Opening Statement of Chairman Jeff Miller
House Committee on Veterans' Affairs
Full Committee Hearing
Tuesday, April 19, 2016
10:30 a.m. – 334 Cannon HOB

I would like to welcome everyone to today's hearing titled, "A Continued Assessment of Delays in Veterans' Access to Health Care." This hearing marks two years since this Committee exposed the wait times scandal that gripped the department in 2014. I am proud of the work we have done in those two years, particularly digging into the actions of corrupt bureaucrats who put self-interest ahead of the veterans they are charged with assisting.

The purpose of this hearing is to examine the efforts VA has taken to improve access to care for veterans and to identify where serious issues persist. Based on this Committee's investigation, GAO undertook an audit of new patient primary care wait times at six facilities across VHA. GAO's review found that veterans at those facilities waited between 22 to 71 days, which is significantly more than the five-day average Secretary McDonald declared earlier this month. This discrepancy can be easily explained.

First, VA only tracks and monitors a portion of a veteran's actual wait time when tracking access data. Instead of considering a veteran's wait time to be from the date when the veteran first contacts VA to request an appointment to when the appointment takes place, VA considers a veteran's wait time to be from the date when the veteran wants the appointment to occur to the date when the appointment actually occurs.

This is problematic because it does not take into account: the time it takes a VA scheduler to contact the veteran to schedule the appointment; the fact that it is a regular practice for schedulers to "negotiate" a desired date with a veteran; or the fact that outright manipulation of desired dates to zero-out wait times is one of the most prevalent types of data manipulation occurring in VHA. In effect, VA continues to ignore the main forms of data manipulation, while it continues to come to congress saying it no longer occurs. To this point, you will not find what you do not seek.

The obvious result of VA reporting only a portion of veterans' actual wait times is artificially low results. I still do not understand a culture that persists in presenting inaccurate data. A true picture of wait times, or more importantly the veteran experience, can help us ensure an adequate allocation of resources. But, when this Committee only hears requests for more manpower, more space, and more flexibility, it is hard to reconcile the additional resources with a reported "wait time" of only five days. This discrepancy between reality and VA's claims was captured by GAO in its report where VA data shows that wait times were at best understated by 2½ times and at worst 11 times the full wait times experience of veterans reviewed in the audit.

Another tactic VA uses to make its wait times appear lower is to combine the shorter wait times for the large pool of established patients with the longer wait times of the smaller pool of new patients. This dilutes the wait times data making new patients' waits appear shorter since they have been comingled with data from the other cohort.

For years, VA has blamed incorrect appointment scheduling and long wait times on training issues, largely because it was warned about those issues as far back as 2005, when the OIG published a report highlighting improper scheduling practices and poor training. Many OIG and GAO reports since then have found the same scheduling problems. Yet, in the 11 years since, VA continues to blame wait time manipulation on the same cause, a cause over which VA has complete control.

Secretary McDonald has repeatedly asked that we allow him to run VA like a business. But, I can assure you that if an executive running a company used the same excuse to explain away problems 11 years in a row, with no change to show for it, that individual would be out of a job. But, not at VA. Despite years of reports confirming systemic issues, the department has successfully fired just four people for wait time manipulation while letting the bulk of those behind its nationwide delays-in-care scandal off with no discipline or weak slaps on the wrist.

Another issue regarding accountability is how VA continues to ignore retaliation against whistleblowers who report wrongdoing. The Committee asked VA for all adverse actions where an employee was disciplined for "retaliation against a whistleblower". VA provided the Committee a list showing that as of March 15, 2016, only six individuals were disciplined for whistleblower retaliation.

However, upon further review, one of the listed employees is Sharon Helman, who the committee has shown was not successfully disciplined for whistleblower retaliation and was in fact successfully disciplined for failing to report accepted gifts. Two of the other disciplined employees listed were "Houskeeping Aid Supervisors", who are clearly not high-level supervisors. That leaves three employees: two received reprimands and one received a less-than-fourteen-day suspension. To be clear, according to VA provided documentation, no employee has been removed for whistleblower retaliation. This is representative of the fact that, contrary to public statements by VA officials, whistleblower retaliation appears to most certainly be tolerated by the department.

So now, two years after what was and is a systemic crisis in care being brought to light, it is time for VA to stop using misleading data to tout wait times successes that simply do not show the real wait time experience of veterans. I want to hear what concrete actions have been taken, what fundamental changes have been made, and what tangible, cultural shifts are occurring. Advertising artificially lowered numbers does nothing to stimulate the change needed to improve veterans' access to care.