ROLES AND RESPONSIBILITIES: EVALUATING VA COMMUNITY CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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C O N T E N T S

WEDNESDAY, FEBRUARY 12, 2025

ROLES AND RESPONSIBILITIES: EVALUATING VA COMMUNITY CARE

WEDNESDAY, FEBRUARY 12, 2025

SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:17 p.m., in room 360, Cannon House Office Building, Hon. Mariannette Miller-Meeks [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meeks, Bost, Bergman, Murphy, Van Orden, Kiggans, Hamadeh, King-Hinds, Brownley, Takano, Cherfilus-McCormick, Conaway, and Morrison.

OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. Good afternoon. This oversight hearing for the Subcommittee on Health will now come to order.

It is not often in Washington, DC, you start very early in the morning shoveling snow, but thank you all for making it despite the snow.

I understand this hearing focused on community care has garnered significant member interest, including from committee members who are not on my Health Subcommittee. Before we get started, in accordance with committee rule 5(e), I ask unanimous consent that all off-subcommittee members be permitted to participate in today's committee hearing.

Without objection, so ordered.

As a 24-year Army veteran and a healthcare provider, I have seen firsthand the struggles our veterans face in accessing the care they have earned. I have also experienced the challenges providers encounter when trying to deliver the care.

Let me make two things perfectly clear at the start of today's hearing. Veterans should never have to fight through a maze of bureaucracy to get the healthcare they deserve, and providers should not be bogged down by administrative hurdles just to serve them. These two statements should not be considered partisan.

This subcommittee has received multiple reports regarding delayed referrals, canceled appointments, lack of reimbursement, and long wait times for treatment that should be available much sooner. These are not isolated incidents. These are systemic failures that have real harmful impacts on the everyday lives of veterans.

Let me also say that I know that the U.S. Department of Veterans Affairs (VA) is working very hard and very diligently to serve

our veterans and to remedy these incidents, and it is why today's hearing is so important. Today is our follow up to our previous full committee hearing where we heard directly from veterans and their families about the barriers they experienced in accessing community care.

With the new administration comes new opportunities. Under the leadership of Secretary Collins, I have total confidence that the VA will course correct the failures of the previous administration to protect healthcare access for veterans.

In our last hearing, we saw attempts by some members to shift the failures of the Biden-Harris administration to third-party administrators and providers. There was also yet another attempt to propagate the myth that Republicans want to privatize VA. Let me once again address this falsehood and state the position I share with Chairman Bost: Community care is VA care. It is designed to supplement VA's direct care system, not replace it.

The purpose of today's hearing is to provide a refresher on the roles and responsibilities of the outside providers who are responsible for administering the community care program (CCP) so that all members of the committee can refocus efforts on holding the right people accountable. This is about making sure the community care program works for veterans, not for bureaucrats in Washington, DC.

Let me spell out who is responsible for one. Third-party administrators are tasked with building provider networks and paying claims for services rendered by community care providers. Third-party administrators do not determine veterans' eligibility for community care. They do not authorize referrals, and they do not manage the transfer of medical records between VA facilities and community providers. Those responsibilities belong to the VA. When the VA fails to authorize referrals in a timely manner or delays sending the necessary documentation, veterans are the ones that suffer.

We have heard countless stories from veterans who have waited months for care because their referrals were stuck in the system or who received approval for care just prior to the expiration of that care, veterans who have had to navigate confusing and inconsistent communication because the VA, not the outside providers, cannot get it together.

One of those veterans is my constituent, Mr. Terry Barngrover, a Vietnam veteran battling blood cancer. I would like to take a moment to describe Terry's community care experience in his own words. "They just expect us to know all the rules. No one answers the phone or returns calls. We get the feeling the VA does all of this extra work so we will give up and not use the VA at all." Just last night and this morning, I had a veteran in my community text me about his experience at the VA with a urinary tract infection caused by a kidney stone.

We cannot allow these issues to persist. Veterans like Terry and the veterans we all heard from a few weeks ago in this room deserve better. They deserve a system that works for them, not against them. That is my number one priority from my seat as the chairwoman.

Today, we will hear from VA officials and stakeholders about the steps they are taking to improve the administration of community care and ensure that the program operates sufficiently and effectively so veterans can get the care they need without unnecessary delays.

Thank you all for being here today. I look forward to hearing from our witnesses on how they can improve the VA Community Care Program for the veterans who rely upon it.

With that, I yield to Ranking Member Brownley for her opening statement. The chair recognizes Ranking Member Brownley.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Madam Chairwoman. I am glad the subcommittee is holding this hearing today. Prior to last month, neither the committee nor the subcommittee had held an oversight hearing on community care since July 2022, nearly 3 years ago when Democrats held the majority.

I want to acknowledge and make clear at the outset that there will always be a place for community care. VA cannot provide all the care our veterans need on its own. This is especially true for women veterans needing specialized women's health and maternity care.

Community care is an important part of the healthcare that VA provides. Finding the right balance is important, and I am concerned that we have not yet found that balance.

Today, I expect we will hear some of my colleagues on the other side of the aisle say that VA is restricting veterans' access to community care, but veterans are now receiving more than 40 percent of their care in the community versus only about 23 percent in the year before the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act was implemented. Spending on community care has risen sharply over that period of time, ballooning to what some have argued is an unsustainable amount. Yet, in all that time, particularly over the last 2 years, our committee and this subcommittee have conducted limited oversight in one of the most significantly growing segments of the VA's budget.

VA is on track to spend $42 billion on community care referrals this fiscal year. That should not be a surprising number to everyone in this room, as more and more veterans are referred to community care every single year. It should be shocking to everyone here that VA is sending that much money out of the door every year to a community care network (CCN) over which VA and this committee have devoted very little oversight.

As we will hear from our Office of Inspector General (OIG) and Government Accountability Office (GAO) witnesses, there are numerous weaknesses in VA's oversight over the performance of its third-party administrators Optum and TriWest. These contractors who we will hear from on the second panel have contracts with VA worth tens of billions of dollars. Yet our witnesses from GAO and OIG have detailed in many, many reports that VA needs to perform additional oversight about how they are maintaining their

provider networks and whether—and whether their providers are properly coordinating veterans care with the VA.

Worse still, we do not even know whether patients that are referred to the community are receiving more timely access to care or even high-quality care in the community. We do not know because VA has not established sufficient contractual requirements and metrics through—through with it—through with it can hold its contractors accountable.

Three weeks ago at a full committee hearing, my colleagues and I had the chance to hear from veterans who had difficulties accessing community care. Unfortunately, the limited witness list and hasty organization of that hearing meant that we did not get a chance to hold VA or the third-party administrators accountable for these failures, nor did we have a chance to discuss them with the experts at GAO and OIG who have done some excellent work to find room for improvement in the community care program.

I am glad we have you all here today.

As I said at the hearing 3 weeks ago, I think there is absolutely room to improve the coordination of community care. On Monday, GAO published a report about this very topic, one that I requested, along with some Democratic colleagues of mine.

GAO found that there is inconsistency and variation across facilities in terms of how long it takes to schedule appointments and that VA lacks a comprehensive national policy that clearly defines roles and responsibilities for local facilities. We are rapidly hurdling ahead toward a legislative hearing and a markup on Chairman Bost's community care legislation beginning less than 2 weeks from now. My colleagues and I have many questions about the current state of community care that I am not sure can all be answered in this one subcommittee hearing.

I am also concerned that Chairman Bost's bill would—could exasperate existing challenges in VA community care rather than equipping VA with the resources it needs to properly operate the community care program we already have.

This committee, and the health subcommittee in particular, has an obligation to conduct robust oversight over the healthcare that VA is providing, including through its community care program. I am concerned that the committee's current level of oversight is not sufficient for us to move straight to legislating.

While this hearing today is an important opportunity to hear directly from VA, Optum, and TriWest, I sincerely urge my colleagues to consider what additional oversight is needed to inform our legislative efforts.

With that, I thank you, and I yield back, Madam Chair.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley.

The chair would also like to acknowledge that the chair of the full committee, Chairman Bost, is here with us today, and we will hear from him later.

I would now like to introduce the Panel I witnesses testifying before us today.

We have Dr. Steven Braverman, chief operating officer of the Veterans Health Administration (VHA) at the Department of Veterans Affairs. Accompanying Dr. Braverman representing the Department of Veterans Affairs is Dr. Sachin Yende, chief medical of-

ficer, Office of Integrated Veteran Care. Also with us today is Sharon Silas, director of Health Care for the Government Accountability Office, and Dr. Julie Kroviak, principal deputy assistant inspector general (IG) for the Healthcare Inspections for the VA's Office of Inspector General.

Dr. Braverman, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF STEVEN BRAVERMAN

Dr. BRAVERMAN. Okay. Thank you. Before I get started, I just want to apologize up front for any coughing or sneezing that occurs during the discussion, but I thought it was really important to be here with you today.

I want to recognize Chairman Bost for joining us.

Good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee. Thank you for inviting me here today to discuss the Department of Veterans Affairs Community Care Program. I am accompanied by Dr. Sachin Yende, chief medical officer of the Office of Integrated Veteran Care, or IVC.

It is an honor to be here representing the Veterans Health Administration for the first time as its inaugural chief operating officer. I am responsible for ensuring we continue to live up to the standard the veterans expect and deserve by overseeing operations for VA's 18 Veterans Integrated Service Networks, or VISNs, and providing executive leadership and oversight to 34 program offices within the Offices of Integrated Veterans Care, patient care services, and clinical services.

It is a great responsibility, and I bring to bear the same philosophy I have shared with my teams as a leader in the Army and VA, a philosophy I call the four Cs to Success. They are communication, care of the veteran, customer service, and common sense.

Over the last decade, our system has been faced with many challenges. Following my Army retirement, I joined the Edward Hines, Jr. VA Hospital as its director in 2016. Frustrations with veteran access to care were at a peak and employee morale was low. Employing those four Cs to success, we worked hard to implement the changes necessary to boost morale while keeping veteran care at the core of every decision we made.

The 2018 MISSION Act passed by this committee gave us the authority to put processes in place to ensure veterans had access to timely appropriate care in the community when VA was unable to provide it in our direct care system. Since the MISSION Act became law, VA has referred over 5.4 million unique veterans to community care providers, encompassing more than 228 million community care appointments. As with the implementation of any law, we have had to make systemic improvements to ensure timely access and build veterans' trust in our system.

While serving as the director of the VA Greater Los Angeles Healthcare System, we hired and trained dedicated staff for referring and appointing veterans into community care. We piloted the VA's initial tele-emergency medicine initiative that enabled most veterans to be evaluated without costly emergency room visits and

receive appropriate follow on specialty outpatient referrals as needed. It is now a national program.

During my time as the VISN 22 director, the Phoenix VA became a model for the referral coordination initiative, a nurse-led effort to connect veterans eligible for community care with the right provider for his or her needs.

With implementation of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act, demand on the VA has never been greater. Since the law took effect, nearly 900,000 veterans have enrolled in VA care, with even more moving into higher priority groups due in part to the resulting increase in service-connected disability ratings. The corresponding elimination of copays and increased eligibility for additional medical services led to more reliance on VA care that cannot be met in the direct care system alone.

I can confidently say that we could not meet veteran demand without the partnership and collaboration among our third-party administrators and community care providers. Still, challenges remain with care coordination and the veteran and provider experience within the community care program.

A recent series of OIG inspections of VISN's community care programs, including my former network, identified several similar findings and recommendations. Those included strengthening community care oversight councils, scanning of care documents into veterans' electronic health records and referrals, and timely processing of follow-up requests for services. Based on these findings, IVC leaders, VISN directors, and VHA's Office of Integrity and Compliance are working together to execute consistent action plans across the country to address OIG's recommendations.

Prior to joining the VA, I served 29 years as a physiatrist in the Army Medical Corps in both academic and operational leadership roles. As an Army retiree, a Federal employee, and a deployed veteran, I have multiple options for my healthcare. I am proud to say that I receive all my medical care at VA. It is the best care available.

Madam Chair, Ranking Member Brownley, and members of the committee, I look forward to working with you to continue to strengthen our healthcare system and to answering your questions.

[THE PREPARED STATEMENT OF STEVEN BRAVERMAN APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Dr. Braverman.

Ms. Silas, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF SHARON SILAS

Ms. SILAS. Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, thank you for the opportunity to be here today to discuss VA's efforts to ensure veterans have timely access to healthcare through the community care program.

Although the majority of veterans receiving VA healthcare still receive their care at VA medical facilities, the number of veterans receiving care through the Veterans Community Care Program has

increased greatly. In Fiscal Year 2023, community care represented about 40 percent of all VA healthcare.

In 2018, in an effort to help alleviate long wait times for care at VA medical facilities, Congress created the most recent version of community care, the Veterans Community Care Program, expanding access to providers in veterans communities. Since the implementation of the program, the Veterans Health Administration has made numerous changes to how the program is administered, how referrals for appointments for community care providers are processed, and how the agency tracks data and information on the performance of the program.

My remarks today address findings and recommendations from seven reports that we have issued since 2018 and includes 27 recommendations that we have made to improve the community care program. Although VA has fully implemented some of those recommendations and taken steps to address others, 17 of the 27 recommendations remain open as of February 2025.

There are a few areas that I would like to focus on today where we believe that there are opportunities for VA to continue to make improvements to the community care program.

First, we have long provided oversight of VA's appointment scheduling processes and monitoring of wait times. VA has taken some actions to address challenges both with scheduling appointments with VA and community care providers, such as establishing timeline standards for scheduling appointments. VA has also established a timeline standard for when a veteran's appointment should occur with a VA provider. However, VA has still not fully implemented our 2018 recommendation to establish a similar timeline standard for community providers.

Without a complete picture of how long it takes a veteran to receive care, whether that care is being delivered at the VA or through a community provider, it will continue to be difficult for the VA to know whether it is achieving its goal of providing veterans with timely access to care.

Further, we recently issued a report on VA's referral coordination initiative, the new process with the potential to transform the effectiveness of VA medical center's processing of community care referrals and appointment scheduling. In our 2025 report, we identified challenges with the implementation of the new program, including needed improvements to the program's direction, guidance, and performance metrics.

For example, we found that the regional networks and medical facilities did not have guidance that was aligned with policy, was evidence-based, nor was it timely or consistent, resulting in inconsistent implementation of the initiative and potentially impacting VA medical facility staff's ability to effectively serve veterans. We made five recommendations based on our findings.

Second, I would like to highlight VA's oversight of community of care contracts and network adequacy. Oversight of these contracts and effective monitoring of the contractor's network of community providers and their capacity to see veterans contributes to VA's ability to provide timely access to care.

The Veterans Health Administration is responsible for measuring the community care contractor's performance, including network

adequacy. In our August 2024 report, we reported weaknesses in VA's oversight of these contracts. Specifically, we found that the continued restructuring within the office responsible for contract oversight resulted in a lack of clarity and completeness in oversight procedures and roles and responsibilities. We made three recommendations to address the deficiencies that we identified.

We have also found opportunities for VA to better ensure community care program network adequacy. Specifically in our 2024 report, we found that VA's methodology to calculate network adequacy for specialty care through the program does not include all claims in their calculation. This raises concerns as to whether VA is fully assessing the adequacy of community care contractors' networks.

As I have highlighted in my remarks and in the statement that we submitted, GAO will continue to monitor VA's actions addressing our open community care recommendations. We also have ongoing and future audits that will build on our existing body of work in this area, including a review of VA's medical document exchange with community providers, which we plan to issue this spring.

Especially as VA has seen an increase in enrollment and reliance on VA healthcare and the agency prepares for the next generation of community care contracts, the community care program will continue to be an important resource for expanded healthcare options for veterans in ensuring they receive timely access to care, a key goal for VA. Addressing both our outstanding and new recommendations will help VA to provide consistent high-quality healthcare regardless of where veterans receive their care.

Thank you. That concludes my statement.

[THE PREPARED STATEMENT OF SHARON SILAS APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Silas.

Dr. Kroviak, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF JULIE KROVIAK

Dr. KROVIAK. Thank you.

Dr. Miller-Meeks, Ranking Member Brownley, Chairman Bost, and subcommittee members, I am pleased to discuss the OIG's oversight work related to VA community care.

Since 2020, we have published over 50 reports that highlight the significant challenges VA faces in ensuring veterans get timely and high-quality care in the community.

My colleagues in the Office of Healthcare Inspections, or OHI, include physicians, nurses, pharmacists, clinical psychologists, and social workers with decades of clinical experience. This expertise allows in-depth review and analysis of not only community care's administrative issues, but also a credible perspective on how these issues affect the actual quality of care for veterans.

For example, OHI's Care in the Community teams conduct cyclical VISN-level reviews to evaluate compliance with VHA's community care referral and coordination processes. These reviews intentionally evaluate administrative processes that have direct impact on the healthcare providers' ability to manage and coordinate a patient's care.

OHI also conducts inspections to evaluate issues specific to individual episodes of community care, again, through a clinical lens, for stakeholders to understand exactly how certain events influence the quality and timeliness of care. Additionally, OIG's Office of Audits and Evaluations have conducted multiple national reviews that highlight issues in community care related to contractor oversight, VA staffing, Information Technology (IT) systems, and financial management processes. This oversight work has informed my testimony before this subcommittee, as well as the many briefings we give to committee staff, individual members, and VA leaders.

What we have consistently found can be organized into four areas of concern. First, veterans may not experience timely and seamless coordinated care when they are referred to the community. Referrals designated as high risk must be consistently prioritized. Requests for additional services must be acted upon quickly to avoid interruptions to care, and results of that care must be appropriately uploaded in a patient's medical record to ensure care teams have up-to-date information and can take action that is needed.

To do this, VHA must further develop administrative processes to get patients to the right provider in a timely manner and then follow up to ensure veterans received the appropriate care.

Second, VHA has inadequate oversight of community care providers and cannot ensure the quality of care that is being provided. Unlike care provided at VHA, the community care program lacks robust quality assurance processes that monitor the performance of care specific to veterans, such as screenings for suicidal ideation and military sexual trauma, as well as real-time oversight of opioid prescribing practices. For example, community care providers may not be complying with VHA's opioid safety initiative, risking the close monitoring of these prescriptions for veterans.

When VA providers cannot even get timely access to basic clinical documentation detailing a community provider's management of a referred veteran, any opportunity to monitor that quality or address additional identified needs is lost. Basic qualifications of community providers must be thoroughly reviewed and verified prior to joining the community care network.

Third, VHA staffing shortages further undermine community care coordination efforts. Reliance on community providers is necessary, but as we have seen, it does not guarantee veterans will get the timely care they need. VHA must commit adequate staffing and resources to ensure community care is as seamless as it is in house.

Fourth, substandard IT systems and inaccurate and incomplete data significantly restrict VA's ability to manage community care payments. VA has a right and an obligation to recover community care treatment costs for conditions unrelated to military service from veterans' private health insurers. The OIG has found that VHA has not enacted effective processes to do this, compounded further by the pause of the program integrity tool which is used to identify billable claims.

OIG teams will continue to conduct meaningful independent oversight to ensure veterans receive the timely high-quality care they deserve. We look forward to working with the subcommittee

to advance VHA's provision of care to veterans regardless of where it is provided.

Dr. Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, this concludes my statement. I look forward to your questions.

[THE PREPARED STATEMENT OF JULIE KROVIAK APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you very much, Dr. Kroviak.

As is customary, I will reserve my time until all of the members have had a chance to ask their questions.

With that, I now recognize our chair of the full committee, Chairman Bost, for 5 minutes for any questions he may have.

Mr. BOST. First I want to thank Chairman Dr. Miller-Meeks. You know, I appreciate your friendship and the continued leadership that you are due here with the VA. It puts veterans front and center, and thank you for that.

You know, as chairman, I am deeply committed to our shared mission of improving, delivering the care and services to our Nation's veterans. You have all heard me say it before, and I am going to say it again, VA was built, not for VA bureaucracy, but for the veterans themselves, and we have to remember that.

That is why, last month, I held a hearing to learn what veterans and their family members think about community care. The witnesses put their trust in the VA, and the bureaucracy burned them in the process.

Mr. Dooley, an Army veteran of 20 years, described his experience with VA saying, I was treated like I was asking for charity and not treated as a disabled veteran that was trying to receive life-saving treatment.

Ms. Locklear, a former VA employee who tragically lost her son, stated, I believe my child would still be here today if the VA had lived up to their promise and the promises that were made to him.

Ms. Diamond, a Navy veteran, struggled with access—appropriate community care, and she shared this. VA must stop its practice of rationing inpatient mental healthcare based on arbitrary seemingly thoughtless guidelines.

You would think that these testimoneys would be sufficient for anyone to realize that VA community care reforms are needed.

Some members wanted another hearing to talk about the community care and accuse us of not conducting oversight on the community care. This statement is inaccurate. Let me say that again. These statements are inaccurate.

Last Congress—and I want to be very clear that all members hear this. Last Congress, we held nine hearings, nine hearings that focused on community care. For someone to say we are not focused on it, we held nine hearings. Now, I do not expect Congress—this Congress to be any different.

Last week, I and 10 cosponsors introduced the ACCESS Act, because veterans have earned access, timely and quality healthcare, whether in the VA at home or in the community. The ACCESS Act would codify care access standards, give veterans a say in their care choices, and provide access to urgent mental health residential care.

The VA MISSION Act passed in 2018 with overwhelming bipartisan support, like the MISSION Act, the ACCESS Act does nothing to privatize VA. Now, let me say that again. The VA MISSION Act, like the ACCESS Act, does nothing to privatize VA. Anyone who suggests otherwise based on how they feel or how their party feels needs to put a pair of glasses on and read the bill.

Make no mistake, the ACCESS Act embodies the committee's position. Community care is VA care. Community care is VA care. Community care is not a substitute but an essential extension of VA's mission.

Now, I look forward to working with my good friend, Mr.—the Secretary, Doug Collins. He and I have been friends a long time, and we are going to focus on VA and its only mission, and that is caring for our veterans. That is our only mission.

Now my question. Dr. Braverman, what is the Trump administration doing to ensure that veterans are at the center of every VA decision?

Dr. BRAVERMAN. Chairman Bost, I think the most important answer to your question is that that is already the guidance from Secretary Collins, and it is guidance that we all have and all believe in in regards to the decision-making. That was also something that I put in my original opening statement that as I have gone through my VA career, those decisions really are made with the best interests of the veterans at heart. We will continue to do that for every decision that we make along the way.

Mr. BOST. I look forward to helping you achieve that, not only with the new Secretary, but everybody that is involved. I hope that that is the mission of everyone there at the VA, and know that we are going to be working together to make that happen.

Madam Chair, I yield back. My time has expired.

Ms. MILLER-MEEKS. Thank you very much, Chair Bost.

I now recognize Ranking Member Brownley for 5 minutes for any questions she may have.

Ms. BROWNLEY. Thank you, Madam Chair.

Dr. Braverman, it is really good to see you. Congratulations on your assignment here in Washington.

I just have to say that I have worked with Dr. Braverman very closely over the years, and he has done really terrific work in the Los Angeles Medical Center but for all of VISN 22 and really appreciate your leadership and seeing through the Community Based Outpatient Clinic (CBOC) in my district as well. Thank you for that.

Mr. Braverman, Secretary Collins just informed the committee today that VA does not expect to award a next generation of community care network contracts. Might be two to three more years before—before they are ready to do that. Obviously, the current Optum and TriWest contracts are set to expire.

In his letter, he said that in the previous administration there were delayed key programmatic decisions. What were those delayed key programmatic decisions?

Dr. BRAVERMAN. Well, I think the basics to that is that as we are going through the requirements process to identify and the decisions to identify what needs to be in these contracts, we want to

make sure that they are done according to acquisition standards. That is what we will be doing moving forward.

The timeline that was identified in the letter that you received is, you know, based on us committing to moving as quickly as possible to making those decisions and being able to award the next set of contracts by the summer of 2027.

Ms. BROWNLEY. Thank you. I agree with your remarks as well that community care is really important and what TriWest and Optum do is critically important. Those contracts are very important.

Certainly, GAO has identified areas where we can improve those contracts and identified a lack of formal lessons learned, a process of that in the current—for the past and current community care contracts. I just—you know, maybe today is not the right day to talk about it, but I want to talk about what—what we have learned, what we—do you really think—let me get to this question.

Do you think that we need to include in their contracts our ability to have stronger oversight in terms of, you know, the wait times issue and other things like that built in so that—there have been a lot of recommendations, I think, that we could make the contracts better, and I believe that they perform well. I just want to make sure that we are trying to find what the right balance here is between VA care and community care, and to really find that out we need a lot more data to make some, I think, rather tough decisions.

Dr. BRAVERMAN. We—we absolutely want to work together with the next contractors to make sure that that partnership identifies ways in which we can really focus on the quality of care that is being delivered within—by the contractors, by the third-party administrators to be able to ensure that we have a way to communicate what those wait times are, what those capabilities are, network adequacy, taking a look at those areas for improvement that have been identified in the—you know, from the current contract administration and building on those to make requirements that will enable us to improve those.

I will actually yield here to Dr. Yende a moment, who has some more specific information on the kinds of things that we are looking at.

Dr. YENDE. Appreciate that question.

I would just say we have a lot of lessons learned within our legacy contract and based on input from both OIG and GAO. While we cannot discuss acquisition-specific issues today, I would just like to reassure this committee that we are focusing for next generation on better approaches to return medical documents, a more robust——

Ms. BROWNLEY. I do not have much time, so if you cannot really talk about it, I just would like to move on. Thank you.

In terms of just community care scheduling and care coordination by the VA in this process, do you think that we need to do a better job?

Dr. BRAVERMAN. Absolutely. One of the things we are doing now is tracking that at my level to identify what the wait times are, and then also focus on integration as we reassess what our whole IVC organization is going to look like moving forward.

Ms. BROWNLEY. This whole offer to employees for—you know, to—the buyout for leaving the organization and so forth, a lot of that—I think most of it has been rescinded now. I am worried about what—those people who are prepared and ready to take it, and now that has—that offer has been rescinded.

Dr. BRAVERMAN. Well, in the VA, we have been very proactive in identifying exemptions from the hiring freeze and exemptions from participation or exclusions from participation in the deferred resignation program, which accounts for more than 90 percent of the employees that work within our field hospitals and clinics. That I think that, for the most part, our ability to care for our veterans is pretty much preserved, and I think we will be able to continue to move forward.

This is an anxious time for all of our Federal employees, and we will continue to work with them to move forward.

Ms. BROWNLEY. Thank you.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley.

The chair now recognizes Dr. Murphy for 5 minutes for any questions he may have.

Mr. MURPHY. Thank you, Mr. Chairman. I want to say thank you to all our witnesses today.

You know, I just—I have to reiterate the chairman's comment about community care. I just do not understand the rationale of beating up on it. We do not have enough doctors in the VA. We have to refer our other patients out into the community. Making that a seamless process rather than just beating on the fact that community care is here with us is, my opinion, just ridiculous. It is a waste of time, and it is just something that the committee does not need to do. It is just insult after insult. As a community care provider myself, it is just ridiculous that we have it.

You know, we have come before this committee—I have been on this committee now for 5 years, and I have just come up and I have heard the same litany of excuses, excuses that has gone on and the same story about delayed care, especially in the community. I am hopeful that with new leadership coming in and actually with the tenor of what is going on in Washington, DC, that we actually get back to not only serving the people of the country but the veterans who served us so dearly.

Let me ask just a couple of questions. Dr. Kroviak, just, you know, I am in awe of all the things that you spoke about. Your testimony highlighted some reported delays in the processing of community care referrals, even for veterans with serious conditions. We had—I had a constituent here at our last meeting that was still waiting 9 months to get a referral.

What changes do you believe, concrete changes, something that actually not to be talked about, that needs to be done, should the VA implement to prevent these serious delays occurring, especially ones with time-sensitive things like cardiac disease or cancer care?

Dr. KROVIAK. Thank you. I think the most important thing is clear policies on prioritizing the very specialties you are describing that would be automatically considered high risk, and then internal oversight that ensures that frontline staff are following through consistently on those policies and practices. We have seen that is not happening.

Mr. MURPHY. Yes. You know, people say that we want to privatize the VA. In certain ways, I think the private—the actions of the healthcare community and the private world should be mimicked because it is—it is a tone within our VA that there is no expediency to this. Again, with new leadership coming in, I think there will be now a different tenor of expediency.

Follow-up question. What happened at the Buffalo VA? The staff raised concerns, but the leadership did not do anything about it. What mechanisms now should be in place to hold the VA leaders responsible when they ignore or dismiss staff with concerns about patient safety?

Dr. KROVIAK. As we have said in much of our testimony and in our reports, it is clearly defined roles and responsibilities that will establish the authority that we are all looking for. If you know it is your job to follow up and make sure that your staff are performing certain activities, and they are not, then you need to have the authority to hold them accountable. If you are still not getting where you need to go, you need to know to go to the level above, and that is just not consistently happening.

Mr. MURPHY. Well, I think it needs to, and there needs to be accountability. I think if one word is describing the tenor in the country right now, it is called accountability. We know that delay in care changes outcomes, period. Everybody knows. Especially in cancer care. You are delayed in diagnosis, delayed in treatment, your outcome is worse.

Dr. Braverman, when veterans face delays in care due to administrative failures within the VA, what processes regarding their lost referrals, miscommunications, delayed authorizations, what accountability measures are in place or need to be in place that staff and leadership are responsible for these failures? Again, accountability, meaning the—in the word—the imperative word there.

Dr. BRAVERMAN. One of the things that we have to do is identify the why for when these things happen, and is it a matter of failure to execute, failure to oversee, or just making errors because the processes are not clear. Once we have that information at hand, we can fix the processes, if that is what is going on. Then hold leaders accountable for failure to take actions when information——

Mr. MURPHY. Is the VA aware of something just called a basic root cause analysis?

Dr. BRAVERMAN. Absolutely.

Mr. MURPHY. Sentinel events?

Dr. BRAVERMAN. Yes, sir.

Mr. MURPHY. Okay. In my world where we have had those, if, God forbid, there was a sentinel event where some patient was injured, did not get the care, et cetera, there is an action team that goes in there. That is then a zero recurrent event. It is deemed to be not to ever occur again.

Sadly enough, we have heard this litany of 5 years—I have anyway—of these same things being done over and over and over again. Last 4 years, scandal after scandal after scandal. I do not think we made one inch of progress toward getting better care, more efficient care for our VA.

We should not be hearing these stories. Stories occur, sure. Mistakes happen because we are a human institution. The fact that

these are recurring and over and over again with no improvement is anathema to what this committee should be all about.

Thank you, Madam Chairman. I will yield back.

Ms. MILLER-MEEKS. Thank you, Dr. Murphy.

The chair now recognizes Representative Cherfilus-McCormick for 5 minutes for any questions she may have.

Ms. CHERFILUS-MCCORMICK. Thank you, Chairwoman Miller-Meeks and Ranking Member Brownley for holding this hearing today.

The VA has faced persistent issues with staffing clinical and administrative positions essential for managing veterans community care. Reports from the GAO and VA OIG reveal challenges, including unreliable data for staffing assessments, inconsistent staffing practices across facilities, and inadequate staffing tools.

Facility leaders lack the authority to enforce recommended staffing levels, and some question whether the suggested numbers are too high. These ongoing staffing challenges impact the effective administration of community care for our veterans. I am deeply concerned that this problem will be further exacerbated by President Trump's recent executive order to freeze Federal workforces.

Dr. Braverman, what is your plan to ensure that the VA medical facility has the staff necessary to coordinate veterans' care within the community care program?

Dr. BRAVERMAN. The Secretary has made it clear that we are going to have the staff required in order to do our mission, which is basically taking care of veterans.

Ms. CHERFILUS-MCCORMICK. Is there a plan as of right now?

Dr. BRAVERMAN. As of right now, there is, in that we have these exemptions against the hiring freeze for the people that are necessary in order to coordinate that care, in order to——

Ms. CHERFILUS-MCCORMICK. Could you tell us some of the exemptions?

Dr. BRAVERMAN. I have a—all of the medical support assistants, the nurses, the team that is associated with the provision and scheduling of these are on the exemption list. There is—I do not know the exact number of occupations that are, you know, on that list, but we certainly can provide that list to you.

Ms. CHERFILUS-MCCORMICK. Thank you.

My second question is, since the enactment of the MISSION Act, the veterans at—the Veterans Community Care Program has grown exponentially, straining the budget of the VA and threatening the ability of the VA to provide direct care to our veterans. In fact, the VA is on track to obligate $42 billion in Fiscal Year 2025 for the community care program, up from $14.3 billion before the enactment of the MISSION Act.

If this unsustainable trend continues, the VA will be unable to fulfill its four core missions, one of which is to serve a backstop—a backstop for emergencies of hurricanes that affect my constituents in Florida immensely.

Dr. Yende, would you agree that it is important for the VA to achieve all of its four key missions?

Dr. BRAVERMAN. I am sorry. Who was that referred to?

Ms. CHERFILUS-MCCORMICK. Oh, Dr. Yende.

Dr. BRAVERMAN. Oh, Okay. Sorry.

Dr. YENDE. Yes. Absolutely, Congresswoman. We do agree with you. Just to be clear, we believe that community care is an important part of VA care, and we will continue to support when veterans are eligible for community care that they are offered community care and veterans, obviously, will have the choice to determine whether they want to stay in the VA or choose community care.

Ms. CHERFILUS-MCCORMICK. Specifically, what I was asking is that do you believe that there would be a negative impact to veterans who are trying to—the VA is supposed to be the backstop for emergency care, like hurricanes. With this exponential amount rising consistently, is there a concern for you?

Dr. YENDE. We are not aware of any direct impacts on our fourth mission due to community care increase, but we can definitely take that back and give you some more details.

Ms. CHERFILUS-MCCORMICK. Would you agree that the rapid growth of spending on a community care program would potentially affect VA's ability to achieve its fourth mission, especially the fourth mission—I guess we already discussed that.

My next concern then would be, what would you propose that we could do that would kind of merge and subside the rising number of community care—community care?

Dr. YENDE. Congresswoman, I just want to be clear over here. Our principles when we discuss care options with the veterans are, if the veteran is eligible for community care, our staff should be offering those options to the veterans. Then if the veteran chooses to stay in the VA, then they would get their care in the VA. If they are choosing to go into the community, we should be able to offer that care in the community.

Having said that, everyday VA facilities are trying to build capacity within the direct care system to offer more and more services. A good example of this is residential treatment programs. We have increased capacity for beds within our VA direct care system, and that is how we are offering more VA care in the current system.

We just want to be clear, we do not believe these are competing. We want to make sure we follow the law in this particular case.

Ms. CHERFILUS-MCCORMICK. Thank you. I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Cherfilus-McCormick.

The chair now recognizes Representative Van Orden for 5 minutes for any questions he may have.

Mr. VAN ORDEN. Thank you, Madam Chair. Thanks for having us here today.

I am the—I am the longest serving enlisted member of the United States military to ever get elected to Congress in the history of the Nation. I get all my healthcare through the VA, and I love the VA. I want everybody to go to the VA who has served our country. I get these rocking glasses in LaCrosse, I also get seen in Tomah. When I say I get all of my healthcare at the VA, I mean also at Crossing Rivers Hospital in Prairie du Chien, Wisconsin, when I cannot get an appointment.

Again, I cannot stress enough that community care is Veterans Administration care because the check is coming from there. I just

want to—because I was an enlisted guy, I wanted to show you something here.

These—these are the recommendations that were made by Ms. Silas' office. Your reports are fantastic. Fifty reports is a lot. Okay. These are the things that the VA has not done. If you look at them sideways, they look like they are just about exactly the same thickness, don't they?

If we have the—the GAO working hard—sorry, enlisted guy, almost came out—and Dr. Kroviak working hard, and over years and years—since 2018, they gave you this stuff. You have 18 out of the 21 have not been done? This is—this is—this is a—it is endemic, and I have learned this as a chair of the Subcommittee for Economic Opportunity, that we seem to keep going in these circles. You know what I mean?

We have got the Government Accountability Office, we have got the IG doing stuff, and then it goes to the VA and just falls into a hole. We forget about it for a while, and then another report—you said you do 50 reports, ma'am? Fifty reports.

If you are by volume to take the amount of recommendations in those 50 reports and showed us what was not acted on in any of those reports, what do you think that ratio would be? There has got to be—how many recommendations are in 50 reports? A lot.

Dr. KROVIAK. There are hundreds of recommendations.

Mr. VAN ORDEN. To scale, like, how many you think the Veterans Affairs Administration has not acted on?

Dr. KROVIAK. I would be much more comfortable getting that number back to you formally, but yes——

Mr. VAN ORDEN. Okay. We can do that. I am okay with that.

The point being this: There is zero accountability at the Veterans Affairs Administration, Doctor. I am glad you are coming in, and I am glad Secretary Collins is here. There is zero accountability at the Veterans Affairs Administration. I do not have—hopefully, this will change. I do not have any confidence—I mean zero confidence—in the Veterans Affairs Administration to be able to plan itself even out of a wet paper sack, because I have seen it to the tune of billions and billions and billions of dollars of waste.

One example is the electronic GI Bill. The estimate from the guys at the VA, that it was going to cost $25 million. You know what they are up to now? $960 million from a $25 million estimate.

Mrs. Cherfilus-McCormick, we had this hearing the other day about the electronic service record. Wow. I mean, it is shocking. I mean, they are up to like $50 billion they think it is going to take to implement from a $16 billion initial estimate. Okay. That is unacceptable.

I mean, it begs the question, Ms. Silas and Ms. Kroviak, you know, why do you guys even exist if you are doing this, and I mean quality work, if it is not going to be acted on?

This is more of an encouragement, you know, senior enlisted to—you were probably a colonel or something when you got out?

Dr. BRAVERMAN. Yes, I was.

Mr. VAN ORDEN. Okay. There you go. This is your senior listed adviser to the incoming colonel. Your command is broken, and it needs to be fixed. It will not be fixed until you hold people accountable like you would in the military.

The Veterans Affairs Administration has to stop acting on a long series of suggestions. Those should not be suggestions. We have got to figure out a way to empower you to hold people accountable that do not follow the findings in your reports, and nothing is going to change until that happens.

I do not really have a question. I just—I am offering you encouragement. I want to thank you ladies for your exceptional work. If you ever need anything, I am really good at yelling at people. I can do that all day long. Just reach out to my office, I will scream at them on the phone for you. Is that good?

Dr. BRAVERMAN. Yes, thank you.

Mr. VAN ORDEN. All right. Thanks, Colonel.

I yield back.

Ms. MILLER-MEEKS. I would echo that about Representative Van Orden, and thank you very much Representative Van Orden.

The chair now recognizes Dr. Conaway for 5 minutes for any questions he may have.

Mr. CONAWAY. Thank you, Madam Chair.

Thank you, ladies and gentlemen, for presenting yourselves to us today.

I am—I suspect there is going to be broad agreement on this committee that community care is VA care and is necessary. And—but, of course, the devil is in the details and the implementation, of course, we must, as we always do, have cost concerns as part of our deliberations.

It has been noted, the rise in the use of community care. Dr. Braverman—and perhaps Mr. Yende may want to chime in as well—do you have a concern about the growth of the community care program and what that might mean for the direct care program?

What we also know is, what is in our notes and has been said here at this dais, is that veterans certainly want the direct care program to continue. They want to have—receive their healthcare there. Numerous reports show that the quality of care delivered there is better than you are going to get out in the private sector.

Do you have a concern about the growth of the community care program and the potential negative impact on the direct care program within the VA?

Dr. BRAVERMAN. Thank you for the question. The way I would answer that is, first off, to make sure that we have a direct care system that provides, to the best of our ability, the needs for all of the veterans. That their initial justification for care and availability for care is maximized within our system, and then continue to use the community care as that partner as VA care, as many folks have identified that before.

We are venturing on a productivity and efficiency initiative in order to try to maximize the ability to provide care in the direct care system, which will then——

Mr. CONAWAY. Pardon me. Do you have a concern about the direct care system being able to function in a way that meets the demand in the eyes of the veteran community—and I think this committee—that the direct care program thrives and is there for the veterans well into the future?

Dr. BRAVERMAN. I—I do not have concern about the ability to do that as long as Congress identifies the—and approves the——

Mr. CONAWAY. The funds.

Dr. BRAVERMAN [continuing]. resources that we need to make that happen.

Mr. CONAWAY. Thank you.

My next question is for Dr. Kroviak. You know, one of the things that we are seeing in our notes which is concerning to me, when you look at the sort of schematic they lay out for referrals, getting them done, getting people moved through a system to get care, one of the things that was noted is that there is a disconnect between what is in the Veterans Administration's regulations around referrals and the timeliness there and what the actual practice is when they get out into the community setting.

Now, in your investigations, you actually go to the third-party providers, Third Party Administrators (TPA) and others, to look at their processes as well as the ones in the VA or no?

Dr. KROVIAK. No. We look exclusively at VA.

Mr. CONAWAY. VA exclusively. Does anybody look at the processes in—in the third-party community?

Dr. KROVIAK. We do not have that authority to look at the——

Mr. CONAWAY. You do not have the authority.

Well, let me—let me bounce back to Dr. Braverman then. Is there a—as you think about this next—current contract or perhaps the next contract, recognizing—and first off, I will ask you—you can agree or disagree—do you recognize there is a mismatch between what the VA rules are about referral and getting—and the timeliness and what actually happens in practice when people are referred to the community? Do you agree that there is a mismatch there?

Dr. BRAVERMAN. I would agree that we have these set of standards that are identified in the VA access standards and we do not have those same standards in the community care.

Mr. CONAWAY. That—that sounds—I mean, am I right, then, that that is a contracting problem in the way the contracts are drafted to direct the operations of the vendors, that is, Optum and, what is it, TriWest and others who are providing community care? Is that—is that part of the problem here with this—this disconnect and people not getting timely care in the community?

Dr. BRAVERMAN. I will let you respond to that.

Dr. YENDE. You are right. In our current contract, we do not have that requirement. I would just add that, from our standpoint, community care is a partner when a VA care option is not available.

Mr. CONAWAY. Understood.

Dr. YENDE. That is a backstop, and these are some of the challenges within the U.S. healthcare system, so we have to work within those confines.

Mr. CONAWAY. Well, it sounds like it might be a contracting issue. I do wonder whether or not—I mean, contracts, you are not supposed to change them. Is there a way that—well, let us just say that—for myself, and maybe there will be others that disagree or agree with me, that we need to look more carefully at the contracts—the current contracts, what remedies we might have within

the current contracts if people are not adhering to the contracts. Then, certainly, when we recontract, that we take care to make sure there is a match between what we are requiring and what they actually do.

Thank you, Madam Chair.

Ms. MILLER-MEEKS. Thank you very much, Dr. Conaway.

The chair now recognizes Representative Hamadeh for 5 minutes for any questions he may have.

Mr. HAMADEH. Thank you, Madam Chairwoman.

As a veteran, I am deeply troubled by reports of systemic delays veterans face accessing care through the VA's Community Care Program. As mentioned earlier, we had—a few weeks ago, really, we heard tragic stories. I mean, it was quite an emotional hearing of so many failures within the VA system and referrals to the community care program.

Now, despite reforms, VA mismanagement continues to put bureaucracy over timely healthcare, using dishonest wait time metrics, excessive appointment cancellations, and barriers to community care referrals. The VA fails on its most basic mission: caring for those who served. My question will focus on identifying specific actions to streamline care access. Veterans deserve accountability, transparency, and flexible care options. We must focus on empowering veterans through healthcare choice.

My first question is for Ms. Silas. What main factors drive continued barriers to community care access?

Ms. SILAS. There is a number of barriers in terms of getting timely access to the community care program. One is the process within VA to determine eligibility for the program to identify providers of the community that are available to see veterans for care. The process itself, there is a lot of back and forth in discussing the options with the veteran, identifying the provider availability, and then working on an appointment scheduling time that works for both. There is a lot of back and forth that can go on during that time. It is the nature of the process.

Sometimes when there is this back and forth and there may be challenges in contacting the veteran to get their preferences of times and availability. Maybe those appointments, slots may get picked up by other patients not even in VA care. There is a constant juggle of doing that within the process itself.

I think one of the other issues is that veterans are competing with other patients out in the community for these appointment slots. We know just in general in the healthcare industry that it is difficult to find providers. There is a shortage of providers. When you are working in an environment and the VA is responsible for ensuring that these veterans get timely care, those create a lot of challenges for them.

Mr. HAMADEH. Would codifying access standards into law help ensure access?

Ms. SILAS. I think establishing—and this goes back to our 2018 recommendation that we made where we recommended VA establish a standard for when veterans receive care in the community.

Right now, there is a standard for when an appointment is scheduled for the veteran in the community, which is great for holding the VA staff accountable for meeting that standard. We do

not have a similar standard for when the veteran actually receives care in the community. We have had conversations with VA officials during our follow up on these recommendations to see what actions they have taken, and there are concerns that they do not have any control over the community providers' schedules and their capacity to see veterans.

I do believe by establishing and fulfilling our recommendation of establishing a standard for receipt of care it would at least help VA to better monitor whether or not veterans are getting timely access to care, and it would actually provide an indicator to see if they are actually meeting their goal of providing timely care.

Mr. HAMADEH. That leads me to Dr. Braverman. Why has not the VA complied with using the date requested versus the patient indicated dates to ensure the accurate wait times that Ms. Silas just noted?

Dr. BRAVERMAN. I am going to refer that to Dr. Yende, because he is more familiar with the specifics.

Dr. YENDE. Our wait time calculations start from the time the service is requested. If a primary care physician requested a cardiology appointment, that is when time zero starts and that is how we calculate our wait times, at least in the last few years. It is not from the clinically indicated date as you are referring to.

Mr. HAMADEH. It just seems like there is a mismatch. I think what we need is to know what the actual wait time is and not what is most convenient for the VA. That is something that has been a frustration for so many people.

Dr. YENDE. If I can just clarify——

Mr. HAMADEH. Sure.

Dr. YENDE [continuing]. Congressman. Time zero, which is when the primary care physician requests that appointment, is the most proximal time. That cannot be fudged. That is saying the request is made by the primary care physician. I know when people have used clinically indicated data as you are referring to, there may be ways to change that, but in general, we start calculating wait times from the point the request for service has been made.

I would just submit to you that there is usually no way to change that time, and that is a very conservative estimate to look at wait times.

Mr. HAMADEH. My time is up. I yield back.

Ms. MILLER-MEEKS. I thank you, Representative Hamadeh.

The chair now recognizes Dr. Morrison for 5 minutes for any questions she may have.

Ms. MORRISON. Thank you, Madam Chair, for holding this hearing. Thanks to the witnesses for being here today. I have enjoyed this discussion. I think we have all learned a lot.

You know, as one of the five physicians serving on the subcommittee, I am deeply committed to working with my colleagues on both sides of the aisle to ensure that our veterans receive the highest standard of care. As an OB/GYN, I am especially focused on making sure women veterans get the quality care that they have earned and deserve.

Last week, I had the opportunity to visit the Minneapolis VA, learn about its new women's veterans clinic that is scheduled to open next year. We are lucky in the Twin Cities our VA is pretty

well equipped to meet the needs of our women veterans, but we know this is not the case everywhere across the country. In parts of the country where women's healthcare is not as readily available, we need to take extra care to ensure that community providers are filling those gaps.

Ms. Silas, in its most recent report on women veterans, which was actually I believe in 2016, the GAO found that improving oversight of the community care program is essential to improving healthcare for women veterans. We know this because many women specific procedures, like mammograms, maternity care, and gynecology, are not always available at the VA. As you know, GAO issued a priority recommendation that the VA include performance metrics for access to these women specific procedures in its community care contracts, the rationale being that it would give VA a mechanism to work with a third-party administrator to ensure network adequacy for women's health.

This recommendation was closed in 2023, but did VA ever actually incorporate any performance metrics into its community care contracts?

Ms. SILAS. Thank you for the question.

No, they did not. They created a dashboard to monitor access to care for women's veterans care. While that is a good tool to monitor access, timely access to care, having contract requirements or performance metrics in a contract would have a higher level of accountability in place. To do that you would have to do a contract modification, which is never popular with existing contracts. There is a window now as VA is gearing up for the next generation of community care contracts for VA to take that into consideration.

Ms. MORRISON. That is great news, and you answered my next question so thank you.

Dr. Braverman, thank you for being here today. My question for you is, why did not VA choose to follow the GAO recommendation and modify its community care contracts to implement these performance metrics for women's health, which as we know disproportionately referred to community providers?

Dr. BRAVERMAN. Unfortunately, I cannot answer the why did not we because I was not there. We are going to take all of the recommendations that we are hearing here and identify how they can be incorporated in the next set of contracts.

Ms. MORRISON. That is great. It sounds like you are open to considering this recommendation for future community care contracts.

Dr. BRAVERMAN. We are open to everybody's good ideas, and some of that will be in the request for information as we move forward through the process as well.

Ms. MORRISON. I appreciate that. Thank you, sir.

Dr. Kroviak, OIG has done a lot of excellent work identifying any inefficiencies in the community care program when it comes to getting medical records from community providers back to VA. In your observation, what are the biggest challenges facing VA, and how would you recommend that we chip away at them?

Dr. KROVIAK. It is incredibly discouraging but a real quality of care issue for the providers who refer their patients to the community. There are delays in receiving those documents, there are delays in uploading those documents, and there are issues with

uploading those documents to the correct space in the medical records where providers can access the results easily.

Again, I would go back to the oversight of these functions, making sure that frontline staff understand clearly what their responsibilities are and that there is continuous supervisory oversight to ensure those functions are happening consistently.

Ms. MORRISON. Thank you for that answer.

I yield my time back. Thank you, Madam Chair.

Ms. MILLER-MEEKS. Thank you very much, Dr. Morrison.

The chair now recognizes Representative King-Hinds for 5 minutes for any questions she may have.

Ms. KING-HINDS. Thank you, Chair. Thank you to all of our witnesses for making it out here today. I know the storm is—the winter storm is not for me coming from the islands.

I am from the Northern Mariana Islands, and there are hundreds of veterans facing extreme limitations when accessing healthcare professionals and resources. In the Northern Mariana Islands, for context, there are three islands with permanent populations—Tinian, Rota, and Saipan—with roughly 47,000 people. Covering these regions on a part-time basis is one doctor who is contracted to treat veterans only 2 days a week and one nurse. If a veteran lives in Tinian or Rota, they must travel to Saipan to visit these two healthcare professionals, costing hundreds of dollars in airfare alone, not to mention lodging, meals, ground transportation and other expenses.

The VHA will occasionally send specialty care doctors to the Northern Marianas, but only once every other couple of months. If a veteran from the Marianas needs more advanced specialized care from Veterans Affairs directly, the nearest VA hospital is in Honolulu. These veterans, including many who are older and living on fixed income, must pay out of pocket to travel for care and then wait, often too long, to receive their reimbursements.

Our communities have long been working to establish community based outpatient clinic, or a CBOC, but the threshold is 1,000, and because of the lack of care and access to care, whether it be direct or community based care, we just see these veterans return home only to leave to look for adequate care somewhere else.

I am sitting here and I am listening to, you know, my colleagues argue about whether or not direct care or community care is the most viable solution. Then I am listening to Ms. Silas and Ms. Kroviak talk about just the issues and the challenges with both situations. I am sitting here having to go back home on a monthly basis and talk to veterans who, one, are killing themselves, two, are dying because they do not have any service at all. I say that to go on record because too often people from the territories are not heard in terms of their needs being met, and so I thought it was important that you all hear that directly from me.

Listen, I get how expensive healthcare can be, right. The challenge is not just for our veterans; we have challenge to access to healthcare for nonveterans as well. You know, what would it take, basically, for the VA to provide any type of service for our veterans that would provide some of this—would provide some of our people the relief that they are desperately seeking?

Dr. BRAVERMAN. Congresswoman, I have to admit that I do not know much about the program that you are describing, and I will get some more information and get back to you.

Ms. KING-HINDS. I will refer you to a GAO report that was published in May 2024. I think that is the problem, right, is that too often we leave these territories behind. Too often it is where these territories of these soldiers—you know, we are basically like a soldier-producing island. In 10 or 20 years from now, our whole entire island's population will be nothing but vets. Yet we have to deal with all these restrictive regulations, one-size-fits-all regulations that may work here, but obviously it is not working here because we are arguing about direct services or community—you know, community access services, right. If you can just please take note of that and let us try to figure out how to make the situation better.

Also, I have one more question. We had one VHA administrative specialist whose duties included assisting patients and securing appointments with a part-time physician or nurse. She recently retired in 2023, and her position has been vacant since then. Can you please help us out in terms of making sure that we fill that position as soon as possible? She is the only person that provides a direct lifeline to our veterans and she is badly needed. One person, that is all we have. All right.

Dr. YENDE. If I can just add to what Dr. Braverman said. Places like Alaska, Pacific Islands have unique challenges that are different from the rest of the country, and we realize that sometimes the solutions have to be different.

Ms. KING-HINDS. Creative.

Dr. YENDE. Yes. We work closely with our TriWest TPA partners in those regions, so we will commit to looking into this as a follow up from this hearing. I appreciate the opportunity to look into it.

Ms. KING-HINDS. Thank you. I appreciate it.

Ms. MILLER-MEEKS. The gentlewoman yields.

Thank you, Representative King-Hinds.

I now yield myself 5 minutes to ask questions.

As I have listened to the dialog, which I think is very helpful to do, other questions have arisen as we have gone through this.

Dr. Kroviak, you mentioned some metrics that are required for care within the VA but not for care within the community. I found that interesting because one of the things that you addressed was opioid prescribing. As a person who has provided community care and as a veteran, for every doctor that is out in the community, you have to access and go to the prescription drug monitoring program (PDMP) of your State, and you are required, in order to get your license, to have familiarity and continuing education on prescription drug monitoring. Before you can prescribe a medication, you have to go to the prescription drug monitoring, especially if it is a opioid.

Have you actually looked at what is required for physicians within the community that may be the same standard as what the VA is requesting?

Dr. KROVIAK. They might very well be the same standard based on the State requirements for the license. However, we have done work that has discovered there was not documentation or even a

reference to a PDMP query or a urine drug screen within the community when we were trying to verify that those——

Ms. MILLER-MEEKS. You have not accessed the PMPD [sic] or gone to the State to see if it is accessed?

Dr. KROVIAK. Correct.

Ms. MILLER-MEEKS. Okay. Thank you.

Then I was listening to the dialog over waiting times. Although I may not have a difficulty with that being part of a contractual obligation, as I listened to it and heard that we do not have a standard—so if a veteran tries to make an appointment for a VA, they either cannot get an appointment within 30 days or sometimes they are called back on the 29th day of 30 days to extend the timeline and/or they are greater than 40 miles away.

If a veteran could not get an appointment within 30 days and they want to assess community care, but let us say the appointment at the VA is 6 weeks away, the appointment in community care is 8 weeks away, is not the standard then the veteran? Is not it up to the veteran to decide which waiting time they prefer or not prefer? If they—you know, they can get an earlier appointment at a VA, they can decide whether or not they want to travel the distance or, in our case, our Veterans' Affairs will arrange transportation.

Is not the standard the veteran? Is not there a standard in place now?

It is okay, Dr. Yende, you can just talk louder.

Dr. YENDE. You are absolutely right, that is exactly what the referral coordination team should be doing is presenting that information to the veteran and the veteran should be making that choice. If a veteran chooses VA, we are very happy to support. If the veteran opts out and goes to the community, then we will make certain the veteran gets care.

Ms. MILLER-MEEKS. If there is a holdup in the amount of time from which a veteran requests community care but the authorization's not given to the community care provider so then they cannot request to—or they cannot make an appointment, that then will lead to further delays.

Additionally—I have got to find my document here, so I apologize. I have got all these papers because I have completely changed my testimony.

Since I have been on this committee, I have heard one insult after another hurled at VA community care. My Democrat colleagues, with all due respect, and the Biden administration have described community care as inferior to VA care and certainly argued that it is more expensive. As I said, I am not only a veteran, but a community provider.

I know that, you know, community care is ordinarily excellent care, just like care at the VA is ordinarily excellent care. In many cases, it is specialty care that is not available at the VA or at a distance that is, you know, manageable.

Ms. Silas, your testimony also suggests that community care is often more affordable than in-house care. Your written testimony states, and I am going to quote because I think it is important, "VA documentation shows that community care represented about 40 percent of all VA healthcare in Fiscal Year 2023. According to

VHA, the Department spent about $26.7 billion on this care in the same year, out of a total of 126.—$128.6 billion appropriated for all VA healthcare."

By my math, 40 percent of the VA's healthcare is community care but community care costs less than 25 percent of the VA healthcare budget. Do you agree that community care is more cost effective than VA care?

Ms. SILAS. I would have to see the details of the budget. What the facts that you are stating are in our report and in the statement.

Ms. MILLER-MEEKS. This question may be rhetorical and you may not be able to answer it, especially Dr. Braverman who is new in this position, but the important question to ask would be—especially, Dr. Braverman, you mentioned the PACT Act and the stress of the PACT Act on to being able to deliver care at the VA system. What would the cost to the VA be of all of the care currently provided in the community? We know that it was $26 billion in 2023. What would the cost be to the VA itself?

Dr. BRAVERMAN. I agree that is somewhat rhetorical based on the information that I have. The one thing that I would identify in the calculations here is that we do have a lot of fixed costs that are not directly related to Relative Value Units (RVU). The actual calculation of what it costs for, you know, the direct care system for a per patient visit is more difficult to identify.

Ms. MILLER-MEEKS. As is the cost to community providers as well. I would wholeheartedly agree.

Thank you all so much. On behalf of the subcommittee, I want to thank you for joining us today. You are now excused, and we will wait for a moment as the second panel comes to the witness table. Thank you so much.

[Recess.]

Ms. MILLER-MEEKS. Thank you very much. That is my signal. Before I introduce Panel II witnesses, I would also like to acknowledge that the ranking member of the full committee, Representative Takano, is here with us as well. We will hear from him later.

I would like now to introduce the Panel II witnesses.

Testifying before us today we have Dr. Scott Kruger, Army veteran and physician, Virginia Oncology Associates; Dr. Dave McIntyre, president and CEO, TriWest Healthcare Alliance; Mr. Ed Weinberg, president and CEO, OptumServe; and Mr. Chris Faraji, president of Wellhive.

Dr. Kruger, you are now recognized for 5 minutes.

Mr. TAKANO. Madam Chair, before we begin, I have a point of parliamentary inquiry.

Ms. MILLER-MEEKS. So recognized.

Mr. TAKANO. May I state my inquiry?

Both the House rules and our committee rules require nongovernment witnesses to submit a truth in testimony form. These forms include a question about whether the witness is, quote, a fiduciary, including, but not limited to, a director, officer, advisor, or resident agent of any organization or entity that has an interest in the subject matter of the hearing, end quote.

It has come to my attention that both Mr. Weinberg and Mr. McIntyre indicated on their truth and testimony forms that they are not fiduciaries of their respective organizations.

My inquiry is this, Madam Chairwoman, did the majority advise the witnesses about this form and instruct them to indicate that they were not fiduciaries of their organizations?

Ms. MILLER-MEEKS. We did not.

Mr. TAKANO. If not, does the chairwoman find that these two witnesses who are CEOs of the third-party administrators who manage VA's community care network and hold at least $70 billion in VA contracts, that they are not fiduciaries who have an interest in the subject matter of this hearing?

Ms. MILLER-MEEKS. I think it is important to hear from the people that are third-party administrators since we are talking about contracting, and that is one of the questions that has been brought up.

Mr. TAKANO. My question relates to the truth in testimony form which nongovernment witnesses must fill out. It is important for us to know whether or not it is accurate that they are not fiduciaries. It is something that we require of all of our nongovernment witnesses.

Ms. MILLER-MEEKS. They said that they are not fiduciaries. We have asked them to fill out and disclose the form and they correctly filled out and disclosed on the form.

Mr. TAKANO. Okay. It is your determination they are not. Thank you.

Ms. MILLER-MEEKS. Thank you.

We are now going to hear from our witnesses.

Dr. Kruger, you are recognized for 5 minutes.

STATEMENT OF SCOTT KRUGER

Dr. KRUGER. Thank you.

Chairwoman Miller-Meeks, Ranking Members Brownley and Takano, and distinguished members of the committee, thank you so much for the opportunity to testify today on the Department of Veterans program of community care medicine on behalf of my practice, Virginia Oncology Associates, and a member of the U.S. Oncology Network. This is one of the largest networks of integrated community based oncology care in the United States.

I am Scott Kruger, and I am practicing medical oncologist and hematologist and medical director of Virginia Oncology Associates. I have had the privilege of providing care to many of our Nation's veterans through the CCP. I appreciate the subcommittee's attention to the critical role this program has in providing care, the highest quality and the best quality of care to our veterans.

The CCP has helped bridge care gaps; however, there are significant challenges that must be addressed to enhance its effectiveness. For veterans with complex medical conditions like cancer, timely access to cancer care is critical. Many veterans experience significant delays in receiving authorizations for community care, which can be particularly detrimental for patients requiring time-sensitive treatments. In my area, it can take more than 4 to 6 months to get an approval for a mammogram and a breast biopsy,

and that is due to the ineffective communication with the Office of Community Care.

Furthermore, coordination between the VA and the community provider is often lacking, resulting in fragmented access to medical records, treatment plans, and follow-up care. This lack of data sharing can lead to incomplete medical histories, duplicated tests and procedures. In some cases, delaying transmitting critical biopsy results, Computed Tomography (CT) scans, Magnetic Resonance Imaging (MRI) scans, and other vital data just delays the care even more. These challenges in coordination and communication are further compounded by the inefficiencies faced by the third-party administrators.

TPAs are struggling with the high case loads that cause delayed responses and administrator strain for both providers and patients. Although TPAs have provided our practice with a liaison to ease in some of these communication barriers, we still struggle to reach the community care office effectively.

Regarding reimbursement and financial stability, we used to face significant delays in receiving reimbursements from the VA, over 5 years for a payment of one particular claim. We actually had 5 years of no nonpayments for all claims.

Unfortunately, when you do not pay your bills, it discourages people like myself from taking care of patients, and we want to take care of the VA patients. I myself am a veteran, and we want that to happen.

It is difficult for the veterans because frequently they encounter difficulties navigating the complexities of the CCP, including eligibility requirements, scheduling, coordinating care between the VA and community providers. For instance, I saw an elderly woman in her seventies who was sent to me for an evaluation of a blood cancer. Of course, I was only allowed to see her. I could not do a Complete Blood Count (CBC), I could not look at her blood. I was not allowed to order any testing. When I saw her, she had had a stroke. She could not walk, she had skin breakdown, and she had signs of dementia.

Although I was authorized one clinical visit, I tried to arrange for her to have home care with physical therapy, occupational therapy, wound care, and rehabilitation. I set up it up with two different home healthcare agencies. The VA did not approve any of the agencies. After 2 months and then 4 months, so far she still has not had any care.

I have a few recommendations for the committee. Basically, we need to enhance the effectiveness of our communication. First, I would recognize that we need a better referral process to help expedite and implement the standardized guidelines and timeliness for approvals. This would streamline operations and reduce delays in service.

Second, improving care coordination is crucial. This can be achieved through sharing of medical records and the use of effective communication between our platforms. As community partners, we are committed to collaborating with the VA to ensure our veterans receive the care that they deserve.

Additionally, the efficiencies of the TPAs can be enhanced by establishing clear performance benchmarks and accountability meas-

ures. This will ensure that the TPAs operate effectively and contribute positively to the program.

Furthermore, timely and fair reimbursement for the community providers is essential, because they will not participate if there is a financial strain on their own practice.

Last, we must strengthen and provide education and navigational resources for the veterans to help them better understand their care more efficiently and ensuring that they receive the best possible care.

I briefly want to say, and I have listened to this first group of testimoneys, and it would be so much easier if you just say, okay, Dr. Kruger, please take care of my patient. Here is 6 months, you can order your tests, you can order your chemotherapy, you can order your biopsy, and I will treat that veteran and get them treated clearly, efficiently, and do a great job.

The current system makes me go through so much red tape. Before I can even start, a month and a half has gone by.

I really want to thank you for the opportunity of testifying today. I look forward to answering your questions. I think this subcommittee has the right idea. We have to put the veteran in the center in order to strengthen the program. Our job is to work together to help the veteran to get them get the care they need.

Thank you.

[THE PREPARED STATEMENT OF SCOTT KRUGER APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you very much, Dr. Kruger.

Mr. McIntyre, you are now recognized for 5 minutes for delivering your opening statement.

STATEMENT OF DAVE MCINTYRE

Mr. MCINTYRE. Thank you, ma'am.

Chairman Miller-Meeks, Ranking Member Brownley, and distinguished members of the Health Subcommittee, it is a privilege to testify before the subcommittee today on behalf of all associated with TriWest Healthcare Alliance.

For me, this is a return to this witness table, having been here multiple times in the last 10 years. To those members who I have not yet had a chance to meet, I look forward to doing so soon and working closely with you on things that matter, including in the Marianas and in my home State of Arizona. I ask that my written statement be entered into the record.

Established nearly 30 years ago by a group of nonprofit health plans and two university hospital systems, our sole purpose since then has been supporting VA and DOD in meeting the healthcare needs of the military and veterans' communities in our geographic area of operation. Nearly all who work for TriWest either served this country or their families served.

We began a work in support of VA a couple of months before the crisis of access in care in our hometown of Phoenix hit the media. Armed with a mature and robust network from our 18 years of work for the DOD, we quickly went to work to support the VA in eliminating the backlogs in needed care. Well, it has been quite a journey the last decade. Today, we serve in support of VA through the Community Care Network program across a geographic space

that spans 14 States and the Pacific, comprising Regions 4 and 5. Our network has delivered more than 65 million community care appointments in support of VA.

Today, we have the privilege of supporting VA in serving the needs of nearly 4.7 million veterans through our network of over 300,000 credentialed community care providers, offering in VA and VA access to care at over 750,000 provider locations. Each day, they deliver between 12,500 and 16,275 needed appointments, spanning all areas especially. We pay their bills in 3 days to an accuracy rate in excess of 99 percent.

We have been working a number of initiatives collaboratively with VA in our markets to demonstrate the art of the possible through a tighter partnership to strengthening VA and allowing them to fully leverage us for the benefit of veterans that reside in their area. I think of two markets to highlight that promise, the valley in Texas and Montana, as they are leading the way.

Second, we are working with many of the VISNs and VA Medical Center VA Medical Center (VAMC) in our area who have a responsibility to try and make things more efficient in terms of how we are doing our work, all with an eye toward how do we do appointment scheduling more effectively between us and what provider changes need to be made that impact care delivery in a positive way.

Fourth [sic], many more collaborative initiatives have been underway in our geographic area of responsibility, all with the goal of effective refinement to our collective performance. In fact, next week, we in the VA team are gathering for 2 days to discuss what we want to add to our collective list in our further request to improve collective performance.

Last, I would like to thank this committee and the leadership for your focus on fixing once and for all the rule that forces us to reject provider claims that arrive 6 months after the date of service rather than allowing 12 months, as is the case for TRICARE, Medicare, Medicaid, and the private insurance market. It is beyond time that this gets fixed and that we execute properly and promptly the change once it is law.

We are proud of the progress that we have made together over the past decade. It has been painful for many of us, but we have made progress. Yet we all know that work remains to achieve our true potential of delivering fully for this generation's heroes. As we know, this committee is focused on the refinements necessary to ensuring that what was envisioned in the yearlong bipartisan effort that led to the passage of the MISSION Act and the authorities and the resources that have followed in the years since is going to be delivered on.

From all of us associated with TriWest, we look forward to doing our part in collaborating with this committee to respond to those adjustments believed necessary to achieve our collective potential so that our Nation's heroes, their families, caregivers, and survivors receive that which we owe them.

[THE PREPARED STATEMENT OF DAVE MCINTYRE APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. McIntyre.

We have votes at 4:30, so I am going to remind our witnesses to be within their 5-minute timeframe. I am also going to remind all members that I will be gaveling them out at the 5-minute interval. I thank you.

Mr. Weinberg, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF ED WEINBERG

Mr. WEINBERG. Chairwoman Miller-Meeks, Ranking Member Brownley, Ranking Member Takano, and distinguished members of the subcommittee, good afternoon. Thank you for the opportunity to discuss OptumServe's role as the third-party administrator for the VA CCN program in Regions 1, 2, and 3, where we have been supporting veterans' choice and access to care for nearly 6 years.

As a combat veteran, retired Army officer, and a proud father of a soldier, I have a deep understanding for the sacrifices made by our Nation's veterans and their families. I am deeply connected to our purpose, and I am also committed to the success of the entire VA health ecosystem. I certainly cannot do it alone. At OptumServe, I am humbled to be surrounded by 5,000 great Americans, many of whom have serve in the Armed Forces or in the VA or as military spouses and caregivers.

Through the VA CCN program, we have the privilege of supporting nearly 6.5 million veterans across 36 States, Washington, DC, the U.S. Virgin Islands, and Puerto Rico. We are making a clear difference.

With our robust network of providers, nearly 2.4 million credentialed care sites, we have facilitated over 159 million veteran care visits since we started healthcare delivery in 2019. We also know that building the provider network is only half the story. It is the maintaining of the network for our veterans that really matters. Our success in sustaining the network is in large part due to adjudicating and paying provider claims in 7 days on average, far exceeding the requirements set forth by the VA.

Another critical factor in our success story is the collaborative relationships that we have developed throughout the veteran community. We enjoy strong relationships with VA at every level to ensure veterans have access to the right care wherever and whenever they need it, meeting at least monthly with each of our 109 VA medical centers and VISNs in our regions.

We hold quarterly program management review meetings with VA central office to ensure proper oversight, and we do in-person updates and engage with our military and veteran service organizations. We have consistently worked with Congress, ensuring that you and your staff receive quarterly updates on the important work that we are leading.

One of the many ways we manage these relationships is through veteran experience officers who provide boots on the ground support at each VA medical center and through our provider advocates who work between VA and community providers to ensure veteran care needs are being met.

At OptumServe we remain purpose-oriented by keeping the veteran at the center of everything that we do. While the total numbers of our impact are interesting, I always remind my team to

focus on the power of one. Each phone call, every pharmacy transaction, every response to a VA staff member, that is where the magic happens. While we are laser-focused on our stated requirements, we also seek ways to help the VA system work better for everyone.

One such area is in medical records retrieval. While we fulfill our obligations of educating providers on medical record return policies, we do not stop there. We have developed mechanisms for VA staff and providers to escalate if they are not receiving their records back in a timely manner.

Additionally, we collaborate with VA leadership to identify ways we can improve existing processes. For example, we are actively engaged in a VISN 01 pilot with the goal of improving the exchange of medical record documentation between community providers and the VA.

I am deeply grateful for the opportunity to share OptumServe's unwavering dedication to veterans through the VA CCN program. We look forward to our ongoing collaboration with the VA, with this subcommittee, and all of the partners that we work with. We are making a difference. My belief is that we will always be better together.

Thank you again for the opportunity to be here today, and I look forward to your questions.

[THE PREPARED STATEMENT OF ED WEINBERG APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Weinberg.

Mr. Faraji, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF CHRIS FARAJI

Mr. FARAJI. Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the subcommittee, thank you for the opportunity to speak to you today. My name is Chris Faraji, and I am the president of Wellhive. We are a healthcare software company dedicated to modernizing the VA's approach to community care scheduling.

Our technology is not theoretical. It is real, it is proven, and it is successful. It was purposely built to address the VA's long-standing inefficiencies in scheduling, ensuring veterans receive the care from the right provider at the right time. This is why VA contracted with us in 2023 to deliver this technology nationwide.

The issues for tackling is one we all recognize. Veterans are patiently waiting to get the care they need. Right now, scheduling a VA community care appointment is like booking a flight before Expedia or Travelocity even existed. Imagine needing to fly across the country, but instead of searching online, you have to call each airline separately. You are waiting on hold, you are checking availability one by one, repeating this process until you finally find the flight that works. That is exactly how the VA community care scheduling system works today.

Medical support assistants, also known as MSAs, have a hard job. They spend hours making calls, waiting for responses and mainly piecing together the appointment availability while veterans are waiting. This is where things change. With the External

Provider Scheduling (EPS), it allows schedulers to instantly see real-time appointment availability across multiple provider groups in the community and book on the spot. No more phone tag, no more unnecessary delays, just fast, efficient scheduling that ensures veterans get the care they need when they need it.

We know it works. At sites using EPS, MSA schedulers book up to four times as many appointments per day, compared to the outdated manual methods. The most compelling proof comes from those from the front lines. One scheduler calls EPS a godsend, saying, "Before, I spent hours tracking down appointments. Now, I see them instantly." The time saved is making a world of difference for veterans. Another shared, "Before EPS, I would schedule an appointment, only to find out later that the provider was not available, forcing me to reschedule. Now, I know exactly when and where the veteran can be seen, avoiding unnecessary delays."

EPS is directly reducing wait times. The current average wait to schedule a VA community care appointment is 31 days. With EPS and even without the critical integrations into systems like HealthShare Referral Manager (HSRM) or Consult Toolbox, that wait drops by 33 percent. In some locations, the improvement is even more dramatic. For example, Columbia, South Carolina, their wait times have dropped by 52 percent. In Dallas, Texas, the wait times have fallen by 46 percent.

Yet despite these results, EPS remains optional. This means many schedulers are still relying on outdated methods. Even at sites where EPS is fully available, more than half the appointments are still booked manually.

We are encouraged by the direction of this Congress, the new administration, and Secretary Collins, who have made it clear to the commitment to ensuring veterans receive the care they deserve. We at Wellhive stand ready to work side by side, Secretary Collins, Congress, VA, to ensure an aggressive rollout of EPS.

Technology is not the obstacle. Bureaucracy is. The solution is simple. Let us just cut through the red tape and let us fully integrate EPS into the VA's mission across the country.

Before concluding, I would like to briefly address some of the comments from the first panel. There is obviously a pattern of scheduling that is inherent into the conversations of today's questions. Ms. Silas mentioned some of the nuances that these schedulers and veterans are facing when they are not able to have that information at their fingertips. They are waiting. They do not know. They will get back to them; they make these telephone calls.

They also made a comment about the veterans competing with nonveterans for these appointment slots. What the EPS Wellhive platform has been able to do is provide and equip these schedulers with that information so that, hey, if there is a provider that does not have availability, they are going to see it. If the provider does have availability, they will also be able to see it. They are not wasting time calling providers that do not have availability in the first place.

Another point that I would like to make with my remaining time is that—you know, from Dr. Morrison. You made mention of women's health. We are really excited because this week we were able to activate and provide mammograms where they can now be

scheduled. It is not just providers but it is mammograms, and in addition to that we also have imaging.

I thank you very much for the time, and I look forward to your questions.

[THE PREPARED STATEMENT OF CHRIS FARAJI APPEARS ON IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you very much, Mr. Faraji.

I now recognize the ranking member of the full committee, Representative Takano, for 5 minutes for any questions he may have.

Mr. TAKANO. Thank you, Madam Chair, for this courtesy.

I have a question for both Mr. McIntyre and Mr. Weinberg. You were both paid capitated rates that are calculated on the basis of how many veterans are directed to your networks. That means the more veterans referred to you, the more you are paid. Is that right, Mr. McIntyre?

Mr. MCINTYRE. We are paid in administra-——

Mr. TAKANO. Just answer the question. The more they are referred to you, the more you are paid. Is that right?

Mr. MCINTYRE. Yes.

Mr. TAKANO. Yes.

Mr. Weinberg.

Mr. WEINBERG. Congressman, we get paid if there is a paid——

Mr. TAKANO. It is a very simple question. The more veterans are referred to you, the more you are paid. Is that right?

Mr. WEINBERG. That is correct for——

Mr. TAKANO. Thank you. Do either of you conduct assessments of the quality of care delivered by specific providers in your networks?

Mr. MCINTYRE. Yes.

Mr. WEINBERG. Yes, we do.

Mr. TAKANO. You do. You make this information available to veterans?

Mr. MCINTYRE. We make the information available to the VA.

Mr. TAKANO. Mr. Weinberg.

Mr. WEINBERG. We as well make it available to the VA.

Mr. TAKANO. Well, I am going to tell you that VA facilities are regularly rated on quality of measures, and this public is provided to veterans and the public.

I find it extremely hard to believe that you actually do these assessments, since you do not require your network providers to return medical records to you or the VA. I heard about all the pilots, but, in general, you do not require this. I do not know how you could be assessing the quality of care.

What would you be even using to assess the quality of care? Either one of you have a—Mr. Weinberg?

Mr. WEINBERG. Well, thanks for the question.

What I would probably start with is we have got a credentialed network. Quality starts with verification of State license. It also—board certifications, education. We do verify that with all of our providers.

Mr. TAKANO. Well, thank you very much for that, but I do not believe it is the kind of rating and assessment that VA the does.

I know that United Healthcare Group has plenty of experience reviewing medical records when it is deciding whether to pay a

claim or make a patient prove medical necessity. It astounds me that there is no conditioning of payment on the return of records for veterans community care.

Do you conduct audits to identify whether or not your network providers are opportunistically billing VA for additional services or requesting additional authorizations rather than referring veterans back to the VA for coordinated care? Mr. McIntyre.

Mr. MCINTYRE. Thank you for the question, sir.

When we started——

Mr. TAKANO. Do you actually do audits regularly, systematically of your network?

Mr. MCINTYRE. Yes, we do.

Mr. TAKANO. You do.

Mr. MCINTYRE. If I can——

Mr. TAKANO. Mr. Weinberg.

Mr. MCINTYRE. If I can answer——

Mr. TAKANO. Mr. Weinberg. Mr. Weinberg.

Please, can I reclaim my time?

Mr. WEINBERG. Congressman, we not only audit, but we are audited by independent external auditors quarterly, and those data are all provided back——

Mr. TAKANO. I would be interested in knowing whether there is any opportunistic billing.

Mr. Weinberg, this question is for you. How many veterans currently enrolled in United Healthcare Group's Medicare Advantage plans are also receiving care through VA's Community Care Program?

Mr. WEINBERG. Congressman, I appreciate the question. I do not know the answer to how many.

Mr. TAKANO. Well, thank you. I would hope that you would get that answer back to the committee within a week.

Mr. WEINBERG. We would be happy to do that.

Mr. TAKANO. United Healthcare Group operates one of the largest Medicare Advantage programs in the country, so it is collecting premiums for veterans. Through its Optum subsidiary is collecting payments from the VA under the community care program. Veterans receive the care once, but United Healthcare ostensibly is getting paid twice.

Do you think the Federal Government and taxpayers are overpaying because of this double-billing practice?

Mr. WEINBERG. Thank you for the question, Congressman.

No, I do not. I believe that veterans have choices for their healthcare and they have earned the right to use the VA, as well as any other benefit they——

Mr. TAKANO. That is really nonresponsive to my question, because it is really about the double billing. United Healthcare is receiving Medicare Advantage premiums, but yet they are also being—you are also receiving money from the community care program. My question was, is not that double billing?

Mr. WEINBERG. Congressman, we do not view it that way. We view it as the administrative fees that we need to manage both programs——

Mr. TAKANO. I see. Well, Mr. McIntyre, just because you found a loophole to collect from both Medicare Advantage and VA for the

same veterans care does not make it right. It makes it a taxpayer-funded windfall for your company at the expense of veterans and the American people.

Mr. Weinberg, how much revenue does Optum, United Healthcare Group, and TriWe-—well, for both of you, how much does is generate from the community care contracts over the past year, 5 years, or the entire time you have held the community care contracts? Mr. McIntyre.

Mr. MCINTYRE. I would be glad to get you that information, Congressman. I would say that——

Mr. TAKANO. Mr. Weinberg.

Mr. MCINTYRE [continuing]. we used——

Mr. TAKANO. Mr. Weinberg, how much money would you say?

Mr. WEINBERG. Congressman, can you repeat the question?

Mr. TAKANO. How much money have you contracts generated from the community care program?

Mr. WEINBERG. I mean, if you want the specific number, Congressman, I would prefer to come back to you with that for the record.

Mr. TAKANO. Okay. Tens of billions of dollars?

Mr. WEINBERG. I would say yes. I would also remind you, sir, that many of those dollars are passthrough dollars so they are paying the provider directly. They are not coming back to——

Mr. TAKANO. Thank you. I yield back.

Ms. MILLER-MEEKS. Thank you. The gentleman's time has expired.

The chair now recognizes Representative Hamadeh for 5 minutes for any questions he may have.

Mr. HAMADEH. Thank you, Madam Chair.

As I sit here in this committee and other committees on the VA, I am deeply concerned by my Democrat colleagues' attempt to scapegoat community care providers caused by VA mismanagement. I feel as if too often some of our colleagues are focused on protecting the bureaucracy and not veterans' care.

As outlined in the staff memo titled, On Most Alarming Aspects of VA Document Review: Efforts to mitigate community care aimed to trap veterans in a broken VA system limiting choice in access.

Now, Madam chair, at this time I ask unanimous consent to insert our staff memo into the hearing record.

Ms. MILLER-MEEKS. No objection.

Mr. HAMADEH. Rather than attacking partners trying to serve veterans, we must identify solutions to cutting bureaucratic red tape and empower veterans through accountable, flexible care options. They deserve nothing less.

Now, my question is for my fellow Arizonian, Mr. McIntyre. During COVID, you took over appointment scheduling responsibilities from the VA, correct?

Mr. MCINTYRE. Yes, sir.

Mr. HAMADEH. Could resuming centralized scheduling improve access?

Mr. MCINTYRE. Used to do the things that were to the right of the line of demarcation and the VA did the work to the left, and that worked. The current system could be refined, but that worked.

The second thing that we did is we did not, back in the day, pay a provider's claim until they submitted their medical records. We paid the claims in days. Congress felt that it was problematic because some providers were complaining about that requirement. 85 percent of the doctors were providing the medical records to the system under that approach.

Mr. HAMADEH. What obstacles have you faced building robust provider networks due to burdensome VA administrative barriers?

Mr. MCINTYRE. We have not faced problems in the development of network because of that. It is maintaining this network that is challenging. We are working together with the VA to try and make sure that those challenges are addressed in the markets where we face them.

Mr. HAMADEH. It seems like you guys are working together right now?

Mr. MCINTYRE. We are trying——

Mr. HAMADEH. Okay.

Mr. MCINTYRE [continuing]. on both sides.

Mr. HAMADEH. That is good to hear.

Now, Mr. Weinberg, what specific steps can the VA take to improve the referral process?

Mr. WEINBERG. Congressman, great question. I do believe that a lot of what I heard on Panel I in that discussion was on point. We are talking about standards, not standardization. I think we are reminding ourselves that healthcare is local. I believe that there has got to be accountability in the system. We need to be measuring, we need to be tracking, and we need to be holding folks accountable.

Mr. HAMADEH. Thank you. I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Hamadeh.

The chair now recognizes Dr.—excuse me, Representative Brownley, Ranking Member Brownley, for 5 minutes.

Ms. BROWNLEY. Thank you, Madam Chair.

Mr. Weinberg, I was concerned to read in Dr. Kruger's testimony that the reimbursement rates his practice receives are often lower than those offered by Medicare.

Is Optum reimbursing providers that are lower than Medicare rate?

Mr. WEINBERG. Congresswoman, thank you for the question.

We do follow the strict adherence of the payment rates that are given to us by the VA, primarily for medical care that would be in line with Centers for Medicare and Medicaid Services (CMS)—with the CMS rates.

Ms. BROWNLEY. The MISSION Act clearly states that you must be paid by Medicare rates. I am just making sure——

Mr. WEINBERG. Correct.

Ms. BROWNLEY [continuing]. that that is what you are paying.

Mr. Kruger, is that inconsistent with what you understand?

Dr. KRUGER. The problem is the VA initially—and this has been happening for about the last 7 years. It got better about 2 years ago—basically did not pay any claims for over 5 years with multiple submissions and multiple fights between our local VA and the VA in Salem. Eventually it was paid. They were paying it on the current rates when they approved the bill——

Ms. BROWNLEY. I see.

Dr. KRUGER [continuing]. even though the treatment was done 4 years ago.

Ms. BROWNLEY. I see.

Dr. KRUGER. The drugs then——

Ms. BROWNLEY. That has smoothed out?

Dr. KRUGER. It has smoothed out.

Ms. BROWNLEY. Okay. I am—so, again, maybe you are clarifying another question that I had, because Mr. McIntyre is saying that he is providing a 3-day turnaround on reimbursements and you were saying sometimes it is up to 5 years. There was a lot of inconsistency there. You are saying now that that reimbursement process has improved significantly.

Dr. KRUGER. It has improved significantly over the last 6 months. What has helped significantly was we have been given a liaison that we can talk to in Optum, and they are helpful with the billing, but they do not really get involved with ordering the care for the patient. That is up to the VA community care office.

Ms. BROWNLEY. Thank you.

To Optum and TriWest, you know, in the first panel, we talked about the contract, the delay in the contract, possible additions to a future contract.

Would you have any issue in terms of transparency around wait times within community care?

Mr. MCINTYRE. I believe personally that there needs to be accountability and transparency on both sides with regard to wait times. Currently, in our area for last year, it was an average 7 days to schedule once the appointment request was given by VA, an average of 20 days to be seen and an average of 15 days to be seen at the date preferred by the veteran.

Ms. BROWNLEY. Right. I mean, but what we would like to see is really, you know, on sort of a monthly basis, to know what—what is happening in direct care with the VA and what their wait times are and what your wait times are, not so much the averages over, you know, a long period of time.

Mr. MCINTYRE. Agreed.

Ms. BROWNLEY. That would not be a problem.

Mr. MCINTYRE. No. We had talked about years ago the——

Ms. BROWNLEY. Yes.

Mr. MCINTYRE [continuing]. longitudinal look at this and needed to be doing that.

Ms. BROWNLEY. Mr. Weinberg, do you agree or——

Mr. WEINBERG. Congresswoman, I would agree. We do provide hundreds of deliverables to the VA, which would include, you know, performance for our network adequacy.

The only other thing I would add is that I think it is essential, if we are talking about access and choice for veterans, they need to be able to see those data so they can make the most informed choice.

Ms. BROWNLEY. It is clear to me that this EPS system that has been described today is music to my ears, honestly. I think we need to do a lot of technology outside of the VA to bring it in. It seems as though this could be a huge improvement in terms of community care scheduling, although it is optional.

Did the VA decide that it was just going to be optional, not—or did you decide that it should be optional? I am trying to understand why it cannot be universal across the board, because it seems like it really would improve that process.

Mr. FARAJI. Sorry. Was that question to me?

Ms. BROWNLEY. Well, I think it needs to be to——

Mr. FARAJI. Well, I can answer it. I mean, it is not—it is actually not coming from the vendor or it is not coming from the TPAs. It is—it is coming directly from VA. The VA——

Ms. BROWNLEY. Okay. It is VA that is saying——

Mr. FARAJI. They have not—no, there has not been any sort of directive to be able to use——

Ms. BROWNLEY. Okay. For Optum and TriWest, you have not asked VA to make it optional, that that would be preferable to you?

Mr. MCINTYRE. No, ma'am.

Ms. BROWNLEY. Would—Dr. Kruger, would physicians or providers have a problem putting out their schedules in the ether?

Dr. KRUGER. For us, that would be a little bit of a challenge because different oncologists specialize in different areas. A vendor may not know that.

Basically, if they send us a consult, they will get an answer in 48 hours. All oncology is seen within 24 hours of the appointment. All hematology is seen within 3 days. That is our working——

Ms. BROWNLEY. Thank you. I yield back. Sorry. I did not——

Ms. MILLER-MEEKS. Thank you. If you have other questions, please submit them in writing. We will make sure that they are answered.

The chair now recognizes Representative King-Hinds for 5 minutes for any questions she may have.

Ms. KING-HINDS. Thank you, Chair.

I just have one quick question for Mr. McIntyre since you provide—or provide coverage for the Marianas.

Mr. MCINTYRE. Yes, ma'am.

Ms. KING-HINDS. I know that access to healthcare just for the average, ordinary citizen is a challenge because of the amount of providers that are available out there, whether it be mental health or any type of care.

What—can you just share a little bit, if you are having challenges with insuring, that you have an adequate pool of providers to be able to provide, you know, the care that we are trying to give to veterans?

Mr. MCINTYRE. For your area in the country, ma'am, I made two visits to Tinian and Rota and to the Marianas. We have the providers in that community under contract.

As you well stated, it is important to make sure that there is a footprint at some of those places like Tinian that does not have healthcare to be able to allow Circuit Riders to come in and out of that area to meet the needs versus people traveling.

We look forward to working with you and with the VA to pick up a topic that we worked on 5 years ago.

Ms. KING-HINDS. Okay. We will speak offline. We will have the office reach out. Thank you.

Mr. MCINTYRE. Look forward to it.

Ms. KING-HINDS. Appreciate it.

I yield back, Chair.

Ms. MILLER-MEEKS. Thank you, Representative King-Hinds.

The chair now recognizes Dr. Morrison for 5 minutes for any questions she may have.

Ms. MORRISON. Thank you, Madam Chair. Thank you to the witnesses for being present to answer our questions today.

During the first panel, I think you may have heard me ask witnesses from VA and GAO about including performance metrics that would track access to women-specific procedures in community care contracts. Since women's healthcare is disproportionately referred to the community, we need to make sure that our community providers are delivering this essential care. They indicated that they thought it would be an effective way to improve care for women veterans.

Mr. Weinberg and Mr. McIntyre, what do you think about this sort of contractual requirement in TPA contracts?

Mr. WEINBERG. Congresswoman, thank you for the question.

Again, I think that transparency is really kind of rule the day here. I think that the more we know and the more veterans know, the better choices they will be able to make.

Ms. MORRISON. Thank you.

Mr. MCINTYRE. Agree. I think tracking standards and making sure that we are being transparent about where we are juxtaposed to the standards makes a lot of sense.

Ms. MORRISON. Appreciate that. Thank you, gentlemen.

Back to the two of you again. We know that community care is an essential piece of the puzzle, but we also know that, in general, veterans prefer VA care, in part, because many VA providers are veterans themselves and understand the military and veteran experience.

I have trained at a VA during my early medical career, and I can tell you that even those of us who are not veterans are still required to take military cultural competency trainings and a myriad of other trainings that are sensitive to veterans' needs.

Do you know what percentage of your network providers have completed optional trainings on military cultural competency, suicide prevention, and opioid safety?

Mr. WEINBERG. Congresswoman, thank you for the question.

While I do not know the exact percentage, what I can tell you is that we do have a pretty robust suite of training offerings, to include a partnership we have just formed with PsychArmor who offers additional ones.

The other thing that I think is really important as we think about incentivizing providers to take the trainings is to actually start to offer Continuing Education Units (CEU). We have done that with a couple of courses now, one for opioids and the other one on suicide prevention, and we have got a few others in the queue as well.

Mr. MCINTYRE. We also have a similar suite of products and content, to include VA-provided content, and we have been working with PsychArmor for 5 or 6 years.

I would say that in the area of opioid training, the question is do the providers need to take VA-specific training or is it sufficient

to use their State licensure requirement, which is required of all of them.

I think to the last panel, it would be worth all of us taking a look at what reality is and what is occurring in that place.

Ms. MORRISON. Thank you. Then one final question, Mr. Weinberg. These same trainings that all VA providers are required to take are optional but available through Optum, right?

Mr. WEINBERG. That is correct, Congresswoman.

Ms. MORRISON. Is there a way for a veteran to know if one of your providers has completed trainings about suicide prevention in that spirit of transparency?

Mr. WEINBERG. At this time, there is not. We are not required to transmit those level of data over in our provider data file, but I think it is a great point, and it is something that we would be willing to talk through if it becomes a requirement from the VA. I think it, again, gives more transparency to the veteran as they are making their choice.

Ms. MORRISON. Appreciate that. Thank you for your service.

I yield back. Thank you.

Ms. MILLER-MEEKS. Thank you very much, Dr. Morrison.

I now recognize myself for 5 minutes.

Dr. Morrison, thank you for that excellent question. I am going to pose to the VA that I would also like to see the VA stats on how many veterans ask if a VA provider has completed and done VA-specific care, whether it is opioid, suicide prevention, mental health, or any of the other variety of things that continually get brought up in this hearing as a difference.

Again, being a veteran who does not access VA care and I prefer to get my care in the community and a community provider, we want the best care for veterans where veterans are located.

Mr. Faraji, I am going to actually go to you first because the reason you are here is actually the point that Ranking Member Brownley made. Given the success of External Provider Scheduling program, or EPS, do you believe EPS should be adopted across all VISNs to eliminate the inconsistent care scheduling veterans currently experience?

Mr. FARAJI. Thank you for the question. I absolutely believe that it should be rolled out across the country and have the equitable care so that there are veterans that do not—are not able to experience EPS because it is not live in their sites. They are not being able to take advantage of the efficiencies that the platform is already doing today for the sites that do have it by decreasing wait times, allowing the schedulers to be even more productive.

Ms. MILLER-MEEKS. I have no fiduciary interest in you or your product, but—however, would such a scheduling platform be beneficial even within the VA system for scheduling appointments?

Mr. FARAJI. I am sorry. What was that?

Ms. MILLER-MEEKS. Would it be beneficial even within the VA, not just in community care, to schedule such a platform to schedule appointments?

Mr. FARAJI. Yes, that is correct. We actually did a pilot in January 2023 where we actually integrated into VISN 7 and 8 with 15 instances of Veterans Health Information Systems and Technology Architecture (VistA), and we were able to demonstrate to be able

to see across those VistA instances and be able to compare that availability with those providers.

The goal would be to then add on the Community Care Network to be able to give you the apples-to-apples comparison, which the comment that you made earlier about it is up to the veteran if you want to have the VA care or community care because they are both at the point where it is—they are further out, right. Being able to have that.

Ms. MILLER-MEEKS. Thank you for saving me. That was a big faux pas. I am never supposed to ask a question I do not know the answer to, and I did not know the answer to that question. Thank you that it worked out well for us.

Dr. Kruger, could you share some of the difficulties you have experienced with sending and receiving medical records to the VA?

Dr. KRUGER. Thank you. Sending—we do send the records. I do not know where they go to, but we do fax them. That is the only way we are supposed to send them. Our communication systems and computers do not talk to the VA. In terms of receiving records, the VA in my community says that we are their last priority, and they will get around to it when they can.

The difficulty that I have of taking care of patients is that, if I have to do a CAT scan, the VA determines where it is going to be. I do not know where it is going to be. I do not know where to get the results. I have to wait for the VA to tell me it has been done and to give me the results. Very difficult if I find out it has been done at one of the military hospitals and I am told it is a Health Insurance Portability and Accountability Act (HIPAA) breach, even though I am the one who ordered it, it is really the VA who ordered it, but I cannot get the results.

Ms. MILLER-MEEKS. Thank you very much for that. It sounds like there is some work we have to do on both ends on the medical records and also to have interoperability, which may be beneficial rather than faxing.

Mr. Weinberg, how do—excuse me. How do delays—I know it was Dr. Braverman who had the cold, but I am the one that is stuttering.

How do delays in VA referral authorizations impact your ability to provide timely care for veterans?

Mr. WEINBERG. Yes. Madam Chair, thanks for the question.

You know, one of the things that we try to do is make sure that there is as much coordination between us and the VA as possible. I go back to my statements about relationships at the central office level, VISN level, VA medical center office, to include sitting down and doing network adequacy meetings every single month. You know, the impact for me, it is not about our organization. It is really about the veteran. What we—what we are trying to do is help make that go as fast as possible.

Ms. MILLER-MEEKS. Thank you. I yield back.

Ranking Member Brownley, would you like to make any closing remarks?

Ms. BROWNLEY. Well, I will just be brief. I think that this has been an important meeting, and I am glad you have called it. I think we still—there is still a lot for us to learn and to understand. Now that we have a delay in this contract, I hope that we can take

the time to think about what can be included in the contract to improve services for our veterans.

I think this EPS system, I think, is—should, you know, be universal across the board, and if it can be internal within the VA, I think we need to do that. I mean, this could be a huge, huge improvement just by doing this.

I think, you know, we still need a lot—I think we still need more hearings and a deeper understanding of where the right balance is. This is what I continue to say over and over and over again in these hearings is the right balance between community care and VA care. You know, where is that—where is that balance?

I took offense to Dr. Murphy saying that I am being critical, always continuing to be critical about community care. That is quite the opposite. I believe that the community care is an essential part, which I even said in my opening comments, but community care is essential to the success of the VA in providing services to our veterans when they need it and where they need it.

I just think that we have got to be clear about the direction that we are going in and trying to find that right balance. I mean, I would wonder from really the two—two providers here, Optum and TriWest, if you had a huge increase, a very significant increase in patients, you know, over a period of time, is that something that you could actually handle? You know, I do not know if you——

Ms. MILLER-MEEKS. You want to submit that question for the record?

Ms. BROWNLEY. Thank you. That is a question that I would really like to have answered.

I will yield back.

Ms. MILLER-MEEKS. Thank you very much, Ranking Member Brownley.

I would like to thank everyone for their participation in today's hearing and for the great discussions we have had on this important topic.

I also would say I would be happy to accommodate Ranking Member Brownley on having more hearings on community care and on this topic because, as I stated earlier, our veterans' biggest barrier to receiving the care they deserve should not be the VA itself.

Today's hearing reinforced the importance of the clear roles and responsibilities within the community care program and the need to focus on solutions that work for veterans, such as what we heard today with Mr. Faraji and Wellhive, and it focuses on the veterans and not on the people who run the system.

I look forward to working with Secretary Collins and the VA, Dr. Braverman especially, to ensure the high-quality care is delivered to our veterans.

The complete written statement of today's witnesses will be entered into the hearing record.

I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material.

Hearing no objection, so ordered.

I thank all members and the witnesses for their attendance and participation today. The hearing is now adjourned.

[Whereupon, at 4:31 p.m., the subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Steven Braverman

Good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting me to discuss how VA ensures that Veterans have access to the excellent, timely care they have earned. I am accompanied by Dr. Sachin Yende, Chief Medical Officer of the Office of Integrated Veteran Care, Veterans Health Administration. We 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.

Expanding Health Care Access for Veterans

At VA, we prioritize Veterans. We have expanded health care services throughout VA facilities, thereby increasing our capacity to provide direct care across many regions. We see community care as an integral part of VA care. The Department supports Veterans in choosing between receiving care directly from VA facilities or from community providers, as outlined in P.L. 15–182, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018. Our integrated approach to total Veteran health is based on the idea that Veterans have earned the right to choose world-class health care services when and where they need them as authorized by law. Our network of community care providers effectively bridges the gaps between Veteran needs and the limitations of VA's direct care system.

Congress provided authority to VA under the MISSION Act that extended community care access for Veterans. In 2019, VA began implementing the MISSION Act and has since referred over 5.4 million unique Veterans to community care providers. Veterans have accessed more than 228 million community care appointments. The enactment of P.L. 117–168, the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022, enabled VA to expand its reach and provide health care to even more Veterans. Since the PACT Act was signed into law in August 2022, nearly 900,000 Veterans have enrolled in VA health care. The combined results of empowering Veterans to choose providers authorized by the MISSION Act, in conjunction with the expanded enrollment following enactment of the PACT Act, has resulted in VA delivering 78.8 million appointments in VA facilities along with 53.6 million appointments in the community since August 2022. This unprecedented enrollment and care delivery growth has resulted in the greatest number of Veterans receiving the world-class health experiences they have earned.

Enhancing Community Care Coordination

With the rapid expansion of community care eligibility under the MISSION Act, the Department improved its ability to accommodate the growing number of Veteran patients referred to our community providers. Once community care eligibility is established, VA's referral process includes measures to ensure each Veteran achieves a positive outcome.

Referrals begin when VA receives a request for community care, managed through the HealthShare Referral Manager (HSRM) system. The HSRM system is used by facility community care staff to generate referrals and authorizations for Veterans receiving care in the community. Clinical and community care staff at VA medical centers, outpatient clinics, community-based outpatient clinics, and Veterans Integrated Service Network (VISN) offices use this solution to enhance Veteran access to care. Each facility's Community Care Integrated Team (CCIT) determines the appropriate level of care coordination for each Veteran using VA's Screening Triage Tool to aid in standardizing episodes of care. The Screening Triage Tool allows Veterans to complete clinical screenings from any connected device. Patients can report symptoms or complete standardized screening questions before their medical appointments, which results in a more efficient visit. Together with community providers, CCITs develop an individualized care coordination plan with the Veteran

and their care team. Third-Party Administrator (TPA) services include scheduling, process navigation, and other follow-up activities. Care coordination involves assessing the complexity of care needs for Veterans receiving community care, care delivery, and returning health records back to VA.

Role of Third-Party Administrators

TPA's play a crucial role in the VA Community Care Network by locating community providers who can provide timely, quality care. TPAs also process care claims from these providers and work to schedule appointments and support other technical aspects of Veteran care coordination. The CCIT facilitates collaboration across each component of the care coordination process. TPA actions streamline information flows among Veterans, CCITs, VA providers, and community providers. After an episode of care concludes, the CCIT connects with the Veteran to ensure all services were performed appropriately. The CCIT also facilitates any necessary patient care handoff, closing the consult.

Enhancing Veteran Health Care Through Innovative Technology

As VA advances its mission to care for Veterans, we continually seek innovative approaches to the future of Veteran health care in the community. A key component of implementing change is effectively communicating Veteran needs among various stakeholders. To this end, VHA is transitioning from a blended network of call centers to a standard, enterprise-wide system called VA Health Connect. This clinical contact center modernization supports in-person care and continues to utilize telehealth capabilities, a core component of VA Health Connect. Through VA Health Connect, Veterans can engage with health care delivery at their convenience, any time or day, to discuss health concerns with a nurse. Veteran patients are empowered to contact medical support assistants for help with scheduling appointments. Veterans also have a communications channel with pharmacists to refill prescriptions and, when clinically appropriate, can meet with a provider via video appointment.

VA Health Connect is just one component of a technology modernization effort well underway, with anticipated completion in the next 2 years. Additionally, we are deploying Clinical Resource Hubs to provide virtual care options, increasing access to VHA services when local facilities face limitations in care or service capabilities.

Building Trust and Advancing Toward a Future of Quality Services

VA is a trusted Veteran health care provider, furnishing high-quality care that surpasses our private sector counterparts. Veterans notice the difference. In Fiscal Year (FY) 2024, VA internal survey data showed an unprecedented trust rate of 92 percent in the Department's health service delivery, surpassing our private sector counterparts. Our longstanding relationship with Congress, and with this Subcommittee specifically, has resulted in nearly 70 percent of VA hospitals receiving 4 or 5 stars in the Overall Hospital Quality Star Ratings by the Centers for Medicare and Medicaid Services, compared to only 41 percent of non-VA hospitals. This achievement highlights our opportunity to further enhance care for Veterans.

Despite our successes, we acknowledge the need for process improvements to continue achieving positive outcomes for those who have taken on the mantle of protecting freedom. Building and maintaining trust with Veteran stakeholders is crucial for enhancing health outcomes. In 2019, VHA underwent transformational modernization, becoming a High Reliability Organization (HRO) led by VHA's HRO Steering Committee. Utilizing HRO practices results in fewer than expected accidents or harmful events, even in complex, high-risk environments where minor errors can lead to tragic results. VA established trust among its leaders and staff by implementing this effort. This transformation to an HRO unleashed incredible talent and commitment within our system and strengthened trust in VA from Veterans and the American people.

We are committed to improving safety and quality of care in VA facilities and our network of community providers. VISNs and medical centers are advancing toward HRO maturity, which is defined as instilling an organization-wide commitment to a zero—harm approach to medical safety that aims to operate care centers without exposing staff or non-staff to injury through the implementation of systems.

In Fiscal Year 2024, VA conducted more than 127.5 million healthcare appointments between direct care and community care, a 6 percent increase over the previous year's record volume of 119.8 million appointments. Thanks to our network of providers, we also decreased wait times while delivering more care to many Veterans, caregivers, and survivors.

Conclusion

Madam Chair and Ranking Member Brownley, thank you for your continued dedication and leadership. We are pleased to share our efforts to enhance medical outcomes for our Veterans, who served to safeguard the American way of life. My team and I look forward to today's discussion.

Prepared Statement of Sharon Silas

United States Government Accountability Office

Testimony

Before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
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VETERANS HEALTH CARE

Opportunities to Improve Access to Care Through the Veterans Community Care Program

Statement of Sharon M. Silas, Director, Health Care

GAO-25-108101

GAO Highlights

Highlights of GAO-25-108101, a testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

February 2025

VETERANS HEALTH CARE

Opportunities to Improve Access to Care Through the Veterans Community Care Program

Why GAO Did This Study

VHA operates one of the largest health care delivery systems in the U.S. It provides health care to more than 6 million veterans. The majority of veterans receive care in VHA-operated medical facilities. However, the number of veterans receiving care from community health care providers has increased from about 1.1 million in 2014 to about 2.8 million in 2023, according to VA.

This statement focuses on VA's efforts to ensure that veterans have access to high-quality health care, particularly through community providers. It also discusses opportunities GAO has identified to improve VA operations. This statement is based on seven GAO reports that were issued between 2018 and 2025. See GAO-18-281, GAO-20-643, GAO-23-105290, GAO-23-105617, GAO-24-106410, GAO-24-106390, and GAO-25-106678. This statement also includes updated information on the status of GAO's recommendations made in those reports.

What GAO Recommends

GAO has made 27 recommendations to VHA to address challenges related to aspects of the Veterans Community Care Program in the reports covered in this statement. VA has implemented 9 of these recommendations. VA has taken steps to address the remaining 17 but has not fully implemented them as of February 2025. GAO closed one recommendation as not implemented because it was no longer valid given changes in VA. Fully implementing all the recommendations would help ensure VHA can provide veterans timely access to care.

View GAO-25-108101. For more information, contact Sharon M. Silas at (202) 512-7114 or SilasS@gao.gov.

What GAO Found

In the last decade, Congress has taken steps to expand the ability of eligible veterans to receive care from community health care providers. In particular, the VA MISSION Act of 2018 established the current Veterans Community Care Program. The increased use of community care through this program is a major change for the Department of Veterans Affairs (VA).

GAO has identified challenges and made 27 recommendations related to the Veterans Community Care Program regarding (1) scheduling and wait times and (2) VA oversight of the contractors used to implement the program, including provider network adequacy. VA has implemented 9 of these recommendations and taken steps to implement others.

Scheduling and wait times. VA considers a key component of access to be the time it takes veterans to receive care at Veterans Health Administration (VHA) facilities or in the community.

- In a June 2018 report, GAO recommended that VA establish a community care scheduling process with time frames within which veterans' (1) referrals must be processed, (2) appointments must be scheduled, and (3) appointments must occur. Although VA concurred with this recommendation and implemented the first two components, it has not established standard time frames within which appointments must occur. Thus, this recommendation has not been fully implemented.
- In January 2025, GAO found that VHA's Referral Coordination Initiative—intended to improve scheduling timeliness and veterans' experiences—needs improved program direction and guidance. VHA officials acknowledged that implementation of the initiative had been inconsistent. GAO recommended that VHA ensure program direction—specifically strategic goals, standards for consistent implementation, roles and responsibilities, and oversight and accountability—is documented in national policy and guidance. VA concurred in principle with this recommendation.

Contract oversight and network adequacy. VHA's Office of Integrated External Networks leads, develops, and oversees community care contracts and networks for veterans.

- In a November 2022 report, GAO found that VA needed to strengthen its oversight and improve data on its community care network providers and made two recommendations accordingly. VA has implemented both of these recommendations.
- In an August 2024 report, GAO found weaknesses in VA's oversight of the community care contracts. For example, the office responsible for contract oversight had not developed a clear and complete set of documents to guide oversight, among other concerns. GAO made three recommendations to address these findings. VA concurred with these recommendations and described planned actions to address them, which GAO will evaluate during the recommendation follow-up process.

February 12, 2025

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee:

I appreciate the opportunity to be here today to discuss the Department of Veterans Affairs' (VA) efforts to ensure veterans have timely access to health care, particularly care provided through private health care providers in the community. VA has a long history of using community providers under various programs—including the current Veterans Community Care Program—as a way to address veterans' challenges accessing care at VA's Veterans Health Administration (VHA) medical facilities.[1] In the last decade, Congress has taken steps to improve veterans' access to care, including expanding the ability for eligible veterans to receive care from community providers when they face challenges accessing care at VHA medical facilities.[2] In particular, the VA MISSION Act of 2018 made community care a more central part of how VA accomplishes its mission.[3] However, the increased role of community care is a major change for VA as an organization.

Although the majority of veterans utilizing health care services delivered by VA still receive care in VHA-operated medical facilities, the number of veterans receiving care through the Veterans Community Care Program has increased. According to VA, the number of veterans who received services through community care increased from about 1.1 million in 2014 to about 2.8 million in 2023. VA documentation shows that community

[1]VHA operates 170 medical centers and more than 1,100 outpatient facilities, which we refer to collectively as "VHA medical facilities."

[2]In August 2014, after several well-publicized events highlighted serious and longstanding issues with veterans' access to care, Congress enacted the Veterans Access, Choice, and Accountability Act of 2014. Among other things, the law established a temporary program—called the Veterans Choice Program—and provided up to $10 billion in funding for veterans to obtain health care services from community providers when they faced long wait times, lengthy travel distances, or other challenges accessing care at VHA facilities. Pub. L. No. 113-146, tit. I, §§ 101, 802(d), 128 Stat. 1754, 1755-1765, 1802-1803 (2014).

In 2019, the Veterans Community Care Program replaced the Veterans Choice Program and consolidated other existing community care programs. The VA MISSION Act of 2018 (VA MISSION Act) broadened veterans' eligibility to receive care outside of the VA health care system under this program. Pub. L. No. 115-182, tit. I, §101, 132 Stat. 1393, 1395 (2018).

[3]Pub. L. No. 115-182, tit. I, § 101(a), 132 Stat. at 1395 (codified at 38 U.S.C. § 1703(d)(1)(E)).

care represented about 40 percent of all VA health care in fiscal year 2023. According to VHA, the department spent about $26.7 billion on this care in this same year, out of the total $128.6 billion appropriated for all of VA health care.

For nearly 25 years, we have reported on the challenges VA has faced providing health care services in a timely manner. We have issued reports recommending that VHA improve appointment scheduling, ensure the reliability of wait time and other performance data, and improve oversight. Due, in part, to issues in VA's ability to ensure consistent and timely access to health care, GAO added VA health care to GAO's High-Risk List in 2015.[4]

My statement today summarizes the recommendations we have made to improve VA's Veterans Community Care Program and the status of VA's efforts to implement them. This statement is based on a body of work from June 2018, when the Veterans Community Care Program was being planned, through January 2025. Specifically, this statement includes information from seven reports with 27 recommendations to VA during this time period. VA has fully implemented 9 recommendations and taken some steps to address others, 17 of which remain open as of February 2025.[5]

More detailed information on the scope and methodology of our prior work can be found within the specific reports on which this statement is based. These reports are listed in the related products page at the end of this statement. This statement also includes preliminary observations from our ongoing work examining VHA's efforts to coordinate with community care providers on medical documentation exchange for veterans receiving behavioral health services. For this work, we analyzed VA data on recent behavioral health referrals and VHA guidance on

[4]Similarly, GAO added VA acquisition management to our High-Risk List in 2019. This list focuses attention on government operations that are most vulnerable to fraud, waste, abuse, or mismanagement, or in need of transformation. To determine which federal government programs and functions should be designated "high risk," we consider factors such as whether the risk involves public health or safety. See GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 11, 2015).

[5]GAO recommendations not yet fully implemented include ones that VA has partially addressed and those that VA has not yet addressed. We also closed one recommendation as not implemented as the time for VA to have addressed the recommendation before implementing the Veterans Community Care Program had passed.

medical documentation exchange, and interviewed VHA officials and others.

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VHA operates one of the largest health care delivery systems in the nation, serving over 6 million veterans. VHA's system is organized into 18 regional networks known as Veterans Integrated Service Networks (VISN) that manage the day-to-day functions of VHA's medical facilities, including outpatient facilities. VHA headquarters, its regional network of VISNs, and VHA medical facilities all play a role in managing referrals and scheduling veterans' appointments for care in a timely manner at VHA medical facilities and in the community. For example, each VISN is responsible for overseeing policy implementation and the performance of the VHA facilities within its network.

VHA Appointment Scheduling

Access to timely medical appointments is critical to ensuring that veterans obtain needed medical care. In particular, access to timely primary care appointments is essential as a gateway to obtaining other health care services such as specialty care. There are three ways to initiate a request for health care once a veteran is enrolled in VHA:

(1) A veteran-initiated appointment request

(2) A provider request for a follow-up appointment with the veteran

(3) A provider referral of the veteran to a specialty care appointment

For a veteran to receive a specialty care appointment, a VHA provider must initiate a request by submitting a referral.[6] Clinical staff (e.g., providers and nurses) and administrative staff (e.g., schedulers) at the VHA facility review the referral and consider eligibility for community care. Then, depending on whether the veteran is eligible for community care

[6]VHA policy uses the terms "consult" and "referral" when describing requests placed by VHA providers. For the purposes of this testimony, we will use the term referral. For a limited number of outpatient specialty services, veterans can schedule an initial or follow-up appointment at VHA medical facilities without a referral from a provider. Veterans can use this option for audiology, optometry, and podiatry, among other services.

and the veteran's scheduling preferences, facility staff will schedule an appointment either with a provider at a VHA medical facility or with a provider in the community.[7]

In 2019, VHA updated its process for scheduling specialty care appointments, shortly after implementation of the VA MISSION Act. Under this process, called the Referral Coordination Initiative, referral coordination teams at VHA medical facilities review referrals for specialty care and discuss care options with veterans. The implementation of the initiative marked a significant change to the process previously followed by VHA medical facility staff for management of specialty care referrals.

According to VHA guidance, the initiative is intended to

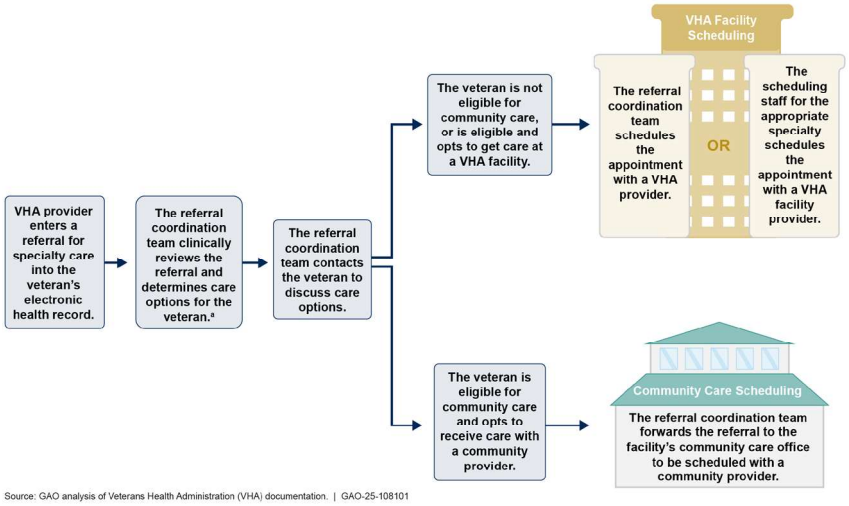
- create dedicated referral coordination teams that are focused on sharing with veterans their health care options,
- empower veterans to make the health care choice that is right for them, and
- improve scheduling timeliness.

The revised referral process is handled by facility referral coordination teams that include designated clinical and administrative staff who assist with scheduling and are trained to discuss veterans' options for care at the time of scheduling. The process is intended to ensure that referral documentation is complete and includes all pertinent clinical information before the coordination teams discuss care options with veterans and schedule appointments in VHA medical facilities or with community providers. Prior to implementation of the revised process, if a veteran met community care eligibility criteria, the referral for specialty care could be sent directly to community care staff for scheduling. However, the veteran might not be informed of their options to obtain care in a VHA medical facility. In implementing the initiative, VHA—specifically, its Office of Integrated Veteran Care—provided facilities with guidance describing the different ways to structure their referral coordination teams, but gave

[7]In addition to VHA medical facility scheduling on behalf of veterans, as of March 2024, 33 of 139 facilities were receiving contractor support in scheduling community care appointments. In some limited cases, veterans may also directly schedule appointments with providers.

facilities flexibility to determine what worked best for their circumstances.[8] See figure 1 for an overview of the initiative's scheduling process.

Figure 1: VHA Referral Coordination Initiative Specialty Care Appointment Scheduling Process



Source: GAO analysis of Veterans Health Administration (VHA) documentation. | GAO-25-108101

[a]This step includes determining whether the veteran is eligible for community care. If the referral coordination team contacts the veteran to gather missing clinical information, they are to discuss care options with the veteran at that time.

Community Care Eligibility

When VHA staff review a referral to schedule an appointment, there are six criteria that can qualify a veteran to receive care under the Veterans Community Care Program.[9] For example, veterans may qualify for community care when the needed services are not offered at a VHA

[8]We have ongoing work examining the creation and implementation of VHA's Office of Integrated Veteran Care.

[9]See 10 U.S.C. § 1703 and implementing regulations at 38 C.F.R. §§ 17.4000 - 17.4040 (2024).

facility or if VHA cannot provide care within its designated access standards. VHA's designated access standards specify that a veteran may be eligible for community care if

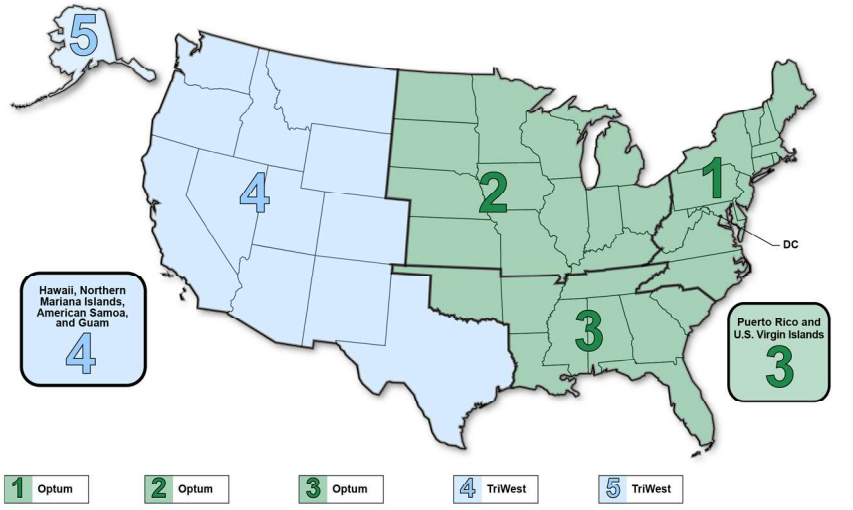
- the average drive time to a VHA provider (from the veteran's residence) is more than 30 minutes for primary care or more than 60 minutes for specialty care, or
- the first next available appointment with a VHA provider is not available within 20 days for primary care or 28 days for specialty care based on the date from the request for care unless a later date has been agreed upon.[10]

Community Care Contracts and Network Adequacy

VA implements the Veterans Community Care Program through five contracts with third-party administrators—with each contract covering services in one of the five community care regions. (See fig. 2.) The third-party administrators are contractors that are responsible for maintaining provider networks that are both adequate in size and have the capacity to ensure veterans' timely access to care. The organizational structures, policies, and processes needed to effectively oversee care provided through contracts with third-party administrators are different from those required to manage care provided directly by VHA staff.

[10]In addition to the six criteria, veterans must either be enrolled in VA health care or be eligible for VA care without needing to enroll, and in most circumstances, veterans must receive approval from VHA prior to obtaining care from a community provider. See Pub. L. No. 115-182, tit. I, § 101, 132 Stat. at 1395-1404 (codified, as amended, at 38 U.S.C. § 1703(d), (e)) and implementing regulations at 38 C.F.R. §§ 17.4000 - 17.4040.

Figure 2: Map of VA's Five Community Care Network Regions



Source: GAO analysis of Department of Veterans Affairs (VA) information (data); Map Resources (map). | GAO 25 108101

In December 2018, VA awarded community care contracts for regions 1, 2, and 3 to Optum Public Sector Solutions, Inc. In 2019 and 2020, VA awarded community care contracts for regions 4 and 5 to TriWest Healthcare Alliance Corp. Each of the contracts was awarded with an initial base period of performance and seven 12-month option periods, the last of which would conclude between 2026 and 2028, depending on the region. Although the work performed under the five contracts is generally the same, there are some variations in contract terms across the contracts, and each regional contract is administered separately.

The two contractors are responsible for establishing and maintaining networks of licensed health care community providers and practitioners across their respective regions, including hospitals, physician group practices, and individual physicians, and paying community provider

claims. Services provided include primary care and specialty care, such as cardiology and gastroenterology. VHA's Office of Integrated Veteran Care oversees the two contractors, including the adequacy of the five regional networks to provide veterans with sufficient access to care. In each community care contract, network adequacy is measured using two primary standards: (1) geographic accessibility based on drive time and (2) appointment availability. Both network adequacy standards vary by the category of care (e.g., primary or specialty care).

VHA Could Make Further Improvements to the Veterans Community Care Program by Fully Implementing GAO Recommendations

In reports issued from June 2018 through January 2025, we have made 27 recommendations related to the Veterans Community Care Program, which are intended to support VA in improving veterans' access to care. In particular we have made recommendations to strengthen (1) community care appointment scheduling processes and monitoring of wait times and (2) oversight of the community care contracts and provider network adequacy.[11] As of February 2025, VA has implemented 9 of these recommendations and taken steps to implement others. (See appendix I for additional information on recommendations we have made regarding VA's Veterans Community Care Program.)

Scheduling and wait times. VA considers a key component of access to be the time it takes veterans to receive care at VHA facilities and in the community. To this end, VA monitors certain wait times veterans experience, including the amount of time it takes for an appointment to be scheduled both with VHA providers and with community providers. Since 2018, we have made 21 recommendations for VA to improve its appointment scheduling processes and monitoring of wait times for community care. Among these, we recommended that VA establish timeliness standards (a time frame within which a veteran's appointment should occur) and metrics to measure whether VA is meeting those standards.

[11]Network adequacy is measured by standards designed to ensure that veterans have access to community providers who can offer timely care.

VA has taken actions to address some of the 21 recommendations, and we have closed seven recommendations as fully implemented.[12] For example, in 2018, we recommended that VA establish a mechanism that would allow for systematic monitoring of the average number of days it takes to schedule community care appointments.[13] We closed this recommendation as fully implemented in October 2021, based on VA's development and deployment of a data system that can monitor various time frames in the referral lifecycle.

In contrast, five of our early recommendations directed at the basic tenets of the Veterans Community Care Program remain open, including:

- In our June 2018 report on the prior community care program—Veterans Choice Program—we identified lessons learned that could be considered for the Veterans Community Care Program.[14] Specifically, we recommended that VA establish a community care scheduling process with time frames within which veterans' (1) referrals must be processed, (2) appointments must be scheduled, and (3) appointments must occur. VA concurred with this recommendation. Although VA implemented the first two components of our recommendation, the department has not established a timeliness standard within which veterans' appointments must occur. As a result, our recommendation related to community care appointments has not yet been fully implemented as of February 2025.
- In 2020, we made a recommendation related to the one we made in June 2018, that VA align its monitoring metrics with its time frames established for scheduling community care appointments to effectively monitor the extent to which veterans receive care within such specified time frames.[15] VA did not agree with our recommendation at the time of our report but has since taken some steps to address it.

[12]See Recommendations 3, 4, 5, 6, 7, and 8 from *Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of its Community Care Programs*, GAO-18-281 (Washington, D.C.: June 4, 2018) and Recommendation 2 from *Veterans Community Care Program: Improvements Needed to Help Ensure Timely Access to Care*, GAO-20-643 (Washington, D.C.: Sept. 28, 2020). We also closed one recommendation as not implemented because it was no longer valid given changes in VA.

[13]GAO-18-281.

[14]GAO-18-281.

[15]GAO-20-643.

We continue to believe that correcting deficiencies in VA's alignment of its monitoring metrics and establishing a performance metric to measure wait times for the receipt of community care will permit VA to more effectively monitor the timeliness of veterans receiving care regardless of whether the care is received at a VHA facility or in the community.

More recently, we have made eight additional recommendations to VA on its ongoing efforts to improve scheduling and reduce veteran wait times, all of which remain open, including:

- In a January 2023 report, we found that VHA appointment scheduling data indicated that most VHA medical facilities did not meet the timeliness standard for scheduling community care appointments.[16] We further reported that this standard was developed and implemented based on data from a limited number of VHA medical facilities, potentially limiting its utility. VHA did not have a clear rationale for setting the standard at 7 days, and officials were unable to provide documentation that explained the basis for the standard. We recommended that VHA conduct a comprehensive analysis of appointment scheduling data from all VHA medical facilities to determine whether the community care timeliness standards are achievable and revise them as necessary.

  VA agreed with this recommendation and has taken some steps to address it. In May 2023, VA officials reported that VA had conducted an analysis of community care scheduling timeliness standards to determine whether these standards were achievable. Consistent with our finding, VA's analysis showed that most VHA facilities were not achieving the current timeliness standard of scheduling appointments within 7 days of the relevant file entry dates. Subsequently, in June and November 2024, VA reported that VHA leadership is in the process of re-evaluating the 7-day community care referral scheduling metric and considering a proposed change. Once VHA leadership makes a final decision, we will evaluate whether our recommendation has been implemented.
- In June 2024, we recommended VA systematically capture the reasons for community care appointment scheduling challenges and use the information to address those challenges.[17] VA concurred in principle with this recommendation and said that it had put in place

[16]GAO-23-105617.

[17]GAO, *Veterans Health Care: Opportunities Exist to Improve Assessment of Network Adequacy for Mental Health*, GAO-24-106410 (Washington, D.C., June 3, 2024).

mechanisms to track such challenges. VA officials also stated that they plan to conduct an analysis of scheduling challenges based on data obtained through these mechanisms. We will evaluate whether these actions address the intent of our recommendation.

- In January 2025, we found that VHA's Referral Coordination Initiative needs improved program direction and guidance.[18] VHA began implementing this program aimed at streamlining scheduling for specialty care appointments at its medical facilities across the country in 2019. In our survey of VHA medical facility officials responsible for implementing this initiative, facility officials reported implementation difficulties. Specifically, 80 percent (103 of 129 responses) of officials from facilities that implemented the Referral Coordination Initiative somewhat or strongly agreed that the process had been challenging to implement. Some VHA medical facility and VISN officials noted challenges they experienced due to the lack of clear policy for the initiative, and VHA officials acknowledged that implementation of the initiative had been inconsistent.

  Given the transformative potential of this process change as it continues implementation across the VHA health care system, particularly the increased focus on communication with veterans about their care options, we recommended that VA make improvements to its program direction and guidance for this initiative. In particular, we recommended that VHA ensure key aspects of program direction—specifically strategic goals, standards for consistent implementation, roles and responsibilities, and oversight and accountability—are documented in national policy and guidance. Doing so would help VHA medical facilities provide veterans with a consistent appointment scheduling experience across VHA's health care system. Moreover, we recommended VHA ensure it aligns performance metrics for this initiative with the defined strategic goals and communicate how to use these metrics.

  VA concurred with four of our five recommendations and concurred in principle with the recommendation to include program direction in national policy. VHA published a new national referral management policy—which includes some information regarding the Referral Coordination Initiative—on November 22, 2024. We will review this new policy, and the extent to which it fulfills the intent of our recommendation, as part of our recommendation follow-up process.

[18]GAO, *Veterans Health Care: Referral Coordination Initiative for Specialty Care Needs Improved Program Direction and Guidance*, GAO-25-106678 (Washington, D.C.: Jan. 21, 2025).

Contract oversight and network adequacy. Within VHA's Office of Integrated Veteran Care, the Office of Integrated External Networks leads, develops, and oversees contracts and their networks of providers for the Veterans Community Care Program to ensure high quality and timely health care services for veterans. As part of its oversight, the office (1) measures the contractors' performance compared with contract terms, including provider network adequacy, (2) manages the reporting of quality issues, (3) oversees the credentialing of network providers, and (4) manages the resolution of disputes, complaints, and grievances. We have made six recommendations in this area, and VA has implemented two of them. Specifically, in a November 2022 report, we made two recommendations for VA to strengthen its oversight and improve data on its community care network providers.[19] VA took actions in response to our recommendations, which we closed as implemented in fall 2024.

We made other recommendations related to the community care contracts. VA concurred with these recommendations but not yet implemented them as of February 2025.

- In an August 2024 report, we found weaknesses in VA's oversight of the Veterans Community Care Program contracts.[20] For example, we found that the office responsible for contract oversight has not developed a clear and complete set of documents to guide oversight, among other concerns. Likewise, while VHA officials have begun discussing how to address oversight challenges with the current contracts, we found that VA does not have a formal process for documenting lessons learned. We made three recommendations to address our findings. VA concurred with our recommendations and described planned actions to address them. We expect to receive updates from VA on these actions later this month, and will assess the extent to which the actions meet the intent of our recommendations.
- In June 2024, we reported on opportunities we identified for potential improvements to ensure network adequacy for the community care networks.[21] VA assesses community care contractors' network adequacy performance against two primary standards: drive time and

[19]GAO, *Veterans Community Care Program: VA Needs to Strengthen Its Oversight and Improve Data on Its Community Care Network Providers*, GAO-23-105290 (Washington, D.C.: Nov. 10, 2022).

[20]GAO, *Veterans Community Care Program: VA Needs to Strengthen Contract Oversight*, GAO-24-106390 (Washington, D.C.: Aug. 21, 2024).

[21]GAO-24-106410.

appointment availability. VA's methodology to calculate specialty care network adequacy—specifically, excluding certain claims when they do not meet the standard and including them when they do—poses a risk to VA's ability to fully assess the extent to which community care networks are adequate to meet veterans' needs, including for mental health care. As VA begins to develop the next generation of community care contracts, it is important for VA to understand the risks associated with its existing methodology, and whether an alternative approach might be warranted. We recommended that VA assess the risks associated with its methodology for calculating specialty care network adequacy and revise its approach accordingly. VA concurred with this recommendation and described planned actions to address it by early 2025. We will continue to monitor VA's progress in implementing this recommendation.

We also have ongoing work related to other aspects of community care—specifically, examining the various information technology systems involved in scheduling and related operations, and examining VHA's efforts to coordinate care with community providers.

- **Scheduling systems.** We have ongoing work examining the systems VA uses to schedule appointments and monitor wait times and any challenges VHA facilities and veterans experience using these systems, among other questions. These systems include those related to determining community care eligibility and managing community care referrals. To do this work, we have reviewed VA documents, interviewed VA officials, and conducted site visits with VHA medical facilities. We anticipate issuing our report in late spring 2025.
- **Care coordination.** We also have ongoing work examining VHA's efforts to coordinate with community care providers on medical documentation exchange for veterans receiving behavioral health services. As part of this work, we are reviewing data on behavioral health referrals to community care providers and assessing VHA's oversight of medical documentation exchange.

  Our preliminary observations show that from fiscal years 2021 through 2023, 224,741 veterans used referrals to receive behavioral health services from community providers. The majority of these veterans maintained a connection with a VHA medical facility, with about 90 percent keeping a VHA primary care provider and about 71 percent returning to VHA medical facilities to receive further behavioral health services. With nearly three-fourths of veterans returning to VHA medical facilities for behavioral health services after seeing a

community provider for such services, ensuring that VHA medical facilities and community providers exchange medical documentation is critical to avoiding risks to the veterans' continuity of care. We anticipate issuing our report by summer 2025.

In summary, VHA has faced a variety of challenges with the Veterans Community Care Program, including monitoring its facilities' performance in scheduling appointments with community providers. Our work has identified a number of areas for improvement to the program. Since 2018, VHA has implemented some of our recommendations and taken steps to address others. Fully implementing our recommendations related to community care is important to ensuring that veterans have timely access to care. We stand ready to assist with providing continued oversight in this area.

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee, this concludes my statement. I would be pleased to respond to any questions you may have.

GAO Contacts and Acknowledgments

If you or your staff have any questions about this testimony, please contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Marcia A. Mann (Assistant Director), Julie T. Stewart (Analyst-in-Charge), Ying Hu, Megan Knox, Kelly Turner, and E. Jane Whipple. Other contributors include Jacquelyn Hamilton and Kate Tussey.

Appendix I: Open GAO Recommendations Related to the Department of Veterans Affairs (VA) Community Care Program

Table 1: Status of Open Recommendations Related to the Veterans Community Care Program for GAO Reports Included in This Statement, as of February 2025

GAO recommendation (GAO Report, Date)	Implementation status
The Under Secretary for Health should ensure that the Office of Integrated Veteran Care defines Referral Coordination Initiative program direction—strategic goals, roles and responsibilities, standards for consistent implementation, and oversight and accountability—in appropriate VHA national policy. (GAO-25-106678, January 2025)	**Open – Not Addressed.** VA concurred in principle with our recommendation. In response to our draft report, VA acknowledged the importance of clear program direction and stated that the Referral Coordination Initiative was created to improve the referral coordination process, which is one piece of the overarching consult and referral management process. VA also said that the Referral Coordination Initiative should not be interpreted as a stand-alone process. We maintain that the Referral Coordination Initiative marks a significant change from how referrals have historically been managed within VA, and as such, our recommendation that program direction be fully defined in national policy would increase accountability mechanisms and help ensure veterans receive timely and effective care. The Veterans Health Administration (VHA) published a new national referral management policy on November 22, 2024. We will review this new policy as part of our recommendation follow-up process.
The Under Secretary for Health, upon inclusion of the Referral Coordination Initiative in the appropriate VHA national policy, should ensure that the Office of Integrated Veteran Care aligns Referral Coordination Initiative guidance with VHA national policy and updates it as needed to reflect available evidence, such as findings from studies, best practices, and other elements that promote consistent implementation. (GAO-25-106678, January 2025)	**Open – Not Addressed.** VA concurred with our recommendation. In response to our draft report, VA described actions the Office of Integrated Veteran Care would take to promote consistent implementation, such as a future update to Referral Coordination Initiative guidance. For example, VA stated that the Office of Integrated Veteran Care will update Referral Coordination Initiative guidance to include a Veterans Integrated Service Network-led model that is based on evidence-based studies and identified best practices. VA estimated that their actions would be completed by November 2025.
The Under Secretary for Health, following initial alignment of Referral Coordination Initiative guidance and national policy, should ensure that the Office of Integrated Veteran Care establishes a process to ensure that any guidance remains current and accurate when the Office of Integrated Veteran Care makes changes to Referral Coordination Initiative policy or program requirements. (GAO-25-106678, January 2025)	**Open – Not Addressed.** VA concurred with our recommendation. In response to our draft report, VA stated that the Office of Integrated Veteran Care will establish a process for recurring reviews and revisions of Referral Coordination Initiative guidance and other resources. VA estimated that their actions would be completed by November 2025.
The Under Secretary for Health should ensure that the Office of Integrated Veteran Care reviews the Referral Coordination Initiative performance metrics, and updates them as needed, to ensure that the metrics align with and assess progress toward all aspects of Referral Coordination Initiative's strategic goals. (GAO-25-106678, January 2025)	**Open – Not Addressed.** VA concurred with our recommendation. In response to our draft report, VA stated that the Office of Integrated Veteran Care is in the process of reviewing, revising, and developing key performance indicators to assess its progress against Referral Coordination Initiative's strategic goals. VA estimated that their actions would be completed by November 2025.

The Under Secretary for Health should ensure that the Office of Integrated Veteran Care communicates with Veterans Integrated Service Networks and VHA facilities regarding how to use its metrics to measure performance toward the Referral Coordination Initiative goals. (GAO-25-106678, January 2025)	**Open – Not Addressed.** VA concurred with our recommendation. In response to our draft report, VA described actions the Office of Integrated Veteran Care will take, including publishing information on the key performance indicators it develops on the internal Referral Coordination Initiative SharePoint. Further, the Office of Integrated Veteran Care plans to use community of practice calls and site visits to communicate informational updates. VA noted that, through these efforts, the Office of Integrated Veteran Care will also be able to incorporate feedback from Veterans Integrated Service Networks and facilities into the development of its program documentation. VA estimated that their actions would be completed by November 2025.
The Secretary of VA should ensure that the Assistant Under Secretary for Health for Integrated Veteran Care establishes a complete set of documentation for oversight of the Community Care contracts, including documentation of clear and complete procedures and the identification of roles and responsibilities. (GAO-24-106390, August 2024)	**Open – Not Addressed.** VA concurred with our recommendation. In response to our draft report, VA stated that the Office of Integrated Veteran Care will review existing contract oversight documentation and update the documentation accordingly. As of February 2025, we have not received an update from VA on actions taken to address this recommendation.
The Secretary of VA should ensure that the Assistant Under Secretary for Health for Integrated Veteran Care assesses whether the oversight and reporting responsibilities of the program manager position outlined in the Quality Assurance Surveillance Plans are being effectively fulfilled by current processes and, if not, updates the plans as appropriate. (GAO-24-106390, August 2024)	**Open – Not Addressed.** VA concurred in principle with our recommendation. In response to our draft report, VA stated that the Office of Integrated Veteran Care will review the responsibilities outlined in the Quality Assurance Surveillance Plans and mitigate any identified gaps. As of February 2025, we have not received an update from VA on actions taken to address this recommendation.
The Secretary of VA should ensure that the Assistant Under Secretary for Health for Integrated Veteran Care develops a formal lessons learned process, consistent with leading practices, for the Community Care contracts to inform VA's plans for the next set of contracts and its continuing oversight efforts. (GAO-24-106390, August 2024)	**Open – Not Addressed.** VA concurred with our recommendation. In response to our draft report, VA stated that the Office of Integrated Veteran Care will use and refine the existing lessons learned process, including identifying areas for improvement. As of February 2025, we have not received an update from VA on actions taken to address this recommendation.
The Undersecretary for Health should assess the risks associated with VA's methodology for calculating specialty care network adequacy and revise its approach accordingly. (GAO-24-106410, June 2024)	**Open – Not Addressed.** VA concurred with our recommendation. In November 2024, VA officials reported that VHA was in the process of assessing the methodology for specialty care network adequacy calculations and the requirements in VHA's current community care contracts to identify risks and opportunities for improvement. According to officials, VHA is conducting this assessment in conjunction with its activities to prepare for the next generation of community care contracts. For example, officials state that one of their activities to prepare for the next community care contract is the development of a detailed operational plan that will include key objectives and milestones that are intended to enhance oversight and ensure that contractors maintain an adequate network. When VHA completes its assessment and preparations for the next generation of community care contracts, we will review these actions and evaluate whether they are sufficient to address our recommendation.

The Undersecretary for Health should ensure that VA facility staff systematically capture the reasons for community care appointment scheduling challenges and use this information to help address those challenges. (GAO-24-106410, June 2024)	**Open – Not Addressed.** VA concurred in principle with our recommendation. In response to our draft report, VA stated that it had put in place mechanisms to track community care appointment scheduling challenges. However, VA also noted it had not mandated the capture and reporting of reasons for scheduling delays due, in part, to the need for stronger contractual requirements that would require the contractor to act on the reasons. In December 2024, VA stated that it continued to use these mechanisms, which include, for example, required monthly meetings between the contractors and VA facilities, and the development of a ticketing system for VA facility staff to document recurring community care access issues. VA officials reported that they are using these mechanisms because requiring facility staff to systematically capture the reasons for appointment scheduling challenges would increase the administrative workload of VA staff. VA officials also stated that they are planning to conduct an analysis of scheduling challenges based on data obtained through these mechanisms. We will evaluate whether VA's actions are sufficient to address our recommendation.
The Undersecretary of Health should conduct a comprehensive analysis of appointment scheduling data from all VA medical centers to determine whether the community care timeliness standards are achievable and revise them as necessary. (GAO-23-105617, January 2023)	**Open – Partially Addressed.** VA concurred with our recommendation. In May 2023, VA stated that VHA had conducted an analysis of community care scheduling for referrals VA medical centers scheduled from October 2022 through January 2023 against the timeliness standards to determine whether these standards were achievable. Consistent with our finding, VA's analysis showed that many VHA facilities were not achieving the current timeliness standard of scheduling an appointment within 7 days of the file entry date. In response, VHA established a goal for each VHA facility to reduce the average number of days it takes to schedule appointments by specific percentage targets over time, in an effort to meet the 7-day scheduling standard. In June 2024, VHA officials reported that they continued to monitor this goal but also stated that VHA leadership was in the process of re-evaluating the 7-day scheduling standard. In November 2024, VHA officials reported that they had presented options for modifying the standard to the VHA Governance Board and that the Board had approved a proposed change in September. According to officials, VHA leadership is in the process of considering this proposed change. When VA completes these activities, we will evaluate the extent to which they have addressed our recommendation.

The Undersecretary of Health should require referring providers and referral coordination team clinical reviewers to complete the role-based Referral Coordination Initiative training that VHA developed and track completion of the training to ensure familiarity with its updated scheduling process for VHA facility and community care appointments. (GAO-23-105617, January 2023)	**Open – Not Addressed.** VA concurred with our recommendation. In response to our recommendation, VA officials have reported that they were updating available trainings on the referral management process to ensure that they fully reflect the process and that the documentation that referral coordination team reviewers complete is standardized. In a November 2024 update to its referral management directive, VHA required that providers complete referral management training within 120 calendar days of the directive's publication. New providers are required to complete the training within 120 calendar days of their start date. According to VA officials, this required training will include a Referral Coordination Initiative role-based module. VA officials said VHA will track providers' completion of this mandatory training. VA estimated that their actions would be completed by April 2025. At that time, we will evaluate whether the steps VA has taken are sufficient to address our recommendation.
The Undersecretary of Health should align its monitoring metrics with the time frames established in the Veterans Community Care Program scheduling process[a] (GAO-20-643, September 2020)	**Open – Partially Addressed.** VA initially did not agree with our recommendation but since February 2022 has started to address it. In a directive and standard operating procedure, VHA defined some time frames for VHA facilities to follow when scheduling appointments under the Veterans Community Care Program. However, VHA has not yet defined a timeliness standard for when a veteran's appointment should occur (i.e., receipt of care). The Consolidated Appropriations Act, 2023, enacted on December 29, 2022, requires VHA to establish a specific wait time measure (the number of days from the date of request for the appointment to the first next available appointment) for veterans eligible for care under the Veterans Community Care Program and requires program third-party administrators to furnish care within this standard. In September 2023, VA officials stated that they continue to evaluate the technical, logistical, and financial implications of operationalizing these legislative requirements. When VA takes further actions, we will evaluate the extent to which those actions address our recommendation.
The Under Secretary of Health should direct VA medical center leadership to assess their community care staffing and resource needs, and develop a plan to address any identified risks to their ability to schedule appointments in a timely manner, including strategies to adjust staff levels and address recruitment and retention challenges as needed. (GAO-20-643, September 2020)	**Open – Partially Addressed.** VA agreed with our recommendation and in January 2023, stated that it last updated its staffing tool in March 2022 to enable each VA medical facility to quantify resource needs and identify the recommended number of administrative and clinical staff based on current workload data, systems, and processes. VA also stated that VA medical facilities are to make quarterly updates to the staffing tool, which is then used by the facility community care offices to support position requests and for discussions with leadership regarding community care staffing levels. In addition, VHA submits staffing tool results to Congress every 180 days. Under the Referral Coordination Initiative, VHA transitioned responsibilities for community care appointments from multiple clinical employees to designated referral coordination teams at each VA medical facility. In January 2023, VHA stated that community care staffing needs are expected to evolve further over the next year as VA medical facilities continue to recruit staff and implement new business processes, like the use of referral coordination teams and enhanced technological tools to expedite referral management and appointment scheduling. Although VA has made some progress in implementing this recommendation, we have asked for more evidence to show how VA uses the tool to help VA medical facilities develop plans to address any identified scheduling risks or to address recruitment and retention challenges.

The Undersecretary for Health should establish an achievable wait-time goal for the consolidated community care program that VA plans to implement that will permit VHA to monitor whether veterans are receiving community care within time frames that are comparable to the amount of time they would otherwise wait to receive care at VHA medical facilities.[a] (GAO-18-281, June 2018)	**Open – Partially Addressed.** VA agreed with our recommendation. The Consolidated Appropriations Act, 2023, enacted on December 29, 2022, requires VHA to establish a specific wait time measure (the number of days from the date of request for the appointment to the first next available appointment) for veterans eligible for care under the Veterans Community Care Program and requires program third-party administrators to furnish care within this standard. In September 2023, VA officials stated that they continue to evaluate the technical, logistical, and financial implications of operationalizing these legislative requirements. When VA takes further actions, we will evaluate the extent to which those actions address our recommendation.
The Undersecretary for Health should design an appointment scheduling process for the consolidated community care program that VA plans to implement that sets forth time frames within which (1) veterans' referrals must be processed, (2) veterans' appointments must be scheduled, and (3) veterans' appointments must occur, which are consistent with the wait-time goal VHA has established for the program.[a] (GAO-18-281, June 2018)	**Open – Partially Addressed.** VA agreed with our recommendation and has so far, defined time frames for when a community care referral must be processed and scheduled, but has not yet defined a timeliness standard for when a veteran's appointment should occur (i.e., receipt of care). The Consolidated Appropriations Act, 2023, enacted on December 29, 2022, requires VHA to establish a specific wait time measure (the number of days from the date of request for the appointment to the first next available appointment) for veterans eligible for care under the Veterans Community Care Program and requires program third-party administrators to furnish care within this standard. In September 2023, VA officials stated that they continue to evaluate the technical, logistical, and financial implications of operationalizing these legislative requirements. When VA takes further actions, we will evaluate the extent to which those actions address our recommendation.
The Under Secretary for Health should issue a comprehensive policy directive and operations manual for the consolidated community care program VA plans to implement and ensure that these documents are reviewed and updated in a timely manner after any significant changes to the program occur. (GAO-18-281, June 2018)	**Open – Not Addressed.** VHA agreed in principle with this recommendation and in January 2025, stated that the Office of Integrated Veteran Care has continued its development of a community care directive. VA estimated that their actions to develop the directive would be completed by June 2025.

Source: GAO-25-106678, GAO-24-106390, GAO-24-106410, GAO-23-105617, GAO-20-643, and GAO-18-281 and GAO analysis of Veterans Health Administration (VHA) information. | GAO-25-108101

[a]GAO identifies priority open recommendations each year. These are GAO recommendations that have not been implemented and warrant priority attention from heads of key departments or agencies because their implementation could help the federal government save large amounts of money or significantly improve government operations. In the 2024 update, this was a priority open recommendation for VA. See GAO, *Priority Open Recommendations: Department of Veterans Affairs*, GAO-24-107265 (Washington, D.C.: June 3, 2024).

Related GAO Products

Veterans Health Care: Referral Coordination Initiative for Specialty Care Needs Improved Program Direction and Guidance. GAO-25-106678. Washington, D.C.: Jan. 21, 2025.

Veterans Community Care Program: VA Needs to Strengthen Contract Oversight. GAO-24-106390. Washington, D.C.: Aug. 21, 2024.

Veterans Health Care: Opportunities Exist to Improve Assessment of Network Adequacy for Mental Health. GAO-24-106410. Washington, D.C.: June 3, 2024.

Veterans Health Care: VA Actions Needed to Ensure Timely Scheduling of Specialty Care Appointments. GAO-23-105617. Washington, D.C.: Jan. 4, 2023.

Veterans Community Care Program: VA Needs to Strengthen Its Oversight and Improve Data on Its Community Care Network Providers. GAO-23-105290. Washington, D.C.: Nov. 10, 2022.

Veterans Community Care Program: Improvements Needed to Help Ensure Timely Access to Care. GAO-20-643. Washington, D.C.: Sept. 28, 2020.

Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of its Community Care Programs. GAO-18-281. Washington, D.C.: June 4, 2018.

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US HOUSE OF REPRESENTATIVES
HEARING ON
"ROLES AND RESPONSIBILITIES: EVALUATING VA COMMUNITY CARE"
FEBRUARY 12, 2025

Chairwoman Dr. Miller-Meeks, Ranking Member Brownley, and subcommittee members, thank you for the opportunity to discuss the oversight conducted by the Office of Inspector General (OIG) related to VA community care. The OIG's Office of Healthcare Inspections (OHI) has reported on the many challenges VA faces in consistently providing high-quality care to eligible veterans. Meeting their healthcare needs requires coordinating highly skilled multidisciplinary teams as well as efficient processes that prioritize the safety and timely delivery of that care. Additional complexities often arise when veterans are referred by VA to the community for care. The OIG recognizes the efforts of VA staff to provide veterans with the care and services they need and deserve, particularly when care in the community is the patient's best or only option.

For years, a top focus of the OIG's body of work has been ensuring veterans receive high-quality, coordinated care when using community providers. Since the start of fiscal year 2024 alone, the OIG has issued 21 reports detailing the challenges VA faces in administering community care, and many additional work products have touched on aspects of the program. Through numerous ongoing inspections, reviews, and audits, the OIG continues to examine VA's community care program. For example, OHI's Care in the Community (CITC) teams conduct cyclical VISN-level reviews and on-site inspections of individual medical facilities to evaluate compliance with VA's community care referral and coordination processes.[1] Additionally, OHI conducts healthcare inspections to evaluate complaints or concerns specific to individual episodes of community care. Finally, both OHI and the OIG's Office of Audits and Evaluations have conducted national reviews of community care that highlight issues

[1] VA has 18 Veterans Integrated Service Networks, known as VISNs, across the nation. They comprise a regional network of care in which each VISN oversees VHA local healthcare facilities in their assigned area. Under the CITC program, the OIG reviews VISNs and individual medical facilities on an approximate three-year schedule.

across the system. This statement highlights specific findings from OIG healthcare inspections on quality and timely coordination of care as well as audits related to contractor oversight, staffing, information technology (IT) systems, and financial management processes that together illustrate the major challenges VA faces in this area.

Through this collective oversight, the OIG consistently finds that (1) VHA struggles to ensure veterans experience timely and seamless coordinated care when they are referred to the community, (2) VHA cannot ensure the quality of care community providers deliver, (3) staffing challenges and inadequate oversight of community care providers further challenge coordination efforts, and (4) substandard IT systems and inaccurate and incomplete data significantly restrict VA's ability to manage community care payments.

VA STRUGGLES TO ENSURE VETERANS EXPERIENCE TIMELY AND SEAMLESS COORDINATED CARE WHEN REFERRED TO THE COMMUNITY

When a veteran is referred for care in the community, there are a series of processes that must occur within a required timeframe to ensure the patient receives timely and appropriate care. As shown through the examples that follow, the OIG has consistently found breakdowns in these processes that have resulted in delays, placed patients at risk and, in some instances, have actually caused patients harm.

Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at the Buffalo VA Medical Center

The OIG initiated this healthcare inspection at the VA Western New York Healthcare System in Buffalo to assess allegations regarding community care consult appointment scheduling practices and delays for patients with serious health conditions who received community care.[2] The OIG substantiated that community care staff did not schedule patients within set timelines for radiation therapy and neurosurgery appointments, which resulted in delays in patient care and, in some cases, caused or increased the risk of patient harm. In particular, had there not been a delay in scheduling, and eventual cancellation of, community care radiation therapy to treat a patient's cancer-related pain, efforts could have been made to alleviate that pain and improve the quality of life in the patient's final months. Facility leaders also failed to conduct an institutional disclosure to the patient's family.[3]

The Buffalo healthcare system and its community care leaders did not resolve the scheduling delays, despite advocacy by care providers and staff. Leaders relied on inaccurate assurances from the healthcare system's community care managers that urgent, high-risk patient care consults (referrals)

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[2] VA OIG, *Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo*, September 27, 2024.

[3] An institutional disclosure is made when a healthcare provider informs a patient or their family when a medical error or unexpected complication occurs during treatment that resulted in harm (an adverse event).

were reviewed and prioritized, even as they received ongoing alerts about care concerns regarding those patients. The healthcare system and community care leaders' inactions were inconsistent with VA's stated commitment to the principles and values of high-reliability organizations, as they failed to consistently focus on patients, get to the root causes of concerns, and predict and eliminate risks before causing patient harm. This widespread breakdown in community care processes should serve as a cautionary tale for other VA facilities and reinforces the need for leaders at all levels to be aware of and responsive to concerns brought forward by staff.

The OIG made two recommendations to the VISN director related to the healthcare system leaders' response to patient concerns and oversight of community care. Two recommendations were also directed to the Buffalo system's director related to establishing community care policies aligned with VHA standards, as well as the institutional disclosure of the adverse event (which has now been completed).

Issues with Scheduling and Communication with Patients Referred for Community Care

The OIG's CITC program examines key clinical and administrative VA processes that are associated with providing quality community care, specifically focusing on processes for community care referral and care coordination.[4] OIG teams interview VHA staff and analyze data to identify deficiencies that hinder the proper administration of VHA's community care program. The CITC teams have found consistent care coordination challenges related to processing requests for additional services and timely managing information in patients' medical records.

Community Care Provider Requests for Additional Services

When a patient is evaluated by a community provider, additional care needs may be identified that were not included in the initial referral from VA. The community provider can send a request for additional services back to VA for approval. The OIG's inspection teams evaluated whether the requests for additional services were processed according to VA requirements and determined that the majority of VA community care staff did not consistently process requests for additional services within the required three business days of receipt. Additionally, some community care staff did not consistently incorporate the community provider's requests for additional services from the community provider into patients' electronic health records. Lastly, the OIG found that VA community care staff routinely failed to send required letters to community providers when requests for additional services were denied. These deficiencies in processing and documenting important clinical information can further delay needed follow-up diagnostic evaluations and treatment.

[4] All CITC reports can be found on the OIG website.

Obtaining and Importing Community Care Documents to the Patient's VA Electronic Health Record

Many VA leaders reported having a backlog from the time records are received by the facility, assuming they are received from community providers, to when they are scanned into the patient's electronic health record. Such delays in importing incoming medical documentation from community care providers compromises timely coordination and quality of care oversight.

While community care consults should be administratively closed after staff make one attempt to receive medical documentation from community providers, VHA staff are still expected to make two additional attempts after closure to obtain the records. Without the medical documentation from community care appointments, a veteran's VHA providers are tasked with providing comprehensive care with incomplete information. OIG inspection teams found community care staff did not consistently meet requirements to make two additional attempts to obtain community providers' medical documentation within 90 days of the appointment after administratively closing consults. During interviews, the inspection team learned that many leaders direct their staff to keep community care consults in an open status in order to better track the status of documentation return. VHA's Office of Integrated Veteran Care (IVC), which manages the community care program, has since notified the OIG that they are in the process of revising this policy.[5]

Finally, CITC teams evaluated compliance with processes related to community care diagnostic imaging results by reviewing patients' electronic health records. The teams found that community care staff did not consistently attach diagnostic imaging results to the correct progress note in the electronic medical record. The failure to attach diagnostic imaging results to the correct note affects VA providers' ability to locate results efficiently and could delay patients' diagnosis and treatment or lead to repeat studies and procedures. CITC teams evaluated how effectively facility community care staff communicated results of diagnostic imaging by community providers to the ordering VA providers, especially for abnormal results. The teams found that community care staff consistently failed to use the significant findings alert to notify the ordering VA providers of abnormal diagnostic imaging results as required. With this failure, the ordering VA providers may be unaware of abnormal test results, and patients' diagnosis and treatment may be delayed or never initiated.

VA CANNOT ENSURE THE QUALITY OF CARE THAT IS PROVIDED TO VETERANS REFERRED TO THE COMMUNITY

The OIG has repeatedly found significant barriers to ensuring that veterans referred to the community are receiving health care that meets the quality standards established by VHA. As the following OIG reports demonstrate, deficiencies in the credentialing process, inadequate oversight of community

[5] IVC coordinates veterans' access to community care services by developing and overseeing contracts for veterans' healthcare services and payments to third-party administrators.

providers' prescribing practices, and the failure to record and track patient safety events in the community all impede VHA's efforts to oversee the safe provision of care for every veteran.

Deficiencies in the Credentialing Process Allowed a Former VA Surgeon with Competency Concerns to Operate in the Community Care Network

In this follow-up inspection, the OIG reviewed a former VA surgeon's eligibility to provide health care as a participant in VA's community care network and how the Marion VA Healthcare System in Illinois managed community care patient safety events.[6] Previously, the OIG had substantiated concerns with the surgeon's quality of patient care at the VA medical center in Biloxi, Mississippi.[7] Biloxi facility leaders missed opportunities to clearly convey, record, and take action against the surgeon in response to identified clinical competence concerns. Specifically, the facility failed to provide the surgeon with a written proposal to terminate VA employment before the surgeon resigned and failed to record the departure as a "resignation in lieu of involuntary action."

During this follow-up inspection, the OIG identified multiple failures by IVC and the third-party administrator (TPA) that served to undermine credentialing and oversight processes and ultimately allowed the surgeon to practice in the VA community care program.[8] First, the TPA failed to address concerns identified by a company responsible for independently verifying the surgeon's 2018 credentialing file. Second, imprecise language in the VA's contract with the TPA did not provide adequate guidance for determining whether to exclude the surgeon from the community care network. Additionally, IVC failed to identify inconsistencies in the surgeon's file that should have influenced credentialing decisions. Finally, the TPA misapplied privacy rules, which prevented its leaders from releasing important information to IVC relevant to the surgeon's voluntary relinquishment of their Florida medical license. The OIG concluded that the facility's patient safety training did not include completing patient safety reports for events in the community and the patient safety manager was unaware of the option to contact the TPA for updates on the status of patient safety concerns reported to the TPA.

Given the potential for these issues to be repeated across the country, the OIG made two recommendations to the under secretary for health related to a review of the surgeon's eligibility to participate in the community care network and contract; four recommendations to the IVC executive director related to ensuring the TPA's sufficient review, documentation, and compliance of network providers; one recommendation to the VISN director to review all community care provided by the surgeon; and one recommendation to the facility director related to patient safety event report education

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[6] VA OIG, *Deficiencies in the Community Care Network Credentialing Process of a Former VA Surgeon and Veterans Health Administration Oversight Failures*, January 4, 2024.
[7] VA OIG, *Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System in Biloxi, Mississippi*, August 28, 2019.
[8] TPAs are responsible for developing and maintaining a pool of community providers who meet VA's quality standards and process care claims.

and follow-up. Five of the eight recommendations are currently open, and the OIG continues to monitor VA's progress in implementing these recommendations until sufficient evidence is provided to enable closure.

VHA Did Not Provide Necessary Oversight of Community Care Providers' Opioid Prescriptions

Veterans have a higher risk of opioid overdose often due to higher rates of chronic pain caused by military related trauma as well as a variety of mental health issues such as PTSD and Military Sexual Trauma that increase the likelihood of misuse and abuse of opioids. When veterans receive care in the community, it is of vital importance that opioid prescriptions are appropriately tracked and coordinated with VA. The failure to do so puts patients at increased risk of opioid misuse and overdose.

The MISSION Act of 2018 requires VA to ensure that non-VA providers who prescribe opioids to veterans receive and certify their review of VA's Opioid Safety Initiative (OSI) guidelines.[9] These guidelines require providers to query state prescription drug monitoring programs to determine whether veterans already have other opioid prescriptions before writing a new opioid prescription. In an audit published in September 2023, the OIG assessed whether VA ensured non-VA providers were provided a copy of the OSI guidelines and certified that they have reviewed them, whether a sample of non-VA providers conducted required queries, and whether sampled veterans' medical records included opioid prescriptions, as required by the MISSION Act.[10] The OIG found that IVC did not provide adequate oversight for either the TPA or non-VA providers to ensure the providers received and certified they reviewed the OSI guidelines. IVC also did not monitor the TPA to ensure non-VA providers completing prescription drug monitoring programs queries as required. The sampled medical records generally contained the non-VA provider opioid prescription information as required. However, this information was documented in different sections of VA medical records, which may make it difficult for providers to access this critical information. The OIG made three recommendations to improve compliance with *MISSION Act* requirements and OSI guidelines.

In a separate healthcare inspection, an OIG team assessed care coordination for patients of the VA Eastern Kansas Health Care System (VA Eastern Kansas) who also received community care and were dually prescribed opioids and benzodiazepines from community care network providers.[11] The inspection team also reviewed compliance with public law and VHA policies and guidelines specific to the oversight of community providers' opioid prescribing practices. The OIG found issues related to

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[9] P.L. 115-182. The VA MISSION Act of 2018 is also known as the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018. It established a permanent community care program for veterans.
[10] VA OIG, *Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans*, September 26, 2023.
[11] VA OIG, *Review of VHA's Oversight of Community Care Providers' Opioid Prescribing at the Eastern Kansas Health Care System in Topeka and Leavenworth*, September 26, 2023.

incomplete and delayed community provider documentation, OSI prescribing risk-mitigation strategies, prescriptions dispensed at VHA pharmacies versus non-VA pharmacies, and lack of medication reconciliation and VHA medication profile updates. These deficiencies place patients at risk for adverse opioid-related events. Additionally, the team identified two examples in which patients received multiple controlled substance prescriptions from a combination of VA Eastern Kansas, non-VA Eastern Kansas VHA providers, and community care network providers. The OIG found the VISN director and medical center staff were not conducting oversight of the community providers' opioid prescribing practices as required under the MISSION Act and as recommended by the OIG in 2019. In addition, they were not reporting concerns of unsafe community care network provider practices to the TPA. The OIG made seven recommendations to the under secretary for health related to community care provider documentation, evidence of network providers' training and use of OSI risk-mitigation strategies, state prescription drug monitoring program queries, and the capture of community-provider-prescribed medications in electronic health records. The OIG made two recommendations to the VISN director related to ensuring VA Eastern Kansas has processes in place to conduct oversight of community care network providers' prescribing practices. The OIG made four recommendations to the VA Eastern Kansas director related to documenting the use of OSI risk-mitigation strategies, capturing community-provider-prescribed medications in the electronic health record, filling vacant pain management positions, and educating staff on reporting patient safety concerns involving community care providers. Six of the thirteen recommendations remain open.

CITC Inspections Repeatedly Find Patient Safety and Quality of Care Incident Reports from Community Providers Are Not Properly Tracked

OIG's CITC program also evaluates performance and facility staff compliance with requirements that are critical to ensuring the provision of high-quality care.

For example, the CITC teams compared community care patient safety and quality of care reports to the TPA with those entered in the VHA's Joint Patient Safety Reporting system, which standardizes the process for medical teams to identify and document medical errors, near-miss events, and close calls within their facilities. The teams found recurring issues with staff not entering and tracking events related to community care patient safety or quality of care in VA's reporting system. VA requires staff to report these events internally. Facility patient safety managers then review the events to determine the need for any immediate action. When staff do not report these community care events internally, patient safety managers miss opportunities to take corrective actions to address community care patient safety risks. Adding to this concern, there is a lack of transparency in the process for TPAs to review and respond to reported quality and patient safety issues. VA does not participate in or have visibility over the process by which a TPA determines if the standard of care was met and is only made aware of the end result of a review. The TPA then has sole discretion as to which providers may continue to operate and receive referrals within VA's community care network, regardless of the concerns raised by veterans who have received care from the provider.

VHA LACKS ADEQUATE STAFFING AND OVERSIGHT TO MANAGE COMMUNITY CARE

VHA uses staffing data to assess whether medical facilities have the necessary resources to manage community care needs. Accurate staffing data are critical for decision-making and allocating funds to support veterans' access to community care. As more and more veterans are referred to the community, VA must continually assess needs and reinforce staffing to respond to the workload demands. Further, VHA is responsible for overseeing community care networks and TPAs to ensure sufficient qualified providers are available and that their performance and competency is monitored.

Community Care Departments Need Reliable Data to Ensure Adequate Resources for Timely Scheduling and Care Coordination

An OIG audit team assessed whether medical facility leaders identified, authorized, recruited, and retained nurses and medical support assistants (MSAs) to process referrals for community care.[12] The team found that VHA does not have reliable data or sufficient tools to assess community care staffing levels and needs at the network or national level. Notably, facility leaders do not use consistent organizational codes to identify community care staff across VA medical facilities. Additionally, VA's staffing assessment tool relies on self-reported data that cannot be effectively verified. Due to data entry errors and a lack of consistent validation or quality review, VHA included inaccurate information in congressionally mandated reports. Despite these limitations on the VISN or national level, facility community care leaders generally identified local staffing needs, and their resource management committees authorized the requested staff. Although most facilities could adequately recruit and retain community care nurses, many could not recruit and retain MSAs. To compensate for the lack of MSAs, some facilities used strategies such as hiring incentives or consolidated community care units to help process community care referrals. The undersecretary for health concurred with the OIG's five recommendations to improve the reliability of community care staffing data and recruitment and retention of MSAs. One recommendation remains open at this time.

Staffing needs were also assessed by OIG CITC teams. As part of these reviews, the OIG teams requested each VA facility provide evidence that leaders reassessed community care staffing every 90 days as required using the staffing tool created by IVC. Teams found that VA staff could not provide evidence that these reassessments occurred at the required intervals. Failures to conduct these assessments as required could negatively affect community care program operations, and thus timely patient care. Notably, during their on-site inspections over the past year, CITC teams have repeatedly heard concerns about the lack of community care staff to keep up with increases in referrals.

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[12] VA OIG, *Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff*, July 19, 2023.

VA Needs Better Oversight to Evaluate Network Adequacy and Contractor Performance

VHA purchases community care for veterans through geographically based networks managed by the TPAs or through veteran care agreements, which are contracts with community providers in limited situations where the network is not provided or insufficient. IVC is responsible for overseeing execution of community care network contracts, while individual VA medical facilities establish the veteran care agreements.

The OIG conducted an audit to determine whether VHA provided effective oversight of its TPAs and VA medical facilities.[13] The review team evaluated IVC's oversight of the TPAs' adherence to four contract requirements designed to ensure facilities have enough community providers to administer care within the timeliness and drive-time standards established in the contracts. The OIG found that IVC did not hold TPAs accountable for implementing these contract requirements, causing facility staff to struggle to convince TPAs to add community providers to their networks at the eight facilities the audit team visited.

While IVC provided proof of TPAs discussing community care needs with three facilities, similar evidence for other facilities was not produced. Furthermore, IVC did not conduct any analyses of facilities' network adequacy needs to help TPAs build provider networks and did not ensure TPAs maintained provider networks that were accepting VA patients. IVC also did not position itself to defend facilities' needs for additional community care providers.

The OIG recommended to the undersecretary for health that the IVC hold future TPAs accountable for operational readiness and provider network adequacy. IVC should also develop processes to update and maintain community care network data, challenges, and needs. Advanced Medical Cost Management Solution training also needed to be conducted on evaluating network adequacy through the tool for community care staff. Finally, IVC should not only develop its own network adequacy performance reports but also evaluate TPAs' reports, holding them accountable for resolving identified issues. Six of the eight recommendations are closed, and the OIG will continue to follow up on the open recommendations until they have been satisfactorily implemented.

OIG AUDITS HAVE FOUND ADDITIONAL CHALLENGES RELATED TO IT SYSTEMS AND FINANCIAL MANAGEMENT

The OIG's Office of Audits and Evaluations teams have published multiple reviews that found deficient IT systems and data has hindered VA's ability to properly manage community care billing and payment. The reports summarized here further detail these issues.

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[13] VA OIG, *Improved Oversight Needed to Evaluate Network Adequacy and Contractor Performance*, April 9, 2024.

VHA Continues to Face Challenges with Billing Private Insurers for Community Care

VA has a right to recover community care treatment costs for conditions unrelated to military service from veterans' private health insurers. The OIG conducted an audit to determine how effectively the VHA billed private insurers.[14] Prior OIG work had shown that VHA has missed opportunities to recover funds that could be used to help finance care for other veterans. VHA's Office of Community Care (OCC), the precursor to IVC, managed community care programs and billed private insurers when needed. OCC was required to submit reimbursement claims before insurers' deadlines are reached, or they may be denied. The OIG found OCC did not establish an effective process to ensure staff billed veterans' private health insurers as required. An estimated 54 percent of billable community care claims paid between April 20, 2017, and October 31, 2020, were not submitted before filing deadlines expired. As a result, OCC did not collect an estimated $217.5 million that should have been recovered, a figure that could have grown to $805.2 million by September 30, 2022, if problems were not corrected. OCC's billing and revenue collection process also was not synchronized with insurers' filing deadlines, and claims information was not always available for billing. Also, pending workload volume and staff shortages hindered effective billing. Although OCC was broadly aware of challenges to its process to bill and collect revenue from private insurers, its responses were not sufficient to correct these issues. VHA concurred with the OIG's recommendations to develop procedures that prioritize processing to meet insurers' filing deadlines and strengthen its information system controls to ensure information needed to process bills for reimbursement is complete and accurate. VHA should have also assessed staff resources and workload to make certain they are sufficiently aligned to process the anticipated volume of claims to be billed.

Although this report was issued in May 2022, all three recommendations remain open as unimplemented, signaling the challenges VHA faces in maintaining adequate processes and systems to carry out these tasks.

The Pause of the Program Integrity Tool Impeded Community Care Revenue Collections and Related Oversight Operations

VA must have the ability to accurately forecast budget needs for its administrations and staff offices, and then properly execute appropriated funds. The OIG has documented how the absence of well-functioning IT and internal quality monitoring systems can exacerbate financial management problems. A recent example affecting revenues is the OIG's July 2024 management advisory memorandum to VHA regarding the pause in using its Program Integrity Tool (PIT).[15] VHA uses PIT data to determine if

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[14] VA OIG, *VHA Continues to Face Challenges with Billing Private Insurers for Community Care*, May 24, 2022

[15] VA OIG, *The Pause of the Program Integrity Tool Is Impeding Community Care Revenue Collections and Related Oversight Operations*, July 16, 2024. While the OIG made no recommendations in this memorandum, the OIG remains concerned about whether VHA's Revenue Operations will have sufficient resources to timely bill the backlog of community care claims, and how the pause will affect fraud, waste, and abuse activities for community care claims.

healthcare claims should be billed to veterans or private insurance companies for the treatment of conditions unrelated to military service. VHA paused using the PIT in February 2023 after becoming aware of numerous issues, including inaccurate or duplicate claims and defective code. The pause had two major impacts: First, VHA could not bill veterans or private insurance companies for community care copayments or coinsurance because VHA relies on PIT data to do so. Second, the pause impeded internal oversight efforts that utilize the PIT to prevent, detect, and mitigate fraud, waste, and abuse related to community care claims. While VHA has reported that use of the PIT partially resumed in recent months, they now must review the backlog of claims to determine which are eligible to be billed to veterans or private insurers. The OIG estimated that VHA would be delayed in billing an estimated 2.8 million community care claims totaling about $2 billion that were paid between February 1, 2023, and February 1, 2024. According to VHA, the pause resulted in veteran copayment billings that were approximately $23 million lower for the first two quarters of FY 2024 than the same period in 2023. The pause could also have negatively affected veterans because VHA may have sent them copayment bills for care over a year old. To ensure the PIT fully recovered from these issues and would be reliable moving forward, the OIG determined that VHA must commit to providing strong governance, updated IT systems, and effective quality assurance and monitoring.

THE OIG WILL SOON RELEASE ADDITIONAL REPORTS THAT SHOW COMMUNITY CARE CONCERNS PERSIST

The OIG continues to focus on VA community care and has many ongoing projects that explore new areas and highlight continual concerns with the program. Below are previews of two such reports that will soon be published.

An OHI inspection at the VA Eastern Kansas Healthcare System found deficiencies in community care staff's efforts to retrieve records that may have contributed to a delay in a patient's cancer diagnosis and care. The patient had a scan completed at a community hospital, with abnormal results consistent with lung cancer with metastatic spread to the lymph nodes of the chest. That same day, the community hospital faxed the scan results to the wrong VA facility. It was not until the patient presented with concerning symptoms and was admitted to a VA facility over three months later that the abnormal scan results were identified and reviewed. The OIG also determined Eastern Kansas VA leaders did not meet institutional disclosure requirements as crucial components of the disclosure were not documented, and it was not possible to discern the nature of the adverse event disclosed or what was explained to the patient.

A review conducted by the OIG's Office of Audits and Evaluations found that the Veteran Self-Scheduling (VSS) process needs better support and stronger controls and oversight. VSS allows eligible veterans to schedule their appointments directly with community providers once they receive an

authorization for a community care provider and an approved consult.[16] Importantly, this process is only designed for consults designated as requiring basic care coordination. The OIG found that IVC needs to improve its oversight of the VSS process to strengthen support and mitigate the risk of potential misuse of the scheduling option. Neither IVC nor facility leaders implemented controls to identify the potential misuse of VSS. For example, staff at the four facilities the OIG team visited processed VSS consults inappropriately by selecting the VSS option for veterans without their permission. Staff also opted veterans into VSS with urgent consults, despite the fact that veterans with these needs are not eligible for the VSS process. In addition, clinical staff are required to initiate contact with veterans that have more complex consults to help manage the "opt-in" process, a step the review team found was not generally completed at the facilities they visited. Finally, neither IVC nor facility leaders provided effective oversight of VSS. Without better oversight, inappropriate use of the VSS option may go undetected, and veterans may experience delays in care.

CONCLUSION

Time and again, the OIG finds engaged and highly qualified VA clinical staff providing direct care to veterans. Despite the efforts of dedicated staff, VA continues to experience challenges in coordinating and streamlining care when veterans are referred to the community. Our oversight work has repeatedly identified gaps in assessing the safety and quality of community care and repeated deficiencies in coordinating that care. Through over 50 community care reports and hundreds of recommendations, OIG has identified risk, noncompliance with policy, and unclear guidance to the field. Our teams have also supported solution-focused conversations between IVC, VISNs, and facility leaders and staff, which have helped leaders target many significant operational deficiencies. OIG recognizes the need for community providers to partner with VA to meet the often-complex needs of veterans, and we will continue our independent oversight efforts to ensure veterans and their families are receiving the timely high-quality care they need.

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee, this concludes my statement. The OIG looks forward to working with you and this Congress to advance VHA's provision of care to veterans, regardless of where it is delivered. I would be happy to answer any questions you may have.

[16] If a veteran chooses self-scheduling and opts in, VHA staff collect the veteran's additional scheduling preferences, such as which community providers the veteran wants to see, and then informs the veteran they will receive a letter about scheduling their own appointment with instructions on how to notify VHA staff of their appointment details.

Prepared Statement of Scott Kruger

February 12, 2025

The Honorable Mariannette Miller-Meeks
Chairwoman
Subcommittee on Health
House Committee on Veterans Affairs
364 Cannon House Office Building
Washington, D.C.20515

The Honorable Mark Takano
Ranking Member
Subcommittee on Health
House Committee on Veteran Affairs
364 Cannon House Office Building
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Testimony of Scott Kruger, MD
Before House Veterans' Affairs Subcommittee on Health
Hearing: "Roles and Responsibilities: Evaluating VA Community Care"

Dear Chairwoman Miller-Meeks and Ranking Member Takano:

Chairwoman Miller-Meeks, Ranking Member Takano, and distinguished members of the Subcommittee, thank you for the opportunity to testify today on the Department of Veterans Affairs' (VA) Community Care Program (CCP) on behalf of my practice Virginia Oncology Associates (VOA), a member of The US Oncology Network, which is one of the largest networks of integrated, community-based oncology practices in the United States. My name is Scott Kruger, and I am a practicing medical oncologist and hematologist with VOA in Hampton, Virginia. I have had the privilege of providing care to many of our nation's veterans through the CCP, and I appreciate the Subcommittee's attention to the critical role that this program plays in ensuring access to timely and high-quality medical care.

Challenges in the Current System

The CCP has helped bridge care gaps. However, there are significant challenges that must be addressed to enhance its effectiveness. For veterans with complex and urgent medical conditions, such as cancer, timely access to specialized care is critical.

Many veterans experience significant delays in receiving authorization for community care, which can be particularly detrimental for patients requiring time-sensitive cancer treatments. In my area, it can take more than 4-6 months to get approval for essential procedures like a mammogram, ultrasound, and biopsy for a breast mass due to the absence of effective communication with the VA. Furthermore, coordination between the VA and community providers is often lacking, resulting in fragmented access to medical records, treatment plans, and follow-up care. This lack of data-sharing can lead to incomplete medical histories and duplicated tests or procedures. In some cases, delays in transmitting crucial biopsy reports, CT scans, MRI results, and other vital data have resulted in care delays or have necessitated repeat procedures. These challenges in coordination and communication are further compounded by the inefficiencies faced by Third-Party Administrators (TPAs).

TPAs are struggling with high caseloads that cause delayed responses and administrative strain for both providers and patients. Although TPAs have provided our practice with a liaison to ease communication, we still struggle to reach the community care office effectively. Regarding reimbursement and financial stability, the reimbursement rates under the CCP are often lower than those offered by Medicare or private insurance, which discourages providers from participating in the program. The administrative burden of claims processing, alongside frequent claim denials or rejections due to clerical errors, further limits provider participation and access to care. Finally, patient navigation and education are critical issues, as veterans frequently encounter difficulties navigating the complexities of the CCP, including understanding eligibility requirements, scheduling appointments, and coordinating care between VA and community providers.

For instance, an elderly woman in her late 70s, who was sent to me for evaluation of blood cancer, faced numerous challenges. She had suffered a stroke, could not walk, had skin breakdown, and showed signs of dementia. Although I was authorized to draw a complete blood count, she required additional services such as home health care, wound care, physical therapy, and rehabilitation. Despite setting up care with two different agencies, neither received VA approval, and after two months, I still had not received any communication from the VA regarding her care.

Recommendations for Improvement

To enhance the effectiveness of the VA Community Care Program, I propose several recommendations. Firstly, the authorization and referral process should be expedited by implementing standardized guidelines and timelines for approvals. This will streamline operations and reduce delays in service delivery. Secondly, improving care coordination is

crucial; this can be achieved through the sharing of medical records and the use of effective communication platforms. As community partners, we are committed to collaborating with the VA to ensure our veterans receive the care they deserve. Additionally, the efficiency of TPAs can be enhanced by establishing clear performance benchmarks and accountability measures. This will ensure that TPAs operate effectively and contribute positively to the program. Furthermore, timely and fair reimbursement for community providers is essential to encourage their participation and prevent financial strain on healthcare facilities serving veterans. Lastly, strengthening patient education and navigation resources will assist veterans in understanding and accessing their care options more effectively, ensuring they receive the best possible support and treatment.

While the VA Community Care Program has made significant strides in expanding access to care, improvements are necessary to eliminate inefficiencies. As a community oncologist dedicated to serving veterans, I look forward to working with this Subcommittee to prioritize reforms to strengthen the program's operations.

Thank you for the opportunity to testify today. I look forward to answering any questions you may have.

Scott Kruger MD

Scott Kruger MD
Virginia Oncology Associates

Prepared Statement of Dave McIntyre

Introduction

Chairwoman Miller-Meeks, Ranking Member Brownley and Distinguished Members of the Health Subcommittee, it is a privilege to testify before this Subcommittee as it examines the roles and responsibilities of the Department of Veterans Affairs (VA), Third-Party Administrators (TPAs), and community care providers in administering VA community care. Thank you for your principled leadership and unwavering commitment to ensuring America's Veterans receive timely access to the high-quality care they deserve, both within VA health care facilities and in the Community Care Network (CCN) that supports VA when it is unable to provide that care directly.

Background on TriWest

Established nearly 30 years ago by a group of non-profit health plans and two university hospital systems, TriWest Healthcare Alliance's sole purpose has been supporting VA and the Department of Defense (DoD) in meeting the health care needs of the military and Veteran communities. Since inception, we at TriWest have worked collaboratively with the Federal Government agencies we have been privileged to support to fully understand their unique requirements, down to the local level, to meet the health care needs of military service members, their families, retirees and Veterans. Our mission has been – and continues to be – doing Whatever it Takes!® to ensure our Nation's heroes and their families have ready access to needed care when the Federal systems on which they rely are unable to meet their needs directly.

Our first 18 years were spent supporting DoD in standing up and operating the TRICARE program in a 21-State area. I am proud of the work we did to assist DoD in implementing and refining TRICARE to meet the needs of millions of TRICARE beneficiaries across the western United States who relied on us for services and support. The first 24 months was neither an easy nor painless road, which involved a 15-month preparation for the startup of TRICARE and 9 months to stand up the program before the demand for services arrived. Getting to success in TRICARE, just like other new large health programs (e.g., Medicare and Medicaid), took working closely with DoD and Congress. Through this partnership, TriWest, DoD and the military services developed many key process and program improvements that benefited the entire TRICARE community including in such critical areas as behavioral health and suicide prevention, as well as case management, disease management and cross-contractor continuity of care.

Our years of experience with TRICARE were essential to our work over the last seven and a half years supporting VA's community care programs beginning in September 2013, when TriWest was awarded a Patient-Centered Community Care (PC3) contract for a 28-State region. PC3 was a nationwide program designed to give VA Medical Centers (VAMC) an efficient and consistent way to provide access to coordinated care for Veterans from a network of credentialed specialty care providers in the community when VA was unable to deliver the care directly. With only 90 days to begin operations, we immediately tapped into our Whatever it Takes! ® ethos and our strong commitment to partnership and leveraged our long-standing relationship with community providers to deliver a network and service operation designed specifically to support the VA health care system across 28 states and the Pacific.

Building VA's Community Care Program

From the start, PC3 was a dynamic effort as VA and Congress sought to refine it. Shortly after access to specialty care from our provider network began in January 2014, VA expanded PC3 to include primary care providers. During that expansion of PC3, an access to care crisis erupted in April 2014 at the Phoenix VA Medical Center which revealed the fact that 14,700 Veterans were on a wait list for care at VA. This spurred immediate congressional action and led to the enactment of the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113–146) in August 2014.

Based on the short implementation timeframe for the new VA Choice Program, and the fact that many in the health care industry said it couldn't be done in 90 days, VA turned to TriWest and its other PC3 contractor to take on the challenge. Working once again in close collaboration with VA, we were able to design and implement the Choice program within the statutory requirement, by November 5, 2014. In just over 30 days, we created the infrastructure, hired and trained hundreds of staff, sent Choice cards to 4 million Veterans in our area of responsibility, and operationalized a state-of-the-art contact center making sure that callers to the

toll-free line were greeted by the voice of then-Secretary McDonald to underscore the importance of this new initiative.

Then, in September 2018, TriWest accepted another challenge from VA – to stabilize and protect VA by expanding our support of VA community care nationwide after VA elected not to extend the contract of the other PC3/Choice contractor. We accepted the challenge with one caveat, that we – TriWest and VA – do it collaboratively to ensure success for the Veterans ultimately being served. In just 90 days, after working closely with each VA medical center in the new region, we delivered a nationwide network of community providers to support VA in serving 9.2 million enrolled Veterans in all 50 states and territories.

At its apex, we provided VA with a consolidated network of over 639,000 individual providers offering more than 1.2 million access points of care. Monthly, we received more than 400,000 requests for care in the community and handled roughly 700,000 calls. From the start of our work supporting VA until the end of Fiscal Year 2019, we assisted over 1.9 million unique Veterans, scheduling more than 6.2 million initial appointments and 10 million follow-up appointments. We processed and paid over 19 million health care claims to community providers. On average, TriWest processed and paid clean claims within 18 days in our legacy area, and within 10 days in the expansion states, with an accuracy rate of 96 percent.

Subsequent to our national expansion implementation, we were honored to have been awarded the contract for CCN Region 4 in August 2019 and CCN Region 5 in October 2020. The Region 4 contract was then amended to include coverage of the Northern Mariana Islands, American Samoa and Guam. We continue to collaborate closely with VA in the regions we serve.

VA Community Care Program

The effectiveness of our partnership with VA is evident in the details of the community care services we have delivered to date. Since the start of our work supporting VA community care, Veterans have received more than 75 million community care appointments through our network provided in support of VA.

We have the privilege of serving nearly 4.7 million Veterans through our network of over 300,000 credentialed community providers offering Veterans and VA access to care at over 750,000 provider locations. The top ten categories of care provided in CCN include cardiology, chiropractic care, complimentary and integrative health, emergency care, homemaker/home health aide, mental health, ophthalmology, orthopedic, physical therapy, and skilled home health care. And, we are paying claims on average in 3 days to 99 percent accuracy.

Refining VA Community Care through Collaboration

In our constant effort to better serve VA, local VA facilities, Veterans and community care providers, we have worked closely with VA on a number of key initiatives designed to improve the Veteran experience and the provider experience – both within the community and in VA – and to enhance VA's capacity to deliver needed health care services. We would like to highlight a few of these initiatives.

South Texas—In 2017, a collaboration led by the VA Valley Coastal Bend Health Care System (HCS) in Harlingen, Texas, and TriWest to pilot a high performing, integrated health care network with preferred providers in the community resulted in delivering timely, high-quality care for Veterans. For years, South Texas Veterans were burdened with having to drive eight or more hours to make the 500-mile round trip to receive care at the Audie Murphy Memorial VAMC.

This pilot has resulted in key process improvements: same-day community care authorizations; digital sharing of medical records between community providers and VA; navigators at preferred provider sites who assist Veterans with setting appointments; and better transition of care between providers and medical documentation return to VA. Only with the commitment and support of other important partners were these critical changes achieved including from VA Central Office, Veterans Integrated Services Network (VISN) 17 leadership and Community Care staff, local congressional offices, Veterans Service Organizations and community care providers such as Doctors Hospital at Renaissance, Valley Baptist Medical Center, and Harlingen Regional Academic Health Center.

The integration of community care under VA's leading role as primary provider and coordinator of Veteran care resulted in reducing the hardship on thousands of Veterans traveling hundreds of miles to VA for specialty care, and dramatically reduced community care claims processing times, dismissal rates and errors.

This South Texas effort is a good example of the importance of integrated VA community care. It means coordinated, quality, and timely care closer to Veterans' homes and stronger partnership between VAMCs, VA clinics, and community providers.

Customized network and support—We redesigned our engagements with VAMC staff and leadership to achieve greater effectiveness, improve issue management, and attain higher satisfaction among our partners at VA.

Though this new model requires resources and reengineering on our part, it allows us to provide a more consistent, tailored and direct engagement with VA, VISNs, and VAMCs to focus on and continually improve core items such as network adequacy, including access by specialty by geographic areas, efficient network utilization, timely appointment scheduling, and provider changes that may impact health care delivery. Equally important, this model also promotes issue identification and resolution through close collaboration, careful review of relevant information and meaningful feedback. Still in the refinement phase, we are pleased to report improved VAMC satisfaction with this new collaborative model. VAMCs report greater appreciation with the direct engagement and improved timeliness of our feedback, which allows them to focus on their own market to meet the health care needs of their local Veteran patient population.

Improving access to behavioral health—A VAMC and VISN team-led collaboration along with a dedicated TriWest team worked together to improve our network of community behavioral health providers, deliver better support to VA facilities through direct engagements, more consistently match the right specialty with the right skillset based on Veterans' needs and improve Veteran wait times and satisfaction of community behavioral health care.

We worked with four VAMCs including the Jennifer Moreno VAMC in San Diego, the Carl T. Hayden VAMC in Phoenix, El Paso VAMC, and Fresno VAMC. In this partnership, we worked closely with VAMC staff to create a local network of preferred behavioral health providers, create markets based on capabilities, improve the speed of appointing, and review business processes for efficiency and effectiveness. This joint effort had a simple goal of ensuring no Veteran was waiting in line for behavioral health care.

Community provider education and training—Our work in support of VA's health care mission also focuses on community provider education and training. We will be requiring community providers to certify they have reviewed the Opioid Safety Initiative guidelines. Also, in our communication with community providers, we continually promote VA training and urge network providers to take advantage of free training on Veteran culture, preventing suicide through lethal means safety and safety planning, and other topics that help providers understand the unique needs of Veterans.

We also provide webinars related to claims submission to improve claims payment accuracy and timeliness, appointing and approved referrals/authorizations, urgent and emergent care, and other CCN processes and procedures.

Community provider claims—Veterans' access to care in their local communities depends in large part on providers being willing to participate in CCN, and when needed care is rendered, on ensuring these providers are paid in a timely and consistent manner. A primary reason for CCN claims denials in the regions we serve (Regions 4 and 5) is the statutory requirement under 38 U.S.C. section 1703D(b) that CCN providers file claims to VA within 180 days. This requirement is inconsistent with Medicare, Medicaid, TRICARE, and the private sector, which all allow up to 1 year for the filing of a claim to be considered timely.

Despite our efforts to ensure providers understand this VA-unique requirement, it continues to create substantial confusion and complication for community care providers. Additionally, many provider practices have claims submission systems that are set up to meet standard 365-day requirements, so the VA-unique 180-day standard requires expensive process modifications and/or manual overrides of claims submission. And, at the end of the day, those who are unable to file within 6 months don't get paid for the care they delivered. Obviously, this is inconsistent with keeping a strong and stable network.

As you know, the committees of jurisdiction attempted to address this issue in the last Congress. However, the provision to align the VA requirement with other Federal programs was removed from VA authorization legislation due to a Congressional Budget Office projection of the cost to extend the deadline.

Based on our experience, we know that unless this issue is legislatively addressed, it likely will have an impact on community provider participation in CCN and thus on Veterans' access to care, especially in rural, highly rural, and remote areas. The requirement continues to be viewed as a significant administrative burden by many community health care professionals. As a result, we believe that VA, and especially Veterans, would be better served by adopting the same standard used by other Federal programs and private health plans – a timely filing requirement of 1 year.

We appreciate Chairman Bost for including this modification in the ACCESS Act of 2025. We strongly encourage Congress adopt this change. Doing so will result in increased provider satisfaction, reduced re-work by all parties, and unnecessary delays in claims payment.

Closing

Through nearly three decades of operating in support of DoD and VA, we have steadfastly sought to work very collaboratively to deliver tailored solutions designed to best meet the needs of those we serve. Through these efforts, we have developed crucial experience in helping these systems implement and mature their programs to provide timely and convenient access to quality health care services. We have honed expertise in navigating and supporting the department that was created to serve the needs of Veterans with the essential services they deserve. This is sacred work for us. Our mission is to serve those in need, ensuring they have access to the right services and health care providers while also supporting community care providers fully as they serve the needs of our nation's heroes. We know what it takes and will continue to do Whatever it Takes!® to flex in support of these systems that are critical to meeting the needs of those who sacrifice so much on our behalf.

Prepared Statement of Ed Weinberg

Chairman Bost, Chairwoman Miller-Meeks, Ranking Member Takano, Ranking Member Brownley, and members of the sub-committee, thank you for the opportunity to join you today to discuss the U.S. Department of Veterans Affairs (VA) Community Care Network (CCN.) I am the Chief Executive Officer of Optum Serve, the Federal health services business of UnitedHealth Group (UHG).

I am pleased to submit this written statement for the record regarding Optum Serve's work administering the VA's CCN program in regions 1, 2, and 3, since 2018 which provides a comprehensive, high-quality approach to supporting Veterans' choice and access to the care they have earned.

On behalf of the dedicated women and men at Optum Serve, who tirelessly work to deliver solutions that meet the health needs throughout the Federal Government, we are thankful for our partnership with the VA, and our collaboration with Veterans and their caregivers, Veteran Service Organizations, community providers, and our exceptional program partners.

As a combat Veteran, retired Army officer, and proud father of a Soldier, I fully recognize the magnitude of the selfless sacrifices made by our Veterans and their families. Because of this, I am deeply committed and laser focused on the success of the entire VA health system, inclusive of the VA Community Care Program and Optum Serve's role and responsibility in ensuring access to quality care for our Nation's Veterans. Our commitment is not only demonstrated by meeting and exceeding our requirements across all three regions, but also through the partnership we have fostered with VA at every level, and by building trusted relationships with Military and Veteran Service Organizations. The invaluable feedback from these key stakeholders offers us a sharper lens as we seek to continuously fine-tune and tailor our services to improve the Veteran's experience.

Optum Serve is honored to support health programs that touch virtually every point in a Veteran's journey, from the time they raise their right hand to take the oath until the time they separate from military service and return to civilian life as a Veteran. Here are some of the programs that we proudly support:

- **U.S. Military Entrance Processing Command**: Providing specialty consult exams in support of the U.S. Military's recruitment mission.
- **Military Health System Nurse Advice Line**: Managing the Military Health System's 24/7/365 Global Nurse Advice Line for active-duty service members, retirees, and their families.
- **Veterans Benefits Administration (VBA) Compensation and Pension Exams**: Ensuring quality and timely exams for Veterans and transitioning military service members through the VBA Medical Disability Exam program.
- **VA CCN Program**: Delivering quality care in the community in regions 1, 2, and 3, when and where a Veteran needs it.

Our position supporting Department of Defense (DoD) and VA programs throughout this entire lifecycle offers Optum Serve a truly unique perspective as we work restlessly to enhance the overall quality and experience of the members we serve.

Optum Serve's Support of VA CCN

Since 2019, we have focused on the ever-evolving needs of VA in support of improving Veteran access to high quality care through continuous network refinement and optimization. Our provider network offers a wide range of services including primary and specialty medical and dental care services, behavioral health, complementary and integrative health care services (e.g., chiropractic, acupuncture, and massage therapy), urgent care and transplant services.

Through the VA CCN program, we have the privilege of supporting approximately 6.5 million eligible Veterans across three regions comprised of 36 states, the District of Columbia, U.S. Virgin Islands, and Puerto Rico. I vividly recall meeting with VA leaders and clinicians in Philadelphia, Pennsylvania, in June 2019 where we began the phased implementation of the VA CCN program and monitored the first Veteran referral for care in the community move through our collective systems. After we successfully deployed region 1 and were making strong progress deploying in regions 2 and 3, the COVID–19 pandemic struck, creating significant challenges for us and the entire healthcare system. Despite these headwinds, Optum Serve remained undeterred. Today, Optum's VA CCN program is making a clear difference in the lives of Veterans, having completed over 159 million Veteran care visits through our robust provider network of 2.4 million care sites.

But it isn't just about building the provider network. What has become increasingly clear is the importance of preserving the network for future Veterans. Timely and accurate reimbursement is crucial for maintaining our strong provider network for Veteran care. Therefore, it is of highest priority to ensure that community providers, especially smaller practices in rural areas, have the positive cash-flow needed to sustain their operations. We're pleased to report that we have adjudicated over 116 million claims since program inception, and providers have been paid in an average of 7 days or less. This efficiency supports future Veteran care and helps providers continue serving their broader communities.

Improving Veteran Experience & Wellness

The well-being and experiences of Veterans are the driving force behind everything we do. One Veteran's spouse shared a heart-wrenching story about how a gun lock, provided by an Optum Serve community care provider, saved her husband's life. In a moment of crisis, the gun lock caused just enough of a delay for her to realize what was happening. Those precious extra minutes allowed her to intervene, preventing another tragic loss. Thanks to that brief delay, her husband is still here today.

We share the unwavering belief with this committee and the VA that even one Veteran suicide is too many; which is why we do what we do. At Optum Serve, we recognize that Veteran mental health is a national issue and one of the greatest challenges we must come together to solve, and we are working hard to move the needle in several impactful areas. To further promote Lethal Means Safety through our community providers, Optum Serve partners directly with VA's Office of Mental Health. This collaboration aims to prevent Veteran suicide by distributing gun locks to community providers, who then give them directly to Veterans. Since we began this initiative in September 2023, we have distributed over 12,000. Additionally, Optum Serve partnered with our broader organization to create and deliver tailored provider training courses on topics like *Suicide Screenings & Prevention and Opioid Safety Training*. We also ensured these courses provide continuing education credits, which is a great incentive for providers to increase participation.

Veteran-Centric Service & Timely Access to Care

Optum Serve is committed to our partnership with VA to identify and solve challenges which require local level relationships between our organizations. Even prior to implementation in 2019, Optum Serve established Community Care Experience Teams (CCET), comprised of Veteran Experience Officers (VEO), to provide on-the-ground support and resources to every VAMC and their staff. Optum Serve VEOs maintain strong relationships with the local VAMC and Veteran Integrated Service Network (VISN) leaders, and each of the VAMC community care offices to better meet the needs of the VA at the local level and by extension, the Veterans we collectively serve. Additionally, each VISN has an assigned and dedicated Optum Serve Provider Advocate who stands ready to support with any unique challenges a Veteran may encounter in connecting with the care they need.

One such example of the power and purpose of having dedicated Optum Serve VEO and Provider Advocates with a Veteran-centric focus is the support recently provided to a Veteran in VISN 16. This Veteran had been suffering from debilitating migraines for over a year and had recently lost his job. Optum Serve's VEO and Provider Advocate collaborated with the VAMC registered nurse to identify an out-of-network provider who offered an individualized treatment plan that the Veteran had not yet tried. This provider agreed to join CCN based on the Veteran's case and their onboarding was expedited.. As a result, the Veteran received successful treatment and experienced a significant improvement in quality of life. This is just one example of how these advocates are making a difference in helping the entire system work better.

As VA shifted their focus to fulfill their fourth mission at the height of the COVID–19 pandemic, Optum Serve responded to VA's immediate need for support with appointment scheduling activities and quickly pivoted to develop a scalable solution to meet individual VAMC needs. Optum Serve provided high quality appointment scheduling support to these VAMCs from February 2021 through October 31, 2024. During this period, Optum Serve supported 29 of the 109 VAMCs within our three regions, scheduling over 694,000 Veteran appointments with participating CCN providers in less than 9 days on average.

In response to referral surges based on individual VAMC needs, Optum Serve quickly adapted by increasing staffing, building specialized teams based on category of care and built direct partnerships with individual VAMCs to tailor solutions as needed to address specific regional challenges and improve care delivery. One of our specialized teams was dedicated to supporting Veterans with a behavioral health referral. Every Veteran was assigned a highly trained Appointment Scheduling Representative (ASR) who helped them identify the right provider and schedule their appointment with one of our 65,000 behavioral health providers at one of the 50,000 available locations which include over 1,100 substance abuse centers across all three regions. Each VAMC was assigned a newly created Veteran Scheduling Experience Officer (VSEO) whose primary role was staying connected to local VA staff and ensuring Veterans were appointed with the community provider to best suit their health care needs. Optum Serve's scalability and automation enabled us to meet the growing needs of Veterans while maintaining top-notch performance and service. Although VA decided to conclude our appointment scheduling activities, we stand ready to support any VAMC should the need arise again.

Access to care can come in many forms, and the COVID–19 pandemic sparked a rapid increase in telehealth services. While still small compared to VA's direct telehealth services, the use of telehealth through VA CCN has surged from double-digit visits prior to the pandemic to over 35,000 per month. This significant growth highlights the value Veterans place on the flexibility to receive care when and where they need it. To continue this work, license portability is essential, allowing a provider to deliver quality telehealth services across State lines. We look forward to working with this body to ensure they continue to have this choice for future care needs.

Ensuring High-Quality Care

Delivering high quality care for our Nation's Veterans through the CCN program is our top priority. Our rigorous credentialing and recredentialing processes ensure providers meet the highest qualifications through National Committee for Quality Assurance (NCQA) accreditation. Optum Serve has demonstrated our unwavering commitment to excellence by consistently achieving 98 percent or higher on our monthly credentialing audits conducted by VA. Through our ongoing monitoring of potential provider sanctions and exclusions, and taking appropriate actions based on the data, we uphold our dedication to delivering superior healthcare services to our Veterans. This relentless pursuit of excellence underscores our network's reputation in delivering quality healthcare. Our network of providers also stands out for its exceptional commitment to quality, and consistently far exceeds the VA's high-performing provider (HPP) benchmark of 10 percent. In fact, across all three regions over 60 percent of Optum Serve's eligible network has been recognized as a HPP as of December 31, 2024.

Optum Serve is firmly invested in upholding the highest standards by offering a clear pathway for reporting concerns about patient safety, harm, quality-of-care, and any deviations from national care standards through our Potential Quality Issue (PQI) process. Our Clinical Quality Department thoroughly reviews every PQI reported by Veterans their families, caregivers, VA staff, and providers. Additionally, our Clinical Quality Department proactively utilizes measures from the Centers for Medicare and Medicaid Services (CMS) Hospital Acquired Conditions (HAC) and Hospital Acquired Infections (HAI), as well as Agency for Healthcare Research and

Quality's (AHRQ) Patient Safety Indicators (PSI) to identify, and address Veteran care concerns.

Optum Serve's Clinical Quality program is devoted to improving care by reducing harm, sentinel events, serious reportable events, and medical errors. A PQI and/or Optum's claims data mining efforts may result in a provider being reviewed by one of Optum's Peer Review Committees (Medical-Surgical, Behavioral Health, or Dental). Optum's Clinical Quality team conducts regular PQI reviews and facilitates monthly Peer Review Committee meetings to ensure provider adherence to clinical standards and implement corrective actions as needed. If an Optum Serve provider does not engage in quality improvement efforts, the Peer Review Committee may make the recommendation to remove the provider from the network. It is important to highlight that a non-voting VA representative is invited to all committee meetings to ensure transparency in the Veteran safety and quality process within the Community Care Network. Additionally, to support VA's desire to have real-time awareness of clinical quality cases moving through the system, we produced a highly touted dashboard to assist VA users with tracking, and receiving quality information in near real-time which allows for enhanced management and coordination of quality oversight between Optum Serve and VA.

Achieving quality outcomes for Veterans' health depends directly on the quality-of-care delivery. A key component in this process is the Veterans' medical record. Optum Serve educates all community providers on the importance of returning medical records to VA in a timely manner. The requirements regarding medical documentation are specifically outlined in the Optum VA CCN Provider Manual, which is an extension of every provider's contract. We also reinforce this information through various provider education modalities including virtual trainings with an Optum Serve Provider Advocate, medical documentation requirements fact sheets, and our quarterly Optum VA CCN medical and dental newsletters. To best support VA, Optum Serve established a standardized process whereby VA may escalate a request for provider education in the event medical documentation has not been received. Optum Serve's Provider Advocate team then conducts targeted educational outreach to the identified provider.

We are aware there are current barriers with this process and have partnered with the VA to identify and implement efficiencies. We believe more needs to be done to safeguard seamless sharing of these records between providers and the VA by streamlining the available pathways to transmit records and stronger oversight to verify records have been sent timely in order to create the coordination of care our Veterans deserve.

Partners in Serving the Veteran Community

We recognize that the well-being of our Nation's heroes extends beyond the services we provide. To further our mission of ensuring the holistic well-being of Veterans, Service Members, and their families, Optum Serve has partnered with numerous Veteran and Military Service Organizations. Through these partnerships, we provide resources to address the physical, mental, and emotional health care needs of the military and Veteran community. Optum Serve has long-standing partnerships including numerous Veteran centric service organizations. During our quarterly Program Management Review (PMR) with VA leadership, we have coordinated a variety of engagements that emphasize our commitment to the Veteran community. For example, Optum Serve and VA leaders greeted Honor Flight Veterans from Missouri when they arrived at the WWII Memorial in Washington D.C., we tie-dyed shirts with Veterans who reside at a VA Community Living Center, we visited with Veteran caregivers at the South Carolina Fisher House and recorded individual Veteran stories which are permanently stored at the Library of Congress as part of the Veteran History Project. Through these partnerships, we strive to create a robust support network that empowers Veterans and their families to lead healthier, more fulfilling lives while also heightening the sense of purpose and commitment of our staff.

Closing

We strongly share this Committee's dedication to improving the lives of Veterans and the well-being of our Nation's heroes, which is at the center of all we do. Optum Serve has had the distinct honor to work with this Committee through the passage and/or the implementation of landmark legislation including the MISSION Act, PACT Act, Cleland Dole Act, and most recently the Elizabeth Dole Act as Congress has evolved and improved Veteran benefits and the VA's care ecosystem. We stand ready to continue working with this Committee and the rest of the 119th Congress on future legislation aimed at improving the benefits and services for our Veterans.

In closing, I am humbled and deeply grateful for the opportunity to share this statement, highlighting Optum Serve's unwavering dedication to Veterans through the VA CCN program. We remain steadfast in our commitment to enhancing the experiences and outcomes for those we serve. Our passionate and devoted team eagerly anticipates ongoing collaboration with the VA, this sub-committee, and all our partners. Together, we will ensure that our Nation's heroes receive the exceptional health care they have rightfully earned and truly deserve.

Prepared Statement of Chris Faraji

Written Testimony of Chris Faraji
President, WellHive
Before the **House Veterans Affairs Committee, Subcommittee on Health** Hearing: *Roles and Responsibilities: Evaluating Community Care*
February 12, 2025

Introduction

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the Subcommittee, thank you for the opportunity to testify today. My name is Chris Faraji, and I serve as the President of WellHive, a proven SaaS technology provider supporting the Department of Veterans Affairs (VA) through our role in the External Provider Scheduling (EPS) program. WellHive is committed to modernizing scheduling, improving care coordination, and ensuring Veterans receive timely, high-quality healthcare. Our platform successfully integrates directly into health systems, electronic health records, and practice management systems, providing real-time visibility into provider availability, similar to how Expedia streamlines travel bookings.

Today, I will highlight the transformative role of External Provider Scheduling in successfully streamlining scheduling, the measurable impact on Veterans, and opportunities for broadscale optimization.

Background and Historical Development of External Provider Scheduling (EPS)

In 2020, the Veterans Health Administration (VHA) launched a three-year pilot program at the Orlando VA Medical Center, later expanding it to the Columbia, South Carolina VA Medical Center, to test the feasibility and scalability of what is now known as the External Provider Scheduling (EPS) program. This pilot aimed to answer three critical questions:

- Can this technology concept demonstrate utility and reliability within VHA?
- Is it scalable across different VA markets and facilities?
- Does it enable faster access to care for Veterans?

To ensure a thorough understanding of both the challenges and potential solutions, VA implemented a structured and competitive evaluation process. As part of this approach, they conducted an in-depth analysis of the pilot programs and, at different stages, formed two Integrated Project Teams (IPTs). These teams, composed of experts from VHA, OI&T, and VACO, defined the necessary requirements for modernizing Community Care Access.

Following the IPTs' findings, the VHA issued two separate Requests for Information (RFIs) to collect industry input on Community Care Scheduling solutions. This process was designed to ensure that any future system would align with both Veteran needs and VA operational requirements.

Key Leadership Decisions and Timeline

The process to ensure VA procured the right solution included top VHA leadership and multiple decision points. The following timeline highlights key moments, providing a high-level overview of everything that has happened up to this point.

- **June 2023** – Senior VHA leaders, including Shereef Elnahal (former Under Secretary for Health), Miguel Lapuz (former Assistant Under Secretary for Health for Integrated Veteran Care), and Hillary Peabody (Former Deputy Assistant Under Secretary for Health for Integrated Veteran Care), testified before the Senate Veterans Affairs Committee (SVAC) that they were procuring a technology solution to address Community Care Access.
- **September 2023** – The VHA Governance Board, composed of the USH, DUSH, AUSHs, VISN Directors, and other senior VHA officials, formally approved and funded a mandated phased nationwide rollout of EPS to all 18 VISNs, with at least one VA Medical Center in each VISN launching within the first year.
- **September 23, 2023** – After a robust competitive solicitation process, VA awarded the licensing contract to V3Gate/WellHive. The Request For Quote (RFQ) required a minimum of 25,000 providers; WellHive already had 100,000 network providers at the time of award.
- **December 2023** – IVC placed a pause on all provider outreach and onboarding, preventing WellHive from bringing new providers onto the platform for rollout.
- **January 8, 2024** – Phase 1 of EPS officially launched.
- **March 2024** – IVC lifted the pause on provider outreach, allowing onboarding efforts to resume.
- **May 1, 2024** – Phase 2 of EPS launched.
- **June 10, 2024** – The Governance Board voted to scale back EPS expansion from 18 VISNs to just 5, citing budget constraints. As a result, 13 VISNs were left without access to EPS, with no clear timeline for future implementation. This decision significantly impacted over 400 Community Provider Groups across these sites, who had invested time and resources into enrollment. Their trust in both the VA and the initiative was severely impacted.

Overcoming Obstacles to Success

Successful enterprise-wide digital transformation relies on three pillars: people, process, and technology. When technology is proven and effectively addresses its intended challenges, the focus must shift to leadership to provide strategic direction. Strong leadership ensures alignment, execution, oversight, and accountability, while well-defined processes refine outdated methods, streamline operations, and drive change management, training, and support to maximize the technology's impact.

Since its award in September 2023, the External Provider Scheduling (EPS) program has faced avoidable challenges, including shifting priorities, lack of coordination, and limited resources.

Every time the team gained momentum, unexpected obstacles forced reassessment and adaptation. Without clear leadership and strategic direction, VA employees and front-line staff tried their best to engage in a system they found user-friendly and effective but lacked integration resulting in inefficiencies and unaccountability.

Despite these obstacles, the technology has been rigorously validated and consistently proven to reduce wait times and enhance the experiences of both Veterans and employees. From its initial concept pilot programs in 2021 to the past 18 months of implementation, EPS has undergone continuous refinement and VA-led market research, demonstrating its long-term value. Over time, it has driven significant efficiencies and garnered widespread positive feedback from both end users and Veterans, further reinforcing its impact and effectiveness.

The core issue is not technology but mixed leadership messaging/commitment, process gaps, and the need for more change management and field engagement. Addressing these will eliminate barriers and enable a successful nationwide rollout, ensuring EPS fulfills its potential to enhance operational efficiency and improve the Veteran experience.

Opportunities for Broadscale Success with Immediate Impact:

1. **Need for Critical Support and Resources**
   Essential components of systems integration were either missing or implemented on a limited scale, resulting in widespread confusion and inefficiencies with the launching of the program. Successfully deploying large-scale enterprise technology solutions requires a system integrator to manage project execution, change management, VA system integrations, and communication across all stakeholders. This includes VA employees, contractors, Third Party Administrators, community care providers, and the general public.
2. **Fluctuating Rollout Plans**
   The initial one-year rollout plan was disrupted by frequent changes—sometimes weekly—making provider onboarding unnecessarily protracted and arduous. Many community care providers were hesitant to participate, fearing the program was not legitimate due to a lack of outreach and formal communications from VA. This failure to build trust delayed adoption and undermined the program's effectiveness. Despite these obstacles, the EPS program has achieved notable success, as community providers recognize and support the VA's mission to care for our nation's Veterans. Establishing a consistent and clear enterprise-wide rollout plan will generate the momentum needed to build integrated provider networks that deliver high-quality care to Veterans nationwide.
3. **Leadership and Coordination Failures**
   One of the biggest challenges was the absence of strong leadership, including at the IVC level, resulting in suboptimal collaboration across VA entities. This is not just a program but a movement. We are creating this in collaboration with the community providers, and we are transforming the care for our Veterans by activating MISSION Act 2.0 through technology. The endorsement, support, executive sponsorship, and ownership of this enterprise-wide program at the highest level of the VA and VHA is critical to its success.

4. **Optional Site Adoption**
   Today, the EPS program remains optional, with no mandate for field staff or leadership to use the tool VA has invested in. Meanwhile, community care providers increasingly rely on digital solutions like WellHive, but a significant number of VA schedulers are forced to use outdated methods to book appointments manually instead of leveraging EPS. Data indicates that over 50% of appointments eligible for booking through EPS are still being scheduled using traditional methods across live sites. This inefficiency delays care for Veterans and frustrates providers who expect a modernized process that aligns with industry standards. It is important for VHA to send a directive that requires the use of EPS by the field to gain efficiency, productivity, improved Veteran experience, and timeliness of access to care.
5. **Confusing and Uncoordinated Initiatives**
   Most recently, the TAC's release of the *VA Community Care Provider Directory* Request for Information caused widespread confusion among VA staff, providers, and industry stakeholders. The request pulled directly from EPS capabilities being used today without acknowledging the program itself, demonstrating yet again the lack of coordination and communication within VA. It is paramount that this program, which is the enabling technology for MISSION ACT 2.0, is at the highest level of the VA's organizational structure so that there is clear direction, strong communication, and unequivocal support.

Moving Forward

Despite these roadblocks, the small but dedicated VA team assigned to the program has remained committed to its success. Their unwavering belief in the mission and its impact on Veterans is commendable, and their efforts deserve recognition. However, as stated above, for EPS to reach its full potential, systemic changes in leadership and processes are essential.

We are encouraged by the new Congress, administration, and Secretary Collins' commitment to improving care for veterans and ensuring accountability within the Department of Veterans Affairs. With the right approach, External Provider Scheduling can fulfill its intended purpose and support the Secretary's promise to expand access to care for veterans nationwide.

EPS Performance and Measurable Impact

The EPS platform has already made a significant impact on improving access to care for Veterans. However, its full potential is still constrained by policy limitations rather than technological capabilities. The data below highlights the measurable benefits EPS has provided and the opportunities for even greater impact.

A) Scheduler Efficiency and Increased Appointment Capacity

At one VA Medical Center, for example, 15 schedulers manage mental health appointments, yet only one Medical Support Assistant (MSA) is actively using EPS to book them. If all schedulers fully adopted EPS, it would significantly reduce the mental health appointment backlog.

One of the greatest successes of External Provider Scheduling (EPS) is its ability to streamline the scheduling of both virtual and in-person mental health appointments with a single click. Historically, schedulers must send consults to providers, wait for their review and feedback, and then engage in a lengthy process of phone tag between the Veteran, VA, and the provider, just to secure one appointment.

EPS revolutionizes this process by simplifying complex decision trees into standardized appointment types that VA schedulers can easily navigate. When paired with our provider notes feature, this enables schedulers to book appointments directly, eliminating unnecessary delays and ensuring that Veterans receive timely mental and behavioral health care in the format that best suits their needs. In partnership with Grow Therapy, we have further expanded access to over 15,000 mental health providers, which will significantly increase care availability for Veterans.

B) Impact on Scheduling Efficiency

- Without EPS, a VA scheduler books an average of seven appointments per day.
- With EPS, the volume increases by four times. With additional system integrations like CCRA/HSRM and Consult Tool Box, productivity is expected to increase even more significantly.

C) Reduction in Wait Times

EPS has significantly reduced appointment wait times, ensuring that Veterans receive the care they need when they need it. Behind every appointment scheduled through External Provider Scheduling are Veterans who now have the opportunity to make informed decisions and access the fastest and most appropriate care available to them. Instead of waiting weeks, months, or even years, they can connect with a vetted and trusted community provider in a timely manner. When you or a loved one need medical care, waiting is more than just frustrating, it can be the most painful part of the process and a critical factor in overall health outcomes. Timely access to care can make all the difference in treatment effectiveness and quality of life. It can literally be the difference between life and death.

- Traditional scheduling wait time: 31.7 days
- EPS scheduling wait time: 21.0 days (33% faster)

Site-specific improvements:

- **Columbia, SC:** Reduced from 53.1 days to 25.3 days (27.8 days faster)
- **Dallas, TX:** Reduced from 59.3 days to 32.4 days (26.9 days faster)
- **Orlando, FL:** Reduced from 27.4 days to 17.0 days (10.4 days faster)

Expansion of Provider Access:

- EPS is currently live at 23 VA Medical Centers.
- The provider network now includes over 100,000 network providers.
- 224 additional provider groups are actively onboarding.

- 54 additional major health systems across the country are in the onboarding process.
- 114% increase in provider onboarding, which continues to improve month over month.

Exciting Enhancements to the Program

We recognize that Veterans have different preferences when scheduling their healthcare appointments. Some prefer to book their own appointments directly, while others value the convenience and familiarity of having VA handle scheduling on their behalf.

This year, in collaboration with the VA.gov team, we are making a significant advancement in fulfilling the Cleland-Dole Act by introducing self-scheduling capabilities in select locations. Veterans will continue to use the familiar VA.gov interface, but behind the scenes, WellHive will power the technology that enables seamless appointment scheduling.

This enhancement represents a major step forward in empowering Veterans with greater control over their healthcare by reducing wait times and improving accessibility. We are excited about the recent integration into the Provider Profile Management System, which now seamlessly incorporates over 1.4 million providers within the EPS/WellHive platform. This integration has significantly streamlined the scheduling process, eliminating the need for manual data entry and ensuring schedulers have instant access to comprehensive provider information.

The EPS program provides the VA with an agnostic platform that integrates with all major health systems nationwide, regardless of EHR, geographic location, or TPA affiliation. This enables Veterans to make informed decisions and access care efficiently while allowing the VA to maintain oversight and accountability. By aggregating provider availability in real-time, EPS ensures seamless self-scheduling through VA.gov, enhancing the Veteran experience. Without this unified platform, the VA would face fragmentation from various health systems, EHRs, and TPAs, leading to conflicts and inefficiencies. EPS streamlines provider access, strengthens VA's control, and improves healthcare delivery for Veterans. With these advancements, we remain committed to delivering innovative solutions that prioritize Veterans' needs and enhance their healthcare experience.

What's Next for the Platform?

- Automated health record exchange to ensure referred providers have the necessary patient medical history, enhancing continuity and quality of care.
- Integration with the VA's Community Care Referral and Authorization (CCRA) system, eliminating manual processes and streamlining self-scheduling. This will further expedite appointment bookings allowing more Veterans to be scheduled.
- Enhancing EPS by integrating it with Referral Coordination Teams (RCTs) would enable a direct comparison between VHA and Community Care providers, streamlining the referral authorization process. This integration not only aligns care with Veterans' preferences but also ensures that VA prioritizes its direct care resources whenever clinically appropriate before outsourcing. EPS provides real-time intelligence, allowing RCT teams to see both available and unavailable options in the community. This

apples-to-apples comparison empowers nurses and schedulers to redirect care back into the VA whenever feasible, optimizing resource utilization and ensuring Veterans receive timely, high-quality care.

- Integration with VSignals, the VA's patient feedback platform, to gather real-time Veteran reviews after community care visits. This will provide Referral Coordination Teams and Medical Support Assistants with provider ratings, helping ensure Veterans receive high-quality care, similar to online review platforms like Google or Yelp.
- Displaying appointment availability in all modalities including home health.
- Capability to integrate with VA's internal VistA scheduling system and do an "apples to apples" comparison of appointment availability both inside and outside the VA.

These enhancements will further streamline the scheduling process, improve Veteran satisfaction, and ensure the VA continues to provide high-quality, timely care. We look forward to bringing these capabilities to more Veterans in the near future.

MISSION ACT: Improving Veteran CHOICE and ACCESS

One of the core principles of the MISSION Act and the recently proposed Veterans ACCESS legislation is to ensure that Veterans have a genuine choice between receiving care through VA facilities or trusted private providers. To truly achieve this, the ability to compare availability and scheduling options in real-time is critically important.

In January 2023, WellHive successfully demonstrated an apples-to-apples comparison by integrating over 15 instances of VistA across VISN 7 and VISN 8. This integration allowed VA schedulers to view real-time VA provider availability across multiple facilities, ensuring that VA resources were fully utilized while still offering Veterans access to community care options. Congressional intent, along with the priorities voiced by Veterans Service Organizations (VSOs) and Veterans themselves, is driving the expansion of this capability through new legislative initiatives. These efforts aim to enhance access, improve efficiency, and ensure Veterans receive the care they need in alignment with their preferences.

Key Achievements of the Pilot:

- Displayed real-time VA provider availability across multiple VistA instances, ensuring VA providers' schedules were maximized
- Gained efficiencies in the scheduling process for VA staff by reducing the number of systems they were required to access
- Provided a direct comparison of VA and Community Care provider availability within a given geographical area.
- Gave Veterans true choice by offering full visibility into all available care options.

Despite the pilot's success, VA shut it down. This was due to policy, not technology. The capability still exists and could be reimplemented immediately. Doing so would optimize VA provider utilization while preserving Veterans' ability to choose their preferred care options.

Veteran Service Organization's Support for External Provider Scheduling

The External Provider Scheduling program has received widespread support from key stakeholders who recognize its potential to enhance healthcare access for Veterans. First, the letter and spirit of the MISSION Act, reinforced through bipartisan oversight from this Committee and others, provides the sustained framework we need to ease the burden experienced by Veterans in scheduling appointments. Leading Veterans Service Organizations such as the Veterans of Foreign Wars, Disabled American Veterans, and the American Legion have strongly advocated for its implementation, emphasizing its role in reducing delays and improving care coordination for Veterans. These organizations have been at the forefront of efforts to ensure timely and quality healthcare access.

Additionally, the National Association of State Directors of Veterans Affairs, which represents state-level VA leadership across all 50 states and territories, has expressed strong backing for the program. NASDVA leaders recognize the need for modern scheduling solutions that can streamline provider coordination, reduce wait times, and improve the overall efficiency of community care services for Veterans in their States and Territories. The endorsement of these major service organizations and stakeholders highlights the importance of EPS as a critical step towards enhancing VA's ability to connect Veterans with the best available appointment.

The support from these organizations highlights the growing demand for a seamless, technology-driven approach to Veteran healthcare access, reinforcing the urgency of implementing External Provider Scheduling nationwide.

Testimonials from VA Schedulers on EPS: A Game-Changer for Veterans

VA schedulers who use the External Provider Scheduling (EPS) platform have seen firsthand how it transforms the scheduling process, saves time, and improves access to care for Veterans. Here's what they have to say:

"EPS is a Game-Changer"

"EPS is a Godsend. Before, I spent hours tracking down available appointments. Now, I can see them instantly, and the time saved is making a world of difference for Veterans."

"EPS is Easy to Use and Increases Productivity"

"I was hesitant at first, but after just a few days, I couldn't imagine going back. It's so easy to use, and I can now schedule multiple appointments in a fraction of the time."

"EPS Gets Veterans the Care They Need Faster"

"Veterans used to wait weeks or even months for a community care appointment. Now, I can book them in real-time. Some Veterans get scheduled in just days instead of weeks."

"EPS Helps Veterans Avoid Cancellations and Reschedules"

"Before EPS, I would schedule an appointment only to find out later that the provider wasn't available, forcing me to reschedule. Now, I know exactly when and where the Veteran can be seen, avoiding unnecessary delays."

These voices from the front lines of scheduling highlight how EPS improves efficiency, reduces wait times, and ensures Veterans receive the care they need without frustrating delays. With full implementation, even more schedulers and Veterans could experience these life-changing benefits.

A Call to Action: Ensuring Veterans Receive the Care They Deserve

I ask everyone here today: If you or a loved one were sick and needed care immediately, would you be willing to wait 33 days or more to get someone on the phone just to start scheduling an appointment? We know that early detection and early action can mean the difference between a positive outcome and a life-threatening situation. You have heard that directly from Veterans in previous hearings. That is why the External Provider Scheduling (EPS) program is critical—it is not just improving scheduling, it saves lives.

Key Takeaways and Urgent Recommendations

From a technology perspective, EPS has already demonstrated its impact by providing Veterans with faster, more efficient access to care. However, under the new administration, Secretary Collins' leadership, and the new Congress, the missing people and processes can be seamlessly integrated to ensure Veterans receive timely care. Now, decisive action is needed to make this a reality.

- **Restore the original 18 VISN rollout** plan and expand EPS nationwide.
- **Mandate EPS use** at all live sites to ensure consistency and avoid fragmented adoption.
- **Reimplement real-time VA and Community Care provider comparisons** to give Veterans true well-informed choices in their healthcare options.
- **Ensure CCRA and Consult Tool Box integration is prioritized** to streamline the referral process.
- **Streamline scheduling processes** with well-defined processes, refine outdated methods, streamline operations, and drive change management, training, and support to maximize the technology's impact.
- **Provide dedicated funding** for onboarding and training to support seamless implementation.
- **Secure full VA commitment** to remove policy barriers, assign and align organizational resources to oversee and support EPS implementation, and fully leverage this technology in service to America's Veterans.

The Immediate Need for Expansion

EPS is a proven, scalable solution to one of VA's most pervasive and pressing challenges—healthcare scheduling. The technology to improve both VA and community care scheduling exists and is demonstrably successful. The only obstacle is the failure to act.

No Veteran should have to wait weeks or months for care when the tools to fix this problem are available today. Congress has the opportunity to remove unnecessary barriers and ensure that every Veteran, no matter where they live, has timely access to care when they need it most.

I appreciate the opportunity to speak before you today and look forward to your questions.

Chris Faraji
President
WellHive

STATEMENTS FOR THE RECORD

Prepared Statement of The American Legion

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the subcommittee, on behalf of National Commander James A. LaCoursiere Jr. and more than 1.6 million dues-paying members of The American Legion, we thank you for the opportunity to comment on the Department of Veterans' Affairs' Community Care Program. The American Legion is guided by Legionnaires who dedicate time and resources to serving veterans and their families. As a resolution-based organization, our positions are guided by almost 106 years of advocacy that originate at the grassroots level of our organization. Every time The American Legion testifies, we offer a direct voice from the veteran community to Congress.

The American Legion (TAL) advocated for the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 as a much-needed relief valve when the VA was unable to provide a veteran's healthcare within a reasonable time or distance after the 2014 Phoenix VA waitlist scandal. As TAL stated in a letter with other VSOs at the time, "[it] would consolidate VA's community care programs and develop integrated networks of VA and community providers to supplement, not supplant VA healthcare . . . This carefully crafted compromise represents a balanced approach to ensuring timely access to care while continuing to strengthen the VA healthcare system that millions of veterans choose and rely on." [1]

TAL stands by our view that the MISSION Act is intended to supplement – but not supplant – the VA direct care system. The VA should remain the center of veteran healthcare with a constant focus on improvement—keeping the veteran as their North Star. In December 2024, Veterans Affairs and rehabilitation (VA&R) Division Director Cole Lyle highlighted The American Legion's staunch support of keeping the VHA as the coordinator of care for U.S. veterans. Doing so, however, is becoming harder and harder as the VA continues sending more veterans into the community with contract oversight spread across multiple areas within the VA's Office of Integrated Veteran Care (IVC). With the VA now spending more than 39 percent of its healthcare budget on community provider reimbursements[2] and congressional efforts to codify community care access standards, setting clear guidelines for contract oversight will be a monumental issue as the VA negotiates a new community care contract. However, even with clear guidelines for oversight, the VA will continue sending a larger number of veterans into the community if Congress does not consider and act upon a comprehensive plan for infrastructure reform. Congress' disregard for the Asset & Infrastructure Review (AIR) Commission, housed within the MISSION Act and designed to address VA's long-standing infrastructure issues, is a large part of the reason the VA is facing a growing community care budget[3]. Important changes in policy to improve infrastructure, reduce barriers to accessing care, streamline appointment scheduling, support women veterans, and improve reimbursement requirements are critical to providing veterans with the healthcare they have earned.

The American Legion conducts regular visits to VA facilities each year as part of our System Worth Saving (SWS) program. In these visits, we talk to veterans at VA hospitals, along with staff, to find ways to work with the VA and Congress to improve veteran outcomes. Access standards were identified as an area for improvement. Who qualifies and how can sometimes seem unclear, and veterans report facing unexpected barriers to actually getting referrals. This goes against the spirit of the MISSION Act, which was to provide veterans with closer and timelier access

[1] DAV Communications. "VSO Letter Supporting VA Mission Act of 2018." DAV, May 7, 2018. https://www.dav.org/learn-more/news/2018/vso-letter-supporting-va-mission-act-of–2018/.

[2] "Veterans Community Care Program: VA Needs to Strengthen Contract Oversight." GAO Report, August 2024. https://www.gao.gov/assets/gao–24–106390.pdf

[3] "VA Recommendations to the AIR Commission." VA.gov, March 2022. VA Recommendations to the AIR Commission Home

to care. Congress and the VA should look closely at codifying access standards but also ensuring that veterans aren't going out of VA care just to receive care that is further away, a longer wait, or both, as we heard about anecdotally multiple times on our SWS visits.

For many Veterans—especially those who are women—community care is the only viable option for specialized care. The VA is not set up to provide women veterans with maternity care, obstetric services, or fertility treatment, therefore necessitating the use of a community provider to access gender-specific care. Lapses in coverage, unclear access standards, and lengthy wait times jeopardize the quality of care that our female Legionnaires already struggle to receive.

At the grassroots level, TAL has been interviewing veterans across the country, and access to community care under current laws and regulations continues to be a systemic issue. TAL met with Lillian Moss, a Legionnaire and member of Post 310 in San Diego, CA, who highlighted several stark inadequacies of referrals and VA operations. In addition to being a survivor of combat and military sexual trauma (MST), Lillian was diagnosed with cancer in December 2017. Thanks to her VA care, she underwent a double mastectomy in 2020. Her cancer was removed, but inadequacies with her follow-up reconstructive surgery were left unresolved for years. She described waiting on various calls and confirmations that always seemed to be just around the corner and just out of reach.

Lillian further struggled with financial hardship after her local VA pulled back her community care referral for her psychologist. Devastated at the thought of losing a trusted provider, Lillian was forced to pay out of pocket for her desired mental healthcare. She is now waiting for what she was told would be another quick call to requalify her referral but has been waiting for months with no progress made. This is an unacceptable burden to place on veterans seeking mental healthcare. For veterans engaged in specialty care, a continuum of care is critical to the veterans' well-being. We know how challenging transitions can be for members of the veteran community and abrupt changes can be devastating to those receiving care.

Another veteran who receives care from the Portland, Oregon VA, Martha Nava, has faced repeated denials and delays for necessary medical treatments, including a 3-year wait for back surgery and a mismanaged kidney procedure that led to severe complications. Despite VA policy stating that community care should be approved in the "best interest of the veteran," the patient advocate system has failed to provide her with necessary referrals, leaving her trapped in a cycle of inadequate care, prolonged suffering, and a lack of accountability.

When veterans qualify for community care and elect to go that direction, that decision should be between a veteran and their providers. While current access standards are not codified, they are part of VA policy and need to be followed. The Secretary of the VA has discussed making changes to access standards in the past to keep more care in the VA[4]. While no official changes to access standards have been made, there are reports that the VA has been informally restricting access[5]. We have heard this on our site visits as well, both from veterans and VA employees. Efforts to keep a veteran in VHA care should be made before treatment is needed, not at a time when a veteran is simply trying to get better. Sidelining veterans with bureaucratic roadblocks requiring extra reviews, referrals, and conversations does nothing to accomplish VA's mission or improve on it, nor does it help veterans.

Improving access to specialty services in VHA facilities for these two veterans would require the infrastructure reforms previously highlighted, particularly in urban facilities with large catchment populations. These assessments could also address proper staffing levels to help alleviate the VA's capacity problems. We have continually heard of staff recruitment and retention as an issue on our SWS visits. Adequate staffing in all areas helps improve veteran health outcomes and increase VHA capacity.

Furthermore, transportation remains a significant obstacle when it comes to veterans getting to their appointments for care in the community. The VA has several programs available to help veterans get to and from their VA and non-VA appointments such as the Veterans Transportation Service (VTS), Beneficiary Travel (BT),

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[4] Kime, Patricia. "VA Weighs Limiting Access to Outside Doctors to Curb Rising Costs." Military.com, June 15, 2022. https://www.military.com/daily news/2022/06/15/va-weighs-limiting-access-outside-doctors-curb-rising-costs.html.

[5] "Sen. Moran Speaks on Senate floor Regarding VA Decisions That Are Limiting Veterans' Access to Care." U.S. Senate Committee on Veterans' Affairs, June 21, 2024. https://www.veterans.senate.gov/2024/6/sen-moran-speaks-on-senate-floor-regarding-va-decisions-that-are-limiting-veterans-access-to-care.

Highly Rural Transportation Grants (HRTG)[6], and a new partnership with Uber, Uber Health. However, on our SWS visits, TAL found these programs all suffered from the same issue: a lack of drivers. Even with funding available and programs in place, highly rural catchment areas struggle to find enough employees, a problem that exists in nearly all sectors in some rural communities. TAL urges Congress to understand there is a gap here that cannot be covered by transportation programs in certain areas, and to look at providing more in-house services in such communities.

Infrastructure reform, ensuring adequate transportation, and addressing provider recruitment and retention are all crucial to providing veteran healthcare in an effective and timely manner, and TAL urges Congress to address these issues while holding the VA accountable for delays and denials of veterans who need healthcare in their community.

We must, in every effort to properly address balancing VA direct care with community care, keep the individual veteran as our focus. While VA's sheer size means agency consideration must sometimes be weighed in policy decisions, its parochial interest must come second to those of the end-user.

Chairwoman Miller-Meeks, Ranking Member Brownley, and all the distinguished members of this committee, on behalf of National Commander James A. LaCoursiere Jr. and members of The American Legion, thank you again for the opportunity to amplify the voice of the veteran. It is together with you that we do the great work of making a truly modern VA that provides the top-of-the-line healthcare veterans deserve. We look forward to working together with you to continue this sacred duty.

For additional information regarding this testimony, please contact The American Legion Senior Legislative Associate, Bailey Bishop, at b.bishop@legion.org.

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[6] US Department of Veterans Affairs, Veterans Health Administration. "Veterans Transportation Program." US Department of Veterans Affairs, January 12, 2015. https://www.va.gov/healthbenefits/vtp/.

Document for the Record Submitted by Abe Hamadeh

Most Alarming Aspects of VA Document Review

Prepared by Office of Congressman Abraham J. Hamadeh (AZ-08)

Staff Contact: Cam Erickson, 612-469-7651

Executive Summary: Internal VA guidance directs staff to dissuade veterans from using community care options, with the VA Undersecretary for Health instructing employees to *"press the easy button less with community care"* to drive more veterans to VA facilities. The VA is also attempting to revise drive time and wait time standards without Congressional approval, potentially gutting community care access and contradicting the MISSION Act's goal of expanding veterans' healthcare choices.

1. The VA is attempting to revise drive and wait time standards, including potentially modifying wait time criteria to include telehealth appointments within VHA. This attempt to unilaterally change access standards without Congressional approval directly contradicts the MISSION Act's goal of expanding community care options and improving quality of care
2. There are efforts to enhance initiatives designed to mitigate spending in various areas like Emergency Care, Mental Health, Orthopedics, Cardiology, and Oncology. While cost management is important, these efforts are primarily aimed at reducing community care utilization, ultimately decreasing the veteran's access to care and increasing wait times, rather than focusing on expanding timely access to quality care per the MISSION Act.
3. The VA is considering financial incentives, such as co-pay waivers, to encourage veterans to stay within direct care, limiting choice and prioritizing keeping the veteran trapped within the VA system over ensuring they receive the quality and timely care for their needs they have earned.
4. There are proposals to modify Third Party Administrators (TPA) contracts to require more involvement in directing veterans to the direct care system, which could limit community care options. This arbitrary repatriation of veteranas from community care not only limits choice and access but also jeopardizes quality of care by disrupting continuity of treatment, risking serious impacts on health outcomes.
5. The VA's "Red Team" report concludes that continued rapid growth of the Veterans Community Care Program (VCCP) presents an "existential conundrum" for VA leadership, rather than focusing on how best to serve veterans. The report neglects to mention the real issue: ensuring veterans have the choice to access care that works best for them, whether within VA facilities or through community providers. Any approach that doesn't put veterans' needs at the center is fundamentally flawed.

The most alarming aspect is the VA's consideration of including telehealth appointments in wait time calculations. This change could effectively *eliminate* eligibility for community care.

By counting telehealth options, the VA could claim no access standard violations for distance or wait time, regardless of the veteran's actual ability to receive timely, quality in-person care.

This potential "nuclear option" would allow the VA to severely restrict or even eliminate community care access at will, completely undermining the intent of the MISSION Act.

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