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REVIEW OF THE FISCAL YEAR 2023 BUDGET AND 2024 ADVANCE APPROPRIATIONS REQUESTS FOR THE DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

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QUESTIONS FOR THE RECORD

REVIEW OF THE FISCAL YEAR 2023 BUDGET AND 2024 ADVANCE APPROPRIATIONS REQUESTS FOR THE DEPARTMENT OF VETERANS AFFAIRS

TUESDAY, JUNE 14, 2022

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 3:06 p.m., in Room SR–418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

Present: Senators Tester, Brown, Blumenthal, Sinema, Hassan, Moran, Boozman, Tillis, Sullivan, Blackburn, and Tuberville.

OPENING STATEMENT OF CHAIRMAN TESTER

Chairman TESTER. I call this hearing to order.

It is great to have the Secretary of the VA in front of us again today. Considering what we are dealing with on the floor, I am sure there are going to be a lot of good questions. But the reason for this hearing is to take a look at the budget for fiscal year 2023 that you put forth.

As I said earlier, we are very, very close, as you all know, to having this PACT Act become a reality. It is a big deal because we are taking care of all areas of toxic-exposed veterans after decades of inaction by our Government. This bill has had broad bipartisan support with the vast majority of Senators voting to move it forward, and I think everybody on this Committee could agree there is no need to waste a lot more time to get the benefits where they are due.

There is a negotiation on amendments going as we speak, and the Ranking Member and I could not do this, but we did agree upon a couple amendments when this bill went out, both Republican amendments. Unfortunately, we are not the ones doing the negotiation; the leadership is. And so they are continuing to hopefully move forward on that.

So we have got a lot to visit about today, and I am sorry about my dysfunction. I apologize for that. But with that, I will turn it over to you.

OPENING STATEMENT OF SENATOR MORAN

Senator MORAN. You gave me such an opening, Mr. Chairman, but since we are on the record . . .

Chairman TESTER. I know, I know.

Senator MORAN. Mr. Chairman, thank you. I would leave my remarks about this hearing for the time when it comes for me to ask questions, because I do want to address the topic that Senator Tester raised in regard to Sergeant First Class Heath Robinson honoring our PACT Act. We are currently considering this Act. Tonight at midnight, 30 hours will expire, and we should have another set of votes. We are able to have this hearing because we are not being intruded on by any votes for amendments. And passing toxic exposure legislation has been a significant priority for Senator Tester and for me in this Congress. In the last Congress, in my view, we were able to deliver a number of landmark pieces of legislation, most importantly mental health legislation for veterans. In this Congress, we are committed to passing long-lasting solutions for reforms for veterans exposed to burn pits.

About a month ago, we announced a bipartisan agreement and introduced the legislation that the Senate is considering. Part of that agreement, as the Chairman indicated, was that he and I agreed that there would be two amendments considered on the Senate floor; during our negotiations, we reached that agreement. Those two amendments would be Republican amendments. There would be no Democrat amendments. And the reason that I am here talking about this topic is that even the two amendments that Senator Tester and I agreed on certainly have not been brought for consideration on the Senate floor.

I indicated to Senator Tester when we negotiated the agreement about amendments that I could not bind my colleagues, and other members, including members of this Committee, have offered amendments, and my view is that a bipartisan bill on toxic exposure should have a bipartisan opportunity for the minority to make some suggested changes.

Here are a few of the reasonable amendments. Every amendment that has been offered by Republicans appears to me to be reasonable. It is not outside the realm of this legislation. They are all germane. I have an amendment to codify existing law on the accurate method of counting a veteran's wait time at the VA and that the access standards which determine when a veteran may choose care in the community should be codified.

Senator Blackburn also has an important amendment giving greater choice to veterans. The intent of these amendments is to assure that veterans, if there are operational problems created at the VA hospitals and clinics as a consequence of the toxic exposure bill, then community care is more readily available as a safety valve.

I also offered an amendment to strike the creation of a fund which would classify over $116 billion in discretionary costs associated with the bill as entitlement spending. I believe this untested and unique way of classifying spending lessens congressional oversight at a time of massive debt and deficits, and it sets a bad precedent.

That said, I have since filed amendments to merely get the policy of this fund to what I think was the intent of my colleagues who supported its creation.

Senator Lee has an amendment requiring the Secretary to use science when evaluating presumptions established under the bill.

Senator Ernst has an amendment requiring the Secretary to certify that the resources and authorities provided through this bill will not be a negative consequence for veterans in the system. And there are at least three amendments proposing offsets to the cost of the bill with spending reductions elsewhere.

My colleagues deserve a fair consideration of reasonable and thoughtful amendments to improve this bill for our veterans. Regardless whether any of these amendments are adopted, I am frustrated there has been no movement on even considering them.

In comparison, the House had 6 votes and adopted 27 amendments when it considered the PACT Act. This is one of the most significant legislative packages ever to come out of this Committee, and I am proud of the work that the Chairman and I and our members of this Committee have done to reach an agreement. Given the magnitude and size of this legislation, there needs to be a bipartisan process on the Senate floor. This bipartisan process should include the input from my colleagues, especially when it is included in our agreement.

I want to advance the Robinson Act without unnecessary delay, and reaching agreement on amendments is the fastest way to do that. I am hopeful that in the days ahead before final passage of this bill we can let our colleagues be heard through the amendment process, pass or fail.

Thank you, Mr. Chairman.

Chairman TESTER. Thank you, Ranking Member.

I would just say that negotiations are going on. We just came out of a caucus, you guys just came out of a caucus, and we continue to push folks—I do, anyway—to negotiate in good faith and come up with a set of amendments that hopefully both sides can agree upon. That has not happened yet, which is fairly typical in bills that go down. You are right, this is a big bill, and I think there is some opportunity to do some stuff.

Just one thing on the OCO account, though, the OCO-esque account. It is not a new idea. It is patterned exactly after the OCO account that was used to fund the conflict that we are treating the veterans for when they come back home. So that is it. But I appreciate the working relationship we have, and that is going to continue.

Secretary McDonough, you are on the first panel. We are going to hear from the VA on why they believe this budget is appropriate and how it will enable them to support the veterans in fiscal year 2023 and beyond.

On the second panel, we are going to hear from VSOs, veterans service organizations, who wrote this year's Independent Budget. Each year the Independent Budget offers an informed perspective on what the VA needs to live up to the promises our Nation has made to our veterans. Right now their voices are more essential than ever as we work to get the toxic exposure legislation across the finish line.

Now I want to introduce Secretary McDonough, but, first, and more importantly, I want to introduce his daughter, Addie, and his niece, Grace, who are in the audience. It is good to have you here, ladies, and it should be an interesting meeting. You get to watch your uncle and father get totally slammed to the ground.

[Laughter.]

Chairman TESTER. Secretary McDonough, the floor is yours.

PANEL I

STATEMENT OF THE HONORABLE DENIS MCDONOUGH

Secretary MCDONOUGH. Mr. Chairman, thank you, Ranking Member Moran, thank you very much. Thanks in particular for expressing the welcome to my family, about whom I am very, very proud.

With your consent, Mr. Chairman, and with the Ranking Member's consent, I will just submit my opening comments for the record, and we can get straight into questions.

Chairman TESTER. So ordered.

Secretary MCDONOUGH. Great.

[The opening statement of Secretary McDonough appears on page 33 of the Appendix.]

Chairman TESTER. So the fiscal year 2023 request includes resources needed to process newly announced presumptions to include asthma, sinusitis, rhinitis. Is that correct?

Secretary MCDONOUGH. That is correct.

Chairman TESTER. Does it include the rare cancer presumptions?

Secretary MCDONOUGH. It does.

Chairman TESTER. Okay. How many claims from asthma, sinusitis, and rhinitis does VA anticipate for fiscal year 2023?

Secretary MCDONOUGH. For FY 2023, for those three, we anticipate 100,144 claims and about 70,000—69,886—appeals. So that is a workload of around just over 170,000 cases.

On the rare respiratory cancers, we think that these—since we call them "rare," we believe the claims will be rare. So we think that those will be accounted for in our overall request.

Chairman TESTER. Okay. If we are able to pass the Sergeant First Class Heath Robinson PACT Act, which has less than a quarter of the claims in fiscal year 2023 that you anticipate for the three that I just mentioned—asthma, sinusitis, and rhinitis—what kind of resource support would you need?

Secretary MCDONOUGH. Well, we are running that through our process right now, Mr. Chairman, so I do not have a specific number for you. But we have been looking at a series of enhancements under existing authorities and existing dollars to get ready for this. So from automation to hires—we are in the process of hiring over 2,000 additional claims personnel to potential contracting and claims process improvements. We think that we will be in a good position to handle that in the first year.

Chairman TESTER. As far as workforce goes, this budget requests $42.2 billion for medical service staffing to provide for 282,789 FTE, an increase of just over 14,000 over last fiscal year. However, we have heard from the VA about the difficulty of recruiting and retaining health care providers in this labor market where anybody can get two jobs if they are looking for one.

Is the requested funding level adequate given that the latest data—although it was challenged at the last hearing we had, but given the latest data shows 56,000 vacancies at VHA?

Secretary MCDONOUGH. Yes, our request includes all the necessary funding for the needs that we see in the system for FY 2023. So we think that the funding for the health care personnel is up to date and is sufficient.

We think, though, as we have discussed in this room, and you and Senator Moran have been generous enough to provide in the context of your agreement, that we need additional authorities to enhance pay in certain instances, to enhance retention capability in certain instances. So it is true that is a very tight, very dynamic labor market, especially for health care personnel. But we think that both in the President's request and in the authorities that you have given us that we will be in a position to handle it, notwithstanding the fact that that aggregation of vacancies over time continues, but we do this year by year to make sure that we have the people that we need.

Chairman TESTER. Okay. The fiscal year 2023 revised request includes an additional $4.3 billion in community care funding. My understanding is this funding level is driven in part by a lack of administrative staff and support necessary to execute in-house dollars. Correct me if I am wrong on that.

Secretary MCDONOUGH. That is a variable in the equation. Probably the more impactful variable in that equation is use, both because—mostly because of pent-up demand in the system and greater eligibility because of the way we handled the pandemic. And so, yes, our ability to manage more quickly and get people into care more quickly is obviously impacted by the tightness of the labor market. That is why the President's request does ask for additional HR personnel and why we continue to ask you for the authorities that you have included in the PACT Act.

Chairman TESTER. Okay. The caregivers program funding budget asks for $1.9 billion, which is a $433 million increase over the last fiscal year. However, the VA recently halted discharges from the program and expansion to veterans of all areas and is scheduled to begin in October 2022.

Secretary MCDONOUGH. Yes.

Chairman TESTER. So is the requested level of funding adequate to provide for the influx of applicants and participants that, quite frankly, are expected and I hope occurs in the caregiver program?

Secretary MCDONOUGH. Yes, we believe it is adequate, and we are hoping for the same thing that you are hoping for.

Chairman TESTER. Okay. I am going to turn it over to Senator Moran for his questions. I am going to also turn—because I do not know what Jerry's schedule is, I will turn the gavel over to Brown, and I am going to go see a doctor.

Secretary MCDONOUGH. Okay. Godspeed.

Senator MORAN. Well, Mr. Secretary, since I now do not have to worry about the gavel being held by Senator Tester, I am going to take a moment to tell you that, in difficult town hall meetings in my time as attempting to be an elected official, I always invited my 90-plus-year-old mother to come to the town hall meeting with me. And it calmed the nature of the questions and attacks that were made against me. I could never convince our two daughters to ever sit behind me, so you are fortunate to have a niece and a daughter

here. I am now calmed down and will act very respectful toward you this afternoon.

Secretary MCDONOUGH. Mission accomplished.

Senator MORAN. Well done. I outlined, as you know, that we are considering the Heath Robinson PACT Act in the Senate. Senator Ernst has an amendment that I outlined to you in my opening statement. The administration issued statements of support for both the House-passed PACT Act and the Robinson Act currently on the Senate floor.

Can you certify, which is what Senator Ernst is looking for, is this indication that you can execute this bill that includes supportive resources and funding that you ask for and sets up funding for the future, can you implement this legislation without negative operational impacts on existing disability claims processing and health care delivery for veterans?

Secretary MCDONOUGH. I can, Senator. I can certify that. I understand—you and I have talked about this for some time. I believe this is a very important piece of legislation. I think it will be very difficult to implement. But oftentimes the most important things are difficult, and I think that we are ready for it. We have been preparing for this. You are giving us additional authorities and additional funding. And taking care of one generation of veterans, for example, those who were exposed to burn pits after 1991 need not come at the expense of veterans who sacrificed so heroically for us in World War II or Korea or Vietnam or otherwise. And so I think that we can do this and we can do this well and will in all cases do it transparently with you so that you understand precisely what we are doing.

Senator MORAN. The medical care budget request for fiscal year 2023 and the advanced appropriation request for 2024 requested $70.5 and $74 billion, respectively, for VA's medical services account.

Secretary MCDONOUGH. Right.

Senator MORAN. During the pandemic the VA requested and received supplementary funding to help combat COVID–19 as well as adjusted its base request for fiscal year 2022 to account for long-term COVID funding. In written responses to prehearing questions ahead of the 2022 budget hearing, VA officials wrote that while the 2023 advanced appropriation request of $70.3 billion would help address a wave of veteran utilization due to deferred care, it expected the growth in workload levels to stabilize to pre-pandemic levels, thus requiring fewer resources in fiscal year 2024. However, the fiscal year 2024 advance appropriation request shows an increase in appropriations well above the pandemic levels.

And so my question is: Please explain what conditions have changed over the past year that support an increase in fiscal year 2024 instead of a decrease to pre-pandemic funding levels as previously projected?

Secretary MCDONOUGH. Yes, I think it is a fair question, and I think it is a good question. I think the principal issue is the Omicron variant, meaning that we would have anticipated that the return to care would have peaked by now, surely, but even several months ago. But because of the virulence of the Omnicron variant, we did not see the peak return to care that we anticipated.

Moreover, we continue to believe and continue to see more complex conditions related to complications from veterans infected by the various variants of COVID–19. So the difference between last year and this is the introduction of the Omicron variant and the impact that had on ongoing operations. You will recall that our staff unable to work, which today is about 3,000, got as high as 16,500 in January and February, which impacted access to care. It is an introduction of the Omnicron variant and ongoing recognition of the intensity of long COVID and the complications that come with it, especially with an older, more complex set of health conditions for older veterans that has complicated the outlook for fiscal year 2024.

Senator MORAN. Let me ask another question this round. I introduced a bill called the "GHAPS Act." You and I have had this conversation about access standards under community care. You have indicated, the VA has indicated to us that it is premature, you are reviewing. We expected a report on June 6th. A few days before that, we were noticed that that report would not be available on time.

Can you explain to the Committee—let me say it this way: As a result of the review, at this point in time you ought to be able to tell us what is the content——

Secretary MCDONOUGH. Yes.

Senator MORAN [continuing]. Even though the report has not yet been delivered to Congress.

Secretary MCDONOUGH. Fair.

Senator MORAN. Do you have any plans to change the access standards or change the way that wait times are calculated in community care eligibility?

Secretary MCDONOUGH. Yes. Yeah, so good, and look, I have tried to say into the record and in discussions with individual Senators, both privately and here publicly, as well as House members, that I consider the June report very, very important. In fact, I consider it so important, I asked for an extra month to work on it. We have, in fact, completed much of the work on it. What we know is that demand for health care over the course of the pendency of these three years of the Mission Act has increased. It has increased more intensively for care in the community than for care in the direct system, such that right now I could tell you, if you were to roughly measure by relative value units, the units by which we measure how much care we give to veterans, about a third of the care that we give right now is care in the community. That is a high number, and that is the highest number yet of the three years of the Mission Act. So that gives you a rough order of magnitude of what we are seeing.

Care overall, as you have seen in the budget itself, is growing. Care in the community as a portion of that is growing. I said to you guys last year in this round of hearings on the budget that I was worried about the rate. Last year, it was about 26, 27 percent. Now it is about 33 percent. So that is the finding.

And, again, I did not want to surprise you when we sent it up here in writing. It is good idea to make sure that you saw it in writing. I thought I had flagged for you that it was going to take until July.

One of the things that would help is if we could get our Under Secretary, because I would like him in the chair, because—and this gets to the last question. My hunch is that we should change the access standards. We would do that pursuant to public comment and regulation making, and we would do that in full consultation with you, such that you would be in a position to comment about it; you would be in a position to share your reaction to it, as would the general public.

Senator MORAN. I, too, Mr. Secretary, am anxious for the deputy, the Under Secretary, to be in his job because he testified he supports the current access standard guidelines.

Secretary MCDONOUGH. Okay. Well, look, for that reason, I am not going to hoist him with my views. You know, I think he happens to be a health care professional, so we should probably have his views on this.

[The prepared statement of Secretary McDonough appears on page 39 of the Appendix.]

SENATOR SHERROD BROWN

Senator BROWN [presiding]. Thank you, Senator Moran. Welcome, Mr. Secretary. Nice to see you and your family again.

Secretary MCDONOUGH. Nice to see you.

Senator BROWN. First of all, thank you for the special attention, including your visit to Chillicothe and the attention you have paid to that very important and historical hospital center, so thank you.

Secretary MCDONOUGH. You bet.

Senator BROWN. The Senate is close to keeping our commitment. I particularly credit Senator Moran and Senator Tester, everybody on this Committee but particularly the two leaders, the Heath Robinson Honoring Our Veterans Act, Honoring Our PACT Act. I appreciate the support and the work you and your staff did. I would like to ask you about the steps you are taking, taking off on Chairman Tester's comments and assertion, to make sure VA medical facilities are prepared for more veteran patients. We are aware of the recommendations you sent forth earlier this year to modify or close VA facilities. Those recommendations were based on old pre-COVID–19 data and certainly did not take into consideration the reach of COVID and did not take into consideration the PACT Act, obviously. So as you saw when you visited Chillicothe, these facilities mean so much to veterans.

So talk about the steps you are taking to ensure that the VA workforce and physical facilities will be ready for expanded enrollment because of the Heath Robinson Act. And how would the enrollment change your planning for VHA's future requirements?

Secretary MCDONOUGH. Yes, I think that is a very helpful question. First and foremost, as we discussed the last time I was here for the hearing on the PACT Act, I asked for some relief from the, I would suggest, anachronistic way that CBO scores how we get new leases. As you know, we are the only Federal Government agency that is required with each new lease to get a new independent legislated authorization. So you have now included that, the Chairman and Ranking Member Moran have included that for 31 new leases. So those are for clinics and facilities across the

country that will be then available as we ramp up the number of veterans over the course of the life of the PACT Act. So that is the first thing.

The second thing, on health care workforce, you included the RAISE Act in the context of the omnibus this year wherein we also got a very generous appropriation for this year, especially for the health care account, the medical care account. So we are now in a position to compete more aggressively with nurses. We have some 10,000 nurses next month who will be in a position to see—that is about one-eighth or one-ninth of our workforce of nurses—will see their salary increase as a result of that action.

Third, included in the PACT Act are a series of workforce authorizations that will allow us to be more competitive in hiring and then, therefore, retaining specialists and experts in VA clinical positions. So that is the answer to the first part of your question.

The answer to the rest of the question is we are watching to see what you all choose to do with the nominees for the AIR Commission. In all cases, under the Mission Act we are required to go back and look each four years at what the needs are in each of those markets across the country. We are prepared to continue to do that in coordination with and consultation with local stakeholders, local communities, informed by new data, informed by new statute, including the PACT Act.

So an example of that: VISN 10, in which Chillicothe resides, the leadership in VISN 10 is talking with the medical center director in Chillicothe about one of the issues that we talked about on our visit, which is residential treatment programming for Chillicothe. We will be looking at steps like that irrespective of what you all decide to do with the commission, the commissioners. But we will be looking at that in the context of the second four years or the second Quadrennial Review. We will continue to look at that informed by new data and share the outcome of that consideration with you.

Senator BROWN. I know it is not an easy juggling act with COVID, with the AIR Commission still hanging out there, and with the new responsibilities that you are happily taking with the Heath Robinson Act, so thank you.

The last point I want to make. My time is about up. You have answered questions about this in the Committee. We have had individual conversations at the VA and elsewhere about it, with the electronic health record modernization rollout. Thank you for the steps you have taken to hold Cerner accountable for the recent outages and degradations. I have had conversation with them, as many have. It is a large endeavor. We need to know the system is reliable. Some members of this Committee I would say are more unhappy than I am with the Cerner rollout in Columbus.

Secretary MCDONOUGH. I have noticed.

Senator BROWN. I know you know that. Columbus has gone pretty well. Just reassure me that you understand these problems and that you will work in Washington State and Ohio, and I believe the next State is Idaho. Is that right?

Secretary MCDONOUGH. Oregon.

Senator BROWN. Oregon.

Secretary MCDONOUGH. It went live in Oregon this weekend.

Senator BROWN. I get those Western States mixed up. I am sorry.

Secretary MCDONOUGH. Yes, well, I do not. But I hear you. You have my commitment on that. Let me just say on Columbus, I think you are right. I mean, I agree with your characterization, which is it has been relatively smoother. That said, to my considerable frustration, this issue of the pharmacy component of the Cerner product is still not what it should be in the 21st century. It turns out that pharmaceuticals are a big part of how we provide care, and the fact that that operates the way it does in certain areas, a massive frustration. And I know that is true in each of the facilities so far.

So we will stay on top of it. I have been staying in touch with members both in these public settings and with updates, especially those in Ohio, like your State, obviously, Washington State, and now Oregon, and we will stay on top of this.

Senator BROWN. Thank you, and I will have a question for the record about veterans' homelessness.

Senator BROWN. Senator Boozman from Arkansas.

SENATOR JOHN BOOZMAN

Senator BOOZMAN. Thank you, Mr. Chairman. And, again, thank you for being here, Mr. Secretary.

Secretary MCDONOUGH. Thank you.

Senator BOOZMAN. It is always good to see you. I appreciate the communication and the outreach. You do a great job in that regard. We appreciate your work on behalf of veterans and your ongoing efforts with the implementation of Staff Sergeant Parker Gordon Fox Suicide Prevention Grants and the women's health initiatives passed in the Deb Sampson Act over the past year.

Secretary MCDONOUGH. Yes.

Senator BOOZMAN. Preventing veteran suicide, supporting the VA and their changes to better provide care to female veterans and ensuring veterans have access to the care and benefit certainly is a priority of mine, and I know it is a priority of yours and a priority of the Committee. I commit to continue working with you through this budget process to ensure those priorities are resourced and supported.

Secretary MCDONOUGH. Thank you.

Senator BOOZMAN. It is good to see your daughter and niece here. I have got three daughters and three grand-daughters.

Secretary MCDONOUGH. You are six times blessed, my friend.

[Laughter.]

Secretary MCDONOUGH. Six times blessed.

Senator BOOZMAN. The VA's fiscal year 2023 budget request of $301.4 billion is a 13.3-percent increase from last year's record budget. As you point out in your testimony, this is a 114-percent increase in the VA budget since fiscal year 2013. Regarding medical care, the VA requested $122.7 billion, almost a 22-percent increase from last year, noting that the VHA did not see a 22-percent increase in veteran enrollment.

What are the primary factors contributing to the significant increase in health care costs? And do you believe this trend will continue?

Secretary MCDONOUGH. Yes, thank you very much. Let me just go back to the—I just want to say the President signed into law

two additional Acts last week that will increase our ability to provide timely access to mammography across the VA system. That is because of you and your leadership on this. Nobody has been more aggressive and more supportive of our women veterans than you have been, and so I am really, really grateful for your work on that.

Senator BOOZMAN. Thank you.

Secretary MCDONOUGH. We believe that the issue that is driving cost overall is obviously health care cost inflation, which has been an issue for us for generations, one.

Two, complexity. Fifty percent of our veterans are 60 or older, we know that, so that number is only going to increase over time, that is to say, their age. And as veterans age, as anybody ages, the intensity of the cost and the reliance on the system increases.

I will say that the pandemic definitely had an impact on cost and on spending on the health care, the medical care account, and the last thing is, you know, I have been studying a lot of charts pursuant to the questioning that I was just going back and forth with the Ranking Member on related to the Mission Act. CBO did anticipate increased costs associated with the Mission Act, and we see that. And so that would be the fifth thing I would say in terms of the impact on cost.

So, overall, health care inflation, reliance, intensity, I put those together as complexity, the COVID pandemic, and then the Mission Act. I think those are the things—I think those continue to be complicating factors. I like to believe that we are getting smarter at this and are going to be in a better position to manage those costs, though, and so I hope we can get those under better control. A 100-percent increase over, you know, these basically 9, 10 years is a lot.

Senator BOOZMAN. I appreciate the VA's continued commitment to improving the care and the access for veterans in geographically rural areas. In my home State of Arkansas providing access to high-quality health care in rural areas of the State is a significant challenge for the VA medical system. The fiscal year 2023 budget request includes $307 million for the Rural Health Initiative, which is level with 2022 funding. Is the VA assuming any risk in providing care to veterans who live in rural parts of the country by not increasing funding?

Secretary MCDONOUGH. We do not think so. Due to your generosity, we grew that account by about 20 percent last year, so we feel like we are in a good position because of the investments we have been able to make over the last year. And so I think what you see there in terms of our planning for 2023 is a recognition that we can get better and more strategic about how we are making these investments, and we are not assuming additional risk. I think we are just trying to get more competent in our economic management of the budget.

Senator BOOZMAN. Thank you, Mr. Secretary.

Secretary MCDONOUGH. Thank you, Senator.

Senator MORAN [presiding]. Senator Blumenthal.

SENATOR RICHARD BLUMENTHAL

Senator BLUMENTHAL. Thank you, Senator Moran. Thanks for being here, Mr. Secretary.

Secretary MCDONOUGH. Thank you, Senator.

Senator BLUMENTHAL. You and I have talked frequently about the VA facility in West Haven. I think we are in agreement that it needs rebuilding beyond just cosmetic renovation. There is construction going on concerning a new surgical suite and new parking, but the main facility itself is more than 50-years-old. In fact, it really requires that investment provide some world-class care from doctors and nurses and other staff that are really the gold star of medical care and quality, but they are working with a facility that is aged and aging. So I hope that your continued commitment to that cause will be there.

But that facility is only one of many that require similar reconstruction, and your discussion of the VA facilities in your testimony indicates that the median age of the VA's physical portfolio is 58 years as compared to private hospitals at 11 years. I think that is just extraordinary. And 69 percent of VA hospitals are over the age of 50. There is no way that the Veterans Administration can continue quality care with facilities of that age at a time when technology requires that the entire structure of a facility be designed and built to accommodate the most modern means of delivering care, of monitoring patient health, of summoning help when it is needed.

I am not a doc, but I have been through VA facilities, some of the oldest and some of the newest, and other hospitals, and even to this semi-informed layperson, this strategy is untenable. In fact, it is not a strategy. And I know I am telling you something you and the VA already know, but I am disappointed, as are the VSOs, to see that the investment this year is only $2.2 billion or $3 billion. I am not sure which number is correct: $3 billion in your testimony, $2.2 billion by my calculation. But you have determined that $24.1 billion is required to address major construction infrastructure requirements over the next 10 years.

So what are we doing?

Secretary MCDONOUGH. Yes, fair enough. I think the difference—thank you very much for the question. I think the difference between the two numbers that you are pointing to reflects our use of the transformation fund.

Senator BLUMENTHAL. Right.

Secretary MCDONOUGH. This is a fund that allows us to re-plow overages back into VA IT and VA infrastructure so——

Senator BLUMENTHAL. That is the $968 million in estimated unobligated balances.

Secretary MCDONOUGH. Exactly. So I think that is the—when you talk about the difference between 2.2 and 3, that is the difference. Point one.

Point two, the investment that the President has submitted in this budget is the highest ever investment in VA infrastructure. Do I wish it were more? I do, because the needs are extraordinary. But we are in a position that we can only execute—we are asking for as much as we can execute well. You know, we have a history of underperforming, shall we say. One need only recall the situation in Denver.

Senator BLUMENTHAL. And I visited there, so I am personally familiar with it.

Secretary MCDONOUGH. So we are showing by our work and I think showing quite well—our most innovative new project is in El Paso where we are demonstrating, again, a quicker, more effective, more cost-effective way of deploying new infrastructure investment. So there is only so much we can credibly execute. There is only so much we can do on the ground, so think of West Haven. It is a pretty big campus, but not huge. You could not go in there and continue doing what we do every day and do all of the overhaul that we need to do. So there is a give-and-take between provision of care every day and upgrading of the facilities.

So what you see in that budget is, A, the largest-ever request; B, what we believe we can execute cost-effectively for the taxpayer; and, C, what we think we can execute while not having it come at the expense of care of veterans. And so until we can look at this holistically, as we propose, for example, in the AIR Commission, we are not going to be in a position to continue to do this piecemeal.

Senator BLUMENTHAL. My time has expired, so I have other questions. I may try to come back for a second round. But let me just say, you know, America is America. It builds trillions of dollars of office buildings and residential complexes. In my part of the State, it is more than possible to execute better and more. I am putting it in very simplistic terms.

Secretary MCDONOUGH. Yes.

Senator BLUMENTHAL. But if we do anything in terms of building, it ought to be for our veterans, and we get the best minds, the best contractors, best subcontractors to do it for the VA. And I take your point about having to deliver care—in other words, fly the plane at the same time you are trying to build it. But I will take you through the West Haven campus, another personal invitation to you, and show you where you can start building a new facility and keep the old one still running.

Secretary MCDONOUGH. Okay.

Senator BLUMENTHAL. I guarantee you, I will do it.

Secretary MCDONOUGH. I will look forward to that.

Senator BLUMENTHAL. I will join arm in arm with you.

Secretary MCDONOUGH. Okay.

Senator BLUMENTHAL. And I have been to Colorado, so I know how things can go south with lack of proper supervision, and I will just say your administration has been very different from the ones that we have seen before. I have been on this Committee for 12 years now, and I am proud of the work that you are doing, and I think that gives us an opportunity that we should seize with this new era.

Thank you.

Secretary MCDONOUGH. Fair enough. Thank you very much.

Senator MORAN. Senator Blackburn.

SENATOR MARSHA BLACKBURN

Senator BLACKBURN. Thank you. And we appreciate your time as always.

Secretary MCDONOUGH. Thank you, Senator.

Senator BLACKBURN. I want to pick up right where I talked with you the last time you were before us.

Secretary MCDONOUGH. Yes.

Senator BLACKBURN. And, of course, with the PACT Act, looking at the workload, and you all do not have the personnel to meet that added workload. You know you would need more people. You know there will be a ramp-up time that is necessary to meet that impact. And when you look at the hiring process, I had down in my notes that it is taking you all 95 days to hire and on-board someone. So I looked at some of the models that are used by hospitals and other organizations, and doing an algorithmic pre-vetting, they are lowering that hiring process to 16 days to get someone through that process. That is attractive to a lot of doctors and nurse talent, things of that nature.

So where are you all with this hiring process and when it comes to staffing and moving people within the organization from one position to another where you are needing to fill those positions? Talk with me a little bit about that.

Secretary MCDONOUGH. Yes, I think it is an excellent question. I appreciate your asking it. I think, you know, what precisely we will need in the Veterans Health Administration and in the Veterans Benefits Administration to execute the PACT Act, we are going through that with a fine-toothed comb now, and we will come back with you and we will work with you on that.

There is no doubt, however, in either case that our hiring and on-boarding is too slow. I have been updating you on the process at VBA, the Benefits Administration, for the last seven months about how quickly we can hire and on-board 2,094 people. We are still at between 1,850 and 1,900 of those people. I think that is too slow, because there is a hiring and then there is a training tail on the end of that.

So what are we doing? So now let us talk about VHA. We are immersed in more rapid hiring and on-boarding. We have just gotten agreement from OPM to continue for another year the direct hire authority, which of the many variables in the equation of bringing people on is perhaps the most impactful, accounts for probably a third of the savings we are able to get in terms of time to hiring. But the hiring and on-boarding process is still so sclerotic that we are finding things that can change. So let me give you an example——

Senator BLACKBURN. Okay. You have—let me interrupt you just a second.

Secretary MCDONOUGH. Sure.

Senator BLACKBURN. When you look at the budget, do you have the money positioned properly to rectify this situation?

Secretary MCDONOUGH. We do.

Senator BLACKBURN. Okay. And when you look at claims that are there, I think VBA's claim backlog right now is just north of 188,000.

Secretary MCDONOUGH. Correct.

Senator BLACKBURN. So what is the process for speeding up that? Because my VSOs talk to me all the time about the length of time that it takes to even get a response that the claim is in the queue.

Secretary MCDONOUGH. Yes, so I want to just give you an example, and I will come back to that question. On VHA, if you are on-boarding as a nurse, you still in VA, I am told, have to write an essay about being a nurse at VA. I think that is antiquated and

we should get rid of that. So that is the degree, that is the level at which we are operating and getting to the bottom of this onboarding.

Senator BLACKBURN. Okay.

Secretary MCDONOUGH. On claims, we are, as you say, just under 190,000. We were at 265,000 a couple months ago. We are bringing that down because of overtime, because of hiring, and because of——

Senator BLACKBURN. And returning people to work?

Secretary MCDONOUGH. Yes, well, our people, to their great good credit, I have to say, productivity in VBA in the context of the pandemic increased.

Senator BLACKBURN. Okay.

Secretary MCDONOUGH. It actually did not decrease; it increased. And so as we think about questions about do people come back into the office or do they work virtually, we are taking that into consideration. We are just about done with all of our negotiating on that, so we will come up with kind of a full report.

Senator BLACKBURN. Okay. I have got one other thing.

Secretary MCDONOUGH. Sure.

Senator BLACKBURN. I understand that the White House is considering appointing Brenda Sue Fulton as the VA Assistant Secretary——

Secretary MCDONOUGH. Yes.

Senator BLACKBURN [continuing]. For Public and Intergovernmental Affairs. They are doing this because they could not get her into a Senate-confirmed position. And for your awareness, in the past Ms. Fulton has tweeted, and I am quoting the tweet: "Let us be real. When one of our two national political parties is unable to call out racism, our system is broken. It is not a political statement to say the GOP is racist. It is a moral statement and one backed up by an increasing mountain of evidence."

And she was quoted in the Windy City Times with this quote: "The U.S. has a powerful right-wing, anti-gay, anti-abortion lobby that purports to represent Christians. These radicals—I cannot bring myself to call them Christians since their language and actions hold no resemblance to the Jesus I know from the Bible."

Now, she is not qualified to serve our Nation's veterans and to serve as a member of your staff, and I hope that you will resist the push to put her in as the Assistant Secretary.

Thank you. I yield back.

Secretary MCDONOUGH. Senator, I just want to—I do not know Sue Fulton well, but what I know of her—I was not aware of those quotes, but I have no reason to rebut them if you found them. I am not trying to question their veracity. Sue Fulton is a United States Army officer who served with—you know, honorably, a West Point graduate, and a committed public servant. And so, you know, I would not write similar things, but I can commend to you that the Sue Fulton that I have come to know has served the country well, and I think she would be a credit to the VA team.

Again, I am just learning these things that you have just read.

Senator BLACKBURN. [Off microphone—inaudible.]

Secretary MCDONOUGH. Okay. Thank you.

Senator MORAN. Senator Blackburn, thank you.

Senator Hassan?

SENATOR MARGARET WOOD HASSAN

Senator HASSAN. Thank you, Senator Moran. I want to thank you and the Chairman for having this opportunity with the Secretary.

Secretary McDonough, it is really good to see you.

Secretary MCDONOUGH. Thank you.

Senator HASSAN. Thank you again for coming to the New Hampshire Memorial Day ceremony at the veterans' cemetery. Your participation really was appreciated by Granite Staters, by our veterans, and the veterans service organizations who got to meet with you afterwards.

Secretary MCDONOUGH. I was thrilled to be there.

Senator HASSAN. It was a great visit, so thank you.

As you know and as I am sure you were reminded of during your visit, New Hampshire is one of three States, along with Alaska and Hawaii, that does not have a full service VA hospital.

Secretary MCDONOUGH. Yes.

Senator HASSAN. Something I have long sought to change. My colleagues and I have consistently pushed the VA to appropriately prioritize infrastructure and maintenance projects in its annual budget to ensure that all veterans have access to the care that they need. However, it is important that the VA recognize the undue burden placed on veterans who live in States without a full-service VA hospital like New Hampshire.

Mr. Secretary, you have previously testified that the VA considers the fact that some States lack a full-service hospital when you are planning the budget.

Secretary MCDONOUGH. Right.

Senator HASSAN. Can you provide more information about that? How did the VA actually consider the lack of a full-service hospital when developing the allocations for this year's budget proposal?

Secretary MCDONOUGH. Yes, it is a fair question, and what I would like to do is take that one, Senator, and come back to you in writing on it or come see you and talk you through on it, because I think I have enough of an answer to be not particularly informative.

Senator HASSAN. Okay.

Secretary MCDONOUGH. So if I might take that one and come talk to you.

Senator HASSAN. That would be good to follow up on because I think that is the kind of tangible examples we are trying to find and follow up on.

Secretary MCDONOUGH. Yes.

Senator HASSAN. Let me ask you another question. You and I previously discussed the importance of the VA's Solid Start program——

Secretary MCDONOUGH. Yes.

Senator HASSAN [continuing]. Which is an initiative begun under the prior administration to contact newly separated veterans to help them access the resources and programs that they need and they have earned. My bipartisan bill with Senators Cramer and Cassidy, the Solid Start Act, would strengthen and make perma-

nent this essential VA program, and I hope we can get the bill signed into law in the coming months.

The VA's second annual report on the Solid Start program came out just a few weeks ago. The report shows that those who have successful Solid Start interactions are more likely to take advantage of the benefits and services that they have earned due to their military service. However, that same report showed that the VA was only able to reach 41 percent of the youngest veterans, age 18 to 22, compared to more than 80 percent of veterans in the higher age brackets. Younger veterans can benefit from many of the VA's programs, including for education and health care, but they may not be aware of these programs or be thinking about the long-term importance of these services.

So as the VA continues to refine this program and hopefully when it becomes permanent under our legislation, how will you work to ensure that the VA is more successful in reaching younger veterans so that they can better understand and access the VA services that they have earned?

Secretary MCDONOUGH. I think that is a good question. I agree with you that Solid Start, as you said, which was started a couple years ago under the previous administration, is a good innovation. We are taking three concrete steps and then we are taking a fourth thing which I will lift up.

First, we are using more targeted emails with younger vets.

Second, we are trying to use text messaging as a reminder for younger vets.

And third is we are trying to use two-way text messaging to schedule our outreaches to vets so they are not just cold calls, that, in fact, they arrive at a time of the vet's preferred—that the vet prefers.

So those are the three steps we are using technology—albeit the first step is email, but more targeted email—that is going to be more conducive to younger vets.

Senator HASSAN. Yes.

Secretary MCDONOUGH. The fourth and perhaps more important thing, as with so much else we are doing, we have started a human-centered design project with the Veterans Experience Office to build the Solid Start around younger vets rather than just build a program and hope that younger vets come to the program. So we will be more than happy to come up and talk to you and your fellow cosponsors about that if that would be useful to you. But as with so much else that we have done over the course of the last, you know, 8 or 10 years, we are trying to build programs in a way that respond to veterans' lives rather than just building a program and then making them change their life to come to us. That is the whole idea behind this VEO project.

Senator HASSAN. Well, thank you for that. And because I am almost out of time, I am not going to go into my last question in full. I know Senator Tester talked to you about the caregivers program.

Secretary MCDONOUGH. Yes.

Senator HASSAN. Obviously, a great concern to a lot of my constituents who have relied on caregivers, and why don't I submit to you for the record just the steps involved in your team's reassessment of the eligibility criteria for the caregivers program and

where we are right now and kind of follow through with that. I am hearing a great deal of concern. I also know how important and successful the program has been.

Secretary MCDONOUGH. Yes, I am hearing the same concern where I have talked, I think, to almost every member of the Committee on this question because you are all hearing that concern. We have put a stop to reassessments. Nobody will be moved out of the program. And as importantly, we are talking to VSOs, many of them here today, and directly with caregivers and veterans about how to improve the program.

Senator HASSAN. Okay.

Secretary MCDONOUGH. The bottom line is it has not lived up to expectations in many ways, so we are going to work that.

Senator HASSAN. Okay.

Secretary MCDONOUGH. And you have my commitment to do that.

Senator HASSAN. All right. I appreciate that very much. Thank you, Mr. Chair.

Senator MORAN. Senator Tillis.

SENATOR THOM TILLIS

Senator TILLIS. Thank you, Mr. Chairman. And thank you, Secretary, for being here.

Secretary MCDONOUGH. Thanks, Senator.

Senator TILLIS. I especially appreciate you bringing your daughter, who is a proud Davidson Wildcat, going to school only about 10 minutes from where I live.

I also want to thank Chairman Tester, Ranking Member Moran, and all the Committee's professional staff members for their tireless work to get to the point where you are on the PACT Act. I started working on toxic substances issues when I first came to the Senate with the Ensminger Act and a number of other things that I feel like we were woefully behind.

I support the vast majority of what is in the PACT Act. In fact, some of the work that my team did and other members on the TEAM Act are embedded in there, and, of course, the Camp LeJeune toxics language is in the bill, too. But I am still concerned with the operational impact. It is more of a scale. Secretary McDonough, you and I have met many times—I want to continue to thank you for your accessibility—and talked a little bit about my background in terms of operational implementations. And I know in response to Ranking Member Moran, you said that you certified that the PACT Act could be implemented.

Secretary MCDONOUGH. Yes.

Senator TILLIS. And it could be implemented within acceptable margins for performance, I assume. I do not think you said that, but I assume that.

Secretary MCDONOUGH. You say it better than I did.

Senator TILLIS. I am trying to get my head around, if I were working with a company—and I have worked with companies in the past—and they said we are about to have a 10- or 15-fold increase in demand—in this case, claims backlog—over a brief period of time, what gives you a level of confidence to say that you can certify it and have it achieve acceptable levels of performance? I am

worried about the estimates. It is an estimated 220,000 claims backlog today. I have heard estimates on the benefits side and the health care side, I think about 75 percent of the population may not be receiving medical care today; the other 75 percent are either through the VA or other options. But just the sheer magnitude with all the work that you are doing, with the implementation of the electronic medical record, the transformation that you are going through, how can the VA absorb this level of change with the high degree of success in the time frames outlined in the PACT Act?

Secretary MCDONOUGH. Yeah, I think it is a fair question, and so we have been thinking about this and talking to a great number of people across the board on this, and I have been using some of the language that I learned from you, including there is somebody sitting very near me who is going to be the one throat to choke on overseeing this.

So let us take a step back. Let us just talk about claims for a minute. Last year, we got a hundred—1.65 million claims, roughly, right? This year, we think we will get 1.75 million claims.

Senator TILLIS. And would you consider that a run rate—we are talking about—so that is current run rate, current benefits.

Secretary MCDONOUGH. Current run rate, the number this year includes the rare respiratory cancers, the three presumptives that we got in there, Blue Water Navy, but to be honest, we are probably a good 10 to 12 months ahead of the timeline that we have given you on Blue Water Navy, for example, and then the three additional presumptives that you all put in the Defense Authorization Act at the end of 2020. So we began servicing those claims in early 2021.

So, yes, that is run rate, but that is a run rate that came up—that is three, six, 15 additional claims. Now, those are of different levels of rarity, and some are Vietnam level claims and some are post-9/11 claims. But that will give you a sense—so 175 is current run rate, but that was not the run rate a year ago, as we just said, and it sure was not the run rate two years ago.

So what have we done in the meantime? We have hired basically 2,000 people, and of those, we have, I think, 94 percent of the claims professionals in chairs right now, meaning they are getting trained. Now, as you know, the problem with training is both somebody who just gets hired is not fully productive, but somebody else who is fully productive is training that guy. So he is off the line and the new guy is not yet on it. So we are going to get those 2,000 up to speed. So, that is step one.

Step two is what can we take out of this process that is superfluous, right? So we are looking at this significantly. Right? I do not know how much is there. There is not as much there as there was 10 years ago, but I refuse to believe that there is zero.

The third thing, we have been digitizing records, well, for the last 10 years, but intensively for the last two years. We are now in a position using AI to automate claims. By the end of this year, we will have the 12 most frequent claims automatable, right? How much reduction is that going to get us? I am not in a position yet to know, but I will know in the next, you know, month to six weeks.

Lastly, since these claims are, you know, we basically think a million and a half, so you go from a million and a half claims over the next two years, so you go from a million seven five this year to, you know, an incremental—you know, almost a 100-percent increase. That is going to be—it looked pretty lumpy. So do we need to entirely hire up for that, or can we both hire up and contract out?

So those are the four steps. Those are the four steps that I think you would sit down with any CEO and say these are the things that can move this. I will be in a position, as I say, in the next couple of months to come sit with you guys and say this is where I think the savings are, this is where I think we can get, because, you know, each claim is going to probably have multi-pieces to it. These are the things that we can move more quickly; these are going to be the things that are going to take longer. And I think with that kind of precision, when you have 420,000 people, the guys working the claims are not the guys working the EHRM, right? And so the challenge for us is to be transparent about it, to be clear about what people should expect of it, establish goals, and then hold ourselves to those and hold ourselves accountable to you. And that is what we will do.

Senator TILLIS. Thank you. I am also going to submit some questions for the record.

Senator TILLIS. Thank you for being here today.

Secretary MCDONOUGH. Yes, thank you.

Senator MORAN. Senator Sullivan, finally.

SENATOR DAN SULLIVAN

Senator SULLIVAN. Thank you, Mr. Chairman. And, Mr. Secretary, good to see you.

Secretary MCDONOUGH. Nice to see you.

Senator SULLIVAN. By the way, to Senator Blackburn's statement on Ms. Fulton, you might want to look at the tweets, derogatory tweets she made about women Marines. I am not sure you want someone serving veterans who has put out some, you know, not so pleasant stuff about women serving in the Marine Corps, but that is a whole other topic.

I think Senator——

Secretary MCDONOUGH. As a general matter, I am not for picking on Marines one way or the other.

Senator SULLIVAN. Well, you better watch out if you are picking on Marines, but Senator Tillis—but I do not want to make light of that.

Secretary MCDONOUGH. No, I do not——

Senator SULLIVAN. I do not think she is qualified at all, a Senate confirmation for being really problematic, and——

Secretary MCDONOUGH. I know I am talking to a Marine, so that is why——

Senator SULLIVAN [continuing]. You need to take a hard look. Seriously, you need to take a hard look. I agree with Senator Blackburn 100 percent.

Senator Tillis' line of questioning I think was really important. A number of us have been working on toxic exposure with you in a bipartisan way.

Secretary MCDONOUGH. Yes.

Senator SULLIVAN. I know Senator Moran has been working on this really hard. I sure hope the Majority Leader and Senator Tester can keep their commitment to us to make this a bipartisan bill. But I will be a little bit more blunt because I do not have, you know, the consulting background and expertise that Senator Tillis has. Here is my concern: We all want to help these veterans. I have been focused on this issue, like him, for years. But I am worried that the eligibility and the ramp-up—my understanding is 2.5 million veterans will have eligibility-—will be so dramatic that the system itself risks collapsing or delaying so much that veterans currently in the system—say a Marine who got his legs blown off in Afghanistan, right?—that all of a sudden the ability to care for that person gets delayed.

Secretary MCDONOUGH. Yes.

Senator SULLIVAN. So there are some huge issues here.

Secretary MCDONOUGH. I agree.

Senator SULLIVAN. Can you commit to us to say, no, I have looked at the PACT Act, the 23 presumptives—by the way, how many of those are based on science that the VA supported, the 23 presumptives in the bill?

Secretary MCDONOUGH. I have to refresh my memory on which were in the House, which were in the Senate. As you know, like you, since I got in this job, I have been moving presumptives as quickly as we can.

Senator SULLIVAN. I know you have.

Secretary MCDONOUGH. We have done now 12, and so some of those are included, at least some that were in the House and some in the Senate. And so——

Senator SULLIVAN. Maybe you can get back to me on that. But can you assure this Committee that what we are all trying to make sure does not happen will not happen.

Secretary MCDONOUGH. Yes.

Senator SULLIVAN. And 2.5 million people being eligible, the numbers—and what can we do to prepare for that.

Secretary MCDONOUGH. Yes, look, I—yes, you have my commitment on that, right? That is point one.

But I have been thinking a lot about this, as you might suspect, as you have, too, and I guess I am also sitting here and asking myself the question: If these veterans are suffering from conditions that were incurred because of their service, because it happened at a different time than another veteran, and because it is going to be hard on VA and us and our people is not a good enough reason, in my view, to wait to get this person taken care of. And I am not saying that is what you are arguing, but I do think that——

Senator SULLIVAN. I am not arguing——

Secretary MCDONOUGH. Yes, I know you are not arguing that. But my point is if we are in a position now to get millions more claims—right?—is it 2 million new veterans, 3 million new veterans, 4 million new veterans? We are going to get detail on that. And is it one claim per or is it three? Generally, we see one veteran makes a new claim every three years. So the numbers matter, as Senator Tillis is asking; the sequencing matters. We are digging into all of that.

Senator SULLIVAN. I am just worried about the due diligence on this in a whole host of areas that the macro impact—I have seen the VA make decisions that have collapsed the system in my State.

Secretary MCDONOUGH. Yes, you and I have talked about that.

Senator SULLIVAN. And that hurts everybody.

Secretary MCDONOUGH. Yes.

Senator SULLIVAN. Everybody, and I worry about that right now.

Secretary MCDONOUGH. If I can assure you that I worry enough about this for both of us, I would do that. But, you know——

Senator SULLIVAN. Let me turn to my State because we have still got to get you up to Alaska. We have had——

Secretary MCDONOUGH. I tried.

Senator SULLIVAN. Well, we are not done yet. The Senate was in session when you were going to be there, which I did not want you to go without me.

Secretary MCDONOUGH. I am teasing. I just do not want anybody to think I was waiting for summer or something. I want to go in the winter.

Senator SULLIVAN. I know you did, and I appreciate that. Mr. Chairman, if I may just finish my question?

We have had an expansion of our VA facilities across a number of communities, which we really appreciate. I was actually visiting one on the Kenai Peninsula very recently. But there has been this issue of the VA budget as it relates to Alaska. Senator Hassan mentioned that we are one of three States that do not have a full-service VA.

Secretary MCDONOUGH. Right.

Senator SULLIVAN. And the smallest within its regional network, the VA health care system. So here is my concern: Is there a way to get more flexibility in terms of spending to hire more people in the VA systems, in the VA facilities that we are now building? And related again to the PACT Act, would expanded enrollment in the VHA, which we are likely to see, impact States like Alaska with a smaller workforce but still a very large veteran population per capita? Again, I am worried about kind of a confluence of events that could really negatively impact——

Secretary MCDONOUGH. Yes.

Senator SULLIVAN. I was just home last weekend. We have a CBOC in Wasilla that we have lost a doctor. We have had some problems now there with wait times. Once again, we are kind of falling behind from a spot where we have made a lot of improvements, and I am wondering if there is more focus on States like mine without full-service VA facilities but big populations in the PACT Act coming.

Secretary MCDONOUGH. Yes, so we are looking aggressively at time to hire, on-boarding, what we can get out of there, what of the improvements that we have made in terms of time to hire during the pandemic we can maintain. Importantly, OPM is helping us there. And even more importantly, you all in the context of the pandemic are giving us additional workforce authorities to ensure that we can both—I do not know what happened with the doc, but the first thing we need to do is retain the docs that we have. And you are giving us new authorities to do that. Pay is a big one. And then you are giving us enhanced recruiting authorities as well.

And so, yes, we are thinking very diligently about this and planning very diligently about making sure that we have the people in the spots and that we have the buildings for the increased demand that we anticipate seeing. So each of these things are envisioned in the Ranking Member's agreement with the Chairman. We feel good about that. There will be execution challenges, to be sure, but we are aggressively planning and preparing for that.

Senator SULLIVAN. Okay. Thank you.

Thank you, Mr. Chairman.

Senator MORAN. Senator Sullivan, thank you.

Mr. Secretary, thank you for being with us.

Secretary MCDONOUGH. Thank you.

Senator MORAN. I appreciate your conversation. You can imagine that at least one of your answers to my questions means I have a lot of follow up to do.

Secretary MCDONOUGH. Yes, you do, and I look forward to it. Thank you very much.

Senator MORAN. I will now call the second panel, three veterans service organizations who wrote this year's Independent Budget. We have said many times that Congress needs to take its cues from the veterans, and I am looking forward to hearing your thoughts on this year's budget proposal.

First, I would introduce Roscoe Butler, the Associate Legislative Director for the Paralyzed Veterans of America.

We also have Shane Liermann, the Deputy National Legislative Director of Disabled American Veterans.

And, lastly, we have Patrick Murray, Director of National Legislative Service for the Veterans of Foreign Wars.

They will each provide a part of one joint statement on behalf of the Independent Budget. Gentlemen, the floor is all yours, although I have got some housekeeping to do. I need to go vote in the HELP Committee, and I am trying to figure out if there is anybody here who is going to not only hear your testimony but conduct the hearing. The answer apparently is yes, and I will work my way back here. And, Senator Sullivan, given the chance that you might have to ask unlimited questions, you may decide that you want to chair this hearing.

[Pause.]

Senator TILLIS [presiding]. Thank you all for being here. Sorry, I have been in and out, because this is also NDAA markup week, and I serve on three subcommittees. I have another subcommittee that I will have to be going to shortly. But we do want to hear your testimony.

Do you have prepared opening statements?

Mr. MURRAY. We do.

Senator TILLIS. We want to move, starting with Mr. Butler—oh, I am sorry. Mr. Murray.

PANEL II

STATEMENT OF PATRICK MURRAY

Mr. MURRAY. Thank you very much, Senator Tillis.

The Independent Budget, or IB, is a collaboration of DAV, PVA, and the VFW that for more than 30 years has provided independent, nonpartisan feedback and recommendations on the administration's budget.

We would like to thank this Committee and especially the staff. We are on the eve of passing one of the largest veterans benefits expansions in generations. We are pleased to see that VA will direct funds from the Recurring Expenses Transformational Fund toward its construction accounts, but while this is a good step, we believe it only shows the lack of a sufficient amount in the original budget request. VA's construction budget should be at a minimum 3 percent of its overall operating budget just to keep up with the growing backlog. But in order to reduce the backlog, in addition to a higher budget request, more employees and contractors would be needed to oversee the resulting workload.

Neither VA's Office of Construction and Facilities Management, or CFM, nor the individual VA facilities have the manpower to plan and oversee VA's infrastructure at the levels needed to significantly reduce the construction backlog.

Traditionally, when the IB testifies before Congress about staffing, as we will here in a minute, we discuss the tens of thousands of shortages of medical providers. That is an incredibly important topic considering the reports about VA's staffing often cite the words "severe shortages" in critical medical fields. However, I would like to use this opportunity to discuss the hundreds and thousands of unfilled facility management positions. These often overlooked staffing shortages could provide immediate remedy for some of VA's infrastructure problems.

CFM has approximately 32 percent vacancies at VA's central office and throughout the VA system of facilities. An entity that has an even higher vacancy is the seismic program, which currently has an 86-percent vacancy rate since being established in 2019.

These positions are critical for VA to eventually eliminate the infrastructure backlog, and every effort needs to be made to fill these jobs. In a May 2020 report to Congress, VA described the challenges of hiring and retaining CFM personnel. There needs to be changes to the hiring authorities to make these positions more competitive not only with the private sector but with other Government agencies.

Partnerships in VA are incredibly important. Congress must eliminate the sunset date on the CHIP-IN program and expand enhanced-use lease programs. The CHIP-IN is not an everyday solution to VA infrastructure issues, but whenever an opportunity arises to accept donated facilities, VA must be able to accept any facility at any value if it is in VA's best interest.

The VA Medical Center in Aurora, Colorado, was finally completed in 2018 after being delayed over a decade and costing millions of dollars over the original cost estimate. Part of this reason was the project was finally brought back on track with the inclusion of the U.S. Army Corps of Engineers. The Independent Budget believes VA should partner with the Army Corps whenever possible to help reduce the construction backlog.

Senator Tillis, thank you for the opportunity to discuss these topics. I would now like for Mr. Butler to discuss some of our thoughts on health care.

[The joint statement of Messrs. Murray, Butler, and Liermann appear on page 57 of the Appendix.]

STATEMENT OF ROSCOE BUTLER

Mr. BUTLER. Thank you.

Overall, the IBVSOs believe the Administration's VA budget request for fiscal year 2023 is a very strong proposal that would provide comprehensive and justified increases across most of the discretionary appropriation accounts. The Administration's total medical care funding request of approximately $122 billion is relatively close to the IB estimate.

Although the IB's and Administration's recommendations for fiscal year 2023 are much closer than they have been in recent years, we continue to differ on the appropriations for VA health care. Our recommendation reflects multiple components, including the current service estimate, the increase in patient workload, and additional medical care program costs. It reflects increases based on uncontrollable inflation and a projected Federal pay raise for all VA employees in fiscal year 2023. The IBVSOs estimated a 4 percent increase in VA health care utilization due to deferred demand, increase sickness, and morbidity for COVID. Our estimate of growth in patient workload is based on a projected increase of approximately 81,000 new unique patients.

The IBVSOs differ with the Administration in terms of funding for suicide prevention. The Administration says its plan to reduce spending in this area by $101 million, which is largely driven by the completion of the requirements of the 2019 Executive Order establishing PREVENTS. We believe the move to reduce funding in this area is premature and could undermine the recent progress achieved in combating this complex problem. Our recommendation includes sufficient funding to hire approximately 450 new FTEs to support the new 988 National Suicide Prevention Lifeline and increases in staffing and resources so the vets in the program can expand their fleet of aging Mobile Vet Center Vans.

Lastly, VA has underprioritized the long-term services and support programs for years. This cannot continue, as the number of veterans in the oldest age cohorts are increasing significantly. VA's Geriatric and Extended Care Strategic FY 2020 to FY 2024 Plan projects expenditures for long-term care will double by 2037. To keep up with the demand for long-term services and supports, the IBVSOs are recommending an increase of $375 million for VHA's Institutional Care and Home and Community Based Programs.

Thank you, Senator Tillis, and I will be available to answer any questions you may have.

STATEMENT OF SHANE LIERMANN

Mr. LIERMANN. Senator Tillis, on behalf of the Independent Budget VSOs, we are pleased with the Administration's budget request for the general operating expenses, specifically the Veterans Benefits Administration (VBA) and Board of Veterans' Appeals (BVA).

Earlier this year, the IBVSOs recommend additional FTE and $100 million for overtime, primarily to help VBA make progress on reducing the backlog of disability claims. Additionally, we requested these resources to prepare VBA for an influx of claims related to VA adding new presumption diseases, now 12, and in anticipation of Congress passing toxic exposure legislation, the PACT Act, hopefully very soon.

VA's budget request would provide funding to add 795 new FTE, which will aid in processing claims for new respiratory conditions associated with toxic exposures and it will provide for claims modernization and automation, as well.

This funding will also be instrumental in helping to drive down the current backlog of pending claims.

For the Board of Veterans' Appeals, the IBVSOs recommend an additional 15 Veterans Law Judges, or VLJs, and an additional 100 FTE to assist in reducing the backlog of hearings that are currently pending within the Board.

VA's budget request for the Board of $285 million is a 25 percent increase over fiscal year 2022. This would provide the Board with 256 new FTE, including 12 additional Veterans Law Judges, 151 decision writing attorneys, and 93 appellate support and administrative staff. We believe these funding levels will assist in addressing the legacy and AMA appeals while also putting the Board in a position to prepare for the potential influx of appeals due to the court decision of *Beaudette* v. *McDonough*.

While there are a few minor differences, VA's budget request for VBA and the Board of Veterans' Appeals is very much in alignment with the Independent Budget's recommendations.

Senator Tillis, overall the proposed budget for the general operating expenses is a 13 percent increase over fiscal year 2022 and the IBVSOs are pleased with this strong budget proposal from VA.

This concludes our testimony and we would be pleased to answer any questions you, Senator Tillis, may have.

Senator TILLIS. Well, thank you all.

I want to start by thanking you for your past service and your continued service to our country and to veterans.

As you were going through your testimony, Mr. Murray, I was trying to tally things. I did not get the numbers, but you were talking about additional positions that you feel like the budget request fell short on. What was that number again?

Mr. MURRAY. For which position? We talked about

Senator TILLIS. Roughly, what order of magnitude for all of them?

Mr. MURRAY. I believe it was 30 or 32 percent for CFM positions across VA. The Secretary mentioned, they can only do so much workload. They only have so many people. We want them to increase—not only fill the positions they have, increase that amount so we can give them more workload to knock down the budget.

Senator TILLIS. Mr. Butler, on suicide prevention, I think you mentioned about 450 FTEs. Incidentally, I am sympathetic with your position. I do not think we need to take a step back. But I think it was 450 FTEs?

Mr. BUTLER. Yes, sir.

Senator TILLIS. The reason I ask that question again, there are so many things I am learning in the U.S. Senate. But one thing I did relatively well when I had a day job was organizational transformation. And I have heard, in your testimony, hundreds of positions that need to be filled to fulfill current promises.

The budget request has another 795 FTEs to process claims for the current run rate, not the future run rate for the PACT Act.

Mr. Murray, I heard you loud and clear. I think the PACT Act has tremendous policy in it. But I am very worried—I actually was on a train between Dirksen and the Capitol and I ran into some folks who were from VFW visiting members on the Hill. I think you were on that train.

Mr. MURRAY. You ran into me.

Senator TILLIS. Yes. And I remember saying that my concern has more to do with us getting this right. And I believe you said it may be a long line, but at least it is one that they will be able to stand in.

I think at the end of the day though, we have to get this right. I hope that through agreement we can consider amendments that we can convince you all would be positive and make it more likely that we can actually implement the policy, which we all agree with.

But I do have to continue. I am looking at one amendment, for example, I am cosponsoring is Senator Blackburn's amendment on community care as a safety valve. Are you familiar with that amendment?

Mr. MURRAY. A little, yes.

Senator TILLIS. It would be interesting, I will not stake you out here, but it would be interesting as we are talking about some possible amendments, and if we keep the agreement that there will be two Republican amendments, I think it would be very helpful for you all, for your respective organizations, to take a position on it. Because I do think it is a safety valve in community care for the roughly 25 percent of veterans that we think are not receiving some care for the illness that when the PACT Act is passed will be a presumptive condition where they are entitled to care.

So it would be helpful to look at that. I think Senator Lee's amendment on science-driven presumptions are also ones that I would hope that you all would look at.

In terms of your opening statements, the resourcing for current commitments and programs, I tend to agree with. I think PREVENTS is one that I am particularly concerned with. But I am concerned with the implementation of this program.

After we got off the train, I got to thinking, I hope we are having a good discussion two years from now. When the zone gets flooded and the hundreds or thousands of people that may be necessary, either within the VA or within the community, to actually fulfill a promise we are going to make. And what we have to do along the way is not break promises that we have already made.

This is a new promise. It is an important one. But all of our former promises are every bit as important.

Mr. MURRAY. So Senator, I agree with you. However, I would say that I believe we are in this position because we are already breaking our promise to the men and women who served our country. Honoring the PACT Act is fulfilling that promise.

To your point about workload and capacity, I understand that this could result in 1.5 million claims, as has been said before. But it is not all at once. It is a phased-in approach. And the work done by the House and by the folks in the Senate here to mitigate that, is meant to make sure that we are not going to flood the system.

Part of the PACT Act has those workforce provisions so that we cannot only take care of the people that we will be adding to the system, but the current personnel, as well. So we do believe this is incredibly important.

To your amendment about community care. Community care is VA care. Community care is a needed supplement to VA care. However, I believe the language of that amendment is maybe a little bit too prescriptive in that it would allow every veteran who is exposed to toxic—it would push every veteran who is exposed to toxic substance into community care. So while I understand the intent, to make sure that veterans get the care they need, I believe it would then push every single person to the community.

As we have seen what happened with COVID–19, the community was the one that was facing the breaking point. VA was actually the health system in America that stood up, took those punches, and not only withstood and provided care to veterans, actually helped out in the communities in which they are in.

Senator TILLIS. I think that is a fair point. I guess we will talk with Senator Blackburn's staff. I do not think it is a complete—I mean, if you just assume, for the sake of simplification, that the 25 percent are not receiving care, this is not a mandate to send them all into community care. There has to be some balancing. And that difference, you know, my State has very different capacity from many other States in the Nation. So I think that that is a fair point.

Mr. MURRAY. And again, well intentioned but we believe the language maybe needs to be looked at a little closer. That is all.

Senator TILLIS. I think, you know things are moving fairly quickly. So I think that the other proposals, the amendment could get in there and that we could vote on in the coming days or the next week or so, I think it would be helpful for you all to weigh in so that we have your opinion.

Mr. MURRAY. Gladly.

Senator TILLIS. Again, it is not about—and I think you are right. I mean, if they have a service-connected illness, we have an obligation to support our veterans. I support that. I have since I have been here. I just want to make sure we get this right and I do not want to see you all on a panel 18 or 24 months from now saying we got it wrong. So it takes a lot of eyes on it. We are all partners together and we have to own jointly, not only Members of Congress but the VSOs, to make it work.

Well, thank you all for your testimony. If I did not have two other markups that I had to go to, I would probably pepper you for another 20 or 30 minutes.

Thank you again for your service and I look forward to our continued engagement.

We are going to keep the record open for five days.

The Committee is adjourned.

[Whereupon, at 4:36 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statements

FINAL

Secretary of Veterans Affairs Opening Statement

SVAC BUDGET HEARING

June 14, 2022

Chairman Tester, Ranking Member Moran, and distinguished Members of the Committee: thank you for the opportunity to testify today.

Let me begin with a word of thanks to the Committee for the critical work you've done on the PACT Act.

This bill will ensure that millions of Veterans get the toxic exposure care and benefits that they deserve, and help VA by investing heavily in our claims processing, our workforce, and our health care facilities.

On top of that, the bill will help us advance one of the Department's top priorities: getting more Veterans into VA care, because study after study shows, Vets in VA care do better.

...

Here's just one example.

Recently, a Veteran came to one of our great nurses, Richard Hall, experiencing a variety of symptoms. But all of the tests came back normal, so the Veteran went home.

A couple days later, the Veteran came back to the hospital—this time with his wife—complaining of similar symptoms.

So, Richard took the time to interview the Veteran, and in doing so, he found out that the Vet was feeling worse every time he was at home, and better every time he went outside.

Thinking on his feet, Richard realized that something must be going on at the house. So, he asked the Veteran's wife if she was feeling sick too. Turned out, she was.

Then, Richard asked the life-saving question: has there been any work done at the house recently?

The Veteran and his wife said yes. Their landlord had just put in a furnace.

Hearing that, Richard sprang into action, told the Veteran and his wife not to go home, and had them call the gas company to check for a carbon monoxide leak at the apartment complex.

2

It turned out that there was a carbon monoxide leak ...

... meaning that Richard not only saved the lives of that Veteran and his wife—but also the lives of everyone else who lived in that apartment complex.

That's what fighting like hell for Vets looks like, and that's what VA employees like Richard Hall do every day—and have done throughout the pandemic.

That's why VHA outpatient trust scores are above 90%, and studies show that we're delivering better outcomes than the private sector.

That's why VBA's processed more than 927,000 Veteran claims already this year—the fastest pace in history ...

And that's why NCA's approaching our goal of providing 95% of Vets with access to burial sites within 75 miles of their homes.

All told, we're now providing more care and more benefits to more Veterans than ever before.

But make no mistake: our great public servants can't do that great work unless they have the resources they need to do it.

And that is why this budget is so important.

It'll not only help us continue down this path, but also empower us to do even better for Vets, families, caregivers, and survivors.

...

Specifically, this budget will help us get 38,000 homeless Veterans into permanent housing by the end of this year.

It will help us deliver the toxic exposure benefits that Veterans deserve—as fast as possible—by researching military exposures, hiring claims processors, and investing in claims automation.

It will help us save Veterans from suicide by expanding the Veterans Crisis Line, investing in lethal means safety, and funding local intervention programs.

It will help us deliver for all Veterans—including women Veterans, our fastest growing demographic—by investing the highest amount ever in our women's health program ... which delivers tailored, world-class health care to women Vets.

It will improve access and outcomes for Tribal Veterans by helping us invest in resources to launch the Tribal Health Office—which will make health care more equitable and accessible—and the Tribal Representative Expansion Program, which will establish Tribal Veteran Service Officers to help these Vets get the benefits they deserve.

It will help us save lives by investing nearly a billion dollars in VA's ground-breaking research, including Long-COVID and cancer research.

And it'll help us continue to save Veterans from COVID-19, which is very much still here and very much still a threat for Veterans across America.

I could go on and on, but the bottom line is this: The number you see when you look at this budget request is $301.4 billion.

But what this budget really means is health care for an estimated 9.2 million Vets ...

... disability and survivor benefits for an estimated 6 million Vets and their families ...

... and lasting resting places for an estimated 135,000 heroes and family members.

In short, this budget means Veterans' lives saved, or improved, by the work this funding makes possible.

...

You know, President Biden often repeats a quote from his dad, saying, "Show me your budget, and I'll tell you what you value."

Well, this budget shows how deeply this President—and our country—values Veterans, their families, caregivers, and survivors.

They are the backbone of America.

They deserve our very best.

And with this budget, that's exactly what we'll give them.

Thank you for the opportunity to testify, and for your support of Veterans and VA.

I look forward to your questions.

STATEMENT OF
THE HONORABLE DENIS MCDONOUGH
SECRETARY OF VETERANS AFFAIRS
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

A REVIEW OF THE FY 2023 BUDGET AND FY 2024 ADVANCE APPROPRIATIONS REQUESTS FOR THE DEPARTMENT OF VETERANS AFFAIRS

JUNE 14, 2022

Chairman Tester, Ranking Member Moran, and distinguished Members of the Committee. Thank you for the opportunity to testify today in support of the President's Fiscal Year (FY) 2023 Budget and FY 2024 Advance Appropriations Request for the Department of Veterans Affairs (VA), and for your longstanding support of Veterans and their families.

President Biden describes our country's most sacred obligation as preparing and equipping the troops we send into harm's way and then caring for them and their families when they return. The President's FY 2023 Budget reflects this commitment and honors this sacred obligation to the Nation's 19.2 million Veterans by investing in: world-class health care, including mental health care, and enhancing Veterans general well-being; benefits delivery, including disability claims processing; education; employment training; and insurance, burial, and other benefits to enhance Veterans' prosperity.

This Budget will ensure VA is moving swiftly and smartly into the future as we serve our two core requirements: timely access to world-class care, and timely access to earned benefits. This Budget ensures all Veterans, including women Veterans, Veterans of color and LGBTQ+ Veterans, receive the care and benefits they have earned and prioritizes Veteran homelessness, suicide prevention outreach and caregiver support.

I also want to thank this Committee for the critical work it has done on the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act. VA strongly supports this legislation because the bill will help us advance one of the Department's top priorities: getting more Veterans into VA care. It will also improve our ability to recruit and retain a world class workforce and provide long-needed fixes to our leasing process. We look forward to working with the Office of Management and Budget, Veterans, this Committee and others in Congress, Veteran Service Organizations and other stakeholders to address the significant and transformative operational impact and resource requirements of the PACT Act. Our FY 2023 Budget and FY 2024 advance appropriations request does not include the additional resources needed for the implementation of PACT Act.

FY 2023 Budget and FY 2024 Advance Appropriations

The President's FY 2023 Budget includes $301.4 billion (with medical collections and Recurring Expenses Transformational Fund), $30.7 billion (11.3%) above the President's FY 2022 Budget. The discretionary request is $139.1 billion (with collections), $21.9 billion (18.7%) above the 2022 Budget. The request includes $122.7 billion (with collections) for VA medical care, $21.6 billion (21.5%) above 2022. The 2023 mandatory funding request totals $161 billion, $8.6 billion (5.7%) above 2022. This funding is in addition to the substantial resources provided in the American Rescue Plan Act of 2021 (P.L. 117-2).

The 2024 Medical Care Advance Appropriations request includes a discretionary funding request of $132.1 billion (with medical care collections). The 2024 mandatory Advance Appropriations request is $155.4 billion for Veterans benefits programs (Compensation and Pensions, Readjustment Benefits, and Veterans Insurance and Indemnities).

The 2023 Budget proposes separating out VA health care as its own category of discretionary funding. Historically, the VA health care budget for veterans has been grouped together in one budget category with the budgets for other governmental agencies — meaning VA has had to compete with other non-defense departments and agencies for financial resources in the budgetary process. VA health care should not be subject to competition with other funding needs — it is a sacred obligation we owe to those who serve, and we must fulfill that obligation each and every year.

This budgetary change is particularly important now because the health care needs of veterans are becoming more complex, which means the cost of VA health care is rising. Since President Biden took office, VA has delivered more care to more veterans than ever before. Moreover, VA funding has more than doubled since 2013, and it will likely increase further in the coming years as President Biden delivers long-overdue presumptive benefits and care to vets who suffer from conditions related to military environmental exposures.

If we maintain the budgetary status quo amidst this continued growth, we will risk underfunding VA at a time when veterans need us most. Additionally, if we maintain the status quo, we will risk underinvesting in other non-defense agencies due to the growth of VA health care. This would be a bad outcome for all Americans — including veterans who often benefit directly from the federal programs that are currently competing against the VA for resources.

Delivers Benefits for Veterans

Investing in our Workforce

Serving as Secretary of VA along with the dedicated, highly skilled professionals who constitute the VA workforce —many of them Veterans themselves – is the honor of

my lifetime. VA employees are committed to serving Veterans, their families, caregivers and survivors. Over the course of the COVID-19 pandemic, VA employees have ensured that VA did not weaken or slow down. VA got stronger and took care of Veterans when they needed it most. The 2023 Budget supports 435,840 Full Time Equivalent (FTE), an increase of 28,963 from the 2022 estimated level. This Budget will allow us to take care of the great people who have diligently balanced the challenges of life during the pandemic, and during unprecedented demand for frontline workers, have continued to serve Veterans. As we have seen during this period, we need to do more to invest in our employees, because VA's employees are the foundation that make all the Services VA provides possible.

In order to attract and recruit qualified diverse talent, VA is seeking funding for a critical investment in talent teams, which will be instrumental in improving the hiring experience for applicants and hiring managers and implementing data-driven assessment strategies to improve selection outcomes. Talent teams will be instrumental in conducting outreach and recruitment for interns and early career positions and designing and deploying assessments that can be used to reduce time to hire and improve identification of qualified candidates.

In order to recruit and retain employees in mission critical occupations, particularly in a competitive market, VA is seeking legislative relief from certain limits on pay. VA is deeply appreciative of Congress's passage of the RAISE Act which will assist in recruiting and retaining Physician Assistants, Registered Nurses, and Advanced Practice Registered Nurses. VA is seeking legislative relief to modify the compensation system for healthcare leaders to more successfully compete with the levels private industry offers. VA is seeking legislative relief to limits on pharmacist pay.

Another tool to invest in our workforce is through student loan repayment programs, education debt reduction programs, and scholarships. Continuous development in leadership and technical skills enhances employees' service and performance. Limits on current programs have not kept up with the increasing costs of education and have a greater impact on underserved and underrepresented groups. Our proposals expand access to these programs and ensure we are reaching more groups.

Finally, our Budget reflects an investment in people and technology to:

- Promote employee whole health and reduce employee burnout;
- Develop and implement staffing models throughout the VA;
- Promote strong labor relations with our national unions;
- Lead our post-pandemic occupational safety and health planning and programs; and
- Improve the hiring experience for applicants, managers, and HR professionals.

Three personnel systems have created a complex set of rules. Automating these processes has been challenging. There is wide agreement that we need to do better,

and we will. Stakeholders are working to identify and implement changes and resources are needed to support improved outcomes.

Veterans Benefits Administration (VBA)

The 2023 Budget includes $3.9 billion in discretionary funding for the General Operating Expenses, VBA account, a $440 million increase over the 2022 Budget. This includes funds to hire 379 additional claims processors to support growing demands and the increased scope of disability compensation claims as well as to advance claims automation and modernization efforts. It also supports 795 FTE employees for processing claims related to the three new Gulf War presumptive conditions VA implemented in 2021.

The Budget provides disability compensation and survivor benefits to 6 million Veterans and their families; education and job training benefits to 921,000 Veterans and qualified dependents; guarantees nearly 995,000 home loans and funds 5.8 million total lives insured for Veterans, Service members and qualified dependents.

The Budget provides $120 million for VA to support automating the disability compensation claims process from submission to authorization. VBA is leading a comprehensive modernization of the claims process through the utilization of data and automation and leveraging technology. VBA will use datasets specific to a Veteran's military service, claims history, and medical encounters to feed automation models. Historically, manual administrative tasks and workflows are being automated to enable more effective claim decisions. Investments in automation will increase VA's ability to deliver faster and more accurate claims decisions for Veterans.

National Cemetery Administration (NCA)

The 2023 Budget includes $430 million for the NCA operations and maintenance account, an increase of $36 million (9.1%) over the 2022 Budget, to ensure Veterans and their families have access to exceptional burial and memorial benefits including expansion of existing cemeteries, as well as new and replacement cemeteries. With this Budget, NCA will provide for an estimated 135,100 interments, the perpetual care of almost 4.2 million gravesites, and the operations and maintenance of 158 national cemeteries and 34 other cemeterial installations in a manner befitting national shrines. This request will fund 2,281 FTE needed to meet NCA's increasing workload and expansion of services, while maintaining our reputation as a world-class service provider. NCA field employees (85% of the total NCA workforce) provide direct support to Veterans and their families and ensure that the service they receive is dignified, respectful and courteous.

NCA is nearing its goal of providing 95% of Veterans with access to a burial option in a national, State, territorial or tribal Veterans' cemetery within 75 miles of their homes. To achieve this goal, NCA will establish the remaining planned new national cemeteries and expand existing national cemeteries to meet projected demand,

including the development of columbaria and the acquisition of additional land. Construction projects to develop new national cemeteries will enhance burial services and provide new burial options to Veterans and their families. Construction projects also keep existing national cemeteries open by developing additional gravesites and columbaria or by acquiring and developing additional land. The 2023 Budget includes $140 million in major construction funds for a replacement cemetery in Albuquerque, New Mexico, a gravesite expansion at Jefferson Barracks, Missouri, and completion of a new national cemetery in Western New York. The Budget also includes $157.3 million in minor construction funds for gravesite expansion and columbaria projects to keep existing national cemeteries open and for projects that address infrastructure deficiencies and other requirements necessary to support national cemetery operations. The 2023 Budget also includes $50 million for the Veterans Cemetery Grants Program to continue important partnerships with states and tribal organizations. This Grants Program plays a crucial role in achieving NCA's strategic target of providing 95% of Veterans with reasonable access to a burial option.

Continues Timely Access to High Quality Health Care and Support Services

The 2023 Budget includes $122.7 billion (with collections) for VA medical care, $21.5 billion or 21% above the 2022 Budget. The 2024 Medical Care Advance Appropriations Request includes a discretionary funding request of $132.1 billion (with medical care collections). I acknowledge that these requests, and their annual rates of increase, are significant. However, the challenges VHA has faced these past two pandemic years, and will continue to face, are just as significant, and the requested resources are essential to ensuring the 9.2 million enrolled Veterans will continue to receive the high quality, timely health care they need and have earned.

VHA successfully met the challenge posed by COVID-19, delivering improved health outcomes for Veterans while successfully supporting the broader American health care system as part of its "fourth mission." And while we are optimistic that the world has turned the tide against this horrific disease, much of this Budget's substantial requested increase is evidence of the continuing pandemic impacts being felt today. We anticipate higher health care costs in FY 2023 in part due to the returning wave of health care that was delayed over the past 2 years, and that care is more complex and expensive due to the effects of that delay or the confounding impacts of long COVID-19 disease or other pandemic-related exacerbation. We also need to continue to be prepared for additional waves and new variants of the COVID-19 disease. VHA continues to struggle with lingering supply chain complications, inflationary pressures and national health care workforce staffing challenges.

VA researchers are generating real-world evidence of COVID-19 vaccines' effectiveness over time across the country. Through collaborations with the Food and Drug Administration, Centers for Disease Control, and National Institutes for Health, this knowledge helps to inform decisions on significant issues such as the need for boosters and new vaccine targets.

Addresses Veterans' Specific Needs

Improves Support for Veterans Impacted by Military Environmental Exposure (MEE) During Service

To deliver benefits more quickly to Veterans who developed disabling conditions due to exposure to environmental hazards and to reduce the evidentiary burden on such Veterans, VA is piloting a new approach to accelerate and improve the decision-making process for considering whether to add new presumptive conditions through rulemaking. The new model is evidence-based, transparent, and allows VA to make faster policy decisions on crucial MEE issues. This new approach considers all available data, listens to and learns from Veterans' experience, and is guided by one core principle: getting Veterans the benefits and health care they've earned and therefore deserve. Recognizing that incomplete and inconclusive research often hampers VA's ability to take timely action, the new model fills this void with other evidence-based data to reach a recommendation, including VA claims data analysis and trends. It also incorporates other mitigating factors that may otherwise impact the scientific and claims data findings. This new model will fundamentally change how VA makes decisions on environmental exposures. Key components of the proposed presumptive decision-making model framework include:

1. Review of relevant medical and scientific literature, including but not limited to reports from the National Academies of Science, Engineering, and Medicine (NASEM).
2. Review of benefits claims data to identify trends in claims to help inform which reviews of conditions are needed.
3. Review of relevant other data, including but not limited to manifestation periods and life expectancy prognoses.

VA is fully committed to this deliberate forward-leaning approach to deliver benefits and health care services more quickly to Veterans who develop conditions related to military environmental hazards. In addition to modernizing the presumptive decision-making process, VA is also proactively taking the following direct steps to respond to Veterans' concerns in this area:

1. Expanding training for health care providers,
2. Improving science, surveillance, epidemiology, and research, and
3. Increasing Veteran outreach and employing an integrative approach leveraging internal and external partnerships.

VA has developed policy and research regarding the health outcomes of MEE to Veterans deployed or in garrison at Camp Lejeune (includes family members). VA conducts epidemiological research, education, risk communication, and consultation with clinicians in the field and translational clinical research for care of MEE though the War-Related Illness and Injury Study Center (at 3 sites; in New Jersey, Washington, D.C., and California).

VA conducts research that improves health care through the development of best practices and improves policy decisions related to support of benefits for Veterans. VA subject atter experts review current scientific literature and provide surveillance to develop policy recommendations grounded in science. The Cancer Moonshot reignited initiative includes two projects focused on MEE: an interagency effort will develop a cohort of Veteran tumor samples from various registries to conduct sequencing and identify genomic signatures that may be associated with carcinogens from military and environmental exposures, and VA will develop a centralized and accessible data compilation to better understand the unique exposures of Veterans and ensure 2-way data exchange. With this data made accessible in this way, VA, as well as other agencies and institutions, will have the ability to learn from more patients and reduce the cost and time of data curation.

To define adverse health outcomes as well as emerging environmental threats, VA:

- Improves scientific understanding of health effects of military (toxic and other hazards) environmental exposures,
- Translates the MEE science into care and treatment for Veterans, and
- Provides access to health services for individuals who were exposed.

VA administers Congressionally mandated programs related to environmental, occupational and garrison exposures that may have affected U.S. Veterans and some family members during military service, including six exposure registries. VA is developing Veterans Exposure Team – Health Outcomes of Military Exposures (VET-HOME), a tele-health pathway for Veterans and providers to access resources and services related to MEE. VET-HOME will consist of two interconnected parts: a call center for Veterans and providers, and a nationwide network of specialists. Veterans with questions about MEE will call into a central location and be guided through the registry exam or environmental exposure process. They would then be referred to one of 40 environmental health providers across the United States who would use a telemedicine platform to assess and, if necessary, refer the Veteran to a VA facility to complete any specialty testing, like a pulmonary function test or other lab work. Providers with questions on MEE would be referred to one of the 40 military environmental heath SMEs. The results of the consultation would be shared with the Veteran's primary care doctor, helping to deliver better care to the Veteran.

The Budget increases resources for these efforts, including $111 million for processing new presumptive disability compensation claims related to environmental exposures from military service that VA has already announced (but not those included in the PACT Act legislation), as well as $63 million within the VA medical care program for Health Outcomes of Military Exposures (HOME) to increase scientific understanding of and clinical support for Veterans and health care providers regarding the potential adverse impacts resulting from environmental exposures during military service.

The Budget also invests $51 million in funding to support medical research related to MEE, an increase of $20 million over the 2022 Budget. VA is expanding its military exposures research efforts. Funding supports the VHA Office of Research and Development (ORD) Military Exposures Research Program, established in 2022 with an emphasis on advancing military exposure assessments and understanding the effects of military exposures on Veterans' health outcomes to inform care and policy. In a phased approach, ORD will build upon ongoing research on health outcomes resulting from exposure to burn pits, Gulf War Illness, Vietnam Veterans' health and precision oncology to develop new work in areas such as constrictive bronchiolitis, genomics and other emerging technologies. We will ensure collaborations across the Department with academic institutions and with other Federal agencies and our prospective efforts will include close partnerships with exposed Veterans.

From a benefits perspective, VBA will establish a new Military Exposures Team (MET) that will provide resources and a dedicated focus to issues related to MEE. This initiative supports my commitment to Veterans and stakeholders to expedite review and analysis of the types of conditions potentially warranting initiation of rulemaking to establish a presumption of service connection under part 3 of title 38 of the U.S. Code of Federal Regulations. MET is part of my aggressive MEE strategy, fortified by a new model for considering additional presumptive conditions and the elevation and expansion of VHA's new HOME Office.

MET will have program oversight and management responsibility to address all disability benefit claim related program research and supporting data analysis for making recommendations for service-connected conditions deemed presumptive due to military exposure, as well as supporting claims research and data analysis necessary to address evidence-based policy determinations for compensation benefits under the VA directives and framework that govern such decisions.

Through these efforts, VA will accelerate Veterans' ability to access the health care and services they have earned and deserve.

Bolsters Inclusion for Caregiver Support

Family caregivers of Veterans are force multipliers for VA. Supporting caregivers provides those family and friends who care for Veterans with the support, services and tools they need to successfully support Veterans, resulting in better health and well-being outcomes for both the Veteran and the caregiver. VA has long supported caregivers through the delivery of a host of supports and services, as well as home and community-based services. Our Caregiver Support Program (CSP) is designed to promote the health and wellbeing of family caregivers who care for our Nation's Veterans, through education, resources, support, and services. CSP administers two programs: the Program of General Caregiver Support Services (PGCSS) and the Program of Comprehensive Assistance for Family Caregivers (PCAFC). Both programs provide services to support and engage caregivers of Veterans as partners in care, integrating caregivers as members of the Veteran's health care team. The Budget

recognizes the important role of these family caregivers in supporting the health and wellness of Veterans. The $1.8 billion included in this Budget provides funding for both PCAFC and PGCSS, including staffing, stipend payments and many other supports and services to help empower family caregivers of eligible Veterans. In addition, this funding allows for further improvements and enhancements to both PCAFC and PGCSS, allowing VA to reach and support more caregivers than before.

In 2011, PCAFC was implemented for caregivers of eligible Veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001. The VA MISSION ACT of 2018 (P.L. 115-182) expanded eligibility to Veterans of all eras in a phased approach, among other changes. The first phase of this expansion occurred on October 1, 2020, expanding eligibility to Veterans who incurred or aggravated a serious injury in the line of duty on or before May 7, 1975. On October 1, 2022, eligibility will be further expanded to Veterans who incurred or aggravated a serious injury in the line of duty in all service eras.

VA is currently reviewing all aspects of eligibility for PCAFC. While this review is underway, VA will not discharge any caregivers or Veterans who were participating before the first phase of expansion on October 1, 2020, referred to as Legacy Participants. This review will result in an improved and expanded PCAFC with a focus on providing accurate, consistent and transparent decisions. CSP strives to make the right decision the first time, but if a Veteran or caregiver believes we've gotten it wrong, Veterans and caregivers have more options to seek further review of PCAFC decisions than ever before. The VHA Clinical Appeals process, also known as the VHA Clinical Review process, is one option for seeking further review of decisions. In April 2021, the U.S. Court of Appeals for Veterans Claims ruled that PCAFC decisions are now appealable to the Board of Veterans' Appeals. As a result of this ruling, the CSP and the Board are diligently working to develop the necessary infrastructure and processes to offer the full spectrum of options available under the Veteran Appeals Improvement and Modernization Act of 2017 (AMA) (P.L. 115-55), including additional AMA options for Supplemental Claims and Higher-Level Reviews. The implementations of these processes require the development of new workflows, procedures, training, information, and technology.

At the same time, VA has significantly strengthened and enhanced PGCSS. CSP increased PGCSS staff to enhance program capabilities that offer caregivers access to standard and consistent assistance such as psychosocial support, coaching, and skills training inclusive of the evidence-based suicide prevention training, termed VA S.A.V.E. Training, which is offered at every VA Medical Center (VAMC). In addition, PGCSS staff are responsible for coordinating and facilitating an annual resource fair at every VAMC. These required events provide opportunities for caregivers and families to learn about the supports and services available to them through VA as well as through community resources.

VA continues to expedite the hiring of key staff to standardize application processing and adjudication, ensuring consistent eligibility decision-making, ensuring

Veterans and caregivers receive timely, accurate assessments and an improved customer experience.

Invests in Access to Mental Health, Suicide Prevention, and Substance Use Disorder Treatment

VA has made suicide prevention a top clinical priority and is implementing a comprehensive public health approach to reach all Veterans. This approach is in full alignment with the President's new National Strategy for Reducing Military and Veteran Suicide, advancing a comprehensive, cross-sector, evidence-informed public health approach with focal areas in lethal means safety, crisis care and care transition enhancements, increased access to effective care, addressing upstream risk and protective factors, and enhanced research coordination, data sharing and program evaluation efforts. The 2023 Budget includes $497 million to support suicide prevention initiatives and programs. Funding for mental health in total grows to $13.9 billion in 2023, up from $12.3 billion in 2022. This funding will support our system of comprehensive treatments and services to meet the needs of each Veteran and the family members involved in the Veteran's care. Our commitment to a proactive, Veteran-centered Whole Health approach is integral to our mental health care efforts and includes online and telehealth access strategies. Whole Health can help Veterans reconnect with their mission and purpose in life as part of our comprehensive approach to reducing risk. Suicide is a complex issue with no single cause. Maintaining the integrity of VA's mental health care system is vitally important, but it is not enough. We know some Veterans may not receive any health care services from VA, which highlights VA alone cannot end Veteran suicide. This requires a nationwide effort.

The new Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) will enable VA to provide resources toward community-based suicide prevention efforts to meet the needs of Veterans and their families through outreach, suicide prevention services, and connection to VA and community resources. In alignment with VA's National Strategy for Preventing Veteran Suicide,[1] this grant program will assist in further implementing a public health approach that blends community-based prevention with evidence-based clinical strategies through community efforts.

The Budget includes $663 million toward opioid use disorder prevention and treatment programs, including programs associated with the Jason Simcakoski Memorial and Promise Act (P.L. 114-198). Among the risk factors for suicide, substance use disorder is strongly implicated. In addition, drug overdose fatalities inclusive of suicide have escalated dramatically in the Nation. Therefore, the need for effective interventions to address substance use cannot be overstated. Supported by the President's Budget, VA is expanding evidence-based substance use disorder treatment and harm reduction initiatives consistent with the Biden-Harris Statement of Drug Policy

[1] Department of Veterans Affairs (2018). National Strategy for Preventing Veteran Suicide. Washington, DC. Available at https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

Priorities. The FY 2023 request includes a projected budget of $181 million for the following staffing initiatives: 1) Supported Employment Specialists to expand access to employment opportunities for Veterans in treatment and recovery; 2) Peer Specialists to work with Veterans with substance use disorder to increase their engagement and retention in substance use disorder evidence-based treatment; 3) Substance use disorder staff on Behavioral Health Interdisciplinary Program and Primary Care Mental Health Integration teams to support evidence-based treatment outside of specialty care, including medications for opioid use disorder and treatment of alcohol use disorder; 4) VA case managers to work with Supportive Services for Veteran Families (SSVF) grantees and homeless program staff assisting Veterans experiencing housing instability and substance use disorder; and 5) Staff to improve access to residential substance use disorder treatment programs. Furthermore, VA's Budget will support expansion of its Psychotropic Drug Safety Initiative to address the growing crisis of stimulant use overdose fatalities. This initiative will ensure the safe and appropriate prescribing of stimulant medications as well as expanding Veterans' access to evidence-based treatments for stimulant use disorder including cognitive-behavioral therapy and contingency management, both of which are recommended by the VA-Department of Defense Clinical Practice Guidelines for the Management of Substance Use Disorders.

President Biden's new strategy for addressing the national mental health crisis recognizes that many people face challenges in accessing mental health care. VA continues to evaluate staffing needs and prioritizes mental health hiring and training. However, we recognize that hiring additional mental health staff in VA will not resolve the growing demand. To address President Biden's vision to build system capacity, connect Veterans to care and create a full continuum of support for Veterans, VA is committed to being the Nation's leader in ongoing research enhancing current mental health treatment, identifying new mental health interventions and developing effective prevention and at-risk identification protocols. Ongoing Congressional support for VA Mental Health Centers of Excellence (CoE), the Mental Illness Research, Education, and Clinical Centers (MIRECCs), and mental health research initiatives through the Health Services Research and Development Service (HSR&D) will be essential as VA continues to address access, mental health care, and suicide prevention.

Improves Support for Women Veterans

This Budget requests $9.8 billion for all women Veterans' health care, including an estimated $767 million to support women's gender-specific care. The Budget also includes $134 million for women's health program efforts. VA continues outreach to women Service members and Veterans, to encourage them to enroll and use the services they have earned. As a result, the number of women Veterans enrolling in VA health care is rapidly increasing. More women are choosing VA for their health care than ever before, with women accounting for over 30% of the increase in Veterans served over the past 5 years. Investments support comprehensive specialty medical and surgical services for women Veterans at a VA facility or through referrals to the community. The number of women Veterans using VA services has more than tripled

since 2001, growing from 159,810 to more than 600,000 today. VA is committed to providing high quality, equitable care to women Veterans at all sites of care. To address the growing number of women Veterans who are eligible for health care, VA is strategically improving services and access.

VA is enhancing services and access for women Veterans by continuing to invest in hiring initiatives in 2022, providing funding for a total of over 800 women's health personnel nationally: primary care providers, gynecologists, mental health providers, and care coordinators. VA has also addressed clinical equipment needs such as those for mammography, exam tables designed for women with low mobility, and breastfeeding pods. Funds are available for programs that have traditionally not been offered by VA, such as pelvic floor physical therapy, lactation support and maternity care coordination.

The Budget fully funds women's health care provisions of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116-315), which improves access to VA care for women Veterans. The Budget also supports implementation of VA's zero tolerance policy for sexual harassment and assault.

The Budget further supports all Veterans by including a legislative proposal to enhance equity by expanding access to assisted reproductive technology, including in vitro fertilization and adoption reimbursement, and to eliminate cost sharing for contraception-related health care and services.

Increases Effort to End Veteran Homelessness

The 2023 Budget increases resources for Veterans' homelessness programs to $2.7 billion, with the goal of ensuring every Veteran has permanent, sustainable housing with access to high-quality health care and other supportive services to end and prevent future Veteran homelessness. This Budget includes funds to assist with the design and development of project-based housing partnerships for aging Veterans, a growing need and area of focus for the Department of Housing and Urban Development (HUD) – VA Supportive Housing program. In addition, funds will be used to provide additional grant funds for special needs grants that provide transitional housing through the Grant and Per Diem program. Funds will be used to support the following staffing initiatives: 1) The Health Care for Homeless Veterans (program will hire an additional 140 social workers to assist homeless Veterans in enrolling in VA health care or community health care); 2) The Veterans Justice Programs will support outreach and linkages to VA services for justice-involved Veterans by providing funding to expand Veteran Justice Outreach to approximately 440 staff; and 3) The SSVF program will continue to maintain health care navigator positions to connect Veterans to VA or community health care.

Since 2010, VA and its Federal and nonprofit partners have helped house or prevent from experiencing homelessness more than 938,000 Veterans and family

members. These efforts have led to a 55% reduction in sheltered Veteran homelessness since 2010. On a single night in January 2021, there were 19,750 Veterans experiencing sheltered homelessness in the U.S. Between 2020 and 2021, the number of Veterans experiencing sheltered homelessness decreased by 10.4% (2,298 fewer people). However, COVID-19 impacted the ability of communities to do their counts in January 2021. The report is only able to provide national estimates on sheltered homelessness. Therefore, while it is an important snapshot of sheltered homelessness, the report does not provide a complete picture of homelessness in the United States.

As of March 21, 2022, there were 86 areas (83 communities and 3 States: Delaware, Connecticut and Virginia) that met the criteria and benchmarks established by the U.S. Interagency Council on Homelessness, VA and HUD, for eliminating Veteran homelessness and those areas have publicly announced an effective end to Veteran homelessness.

VA's goal is to prevent and end Veteran homelessness by providing support and services to homeless and at-risk Veterans that enable them to lead independent lives in the community of their choosing. In support of this, VA's homeless programs provide a comprehensive and practical range of services, including outreach, prevention assistance, housing solutions, employment assistance, health care, and justice and re-entry services. Notably, VA has set goals to permanently house more Veterans in calendar year 2022 and is actively collaborating with HUD, the US Interagency Council, and a broad range of state and local partners to achieve joint progress for Veterans and Americans.

Supports Research Critical to Veterans' Health Needs

The 2023 Budget requests $916 million in appropriations for VA's Medical and Prosthetic Research account to continue the development of VA's research enterprise, including research in support of American Pandemic Preparedness plan goals. This request builds upon the historic investment from the 2022 Budget to continue to increase funding to advance the Department's research missions in MEE, traumatic brain injury, cancer and precision oncology and mental health. These efforts will be conducted under a recent enterprise strategy aimed at optimizing a range of capabilities and expertise in clinical, informatics/data science, genomics, and other biomedical research strengths that actively partner with VA clinical and operations partners to help bring real world impact to Veterans within the Nation's largest integrated health care system. VA research has been a leader in bringing many breakthrough advances for treatment and care to Veterans and the Nation. The Budget will help continue that leadership while also expanding into newer areas of science for which VA is uniquely positioned. These efforts have also enabled VA to be a partner of choice with Federal, academic and industry groups to provide more opportunities for Veterans through research and allowing them to further service their country by participating in groundbreaking science. Most recently, VA not only contributed to the Nation's understanding of COVID-19 vaccines and treatments, but also to better understanding

of possible long-term outcomes related to COVID-19 infection. These efforts capitalized on the extensive data that VA possesses to allow large-scale analyses that are not often possible in other settings.

The Budget is also poised to support activities in the Cancer Moonshot initiative, with an investment of $81 million in research programs. Funds will support research in molecular diagnostics, accessing our diverse patient population. Through this population, we can identify genomic signatures that may be associated with carcinogens from MEE, identify druggable targets and pathways in rare and common cancers based on understanding of their unique characteristics and apply precision oncology approaches to cancer screening and early detection.

As you know, VA has ownership interests in inventions and patents that are licensed to commercial entities where the inventions were made in whole or in part with the support of VA resources, including funds, personnel, space, and equipment. The Department is taking important steps to strengthen its oversight and audit of its intellectual property rights, and we are accelerating our efforts to ensure that VA is able to recoup royalties from any invention that is licensed. This will benefit not only Veterans, but also taxpayers. We are ensuring that the hundreds of millions of dollars we spend on research not only go to advance medical understanding that helps Veterans, but that those expenditures also serve to produce a return on our investment to help our mission.

Leverages Technology to Support Service and Medical Care Delivery

VA is undergoing one of the most comprehensive information technology (IT) infrastructure modernizations in the Federal government, which will support seamless transition of health care information throughout an individual's journey from military service to Veteran status. Additionally, with Congressional support, VA is moving to significantly enhance filings, information collection and decisions on Veterans' claims through automation and improved digital interactions to include claimants, authorized agents or representatives. The 2023 Budget includes $5.8 billion in appropriations for the Office of Information and Technology (OIT) to pilot application transformation efforts, support cloud modernization, deliver efficient IT services and enhance the customer service experience. The Budget prioritizes cybersecurity, Infrastructure Readiness Program (IRP) and claims automation, with the mission to ensure a seamless customer experience for Veterans. In particular, the Budget includes $402 million for cybersecurity that will allow OIT to deliver enterprise-wide cybersecurity strategies, policy, governance, oversight, and network defenses to protect Veterans' information and VA's information systems. Further, the FY 2023 Budget strengthens platforms to support emerging business requirements and accelerates adoption and rollout of VA-requested Software as a Service products. This is necessary to respond to increased demand for new IT capabilities, increased growth identified by our business partners requesting new space and facility activations, as well as increased modernization to enhance and optimize the infrastructure.

Our main transformative projects are the implementation of the Electronic Health Record Modernization (EHRM) program and the adoption of a new financial and acquisition management system — our Financial Management Business Transformation (FMBT).

Renewed Focus on EHRM

VA has moved forward with the EHRM program following the strategic review and has incorporated lessons learned from initial operating capability deployment in Spokane, Washington. On March 26, 2022, VA deployed the new EHR solution to our second initial operating capability site, the Jonathan M. Wainwright Memorial VAMC in Walla Walla, Washington, and on April 30, 2022, the new EHR solution went live at the VA Central Ohio Health Care System in Columbus, Ohio. In addition, new EHR governance and management structures have been established, and the strategy has been updated to rebuild a core foundation to right size the organization with a focus on people, processes, policy and systems. The program is aligned to a revised schedule for the rollout of the EHR solution through early FY 2024, with deployments at sites in Veterans Integrated Service Networks (VISN) 10, 12 and 20.

In support of this effort, VA requests $1.8 billion for FY 2023. This is in accordance with the new strategy, which re-baselined the requirements to align with VA's updated deployment plans. This funding is vital to support the 19 EHR deployments scheduled for FY 2023, as well as the pre-deployment activities at future sites, which are conducted 6 to 18 months in advance of go-live to ensure sites are equipped to receive the new EHR system. In FY 2023, VA plans to conduct EHR activities at 34 sites across four VISNs and infrastructure readiness activities at 68 sites across seven VISNs. The funding will provide for:

- **EHR Contract:** Contracts for site assessments, site transitions, enterprise integration and site implementation, which include activities such as site activation, training and workflow development.
- **Infrastructure Readiness:** Infrastructure upgrades to support the new EHR solution, which includes activities to update computers and network infrastructure, and efforts related to system interfaces and cybersecurity.
- **Program Management Office:** EHRM Integration Office (EHRM IO) hiring and retention of staff with the necessary expertise to support effective change management and implementation of the EHR.

Continuity of funding is integral to our ability to prepare sites for the deployment of the new EHR and execute VA's rollout schedule. By the end of FY 2022, EHRM IO plans to have invested infrastructure readiness funding across 15 of VHA's 18 VISNs. The vast majority of infrastructure modernization work will be completed in VISNs 10 and 20, with initial progress already made in 13 additional VISNs. The 2023 Budget supports security, server stack and Local Area Network work at the final three VISNs, which represent the initial set of infrastructure readiness items that the sites receive.

In addition to the funding requested for the EHRM account, VHA's Medical Facilities request includes $505 million in Non-Recurring Maintenance (NRM) funding for infrastructure projects required to support EHRM.

Financial Management Business Transformation

The Financial Management Business Transformation (FMBT) program is increasing the transparency, accuracy, timeliness and reliability of financial and acquisition activities across the Department. The 2023 Budget includes $350 million (including General Administration, Information and Technology, Supply Fund and Franchise Fund sources) for FMBT, a program that is improving fiscal accountability to taxpayers and enhancing mission outcomes for our employees who serve Veterans. We completed three successful deployments of the new Integrated Financial and Acquisition Management System (iFAMS) at NCA and VBA and identified opportunities to improve our approach. We are learning from these early deployments and adjusting our strategy to manage the complexities inherent in a financial and acquisition system implementation of this magnitude. Each implementation brings us one step closer to providing a modern, standardized and secure integrated solution that enables VA to meet its objectives and fully comply with financial management and acquisition mandates and directives. Deployment of iFAMS is taking place over 21 phased implementation "waves" across NCA, VBA, VHA, and VA staff offices. Four waves will have been completed by the end of FY 2022. As of April 2022, there have been over 400,000 transactions successfully processed in iFAMS, and over $3.2 billion in payments made to the Department of Treasury. The next system the Office of Management and all Staff Offices it supports in October 2022. System rollouts will then continue across the remaining Administrations and Staff Offices until enterprise-wide implementation is complete.

Prioritizes VA Facilities

The 2023 Budget includes $3 billion for construction requirements in 2023 -- $2.1 billion in major and minor construction appropriations in addition to $968 million in estimated unobligated balances from the Recurring Expenses Transformational Fund (RETF) planned for major and minor construction requirements. Funding for four medical facility and three national cemetery expansion projects are included in the request. The RETF will provide funding for three additional medical facility major construction projects, bringing the total to 10 major construction projects funded in FY 2023. In addition, VHA's Medical Facilities account includes $2.5 billion for non-recurring maintenance (NRM).

VA operates the largest integrated health care, member benefits and cemetery system in the Nation, with more than 1,700 hospitals, clinics and other health care facilities; a variety of benefits and service locations; and national cemeteries. The VA infrastructure portfolio consists of approximately 184 million owned and leased square feet — one of the largest in the Federal Government.

While the median age of U.S. private sector hospitals is 11 years, the median age of VA's portfolio is 58 years, with 69% of VA hospitals over the age of 50. With aging infrastructure comes operational disruption, risk and cost. VA estimates between $58 billion and $70 billion will be needed over the next 10 years to maintain and enhance our infrastructure through our annual Strategic Capital Investment Planning process. However, efforts to fully address the aging infrastructure portfolio needs by recapitalization would exceed those funding estimates and occur over a longer timeline.

At current funding levels, some facility conditions will continue to degrade, and the highest priority selected improvements will continue to reflect short-term capital investments designed to meet immediate business needs versus long-term plans that meet the optimal service delivery objectives expected of modern health care delivery infrastructure. The funding originally proposed in the American Jobs Plan and the Build Back Better Bill would allow VA to begin structuring a recapitalization effort designed to fully upgrade and modernize our facilities, bringing them up to the standards Veterans deserve. This need still exists and VA will continue to develop our strategy to fully modernize or replace outdated medical centers with state-of-the-art facilities.

Transforming VA health care to achieve a safer, sustainable, pollution-free, person-centered national health care model is a priority for this Administration and we are committed to ensuring our facilities represent the best for Veterans. We look forward to working with Congress to achieve our shared goal of addressing VA's aging infrastructure.

AIR Commission

On March 14, 2022, VA published the Asset and Infrastructure Review (AIR) Commission recommendations in the Federal Register as required by the MISSION Act. The recommendations within this report are the result of years of research and analysis studying the VA health care system and the Veteran population. We solicited feedback from Veterans, collected and poured over data, visited VA facilities, talked to VA employees across the country, met with key partners and asked ourselves one question above all else: *what is best for the Veterans we serve?*

The result of asking that question over and over again, in markets across the country, is a set of recommendations that will:

- Cement VA as the primary, world-class provider, integrator and coordinator of Veterans' health care for generations to come.
- Build a health care network with the right facilities, in the right places, to provide the right care for Veterans in every part of the country.
- Ensure that the infrastructure that makes up VA in the decades ahead reflects the needs of 21st Century Veterans—not the needs and challenges of a health care system that was built, in many cases, 80 years ago; and
- Strengthen VA's dual roles as the leading health care researcher in the U.S. and the leading health care training institution in America.

In short, these recommendations represent a massive investment that will make VA stronger—and fortify our ability to deliver the timely, world-class health care that Veterans so rightly deserve.

Conclusion

Chairman Tester, Ranking Member Moran, I look forward to working with you and Committee. Thank you for the opportunity to appear before you today to discuss our progress at the Department and how the President's FY 2023 and FY 2024 Advance Appropriations Request will serve our Nation's Veterans.

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JOINT STATEMENT OF

THE CO-AUTHORS OF THE INDEPENDENT BUDGET:
DISABLED AMERICAN VETERANS
PARALYZED VETERANS OF AMERICA
VETERANS OF FOREIGN WARS

BEFORE
THE SENATE COMMITTEE ON VETERANS' AFFAIRS

ON

A REVIEW OF THE FISCAL YEAR 2023 BUDGET AND 2024 ADVANCE APPROPRIATIONS REQUESTS FOR THE DEPARTMENT OF VETERANS AFFAIRS

JUNE 14, 2022

Chairman Tester, Ranking Member Moran, and members of the Committee, the co-authors of The Independent Budget (IB)—DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars (VFW)—are pleased to present our views regarding the President's funding request for the Department of Veterans Affairs (VA) for Fiscal Year (FY) 2023, including advance appropriations for FY 2024.

Earlier this year, on February 7, the Independent Budget Veterans Service Organizations (IBVSOs) released comprehensive recommendations for VA's FY 2023 and FY 2024 advance appropriations. The IB Budget Report, a copy of which is attached to this testimony, includes our detailed estimates of the level of funding required to meet the full veteran demand for VA services, benefits, and programs. Since the release of the IB Budget Report, Congress and the Administration completed work on the FY 2022 budget – almost six months into the fiscal year – and the Administration's new budget proposal was released. In today's testimony, we will primarily comment on VA's new budget request and how it compares to the IB's recommendations.

Veterans Health Administration (VHA)

Overall, the Administration's VA budget request for FY 2023 is a very strong proposal that would provide comprehensive and justified increases across most of the discretionary appropriations accounts. The largest share of the discretionary budget request is for the VA health care system.

The Administration's Total Medical Care funding request for FY 2023, including both VA- and community-provided care, is approximately $122.7 billion, which is slightly higher than the IB's estimate of $121.2 billion. However, we note that Administration's request for VA-provided medical care was slightly lower than the IB's estimate ($93.6 billion v. $95.0 billion), whereas the Administration's request for Medical Community Care was higher than the IB's estimate ($29.0 billion v. $26.1 billion). In addition, the Administration's FY 2024 advance appropriation request for Medical Community Care is significantly higher than the IB's estimate: $33.6 billion v. $27.3 billion.

Veterans must have access to both timely and high-quality care and we recognize that at times care must be provided in the community; however, the IBVSOs strongly recommend VA expand its capacity to directly provide medical care to veterans whenever and wherever feasible, rather than rely on purchased care for the long term.

We also note that VA and Congress must be prepared to adjust the level of VA medical care funding for FY 2023 and FY 2024 in response to significant changes in demand, whether resulting from unprojected utilization due to the pandemic, or changes in enrollment or utilization resulting from administrative, regulatory, or statutory changes. For example, enactment of comprehensive toxic exposure legislation or extension of the Secretary's freeze on caregiver program reassessments could increase funding requirements for both FY 2023 and FY 2024. If these or similar types of policy changes occur, VA must be prepared to request, and Congress must be prepared to approve, increased funding, including supplemental appropriations if necessary.

Medical Services

The IB's and Administration's recommendations for FY 2023 are much closer than they have been in recent years, but we continue to differ on the appropriate amount for VA health care.

Our recommendation reflects multiple components including the current services estimate, the increase in patient workload, and additional medical care program costs. It reflects increases based on uncontrollable inflation and a projected 4.6 percent federal pay raise for all VA employees in FY 2023. The IBVSOs also estimate a four percent increase in VA health care utilization due to deferred demand, increased sickness, and morbidity from COVID as discussed above. In addition, if major toxic exposure legislation is enacted in 2023, VA may need additional funding to cover expanded health care eligibility. Our estimate of growth in patient workload is based on a projected increase of approximately 81,000 new unique patients, which includes an increase of approximately 78,000 new priority groups 1-6 veterans, a decrease of 23,000 priority groups 7 and 8 veterans, and an increase of 26,000 non-veteran users.

We believe there are additional projected medical program funding needs for VA totaling over $2.7 billion. Specifically, the cost to expand and improve services for women veterans, implement phase two expansion and the Beaudette v. McDonough court ruling regarding VA's comprehensive caregiver support program, and the cost to fill at least 33 percent of VHA's pending clinical care and support vacancies, which at the time our recommendations were prepared would have been approximately 13,000 full-time employees (FTE). According to VA's Section 505 (d) reporting for the first quarter of FY 2023, VHA's open vacancies have risen to 56,674 so we recommend sufficient funding be provided to fill 18,891 of VHA's open vacancies.

Suicide Prevention

The IBVSOs also differ with the Administration in terms of funding for suicide prevention. The Administration says it plans to reduce spending in this area by $101 million which is largely driven by the completion of the requirements of the 2019 Executive Order 13861, the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS). We believe the move to reduce funding in this area is premature and could undermine the recent progress achieved in combating this complex problem. The IBVSOs' recommendations include sufficient funding to hire approximately 450 new FTE ($63 million) to support the new 988 National Suicide Prevention Lifeline, and for the Vet Center program to increase staffing, resources, and expand their fleet of aging Mobile Vet Centers Vans.

Medical and Prosthetic Research

VA's Medical and Prosthetic Research program generates research discoveries that have made significant contributions to improve health for veterans and all Americans. The VA research program also continues to support recruitment and retention of health care professionals and clinician scientists to serve our nation's veterans. For FY 2023, the IBVSOs' recommendation covers the cost of inflation and accelerates investments in research to address COVID-19, veterans' health disparities, clinical trials access, and veterans' mental health needs while renewing support for groundbreaking programs, like the Million Veteran Program, and expanding research on chronic and emerging needs of our nation's veterans. The value of cutting-edge research has never been demonstrated more clearly than over the past two years, and as a national leader, VA must continue to aggressively grow this program.

Long-Term Services and Supports

VA's Geriatric and Extended Care Strategic FY 2020-FY 2024 Plan projects expenditures for long-term care will double by 2037. In order to keep up with the demand for long-term services and supports, the IBVSOs recommended an increase of $375 million for VHA's Institutional Care and Home and Community Based programs.

Program of Comprehensive Assistance for Family Caregivers (PCAFC)

As the implementation date for PCAFC's phase two expansion approaches, VHA needs adequate funding to support the inclusion of more veterans into the program, and the Beaudette v. McDonough court ruling. Although the Caregiver Support Program (CSP) indicates it is on track to hire the authorized new staff it needs to handle the increased workload from the upcoming eligibility expansion, the work of restructuring the caregiver appeal program as required by the Beaudette decision and in compliance with new procedures mandated by the Appeals Modernization Act, P.L. 115-55, has been a challenge for VA's existing staff. In order to allow VA to meet these new requirements without negatively impacting the program, the IBVSOs recommended 100 new FTE be dedicated to appeals work in the CSP's central office and to cover the cost of caregiver benefits and increased staffing, which the IBVSOs recommended also be added to the caregiver program's budget.

Women Veterans

Women are the fastest growing group in the veteran population and the IBVSOs recommend greater investment towards their care. We recommended an additional $200 million be provided with $150 million of that amount dedicated to support for: VA creating and fully staffing high-quality, clinically relevant services for women veterans; VA's strategic planning for meeting women veterans' health care needs; VA increasing the number and quality of peer support specialists, care navigators, and doulas to assist women veterans; and for VA to create and maintain a dedicated consultative team to assist with managing the care of veterans throughout the maternity cycle. VA must be prepared to provide the highest quality of care to women veterans to guide and assist them during their seasons of life.

General Operating Expenses

Overall, the IBVSOs are pleased with the Administration's proposed budget for the General Operating Expenses, which includes the Veterans Benefits Administration, General Administration, and the Board of Veterans' Appeals. The proposed amount is a 13 percent increase over FY 2022.

Veterans Benefits Administration (VBA)

The COVID-19 pandemic continues to impact disability compensation claims processing with a current backlog of over 200,000 claims. Some veterans who missed their compensation and pension examinations in 2020 were able to reschedule and attend either in-person or virtual appointments during 2021, while others were hesitant to attend in-person exams.

In August 2021, VA added three new presumptive conditions associated with particulate matter exposure and has since hired 2,100 FTE to address the growing number of claims. In addition, the House and Senate introduced large, comprehensive legislative packages on environmental hazards incurred through military service. In November 2021, VA announced a new pilot program to review certain cancers and serious respiratory conditions and their relation to toxic exposures, and recently, VBA announced they are considering the addition of nine new cancers. The IBVSOs anticipate the spotlight on toxic exposures will result in additional presumptive conditions, whether because of legislation or through a new VA presumptive process, which will further increase disability compensation claims.

The IBVSOs recommended additional FTE and $100 million for overtime in FY 2023, primarily to help VBA make progress on reducing the current backlog of disability compensation claims. In addition, these resources will help prepare VBA for an influx of claims related to toxic exposures in anticipation of Congress passing legislation and VA adding new presumptive conditions.

The Administration's budget will provide funding for 795 FTE to process claims for new respiratory conditions associated with environmental exposure; compensation and pension claims modernization to automate process from submission to authorization; and the Pension Optimization Initiative to reduce processing and wait times.

Board of Veterans' Appeals (Board)

The Appeals Modernization Act (AMA), effective in February 2019, has dramatically changed how veterans appeal decisions on claims for benefits from VBA, VHA, and the National Cemetery Administration. At the Board, appeals are separated between legacy appeals, those pending prior to AMA, and AMA appeals.

The Board employs Veterans Law Judges (VLJs) to conduct hearings and render decisions. Each VLJ requires support from attorneys and administrative staff. Recently, the VA Secretary authorized the Board to increase the number of VLJs. The Board is in the process of filling 35 VLJ positions; however, it was hampered by the Continuing Resolution that the federal government operated under until a final, full-year FY 2022 appropriation was approved. With 86,000 legacy appeals pending, 24,000 of them waiting for hearings; 115,000 AMA appeals; and 60,000 waiting for hearings, the Board needs to be fully staffed and provided adequate resources to increase timeliness and reduce the backlog of appeals.

For FY 2023, the IBVSOs recommended an additional 15 VLJs and an additional 100 FTE in other positions, to assist in driving down the backlog. The Administration's budget proposal of $285 million is an increase of 25 percent over FY 2022. This would provide the Board with 256 new FTEs, including 12 additional VLJs, 151 decision writing attorneys, and 93 appellate operational support and administrative staff. This budget request is projecting to increase the number of Board decisions by 15 percent and a reduction of legacy appeals by 57 percent. This budget is also crucial to addressing AMA appeals, caregiver appeals, and reduce the backlog of pending hearings.

Infrastructure

Over the past decade, the VA health care system has faced significant challenges and undergone historic reforms to improve veterans' access to timely and high-quality health care.

While VA has received increased funding levels to support the veterans' health care system and an increasing number of veterans are seeking VA care, the lack of resources for facilities management and modernization, sufficient health personnel to meet the demand for care and benefits, and replacement of aging systems of support continue to negatively impact accessibility. VA's aging infrastructure not only causes many veterans to wait too long and travel too far for care but also potentially endangers the health and lives of veteran patients and VA personnel.

We are pleased to see VA will direct funds from the Recurring Expenses Transformational Fund toward its construction accounts, but while this is a good step, we believe it clearly reflects the lack of a sufficient funding amount in the original budget request.

While VA's Strategic Capital Investment Planning (SCIP) process ostensibly provides a consolidated and prioritized list of all VA major construction, minor construction, non-recurring maintenance (NRM), and lease projects, VA's budget request regularly fails to include the full SCIP funding estimates or priorities. The SCIP process does not provide a chronological list of anticipated repairs, renovations, and replacements of facilities necessary to develop an actuarial schedule of facility lifecycle repair and replacement costs. At best, SCIP provides nonbinding suggestions to the VA budget process, which are regularly ignored, resulting in an ever-increasing

backlog of overdue maintenance and construction projects. Furthermore, as long as funding for VA infrastructure remains part of its discretionary budget, it must compete with other VA health care and benefit delivery priorities in an era of rising deficits and debt, budget caps, and sequestration. In this limited fiscal environment, VA is forced to choose between properly funding the maintenance of existing facilities or making overdue modernizations and expansions to meet veterans' future health care needs. As a result, the annual discretionary appropriations process has resulted in more than two decades of inadequate funding and a rising backlog of critical VA health care construction projects and leasing requirements. This underprioritizing has led to the need for the AIR (Asset Infrastructure Review) Commission, and we hope this Committee stands ready to remedy all of VA's infrastructure requirements needs.

Insufficient VA construction management and congressional oversight procedures are obstacles to timely and cost-effective infrastructure maintenance and construction. Neither VA's Office of Construction and Facilities Management nor individual VA facilities have the staffing or expertise required to plan or oversee VA's infrastructure at the levels needed to reduce the construction backlog. VA's multi-step planning, contracting, funding, and approval process is consistently plagued by delays and cost overruns, and low funding thresholds for minor construction and NRM, as well as PAYGO scoring rules, have unnecessarily limited clinical treatment.

To overcome VA's infrastructure challenges, Congress must not only provide significantly increased funding to fully address these long-standing issues, but also enact comprehensive planning, budgeting, management, and oversight reforms to ensure more effective use of those funds. The IBVSOs recommend VA's construction budget should be, at a minimum, three percent of its overall operating budget, just to keep up with the growing backlog. In order to reduce the backlog, in addition to increased funding, more employees and contractors are needed to oversee the necessarily increased workload. The IBVSOs also recommended partnering with the Army Corps of Engineers whenever possible to help reduce the construction backlog.

These construction dollars should also be separate from the AIR recommendations. As we have seen from the initial AIR recommendations there are a substantial number of changes proposed for the VA health care system. However, the recommendations do not close as many buildings as some proponents of the process anticipated. Many services within VA facilities will be shifted to community partners, or other VA clinics or hospitals. Most of the market assessments initially recommend retaining a large percentage of VA facilities and simply shifting services at those facilities.

If these initial recommendations are an indication of the final product of the AIR Commission, they reinforce the notion that we should not wait until the completion of the AIR process and instead, redouble efforts to improve the facilities VA already has. There are billions of dollars' worth of necessary repairs and upgrades needed for VA buildings, and those need to take place concurrently with the AIR process.

Lastly, the IBVSOs are concerned about the seemingly lack of priority for seismic corrections in this budget request. VA has identified approximately seven billion dollars' worth of necessary corrections. We view seismic deficiencies as potential life safety issues and that work should not be spread out over years. Instead, they should be prioritized and rectified as quickly as practical.

Thank you for the opportunity to submit our views on the Administration's budget request for VA. We firmly believe that unless Congress acts to substantially increase VA's funding for FY 2023, veterans will be forced to wait longer for care, whether they seek it at VA or in the community, leaving unfulfilled the promises made to veterans.

Pre-Hearing
Questions for the Record

Pre-Hearing Questions on the Department of Veterans Affairs
Fiscal Year 2023 Budget Request
From Senator Jerry Moran

1. **(VHA)** For FY21, VA asked for and received $1.19 billion to carry out the Caregiver Support Program--which included funding to implement the expansion of the Program of Comprehensive Assistance for Family Caregivers. At the beginning of FY22, VA disclosed that it forgot about approximately $300 million in FY21 funding meant for the program that it had set aside. However, VA planned to carry over the funding for future use.
    a. How was the $300 million reflected in the FY22 and FY23 budget?
    b. Did VA set aside funding for FY22, and if so how much was set aside?
    c. Has VA fully utilized the $300 million? If so, please explain how.

VA Response: On page VHA-207 the 2022 current estimate of $1.413 billion reflects an increase of $60 million above the 2022 President's Budget request of $1.353 billion and is afforded by the $321 million 2021 carryover. Not all of the $321 million is expected to be obligated in 2022. For details on the 2022 caregiver allocation, including the $321 million set aside, please see the attached CTR which identifies $261 million excess funding from the total allocated amount of $1.674 billion. This CTR was sent forth prior to the 2022 enacted appropriation.

The carryover funding was reflected as a separate line item outside the FY22 president's budget. The full carryover funding amount of $300 million was set aside to be used in FY22.

The Caregiver Support Program has not utilized the carryover funds in FY22. Due to lower-than-anticipated enrollment of the Program of Comprehensive Assistance for Family Caregivers (PCAFC) during Phase I expansion, and lower-than-anticipated cases being overturned in appeal, the carryover funding has not been utilized. During the last quarter of FY21, CSP anticipated that the extension of reassessments of Legacy Applicants, Legacy Participants, and their Family Caregivers for an additional year would require additional financial resources to cover benefits. Additionally, the U.S. Court of Appeals for Veterans Claims, in the case of Jeremy Beaudette & Maya Beaudette v. Denis McDonough, ruled in favor of petitioners seeking review by the Board of Veterans' Appeals of decisions under PCAFC, which was anticipated to create a potential impact on benefits; to date, these anticipated expenditures have not been realized -- but are still anticipated.

2. **(VBA)** Your budget request includes an additional 1,209 direct FTE for claims processing.
    a. With these additional FTE, what does the Department expect the backlog to be by the end of FY23 and what is the Department's plan for overtime hours?

VA Response: Due to supply chain impacts of the pandemic in 2020-2022 as well as the assignment of 25% of claims processing resources to work time-consuming Agent Orange claims with Court oversight, the Department of Veterans Affairs (VA) has a high inventory of claims awaiting a decision. VA expects continued improvement, and while there will be fluctuations, will return to a baseline backlog level of 100,000 claims or fewer by mid-fiscal year (FY)

2024. This will require the requested staffing as well as continued use of mandatory overtime. The estimates for the President's Budget do not factor the impact of legislation currently under consideration (e.g. the PACT Act).

b. Does this budget request take into account overtime hours for claims processors?

VA Response: Yes, the current FY 2023 budget request takes into account overtime for hours claims processors.

c. Based on this FY23 budget request, if Congress fulfilled this request at these levels, when would the claims backlog be eliminated?

VA Response: VA will return to normal backlog levels by mid-FY 2024, barring changes to entitlement or other external factors, such as the pandemic.

3. **(VHA)** How does the budget request account for the expanded telehealth and acceptable clinical evidence exams (ACE) that were conducted the last two years during the suspension of in-person exams?

VA Response: The 2023 President's Budget reflects total projected exams required, independent of the setting. The unit cost of an exam has been updated to reflect 2021 actuals that took place in multiple settings.

4. **(VBA)** Your budget request includes a request of $3.6 million for VBA to implement an innovative pilot program aimed at providing employment opportunities for veterans and servicemembers with service-connected disabilities. Can you please expound on how this will differ from the work coming out of and resources going to OTED and the work already being done by the Department of Labor Veteran Employment and Training Service?

VA Response: The Veterans Disability Employment Pilot is a concept explored to provide meaningful opportunities and empower service-disabled Veterans seeking employment. The Department of Veterans Affairs (VA) considered rigorous evaluation using Randomized Controlled Trials (RTC), to propose courses of action. The RTC would focus on highly prevalent service-connected disabilities among new applicants, such as tinnitus, limitation of flexion of knee, hearing loss, and lumbosacral (lower-back) or cervical (neck) strains. VA worked to identify best approaches for the pilot design and integration of already existing VA programs, such as the Transition Assistance Program (TAP) under Outreach, Transition and Economic Development, as well as Veteran Readiness and Employment (VR&E), and Disability Compensation. Furthermore, VA collaborated with partners from the U.S. Department of Labor (DOL), to discuss pilot development, execution, and compatibility with DOL's Veterans' Employment and Training Service.

5. **(VBA)** How does your budget request reflect the continuation of the CAR pilot? How many FTE are allotted for the CAR pilot and how many claims are estimated for FY23 based on FY22 numbers?

VA Response: There is no specific request for full-time equivalent employees (FTE) resources for the Claim Accuracy Request (CAR) pilot program, as it is adjudicated within VBA's current higher-level review program (HLR). VBA has five employees processing these claims expeditiously, as part of their normal non-expedited HLR duties. VBA does not have any FTE dedicated to the program. VBA only received approximately 650 claims within the first year of the program (April 2021-April 2022) and expects to be able to absorb the work associated with any increased receipts within its current FTE request.

6. **(VHA)** How does your budget reflect the division of labor of medical disability exams between VHA providers and contract providers? Is the $3.5 billion in mandatory funding request only for the VBA vendors to continue exams?

VA Response: Regarding the VHA portion of the question: VHA's budget projection includes a status quo level of VHA-provided C&P exams. Currently, VHA receives approximately 13 to 14 percent of the total medical disability examination requests from VA. The $3.5 billion in mandatory funding requested only for VBA cannot be used to support any VHA provided medical disability examinations based on associated budget appropriations. The VHA budget allocation for the provision of medical disability examinations is currently inclusive of VHA's operating budget, which supports all provisions of VHA health care services. While there is not currently a separate or distinct mandatory funding allocation for VHA supported disability examinations provided by VHA C&P examiners at VA medical facilities, separate or distinct mandatory funding within the VHA budget for disability examinations would support a more accurate reflection of the division of labor provided by VHA C&P examiners.

7. **(VBA)** The VET TEC pilot program was authorized by Congress to connect veterans with industry-leading high technology programs and was structured in a way to ensure employment after completion in the field of training that the veteran participates in. The original authorization cap on the program in the Forever GI Bill was $15 million and then Congress increased that cap to $45 million in the Johnny Isakson and David P. Roe Veterans Health Care and Benefits Improvement Act of 2020 and increased it again to $125 million in the Consolidated Appropriations Act of 2022.

   With this large increase, how will the Department ensure that these resources do not run out again, and will the Department continue to provide us with regular data points regarding the programs outcomes, including the following: graduates to date; how many veterans have found employment as a result of the program; a list of providers; a list of fields of employment that veterans find employment in; the average salary of veterans after the program; and states in which approved providers are located?

VA Response: Resources used in support of the Veteran Employment Through Technology Education Courses (VET TEC) pilot program are based on the level of high demand for this 5-year pilot program. VA is on track to allocate the $125 million in funding for this fiscal year. Due to the popularity of the VET TEC pilot program, VA recommends Congress consider converting the pilot program to a permanent GI Bill benefit. VA does not have the statutory authority to increase VET TEC's budget cap, in circumstances where funding has exhausted.

VA will gladly provide the data points identified on a regular basis. VA has already found that Veterans acquire high-tech skills to assist them in moving quickly into in-demand jobs in the following five areas: information science, computer programming, data processing, media applications, and computer science. Since launching the VET TEC pilot program on April 1, 2019 through May 2022, VA certified entitlement for 43,968 eligible Veterans; 1,321 Veterans are currently enrolled; and 2,158 Veterans have secured employment out of the 4,698 who have graduated. 1,644 students are currently within their 180-day employment window after graduating. On average, students are earning approximately a $60,000 annual salary. VET TEC approved providers are located in the following states:

- California
- Colorado
- Delaware
- Florida
- Illinois
- Michigan
- Minnesota
- Missouri
- New York
- Oregon
- South Carolina
- Texas
- Virginia
- Washington

8. **(VBA)** The seamless transition from active duty to veteran status is a priority of this Committee. Great strides and improvements have been made in recent years to improve this transition, however improvements still need to be made. How does the FY23 budget request reflect the work VA will do with your interagency partners such as the Departments of Defense and Labor, and with community partners, to provide thorough resources and assistance to veterans and their families as they leave the military?

VA Response: The Transition Assistance Program (TAP) delivery is a collaborative effort between the Department of Defense (DoD) and the Military Services, Department of Labor (DOL), VA, and Small Business Administration (SBA); each with a primary area of responsibility and focus. However, the program succeeds due to a robust interagency collaboration and communications strategy that encompasses the four agencies listed above, and three additional agencies--Department of Homeland Security (DHS), Department of Education (DE), and the U.S. Office of Personnel Management (OPM). These seven agencies work in tandem to provide consistent messaging and ensure collaboration and synchronization in the delivery of the program. The FY 2023 budget will support the TAP interagency governance structure's role in the oversight and monitoring of the program for continuous program improvement via the Post Separation Transition Assessment (PSTAP) Outcome Study, the One-Year Independent Assessment of TAP (P.L. 116-315, Section 4305), and other internal Human Centered Design (HCD) studies. The FY 2023 budget will provide the resources required to redesign TAP curriculum, when required, so that it becomes even more individualized and

empowers transitioning Service members to have control of their transition journey by utilizing the resources provided for them and their families. VA will also continue to provide transition-related support to transitioning Service women through the Women's Health Transition Training (WHTT) by increasing its marketing and promotion activities to ensure all transitioning Service women and newly separated women Veterans can learn about the women health care resources available with VA.

Additionally, the FY 2023 budget request supports implementation of P.L. 116 - 315 Section 4304. Section 4304 requires VA to make grants available to eligible organizations to provide resume assistance, interview training, job recruitment training, and related services to members of the U.S. Armed Forces who are separated, retired, or discharged, to include their spouses, leading to successful transition as determined by the Secretary. Section 4304 also requires VA to consult with the Secretary of Labor. VA has drafted a Charter (currently with DOL for concurrence) formalizing roles and responsibilities to comply with the statute.

9. **(VBA)** Over the past couple of years, we've continued to see problems, especially in rural areas, for veteran homebuyers to close on a home compared to their civilian counterparts, using conventional loans.

a. Does your budget reflect any increased resources for the Loan Guaranty Service to improve the home buying process for veterans? Are there any additional resources requested for additional VA-approved appraisers and improvements to the desktop appraisal platform?

VA Response: VA Loan Guaranty Service (LGY) continues to explore opportunities through automation, which is focused on improving benefit delivery. Resources were requested for technology modernization, as well as resources to train and inform program participants to ensure effective program oversight, compliance, and access to the benefit.

Please note, VA appraisals are generally completed by VA fee panel appraisers (third-party licensed appraisers) and not VA staff. The request includes some additional full-time employees who are focused on appraisal policy, fee panel administration, and oversight, as well as other functional areas of LGY that play a vital role in supporting valuation, such as training and communications.

VA LGY staff have reviewed and recommended increases to appraisal fees, as well as recruited 85 additional fee panel appraisers since January 1, 2022. VA has seen a decrease in its appraisal turn times nationwide from 11.8 business days in FY 2021 to 10.8 business days in FY 2022, through May 6, 2022. Some parts of the country are experiencing shortages of appraisers, which is an industry-wide issue and not unique to VA, which can impact the number of new fee panel appraisers available for recruitment.

VA has already begun reevaluating the appraisal processes to enable appraisers to leverage technology, including desktop appraisals, in the valuation process and expects to publish procedures on this topic.

10. (NCA) NCA currently finds itself at or near the peak of expected veteran interments before a gradual decline. Approximately 34% of the requested increase is for operations and maintenance (O&M), with O&M accounting for a little less than half of the total budget-which is in line with recent budget requests.

a. Does NCA anticipate this ratio to remain fairly consistent as it continues to accumulate gravesites to maintain in perpetuity?

VA Response: The total FY 2023 budget request of $909 million for the National Cemetery Administration (NCA) is an increase of $105 million from the FY 2022 current estimate. Within this request, $430 million is requested for the Operations and Maintenance (O&M) account, an increase of $36 million (9.1%) over FY 2022, which represents 34% of the total requested increase. NCA cannot project if this ratio will remain consistent in future budget requests. The total NCA budget of $909 million includes funding from seven appropriation accounts, which include three capital accounts (Major and Minor Construction and the Grants for Construction of Veterans Cemeteries appropriations), NCA Facilities Operation Fund, National Cemetery Gift Fund, Compensation and Pensions appropriation and the O&M account. Synergy among the accounts is incorporated in the budget projection process, however the ratio of increases between these accounts is not used as a formulation component. For example, funding for a major construction cemetery expansion project provided in a given year would not impact the O&M account for increased workload due to newly developed acreage until the construction project is complete.

The FY 2023 budget for O&M funds the operation of an anticipated 158 national cemeteries and 34 cemeterial installations as well as their maintenance as national shrines. Cemetery workload is not static. While the number of interments is expected to peak and then slowly decline, NCA must maintain the accumulation of gravesites in perpetuity. The total number of gravesites maintained increased from nearly 3.7 million in 2018 to more than 4.0 million in 2021 and is expected to reach almost 4.2 million in 2023. NCA maintains more than 23,000 acres with the total developed acreage projected to reach 9,702 in 2023, an increase of 1.5% over the 9,559 developed acreage in 2022. As NCA's workload continues to increase, additional cemetery staff, contracts, equipment and supplies are essential for NCA to maintain its developed acreage and increasing number of gravesites in a manner befitting a national shrine. Additional funds are required each year to maintain the frequency of cemetery ground and gravesite maintenance activities including mowing, trimming grass and maintaining trees, as well as cleaning headstones and markers at existing cemeteries.

11. (NCA) In line with NCA's long range goals and plan, the access options afforded to veterans and eligible family members will expand as Rural and Urban Initiative cemeteries come online in the next 5 years. These initiatives, long over budget and behind schedule, seem to at last have firm projections for coming online (save one, Indianapolis).

a. Does NCA anticipate having enough resources to open these new sites in the projected timelines?

VA Response: Yes – The FY 2023 budget request provides sufficient funds to open the new sites within the planned timelines. NCA utilizes both construction funds and O&M resources to construct and activate new cemeteries. For the rural cemeteries, NCA has expended construction

funds of $21 million to date with another $9 million projected. NCA will use both current construction resources and construction funds requested in the FY 2023 budget to fund the projected requirements. Urban cemetery projects will be funded with current NCA construction resources.

By the end of FY 2022, seven of the eight planned rural cemeteries and three of five urban cemeteries will be open; by the end of FY 2024, all eight planned rural cemeteries will be open. The 2023 budget includes O&M funding for initial and continued activation of the new cemeteries. NCA deploys an initial cadre of staff at each new national cemetery well in advance of the formal opening to perform various tasks in support of a successful formal opening. Continued activation funding ensures that newly opened cemeteries receive the resources required as interment activity and maintenance workload increase after the initial opening.

The 2023 budget request includes 5 FTE and $3.0 million for the continued activation of the St. Albans and Indianapolis columbaria-only urban cemeteries and the Cedar City rural cemetery, as well as initial activation for the Elko rural cemetery.

12. (NCA) After years of remaining flat, the budget request for the Veterans Cemetery Grants Program has increased by $5M.

a. Please elaborate on the commentary included in the budget request on the impact this increase would have on veteran access to burial options and ability to fund projects in the queue.

VA Response: In the 2023 budget, NCA requests $50 million to fund grants to state, territory, county and tribal organizations for the establishment, expansion, improvement or operations and maintenance of Veterans cemeteries. This request is $1.5 million above the 2022 enacted amount of $48.5 million. The Veteran Cemetery Grant Program (VCGP) has played a significant role in NCA's goal to provide 95% of Veterans with reasonable access to a burial option within 75 miles of their homes by assisting States and tribes in establishing Veteran's cemeteries in areas of the country in which VA is unlikely to establish a new national cemetery.

NCA increased the percentage of Veterans with reasonable access to 93.7% with the recent opening of the grant-funded cemetery in Ardmore, OK. The access percentage of 93.7% is comprised of access to national cemeteries (77.04%) and grant-funded cemeteries (16.67%).

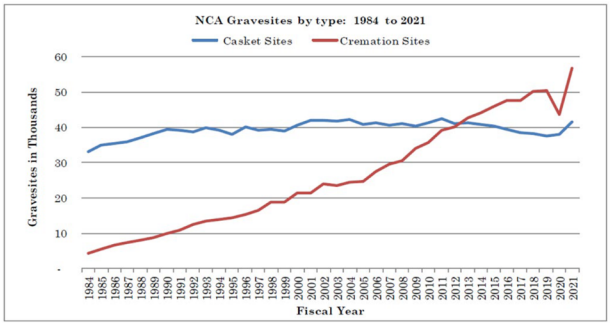
The 2022 Grants Priority List has 43 conforming projects totaling over $110 million in grant opportunities. Of this list, 10 grant requests are for establishment projects (i.e., potential new cemeteries) totaling $36 million in grant opportunities. While not all establishment projects will significantly impact increasing Veteran access (for instance, tribal cemeteries do not increase access due to tribal burial eligibility requirements), 3 of the 10 establishment grants on the current priority list will provide new access to over 21,000 Veterans, increasing nationwide access by 0.12%. In recent years, NCA has been unable to take advantage of some higher dollar, higher impact establishment grants in unserved rural areas. These projects are critical to meeting NCA's objective of serving Veterans throughout the country. In addition, as the number of state and tribal Veterans Cemeteries have grown over the last 10 years from approximately 80

cemeteries to now 120 cemeteries, the requests for expansion and improvement grants have grown in numbers and dollar amounts. Additional funding is needed to keep existing facilities open and keep burial options available to Veterans.

13. (NCA) As more and more Americans choose cremation, what are the projections for expanded columbaria options as part of the planning for cemetery expansions and Veteran Cemetery Grants Program establishments and expansions?

a. With the Urban Initiative sites being columbarium-only cemeteries, what budgetary effects does NCA anticipate with regard to maintaining more and more columbaria versus traditional in-ground burials?

VA Response: NCA has seen a 77% increase in full-casket interments and over 7,200% increase in cremation interments since VA assumed responsibility for the VA national cemeteries in 1973. The graph below depicts the growth in casketed and cremation gravesites since 1984.



NCA monitors both national and cemetery-level interment data for forecasting and budgetary purposes. NCA maintains a depletion model to predict usage of each cemetery burial option using current and projected usage based on local Veteran population data. Projected usage includes the local burial trends to include increased cremation rates. NCA's depletion model serves as the basis for outyear construction project planning. All cemetery columbarium expansion construction projects are designed to accommodate 15 years of predicted usage.

NCA uses columbaria, in-ground cremation sites and memorial walls for those who choose cremation. The use of columbaria and memorial walls conserves traditional burial space, keeping it available for Veterans who choose to be buried in-ground. Savings to the O&M account include reduced inurnment time (15 minutes vs 1 hour for in-ground), less landscaping (trimming/fertilizer) and irrigation work, and no future headstone/alignment work. These efficiencies are incorporated in the resource requests submitted by each cemetery as part of the annual budget formulation process.

14. (NCA) With the Veterans Legacy Program now fully transitioned to grants versus contracts, what budgetary impacts does NCA anticipate pursuant to broader participation in the program by qualifying academic entities?

VA Response: The Veterans Legacy Program (VLP) has not yet fully transitioned to grants as contracts awarded in FY 2021 will continue to run thru the current academic year. The FY 2023 budget request includes $2 million for the VLP Grant Program, the same level anticipated for award in FY 2022. NCA anticipates a full and solid response to the Notice of Funding Availability (NOFA) during FY 2022 and will use the experience of the first years of the grant award process to determine potential expansion of the grant program in future budget requests.

15. (VHA) Through the new presumptive decision-making model, the VA has generated regulations to grant presumptions of service connection for 12 conditions to ensure veterans who served in Southwest Asia since 1991 and were exposed to burn pits and other environmental hazards have faster access to care and benefits. However, the FY23 Budget proposal does not account for the adding of nine rare respiratory cancers to the list of presumed service-connected disabilities due to military environmental exposures to fine particulate matter.

a. Why weren't the nine new respiratory cancers factored into the budget proposal?
b. What is the total estimated cost for each condition?

VA Response: Regarding the Medical Care costs of the estimated $3 million for the nine new presumptions announced in March can be afforded within the 2023 Medical Care topline request. Here is a by cancer budget impact including the net of reduced collection revenue ($000):

Scenario - Conditions	2023
Rare Cancers - Respiratory - Total	**$3,442**
Rare Cancers - Respiratory - Squamous Cell Carcinoma (SCC) of Larynx	$1,301
Rare Cancers - Respiratory - Squamous Cell Carcinoma (SCC) of Trachea	$13
Rare Cancers - Respiratory - Adenocarcinoma of Trachea	$0
Rare Cancers - Respiratory - Salivary Gland Tumors of Trachea	$7
Rare Cancers - Respiratory - Adenosquamous carcinoma of Lung	$625
Rare Cancers - Respiratory - Large Cell carcinoma of Lung	$563
Rare Cancers - Respiratory - Salivary Gland-type Tumors of Lung	$48
Rare Cancers - Respiratory - Sarcomatoid Carcinoma of Lung	$131
Rare Cancers - Respiratory - Typical & Atypical Carcinoid of Lung	$754

16. (VHA, VBA) VA and the Biden Administration support passage of H.R. 3967, the Honoring Our PACT Act. However, the operational costs and benefit obligations of this bill, if it were enacted, are not reflected in VA's FY23 Budget Proposal. Please list specific programs, projects, and activities across administrations and central office that are likely to require increased funding if the Honoring Our Pact Act is enacted.

VA Response: If enacted, VBA will require increased discretionary funding for claims processing, call centers, /human resources / finance support staff, outreach and training, as well as other mission critical resources for the expanded scope and workload. VBA will complete a

detailed cost estimate upon review and analysis of the final version of the bill. In addition, VA would require mandatory funding for benefit payments. Most costs would be associated with compensation payments to Veterans and Survivors, but costs would also be associated with other benefits, such as Veteran Readiness and Employment and Survivors' and Dependents' Educational Assistance.

The Veterans Health Administration will require additional funding to support several key areas:

- Veteran Outreach and Communication – In order to ensure comprehensive outreach to Veterans, VHA will need additional paid marketing, advertising and VAMC Public Affairs Officers.
- Health Outcomes and Military Exposures – To address the vast amount of requirements in a condensed timeframe, additional staffing needs include epidemiology staff, data analysis experts, and contracting expert. The War Related Illness and Injury Study Center will start two centers to conduct research related to PACT Act requirements. Three studies required in the bill, including one on studying mental health and exposures, will require a contract with National Academies of Sciences, Engineering, and Medicine. VHA is expanding care to Veterans for military environmental exposures through an intake center, using telehealth to Veterans for registry exams and other environmental health military exposure assessments and counseling which will require additional clinical and other staff.
- Health Eligibility – With the increase in Veteran eligibility, VHA will need additional staff to support enrollment and eligibility, case management, pharmacy, homeless, help desk, and billing.
- Construction and Assess Management - Additional staff will be needed to conduct an analysis of VHA's existing FY2022 and FY2023 lease plans and reconciliation with DoD to identify opportunities to acquire shared leased medical facilities. Additional staff is also needed to develop program, policy, and controls, and to incorporate new authority and planning guidance into SCIP 2025 process.
- Human Capital Management – VHA will require additional staff for policy writing, communications, oversight, and compliance, training, reporting, and hiring actions. Additional funding will be required for contract buy-outs to recruit providers in rural areas.
- Research - Additional staff will be needed to support research studies and a public website on toxic exposure research.
- Information Technology – New or enhanced systems will be needed to support human resources, eligibility, environmental exposure screening tool, and modernizing the registry.
- Clinical and Administrative Field Staffing - New clinical staff will be needed to support increase utilization as well as administrative providers to complete toxic exposure screenings during VAMC appointments.

17. **(VHA)** During FY21, the "Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020" (P.L. 116-315) contained various provisions for VA to care for homeless veterans during a covered public health emergency. Recently, VA announced the Permanent Housing Placement National Challenge to House 38,000 veterans in 2022. VA has indicated that achieving this goal requires a collective effort by all VA

homeless program providers, with particular focus on Grant and Per Diem (GPD), Health Care for Homeless Veterans (HCHV) Contract Residential Services (CRS) and Low-demand Safe Haven (LDSH), Supportive Services for Veteran Families (SSVF), and Housing and Urban Development-VA Supportive Housing (HUD-VASH).

a. How will the various mechanisms of funding from the CARES Act (P.L. 116-136) and the ARP Act (P.L. 117-2) be utilized in the National Challenge?
b. How will the Homeless Program Office aforementioned programs' funding levels be impacted by this initiative?

VA Response: ARP funding is supporting three SSVF initiatives in FY 2022.

- The national expansion of Shallow Subsidies ($200 million from ARP and $150 million from SP)
- Screening all SSVF enrollees for legal assistance needs ($24 million from ARP)
- Sustainment of Health Care Navigator initiative ($20 million from ARP)

CARES Act and ARP funds have supported the establishment of new HCHV CRS contracts as well as the expansion of current contracts across the country in response to COVID 19. This expansion allows these programs to assist more Veterans with emergency housing as they work with VA staff to secure permanent housing.

ARP funds were allocated to each VAMC to utilize under the 4201 authority. The 4201 authority allows VHA to pay for goods and services that secure housing for homeless Veterans or ensure the stabilization of housing for HUD-VASH Veterans.

The FY 2023 President's Budget proposes to increase SSVF appropriations to $731 million up from $420 million in FY 2022. This will be sufficient to sustain initiatives currently supported with ARP funding.

HCHV budget does not currently include funds to sustain the two initiatives that were expanded using ARP and CARES funds.

18. **(VHA)** The FY23 budget assumes an investment of $81 million in research and $167 million in medical care funds for precision oncology and to support the multi-agency federal government cancer moonshot. Further, the budget claims to fully fund the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (P.L. 116-171). However, there isn't any mention in the budget for the VA's Precision Brain and Mental Health Initiative as directed in P.L. 116-171, which is a priority of the Committee.

a. Can the Department clarify the VA's planned investment in the Precision Brain and Mental Health Initiative?

VA Response: The Scott Hannon Initiative for Precision Brain and Mental Health is one of several components of the Hannon Act that are being funded through VA's Office of Research and Development, so its budget is partially embedded in the overall funding for implementation of the research components of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (P.L. 116-171). However, as part of a multi-pronged approach for this initiative, VA is also leveraging other ongoing efforts to support this initiative. For example, the

Open Data Commons effort is not being funded solely as part of the Scott Hannon Initiative for Precision Brain and Mental Health but will support access to data that will contribute to the achievement of the initiative's objectives. Because of this multi-pronged approach by which the Scott Hannon Initiative for Precision Brain and Mental Health is embedded across multiple programs, there is not a single line-item in the budget that captures VA's investment in this initiative.

The Initiative includes the following ongoing and planned investments:

- The VA is actively engaging with two very large longitudinal brain health studies and has funded 3 data scientist positions to accelerate ongoing data sharing under the Federal Interagency TBI Research Informatics System.
- VA is planning to rollout the use of pharmacogenetic testing for clinical application in managing medication for opioid use disorder (OUD).
- VA is in the process of standing up an initiative to integrate a wide range of biomarkers (neuroimaging, blood/serum, EEG, neurobehavioral assessments, genomic, etc.) using machine learning to create a clinically actionable assessment of Brain and Mental Health.
- Million Veteran Program (MVP)/MVP-Measures Investigating Neuropsychiatric Disorders (MVP-MIND) has launched 3 Vanguard sites for end-to-end testing.
- The Open Data Commons for sharing of MVP data, including data collected under MVP-MIND is beta testing with 13 pilot studies scheduled to begin in July 2022.
- VA is conducting an Evidence Synthesis Review of biomarkers for mental health conditions.

19. (VHA) Can the Department provide more detail on its implementation plan for the ongoing expansion of video-to-home services, enhanced video-to-home telehealth capabilities, and the telehealth grant funding expansion directed in P.L. 116-171 sec. 701?

a. Further, can the Office of Connected Care provide a draft spend plan for how the FY2023 request of approximately $329M for Office of Connected Care Program Funding: Sustainment and Expansion will be utilized?
b. Can the Department ensure that no further funding will be spent on tablets or devices that have been activated with data plans but remain in storage?

VA Response: VA has established a five-year strategic vision for connected care which will enhance Veteran digital engagement, deliver health care without walls, sustain and increase capacity in rural and highly rural locations, and solidify VA's connected care foundations. The strategic vision includes initiatives that will enhance the accessibility of VA health care, including in rural and other underserved areas, by delivering enhanced video telehealth care in the home using VA Video Connect, VA provided examination peripherals (e.g., digital stethoscopes), and other novel technologies for remote assessments.

After delivering over 9.5 million visits in the home in FY 2021, an increase of over 3100% when compared to FY 2019, VA is focusing on enhancing the accessibility and experience of video care to home. To enhance accessibility and experience, VA is upgrading VA Video Connect with new capabilities (e.g., audio-dial, closed captioning), integrating technical education and the ability to invite caregivers to video calls (e.g., VA Video Connect test calls) into scheduling

scripts, and developing new processes to ensure Veterans are offered video telehealth care as an option when deemed clinically appropriate by their providers.

As part of its vision to address health care access inequities and deliver trusted VA care, anytime and anywhere through connected technologies, VA is enhancing its efforts to bridge the digital divide for Veterans who lack digital access to VA services. Central to this effort is VA's national digital divide consult processes. Through this process, qualifying Veterans can obtain an internet connected device from VA or assistance in applying for Federal Communications Commission administered internet subsidies (Lifeline, Affordable Connective Program).

VA is also working to understand how best to establish and leverage community-based telehealth access points for Veterans through its ATLAS (Accessing Telehealth through Local Area Stations) pilot program. ATLAS is a pilot designed to bridge the digital divide and reach rural and underserved Veterans in areas with limited access to affordable broadband and in-person health care. With respect to the telehealth grant funding expansion directed in P.L. 116-171 Sec. 70, regulation has been drafted and the impact analysis is under development. Understanding the interest in this program from Congress, VA is looking for opportunities to expedite the concurrence process for the Telehealth Grant Program. At this time, VA anticipates awarding the first Telehealth Grant in late 2024.

The Office of Connected Care (OCC) has the mission to support the Department's provision of high-quality, Veteran-centered connected care – leveraging digital technologies to deliver trusted VA services to Veterans, anytime and anywhere. VA's vision of Connected Care is to increase the accessibility, capacity, quality, and experience of VA care for Veterans, their families and caregivers. OCC's draft spend plan for the $329M budget is included below.

- **Home and Community Based Services ($70,232,000)**

Funds in this category support sustainment and expansion of synchronous telehealth, asynchronous telehealth, and remote patient monitoring services in Veterans' homes or communities. This category includes VA Video Connect, the Veteran tablet initiative, and VA's ATLAS pilot.

- **Clinic Based Services ($32,708,000)**

Funds in this category support expansion of clinical resource hubs for primary care, mental health, and specialty care; expansion of targeted initiatives such at TeleDermatology, TeleEye Care, and TeleSleep medicine; and expansion of national expert consultation services.

- **Hospital and Emergency Services ($40,300,000)**

Funds in this category support expansion of inpatient and emergency room telehealth programs including TeleStroke Care and TeleCritical Care. It also includes the telehealth emergency management initiative.

- **Program Foundations ($186,666,000)**

Funds in this category support the staffing, training, application development and remediation, national equipment maintenance and refresh, provider and Veteran-facing help desk support, communications, and research needed to support and expand Connected Care services.

Can the Department ensure that no further funding will be spent on tablets or devices that have been activated with data plans but remain in storage?

VHA's digital divide efforts have been successful in providing Veterans with the equipment and services they need to access telehealth care. Since inception, VHA has completed over 98,000 digital divide consults and currently has over 100,000 tablets in the hands of Veterans. Further, evidence demonstrates the value of these efforts. A study of 471,791 rural US veterans with a history of accessing mental health care was published on April 6, 2022 by the Journal of the American Medical Association's JAMA Network Open. The peer-reviewed study found that Veterans receiving a VA tablet demonstrated increased use of mental health care services via video, increased psychotherapy visits (across all modalities), and reduced suicide behavior and emergency department visits.(JAMA Network Open. 2022;5(4):e226250. doi:10.1001/jamanetworkopen.2022.6250).

VA is seeking to enhance the digital divide program based on OIG's recommendations with a specific goal to reduce average days in storage for tablets awaiting shipment. A key component of this will be learning from historical supply and demand trends to project future inventory needs. VA will additionally be reviewing its current cellular data contract to assess feasible options that would either result in the initiation of the data plan upon device issuance to the Veteran or lead to a net reduction in data plan and management costs.

20. (VHA) VA's FY23 Budget Request includes 388,846 FTE for medical care, Canteen Service, prosthetics, and joint DoD-VA funds. This is an increase of 24,922 FTE over the FY22 level.

a. If these FTE are all funded and VHA does not have any funded vacancies, does that mean VHA will have all the personnel necessary to provide timely access to care provided by VA facilities?
b. How does VHA know what number of FTE, and which type of FTE it needs to have on board in order to provide timely services to veterans based on patient projections, health care trends, and increases in reliance projected by the EHCPM?

VA Response: If Congress appropriates the 2023 Presidents Budget request and VA is able execute those funds, VA will have sufficient resources to provide timely access to care provided in VA facilities.

VA's Medical Care budget request is driven by an actuarial model that projects an amount of services and a unit cost of those services. The FTE projection is an estimate of how the total projected cost will be obligated. However, the funding is provided to VAMCs whom determine how allocated resources are obligated to meet patient demands. The FTE projection for Medical Services was based on a pattern of hiring following the CARES Act. The FTE projection for Medical Support and Compliance was based on increasing Human Resource and Contracting staff nationwide to help facilitate provider hiring and acquisitions of necessary medical supplies, equipment, and engineering support. The FTE projection for Medical Facilities was based on increasing engineering staff nationwide to expand Non-Recurring Maintenance and Minor Construction project capacity. Modernizing VA's bed capacity both serves Veterans and reinforces VA's fourth mission capacity in emergent

health care demand surges that overwhelm private sector capacity as recently experienced in the COVID-19 pandemic.

The working definition of unfunded vacancies in VA is:

- "Positions that do not have an employee,
- measured by FTEs (with one FTE equaling 2,080 hours),
- do not have a recruitment action indicating that the position has funding and are in excess of the VA's approved operating plan targets."

The Q1 FY 2022 VA Mission Act Section 505 report incorrectly reported that none of VHA's vacancies were funded. This is being revised in the Q2 report (not yet published), which will indicate VHA had more than 30,000 funded vacancies in both Q1 and Q2 of FY 2022. At any given time, VHA typically has more than 40,000 recruitment actions in progress to address constant turnover, internal churn/movement, and growth. Active recruitment actions are considered "funded" although they don't use any funding until they are actually filled. While VHA tracks a number of metrics to measure VHA's ability to provide timely access to care for Veterans, vacancies are not a good metric to assess timely access.

VHA provides tools through the Office of Productivity, Efficiency, and Staffing to determine optimal staffing levels as well as a variety of ratio- and workload-based staffing models; however, Medical Center Directors are ultimately responsible for ensuring appropriate staffing mix and levels at the facility level.

Questions for the Record

Department of Veterans Affairs (VA)
Questions for the Record
Committee on Veterans' Affairs
United States Senate
Budget Hearing
on
"Review of the Fiscal Year 2023 Budget
and 2024 Advance Appropriations Requests
for the Department of Veteran Affairs"

June 14, 2022

Questions for the Record from Senator Jerry Moran

With regard to section 805 of the Heath Robinson PACT Act, the Office of Management stated in communications to Congress dated June 8, 2022, that "VA does not intend to transfer discretionary costs for similar activities under current law to the Toxic Exposures Fund."

Question 1a: How much does the VA currently spend each year from discretionary accounts on toxic exposure-related care, research, benefits administration, and other activities?

VA Response: VA's policies and procedures for estimating and executing costs related to toxic exposure remain under development with the Office of Management and Budget and (OMB).

1b: Please identify each place in the FY23 budget request, along with corresponding appropriations accounts, the requests for funding to care for toxic-exposed veterans are contained.

VA Response: VA continues to work with OMB to develop options and recommendations for additional costs that potentially could be included in the TEF in FY 2023.

Question 1c: Please provide itemized dollar amounts of discretionary outlays for toxic exposure-related care for the most recent three fiscal years for which data is available, as well as aggregate totals for each year.

VA Response: VA's policies and procedures for estimating and executing costs related to toxic exposure remain under development with OMB.

Question 2: During the Budget Hearing, the Secretary noted that one third of expenditures for health care were community care expenditures. He further intimated that because of these expenses and the number of veterans seeking care in the community, there may be a need to readjust the access standards to reduce community care expenditures. Can you please provide the following

information regarding FY21 and FY22 community care expenditures: (a) Please provide detailed information on the FY21 and FY22 community care expenditures broken down by each of the five eligibility categories described in 38 USC 1703(d); (b). Please provide detailed information on the number of veterans treated in the community for FY22 broken down by each of the five eligibility categories described in 38 USC 1703(d); and (c) Please provide detailed information on the number of unique community care visits for FY21 and FY22 broken down by each of the five eligibility categories described in 38 USC 1703(d).

VA Response: Due to system gaps in VA's community care eligibility data, VA is unable to provide accurate information broken down by specific eligibilities at this time. While our systems capture the eligibility information, it is not available for all community care episodes of care and is not consistently recorded. In addition, Veterans also may be eligible under multiple criteria, which complicates our ability to report. VA has worked on a resolution by implementing updates to its systems. In particular, VA implemented a new version of its consult software that enables more accurate reporting on community care eligibility. However, the consult software updates just recently were implemented at the start of FY 2022 and continue to be adopted across our health care system. VA will continue to evaluate methods of capturing this information through future upgrades to our systems.

Question 3: I am encouraged to see the Department ask for increased community care funding for FY23, but I have some concerns related to decommissioning the Office of Community Care to create the new Office of Integrated Veterans Care. The IVC is supposed to handle the operation of the community care program and is slated to go live in FY23. However, the Department has been less than transparent on how it plans to stand up the IVC and has failed to provide adequate details on how the office will function. While the VA highlights the IVC initiative as a key priority in the budget justification book for FY23, it failed to provide any information on required FY23 funding levels for the office through the Medical Support and Compliance account. Is the Department still on track to stand up the office in FY23? If so, what is the projected funding required from the Medical Support and Compliance account to run the office for FY23?

VA Response: The estimated FY 2023 Medical Support and Compliance funding for Integrated Veteran Care (IVC) is $415.5 million. The new Office of Integrated Veteran Care was successfully established on June 5, 2022. IVC will provide Veterans with the same access to community care they have now. Nothing in the implementation of IVC will limit a Veteran's access to, or ability to choose community care.

In your testimony for the hearing, you referenced a new Military Exposures Team within VBA that will provide resources and a dedicated focus on issues related to military environmental exposures.

Question 4a: Can you elaborate on the composition of this team and how this newly formed team will fit into VA's newly established presumption decision-making framework?

VA Response: VBA is establishing a new Military Exposures Team (MET) with 25 full-time equivalent (FTE) employees under the Disability Compensation Program. The MET is in support of the Secretary's commitment to Veterans and partners to expedite review and analysis on the types of conditions potentially eligible to meet the threshold for the Secretary to pursue rulemaking as part of a presumptive disability under Part 3 of title 38, United States Code of Federal Regulations. MET is part of the Secretary's aggressive military exposures strategy, fortified by a new presumptive decision-making framework for considering additional presumptive conditions in the elevation and expansion of MET. MET staff will serve as the technical experts closely working with VHA HOME to execute the Secretary's vision and the provisions under the Honoring our PACT Act of 2022. VA anticipates that the MET will be staffed fully by the end of FY 2023.

Question 4b: What kind of resources will you provide to this team, and where in the budget will those resources come from?

VA Response: VBA requested $4.9 million for MET in the FY 2023 budget request as a disability compensation initiative.

Question 5: The President's budget request doubles the amount requested for the Veterans Exposure Team - Health Outcomes Military Exposures, or VET-HOME, program. With the Department's new presumptions of service-connection for particulate matter in the past year, how would this robust increase in funding help VA's capability to care for toxic-exposed veterans, and how quickly do you anticipate making impacts for veterans?

VA Response: Background: Military Environmental Exposures (MEE) are of great concern for Veterans, Veterans Service Organizations (VSO), Congress, the White House, the media and the Nation. Efforts to address these concerns are reflected in the Honoring Our PACT Act of 2022.

Veterans Exposure Team (VET)-HOME, the registry program under VHA HOME, is created expressly to serve Veterans with MEE. Projected to go-live in January 2023, VET-HOME is composed of 70 staff consisting of 30 intake center staff and 40 clinicians specially trained in military environmental exposures. The primary objective for VET-HOME is completion of Congressionally mandated registry exams, with particular emphasis on the Airborne Hazard/Open Burn Pit Registry (AHOBPR), VA's newest and fastest growing registry. When fully staffed, VET-HOME anticipates the completion of 40,000-50,000 registry exams per year.

Future demand for registry exams is expected to increase dramatically in response to the Honoring our PACT Act of 2022 because of universal screening, expanded

AHOBPR eligibility and the creation of new presumptions. Starting in 2022, VA primary care teams will begin screening all Veterans for MEE. AHOBPR Veterans are most likely to be impacted as only 225,600 of the 3.5 million AHOBPR-eligible Veterans currently are enrolled in the registry. If screening prompts even half of the remaining 3.3 million AHOBPR-eligible Veterans to enroll, AHOBPR enrollment would increase to 1.65 million Veterans, with over 900,000 of these Veterans requesting AHOBPR exams based on existing data. Moreover, the total number of Veterans needing registry exams is likely to exceed a million under the Honoring our PACT Act of 2022.

The requested funding would allow VA to hire additional staff to increase VET-HOME's exam capacity from 50,000 exams/year to 250,000 exams/year and allow for other MEE-related services, while offering diagnostic consultations such as environmental exposure assessments to primary care providers and other clinicians.

The budget request states that one of the significant challenges of military environmental exposure is a lack of exposure assessment at the individual level.

Question 6a: How will this increased support for VET-HOME aid toward meeting that challenge?

VA Response: As noted in the preamble to the question, VA often lacks objective environmental exposure data at the individual level in many cases. Exposures are determined from area-level environmental surveys and approximations from a number of data sources or by using proxy measures like deployment at a specific place and time when a known hazard was in the area. VET-HOME will use subjective information from Veterans by asking directly about their known exposures. VET-HOME will use the Individual Longitudinal Exposure Record (ILER) and other databases for unit or area/region level documentation of exposure or exposures.

Question 6b: And how does the Department expect the Individual Longitudinal Exposure Record, or ILER, set to reach full operational capacity next year to help meet the challenge for veterans?

VA Response: ILER will provide an objective exposure profile for each Veteran, determined through area or regional-level environmental surveys, monitoring and at time providing approximations from a number of data sources or by using proxy measures like deployment at a specific place and time when a known hazard was in the area. Having existing objective data available in one place (ILER report) will assist in evaluating individual Veterans with their claims and health concerns.

Effective training for personnel relating to providing services to veterans and adjudicating claims in a timely manner is essential to maximizing resources. The budget request references new e-learning courses to help employees navigate standard operating procedures on how to apply earlier effective dates within the Blue Water Navy program.

Question 7a: With pending legislation that would mandate new and complicated effective date determinations for 23 presumptive conditions, do you plan to expand this training?

VA Response: VBA is reviewing claims processor's training courses that will require updates based on the Honoring our PACT Act of 2022. In addition, VBA is exploring whether the training courses will need to be expanded.

Question 7b: Is this training mandatory?

VA Response: All claims processor's training courses related to the Honoring our PACT Act of 2022 will be mandated.

VA's dedicated employees are its greatest asset, and also account for most of its costs outside monetary benefit payments. Meaningful access to benefits and health care depends on having the right professional onboard and able to assist the veteran, yet VA is still developing staffing models to help ensure each business function and service knows how many and what type of employees it needs.

Question 8a: When will VA have staffing models in place for all of its business functions and services?

VA Response: VA is continuing to develop staffing models across VA and has made some notable progress such as the recently validated staffing models for the Caregiver program, VA Police and VA's Office of Information and Technology. There is also an ongoing effort to develop staffing models and requirements for all VA medical center (VAMC) functions, which will contain sufficient detail to inform requirements by occupation. These staffing requirements will help each VHA network allocate resources in a manner that will produce the best outcomes for each VAMC's functional area. These staffing models, which focus on productivity standards and efficiency metrics, will draw upon existing productivity standards and outcomes to determine optimal VAMC staffing levels. Since these models are the first effort to produce VAMC-wide staffing models, before the results are finalized, they must be reviewed by each VAMC to address unknown factors impacting productivity. VA anticipates that the initial review of the staffing models will be completed by mid FY 2023.

Question 8b: How will those models inform VA planning and budgeting, and what are some examples of how outcome measures will be used to refine those models after they are in place?

VA Response: VA will use staffing models as a tool to provide workload-based staffing requirements to make data-driven decisions on hiring priorities (staffing plans). These models also inform the capacity gap between requirements and available funding. The manpower staffing models use productivity standards or other analytic processes to

determine the minimum number of people required to meet the functional requirements to execute the mission for a program or facility.

Staffing models also are used to inform hiring decisions, relative to available budget, and validated staffing requirements are used to inform budget requests. The outcome measures are relative to the key performance indicators for program effectiveness (i.e., time-to-hire, turnaround time for completing benefits claims requests, time to next available appointment for care, etc.) after the staffing model requirements are implemented.

Question 9: VA measures the time to hire new employees based on both the Office of Personnel Management's 80-day timeline, and VHA's own 100-day timeline for health care providers. VA reported its goal is for 58% of new title 5 and hybrid title 38 employees to meet the 80-day requirement. Why is VA's goal 58% of new hires instead of 100%? These are just for non-health care providers, so why not try to have each hire meet the OPM timeline?

VA Response: These goals are based on the Office of Personnel Management (OPM) and VA's historic analysis of time-to-hire data. When OPM started requiring reporting and tracking of time-to-hire data, the goal was set at 51% meeting the 80 Day model. Since that initial reporting year, VA has worked with VHA and the other administrations to increase the percentage goal each year. The goals were set based on a realistic stretch from what was previously achieved in the prior fiscal year. Complete compliance could be set as a goal but would likely not be achievable due to various circumstances outside the control of VA or VHA. The goal setting process is underway for FY 2023. The idea of setting it at 100% will be discussed along with the pros and cons of that approach for the HR workforce and selecting officials.

Hybrid title 38 employees include clinical providers such as psychologists, pharmacists, social workers and licensed practical nurses who must meet substantial qualification standards and pre-employment credentialing and verification. While 80 days is a useful model for hiring, extenuating circumstances often exist that make it impossible to achieve a 100% compliance with the model. Deviations from the 80-day goal may occur when HR is short-staffed; when hiring managers take a lengthy time to make a selection; when candidates delay start dates or are slow to return required pre-employment paperwork; or when an initial hiring attempt is unsuccessful, and the process has to restart. VHA is working diligently to achieve faster time-to-hire metrics, but the current labor market is driving longer hiring timelines across government and non-government health care organizations alike.

It is worth noting that the OPM model was developed around the process used to fill Title 5 positions and that VA's time-to-hire Department-wide average has been better than the government-wide average for several years. In 2021, VA's average time-to-hire was 85 days and Government-wide average was 93 days. The 2021 average combines VA's Title 5 and Title 38 hires. As mentioned previously herein, title 38 hiring impacts VA's ability to meet 80 days every time. There are more steps in title 38 hiring than the

OPM model includes. As of July 2022, time-to-hire for FY 2022 in VBA was 89% of all hires within 80 days, and in NCA 79% of all hires within 80 days. VA will continue to improve time-to hire by looking at our title 5 and title 38 processes, averages and percentages of all hires.

Question 10: In recent years, VA has shifted its efforts to decrease the need for institutionalization to promote veterans receiving care at home as long as possible. Several of the programs necessary to keep veterans at home fall under the Long-Term Services and Support Program budget. The Elizabeth Dole Home and Community Based Services for Veterans and Caregivers Act was recently introduced in both chambers and is designed to improve home and community-based services in line with VA's goal. If passed this year, how would the implementation of the Elizabeth Dole Act impact the FY23 budget request related to Long Term Support Services institutional and non-institutional programs?

VA Response: The budget impact of the first full year of implementation of the Elizabeth Dole Home Care Act (S. 3854) is expected to be:

- $6.0 million for section 4 (Programs of All-Inclusive Care for the Elderly (PACE) program)
- $1.6 million for additional section 5 FTE employees
- $9.7 million for section 5 (Veteran Directed Care (VDC))
- $26.6 million for section 5 (Respite)
- $12.4 million for section 6 (Caregiver Coordination)
- $0.2 million for section 7 (Website)
- $12.0 million for section 8 (Home Health Aides pilot).
- $0.4 million for reporting requirements

Total first full year cost = $68.9 million

No additional costs are projected for the other sections.

Question 11: The Department is requesting a substantial increase in the FY 2023 budget request for the Office of Telehealth and Office of Connected Care Services. The justification VA gives for part of the increase is implementation of section 701 of the Commander Hannon Act. While I appreciate that the Department continues to fully fund the Hannon Act and is prioritizing making grants for the sustainment and expansion of the ATLAS telehealth program, my staff was recently informed that these grants would not be made available until approximately 2024. If Congress fully funds this request, can you commit to expediting the grant process in section 701 of the Commander Hannon Act so that grants will be made available in 2023?

VA Response: Currently, VA is working through the rulemaking process to expedite requirements for the Telehealth Grant Program authorized by the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act). Despite these accelerated efforts, the process to finalize the regulation includes

requirements outside of VA's control. Currently, VA is forecasting publication of the final rule in FY 2024, with an award of grants in FY 2025.

It is Important to note, That the budget request to support the telehealth grant program is less than 3% of the budget increase requested in the "Office of Connected Care program and medical center support" lines, respectively. Further increases in the requirements for video-to-home services, to include enhanced services through peripheral technologies and digital divide initiatives, remain critical funding requirements if grants cannot be awarded in FY 2023.

Most of the proposed FY 2023 budget increase is included in the Telehealth Treatment line. This line represents VA general purpose expenditures for telehealth services and includes the proportional salaries of physicians, nurses and ancillary care staff to account for their time delivering telehealth care. The expenditures also reflect the cost of equipment, space and other overhead costs to account for the time they are being used to deliver telehealth. As VA clinicians have been delivering a higher percentage of their care through telehealth, a higher percentage of their cost, including their space and equipment costs, becomes attributed to telehealth in this budget line. The funds that account for these costs are distributed directly to facilities as part of the general purpose allocation and can be used for any purpose by the facilities.

The VA budget also includes a section titled "Connected Care Program Funding: Sustainment and Expansion." This section is specific purpose funding managed at the national level to support sustainment and expansion of strategic initiatives and national program office functions. The program budget justification found in Volume II, page VHA-271 that mentions the Hannon Act is referencing this part of the budget.

Question 12: I am pleased to see the President's budget request include an increased allotment for the Veterans Cemetery Grant Program. These partnerships with state and tribal governments are important extension of the Department's mission to honor and remember veterans, and help reach more veterans with dignified, perpetually maintained burial options. Due to the pressures on supply chains and price disruptions during the COVID-19 pandemic, NCA has not been able to grant the same number of conforming requests as it typically would. With lingering disruptions in materials supply chains and inflation driving prices upward are you confident that this increase will allow the department to fund a greater number of conforming grant request projects?

VA Response: NCA will continue to monitor issues that affect our ability to fund grant projects, continuing to follow our normal processes to prioritize grant projects. The FY 2022 priority list included 43 conforming projects totaling over $110 million in grant opportunities. Of this list, in FY 2022, NCA expects to fund 12 grants that were the highest priorities on the FY 2022 list. While these 12 grants will reduce the project list, new conforming projects will be prioritized and added to the list in FY 2023 based on the pre-applications received and updated project prioritizations. The new FY 2023 list will likely show changes and additions to the number of projects and the estimated cost of

each project. The FY 2023 priority list was published on October 1, 2022, and now the Veteran Cemetery Grant Program will create its plan of grant awards based on the enacted FY 2023 budget.

Question 13: In reaching NCA's strategic goal of affording 95% of American veterans with reasonably accessible burial options within 75 miles of where they live, the Rural and Urban Initiatives that kicked off in 2014 are important components of a national cemetery system to serve rural and highly rural veterans in areas that would not meet traditional requirements for a national cemetery. Additionally, columbaria-only sites near underserved urban cores will afford more veterans and families interment options nearer where they live. A handful of sites have yet to come online, including 2 of the 8 planned rural sites and 4 of the 5 planned urban sites. These 13 cemeteries were projected to be open and operational by 2018. When can veterans in the vicinity of these planned cemeteries expect them to be opened?

VA Response: The National Cemetery Administration (NCA) dedicated the urban columbaria-only cemetery in Indianapolis, Indiana, on July 1, 2022, and expects to open the urban cemetery in St. Albans. New York, in 2023. NCA anticipates opening the remaining two rural cemeteries in Cedar City, Utah, and Elko, Nevada, by 2024. The remaining two cemeteries are planned as follows:

Chicago Urban Initiative: The Chicago columbarium-only cemetery in Illinois was originally planned to open in 2021. VA faced unsuccessful efforts to identify suitable land between 2011 and 2017 due to several factors including lack of reasonably priced land, lack of support from local organizations and lack of interest from seller to support construction of a cemetery. In 2017, VA found a potential site in South Barrington, Illinois; however, the NEPA process identified concerns from the community that may have led to further delays. VA continues to search for potential suitable land in the Chicago area and anticipates cemetery opening in 2025. (Note: Ft. Sheridan Army Post Cemetery in Fort Sheridan, Illinois, was transferred to NCA in 2019. This cemetery is expected to be open for cremated remains for another 50 years and currently provides another alternative for Veterans in the Chicago area).

Alameda Point Urban Initiative: The Alameda Point columbarium-only cemetery in California was originally planned to open in 2020. The land acquisition was completed with the Navy in June 2014, and VA initiated extensive environmental and regulatory review processes as well as design efforts. In 2018, the review processes and design efforts transferred from VA to the Army Corps of Engineers. NCA is awaiting the results of the review process to determine next steps.

Question 14: In response to Sen. Blackburn's question about whether VBA employees "returning...to work" was responsible for bringing disability backlogs down, Secretary McDonough stated that "productivity in VBA in the context of the pandemic increased. Actually, did not decrease...." Further, the Secretary said in the light of the asserted productivity increase during the pandemic when many

employees were working from home an analysis is being conducted about the appropriate blend of virtual work vs. in-office work. However, the chart below using data from VA's budget requests using actual direct labor FTE and rating production numbers shows that although overall "production" increased actual "productivity" (defined as rating claims decided per direct labor FTE) is lower in FY 2021 than it was in FY 2019 before the pandemic started. Please help us understand the Secretary's answer in light of these data.

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Comp Direct Labor FTE	13,783	14,181	14,558	15,505	15,748
Rating Production	1,237,834	1,241,821	1,322,139	1,337,075	1,399,049
Rating Claims per FTE	89.8	87.6	90.8	86.2	88.8

VA Response: The FTE totals in the President's Budget include policy and oversight staff as well as an expanded Medical Disability Examination Program Office at VA Central Office. While these program offices support delivery of benefits, VA's assessments of productivity focus instead on the field employees assigned to VBA's 56 regional offices who are directly deciding or managing claims processors, such as Veterans Service Representatives and Rating Veterans Service Representatives and their direct management and quality oversight staff. Comparing this cohort of FTE against VBA's rating production shows that VBA has returned to the path of increased productivity.

Although VBA's rating productivity dipped in 2020 due to early impacts of the COVID-19 pandemic, VA continued to serve Veterans by completing some decisions based on available evidence and completed work not reliant on records or exams. Rating productivity increased during the COVID-19 pandemic in 2021 and remains on a positive trajectory.

Questions for the Record from Senator Patty Murray

Question 1: The Phase Two expansion of the Family Caregivers program to veterans of all eras is expected on October 1, 2022. This includes the hiring and training of sufficient staff to manage the workload. The President's budget requested an almost $500 million dollar increase for the Caregivers program. How will these funds be used to ensure Caregiver Support Coordinators have a reasonable workload to be able to meet the needs of veterans and families?

VA Response: The Caregiver Support Program (CSP) has approved an additional 360 FTE employees to be hired and trained, and as of September 2022 has reached 91% of FTEs approved. This analysis was based on the VA Manpower Management Service staffing model and a review of each facility's current and anticipated workload for FY 2023. These additional staff will support the high volume of Program of Comprehensive Assistance for Family Caregivers (PCAFC) Phase II applications, and the associated workload as a result of Phase II expansion. The budget increase supports the additional salary funding for CSPs current and new FTEs, as well as allows for increases to staffing with changing workload; $38 million of the $500 million has been reserved for salaries and contracts.

Question 2: When does VA expect to have a new regulatory scheme in place for the Phase Two expansion of the Caregivers program and how is VA communicating changes regarding the Family Caregivers program to veterans and their Caregivers?

VA Response: At this time, VA does not expect to have a new regulatory scheme in place for the Phase Two expansion of PCAFC. VA launched the Phase Two expansion of PCAFC successfully on October 1, 2022.

Recently, VA announced that it was reviewing and examining the current PCAFC eligibility criteria listed in 38 C.F.R. § 71.20(a)(1)-(4) and the stipend level criteria listed in 38 C.F.R. § 71.40(c)(4)(i)(A). VA has also undertaken many efforts to put meaningful solutions in place that will have an immediate and positive impact on current and new caregivers and Veterans participating in PCAFC, to include hosting numerous listening sessions with stakeholders and collaborating with VBA with the aim of implementing strong practices within CSP to process PCAFC applications. Currently, VA is continuing its review of the current eligibility and stipend level criteria; and listening sessions with stakeholders and collaboration with VBA is still ongoing. VA does not have a timeline for completion for this review and these efforts.

Question 3: VA recently announced that it is behind on its goal to place 38,000 veterans in permanent housing by the end of the year. Do you think the current number, value, and duration of HUD-VASH vouchers is sufficient?
How will VA use funds in FY 2023 differently to ensure it meets its homelessness prevention goals?

VA Response: At present, the U.S. Department of Housing and Urban Development (HUD)-Veterans Affairs Supportive Housing (VASH) is satisfied that the number and duration of vouchers allocated is sufficient and is working with HUD on a number of projects intended to increase voucher usage and overall efficacy of the HUD-VASH program, including implementing recapture of excess vouchers from any Public Housing Authority (PHA) that no longer needs them and reallocating them to PHAs that do need them, thus encouraging PHAs to develop project-based housing in which the voucher is allocated to a housing unit, increase payment standards to 120% of Fair Market Rents (FMR) and pegging Veteran family income eligibility to 80% of Area Median Income (AMI). These efforts are intended to directly address the most prominent challenges to housing Veterans: the dearth of affordable housing, the insufficiency of Housing Choice Voucher Program payment standards in high-cost rental markets and the unnecessary administrative constraints of the HUD-VASH client pool based on income.

The lack of affordable housing has been exacerbated by housing inflation. In the past year, the national median rental price increased 18% (www.apartmentlist.com/research/category/data-rent-estimates). High demand for affordable housing has created additional barriers for the homeless Veterans served by VA who frequently have poor credit histories and background checks that create barriers to tenancy that can be particularly challenging when landlords have lower risk prospective tenants available in the current market. VA has responded to this challenge with a new landlord recruitment effort. On June 24, 2022, Supportive Services for Veteran Families (SSVF) announced a new Notice of Funding Availability (NOFA) that will make $137 million available with funding support from the American Rescue Act Plan of 2021 (ARP), P.L. 117-2, for funding available in high need communities. This NOFA creates landlord incentives and support the hiring of new SSVF housing navigators to be embedded in HUD-VASH teams. These awards were made in September 2022, thus spurring HUD-VASH placement rates. Landlord and tenant incentives made available in this NOFA will be extended nationally in SSVF's FY 2023 NOFA, expected to be published early in FY 2023.

Regarding how VA will use funds in FY 2023 differently to ensure it meets its homelessness prevention goals, on October 1, 2021, working in collaboration with HUD and leading researchers, SSVF released its revised homeless prevention screening tool designed to identify Veteran families at highest risk of homelessness. This equity-informed screening tool will allow providers to target resources more accurately to Veteran households likely to become homeless. Such targeting is necessary as evictions generally do not lead to homelessness. This screener was incorporated into HUD's Homeless Management Information System (HMIS) and is available to all homeless providers.
In addition, beginning January 2023, SSVF will provide Rapid Resolution training to grantees and VA staff involved in outreach and screening. Rapid Resolution is an evidence-based intervention that seeks to reunify imminently at-risk Veterans with family or friends as an alternative to entering the homeless system. When someone reaches out for assistance with a housing crisis, practitioners start the process of engaging them in a conversation that explores other alternatives and potential

assistance needed to access those alternatives. These supportive services may include mediation with a landlord, resolving conflicts or concerns with a family member or connections to support networks in other places. Through active-listening, staff learn about the person's housing crisis and what their support network looks like. The conversation can be a deep exploration of social network relationships, potential safe housing alternatives and community resources. By preventing or rapidly ending a homeless episode, Rapid Resolution can have a lasting impact on a Veteran family's stability. As the demand for affordable housing significantly outstrips supply, Rapid Resolution seeks to reduce overall demand for traditional affordable housing resources while simultaneously reducing trauma for Veterans and their families who would otherwise become or remain homeless.

Question 4: Women currently make up 16.9 percent of today's Active-Duty military forces and 19 percent of National Guard and Reserves. With the President's budget request for a $60 million increase for gender-specific women's health care, how would those funds be used to expand gender-specific care so that all women veterans have access to care?

VA Response: VA continues outreach to women Service members and Veterans to encourage them to enroll and use the services they have earned. As a result, the number of women Veterans enrolling in VA health care is rapidly increasing. More women are choosing VA for their health care than ever before, with women accounting for over 30% of the increase in Veterans served over the past 5 years. Investments support comprehensive specialty medical and surgical services for women Veterans at a VA facility or through referrals to the community. The number of women Veterans using VA services has more than tripled since 2001, growing from 159,810 to more than 600,000 today. VA is committed to providing high quality, equitable care to women Veterans at all sites of care. To address the growing number of women Veterans who are eligible for health care, VA is strategically improving services and access.

VA is applying the increased gender-specific budget to enhance services and access for women Veterans by continuing to invest in hiring initiatives in 2022. The Office of Women's Health provided funding to the field for a total of over 800 women's health personnel nationally: primary care providers, gynecologists, mental health providers and care coordinators. VA also has addressed clinical equipment needs such as those for mammography, exam tables designed for women with low mobility and breastfeeding pods. Funds are available for programs that have traditionally not been offered by VA, such as pelvic floor physical therapy, lactation support and maternity care coordination.

Question 5: How many of the VA health care facilities in Washington state have a separate women's health clinic?

VA Response: The state of Washington has two stand-alone VA women's clinics. Both are located in the Puget Sound Healthcare System and have separate entrances. One is located at the Seattle VAMC campus and the other is at the American Lake VAMC in Tacoma, Washington. These clinics are Comprehensive Women's Health Centers

(WHC). VAMCs with a large women Veteran population are encouraged to create WHCs that provide the highest level of coordinated, high-quality, comprehensive care to women Veterans. Comprehensive primary care is delivered to women Veterans by Women's Health (WH) primary care providers and WH-Patient Aligned Care Team teams in a separate space. Whenever possible, a WHC should have a separate entrance into the clinical area and a separate waiting room with attention to privacy, sensitivity, safety and physical comfort; the Seattle VAMC and the American Lake VAMC have these separate entrances. By policy, specialty gynecological care; mental health and social work services; and pharmacy must be co-located in this space. Other sub-specialty services, such as breast care, endocrinology, rheumatology, neurology, cardiology, nutrition, etc., also may be provided in the same physical location.

Question 6: There have been recent reports of a backlog in the thousands of non-filled medications at VA facilities that use the Cerner electronic health record system. What is being done to fix the delays for medication being sent to veterans and prevent these issues at future sites?

VA Response: The Cerner Millennium report used to identify pending medications (those in the queue to be filled and dispensed) has been repaired and is available to all facilities. First, a process of reporting this data to Pharmacy Benefits Management on a weekly basis is underway. Second, a task order modification for seven pharmacy capability enhancements was awarded to Cerner Government Services on July 6, 2022. These enhancements will address some of the root causes of decreased efficiency in the pharmacy workflow process. The preliminary timeline for development of all seven enhancements was 13-36 months. Oracle Cerner recently indicated that it would deliver the top three capability enhancements prioritized by the pharmacy community in 6-9 months. In the interim, VA has engaged MITRE Corporation experts to evaluate and provide recommendations to optimize the current pharmacy process to reduce burden on medical personnel. Finally, additional staff resources from the Veterans Integrated Service Network (VISN), Pharmacy Benefits Management (Readiness, Preparedness and Response Team), Multidisciplinary Efficiency Response–Cerner (MER-C) pool, Clinical Resource Hub and VHA's National Electronic Health Record Modernization (EHRM) Supplemental Staffing Unit (NESSU) have been assigned to address the backlog, which is now below 20 prescriptions more than a week old at any station.

Question 7: How many VA employees have raised concerns about pharmacy issues with the Cerner system?

VA Response: VHA is aware of concerns that have been routed to the National Pharmacy Council. Employees can raise concerns in many ways including escalation through local leadership, discussing with program office or Cerner personnel or entering trouble tickets.

Questions for the Record from Senator Kyrsten Sinema

Your testimony mentioned the VHA's struggles with lingering supply chain complications. For example, we have heard from hospitals and VA medical centers in Arizona suffering from a shortage of contrast media needed for medical imaging. Some facilities are operating under tight contingencies, including searching for alternative suppliers or stretching existing supplies.

However, it is not always possible or recommended to delay a veteran's scan, use an alternative procedure, or refer a veteran out to community care if the shortage is widespread in the community.

Question 1: Secretary McDonough, can you elaborate on what challenges the VA is seeing specifically in terms of medical shortages and what actions the VA is taking to ensure those shortages don't impact our veterans' access to care?

VA Response: The National Radiology Program has acknowledged the difficulty associated with imaging exam exchange to and from community care providers, which is a complicated process often necessitating use of CD/DVD media to be physically carried or sent to or from the VA for importing. However, there is currently no mechanism for tracking all instances of this process at the enterprise level within the Veterans Health Information Systems and Technology Architecture (VistA). The new Electronic Health Record (EHR) system will implement an electronic image exchange solution that should provide some standardization to this process, which we hope will be a significant improvement.

The shortages of iodinated contract media are due to production disruptions to General Electric (GE) Healthcare products. The shortages are global in nature and affect not only VA but also the entire U.S. health care system. As of June 13, 2022, GE Healthcare augmented production by 100%. GE Healthcare anticipates full recovery of the global supply chain for this product by the end of the calendar year.

The Assistant Under Secretary for Health for Clinical Services issued guidance to the field detailing the principles and strategies for facility-based plans for prioritization, conservation and inventory tracking of iodinated contrast media for the duration of the global shortage affecting clinical care. VISN Directors or their designee (e.g., Chief Medical Officer; Facility Directors; Chiefs of Staff; VISN Integrated Clinical Communities (ICC) Clinical Leads; VISN Pharmacist Executives and Logistics Leads; Facility Clinical Service Chiefs; Pharmacy and Logistics Chiefs) are responsible for developing and implementing the following processes to address VHA clinical needs in the face of this global shortage:

a. Conservation through clinical review, prioritization and application of alternate imaging strategies as appropriate, which may include reduced contrast dose in select cases.
b. When alternative strategies are not possible, deferment of elective procedures/exams according to clinical urgency and necessity.

c. Establishment of a multidisciplinary contrast management workgroup at each facility.
d. Close and transparent tracking of iodinated contrast to facilitate interfacility/inter-VISN cross-leveling when possible and as necessary.
e. Specific guidance on contrast mitigation strategies and inventory tracking.

Pharmacy Benefits Management Services sent guidance to the field on how to safely compound smaller doses of iodinated contrast from single use vials in compliance with United States Pharmacopeia (USP) 797 standards in an effort to maximize use of available product and minimize waste.

Question 2a: What is the rate of repeat advanced imaging (i.e., CT, MRI, mammograms) provided to veterans due to VA clinicians not having timely access to prior images through a private provider?

VA Response: The National Radiology Program has acknowledged the difficulty associated with imaging exam exchange to and from community care providers, which is a complicated process often necessitating use of CD/DVD media to be physically carried or sent to or from the VA for importing. However, there is currently no mechanism for tracking all instances of this process at the enterprise level within VistA. The new EHR system will implement an electronic image exchange solution that should provide some standardization to this process, which we hope will be a significant improvement.

Question 2b: In places such as Phoenix and the Tucson VAMCs and other VISNs where they have a tool for electronic radiology image transmission, how did the rate of repeat imaging and number of unnecessary imaginings such as mammograms change?

VA Response: Although review of individual patient records may reveal detailed information about imaging exams done in community care and VHA facilities, there is no national dashboard that allows aggregated information about repeat rates or the reasons for the repeat exams that would provide this kind of information at the enterprise level.

Question 2c: What are the VA's plans for providing all VAMCs access to electronic radiology image transmission?

VA Response: As part of EHRM, VA plans for Cerner sites to have access to LifeImage, a bi-directional image sharing platform. Implementation of this technology is another example of VA striving to be the national leader in high-quality, efficient health care.

Question 2d: What are the VA's plans for integrating this capability into EHRM?

VA Response: See response to Question 2c.

Question 3: One topic that came up was how the VA plans to use a budgetary increase to balance the VA's ability to provide direct care at a VA facility versus referring out to community care. How will the investments being requested help the VA provide more direct care for more veterans – whether it is in IT, facility upgrades, or increasing recruitment and retainment efforts?

VA Response: The 2023 President's Budget supports direct system investments in facility upgrades as well as human resource efforts and logistic enhancements. Following are descriptions of these efforts:

Non-Recurring Maintenance (NRM). This budget supports use of the NRM program as a primary means of addressing VHA's most pressing infrastructure needs, including mission critical repair and maintenance needs. In addition, Clinical Specific Initiative projects are emergent projects that cannot be planned due to dynamic health care environments. Associated funding for these projects is distributed to the VISNs at the beginning of each year to obligate toward existing clinical building space and address workload gaps or support access within the VHA high-profile categories such as Women's Health, Mental Health, High-Cost/High Tech Medical Equipment Site Prep/Installations, conversion of under-used space to clinical functions, and other emergent needs based on direction from the Under Secretary for Health.

Logistics. As part of its continued commitment to the modernization of its supply chain and support systems, the 2023 budget would further allow VA to recruit for and hire a workforce of skilled VHA supply chain, health care technology and facilities management staff. VHA will increase health care logistics staff capacity at each VAMC to ease and facilitate the transition to a new integrated logistics and medical support services system enterprise wide. Moreover, this increased capacity also will ensure health care logistics assistance in VAMCs fully supports the needs of Veterans and staff nationwide, in addition to furthering VA's commitment to transform business operations by modernizing systems and focusing resources more efficiently to be competitive and to provide world-class customer service to Veterans and VA employees.

Human Capital Management.
VHA is the largest integrated health care system in the United States, with 382,000 employees in 300 different occupations and health care specialties. To maintain and grow this incredible workforce of health care providers and support staff, VHA needs to hire 48,000 to 52,000 new employees annually for a total of more than 240,000 over the next 5 years. VHA needs to do this in an unprecedented time of competition for both health care providers and entry level employees as a result of the unique economic and labor market trends associated the evolution of the pandemic.

The 2023 budget supports VA's efforts to:

- Maximize bonuses where appropriate and retention incentives as justified.
- Expedite the hiring process by simplifying the application requirements and streamlining the onboarding process.

- Invest in scholarship programs to offer educational opportunities to even more employees.
- The PACT Act has provided VA new flexibilities and authorities related to pay, awards, incentives, and hiring flexibilities that will help position VHA to effectively compete in this uniquely competitive labor market.
- Continue to work with Congress on legislation to resource employee wages and additional workforce offerings and incentives.

Moreover, the 2023 budget supports VHA's efforts to expand the Physician/Provider Recruiter role by adding this specialty to local infrastructure to recruit hard-to-find physicians and advanced practice providers in the Nation's most scarce specialties. In addition, to supplement and support our expanded specialized recruitment function, VHA is investing in expanding its national recruitment and sourcing capabilities to build and leverage what would become the Nation's largest database of practicing physicians and advanced practice providers that would be provided to VAMCs for immediate consideration and appointment at VA hospitals and outpatient clinics. These actions allow VA to expand the healthcare workforce pipeline with continued focus on mental health, long-term care and rural communities. These expanded capabilities provide VHA with a market advantage by generating large actionable and diverse talent pools of candidates for current and future needs, thus solidifying our readiness to meet emerging clinical workforce demands.

For eligible Veterans, the choice between direct VA care and community care remains the Veteran's choice. Veterans' Experience Office (VEO) surveys and V-Signals results show that Veterans have higher trust scores in VA's direct care system. On the other hand, community care usage is continuing to increase, driven by wait times, services not available and drive times. Thus, to enhance services already provided at the facilities and to provide new services currently not offered by facilities, it will be necessary to provide new funding to VISNs and VAMCs to improve wait times and to provide select specialty services in their community-based outpatient clinics (CBOC) and other access sites to stand up new services. IVC continues to emphasize the Referral Coordination Initiative (RCI) and the implementation of Referral Coordination Teams (RCT), which are a one-stop shop to assist Veterans with making informed decisions. Furthermore, an expansion of Clinical Contact Centers is planned for 2023; these are a major entry point for Veterans.

Question 4: How much of the current inflationary environment and upward pressure on both wages and costs has been factored into the Administration's budget request for the VA? Especially when it comes to increasing the VA's ability to compete with the private sector for highly-demanded Physician Assistants, Registered Nurses, and Advanced Practice Registered Nurses?

VA Response: VA factored in an increase of $3.566 billion between 2022 and 2023 for inflation, including wages, associated increases from the Rewarding Achievement and Incentivizing Successful Employees Act (RAISE Act) and increases in incentives for recruitment and retention of high demand health care providers.

Question 5a: The telehealth budget has a 100% increase from FY22. In what ways are these additional funding planned to be used to assist rural populations and those unable to physically go to a clinic?

VA Response: The projected health care costs delivered via telehealth are $4.8 billion in 2023, an increase of $622 million over the 2022 current estimate of $4.2 billion.

The 2022 current estimate was an upward revision to the FY 2022 President's Budget estimate of $2.1 billion driven mostly by the 2021 actuals of $3.9 billion. The FY 2023 President's Budget reflects the recent shift towards care delivered via telehealth and projected sustaining this delivery modality.

The increase in the FY 2023 budget primarily reflects an increase in telehealth usage by Veterans as a result of increased use during the COVID-19 pandemic. These higher levels of usage are sustained and are anticipated to remain.

VA general purpose expenditures for telehealth services, as reflected in the budget line item titled "Telehealth Treatment," include proportional salaries of physicians, nurses and ancillary care staff to account for their time delivering telehealth care. The expenditures also reflect the cost of equipment, space and other overhead costs to account for the time they are being used to deliver telehealth. As staff allocate a higher percentage of their care delivery through telehealth, a higher percentage of their cost, including their space and equipment costs, becomes attributed to telehealth in this budget line. The funds that account for these costs are distributed directly to facilities as part of the general purpose allocation and can be used for any purpose by the facilities. The funds are generally not associated with requirements that telehealth expand or that the staff continue to deliver telehealth at the same percentage as in previous years. The 100% increase from FY 2022 is accounted for in this increase in the amount of "telehealth treatment."

The VA budget also includes a section titled "Connected Care Program Funding: Sustainment and Support," which is specific purpose funding. As reflected in the current budget, this section shows a decrease in FY 2023. This is secondary to the conclusion of supplemental COVID-19 pandemic funds, which totaled $150 million in FY 2022.

VA is using its Connected Care program funding to invest in key strategies that enhance the access and care for Veterans in rural communities. The strategies include initiatives that (1) enhance the accessibility of VA health care in rural areas by delivering enhanced telehealth care in the home, (2) expand the capacity of VA services in rural and underserved areas by distributing clinical resources from urban centers through clinical resource hubs and specialty telehealth centers, (3) address health care disparities by bridging the digital divide and (4) improve the quality of care by enhancing Home-Based Primary Care and other rural focused clinical services.

Examples of key initiatives that enhance access and care for rural Veterans include the following:

- VA Video Connect. Delivering Services to the Home Using Video Telehealth. After delivering over 9.5 million video visits in the home in FY 2021, an increase of over 3100% when compared to FY 2019, VA has focused on enhancing the accessibility and experience of video care to home. To enhance accessibility and experience, VA is working to upgrade VA Video Connect (VVC) with new capabilities (e.g., audio dial-in, closed captioning); integrating technical education (e.g., VVC test calls) and the ability to invite caregivers to video calls into scheduling scripts; and developing new processes to ensure Veterans are offered video telehealth care as an option when deemed clinically appropriate by their providers.

  In FY 2022 through mid-July 2022, VA has provided 419,151 Veterans in rural, highly rural and insular island areas with over 1.75 million telehealth encounters into their home or community location. Among Veterans surveyed from rural areas (N = 13,744), video-to-home experience data shows an increase in ease/simplicity (86.5% to 89.0%), quality (93.2% to 94.2%) satisfaction (85.0% to 88.4%) and trust (84.9% to 87.7%) as compared with FY 2021 survey results. Related, after receiving video care in the home, rural Veterans choose video care in the home (45.2%) as their preferred modality of care over in-person care (33.2 %) or telephone care (4.4%) or not having a preference (17.2%).
- Clinical Resource Hubs (CRH). VA is using telehealth to increase access to primary care, mental health and specialty care services in rural and identified underserved areas. VA has a regional telehealth center, called a Clinical Resource Hub (CRH), in each of its 18 clinical networks. The health care professionals working in these CRHs distribute their services across significant distances using telehealth, helping to address access needs and health care disparities in rural communities and other parts of the country where health care resources are limited.
  Since CRH's inception in 2018, clinicians have had over 1.9 million encounters with Veterans. In FY 2022, through mid-July 2022, 46% of all CRH encounters have been with Veterans in rural, highly rural or insular island areas. In addition, CRH clinicians as of mid-July 2022, are providing clinical support into 1,042 VA sites of care, 420 of which are rural.
- TeleSpecialty Care Centers. VA is using telehealth to enhance the quality of health care services by delivering specialized expertise to rural and underserved communities. In FY 2022, VA has been expanding its TeleStroke and TeleCritical Care programs.
  - The VA TeleStroke program enables rural Veterans to have access to stroke neurologists through telehealth. In facilities that have activated the service, a stroke neurologist can be contacted at any time to assist with evaluation and treatment decisions for a Veteran with a suspected stroke. In FY 2022, the TeleStroke program expanded from 53 facilities to 59 facilities and responded to 2,473 acute consults; 1,050 of those cases were Veterans with acute stroke, and 163 of those Veterans received clot dissolving medical treatment.
  - VA's TeleCritical Care program uses telehealth to connect rural intensive care units with intensive care nurses and physician specialists, enabling remote

monitoring, assessment and treatment. Through July 2022, the TeleCritical Care program has expanded from 50 facilities to 67 facilities with 5 more activations planned by the end of FY 2022. In addition, throughout the COVID-19 pandemic, the National TeleCritical Care Program has continued telecritical care management services through mobile carts that provide audiovisual connectivity between the bedside and the TeleCritical Care Program. During FY 2022, TeleCritical Care admitted an average of over 6,100 patients per quarter and provided approximately 19,000 patient days of care with a length of stay of 2.75 days; 5.6% of these patients received mechanical ventilatory support.

- Digital Divide Consultations. To help ensure all Veterans have convenient access to health care services, VA developed a digital divide consult process in the electronic medical record to assist Veterans who do not have access to internet services or the technology needed for telehealth. Through the digital divide consult process, Veterans can receive an internet-connected device from VA or assistance in applying for an internet discount administered by the Federal Communications Commission (e.g., Lifeline, Affordable Connectivity Program) for their own device or services. Over 79,000 digital divide consults have been completed within VHA since the beginning of FY 2021, including over 22,000 through mid-July 2022. VA also distributed more than 100,000 internet-enabled tablets to Veterans to ensure they have access to their VA health care services.
- Accessing Telehealth Through Local Area Stations Pilot (ATLAS). VA is evaluating the opportunity to leverage community-based telehealth access points through the ATLAS pilot program. ATLAS is a pilot designed to bridge the digital divide and reach rural and underserved Veterans in areas with limited access to broadband and health care. Through this initiative, VA is working with partners (e.g., Philips, Walmart, Veterans of Foreign Wars and The American Legion) to provide convenient locations within Veterans' communities equipped with the broadband and telehealth technology necessary to access VA health care.

Question 5b: 10% of CBOCS are still lacking a dedicated women's health primary provider. Do you feel that more focus is needed on giving women veterans access to a women's health provider through this method?

VA Response: VHA Office of Women's Health closely tracks the availability of Women's Health Primary Care Providers (WH-PCP) across all sites of care. As of the end of 2021, 93.8% of CBOCs have a dedicated women's health provider (data for FY 2022 is not yet available). This percentage is a significant increase over prior years due largely to the increased focus on hiring primary care providers for women, as well as the on-site rural health training initiative for training women's health primary care providers.

VA's goal is to have at least two WH-PCPs at all sites of care, including CBOCs. National Women's Health Mini-Residency trainings, and Rural Health Mini-Residency trainings targeted toward rural CBOCs, as well as national hiring initiatives, have narrowed the remaining gap in women's health providers.

Telehealth programs can and are being used to improve women's health access in rural CBOCs as well. Women's health primary care providers at CBOCs can offer telehealth as an alternative to face-to-face visits when a physical exam is not needed. This practice can enhance access for women Veterans who may have barriers related to distance, childcare, employment or other factors.

In sites with only one WH-PCP, telehealth can be used for gap coverage during sick leave or vacation. In sites with no WH-PCPs, telehealth is encouraged as a temporary option to provide access to a trained and experienced women's health providers until a women's health provider is identified and trained or hired for that location. Women requiring physical exam or procedures will be referred to a convenient location in the community or to another VAMC or nearby CBOC as needed.

Question 6a: The VA recently announced that all annual reassessments through the Comprehensive Assistance for Family Caregivers were being suspended for the time being. What processes are being put in place to assist the families now that the added burden of reevaluations is being lifted?

VA Response: Facility Caregiver Support Program (CSP) staff support Veterans and Family Caregivers enrolled in the Program of Comprehensive Assistance for Family Caregivers (PCAFC) through Wellness Contacts, at a minimum, of once every 120 days. In addition, CSP staff are available to offer certain mental health services, coaching, one-on-one and/or group support, skills training, peer mentoring and referrals to other VA and community resources.

Question 6b: Do you anticipate issues in the program with the eligibility being opened up to all eras of Veterans come the fall of this year?

VA Response: At the onset of Phase II expansion, CSP expects to receive an influx of applications for PCAFC for newly eligible Veterans, who served after May 7,1975 and before September 11, 2001. CSP facility staff and Centralized Eligibility and Appeals Teams have had an increase in staff in anticipation of this influx to continue to support those currently enrolled, as well as new applicants. CSP staff have been trained in how to process applications and conduct assessments. As a result of the experience of Phase I expansion, CSP staff have developed expertise in completing a thorough assessment of PCAFC applicants in an expeditious manner while providing direct clinical supports and services to caregivers. In addition, the Caregiver Support Line (CSL) has increased staffing to support callers inquiring about the program, to provide clinical supports and to respond to appeal information requests. With these additional staff, CSL is expected to maintain and exceed the current call center standards for average speed of answer and abandonment rate, thus providing an exceptional experience for the caller.

Question 7: Research has found that receiving a video-enabled devices with a data plan was associated with a 22% reduction in the likelihood of suicide

behavior among U.S. veterans living in rural areas. Yet the VA IG recently found that 8,500 of the 10,000 iPhones the VA purchased through the Connected Care program have not been issued. How can we get these devices in the hands of veterans in need?

VA Response: VA is leveraging the VA Homeless Program Office (HPO) Smartphone Initiative. In August 2021, the VA Office of Connected Care transitioned the smartphones to HPO to expedite dissemination to Veterans in need. HPO distributed the phones to VA's Supportive Services for Veteran Families grantees to support homeless or at-risk Veterans. As of June 2022, 8,051 of the loaner smartphones have been distributed to grantees to assist with an identified Veteran's need, and over 5,500 are in the hands of Veterans. Smartphone distributions by SSVF grantees is based on Veteran need. SSVF grantees work closely to assess each Veteran and determine their technology needs. Grantees then look to resources, such as this one, to support in fulfilling any technology gaps and ensure Veterans have access to continued engagement and receipt of homeless services. For awareness, this number has recently increased to 6,524 smartphone devices (81% of allocated devices) distributed by VA SSVF grantees to eligible Veterans as of August 19, 2022. VA homeless programs continue to work closely with VAMCs and community organizations to assess the need for devices and ensure that resources are available to support the Veteran population.

Question 8a: In the hearing you mentioned that the community care program now accounts for 33% of the VA's total health care demands. A recent VA IOG report indicated that 1.3 million of 2.4 million billable community care claims were not submitted to private health insurers before the filing deadline expired. Roughly $217.5 million was not recovered, and the cost is estimated to grow to $805.2 million if the issue is not corrected by the end of September. From your estimates, how much of the 33% accounts for money not recovered from claims?

VA Response: OIG estimated VHA was unable to collect $217.5 million from billable Community Care encounters between April 2017 and October 2020 due to the expiration of timely filing limits. During the timeframe OIG reviewed, VHA collected $1.4 billion from Veterans' outside health insurance for Community Care claims.

Question 8b: How much of the total health care demand is due to associated costs with outside providers?

VA Response: The FY 2023 President's Budget projects a total Medical Care obligation requirement of $128.5 billion in 2023, of which $31.6 billion is for Community Care which affords the costs of outside providers. These amounts are not comparable to the workload percentage referenced in the question because the $31.6 billion does not account for costs that are primarily applied to the Medical Care appropriation such as Pharmacy, Prosthetics, Beneficiary Travel, claim processing, etc. The referenced 33% was likely based on the number of Veterans receiving care in different settings and limited to care provided in both settings; it was not a percentage of total care provided.

Questions for the Record from Senator Sherrod Brown

Question 1: Two weeks ago, VA announced it would suspend annual reassessments of veterans currently in the Caregiver program. I support this decision. As VA moves forward with a review of the Caregiver program, I urge you to hold listening sessions with veterans and their caregivers, as well as VSOs. Their insights will provide invaluable information as VA reviews the program and writes new regulations. Please tell me how you will ensure veterans and caregivers are at the table as the Department moves forward.

VA Response: Recently, VA suspended discharges and reductions for legacy participants, legacy applicants and their Family caregivers due to a change based on eligibility criteria listed in 38 C.F.R. § 71.20(a)(1)-(4) and the stipend level criteria listed in 38 C.F.R. §71.40(c)(4)(i)(A) during their transitional assessments. VA also suspended annual reassessments for all participants and undertook an effort to put meaningful solutions in place that will have an immediate and positive impact on current and new caregivers and Veterans participating in PCAFC.

In April 2022, VA began conducting listening sessions with its strategic partners, which included 40 unique caregivers, Veteran Service Organizations, Military Service Organizations, Caregiver Support Program (CSP) staff and other strategic stakeholders to obtain feedback that will inform the continuous improvement process for CSP's programs. In addition, VA is administering an ongoing customer experience survey to capture the voice of the Veteran and caregiver.

VA is committed to supporting Veterans and their caregivers by listening to concerns raised and working diligently to address those items while continuing to provide the support they need and deserve.

Question 2: According to the 2021 Annual Homeless Assessment Report to Congress, the Department of Housing and Urban Development (HUD) showed sheltered veterans decreased by about 10 percent from January 2020-January 2021. The President's FY23 budget request includes $2.685 billion for homelessness prevention efforts. Please tell me the steps VA plans to take to increase recruitment and retention of HUD-VASH case managers?

VA Response: The Homeless Programs Office (HPO) has taken the following actions to help ensure staffing resources are available to support HUD-VASH case management:

- In January 2022, VHA Clinical Services released a memo, Required Filled Rates for Homeless Programs Specific Purpose Funded Positions, to support increased staffing rates for homeless-specific purpose-funded positions. The memo requires the following:
    - (VAMCs to have a minimum homeless program position fill rate of 90% at any given time;
    - Recruitment for vacant positions begins immediately;

  - Prohibition of appointing temporary "Not-to-Exceed" for new hires;
  - Prohibition of the use of VAMC Resource Management Committees to approve positions before posting;
  - Intensive consultative staffing support team in VA Central Office to support VISNs and VAMCs; and
  - VAMCs to report on the status of positions monthly.
- Encouraging and supporting the use of Recruitment, Retention and Relocation (3R) incentives to retain and recruit highly qualified candidates by providing funding availability, tools and data resources to support 3Rs. As of July 2022, HPO has approved over $6 million in 3R incentive requests from various VAMC Homeless programs experiencing recruitment and retention issues, with $4.6 million of those approved requests to support HUD-VASH positions alone.
- Collaborating with the Office of Mental Health and Suicide Prevention to provide hiring/retention training/best practice calls for both homeless and mental health field staff.
- Providing regular, direct consultative support to VAMCs and VISNs on issues related to staffing, with a direct focus on those VAMCs not meeting the 90% staffing requirement.
- Distributing monthly news blasts that provide education and resources to hiring officials on topics to increase staffing levels and practices to retain highly qualified individuals.
- Created a VISN Quarterly Report to assist VISNs and VAMCs with understanding local hiring and staffing circumstances including such factors as turnover rates, the status of all funded positions, and the length of time positions have been vacant.
- Full implementation of section 4207 of P.L. 116-315, which took effect on January 5, 2022, and requires that VAMCs "shall seek to enter into one or more" contracts or agreements for certain HUD-VASH case manager vacancies that meet the following criteria, as determined by the Secretary: (1) the VAMC has more than 15% of HUD-VASH vouchers unused due to lack of case management services during the prior fiscal year and (2) one or more case manager positions has been vacant for at least nine consecutive months immediately preceding the date of such determination.
- HPO continues to work with VISNs and VAMCs to analyze pay disparities and identify the actions necessary to compete with both public and private employers, including the implementation of special salary rates for high-demand disciplines in particularly hard to recruit/retain geographical areas.

Question 3: Please tell me how VA will work with HUD to prevent veteran's homelessness.

VA Response: VA continues to work with HUD as well as the U.S. Interagency Council on Homeless on amplifying VA's plans to accelerate permanent housing placements among Veterans in 2022 and highlighting ways in which Mayors and other leaders can align their House America goals with VA's efforts to end Veteran homelessness. To

learn more about House America please use this link: House America: Goals | HUD.gov / U.S. Department of Housing and Urban Development (HUD)

VA's Grant and Per Diem (GPD) Program offers case management grants to community organizations to increase the availability of quality time-limited case management services for Veterans who are housed. The case management services support Veterans in retaining their housing and preventing homelessness. In addition, GPD, in partnership with HUD-VASH, offers an initiative called Collaborative Case Management (CCM), which is an opportunity for GPD case managers to collaborate with their local VAMC HUD-VASH program to provide housing navigation and time-limited case management services to lower acuity Veterans. CCM case managers assist Veterans with searching for housing, obtaining housing placements, using a HUD-VASH voucher and receiving time-limited case management services after placement in permanent housing. CCM enhances and expedites HUD-VASH voucher use by partnering with existing GPD case management services, ultimately leading to Veterans obtaining and sustaining permanent supportive housing.

Questions for the Record from Senator Bill Cassidy

Question 1: The proposed VA health care budget increases for FY23, reflecting a 20 % increase in VA-provided medical services, a 22 % increase in community care, and a 29 % increase in medical facilities. A utilization review program seems essential to ensuring that one of the three critical aspects of quality, avoiding overuse, is achieved. Utilization review is a common feature of civilian care, and its lack of VA-sponsored civilian care is a deficiency that should be addressed. Are there any plans for the VA to conduct a utilization review into the management of veterans' health care compared to the utilization trends we are seeing in civilian care across the nation?

VA Response: Utilization reviews (UR) for internal VA care and community care are managed at the VISN and facility level. Many locations have UR teams, and, in other cases, these reviews are completed by local Access Committees and Group Practice Managers (GPM). Today, VHA cannot compare to civilian utilization trends due to lack of readily accessible data. IVC will investigate what options may exist as a future enhancement to our processes.

Question 2: The GAPS Act and access standards under the community care report on June 6th were not made available to the committee and are now past due. Relative value units from the FY23 budget show that 1/3 of care for the VA community is now community care, the rate of community care overall in the budget is growing, and care in the community is growing. Given that the rate for community care is at 33 %, how are wait times for veterans calculated, and what changes in access standards for veterans seeking care in the community should be applied to help reduce wait times, given your testimony?

VA Response: VA has published average wait times for primary care, mental health, and specialty care appointments at each of its medical centers since 2014. Since that time, VA has received feedback from Veterans, caregivers, VSOs, oversight authorities and Congress, which led VA to revise the wait time metrics presented on the Access to Care website to better reflect Veterans' experience. VA updated the definition and calculation methodology for average wait times and publication of information on the use of Third Next Available Appointment (TNAA) for those VAMCs that have implemented the new EHR.

To further improve user experience, VA also has upgraded the way average wait times are calculated and displayed on the website. The average wait times that VA displays on its website represents a guide that can assist Veterans in making informed health care decisions.

Average wait times for all VA medical centers and clinics (except those that have transitioned to VA's new EHR) are now calculated to include additional steps in the appointment process that had not been captured in the past. As of July 25, 2022, the VAMCs and clinics that have adopted the new EHR include Spokane, Washington;

Walla Walla, Washington; Columbus, Ohio; and White City, Oregon. Averages are representative of general performance and may not represent individual experience.

For purposes of the following discussion, Veterans are considered new patients if they have not been seen by a provider or a clinical service at the same VAMC for the same, or a related, health care need in the past 3 years. If they had an appointment in a clinical service at the same VAMC for the same or similar health care need in the past 3 years (either in person or via phone/video), they are considered an established patient. The revised calculation includes the following changes:

- For new patient appointments, the average wait time is calculated from the earliest recorded date in the scheduling system, to the date the appointment is completed, or the date it is scheduled to occur if it is not yet completed.
    - For example, in many cases, Veterans who need a new type of care will have a referral entered by their provider into the medical record during a visit, and this starts the care coordination process. For appointments with a referral, this referral date is the starting point used for measuring average wait times, and the end point is the date care is received or the date it is scheduled to occur if not yet completed.
    - For appointments without a referral, the average wait time starts with the earliest recorded date in the process of receiving care, typically the date a scheduler works with a veteran to coordinate a future appointment, and it ends on the date care is received or the date it is scheduled to occur if not yet completed.
- For established patient appointments, average wait times are measured from the date agreed upon between a Veteran and provider for future care and ends on the date care is received, or the date that care is scheduled to occur if it has not yet occurred.

VA sites that have implemented the new EHR will display information known as Third Next Available Appointment (TNAA).

Other major health systems also use this measure, and it reflects availability for upcoming appointments so Veterans can anticipate what their experience will be when they request care.

TNAA is a measure of appointment availability that displays the number of days between today's date and the date of the TNAA in VA's scheduling system. The technology in our new EHR system allows us to use this more modern, industry standard measure at these sites. This measure is considered a more accurate measure of elective service availability than the next available appointment or second-next available appointment.

VA is transitioning to use of TNAA for several reasons, including that this measure informs Veterans of their likely experience when seeking care. This transition also will ensure consistency in measuring appointment availability across VAMC as the enterprise transitions to a new EHR.

As previously described, averages that reflect a small number of appointments—for example, in a geographic area where only a few Veterans seek a certain type of subspecialty care in any given month—may show average wait times that are skewed high or low due to the small number.

Based on Veteran, VA employee and public feedback, analyses of internal VA data and trends and consideration of best practices elsewhere in government and the private sector, VA is proposing no changes to the current designated access standards. VA is, however, carefully considering how best to incorporate VA telehealth availability into its access standards as well as broader approaches to streamline and enhance Veteran access to care.

Question 3: **Given the closure of the Alexandria VA medical center in Louisiana and the recommendations of the Asset and Infrastructure Review (AIR) Commission, how is the VA budget accounting for the expenses related to the relocation of outpatient and community living center (CLC) services to a new site and the relocation of inpatient medicine, inpatient mental health and outpatient surgery to community providers in the Alexandria VA medical center?**

VA Response: Independent of the AIR Commission's existence, VA has a clear need and an obligation to modernize and provide Veterans with the best possible health care outcomes while also providing the VA workforce with the safest environment and the most modern means possible through which to deliver care. Since releasing initial recommendations in March 2022, VA has begun an effort to refine the recommendations to reflect the most current and insightful data available, consider the impacts of the COVID-19 pandemic and incorporate stakeholder engagement.

- VAMC leadership and VISN Directors will drive the effort to refine the recommendations.
- Within each market, local VA leadership will solicit feedback and information from community, public and academic health care institutions; VSOs and other Veteran-advocacy groups; and Federal, State and local officials.
- VA will gather additional feedback from Veterans, building on the initial feedback gathered from listening sessions that were held across the country in 2021.

Based on the additional data analysis and engagement with stakeholders, VA will develop a new health care infrastructure investment strategy for the VA health care system that modernizes VA health care facilities to increase access to care and improve outcomes for Veterans. The strategy will include a strategic capital investment way forward and will be used to inform future VA strategic planning and budget submissions.

VA's approach to the health care infrastructure investment strategy will be a field-driven approach that maximizes collaboration, transparency and stakeholder engagement to ensure that proposed changes to the VA health care system meet Veterans' needs. VA has established work groups with representation from across national and local leadership to prepare to execute the large volume of construction, leasing and overall

modernization projects. The following graphic provides an overview of how VA will work with stakeholders to further review and refine the recommendations initially published in March 2022.

VA will assess routinely its health care markets and will ensure that all markets have been reviewed and approaches to increasing access to care and improving health care outcomes have been updated as necessary every 4 years. VA will continue to perform strategic planning on a regular basis. All facility planning will align with the VA Strategic Plan, which was published in April 2022, and with VA Administrations' long-range plans, which are scheduled to be published later in 2022. Large, robust organizations routinely undergo enterprise-wide planning to evaluate and identify system-wide priorities.

Questions for the Record from Senator Mazie Hirono

Question 1: The VA's growing reliance on Community Care is exacerbated by challenges of staffing and a national shortage of nurses and doctors. 90 percent of VA facilities reported severe staffing shortages for Medical Officers and 73 percent had severe shortages for Nurses. I see this budget does provide resources for provider growth, in a tightening labor market. Are patients being driven into the community because VA doesn't have the internal support to hire providers?

VA Response: Veterans are getting more care through VA than ever, with VA completing 78.8 million Veteran health care visits in FY 2021. Veterans have continued to receive clinically urgent care within an average of 2 days, whether in VA or community care. We are committed to ensuring that we provide the most accessible, convenient, and high-quality care possible through the VA system as well as through our community partners and that we do so in a transparent, patient-centric way. The best indicator of adequate staffing levels is not vacancies, but Veteran access to care and health care outcomes. By those standards, VA is doing well. VA is seeing more patients than ever before, it has more employees than ever before, its budget is bigger than ever before, and Veterans are more satisfied with wait times than they have been previously.

Staffing shortage occupations exist when there is a severe shortage of candidates for an occupation. Occupations identified by 20% or more of VHA health care systems or 50% or more of VISNs or national offices for consolidated occupations during the annual workforce planning cycle were determined to meet the criteria for a national shortage occupation. Designation as a shortage occupation does not necessarily mean that there are actual shortages at a facility. Indeed, most of these shortage occupations continue to experience net growth year after year and are not critically short in most facilities. Rather, designation as a shortage occupation represents a challenge for recruitment and retention due to shortages and competition in the national labor force.

Despite the extremely challenging labor market, VHA has hired more external employees in the first three quarters of FY 2022 (35,400) than in the first three quarters of FY 2020 (34,500) or FY 2021 (34,800). Unfortunately, turnover also is trending higher this year than in previous years, resulting in extremely low or net negative growth in certain critical occupations including physicians, nurses, environmental services technicians (i.e., housekeeping aids) and food service workers. HR specialists in VHA are accomplishing record levels of both internal and external hiring, but it is also true that more support is needed. To meet this need, VHA is developing an intern program called HR Specialist Training and Accelerated Readiness (HR STAR) to address the unique and highly specialized training that HR specialists in VHA require. The COVID-19 pandemic has brought about staffing challenges for all industries including health care. While VHA's turnover rate of 10% is the highest it's been in 15 years, it compares favorably to the non-VA health care turnover rate of 39.4% (according to BLS).

Question 2: In February 2022, you announced a ten-point human infrastructure plan to recruit and retain VA employees, including raising the minimum wage, maximizing bonuses and incentives, offering greater flexibility to employees, and expediting the hiring process. Are these efforts working?

VA Response: The 10-point human infrastructure plan announced in February 2022 is already being implemented in VA, including raising minimum VA employee wages, maximizing bonuses and incentives, offering greater workforce flexibility and doing everything we can to expedite the hiring process. And these efforts are essential to assist VA during this time of unprecedented challenges driven by labor market and workforce trends as a result of the COVID-19 pandemic, high inflation, low unemployment, reduced availability of childcare, extreme competition with private sector for healthcare and entry-level employees and so much more. The longer-term pay-off of these efforts may take a bit more time to be realized, but short-term, they are working to minimize the negative impact of the broader market trends.

Increasing the Federal employee minimum wage to $15 per hour impacted over 9,600 employees across all VA administrations, resulting in an average salary increase of $2.86/hour. While an important first step in addressing pay disparity for low-wage workers in the Federal government, $15 per hour is still an extremely low wage for certain critical positions in VA, such as environmental services technicians (i.e., housekeeping aides) who are the first line of defense in the spread of disease and food service workers, who provide a critical health-impacting service to Veterans receiving inpatient care.

VA continues to maximize flexibility where employees work. As part of workforce re-entry, the VA is managing an increasingly hybrid workforce, with the number of remote workers having doubled from 7,610 in the fourth quarter of FY 2021 to 15,840 in the third quarter of FY 2022. VA continues to expand compressed work schedules and telework while ensuring patient care is maximized.

Another aspect of the ten-point human infrastructure plan is the RAISE Act. To date, over 6,193 registered nurses (RN), physician assistants (PA) and advanced practice registered nurses (APRN) have received pay increases as a result of implementation of the RAISE Act. The average increase in pay for RNs, PAs and APRNs across VHA is 5.7%.

VHA also is investing substantially more in employee recruitment, retention and relocation (3R) bonuses to better manage the workforce effectively in response to the current national labor market and to provide appropriate level of patient care and veteran support services. So far in FY 2022 (through pay period 12), 3R spending is at $184M, compared to the same time in FY 2021 where VHA had only spent $86M. Compared to FY 2021, this reflects a 113% increase in total 3R spending and an 8-percentage point increase in the proportion of 3Rs going to shortage occupations at 90% so far in FY 2022.

The Committee continues to be concerned about the growth in funding for Community Care compared to VA's in-house medical care. The Community Care account from FY 2018 to FY 2023 has grown at a rate over 3.5 times as much as the Medical Services account.

When the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act of 2018) was signed in 2018, the aim was to "supplement, not supplant" the VHA. VA understands that offering the Community Care option to Veterans is necessary, particularly when it comes to reducing appointment wait-times and the sometimes lengthy travel to VA treatment facilities. However, the concern is that VHA may become too reliant on this outsourcing which appears to have become the standard model. VHA services are being rapidly replaced by private-sector care, even as studies continue to confirm that non-VA care generally is of lower quality and higher costs.

Question 3: Is the sharp rise in utilization and increasing cost of Community Care a concern for VA leadership? Do you expect this trend to continue and what steps, if any, are you taking to reel it in?

VA Response: Since VA implemented the Veterans Community Care Program required by the VA MISSION Act of 2018 in June 2019, more than 3.4 million Veterans have received care through community providers, including through the use of emergency department and walk-in care options. Moreover, the number of Veterans authorized to use community care has increased every year since 2014, with a record high number of authorizations made and appointments completed – the latter, more than 33 million – in FY 2021. VHA continues to diligently manage the balance between creating access for Veterans, internally and with community care, and our responsibility to manage resources.

To better understand the impact of the growth in community care, VHA conducted an analysis of FY 2021 workload provided in VHA and community care settings. The VHA analysis examined the workload for all services and identified that 73% of all services are available in VHA facilities and community care settings. VHA found that 44% of services available in both settings were provided through community care. While the percentage of care provided through community care would have been slightly lower if the COVID-19 pandemic had not occurred, it is significant to note that VA is rapidly approaching a point where half of all care available in both settings is provided through community care. Operational leaders already note concern for the potential of a "spiral effect" in some areas, where workload and talent are shifting externally and thus threaten to harm VA's training, research and emergency preparedness missions.

The Independent Budget formulated by the Disabled American Veterans, Veterans of Foreign Wars and Paralyzed Veterans of America considers increases based on inflation, a projected 4.6% percent Federal pay raise for VA employees in CY 2023, and

an estimated 4% increase in VA health care usage due to deferred demand, increased sickness and morbidity from the COVID-19 pandemic.

Question 4: Does the President's budget for Department of Veterans Affairs consider these important factors? If not, why?

VA Response: Yes. The FY 2023 President's Budget for VA considers a variety of factors including increased staff, pay raises and health care usage. The COVID-19 pandemic is expected to have a continuing impact on VHA and Veteran health care for several years. During the COVID-19 pandemic, nationwide health care usage saw a reduced amount of care provided in 2020 and 2021 as individuals chose to defer certain care. It is anticipated that less care will be deferred in 2022 and that care previously deferred started to return in 2021 and will continue through 2024. This return to care is one of the factors driving budgetary increases for medical care in 2023. As we've discussed before, many of your predecessors have included ending Veteran homelessness in their top priorities. VA was provided essentially unprecedented investments throughout the COVID-19 pandemic to alleviate this issue.

Question 5: How does this budget build on those initiatives/investments to continue working toward the goal of functionally ending homelessness for veterans?

VA Response: Although SSVF's emergency housing response was designed to be for a limited time, data and outcomes generated by this initiative demonstrates its potential for enduring value. Between March 2020 and September 2021, SSVF grantees placed 32,000 homeless Veterans in hotels and motels to reduce their risks of contagion. 20,000 of these Veterans exited to permanent housing. Of the remaining 12,000, 3,000 were still in hotels or motels at the end of FY 2021 and 5,000 had exited to other temporary or transitional housing destinations. A hotel or motel emergency housing option can be a critical engagement tool for those unsheltered homeless unwilling to go into traditional shelter or emergency housing options available through the community or VA. SSVF's hotel and motel option will continue to be used post-COVID19 pandemic as a critical engagement option for this population. A current example of this value is the recent success moving Veterans out of encampments near the Greater Los Angeles VAMC and into permanent housing. As of May 31, 2022, SSVF grantees have nearly 3000 Veterans temporarily placed in hotel or motels while working towards their placement in permanent housing.

Creating attractive new emergency housing alternatives engaged more seriously ill Veterans. Between FY 2019 (pre-pandemic) and FY 2020, SSVF participants with substance use disorders increased from 46 to 59% and major depressive disorders increased from 35 to 56%. Hotels and motels offer safer, less restrictive and more private accommodations than traditional shelters or other program-based temporary housing. Upgraded health care supports, such as the health care navigators now offered by all SSVF grantees, help homeless and at-risk Veteran families access critically needed health and mental health resources. Initially supported with CARES

funding, this initiative is now sustained with $20 million in ARP funding and the proposed FY 2023 President's Budget would continue this initiative.

SSVF has distributed $24 million in ARP funds to support direct access to legal services for those enrolled in SSVF programs. The eviction moratorium demonstrated the importance of policy and legal remedies in preventing homelessness. The proposed FY 2023 President's Budget would continue this initiative.

The housing affordability crisis has been exacerbated by the COVID-19 epidemic. On January 30, 2022, The Washington Post reported, "Rents are up more than 30% in some cities, forcing millions to find another place to live." In November 2021, SSVF expanded its Shallow Subsidy initiative nationally. The Shallow Subsidy provides up to 50% rental subsidies for 2-years to very low-income Veteran households. This rental support remains the same throughout the entire 2-year period regardless of changes in household income, incentivizing income growth. SSVF is partnering with Department of Labor's Homeless Veterans Reintegration Program, a Veteran specific employment and training program, co-enrolling and coordinating care to participants so that they may reach economic self-sufficiency by the end of the 2-year rental subsidy. This expansion was supported with ARP funding. The President's proposed FY 2023 Budget would sustain this initiative.

Landlords are less likely to lease to certain groups due to the risk of non-payment of rent or concerns about damage or disruption to their buildings. High-risk tenants might include Veterans with poor credit histories and background checks that might otherwise disqualify them from obtaining a lease. Generally, Veterans with histories of sex offenses also are considered a high-risk tenant by landlords. SSVF recently made ARP funding available to selected high-need communities where grantees will be able to offer financial incentives as a way to recruit landlords who might otherwise be reluctant to lease apartments to the Veterans served by VA Homeless Programs. Fully funding the President's FY 2023 Budget will allow SSVF to offer these incentives nationally.

Question 6: How can VA support other components of states' Continuums of Care to ensure an efficient, fair distribution of federal funding to address homelessness?

VA Response: VA can and does support this effort by its participation in local coordinated entry systems and participation on continuum of care (CoC) boards and committees that are focused on Veteran homelessness.

Question 7: How does this budget work to address the ongoing issue of caseworker recruiting and retention, which can cause states like Hawaii – especially those with a high cost of living – to be unable to utilize all available HUD-VASH vouchers?

VA Response: Many facilities located in areas with a high cost of living – including Hawaii – have implemented special salary rates for social workers as a means of

addressing the ongoing issue of caseworker recruiting and retention. Along with these higher salary rates, facilities are encouraged to use recruitment and retention incentives to attract and retain HUD-VASH caseworkers.

VA has implemented a variety of changes intended to attract and retain qualified staff to HUD-VASH, including encouraging facilities to award recruitment and retention incentives, special salary rates for social workers, diversification of staff disciplines and contracting for positions that have proven to be difficult to fill. As of July 2022, VHA HPO has approved over $6M in 3R incentive requests from various VAMC Homeless programs experiencing recruitment and retention issues, with $4.6M of those approved requests to support HUD-VASH positions alone. VA will continue to encourage the use of 3R incentives and special salary rates to support in the recruitment and retention of highly-qualified HUD-VASH and will analyze the effectiveness of these interventions over time.

Question 8: Does this budget make investments in infrastructure to alleviate homelessness? If so, how?

VA Response: VA's GPD Program offered new capital grants to current GPD grantees to improve existing transitional housing during the public health emergency. These grants decrease shared and congregate accommodations within the transitional housing stock and increase private rooms with private bathrooms for Veterans experiencing homelessness as they transition to permanent housing. Approximately $64.2 million in Coronavirus Aid, Relief, and Economic Security Act (CARES Act) funds was awarded to support capital grants starting on October 1, 2021, and approximately $64.7 in ARP funds was awarded to support similar grants starting on May 1, 2022. Upon completion of the capital projects, approximately 2,000 GPD beds will be improved to support the health and safety of Veterans.

Thank you for your Department's willingness to engage with me and my staff on the issue of mental health and suicide prevention among AAPI veterans.

Question 9: What progress has been made in this area?

VA Response: To further advance efforts with Asian American and Pacific Islander (AAPI) Veterans, VA Suicide Prevention has funded the launch of efforts in FY 2022 entitled, *Understanding Suicide Risk and Enhancing Suicide Prevention among AAPI Veterans*. The project aims to understand characteristics of AAPI Veterans who died by suicide and look at differences between AAPI and non-AAPI Veterans who die by suicide. The project will assess demographic and military service characteristics, social determinants of health, suicide methods, VA health care usage and circumstances surrounding death. This information and analysis will identify suicide prevention needs, barriers and critical next steps for enhancing suicide prevention care to reduce suicide among AAPI Veterans. VA is developing an AAPI Veteran Engagement Group to inform this project and an analysis of suicide death data to better understand risk and barriers unique to these Veterans. A geospatial analysis has been conducted, resulting in this

initial publication: Spark et al. 2022, Putting it on a map: Geographic visualization to inform suicide prevention in Asian, Native Hawaiian and Pacific Islander Veterans. *Asian Journal of Psychiatry*, 73, doi:10.1016/j.ajp.2022.103125.

In addition, VA is working with local communities as part of Suicide Prevention 2.0 (SP 2.0), a population-based, public health model, which was approved by the Executive in Charge of VHA. To reach Veterans inside and outside VA care, SP 2.0 is moving suicide prevention beyond a one-size-fits-all model to a blended model combining community-based prevention strategies and evidence-based clinical strategies that will empower action at the national, regional and local levels. The SP 2.0 Community-Based Interventions for Suicide Prevention (CBI-SP) model builds upon VA's current efforts and reaches Veterans through facilitating community coalitions focused on working toward ending Veteran suicide. The program aligns State Governor's Challenge initiatives, the Together with Veterans rural peer-to-peer initiative and VHA Community Engagement and Partnership Coordinators (CEPC) to help local communities adapt an evidence-informed public health model to local needs and resources. This year Guam, the Commonwealth of the Northern Marianas Islands and American Samoa have engaged the Governor's Challenge program, and VHA has implemented CBI-SP in VISN 21 and ISN 22 with CEPCs starting to work with communities across the Pacific Rim.

Question 10: How does this budget support culturally-competent outreach to communities of veterans who suffer disproportionately with high rates of suicide and mental health issues?

VA Response: SP 2.0, a significant portion of the budget, is informed by the evidence supporting suicide prevention interventions and public health approaches to include outreach to diverse populations. The Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration and the National Action Alliance for Suicide have all moved toward a public health approach to suicide prevention. The model works to incorporate reaching Veterans in the community as well as those we currently serve in VA with evidence-informed, community-based prevention strategies combined with strategies with known outcomes for reducing suicide and suicide attempts based upon the VA-Department of Defense (DoD) Clinical Practice Guidelines. CBI-SP works toward ending suicide for all Veterans through work with the communities in which they live and connect using a public health model based in facilitated community engagement and collaborative action that is led by the community. Integrating diversity, equity and inclusion (DEI) is a critical aspect of community work. CEPCs are trained in DEI considerations and prompt potential DEI questions through each phase of the CEPC's work (Engage, Plan, Implement and Sustain) with local communities. This localized work is critical to designing strategic plans for suicide prevention for each unique community.

In addition to these efforts, VA funds demonstration projects to support ongoing development and dissemination of best practices. Several demonstration projects are focused on tailoring outreach to specific Veteran populations, including the AAPI

population (discussed previously), Native Veterans, geriatric populations, homeless Veterans, women Veterans and Veterans with substance abuse and opioid dependence. Further, our communication campaigns include specific outreach in reaching diverse populations through focused airtime slots and channels that demonstrate higher market shares representative of diverse Veteran populations (e.g., Black, Hispanic, Native American, Asian/Pacific Islander and female populations) and through the development of creative materials that represent diverse population representative of Veterans broadly. Using a data-driven approach and a wide variety of advertising platforms and targeting tactics allows the team to reach our audiences where they are online and in-person. VA is committed to implementation of targeted platform selection to ensure reach to a racially and ethnically diverse population of Veterans. Advertising assets are tailored with photography and messaging aligned to diverse audiences.

Questions for the Record from Senator Tommy Tuberville

Secretary McDonough, as you said in your testimony, the FY2023 budget request includes $497 million for suicide prevention and outreach programs. However, this request is approximately $100 million less than what the VA spent on these same programs for the current fiscal year.

Question 1a: How does the VA intend to use this funding for the FY2023 versus in past years?

VA Response: This funding change denoted is related to the completion of the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) in FY 2022 and not a reduction in funding. The 2023 plan will continue to expand efforts to fully implement VA's National Strategy for Preventing Veteran Suicide (2018) and the White House Strategy for Reducing Military and Veteran Suicide (2021). The suicide prevention budget for 2023 will continue to focus on expansion of the Veterans Crisis Line (VCL) for support of 988. VCL has projected it will need a total of 2,568 FTEs to fulfill its mission, with recruitment efforts continuing in FY 2022 through FY 2023. The National Suicide Prevention Strategy serves as the core operational budget for the National Suicide Prevention Program (SPP). SPP expanded the program from 27 FTEs in 2020 to 66 FTEs in 2021. In the coming years, SPP projects the need for further expansion to approximately 82 total FTEs, including the absorption of the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) FTEs, to support the ongoing development and roll out of our public health work, primarily under the SP 2.0 Initiative. The core budget also supports a number of contracts including those that focus on our communications and paid media efforts that aim to raise awareness about mental health and suicide prevention and educate Veterans, their families and communities about the suicide prevention resources available to them. Contracts also support work for the Clay Hunt Suicide Prevention for American Veterans Act (P.L. 114-2), community engagement and awareness materials that include the VCL phone number and gun lock acquisitions, which is an important element of lethal means safety for suicide prevention and part of the National Strategy. This core budget also supports VA national FTEs and contracts, all of which supports the work of the additional SPP components that operate at the VISN and facility level as well as VA's SPP Now Initiative.

The 2023 budget also covers demonstration projects, which support the funding of innovative and promising practices intended to address risk factors and enhance known protective factors of suicide. The development and dissemination of promising practices and innovative strategies and interventions are an important component of VA's suicide prevention work. Funding is provided to national centers and facility-based initiatives to support efforts focused on crucial areas such as rural Veterans; American Indian and Alaskan Native Veterans; suicide risk screening and caring communications efforts; and the exploration of digital interventions addressing anxiety and depressive disorders. These efforts are working to fill identified needs in support of the National Strategy for Preventing Veteran Suicide.

The 2023 budget request further covers field implementation of SP 2.0, which started in the fourth quarter of FY 2020, with the phased implementation continuing through 2023 and moving to sustainment in 2023 and 2024. Currently, 47 States in the Governor's Challenge are engaged with technical assistance around implementation of action plans and CEPCs are being funded across all VISNs. By the end of the phased roll out in 2023, SP 2.0 Community will have expanded to all 18 VISNs, and all 50 States will have been invited to participate in the Governor's Challenge. This phased approach for SP 2.0 allows us to adapt our approach based on lessons learned over time and to improve innovative community strategies and engagement, which will allow for the selection of specific unique intervention and prevention strategies for local context, the promotion of testing of assumptions and workload over time and the opportunity to study what works to promote suicide prevention strategies for all Americans. For the clinical component of SP 2.0, the program has focused on building the infrastructure and capacity for the nationwide implementation of evidence-based suicide prevention treatments for Veterans with a history of suicidal self-directed violence in collaboration with VISN CRHs. SP 2.0 Clinical Telehealth is in its final stage of phased implementation roll out. The program has hired over 97 psychotherapists (at least 1 psychotherapist in each of the 18 VISNs), and over 90% of therapists are trained in evidence-based protocols for suicide prevention. Sustainment plans include training trainers and consultants within the CRH system to ensure the continued capacity of trained therapists.

The National SPP has dedicated staff and resources to design and implement program monitoring and evaluation protocols for SP 2.0. Program evaluation and implementation science experts have designed measurement protocols that will allow for the assessment of process measures, short- and long-term outcomes over time for each of the components of SP 2.0. Unique elements of SP 2.0 using community prevention and clinical intervention strategies will be studied including such variables as:

- Increased awareness and use of suicide prevention resources for Veterans;
- Lowered stigma and increased willingness to seek care;
- Increased availability of suicide prevention-specific, evidence-based clinical treatments for Veterans at risk;
- Increased State and community coalitions;
- Increased policies and programs being implemented in the six key priority areas by local communities;
- Increased collaboration between communities and VA facilities to support Veterans in need; and
- Decreased Veteran suicide attempts and behaviors and Veteran suicides

The 2023 budget also focuses on implementation of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP). The SSG Fox SPGP will enable VA to provide resources toward community-based suicide prevention efforts to meet the needs of Veterans and their families through outreach, suicide prevention services and connection to VA and community resources. The SSG Fox SPGP is a 3-year, community-based grant program that will provide resources to community organizations serving certain eligible individuals and their families across the country. Organizations can apply for grants worth up to $750,000 each year and may apply to

renew awards from year to year throughout the length of the program. Grants will be awarded to organizations that provide or coordinate the provision of suicide prevention services for eligible individuals at risk of suicide and their families that qualify, including:

- Outreach as specified in 38 C.F.R. § 78.45;
- Baseline mental health screening as specified in 38 C.F.R. § 78.50;
- Education as specified in 38 C.F.R. § 78.55;
- Clinical services for emergency treatment as specified in 38 C.F.R. § 78.60;
- Case management services as specified in 38 C.F.R. § 78.65;
- Peer support services as specified in 38 C.F.R. § 78.70;
- Assistance in obtaining VA benefits as specified in 38 C.F.R. § 78.75;
- Assistance in obtaining and coordinating other public benefits and assistance with emergent needs as specified in 38 C.F.R. § 78.80;
- Nontraditional and innovative approaches and treatment practices as specified in 38 C.F.R. § 78.85; and
- Other services as specified in 38 C.F.R. § 78.90.

In 2022, VA has been establishing critical program infrastructure and regulations to ensure successful implementation of the SSG Fox SPGP. The first grant awards are expected in late FY 2022 with further work moving forward in 2023.

The Suicide Prevention budget also provides support to the VHA Centers of Excellence and Program Evaluation Centers provide in supporting the National SPP. VA has two nationally recognized research centers that work in collaboration with other Federal, academic and community partners and with each other to advance the science and strategy related to suicide prevention. In addition to these Centers, program evaluation centers such as the Serious Mental Illness Treatment Center (SMITREC) and the Program Evaluation Resource Center (PERC) support suicide prevention by evaluating a variety of initiatives and ongoing programs to determine utilization and improve effectiveness in both mental health services and suicide prevention efforts.

Question 1b: What specific programs has the VA determined have the biggest impact on suicide prevention efforts?

VA Response: It is difficult to isolate precisely what has the biggest impact on suicide prevention efforts. However, we highlight a few initiatives that have shown significant positive impacts to date. VA's initiation of the public health approach in 2019, was also the first year a reduction of Veteran suicide was noted in the 2021 National Suicide Prevention Annual Report. While we are unable to identify causation, long-term evaluations are underway for VA's public health approach, which is a part of our funding budget. The evaluation design for SP 2.0 is not a single design, but several different designs that will vary between the community and clinical interventions as well as the stage of implementation of both. Formative evaluation techniques are used as appropriate to collect and analyze data that may be helpful in program development. Process measures have been developed to assist program leadership in assessing whether program implementation is going as planned and whether course corrections are required. A combination of interrupted time series and a modified stepped wedge

design are used to assess short and intermediate outcomes of programs, and surveillance data is used to evaluate population impact. SP 2.0 initial positive outcomes include engagement of 47 States in the Governor's Challenge, over 500 local community coalitions involved in local strategic efforts, over 97 therapists hired and over 3,000 consults received for the provision of evidence-based psychotherapies, which show the greatest outcomes for Veterans at risk for suicide (see VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide, 2019).

In Suicide Prevention Now, we see positive outcomes for several areas of implementation. A few examples include Naloxone distribution, the Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) program and Safety Planning in the Emergency Department (SPED). VA worked to increase distribution of Naloxone to Veterans diagnosed with opioid use disorders (OUD) which has resulted in an initial 25% increase in Naloxone prescribing, which we know saves lives. VA also implemented REACH VET, which uses predictive modeling to identify Veterans at highest risk for suicide and then works to outreach and engage Veterans in care. REACH VET has been associated with increased attendance at outpatient appointments, proportion of individuals with new safety plans and reductions in mental health admissions, emergency department visits and suicide attempts (McCarthy et al., 2021, Evaluation of the Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment Suicide Risk Modeling Clinical Program in the Veterans Health Administration, *JAMA Network Open,* doi:10.1001/jamanetworkopen.2021.29900). VA is exceeding benchmarks for all five REACH VET metrics. The Now initiative also has enhanced implementation of SPED, an evidence-based practice shown to reduce suicidal behaviors by 45% (Stanley et al., 2018, Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department, *JAMA Psychiatry* doi:10.1011/jamapshchiatry.2018.1776).

Question 1c: Do you foresee suicide prevention funding continuing to decrease in future years?

VA Response: No. This funding change was related to the completion of the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) in FY 2022. As of June 2022, PREVENTS has completed the requirements of Executive Order 13861, which established the PREVENTS Task Force. Ongoing efforts from PREVENTS have moved into sustainment in alignment with the overarching National Strategy for Preventing Veteran Suicide (2018), the White House National Military and Veteran Suicide Prevention Strategy (2021), and will include ongoing increased focus on lethal means safety efforts, public health campaigns and community-based prevention strategies with ongoing program evaluation and research to expand implementation of practices in collaboration with other Federal agencies as part of the Administration's efforts at the national level. These areas are covered in other topics within VA's responses. The PREVENTS Office staff will continue to move these efforts forward in a streamlined manner with the SPP efforts underway.

Question 1d: When can we expect the suicide prevention grant program going into effect?

VA Response: The SSG Fox SPGP's application deadline was June 10, 2022; VA received more than 250 applications. VA announced awards on September 19, 2022. Grants were awarded to organizations, encompassing 43 States, the District of Columbia and American Samoa.

Question 2: I know you and your staff are focused on the anticipated increase of veterans over the next several years enrolling in VA health care. Can you please discuss how you plan to leverage community care for this purpose, especially for mental health and suicide prevention services?

VA Response: VA's network of community providers, including through its Community Care Network (CCN) contracts, is designed to address current and future demand for medical services for Veterans, including new enrollees. The network allows VAMCs to leverage providers in their area to ensure Veterans receive the care they need when and where they need it. As VA is a leader in mental health services, it has taken its internal requirements for mental health treatment and suicide prevention services and incorporated them as CCN requirements. VA has made some modifications to its contracts and is working on others to ensure eligible Veterans and former Service members can receive appropriate mental health or suicide prevention care from CCN providers for emergent and scheduled mental health care. In combination with increasing internal capacity to render mental health services, enhancing VA infrastructure and maximizing use of existing capacity, and staffing, this incorporation will allow VA to support any increased growth in enrollment by leveraging the current network for any emergent needs for mental health and suicide prevention services.

Question 3a: While the budget request includes increased funding for VA infrastructure needs, how did the $18 billion included in the American Rescue Plan, also for VA infrastructure needs, get distributed?

VA Response: The Spend Plan for the ARP Act describes how the ARP funding was distributed. See the ARP Spend Plan attached to these Questions for the Record.

Question 3b: Does the FY2023 funding for infrastructure take into account the money appropriated from ARP, or will it address entirely different projects?

VA Response: The infrastructure requests included in the 2023 President's Budget are distinct and separate from the ARP Act spend plan. The Spend Plan for the ARP Act describes how the ARP funding was distributed. See the ARP Spend Plan attached to these Questions for the Record.

Questions for the Record from Senator Marsha Blackburn

Hiring Process- Many large health systems are moving to nurse talent marketplace platforms to combat the healthcare workforce shortage and fill clinical roles. One such platform uses algorithms to automate the pre-vetting and has sped the hiring process from 90 days to as low as 16 days using the platform.

Question 1: How is the VA working to modernize and automate the hiring process?

VA Response: The introduction of the talent team function will move VA more in line with private sector practices regarding candidate assessments. The intent is to more quickly engage with and assess job applicants, which has the potential to bring new staff onboard more quickly. Automation products under consideration have the capability of starting communications with candidates via text, as well as allowing for interviews to be conducted via mobile phone.

These advances in our system capabilities could improve candidate engagement and experience similar to what they experience when applying for jobs in the private sector. In addition, many unique techniques that have proven effective in the private sector will be considered including more immersive leadership assessments, game-based assessments and person/job fit assessments. These techniques, among many others, will be under consideration for development and use as VA moves forward with improved talent assessments. These approaches can help VA find the right person for a job more quickly and more effectively, which in turn has the potential to reduce turnover and improve hiring times.

Question 2: When considering ways to modernize the VA hiring process, is the VA looking into ways the private sector is navigating workforce shortages?

VA Response: Health care organizations are struggling to keep valuable employees and also are facing a growing skills gap that threatens their ability to keep pace with an increasing and evolving demand for health care. As Secretary McDonough mentioned as part of his Human Infrastructure Plan, VA continues to invest in employees' education to enhance clinical workforce retention and to create a workforce pipeline for the future. This includes use of the Education Debt Reduction Program (EDRP), which approved more than 3,000 new applications this year, a nearly 50% increase over FY 2021, and both employee and externship scholarships, which have also expanded to 3000 scholarships. In addition, VA has increased the use of recruitment, retention and relocation (3R) incentives this year, especially for providers in VHA, where spending on 3Rs increased from $115.5M in FY 2021 to $257.2M in FY 2022.

Question 3: Has the VA looked into "grow your own" concepts that retrain and reposition nonclinical staff to fill clinical roles?

VA Response: As one of the largest integrated health systems, VA can reach frontline employees and provide them with access to education through employee scholarship programs. The VA administers an array of scholarship programs for frontline clinical and nonclinical staff interested in pursuing academic degrees leading to appointment or retention in clinical occupations. These scholarship programs encourage employees to stay, develop and grow within the VA. The scholarship programs are multiyear programs that provide tuition, allowable fees and, in the case of the Health Professional Scholarship Program (HPSP), a monthly stipend. The HPSP, Employee Incentive Scholarship Program (EISP) including the National Nursing Education Initiative (NNEI) and the Veterans Affairs National Education for Employees Program (VANEEP), help VA meet its need for critical healthcare staff by obligating scholarship recipients to complete a service obligation at a VA healthcare facility. These service obligations secure the graduates' services for up to 3 years. Our employee scholarship programs help pave the way for frontline employees to fill clinical roles but also have the benefit of strengthening employee retention. VA is promoting the Public Service Loan Forgiveness program and looks forward to implementing the Honoring our PACT Act of 2022 which includes higher annual and lifetime limits under the Student Loan Repayment Program.

In FY 2022, VHA supported nearly 3,000 new and continuing scholarship recipients during the year. With additional funding, VHA will continue to expand these programs with the goal to meet at least 10% of the annual new hires needed in critical occupations appropriate for scholarships.

Staffing Models

Question 4: It is critical to patient safety that positions are filled with the right people, but, as you know, this has been a challenge for the VA. In your testimony, you mentioned that the VA is working to develop and implement staffing models throughout the VA. These staffing models should guide facility directors in allocating resources to ensure they have the needed staff to meet their projected workloads within acceptable timeliness and quality standards.

VA Response: VA is increasing opportunities for internships and hiring college graduates under new OPM and Honoring our PACT Act 0f 2022 (P.L. 117-168) authorities. VA's Veteran and Military Spouse Employment Programs are leveraging relationships with DoD and VBA to establish more Skillbridge Programs and outreach to individuals and schools participating in the GI Bill.

Question 5: How long has the VA been working on its methodology for establishing staffing models?

VA Response: One of the VA's manpower management program's primary responsibilities is to develop validated staffing requirements. The concept of validated

staffing requirements and the manpower management program was initiated in FY 2018, so it is relatively new. VA started the work on staffing models in FY 2019 to review approaches to standardize how functions were aggregated and to improve the baseline staffing data needed to apply standards or benchmark analysis. VA has admittedly not made as much progress as we would have liked on developing and implementing staffing models to date. Progress was delayed by a shift in priority to hire the staff needed to care for our Veterans to meet the surge in demand during the COVID-19 pandemic, but progress continued throughout the COVID-19 pandemic.

Question 6: How many models has the VA developed?

VA Response: VA validated initial staffing models for the Office of Information Technology (OIT). VA completed staffing models for the Caregiver program and Police staffing. VA has developed a Human Resources Office staffing model that is currently being reviewed by the Administrations.

Question 7: How much longer will it take to have all the models in place?

VA Response: Since the majority of VA's positions are in VAMCs, the VA currently is focused on VAMC staffing models. Since these models are the first effort to produce VAMC-wide staffing models, before the results are finalized, they must be reviewed by each VAMC to address unknown factors impacting productivity. VA anticipates that the reviews for these initial staffing models that cover ~80% of all VA staffing requirements will be completed in mid-FY 2023. VA anticipates that the second iteration of the VAMC staffing models and the staffing models for the majority of the remaining functions in VA will be completed by the end of FY 2024.

Claims Process

Question 8: In Tennessee, I hear from VSOs, Veterans, and spouses about how cumbersome and frustrating it can be to file a VA disability claim. In your testimony, you note that the budget provides $120 million for VA to support automating the disability compensation claims process from submission to authorization. How does the VA plan to improve the end-user experience and streamline the filing process for the local VSOs, veterans, and spouses?

VA Response: VA continues to evolve digital claim submission and status tracking capabilities for Service Members, Veterans, spouses and VSOs to create an exceptional customer experience. These self-service products provide a seamless, intuitive and personalized claims experience on par with top private sector companies ensuring VA clients receive the best online experience in the Federal Government. Funding will allow for improvements, to include Veteran-centric products with early Veteran input, so VA can deploy apps and services that are easily accessible and accomplish what Veterans need. In addition, VBA continues to develop automated decision support tools to improve timeliness and efficiency of the existing claims process. This modernization effort leverages technology to automate administrative

tasks and workflows and equips employees to provide faster, more accurate and consistent decisions. VBA will continue to support this using the additional funding provided in addition to existing allotments.

Claims Automation

Question 9: The traditional method of processing disability-related claims currently takes well over 100 days. For example, in May 2022, it took, on average, over 141 days for the VA to make a decision on a claim. I applaud your effort to explore ways to speed up claim processing by launching an automation pilot through the Office of Automated Benefit Delivery. However, more action must be taken to reduce the backlog (Claims Backlog: 188,579) and speed up VBA's delivery of benefits. What are some results you have seen from the claim automation pilot?

VA Response: Using the claims automation process, VBA is able to process claims in more rapidly, with some claims decided within 24 hours from submission. VA also has made significant improvements in employee experience through the use of its automated decision-support system. VA claims processors are using the intelligently indexed records to provide Veterans with fast, accurate and consistent claim decisions.

Question 10: How much of the claims process can be automated to increase the VA's ability to deliver faster and more accurate claims decisions for veterans?

VA Response: VA is currently focused on automating claims for increase and claims for presumptive service connection. We are exploring additional opportunities to add other claim types to its automation efforts. We would be happy to offer Senator Blackburn's office a briefing to further discuss the future of VA's claim automation efforts.

Department of Veterans Affairs
November2022

Responses from The Independent Budget VSOs (DAV, PVA, VFW) to Questions for the Record from SVAC Hearing on June 14, 2022 From Senators Blumenthal, Cassidy, Hirono and Sinema

From Senator Blumenthal:

Q. What is the most pronounced trend in veteran suicide or mental health data you have observed since the beginning of the COVID-19 pandemic?

VA's most recent *2021 National Veteran Suicide Prevention Annual* Report covers data from 2001 through 2019, prior to the declaration of the pandemic in March 2020. The next report, which is expected to be released this fall, should include relevant data and trends for the first year of the pandemic. Despite grim forecasts about the COVID-19 pandemic possibly creating a perfect storm for suicidal behavior, a 2021 study published in the Journal of the American Medical Association found suicidal thoughts and suicide attempts among veterans declined significantly in the first 10 months of the COVID-19 pandemic, particularly for those under age 65.[1] Over the past three years, health surveys conducted by the VFW gauged mental health by inquiring through a question following the CDC Health Days guidelines.[2] In each of those years, respondents ages 49 and younger had a higher percentage reporting more than half of the month as poor mental health days compared to respondents aged 50 and older. The Journal of the American Medical Association study and the VFW 2020-2022 health surveys yielded different results regarding the mental health of the young veteran population.

Q. How do you best recommend Congress take action to address the alarming rates of suicide for our young, post-9/11 veterans?

There are many causes of suicidal thinking, so a comprehensive approach is needed to effectively address this issue. Post 9/11 veterans separating from military service, like veterans of other eras, often find it difficult to transition from active duty back into civilian life. There are many issues that come into play, such as injuries sustained during military service; marital issues; employment issues due to employers not understanding how the hidden wounds of war can impact veterans; lack of access to mental health care; abuse of controlled drugs, and the effects of military sexual trauma. Congress must closely monitor VA's implementation of its ten-year National Strategy for Preventing Veteran Suicide (2018-2028) and ensure VA has the resources needed to ensure the plan is effective in reducing the number of veteran suicides.

Additionally, VA needs to include Veterans Benefits Administration (VBA) data in the *National Veteran Suicide Prevention Report*. The report in its current form does not capture social determinants of health, which VA's own research indicates are often better predictors of suicide or suicidal ideation. Many VBA programs like disability compensation, GI Bill, or home loan guaranty are facets of critical social determinants of health such as steady income, workforce skill attainment, and stable housing.

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[1] Prevalence and Trends in Suicidal Behavior Among US Military Veterans During the COVID-19 Pandemic

[2] Healthy Days Methods and Measures | HRQOL | CDC

Q. Are there specific ways to tailor strategies to hire more mental health providers at VA, where shortages are a real problem in many areas including my home state of Connecticut?

VA's bureaucratic hiring process poses a big challenge for the department and the persistent lack of staff has been one of the biggest barriers for veterans seeking care at VA facilities. Despite the use of relaxed hiring rules during the pandemic, the department's MISSION Act Section 505 Fiscal Year (FY) 2022 Second Quarter staffing report shows VA currently has 61,182 vacancies. At the beginning of FY 2020, there were about 49,000 openings, so the staffing problem is not improving.

The department is competing with local health care systems, which may be offering higher pay, large hiring and retention bonuses, and greater student loan paybacks. One strategy is to package all the benefits health care providers can receive while working for the VA and using this as a recruitment strategy to attract more health care providers to the department. VA needs to do a better job of showing areas where its pay and benefits are comparable with the private sector, and highlighting the advantages of working at the department, like stability of work schedules, reimbursable continuing professional education expenses, and federal retirement pensions.

VA and Congress should also explore if adding a housing allowance to the department's compensation package is feasible. Housing is typically the largest expenditure item in a household budget, and skyrocketing home prices reduced the standard of living for many providers by consuming funds otherwise available to purchase other goods and services. The department has difficulty recruiting health care professionals to high cost-of-living areas, so any assistance to this area may entice them to serve in these locations.

Q. What are your recommendations to help with the recruitment and retention of the VA's medical providers?

In addition to help with housing costs as suggested above, streamlining VA's credentialing and privileging process could go a long way toward the hiring and retention of VA medical providers. It makes no sense for a VA medical provider who is credentialed in one state and accepts a position at a VA in another state to be recredentialed to perform the same scope of work they are currently licensed to perform. This may or may not require congressional action but would help the department with its recruiting and retention efforts.

Q. How do you envision the expansion of the VA's Peer Specialist Support program to all VA Medical Centers will serve veterans?

Expanding VA's peer support program to all VA medical centers would create a stronger network of veterans trained to identify the signs of struggle among their peers. Veterans in crisis or need will relate better with veterans going through similar experiences, they'll learn effective tips on handling day-to-day challenges, and they will learn from others how to effectively communicate their experiences. Learning these strategies and being connected to another veteran or the veteran community, will ensure that fewer veterans feel isolated, and hopefully, increase their engagement with VA services.

Q. Are there existing VA peer support programs you recommend Congress prioritize expansion of or direct additional resources to?

The IBVSOs are recommending $10 million of additional funding to increase the number and quality of peer support specialists, care navigators, and doulas to assist women veterans. Peer support specialists have been very useful in helping veterans with mental health conditions, including those dealing with the aftermath of military sexual trauma, post-traumatic stress disorder, and substance-use disorders. Similarly, care navigators and doulas can provide valuable assistance to women veterans with highly complex medical conditions, such as cancer, amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), post-partum maternal care, and chronic pain management.

Q: May you share more insight about what the shortcomings of VA's infrastructure budget could have on your ability for the department to perform its duties if confirmed?

VA's infrastructure budget has been underprioritized for years. There is no current plan to reduce or eliminate the $70-80 billion in backlogged work. The IBVSOs recommend increasing the funding for all VA construction accounts until the backlog begins to decrease.

From Senator Cassidy

Q: Given your role as a VSO leader, what is your opinion on the Asset and Infrastructure Review (AIR) commission recommendations to close the Alexandria, Louisiana VA health center, and how will it impact veteran healthcare utilization and quality of care with more use in the community care network in Louisiana?

The IBVSOs supported the VA MISSION Act of 2018, which established the Asset and Infrastructure Review (AIR) process, including an independent AIR Commission. We recognize the critical importance of VA's infrastructure in ensuring veterans receive needed care and believe it has been underprioritized for years.

Over the past several years, we have testified numerous times about our concerns with the AIR process, particularly VA's market assessments, and the need for rigorous oversight. In order for it to succeed, there needed to be complete buy-in and full transparency among all stakeholders. This did not happen.

The announcement that the AIR Commission will not move forward as intended is disheartening but not unexpected. The process was flawed from the beginning, in part due to a global pandemic, and did not have the necessary support from Congress or the Administration. For these reasons and others, the IBVSOs believe the best course of action is to stand down the process rather than proceed with a half-measured attempt at a major overhaul of VA's infrastructure.

While the AIR process appears over, it shined much-needed light on the urgent need to prioritize VA facilities. This reenergized conversation cannot be allowed to crumble apart, like too many of the VA buildings this Commission was meant to address.

From Senator Hirono

Q: The Independent Budget formulated by representatives from the Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars asks for an increase in every single line item except Electronic Health Record Modernization in which you call for a reduction of $63 million. The President's budget goes even further calling for a 30%, or $742 million reduction in funding.

- ***Can you explain why this particular area is a concern for you and your fellow advocates?***
- ***Why do you feel that funding for what has been seen as a critical modernization project should be reduced?***
- ***Are there oversights or redundancy in VA's plan for EHRM that are of particular concern for PVA?***

The IB's fiscal year (FY) 2023 budget recommendation for Electronic Health Record Modernization (EHRM) was $2.6 billion, which was consistent with $2.633 billion that was appropriated for FY 2022. The minor reduction reflects our best estimate of the impact of VA's revised rollout schedule for calendar years 2022 and 2023 following its strategic review of the EHRM initiative undertaken early in 2021. At the time of the IB Budget Report's release in January 2022, there was not sufficient clarity about the level of work on EHRM in FY 2023, and as a result, the IBVSOs recommended that FY 2023 funding remain consistent with FY 2022 funding, understanding that any funding not used in FY 2023 could and should be transferred forward for use in FY 2024.

Since the release of the IB Budget Report, there have been additional reports and admissions of problems in both implementation and operation of VA's new EHR system, raising concerns about the status and outlook for this critical transition. The IBVSOs expect that Congress will continue to closely and aggressively oversee implementation of this vital technology modernization, which is critical to the delivery of safe and high-quality care to America's veterans.

From Senator Sinema

Q. The FY 23 budget includes an increase of $379 million for mental health services. How will these funds be used to both hire and retain providers, and account for the growing demand for mental health care?

Although VA is best positioned to provide this answer, we believe the Veterans Health Administration needs to ensure that these funds are used to support the hiring and retention of mental health professionals to include psychologists, social workers, licensed professional mental health counselors (LPMHC), and marriage and family therapists (MFT).

According to a March 2022 U.S. Government Accountability Office report, LPMHCs and MFTs comprised about four percent of mental health professions at VA medical facilities in fiscal year 2021, with psychologists at 45% and social workers at about 51%. While the number of psychologists and social workers employed at the VA ranges between 45 to 51%, the number of LPMHCs and MFTs has not kept pace. We believe LPMHCs and MFTs are an important part of VA's mental health team and VA needs to make a greater effort to increase the number employed by the department. VA should also be using all available incentives to hire and retain mental health providers and requesting any new hiring authorities whenever needed.

Q: The VA is also proposing to eliminate copayments for all enrolled Veterans for outpatient mental health visits. What is the best way to implement this change?

Earlier this year, VA proposed eliminating all copayments for outpatient care and medication for veterans who are determined by VA to be at high-risk of suicide, as indicated by an alert that has been placed in their electronic health record. The elimination of copayments would continue until the veteran is no longer at high risk of suicide.

Reducing access barriers to care for veterans at risk of suicide is an important element of a comprehensive approach to suicide reduction. Financial strain can be both a contributing factor to suicide and a barrier to accessing care and services that can help prevent it. As such, we support eliminating copayments to help reduce financial barriers to care for veterans at high risk of suicide.

In order for this proposal to be successful, however, veterans, their families, and friends must be aware of the policy. VA should undertake a coordinated communication campaign to reach those at highest risk with information about their enhanced access. VA may also want to consider similar, though perhaps more modest reductions of copayments to encourage veterans at elevated, but not high risk of suicide to seek care through VA.

***Q: The VA Electronic Health Record Modernization (EHRM) Program continues to create challenges, from cost and schedule overruns to cybersecurity vulnerabilities. FY 23 funds will go towards deployment readiness in multiple VISNs, including VISN 22 where most of Arizona's VA hospitals are located. What steps do you feel are necessary to ensure future roll outs avoid previously identified* issues?**

As has been well documented, the rollout of the new EHR system will only be successful if a number of critical steps are taken, most notably proper user acceptance training and supporting IT infrastructure. VA must coordinate and complete IT infrastructure upgrades, including high-speed internet connectivity and modernized hardware replacements before attempting to go-live with the new EHR. At the same time, VA must develop a more consistent and effective method of training employees on the use of, and full benefits that come from the new EHR system. One of the key findings of VA's strategic review was to rollout only to those locations that are fully prepared for the transition, rather than forging ahead on a pre-planned rollout schedule. In addition, it remains absolutely critical that Congress continue to closely and aggressively oversee implementation of this vital technology modernization.

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