Relaxing Barriers to Care
Through Veterans Choice and Mission Act

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Abstract

We use a difference in difference approach to study how the Veteran's Choice and Mission Acts' provision of local community care to geographically isolated veterans impacted Veteran's Health Administration facility level measures of backlog and wait times. We find evidence that access to local care leads to a reduction in appointment loads, share of appointments completed over 30 days, and mental health wait times. We find stronger effects at Veteran's Health Administration Clinics as opposed to Hospitals and substantial heterogeneity whether access to care was provided via the 2014 Choice Act or the expanded 2018 Mission Act with the Mission Act having a greater impact on share of appointments completed over 30 days. We also find evidence that reduced backlog increased the quality of care, where Hospitals that were more impacted by the Mission Act experienced a decrease in risk adjusted 30-day mortality rates.

Introduction

The Veteran's Health Administration (VHA) is one of the largest medical providers in the United States, providing care to more than 9 million veterans across the United States and abroad (VHA 2025). Past work has found that receiving care from the VHA has led to many positive benefits for veterans. These include reduced mortality after ambulance visits (Chan et al 2023), increased healthcare utilization, decreased food insecurity, and decreased homelessness (Silver and Zhang 2022). Despite these benefits, historically the VHA has not always been able to provide veterans with the care that they need in a timely manner.

For instance, in April 2014 CNN reported that excessive wait times at the Phoenix AZ VA medical center lead to the deaths of 40 veterans who were waiting months to receive care (Bronstein and Griffin 2014). As a result of the controversy, the United States congress passed the Veterans' Access to Care through Choice, Accountability, and Transparency Act or the Choice Act that was signed into law on August 2014. One of the provisions of the Choice Act intended to provide timely access to care was the option for veterans who lived more than 40 miles away from the closest VHA hospital or clinic to be able to access local private community care. This was followed by an expansion of the program, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, or the Mission Act which now allowed veterans who lived more than a 30-minute drive away from their closest VHA facility to access private care.

In this paper, we examine the impact of the Veteran's Choice and Mission Act on measures of backlog and quality of care at VHA facilities. The option for geographically isolated veterans to receive care at local private facilities may have led to a reduction in patient loads that may have not only lowered wait times but also allowed VHA facilities to provide more adequate care to veterans given less constraints. We do this by using a difference in differences approach where we leverage VHA facilities differing exposure to the distance criterion for access to private care as measured by the share of veterans who meet the eligibility criterion of the two policies. For the Choice Act we use the event time of August 2014 and measure exposure by the share of veterans in the facility's service area residing 40 miles away from their nearest facility. While for the Mission Act we use the event time of June 2018 and measure exposure by the share

of veterans in the facility's service area that live between 20 and 40 miles away from their nearest facility.

Overall, we find that Choice Act led to a decline in total appointments at facilities that were more exposed to the policy, and that the Mission Act led to a decline in the share of appointments completed in more than 30 days for facilities that were more exposed to the policy. We also find that both policies lead to a reduction in wait-times for mental health and primary care appointments. For instance, for mental health appointments we find that a standard deviation increase in percent of veterans eligible for each policy led to between a 4 to 6.3 percent decline in average wait days for mental health appointments. We also find substantial heterogeneity in results for whether the VHA facility is a VA hospital or clinic. For instance, we find stronger impacts on appointments and share of appointments completed in over 30 days for VHA clinics. While for the Mission Act, we find stronger impacts on both mental health and primary care wait times for VHA hospitals.

Additionally, we also examine the impact of the Mission Act on quality of care at VHA facilities. This is because relaxation of patient loads may allow VHA facilities to provide better quality of care to patients. We do this by using quarterly data on 30-day risk adjusted mortality rates following acute hospital care from the VHA's Strategic Analytics for Improvement and Learning (SAIL) program. We find that Hospitals that were more exposed to the Mission Act, experienced a decline in 30-day mortality rates, where a standard deviation increase in share of veterans eligible for the Mission Act was associated with a 3% decrease in 30-day mortality.

Overall, this paper contributes to the literature examining the impact of backlog on various health outcomes. For instance, Riganti et al. (2017) find that demand for surgical procedures does not respond dramatically to wait-times. While Moscelli et al. 2016 shows that long waiting times for non-emergency services has no effect on mortality rates from coronary bypass surgery. The fact that we find a reduction in the share of appointments completed in more than 30 days, primary care wait-times, and mortality from acute care suggests that seeing veterans in a timely manner for less serious issues may lead to better outcomes in the event that a patient requires a sudden hospitalization or operation. Additionally, this suggests that reductions in backlog may have a differential impact on VHA services than other healthcare providers.

This paper also contributes to the literature examining the impact of VHA usage on health and economic outcomes. Chan et al 2023 study the impact of emergency ambulance service to VHA facilities on mortality, while Silver and Zhang examine the impact of higher service disconnected disability rating (the VHA's system's for prioritizing care) on healthcare usage, mental health outcomes, homelessness, and food security. More closely related to this paper, is work examining the impact of the Choice Act on veteran's outcomes and private care usage (Saruya, Wagner, and Zhu 2023). Similar to our findings, Saruya, Wagner and Zhu find that that veteran's eligible for the Choice Act switched from VHA to private care and experienced decreases in mortality. Our paper takes a different approach by exclusively focusing on the impact of not only the Choice Act but also the Mission Act on VHA facilities. By doing this we are also able to estimate the impact that the Choice and Mission Act have on veterans that still use VHA facilities either because they chose to continue receiving care at VHA facilities or because they did not meet the eligibility criteria. The findings of this paper therefore suggest that increasing options for private care, benefitted other veterans who were ineligible for private care by reducing wait-times and decreasing mortality.

Our findings that both the Choice Act and the Mission Act decreased wait times are especially important considering high rates of mental health distress and suicide among veterans. For instance, the U.S. Department of Veterans Affairs (VA) estimated that veterans were 57.3% more likely to die by suicide compared to similarly aged non-veterans of the same gender. Additionally, more than half of the 5 million veterans that experienced some form of mental health crises in 2020 had not received any treatment in the previous year (Owens, 2022). If receipt of care is negatively impacted by mental health appointment wait times, then our findings suggest that the Mission and Choice Act may help veterans experiencing mental health crises receive care.

Background

The VHA's provision of care largely depends on the provision of funds made available to it by Congress. Because of this the VHA decides which veterans it serves based on a priority system. This priority system depends on a veteran's income level, service-connected disability rating, which is a measure of health issues acquired during a veteran's service period, and in recent

years level of exposure to environmental toxins. A veteran's priority status not only determines whether a veteran is approved to receive care at a VHA facility but also determines out of pocket expenses incurred from receipt of care (Congressional Budget Office 2022).

In 2021, there were 16.5 million veterans in the US population (US Census Bureau 2023). Of these 16.5 million, 9.2 million are enrolled in VHA, with 6.2 million actively receiving healthcare through the VHA (Congressional Budget Office 2022). To serve this population, the VA has over 160 VA medical centers, which are VA hospitals, and over 1000 clinics, rehabilitation centers, and other specialized care facilities. Figure 1 provides a snapshot of the spatial distribution of veterans by showing veteran population share in Panel A, and spatial distribution of VHA Hospitals and Clinics in Panel B.

If veterans were evenly distributed across the VA health system, then that would mean each facility would serve roughly 5,300 veterans. Of course, Hospitals have a greater capacity to serve more veterans than clinics, and as Figure 1 shows there are particular areas in the country, like the Midwest and Northwest, were veterans comprise a large share of the population and yet there is a scarcity of facilities. Additionally, there may be geographic sorting of veterans that is related to relevant health determinants like age that may lead to certain facilities facing more demand than others. All of these factors can lead to differences in backlog and wait times, especially if the VHA is unable to quickly adjust its facility presence and staff size due to congressional restrictions.

As mentioned in the previous section, the VA Choice Act was implemented in response to the VA wait times scandal, were CNN reported that excessive wait times lead to a significant number of veteran deaths. After the news broke regarding Phoenix's wait time issues, several other stories broke of veterans at other facilities facing long wait times, as well as the manipulation of wait time data to make facilities appear compliant with VA policy. This prompted the federal government to audit facility level appointment and wait time data that was made publicly available starting in May 2015 via the VA's Patient Access data, which is used as a data source in this project. Shortly after, the Choice Act was signed into law on August 2014, and as part of the law facilities had to be ready to provide the services required by the law within 90 days of the law's passage.

The Choice Act as a whole was meant to solve the underlying issues leading to backlog. Provisions of the law included easing the VA's ability to fire staff and doctors, including senior officials. The act also authorized and provided more funding for the opening of new VHA facilities and hiring more doctors. Most important for this paper, veterans were given Choice cards that allowed them to access local private care if they're closest VA facility was 40 miles or more away, or if wait times for primary care and mental health appointments exceeded 30 days. Initially under the Choice Act, the VHA would not necessarily cover all expenses incurred at private facilities and there were issues with the sharing of medical files between VHA facilities and private partners (Congressional Budget Office 2022).

The Choice Act was further strengthened in June 2018 with the Mission Act. This program extended eligibility requirements for receipt of outside care. Veterans who were eligible under the Choice Act were grandfathered into the program. Eligibility for private care was expanded to veterans who lived more than a 30 minute drive away from their closest facility, experienced wait times for primary and mental health care that exceeded 20 days, and who couldn't receive the quality of care that they needed at a VHA facility. Additionally, by the time the Mission Act eased information sharing between private providers and the VA and required the VA to completely cover the costs of outside care (Department of Veteran's Affairs 2019).

Under the Choice Act, 1.3 to 1.8 million veterans, roughly 14 to 20 percent of enrolled veterans, received authorization to receive outside local private care between 2014 to 2018. The number of veterans eligible for outside care increased to between 2.1 and 2.3 million veterans, roughly 23 to 25 percent of enrolled veterans, after the passage of the Mission Act in 2019 and 2020. During this time period the number of enrolled veterans only modestly increased from 9.0 to 9.2 million veterans, and the number of active patients only increased from 6.0 to 6.3 million veterans (Congressional Budget Office 2022). Under both Acts it is possible for veterans to still receive care from private and VHA, however it remains an open question to what extent the Choice and Care Act lead to the easing of backlog in facilities with more eligibility.

Data and Methodology

We use data from the VHA's publicly archived Patient Access Data, Strategic Analytics for Improvement and Learning (SAIL) data, and the American Community Survey. The Patient

Access Data reports monthly appointments, wait times, and share of appointments completed within certain time frames for VHA clinics and hospitals across the United States. The American Community Survey provides tract and county level veteran characteristics including population size, age, race, gender, employment, median earnings, service-connected disability ratings, as well as period of service. Data from SAIL provides quarterly measures of quality of care including acute care 30-day risk adjusted mortality.

The three data sources were merged together to create a monthly facility panel that contained appointment loads, appointment completion times, wait times, mortality rates, and veteran characteristics for veterans in each facility's service area. First each facility was geocoded by using publicly available addresses of VHA hospitals and clinics. Then after each facility was geocoded, we calculated the closest distance of each census tract to each facility while recording the facility closest to each tract. Each facility's service area was defined as the set of census tracts who were closest to that facility. Then using the data from the ACS, we collected characteristics of veterans in each facility's service area, including the share of veterans between 25-40 miles away from the facility and more than 40 miles away from the facility.

For the Choice Act we defined exposure as the 2013 percent of veterans in the facility's service area that resided in a census tract 40 or more miles away from the facility using straight line distance. While for the Mission Act we defined exposure as the 2017 share of veterans in the facility's service area that resided in census tracts between 20 and 40 miles away from the facility using straight line distance. We used lagged exposure shares to avoid simultaneity bias from exposure shares changing in response to the policy.

There are a couple of issues to point out regarding definition of exposure. We use the maximum cutoff of 40 for the Mission Act since we are evaluating the impact of expanded eligibility from the Mission Act instead of just eligibility that included veterans formerly eligible under the Choice Act. The lower cutoff is set to 20 miles, since 20 miles is a safe estimate for not residing within the same locality as a facility. Furthermore, as long as the average speed limit for traveling between cities or towns is less than 40 miles per hour than veterans who reside within 20 miles are still eligible for the program. Additionally, since we are using straight line distance, instead of actual road distance we are likely underestimating distance and drivetime to facility, and hence the share of veterans eligible for the program.

We split the panel into a Choice Act and Mission Act sample. The Choice Act sample ranged from the earliest available month of Patient Access Data, June 2014, until two years after the passage of the Choice Act August 2016. While the Mission Act sample ranged from May 2017 until February 2020 right before the start of shutdowns from the COVID 19 pandemic. For the quality analysis we use a quarterly facility panel that ranges from the second quarter of 2017 until the fourth quarter of 2019 to roughly match the Mission Act monthly panel time frame. For the quality analysis we focus on the Mission Act's expanded eligibility since the earliest available date of quality measures is the first quarter of 2015.

To estimate the impact of the Choice and Mission Act on backlog measures we estimate the following two-way fixed effects difference in difference equation.

$$(1) \quad Y_{i,t} = \alpha_i + \theta_{t,f} + \beta Post_t \times Exposure\ Share_i + \varepsilon_{i,t}$$

The subscript i is for facility and t is for year-month combination t. Our outcomes include log appointments, percent of appointments completed in 30 or more days, electronic wait list which measures new enrollees, percent of electronic waitlist exceeding more than 30 day waits, and wait times for mental health, primary care, and specialty care. We include facility level fixed effects with α_i and year-month facility type specific fixed effects with $\theta_{t,f}$. $Post_t$ is an indicator for whether the year-month observation occurred after the policy was passed, August 2014 for the Choice Act and June 2018 for the Mission Act. $Exposure\ Share_i$ is a one year lagged veteran share in the facilities service area that were in the policy eligibility thresholds, 40 or more miles for the Choice Act and between 20 to 40 miles for the Mission Act. All standard errors are clustered at the facility level.

To estimate the impact of the Mission Act on quality of care we estimate the following two-way fixed effects difference in difference equation.

$$(2) \quad Mortality_{i,q} = \alpha_i + \theta_q + \beta Post_q \times Exposure\ Share_i + \varepsilon_{i,q}$$

$Mortality_{i,q}$is 30-day risk adjusted mortality following receipt of acute care at VHA hospital i in year quarter q. Equation (2) is similar to Equation (1) except that we include year-quarter fixed effects θ_q .$Post_q$ is equal to 1 starting the third quarter of 2018 after the Mission

Act was passed. The sample period for equation (2) is 5 year-quarters before the Mission Act and 5 year-quarters after the Mission Act was passed.

Additionally, we perform heterogeneity analysis on equation (1) where we interact the $Exposure\ Share_i$ variable and the year-month fixed effect with the facility type. This is to allow for differential impacts of the Choice and Mission Act between VHA hospitals and clinics. We also estimate event study corollaries for equation (1) and (2) in order to assess timing of impacts and to examine if there is visual evidence for parallel trends before the policy is implemented. Specifically, we estimate the equation below.

$$(3) \quad Y_{i,t} = \alpha_i + \sum_{l=-\tau}^{T} \theta_l \, 1(t - Event = l) \times Exposure\ Share_i + \varepsilon_{i,t}$$

In equation (3) l represents leads and lags. $Event$ is the policy implementation date, August 2014 for the Care Act and June 2016 (or quarter 3 2016 for quality analysis) for the Mission Act. We plot the estimated coefficients θ_l along with the 5 percent level of significance confidence interval. The omitted category is $l = -1$, so that θ_l is relative to one period prior to the event.

Results

Our first set of results is presented in Table 1, where we estimate the impact of the Choice and Mission Act on appointments, appointment completion times, and electronic wait list composition. Panel 1 examines outcomes resulting from the Choice Act, while Panel 2 examines outcomes resulting from the Mission Act. Panel 1 shows that more exposure to the Choice Act was associated with less log appointments, where a 1 percentage point increase in veteran share living more than 40 miles away from the facility was associated with a 3.1% decline in appointments after the Choice Act was implemented. Although not statistically significant we see that the choice act was also associated with a decline in the share of appointments completed in more than 30 days.

Panel 2 shows that increased eligibility for private care through the Mission Act was not associated with a statistically significant change in log appointments. However it was associated

with a statistically significant decline in the share of appointments completed in more than 30 days, where a 1 percentage point increase in veteran share living between 20 to 40 miles away from the facility was associated with a 1.3 percentage point decline in the share of appointments completed after 30 days.

Figures 2 and 3 present the event study results for log appointments following the Choice Act and percent of appointments completed after 30 days following the Mission Act. Both event study plots provide evidence of parallel trends prior to treatment and both show a persistent decline in the outcomes of interest after the policies are implemented. However, we do see that there is more precision in the estimates for the impact of the Choice Act on log appointments.

Table 2 examines the impact of the Choice and Mission Act on wait-times. The outcome of interest in Columns (2) –(4) is average monthly wait time in days for mental health, primary care, and specialty care appointments, while the outcome of interest in Column (1) is a wait time index constructed from the first principal component of the three wait time measures in Columns (2)-(4). Table 2 shows that both the Choice and Mission Act are associated with a decline in average wait-days for appointments at VHA facilities. This is especially the case for mental health, where a 1 percentage point increase in policy exposure is associated with a 0.016 and 0.0093 decline in average wait-days for a mental health appointment after the implementation of the Choice and Mission Act respectively. This is equivalent to a standard deviation increase in exposure leading to between 4 to 6.3 percent decline in wait days relative to the pre-treatment mean.[1] Additionally, we see that the Mission Act was also associated with a decline in wait times for primary care appointments, where a 1 percentage point increase in policy exposure is associated with a 0.012 decline in average wait days for primary care appointments after the Mission Act is implemented. This is equivalent to a standard deviation increase in exposure leading to a 4.2 percent decrease in wait days for primary care appointments relative to the pre-treatment mean.

Figures 4 and 5 present event study results for mental health wait days following the Choice Act and primary care wait days following the Mission Act. The mental health event study provides evidence of parallel trends prior to treatment, while the primary care event study shows

[1] A standard deviation increase in exposure for the Choice Act is about 7.5 percentage points, while for the Mission Act it is about 13.7 percentage points.

some evidence of decreasing trends before the policy however we can not reject that the pre event coefficients are not equal to zero. Both event studies show fairly persistent yet imprecise declines in the outcomes of interest after the policies are implemented. We do see some seasonal fluctuations that still remain even after including year-month fixed effects.

Next Table 3 and 4 report heterogenous impacts of the Choice and Mission Act on appointment and electronic waitlist composition by facility type respectively. Panel 1 in both tables presents estimates for VHA clinics, while Panel 2 in both tables presents estimates for VHA hospitals. Table 3 shows that the impact of the Choice Act on log appointments is stronger for VHA clinics than VHA hospitals. Table 4 shows little difference between facility type in the coefficient on percent of appointments completed in more than 30 days. However, we do see that for clinics the Mission Act was associated with a decline in the share of new patients on the Electronic Wait Lists for longer than 30 days. It is important to note that the estimates for clinics are more precise than for Hospitals perhaps due to the larger sample size of clinics relative to Hospitals.

Table 5 and 6 examine heterogeneous impacts of the Choice and Mission Act on wait times by facility type respectively. Table 5 shows that similar to Table 3 and 4 estimates on clinics are more precise. Despite this it appears that the Choice Act had a bigger impact on wait times at VHA clinics as measured by the coefficient on the wait time index, primary care, and specialty care wait days. Table 6 on the contrary shows that the Mission Act had a stronger impact on wait times at VHA hospitals than on VHA clinics.

Finally, Table 7 presents results examining the impact of the Mission Act on quality of care at VHA hospitals as measured by 30 day risk adjusted mortality following acute care. Column (1) measures exposure as in Tables 1-6 as percent of veterans who live between 20 and 40 miles away from the facility, while Column (2) measures exposure as being above the median in share of veterans who live between 20 and 40 miles away from the facility. Table 7 shows a modest decline in mortality for hospitals more exposed to the mission act. The estimate in column 1 suggests a standard deviation increase in exposure (roughly 10.3 percentage points) is associated with a 2.9 percent decline in mortality relative to the mean, while being above the median in exposure is associated with a 5.2 percent decline in mortality relative to the mean. Figure 6 shows the results of the event study and shows evidence of parallel trends prior to the

policy being implemented and persistent declines in mortality at least up until the final period right before the COVID 19 pandemic.

Conclusion

In this paper we study the impact of the VA Choice and Mission Act, which allowed geographically isolated veterans the option to pursue private care sponsored by the VA, on measures of backlog, wait times, and quality of care at VHA facilities. We find that facilities that had more veterans in their service area eligible for private care under both the VA Choice Act and Mission Act lead to a decline in backlog at VHA facilities, albeit in different ways. The Choice Act impacted total appointment loads, while the Mission Act lead to a higher share of appointments being completed within 30 days. Both acts reduced wait days for appointments at facilities. We also find evidence that the Mission Act improved quality care for veterans who still received services at facilities that were more exposed to the Mission Act. Specifically, we find a decline in 30-day risk adjusted mortality after receiving acute care at a facility.

Overall, these findings suggest that the policies were successful in reducing backlog problems, especially wait-times at facilities that had a high share of veterans who were geographically isolated from facilities. Furthermore, we provide evidence that this reduction in backlog may have benefitted veterans who still received care at these facilities. Although our quality of care measure is restricted to acute care, future work should consider the impact on other aspects of care, especially mental health services.

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Tables

Table 1: VA Choice & Mission Act Impact on Appointments

Panel 1: Choice Act				
	(1)	(2)	(3)	(4)
VARIABLES	Log Appointments	% Appts Complete 30+	Electronic Wait List	%Electronic Wait List 30+
Post x Exposure Share	-0.0312***	-0.00773	-0.328	-0.163
	(0.00436)	(0.00700)	(0.664)	(0.178)
Pre Treatment Mean	8.61	1.68	85.0	31.8
Observations	22,469	22,469	22,805	11,314

Panel 2: Mission Act				
VARIABLES	Log Appointments	% Appts Complete 30+	Electronic Wait List	%Electronic Wait List 30+
Post x Exposure Share	0.000147	-0.0127***	0.243	-0.0608
	(0.000335)	(0.00455)	(0.183)	(0.0867)
Pre Treatment Mean	7.43	2.67	43.8	52.2
Observations	28,846	28,846	28,852	11,090

Standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Table 1: Presents results from the Difference in Difference estimates of the impact of the Choice Act and Mission Act on appointment measures. Panel 1 is the Choice Act analysis and ranges from May 2014 to August 2016. Panel 2 is the Mission Act analysis and ranges from May 2017 until February 2020. Post is an indicator for post policy implementation, August 2014 for the Choice Act, June 208 for the Mission Act. While Exposure Share is the share of veterans in the facilities service area that are eligible for the policy. Each regression includes facility specific fixed effects as well as facility type specific year-month fixed effects. Standard errors are clustered at the facility level.

Table 2: VA Choice Act Impact on Wait Times

Panel 1: VA Choice Act

VARIABLES	(1) Wait Time Index	(2) Avg MH Wait (Days)	(3) Avg PC Wait (Days)	(4) Avg SC Wait (Days)
Post x Exposure Share	-0.00789***	-0.0163**	-0.0209	-0.0221
	(0.00211)	(0.00763)	(0.0135)	(0.0141)
Pre Treatment Mean	-0.693	1.94	2.68	2.15
Observations	21,408	22,227	22,372	21,489

Panel 2: VA Mission Act

VARIABLES	Wait Time Index	Avg MH Wait (Days)	Avg PC Wait (Days)	Avg SC Wait (Days)
Post x Exposure Share	-0.00308*	-0.00929*	-0.0122***	0.000158
	(0.00170)	(0.00488)	(0.00465)	(0.0102)
Pre Treatment Mean	-0.24	3.16	3.93	5.25
Observations	27,390	28,365	28,721	27,662

Standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Table 2: Presents results from the Difference in Difference estimates of the impact of the Choice Act and Mission Act on wait times. Panel 1 is the Choice Act analysis and ranges from May 2014 to August 2016. Panel 2 is the Mission Act analysis and ranges from May 2017 until February 2020. Post is an indicator for post policy implementation, August 2014 for the Choice Act, June 208 for the Mission Act. While Exposure Share is the share of veterans in the facilities service area that are eligible for the policy. Each regression includes facility specific fixed effects as well as facility type specific year-month fixed effects. Standard errors are clustered at the facility level.

Table 3: VA Choice Act Heterogenous Impact on Appointments

Panel 1: Clinics				
VARIABLES	(1) Log Appointments	(2) % Appts Complete 30+	(3) Electronic Wait List	(4) %Electronic Wait List 30+
Post x Exposure Share	-0.0319***	-0.0113	0.0934	-0.176
	(0.00462)	(0.00728)	(0.255)	(0.194)
Pre Treatment Mean	8.51	1.44	28.3	30.5
Observations	18,652	18,652	18,980	7,779
Panel 2: Hospitals				
VARIABLES	Log Appointments	% Appts Complete 30+	Electronic Wait List	%Electronic Wait List 30+
Post x Exposure Share	-0.0214**	0.0457*	-7.547	-0.0783
	(0.00865)	(0.0277)	(10.25)	(0.449)
Pre Treatment Mean	9.05	2.78	368.5	34.5
Observations	3,817	3,817	3,825	3,535

Standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Table 3: Presents results from the Difference in Difference estimates of the impact of the Choice Act on appointments by facility type. The sample from May 2014 to August 2016. Panel 1 presents results for VHA clinics while Panel 2 presents results for VHA Hospitals. Post is an indicator for post policy implementation, August 2014. While Exposure Share is the share of veterans in the facilities service area that are eligible for the policy. Each regression includes facility specific fixed effects as well as facility type specific year-month fixed effects. Standard errors are clustered at the facility level.

Table 4: VA Mission Act Heterogenous Impact on Appointments

Panel 1: Clinics				
	(1)	(2)	(3)	(4)
VARIABLES	Log Appointments	% Appts Complete 30+	Electronic Wait List	%Electronic Wait List 30+
Post x Exposure Share	-0.000103	-0.0121**	-0.0478	-0.239**
	(0.000359)	(0.00492)	(0.109)	(0.113)
Pre Treatment Mean	6.97	2.33	13.6	49.2
Observations	23,950	23,950	23,956	6,937
Panel 2: Hospitals				
VARIABLES	Log Appointments	% Appts Complete 30+	Electronic Wait List	%Electronic Wait List 30+
Post x Exposure Share	0.000408	-0.0132	-0.510	0.221*
	(0.000696)	(0.0132)	(1.462)	(0.124)
Pre Treatment Mean	9.66	4.34	192.05	57.9
Observations	4,896	4,896	4,896	4,153

Standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Table 4: Presents results from the Difference in Difference estimates of the impact of the Mission Act on appointments by facility type. The sample ranges from May 2017 to February 2020. Panel 1 presents results for VHA clinics while Panel 2 presents results for VHA Hospitals. Post is an indicator for post policy implementation, June 2018. While Exposure Share is the share of veterans in the facilities service area that are eligible for the policy. Each regression includes facility specific fixed effects as well as facility type specific year-month fixed effects. Standard errors are clustered at the facility level.

Table 5: VA Choice Act Impact on Wait Times

Panel 1: Clinics				
	(1)	(2)	(3)	(4)
VARIABLES	Wait Time Index	Avg MH Wait (Days)	Avg PC Wait (Days)	Avg SC Wait (Days)
Post x Exposure Share	-0.00840***	-0.0161**	-0.0219	-0.0262*
	(0.00215)	(0.00797)	(0.0141)	(0.0149)
Pre Treatment Mean	-0.641	1.92	2.64	2.06
Observations	17,622	18,414	18,586	17,676
Panel 2: Hospitals				
VARIABLES	Wait Time Index	Avg MH Wait (Days)	Avg PC Wait (Days)	Avg SC Wait (Days)
Post x Exposure Share	-0.000456	-0.0197	-0.00564	0.0373
	(0.0103)	(0.0248)	(0.0507)	(0.0307)
Pre Treatment Mean	-1.11	2.04	2.82	2.57
Observations	3,786	3,813	3,786	3,813

Standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Table 5: Presents results from the Difference in Difference estimates of the impact of the Choice Act on wait times by facility type. The sample ranges from May 2014 to August 2016. Panel 1 presents results for VHA clinics while Panel 2 presents results for VHA Hospitals. Post is an indicator for post policy implementation, August 2014. While Exposure Share is the share of veterans in the facilities service area that are eligible for the policy. Each regression includes facility specific fixed effects as well as facility type specific year-month fixed effects. Standard errors are clustered at the facility level.

Table 6: VA Mission Act Impact on Wait Times

Panel 1: Clinics				
VARIABLES	Wait Time Index	Avg MH Wait (Days)	Avg PC Wait (Days)	Avg SC Wait (Days)
Post x Exposure Share	-0.00290	-0.00885*	-0.0119**	0.000872
	(0.00188)	(0.00535)	(0.00502)	(0.0113)
Pre Treatment Mean	-0.240	1.76	2.92	2.83
Observations	22,564	23,469	23,895	22,766
Panel 2: Hospitals				
VARIABLES	Wait Time Index	Avg MH Wait (Days)	Avg PC Wait (Days)	Avg SC Wait (Days)
Post x Exposure Share	-0.00905**	-0.0226**	-0.0255**	-0.0160
	(0.00363)	(0.0108)	(0.0121)	(0.0164)
Pre Treatment Mean	-0.301	3.27	3.73	4.84
Observations	4,826	4,896	4,826	4,896

Standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Table 6: Presents results from the Difference in Difference estimates of the impact of the Mission Act on wait times by facility type. The sample ranges from May 2017 to February 2020. Panel 1 presents results for VHA clinics while Panel 2 presents results for VHA Hospitals. Post is an indicator for post policy implementation, June 2018. While Exposure Share is the share of veterans in the facilities service area that are eligible for the policy. Each regression includes facility specific fixed effects as well as facility type specific year-month fixed effects. Standard errors are clustered at the facility level.

Table 7: VA Mission Act Impact on Quality of Care

VARIABLES	(1) 30 Day Risk Adj Mortality Acute	(2) 30 Day Risk Adj Mortality Acute
Post x Exposure Share	-0.00272*	
	(0.00160)	
Post x Top Half Exposure		-0.0501*
		(0.0293)
Pre Treatment Mean	0.966	0.966
Observations	22,564	23,469

Standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Table 7: Presents results from the Difference in Difference estimates of the impact of the Mission Act on quality of care in VHA hospitals. The sample ranges from the second quarter of 2017 to third quarter of 2019. Post is an indicator for post policy implementation, third quarter of 2018. While Exposure Share is the share of veterans in the facilities service area that are eligible for the policy. Each regression includes facility specific fixed effects as well as year quarter fixed effects. Standard errors are clustered at the facility level.

Figures

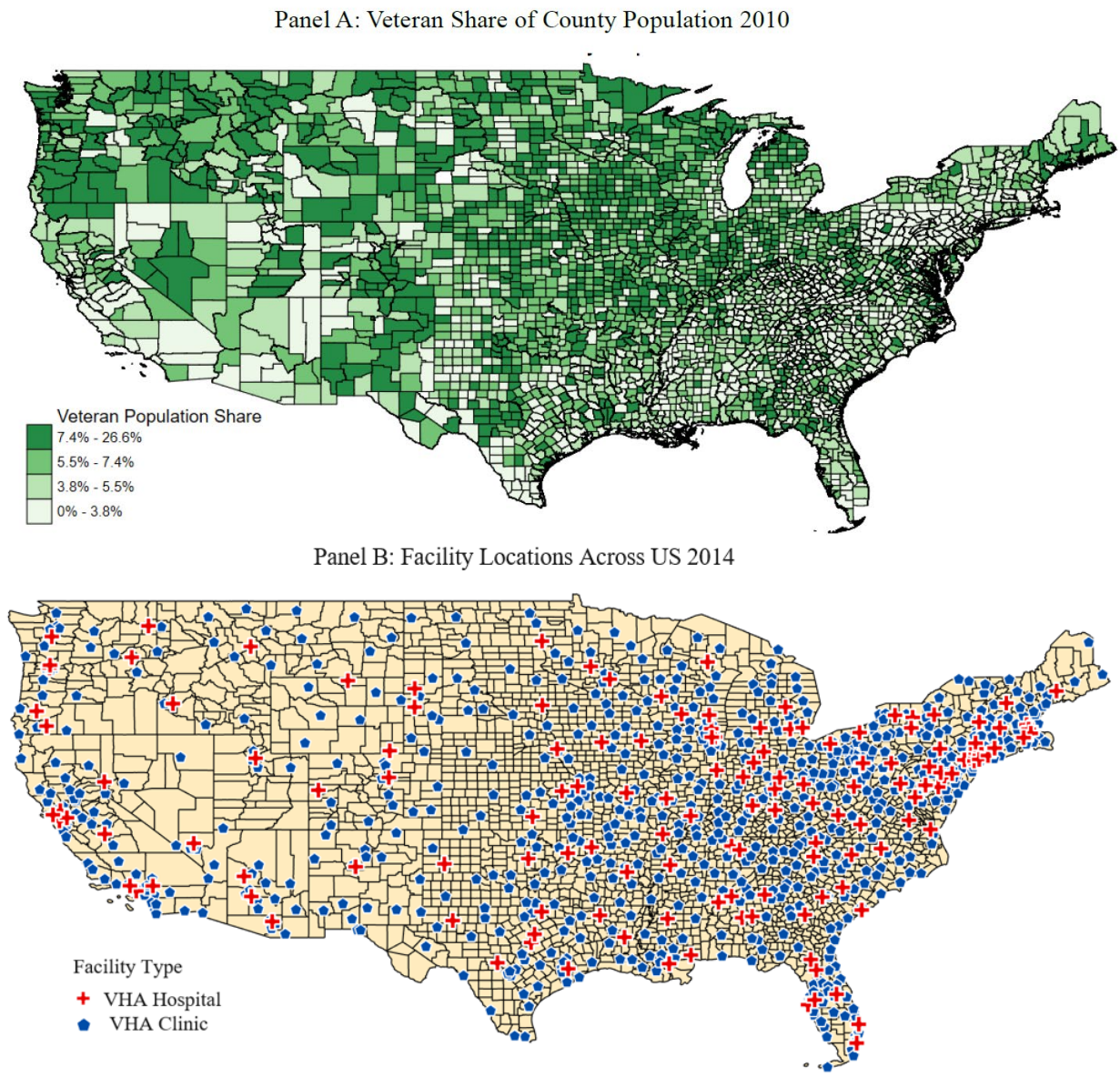

Figure 1: VHA Facility Location and Veteran Share of Population

Note: Panel A shows county veteran share of the population from the 2010 American Community Survey. Panel B shows the locations of VHA hospitals and VHA clinics

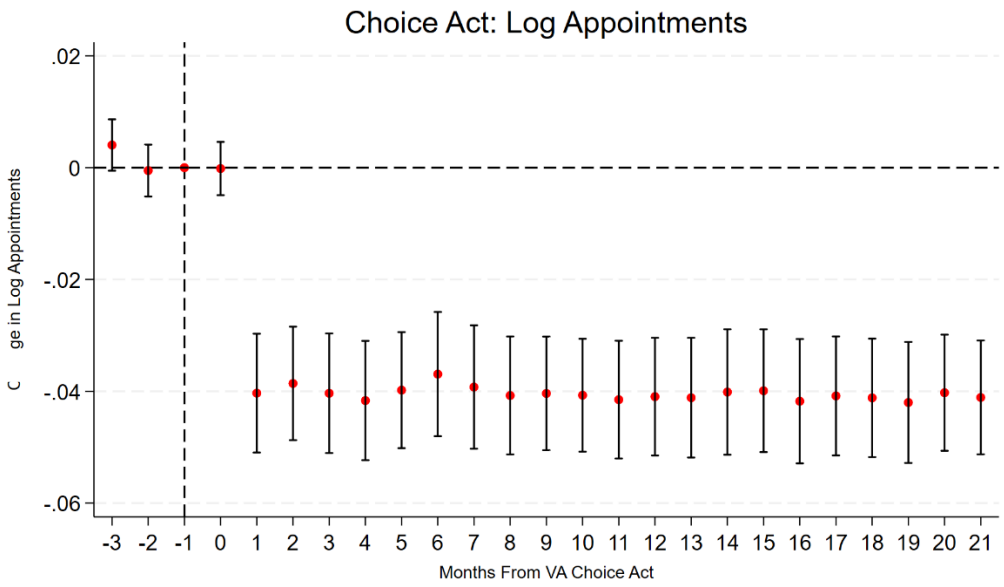

Figure 2: Event Study Choice Act and Log Appointments

Note: Presents the results of an event study examining the differential impacts by timing of the Choice Act on log appointments. The plot shows the coefficients from month relative to Choice Act implementation interacted with policy exposure measured as facility percent of veterans living 40 or more miles away

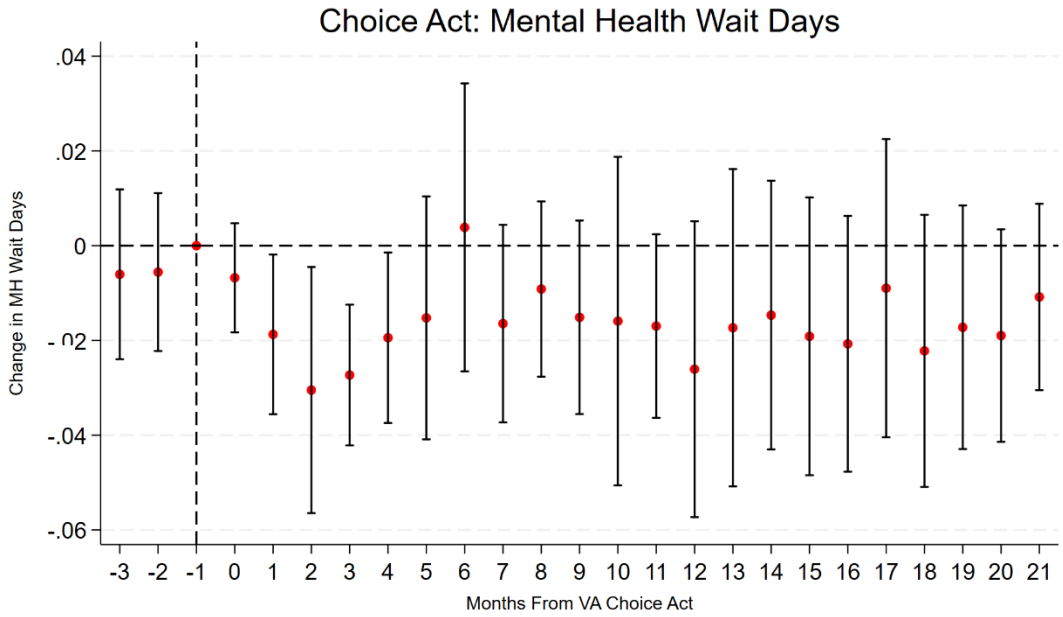

Figure 3: Event Study Choice Act and Mental Health Wait Days

Note: Presents the results of an event study examining the differential impacts by timing of the Choice Act on average wait days for mental health appointments. The plot shows the coefficients from month relative to Choice Act implementation interacted with policy exposure measured as facility percent of veterans living 40 or more miles away

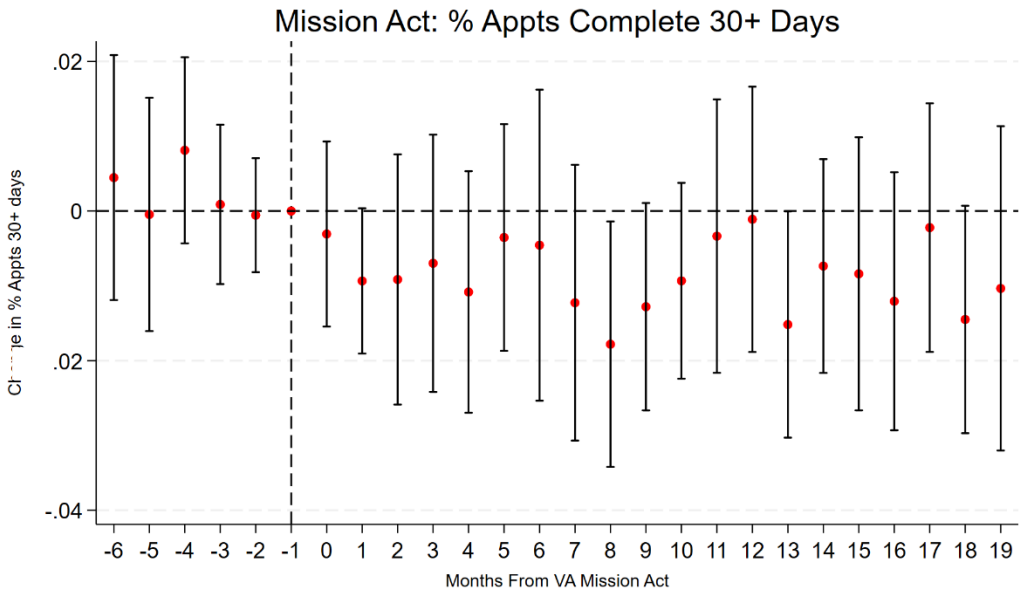

Figure 4: Event Study Mission Act and Percent of Appointments Completed in over 30 days

Note: Presents the results of an event study examining the differential impacts by timing of the Mission Act on percent of appointments completed in over 30 day. The plot shows the coefficients from month relative to Mission Act implementation interacted with policy exposure measured as facility percent of veterans living 20 to 40 miles away.

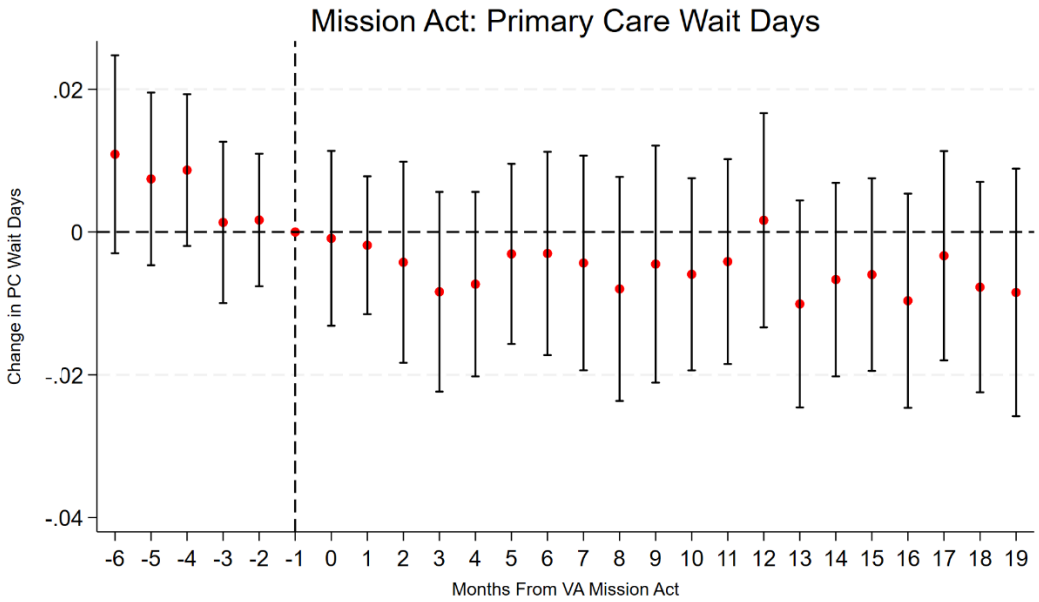

Figure 5: Event Study Mission Act and Primary Care Wait Days

Note: Presents the results of an event study examining the differential impacts by timing of the Mission Act on average wait days for a primary care appointment. The plot shows the coefficients from month relative to Mission Act implementation interacted with policy exposure measured as facility percent of veterans living 20 to 40 miles away.

Figure 6: Event Study Mission Act and Mortality Rate

Note: Presents the results of an event study examining the differential impacts by timing of the Mission Act on 30-day risk adjusted mortality from acute care. The plot shows the coefficients from month relative to Mission Act implementation interacted with policy exposure measured as facility percent of veterans living 20 to 40 miles away.