DELIVERING QUALITY AND MODERN HEALTHCARE TO MICHIGAN'S VETERANS AND SERVICEMEMBERS

HEARING

BEFORE THE

SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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DELIVERING QUALITY AND MODERN HEALTHCARE TO MICHIGAN'S VETERANS AND SERVICEMEMBERS

FRIDAY, JUNE 12, 2026

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

The subcommittee met, pursuant to notice, at 10:12 a.m., in Grand Ledge Army Aviation Facility (Hangar), 10700 West Eaton Highway, Grand Ledge, MI, 48837, Hon. Tom Barrett (chairman of the subcommittee) presiding.

Present: Representatives Barrett and Budzinski.

OPENING STATEMENT OF TOM BARRETT, CHAIRMAN

Mr. BARRETT. All right. Good morning, everyone, and thank you for joining us. Thank you, everybody who is here.

This is an exciting opportunity to bring Congress back home to my district here in the Seventh congressional District, in a place that I have a special point of pride in, an area and a community and a unit that I trained in, in the Army, for about half of my career.

Over the 22 years that I served, I spent about half of the time in uniform serving in this facility. It is a beautiful facility where we have some of the most technologically advanced helicopters in the entire world right behind us. It is something that I am certainly proud to represent and proud to show off to many of you today.

I want to give a special thanks to my friend, the ranking member, Nikki Budzinski, up here from her district in Illinois.

I want to thank you and welcome you to Michigan, welcome you to my district, and I look forward to our hearing today. I really enjoyed coming to your district last year.

Ms. BUDZINSKI. Thank you.

Mr. BARRETT. We were talking before this about the similarities of the kind of communities that we represent and a lot of the overlap of the types of people, the types of communities, the small towns and areas that we represent.

It is great to have you here. Thank you.

Without objection, the chair may declare a recess at any point.

I also want to give a special thanks to the Michigan Army National Guard for hosting us here in Grand Ledge at the Army Aviation Support Facility and the staff from Michigan's Department of

Military and Veterans Affairs that helped make this hearing possible.

I want to thank General Rogers, our Adjutant General, for his willingness to open this facility for us today.

Of course I have the privilege of representing this community, and it is especially meaningful to return to the facility where I personally trained and served with so many others that are here still serving today.

I brought the House Committee on Veterans' Affairs' Subcommittee on Technology Modernization here because oversight does not stop in Washington, DC. We represent communities all across America. I think a lot about how it is my job to be our district's Representative in Washington, not Washington's Representative back home here in Michigan.

Bringing this committee here today allows both the ranking member and I, and folks from Washington, to hear about what is happening in communities like ours.

It is important for Congress to hear from veterans, providers, and leaders in the community where they live, where they receive care, and where the rubber meets the road with Department of Veterans Affairs (VA) systems that are felt every day by real patients.

The mission of this subcommittee is to make sure that VA is leveraging the right technology to deliver the best healthcare and benefits to veterans, not only in Michigan, but across the country. This means finally transitioning the VA into the 21st century.

The modern healthcare landscape demands agility. We can no longer remain anchored to the expensive, inefficient, hospital-centric care models of the past.

Technology alone will not make new healthcare providers appear. VA must continue to strengthen its community care program to ensure that the doctors and providers living in our communities can continue to meet veterans where they live and work. Every decision VA makes should focus on putting veterans first, not bureaucracy.

As many of you know, veterans here in the Greater Lansing area are about an hour away from both the Battle Creek and Ann Arbor VA Medical Centers and further than that from Saginaw.

That means that in this community here in Grand Ledge, you would have to travel more than an hour to go to a large VA Medical Center.

We have a community outpatient clinic in Lansing that does great work, but if you need to go to one of the hospitals, you are more than an hour away from any of them.

That is not unique to this community. If you live in northern Michigan, you are two or even more hours away from a VA hospital in many instances.

For some veterans, this distance makes getting care a burden, especially for the long wait times that can come from a VA hospital in certain instances.

This topic is personal to me. When veterans are referred to community care, the scheduling process should be simple, fast, and focused on their healthcare, but for too long that has not been the case.

What happens now is a scheduler ends up calling the veteran to book an appointment, gets some of their availability—a process that can stretch quite a long time—and then they call a whole bunch of providers in their catalog of community care partners that they work with. That ends up delaying care for men and women who have earned it.

I have experienced this myself. I was referred for a very routine audiology appointment last year. I got called by a scheduler. They asked me what my availability was. I told them, over the following few weeks, here is when I am available, here is when I am not.

I did not disclose to the scheduler that I was a Member of Congress and would be traveling to Washington, DC, three or 4 days a week, but I did tell her I was not going to be in Michigan.

Then a couple days went by and I got a text alerting me to my scheduled appointment in the middle of the week when I was going to be in Washington, DC. I called back, and they told me that because they could not accommodate my scheduling request, they just booked me for the next available appointment.

I said, well, the next available appointment I am going to be 600 miles away. That does not really help any of us. Then that takes more time out of their schedule for me to call and reschedule it, for them to go back out and look for the appointment, and to finally make something that is very routine finally happen.

I am pleased to see the VA finally taking steps to address these issues and update the technology and systems our veterans rely on. VA has been piloting the technology known as the External Provider Scheduling system, or EPS for short.

This scheduling system eliminates a large portion of the time and labor-intensive aspects of community care scheduling by giving VA schedulers direct access to community providers' appointment availability. They can see in real time the audiology clinic down the street, what their availability is, and how they can sync a veteran's availability for an appointment that can be done very easily.

Prior to this pilot, VA staff had to pick up the phone again and again, often calling the veteran and the provider multiple times to schedule a simple appointment, getting in between that relationship.

The telephone is an invention of the 19th century. The EPS program is an invention of the 21st century, and it is exactly the type of modern tool that VA should be using to advance access to care in mid-Michigan and nationwide.

When servicemembers sign up, and when our sons and daughters go to war, they make a commitment to this country with the expectation that we will uphold our promise to them through high-quality VA healthcare access when they return home.

When they walk through the doors at a VA hospital or call to receive care in their community, that promise should not fall through.

The VA piloting of EPS is one of the many ways VA has begun to fix the problem and uphold that commitment.

Through EPS, providers agree to share their scheduling grids with the VA and allow VA schedulers to search and sort appointments by distance, drive time, and availability in a matter of minutes.

With available community care appointments on one screen, a VA scheduler can book the appointment directly with a provider with just one call to a veteran. This allows them to spend less time scheduling each appointment. It means schedulers can be more efficient, and veterans, like the ones in this room, can get their appointments faster.

EPS is now active nationwide in all VA Medical Centers, and I want to thank Secretary Collins for his work on delivering for our Nation's veterans in this way.

There are roughly 24,000 community care providers currently active in EPS, and that number will need to keep growing if that number is going to reach its full potential.

While provider participation is critical, VA must also ensure that the technology is being utilized across the Nation.

Despite EPS' strong results, the prior administration repeatedly put roadblocks in front of the program, directly impacting veterans here in Michigan.

In 2024, the Biden administration paused enrollment of community care providers, shut down active EPS sites, and halted nationwide expansion plans, all while citing budget shortfalls that never materialized.

The damage went beyond veterans. VA also undermined trust with the community care providers we are trying to recruit to participate in this program who now are going to think twice before partnering with the VA again.

When I first heard about this, I knew we needed to take action to get the program back on track for good. That is why I, along with my fellow Midwesterner, Ranking Member Budzinski, introduced the bipartisan H.R. 3482, the Veterans Community Care Scheduling Improvement Act.

This legislation will codify and expand VA's EPS program by authorizing a nationwide electronic scheduling process that allows VA staff to efficiently schedule appointments for veterans right away.

This legislation would ensure that no matter who is in the White House, veterans are still able to access the quick appointments they have earned.

My commonsense bill passed the House last month unanimously, and I am excited to see it included in the Take Care of America's Veterans Act.

This package includes more than 60 other bipartisan bills to modernize, enhance, and reform the delivery of healthcare and benefits for veterans, and I look forward to President Trump signing this bill into law.

This great effort will ensure EPS is not just a pilot or a 4-year program only available in certain communities, but rather a permanent capability for the betterment of veterans.

VA has a real opportunity to improve veterans' lives with this technology, and I am proud to lead the charge on it.

At today's hearing, I expect VA to outline the progress made thus far, how integrated scheduling will be fully optimized, and its plans to integrate with the new electronic health records system that we just rolled out here in Michigan and ensure that veterans receive appointments when they need them most.

Before I turn it over to Ranking Member Budzinski, I want to remind everyone here today that this is a congressional oversight hearing, not an open forum. Only Members of Congress and invited witnesses will be recognized to speak.

If anyone has specific issues or concerns with the VA, I encourage you to reach out to my district office, and we would be happy to assist you with that directly.

Thank you.

With that, I yield to Ranking Member Budzinski for her opening statement.

OPENING STATEMENT OF NIKKI BUDZINSKI, RANKING MEMBER

Ms. BUDZINSKI. Thank you very much, Chairman Barrett, and thank you again for welcoming me here to Grand Ledge and to your district, the Seventh District of Michigan.

I appreciated you coming to my district. Gosh, I think it is been a little over a year now maybe. Very excited to be here today and could not agree with you more that being here reminds me of home, very similar districts and feels from the Midwest.

I suspect that the issues also that face our veterans in both of our districts are very similar too. For me, the closest VA facilities are outside of my district, and many veterans drive long distances to the closest one to receive care. It is a real struggle, in particular, for our rural veterans.

It is for this reason that I believe that community care is an important part of VA healthcare, especially in rural America.

However, getting a community care appointment from VA continues to be a major pain point. Veterans wait for a scheduler to call them. Then they wait while the scheduler calls around to different providers looking for an available slot.

The whole process takes far too many phone calls and, quite frankly, far too much time. It delays veterans' care, and it needs to be fixed.

The External Provider Scheduling program, or EPS, is a promising new tool in that effort. The technology allows VA schedulers to book appointments directly into community care providers' scheduling grids, eliminating or at least reducing cumbersome phone-based processes.

It is a great idea and a good tool. I absolutely support this effort. In fact, as Chairman Barrett mentioned, he and I wrote a bill to support and improve the EPS program.

That being said, we must be clear-eyed about the reality of VA's efforts with EPS. While they may have successfully deployed the technology, the network of community care providers sharing their scheduling grids continues to be insufficient in the number and diversity of specialties to make it a meaningful tool.

There are well over 1 million community providers, and VA has only signed up about 25,000. That is barely 2 percent.

Additionally, we recently learned that of the providers that have signed up, they have a greater than 30 percent turnover rate, meaning they are losing providers almost as fast as they are signing them up.

VA prioritized the deployment over recruiting efforts, and now I suspect there are many facilities with a shiny new tool that is effectively useless. I wonder what it is costing the taxpayers to maintain a system that is under-resourced and under-utilized.

Without a critical mass of providers in different specialties, VA schedulers will only be able to use EPS for just some appointments, if they are lucky. For the rest of the appointments, the schedulers will continue to rely on multiple phone calls between the veteran and different providers to find an available appointment, book it, and then call to confirm. This is inefficient and leads to veterans waiting weeks just to schedule an appointment.

In 2026, the technology exists. VA bought the technology. I want to understand why it is not being used to the full effect and how VA intends to get it on track.

Additionally, VA recently began to pilot a capability in EPS that will allow schedulers to see VA's own appointments as well as community care appointments.

This capability that was already available during the earlier EPS pilots but then was shut off was shut down inexplicably.

This integrated scheduling tool could ensure veterans have the opportunity to make informed decisions about when and where they receive care.

We keep hearing that when we give the choice, veterans will choose VA. With integrated scheduling, we are giving them that opportunity.

I want to hear more about this pilot, including how they will determine the requirements for the new tool, what measures of success they have established, and how they are defining success.

Veterans deserve to have the ability to see VA's access alongside community care. I want them to have the capability, but we have to ensure that the tools are properly developed and also deployed.

As I said in the beginning, community care is an important part of VA healthcare, especially for our rural veterans, but I feel like we need to acknowledge that rural healthcare is struggling. Almost 200 rural hospitals have closed in the last 20 years, and hundreds more are at risk right now.

We must ensure access to quality healthcare for everyone, but especially for veterans that we committed to care for.

As we look to make it easier for veterans to get care in the community, we need to also ensure the longevity of the VA.

Both VA and community care need to be fully funded so one does not happen at the expense of the other and that VA will continue to be there to care for our Nation's veterans. It was a part of the contract, and it is a part of the cost of war.

Thank you, Mr. Chairman. I will yield back.

Mr. BARRETT. Thank you, Ranking Member Budzinski.

I also just want to briefly point out that my mom and dad are here, Pat and Mary Anne Barrett, along with three of my four kids.

Appreciate you guys.

I guess they did not actually believe I was in Congress, so they had to come see it for themselves.

Thank you.

I will now introduce our witnesses.

From the Department of Veterans Affairs, we have Mr. Andrew Gradison, senior advisor to the Under Secretary for Health at the Veterans Health Administration (VHA).

Thank you.

Accompanying Mr. Gradison is Dr. Mark Hausman, chief medical officer for Veterans Integrated Service Network 10, VISN 10, and Mr. Zachary Schwartz, principal deputy assistant secretary for the Office of Information and Technology.

Finally, from the Government Accountability Office (GAO), we have Ms. Carol Harris, the director of Information Technology (IT) and cybersecurity at GAO.

Welcome to my district, and thank you all for making the time to be here with us.

At this time I will ask the witnesses to please stand and raise your right hand.

[Witnesses sworn.]

Mr. BARRETT. Thank you.

Let the record reflect that all witnesses have answered in the affirmative.

Mr. Gradison, you are now recognized for 5 minutes to deliver your opening statement on behalf of VA.

STATEMENT OF ANDREW GRADISON

Mr. GRADISON. Chairman Barrett, Ranking Member Budzinski, thank you for the opportunity to testify on VA's efforts to modernize scheduling and improve community care access.

Joining me today are Dr. Mark Hausman, chief medical officer of VISN 10, and Mr. Zachary Schwartz, principal deputy assistant secretary in our Office of Information and Technology.

We will update the subcommittee on the External Provider Scheduling, or EPS, program and our integrated scheduling pilots underway in Charleston, South Carolina, and Atlanta, Georgia.

Veterans, Veteran Service Organizations, and members of this committee have consistently emphasized that scheduling challenges have been one of the most significant pain points for veterans seeking care.

Secretary Doug Collins listened to VA's customers, and under his leadership VA is making it easier and more convenient than ever for those who have worn the uniform to choose the care for which they are eligible that best fits their lifestyle.

EPS is a technology platform that improves the process of scheduling veterans with community care providers by supplying information and allowing VA staff to schedule veterans directly into available community care provider appointment slots through a single user interface.

As you are aware, under the Biden administration veterans faced unnecessary delays in accessing community care due to the decision to pause the implementation plan on EPS. This slowdown limited veterans' ability to quickly and easily schedule appointments with community providers.

The EPS program is now directly advancing VA's modernization goals by delivering a more consistent, transparent, and intuitive scheduling experience.

The modernized EPS program now delivers the following benefits to veterans and their caregivers.

Improved productivity that enables VA to schedule more than three times as many community care appointments per day compared to what we were doing before.

Clear, timely choices that allow appointments to be booked in minutes, not days or weeks.

Real-time visibility into eligible community care provider appointment availability.

Increased efficiency that will eliminate many calls, faxes, and emails.

Taken together, these improvements ensure greater consistency of services across VA Medical Centers nationwide.

Since we last testified before this subcommittee in May 2025, VA has moved from incremental deployment to nationwide availability of the EPS program platform.

Since late 2025, the EPS program has been rolled out across every VA Medical Center. As of May 2026, there were over 29,000 community providers and more than 41,000 provider services available under EPS. More than 150,000 appointments have been booked through the platform.

In January 2026, VA commenced two integrated scheduling pilots in Charleston, South Carolina, and Atlanta, Georgia. This effort allows viewing both direct care and community care appointments on the same platform. Within 3 months of the commencement of these integrated scheduling pilots, VA scheduled over a thousand appointments.

Both sides are also testing new veteran self-scheduling capabilities through EPS that would allow eligible veterans to book their own appointments with VA providers or certain community care providers online through VA.gov or using our mobile app, without calling VA or a provider's office.

While the EPS program has reached national availability, we recognize its long-term success and value to veterans depend heavily on community provider participation.

Not all community providers are familiar with our technology. To increase awareness, VA meets with community care providers and explains the benefits in their clinical operations and VA's ability to support the coordination of care efforts.

VA leverages data to identify and engage community care providers who specialize in a category of care with a high annual referral volume in geographic areas with limited EPS program coverage.

When VA engages with community clinicians and provider organizations to explain the program's benefits, we highlight that there are no fees, no change to their health records or scheduling platforms, and our community providers retain full control over the appointment grids with secure schedule sharing.

Nebraska's statewide rural transformation initiative is a leading model, having expanded EPS program connectivity across dozens of rural hospitals and clinics.

VA is similarly working with third-party administrators and providers who have entered into a Veterans Care Agreement to sim-

plify participation and ensure broad understanding across the community care network.

In conclusion, I am pleased to inform this committee that under Secretary Collins' leadership, the EPS program is a nationally deployed scheduling capability that is reshaping how veterans access their care.

VA is moving closer to our goal of having a single scheduling solution that allows veterans to book appointments that are best for them, whether at VA or in the community, through modern and convenient methods that meet their expectations.

VA remains fully committed to ensuring that EPS supports timely high-quality care and enhances veteran expectations across the entire scheduling journey.

Thank you, and I look forward to your questions.

[THE PREPARED STATEMENT OF ANDREW GRADISON APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you, Mr. Gradison.

The written statement of Mr. Gradison will be entered into the hearing record.

Ms. Harris, you are now recognized for 5 minutes to deliver your opening statement on behalf of GAO.

STATEMENT OF CAROL HARRIS

Ms. HARRIS. Chairman Barrett and Ranking Member Budzinski, I want to thank you for inviting us to testify today on VA's efforts to ensure that veterans have timely access to healthcare through its scheduling system.

As requested, I will briefly summarize our prior work on VA's scheduling environment and the related challenges for VA providers, schedulers, and veterans.

In Fiscal Year 2023, VHA provided roughly 71 million appointments to veterans. VHA also provided roughly 47 million appointments with non-VHA providers through the Veterans Community Care Program during that same time period.

In doing so, the Department uses a patchwork of systems that have been developed in ways that make scheduling with both VHA and non-VHA providers difficult for veterans and staff.

Additionally, VA has experienced IT challenges related to the outdated, inefficient nature of systems in its efforts to modernize its health information system.

VA has dozens of systems and tools that support scheduling appointments, managing referrals, and monitoring wait times.

Veterans Health Information Systems and Technology Architecture (VistA) facilities primarily use VistA scheduling, but it may also access at least nine additional systems in the process of scheduling appointments with VA providers.

VA operates another five systems used by staff for managing referrals and another eight systems to engage with veterans about medical appointments.

That brings the tally to 22 systems.

Oracle Health facilities have another set of scheduling systems, 14 in total, and they use some of the same systems that VistA facilities use as well to schedule those appointments and manage referrals.

Adding to that tally, that is a total of 36 systems right there.

Additionally, VA employs tools for monitoring scheduling timeliness, providing estimates of wait times on its public website, and determining a veteran's eligibility, based on wait time, for community care.

Given this environment, schedulers and veterans are experiencing challenges when making appointments. Facility staff must open multiple applications to schedule a single appointment, and, as you said, then they have to get on the phone and make those phone calls.

They must also run reports in different systems to identify veterans' self-scheduled and self-canceled appointments and appointment requests.

Navigating this complexity makes schedulers inefficient or requires work-arounds that may vary across sites, and VA has told us they are working to standardize veteran appointment scheduling at VistA and Oracle Health sites, but they have not yet determined how the modernized and updated products used for scheduling will interface and be pulled and combined with the data into a comprehensive report.

Consequently, the result is a labor and resource-intensive process for VA staff that has continued to evolve over time.

Our work has shown that less than 40 percent of facilities scheduled more than half of their community care appointments within VHA's 7-day standard. Further, fewer than 10 percent of facilities scheduled more than 75 percent of appointments within the standard.

In 2020, we recommended that leadership assess community care staffing and resource needs and develop a plan to address any identified risks to their ability to schedule timely appointments.

VA concurred, but the Department has yet to fully implement it 6 years later.

Veterans have also experienced challenges requesting an appointment online, getting confirmation once an appointment is scheduled, and receiving duplicative appointment reminders.

VA is working toward have one enterprise-wide solution to address these issues, among other things.

VA's Office of Information Technology (OIT) and VHA have also been collaborating to address its scheduling system challenges. They initiated a project to modernize these systems at VistA facilities which include several concurrent efforts.

For example, one is intended to allow provider-based scheduling, which is the ability to see a provider's schedule across multiple modalities, so that is like in-person and telehealth in a single application.

VA is also deploying EPS for VA schedulers to schedule veteran appointments directly online with community care providers, and deployments have been in progress since 2024.

In May of last year, we reported that while OIT and VHA had employed some key planning practices for the overall modernization effort, there were still gaps, such as accounting for the full scope of IT work in the project schedule and fully developing a requirements management plan.

To this end, we made two recommendations to address these gaps, and moving forward it will be critical for VA to fully and effectively implement the open recommendations we have related to scheduling, which is six in total, and doing so will enable VA to provide more quality, timely care for our veterans.

That concludes my statement. I look forward to your questions.

[THE PREPARED STATEMENT OF CAROL HARRIS APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you, Ms. Harris.

The written statement of Ms. Harris will be entered into the record.

Thank you to all of our witnesses.

We are going to proceed with questioning. I now recognize myself for 5 minutes for questions.

Ms. Harris, I know you mentioned 36, I think you said, different systems that all touch on scheduling, whether that is internal to VA or outside in the community.

Ms. HARRIS. That is correct.

Mr. BARRETT. You also mentioned the breakdown of the total number of appointments for veterans. I think that ratio is roughly 40 percent is done out in the community currently.

Ms. HARRIS. Yes, that is correct.

Mr. BARRETT. Is that relatively accurate?

Ms. HARRIS. Yes.

Mr. BARRETT. I know we have seen a rise in that since the allowances for veterans to be able to do that more easily. Many of them take advantage of that, and I think that speaks to their interest in going, in all likelihood, closer to home for a lot of the more routine appointments that they may have or something that may not be a veteran-specific type of condition that would necessitate their specialized care at the VA, for example.

With the new introduction of the intentionally more rapid deployment of the Electronic Health Record Modernization (EHRM), will that cut down on these 36 systems, or are we just going to multiple that by layering more systems on top of old ones in the meantime.

Ms. HARRIS. I mean, I think I cannot fully answer that question because VA has yet to provide a comprehensive view of what that final scheduling process should be. Again, I think it is like a Lewis Carroll saying, like, if you do not know where you are going, any road will take you there.

VA has not yet defined what that final destination looks like. Again you have a lack of a fully defined business process for what that standardized scheduling workflow looks like, and then what are the underpinning IT solutions that are supposed to support that.

EPS could be one of those systems, but it is not the silver bullet. The sites that we have talked to have said there is promise there, but, again, you need to have more community care participation to make it more effective.

Mr. BARRETT. Right.

Ms. HARRIS. We have not seen how that is going to be integrated with the Oracle Health revenue cycle scheduling suite of applications there, those 14 that I mentioned.

Until we see that comprehensive strategic plan of what that final "to be" state looks like, it is not possible for me to answer your question.

Mr. BARRETT. Yes, I do not want to speak on behalf of the ranking member, but I think we share an interest in the end goal of having veterans being able to pick up the phone or go online, communicate through the VA, and then be given the full portfolio of options available to them, whether that is inside the VA or outside of the VA.

Could say you can get a VA provider here that is further from home, next week, or maybe, if you want a community care provider, it will be in 10 days or 2 weeks, but it will be closer to home for you and might fit your schedule more adequately, or something like that.

That is the end state that we are trying to get to. I know that we have simultaneously EPS coming in while we are doing healthcare modernization. I think the focus of VA has been, in some ways, necessitated by the urgency of the electronic health record rollout to put a lot of emphasis around that.

We have got to be able to walk and chew gum at the same time, and certainly having 36 systems does not make that very ideal.

Mr. Gradison, or from VA, any of those with you on your side, can you speak to what we are doing to bring about more participation by community care partners.

One of the biggest challenges I see is we can build the best system possible, but if we do not have participation, it is not going to benefit anyone. It is not going to benefit the providers and it is not going to benefit the veterans.

We have got thousands of community care providers in this area, but very, very, very few of them are actually signed up through the EPS system in the network of VA facilities in this area.

Mr. GRADISON. Thank you for the question, Mr. Chairman. We agree, the long-term success of EPS is contingent on being able to bring more community care providers into EPS.

How are we going about that? We are going about it at all levels—from our Under Secretary of Health engaging large community care providers at the executive level and being able to bring that business case, and also clearing up misconceptions that some of our providers have, whether there are costs associated with it, whether they retain full control over their scheduling grids, or have to make system upgrades themselves.

Once we clear up those misconceptions, that there is no cost, no electronic health record updates need to be made, and they retain full control, we have seen broader adoption.

We are also leveraging the relationships that our medical center directors have with their communities, and at all levels we are having this engagement to bring more providers on board.

Mr. BARRETT. Great. Thank you.

Ranking Member Budzinski, you are recognized for 5 minutes.

Ms. BUDZINSKI. Yes, thank you. Actually, I will probably pick up where you have left off. I think that is exactly kind of my concern as well, which is this is a great tool, but if we do not have enough—we are estimating, I think it is about 2 percent community providers that are participating—it is just not enough adop-

tion, and we want to see more adoption. I appreciate what you have said about prioritizing that.

I just, I am curious, if I could drill down a little bit more. How do you think the VA is defining what a sufficient network would be of community providers for any one given facility?

Mr. GRADISON. Thank you for the question.

Ultimately, we want to make sure that our veterans are able to select the care that is right for them.

I can get back to you with a specific number or percentage of community care providers that would be sufficient, but it will be reflected in a veteran being able to select the care that is right for them.

We have seen enormous growth in the number of community care providers that are participating in our pilots that are underway in Charleston and Atlanta, where we have really spent a dedicated effort to grow our network of community care providers deliberately.

Those percentages continue to grow, and it is reflected in the number of appointments that we have successfully booked.

Over the last 3 months over those pilots, we have booked more than a thousand appointments, which is more than nationally were booked in January 2025, before this administration took office.

We are seeing enormous growth. Ultimately, we want to get as many providers as possible signed up.

Ms. BUDZINSKI. Could you give a little bit more specificity on what that growth looks like? I think you mentioned North Carolina. North Carolina was the State that you focused in on.

Given that State, because that is been a priority, like, what is the percentage of participation in that State, now that you have been there, that will have community provider participation?

Mr. GRADISON. Today in our pilot sites in Charleston, South Carolina——

Ms. BUDZINSKI. South Carolina, sorry.

Mr. GRADISON [continuing]. and Atlanta, Georgia, we are approaching 7 percent of our community care providers that are currently participating, and that number continues to grow.

When this administration took office, there were fewer than—there were about 3,000 providers nationally that were signed on to EPS, and we are over 34,000. We have seen a 10x increase in the number of providers that are currently enrolled in EPS, but we want to continue to accelerate that growth.

Ms. BUDZINSKI. Just because we are in Michigan and then I represent Illinois, do you know any of the statistics on the percentage of adoption of community care providers in our States?

Mr. GRADISON. I do. There is a lot of room for growth here. Dr. Hausman can help with some of the specific numbers here in Michigan.

This is an area where we want to be able to bring the benefits that our veterans are experiencing at our pilot sites in Atlanta and Charleston, we want to be able to bring those benefits here to veterans in Michigan. We want to bring them to your veterans in Illinois.

Dr. HAUSMAN. Yes, in Michigan participation is low at the moment, but I do want to comment on that.

Michigan is one of the States that when the program was kind of paused and reset and rescaled, Michigan was kind of put on pause for a period of time there.

What is important is there was actually some groundwork that was laid here in the State of Michigan, up to that point, and conversations have taken place since then that I think will allow us to get some key providers ready and preparing to participate sooner than later.

Specifically, we have been engaging with Trinity Health and the University of Michigan, as well as Henry Ford and Ohio Health. Right there, four larger health systems that would make a huge impact in terms of volume of care that they provide and, of course, improving the efficiency and the experience for veterans.

Last thing I would note is, we do enjoy a very productive relationship with the Michigan Health & Hospital Association, and they are an active partner with us in engaging some service intermediary or can help us with making introductions and highlighting the benefits of this program.

That is a really important relationship that we have that we are going to leverage moving forward.

Ms. BUDZINSKI. When you say it is very low, just to put a finer point, like, where are we numbers-wise?

Dr. HAUSMAN. For the four facilities in the Lower Peninsula of Michigan, we have between 500 and 800 providers, EPS providers, enrolled.

Now, the majority of them are telehealth, mental health providers that are part of a national practice. When you look at providers that are actually kind of able to see veterans in person in our region, it is going to be much smaller.

Ms. BUDZINSKI. Okay. I will yield back to you. I just ran out of time.

Mr. BARRETT. Sure. We will do another—we will do a second round.

Dr. Hausman, then, what about—I know you mentioned some of the larger possible networks that you have made inroads with, but what about the small community providers, physical therapy, for example, that might be an independent practice close to home?

Something like that, you have to do twice a week on your way to work. It makes a lot of sense to do that close to home.

What work have we done to do outreach to those smaller providers that may not have the robust technology of a major hospital system?

Dr. HAUSMAN. Yes, I would say that is where we have made the most concrete gains so far. For example, we have in Ann Arbor podiatry, in Battle Creek, in Detroit, dermatology, audiology, optometry and dermatology in Saginaw, plus mental health.

As we kind of look at strategically how to grow this program, the large health systems we know take some more time. They have their own processes and bureaucracy. A lot of the key to that is kind of the relationships that can kind of help open the doors and get the conversation started.

We find that with the smaller clinics—the podiatry clinics, the chiropractic, acupuncture, et cetera, optometry—it can be a much faster and direct process. We particularly engage those that are

doing a good volume of veteran care already and that are, of course, doing a good job taking care of veterans.

Mr. BARRETT. Okay. Then what about our smaller independent hospitals, for example—we are going to hear from some on the next panel—that are not part of a big conglomerate hospital network that goes from coast to coast in Michigan? I have a couple of those in my own district. What are we doing to not overlook the services they can provide?

Dr. HAUSMAN. Yes, I mean, that is a real opportunity as well.

As we approach this challenge of enrolling providers, we do take a look at data. Typically we look at providers, number one, that are doing a good amount of veteran care and that we know do a good job of taking care of veterans.

You have to start somewhere, and that is where we tend to start.

Mr. BARRETT. Not to cut you off, but if they are not currently being looked at for community care, how do we know that they are serving veterans?

I mean, a proportion of the population is veterans that they would naturally serve already. I guess, how is that a threshold if they are not in the system?

We know they are providing quality care because they are licensed, they are doing it.

Dr. HAUSMAN. Right.

Mr. BARRETT. We can look up their records in compliance, their customer reviews, all of those things. How do we know how many veterans they are serving already?

Dr. HAUSMAN. Great question.

For VA-paid care, we know exactly how many referrals we send to exactly which providers in the community.

Mr. BARRETT. Right.

Dr. HAUSMAN. That is something we track actively. As we engage with the enterprise EPS team, that is kind of how the conversation is started. Who are the providers that you rely on most? Which providers do a good job, we know they provide good quality? That is where we start to build out the strategy for engagement.

Mr. BARRETT. Okay. If a hospital was not currently being referred patients from the VA, it would be much harder for them to initiate that community care relationship.

Dr. HAUSMAN. Yes. I would say if they are not doing VA care, they are probably not going to be toward the top of our list. That said, if there is an interest, especially in an area that is not well served, we would be very, very happy to engage early.

Mr. BARRETT. Okay. Thank you.

Mr. Schwartz, what do you see as—I know you are on the tech side of this. I know that in general—this is a broad statement—but a lot of physicians have complained to me, not in the VA system, just out in general, their frustration with health record referrals, with different health record systems, with having to manage all of that when they should be spending their time on patient care.

If this is viewed as one additional tech thing they have to figure out, there might be a resistance to that.

How are we able to break down that barrier for those that might be a little more old school in their practice, for example?

Mr. SCHWARTZ. Their way of thinking. I appreciate the question.

What our complete focus is, is ease of use. We have to develop the technology that brings the grids in from our external providers to make it as easy as possible.

What our team has developed is a way to grab only the information that we need, because I also hear complaints or concerns about privacy and security as well and taking other patient information that are not veterans.

We want to make it as easy as possible. We allow the providers to put the information that they need, and only the information that they need, in a very easy place for us to use technology to grab that, as opposed to building connections or building out new systems.

We work with what they have, so that there is not any new setup they have to do or any new setup or configurations they need to buy, because that is another concern we have.

Mr. BARRETT. Great. Thank you.

Ranking Member Budzinski, you are recognized for 5 minutes.

Ms. BUDZINSKI. Thank you, Chairman.

Could I ask Ms. Harris just to further elaborate on your testimony? We know the number—the history of GAO's—you have had a number of audits of the VHA scheduling process.

Could you just flag concerns that you have in the way EPS has been deployed over these several years and currently, and then maybe what you would recommend or what observations you would be looking for to see, hey, we are making real progress here?

Ms. HARRIS. Sure.

Ms. BUDZINSKI. Yes.

Ms. HARRIS. What we do know is that I think VA has a very good handle on the reasons for why, but their medical centers cannot efficiently and effectively schedule these appointments for community care.

They have been systematically identifying these reasons over years at this point, but it all points to, this is a very labor and resource-intensive process.

I want to make sure we do not have blinders here because EPS is focused on the actual process of scheduling the appointments, but there is also managing the referrals and monitoring the wait times too.

That is how we need to holistically be looking at scheduling appointments. That is also one of the reasons why providers are reluctant to join EPS, because there is also, okay, once they have the referral, they are required to submit medical documentation after the initial visit and the final visit. Getting that documentation back to the VA medical facility is a very difficult process.

That is sort of the bigger picture here.

Anecdotally what we have heard is, while EPS does—yes, it shows promise, but getting community care providers to sign up has been difficult. At this time, the onus has been on the facilities. They have received very little help from VHA, at least the sites that we have talked to, in getting that support to get the community care providers to sign up.

There is also issues with, okay, once a community care provider has been signed up, the coding of their specialties is also in many cases inaccurate.

It still requires a phone call by the scheduler to ensure, okay, a particular aspect of cardiology is, in fact, accurately—is accurate on the website—or within EPS, as an example.

Then also getting, as Andrew had said, specialty care, like pulmonology, cardiology, oncology, getting these specialties and the providers that support those specialties into EPS has also been a challenge as well.

I just want to make sure that we focus not just on the act of scheduling appointments, but it is a holistic process, and that is part of the reason why providers are reluctant to participate.

Ms. BUDZINSKI. Could I just ask, Mr. Gradison, like, in those conversations with the providers, helping to demystify the process for them and getting them on board, just responding to what Ms. Harris has kind of outlined, how have you been kind of working with these community providers to get some of these specialists more on board? Could you share some more specificity around that recruitment process and how it is improved?

Mr. GRADISON. Absolutely. Thank you for the question.

This is an area where we have been fortunate to be able to partner with GAO to better understand the nature of this issue and to engage our community providers.

Part of this—and I am pleased to report, we now have 75 total active specialties that we are able to offer through EPS, but we want to continue to grow that footprint, because ultimately our measure of success will be our veterans being able to access the exact service that they need in the way that is most convenient to them.

When it comes to making sure that we are able to offer our suite of services, it is no different than engaging anyone else and being able to dispel any misconceptions here.

We want to make EPS as robust as possible, a unified platform where a veteran can compare direct care appointments and community care appointments. We think that ultimately they will continue to select our care more often than not because we will put up our wait times against anyone in the community.

Ms. BUDZINSKI. I was just going to ask you one question, though, just to interrupt a little bit, on the community care piece and to drill down on the scheduling.

When you are recruiting them, are they—or once a community provider is in the system—do they, when we are talking about scheduling, have that opportunity to approve or accept the appointment, or what is—do they retroactively get to do that?

Mr. GRADISON. Well, I would engage my partner from the Office of Information and Technology when it comes to approval or disapproval.

Ms. BUDZINSKI. Right.

Mr. GRADISON. When a community care provider makes an appointment available, it is our expectation that we will be able to fill that slot.

Ms. BUDZINSKI. They cannot reject it?

Mr. SCHWARTZ. Just to confirm, you are asking the rejection by VA, saying——

Ms. BUDZINSKI. By community care, the community care provider. Can they reject the appointment?

Mr. SCHWARTZ. No. Once it is made available, it is accepted. They can always cancel an appointment if a doctor is sick or something. No, we expect that the veteran can book that appointment then.

Ms. BUDZINSKI. Okay.

Mr. BARRETT. We are going to try and do a third round, but we might be able to expedite. Two minutes for a third round?

Ms. BUDZINSKI. Sure. Yes.

Mr. BARRETT. Okay. Why do not we do that, just to accommodate for the next panel. Appreciate the conversation, though.

I wanted to get a sense, Ms. Harris, if you have any thoughts on this. There is been allegations that there is been a resistance within VA to embrace community care as an option for veterans by maybe slowing down the implementation or things of that sort.

Do you feel that there is a resistance within VA to make community care scheduling as easy as possible, or is there a reluctance within the VA to maybe skew more veterans toward the internal VA care?

Ms. HARRIS. Yes. Well, we made a recommendation to VA and to VHA to take a look at the 7-day calendar standard for scheduling an appointment for community care, which they did take a look at. They looked at the standard, and they ultimately decided to keep the 7-day standard.

Like I said earlier, less than 40 percent of facilities are able to meet that standard for at least half of those appointments.

Again, I think these facilities are overwhelmed because the process is very labor and resource-intensive. I mean, through the course of our work, we have not seen any evidence that this is done on purpose, but because it is such a labor and resource-intensive thing these facilities are very overwhelmed. If VA is not going to adjust the standard, then they need to find a way to help these facilities to meet it.

Mr. BARRETT. Yes. With 36 now layered systems on there, it begins to question, okay, like, at what point are we having too many systems interface with one another——

Ms. HARRIS. Yes.

Mr. BARRETT [continuing]. causing too much error tendency between systems on the IT side or whether to the human error of inputting into those systems, just cross-filling and everything else.

Thank you. Appreciate it.

Ranking Member Budzinski.

Ms. BUDZINSKI. Yes. I just have one final question.

Actually, if you would not mind, Carol, just further elaborating on a question I had asked earlier around, what would the GAO need to see to kind of better—I guess, a signal that would be sent from the VA that they are actually working to fix some of these issues.

I am glad to see that you are working together, but what would be those steps that you would say they are making progress?

Ms. HARRIS. I mean, the foundational step is for us to see a strategic plan. We need to see how VA intends to streamline and standardize their appointment-scheduling process, from managing the referrals to setting up the appointments to following up and monitoring those wait times, that holistic process.

Then we need to see the IT architecture that is going to support that end state. We need to see, okay, if it is EPS as one of the major tools that they intend to use, okay, how that and any other new applications coming online, how that is going to support that end state.

Then also, of the existing 36-plus systems that we have, what are they going to do to turn them off, or if they are going to keep them on, how that is going to be integrated with all of the other applications that they have.

We need to see a holistic strategic plan from them, because otherwise all these initiatives—EPS included—if we do not have that end state, then the current things they are doing are well-intentioned, but they are aimless.

Ms. BUDZINSKI. Could I just ask, Mr. Gradison, is that something the VA would be open to doing, is putting together kind of a master plan?

I will say, getting the opportunity to serve on this committee, we know there are very large implementation plans. EHRM, EPS, these are all critically important, but it does seem like one bigger vision, a bigger master strategy might be helpful to bringing these systems in.

Mr. GRADISON. Well, I appreciate the opportunity to address this because we are aware of a number of the open recommendations from GAO's May 2025 report and look forward to delivering a comprehensive timeline and plan to the GAO.

We expect to be able to deliver that so that we can close that recommendation later this summer.

Ms. BUDZINSKI. Great. Thank you. I yield back.

Mr. BARRETT. Thank you.

Thank you so much for our first panel. Appreciate you all coming to Grand Ledge, Michigan, to the Seventh congressional District in Michigan, to provide testimony today. We appreciate your partnership in that. Thank you for being here.

You are now excused, and we will wait for just a moment as the second panel comes to the witness table.

If you are on the second panel, if you can come up, they will put your name tag out for you as well.

We are going to do a quick shift change.

[Change of panels.]

Mr. BARRETT. On our second panel, we have Mr. Jed Hansen, co-chair and founder of the Rural Veterans Health Special Interest Group at the National Rural Health Association.

Next we have Major Michael Reeve, director of veterans affairs for Shiawassee County.

Finally, we have Mr. Ben Frederick, associate vice president of advocacy and government relations for Memorial Healthcare and a former colleague of mine in the Michigan Legislature.

Thank you, all three of you, for being here today.

I will ask the witnesses to please stand and raise your right hand.

[Witnesses sworn.]

Mr. BARRETT. Thank you.

Let the record reflect that all witnesses have answered in the affirmative.

Thank you all once again for attending today.

Mr. Hansen, you are now recognized for 5 minutes for your opening statement on behalf of the National Rural Health Association.

STATEMENT OF JED HANSEN

Mr. HANSEN. Chairman Barrett, Ranking Member Budzinski, thank you for the invitation to Michigan's Seventh District and for the opportunity to testify today.

I appreciate your leadership and this committee's continued commitment to improving access to care and services for our Nation's veterans and servicemembers. For those of you on this committee that have served, thank you.

My name is Jed Hansen, the co-chair of the National Rural Health Association's Rural Veterans Health Special Interest Group. I also serve as executive director for the Nebraska Rural Health Association.

Congress expanded veterans' ability to receive care through the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act in 2018. From my perspective, EPS represents a promise kept.

This committee and Secretary Collins and the current VA administration should be commended for prioritizing modernization of the veteran experience.

Across rural America, this effort is seen as both a commitment to our veterans and as an investment in our rural communities, hospitals, and clinics.

While veterans may be eligible for community care, eligibility alone does not create appointments, as we have heard from some of our other testifiers today.

EPS helps translate eligibility into access by connecting veterans, community providers, and VA schedulers through a more coordinated process to ultimately reduce administrative burden, improve scheduling efficiency, and expand access.

The National Rural Health Association's Special Interest Group recently identified expansion of EPS as one of its two policy priorities for 2026.

Through discussions with rural providers, hospital leaders, veterans, and policymakers across the country, one question continued to emerge: How do we move from early adoption to broad, statewide utilization?

In my home State, we are attempting to answer that question. Nebraska's goal is simple: achieve the level of provider participation necessary to make EPS a reliable statewide scheduling tool for veterans, providers, and VA schedulers.

To support that goal, the Nebraska Rural Health Association developed a statewide EPS expansion strategy in partnership with the Nebraska Hospital Association.

Nebraska Department of Health and Human Service (DHHS) and, ultimately, our Governor's team incorporated that approach into Nebraska's Rural Health Transformation Program application (RHTP), creating a strong statewide partnership around this implementation strategy.

The strategy seeks to engage Nebraska's broader rural healthcare network, including hospitals, clinics, Federally Qualified Health Centers (FQHC), behavioral health providers, dental practices, and more to create that critical mass that you have been talking about needed for network adoption.

Importantly, this will demonstrate how existing Federal investment can accelerate implementation.

The veteran EPS project represents the very best of what RHTP funding can be—funding that supports technology, that improves access to essential services for veterans, and supports the rural workforce.

The VA's effort to expand scheduling Compensation and Pension (C&P) examinations through EPS also represents an equally important opportunity, efforts that are particularly important for transitioning servicemembers who may be unaware of available resources and as they transition into civilian life.

Just as EPS can improve access to healthcare services, it can also help connect veterans to disability evaluations needed to establish service-connected conditions and access their earned benefits.

Supporting provider training, onboarding, and outreach is going to be essential. Expanding local capacity alone is not sufficient if veterans remain unaware that these services or examinations are available within their own communities.

Nebraska plans to support regional veteran benefits and resources events that connect veterans, their families and caregivers, and local healthcare professionals to services, disability benefits, and resources into the community support programs that they need.

This first-of-a-kind statewide program is designed to raise awareness for all those supporting veterans in rural areas.

Taken together, Nebraska's plan reflects a broader lesson. Improving access requires more than technology alone. It requires technology, provider capacity, and outreach working together to ensure veterans can successfully access both healthcare services and benefits.

Our experience with EPS and other statewide healthcare modernization initiatives suggests that technology adoption is most successful when innovative tools are paired with trusted implementation partners.

Trusted State and regional organizations, such as the Center for Rural Health here in Michigan or Illinois Critical Access Hospital Network (ICAHN) in Illinois, are great examples of who those partners could be in your own States.

Based on our national discussions and Nebraska's implementation plan, I respectfully offer these three recommendations to the committee.

First, continue supporting statewide implementation strategies that achieve broad participation among community providers.

Second, pair technology deployment with provider onboarding, training, and technical assistance and outreach to ensure successful adoption and utilization of EPS.

Third, continue advancing interoperability and care coordination between the VA and community care providers.

Scheduling is a vital first step, but future success will increasingly depend on stronger integration of referrals, clinical records, benefits processes, and care coordination workflows.

EPS is undoubtedly transforming eligible technology to access care for veterans, but the ultimate measure of success will be whether veterans actually are able to utilize these services.

Chairman Barrett, Ranking Member Budzinski, thank you again for the opportunity to testify and for your commitment to our Nation's veterans and servicemembers. I look forward to answering your questions.

[THE PREPARED STATEMENT OF JED HANSEN APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you.

Mr. Hansen, your written statement will be entered into the hearing record.

Major Reeve, you are now recognized for 5 minutes to deliver your opening statement on behalf of Shiawassee County. Thank you for being here.

STATEMENT OF MICHAEL REEVE

Mr. REEVE. Chairman, Ranking Member, and distinguished members of the committee, thank you for the opportunity to provide testimony regarding the challenges veterans in Shiawassee County, Michigan, face when accessing VA healthcare.

I serve as the director of veterans affairs for Shiawassee County, and I am also a veteran with 27 years of Active-Duty service.

Through both my professional role or personal experiences, I have gained firsthand insight into the barriers veterans encounter when seeking care through the Department of Veterans Affairs.

As a rural Michigan county, Shiawassee has a veteran population of approximately 5,000 individuals. Many of the veterans we serve are older adults. As our demographics suggest, the average age is 75 years old.

Many of these individuals have disabilities and limited transportation options. As of 2018, we have transported 4,729 veterans to VA appointments at VA facilities or to referred healthcare providers.

Accessing care often requires travel to these VA facilities, mostly in Saginaw and Ann Arbor, which are urban, making reliable appointment-scheduling communication especially important. Of note, it takes our drivers 1 hour, 22 minutes to travel 74.5 miles to Ann Arbor or 52 minutes traveling 41.46 miles to Saginaw.

We have also transported veterans to Battle Creek, which is 1 hour, 37 minutes at 102 miles, and also Detroit, which is 1 hour, 33 minutes and 87 miles.

Veterans frequently experience long wait times for appointments and specialized services. In some cases they are told the next available appointment is more than a month away, leading some to seek care through the emergency department for more immediate attention.

We have also encountered situations in which appointments at the Saginaw or Ann Arbor VA Medical Center are canceled or rescheduled without timely notification. This can create unnecessary travel and strain limited transportation resources.

I have experienced this personally having driven to Ann Arbor for a medical appointment only to arrive and learn upon arrival that it had been canceled without prior notice.

Additionally, we have observed situations in which veterans establish successful relationships with their local community care provider only to have their care redirected back to the VA facility when that service or specialty becomes available through the VA system. These transitions often disrupt continuity of care and create frustration for the veterans who then must adjust to either new providers or treatment plans.

From both my professional and personal perspective, improving communication, reducing appointment delays, and supporting continuity of care would significantly enhance veterans' access to healthcare services.

The challenges we see in Shiawassee County reflect broader trends affecting veterans throughout Michigan and across the Nation. More than 30 percent of Michigan's veterans live in rural communities where transportation barriers and travel distances complicate access to care.

Federal oversight agencies and independent researchers have also identified ongoing concerns regarding appointment scheduling, wait times, and coordination within both the VA and community care systems.

These findings reinforce what we experience every day at the county level, that timely communication again, efficient scheduling, and reliable care coordination are essential to ensuring that veterans receive the healthcare they have earned through their service.

I appreciate Congressman Tom Barrett's leadership and collaboration on the Veterans Community Care Scheduling Improvement Act, as well as the continued utilization and a few tweaks for the External Provider Scheduling system. These efforts represent meaningful steps toward improving care coordination and helping veterans access the healthcare services they have earned through their service to our Nation.

Thank you for your attention to this important issue and for your continued commitment in improving access to care for America's veterans. I look forward to answering any questions.

[THE PREPARED STATEMENT OF MICHAEL REEVE APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you, sir. Thank you again for being here.

The written statement of Major Reeve will be entered into the hearing record.

Mr. Frederick, you are now recognized for 5 minutes for your opening statement on behalf of Memorial Healthcare.

STATEMENT OF BEN FREDERICK

Mr. FREDERICK. Thank you, Chairman Barrett, Ranking Member Budzinski. I very much appreciate the invitation to participate in this hearing and offer comments on providing world class healthcare services to our veterans in rural mid-Michigan.

I have the pleasure of serving as associate vice president of advocacy, government relations, and business development for Memo-

rial Healthcare, which is a midsized independent rural hospital located in Owosso, Michigan.

We serve patients at our main hospital in Owosso and more than 40 outpatient sites across six counties, a very wide swath of service delivery, from the standard inpatient to numerous specialty offerings, including neurology, orthopedics, rheumatology, pulmonology, oncology, a freestanding cancer center, Gastroenterology (GI), home health. I do that list to speak to the continuum there.

The other thing I appreciate you mentioning, Mr. Chairman, is that it is not just a hospital building—it is a continuum of care—and in rural areas there is a predominance of employed providers that are in that primary care space.

The front door to the healthcare access system, 90-plus percent chance that that primary care family medicine provider is going to be a Memorial Healthcare-employed provider. It is a true continuum of care.

We very much align with the mission of this committee as the origins of our hospital were directly inspired by the Owosso community's desire to serve the veterans of mid-Michigan following World War I.

Our original 1921 edifice still stands as an ongoing memorial honoring those veterans and the many who have followed. In fact, our legal name remains "The Memorial Hospital," and our campus is home to Owosso's war memorial honoring those who perished in World War I.

Our system's CEO sends his best regards to this committee and regrets being unable to address you personally. He, himself, is a veteran of the United States Marine Corps, and many members of our leadership team and 80-member-strong workforce are proud veterans of the United States military.

The culture of Memorial has long included recognition of our team members who served and a commitment to providing healthcare to the veterans who live within the communities we serve. One of our most solemn traditions at Memorial is a "code honor" staff recognition which marks the passing of any inpatient or long-term care resident who served with our facility.

We flag with a patient's veteran's status during our intake process to ensure a ready connection as we can with available services. We also strive to ensure veterans are aware of their benefits and are enrolled as a participating provider in a community care program and through partnership with our county VA.

Thank you, Chairman Barrett, as well for your efforts to ensure that the VA proactively notifies veterans of their options to receive community care through other work that you have done. Previously, veterans had to know and proactively urge the utilization of those local services.

This simple change in how a conversation is even initiated at the VA will drive convenience and cost savings, timely care, and better outcomes to the VA system. It is also a bit of a warning as to how much work needs to be done in addressing that basic communication or culture so that the veteran is not constantly placed in that self-advocate position of knowing what to ask, when, and so on. Thank you for that effort.

In 2025, we served over 400 individual veterans in an inpatient setting and over 400 in outpatient care; hundreds more veterans were served with primary insurance that was outside of VA insurance.

We are not satisfied with those totals. I am sure if you talked to other rural hospitals, they will have similar responses.

However, they represent a small portion of the estimated veteran population who call Shiawassee and rural mid-Michigan home, as noted by Major Reeve. It does speak to the fact that we have, I think, an additional utilization capacity that but for the option we would absolutely embrace.

As a community hospital in a rural region, our patients already face significant challenges that limit access to essential healthcare services—transportation, average age. Our veterans carry the additional burden of wounds both seen and unseen, which can affect their willingness to seek care and their ability to stay connected to care when facing frustrations or barriers.

Independent hospitals offer a true partnership that is community focused. Our competitive advantage is personalized patient care and that direct connection we establish with each individual in addressing specific needs.

The overarching concern I would wish to bring to this committee on behalf of our team is simply the degree of self-advocacy we see from veterans who are trying to remain with us as their medical home. There is a big travel distance for us, as mentioned by the chairman. The burden often does fall on the veterans themselves to initiate follow up and navigate that system that does not communicate across its own components.

The aspirations of these efforts are quite exciting to us. We are doing as much listening and learning today as anything. It is not something that we have presently looped in on, and we want to make sure that any type of implementation is in accord with our own personalized standard of care and that patient experience as well.

We thank this committee very much for the attention and the time. Thank you.

[THE PREPARED STATEMENT OF BEN FREDERICK APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you Mr. Frederick.

Thank you to all of our panelists.

The written statement of Mr. Frederick will be entered into the hearing record.

I will yield myself 5 minutes for questions.

Major Reeve, you have very succinctly pointed out the commutable distance for veterans seeking care in a traditional VA facility for whether you are providing that transportation service or whether they are on their own traveling there.

I think you referenced those are probably from Owosso to these facilities, I would imagine. Is that correct?

Mr. REEVE. That is correct.

Mr. BARRETT. Yes. If you live in Perry or Laingsburg you are even further away from, say, Saginaw or Detroit or any of these other facilities that may be a further drive for you in that instance, making it definitely well over an hour for a whole number of vet-

erans, depending on where they are geographically even within the county or in other parts of my district, in Clinton County, for example, in other areas as well. These are things that I think stack up on people.

Then you also pointed out that there is an issue of that continuity of referral if you start seeing a provider for maybe a chronic condition that you have and you get referred out to community care and then 6 months goes by and that referral lapses and then they can get you into a VA facility within the limits of what the community care program allows for the VA to retain, and it switches that provider.

I think for a lot of patients having that continuity is very important, having that same provider that you can build a relationship with is very important. I think for veterans maybe it is even more important depending on the types of challenges they are facing, particularly when you look at mental health, for example, that you need to build a relationship with a provider over such a sustained period of time.

Have you observed that in the veterans you have spoken to and the ones that you have served through your work?

Mr. REEVE. Thank you for the question.

I have. A lot of times we will see, as you just said, that veteran having that care at their home of record, if you will, and then having to transfer to a new doctor, new care. A lot of times the treatment plan will go back to something that has already taken place, potentially a referral out to some more tests that those tests are already in the records.

There are other times that, specifically in my line of work—so I am going to kind of narrow it down a little bit even further—but as a veteran service officer we also process claims. A lot of those claims, as you are fully aware, go toward C&P exams.

Those C&P exams in—I will just use my case in particular. I had one scheduled clear up in Midland. That is a 2-hour drive from Owosso. For this particular treatment plan, I looked at how many other providers were in between my house and Midland. There were 51 other providers.

Now, whether or not they were part of the community care network, I cannot answer that, but the propensity to use those providers was there.

Mr. BARRETT. Sure. If it is not a hyper-specialized type of treatment that is only done by a few providers, it begs the question of why they are not using the full complement of availability that is out there. I mean, certainly they are licensed through the State or otherwise to prove their adequacy of doing that kind of treatment. It really does beg the question of why they are not being utilized by the VA for that.

Mr. Frederick, I wanted to ask you, through Memorial, I guess, what options do you see or what partnership availability do you see with the VA? Where are the shortcomings coming from your side of the perspective to open up the pathways for more veterans if they choose to seek services closer to home through the types of services that you provide through Memorial?

Mr. FREDERICK. I think there are a few areas that have been mentioned by my team. I think you have heard a little bit about the connectivity issue and the communication issue.

With other insurance coverage we are able to be more of an advocate alongside the patient just to keep them connected with their care. Often we see in between visits they are charged with that next connection point and we are kind of waiting to see what the determination is going to be.

To your point about the relationship, are they going to be able to maintain that specialist relationship? Oftentimes we have concurrent ticking clocks on number of visits and duration of authorization which compounds the issue.

Mr. BARRETT. I have seen that, yes.

Mr. FREDERICK. That is actually the chief reason we slip into denial situations actually, that we miss a deadline like that. There is a lot of pressure on that veteran.

The other is things that would be rather routine like diagnostic transfer from the VA visit back to that community care primary relationship. Are we stuck with a redundant testing situation or is that veteran now the courier for that information?

On the technology side, secure electronic file transfer type of a model comes to mind pretty readily there. Is there a way for us to have some of that bilateral conversation?

I think some of this is in very good faith, but it is still kind of a one-way communication. If we could really have that bilateral communication in a number of veins, our care team is eager to serve more and also show what we can do. You have been to our facility and know our capabilities. If it is the veteran's choice, we certainly want to serve our own.

Mr. BARRETT. Very good. Thank you.

Ranking Member Budzinski for 5 minutes.

Ms. BUDZINSKI. Thank you, Chairman.

I want to really applaud what is happening in Nebraska and the work that you are doing, Dr. Hansen. I would like to spend a little bit of time on that and learn from your work.

In your testimony, you indicate that the Nebraska Rural Health Association developed a statewide EPS expansion strategy. I was wondering if you could spend some time talking about what was included in that strategy, how it went, lessons learned. I would love for you to talk about that.

Mr. HANSEN. I absolutely love that question, so thank you for asking it.

Through RHTP we developed a plan where we could provide funding to each of our rural hospitals, their associated clinics, our FQHC centers in rural Nebraska, and in roughly 100 independent clinics and offices, so thinking dental offices, therapy, et cetera.

We are providing approximately 75,000 per hospital and then 20,000 per independent clinic site to help accelerate that adoption.

With those dollars, those facilities can use that to offset any type of technical expertise that they are needing to be able to make that connection with EPS.

One of the early challenges that we found with some of our larger tertiary centers was just the data mapping or the schedule mapping and those decision trees that were needed with scheduling.

We also are encouraging or will be encouraging local providers to sign up to get training so they can provide C&P exams, understanding that that is a future strategy of the VA. Then, two, just we know that there is a backlog of that as well, so to encourage that.

Then the final piece I have briefly been able to mention was the idea of these regional benefits exams.

I have had the fortune of attending a NASDVA, which is the National Association of State Directors of Veterans Affairs, a few of their events, and a couple of years ago I was walking the vendor hall and I was amazed at how many different benefits and different services are available for our veterans. I was also equally amazed at how little information is out there and how few know about all those services.

We are really looking in Nebraska to connect our hospital teams, our community health professional teams. Then in these regional events, making sure that our veterans know about the access that they have, the benefits they have, their caregivers, and then our community team, so that we are really taking that comprehensive look at it.

The other thing that really cannot be dismissed here is making sure that our local VAs are synced up. Those schedulers have historically taken on a lot of work, and I was amazed at hearing how many different systems are actually involved on the VA side.

We have been working very closely with the VA center for Nebraska, western Iowa, and that leadership team to work on communication strategies. It is netted even very recently just what that relationship looks like. We had a veteran presented to a critical access hospital. He ended up being moved over into a swing bed care plan and the local facility was receiving denials.

Because of those deeper relationships that we have developed in Nebraska so that we can serve as that liaison, we were able to connect in the VA team so that they could work on that strategy so that it did not have to rely on the veteran to be his, in this case, his own advocate for service coverage there.

Thank you.

Ms. BUDZINSKI. That is really impressive.

Can I just drill down a little bit more. Can you tell me how many providers ended up then in Nebraska actively sharing their grids with the VA through EPS?

Mr. HANSEN. Yes. Currently we have a handful of our critical access hospitals, and then we do have both major—our tertiary centers, our medical centers in the State sharing.

Those efforts to date have been focused more on targeted specialty, understanding that cardiology was a significant challenge in our State. We have also been rapidly expanding mental health and physical therapy in our State as well through RHTP. There are certainly some challenges with the rollout and the procurement processes with that. The plan is to effectively connect the entire rural healthcare grid in the State over the next couple of years.

Ms. BUDZINSKI. I am just curious, have you gotten any pushback from providers then that have been utilizing EPS since they have gone live?

Mr. HANSEN. The biggest challenge—or the biggest pushback in challenges, one was that scheduling mapping that was needed in looking at some of those decision trees, especially for some of the specialty services. Then the other one is just related to that critical mass that is ultimately needed.

When our VA schedulers are not used to being able to go out to a system and netting a positive appointment, they are less likely to continue that adoption. We were understanding that we need that. Any type of technology network needs critical mass, and this is one of them. We were fortunate enough to be able to work to develop a plan and then one that our State ultimately adopted.

Ms. BUDZINSKI. Thank you. I will yield back.

Mr. BARRETT. Thank you.

We are going to do a second round of questions, but we will go to 2 minutes for the second round, if that is okay.

Very good.

Mr. Frederick, just picking up where we left off when the time expired, you mentioned a couple of things that I think are important.

One is the testing redundancy or diagnostic redundancy that is done when moving healthcare back and forth between VA and then outside of the VA.

One of the efforts we have undertaken for modernizing the electronic health record is to more easily share that information both within the VA itself—believe it or not, different VA facilities are not able to share that information today—but then also outside of the VA so that a VA clinician can share information with a clinician outside of the VA network.

That is an effort that we are undertaking and we would certainly appreciate your feedback along the way as this is implemented both locally here in Michigan, but also nationwide as well.

The other thing you pointed out is when VA refers out for community care, often there is both a timeline that that stands for, as well as a number of visits that are allotted.

You could hit your limit on one or the other before—you might go for three visits for a referral before the 90 days that that referral stands for, for example, and then you are forced to kind of renew that referral or ask for additional, which can be bureaucratic and troublesome and can kind of affect the patient care outcome.

Can you talk about how that is different generally than a traditional healthcare model or health insurance reimbursement or another way that a patient may be referred for care?

Mr. FREDERICK. The biggest difference is this combination of visits to time limitation. Typically when you are going through that authorization and you determine that it is a covered benefit, you are able to proceed. Or you have a care plan that speaks to a certain number of engagements in like a physical therapy setting over a period of time. That is just a known schedule.

It is a bit disruptive for our team. It does the running the traps on this to try to manage both of those timelines. Again, whether they have taken it on themselves or not, mentally there is that recognition from the vets themselves that they have to manage that too.

The other challenge that we are seeing—and I know Major Reeve actually may be able to speak to this as well—is that the frequency visits trends, they are worsening. The amount of recurrent visits that are allowed for certain purposes have declined in some of these areas.

We are seeing some challenges with just being able to get a person through rehab or effectively in a place where we are hopefully minimizing readmissions, frankly.

Mr. BARRETT. Sure. Thank you.

Major Reeve, I can give you a moment and then I have got to yield to the ranking member.

Mr. REEVE. Thank you.

From what Ben was saying, in particular we have got a veteran that was receiving some care and the number of visits I believe was 26 for this particular service.

The VA came back in, said, no, we are cutting that down to 12. Then, if you take into account the travel time on top of that, it is no longer feasible for this individual then to take time off of work in order to go to that.

In addition, there is another veteran who is on dialysis three times a week, has to travel down to Ann Arbor, has to have somebody with him. Now there are two people essentially taken out of the fight, if you will, instead of going to Memorial care just down the road 10 minutes to receive that care back at home that afternoon instead of making it a whole day. As we all might be aware, dialysis is one of those things that just take a lot out of both the individual and the family.

Mr. BARRETT. Thank you. Appreciate it. Thank you both.

Ranking Member Budzinski.

Ms. BUDZINSKI. Yes. Thank you.

Maybe I could just pick up with Major Reeve and just say, again, thank you for being here, but thank you for your continued service.

What you are saying is something that I hear from veterans in my rural district pretty consistently. How do we get the VA to do better at communicating? Travel times. We need to shorten wait periods.

I think the VA needs to do better. I am curious if you have any recommendations on ways that we can make those improvements in those areas.

Mr. REEVE. Thank you for the question.

Coming from a rural county in Michigan, one of the big things I would say is the availability of a veteran's records to a third party, if you will. I will just use Memorial Healthcare as the example. Not only if that individual selects through the community care network to receive their treatment closer to home, when that individual files a claim and needs to go to a C&P exam, we can then utilize those same services for that.

Another big thing and issue in a lot of the different organizations—and I hope I am speaking okay for them—are nexus letters. It is one of the key requirements that the VA requires when filing a claim in order to make that service connection, and without that you are going to get denied most days of the week.

A lot of times VA doctors are I do not want to say unwilling, but they are hesitant in doing so. I do not know if it is because—well, I will just leave it at that. I am not quite sure why.

Then that leaves the veteran themselves to find an independent provider to then write that nexus letter, when if that Memorial Healthcare was within that community care network, it would be a one-and-done service, not only for the continuity of care treatment, but then the further service in developing that claim.

Ms. BUDZINSKI. Thank you. I will yield back.

Mr. BARRETT. Thank you.

Thank you to all of you on the second panel. Thank you for being here today. We deeply appreciate your testimony. Thank you.

We are now going to move on to closing statements.

Ranking Member Budzinski.

Ms. BUDZINSKI. Sure. I will just be very brief and say thank you to all the panelists, both the first panel and the second panel, for being here.

Thank you for your hospitality in Michigan's Seventh District.

It is an honor to serve on this committee. There is so much work that we have ahead of us on all of these different implementation programs, whether it is EPS, EHRM. These are big undertakings that the VA needs to be continuing to take on and I want to see them be successful.

I appreciate the opportunity to continue to do this work with you, Chairman. Thank you.

Mr. BARRETT. Thank you. Thank you, Ranking Member Budzinski, for coming to my district today. I really appreciate that.

I also want to thank our friends at the Michigan Army National Guard for allowing us to use this facility.

Steve, please thank The Adjutant General (TAG) on my behalf. I think he did say we can take the Lakota out for a quick trip afterwards. It that true? Okay. It is already out there? Great. Yes. I will not put a scratch on it, I promise.

Please give him our appreciation as well and to everybody here at the Support Facility. Thank you for accommodating us today.

Thank you to our witnesses for being here and sharing your real world experience of what is going on both within the VA, from the GAO, and from our local partners and from our rural leaders in this way to tell us how we can make this work, because ultimately we share this goal of making this the best we can for the veterans that we serve.

This facility that you are in today really serves as an example, I think, of the men and women that we are trying to assist with this. This is deeply rooted in this community. We have seen people leave here on a deployment. Over the 20-year-long War on Terror there was only a handful of months that we did not have some unit from this facility deployed in the fight somewhere or another around the world.

We have seen people leave. We have welcomed them back home. You have soldiers that serve here and then maybe they leave after a number of years that their enlistment lasts for.

Or maybe somebody—one of my friends who I caught up with today is approaching his 38th year in service in the military. It runs the full spectrum.

Communities like this support all the different types of men and women who serve, but often we are a little bit further removed from your larger Active-Duty facilities that might have a more robust VA component accompanying them. When people come back to a unit like this, they are dispersed across this community generally where they are commuting in from, which makes them further away from certain VA facilities, which I think then really brings about an urgency around how we are going to accommodate the community care network to best serve them in the area that we need to.

We have a lot of work ahead of us, to the ranking member's point. We owe it to our men and women to do that work. I am committed to that.

Really appreciate everybody being here today. The work that we are doing here is going to be brought back to Washington, DC, to implement the best that we can.

Hey, Louis, can you come up here a minute? Do you want to swing the gavel, buddy? All right.

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

Without objection, this hearing is adjourned.

[Whereupon, at 11:44 a.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Andrew Gradison

STATEMENT OF
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VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION
U.S. HOUSE OF REPRESENTATIVES
ON
"DELIVERING QUALITY AND MODERN HEALTHCARE TO MICHIGAN'S VETERANS AND SERVICEMEMBERS"
JUNE 12, 2026

Chairman Barrett, Ranking Member Budzinski, and distinguished Members of the Subcommittee, thank you for the opportunity to testify on VA's efforts to modernize scheduling and improve community care access. Joining me to today is Dr. Mark Hausman, Chief Medical Officer, Veterans Integrated Service Network 10, and Mr. Zachary Schwartz, Principal Deputy Assistant Secretary, Office of Information and Technology. We will update the Subcommittee on the External Provider Scheduling (EPS) program and the integrated scheduling pilots underway in Charleston, South Carolina, and Atlanta, Georgia.

Veterans, Veterans Service Organizations, and Members of this Committee have consistently emphasized that scheduling challenges have been one of the most significant pain points for Veterans seeking care. Secretary Douglas A. Collins listened to VA's customers, and under his leadership, VA is making it easier and more convenient than ever for those who have worn the uniform to choose the care for which they are eligible that best fits their lifestyle.

EPS is a technology platform that improves the process of scheduling Veterans with Community Care Providers by supplying information on care availability and

allowing VA staff to schedule Veterans directly into available community care provider appointment slots through a singular user interface.

As you are aware, under the Biden Administration, Veterans faced unnecessary delays in accessing community care due to the decision to pause the implementation plan of the EPS program. This slowdown limited Veterans' ability to quickly and easily schedule appointments with community providers.

The EPS program is now directly advancing VA's modernization goals by delivering a more consistent, transparent, intuitive scheduling experience. The modernized EPS program now delivers the following to Veterans and their caregivers:

- Improved productivity that enables VA to schedule more than three times as many community care appointments per day compared to the previous methodology;
- Clear, timely choices for their care that allows appointments to be booked in minutes, not days;
- Real-time visibility into eligible community provider appointment availability; and
- Increased efficiency by eliminating many manual calls and faxes.

Taken together, these Improvements ensure greater consistency of service across VA medical centers (VAMCs) Nationwide.

Since we last testified before this Subcommittee in May 2025, VA has moved from incremental deployment to Nationwide availability of the EPS program platform. Since late 2025, the EPS program has been rolled out across every VAMC. As of May 2026, there were over 29,000 community providers and more than 41,000 provider services in the EPS program. More than 150,000 appointments have been booked through the platform.

In January 2026, VA commenced the integrated scheduling pilot at two sites, the Ralph H. Johnson VAMC in Charleston, South Carolina, and the Joseph Maxwell Cleland VAMC in Atlanta, Georgia. This effort allows viewing of both direct care and community care appointments on the same platform. Within 3 months of the integrated scheduling pilots, VA scheduled over 1,000 appointments. Both sites are also testing new Veteran self-scheduling capabilities through EPS, that would allow eligible

Veterans to book their own appointments with VA providers—or certain community care providers—online through VA.gov or using our mobile app, without calling VA or a provider's office.

While the EPS program has reached national availability, its long-term success and value to Veterans depend heavily on community provider participation. Not all community care providers are familiar with the technology. To increase awareness, VA meets with community care providers and explains the benefits to their clinic operations and VA's ability to support coordination of care efforts. VA leverages data to identify and engage community care providers who specialize in a category of care with a high annual referral volume in geographic areas with limited EPS program coverage.

When VA engages with community clinicians and provider organizations to explain the EPS program's benefits, VA highlights that there are no fees, no changes to existing electronic health record or scheduling platforms, and full provider control over appointment grids with secure-schedule sharing. Nebraska's state-wide rural transformation initiative is a leading model, having expanded EPS program connectivity across dozens of rural hospitals and clinics. VA is similarly working with third-party administrators and providers who have entered into a Veterans Care Agreement to simplify participation and ensure broad understanding across the Community Care Network.

Conclusion

In conclusion, I am pleased to inform this Committee that under Secretary Collins' leadership, the EPS program is a nationally deployed scheduling capability that is reshaping how Veterans access their care. VA is moving closer to our goal of having singular scheduling solution that allows Veterans to book appointments that are best for them—whether at VA or in the community—through modern and convenient methods that meet their expectations. VA remains fully committed to ensuring that the EPS program supports timely, high-quality care and enhances Veterans' experiences across the entire scheduling journey.

Thank you for the opportunity to answer any questions you may have.

Prepared Statement of Carol Harris

United States Government Accountability Office

Testimony

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

For Release on Delivery
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VETERANS HEALTH CARE

Scheduling Systems and Related Challenges

Statement of Carol C. Harris, Director, Information Technology and Cybersecurity

GAO-26-109213

GAO Highlights

VETERANS HEALTH CARE

Scheduling Systems and Related Challenges

GAO-26-109213 June 2026

A testimony before the Subcommittee on Technology Modernization, Committee on Veterans' Affairs, House of Representatives

For more information, contact: Carol Harris at HarrisCC@gao.gov

What GAO Found

The Department of Veterans Affairs (VA) uses dozens of systems to schedule appointments, manage referrals, and monitor wait times for veterans. The department is also in the process of replacing its primary health information system—the Veterans Health Information Systems and Technology Architecture (VistA)—by deploying a new electronic health record system with Oracle Health. However, the rollout of the new system has been delayed due to technical and performance issues. Some of those scheduling systems and tools are commonly used across the department by many VistA facilities. Schedulers at the handful of facilities that have the new Oracle Health system also have an additional set of scheduling systems and tools available. For example:

- **VistA facilities.** Almost all VA medical facilities use the VistA health information system, which is over 30 years old. These facilities use multiple VistA applications, in addition to other systems, for scheduling health care appointments and managing referrals for specialty care. Both schedulers and veterans must navigate a complex environment when using VA's systems to schedule appointments. VA facility staff are required to open multiple applications to schedule a single appointment. They must also run reports in different systems to identify veteran self-scheduled and self-canceled appointments and appointment requests.
- **Oracle Health facilities.** Due to difficulties in rollout, very few facilities have begun to use the new Oracle Health system. These facilities have another set of scheduling systems, as well as some of the same systems VistA facilities use for scheduling appointments and managing referrals.

In addition, veterans have experienced issues requesting an appointment online, getting confirmation once an appointment is scheduled, and receiving duplicative appointment reminders.

This complex systems environment presents challenges for VA and for veterans scheduling appointments. VA officials acknowledge that some challenges are the result of operating multiple platforms (VistA and Oracle Health) as well as having multiple versions of VistA. VA is taking steps to address these challenges.

VA initiated efforts to modernize its scheduling systems, which included several concurrent efforts to improve scheduling-related systems across VA's medical facilities. For example, one of these efforts is intended to allow provider-based scheduling, which is the ability for VA schedulers to see a provider's schedule across multiple modalities (in-person, telephone, telehealth) in a single scheduling application. According to VA officials, the department is also working to standardize veteran appointment self-scheduling at VistA and Oracle Health sites.

GAO has reported for many years on VA's challenges concerning its scheduling systems and their impact on delivering care to veterans. Although VA has generally agreed with GAO's recommendations, it has not yet fully implemented them. Doing so would aid VA's progress toward providing timely, quality care to veterans.

Why GAO Did This Study

The VA schedules tens of millions of health care appointments for veterans each year. To do so, it uses a patchwork of systems that have been developed in ways that make scheduling—with both Veterans Health Administration (VHA) and non-VHA providers—difficult for veterans and staff. In addition, VA has experienced information technology (IT) challenges related to the outdated, inefficient nature of systems and its efforts to modernize its health information system. VA health care was added to GAO's High Risk List in 2015, where it remains today.

GAO was asked to testify on its key prior work on VA scheduling and the systems involved, as well as the related challenges for VA providers, staff, and veterans, and how VA plans to address those challenges. GAO summarized the results of five prior reports.

What GAO Recommends

GAO has made a total of nine related recommendations in its prior reports for VA to improve its scheduling systems. This includes recommendations about improving the schedule and requirements management plan for its improvement efforts. The agency has fully implemented 3 of 9 recommendations.

Chairman Barrett, Ranking Member Budzinski, and Members of the Subcommittee:

I appreciate the opportunity to be here today to discuss the Department of Veterans Affairs' (VA) Veterans Health Administration's (VHA) efforts to ensure veterans have timely access to health care through its scheduling systems. The majority of veterans utilizing health care services delivered by VA still receive care in VHA-operated medical facilities. VHA provided about 42 million in-person appointments and more than 29 million telehealth and telephone appointments with VHA providers in fiscal year 2023 (for a total of 71 million appointments).[1] However, the number of veterans receiving care from non-VHA providers through the Veterans Community Care Program has increased in recent years, with approximately 47 million appointments with non-VHA providers through community care during that same time period, according to VA.[2]

VHA's systems and processes have been developed in ways that make scheduling—with both VHA and non-VHA providers—difficult for veterans and staff. Schedulers must navigate a complex system environment to schedule medical appointments. Over time, VHA has adopted multiple systems for scheduling, added more steps to processes, and introduced community care and virtual modalities. These factors have increased how long it takes to schedule appointments, exacerbating wait times for veterans. This has also led to the need for schedulers to view provider availability across various systems, which has increased scheduling errors and overbooking.

For nearly 25 years, we have reported on the challenges VA medical facilities have faced providing health care services in a timely manner. We have issued several reports recommending that VHA improve

[1]Under the department's Veterans Community Care Program, veterans enrolled in VA's health care system or eligible for VA care without needing to enroll may choose to obtain health care services from community providers, rather than a VA provider if eligible, according to criteria. For example, veterans may choose to receive care under the program when VA cannot schedule an appointment with a VHA provider within 20 days for primary care, or 28 days for specialty care of the date of the request for care, unless a later date has been agreed upon. 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) (38 U.S.C. § 1703).

[2]Telehealth is the use of telecommunications technologies to deliver health care remotely.

appointment scheduling.[3] Due to issues in VA's ability to ensure consistent, timely access to health care, as well as its information technology (IT) challenges, we determined that VA health care is a High Risk area.[4] The IT challenges are related to the outdated, inefficient nature of systems and VA's efforts to modernize its health information system. We added VA health care to our High-Risk List in 2015, where it remains today.[5]

My statement today will summarize information from five prior products on VA scheduling for VHA care and non-VHA community care and the systems involved, as well as the related challenges for VA providers, staff, and veterans, and how VA plans to address those challenges.[6]

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.

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

[3]See Related Products appendix at end of this report.

[4]Regarding VA health care, we identified five areas of concern: (1) ambiguous policies and inconsistent processes, (2) inadequate oversight and accountability, (3) IT challenges, (4) inadequate training for VA staff, and (5) unclear resource needs and allocation priorities.

[5]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). For the most recent high-risk report, see GAO, *High-Risk Series: Heightened Attention Could Save Billions More and Improve Government Efficiency and Effectiveness*, GAO-25-107743 (Washington, D.C. Feb. 25, 2025).

[6]GAO, *Veterans Health: Improvements Needed to Achieve Successful Appointment Scheduling Modernization*, GAO-25-106851 (Washington, D.C.: May 22, 2025); *Veterans' Community Care: VA Needs Improved Oversight of Behavioral Health Medical Records and Provider Training*, GAO-25-106910 (Washington, D.C: May 5, 2025); *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); and *Veterans Community Care Program: Improvements Needed to Help Ensure Timely Access to Care*, GAO-20-643 (Washington, D.C.: Sept. 8, 2020). We made a total of 9 recommendations related to scheduling systems in these reports. VA has implemented 3 of the recommendations.

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 provides health care services at approximately 1,300 sites, including about 170 medical centers and over 700 outpatient facilities. The services are offered in-person, over the phone, or through video appointments as clinically appropriate. VHA also has a network of about 1.3 million community care providers across all 50 states and U.S. Territories.

VHA's Electronic Health Records System and Replacement

VA's primary health information system is the Veterans Health Information Systems and Technology Architecture (VistA). The system is more than 30 years old and technically complex. It is comprised of about 170 clinical, financial, and administrative applications—including the electronic health record and scheduling applications—that support health care delivery. There are approximately 130 versions of the system departmentwide.

VA is in the process of replacing VistA because it is costly to maintain and does not fully support VA's need to electronically exchange health records with other organizations, such as the Department of Defense. Toward this end, in 2018, VA established the Electronic Health Record Modernization program and contracted with Oracle Health to acquire a new electronic health record system.[7] The department plans to deploy the Oracle Health system at all 170 locations across the country, but VA has experienced significant delays in deploying the new system.[8] The system

[7]VA contracted with Cerner Government Services, Inc., for the department's new electronic health record system in May 2018. Subsequently, in June 2022, Cerner was acquired by Oracle Health Government Services, Inc. ("Oracle Health"). VA and DOD use the same Oracle Health system, called Millenium, with agency-specific configuration differences.

[8]VA deployed the new electronic health record system at six locations between October 2020 and June 2022. In April 2023, VA halted deployments to address technical and performance issues, including scheduling concerns, with the exception of a facility operated by both VA and the Department of Defense that deployed in March 2024. VA continued to assess veteran and clinician experiences and redirect resources to prioritize improvements at the sites where the new electronic health record system had been implemented. In December 2024, the department announced its plan to restart deployments including 13 sites in 2026.

includes scheduling applications that VA intends to use enterprise-wide to schedule veterans' appointments for medical care.

VHA Appointment Scheduling

Access to timely medical appointments is critical to ensuring that veterans obtain needed medical 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.[9] 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 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.

Wait Time Monitoring

VHA is to measure wait times veterans experience when scheduling appointments relative to VHA's established standards.[10] Specifically, VHA is to measure the time it takes VA medical centers to schedule an appointment with a VA provider from the time an appointment is requested, which is expected to be within 3 business days. In addition, VHA is to measure the time it takes for a veteran's appointment with a VA provider to occur from the time it is requested, which is expected to be within 20 days for primary and mental health care or 28 days for specialty care.

VHA is also to measure the time it takes to schedule an appointment with a community care provider. For community care, the time it takes to schedule an appointment from the time an appointment is requested is expected to be within 7 days. VHA is also to measure wait times to determine if a veteran is eligible to receive care from a community care

[9]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.

[10]This is required by VHA internal standard operating procedures.

provider. Specifically, as mentioned earlier, under the department's Veterans Community Care Program, veterans may choose to obtain health care services from community providers, if eligible, rather than a VA provider.[11] One of the eligibility criteria is that the next appointment with a VA provider is not available within 20 days for primary care and mental health or 28 days for specialty care of the date of the request for care, unless a later date has been agreed upon.

VA Uses Dozens of Systems to Schedule Appointments, Manage Referrals, and Monitor Wait Times

VA has an array of systems and tools that comprise the complex environment that supports scheduling appointments, managing referrals, and monitoring wait times.[12] Some of those systems and tools are commonly used by VistA facilities, which are the vast majority of VA's 170 medical facilities. In addition, schedulers at the handful of facilities that have the new Oracle Health system have an additional set of scheduling systems and tools available. VA also has several systems that veterans can use to interact with VA about medical appointments.

- **VistA facilities.** VA medical facilities with the VistA health information system use several VistA applications, in addition to other systems, for scheduling health care appointments and managing referrals for specialty care. Specifically, these facilities primarily use VistA Scheduling, also referred to as VistA Scheduling Enhancement Graphical User Interface, for scheduling appointments. These facilities may use other applications within VistA as well to support scheduling.[13] For a description of each of the VistA applications, see table 1.

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

[12]GAO-25-106851

[13]Facilities use scheduling applications based on their locally determined needs. VA does not track the various software applications used by facilities.

Table 1: Veterans Health Information Systems and Technology Architecture (VistA) Applications Used by the Department of Veterans Affairs (VA) Medical Facilities for Scheduling Appointments and Supporting Scheduling Activities

VistA Application	Description
Admission Discharge Transfer	Supports the administrative functions of patient registration, admission, discharge, transfer, and appointment scheduling.
Computerized Patient Record System	Serves as Veterans Health Administration's electronic medical record system. Enables clinicians to enter, review, and continuously update all order-related information connected with a patient.
Consult/Request Tracking	Used to order consultations and procedures from other providers or services within the hospital system, at their own facility, or another facility. Uses a patient's computerized patient record to store information about consult requests.
Radiology/Nuclear Medicine	Used for processing patients for imaging examinations.
Scheduling (also known as VistA Scheduling Enhancement Graphical User Interface)	Used to manage and schedule appointments with point-and-click user interface software. Also includes recall reminder software that serves as a queue or place to hold requests for appointment scheduling on a future date and time.
Surgery	Used to enter and display information on patients who have undergone, or are about to undergo, surgical procedures. Integrates booking, clinical, and patient data to provide a variety of administrative and clinical reports.
Text Integration Utility	Manages the capture, retention, retrieval, and processing of any document related to a patient visit. Supports discharge summaries, progress notes, and consult results.

Source: GAO analysis of VA documentation | GAO-26-109213

VA facilities that use VistA Scheduling Enhancement Graphical User Interface as the primary means for appointment scheduling may also access nine additional systems in the process of scheduling appointments with VA medical providers. For example, initially, enrollment staff use the VHA Enrollment System to enroll veterans and determine their eligibility for VA health care and benefits. The VHA Support Service Center generates a report called the New Enrollee Appointment Service Request Report, which schedulers use to identify veterans who have requested an appointment when enrolling online. For a description of each of the systems that are used to support scheduling appointments with VA providers, see table 2.

Table 2: Systems and Tools that Support Appointment Scheduling at Department of Veteran Affairs (VA) Medical Facilities That Use Veterans Health Information Systems and Technology Architecture (VistA)

Name	Description
Clinical Staff Viewer	Functions like a "rooming function" in commercial electronic health record software platforms where the patient is tracked while being seen at the appointment.
Customer Relationship Manager	Used by call center staff to track and report customer issues, capture updated demographic information for veterans, and ensure Veterans Health Administration (VHA) systems of record are kept up to date. Provides veterans with information about VA services and upcoming and past appointments; submits refills for existing prescriptions; and sends progress notes for medication renewal requests.
Provation	Used for procedure scheduling with an endoscopist, as well as gastroenterology scheduling. Inputs the images and report dictations into the patient medical record upon completion.
Light Electronic Action Framework Interfacility Transfer List Report	Used to list and track patients who requested a transfer of care to another health care provider or facility within the same organization and are waiting for an opening.
New Enrollee Appointment Request Report	Generated by the VHA Support Service Center to identify veterans who have requested an appointment when enrolling online.
Scheduling Enterprise Appointment System	Standardizes communications between VA scheduling applications and allows integrations with other medical technologies.
Telehealth Management Platform	Used for interfacility scheduling across the VA enterprise. Offers telehealth programs the ability to manage technical and clinical processes in one platform. Also supports communicating important information between providers, VA staff, and veterans.
Veterans Health Administration Enrollment System	Used to enroll veterans and determine their eligibility for VA healthcare and benefits. Serves as the authoritative source for the resulting data which are collected, processed, shared with other VA systems, and stored securely.
Virtual Care Manager	Used by VA providers to manage virtual appointments. Assists in managing VA Video Connect appointments either scheduled or on demand and is used as a backup system for schedulers.

Source: GAO analysis of VA documentation | GAO-26-109213

Note: All systems might not be used by schedulers for each appointment.

In addition, VA operates five systems that are used by VA staff for managing referrals to VA and non-VA health care providers. For example, the HealthShare Referral Manager system is used to generate referrals for veterans receiving care in the community. For a description of each of the systems used for referrals, see table 3.

Table 3: Systems Used by the Department of Veterans Affairs (VA) for Scheduling Referrals to VA and Non-VA Health Care Providers

Name	Description
Community Care – Customer Relationship Management	Allows end users access to all a veteran's non-VA claims and medical information found in multiple systems across the enterprise. In addition, allows users to record inquiries related to non-VA medical care, claims status, and benefits.
Consult Toolbox	Standardizes the documentation process and workflow of VA staff managing referrals for internal care and community care. Includes the Decision Support Tool, which VA staff use to determine if a veteran meets certain eligibilities for community care in real-time.
Consult Tracking Manager Plus	Used to track and schedule consults and return-to-clinic orders.
HealthShare Referral Manager	Used by VA community care staff to generate referrals and authorizations for veterans receiving care in the community.
Provider Profile Management System	Serves as the authoritative source of non-VA providers for VA that offers a layer of validation of non-VA provider data and supports workflow management. Uses a provider locator to identify community care providers in a mapped proximity to a veteran's location for scheduling care.

Source: GAO analysis of VA documentation | GAO-26-109213

Note: All systems might not be used by schedulers for each appointment.

VA also maintains eight systems to engage with veterans about medical appointments through, for example, an online portal and texting. For example, veterans can use the Appointments portal on VA.gov to self-schedule appointments in certain cases, track the status of appointment requests, or request access to telehealth services. Another system, VEText, sends appointment reminders and allows veterans to confirm or cancel an upcoming appointment. For a description of each of these systems, see table 4.

Table 4: Systems Veterans and the Department of Veterans Affairs (VA) Use to Engage Regarding Appointments

Name	Description
Appointments on VA.gov	Allows veterans the ability to schedule their own appointments, track the status of an appointment request, and receive messages and notifications about appointments from VA via an online portal. Also allows veterans to determine and request access to community care and helps manage and schedule telehealth services.
Audiocare	Reminds veterans of appointments via an automatic phone system and provides veterans the capability to request to cancel or request to reschedule their appointments at the time of the phone call.
Kiosk System	Allows veterans to check in for appointments, and update demographics and insurance information, among other things.
MyHealtheVet	Provides access to the Appointments on VA.gov portal for online scheduling and facilitates veteran interaction with health care providers. Also provides veterans access to VA benefits and web-based tools to increase their knowledge about health conditions and manage their health records.

Name	Description
My VA Health Portal	Allows veterans to schedule or request an appointment with a site that uses Oracle Health.
Patient Reminder Notification System	Sends appointment reminders and notifications to veterans.
VA Health Chat	Used by veterans to request, cancel, or reschedule an appointment via online chat, and for VA staff to interact with veterans by, for example, initiating a video visit.
VEText	Used to send appointment reminders to veterans and allows them to either confirm or cancel their appointment.

Source: GAO analysis of VA documentation | GAO-26-109213

- **Oracle Health facilities.** As of May 2025, few facilities were using Oracle Health. These facilities have another set of scheduling systems, as well as some of the same systems VistA facilities use for scheduling appointments and managing referrals. Sites that have transitioned from VistA use the Oracle Health scheduling system called Revenue Cycle for patient registration, admission, discharge, and appointment scheduling. For managing patient-visit documentation, they use Oracle Power Chart. In addition, these facilities use Oracle Referral Management and PowerForms for referral tracking, and Oracle Scheduling Appointment Book to schedule surgery or procedures requiring anesthesia. These sites also use the Telehealth Management Platform for a patient registered at an Oracle Health site but who is receiving care at a VistA site. For a description of the 14 systems used at VA facilities with Oracle Health, see table 5.

Table 5: Systems Used for Appointment Scheduling Activities at Department of Veterans Affairs (VA) Medical Centers That Use Oracle Health

Name	Description
Customer Relationship Manager	Used by call center staff to track and report customer issues, capture updated demographic information for veterans, and ensure Veterans Health Administration (VHA) systems of record are kept up to date. Provides veterans information about VA services and upcoming and past appointments; submits refills for existing prescriptions; and sends progress notes for medication renewal requests.
Healthshare Referral Manager	Used by community care staff to generate referrals and authorizations for veterans receiving care in the community.
My VA Health Portal	Allows a veteran to schedule or request an appointment with a site that uses Oracle Health.
Oracle Power Chart	Used to manage the capture and processing of patient-visit-oriented documents. Also supports discharge summaries, progress notes, and consult results.
Oracle RadNet	Used for processing patients for imaging examinations.
Oracle Referral Management	Used for ordering referrals and procedures from other providers or services.
Oracle Scheduling Appointment Book	Used to schedule appointments for any procedure or surgery that requires anesthesia.

Name	Description
PowerForms	Enables the management of referrals.
Provider Profile Management System	Serves as the authoritative source of non-VA providers for VHA that offers a layer of validation of non-VA provider data and supports workflow management. Uses a provider locator to identify community care providers in a mapped proximity to a veteran's location for scheduling care.
Revenue Cycle	Supports administrative functions of patient registration, admission, discharge, transfer, and appointment scheduling.
Telehealth Management Platform	Used primarily for interfacility scheduling across the VA enterprise. Offers telehealth programs the ability to manage technical and clinical processes in one platform. Also supports communicating important information between providers, VA staff, and veterans.
TeleVox	Sends patients appointment reminders.
VEText	Used to send appointment reminders to veterans and allows them to either confirm or cancel their appointment.
Virtual Care Manager	Used by VA providers to manage virtual appointments. Assists in managing VA Video Connect appointments, either scheduled or on-demand. Also used as a backup system for schedulers.

Source: GAO analysis of VA documentation | GAO-26-109213

In addition, VA has mechanisms used to calculate, report, and monitor wait times. Specifically, VA employs tools for monitoring scheduling timeliness, providing estimates of wait times on its public website, and determining a veteran's eligibility, based on wait time, for community care. In addition, VA staff use a decision support tool to inform veterans about expected wait times.[14] We have made a number of recommendations related to VA's monitoring of wait times for community care, in particular. VA has taken actions to address some of these recommendations.[15]

VA Systems Present Challenges, and VA is Taking Steps to Address Them

Both schedulers and veterans have experienced challenges when using VA's systems to schedule appointments. Specifically, schedulers must navigate a complex environment when using VA's systems to schedule appointments.

According to VA documentation, VA facility staff are required to open multiple applications to schedule a single appointment. They must also

[14]The decision support tool is meant to help staff determine whether a patient is eligible for community care. The tool is intended to provide data such as drive time projections based on the veteran's home address, average wait times for the requested service at VHA facilities near the veteran's home, and average wait times for community care appointments.

[15]GAO, *Veterans Health Care: Opportunities to Improve Access to Care Through the Veterans Community Care Program* GAO-25-108101 (Washington, D.C.: Feb. 12, 2025).

run reports in different systems to identify veteran self-scheduled and self-canceled appointments and appointment requests. Navigating this complexity may make schedulers inefficient or require workarounds that may vary across sites. VA officials explained that this challenge is the result of operating two different platforms (VistA and Oracle Health), as well as having multiple versions of VistA. According to officials, the department is working to standardize veteran appointment self-scheduling at VistA and Oracle Health sites. However, they said the department has not yet determined how the modernized and updated products used for scheduling will interface and be used to pull and combine the data into a comprehensive report.

Consequently, the result is a labor- and resource-intensive process for VA staff that has continued to evolve over time. We found in 2020 that improvements were needed to ensure sufficient staffing for managing community care referrals and appointment scheduling.[16] In that report, we recommended that leadership assess 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. VHA concurred with the recommendation, but as of February 2026, the agency had not fully implemented it.

Veterans have also experienced challenges requesting an appointment online, getting confirmation once an appointment is scheduled, and receiving duplicative appointment reminders. Specifically, the veteran service organizations we spoke to for our prior work stated that veterans may experience a delay between submitting an appointment request online and hearing back from VA staff. Veterans may also receive redundant appointment reminders—letters, phone calls, emails, and text messages—due to multiple systems either at the facility or at the enterprise level sending duplicative messages. The department is working toward having one enterprise-wide solution to address these issues as well as updating the system that veterans use to adjust their notification preferences to allow more control for individuals.

Such challenges related to scheduling make it difficult for VA to ensure veterans receive quality care in a timely manner. For example, our prior work found that in fiscal year 2022, most VA facilities were unable to meet the standard VHA has established for scheduling community care

[16]GAO, *VA Health Care: Recommendations and Observations to Improve Community Care and Support for Caregivers Related to the Dole Act*, GAO-26-108943 (Washington, D.C.: Mar. 2, 2026) and GAO-20-643.

appointments.[17] Specifically, less than 40 percent of facilities scheduled more than half of their community care appointments within the 7-calendar-day standard. Further, fewer than 10 percent of facilities scheduled more than 75 percent of appointments within the standard.

A related challenge that compounds the difficulty VA faces in ensuring that veterans are receiving timely quality care is related to the return of medical documentation when veterans obtain care through non-VA community care providers. When receiving community care, veterans rely on VA facility staff and community providers to coordinate and maintain continuity of care. To coordinate this care, community providers must send medical documentation (e.g., diagnoses, prescriptions, progress notes) to VA after the veteran's initial and final visits for each referral. According to VHA officials, this coordination is especially important so that all a veteran's providers can be well positioned to make sound decisions about the veteran's care. This is especially important when a veteran receives care from a community provider and then returns to the VHA facility to continue receiving care from a VA provider. In our May 2025 report, we found that VA does not monitor whether these medical record exchanges are completed across all VA facilities.[18] We made three recommendations to address this issue, and VA concurred in principle with these recommendations. We continue to monitor the status of these recommendations, which remain open.

Further, among referrals we examined—specifically for behavioral health—we found that 33 percent (118,373 of 357,299) were missing records for initial visits, and no such data were available for final visits, so the extent to which those medical documentation exchanges occur is unknown. VHA officials told us that obtaining medical documentation from community providers is a key challenge because current medical documentation exchange processes are labor intensive and time-consuming for both VA facility staff and community providers. Specifically, they told us that VA facility staff often have to make repeated attempts to

[17]GAO-23-105617 In this report, we recommended that VHA conduct a comprehensive analysis of appointment scheduling data from all VA facilities to determine whether the community care timeliness standards are achievable and revise them as necessary. Subsequently, documentation provided by VHA showed that the agency's analysis validated our findings that many facilities were not meeting the current timeliness standard. VHA officials considered modifying the 7-day standard but ultimately decided not to make the change. We closed this recommendation as implemented.

[18]We analyzed data from VA's Corporate Data Warehouse on all 357,299 behavioral health referrals from fiscal years 2021 through 2023. See GAO-25-106910.

try to obtain documentation from community providers and may not ultimately be successful in retrieving it. Furthermore, VA facility staff often have to search multiple places when community providers do submit medical documentation because community providers vary in their submission methods (e.g., electronic fax, HealthShare Referral Manager, email).

One of VA's planned efforts to improve the process of medical documentation exchange is to increase use of the HealthShare Referral Manager among community care providers. VA facility staff told us they would prefer that these providers use the HealthShare Referral Manager because it keeps documentation in one place and prevents them from having to manage and track the use of multiple methods. Staff said they generally receive medical documentation more quickly from community providers who use this system compared to those who do not, requiring less follow-up by staff.

VA's Office of Information and Technology (OIT) and VHA have been collaborating to address systems challenges. They initiated a project to modernize VA's scheduling systems at sites with the VistA health information system.[19] The initiative includes several concurrent efforts to improve scheduling-related systems across VA's medical facilities. For example, one of these efforts is intended to allow provider-based scheduling, which is the ability to see a provider's schedule across multiple modalities (in-person, telephone, telehealth) in a single scheduling application. An additional tool would also be integrated to allow schedulers to search, view, and schedule in-person and virtual appointments in one application. Another effort is intended to address provider-based scheduling requirements by providing a web-based application to modernize and improve the efficiency of a clinic's scheduling operations.

VA is also deploying a software solution, referred to as External Provider Scheduling. The department acquired this solution for VA schedulers to schedule veteran appointments directly online with community care providers. Deployment has been in progress since 2024. Eventually, this

[19]OIT is a centralized office within VA that is responsible for providing IT services across VA and managing the department's IT assets and resources. According to VA, OIT's mission is to collaborate with its business partners (such as VHA) and provide a seamless, unified veteran experience through the delivery of state-of-the art technology.

software solution is expected to provide the capability for veterans to self-schedule community care appointments online.

In May 2025, we reported that while OIT and VHA had employed some key planning practices for the scheduling systems modernization effort, they had not fully employed others, such as including all IT work needed in the project schedule and fully developing a requirements management plan.[20] We made two recommendations to the department related to developing a comprehensive and credible project schedule and requirements management plan consistent with best practices for the scheduling systems modernization effort. VA concurred with our recommendations, and we are monitoring its progress in implementing them.

In conclusion, VHA's mission is to provide high quality health care for veterans. We have reported for many years on the department's challenges concerning its scheduling systems and their impact on delivering care to veterans. Our work has identified a number of actions that VHA can take to overcome these challenges. Fully implementing our recommendations would aid VA's progress toward providing timely, quality care to veterans.

Chairman Barrett, Ranking Member Budzinski, 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 Carol C. Harris at harriscc@gao.gov or Sharon M. Silas at silass@gao.gov. Contact points for our Offices of Congressional Relations and Media Relations may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Jennifer Stavros-Turner (Assistant Director), Julie T. Stewart (Assistant Director), Kevin R. Smith (Analyst-in-Charge), Jonnie Genova, and Scott Pettis.

[20]GAO-25-106851

Related GAO Products

VA Health Care: Recommendations and Observations to Improve Community Care and Support for Caregivers Related to the Dole Act, GAO-26-108943 (Washington, D.C.: Mar. 2, 2026).

Veterans Health: Improvements Needed to Achieve Successful Appointment Scheduling Modernization, GAO-25-106851 (Washington, D.C.: May 22, 2025).

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Prepared Statement of Jed Hansen

NEBRASKA RURAL HEALTH ASSOCIATION

WRITTEN TESTIMONY

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National Rural Health Association

Before the
U.S. House Committee on Veterans' Affairs: Subcommittee on Technology Modernization

"Delivering Quality and Modern Healthcare to Michigan's Veterans and Servicemembers"

June 8, 2026

Chairman Barrett, Ranking Member Budzinski, and distinguished members of the Subcommittee, thank you for the opportunity to testify today. I appreciate your leadership and the Committee's continued commitment to improving access to care and services for our nation's veterans and servicemembers.

My name is Dr. Jed Hansen. I serve as Co-Chair of the National Rural Health Association's Rural Veterans Health Special Interest Group and as Executive Director of the Nebraska Rural Health Association.

From my perspective, EPS represents the digitization of the MISSION Act. Congress expanded veterans' ability to receive care in their local communities through the MISSION Act. EPS provides the technology infrastructure needed to operationalize that access by connecting VA scheduling processes with community providers.

EPS helps translate eligibility into access. Veterans may be eligible for community care, but eligibility alone does not create appointments. EPS helps connect veterans, VA schedulers, and community providers through a more coordinated process that can reduce administrative burden, improve scheduling efficiency, and expand access to care.

The National Rural Health Association's Rural Veterans Health Special Interest Group recently identified expansion of EPS as one of its top policy priorities for 2026. Through discussions with rural providers, hospitals, researchers, veterans, policymakers, and community partners across the country, a common question continues to emerge: How do we move from successful pilots and early adopters to broad statewide utilization?

Nebraska is attempting to answer that question.

One lesson emerging from Nebraska is that technology adoption accelerates once critical mass

is achieved. Individual facility participation is important, but the greatest value is realized when enough providers participate that utilization becomes part of routine operations. Veterans do not receive care from a single facility. They receive care through networks of hospitals, clinics, specialists, behavioral health providers, therapists, dentists, and other community providers. Successful implementation must reflect how veterans actually access care.

To support this goal, the Nebraska Rural Health Association developed a statewide EPS expansion strategy with support from the Nebraska Hospital Association. The Nebraska Department of Health and Human Services recognized the potential of the approach and incorporated it into Nebraska's Rural Health Transformation Program (RHTP) strategy, creating a strong partnership around implementation.

The strategy seeks to support participation across Nebraska's broader rural healthcare network, including approximately 77 rural hospitals, 110 rural health clinics, all rural federally qualified health centers, and approximately 100 independent healthcare providers, including behavioral health providers, dental practices, therapy groups, and primary care clinics.

The objective is straightforward: create the critical mass necessary to support long-term adoption and utilization of EPS across the state.

Nebraska's approach also demonstrates how existing federal investments can be aligned to accelerate implementation. Through Rural Health Transformation Program funding, Nebraska plans to support interface development, provider onboarding, staff training, implementation assistance, and community engagement activities. The state anticipates providing approximately $75,000 per rural hospital or federally qualified health center and approximately $20,000 per independent provider site to support implementation efforts.

These are often the activities that determine whether technology adoption succeeds, yet they can be difficult for individual facilities to fund independently. Nebraska's experience suggests that states may already possess funding mechanisms capable of supporting EPS implementation if those resources are intentionally aligned with veteran access objectives.

The Nebraska strategy extends beyond scheduling technology alone.

A second component of Nebraska's strategy focuses on improving access to Compensation and Pension (C&P) examinations and strengthening the connection between veterans and the benefits they have earned through their military service.

The VA's efforts to pilot and expand scheduling of C&P examinations through EPS represent an important opportunity to improve access to benefits determination, particularly in rural

communities. Just as EPS can help connect veterans to healthcare services, it can also help connect veterans to disability evaluations that are often necessary to establish service-connected conditions and access benefits.

Nebraska's approach seeks to support those efforts in two ways.

First, Rural Health Transformation Program funding can be used to support provider participation in C&P examination training programs, helping expand the number of community-based providers capable of performing these examinations. Increasing local examination capacity has the potential to reduce travel burdens, improve convenience, and shorten the time required for veterans to complete the benefits determination process.

Second, participating hospitals and clinics may utilize funding to support local outreach and education efforts so veterans are aware that C&P examinations may be available within their own communities. Expanding capacity alone is not sufficient if veterans remain unaware of local options.

This effort is equally important for transitioning servicemembers. Timely access to disability evaluations and benefits determinations can help ensure servicemembers and their families receive the support and resources available to them as they transition from military service to civilian life.

Nebraska also plans to partner with the Veterans Benefits Administration as part of its regional Veteran Benefits and Resource Events. These events will provide opportunities to educate veterans about available benefits, connect them with resources, and, where appropriate, facilitate access to Compensation and Pension examinations and other benefits-related services.

Taken together, this approach reflects a broader lesson from Nebraska's implementation strategy: improving veteran access requires more than technology alone. It requires technology, provider capacity, and outreach working together to ensure veterans can successfully access both healthcare services and benefits.

The Nebraska model also recognizes that technology alone does not improve access if veterans are unaware of the services and benefits available to them.

As a second major component of the initiative, Nebraska plans to support regional Veteran Benefits and Resource Events. These events will bring together VA programs, Veteran Service Officers, veteran service organizations, community providers, caregivers, and local partners to improve awareness of available services and benefits.

The goal is to connect veterans and their families not only to healthcare appointments, but also to

the broader network of benefits, resources, and support services available to them. These events are intended to help veterans better understand eligibility pathways, disability benefits, community care options, caregiver resources, and other programs that can improve health and quality of life.

Technology can improve scheduling and coordination. Outreach and education help ensure veterans can successfully utilize the services available to them. Both are necessary.

Our experience with EPS, health information exchange initiatives, and other statewide healthcare modernization efforts suggests that technology adoption is most successful when innovative software is paired with trusted implementation partners.

Here in Michigan, the Michigan Center for Rural Health is an excellent example of the type of organization that can help convene providers, educate stakeholders, and support implementation efforts. Similar organizations already play important roles across the country, including the Texas Organization of Rural and Community Hospitals (TORCH), the Illinois Critical Access Hospital Network (ICAHN), state rural health associations, state hospital associations, and State Offices of Rural Health.

These organizations understand local healthcare delivery systems, maintain trusted provider relationships, and can help accelerate adoption in ways that national efforts alone often cannot.

Based on our national discussions and Nebraska's implementation experience, I respectfully offer five recommendations for the Committee's consideration.

First, continue supporting statewide implementation strategies that seek critical mass participation among community providers.

Second, support implementation efforts alongside technology deployment through provider onboarding, training, technical assistance, and outreach.

Third, encourage states to identify and leverage existing funding streams like RHTP that can support EPS implementation, provider participation, and veteran engagement.

Fourth, continue engaging trusted state and regional organizations that can serve as implementation partners and help accelerate adoption across community provider networks.

Finally, continue advancing interoperability efforts. Scheduling is an important first step, but future success will increasingly depend on stronger integration of referral information, clinical records, benefits processes, and care coordination workflows between VA and community providers.

NEBRASKA RURAL HEALTH ASSOCIATION

Chairman Barrett and members of the Subcommittee, EPS is demonstrating how technology can strengthen access to care for veterans while improving coordination between VA and community providers. Nebraska's experience suggests that successful implementation depends on achieving critical mass, supporting adoption, leveraging existing resources, expanding access to benefits determination, and maintaining a strong focus on veteran outreach and engagement.

While technology is an important part of the solution, the ultimate measure of success is whether veterans can more easily access the care, services, disability evaluations, and benefits they have earned through their service.

Thank you for your commitment to our nation's veterans and servicemembers. I appreciate the opportunity to testify and look forward to answering your questions.

Thank you for the opportunity to testify.



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Prepared Statement of Michael Reeve

Chairman, Ranking Member, and distinguished members of the Committee, thank you for the opportunity to provide testimony regarding the challenges Veterans in Shiawassee County, Michigan face when accessing VA healthcare.

I serve as the Director of Veterans Affairs for Shiawassee County and am also a Veteran with 27 years of Active Duty service. Through both my professional role and personal experiences, I have gained firsthand insight into the barriers Veterans encounter when seeking care through the Department of Veterans Affairs.

As a rural Michigan County, Shiawassee has a Veteran population of approximately 5,000 individuals. Many of the Veterans we serve are older adults, as our demographics suggest the average age is 75 years old. Many of these individuals have disabilities and limited transportation options. As of 2018, we have transported 4,729 Veterans to VA appointments at VA facilities or to referred health care providers. Accessing care often requires travel to VA facilities in Saginaw and Ann Arbor, which are urban, making reliable appointment scheduling and communication especially important. Please note, it takes our drivers 1 hour, 22 minutes to travel 74.5 miles to Ann Arbor or 52 minutes to travel 41.6 miles to Saginaw. (Battle Creek – 1 hour, 37 minutes at 102 miles, Detroit VA – 1 hour, 33 minutes at 87.2 miles)

Veterans frequently experience long wait times for appointments and specialized services. In some cases, they are told the next available appointment is more than a month away, leading some to seek care through emergency departments for more immediate attention.

We also encounter situations in which appointments at the Saginaw or Ann Arbor VA Medical Centers are canceled or rescheduled without timely notification. This can create unnecessary travel and strain limited transportation resources. I have experienced this personally, having driven to the Ann Arbor VA Medical Center for a scheduled appointment only to learn upon arrival that it had been canceled without prior notice.

Additionally, we have observed situations in which veterans establish successful relationships with local community care providers, only to have their care redirected back to a VA facility when the service becomes available through the VA system. These transitions can disrupt continuity of care and create frustration for veterans who must adjust to new providers or treatment plans.

From both my professional and personal perspectives, improving communication, reducing appointment delays, and supporting continuity of care would significantly enhance veterans' access to healthcare services.

The challenges we see in Shiawassee County reflect broader trends affecting veterans throughout Michigan and across the Nation. More than 30 percent of Michigan's veterans live in rural communities where transportation barriers and travel distances complicate access to care. Federal oversight agencies and independent researchers have also identified ongoing concerns regarding appointment scheduling, wait times, and coordination within both the VA and Community Care systems. These findings reinforce what we experience every day at the county level—that timely communication, efficient scheduling, and reliable care coordination are essential to ensuring veterans receive the healthcare they have earned through their service.

I appreciate Congressman Tom Barrett's leadership and collaboration on the Veterans Community Care Scheduling Improvement Act, as well as the continued utilization of the External Provider Scheduling (EPS) system. These efforts represent meaningful steps toward improving care coordination and helping veterans access the healthcare services they have earned through their service to our Nation.

Thank you for your attention to this important issue and for your continued commitment to improving access to care for America's veterans. I look forward to answering any questions you may have.

Prepared Statement of Ben Frederick

Chairman Barrett and Ranking Member Budzinski:

Thank you for the invitation to participate in this hearing and to offer comments on providing world-class healthcare services to our veterans in Mid-Michigan. My name is Ben Frederick, and I serve as Associate Vice President of Advocacy, Government Relations and Business Development for Memorial Healthcare, a mid-sized independent rural hospital located in Owosso, Michigan.

Memorial Healthcare very much aligns with the mission of the committee from which this subcommittee derives, as the origins of our hospital were directly inspired by the Owosso community's desire to serve the veterans of Mid-Michigan following World War I. Our original 1921 edifice still stands as an ongoing memorial honoring those veterans and the many who have followed. In fact, our legal name remains "The Memorial Hospital," and our campus is home to Owosso's war memorial honoring those who perished in the War to End All Wars.

Our system CEO Brian Long sends his best regards to this committee and regrets being unable to address you personally. Mr. Long is himself a veteran of the United States Marine Corps, and many members of our leadership team and workforce are proud veterans of the United States military. The culture of Memorial has long included recognition of our team members who served, and a commitment to providing healthcare to the veterans who live within the communities we serve.

To that end, we flag a patient's veteran status during our intake process to ensure a ready connection with available services. We also strive to ensure veterans are aware of their benefits and are enrolled as participants in the Community Care Program.

One of our most solemn traditions is a "code honor," which marks the passing of a patient or long-term care resident at our facility.

Thank you, Chairman Barrett, for your efforts to ensure that the VA proactively notifies veterans of their option to receive care through community providers. Previously, veterans had to know to ask to use their hometown service providers. This simple change in how that conversation is initiated at the VA will drive convenience, timely care, and better outcomes – and ultimately yield savings to the VA system.

In 2025, we served over 400 veterans in our inpatient settings and 400 in outpatient care. Hundreds more were served with differing primary insurance. We are not satisfied with those totals, however, as they represent only a small portion of the estimated veteran population living in Shiawassee County.

As a community hospital in a rural region, our patients already face significant challenges that limit access to essential healthcare services. Our veterans carry the additional burden of wounds both seen and unseen, which can affect their willingness to seek care in the first place.

Research has also consistently shown that independent community hospitals deliver cost savings to patients. This reflects the continuous innovation occurring at health systems like Memorial as we work to provide world-class care while navigating the complexity of both reimbursement and regulation. Our competitive advantage is personalized patient care – the direct connection we establish with each individual in addressing their specific needs. From the first scheduling call through every follow-up contact, our team is engaged in a way that larger systems often cannot replicate.

From a fiscal sustainability standpoint, which is a particularly sensitive point for a rural hospital, we want to recognize the VA for its payment performance. Our operational team reports that, for patients who do receive care through us, subsequent denials are minimal and the overall record of paid claims is excellent.

Access to test results completed through the VA would also meaningfully improve care continuity. Currently, the patient is expected to ensure these results reach our practitioners – a gap that creates delays and the potential for duplicate testing and places an unnecessary burden on individuals who may already be managing complex health needs.

Taken together, the overarching concern I wish to bring to this committee on behalf of our team is the degree of self-advocacy veterans must exercise simply to remain connected with their own care. At every stage of the process, the burden falls on the veteran to initiate, follow up, and navigate a system that does not always communicate across its own components. Technology has an important role to play in reducing that burden.

The most immediate and pressing obstacle is the prior authorization process. An authorization is required at the outset for primary care services, and separate authorizations are then needed for any specialty or diagnostic referrals. Each is time-limited, and each requires the veteran to advocate proactively at every subsequent stage for a local option – primary care, diagnostics, and specialty. Memorial Healthcare is not able to assist veterans in navigating these authorizations as we do with other payer coverages, which results in delays, duplication of effort, and frustration as local providers struggle to stay integrated with VA care teams. There is not presently any communication with Memorial's scheduling team to ascertain our "next available" appointment when the VA is weighing the most timely option.

In closing, we deeply value the opportunity to honor every patient's choice of where to receive care – and we take particular pride in the trust our veterans have

placed in us. We would welcome the chance to serve more of our local veterans, should they wish to choose Memorial as their local provider of record.

Thank you again to this committee for your focus on removing barriers to locally delivered care, and for the opportunity to share our perspective.

Reference Points for potential questions and summation:

Tech integration:

Memorial scheduling access: Currently, all professional visits are routed through Memorial's scheduling team for individualized follow-up. This aligns with an organization policy to ensure advance access to patient record information and other necessary context, particularly in the specialist vein before an appointment is confirmed. We are open to engaging with our employed providers and administrative team on this topic.

A significant concern with any direct scheduling integration is inadvertent disclosure of protected health information. Granting VA staff access to our Expanse scheduling system would expose the records of all scheduled patients – not just those with VA affiliation. There is no clear business justification for VA associates to have visibility into non-VA patient information, and that HIPAA exposure would need to be squarely addressed before any integration could move forward.

Assuming that HIPAA concerns were resolved, a second challenge is the training investment required. VA associates would need substantive onboarding in our Expanse system – not just a surface-level orientation.

- That would include understanding system limitations and scheduling guidelines; correctly capturing demographic, employment, and insurance information; entering prior authorization data in the right location for our billing department; uploading orders and referrals; and managing the effective dates, visit limitations, and end dates tied to each authorization. These are not simple tasks – they require a working knowledge of our workflows and the precision our billing process depends on.

There is also the matter of need-specific scheduling constraints. A procedure like an MRI with sedation, for instance, can only be scheduled in certain blocks because of our contracted anesthesia availability. This is a rural reality – and any integration would need to account for those capacity limitations, not simply open a generic scheduling portal.

- Beyond scheduling itself, our staff currently provides detailed preparation instructions to patients before any procedure that requires advance steps – walking them through what to do, what to bring, and how to find the right location. That patient education happens during intake and pre-appointment contact and is central to the personalized care experience we provide. Any hand-off to external staff would require that same level of thoroughness.

Memorial is not consulted when the VA is weighing referral options. We have no channel through which to communicate our availability or capacity, other than through the veteran directly asking. If a member of this committee is inclined to explore a remedy, one practical ask would be for the VA to establish a Secure File Transfer Protocol (SFTP) inbox that would allow their electronic health record system to push notifications of new orders, prior authorizations, referrals, and service approvals directly to community providers like us. That single step would dramatically improve communication and reduce the lag time that currently affects patient care.

Diagnostic Linkage: On the diagnostic side, when a veteran has completed testing through the VA, those results rarely make their way to us automatically. The veteran is expected to ensure the transfer of those records. In practice, this means our practitioners sometimes see patients without the foundational information they need – which leads to redundant testing, delayed diagnoses, and unnecessary cost. A structured result-sharing mechanism between VA and community providers would go a long way toward closing this gap.

Notes on Financials:

The most common reason for VA claim denials is expired authorization – specifically, when the visit limit or date constraint on a prior authorization has lapsed and services are rendered outside those parameters. Currently, there is no pathway to request retroactive approval for provider visits after that happens (though admissions, observations, and emergency visits have a 72-hour notification rule that provides some relief). A similar after-the-fact notification option for outpatient provider visits would be genuinely helpful. The combination of visit-count limits and date

windows – say, four visits within 6 months not to exceed 6 months – creates ambiguity, and our teams and veterans sometimes miss one qualifier or the other.

On the contracting side, Memorial currently operates under single-case arrangements with the VA rather than any formal agreement, and both parties have expressed interest in changing that. The challenge is that we cannot accept a contracted fee schedule on behalf of our independent partners – pathology and radiology groups, for instance – who set their own rates and would need to be part of any negotiated arrangement. In approaching rural providers, this should be accounted for.

Memorial cannot initiate a referral on a veteran's behalf. If a veteran is seen at our facility and our providers determine that specialty care or additional diagnostics are warranted, the veteran must return to the VA to request that referral, and the VA then determines whether and how to proceed. We have no ability to advocate for the patient within the VA system nor speak to our readiness to provide timely care, which creates a gap in care coordination that falls squarely on the veteran to bridge.

The downstream consequence of that gap is redundant testing, delays, and in the case of our mid-Michigan veterans, a lot of unnecessary travel. Without seamless information sharing, veterans frequently undergo the same diagnostic work twice – once at the VA and again at a community provider who lacks access to the prior results. This is wasteful, burdensome for the patient, and entirely avoidable with better system integration.

