

To ensure average wait times are calculated accurately, consistently and in line with the VCCP regulation, do the following: Start with the date of request either veteran or provider, and end with the date the appointment is completed.

#### **Community care wait times**

The health care industry and providers in the VA community care network do not measure wait times. There is no need to measure them since private sector patients have full choice of all providers and can change providers if they are not satisfied with their wait times.

Veterans do not have full choice but instead have choice based on wait time eligibility criteria, therefore VA needs to track community care wait times starting from the veteran's date of request and ending with the date the appointment is completed. This needs to be broken down by how long the wait is in the VA process versus how long the wait time is after the community provider receives the authorization.

The current problem with community care wait times is that VA is not following the 2019 policy of processing the community care request in two business days and instead is adding many additional steps through the referral coordination initiative. The solution is to go back to following the 2019 community care policy, which was based on DoD TRICARE Prime. Once the veteran is approved for community care, simply process the authorization within two business days and notify the veteran. VA's accurate tracking of community care process wait

<sup>17</sup> Elizabeth W. Woodcock, "A Commentary on 'Third Next Available' Appointment," *Patient Access Collaborative*, 2019. <https://pas.memberclicks.net/assets/docs/CommentaryonTNAA.pdf>



times is important so that VA and veterans know where any bottlenecks are and the causes of delays with community care can be addressed.

### **Recommendations for Improvement**

In order for VA to improve its wait times and measurements, it must improve its health care operations: Start seeing more patients per clinician per day, improve its IT systems and training of staff, redo its policies and procedures to follow the VA MISSION Act and VCCP regulation, hold staff accountable, and provide veterans better patient education and easy to understand information. Here are my four recommendations to improve VA wait times, measurements and the information presented to veterans.

**First** – Pass the Guaranteeing Healthcare Access to Personnel Who Served (GHAPS) Act with the existing access standards included. This will provide veterans with a guarantee and certainty on their ability to choose community care when VA facility wait times are too long. It will also provide other needed updates and improvements to the VA MISSION Act such as an online health care education portal for veterans.

**Second** – Follow the VA MISSION Act and VCCP regulation as written when calculating wait times between new and existing patients. For average wait times, start at date of request and end on the date care is received. For community care eligibility, within 20/28 days of the date of request unless a later date has been agreed to by the veteran in consultation with the VA health care provider.

This requires both congressional and veteran service organization buy in and support. VA should withdraw its current submission to the Federal Register “Calculation of Average wait times for New and Established Patients.

**Third** – Improve VA health care operations:

- Update VA’s health IT systems within six months to support proper calculation and reporting on wait time averages for both VA facilities and community care
- Be transparent and start reporting and posting on the VA website all of the national and local wait times for both VA facilities and community care
- Educate staff, providers and veterans on the requirements of the VA MISSION Act and the VCCP regulation as required by SEC 121 - Education program on health care options, and SEC 122. -Training program for administration of non-Department of Veterans Affairs health care. Veterans need to know when they are eligible for community care due to long VA wait times that go beyond the access standards.
- Stop illegal local policy practices such as overriding veterans and VA clinicians on community care eligibility for access standards and best medical interest through the improper use of referral coordination teams and the clinically appropriate standard.
- See more patients per clinician per day at VA facilities to reduce wait times and pressure for community care. The goal should be to see as many patients as DoD sees in a day on average. Prior to COVID-19, VA was seeing around 10 patients per day per clinician, which was very low. I have been contacted by several VA clinicians who have told me they are seeing only six patients per day.

**Fourth** – Improve VA communications and methods in delivering information to veterans. At the national level this can be done by reinstating an updated version of the VA MISSION Act website ([missionact.va.gov](http://missionact.va.gov)). This will provide veterans and stakeholders once again a centralized hub on all information related to the VA MISSION Act, including all of the education requirements for veterans and community care providers contained in SEC 121 and SEC 122 of the VA MISSION Act.

At the local level VA needs to follow the letter and full intent of SEC 121 and SEC 122 of the VA MISSION Act. VA should also develop and implement an education and communication plan and a variety of delivery mechanisms to ensure veterans can obtain all of the education and information needed to successfully navigate their health care both at the facility and in the community.

### **Conclusion**

As VA goes forward it must change its culture, become veteran centric, and do what is best for the veteran, not what is best for VA. Only then will veterans have accurate wait times and be provided access to timely care. As General Omar Bradley said, “We are dealing with veterans, not procedures; with their problems, not ours.”

And as President Theodore Roosevelt said, “A man who is good enough to shed his blood for the country is good enough to be given a square deal afterwards.” Through accurate wait times and timely access to quality care, either through VA facilities or the community, let’s make sure our veterans get the square deal they deserve on their health care.

I am committed to overcoming any and all obstacles that stand in the way of achieving what is best for veterans. I look forward to working with the chairman, ranking member, and all members of this committee to achieve this shared commitment. I am happy to answer any questions.

# DELAYED AND DENIED CARE

Transparency and Oversight Needed for VA Wait Times



## Our View

Veterans deserve access to quality health care in a timely manner. Reports of delayed, denied, and cancelled health care appointments at the Department of Veterans Affairs are unacceptable and require robust oversight by Congress. The VA is required to follow the policies, procedures, and training from VA MISSION Act law and regulations. Selectively picking and choosing what regulations or sections of the law to follow, resulting in 20 million cancelled appointments, is unacceptable.

## Background

The VA MISSION Act created the Veterans Community Care Program, which was rolled out in 2019 to give greater health care choice to veterans. A key component of the new program is new access standards and eligibility criteria for community care. While access to care was disrupted across every single health care system in 2020 due to a global pandemic, this does not excuse the VA from following and fully implementing the law and regulations.

In September 2020, the [Inspector General reported](#) nearly 20 million VA appointments cancelled or delayed during the pandemic, denying millions of veterans' access to critical care. Moreover, [evidence suggests](#) a potential trend of the VA using improper wait time calculations to limit access to community care under the VA MISSION Act access standards. Documents obtained through a [Freedom of Information Act lawsuit](#) filed by Americans for Prosperity Foundation on July 20, 2021 confirm and expand upon concerns outlined by the Government Accountability Office.

The VA announced in October 2021 they were [decommissioning](#) and closing the Office of Community Care as well as shutting down the VA MISSION Act website ([missionact.va.gov](http://missionact.va.gov)). This move by the VA comes as many veterans are still learning about their health care options and will only make it harder for veterans to access information regarding their options and eligibility.

Americans for Prosperity Foundation released all documents obtained via FOIA on [October 1, 2021](#) and [January 28, 2022](#). Below are key findings from reports from the OIG, GAO, news reports, and the FOIA documents.

## Key Findings And Oversight Opportunities

- Failing to follow VA MISSION Act eligibility requirements and denying community care.** The VA continues to use [old scheduling guidance](#) from legacy community care programs instead of following the VA MISSION Act and its [regulatory guidance](#). The VA's Referral Coordination Initiative Implementation Guidebook (updated Oct. 28, 2021) details the VA's push to [reduce community care](#) because "more veterans being referred to the community than expected." These training materials obtained via a FOIA request reveal the VA has created a web of steps to make it easier for the VA to deny community care and harder for veterans to receive timely care. This includes:

  - Denying Community Care referrals based on clinical appropriateness requirement.** [Flowcharts](#) used in VA training documents reveal an added layer after a veteran has been determined eligible for community care. The VA has created a new "clinically appropriate" standard that must be met before completing referrals. This additional step is not allowed by the VA MISSION Act and can leave veterans waiting even longer for care, or simply being denied community care despite being found eligible.
  - Waiving wait time access standards.** According to VA training guidance, "for veterans with a return to clinic order with a CID (clinically indicated date) greater than 20/28 days, the wait time standard is considered waived." This guidance creates a carve out exemption to the access standards created by the VA MISSION Act and takes the decision away from the veteran to waive wait time standards. This practice allows the VA to deny community care for eligible veterans without the veteran's consent.
  - Granting administrators, instead of providers and veterans, the final decision-making authority on "Best Medical Interest" eligibility.** Findings in an [inewssource/USA Today investigative story](#) from November 1, 2021 revealed VA administrators and schedulers actively countering the clinician referral recommendation to limit veterans access to community care. The VA MISSION Act includes the eligibility criteria of "best medical interest" in the text of the law, however VA administrators are leveraging that eligibility criteria to limit access instead of giving clinicians maximum flexibility to

refer patients to community providers if it is in their best interest. Ultimately clinicians and veterans should be trusted to know when it is in the veterans' best interest to receive non-VA care.

- **Using "Patient Indicated Date" to misrepresent wait times.** The VA is using what is called the "patient indicated date (PID)" instead of the "date of request," as required by the current access standard regulation, to calculate and report wait times. In practice, the PID is usually set by a scheduler instead of the "date of request," which is set by the veteran. The [VA's own guidance](#) on their website admits to using two different methods to measure wait times. The [GAO found](#) that this standard is subject to scheduler interpretation and ripe for manipulation. Ultimately this can leave veterans not just waiting longer, but also denied access to community care referrals.

#### Example A: Case Study on Finding #1 via FOIA for Arizona

Data obtained from the [Southern Arizona VA](#) (Tucson), the [Northern Arizona VA](#) (Prescott), reveals how the VA's use of two different methods of calculating wait time impacts who might be eligible for community care. Using the PID for existing patients overwhelmingly leads to the appearance of shorter wait times for veterans. Completed appointment data obtained via FOIA from January 2020 through June 2021 found:

##### Primary Care

- Tucson: Under MISSION Act standards, 21% of appointments would be eligible instead of 4.2%.
- Prescott: Under MISSION Act standards in the pre-COVID month of January 2020, 68% of appointments would be eligible instead of 10.3%.

##### Specialty Care

- Tucson: Under MISSION Act standards, 26.7% of appointments would be eligible instead of 9.3%.
- Prescott: Under MISSION Act standards in the pre-COVID month of January 2020, 54.4% of appointments would be eligible instead of 14.8%.

##### Mental Health Care

- Tucson: The wait times for new patients and existing patients for mental health care differs only slightly with a 5 percent difference using PID or date of request to calculate wait time.

#### Example B: Case Study on Finding #1 via Public VA Wait Time Access Data

Data from the [VA website](#) accessed on January 25, 2022 reveals significant differences between how long a veteran waits for care based on whether they are a new patient (Date of Request) or an existing patient (Patient Indicated Date), for the following facilities:

##### Primary Care in Montana at Hamilton VA Clinic

- New Patient based on Date of Request: 74 days
- Returning Patient based on Patient Indicated Date: 3 days

##### Primary Care in Kansas at Shawnee VA Clinic

- New Patient based on Date of Request: 43 days
- Returning Patient based on Patient Indicated Date: 2 days

##### Primary Care in Tennessee at the Nashville VA Medical Center

- New Patient based on Date of Request: 61 days
- Returning Patient based on Patient Indicated Date: 7 days

##### Primary Care in Illinois at the Mount Vernon VA Clinic

- New Patient based on Date of Request: 26 days
- Returning Patient based on Patient Indicated Date: 1 day

2. **Canceling and rescheduling of appointments without agreement of the veteran or offering community care.** Data obtained from the [North Florida and South Georgia VA](#) (Gainesville) found out of 682,739 canceled appointments made by the VA from January 2020 through May 2021, a total of 427,466 lacked evidence that they were canceled with the permission of the veteran. Canceling or canceling and rescheduling appointments should be done with consultation of the veteran, otherwise this practice can be abused and used to [reset the wait time clock](#) and used as a backdoor method of denying veterans referrals to community care. In [Montana](#), from January 2020 through May 2021 over 93,000 appointments were canceled by the VA, and it is unknown if those patients were ever rescheduled, offered community care or left waiting. Materials received through the FOIA process include training documentation with a patient with a PID of April 20, 2020 that was canceled and moved to August 14, 2020 due to the pandemic. Yet the patient was never offered community care as an option nor does the training scenario indicate the VA was obligated to offer it, even though the patient waited four months for care.

3. **Inadequate documentation of when veterans opt-out of community care.** According to guidance from the [Office of Community Care Field Guidebook](#), the VA is responsible for documenting when a veteran opts out of community care. FOIA data obtained from the [North Florida and Southern Georgia VA](#) (Gainesville) found the VA scheduled 187,385 appointments outside of the wait time access standard but only had 5,975 that contained proper documentation in the record that there was agreement by the veteran to opt out of community care. Either the VA is not to accurately document conversations with veterans or not offering community care to eligible veterans.
4. **Using cost to determine administration of community care program.** Funding for community care as well as VA health care should not determine where or how a veteran accesses health care. However, [internal guidance](#) being used by the VA states, when reviewing community care options, "staff must also consider funding availability." This type of language should be removed from any VA scheduling guidance to avoid any miscommunication.
5. **Neglecting to advise veterans of their options and actively dissuading use of community care.** [Guidance](#) being used by the VA discourages VA employees from offering to review eligibility for community care for veterans unless they ask for it themselves. Furthermore, the VA is actively providing sample scripts for employees to use when talking to veterans eligible for community care. The [VA's script](#) actively dissuades veterans from choosing community care by using inaccurate community wait time data and placing the expectation on the veteran to ensure their care is coordinated and to obtain their medical records – both of which are, and have always been, the VA's responsibility. These are misleading practices because the VA does not have the ability to know the wait times for community providers because those are not reported to the VA.

#### Read More

- All FOIA documents released by Americans for Prosperity Foundation on October 1, 2021, "[Records confirm VA's use of inaccurate wait time numbers.](#)"
- All FOIA documents released Americans for Prosperity Foundation on January 28, 2022, "[More evidence the VA is improperly delaying or denying community care to eligible veterans.](#)"

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**Submission for the Record**

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Biden's VA undermining law that gives veterans access to private health care



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## Biden's VA undermining law that gives veterans access to private health care

By Peter Kasperowicz

Published September 13, 2022

Fox News

Sometime in 2021, the Department of Veterans Affairs took down a popular link on its website that explained how veterans can access medical care in the private sector under a law known as the Mission Act.

The law was the latest congressional response to the scandal that erupted in 2014, when Veterans Affairs facilities across the country were found to be manipulating data to make it look like veterans were receiving timely care. In reality, veterans were waiting months to be seen by their doctors, and federal investigators said those delays contributed to their deaths.

The Mission Act sought to remedy the problem by allowing veterans to seek care outside VA for a broad range of reasons – including when wait times are too long at VA – and making VA pay for that coverage. When the law first took effect in 2019, VA created a MissionAct.Va.Gov link to educate veterans about their options, explain eligibility requirements and provide links to community health providers.

But in the late summer or early fall of 2021, that link suddenly directed veterans to a page called "Choose VA," which encouraged veterans to use VA for their health care. VA also buried the link – it's no longer visible on the front page or the main health care page.

### VETERANS CONFRONT VULNERABLE NJ DEM AT TOWN HALL: 'ARE YOU HELPING ME? NO.'

VA declined to answer specific questions from Fox News Digital about when or why the link was changed to steer veterans toward VA care, and insisted VA remains committed to implementing the law.



The US Department of Veterans Affairs building is seen in Washington, D.C. The agency said Friday it will offer abortions for veterans in certain cases. (ALASTAIR PIKE/AFP via Getty Images)

"VA is laser-focused on getting Veterans access to the best possible health care, whether that comes directly from VA or from the community," said VA Press Secretary Terrence Hayes, who added that all the information veterans need to use the Mission Act is still online on its community care page. "As a part of that effort, VA continues to implement the Mission Act faithfully, transparently and in its entirety."

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Biden's VA undermining law that gives veterans access to private health care

But those who worked to implement the Mission Act say the website change was the first shot fired in the Biden administration's campaign to thwart the law, and that VA has taken several steps since then to steer veterans away from exploring private sector care.

"The Mission Act represents the ability to choose something other than VA, and they took it down," said Darin Selnick, a senior adviser to Concerned Veterans for America and former top adviser to VA Secretaries David Shulkin and Robert Wilkie.

Selnick said the remaining information about the Mission Act is much more difficult for veterans to locate and is a far cry from explicit language in the Mission Act that requires VA to educate veterans about their new choices. "All they want you to be able to do is to choose VA care," he said.

#### DEPARTMENT OF VETERANS AFFAIRS TO OFFER ABORTIONS TO VETERANS IN CERTAIN CASES

Selnick and others say VA's opposition to the law has only become clearer since the Mission Act link was turned into a "Choose VA" tool. In October 2021, VA announced it would close the Office of Community Care and start designing a "new integrated access and care coordination model."



Darin Selnick (Concerned Veterans for America)

VA's vague announcement worried veterans' groups and lawmakers, who suspected it would make it easier for VA to downplay and dismantle the Mission Act.

Later in 2021, some of those suspicions were confirmed as complaints from veterans about wait times began to pile up. At about the same time, the Americans for Prosperity Foundation sued VA under the Freedom of Information Act for information about its implementation of the Mission Act and found evidence that VA was still playing around with patient wait-time data.

For example, current Mission Act regulations say a veteran is eligible for care outside VA if wait times at their VA facility are longer than 20 days for primary and mental health care or 28 days for specialty care. But FOIA documents showed that VA is not starting the clock when a veteran asks for an appointment and instead is using a date set by VA schedulers, which means veterans are waiting longer for appointments than indicated by official VA data.

#### 9/11 ANNIVERSARY MAKES IT EASY FOR VETERANS TO REMEMBER WHY WE WERE IN AFGHANISTAN

A USA Today report in November confirmed other complaints that VA bureaucrats are getting in the way of medical decisions to seek community care. The Mission Act says veterans are eligible for community care whenever it's in their best interest, but USA Today found that VA quashed at least one veteran's effort to seek outside medical care by ruling that doing so was not "clinically appropriate."

As the complaints mounted, lawmakers geared up to protect the Mission Act. Senators Marsha Blackburn, R-Tenn., and Tommy Tuberville, R-Ala., introduced legislation in early 2022 that would take VA out of the business of referring veterans to community care and allow veterans to make that choice on their own.

"In Tennessee, I have heard from countless veterans about their frustrations with how the VA is running the community care program," Blackburn said in February. "My legislation will cut out the middleman and make it easier for veterans to see a doctor."

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Biden's VA undermining law that gives veterans access to private health care



Secretary of Veterans Affairs nominee Denis McDonough speaks during his confirmation hearing before the Senate Committee on Veterans' Affairs on Capitol Hill, Wednesday, Jan. 27, 2021, in Washington. (Sarah Silbiger/Pool via AP)

But by the summer of 2022, VA doubled down and started to acknowledge openly that it was seeking to pare back veteran choice under the Mission Act. In a June 14 hearing at the Senate Veterans' Affairs Committee, VA Secretary Denis McDonough was asked about the department's effort to change access standards for using private care as part of a three-year review of the law.

McDonough replied that demand for health care "has increased more intensively for care in the community than for care in the direct system," said community care now accounts for one-third of all care that goes through the VA. He said that's a "high number," and added that he was already "worried" in 2021 when community care was about one-quarter of all care delivered through VA.

McDonough's comment seems to go against the statement from his own spokesman who said VA wants the best care possible for veterans "whether that comes directly from VA or from the community." But McDonough went further by telling senators that "my hunch is that we should change access standards," a strong indication that VA will propose making it more difficult for veterans to qualify for community care.

#### FLORIDA VETERANS EMPOWERED TO BEGIN NEXT TOUR OF DUTY IN THE CLASSROOM

A month later in the House, Acting Deputy Undersecretary for Health Miguel LaPuz explained why VA wants to limit veterans' access to the private sector. In written testimony to the House Veterans' Affairs Committee, LaPuz said VA's training, research and other missions are threatened by the popularity of getting care outside the VA system.

"Even in the absence of resource constraints, if the balance of care provided in the community continues on its current upward trajectory, we anticipate that certain VA medical facilities, particularly those in rural areas, may not be able to sustain sufficient workload to operate in their current capacity," LaPuz said.



<https://www.foxnews.com/us/bidens-va-undermining-law-gives-veterans-access-private-health-care.print>

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Biden's VA undermining law that gives veterans access to private health care

The next few weeks may determine whether Congress needs to step in again to shore up a law that had wide support among both Republicans and Democrats. The Senate Veterans' Affairs Committee is planning a late September hearing where it might finally hear VA's plans for changing access standards for veterans.

One congressional aide told Fox News Digital that many staffers believe VA is more worried about its own fiscal health than it is about the health of its patients, and it wants more control over the money Congress appropriates. "The bottom line is justifying a budget increase year-over-year," the aide said.

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If VA does impose new hurdles to using the Mission Act, it could set up a new push for Congress to tweak the law, something that could happen if Republicans take control of the House and Senate.

"VA thinks it's better for sick veterans to stay at their facilities and wait rather than allowing them to seek out care with the best providers in the world," the aide said. "In our eyes, a veteran should be able to go wherever they can, regardless of what VA says."

Pete Kasperowicz is a politics editor at Fox News Digital. He can be reached at [Peter.Kasperowicz@Fox.com](mailto:Peter.Kasperowicz@Fox.com) and his Twitter handle is [@PeteKDCNews](https://twitter.com/PeteKDCNews).

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**Questions for the Record**

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**Department of Veterans Affairs (VA)**  
**Questions for the Record Submitted to**  
**The Honorable Denis McDonough, Secretary of Veterans Affairs**  
**Senate Veterans' Affairs Committee**  
**“Ensuring Veterans’ Timely Access to Care in VA and the Community”**

**September 21, 2022**

Questions for the Record from Senator Jerry Moran:

**Question 1: VA is using a different methodology to calculate average wait times for public reporting compared to how it calculates individual wait times to determine eligibility for community care under the MISSION Act’s designated access standards. Should average wait time calculations for meeting the reporting requirement under the Choice Act use the same methodology as calculating wait times for community care eligibility access standards? Why or why not?**

VA Response: VA is steadfastly committed to ensuring that Veterans have the information needed to make informed decisions about their health care – whether that care is in person in VA’s direct care system, through VA virtual care or through community care. An important component of providing this information involves the calculation and communication of wait times. The calculation of aggregate wait times is a complex endeavor. VA is the only health care system in the Nation to provide such depth and transparency in the calculation of wait times, and VA strives to do this effectively for Veterans despite the absence of clear industry or literature best practices.

VA does not endorse using the same methodology as the wait time calculations for reporting and determining an individual Veteran’s eligibility. These methods of calculation are for different purposes and require the incorporation of different data sets. The purpose of reporting average wait times is to provide Veterans with wait time data to inform their health care decisions and to gain insights into the general performance of VA’s direct care system at any given time across a variety of types of care. This means that average wait time calculations do not incorporate an individual Veteran’s unique care needs and circumstances at a specific moment in time, as that information is only known to Veterans and their care team at the time a Veteran requests an appointment. This latter calculation, for an individual Veteran’s wait time from the date of request to the appointment date, is in compliance with 38 U.S.C. § 1703(d)(4), as added by section 121 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022 (the Cleland-Dole Act).

**Question 2: What actions has VA taken to capture the date of request in its scheduling system, either through information technology development or workflow process changes, in order to measure average wait times beginning with the date of request? Please share any analysis on this issue and any projected costs and implementation challenges VA has identified.**

VA Response: VA is committed to ensuring that the way we measure and report wait times accurately reflects Veterans' true wait time experiences, beginning with an initial request for care and concluding when the requested care is delivered. VA scheduling and wait time data have shed further light on opportunities to improve care timeliness for Veterans both in VA's direct care system and in the community. Veterans Health Administration (VHA) is currently optimizing areas in direct and community care appointment processes to optimize access to care and improve reporting capabilities. VA's Office of Integrated Veteran Care (IVC) is focused on these precise opportunities to improve care timeliness for Veterans, regardless of their care setting. For community care wait time calculations, VHA is working with the Office of Information Technology (OIT) to validate the time from when a referral for care is created to when an appointment is made with non-VA providers, which will be incorporated into these calculations. VA is working to develop a plan to inform Veterans of expected wait times through the Veterans Community Care Program (VCCP), which will also be dependent on access to community care scheduling information being procured in support of sections 131-134 of the Cleland-Dole Act.

VA is engaging in an enterprise scheduling modernization effort to improve internal, direct care scheduling as well as community care scheduling systems. The internal systems improvement work is led by an OIT development team, working in close collaboration with VHA. The community care scheduling systems improvements are intended to be accomplished through an acquisition of technology to allow viewing and scheduling directly into community care provider clinic grids. The ability to measure the point in time when care is requested is an established requirement for these modernization efforts. Pilot efforts to date for community care scheduling systems, at 2 sites, have demonstrated a significant boost to scheduler efficiency, as well as a reduction in time from care request to Veteran first appointed to a community care provider. The cost for technology acquisition and implementation will be better understood following an independent government cost estimate (currently underway), and upon conclusion of a request for proposals (RFP) (goal quarter 4, 2023 government fiscal year).



**Question 3: VA announced in its Access to Care Standards report plans to incorporate “VA telehealth availability into determinations regarding eligibility based on the designated access standards.” How do you envision this working both for the wait time access standard and the drive time standard? Please give us an example.**

VA Response: VA is considering rulemaking that would propose incorporating clinically appropriate telehealth availability into determinations regarding eligibility to elect to receive care in the community under the designated access standards.

The specific details of any such proposal have not been finalized at this time. Any proposal would be thoroughly vetted and designed based on feedback from Veterans, Veterans Service Organizations, VA employees, Congress and the general public. The proposal would also be based on analyses of internal VA data and trends and consideration of best practices, both in the Federal Government and the private sector.

We anticipate that any proposal would support Veterans receiving the fastest, high-quality care available in a known setting that understands the unique needs of Veterans. VA will continue to emphasize continuity of care, care coordination and longitudinal care both in direct care and community care systems and will continue to keep Congress apprised of these efforts. We do not have an example at this time, but as VA develops more specific details regarding this effort, we can engage in further discussions with you and your staff to ensure you are kept informed and understand our approach.

**Question 3a: Would this change lessen the “choice” a veteran has to seek care in the community if their preferred method of care is to see a provider in-person and VA is unable to do so within a reasonable time or too far to drive?**

VA Response: VA will take into consideration a Veteran’s preference for in-person care as it develops any proposal to incorporate clinically appropriate telehealth availability into community care eligibility determinations.

**Question 4: VA’s Access Standards report juxtaposes other Federal, State, and commercial insurance access standards with VA’s own standards. Do those other entities incorporate telehealth into their standards as VA proposes?**

VA Response: First, it is important to note that no other health care system, issuer, or payor, other than programs offered by the Department of Defense, uses access standards to determine whether services can be provided in-network or out-of-network at the user’s election. Access standards are generally used by other systems to determine whether a vendor meets certain network adequacy standards at the plan or population level only or to determine cost sharing requirements for the enrollee. Over the past decade, private insurers and health plan providers have allowed coverage for and expanded access to telehealth in an effort to ensure affordable expanded access to needed care for patients. In response to the COVID-19 pandemic, the Federal government, State Medicaid programs, and private insurers expanded coverage for

telehealth services and utilization of telehealth increased. Currently, Medicaid and commercial health plans do not incorporate access to telehealth into the consideration of whether their networks meet access standards. With respect to Medicare Advantage, regulations at 42 C.F.R. § 422.116(d)(5) provide Medicare Advantage plans with a 10-percentage point credit towards the percentage of Medicare beneficiaries residing within published time and distance standards for the applicable provider specialty types by county when the Medicare Advantage plan includes one or more, however, they are continuing to cover telehealth providers for certain specialties that provide additional telehealth benefits, as defined in 42 C.F.R. § 422.135, in its contracted network. visits. Private health plans are encouraging, but not requiring, members to use telehealth where appropriate. A few health plans are now offering "virtual first" health plans, where a member uses telehealth for most routine primary care services. Also, some provider specialty groups, such as gastroenterology, are requiring telehealth for first appointments or follow up visits for their patients.

**Question 5: What role did cost and a declining patient base at some VA facilities – alluded to in the report – play in VA’s decision to plan on incorporating telehealth in its access standards? If there was a role, explain how that is a veteran-centric decision.**

VA Response: Cost and a declining patient base are not driving VA’s decisions around policy considerations related to access standards. It should be noted that telehealth has become a widely accepted and effective modality for health care delivery in the United States, both inside and outside of VA. Telehealth can leverage the breadth and depth of a national health care organization such as VA to provide timely care options for Veterans.

**Question 6: Scheduling appointments seems to be an ongoing challenge. With the PACT Act creating the possibility of significant enrollment growth, how will VA improve its ability to schedule appointments through its call centers?**

VA Response: Today, there are an estimated 45 million calls annually through VHA’s clinical contact centers with almost 50% of the calls involving scheduling. The ability to handle an increase in call volumes within the Clinical Call Centers is being addressed through three key areas:

- Technology enhancements through Clinical Contact Center Modernization efforts to incorporate the VA Integrated Scheduling Solution (ISS) into the Customer Relationship Management (CRM) workflows. Goal is to implement by end of Q1 2024.
- Process changes to standardize the scheduling workflow across VA and optimize existing processes to meet the expected call volumes.
- VHA hiring initiatives to aggressively fill vacancies and fill contact center scheduling positions.

**Question 7: In June, Secretary McDonough stated that because spending on community care was going up so much, the access standards should be more restrictive. What is the monthly or annual spending growth for community care since 2018 (pre-MISSION Act) through FY2022?**

VA Response:

All Community Care (dollars in thousands)		
Fiscal Year	Total Obligations	Growth % from Previous FY
FY18	\$14,855,724	
FY19 <sup>1/</sup>	\$15,356,074	3.37%
FY20 <sup>2/</sup>	\$19,868,301	29.38%
FY21	\$23,555,408	18.56%
FY22	\$27,386,678	16.26%

Note: For year over year comparability, adjustments were made to FY19 and FY20 that deviate from the final financial statements in those fiscal years, explained below.

1/ This amount is higher by \$1.914 billion than the final actuals. This adds the estimated expended obligation from that year to cancel out the one time savings from switching from obligating at the time of authorization to obligating at the time of payment.

2/ This amount is lower by \$5.008 billion than the final actuals. Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and recorded obligations of \$5.008 billion for FY 2020 in the Medical Community Care account. VA lacked sufficient funds within the account to cover the full obligations recorded in FY 2020 consistent with VA OGC's opinion. Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to health care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Anti-deficiency Act (ADA) violation that would have occurred in FY 2020 absent its enactment. To implement the law, VA made

an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.

**Question 7a: How much of that cost is for emergency care reimbursements?**

VA Response:

	ER Costs
FY 2018	\$264,656,307
FY 2019	\$303,384,073
FY 2020	\$373,527,545
FY 2021	\$608,391,474
FY 2022 July	\$585,671,273

Data Source: CCRS, eCAMS, PC3 and FBGS payments files by emergency CPT codes

**Question 7b: Would changing access standards reduce emergency care reimbursements?**

VA Response: No, we do not believe changing the designated access standards would affect emergency care reimbursements. For community care eligibility, the access standards criterion only apply to non-emergent care, and any changes to the access standards would have no impact on emergency care. VA remains committed to ensuring Veterans have excellent access to high quality emergency care. When it comes to emergency care, an important study published in 2022 showed that Veterans requiring emergency care who were transported to VA hospitals had a substantially lower risk of death within one month than those transported to non-VA hospitals (Chan, 2022), which corresponds to a 20% lower mortality rate among Veterans taken to VA hospitals. The advantage was particularly large for Hispanic and Black patients, older patients and patients who arrived with relatively low mortality risk.

**Question 8: In the Access Standards Review report to Congress, one finding was that the Community Care Networks should have the same access standards as VA direct care, specifically the same 30 or 60 minute drive times and 20 or 28 day wait times. I have been calling for VA to make this change to its CCN contracts for the past three years—why has VA still not taken any action to make this change?**

VA Response: Respectfully, this was not one of VA's findings in the report; the report did state, however, that this was feedback VA received during public engagement regarding the access standards (see pages 18 and 30 of the report). The Community Care Network is designed to be a supplemental source of health care for Veterans. Section 125 of the Cleland-Dole Act amended 38 U.S.C. § 1703B(f) to require VA to meet the access standards established under section 1703B(a) when furnishing care and services to a covered Veteran under the VCCP and to ensure that meeting such access standards is reflected in the contractual requirements of third-party

administrators (TPA). Section 125 of the Cleland-Dole Act also created a new section 1703B(f)(2), which requires VA to ensure that health care providers specified in section 1703(c) are able to comply with the access standards established under section 1703B(a) for such providers. VA has expressed concern that these requirements could jeopardize network adequacy and disincentivize community providers from participating in the VCCP. Even so, VA has taken action to work with the Community Care Network (CCN) TPAs to modify the contracts to enhance access for Veterans living in highly rural areas, and modifications reducing drive time standards were made to the CCN contracts across all regions by June 2022. VA is in the final stages of updating the current standards, which will result in Routine Appointing Standards for contractor scheduled appointments to 30 days for mental and behavioral health, and 21 days or less for all other categories of care.

**Question 9: What actions is VA taking to collect information on the quality of the care veterans receive from the Veterans Community Care Program (VCCP)?**

VA Response: To ensure that Veterans receive quality care, VA collects and compares information on an ongoing basis. Comparison data regarding VA's standards for quality are available online at the Access to Care website ([www.accesstocare.va.gov](http://www.accesstocare.va.gov)) and allows Veterans to examine VA and regional community provider performance on key clinical quality and experience metrics. These comparisons depict both VA facility performance and community provider performance at the measure level to aid Veterans in understanding the quality of care available in their geographic region. The metrics included are fundamental indicators of inpatient, outpatient, and patient experience performance that align with three central tenets of VA care:

- **Effective Care:** Is based on scientific knowledge of what is likely to provide benefit to Veterans.
- **Safe Care:** Avoids harm from care that is intended to help Veterans.
- **Veteran-Centered Care:** Anticipates and responds to Veterans' and their caregivers' preferences and needs and ensures that Veterans have input into clinical decisions.

Under the CCN contracts, the Contractors are required to develop and submit a written Clinical Quality Monitoring Plan (CQMP) to VA. The CQMP must include an articulation of the quality monitoring activities for patient safety, clinical quality assurance, clinical quality improvement, and peer review. The Contractor's CQMP must include a detailed description of the purpose, methods, proposed goals, and objectives designed to ensure the highest quality of clinical care under this contract. The TPA must provide a copy of its CQMP to VA in accordance with the Schedule of Deliverables.

VA medical centers (VAMC) work with IVC staff and contractors administering the CCN contract, a Veterans Care Agreement (VCA) or local contracts on all potential quality and patient issues for Veterans who receive care in the community on behalf of VA. All safety and quality events identified by VA staff, regarding care authorized under the

community care program, are required to be reported in the internal tracking system for safety events for VHA-Joint Patient Safety Reporting System. Additionally, for care authorized under regional contracts involving TPAs, VA staff must complete a potential quality issue form to notify the TPA of the event so they can begin their robust investigation process.

For events occurring in CCN, TPAs are contractually required to evaluate potential quality and patient events, applying appropriate medical judgement, evidence-based medicine/best medical practices when identifying, evaluating, and reporting on all quality and patient events. Additionally, TPAs identify, track, trend, and report interventions to resolve any Potential Quality Issues (PQI) or Identified Quality Issues (IQI) using the most current National Quality Forum (Serious Reportable Events, CMS Hospital Acquired Conditions, and Agency for Healthcare Research and Quality Patient Safety Indicators). All identified quality events, regardless of the source, are reviewed, confirmed by a qualified peer review committee to determine deviations from standards of care, severity levels, and recommended interventions to include Corrective Action Plans (CAP), reported to licensure boards if indicated, and monitored through resolution. The TPA must provide aggregate reporting of PQI/IQI data, including severity score, and provide actions taken to resolve the quality issue in accordance with the contract deliverables. VA requires the TPAs to meet a minimum completion closure rate of 95% of all PQI and IQI within 90 days from date of identification and 99% within 180 days of identification. Furthermore, VA IVC participates as a non-voting member on peer review committees, credentialing committees, and clinical quality improvement and management meetings with the TPA for oversight of these processes. Additionally, VA IVC conducts a quarterly analysis of the safety events reported and identifies any issues, trends, and gaps to address as a national office.

Another mechanism for evaluating quality of providers under CCN involves the High Performing Provider (HPP designation) program, which establishes a set of evaluation metrics and a function to support VA users in care coordination and referral management in selecting highly rated clinicians in the community. The HPP designation allows Veterans to have the opportunity to be scheduled with the highest quality CCN providers available. Referring Veterans to HPPs ensures that Veterans are receiving high-quality care inside VA and in the community. Individual providers are evaluated on quality and cost-efficiency measures determined by VA and CCN contractors, which will result in a score. Group provider scores are individual provider results rolled up into a single score. The CCN contractor will determine scoring thresholds for each eligible specialty evaluated. The scores for individual and group providers will result in a Yes, No, or Unknown HPP designation.

**Question 10: When a veteran patient requests care through VCCP, or it is recommended by their provider: How quickly must that care be authorized by VHA according to VHA policy?**

VA Response: Per the Consult Timeliness standard operation procedure (SOP), the consult should be received and status changed from pending to active within 2 business days.

**Question 10a: Once authorized, within how many days must a VA scheduler start to schedule the appointment?**

VA Response: Per the Consult Timeliness SOP, the consult should be placed in a scheduled status within 7 days. This includes clinical review of the consult, determination of community care eligibility, and sending the authorization to the community care provider.

**Question 10b: How is compliance with these timeliness standards tracked, and what action is taken when the timeliness standards are not met?**

VA Response: Veterans Integrated Services Network (VISN) and VAMC leadership use a Consult Activity Measures Report located in VSSC to track and measure internal and community care timeliness metrics. This (1) ensures timeliness standards are met, (2) identifies any challenges or barriers, and (3) ensures VA takes appropriate corrective action as needed. Consult Timeliness standards are outlined in the Consult Timeliness SOP, which is a part of VHA Directive 1232(5). IVC Field Support meet regularly with VISN and VAMC leadership to review data and determine barriers and next steps related to scheduling metrics. The Care Projection Model (CPM) Alert tool is utilized by IVC Field Support to determine top outlier sites and initiate additional support when needed.

Questions for the Record from Senator Tommy Tuberville:

**Question 1:** As I articulated during the SVAC hearing on September 21, I am strongly opposed to the recent interim final rule that permits the VA to provide abortion services in every state, even in those states who have prohibited abortion. During the hearing you admitted that you were aware of at least one abortion that had been performed at a VA facility.

Please provide an update on how many abortions have been performed under the authority of the interim final rule, including a breakdown of the:

- Number of abortions performed at VA facilities vs. Community Care referrals per state.
- Number of abortions classified by the method of abortion (e.g., mifepristone) per state.
- Number of abortions classified by the gestational week during which the pregnancy is terminated per state.

VA Response: VA previously has provided the Committee with information about the number of abortions performed. Providing the detailed information sought in this request threatens to intrude into the Veteran-doctor relationship, putting at risk the inviolable communications between Veterans and their providers. In addition, this more detailed information has the potential to put Veterans' privacy at risk because of the limited number of cases and the improved methods of probabilistic matching using commercially or publicly available datasets.

**Question 1a:** During the hearing you refused to explicitly say whether the VA would impose restrictions on abortion after a certain point in pregnancy. Does the VA plan to perform or facilitate abortions up until the birth of a child?

VA Response: Under the interim final rule, abortions may be provided to Veterans and VA beneficiaries when (1) the life or the health of the pregnant Veteran or VA beneficiary would be endangered if the pregnancy were carried to term; or (2) the pregnancy is the result of an act of rape or incest. Whether these services are needed is determined for each individual on a case-by-case basis between the health care provider and the patient they care for, ensuring that a provider's medical judgment serves as the basis for determining the need for care, consistent with the Veterans' Health Care Eligibility Reform Act. Care included in the medical benefits package is "provided to individuals only if it is determined by appropriate health care professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice." Note that VA providers are subject to 18 U.S.C. § 1531.



**Question 1b:** During the hearing you admitted that the VA conducted estimates of how many abortions would be performed per year should the VA offer abortion services. Please provide all data the VA used to forecast utilization of abortion services.

VA Response: The following information was used to project utilization:

- Cost projections were the total number of female Veterans enrolled in VA by year based on the 2021 (FY 2020) Enrollee Health Care Projection Model (EHCPM)
- The number of CHAMPVA beneficiaries, which includes certain spouses, children, survivors, and caregivers of Veterans who meet specific eligibility criteria under 38 U.S.C. § 1781(a) (Note: Spouses were limited to females).
- The portion of Veteran enrollees who would seek an abortion because the life of the pregnant Veteran is endangered and the portion of Veteran enrollees and CHAMPVA beneficiaries who would seek an abortion because the pregnancy is the result of rape or incest is based on data from the Department of Defense (DoD), which provides abortions in similar circumstances. Based on data from 2013 to 2016, 0.005 percent of active-duty Servicemembers of reproductive age had abortions for these reasons. VA assumed the same frequency of these abortions for Veteran enrollees and CHAMPVA beneficiaries.
- The portion of Veteran enrollees and CHAMPVA beneficiaries who would seek an abortion because the health of the pregnant Veteran or CHAMPVA beneficiary is endangered is based on data reflecting rates of high-risk pregnancies and studies of severe maternal morbidity rates.
- VA assumed that all abortions for Veteran enrollees and CHAMPVA beneficiaries covered under this proposal will be paid for or provided by VA. To the extent that some or all of this care will be paid for by other types of health care coverage, the effect would be a reduced cost for VA.

**Question 2:** I understand that the VA Chief Mental Health Officer issued a directive concerning Community Care referrals to Residential Treatment Programs (Substance abuse, PTSD and/or Mental Health) in the community. The Directive now requires that VA clinicians refer the veteran to a VA Residential Treatment Program before referring to a Community Care program. The VA program will have 7 days to screen the referral and decide whether or not to accept the veteran for admission. If the veteran has been accepted for admission, but no bed will be available within 30 days, then the clinician can order a referral to a Community Residential Treatment Program.

This policy change has a huge impact on community providers and veterans and, again, prevents veterans from seeking timely care in the community.

1. Does the VA have a larger plan to address veterans seeking admittance to residential treatment programs?

2. **What was the reasoning behind this latest directive from the VA Chief Mental Health Officer?**
3. **What does the VA see as the role of community providers for residential treatment programs?**

VA Response: VHA affirms the critical importance of timely access to residential treatment for mental health and substance use concerns. Residential treatment for mental health and substance use concerns in VA is provided through Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) located throughout the country. The MH RRTP continuum includes residential programs for the treatment of substance use disorder (Domiciliary SUD), posttraumatic stress disorder (Domiciliary PTSD), and general mental health concerns including serious mental illness (General Domiciliary). In addition, the continuum includes programs specifically focused on the needs of Veterans who are homeless (Domiciliary Care for Homeless Veterans) and Veterans with vocational treatment needs (Compensated Work Therapy – Transitional Residence). At the current time, VHA operates more than 250 MH RRTPs with nearly 6,800 operational beds. MH RRTPs are considered VISN and regional resources.

Timely access to residential treatment has been a priority area of focus for VHA with several efforts underway to ensure Veterans have access to residential treatment when clinically indicated. One such effort included development of a process to facilitate access to residential care in the community. Historically, residential treatment in the community was not readily accessible, with a limited number of care providers and no direct pathway to authorize and pay for such treatment. When care did occur, it was provided either through inpatient programs for the treatment of substance use disorder or through contracts with community care providers. Recognizing a need to ensure access to this critical level of care, the Office of Mental Health and Suicide Prevention worked collaboratively with IVC to verify authority to provide residential treatment in the community and to provide a mechanism by which VHA could pay for such care. The MH Residential standardized episode of care (SEOC) and the technical mechanism to place a consult for this care were released to VAMCs in October 2020. VHA provided formal guidance to facilities defining how and when referrals for residential care in the community should occur. This guidance was informed by VHA Directive 1162.02, which defines requirements for ensuring timely access to residential treatment. While the MH RRTPs are considered institutional extended care and not subject to the designated access standards, which can establish eligibility to elect to receive care in the community, VHA policy requires that when a Veteran is assessed as requiring residential treatment and the program is unable to meet the Veteran's needs (72 hours for Veterans requiring priority admission and 30 days for Veterans assessed as appropriate for routine admission) an alternate treatment program must be offered.

Alternate treatment may include another MH RRTP in the region, a comparable program appropriate to meet the Veteran's needs (e.g., a homeless grant and per diem program) or referral for care in the community. The policy in question does not reflect a new policy requirement but rather was the first step to provide a clear expectation for

provision of residential treatment within the community and a mechanism to facilitate access.

Since the publication of the MH Residential SEOC, the number of Veterans receiving residential care in the community has rapidly increased. During fiscal year (FY) 2021 there were more than 5,000 referrals for mental health residential care in the community using the new SEOC, with that number increasing to roughly 9,000 during FY 2022. Expenditures for residential care during this time period were approximately \$700 million. Community care residential treatment programs are critical resources when a facility is unable to furnish residential treatment for a Veteran within the VISN. Facilities are actively working with community providers to ensure when a Veteran is referred to a residential treatment program, the program meets quality standards and that there are clear processes for referral (so as to expedite admission) and for engagement in post-discharge continuing care with VHA. Collaboration with community providers also has allowed VISNs to communicate about specific treatment needs (i.e., eating disorders) where residential treatment options may be limited in VHA.

Beyond ensuring that mechanisms exist to ensure Veterans have access to residential treatment when VA is unable to provide such care, VA is committed to addressing internal access challenges. The MH RRTPs were significantly impacted by the pandemic with many programs reducing capacity to ensure both Veteran and staff safety. OMHSP began communicating on the importance of ensuring access to MH RRTP services as early as July 2020, with a focused effort to resume MH RRTP services and increase capacity initiated in February 2021. Since that time, OMHSP has been working collaboratively with the VISNs to increase capacity and reduce wait times with the average number of days between screening and admission approaching pre-pandemic levels. However, VHA recognizes the need to establish accelerated targets informed by Veteran feedback. Beginning in August 2022 and concluding in December 2022, VHA conducted regional meetings specifically focused on access to residential care emphasizing a goal of providing same day or next day admission when clinically indicated. In FY 2022, most Veterans admitted to an MH RRTP were admitted within 30 days (75.6%) with 56% of Veterans admitted within 14 days. Among Veterans screened and identified as needing priority admission, 38.6% were admitted within three days of being accepted for admission. Data were unavailable for 8.1% of admissions.

Additionally, in May 2023, VA held a two-day sequester on RRTP access. The sequester included representatives from VAMC, VISN, and VA Central Office to develop plans to expand access to residential treatment, including in the community. Recommendations from the sequester will be briefed to VA senior leadership for approval and execution with upcoming briefings to be scheduled thereafter.

**Question 3:** Secretary McDonough, the MISSION Act explicitly states that the decision to refer a veteran to the community for care is between the veteran and their provider. I strongly support veterans receiving timely access to quality care, whether that be at a VA facility or in the community.

Yet, my office hears from Alabamians across the state who are frustrated that their care, where once provided in the community, has now been recalled to the VA. This can create travel and logistics delays for veterans and prevent them from seeing the provider with whom they're comfortable, both problems which the MISSION Act aimed to resolve.

**Is the VA attempting to remove veterans from community care to cut costs?**

**VA Response:** No. VA is committed to delivering timely, world-class care and services for Veterans, both in VA's direct care system and in the community.

**Question 3a:** Do you believe that, in revoking such care, the VA is capable of adhering to wait time standards for the VA-enrolled population? Why revoke community care access if the veteran is not able to receive timely access to care within the VA?

**VA Response:** Veterans' community care access is not being revoked. As stated above, VA is committed to delivering timely, world-class care and services for Veterans, both in VA's direct care system and in the community, adhering to all relevant laws, regulations, and policies related to eligibility for community care. The chart below shows the Average Wait Times for new patient appointments for VA direct care and community care.

	Average Wait Times for New Patient Appt in <b>Direct Care</b> (in days)			
	All	Mental Health	Primary Care	Specialty Care and All Other
<i>Pre-MISSION Act (Jun 2018 - May 2019)</i>	23.6	13.2	21.1	24.7
<i>Pre-Pandemic (COVID-19) (Jun 2019 - Feb 2020)</i>	23.8	13.3	19.9	25.0
<i>Pandemic Year 1 (Mar 2020 - Feb 2021)</i>	22.1	11.0	13.9	24.4
<i>Pandemic Year 2 (Mar 2021 - Feb 2022)</i>	24.8	16.2	17.7	26.1
<i>Pandemic Year 3 (Mar 2022 - Jan 2023)</i>	28.6	20.2	24.7	29.6

	Average Wait Times for New Patients in <b>Community Care</b> (in days)			
	All	Mental Health	Primary Care	Specialty Care and All Other
<i>Pre-MISSION Act (Jun 2018 - May 2019)</i>	41.2	41.2	41.3	41.2
<i>Pre-Pandemic (COVID-19) (Jun 2019 - Feb 2020)</i>	39.4	41.7	43.1	39.3
<i>Pandemic Year 1 (Mar 2020 - Feb 2021)</i>	39.6	42.4	45.7	39.5
<i>Pandemic Year 2 (Mar 2021 - Feb 2022)</i>	39.8	37.9	46.7	39.8
<i>Pandemic Year 3 (Mar 2022 - Jan 2023)</i>	39.8	39.1	52.2	39.7

The first table above *Average Wait Times for New Patient Appt in **Direct Care*** displays the average wait times for new patient appointments in VA's direct care system over several time periods. Veterans are considered a new patient if they have not been seen by a provider or a clinical service at the same medical center for the same, or a related, health care need in the past 3 years. For new patient appointments with a referral, the referral date is the starting point used for measuring average wait times, and the end point is the date care is received. For new patient appointments without a referral, the average wait time starts with the earliest consistently-recorded date in the process of receiving care (typically the scheduler works with a Veteran to coordinate a future appointment) to the date care is received.

The second table above *Average Wait Times for New Patients in **Community Care*** represents the average wait time for new patient referrals in community care. In the data above, the referral date is the starting point used for measuring average wait times, and the end point is the date of the scheduled appointment or the date it is scheduled to occur if not yet completed.

**Question 4:** In the recently published report on **Community Care Coordination Delays for a Patient with Oral Cancer**, the VA's Office of the Inspector General found that — among other failures — the facility's failure to schedule community care appointments in a timely manner and failure to coordinate radiation therapy ended up preventing the patient from receiving the recommended treatment. Sadly, the patient passed away after a hard-fought battle against cancer — no thanks to the VA.

**Secretary McDonough, do you believe the facility staff responsible for waiting 140 days before securing the veteran an appointment with a surgeon should be held criminally negligent?**

VA Response: VA is committed to delivering the highest quality care and services to Veterans. When a Veteran is sent to the community for specialized care, our staff work to find providers who can perform the procedures in timely fashion and with the highest quality of care. We deeply regret the delay in scheduling that occurred. Acting on High Reliability principles, we have taken steps to implement community care coordination in a concerted effort to prevent a similar situation from recurring.

**Question 5: Mr. Secretary, in the hearing I raised with you the issue of getting CPAPs into the hands of veterans in need, who have been waiting due to the pandemic, the chip shortage that impacts the modems in these devices, and one manufacturer's global recall of devices, which was in recent weeks, broadened. I was heartened to know that you are hearing directly from frustrated veterans and that you are receiving regular updates on efforts to get these critical care respiratory devices to the veterans who need them. I appreciate your offer to follow up with me and my staff on the regular updates you are receiving. But at the same time, I was disappointed that you seem unfamiliar with the "card-to-cloud" devices that have been made available to VA for purchase, only a small number of which VA has actually purchased.**

According to its manufacturer, "C2C" or "card-to-cloud," refers to the ability of healthcare providers to access patient therapy and usage data via the device's SD card. The devices capture and safely store patient nightly usage data, and there are steps that can be taken so the data is available for the patient and clinician. Clinicians can log patient data using the C2C devices by manually downloading the data off the patient's SD card, located on the side of the device. The C2C provides the same clinical benefits to veterans managing sleep apnea as connected CPAP devices.

**Are all VA clinicians treating patients with sleep apnea aware that the C2C devices are available to veterans? If not, what is VA's plan for making them aware?**

VA Response: Yes, VA clinical staff treating Veterans with sleep apnea are aware that the C2C CPAP machines are available for use. Our CPAP shortage task force, consisting of several experienced VA sleep medicine clinicians, conducts weekly office hours where this is routinely discussed. In addition, weekly emails to VA's sleep medicine workforce also highlight this.

**Question 5a: Does VA plan to purchase additional C2C devices to serve the backlog of patients waiting to start therapy or replace a device that is at the end of its design life? If not, what is the VA's plan/solution to serve the backlog of patients waiting to start therapy?**

VA Response: Through the Denver Logistics Center (DLC), VA monitors its supply of all CPAP/Bi-level positive airway pressure and related equipment and supplies on a daily basis and updates sleep medicine specialty office staff and DLC staff daily. Furthermore, through twice weekly calls with DLC leadership, the VA sleep medicine specialty care office task force for CPAP machine shortages is updated on the level of CPAP machines available through the DLC. We discuss the weekly demand for CPAP machines and how many new CPAP machines will need to be purchased in the upcoming weeks to months to keep our stock at healthy levels.

**Question 5b: If a VA clinician is aware these C2C are available for veterans in need, and in the absence of connected devices, elected not to prescribe a C2C device, would you consider this an ethical violation?**

VA Response: The VA Center for Ethics worked with the sleep medicine specialty care office, specialty care leadership, and VISN Chief Medical Officers, to address the question of the ethics of delaying care for a Veteran with sleep apnea so that a CPAP machine with a modem that can report daily usage can be used vs. the modem-less C2C machines. After lengthy discussions, we agreed that this practice was unethical because the C2C machines are perfectly adequate to treat a Veteran successfully and are readily available whereas the more advanced modem-containing CPAP machines are not readily available due to a variety of supply chain and manufacturing constraints.

Questions for the Record from Senator Maggie Hassan:

**Question 1:** Recently, my office heard from a Granite Stater who serves in the Army Reserves about difficulties she had in managing long-term care needs at the VA when she transitioned off of active duty.

She normally receives her healthcare through the VA, but when she is activated, that care switches over to TRICARE, only to snap back to the VA when she completes her tour.

This whiplash can disrupt care for people like my constituent, for instance because it can lead to delays in scheduling treatments.

How is the VA coordinating with the Department of Defense to ensure that service members such as my constituent can have smooth transitions as they change duty status and move on and off of VA health care?

VA Response: VA recognizes the importance of a seamless transition from Servicemember to civilian life, and we are committed to ensuring Veterans are well-supported through this process.

VA coordinates with DoD in a variety of areas to ensure a safe and smooth transition. Several of these efforts are explained below:

- For a Reserve/Guard member who has been placed on active-duty orders greater than 30 days, TRICARE coverage begins 180 days before the report date and continues 180 days after active-duty benefits end through the TRICARE Transitional Assistance Management Program (TAMP). The Veteran can be seen at their enrolled VA facility during this period. Their TRICARE benefit will be used while they are transitioning on and off orders.
- VA has liaisons embedded in the TRICARE Health Plan Division to facilitate communication and coordination between VHA and TRICARE.
- VA coordinates with Reserve/Guard Transition Assistance Advisors to bring awareness of areas on which they should focus when they educate transitioning Reserve/Guard members. This gives Reserve/Guard members a better understanding of when their TRICARE benefits end and when their Veteran health care benefits start up again.
- VA Liaisons for Healthcare coordinate access to VA health care from a Military Treatment Facility. These liaisons assist Servicemembers, through the Post-9/11 Military2VA Case Management Program, as they navigate between DoD and VA during transitions.
- VA and DoD clinicians use the Joint Longitudinal Viewer (JLV) to access real-time medical information in the treatment of their patients, which ensures continuity of health care between DoD and VA.



Questions for the Record from Senator Mike Rounds

**Question 1: Secretary McDonough, during the hearing I asked you about the possibility of authorizing veterans to schedule their own medical appointments so the Department of Veterans Affairs (VA) wouldn't have to schedule appointments for them, and in response you told me that VA has a couple of pilots to test different scheduling options for veterans. Please describe these pilots in detail and provide answers to the following questions:**

**When did you begin crafting these pilots? Which patient populations and veteran stakeholders did you consult with to develop them?**

VA Response: To implement an online Veteran self-scheduling pilot, VA must first obtain access to community providers' scheduling systems and information. This includes insight into scheduling grids for availability and a system to schedule patients into open grids. This scheduling technology must be integrated into VA scheduling systems, eligibility and referral systems, and billing and payment systems prior to being available for direct Veteran use and being incorporated into an online self-scheduling platform. We note that sections 131-134 of the Cleland-Dole Act require VA to commence a pilot program under which covered Veterans eligible for community care under the VCCP may use a technology that has capabilities specified in the law to schedule and confirm medical appointments with health care providers participating in the VCCP.

On a smaller scale, VA recently completed a pilot effort to expedite the time to schedule community care appointments at two facilities through a licensed technology that provided VA community care schedulers the ability to view and schedule directly into community care provider clinic grids. VA schedulers were able to connect to and display availability in one interface for various electronic medical systems, simplifying the VA staff workflow and improving capabilities in tracking Veteran appointment status in the community. This pilot effort established a proof of concept for potential community care self-scheduling capability. Concurrently, VA performed market research that identified multiple potential vendors who might be able to provide similar solutions for self-scheduling capabilities.

This pilot effort was deployed to Orlando, Florida, in December 2021, and Columbia, South Carolina, in October 2022. By allowing VA schedulers access to community scheduling grids, staff were able to schedule over 400% more appointments per day than with current systems and processes.

As of March 2023, Orlando and Columbia have seen a combined 160% increase in scheduled appointment volume from inception of the pilot to the first quarter of fiscal year 2023. The pilot program shows evidence of a more than 50 percent decrease in time from when care is requested (file entry date) to when the appointment is scheduled

**Question 1a: Are these pilots already in effect? If so, where are they being implemented and how did you decide which areas to test them in? If not, when and where do you plan to implement them?**

VA Response: Yes, these pilots are already in effect and are being implemented in VISN 7 and VISN 8 based on local VISN willingness to participate in pilot programs

**Question 1b: What will be the duration of these pilots? How will VA measure and determine their respective effectiveness?**

VA Response: These pilots have been extended through September 2023. To measure effectiveness, VA will analyze improvements to timeliness of scheduling community care appointments, the number of appointments scheduled, and the number of participating providers.

**Question 1c: Under these pilots, will veterans have direct access to their Veterans Community Care Program health care provider and be able to schedule their own appointments without having to go through the VA's current process for scheduling care in the community?**

VA Response: There is a Community Care Veteran Self-Scheduling (VSS) process which establishes a mechanism for Veterans to call a community provider to schedule their appointments. This process is not new, and the availability of VSS was announced via an Operational Memo in October 2020. Under the Veteran Self Scheduling process, Veterans are able to contact their community provider directly to schedule an appointment. However, they still need a referral and eligibility verification prior to contacting the community provider. We are evaluating the current VSS process and exploring enhancements to increase utilization in the field.

The pilots described above take the scheduling process one step further in that they give VA schedulers visibility into community provider grids. This affords the scheduler the opportunity to both discuss the Veteran's options for care and to directly schedule the appointment based on patient's preferred day/time and community provider availability. The scheduling pilots are being leveraged to establish foundational aspects for expanded scheduling options for VA staff, community providers, and Veterans. The evolution of these capabilities may eventually allow Veterans eligible for community care to self-schedule directly with community providers. However, Veterans currently do not have the ability to directly schedule their own appointments with community providers independent of the VA scheduling process.

Questions for the Record from Senator Marsha Blackburn:

**Question 1:** I have heard from veterans in Tennessee who have been receiving treatment for conditions that VA previously denied were service-connected. With the passage of the PACT Act, many of these veterans will be able to get their claims approved as presumptive service-connections.

I am concerned that if a veteran wants the financial benefit of having these services covered by the VA now that the VA has approved their claim, the VA will force the veteran to leave their established health care provider and instead move their care in-house at the VA. Will VA force veterans whose claims they previously denied to leave their non-VA provider if they want VHA to pay for their service-connected care? Or will VA allow them to continue seeing the provider they have an established relationship with?

VA Response: VA centers everything we do on Veteran experience, access, and outcomes, and we are committed to ensuring a seamless, coordinated care experience for Veterans whether they receive that care in a VA facility or through community care. When Veterans are eligible to receive community care services and chooses to see a provider in the community, the provider they see for their health care must be in the VA network either through the CCN contract or through a Veterans Care Agreement (VCA) or another agreement. VA makes every effort to accommodate Veterans' choice of providers when they are eligible to receive community care. Covered Veterans can be eligible for community care if they and their referring clinicians determine it is in the best medical interest of the Veteran based on specific factors, one of which is "the potential for improved continuity of care" (see 38 CFR 17.4010(a)(5)(v)).

**Question 2:** What percentage of VA patient advocates are also members of the American Federation of Government Employees?

VA Response: As of October 7, 2022, 67.5% of Patient Representatives are covered by the American Federation of Government Employees (AFGE).

**Question 3:** What percentage of the Referral Coordination Team Administrative Staff are also members of the American Federation of Government Employees?

VA Response: VA is not able to isolate data for Referral Coordination Team employees at this time.

**Question 4:** What percentage of the Referral Coordination Team Clinical Staff are also members of the National Federation of Federal Employees, National Nurses United, or National Association of Government Employees?

VA Response: VA is not able to isolate data for Referral Coordination Team employees at this time.

Questions for the Record from Senator Tom Tillis:

**Question 1: For veterans eligible and authorized for community care under the Veterans Community Care Program (VCCP), does the Department equally weigh the various eligibility criteria for community care?**

**Can the Department provide a detailed breakdown of which eligibility criteria of community care veterans have been approved under?**

VA Response: Under the Veterans Community Care Program (VCCP), Veterans need only qualify under one of six criteria to be eligible to elect to receive community care. No one criterion carries more weight than any other, and the criteria are employed collectively to ensure the best and most timely care is delivered for a Veteran's specific needs.

**Question 2: Who within the Veterans Health Administration is ultimately responsible for ensuring the accurate calculation and reporting of wait times?**

VA Response: IVC is responsible for maintaining the appropriate reporting of wait times. In support of VA's mission to manage and treat data as a strategic asset, IVC has established a Data Governance program to consolidate and enhance its existing data governance infrastructure, processes, policies, and strategies. The IVC Data Governance Council (DGC) plays a role in the quality oversight of wait time data itself, and membership includes staff from VA Central Office program offices as well as additional stakeholder representation.

**Question 3: The VA has long faced operational challenges in scheduling timely appointments for veterans. Mr. Secretary, you attributed the lack of automated data collection capabilities as the reason that the average wait time calculation for new patient appointments is based on the create date, rather than the MISSION-required request date.**

- **Has the Department attempted to streamline scheduling processes to calculate average wait time calculations on the request date opposed to the create date?**
- **What does the Department need to automate data collection and standardize reporting?**

VA Response: VA is committed to ensuring that the way we measure and report wait times accurately reflects Veterans' true wait time experiences. Calculating aggregate wait times, particularly for routine, non-emergent care, is a complex endeavor and without clear best practices in industry or literature. For new patient appointments with a referral, the referral date is the starting point used for measuring average wait times, and the end point is the date care is received. For new patient appointments without a referral, the average wait time starts with the earliest consistently recorded date in the process of receiving care to the date care is received. As previously

described to Congress, VA is working to develop a more detailed IVC workflow, which includes adding the VA Online request process into the scheduling software to help capture the appointment request date automatically in the scheduling software system. This would facilitate considering this information in calculating wait times.

**Question 4: As the Department begins to implement the PACT Act and prepares for the increased demand for health care services, has the Department identified a framework to quickly identify and resolve any challenges that arise in terms of access to or quality of care?**

VA Response: Yes, this work is underway. The PACT Act marked the largest and most significant expansion of Veteran care and benefits in decades, empowering VA to deliver additional care and benefits to millions of Veterans and their survivors. VA has undertaken a thorough analysis using all available sources of data – including VA records, DoD records, and actuarial projections – to identify where Veterans are likely to seek health services, and, based on their conditions, what their specific needs may be. As VA accrues additional data on enrollment, screening, and actual utilization, these preliminary estimates will be refined and made available via a real-time tracking system.

**Question 5: The Department and a variety of stakeholders regularly point to incongruent access standards for community care providers as a barrier to determining the accessibility and timeliness of community care. Does the Department agree that access standards should be standardized or, at least, better aligned?**

VA Response: The amendments made by section 125 of the Cleland-Dole Act to 38 U.S.C. § 1703B will have an impact on community care provider access standards. As amended, 38 U.S.C. § 1703B(f) requires VA to meet the access standards established under section 1703B(a) when furnishing care and services to a covered Veteran under the VCCP and to ensure that meeting such access standards is reflected in the contractual requirements of TPAs. Section 125 of the Cleland-Dole Act also created a new section 1703B(f)(2), which requires VA to ensure that health care providers specified in section 1703(c) are able to comply with the access standards established under section 1703B(a) for such providers. VA is in the process of determining the best way to enact the requirements of the recently enacted law.

Generally, though, we do not believe the designated access standards applicable to VA determinations regarding community care eligibility should be applied to community providers. It is important to note that average wait times for both direct VA care and community care will vary based on the type of care and geographic location. Furthermore, the CCN contracts are designed to be a supplemental source of health care for Veterans when VA cannot meet the designated access standards or when Veterans are otherwise eligible to elect to receive care in the community. VA has previously expressed concern that a requirement, as now exists in section 1703B(f), could mean VA would either have to loosen the access standards now applicable to it to be standards that community providers could actually meet (particularly in terms of the

distance standards now applicable to individual providers furnishing care outside of an agreement with a TPA. VA has expressed concern that these requirements could jeopardize network adequacy and disincentivize community providers from participating in the VCCP.

**Question 5a: Does the Department have the existing authority to modify TPA contracts to implement uniform access and quality standards? If so, why has the Department chosen not to do so?**

VA Response: VA centers everything we do on Veteran experience, access and outcomes, and we are committed to ensuring a seamless, coordinated care experience for Veterans whether they receive that care in a VA facility or through community care. The CCN contracts were designed to be a supplemental source of health care for Veterans when VA cannot meet the designated access standards or when Veterans are otherwise eligible to elect to receive care in the community. While VA has the authority to modify contracts with the TPAs, modifications are bilateral, and would require negotiation to come to an agreement by all parties to the contract. The CCN contracts have set standards that hold the TPAs responsible for building a network of providers to ensure that Veterans referred for care will experience access at or above those contractual standards. As stated above, it is important to note that average wait times for both direct VA care and community care will vary based on the type of care and geographic location. VA has previously expressed concern that a requirement, as now exists in section 1703B(f), could mean VA would either have to loosen the access standards now applicable to it to be standards that community providers could actually meet (particularly in terms of the distance standards now applicable to individual providers furnishing care outside of an agreement with a TPA. VA has expressed concern that these requirements could jeopardize network adequacy and disincentivize community providers from participating in the VCCP.

**Question 5b: Does the Department support the Guaranteeing Healthcare Access to Personnel Who Served Act (S. 1863), which would incorporate existing access standards as the minimum standards for community care?**

VA Response: Section 125 of the recently-enacted Cleland-Dole Act amended 38 U.S.C. § 1703B(f), which requires VA to meet the access standards established under section 1703B(a) when furnishing care and services to a covered Veteran under the VCCP and to ensure that meeting such access standards is reflected in the contractual requirements of TPAs. Section 125 of the Cleland-Dole Act also created a new section 1703B(f)(2), which requires VA to ensure that health care providers specified in section 1703(c) are able to comply with the access standards established under section 1703B(a) for such providers. VA is in the process of determining the best way to enact the requirements of the recently enacted law.

Questions for the Record from Senator Kevin Cramer:

**Question 1: During last week's hearing, I raised the idea of allowing Critical Access Hospitals to more freely treat veterans and highlighted the importance, particularly for rural communities across North Dakota. In response to this, you expressed your support for making such a proposal work. Do you commit to working with my office to advance solutions aimed at bolstering Critical Access Hospitals' role in the community care program and simplifying related criteria so these providers may ultimately better serve our veterans?**

VA Response: VA agrees that Critical Access Hospitals serve an important role for access to care in rural communities and veterans in these communities. Critical Access Hospitals (CAHs) are required to make available 24-hour emergency care services, provide not more than 25 beds for acute (hospital-level) inpatient care, or in the case of a CAH with a swing bed agreement, 60 used for a skilled nursing facility-level care. North Dakota currently has a robust network of providers under CCN, and VA works continuously with TPAs to improve and expand the network. We will work with Senator Cramer's office to evaluate ways to make it easier for Veterans to receive care from CAHs and will pursue any potential efficiencies that can be gained within the current framework.

**Question 2: On average, how long does it take VA from date of request to schedule a community care appointment? As I noted during the hearing, veterans, including a member of my own staff have experienced delays in care due to bureaucratic dysfunction. Often times, the veteran pursues community care in the first place due to much shorter wait times than VA's own facilities. Whether these delays are intentional or caused by administrative churn, it is unacceptable for a veteran's health to suffer as a result. Veterans are rightly entitled to community care under certain circumstances as established in the MISSION Act and the Department has an obligation to furnish this care without delay. What is the VA doing to ensure a smoother authorization process for Vets accessing care in the community?**

VA Response: VA currently has a task force of experts reviewing our scheduling processes to identify opportunities for significant system and process improvements. Further, we continue to closely monitor the performance of our CCN and the availability of community providers working with our TPAs to build capacity and address gaps. Today, lessons learned from CCN over the last few years are being incorporated as we prepare for the next generation of CCN contracts, timed for the next calendar year. Finally, it is important to note that unique challenges that are specific to certain facilities and regions often account for some of the most significant barriers to access to care. VA continues to focus on these challenges and is using lessons learned as we work to improve access to care across the country. VA remains committed to ensuring that feedback from Veterans is central to driving improvements and innovations in delivering access to care for Veterans.

The table below illustrates the average number of days from the consult file entry date to the date VA scheduled the appointment in the community.

NOTE: The FY 2023 data is not a full fiscal year so may not be completely comparable to previous FYs. Data represents October 2022 to May 19, 2023.

VA Community Care		
VA Community Care	Appointment Date Fiscal Year	Average Days Consult From File Entry Date (FED) To First Scheduled Date
VHA	FY19	28.6
VHA	FY20	24.3
VHA	FY21	27.8
VHA	FY22	25.9
VHA	FY23	25.7

Methodology:

Source: VSSC Consult Cube Dashboard (VA Community Care)

\*Excludes referrals with a CPRS status of Cancelled, Discontinued, Discontinued/Edit.

Fiscal Year is delineated by the date of the linked (scheduled) appointment.

\*National data does not include wait time data for VA clinical sites after they have deployed the new EHR

Additionally, VHA is exploring opportunities for expanding the community care Veterans Self Scheduling process to allow eligible Veterans to coordinate their own care with community providers. Exploring opportunities to optimize the Referral Coordination Initiative processes, to ensure that the appropriate care option conversations are taking place and that the care coordination process begins sooner in the process. Finally, we are continuing to identify and build on system enhancement opportunities to continue to make the community care scheduling process more simplified and less cumbersome for all involved.



Senator Tuberville  
 Questions for the Record  
 Senate Veterans' Affairs Committee  
 Ensuring Veterans' Timely Access to Care in VA and the Community  
 09/21/22

**Questions for Darin Selnick**

1. Mr. Selnick, in your previous research of the VA's use of inaccurate wait time numbers:
  - a) **Did you ever come across evidence of facility schedulers prioritizing requests for Veterans Health Administration appointments over requests for appointments with community-based clinicians?**

**Answer:** Although schedulers were not directly asked to prioritize requests for VHA appointments over appointments with community-based clinicians, VA guidance directed staff to favor VHA appointments by doing the following, see RCI Implementation Guidebook (<https://www.va.gov/files/2022-04/Referral-Coordination-Initiative-Guidebook-2.pdf>):

1. **Funding availability:** "The process for reviewing available community care options consists of reviewing the Veterans current clinical needs, available community care pathways and **funding availability**. When reviewing the available community care options, Facility Community Care Office staff **must also consider funding availability** under the preferred option(s) guided by local leadership".
2. **Neglecting to advise veterans of their options:** "Unless the patient requests to review their other eligibility, no additional CC eligibility is required to be reviewed other than wait time".
3. **Actively dissuading use of community care:** VA is actively providing sample scripts for employees to use when talking to veterans eligible for community care. The VA's script actively dissuades veterans from choosing community care by using inaccurate community wait time data and placing the expectation on the veteran to ensure their care is coordinated and to obtain their medical records. "we anticipate it will take approximately (*community care wait time in days or weeks*) for your appointment in the community." "by choosing VA, we can better coordinate your overall care", "we will need your help to obtain a copy of your records".
4. RCI key performance indicator and success indicator favors VHA facilities over community care:

**Table 4: RCI Key Performance Indicators**

**FOCUS**

Maintain VA's ability to fund internal/direct VA specialty care services

**MEASURE**

- Community care cost
- Referral Volumes for internal/direct VA vs community care

**b) Did you ever see anything in Freedom of Information Act documents to indicate that a referral coordination team purposefully delayed grant veterans' access to community care?**

**Answer:** Yes, by having Referral Coordination Teams (RCT) use the clinical review process and clinically appropriate standard for veterans already determined to be eligible for community care including Best Medical Record (BMI). The RCT and process used delays approval of community care and can illegally deny veterans community care who are already eligible, by overriding the MISSION Act law, VA Community Care Program Regulation and the veterans clinician, by determining community care is not clinically appropriate. The RCT then returns the referral back to the VA provider for an alternate plan of care at the VA facility. VA Process flow charts used by staff are attached.

2. Mr. Selnick, in your testimony, you cited a 2020 study published in the Journal of the American Medical Association on the negative health consequences of delayed care. Coincidentally, my staff recently came across a different study related to the Veterans Health Administration wait times in the same medical journal. Dr. Farmer cites the same study in her written testimony.

**a) Are you familiar with this study, published last month, on geographic variation in appointment wait times for U.S. veterans?**

As a refresher, the study found that Veterans Health Administration wait times were lower than those for community-based clinicians in many areas, including in VISN (VIZ-IN) 7, which covers my state of Alabama. Based on these findings, the authors of the study suggested that policies intended to increase veterans' access to community-based clinicians may be insufficient to lower wait times.

**Answer:** Yes, the studies name is – Geographic Variation in Appointment Wait Times for US Military Veterans, published 09/25/2022

**b) Would you agree with this assessment?**

**Answer:** No, the study has many flaws and there are questions as to conflict of interest. My concerns are as follows:

1. **Conflict of interest:** A number of the authors work at the VA Boston Healthcare System, therefore there is an inherent conflict of interest and potential bias as to the outcomes of the study.
2. **The data is flawed:** The data for the study comes from 2018-2021. This means that the data before the MISSION Act was implement in June 2018 is not relevant, and the data from 2020-2021 is skewed as it comes during the height of COVID.

3. **Results are based on the flawed data and therefore are meaningless.** For example:
  - a. VHA wait times are known to be inaccurate as there is no standard starting point such as date of request, so the wait times they report are incorrect.
  - b. VA does not know how long community care wait times are, only how long it takes VA to process the authorization and make the appointment. There are many extra steps and delays due to staff, such as contacting the veterans and then the delay in contacting the community providers.
  - c. It is unknown how long the actual wait times are for VHA and community care due to VA not calculating wait times starting from date of request, but instead from date of approval. The delay for each patient is different and unknown. Therefore, each patient wait time has no standard basis for calculation.
4. **Conclusions and findings are based on the same flawed data.** Since all of the VHA and community care wait times are inaccurate, there is no actual way to compare the difference between the VHA and community care wait times. Therefore, the conclusions and findings are erroneous, meaningless and invalid.

**Bottom line:** The question the study asks, “how long do veterans wait when seeking various types of medical care throughout the US” is not answered in this study and can’t be answered until VA creates a single, clear, consistent, and standard way to calculate equally both VHA and community care wait times.

Last Modified on: Tuesday, August 3, 2021

2.23 How to Perform Clinical Review for Services Requested



(Pre/Post CCN)

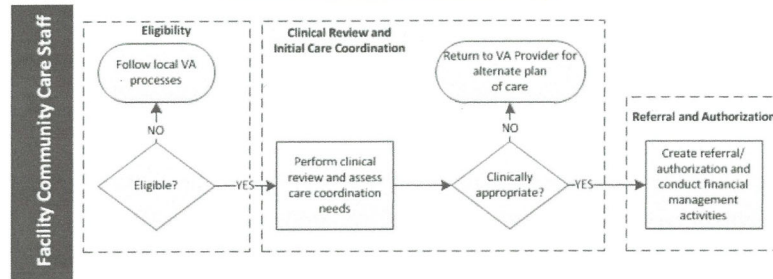
This section contains process information for the clinician performing review of the referral. Care coordination needs are assessed and documented in a standardized manner to ensure continuity of care. A standardized process for care coordination enables the VA to schedule community care services and align resources based on the Veteran's needs. This process is supported by consistent monitoring and tracking of performance throughout the episode of care.

**Note:** Care authorized through the Veterans Choice Program (VCP) (including VCP Provider Agreements) can no longer be furnished as of June 6, 2019. In addition, individual authorizations (IAs) or medical care authorized under traditional community care can no longer be furnished as of September 30, 2019 or the date VAMC transitions to the new Community Care Network (CCN) contract.

As facilities should consider options as outlined in the memorandum titled "Community Care Purchasing Authorities", one principle to conducting clinical review is to determine if the service is clinically appropriate and/or whether it can be delivered at the local VAMC prior to sending the consult to the community.

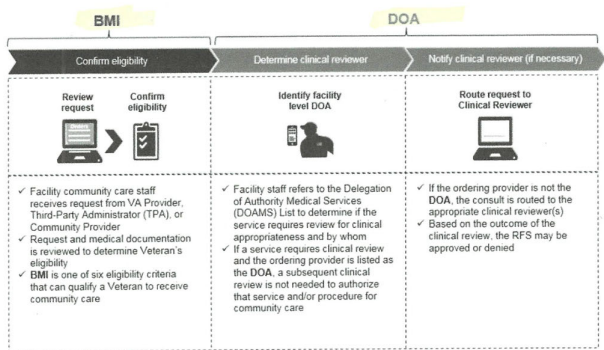
**Remember:** Clinical appropriateness should be determined by clinical staff who have been given DOA for services identified in the consult. Community Care staff assigned DOA (e.g. Registered Nurses) will assess clinical appropriateness using the evidence-based guidelines in the MCG Clinical Review Tool, which OCC will deploy in the first quarter of FY2021. Training is forthcoming. The clinical determination should be documented by the DOA reviewer using the Consult Toolbox and documented within the "Consult review" tab (see Consult Toolbox User Guide).

Clinical Review and Initial Care Coordination Process Flow



The review to determine clinical appropriateness should be based in accordance with the "Community Care Utilization Management Program Guidance" memorandum and including the following considerations:

PROCEDURES	
4e	If the request is from a Community Primary Care Provider for Specialty Care, forward the request to the Provider designated by the Chief of Staff or designee who will place Community Care Provider Orders.



2.7 Special Notes for Former Distance-Eligible Veterans (Grandfathered Veterans)

(Pre/Post CCN)  (Post MISSION) 

Former distance-eligible/grandfathered Veterans who receive care exclusively in the community will be managed by at the facility level.

Per the Veteran Community Care Eligibility Factsheet, a Veteran qualifies under the "Grandfather" provision by two different ways. Initially there are two requirements that must be met in every care:

- Veteran was eligible under the 40-mile criterion under the Veterans Choice Program on the day before the VA MISSION Act was enacted into law (June 2018), and
- Veteran continues to reside in a location that would qualify them under that criterion.

If both requirements have been met, a Veteran may be eligible if one of the following is also true:

- Veteran lives in one of the five States with the lowest population density from the 2010 Census: North Dakota, South Dakota, Montana, Alaska and Wyoming.

