STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING
"A CONTINUED ASSESSMENT OF DELAYS IN VETERANS' ACCESS TO HEALTH CARE"
APRIL 19, 2016

Mr. Chairman and Members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) recent work concerning veterans' access to health care. The OIG has issued many reports that have addressed various impediments to patient access to health care. Most recently, our audit work has centered on VA's purchased care programs and the challenges VA has faced in administering them. I am accompanied by Mr. Gary Abe, Deputy Assistant Inspector General for Audits and Evaluations.

BACKGROUND

For more than a decade, the OIG has conducted oversight of the Veterans Health Administration's (VHA) performance in providing veterans timely access to care. Our reports have brought attention to problems relating to wait times, scheduling practices, consult management, data integrity, clinician staffing shortages, and the lack of physician and nurse staffing standards. We have repeatedly reported that VHA managers need to improve efforts for collecting, trending, and analyzing clinical data.

Two years ago, VHA's inability to provide veterans timely access to care became the subject of national focus following allegations at the Phoenix VA Health Care System (PVAHCS) in Phoenix, Arizona, that included gross mismanagement of VA resources, misconduct by VA senior hospital leadership, systemic patient safety issues, and patient deaths. On May 28, 2014, we published a preliminary report substantiating serious conditions at the PVAHCS.[1] We provided VA leadership with recommendations for immediate implementation to ensure all veterans receive appropriate care. Our August 26, 2014, final report reflected the full results of our review, including case reviews of 45 patients who experienced unacceptable and troubling lapses in follow-up, coordination, quality, and continuity of care.[2] We made 24 recommendations to correct conditions identified at PVAHCS. To date, VHA has implemented 20 of the

[1] *Interim Report - Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System (*May 28, 2014).
[2] *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* (August 26, 2014).

24 recommendations.[3] Recommendations addressing potential disciplinary actions, consult reviews, use of the electronic waiting list, and efforts to improve procedures used by schedulers to make appointments will remain open until VHA completes the actions necessary to implement the recommendations.

As we have previously indicated, the surfacing of allegations related to wait times and delays in care at PVAHCS was a watershed event for VA and the OIG. Since April 2014, the national attention sparked by reporting on PVAHCS led to an increased public awareness of the OIG and resulted in a dramatic increase in the number of contacts to the OIG Hotline and the number of inquiries and requests sent to us by Members of Congress. A number of these Hotline contacts continue to allege inappropriate practices by VHA staff that undermine the integrity and reliability of wait time metrics as well as allege that VHA's initiatives to provide veterans community care are not working.

Since the publication of our August 2014 report on PVAHCS, we have initiated a series of audits and reviews evaluating the extent to which veterans are able to receive timely care. Although we have completed audits and reviews and published comprehensive reports, a number of more recent reviews are still in progress. One example is an audit we are conducting at the request of Congresswoman Kyrsten Sinema to review the PVAHCS Human Resources Department to determine how effectively they manage their Medical Support Assistant workforce to facilitate veteran access to outpatient care. The results of our completed work are consistent—VA continues to face challenges in providing timely access to care and the management of consult appointments at various points of service.

HEALTH CARE ENROLLMENT

Veterans are experiencing delays even at the initial application and enrollment for health care. Most veterans must apply and be determined eligible in order to be enrolled for VA health care. Eligibility for enrollment is determined by evaluating evidence of qualifying military service and financial income status, if necessary. The Health Eligibility Center (HEC), a component of VHA's Chief Business Office (CBO), is VA's central authority for eligibility and enrollment processing activities as well as the business owner for the Enrollment System (ES), the authoritative system for veterans' health enrollment and eligibility information. Although ES serves as VHA's official electronic system of record for veteran health care enrollment information, it also contains the names of all VA patients as well as applicants whose military service was not confirmed.

In our September 2015 report, *Review of Alleged Mismanagement at the Health Eligibility Center,* we substantiated the existence of about 867,000 pending records residing with the HEC that had not reached a final determination as of September 30, 2014. Pending records included entries for over 307,000 individuals reported as deceased by the Social Security Administration. However, due to limitations in the HEC's ES data, we could not reliably determine how many of the pending records

[3] Recommendations 9, 13, 19, and 21 remain open as of April 14, 2016.

existed because of applications for health care. We also determined that employees incorrectly marked unprocessed applications as completed and possibly deleted 10,000 or more transactions from the HEC's Workload Reporting and Productivity (WRAP) tool over the past 5 years. WRAP was vulnerable because the HEC did not ensure that adequate business processes and security controls were in place, manage WRAP user permissions, and maintain audit trails to identify reviews and approvals of any deleted transactions. The HEC identified over 11,000 unprocessed health care applications and about 28,000 other transactions in January 2013. This backlog developed because the HEC did not adequately monitor and manage its workload and lacked controls to ensure entry of WRAP workload into ES. The Under Secretary for Health (USH) and the Assistant Secretary for the Office of Information and Technology concurred with our findings and recommendations. VA implemented Recommendations 2, 7, 9, and 13, and we will continue to follow up until the remaining nine recommendations are implemented.

MENTAL HEALTH CARE

VHA's efforts to increase access to mental health care for veterans face many challenges. These include overcoming stigmas that veterans may associate with seeking care for mental health and fears that associated medical records documenting their care may have an adversarial impact on their lives and employment. Additionally, VHA struggles to attain and retain a sufficient mental health workforce capacity, establish a competency-based practice, and have adequate systems to support improving care nationwide. In the face of these challenges, we continue to focus our efforts on ensuring veterans receive timely access to mental health care. The OIG's Office of Healthcare Inspections has issued a number of reports detailing their reviews of alleged delays in mental health care.[4]

In August 2015, the OIG Office of Audits and Evaluations issued a national review of veterans' access to psychiatrists.[5] We found VHA had not been fully effective in its use of hiring opportunities or its use of existing personnel to improve veterans' access to psychiatrists. From fiscal year (FY) 2012 through FY 2014, VHA increased outpatient psychiatrist full-time equivalents (FTEs) by almost 15 percent. However, during that time the number of veteran outpatient encounters with psychiatrists increased by about 10 percent, and the number of individual veterans who received outpatient care from a psychiatrist increased about 9 percent. This means that while VHA significantly increased the number of psychiatrists providing outpatient clinical care since FY 2012, it did not show a corresponding increase in veterans receiving care from psychiatrists. In fact, some individual facilities did not increase encounters from FY 2012 through FY 2014 even with their additional psychiatrist FTEs. This occurred because VHA did not have an effective method for establishing psychiatrist staffing needs. Throughout recent hiring initiatives, VHA did not stress a specific need for psychiatrists; instead,

[4] See *Healthcare Inspection - Mental Health-Related Deficiencies and Inadequate Leadership Responsiveness Central Alabama VA Health Care System, Montgomery, Alabama* (July 29, 2015) and *Healthcare Inspection - Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine* (June 17, 2015).

[5] *Audit of VHA's Efforts To Improve Veterans' Access to Outpatient Psychiatrists* (August 25, 2015)

facilities determined their own staffing needs. VHA did not ensure facilities used consistent and effective clinic management practices.

This resulted in 94 of 140 health care facilities that needed additional psychiatrist FTEs to meet demand as of December 2014. We found VHA facilities could have better used about 25 percent of psychiatrist FTE clinical time to see veterans in FY 2014, which equated to nearly $113.5 million in psychiatrists' pay. Over the next 5 years, this would equate to over $567 million if clinic management is not strengthened now. The USH agreed to ensure facilities incorporate the Office of Mental Health Operations staffing model to determine the appropriate number of psychiatrists needed and attain appropriate staffing levels or identify alternative options. The USH also agreed to develop clinic management business rules, reassess the appropriateness of VHA's productivity target for psychiatrists, and develop a mechanism to monitor the variance in which psychiatrists code encounters. Since publication, VA implemented Recommendation 4, which was to develop a mechanism to monitor the variance in which psychiatrists' code encounters and determine appropriate coding guidance and training to ensure consistency.

CONSULT MANAGEMENT

In our August 31, 2015 report, *Review of Alleged Mishandling of Ophthalmology Consults at the Oklahoma City, OK, VA Medical Center,* we substantiated that ophthalmology and teleretinal imaging staff, and referring providers, acted inappropriately on discontinued consults. We found:

- Ophthalmology staff discontinued about 31 percent more consults than the national average in FY 2014, and about 42 percent more in FY 2015 (reported as of March 10, 2015).
- Teleretinal imaging staff also discontinued about 9 percent and 10 percent more consults, respectively, than the national average during these same periods.
- Ophthalmology staff discontinued consults without adequate justification and often because they could not provide eye exams to the patients within 30 days.
- Ophthalmology staff and referring providers did not take the necessary steps to refer the patients to non-VA care staff to obtain their medical care outside of the VA.
- Referring providers did not ensure that discontinued teleretinal imaging consults received the appropriate ophthalmology clinic follow-up.

As a result of our inquiries, VA Medical Center (VAMC) leadership reviewed ophthalmology consults discontinued from January 1, 2014, through March 3, 2015, and identified issues with 439 of 1,937 consults. However, ophthalmology leadership did not provide sufficient oversight for processing consults and the VAMC did not have well-defined guidance to ensure staff took appropriate actions when processing consults. We recommended the Oklahoma City VAMC Interim Director take appropriate action on patients affected by ophthalmology and teleretinal imaging consults, as well as formalize guidance and train staff on processing consults. Actions by the VAMC to implement Recommendation 2, which was to initiate a review of discontinued teleretinal

imaging consults and take action to provide eye care when necessary, remain in progress at this time.

PURCHASED CARE

VA's purchased care programs include the Veterans Choice Program (VCP), Patient-Centered Community Care (PC3), Fee Basis Care, and other non-VA care programs. VA's purchased care programs are critical to VA in carrying out its mission of providing medical care, including outpatient services, inpatient care, mental health, dental services, and nursing home care to veterans. Our audits, reviews, and healthcare inspections have reported the challenges VA faces in administering these programs, such as authorizing, scheduling care, ensuring contractors provide medical information to VA in support of the services provided, ensuring VA inputs the medical information from contractors into the veteran's VA medical record, and timely and accurate payment for care purchased outside the VA health care system.

Patient-Centered Community Care Network

The PC3 program is a VHA nationwide program that provides eligible veterans access to care through contracts for certain medical services. VA medical facilities use the PC3 program after they have exhausted other options for purchased care and when local VA medical facilities cannot readily provide the needed care to eligible veterans due to lack of available specialists, long wait times, geographic inaccessibility, or other factors.

In our July 2015 report, *Review of Alleged Delays in Care Caused by Patient-Centered Community Care (PC3) Issues,* we examined VHA's use of PC3 contracted care to determine if it was causing patient care delays. We found that pervasive dissatisfaction with both PC3 contracts has caused all nine of the VA medical facilities we reviewed to stop using the PC3 program as intended. We projected Health Net and TriWest returned, or should have returned, almost 43,500 of 106,000 authorizations (41 percent) because of limited network providers and blind scheduling. We determined that delays in care occurred because of the limited availability of PC3 providers to deliver care.

VHA also lacked controls to ensure VA medical facilities submit timely authorizations, and Health Net and TriWest schedule appointments and return authorizations in a timely manner. VHA needed to improve PC3 contractor compliance with timely notification of missed appointments, providing required medical documentation, and monitoring returned and completed authorizations. The then Interim Under Secretary for Health agreed with our recommendations to ensure PC3 contractors submit timely authorizations, evaluate the PC3 contractors' network, revise contract terms to eliminate blind scheduling, and implement controls to make sure PC3 contractors comply with contract requirements. VA has implemented Recommendations 4, which was to revise contract terms to eliminate the option of scheduling appointments before communicating with the veteran.

In our September 2015 report, *Review of Patient-Centered Community Care (PC3) Provider Network Adequacy,* we reported that inadequate PC3 provider networks contributed significantly to VA medical facilities' limited use of PC3. VHA spent

0.14 percent, or $3.8 million of its $2.8 billion FY 2014 non-VA care budget on PC3. During the first 6 months of FY 2015, VHA's PC3 purchases increased but still constituted less than 5 percent of its non-VA care expenditures. VHA staff attributed the limited use of PC3 to inadequate provider networks that lacked sufficient numbers and mixes of health care providers in the geographic locations where veterans needed them. VA medical facility staff considered the PC3 networks inadequate because:

- The PC3 network lacked needed specialty care providers, such as urologists and cardiologists.
- Returned PC3 authorizations had to be re-authorized through non-VA care and increased veterans' wait times for care.
- Non-VA care provided veterans more timely care than PC3.

For these staff, inadequate PC3 provider networks were a major disincentive to using PC3 because it increased veterans' waiting times, staffs' administrative workload, and delayed the delivery of care. Further, VHA had not ensured the development of adequate PC3 provider networks because it lacked an effective governance structure to oversee the CBO's planning and implementation of PC3, the CBO lacked an effective implementation strategy for the roll-out of PC3, and neither VHA nor Health Net and TriWest maintained adequate data to measure and monitor network adequacy. The Under Secretary for Health agreed with our recommendations to strengthen controls over the monitoring of PC3 network adequacy and ensure adequate implementation and monitoring plans are developed for future complex health care initiatives. VA has implemented Recommendation 3, which was to develop action plans to improve provider networks that are unable to provide health care services at the specific geographic locations identified.

Veterans Choice Program

As a result of Public Law 113-146, the *Veterans Access, Choice, and Accountability Act of 2014* (VACAA) VA created the Veterans Choice Program (VCP) in November 2014. Following enactment of VACAA, VA turned to Health Net and TriWest, the administrators of the PC3 program, who had provider networks in place nation-wide. The VCP allows staff to identify veterans to include on the Veterans Choice List, a list that includes veterans with appointments beyond 30 days from the clinically indicated or preferred appointment dates and veterans who live more than 40 miles from a VA facility. Under this program, VA facilities began providing non-VA care to eligible veterans enrolled in VA health care as of August 1, 2014, and to recently discharged combat veterans who are within 5 years of their post-combat separation date. With a key VCP eligibility criterion being a veteran's inability to receive care within 30 days, VHA's schedulers and supervisors must ensure they follow VHA scheduling guidance when calculating wait times.

In our February 2016 report, *Review of Alleged Untimely Care at the Community Based Outpatient Clinic, Colorado Springs, CO*, we substantiated the allegation that eligible Colorado Springs veterans did not receive timely care in six reviewed services. These services were Audiology, Mental Health, Neurology, Optometry, Orthopedic, and

Primary Care. We found that for 229 of the 288 veterans with appointments over 30 days, Non-VA Care Coordination staff did not add 173 veterans to the Veterans Choice List in a timely manner and they did not add 56 veterans to the list at all. In addition, scheduling staff did not take timely action on 94 consults and primary care appointment requests. We reviewed 150 referrals for specialty care consults and 300 primary care appointments. Of the 450 consults and appointments, 288 veterans encountered wait times in excess of 30 days. For 59 of the 288 veterans, scheduling staff used incorrect dates that made it appear the appointment wait time was less than 30 days.

As a result, VA staff did not fully use VCP funds to afford Colorado Springs veterans the opportunity to receive timely care. The Eastern Colorado Health Care System Acting Director agreed with our recommendations. Based on actions already implemented, we closed the recommendation to ensure that scheduling staff use the clinically indicated or preferred appointment dates when scheduling primary care patient appointments.

In another February 2016 report, *Review of Alleged Patient Scheduling Issues at VA Medical Center, Tampa, Florida,* we substantiated that when veterans received appointments in the community through the VCP, the facility did not cancel their existing VA appointments. For example, we found that for 12 veterans, staff did not cancel the veterans' corresponding VA appointments because Non-VA Care Coordination staff did not receive prompt notification from the contractor when a veteran scheduled a VCP appointment and no longer needed the VA appointment. We also substantiated that the facility did not add all eligible veterans to the Veterans Choice List when their scheduled appointment was greater than 30 days from their preferred date, and that staff inappropriately removed veterans from the Veterans Choice List.

This occurred because Tampa VAMC schedulers thought they were appropriately removing the veteran from the Electronic Wait List, when they were actually removing the veteran from the Veterans Choice List. The Director agreed with our recommendations to ensure the facility receives prompt notification of scheduled VCP appointments, determine if the contractor complies with the notification requirements, ensure appropriate staffs receive scheduling audit results and verify correction of errors, and ensure staff receive training regarding management of the Veterans Choice List. Based on actions already implemented, we closed four of the five recommendations, and will follow up to ensure the facility receives prompt notification of scheduled VCP appointments.

NEW OIG OVERSIGHT INITIATIVE

The OIG's Office of Audits and Evaluations recently initiated a pilot project to audit one Veterans Integrated Service Network (VISN) and its facilities to evaluate three key components of access—data reliability of wait time metrics, implementation of VCP, and consult management. Our objective for this pilot is to provide comprehensive and timely oversight at all facilities within a VISN in order to provide facility directors a report detailing their current data and scheduling practices. We hope that by focusing OIG resources on this issue we can audit each VISN and its facilities every 3 years, as we

currently do with the Veterans Benefits Administration's regional offices. We feel this work is important and will help provide a veteran-centric view of what actions VISN management is taking to ensure situations like Phoenix do not occur in the future.

CONCLUSION

OIG work has shown that VA faces challenges in providing adequate access to health care. Risks to the timeliness, cost-effectiveness, quality, and safety of veterans' health care raised serious concerns about VA's management and oversight of its health care system and resulted in U.S. Government Accountability Office concluding VA health care was a high-risk area in 2015. A recent announcement by VA to once again change their plans on acquiring a new scheduling package aptly characterizes their inability to provide consistent and meaningful tools and guidance to the VA workforce tasked with ensuring veterans receive timely access to care. A major challenge is in administering its purchased care programs, in part because VHA schedulers and their supervisors do not follow established VHA scheduling guidance. We have a number of active projects involving VHA procedures that ultimately affect veterans' access through the VCP. We will continue to work with VA to provide the independent oversight and objective recommendations to help move these programs and initiatives forward on these issues.

Mr. Chairman, this concludes my statement. We would be happy to answer any questions you or members of the Committee may have.