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REVIEW OF THE FISCAL YEAR 2022 BUDGET AND 2023 ADVANCE APPROPRIATIONS REQUEST FOR THE DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

WEDNESDAY, JUNE 16, 2021

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REVIEW OF THE FISCAL YEAR 2022 BUDGET AND 2023 ADVANCE APPROPRIATIONS REQUESTS FOR THE DEPARTMENT OF VETERANS AFFAIRS

WEDNESDAY, JUNE 16, 2021

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

The committee met, pursuant to notice, at 3 p.m., in room 418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the committee, presiding.

Present: Tester, Murray, Brown, Hirono, Hassan, Moran, Boozman, Cassidy, Rounds, Tillis, Sullivan, and Blackburn.

OPENING STATEMENT OF CHAIRMAN TESTER

Chairman TESTER. I call this hearing to order. Good afternoon. I want to thank Secretary McDonough and my favorite Montanan, Jon Rychalski, for being here today. I appreciate you guys taking the time to take a closer look at the President's Fiscal Year 2022 budget for the Department of Veterans Affairs.

Most everyone would agree that the VA handled the COVID–19 pandemic incredibly well. We also know that the ripple effects of this pandemic is going to be felt for years to come. The VA's budget needs to account for this, and we have to do everything possible to ensure that no veteran is left behind or negatively impacted because of COVID–19.

The current proposal in front of us is the largest request we have ever seen from the VA. I am pleased to see increases in funding for suicide prevention, including the implementation of the Scott Hannon Act, and funding to help VA speed up claims decisions for veterans with one of three Agent Orange-related conditions added by Congress just last year. It is a step in the right direction.

I am also glad to see a renewed effort to address veteran homelessness in this budget request. However, the VA still has a ways to go to address deficiencies in other areas.

Just last week, VA released its quarterly staffing numbers. The Veterans Health Administration has 30,000 vacant positions, with the majority of these being medical care providers. Look, we cannot deliver on its promises to veterans if we do not have the work force to do so. This is particularly concerning given the rate the department is sending veterans into the community for care. We need to talk about the balance between in-house care and community care, and VA staffing is critical in that conversation.

Though we talk a lot about health care, we need to ensure VA's other missions are not left on the back burner. As I said during our May hearing on VA compensation and pension, I am concerned about the hundreds of thousands of backlogged VBA claims. The pandemic threw a wrench in the claims processing and the VA needs to address this backlog with the proper balance of speed and quality.

This committee, as evidenced by our unanimous passage of a framework for comprehensive toxic exposure reform will continue to work to ensure that exposed veterans have access to earned care and benefits. We need the VA's cooperation in this endeavor, and I appreciate the Secretary's efforts to provide official views on that legislation.

Finally, as we discussed in our hearing last week, VA has almost $70 billion in unmet infrastructure needs. Simply put, I do not see how the VA achieves any of its missions without the foundation of a modern, efficient, infrastructure. At the end of the day, these are all bipartisan issues, and this committee is going to address them in that fashion.

Mr. Secretary, I know that having more of your leadership team in place will help ensure VA is better delivering for veterans across the board. So hopefully folks up here will stop playing games so we can get the four pending VA nominees confirmed and on the job, working for veterans. Because, quite frankly, the last thing I want to do is bring you up here in 6 months and wring you up for something that we are the problem, not yours.

I look forward to hearing from everyone today, especially the veteran groups here representing the Independent Budget, and how we can support our nation's veterans and their families in next year's budget.

Senator Moran is not here, so I will turn to his right-hand man and say, can we go to the testimony of the good Secretary or do you want me to idle?

Senator ROUNDS. He is en route. Could you idle for 2 minutes?

Chairman TESTER. We are going to idle for 2 minutes. Rounds, you have got to have better control of Moran, I am just telling you.

[Laughter.]

[Pause.]

Chairman TESTER. So just so you guys know, we have got three votes starting at 3:15. Is that correct? Three votes starting at 3:15, so people are going to be shuffling in and out, and it is no disrespect to the VA. Schumer scheduled votes at the wrong damn time.

So that is what we will be doing, and we have got a couple of panels today. We have not only got Secretary McDonough and Jon Rychalski, Assistant Secretary for Management and Chief Financial Officer, we have another panel too, which is equally important, with the Deputy National Legislative Director of the Disabled American Veterans, that would be Shane Liermann; with the Director of National Legislative Services of Veterans of Foreign Wars, that is Patrick Murray; and with the Associate Legislative Director of Government Relations of the Paralyzed Veterans of America, that would be Roscoe Butler.

So we have got a lot of stuff to do, and here is the challenge that we have, so that everybody else knows. At 4:30 the Ranking Member has a hard stop, and quite frankly, I am supposed to have a hard stop at 4, but that is probably not going to happen. So we are where we are.

Man, I am glad we do not have to do push-ups for this 2 minutes, I am telling you.

We are going to recess briefly.

[Recess.]

Chairman TESTER. All right. We will call the meeting back to order, and we will hear from the illustrious Ranking Member, the great Senator from Kansas, Senator Jerry Moran.

OPENING STATEMENT OF SENATOR MORAN

Senator MORAN. Chairman Tester, thank you for that kind introduction, and I will be expecting something that you want from me once again, as a result. Mr. Secretary, nice to see you. I apologize. I assume that your opening statement would have been given in my absence, and I was hoping not to miss that.

Chairman TESTER. We did not do that. He is yet to go, so you are good.

Senator MORAN. Very good. Secretary McDonough, and to our VSO witnesses that will join us in our second panel, I am pleased that you are here. I am eager to hear from all of you your thoughts regarding the VA's proposed budget for the Fiscal Year 2022. These hearings, while sometimes tedious, are very important. We need, in my view, particularly at this point in time, greater transparency and an understanding of the VA's, in this case, funding sources. There have been so many things related to COVID–19 and the infrastructure plan, there are just a lot of things now that are out there for us to figure out, in my view, how it all fits together. And, of course, it is always important for this process to be as transparent as we can make it.

Mr. Secretary, you have helped in the cause today by responding to our April inquiries. I would shorten my paragraph here again to encourage you to insist the VA respond more quickly to this committee. I think that even the pre-hearing questions for today's hearing have only been answered in a small portion. And so in this effort for transparency we still need a better, quicker, more thorough response from your team.

The rest of that page is about criticizing you, and I saw you nod with me so I will assume that means that things will get better.

Turning to the budget request, the VA is seeking another record budget that has grown from roughly $200 billion in 2019, to a proposed $300 billion in 2022, when combined with the American Rescue Plan spending and proposed Jobs Plan spending. Congress has worked hard to deliver VA the funding and resources it needs, and sometimes there is a suggestion that the VA needs resources and I am for that when demonstrated. But I need to make certain that what we are providing is being responsibly spent and that you have the capability of doing so effectively and efficiently.

That budget of the Department of Veterans Affairs has grown significantly, while most budgets in the federal government, our agencies and departments, have remained pretty flat, and some

have seen reductions. That is a testament to the priority that veterans have within the larger debate on spending deficits and debt, a priority that spans administrations and whichever party happens to have the majority. But that does not alleviate our responsibility to taxpayers and veterans to make sure that every dollar requested is adequately justified.

Here is where I think I mostly need answers. The VA is asking for a 15 percent increase in medical care spending this year—15 percent increase in medical spending—which is a 63 percent increase since 2018. VHA staffing is projected to be up 17 percent since 2018 to nearly 370,000 employees, but outpatient visits are only up 5.9 percent since 2018. The average daily inpatient census is down 4.5 percent since 2018, and the number of unique veteran patients seen is only up 2.4 percent since that year.

In short, how do these many sources of funding—the base budget request, CARES, the American Rescue Plan—how do they marry up with actual caseload, actual patient care at the department?

Secretary McDonough, I am hopeful that your testimony will untangle some of these questions so we have a clear understanding of how the VA expects its workload to change and why, and I believe that if we have the full picture, based upon data and sound modeling, then together we can make certain that the VA has the tools it needs to deliver good outcomes for veterans.

Mr. Chairman, thank you for pausing to allow me to make my opening statement, and I welcome the Secretary and look forward to his testimony.

Chairman TESTER. Thank you for your words, Senator Moran. Now we will go to our first panel. Be as concise as possible, Secretary McDonough. Your entire written document will be a part of the record. You may proceed.

STATEMENT OF THE HONORABLE DENIS McDONOUGH, ACCOMPANIED BY THE HONORABLE JON RYCHALSKI, ASSISTANT SECRETARY FOR MANAGEMENT AND CHIEF FINANCIAL OFFICER

Secretary MCDONOUGH. Chairman, thanks very much. It is an honor to be here, and Ranking Member Moran, thank you very much. Let me just also acknowledge the veteran service organizations who will appear after us and our union partners, who I believe make VA stronger.

I am going to take one sentence from my prepared remarks and then just ask that the rest of them be added to the record, and then straight to questions, out of deference to your time and deference to the second panel.

Chairman TESTER. Okay.

Secretary MCDONOUGH. The most important sentence is this one. I commit to using these appropriated resources responsibly, being fully transparent with you, and getting the greatest value out of every dollar.

I will submit the rest of the statement for the record, and I look forward to your questions.

[The prepared statement of Secretary McDonough follows:]

Chairman Tester, Ranking Member Moran, distinguished Members of the committee-thank you for the opportunity to testify today in support of the President's

Fiscal Year 2022 Budget Request and fiscal year Advance Appropriation Request for VA, and for your steadfast support of Veterans. I'm accompanied today by Jon Rychalski, our Assistant Secretary for Management and Chief Financial Officer.

Let me also acknowledge the Veterans service organizations and our Union partners who make VA better and stronger.

We have some great news. First, our goal is, by the end of July, to provide more care than we did before the pandemic. I don't want to call this "reopening," because VA never closed-but I do want to make sure that we're offering in-person programs like residential mental health and substance abuse programs that are currently operating at 50 percent capacity.

We will learn and improve from our pandemic experience-to ensure we're establishing a new, improved version of what VA looks like, a VA that doesn't just go back to how we operated before COVID, but one that we've forged into a stronger department as a result of pandemic challenges.

Second, we've taken steps to reduce the backlog of claims caused by the pandemic. We ramped up scanning efforts to digitize federal records for claims processing, and temporarily assigned VA employees to the National Personnel Records Center to pull records necessary for claims processing. Now, most of VA's requests for records are answered in 2 to 3 days, and the number of pending VA-related records requests dropped by 90 percent to pre-pandemic levels.

Third, VBA rated our one millionth Veterans disability claim last week, hitting this important milestone faster than in all but 1 year in VA history-despite the challenges of COVID.

Fourth, VA has now vaccinated 3.3 million people with at least one dose-Veterans, family members, caregivers, employees, and members of other federal agencies.

Last, and most importantly, on May 24, just 3 weeks ago, there were no COVID-related deaths in any VA facility for the first time in 441 days-since March 18, 2020.

These positive outcomes are a direct result of two factors: resources, and caring, compassionate people. And as always, our efforts will ultimately be judged by the outcomes we produce for Veterans and their families. Let me tell you about one such outcome and the feedback we received from the Veteran's family.

Last month, I received an e-mail from a Veteran's daughter, Dr. Jennifer Bendiske [BEN-disc]. Jennifer's father, a Navy Veteran of Vietnam, is receiving care at the VA Medical Center in Charleston, SC., for both Parkinson's disease and stage IV non-small cell lung cancer.

She wrote:

"Everyone who my parents or I have encountered at the Medical Center, from those who work in the canteen to those who provide medical care seem to genuinely care . . . the care that has been directed toward my parents is a comfort to them, my sister, [me], and our families. In addition to the genuine concern shown by the medical staff, the treatments that have been proposed are in line with current best practices for this type and stage of disease . . . I know this because I am in clinical drug development, working toward new treatment for non-small cell lung cancer . . . I suspect that much of the feedback that you receive relates to that which is not working; I wanted to provide an example of care that meets the expectations of the Veteran and his family."

That's the kind of experience every Veteran and every family member deserves to experience at VA. And let's remember who makes that happen: VA clinicians and staff.

They are the ones who are caring for Jennifer's father.

They are the ones who have spent the pandemic risking their lives to serve the Veterans who served us.

And they are the ones who made zero COVID deaths on May 24th possible.

But those employees will also be the first to tell you that their life-saving work isn't possible without the resources they need.

That's why this budget is so important. The fiscal year budget request will ensure VA can provide care and services for Veterans, their families, caregivers, and survivors-and to other Americans, such as the 488 non-Veterans treated at VA facilities as pandemic related humanitarian admissions-including citizens from Arkansas, Arizona, and Texas, among others.

These resources will be put to good use, empowering our department to fulfill the mission that President Biden charged me with when he nominated me to lead VA: to fight like hell for our Veterans.

This budget ensures we can continue the growth and success of our Caregiver Support Program by fully integrating families and caregivers into the care plans of the Veterans they love, continuing to implement MISSION Act expansion of our Program of Comprehensive Assistance to all generations of eligible Veterans. And

this budget supports the training of over 1,900 field-based staff to improve consistency across the country and increase support of all family caregivers.

The budget provides needed funding for Women Veterans, at a time when the number of women using VA health care has more than tripled since 2001, by funding recruiting and hiring for women's health providers, improved access to reproductive health services, and emergency services.

The budget allows us to continue our success in reducing Veteran homelessness-building on the good work of the last decade, during which we decreased Veteran homelessness by 50 percent.

This budget allows us to provide strong, sustainable, and high-quality direct care to our Veterans at a time when they need it most. Community care and direct care are both important, and care in both contexts is rising, as we knew it would-Veterans are returning to care as we manage the pandemic. And while both are growing, care in the community is rising at a faster rate than direct care.

Veterans need and deserve a thriving direct care system that they can depend upon for generations to come, because it provides higher quality, evidence-based, integrated care-and is tailored for Veterans and their unique needs. Beyond that, our nation depends on the research, innovation, and medical education components of VA direct care-as well as an effective backstop to our country's health care system, VA's 4th mission, that has been critically important during the COVID pandemic.

And that's not all these budget resources will do. They will also fund mental health and suicide prevention initiatives, address major deficits in construction, physical and information technology (IT) infrastructure, continue our electronic health record (EHR) modernization, address issues of environmental exposures among generations of Veterans, and continue to ensure VA is always a place where diversity, equity, and inclusion are valued and sought.

In short, this proposed budget allows us to deliver high quality whole health care and benefits to our Veterans at a time when they need it the most. And it does so, in large part, by enabling the heroic work of great people like those who care for Jennifer Bendiske's father.

I commit to using these appropriated resources responsibly, being fully transparent with you, and getting the greatest value out of every dollar.

Mr. Chairman, Ranking Member Moran, thank you for the opportunity to appear today.

I look forward to your questions.

Chairman TESTER. Thank you, Secretary McDonough. That may be the quickest opening statement on a budget that I have ever heard in my life, but that is fine. That is good, because we will get down to the meat of it.

Secretary MCDONOUGH. I anticipate that.

Chairman TESTER. Yep. Look, we are coming out of a global pandemic, as I said in my opening statement, in which more than 600,000 Americans have lost their lives, including 12,000 veterans in the VA health care system, and likely a whole lot more than that outside the system. VA facilities were filled to the brim, forcing VA leadership to bring mobile medical units and pop-up hospitals to care for sick veterans. VA clinicians worked day-in, day-out, risking exposure to the virus, to take care of every veteran in need, as well as hundreds of non-veterans, because civilian hospitals were stretched to their breaking point.

We know the statistics related to the claims backlogs and wait times at VA facilities were negatively impacted. It was a global pandemic, after all, so that does not come as a surprised to anyone, or at least it should not.

So, Mr. Secretary, as the VA emerges out of this pandemic, can you highlight some of your efforts to address the claims backlog and VA wait times?

Secretary MCDONOUGH. Yes. Thank you very much, Chairman, and this is obviously an issue that has come up in discussions with many of you since I have come into this job. And I think it is im-

portant to highlight some collaborative efforts that we have undertaken to reduce the backlog of claims.

We have revved up significantly scanning efforts to digitize federal records for claims processing. We have temporarily assigned VBA personnel to the National Personnel Records Center in St. Louis to pull records necessary for claims processing.

Now, most of VA's requests for records are answered in two to 3 days, and the number of pending VA-related record requests at that facility have dropped by 90 percent, getting back to pre-pandemic levels.

Importantly, that is happening as we are bringing the debt backlog down. It was about 220,000 cases when I got there. It is about 180,000 cases now. The staffing enhancements that are envisioned in the President's budget request will allow us to bring it down further still, so that we get it entirely accounted for by the end of next fiscal year.

Importantly, this is all happening while we are managing existing claims, and last week VBA rated our one-millionth veteran benefit claim this year at record pace. There has only been one other year that we have rated that many cases, a million, that quickly, and by the way, we did that during the pandemic.

So we have significant investments here, Mr. Chairman, to allow us to continue that performance, and we have anticipated increases in the backlog from, for example, Blue Water Navy, coming in August. But we have a plan to account for that, and more.

Chairman TESTER. Also, can you speak to the urgency of having more of your leadership team on the job and confirmed, and what would it mean for veterans, particularly distressed veterans?

Secretary MCDONOUGH. Well, I thank you very much, Chairman, on that. We have an unbelievable team, a very effective, capable team at VA. I am very proud to be—in fact, honored to be associated with the team. That millionth claim rated as of last week is a perfect example of that. I have just had an opportunity to talk with one of your committee members. I appreciate it very much that she made time for me in that conversation.

The main thing we need is a Deputy Secretary confirmed with your imprimatur, responsive to your concerns, but also in a position to help me staff the commission to find an Under Secretary for Claims. That is supposed to meet next Monday and Tuesday. We really need him in the seat for that job, because we really need a confirmed Under Secretary for the first time in several years on this important thing, including on issues related to the backlog.

Chairman TESTER. Thank you. I will turn it over to Senator Moran.

Senator MORAN. Chairman, thank you. Mr. Secretary, I noted in my opening statement that—incidentally, your opening statement was more popular than mine—I noted in my opening statement VA spending on medical care and staffing for VHA is increasing at a much faster rate than patient visits. Some measures of VHA workload, such as the number of inpatients treated and the average daily count of inpatients is actually dropping.

If less than 5 percent of the cost increases are due to health care trends, like inflation and costlier care, then what is driving the rest of the sharp increases we are seeing?

Secretary MCDONOUGH. Yes, very fair question. I appreciate it. I want to focus on two things. One is something that we have been anticipating and we are now experiencing, which is a significant increase in the demand for care coming out of foregone care during the pandemic, something that we are seeing, incidentally, across the care, for veterans and non-veterans alike.

As an example of that, I will just tell you that from March to May of this year, in the direct care system, we had 16.5 million appointments. In the community care system we had 1.25 million appointments. Compared to the same period last year we had 9 million appointments in the direct care system, less than 700,000 in the community care system. So that is about an 80 percent increase in each—81 in the first, 79 in the second.

Part of our staffing request for this year recognizes that bow wave of care will continue into next year. So that is obviously very important.

Now next—and we have been working with your teams on this—how we calculate care is in virtual care units rather than in FTEs or rather than in people, clinicians to provide the care. And what we know about virtual care units is that our vets generally are bigger consumers of health care, have more complex cases. So individual appointments may be not the best, most comprehensive way, especially as you are thinking about cost, to calculate what we are delivering in terms of value.

And so this is something that obviously we have developed over time, through several Secretaries, in a model, by the way, that has held up pretty well, when you look back at it.

So big bow wave of care, generally more demanding patients, relatively sicker, and so that means more complex cases, which means greater cost.

Senator MORAN. Let me see—is there anything that you said that answers this question. What portion of the 2022–2023 medical care request funds are a result of increasing costs due to deferred care during the pandemic? You may have said that.

Secretary MCDONOUGH. Yes. Rather than Jon whispering it to me, why doesn't he——

Mr. RYCHALSKI. It is really a health care projection model. Due to COVID, it was about 7.9 percent is the estimate.

Senator MORAN. 7.9 percent of the increase?

Mr. RYCHALSKI. Yes. And to your point about 5 percent, 4.9 percent is attributable to intensity, inflation, reliance, and then there is another 2 percent for demographic changes, population changes.

Senator MORAN. OK. Thank you for that. Let me ask a question about community care. Your budget submission notes the department's desire to place veterans at the center of their own care. It also prioritizes a rebalance of direct and community care. I do not know if the department told us in detail what a rebalance would entail in this budget submission. What specific factors and data is the department taking into consideration for a rebalance, and how does this influence your budget and advanced appropriation request?

Secretary MCDONOUGH. Great. Thanks very much for that. I think the numbers are roughly about—we anticipate about $25 to $26 billion in community care in this coming year, and in the ad-

vanced appropriation we are asking for, it is slightly over $24 billion. The first and most important thing is we are trying to understand precisely what the vets want, right. If we are going to put them at the center of their care, the way we do that is we ask them. So the Veterans Experience Office is out in the field with a very aggressive effort to understand from them what it is that they want, specifically what have we learned from the experience of the pandemic, where vets have demonstrated a much greater intensity and interest in, for example, video and telehealth than I would have anticipated, and then any conventional model had been anticipated heretofore.

The second thing relates to making sure that we recognize vets in our care do better in terms of outcomes. And I have committed to you that everything I decide here will be decided on access and outcomes. And so one of the things we know about outcomes is the fact that we have integrated care with the full range of specialties that vets have come to rely on, particularly given their particular challenges of care. One of the things I will be looking at very closely, Senator, is our ability over time, understanding that we will be under budget pressure and we will not see these kinds of record budgets, is maintaining the system and its integrated nature with the full range of specialties that our veterans demand.

And so one of the indicators that you see in our budget is making sure that we can recruit and keep specialists in the system, so we can address those in-house, rather than being at the risk of weakening that if we become over-reliant on the community.

Senator MORAN. I will have a couple of followup questions if I have the chance later. Otherwise, I will submit them to you in writing and we can have a conversation.

I am going to go vote, so Senator Tester can go vote.

SENATOR MARGARET WOOD HASSAN

Chairman TESTER. Senator Hassan?

Senator HASSAN. Well, thank you, Mr. Chair and Ranking Member Moran, and thank you Secretary McDonough and all of our other witnesses for testifying today. Mr. Secretary, I was not on the committee yet when you were confirmed so this is my first hearing where you are appearing. I am really looking forward to working with you to help veterans across the country and in New Hampshire get the benefits they earned and deserve.

New Hampshire is one of three states, along with Alaska and Hawaii, that lacks a full-service VA hospital, something am working to change. As my colleagues have pointed out, the VA's budget is insufficient to meet the agency's dire infrastructure needs.

In your prepared testimony you noted that the President's proposed funding in the American Jobs Plan for VA infrastructure—and that is something I strongly support as well—but we need to make sure that VA funding that goes toward infrastructure adequately addressed the need of Granite state veterans.

So does the agency take into account the lack of full-service VA hospitals in certain states when developing your budget plan and priorities?

Secretary MCDONOUGH. We do.

Senator HASSAN. That is helpful to know, and I would love to continue to work with you to make sure that, especially as we deal with the needs for community care and improved infrastructure at the resources we do have in New Hampshire, that they are attended to.

Secretary MCDONOUGH. You can count on that.

Senator HASSAN. Thank you. The National Cemetery Administration has made increased access to burial benefits a strategic goal. This includes providing additional grant funding to state and tribal organizations. Unfortunately, as a condition of receiving VA money for improvements, state veteran cemeteries are barred from interring many National Guard members and reservists. Today I joined Senator Shaheen, Cramer, and Hoeven in introducing a bipartisan, bicameral bill that addresses this issue.

So Secretary, will you and your team consider this bill and provide us with feedback, and will you work with my office to increase access to burial benefits, including for National Guard members and reservists? It is a matter just incredibly important to Granite state veterans.

Secretary MCDONOUGH. Yes, I will say three things about this. I do not want to eat up your time. One is the budget request in the President's budget for this year continues a strategic expansion of our cemetery footprint to ensure that everybody has access. I am very proud of that service. I think this is really an important investment.

Second is it came to my attention very early in my tenure here that we have a discrepancy whereby New Hampshire has asked for one way to use its state grant from us for its cemetery. It is inconsistent with current reg.

Senator HASSAN. Right.

Chairman TESTER. But there is North Dakota, who is currently using VA-provided funding in that same way.

We have gone out with a Request for Information to the field, to all 50 states, to say hey, how should we do this.

Senator HASSAN. Okay.

Secretary MCDONOUGH. Then we will have a conversation with you about it. In all cases, I will look at your bill.

Senator HASSAN. Well, I appreciate that very much and I know Granite state veterans would too.

Last question. In this year's budget, the Veterans Benefits Administration lists two organizational priorities: benefits delivery and suicide prevention. The veteran suicide rate is highest among those 18 to 34 years old. This age group also accounts for 75 percent of transitioning servicemembers.

You and I have discussed the Solid Start program, an initiative that aims to contact every veteran multiple times by phone in the first year after they leave active duty, to check in and help connect them to VA programs and benefits. I have a bipartisan bill with Senators Cramer and Cassidy to strengthen and make permanent this important program, which the committee will consider further, I hope during our legislative hearing next week.

Secretary McDonough, can you please speak to how the Solid Start program aligns with the Veterans Benefits Administration's

priorities, and will you work with us to support and build on this program?

Secretary MCDONOUGH. So often the benefits package is the introduction to VA service for our vets, and we want to make sure that the introduction is not only professional, transparent, based on the customer service, and a positive experience, but that it also opens the door to the full range of services we have. So being in touch with our vets, including about introducing them to all of our services, including, when necessary, mental health services, is really important, and it is consistent with what we are doing through our program called REACH VET, which is a fundamental tenet of our suicide prevention programming.

Senator HASSAN. Well, thank you. I would love to continue to work on this and the Solid Start program with you. What I am hearing from veterans is just there is so much transition going on in that first period after they leave active service that they could really use that kind of steady outreach, and it may take multiple attempts. And I think it really benefits all our veterans and the country. So thank you.

Secretary MCDONOUGH. Might be a good way for us to get more enrollees too.

Senator HASSAN. Yes. Yes. Thank you. Thank you, Mr. Chair.

Chairman TESTER. Senator Boozman?

SENATOR JOHN BOOZMAN

Senator BOOZMAN. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for being here. I want to be quick because Senator Tillis and I have to go vote. That is the only thing we have got to do around here.

But I appreciate your transparency and I appreciate your willingness to work with us. We had a good talk about Chairman Tester's Cost of War Act, again going further so we can get good information. We are all really interested in doing that and get some really good legislation passed.

The Senator mentioned suicide, and I am pleased that the John Scott Hannon bill, you know, we got that done and we are starting to implement that. Can you briefly discuss how the program is progressing? Do you have any more updates, particularly about the effort with the grant program? Everything tells us once they get in the VA they are going to do better than being on the outside.

Secretary MCDONOUGH. Yes, we have had an extended conversation, now going back a couple of months, on this. Obviously the Hannon Act, as a general matter, offers us a lot of new, additional, very helpful authorities. One in particular is the Sergeant Fox—I think the Sergeant Fox Grant Act. We have been in the field now, seeking public comment on that. We want ideas from the actual service providers we want to fund.

We are aggregating that. We are now in a position that we will be able to invite competition for grants come next spring, and we believe that will be in the field with the funding by next fall. I am thinking October-ish. The President's budget anticipates that. The funding for that program is in the President's budget. It is part of the increase in funding for suicide prevention that the Chairman

talked about in his opening comments, and we think it is really important.

Senator BOOZMAN. Good. I have got an additional question I will put in the record concerning the medical records, you know, the process there.

Thank you, Mr. Chairman.

Chairman TESTER. Thank you, Senator Boozman. Senator Tillis?

SENATOR THOM TILLIS

Senator TILLIS. Thank you, Mr. Chairman, and thank you, Senator Boozman. Secretary McDonough, it is good to see you.

I want to go back. You know, we had the recent addition of three new diseases for the Agent Orange presumptive list, and that could be another potential bow wave if you have seen how the VA has dealt with this in the past. I do not think they were quite prepared for the influx of claims, not under your watch but under a prior administration. Now we have the TEAM Act, and the Cost of War Act, which is far more expansive than that, potentially.

To this point we have not received from the department a position on either the Cost of War Act or the TEAM Act. The puzzle pieces that we have had, had them refer to the legislation that came together under the Cost of War Act.

At some point we are going to need definitive stance on whether or not the legislation is workable and whether or not a budget request would take into account something that is likely, I believe, going to pass out of the Senate and potentially enjoy support on the House side.

So I think I can make an assumption that your current budget request does not in any way account for that additional influx of claims?

Secretary MCDONOUGH. That is correct. So we have several lines of effort going at the moment. You mentioned the three Agent Orange claims. We have just started those presumptive claims. We announced, ourselves, the initiation of rulemaking on three conditions that may be included, related to service in Iraq, Afghanistan, and Uzbekistan. We are continuing to work that.

Our budget anticipates the Agent Orange pieces. Anything beyond that it does not yet anticipate, because I think those would be outside this fiscal year. But you have my commitment, as I have given the Chairman, as I have given Senator Blackburn, as I have given Senator Moran, and I have testified in the House, that we owe you—entirely fair question—we owe you what our estimates are for cost, discretionary, mandatory, what we believe will be required in terms of people, and what we believe will happen as it relates to the backlog.

We are trying to get that accurately, you know, under the theory, you want it bad, you get it bad. I want it good, and I want to be able to stand by it. So I have said we can get that to you while you are still in session, in this summer. If I give it to you now it just would not be accurate, and I do not want to give you something I cannot stand by.

Senator TILLIS. Yes, we need that as quickly as possible, and I think some of your internal reviews on how you may be able to provide a solution to the problem under the current authorities.

I also wanted to talk about your $2.7 billion for the VA health record account and $4.8 billion in total services for the Office of Information Technology. This represents about, I think, a $100 million cut under the 2021 appropriation for OI&T. So I am trying to understand, as you grow, as you add resources there is typically an operational tell for information technology and support. What assumptions did you make to justify the $100 million reduction?

Secretary MCDONOUGH. Yes, so I am going to let Jon do that, but the first thing I want to say is just on EHRM, generally. We have really appreciated your scratching in on that with us. I will be in a position before the end of this month to submit a series of reports to you all. We will talk with our VSO partners, with our staff about that, with our agency staff about that, and with you all. But we know we are on the hook to provide that, and I think we are going to be in a good position to do it. But in terms of the OI&T budget, Jon can talk about the assumptions.

Mr. RYCHALSKI. Sir, that $4.8 billion is part of our budget request, but we also have access to the transformational fund starting in 2022, which is access to our expiring appropriations that we can use for two purposes. One is for IT and one is for physical infrastructure. And so we are going to use about, I think, $600-andsome million of that transformation fund for IT, and that will bring the total funding to about $5.3, $5.4, which is about a 13 percent increase.

Senator TILLIS. So it is only a category cut——

Mr. RYCHALSKI. Source of funding. You do not see that in the budget, or in that table, yes.

Senator TILLIS. Very good. I am going to submit a question for the record about dental health services down in the VA facility. We are building it. We are standing up additional facilities, but I think there is a need down there, with the growing population, that may easily tap the additional facility that you all have in mind, but I will submit a question for the record on that. And I look forward to getting with you all on the progress of the program office for the HR. Thank you, Mr. Chair.

Chairman TESTER. Thank you, Senator Tillis. Senator Murray?

SENATOR PATTY MURRAY

Senator MURRAY. Thank you so much, Secretary McDonough. Good to see you here. Thank you for being with us today. You know, since the implementation of the expanded Caregiver Program last October, VA has reported receiving more than 81,000 applications for the Caregiver Program, and unfortunately VA denied many of these applications because of the activities of daily living requirement and the 70 percent service connection requirement.

Chairman Tester and I actually wrote to you in May about our concerns about how the program is being implemented. It is so critical for so many of our families. It is essential that veterans receive accurate decisions and do not experience delays in approval determinations.

So I wanted to ask you today, what is the VA doing to implement the Caregiver Program, as Congress intended, including addressing these restrictive regulations? And also, what is the VA doing to respond to the Beaudette court decision?

Secretary MCDONOUGH. Yes. Thanks so much. Let me talk about the Beaudette case first. We have submitted paperwork for an appeal of that to the next level court inside the Vet's Court of Appeals. We are working that. We are in direct touch with the litigants on the other side, to make sure that if there is something that we can do to work this out toward shared objectives that we do this, that we do not necessarily need to take an adversarial posture on this.

Second, I do think it is a fair critique that perhaps some of these regulations have been overly restrictive and some of the decisions to date have been insufficiently explained to our applicants. That is why you see what you see in the President's budget request for the year going forward, to allow us not only to be prepared to implement the full expansion of the program at the end of next Fiscal Year but that we are in a position to also adequately staff across the country with 1,900 additional staff offices to address these concerns forthrightly with our vets and their caregivers.

So this is a major priority for the President, as you know. I cannot tell you that we will resolve every question exactly, precisely, but I can tell you that it is a major priority, and the budget gives us some additional resources to make that the case.

Senator MURRAY. Okay. I look forward to working with you to get that. This is just a huge priority for me. It has been for a long time. These families have been waiting, and it is just absolutely critical to them.

Secretary MCDONOUGH. Absolutely.

Senator MURRAY. You know, as VA has transitioned to the Community Care Network, my office has helped a lot of veterans as they adjust to this new system, and as clinics close in some locations and open in new ones across the state. In addition, the President's budget request includes funding for the Asset and Infrastructure Review Commission to review VA's recommendations in realigning the VHA facilities.

How will VA take into account the challenges veterans face in navigating the new Community Care Network as well as existing geographical challenges that rural veterans face when making recommendations about the realignment?

Secretary MCDONOUGH. You know, Access for our rural vets is a fundamental priority of the President. It also happens to be a fundamental priority of this committee, and I have been able to spend some time in your state and Senator Tester's state and Senator Moran's state, exploring exactly these questions.

We do believe that Community Care is a key portion of that, but we also, as I said in response to Senator Moran's questions, want to make sure that we sustain the integrated and full-service nature of the VA system itself. If you look at now as that relates to the AIR Commission, if you look at the criteria on which we will make our decisions about infrastructure in that commission, we published it in the federal register about two and a half weeks ago, we put at the heart of that these questions of the integrated care system and the multiple roles that the VA plays, from education to training to research and to the provision of service across the entire country, to inform those decisionmaking opportunities that we will have in that commission.

So my commitment to this committee is that we will handle all these decisions very publicly, very transparently, including, if necessary, an open session with you, to make sure that you understand the basis for our decisions and that we are able to get your feedback on them. It does not make any sense to me for us to conduct this review on such a critical issue behind closed doors. So that is my commitment to you, and I think you should be able to see that becoming evident in the next months on this.

Senator MURRAY. Okay. Thank you very much. I appreciate it.

Senator BROWN. [Presiding.] Senator Rounds is recognized.

SENATOR MIKE ROUNDS

Senator ROUNDS. Thank you, Mr. Chairman. Gentlemen, first of all, thank you for your service and thanks for appearing here before the committee today.

Mr. Secretary, thank you for the phone call a couple of weeks ago with regard to housing, veterans' housing. I think it is something that we can work on together——

Secretary MCDONOUGH. I agree.

Senator ROUNDS [continuing]. and make some substantial improvements on. So I appreciate your attention to that.

In addition, I will just share with you that I recognize that we have got veterans and we are making more veterans, and we have needed to. And as we do that, we owe them the commitment that we are going to honor our pledge to them with regard to the benefits that they have earned. And I know that there is a cost involved in that.

I appreciate the comments that you made with regard to where the increases have been going and why they are there today. I look forward to working with you in the future. I just want to make sure that the resources that we put in, whatever they may need to do the appropriate job, that they are doing it in as efficient a way as possible but also one which clearly has that veteran first at heart. And I think you feel the same way that I do on that.

I would also like to come back in on an item that is of real interest to me on a personal note, is the Hot Springs VA campus.

Secretary MCDONOUGH. Yes.

Senator ROUNDS. As you know, that particular campus, located in Hot Springs, South Dakota, is a critical part of the department's Black Hills Health Care System. Last October, former Secretary Wilkie rescinded a record of decision on the future of the campus, which provides vital health care services, not only to South Dakotans but residents of four other states. That record of decision would have significantly reduced the Hot Springs campus, and I am very happy that he worked with us to have it rescinded.

In your confirmation hearing you recommitted to working closely on addressing the needs of the Hot Springs VA Medical Center. Has the department developed a long-term plan to modernize and expand this facility?

Secretary MCDONOUGH. If the department has, Senator, candidly, I am not aware of it, but we are in the process, in the context of our infrastructure review and the context of the AIR Commission, and in the context of the annual budget process, continually looking at those questions. Included in this, and this is probably

something I think you or your team would want to dig into, we have been conducting what we call market assessments pursuant to the Asset and Infrastructure Review Commission. My guess is that those market assessments speak a little bit to demand in that region in South Dakota, obviously, including, as you said, Nebraska and the other bordering states.

So no specific plans that I am aware of, but my commitment to you remains, which is that as we do that, my commitment is to work with you closely on it.

Senator ROUNDS. I understand that you are just getting on the ground and rowing through it, and that is what I would ask of you, sir, is that as you move forward in this that we not lose sight of the fact that you have got an absolutely beautiful facility, and you have got one that serves the needs of a large number of vets in a very rural area, and you have a community that clearly wants to continue to provide that service. So I would just ask that you keep us in the loop, and we will make contact and arrange for direct contact continuing in the future.

Secretary MCDONOUGH. You can count on that.

Senator ROUNDS. Thank you.

Secretary MCDONOUGH. Thank you, Senator.

Senator ROUNDS. Thank you, Mr. Chairman.

Senator MORAN. [Presiding.] Senator Rounds, thank you. Senator Brown?

SENATOR SHERROD BROWN

Senator BROWN. Thanks, Ranking Member Moran, and Secretary, nice to see you again. Our committee has made great strides getting veterans and their families vaccinated, making sure that homeless vets and veterans at risk of becoming homeless have additional resources through the ARP. Thank you for your efforts there. The $18 billion in VA funding to improve and modernize VA infrastructure, all of that is really important and it will help improve veterans' access to care, as you point out, and as I know Chairman Tester mentions over and over, getting the care where they want to receive it, that is at the VA, where most veterans want to go.

When Senators Tester, Reed, and I raised concerns about the proposed rule for military borrowers, coming out of the last days of the last administration, you took action to ensure that veterans and servicemembers who struggled had the opportunity to get back on track with their payments and remain in their homes. Thank you for doing that. That was essential.

I also encourage you to keep working with the CFPB's Office of Servicemember Affairs, which plays a critical role advocating for military customers, consumers, if you would be willing to continue to do that.

Secretary MCDONOUGH. You can count on that.

Senator BROWN. Thank you. At last week's hearing, Senator Murray raised whether VA has a comprehensive plan to assess long-term care needs for veterans, whether it be at CLCs or state veterans homes or through home-based care options. Senator Murray and I will be following up with you on that topic, because in-

vesting in veterans' care is so important. I hope you will work with us to make sure VA has the right strategy and resources.

Secretary MCDONOUGH. We will.

Senator BROWN. I know you are thinking about that. Thank you.

Secretary MCDONOUGH. Yes.

Senator BROWN. We recently received a troubling OIG report about Chillicothe in southern Ohio, its facility. It lacks specific physical infrastructure to ensure veterans' physical well-being. That veteran should not have been admitted because, as the report stated, the patient's overall needs did not align with the services and capabilities available in the CLC. The veteran later died, as I think you know. You are aware of that report?

Secretary MCDONOUGH. I am.

Senator BROWN. Okay. Thank you. I hope that VHA leaders review and implement OIG recommendations uniformly across VA's health system to ensure that all veterans at VA remain safe. My question, Mr. Secretary, has VA looked at its CLC facilities to see whether additional security features, like sure outdoor areas, two-door entry systems, might be appropriate to maintain patient safety? If so, could the American Jobs Plan infrastructure funding go toward those projects?

Secretary MCDONOUGH. We are constantly reviewing the CLCs and, in particular, we have taken a deep look at performance in the CLCs during the pandemic, and have been able to apply those lessons learned in privately held facilities and state-run facilities, so I am proud of that.

I will be very candid with you. I do not know whether we have looked at the specific security upgrades you have talked about, but I will find that out.

Then as it relates to the infrastructure money anticipated in the Jobs Plan, of the $18 billion, $3 billion would be set aside for immediate needs. We have a list of those now. I will make sure that we have anticipated any specific security needs for that, and will come back to you on that. The other $15 billion would be dedicated to the kinds of investments that, you know, are pretty evident across the system, and we would be more than happy to talk to you about that in additional detail. But on the specific questions around security upgrades, I do not have that with me. I have not looked into that, and I will.

Senator BROWN. Okay, if you would. Thank you.

Mr. Secretary, last, we know the VA has a huge compensation and pension claims backlog, and exam backlog too. You have publicly discussed the VA using a mix of telehealth and in-person exams at the VA and with contract and medical examiners.

Secretary MCDONOUGH. Yes.

Senator BROWN. I know that you raised this when Senator Tester asked. Please keep us updated, because Ohio veterans raise that issue frequently with me.

Secretary MCDONOUGH. And they are right to, and they are right to expect a fair call on that, and we are trying to turn up the volume on each of those channels, and we want to do it in a way where vets feel like they get a fair shake, and that is what we will intend to do. And, by the way, we have cranked up, thanks to interventions from many of you on this committee, the provision of

C&P exams in the VHA system itself, from our providers. Now that comes at a cost to other services we provide, but we think it important, and Dr. Stone has been a great partner on this.

Senator BROWN. Thank you, Mr. Secretary.

Chairman TESTER. [Presiding.] Senator Moran, you have an important question.

Senator MORAN. Mr. Secretary, or Secretary Rychalski, I want to go back to what is driving increased requests for funding. In the budget document it talks about health care trends as the component that drives 5 percent of the increase, and I assume that is increased demand and inflation. And yet we are at a 15 percent increase. So what is the other 10 percent? Am I missing something here?

Mr. RYCHALSKI. So year to year, the greatest increase for us in health care, and I think in the commercial and Medicare/Medicaid is, it is not the number of appointments. It is the inflation, but also intensity, and I guess the best way to describe intensity is the replacement of one treatment modality with a more expensive, like Hep C treatment or Alzheimer's treatment. And then there is the demographic changes, the population changes, more people come into the system. Their reliance is a big thing for us, how much people rely on the system. Historically, people have relied on the VA for about 30 percent of their health care. That is increasing. And then in our 2022 budget, there is the COVID impact, which is about 7.9 percent, and if you look in our budget and brief book, it breaks out those categories of the things that are major contributors to the 2022 budget request.

Senator MORAN. I think I understand that, and one of my takeaways from that answer is that when I look at increasing number of patients seen, that is an inadequate determiner of the necessary funding for their care.

Mr. RYCHALSKI. Right. The number of patients seen is not—you know, our patients, our actuary had determined that our patients are about 30 percent, I don't want to say sicker, but have more serious conditions, about 30 percent, and that is going to be exacerbated by COVID. And so they tend to cost more. An emergency room visit costs more than, say, you know, a nurse practitioner visit.

That is something else that we are seeing, is a lot of patients, our emergency room visits are sort of off the charts, so to speak. People are accessing emergency rooms at a rate that we have just not seen before. So it is things like that.

Senator MORAN. Did the urgent care clinics diminish emergency——

Mr. RYCHALSKI. No. They increased dramatically, and emergency room visits increased, doubled, dramatically.

Senator MORAN. OK. Thank you both.

Mr. RYCHALSKI. It is hard to know yet whether that is a fleeting thing, inasmuch as this is a tenet of the return to care, but we are very focused on it. I am quite concerned about it. The cost implications are significant. We have been talking to your teams and the appropriators, just in full candor, about whether we have the money to make it through this year, so we would continue to talk

to you about that in terms of Community Care funding. So we will keep a very open line on that.

Senator MORAN. I think absent COVID, Mr. Secretary, with the increasing use of urgent care at the VA, I think I would expect a reduction in emergency room.

Mr. RYCHALSKI. You would think, and there are some of these trends that, on one level, are illogical. But, you know, the question is how much of the logic gets thrown out because of the pandemic.

Senator MORAN. Thank you very much. Thank you, Chairman.

Chairman TESTER. Thank you, Senator Moran. Thanks to both of you for being here today. I wish there could have been more of a grilling, but the votes kind of screwed that up.

Secretary MCDONOUGH. We are not that disappointed.

Chairman TESTER. I bet you are not. That is good, but thank you, guys.

Secretary MCDONOUGH. We are comfortable with the level of grilling.

Chairman TESTER. It will come later, okay, so thank you both for being here.

Now while we get the panel set up, we are going to hear from three veteran service organizations who wrote this year's Independent Budget. I have said many times, and I believe this, that Congress needs to take its cues from veterans, and I am looking forward to hearing the veteran service organizations' views on this year's budget proposal.

I want to introduce three people I guess should be just made part of the committee because they are here every committee meeting: Shane Liermann, Deputy National Legislative Director for DAV, the Disabled American Veterans; Patrick Murray, Director of National Legislative Service at the Veterans of Foreign Wars; and last but not least, Roscoe Butler, Associate Legislative Director for Paralyzed Veterans of America. These guys all know how important the VA is for health care, housing, and others, and we look forward to your words. Mr. Liermann, you may start.

STATEMENT OF SHANE LIERMANN, PATRICK MURRAY AND ROSCOE BUTLER

Mr. LIERMANN. Thank you. Chairman Tester, Ranking Member Moran, and members of the committee, thank you for inviting the Independent Budget veteran service organizations—DAV, PVA, and VFW—to testify on VA's budget request.

For more than 30 years, the IBVSOs have presented comprehensive budget and policy recommendations to ensure that VA is properly funded. Earlier this year, in February, we released the IB budget recommendations for Fiscal Year 2022 and Fiscal Year 2023 advanced appropriations, which detailed our best estimates at the time, and we ask that the full IB report be made part of the record.

On behalf of my colleagues from PVA and the VFW, I am pleased to offer our highlights of the main IB budget recommendations and comment on the administration's request for VA funding.

Mr. Chairman, overall the administration's proposed budget for Fiscal Year 2022, when combined with appropriated funding from the American Rescue Plan, available funding from VA's transformational fund, and proposed funding from the American Jobs

Plan, would fully fund veterans' programs, benefits, and services for the first time in a generation. We commend the administration for this historic VA budget request, and now we call on this committee and Congress to ensure VA and veterans receive what they need and deserve.

Mr. Chairman, for VA medical care the IB recommended a total of $81.5 billion for Fiscal Year 2022. By comparison, the administration has requested $78.1 billion in new appropriations. However, VA will also have an additional $12.5 billion for medical care from the American Rescue Plan that was enacted in March.

The administration also requested a significant increase for medical community care, plus $2 billion from the AARP. We would note that the primary reason for community care increases continues to be inadequate access to VA health care due to a lack of treatment space and health care providers. For this reason, the IBVSOs recommended filling at least 25 percent of pending VHA vacancies, and we are very pleased that the VA's budget request proposes 17,000 new FTEs for VHA.

With more than half the veterans population over age 65, we recommended an additional $335 million to expand VA's long-term care programs. We also recommend that VA be provided sufficient funding to accelerate the Phase 2 expansion of VA's Caregiver Program.

To ensure that VA has adequate IT capabilities, the IVBSOs recommended $5.2 billion to sustain all of VA's critical IT programs for VHA, VBA, and NCA. Within that IT budget, the IBVSOs call on VA to fund some specific needs, to include $42 million to support VA research programs, $175 million to begin funding a portion of VBA's most critical pending IT projects, and $25 million for the Board to modernize its Case Flow program and AI needs.

Mr. Chairman, the COVID–19 pandemic not only delayed VA health care for millions of veterans, it also created backlogs in the delivery of benefits by VBA and the Board. In February 2020, there were approximately 70,000 benefits claims at VBA pending over 125 days. At the end of May of this year, there were more than twice that, almost 190,000 backlogged claims. There are also over 90,000 pending hearing requests with the Board, an increase of 15,000 pending hearings from a year ago.

In order to address these backlogs, IBVSOs called for significant budget and FTE increases. We note that the administration proposed an additional 429 FTEs for VBA, whereas the IBVSOs recommended more than twice that amount to address the claims backlog, expand VA's call center capabilities, and address a growing volume of FOIA requests. The IBVSOs also recommended an additional 200 FTEs to address the hearing backlog, whereas the administration has requested roughly three-quarters that amount.

Mr. Chairman, VA could not provide timely, quality care to enrolled veterans without having adequate and modern health care facilities. For Fiscal Year 2022, the IBVSOs recommended a total of $2.8 billion for major construction, which included $1 billion for seismic deficiencies. Although the administration requested just $1.6 billion, it has also proposed that VA receive $15 billion for VA hospital construction as part of its infrastructure proposal in the American Jobs Plan. More importantly, the IBVSOs recommend

that VA significantly increase its internal capacity to plan and manage infrastructure and construction projects by hiring additional personnel.

As we await the recommendations of the upcoming AIR Commission, Congress and VA must not wait to conduct critical maintenance upgrades and modernizations and new construction of already necessary facilities. While the AIR process will inform the future of VA's health care infrastructure, there is already a $60-plus billion backlog that represents VA's needs right now.

Finally, Mr. Chairman, the IBVSOs remain grateful for the continued bipartisanship support of VA and veterans programs by successive congresses and administrations of both parties. Like all of you, we are committed to ensuring that precious federal resources provided to VA for veterans care, benefits, and services are effectively and efficiently used, and that waste, fraud, and abuse are minimized. However, we must never forget that providing those who served with the health care and benefits they have earned is a part of the cost of our national defense.

As Congress looks to expand benefits for veterans, including those exposed to burn pits and toxic substances, we must never ask veterans themselves to pay for these benefits by cutting veterans programs and services. And for those who would look at the size of VA's budget request and ask, "When will VA be adequately funded?" our answer is clear: when all enrolled veterans have timely access to quality care and all earned benefits are delivered accurately and on time.

Mr. Chairman, we are confident that with the continued bipartisan work of this committee and Congress, we can achieve that goal for all the men and women who served.

This includes the IB testimony on VA's budget. My colleagues and I look forward to any questions you and the committee may have.

Chairman TESTER. Thank you, Mr. Liermann. I have been informed that you did most of the talking and the others will answer all the questions. Is that true?

Mr. LIERMANN. That is right.

Chairman TESTER. Okay. All right. We will start then.

You spoke about this, Shane, in your remarks. Last week we had a hearing on what the VA needs to ensure its infrastructure is ready to support the veterans for years to come. One key component of this is construction. As the Independent Budget notes, VA has multiple sites that lack the funding to complete projects that are underway. The administration is requesting $1.6 billion for major construction. The Independent Budget estimates the need at $2.8 billion. You already pointed out that if we are able to get the infrastructure bill there is another $15 billion there, which would be incredibly significant.

Can you all speak to why you think this account needs more funding, and what it means in terms of service that the VA provides to your members? I would just say this. I am part of the bipartisan team that is doing the negotiations on the $587 billion package. The VA is not in that, OK. So tell me, using the potential infrastructure money, with and without, what the challenges are.

Mr. LIERMANN. Mr. Chairman, thank you for bringing that up. Last week in the hearing, Kaiser mentioned that they go off about 3 percent operating costs. Three percent for VA would put them somewhere, anywhere from last year, this year, the upcoming year, anywhere from $6 to $8 billion. That would probably take care of VA's infrastructure needs.

Currently they cannot do that work, though. They need more people to do the work. We talk about vacancies in VHA, the 30,000 mostly doctors and nurses. That is also critical. But we need the buildings to do that. We need to not only fill the vacancies that are there for the construction jobs—the project managers, the engineers—we need to expand that cap as well. So we think that adding additional personnel to do that would help.

Also a plan to actually knock down the backlog. The Secretary mentioned there were records and claims backlogs that are being addressed by adding VBA personnel, by adding staffing to take care of that. There is no plan to even meet the current backlog, never mind actually start to diminish it. So we think a plan to knock that down, a 10-year projection, whatever it might be, that is something critical in order to address infrastructure.

Chairman TESTER. Okay. So just to be clear, when you say if they build the construction they do not have the manpower, that is not necessary to build the physical infrastructure. That is to actually man the physical infrastructure once it is built.

Mr. LIERMANN. No, it is to actually execute the contracts, specifically like NRM contracts. There are billions of dollars, about $22 billion worth of maintenance needed. If we gave them $22 billion in a year, they would not be able to execute that workload.

Chairman TESTER. I got you.

Mr. LIERMANN. So that is the manpower that we need to actually execute the contracts, and oversee them as well.

Chairman TESTER. That is helpful because I read it a different direction, so thank you.

Let's talk about mental health for a second. The department's request fully funds the Hannon Act, as has been pointed out by several on this panel today on this rostrum, to the previous panel. This is an important step for getting high-quality mental health out to all veterans who need it, and we all know that COVID–19 has not helped the mental health status. But we know that staffing plays a major role in ensuring veterans have the mental health that they need, and make sure their needs are met.

Are there any staffing-related challenges that your members are facing, and how would you suggest that the VA addresses them, or better yet, how would you suggest that we address the challenges so the VA can address them?

Mr. MURRAY. Chairman, it is essential that VA implement the authorities that you have given them, the John Hannon Act, and so forth, and fully ensure that all the things that are in place are implemented, and veterans can receive the mental health services that they deserve. Right now, as you know, with the staffing challenges, a lot of the staffing challenges are clinical service-wise, and when you have those types of challenges, it creates burnout amongst the staff that are there doing the work.

So VA needs to ensure that they have a sufficient staffing plan that they can share with you, to demonstrate how they are going to decrease the staffing shortages, but also ensure that the authorities that you have given them to help offset some of the services being provided in-house can also be provided through the other means made available to them.

Chairman TESTER. Thank you. Senator Moran?

Senator MORAN. Chairman, thank you. Gentlemen, thank you very much.

The VA's budget for 2022 proposes spending from all sources for medical care that is $17.5 billion more than the IB's recommendation. That is a 17 percent difference. Where does that come from?

Mr. MURRAY. Frankly, Senator, as the Secretary mentioned, COVID. There are a lot of details that we do not have as accurate information as the department does. But our recommendations come off of trends, come off of what we have seen, basically appointments, as was also discussed, appointments is not the most accurate way when you are talking about the complexity of the appointments. So that is some of the difference there, that we are basing ours off of appointments, which I am sure we would love to see more about their information. But that is the difference.

Senator MORAN. Okay. Thank you.

Mr. BUTLER. Let me also add, VA released their budget—I mean, the IB released their budget in February. As Shane was saying, or Patrick was saying, Mr. Murray was saying, is that, you know, VA recently released their budget, and so additional information was made available to them that we did not have at the time that we released our budget. But our assessment was an independent assessment of, at that time, what we felt was the need.

Senator MORAN. Thank you both. The Independent Budget's estimate for community care assumes that the existing access standards remain in place. I did not say it quite right. Is that true? So you are estimating the need, the dollars necessary for community care, we have community care standard in place. I assume that your estimate would be based upon those community care standards staying in place as they are.

Mr. MURRAY. Yes, sir, until the next period to review them would be, yes.

Senator MORAN. Okay. Thank you. You noted, in your testimony, the importance of a couple of economic programs that I consider important and have championed, such as the Veteran Rapid Retraining Program and then the VET TEC Act. Do you have any suggestion for how we make certain we have the right kind of data for these programs that would tell us how we can improve employability and mitigate loss of earnings, particularly for disabled veterans, going forward?

Mr. MURRAY. Absolutely. Thank you for bringing those up. The VET TEC Program, we have seen great successes in so far. It is a newer program, and increasing the capacity, the number of slots available we think is very important. It originally started at about 15,000, doubled, now it is to 45,000. There is a bill to increase it to about 125,000. The demand is there. There are a lot of people looking to go back to work through that program.

The Veteran Rapid Retraining Program, some of the last numbers there were about a few thousand applicants so far, so that is getting off the ground. We are very excited about that program. It takes some of the existing employment along with some of the BAH model payments that the GI Bill has, and kind of a hybrid, to get folks back to work.

We are very encouraged by what we have seen so far, and I think transparent, regular reporting about those programs would really help, to let us know where we need to almost double down. If we are going to invest in programs that are going to put people back to work, you know, putting food on the table, paying taxes back into the system, that is important for us to know exactly how successful those are.

Senator MORAN. You said it very well. Thank you, Mr. Murray. Chairman, I will yield back my time.

Chairman TESTER. Senator Hirono?

SENATOR MAZIE HIRONO

Senator HIRONO. Thank you, Mr. Chairman. Thank you, all of you on the panel, for your advocacy on behalf of veterans.

I want to get to the subject of reproductive health, so this is for Mr. Butler and Mr. Liermann. Am I pronouncing your name correctly? So increasing health services for women at VA facilities necessarily includes reproductive care. Would you agree?

So does this budget, in your opinion, support reproductive care, especially as it relates to women veterans with service-connected conditions that may impact their ability to have children? Any of you can respond to that.

Mr. BUTLER. I think the Independent Budget recommendation support the necessary increase for IVF, and that we fully support that recommendation.

Senator HIRONO. So the question was specifically whether it is adequate to provide reproductive health services to women veterans. Have you been in contact with advocacy groups for women veterans on this point, whether they think it is enough funding?

Mr. BUTLER. We have, and our contact at PVA has spoken with many advocates of women veterans, and they support PVA's budget recommendations.

Senator HIRONO. Good, because we are making progress, because at least now we are recognizing this is an important aspect of what should be made available, services to women veterans.

Not too long ago eliminating homelessness among the veterans community was the No. 1 priority for the VA, and Secretary McDonough's statement notes that it still is among those, but it is no longer the top priority. Obviously with COVID there are even more veterans who are homeless. Correct?

So are you satisfied that the VA is doing what is necessary or doing all that it can to eliminate homelessness among veterans, and if not, what should they be doing?

Mr. BUTLER. Well, this predates back to Secretary Shinseki's statement about——

Senator HIRONO. Yes, I know. I was here then.

Mr. BUTLER [continuing]. calling to eliminate homelessness and the initiative that he put forth. So over the past administration,

since Secretary Shinseki left, there has been, in our opinion, a lack of increasing in eliminating homelessness. There are some examples of where they did not spend all of the money that they should have spent toward that initiative.

So we would like to see the VA renew its efforts in eliminating homelessness across the nation.

Senator HIRONO. Well, you are nodding your head. Did you want to add something to this, Mr. Liermann?

Mr. LIERMANN. No, I agree with Mr. Butler's comments. If you take a look at some of the legislation that has been introduced lately, talking about increasing grants and increasing more funding for other organizations that are able to provide those, we absolutely agree.

Then when you try to think of what is the priority, right, homelessness, absolutely. Suicide, absolutely. Mental health services, providing women veterans with what they need. So we believe, and we are all committed, as part of the DAV, to find ways to eliminate and find the right balance of funding for all of these programs.

I think trying to say that one should be a priority over another is very difficult do when they are all just as important as the other, but I do agree that we do need to increase that commitment and renew it. Veterans should not be homeless when there is a means to get them the help they need.

Senator HIRONO. I think we need to become a lot more creative about our approaches, because homelessness among veterans, it is not a monolithic issue. There is a lot that you have to delve into to figure out, you know, how we can house the veterans, how can we provide them with the training they need, if they need training to get jobs, all of that. It is interconnected. So when we talk about mental health needs, that also relates to homelessness, I would say. Suicide also.

So there is an interconnectedness, and I do not know if the VA has really embarked on much more of an interconnected approach to eliminating homelessness among veterans, but what could be—I can't say more important, I knowledge all these things are important. This has been just a perennial issue, and it is very troubling.

Cemetery maintenance. The National Memorial Center of the Pacific, Punchbowl—have you all been there? It is quite the facility, yes—anyway, currently has a number of deferred maintenance projects, some of which have been on the books for nearly 10 years. Now your testimony applauded VA's budget request for the National Cemetery Administration. So knowing that, for example, the Punchbowl facility has been waiting for over 10 years for some needed improvements, do you still think that the funding for the National Cemetery Administration is adequate?

Mr. MURRAY. Ma'am, one of the things that we would really like to see happen is to almost clear the deck of some of these outstanding projects, much the same way that state veterans homes recently, there was about $500 million given to kind of take out that priority list. We think that especially projects like Punchbowl, as you mentioned, and cemeteries around the country that have very similar challenges—you know, space, they need to actually just put in the right facilities in order to place our nation's heroes. That facility mirrors other challenges around the country, and we

think that those are ways that we can just clear that deck, by adding infrastructure moneys to actually address some of these longstanding project issues.

Senator HIRONO. Well, that is the thing—and I am sorry, Mr. Chairman—but I would love to clear the decks on all of these things. You know that we are on the page with you all, but obviously the need exceeds the funds available, not to mention that there are communities of veterans still waiting for, for example, CBOCs to be built. And, you know, we have had situations on Oahu, for example, where the community has been waiting for like 5, 6, 7, 8 years. So, you know, those need to be cleared too.

So I would just like to see the VA, especially under Secretary McDonough's leadership, have a sense of urgency, and let's get on with all of these things. So I got that off my chest, Mr. Chairman.

Chairman TESTER. That's good. Senator Sullivan?

SENATOR DAN SULLIVAN

Senator SULLIVAN. Thank you, Mr. Chairman. Gentlemen, thanks. Mr. Secretary, thanks. Sorry I missed the first panel. Man, that went fast. We had a bunch of votes, but maybe I will call you and give you kind of update on some of the issues I am focused on, one of which I was going to ask the Secretary but I want to ask our VSO leadership. It goes to this issue of VA-DoD integration. You know, we have that in Chicago. It is a good way to actually save money but expand services. You do not have a lot of those opportunities throughout the country, really throughout the federal government.

In Alaska, over 40 percent of our residents are federal health care beneficiaries. That is VA or DoD kind of related, which is really pretty big. I think it is one of the biggest per capita, if not the biggest in the country. But we do not even have a full-service VA hospital, in the whole state. More vets per capita than any state in the country.

What is the general view, from you guys' perspective, on those kind of opportunities—VA-DoD integration in terms of hospitals and health care?

Mr. MURRAY. Senator, one of the things that we really think is critical for VA is flexibility. Hopefully the AIR Commission is going to provide a lot of answers. As you mentioned, Chicago. There are other places where they can have partnerships, the public-private partnerships.

Senator SULLIVAN. I am pushing this in the NDAA this year. I think the VA is supportive. But Alaska, to me, I know Senator Hassan mentioned it a little bit ago, but I think we are kind of a pole position for that.

Mr. MURRAY. But shared facilities is another flexible one. Reviewing the lease authority so that they can execute the leases that are different than the 10-year moneys needed up front. But also looking at areas like medical schools, so that they could partner with places that need a place to train. VA has been a training organization for years. Over 70 percent of physicians have been trained at VA facilities at one point in their career.

Partnering with folks like that, with organizations like that, we think is important, and giving them the authority to start those

sharing facilities from the ground up, not going into an existing one and trying to create an authority to share it once there is already an existing facility in place, but actually starting from, you know, digging the first shovel in the dirt. They do not have that right now. I think that would help add to the flexibility.

Senator SULLIVAN. Good. I am glad you mentioned medical schools. We do not have a medical school in Alaska, unfortunately, but we did have legislation a couple of years ago that had VA residency programs with our Alaska Native health organizations. It was very popular. We are implementing it now, so that is another good example on flexibility. Shane, anyone else, gentlemen, you have views on that first question I asked?

Mr. LIERMANN. Absolutely. Thank you, Senator. Evidence shows, and what we know is veterans do better with VA health care. They thrive. They have better preventative maintenance and they are just long term going to do better. So if we can find ways to provide that with these partnerships and with other facilities, other organizations, it is going to benefit veterans in the long run. It is hard to believe there is not a full hospital there, but providing that access is extremely important.

I come from a very rural part of the country as well, Nebraska, and the nearest VA facility was over 3 hours from where I was living at the time. They have increased CBOCs in those areas, but again, to the point, when you cannot have access to the health care we need to find that flexibility, as Pat mentioned, to get them, because we know they do better with VA health care.

Senator SULLIVAN. Okay. Mr. Butler, do you have a view, sir?

Mr. BUTLER. Well, the Chicago facility has demonstrated to be a proven model. I have also been to Alaska and seen now the integration between DoD and the Alaskan health care system works together.

So I think that there is opportunities for improvement in those areas, and expansion in those areas. So there should be serious concerns, and hopefully this administration will look to do more in those efforts.

Senator SULLIVAN. Good. Thank you. Let me go back, Mr. Liermann, real quick, on the burn pit exposure. You know, my legislation with Senator Manchin, you have been really strong supporters of. You referenced in your opening statement challenges with the current claims backlog.

What we are trying to do here, as you know, is get in front of this, not having an Agent Orange-type of situation, but also make sure the VA is getting the science right and making sure that we can afford this, so there is a balance. One issue that a lot of people forget, if you do massive amounts in this area you start to crowd out people who are already in the system.

Can you kind of unpack a little bit more of the reference you made in your opening statement on the claims backlog and what you think, in addition to my legislation, needs to happen?

Mr. LIERMANN. Thank you, Senator. With over roughly 190,000 pending claims right now, and then we know that VA now has to add the newer implications, Blue Water Navy, Agent Orange cases, the three new presumptives that are starting, any new additional presumptive diseases that would be added, or new exposures, based

on my experience in 2010, when VA added three additional exposures at that time, it really did create a significant amount of additional work, and it really did add to the backlog of pending claims throughout the VA.

So going forward, we need to be mindful that if we are going to add additional presumptive disease and exposures that VA is very well prepared with the number of people in place, and a plan in place before they start, so we do not add an additional one-to 2-year wait on claims, as we have seen in the past.

Senator SULLIVAN. Yes. It is a huge issue, and I think—I am not sure this committee is thinking through that well enough. We do not want to create a giant backlog by doing something we all think—and trust me, I have been, you know, on the front foot on this one for quite a while—what we think we are doing right, but then there are consequences that we are creating even more wait times for not just burn pit exposure veterans but Blue Water Navy, I mean, just the list gets long. Any thoughts on that?

Mr. MURRAY. Yes. We agree with you that we need to be mindful of that. But this is not necessarily a new problem. The scope of what we are talking about is new. This might be larger than anything we have talked about, but in terms of an influx of new claims, we have seen that. In terms of it creating a backlog, we have seen that. So moving forward, when this passes, we want to see that there are resources dedicated up front, so we can do what we can to mitigate that, so we do not run into that problem again. It is the same problem we have seen. This will maybe be something a little bit more expansive, but we should be able to get ahead of it.

Senator SULLIVAN. Yes. We have seen this movie before. The committee and the VA need to be ready for it, right? We know it is coming. We have just got to comprehensively look at how to address it. Mr. Butler, do you have any views on that?

Mr. BUTLER. No.

Senator SULLIVAN. [Presiding.] Okay. All right. I think I have been given the gavel here, and so I want to thank the Secretary and the VSOs, the leadership here. We make a promise to those who serve our country, and if the VA is going to deliver on them they need the resources to do it. I am supportive of that increase.

I am not sure if I should raise it, but I am going to raise it anyways. This administration has put forward a budget that actually cuts the Department of Defense, adjusted for inflation. That is not good. That is not good. I know that is not you guys' area, but you guys care about it. My veterans back home in Alaska, they care about the VA budget. They care about the DoD budget too. We should not be cutting the DoD budget, but that's a whole other topic.

We will keep the record open for a week. Mr. Secretary, I know there were a number of us who wanted to—I did not get here in time for your testimony. It was not at all disrespect. It was just the votes. So I am sure there are going to be questions submitted for the record for you, sir.

Other than that, I want to thank the witnesses for their service, particularly to our great veterans, and this hearing is now adjourned.

[Whereupon, at 4:29 p.m., the Committee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

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

U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST
FOR FISCAL YEAR 2022

JUNE 16, 2021

Chairman Tester, Senator Moran, and distinguished Members of the Committee. Thank you for the opportunity to testify today in support of the President's Fiscal Year (FY) 2022 Budget and FY 2023 Advance Appropriations Request for the Department of Veterans Affairs (VA), and for your longstanding support of Veterans and their families. I am accompanied by Mr. Jon Rychalski, Assistant Secretary for Management and Chief Financial Officer.

President Biden defined 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. It is the honor of my lifetime to join the dedicated, highly skilled professionals who constitute the VA workforce—many of them Veterans themselves. VA employees are committed to serving Veterans, their families, caregivers and survivors. The President's FY 2022 Budget Request reflects this commitment. This budget request will ensure VA is moving swiftly and smartly into the future, with much-needed monetary investments in our most successful and vital programs. 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.

VA faces critical challenges, many of them made even more complex by the COVID-19 pandemic. Getting our Veterans through this pandemic continues to be one of our department's highest priorities. As our country re-opens after 14 months of closures and necessary restrictions on some activities, all of us at VA remain focused on the robust clinical response to COVID-19. Our efforts include expanding COVID-19 vaccinations; ensuring Veterans stay connected to longitudinal care through telehealth and in person care where necessary; keeping employees safe; and, planning how to address the pandemic's future impacts on Veterans and our workforce in the health care, benefits and cemetery systems. VA has demonstrated resiliency through this crisis by providing continuous services in line with national policy, and we continue to update our safety guidelines in accordance with Centers for Disease Control and Prevention (CDC) guidance.

We encourage every Veteran to be vaccinated as soon as possible. That is why we thank Congress for providing additional authorities and we have expanded our efforts to include vaccinations for all Veterans, regardless of whether they are enrolled or eligible to enroll in VA health care, for Veterans' spouses, and for Veterans' caregivers, and, most recently, for some 12- to 17-year-olds, including those serving as Veteran caregivers and those who qualify as beneficiaries under VA's Civilian Health and Medical Program.

As of June 11, VA has fully vaccinated more than 3 million Veterans, family members, caregivers, employees, and federal partners. We are seeing the positive results of those efforts. I am honored and delighted to report that VA recorded zero deaths from COVID-19 in our facilities on May 24 for the first time in more than a year. That is a critically important indicator of significant progress in fighting this pandemic. As we prepared for Memorial Day, a time of special significance for us and our Veteran communities, we followed CDC guidance and relaxed restrictions at our National Cemeteries which allowed us to remember our fallen heroes in person again this year. We are seeking input from VA employees about how we can safely and confidently bring our teams back to work in a manner consistent with CDC guidance and data-driven facts. We look forward to our continued return to normal operations, while recognizing that this pandemic has had an impact on every aspect of daily life for Veterans, their families, and all Americans.

Fiscal Year 2022 Budget and 2023 Advance Appropriations

The President's FY 2022 Budget Request includes $269.9 billion (with medical collections), a 10.0% increase above 2021. This includes a discretionary budget request of $117.2 billion (with medical collections). The request includes $101.5 billion (with collections) for VA medical care, $8.7 billion or 9.4% above the 2021 enacted level. The 2022 mandatory funding request totals $152.7 billion, an increase of $14.9 billion or 10.8% above 2021. This funding is in addition to the substantial resources provided in the American Rescue Plan Act of 2021.

The 2023 Medical Care Advance Appropriations Request includes a discretionary funding request of $115.5 billion (with medical care collections). The 2023 mandatory Advance Appropriations request is $156.6 billion for Veterans benefits programs (Compensation and Pensions, Readjustment Benefits, and Veterans Insurance and Indemnities).

Strategic Focus

To fulfill our country's most sacred obligation, every decision I make will be determined by whether it increases Veterans' access to care and benefits and improves outcomes for them. I will work tirelessly to rebuild trust and restore VA as the premier agency for ensuring the well-being of America's Veterans through a persistent focus on the three core responsibilities of the Department:

1. Providing our Veterans with timely world-class health care;
2. Ensuring our Veterans and their families have timely access to their benefits; and
3. Honoring our Veterans with their final resting place and lasting tributes to their service.

Under my leadership, the Department will make it a priority to implement management reforms to improve accountability and ensure Veterans receive the care and benefits they have earned. In addition to the funding for medical care, this Budget includes $3.4 billion for the General Operating Expenses - Veterans Benefits Administration (VBA) account, including funds to hire 429 new disability compensation claims processors, and $394 million for the National Cemetery Administration (NCA). The Budget fully funds operation of the largest integrated health care system in the United States, with over 9.2 million enrolled Veterans, provides disability compensation benefits to nearly 6 million Veterans and their survivors and administers pension benefits for over 350,000 Veterans and their survivors.

In addition to focusing on these three core responsibilities, President Biden also tasked me with:

1. Getting our Veterans through this COVID-19 pandemic;
2. Helping our Veterans build civilian lives of opportunity with the education and jobs worthy of their skills and talents;
3. Ensuring VA welcomes all our Veterans, including women Veterans, Veterans of color, and LGBTQ+ Veterans; and Diversity, Equity and Inclusion are woven into the fabric of the Department;
4. Working to eliminate Veteran homelessness and prevent suicide; and
5. Keeping faith with our families and caregivers.

Key Challenges:

As VA addresses the numerous challenges brought on or exacerbated by the COVID-19 pandemic, we also will need to tackle other longstanding issues that are essential to the Department's ability to sustainably and effectively execute its mission, including (1) establishing the right balance of direct care and purchased care, (2) delivering timely access to high-quality mental health care, including substance use disorder care, and preventing Veteran suicide, (3) increasing support to families and caregivers, (4) increasing support for the growing number of women Veterans who utilize VA services, (5) providing a whole of government solution to drive progress to eliminate Veteran homelessness, (6) improving support for transitioning servicemembers through improvements to the Transition Assistance Program (TAP), education and job training programs, and (7) addressing an aging medical infrastructure.

Establishing the Right Balance of VA and Community Care

Providing Veterans with timely access to high quality health care is essential. VA remains committed to a strong, thriving direct VA health care system, augmented by a robust and high-quality community care network. We will continue to expand access, innovate, and leverage our research and education missions to push the boundaries of what is possible in serving our Nation's Veterans. In short, we will lead – empowering each Veteran with the confidence that their trusted system will lead with sustained excellence on their behalf and on behalf of future generations of Veterans. For the Veterans listening today: VA is here as a welcoming, steady force ready to help you grow your health and well-being with the excellence you expect from us.

Access to Mental Health and Suicide Prevention

VA has made suicide prevention a top clinical priority and is implementing a comprehensive public health approach to reach all Veterans. The 2022 Budget Request includes $598 million, nearly $287 million above the 2021 enacted level, for existing programs dedicated to suicide prevention outreach and related activities, including funding to increase the capacity of the Veterans Crisis Line. Funding for mental health in total grows to $13.5 billion in 2022, up from $12.0 billion in 2021. 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.

VA developed the *National Strategy for Preventing Veteran Suicide* (2018),[1] which laid the foundation for VA's approach to suicide. This national vision for preventing Veteran suicide is grounded in three major tenets in which we firmly believe: (1) suicide is preventable, (2) suicide requires a public health approach, combining community-based and clinical approaches and (3) everyone has a role to play in suicide prevention. While the development of the National Strategy was groundbreaking in defining the vision of reaching and serving Veterans within and outside Veterans Health Administration (VHA) clinical care, VA moved to translate the vision of the 10-year National Strategy into operational plans of actions in: Suicide Prevention 2.0 (SP 2.0) combined with the Suicide Prevention Now initiative.

My promise to Veterans remains the same: (1) to promote, preserve and restore Veterans' health and well-being, (2) to empower and equip them to achieve their life goals using a whole health approach and (3) to provide state-of-the-art clinical

[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.

treatments. We will continue to invest and share resources with community organizations in the fight against Veteran suicide. We understand Veterans possess unique characteristics and experiences related to their military service that may increase their risk of suicide. Additionally, Veterans also tend to possess skills and protective factors, like resilience and a strong sense of belonging to a group.

Supporting Caregivers

The 2022 request includes $1.4 billion, an increase of $350 million above 2021, in funding dedicated to the Caregiver Support Program (CSP). The CSP empowers caregivers to provide care and support to Veterans with a wide range of resources through the Program of General Caregiver Support Services (PGCSS) and the Program of Comprehensive Assistance for Family Caregivers (PCAFC). As a result of the *John S. McCain III, Daniel Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018*, or *the VA MISSION Act of 2018,* VA began a major expansion of PCAFC.

PCAFC expansion rolls out in two phases. The first phase, which began on October 1, 2020, expands PCAFC eligibility to include eligible Veterans who incurred or aggravated a serious injury in the line of duty on or before May 7, 1975. Effective October 1, 2022, the second phase will expand PCAFC eligibility to include eligible Veterans who incurred or aggravated a serious injury in the line of duty between May 7, 1975, and September 11, 2001.

Expansion of this Program was contingent upon the implementation and certification of the new IT system, Caregiver Record Management Application (CARMA). CARMA automates manual processes and integrates with other VA systems, increasing efficiencies and effectiveness, and allowing for more effective monitoring and management of the program for caregivers and VA staff.

CARMA supports consistency through systematic calculations of monthly stipend payments and provides a mechanism for CARMA users to identify upcoming reassessments of PCAFC participants, among other key functions. A new digital version of VA FORM 10-10CG allows online PCAFC applications.

VA also expedited the hiring of key staff with clinical qualifications and organizational skills to support program needs, provide a strong infrastructure and standardize application processing and adjudication, ensuring consistent eligibility decision-making. The expansion funded by this request will support providing training and education to over 1,900 field-based staff dedicated to the caregiver program. CSP has already expanded to approximately 1,800 staff. These changes will help ensure Veterans and caregivers receive timely, accurate assessments and eligibility determinations, as well as an improved customer experience.

Improving Support for Women Veterans

As the number of women Veterans enrolling in VA health care continues to increase, VA must be prepared to meet their needs. Women make up 16.5% of today's Active Duty military forces and 19% of National Guard and Reserves. Based on the trend, the expected number of women Veterans using VA health care will rise rapidly. More women are choosing VA for their health care than ever before, with women accounting for over 30% of the increase in Veterans enrolled over the past 5 years. The number of women Veterans using VA health care services has more than tripled since 2001, growing from 159,810 to more than 550,000 today. To support the growing number of women Veterans, VA will increase total planned obligations from all funding sources for gender-specific care from $630 million in 2021 to $706 million in 2022, an increase of $76 million, or 12%.

To address the needs of the growing number of women Veterans who are eligible for VA health care, VA is strategically enhancing services and access for women Veterans by hiring women's health personnel nationally to fill any gaps in capacity to provide gender specific care — this includes hiring primary care providers, gynecologists, mental health care providers and care coordinators across all VISNS so that VA is able to fulfill the mission of caring for those we serve. Funds also are available for programs such as pelvic floor physical therapy or lactation support. These efforts will be sustained by the 2022 request, which includes $105 million for the Office of Women's Health.

Each of the 171 VA medical centers across the United States now has a full-time Women Veterans Program Manager tasked with advocating for the health care needs of women Veterans. Mini residencies in women's health with didactic and practicum components have been implemented to enhance clinician proficiency. Since 2008, more than 7,600 health care providers and nurses have been trained in the local and national mini-residency programs and even more have participated in monthly webinars and Talent Management System (TMS) trainings, not only developing women's health experts, but also enhancing competency of all clinicians across the system.

Under a new collaboration with the Office of Rural Health, we established a pathway for accelerating access to women's health training for rural primary care providers. VHA actively recruits providers with experience in women's health care to join its care team. VHA has launched numerous initiatives to improve access to state-of-the-art reproductive health services, mental health services and emergency services for women Veterans, as well as focusing on enhancing care coordination through technological innovations such as registries and mobile applications.

To provide the highest quality of care to women Veterans, VA offers women Veterans trained and experienced designated Women's Health Primary Care Providers (WH-PCP). National VA satisfaction and quality data indicate women who are assigned to WH-PCPs have higher satisfaction and higher quality of gender specific care than those assigned to other providers. Importantly, we also find women assigned to WH-

PCPs are twice as likely to choose to stay in VA health care over time. Designated WH-PCPs are available across all VA Health Care Systems, and VA is actively recruiting additional new providers with even more enhanced proficiency in women's health care. VA provides full services to meet specific needs of women Veterans, such as gynecology, maternity care, infertility services, reproductive mental health services and military sexual trauma assistance.

Eliminating Veteran Homelessness

VA remains committed to ending Veteran homelessness. The 2022 Budget Request includes $2.2 billion for Veteran homelessness programs, an increase of 8.4% over the 2021 enacted level (base funding only). In addition, VA will obligate $486 million in ARP funding in 2022, for a total of $2.6 billion dedicated to reducing Veteran homelessness in 2022. The goal is to ensure every Veteran has permanent, sustainable housing with access to high-quality health care and other supportive services to prevent Veteran homelessness. VA has partnered closely with other Federal agencies and with State and local programs across the country to:

- Identify all Veterans experiencing homelessness;
- Provide shelter immediately to any Veteran experiencing unsheltered homelessness;
- Provide service-intensive transitional housing to Veterans who prefer and choose such a program;
- Move Veterans swiftly into permanent housing; and
- Have resources, plans, partnerships and system capacity in place should any Veteran become homeless or be at risk of homelessness.

VA has made significant progress to prevent and end Veteran homelessness. The number of Veterans experiencing homelessness in the United States has declined by nearly half since 2010. On any given night in January 2020, an estimated 37,252 Veterans were experiencing homelessness. Since 2010, over 850,000 Veterans and their family members have been permanently housed or prevented from becoming homeless. Efforts to end Veteran homelessness have resulted in an expansion of services available to permanently house homeless Veterans and the implementation of new programs aimed at prevention, including low-threshold care/engagement strategies and monitoring homeless outcomes. VA offers a wide array of interventions designed to find Veterans experiencing homelessness, engage them in services, find pathways to permanent housing and prevent homelessness from reoccurring.

Economic Opportunity

As an overall group, Veterans fare better economically than the average American. However, Veterans and their spouses still face economic challenges. Helping Veterans build civilian lives of opportunity with the education and jobs worthy of their skills and talents is a critical priority. The budget request supports this commitment by making key investments in VBA, including an increase of $81.5 million to support the Digital GI Bill Modernization effort, as well as an increase of $5 million for the Veterans'

Clean Energy Job Training program in conjunction with the Department of Labor, and $3.6 million for the VA Disability Employment Pilot Project to assist Veterans with service-connected disabilities seeking employment opportunities.

VA military-to-civilian transition programs are designed to give transitioning Service members the best possible start to their post-military lives. The VA Benefits and Services course, as part of the interagency Transition Assistance Program (TAP), helps Service members and their spouses understand how to access the VA benefits and services they have earned. VA TAP provides resources and tools Service members need to achieve emotional and physical health, attain economic stability in civilian life and become career ready. Although TAP has evolved significantly over the years, we continue to assess its effectiveness and evolve where appropriate to promote meaningful and economically enriching lives for Veterans and their families.

Addressing an Aging Infrastructure

The 2022 request includes $2.2 billion, a 26.8% increase over 2021, for Major and Minor Construction. The Major Construction request includes funding for 12 medical facility and two cemetery expansion projects. Additionally, the President requests $18 billion in mandatory funding in the American Jobs Plan (AJP) to modernize VA health care facilities with $3 billion to address immediate infrastructure needs within VA health care facilities and the remaining $15 billion to fully modernize or replace outdated medical centers with state-of-the-art facilities. We look forward to working with Congress to achieve our shared goal of addressing VA's aging infrastructure.

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. The median age of U.S. private sector hospitals is 11 years; however, 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 that between $49 and $59 billion in short- and medium-term investments will be needed to maintain our infrastructure using our annual Strategic Capital Investment Planning process. However, any effort to fully address the aging infrastructure portfolio needs would likely far exceed those estimates and occur over a significant timeline.

VA's market assessments have been on-going for nearly two years, allowing VA to gain significant insights into trends and needs in the VA health care delivery system – with enhancing Veteran access and outcomes at the core. The VA MISSION Act requires VA to continue construction, leasing, budgeting, and long-range capital planning activities while the market assessment and Asset and Infrastructure Review (AIR) Commission activities are occurring. The additional AJP investment would enable planning to start sooner to address facilities we know are not conducive to future health care delivery, while still being informed by outcomes of the AIR process.

Health care innovation is occurring at an exponential pace and the comparative age between VA facilities and private sector facilities is informed by these trends. The architects who designed and constructed many VA facilities in the decades following World War II could not have anticipated the requirements of today's medical technology and the key role infrastructure—and technological infrastructure—now plays in delivering safe and high-quality health care. As a result, many of VA's facilities were not designed with these technology and infrastructure requirements, which limits our agility and ability to meet the evolving health care needs of Veterans.

The experience of responding to the COVID-19 pandemic brought critical lessons. Uncertainty regarding the timing and location of the next surge or surges in cases across the country underscored the importance of portable capabilities (e.g., 24-bed Intensive Care Unit that can be transported) for VA health care's Fourth Mission role in future public health emergencies.

Transforming VA health care to achieve a safer, sustainable, greener, person-centered national health care model requires VA to leverage innovations in medical technology and clinical procedures. As technology-enabled trends in U.S. medicine bring health care closer to individuals and communities, there is less demand for prodigious, sprawling campuses and more demand for emphasis on ambulatory facilities and virtual care. Many surgical, medical and diagnostic procedures that once required a hospital stay now are performed safely in the outpatient setting, and telehealth and tele-service delivery bring expertise to a patient's own home.

This evolving landscape requires VA to rebalance and recapitalize its infrastructure to optimize the mix of traditional inpatient hospitals with outpatient hospitals, multi-specialty Community Based Outpatient Clinics, single specialty Community Based Outpatient Clinics and virtual care.

Leveraging 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. The 2022 Budget Request includes $4.8 billion in appropriations for the Office of Information and Technology to pilot application transformation efforts, support cloud modernization, deliver efficient IT services and enhance customer service experience. Our three main transformative projects are the implementation of the Electronic Health Record Modernization (EHRM); the replacement of VA's multiple, aging systems to manage its inventory and assets with the enterprise-wide inventory management system used by the Department of Defense (DoD)—the Defense Medical Logistics Standard Support (DMLSS); and the adoption of a new financial and acquisition management system—our Financial Management Business Transformation (FMBT).

EHRM

In October 2020, VA deployed a new electronic health record (EHR) system at the Mann-Grandstaff VA Medical Center in Spokane, Washington. This effort is one of the most complex and transformational enterprise-wide endeavors in the Department's history. The Budget includes $2.7 billion in FY 2022, which maintains a significant level of investment in FY 2022 and in future years and ensures necessary infrastructure upgrades are in place. This EHRM appropriation is in addition to the request for the central IT appropriation. The vision for the new EHR system is to empower Veterans, Service members and care teams with longitudinal health care information to enable the achievement of health and life goals from Service in the military to Veteran status. The new EHR system also presents the opportunity to achieve unprecedented interoperability with the DoD and functions as a catalyst for advancing VA's leadership of health care in the United States.

In my first weeks in VA, I directed a 12-week strategic review of the EHRM program, which consists of a full assessment of ongoing activities in order to ensure the success of future EHR deployments. Based on opportunities identified at the first "go-live" site in Mann-Grandstaff, the strategic review is focused on ensuring patient safety, identifying areas for additional productivity and clinical workflow optimization, change management and team-based training; and driving enhanced rigor into VA's management of cost, schedule, and performance. Additionally, we are conducting a human-centered design initiative to optimize the patient portal experience. We intend not only to get this right but to drive the industry forward alongside DoD. Furthermore, establishing strong, effective management of the EHRM program sets the tone for our other key efforts: modernizing supply chain management and enhancing financial and business transactions.

VA Logistics Redesign (VALOR)

VA's response to COVID-19 highlighted the shortcomings of the software and business practices supporting VA procurement, logistics and infrastructure operations, including a 50-year-old inventory system, separate procurement system and multiple stand-alone systems to manage property accountability, distribution and transportation. VA also uses multiple, stand-alone systems for health care technology and facility management, which limit enterprise visibility of assets and their respective readiness conditions. VA is requesting $299 million in FY 2022, an increase of $103 million (53%) from FY 2021, to continue its efforts in replacing these systems.

VHA is adopting DoD's proven software platform implementing the Defense Medical Logistics Standard Support (DMLSS) information technology system to modernize and standardize our supply chain, property, health care technology and facility management business lines. This improvement will allow us to manage the VHA supply chain and support functions and operate like other integrated medical systems. In doing so, we will ensure clinicians have the supplies and equipment where and when

needed to provide safe and high-quality care to our Veterans. VA completed the first DMLSS deployment at the James A. Lovell Federal Health Care Center in Chicago, Illinois, on September 21, 2020, and is continuing deployment on an accelerated schedule. We are grateful for the ARP funds that will help facilitate the continued modernization of VA's badly antiquated supply chain system.

By implementing DMLSS and standardizing our business practices, leaders at every level will be able to leverage new capabilities and capitalize on enterprise data to drive insights into operations and enable evidence-based decision-making. This implementation, too, offers significant opportunity for cost avoidance.

Financial Management Business Transformation

In support of VA fiscal stewardship, the Financial Management Business Transformation (FMBT) program is increasing the transparency, accuracy, timeliness and reliability of financial and acquisition activities across the Department. The 2022 Budget includes $357 million for FMBT, a program that is improving fiscal accountability to taxpayers and enhancing mission outcomes for those who serve Veterans. Our recent roll-out of the new Integrated Financial and Acquisition Management System (iFAMS) at NCA and VBA has not been without challenges and has exposed the incredible complexities inherent in a financial and acquisition system implementation of this magnitude. We are learning from these early deployments and adjusting our strategy accordingly. Nonetheless, these implementations bring 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 legislation and directives. The next system rollout is Enterprise Acquisition for NCA, which is scheduled for April 2022. System rollouts will then continue across the remaining Administrations and Staff Offices until enterprise-wide implementation is complete.

An Evolving Landscape Will Influence How VA Cares for Veterans

As VA addresses challenges and longstanding issues, several long-term demographic and fiscal trends will shape VA's ability to serve Veterans in the future. Although the U.S. Veteran population is aging and shrinking and simultaneously becoming more diverse, demand for VA services continues to increase. As the Veteran population continues to evolve, it also continues to use VA more—most likely the result of nearly 20 years of sustained conflict, longer average terms of service for military personnel and rising health care and educational costs that will incentivize more Veterans to use the VA benefits they have earned. U.S. health care is changing, too, from a hospital-centric model of care to dispersed (and even virtual) care that can be delivered through networks of direct and purchased-care providers.

Congressional Support

Over the past several years, Congress has generously supported VA's budget requests, which have enabled the Department to address new and growing challenges. More recently, Congress passed the ARP, which will, among other things:

1. Help ensure health care access for the 9.2 million enrolled Veterans who may have delayed care or have more complex health care needs because of the COVID-19 pandemic;
2. Forgive Veteran health care copayments and other cost shares and reimburse copays and other cost shares for care and prescriptions from April 6, 2020 through September 30, 2021;
3. Fund construction grants and payments to State Veterans Homes to greatly improve the living conditions of our most vulnerable Veterans;
4. Provide up to 12 months of training and employment assistance for unemployed Veterans to enter high demand occupations; and
5. Help reduce the backlog of disability compensation and pension claims, which has grown from 73,000 in March 2020 to 188,000 in May 2021.

The Department is grateful for the ARP, which not only will enhance VA's ability to deliver world class services to Veterans and their families, but also will ease thousands of Veterans' worries by forgiving some debt, speed up VA disability compensation claims adjudication and provide much needed funding to retrain Veterans in high-demand occupations. We will work diligently to ensure these funds are effectively and efficiently used.

New Statutory Authorities

Over the past 3 years, Congress has passed into law numerous, far-reaching pieces of legislation, including 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),* the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019*, the *Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020* (Veterans COMPACT Act of 2020), *the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 and the National Defense Authorization Act (NDAA) for Fiscal Year 2021.*

The 2022 Budget Request includes over $500 million within VA's Medical Care accounts to begin implementing new and recently expanded health care programs for Veterans, including a new grant program for suicide prevention outreach, increased eligibility for emergency suicide prevention treatment, new investments in women's health programs, expansion of homeless programs, and military sexual trauma services. The funding also will further support the Department's efforts to address substance use disorders.

Environmental Exposures

For some medical conditions that develop after military service, the information needed to connect these conditions to military service may be incomplete. Information may be needed about specific in-service exposures or there may be incomplete scientific or medical evidence as to whether an exposure causes a particular condition. These issues loom large for all Veterans, represented currently by post-9/11 Veterans, whose exposures to airborne and other environmental hazards may result in unknown long-term health impacts. I am committed to a full review of how VA provides health care and benefits to Veterans exposed to environmental hazards to be responsive to the Veterans we serve. I believe it is possible to strike a balance between the needs of Veterans and the need for an evidentiary scientific basis for action.

In 2019, Congress passed legislation expanding benefits to tens of thousands of Blue Water Navy (BWN) Vietnam Veterans. As of May 1, 2021, VA has completed more than 54,000 BWN claims and paid out nearly 900 million in retroactive benefits. More recently, VA added three new diseases to the Agent Orange presumptive conditions list in the FY 2021 NDAA. VA will begin implementing these provisions so that Vietnam Veterans will no longer wait for these earned benefits. As the Department harnesses its resources to execute these new requirements and ensure Veterans receive the benefits they have earned, I have also recommended initiation of rulemaking to establish a presumption of service connection for respiratory conditions related to exposure to particulate matter and other airborne hazards, which may conclude such conditions as asthma, rhinitis, and sinusitis for Gulf War Veterans. This decision was based on the first iteration of a newly formed internal VA process to review scientific evidence relating to exposures. VA will conduct broad outreach efforts to reach impacted Veterans and encourages them to participate in the rulemaking process.

Research

The Budget includes $882 million, the largest year-over-year increase in recent history, for medical and prosthetic research. This historic investment will advance the Department's understanding of the impact of traumatic brain injury (TBI) and toxic exposure on long-term health outcomes while continuing to prioritize research focused on the needs of Veterans to include Mental Health and Suicide, Rare Cancers and Prosthetics as well as other disease areas.

Increased TBI investment will enhance cutting-edge diagnostics and treatments such as investigating the role genomics plays in resilience and recovery from blast exposure, validating blast models, and studying the link between TBI and suicide. Further investment in environmental exposure includes the VA Military Exposures Research Program (MERP), capacity building with Federal partners, and expanding the workforce in military exposures research and training.

VA will also invest additional resources, including from the American Rescue Plan, to advance the Department's understanding of coronavirus related research and

impacts. To remain on the cutting edge of technology, VA will focus on software-as-a-service, cloud computing, and data security, and will continue to partner with the Department of Energy (DOE) to capitalize on DOE's computing power and technical expertise to put Veteran data to work.

Diversity, Equity and Inclusion

Diversity, equity, and inclusiveness are standards fundamental to everything we do. We will welcome all Veterans, including women Veterans, Veterans of color, and LGBTQ+ Veterans. Every person entering a VA facility must feel safe, free of harassment and discrimination, and we will never accept discrimination, harassment or assault at any VA facility. We will provide a safe, inclusive environment for Veterans and VA employees.

Diversity is a strength, never a weakness, among Veterans, VA employees and all of America. Leveraging diversity, equity and inclusiveness will produce the excellence in all our interactions with Veterans. I recently instructed my team to establish a 120-day task force on diversity, equity and inclusion. The task force's goal is to offer concrete, actionable recommendations while building solidarity across the VA system on diversity, equity and inclusion. To support the Department's commitment to strengthening VA's diversity program and preventing and resolving discrimination at the early stages, the Office of Human Resources and Administration created the new Office of Resolution Management, Diversity, and Inclusion (ORMDI) by consolidating the Office of Diversity and Inclusion and with the Office of Resolution Management. The budget for this combined office will increase by $12.9 million and 74 FTE. These resources will also provide a robust harassment prevention program and counseling services while advancing equity for all who have been historically underserved.

The Budget Request also furthers the commitment of the VHA Office of Health Equity to help eliminate health disparities based on race, gender, age, religion, socio-economic status or disability by improving health outcomes for underserved Veteran populations.

Empowering Leaders to Implement Positive Change

I am mindful VA's capabilities have not always risen to the needs of our Veterans. Consistent throughout many of these past shortcomings has been a theme of leadership inconsistency and cultural challenges. To rebuild trust and restore VA as the premier agency for ensuring the well-being of America's Veterans, I am focusing on building a diverse team of professional, experienced leaders who bring a great breadth and depth of knowledge in government and Veterans issues. To that end, we recently stood up a commission to identify candidates to lead and manage VHA.

At the same time, I also am working to retain the talented and hard-working leaders we currently have by empowering them to make decisions in a structure that allows them to do what's right for Veterans. As an initial step in support of that effort, I

recently signed a memo for VA employees emphasizing my intent to lead with VA's ICARE Core Values—Integrity, Commitment, Advocacy, Respect and Excellence – and have been seeking opportunities to engage with leaders across the system to drive this point home. VA's success as a team—our ability to deliver world-class care for our Veterans—also depends on how employees treat one another and Veterans. Our respect for our fellow VA employees and the Veterans we serve is critical to everything we do.

Essential to ensuring a healthy and accountable culture at VA is the Office of Inspector General's oversight. The 2022 Budget includes the OIG's request of $239 million for 1,100 FTE to support its programs and operations through independent audits, inspections, reviews, and investigations. The OIG's efforts have a significant impact on the services and benefits provided to Veterans. This funding level is prudent to safeguard the significant investments in VA and to help improve services and benefits for Veterans and their families.

I take full responsibility to ensure VA employees have everything they need to carry out the important work before us and we operate in a culture that celebrates and draws strength from our country's great diversity. To ensure a welcoming environment for Veterans, we must foster fair and inclusive VA workplaces where the experiences and perspectives of our diverse employees are valued. The success of our mission depends on everyone being able to contribute their expertise, experience, talents, ideas and perspectives. I commit to advancing equity in VA and providing all employees with opportunities to reach their full potential. I commit to these principles and will make sure my senior leadership team reflects and embeds them in everything we do.

At this moment when our country must come together, caring for our country's Veterans and their families is a mission that can unite us all, and I look forward to working with this Committee, Congress as a whole and our many other partners to embrace our collective responsibility to serve Veterans.

Mr. Chairman, Ranking Member Moran, I look forward to working with you and this Committee. Thank you for the opportunity to appear before you today to discuss my priorities for the Department and how the President's FY 2022 and FY 2023 Advance Appropriations Request will serve our Nation's Veterans.

THE INDEPENDENT BUDGET

A Budget for Veterans by Veterans

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Joint Testimony of
The Independent Budget Veterans Service Organizations
DAV (Disabled American Veterans)
Paralyzed Veterans of America (PVA)
Veterans of Foreign Wars (VFW)

on
VA Budget Request for Fiscal Year 2022 and 2023 Advance Appropriations

Senate Committee on Veterans' Affairs
June 16, 2021

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 recommendations for funding the Department of Veterans Affairs (VA) for fiscal year (FY) 2022, including advance appropriations for FY 2023, as well as present our views on the President's budget request. For more than 30 years, The Independent Budget veterans service organizations (IBVSOs) have presented comprehensive budget and policy recommendations to ensure that VA remains adequately funded and capable of carrying out its mission to serve veterans and their families, both now and in the future.

As is typical in the transition year following a presidential election, the new Administration did not present its federal budget request in February, instead releasing a high-level summary in April, before submitting its full budget request on May 27. Overall, the Administration's budget request for FY 2022—combined with appropriated funding from the American Rescue Plan (ARP), available funding from the Recurring Expenses Transformational Fund (Transformational Fund), and proposed funding from the American Jobs Plan (AJP)—would fully fund veterans' programs, benefits and services for the first time in a generation.

We commend the Administration for this historic VA budget request and call on Congress to ensure that VA receives all of the funding needed to ensure that every enrolled veteran receives timely, high quality health care; that every veteran receives all of the benefits they have earned without delays; and that every transitioning service member has the support to live a high-quality and meaningful life.

Earlier this year, in February, the IBVSOs released our "Budget Recommendations for Fiscal Years 2022 and 2023 for the Department of Veterans Affairs." The IB recommendations reflected a cautious approach based on historical trends, but recognizing that the past year has been one of the most challenging ever for VA and veterans as the COVID-19 pandemic disrupted VA's operations across the country and significantly impacted veterans' ability to access health care, benefits and transition services. As a result of this unprecedented national

public health emergency, there still remains great uncertainty about many of the typical assumptions underlying VA's budget projections, including enrollment, utilization, reliance, inflation, and unemployment.

Furthermore, VA continues to implement three major transformations that are critical to the future of the veterans' health care system and care for our nation's ill and injured veterans: 1) increasing VA staffing levels and building internal capacity as required by the VA MISSION Act of 2018; 2) the upcoming Asset and Infrastructure Review (AIR); and 3) the Electronic Health Record Modernization (EHRM). Each of these systemic changes has significant budgetary consequences for the Veterans Health Administration (VHA) in both the near and long term, and each has been and will continue to be affected by the COVID-19 pandemic and its economic consequences, adding further uncertainty.

The IB budget recommendations also reflect several critical new policy initiatives that cannot be deferred or ignored and are presented as recommended plus-ups to VA's FY 2022 budget. Given the amount of uncertainty in the years ahead, the new Administration and VA leadership must continue to work closely with Congress, the IBVSOs, and other veterans service organization (VSO) stakeholders to ensure that there is full transparency about VA expenditures throughout FY 2021, and VA and Congress must be ready to adjust FY 2022 budget requests and appropriations if warranted. Below are highlights of the IB Budget Recommendations made in February, with relevant comparisons to the Administration's recently released budget request.

VETERANS HEALTH ADMINISTRATION

Total Medical Care—For FY 2022, the IBVSOs recommended $81.4 billion for VA Medical Care. By comparison, the Administration has requested a total of $78.1 billion in new appropriations; however, VA will also have an additional $12.5 billion for Medical Care from the American Rescue Plan that was enacted in March.

The IB recommendation reflects multiple components including the current services estimate, an increase in patient workload, and additional medical care program costs:

- The current services estimate reflects the impact of projected uncontrollable inflation on the cost to provide services to veterans currently using the system. This estimate also assumes a 2.2% increase for pay and benefits across the board for all VA employees in FY 2022.

- Our estimate of growth in patient workload is based on a projected increase of approximately 80,000 new unique patients, partially driven by pandemic-related job and economic losses. These patients include priority group 1– 8 veterans and covered non-veterans. We estimate the cost of these new unique users to be approximately $1.9 billion.

The IBVSOs also recommended a number of additional initiatives to improve the delivery of health care to enrolled veterans. Specifically, an additional $1.4 billion would be needed to fill

at least 25% of pending vacancies, which would be 10,750 full-time employees. The IBVSOs recommended VA's long-term services and supports (LTSS) programs be increased by an additional $335 million to expand capacity to meet the unmet demand of aging veterans. For VA's Caregiver Program, the IBVSOs recommended $73 million to hire approximately 700 Full Time Equivalents (FTE) and $361 million to cover the costs of stipends and other benefits to accelerate phase two of the expansion by a year to October 1, 2021.

The IBVSOs anticipated there will be a significant carryover of prosthetic and sensory funds from FY 2021, so we did not call for additional funding in FY 2022. However, we urge VA and Congress to carefully monitor this account to determine if supplemental appropriations may be required to meet demand.

Following up on last year's recommendation to increase funding for women veterans' health care, the IBVSOs again recommended investing an additional $200 million, of which $120 million would go to Medical Services. The IBVSOs support provisions in the Administration's budget proposal that would provide $105 million for the Women's Health program office; $706 million for gender-specific care; and $1.5 million for the Center for Women Veterans.

Medical Community Care— VA Medical Community Care was significantly impacted by the pandemic and we anticipate the deferral of care by veterans in FY 2020 and FY 2021 could lead to an increase in community care in FY 2022, due to pent-up demand and additional medical need from complications of untreated conditions or COVID-related care. Therefore, the IBVSOs recommended $20.7 billion for FY 2022, which reflects the growth in current services as impacted by uncontrollable medical inflation and utilization increases. VA's budget request was for $23.4 billion for FY 2022 based on updated estimates of the usage of community care not previously available.

Medical and Prosthetic Research— The Administration proposed $882 million in FY 2022, an 8% increase, for medical and prosthetic research to advance VA's understanding of traumatic brain injury, the effects of toxic exposure on long-term health outcomes, and the needs of disabled veterans. The IBVSOs recommended a slightly higher amount of $902 million for VA research to cover inflation and provide new investments to address COVID-19, veterans' health disparities, clinical trials access, and data storage while renewing support for groundbreaking programs like the Million Veteran Program (MVP) and research on chronic and emerging needs of our nation's veterans.

GENERAL OPERATING EXPENSES

Veterans Benefits Administration (VBA)—For FY 2022, the IBVSOs recommended approximately $3.6 billion for VBA operations, an increase of approximately $380 million over the estimated FY 2021 appropriations level, which primarily reflects increases for inflation and federal pay raises, as well as increases in workload. The Administration's proposed budget is recommending $3.4 billion in new appropriations, in addition to $272 million previously appropriated in the ARP to assist in reducing the claims and appeals backlogs.

Claims Backlog—The IBVSOs recommended an additional 1,000 FTE for VBA to primarily address the rising VA claims backlog and prepare for the influx of claims from the recent addition of three new diseases to the Agent Orange presumptive list. In February 2020, there were 70,000 claims pending over 125 days and as of May 29, 2021, there are 187,000 pending over 125 days.

The Administration's proposed budget recommends an additional 429 FTE for VBA, whereas the IBVSOs recommended 1,000 new FTE. In addition to backlog reduction, our recommendation would also allow VA to expand the capabilities of VA Call Centers as well as address the backlog of pending Freedom of Information Act (FOIA) requests. We recommended that each VA Regional Office add at least two FTE to address pending FOIA requests; that each Call Center receive additional FTE; and that the remainder be apportioned among VA Regional Offices based on the need to address claims processing and adjudication workload.

Assist Veterans Return to Work Post-COVID-19 and Beyond—As VA initiate efforts to help veterans get back to work, it must focus valuable resources and time on getting them into jobs that are in demand. Thus, the IBVSOs strongly support programs like the Veterans Employment Through Technology Education Courses (VET TEC) and the Veteran Rapid Retraining Assistance Program (VRRAP) to strengthen existing retraining job opportunities and establish new resources to get veterans back on their feet. We call on Congress to enact legislation expeditiously to support these types of initiatives.

No one entity can meet the needs of all disabled veterans. However, together, we can think beyond what we traditionally do for veterans seeking employment and adopt innovative ways forward to better help veterans with disabilities. This means offering robust training and upskilling programs, including paid training and internships, to bridge the financial gap as well as providing more guided employment programs to assist veterans with disabilities in exploring new career fields.

The early successes of programs like VET TEC and VRRAP show that an investment in veteran economic outcomes is incredibly beneficial. The IBVSOs call for full funding of veteran employment programs to help get as many veterans gainfully employed as quickly as possible.

VA's Veteran Readiness and Employment (VR&E) program has successfully helped many service-connected veterans pursue employment and educational opportunities. However, the IBVSOs remain concerned about the high caseloads VR&E counselors maintain as it limits the amount of time they can spend with veteran clients assessing their current status, needs, goals, and what determines meaningful employment for that veteran. Congress should study changing the current program eligibility standards to determine if doing so would streamline the process by expanding eligibility to all veterans who have been awarded service-connected disability ratings, regardless of the degree of disability. Many veterans also continue to experience high turnover rates of

their VR&E counselors, which can affect their long-term success in the program.

As a result, the IBVSOs recommended the VA Office of Inspector General conduct an assessment of the VR&E program staff. This assessment will determine the average amount of time each counselor spends working with a veteran, the rate of staff turnover, the length of time between counselor engagement, and the length of employment for veterans placed into positions through VR&E. This will ensure that there are sufficient staffing levels and a low rate of attrition, which is vital to the success of this critical program. By pursuing education, training, or civic engagement, veterans will be better equipped to re-enter the workforce when the pandemic subsides or when they have work-from-home employment opportunities.

Digital GI Bill Implementation—The Digital GI Bill upgrade will accommodate many requests Congress and VSOs have been making for years. After the IT overhaul, VA Education Services (VA ES) would have a cleaner platform to replace VA-ONCE for School Certifying Officials, SAAs, and VA officials, so they can all have the ability to view one screen when interacting with each other instead of different individual platforms. The GI Bill Comparison Tool would be able to be upgraded regularly instead of housing years old information that is difficult to corroborate or edit once in place. It could provide a digital Certificate of Eligibility for GI Bill using similar automated technology as the VA Home Loan. It would also allow for platforms to be introduced that can accommodate the data-sharing agreements between VA and other agencies. Finally, it would be able to track GI Bill users so easier notifications can be made to all benefits users to deliver timely information regarding updates or changes.

The Digital GI Bill upgrade is a long-overdue upgrade to a critical program office within VA. Far too many times stakeholders, such as Congress and VSOs, have collectively overlooked IT resources for new programs and needed changes within VA Education Services. For example, a change to VA Work-Study was recently passed into law adjusting the payment schedule for work-study recipients. Unfortunately, VA did not have a platform to calculate and deliver those new payments, and no additional IT funding was provided to support the program's changes. Unfunded mandates such as the work-study change will lead to VA ES trying to create yet another workaround, and to use already overworked and outdated systems to perform a new task for which they were not intended.

The IBVSOs believe that every new proposal going forward must include IT resources to accomplish program goals. Minor delays can be avoided by ensuring proper IT funding is added to all new proposals. Hopefully, we can avoid a repeat of what took place during the Forever GI Bill's final implementation.

A project like the Digital GI Bill upgrade will set VA ES up for success for future years to come. It will also head off any delays by ensuring veterans receive their benefits to utilize some truly life-changing programs offered by VA. Congress must

provide robust oversight of this upgrade in order to ensure this latest IT improvement is correctly implemented, and mistakes of the past are not repeated.

Board of Veterans' Appeals (BVA)—For FY 2022, the IBVSOs recommended approximately $216 million for the Board of Veterans' Appeals (BVA), an increase of approximately $26 million over the estimated FY 2021 appropriations level. We are pleased the Administration's budget request is for $228 million for BVA, although we are not certain it would provide enough new FTE to address the current hearing backlog.

Hearing Backlog—Since the Appeals Modernization Act (AMA) took effect in February 2019, there have been significant changes in how veterans can appeal claims decisions at the Board. As of June 1, 2021, there are 49,154 pending AMA hearings with the Board and 42,299 pending legacy hearings, for a total of over 91,000 pending hearings. This is an increase of 15,000 pending hearings from the previous year. Roughly 50% of all legacy appeals request a hearing versus 60% of AMA appeals.

The Administration's proposed budget will provide an additional 129 FTE, which includes 35 Veterans Law Judges. Coupled with the American Rescue Plan providing for an additional 33 FTE, BVA will add 162 FTE for 2022. For many years, the IBVSOs have been recommending an increase of 100 FTE for BVA; however, based on the increased hearing backlog compared to just a year ago and the increased rate of hearing requests, we recommended an increase of 200 FTE for the Board to address the now 91,000 pending hearings.

To properly implement the AMA as well as address other critical Board improvements, the IBVSOs recommended additional IT funding for both the BVA and the VBA, which is included in the FY 2022 IT budget recommendation below.

DEPARTMENTAL ADMINISTRATION & MISCELLANEOUS PROGRAMS

Information Technology (IT). — The VA Office of Information Technology (IT) provides day-to-day support and development for all of VA's IT needs, including those of the VHA, the VBA, and the National Cemetery Administration (NCA). For FY 2022, the IBVSOs recommended approximately $5.2 billion for the administration of the VA's IT program to meet the need to sustain VistA as well as other critical IT programs for the VHA, the VBA, and the NCA.

The Administration is proposing $4.8 billion in new appropriations for VA IT programs, in addition to $670 million available from the Transformation. Fund, for a total of almost $5.5 billion. We applaud the VA's commitment to modernizing IT systems, and highlight the following IB recommendations for specific IT upgrades:

Medical Research IT Needs—To more effectively support VA research programs, the IBVSOs recommended $42 million be earmarked to accomplish nine specific projects for the Office of Research and Development.

VBA IT Needs—Updated and modern IT is critical to the smooth operation and success of VA's claims and appeals processing systems, and particularly to complete implementation of the AMA. In FY 2020, VBA had over $700 million in shortfalls for funding necessary IT projects, including many that would address the needs of accredited VSOs working in VA Regional Offices. For FY 2022, the IBVSOs recommended $175 million be provided to fund critical pending VBA IT projects, including top VSO priorities.

BVA IT Needs—The Board of Veterans' Appeals uses several IT platforms such as VBMS, Veterans Appeals Control and Locator System (VACOLS), and Case Flow. However, VACOLS is the legacy program for tracking and maintaining appeals within the Board. Case Flow is currently used to manage all Board requested hearings, as well as the pilot program for virtual hearings, and thus is an integral part of their daily functioning. Case Flow was created to replace VACOLS; however, as Case Flow has many functionalities yet to be implemented, both systems must be used by the Board, which greatly reduces their efficiency. VACOLS allows the Board to store data, specifically their decisions on each case. Case Flow was not designed for data storage; however, if it retains the functionality of VACOLS, it will be a better IT platform to phase out VACOLS. The IBVSOs recommended $15 million in IT funding to accelerate and complete BVA's Case Flow system.

Currently, the Board must manually enter and upload all mail received from appellants from either faxes or USPS mail. While the VBA has artificial intelligence AI to scan, read, and upload mail, the Board does not. The IBVSOs recommend $10 million additional IT funding for the Board to develop a modern AI system to address its ever-increasing paper mail volume.

Electronic Health Record Modernization (EHRM)—The EHRM account is comprised of three major sub-accounts: Cerner Contract, Infrastructure Readiness, and Project Management Office (PMO). For FY 2021, Congress appropriated approximately $2.6 billion for EHRM, which included $1.2 billion for the Cerner contract, $1.2 billion for infrastructure readiness, and $255 million for the PMO.

On June 5, 2017, VA awarded a 10-year contract to develop the Department's next-generation Electronic Health Record (EHR) system to Cerner. The EHRM project has its own line within VA appropriations to cover the costs of the $10 billion software contract with Cerner over the course of the 10-year period of performance, as well as $4.3 billion for IT infrastructure and $1.7 billion for program management, totaling just over $16 billion.

In addition to the almost $10 billion contract, VA estimates another $6.1 billion will be needed for program management and infrastructure-related costs. Of this amount, approximately $4.3 billion is for program infrastructure and the remaining $1.8 billion is estimated for program management. The infrastructure cost estimates do not cover, however, some of the physical upgrades to the individual health care facilities, which are to be funded by VHA. VHA and Office of Electronic Health Record Modernization (OEHRM) officials

have indicated that these costs are generally anticipated to be funded from VHA's nonrecurring maintenance budget.

On April 16, 2021, VA paused its EHRM rollout until the agency completes a strategic review of the project and reports the results to Congress. Recently, a VA Office of the Inspector General (VAOIG) audit (#20-03178-116) determined a pair of VHA's formal cost estimates for physical infrastructure upgrades necessary for implementation of the new electronic health record system were not reliable. Statistical projections made by the VAOIG audit team suggest that VHA's two formal estimates for physical infrastructure costs, dated June 2019 and November 2019, may be underestimated by as much as $1 billion and $2.6 billion, respectively. The impact of the strategic pause and the VAOIG findings on the EHRM project going forward is unclear, but VA has a long way to go to reach its goal of full deployment at the Department's 170 other medical centers and more than 1,260 outpatient sites nationwide by 2028.

Our recommendations are based on VA's original plans to deploy its electronic health record across 23 sites of care over the next two years, which will require increased funding and oversight. For FY 2022, the IBVSOs recommended a total of approximately $3 billion, of which approximately $1.5 billion would go to the Cerner contract, an increase of $300 million due to the expanded scope of work; $1.2 billion for VHA infrastructure upgrades, network equipment, and other IT infrastructure upgrades at locations making the conversion to Cerner's EHR; and $260 million for the PMO. In addition, the IBVSOs recommended an additional $60 million to accelerate the deployment of VA's Centralized Scheduling System in FY 2022 to improve access for veterans and streamline medical appointment scheduling operations across VHA.

National Cemetery Administration (NCA)—The NCA, which receives funding from eight appropriations accounts, administers numerous activities to meet the burial needs of our nation's veterans. For FY 2022, the IBVSOs recommend approximately $365 million for NCA, an increase of approximately $13 million over the estimated FY 2021 appropriations level, which primarily reflects current services with increases for inflation and federal pay raises.

The Administration's proposed budget is $394 million, which is $42 million over the previous FY and $29 million over the IBVSOs recommendation. We applaud this significant proposed increase for the NCA as it will allow for maintenance of over 4 million gravesites, provide 136,000 internments and add 97 FTE due to increased workload and new cemeteries.

CONSTRUCTION PROGRAMS

Major Construction—The IBVSOs recommended a total of $2.8 billion for Major Construction for FY 2022, which included $1 billion for VA to address critical seismic deficiencies. The Administration requested $1.6 billion for Major Construction, an increase of 22% over the FY 2021 enacted level, but short of the IB recommendation. However, we must also note that the Administration has proposed that VA receive $18 billion as part of its

infrastructure proposal (AJP), which would provide an historic infusion of funding for VA's health care facilities.

Increasing VA's Capacity to Manage Infrastructure—The IBVSOs recommended an increase of 175 FTE to better plan and oversee construction projects, with new personnel assigned to each of VA's major medical centers or other appropriate regional locations. Neither VA's Office of Construction and Facilities Management nor the individual VA facilities have the manpower to oversee the amount of work necessary to decrease the backlog. VA needs to hire additional FTE to oversee infrastructure projects, should add personnel to an office of strategic planning, and increase the personnel at individual major facilities to oversee local projects.

Asset and Infrastructure Review (AIR)—The VA MISSION Act established the Asset and Infrastructure Review (AIR) process to undertake a systematic review of VA's medical facilities, develop an integrated strategy to deliver health care to enrolled veterans, and present a comprehensive plan to realign and modernize VA's health care infrastructure to achieve those goals. While the AIR process, if successful, will establish a long-term plan for VA's health care infrastructure, it remains vitally important that VA and Congress continue to commit sufficient resources to maintaining VA's existing facilities.

The IBVSOs are supportive of the AIR process and look forward to its results; however, we feel it is imperative that VA continue to receive adequate funding to address current infrastructure needs. VA and Congress must not wait for the results of the AIR process to fund and execute existing maintenance, life-safety corrections, and necessary construction. Waiting an additional two years will only add to the already existing infrastructure backlog, reduce veterans' access to care and threaten the health and safety of veterans and VA health care staff.

Minor Construction—The IBVSOs recommended $810 million for Minor Construction for FY 2022, to include $40 million to support projects designed to improve access for women veterans. The Administration requested $553 million for Minor Construction, together with $150 million from the Transformation Fund, for a total of $703 million in FY 2022, almost double the FY 2021 enacted level.

State Veterans Homes Construction Grants—The IBVSOs recommended $275 million for State Veterans Homes Construction Grants for FY 2022 to fund approximately half of the expected Priority Group 1 projects that had state matching funds. Since the ARP already provided $500 million in additional funding for State Home Construction Grants, the Administration's budget request did not request any new appropriations for FY 2022.

This concludes the IB testimony on VA's budget. My colleagues and I look forward to any questions you and the Committee may have.

Pre-Hearing Questions on the Department of Veterans Affairs
Fiscal Year 2022 Budget Request
From Senator Jerry Moran

Question 1. **How many patient visits and days of inpatient care are projected in Fiscal Year 2022?**

Response: The 2022 PB projected 118.990 million outpatient visits in 2022 and 21.262 million days of care across various Inpatient facility types as shown on page VHA-40.

Question 1a. **Of those, how many are for service-connected care?**

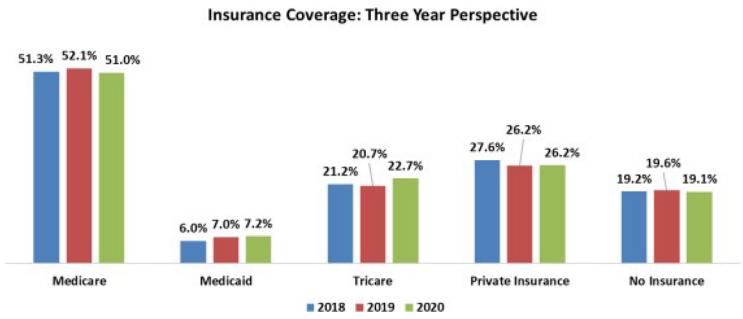
Response: We estimate based on prior year splits, 20% of outpatient and 9% of inpatient will be for service-connected conditions.

*Question 1b***. For each of service-connected and non-service-connected visits and days of care, how many patients have access to other health care or insurance, such as employer provided insurance?**

Response: The enrolled Veterans who have no insurance coverage other than their VA benefits are considered uninsured. The table below provides the breakdown for the enrollees covered by Medicare, Medicaid, Tricare and employer-provided (private) insurance.

	Medicare		Medicaid		Tricare		Private Insurance		No Insurance		
	Weighted Count	Weighted Percent	Weighted Count	Weighted Percent	Weighted Count	Weighted Percent	Weighted Count	Weighted Percent	Weighted Count	Weighted Percent	TOTAL ENROLLEES
Priority 1-3	1,987,623	42.50%	244,894	5.24%	1,549,341	33.12%	1,308,543	27.98%	890,808	19.05%	4,677,255
Priority 4 - 8	2,461,117	60.79%	386,498	9.55%	430,042	10.62%	978,221	24.16%	775,398	19.15%	4,048,292
TOTAL ENROLLEES	**4,448,740**	**50.99%**	**631,392**	**7.24%**	**1,979,383**	**22.68%**	**2,286,764**	**26.21%**	**1,666,206**	**19.10%**	**8,725,547**

Data source: FY2020 Survey of Enrollees (Enrollee count is weighted based on survey methodology)



Question 2. **How did VA's Enrollee Health Care Projection Model account for the impact of the pandemic on demand for care in FY 2022, and what portion of the projected demand (outpatient, inpatient, Community, etc.) for FY 2022 is due to effects of the pandemic?**

Response: Over the past year, VHA has developed a number of scenarios for use in projecting resource requirements for VA's FY 2021-2023 Budgets and 20-year projections to support budgeting, and strategic, capital and workforce planning by making key assumptions about how COVID will impact the health care system informed by national trends and VA's unique experience. The key assumptions developed/included in modeling are the projected reliance changes due to the economic recession, the impact of deferred care and return on projected utilization (including the location of where the care is expected to return), the Medicare sequestration suspension, the pandemic response procurement activities, the copayment suspension policy, and the increase in virtual care modality use.

The table below shows the high-level impact of COVID-19 on workload by care location for FY 2020-2023. There is still a slight increase in workload due to the pandemic in FY 2023, but the majority of the projected increases from FY 2019 to FY 2023 is due to the underlying utilization growth that would have been expected in a non- COVID-19 world.

Impact of COVID-19 on Workload by Care Location

	Fiscal Year			
	2020	2021	2022	2023
Percent Change to All Care Locatio				
Economic Impact on Reliance Behavior	0.70%	1.20%	0.70%	0.50%
Deferred Care - Utilization	-12.60%	-6.30%	0.00%	0.00%
Returning Care - Utilization	0.80%	1.90%	6.80%	0.00%
Other COVID-19 Impacts	0.00%	0.00%	-0.40%	-0.30%
Scenario BRA9 - COVID Total	-11.10%	-3.10%	7.00%	0.20%
Percent Change to VA Facility[1]				
Economic Impact on Reliance Behavior	0.70%	1.30%	0.70%	0.50%
Deferred Care - Utilization	-12.80%	-6.20%	0.00%	0.00%
Returning Care - Utilization	0.00%	2.30%	7.30%	0.00%
Other COVID-19 Impacts	0.00%	0.00%	-0.50%	-0.30%
Scenario BRA9 - VA Facility	-12.20%	-2.60%	7.50%	0.20%
Percent Change to Community Care				
Economic Impact on Reliance Behavior	0.70%	1.20%	0.60%	0.50%
Deferred Care - Utilization	-11.70%	-6.60%	0.00%	0.00%
Returning Care - Utilization	3.30%	0.90%	5.00%	0.00%
Other COVID-19 Impacts	0.00%	0.00%	0.00%	0.00%
Scenario BRA9 - Community Care	-7.70%	-4.40%	5.60%	0.50%

(1) Percent of the Scenario BRA9 projection before COVID-19 impacts are applied.

Question 3. **In December 2020, VA received its full appropriation request for Fiscal Year 2021. With that request, VA's Veterans Health Administration (VHA) expected to sustain 352,084 full time equivalent employees (FTE) in FY 2021, a pre-pandemic estimate. The President's Fiscal Year 2022 request estimates that FY 2021 VHA FTE will only be marginally higher at 352,427. According to VHA Chief Financial Officer, Laura Duke, during a February 5, 2021 briefing to Committee staff, the largest part of the $19.6 Billion CARES Act funding was for additional care delivery costs that were not anticipated due to the pandemic. Increased staffing was a primary component of that cost and sustainment of those FTE was how a large part of residual CARES funding was being used for the remainder of fiscal year 2021. The FY 2022 budget submission (Budget in Brief BiB-6) affirms this when it states that with CARES funding "VHA hired thousands of clinical and administrative staff across the health care system to ensure stability and continued delivery of care." Further, post-hearing question responses in connection with the Committee's February 24, 2021 hearing justified (in part) the immediate**

need for American Rescue Plan (ARP) funding by arguing that VA could "ensure staff hired with CARES Act funds [that] they have job security." *H*ow many employees were hired and are now sustained with CARES funding?

Response: In 2020, CARES Act funded a cumulative net increase in employees of 6,087 in Medical Care.

Question 3a. **If there were thousands hired with CARES funding, how does that explain current FY 2021 VHA FTE levels being almost exactly what VA estimated it would be with base FY 2021 funding alone?**

Response: The 2021 PB provided sufficient funding to reach a projected cumulative net FTE level of 352,093. Throughout the pandemic, VA experienced an increase in overall salary costs associated with premium pays (overtime, shift differentials, and incentives) to ensure Veteran Care.

Question 4. **Workload is a primary driver of VA's resource needs with ambulatory visits being a major component. Congress provided VA's full appropriation request for FY 2021 to meet this workload need. VA's pre-pandemic estimate in its FY 2021 budget submission was that base FY 2021 appropriation resources were needed for 126,492,000 expected outpatient visits in FY 2021, with the forecast for FY 2022 being 128,704,000 outpatient visits. The President's FY 2022 budget submission now assumes 114,721,000 outpatient visits in FY 2021 and 118,900,000 visits in FY 2022. American Rescue Plan funding was justified primarily on an expected surge in demand from veterans who deferred care during the pandemic, yet it appears VA is projecting 10 million fewer visits in FY 2022 than what it assumed a year ago and even 7.5 million fewer visits than it expected for all of FY 2021. Please explain this. Where is the surge in demand occurring that justifies the resources in the FY 2022 request and in the ARP?**

Response: Refer to Question 2.

Question 5. **In the FY 2022 budget submission, the summary for VA's Medical Services FY 2023 advanced appropriation request states, "After VA addresses the return of deferred care, the Department projects that growth in workload levels will stabilize in comparison to pre-pandemic levels, thus requiring fewer total resources in 2023." Looking at FY 2019 actual workload for outpatient visits as a marker for pre-pandemic levels, 120,171,000 outpatient visits were completed. Despite VA's pre-pandemic workload projections, the Department is requesting an increase of $11.4 billion in advanced appropriations for FY 2023. Please explain the**

Department's basis for the increase in the FY2023 advanced appropriation request despite decreased patient workload post-pandemic.

Response: VHA is supplementing its Medical Services FY2022 enacted Advance Appropriation of $58.9 billion with $9.6 billion out of unobligated balances provided by sections 8002 and 8007 of the ARP Act for activities that would otherwise be funded by the Medical Services discretionary appropriation. When these resources are combined with available anticipated collections, transfers, reimbursements, and other net unobligated balances, Medical Services will meet the projected 2022 obligation level of $74.8 billion. Although the FY2023 Advance Appropriation request is $70.3 billion (an increase of $11.4 billion from the 2022 revised discretionary request), total obligations in FY2023 are projected to be $1.2 billion less than total obligations in 2022. VA projects that a significant amount of health care that was delayed during the pandemic will return to the VA health care system in 2022, coupled with the return of care to pre-pandemic levels. The infusion of funding included in the American Rescue Plan Act provides VA with the resources necessary to address total demand in 2022. After VA addresses the return of deferred care, the Department projects that growth in workload levels will stabilize in comparison to pre-pandemic levels, thus requiring fewer total resources in 2023.

Question 6. **The current FY 2021 estimate for VHA FTE is 352,427. The FY 2022 base budget request supports a <u>reduction</u> in VHA FTE for FY 2022 at 341,270. ARP funding is proposed to increase staffing by 28,000 in FY 2022 for a total FTE level (when combined with the FY 2022 request) of 369,847. It appears ARP funding is being used, in part, to relieve base appropriation pressure by first funding roughly 11,000 FTE to keep VHA FTE levels flat with FY 2021 levels, then funding another 17,000 FTE to account for the net FTE increase from FY 2021 to FY 2022. Is this true? Please explain.**

Response: The ARP funding complements the CARES Act funding post pandemic as VHA transitions to post pandemic operations. The ARP Act funds are displayed interchangeably with base year funding in the FY 2022 President's Budget, consistent with the authorities in the ARP Act.

Question 6a. **If it is true, how is it consistent with VA's explanation that ARP funding was needed to meet an expected surge in demand?**

Response: Refer to Question 2.

Question 7. **The FY 2023 advance appropriation requests assumes VHA FTE will be 369,847, the same level projected for FY 2022 with combined base appropriations and ARP funding. In effect, FTE gains from ARP funds are proposed to be absorbed into VA's appropriation baseline for FY 2023. Is this correct?**

Response: Yes.

Question 7a. **If so, how is this consistent with Dr. Stone's assertion at the Committee's February 24, 2021 hearing that ARP was needed to meet a "bow wave" of demand which may subside?**

Response: The pandemic induced bow wave is projected to take place in 2022 and a major driver of projected obligations increasing from 2021. See Question 2 for workload information.

Question 7b. **Again, if so, how is this consistent with VA Chief Financial Officer Jon Rychalski's February 5, 2021 briefing to Committee staff during which he relayed that the ARP is the appropriate funding vehicle to meet pent up demand, similar to a supplemental, in that it gives VA flexibility outside of its base appropriations for FY 2021 and FY 2022 to survey the demand picture if/when the bow wave subsides, permitting VA to then determine appropriate FTE levels?**

Response: The ARP Act provided resources that expire at the end of 2023. The 2023 Budget Cycle will incorporate 2021 actuals and a new actuarial model projection to inform the 2023 Revised Request, at which time VA will reassess FTE levels.

Question 8. **The FY 2022 budget submission notes that this budget fully funds P.L. 116-171, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act.**

Question 8a. **Please provide a detailed summary of FY 2022 budget request for P.L.116-171 provisions outside of the SSG Parker Gordon Fox Suicide Prevention Grant Program (§201) and the Readjustment Center Scholarship (RCS) Scholarship Program (§502)**.

Response: SSG Parker Gordon Fox Suicide Prevention Grant Program (§201) $55.694 M and the Readjustment Center Scholarship (RCS) Scholarship Program (§502) $301 thousand.

Question 8b. **Additionally, please provide detailed information regarding requests for funding of the MVP-MIND research program and the Precision Medicine for Veterans Initiative (§305).**

Response: Million Veteran Program - Measures Investigating Neuropsychiatric Disorders (MVP-MIND) FY22 Budget request:

$1,429,566

The MVP-MIND FY22 budget funds the centralized recruitment infrastructure, including project management, site management and oversight, biospecimen collection and processing, data and informatics activities at the MVP Core as well as funding for recruitment and enrollment staff at sites. The 12 MVP-MIND sites across the country will be responsible for conducting the study recruitment and enrollment activities and will be staffed with 1 FTE per site. Mailing and Public Relations activities include recruitment materials, printing/distribution/scanning of the MVP-MIND Survey, and Public Relations (PR) materials including but not limited to fact sheets and brochures.

In addition, the Precision Medicine for Veterans Initiative (§305) will demonstrate the ability of VA to process large scale multi-modal assessments, VA will tap into the Long-term Impact of Military-relevant Brain Injury Consortium (LIMBIC). LIMBIC is a coordinated, multicenter collaboration linking brain researchers from VA, the military, and academia to effectively address the long-term effects of mild TBI and its frequent co-morbidities, e.g., substance use, depression, and PTSD, to develop better diagnostics and treatments. The participants in this study have had MRI imaging, EEG, and their blood biospecimens are being analyzed for biomarkers. The de-identified data from LIMBIC is being shared through the Federal Interagency Brain Injury Research (FITBIR) Database (housed at the National Institutes of Health) and can be accessed by qualified researchers. Currently, VA is funding this initiative with $5 million per year out of existing funds.

Question 9. **Can the Department provide more detail regarding the request for $25 million for Coronavirus related research?**

Question 9a. **Additionally, please provide the detailed research plan from the Office of Research and Development.**

Response: The $25 Million in additional funding requested is comprised of the following:

$18 Million for COVID Related Research. The table below totals $18.2 Million and represents a portion of the $57 Million estimated in the Designated Research Area (DRA) tables (for all infectious disease studies) on page 584 of the ORD Budget Chapter.

Title	Estimated FY22 need
ORD COVID-19 Biorepository/VA SHIELD	$2,462,366
Variant Sequencing	$2,856,250
Epidemiology, Immunology and Clinical Characteristics of COVID-19 (EPIC3) within the Veterans Health Administration	$5,500,000
COVID-19 Pandemic-Related Disrupted and Deferred Care	$1,400,000
COVID Observational Research Collaboratory	$1,000,000
Study of Vaccine Hesitancy	$500,000
Mobile Phlebotomy Contract	$500,000
New investigator initiated COVID-19 Projects	$4,008,959
Total	$18,227,575

$12 Million to fund projects delayed due to COVID 19: The estimate is based on extensions for projects where funding was distributed related to the impact of COVID-19 in 2020 and 2021.

Note: The request is for $25 million while the total estimated costs related to COVID-19 are $30 million. The additional $5 Million will be funded out of current base resources (within the Infectious Disease Designated Research Area which is estimated at $57 Million for FY 2022).

Question 9b. **Can the Department include a summary quantifying and illustrating how VA research funding is necessary when considering the abundance of national and global research already being conducted on COVID-19?**

Response: VA Research is uniquely positioned to provide its expertise in COVID-19 research as the largest integrated healthcare system in the country. COVID-19 research funding would support efforts begun during the pandemic and done in coordination with other federal agencies. For example, one of the included studies is establishing a

cohort of Veterans and active duty military personnel to determine the longer-term outcomes of individuals infected with COVID-19. Much of the abundance of national efforts were done without VA having received any dedicated COVID-19 funding.

Nonetheless, given VA's capabilities for conducting multi-site activities embedded within the VA healthcare system and a number of national academic and scientific leaders in infectious diseases, several of the national research studies already being conducted include VA contributions. These studies take advantage of VA's ability to connect research and patient care data to more fully understand the disease and its long-term outcomes. Research activities within VA's Veteran population will track real world evidence of vaccine implementation and failure.

Currently, study teams are working with CDC, NIH and other groups to determine how to best share information on the VA population that has a richer dataset in regard to vaccinations, compared to others. This information can aid in determination of need for vaccine booster, new vaccine design, etc. VA is positioned to conduct these analyses because of access to electronic health record data of all patients who are vaccinated within the VA system.

In addition to on-going activities, newer efforts would focus on:

- Vaccine failure – vaccine and time post-vaccination (enhanced with large Veteran population with many comorbidities that are high risk for COVID complications).
- Variant surveillance and correlation with clinical outcome based on medical counter measures (MCM) implemented (vaccine, therapeutic, etc). Real world evidence of efficacy of products.
- Clinical outcome /severity – course of disease, longer term sequelae (Long haulers) in a population with higher rates of comorbidities.

Question 10. **How does the Department plan to utilize FY 2022 funding to maximize high-quality virtual care options for veterans who reside in rural and highly rural areas, besides distributing tablets?**

Response: VA has established a five-year strategic vision for connected care which will leverage VA's connected care appropriation to 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 strategy includes initiatives that will enhance the accessibility of VA health care in rural areas by delivering enhanced video telehealth care in the home using VA Video Connect and VA provided digital stethoscopes and other examination peripherals (e.g., blood pressure cuffs, pulse oximeters, thermometers, etc.). The strategy includes continued focus on expanding the capacity of VA services in rural and underserved areas by distributing clinical

resources using telehealth, through clinical resource hubs and other virtual health care delivery initiatives, including inpatient services such as tele-critical care, high volume outpatient services such primary care and mental health, and low volume, highly specialized services such as stroke neurology. Additionally, the strategy supports expanding remote patient monitoring capabilities, allowing rural and highly rural Veterans to attentively monitor and manage chronic health conditions, in partnership with VA, from their homes.

As part of its vision to deliver trusted VA care, anytime and anywhere, VA will continue efforts to bridge the digital divide for Veterans who lack the technology or broadband internet connectivity required to participate in VA telehealth services irrespective of their location in the country. VA has implemented a national digital divide consult process in the electronic medical record. Through this process, qualifying Veterans can obtain an internet connected device from VA or assistance in applying for Federal Communications Commission administered internet subsidies. The FCC subsidies are available through the LifeLine and Emergency Broadband Benefit (EBB) programs. The Lifeline and EBB programs can combine to provide many qualifying Veterans $59.25 per month for their internet services. Veterans on tribal lands can receive $109.25 through these programs. VA has completed over 49,500 digital divide consultations since the beginning of FY21 and has distributed more than 84,000 internet connected tablets since the start of the pandemic. Additionally, major wireless carriers such as Verizon, T-Mobile, SafeLink by Tracfone and AT&T have partnered with VA to support Veterans' access to VA telehealth services through the Zero Rating program, allowing Veterans, their families and caregivers to use VA Video Connect with fewer worries about data fees.
VA will also use FY 2022 funding to continue enhancing existing telehealth infrastructure at community-based clinics serving rural and highly rural parts of the country. Clinical video telehealth visits, with full remote examination capabilities, allow Veterans to easily receive specialty care services at their closest clinic, even if the specialist is elsewhere in the VA system. VA is also evaluating opportunities to further leverage community-based telehealth access points through its ATLAS (Accessing Telehealth through Local Area Stations) program. VA currently has 12 ATLAS locations nationally that are open and available for scheduling. By the end of 2021, it is anticipated that a total of 15 ATLAS sites will offer clinical services by telehealth from VA providers.

Question 11. **The Department's FY 2022 budget submission states the current estimate for FY 2022 Medical Community Care obligations related to MISSION Act health care services is $12.8 billion. However the FY 2022 revised request for MISSION Act health services is $16.9 billion. Please explain the discrepancy between the estimates and include any factors that may have resulted in such discrepancy.**

Response: Page VHA-332, which has a table with combined Medical Community Care, Veterans Choice Fund, and American Rescue Plan resources

accidently left the label "MISSION Act affected" off the Non-Institutional LTSS line. The amounts cited above appear to be from the table at the top of page VHA-330 which only displays obligations projected from the MCC community care account without CARES Act obligations.

Question 12. **The FY 2022 budget submission's request for Medical Community Care includes $1.2 billion in Third Party Administrator obligations. VA states these funds will cover the costs associated with CCN contract modification among other things. VA's FY2021 budget submission included similar language concerning contract modifications. Does the VA intend to modify CCN contracts for Regions 1-4 to incorporate MISSION access standards which were included in the Region 5 contract awarded last year? If so, would the contract modification take place in FY 2021 or FY 2022?**

Response:

VA has multiple modifications to the five existing Community Care Network (CCN) contracts in progress, so the FY 2021 and FY2022 budgets reflect estimates for the work in progress on all of these modifications. Since contract modifications are bi-lateral, VA cannot estimate when specific modifications will be completed. However, the budget estimates included all known modifications in progress when the budget submission was prepared. We continue to refine the network based on Veteran needs. For example, VA is in advanced stages to modify the CCN contracts to ensure that when a Veteran in highly rural parts of the country needs care (such as in rural Kansas), they will not have to drive up to 3 hours to obtain care if a provider that meets our quality and credentialing standards exists closer to their home. We will use lessons learned from this modification to inform additional changes that may be needed. VA is committed to continuing to review its network to ensure it is meeting emerging Veteran needs but it is important to acknowledge that in many cases specific providers do not exist in various parts of the country. Also, the quality of the care provided to Veterans is of paramount importance and we are committed to having the right network to meet Veterans needs but providers must meet our standards for credentialing and quality in order to participate.

Question 13. **In 2022, Office of Research and Development will launch MERP (Military Exposure Research Program) to focus on gap-filling, evidence-based knowledge for Veterans with toxic exposure health outcomes. This will include collaboration with VA, DoD, National Academy of Science, Engineering, and Medicine (NASEM), and other stakeholders. In what other research partnerships is the VA going to engage?**

Response: The Military Exposure Research Program (MERP) will actively collaborate with Federal agencies, academic affiliates and other organizations to leverage and expand resource capabilities including subject matter expertise, infrastructure, data

bases, technology, and development of exposure assessment assays. Figure 1 below shows an example of agencies, organizations, and subject matter experts that VA will engage.

Question 13a. **What role will VA play in this collaboration?**

Response: VA will play the primary role in making contacts, organizing meetings, and setting goals. As collaborations and agreements are established, roles from each agency will be continuously pliable based on needs and expertise. We anticipate that more collaborations will be formed based on connections through our new partners.

Question 13b. **Will the CDC and NIH be included as stakeholders? What other stakeholders, or types of stakeholders, are envisioned as being part of MERP?**

Response: Yes. Figure 1 below shows a draft list of identified agencies, organizations, and subject matter experts we have identified as instrumental collaborators.

Military Exposure Research Program – Office of Research & Development (ORD)

❖ MERP Partnerships & Roles

Federal Partnerships	Roles
• VA intra – (ORD Services/Programs, Biorepositories, VA Non-Profit Corporations, QUERI)	Infrastructure, Implementation
• VA inter – (Post-Deployment Health, War Related Injury Illness Study Centers)	Priorities, Veteran Communication, Epidemiology
• DOD (Army Public Health, Defense Health Agency, Millennium Cohort Group, DOD Biorepository, Individual Longitudinal Exposure Record (ILER)	Exposure Assessment/Data & Biological Specimens
• National Institutes of Health (Environment Health Safety, Aging, Neurological Diseases, Nursing)	Exposure Assessment, High Impact Collaboration
• Centers for Disease Control and Prevention (CDC)	Data base, Subject Matter Expertise
• Agency for Toxic Substances and Disease Registry (ATSDR)	Data base, Subject Matter Expertise
• Environmental Protection Agency (EPA)	Data base, Subject Matter Expertise
Non-Federal Affiliates and SMEs	
• Academia	Technology, Subject Matter Expertise
• National Academy of Science, Engineering, and Medicine (Emerging Science for Environmental Health Decisions)	New model Development
• Military Exposure Exposome Development (Detection and Health Outcomes)	Subject Matter Expertise
Community Stakeholders	
• Veterans with Toxic Exposures	Subject Matter Expertise
• Veteran Service Organizations (VSO)	Subject Matter Expertise
• Private Foundations – Toxic Exposures	Subject Matter Expertise

Figure 1. MERP Partnerships & Roles

Question 14. **The VA budget listed $7 million for Toxic Exposure/Military Exposures Research as a new or ongoing initiative. VA has consistently testified that they have more than 30 ongoing toxic exposure research projects.**

Will the funding go toward an existing study to expand the research to more veterans?

Response: While the MERP will be a distinct program solely focused on military toxic exposures and directed by subject matter experts, the MERP efforts will build on the existing investigator-initiated projects on toxic exposures that are currently funded by the VA Office of Research and Development. In addition, the MERP will place emphasis on program-directed research to ensure targeted priority areas are covered. The infrastructure and staffing will be critical to establish new partnerships, leverage technology for exposure assessment, and ensure that early intervention is achieved. The MERP is expected to launch FY22, therefore, the new funding will support the launch of the MERP.

Question 14a. **Will the funding go toward a new study focused on burn pit exposure health outcomes?**

Response: Yes. One of the toxic exposure priority areas for the MERP is burn pits. The MERP will establish Military Exposure Research Innovative Centers (MERICs) with the first planned MERIC to have focus on Burn Pits. Additionally, individual projects focused on burn pit exposure assessment and health outcomes of burn pits will be prioritized.

Question 14b. **Can the Office of Research and Development provide a detailed list and summary of the Department's research projects already underway regarding toxic exposure and military exposures research?**

Response: PDHS research is available at:
https://www.publichealth.va.gov/exposures/research-studies.asp
PDHS peer reviewed publications are at:
https://www.publichealth.va.gov/epidemiology/publications.asp

See attachments for Airborne Hazards Burn Pit Center of Excellence research and other on-going VA efforts.

Question 14c. **What are the actual research project titles, summaries, and the approximate number of participants?**

Response: See attachments for Airborne Hazards Burn Pit Center of Excellence research and other on-going VA efforts.

Question 15. **VA recognizes the continued growth in concern surrounding military environmental exposures and garrison exposures due to continued military conflicts, as well as the key role that the Individual Longitudinal Exposure Record (ILER) will play in identifying toxic exposed veterans and cohorts, and connecting them to care. The VA**

acknowledges that ILER will subsume the six congressionally mandated registries that Post Deployment Health Services oversees. Please elaborate on the planned new centralized call center and the plan to ensure greater uniformity in service across VHA.

Response: ILER will include, but not replace the 6 congressionally mandated registries. These legacy registries will remain for Veterans since these registries were developed well before the data integration that can now be done by the Individual Longitudinal Exposure Record; a new way to create better registries to build cohorts for surveillance, research trends and contact Veterans.

To better respond to the increasing concerns of Veterans about exposures, VA is exploring a new way of meeting this need. The Veteran Exposure Team – Health Outcomes Military Exposures (VET-HOME) will leverage lessons learned during COVID regarding telemedicine provision of care and decrease variance in this necessary core VA competency.

Overview: VET-HOME consists of two interconnected parts: a call center for Veterans and providers regarding environmental exposures and existing registries, such as the Airborne Hazards and Open Burn Pit Registry. Veterans and providers with questions on environmental exposures would call into a central location and be followed through the registry exam or environmental exposure process. The Veteran would be referred to one of 40 environmental health providers across the United States who would work with the Veteran using a telemedicine platform to complete the assessment and when necessary refer the Veteran to a VA facility to complete any specialty testing, like a pulmonary function test or other lab work. Providers with exposure questions would consult with these same 40 experts to better care for their Veteran's environmental health concerns, delivering better care to the Veteran. The results of the consultation would be shared with the Veteran's primary care provider. Estimates of costs are $15M, but some personnel already in the military environmental health clinics will be moved to VET-Home so the costs me be slightly less.

Question 15a. **VA cites specifically the opportunity to serve veterans in rural areas particularly well through this new system. How does the VA plan to account for limited access to broadband for highly rural veterans?**

Response: To better respond to the increasing concerns of Veterans about exposures, VA is exploring a new way of meeting this need. The Veteran Exposure Team – Health Outcomes Military Exposures (VET-HOME) will leverage lessons learned during COVID regarding

telemedicine provision of care and decrease variance in this necessary core VA competency.

A great deal of telemedicine can be accomplished by a standard hard-wired phone line. A smart phone or computer access for a "Zoom" call is helpful, but not necessarily needed. When required for labs, x-rays, in-person exam or further consultation via "face to face" telemedicine the call center will arrange and appointment at the closest VA facility.

Question 15b. **With use of the Call Center Centralized, and decentralized examiners, what is the vision for the use of this system as ILER comes online and going into the future? Please explain how these initiatives will work together and the effects on resources, particularly the envisioned "great savings" due to registry exams via telemedicine**.

Response: ILER will be a resource for all VA clinicians to review possible exposures for each Veteran. ILER and VET-Home are complementary, but separate programs.

ILER will allow the VET-HOME healthcare providers to more quickly and completely provide environmental assessments, but the savings are in the remodeling of how VA performs these assessments (VET-HOME) not through ILER.

Each VA Medical Center has at one Environmental Health Coordinator and at least one clinician. At times the clinician is dual hatted for other duties, but this is roughly 150 coordinators and 150 clinicians. The call center and distributed network of providers with solid backgrounds and training in military environmental exposures will decrease the number of personnel to accomplish this important core VA mission. Estimates are 28 in the call center and 40 physicians/PAs/Nurse Practitioners.

Additionally, the distributed network of providers would be available for consultations with local providers to assist with questions about care for Veterans with possible exposures or concerns. Since environmental exposure medicine is not taught in medical, PA or nursing school this service will be especially valuable for providers.

Question 16. **VA announced starting rulemaking on three new presumptions associated with service in Southwest Asia and burn pit exposure. This announcement was mentioned in the Office of Media Relations (OMR) accomplishments in the Budget Request. Still, there is no further information regarding rulemaking, operational impacts, or**

additional administrative costs. What is the impact on claims processing?

Response: As noted in the Department of Veterans Affairs' (VA) May 27, 2021 Press Release, VA is initiating rulemaking to consider adding respiratory conditions, which may include asthma, sinusitis, and rhinitis, to the list of chronic disabilities, based on an association with military service in Southwest Asia, Afghanistan and Uzbekistan during the covered periods of conflict. Currently, VA is considering multiple factors as part of the rulemaking process and is conducting further analysis to determine the potential number of impacted Veterans/claimants. While VA anticipates that there will be a workload impact, a full determination of the impact is not finalized.

Question 16a. **Will this require more FTE to process claims?**

Response: VA is conducting further analysis to determine the potential number of impacted Veterans/claimants. This analysis is necessary to assess the additional resources that may be required.

*Question 16b.***What other operational and administrative impacts will be considering during rulemaking?**

Response: VA is considering the impact on various aspects of disability compensation program, such as people, processes, and technology. VA is working to identify all areas affected, deliverables needed, and other impacts due to this change.

Question 17. **Numerous program offices throughout all three Administrations in VA provide services geared toward preventing and ending veteran homelessness; however, the Budget Request does not provide a total amount of funding attributed this goal across the Department. The VHA Homeless Veterans Program Office received increased flexibilities, additional funding, and an authorization for program expansion during the 116th Congress, in addition to funds from the CARES Act and ARP. The number of homeless veterans has consistently decreased every year since 2009 because of steady yearly budget increases and a sound focus on programs with wrap-around services; however, the number of homeless veterans increased ahead of the COVID-19 pandemic.**
What is the total amount of funding (including CARES and ARP) being allocated to homeless programs across all three Administrations, including those not tracked by the VHA Homeless Program Office's direct support to seven homeless programs initiatives, VBA programs, and NCA apprenticeship efforts?

Response: The 2022 VHA budget for Homeless Prevention Programs is $2.640 billion from all sources of which $$2.028 billion is managed by the program office and remaining $612 million is estimated to come from medical center budgets support the effort. These costs are independent of the health care costs of treating a Homeless Veteran.

Question 17a. **Will VA allocate funding differently in order to maximize additional funds from the pandemic to work toward ending veteran homelessness?**

Response: VA's proposed plan integrates the new ARP funding into a comprehensive and systematic recovery plan to address prevention and ending homelessness. It includes strategies to ensure access to and availability of permanently housing, removing barriers to access and sustain affordable housing, preventing and reducing homelessness exacerbated by the pandemic, mitigate the economic effects that will negatively impact homelessness and the possible wave of evictions by strengthening strategies under a target focus approach. Nine specific strategies are towards addressing the possible wave of evictions. Strategies will be implemented upon HPO receiving the ARP funding. VA intends to monitor ARP funding on a monthly basis and will adjust strategies as needed.

Question 17b. **What will be done differently now that ending veteran homelessness is one of the Secretary's top six priorities?**

Response: We are taking an evidence-based, Housing First approach to reach underserved populations and working with our partners to prioritize increasing the supply of affordable housing. This approach will incorporate recent statutory changes providing us with critical flexibilities in serving homeless Veterans. And it will maximize the impact of the considerable financial resources that have been dedicated to this effort through the traditional budgetary process as well as through special legislation related to the COVID-19 pandemic and economic recovery. Despite the many challenges our country and our Veterans face, those of us responsible for this work have cause for optimism. We have the expertise and experience that generated the early significant declines in Veteran homelessness. VA will ensure that Veteran homelessness is prioritized at the highest level of leadership. The Secretary will be the vice-chair in the US Interagency Council on Homelessness to recommit our efforts to make ending Veteran homelessness a priority.

Question 18. **Your budget requests $137.6 billion for the C&P account, which is an increase of $7.3 billion over your 2022 advance appropriation request. With this budget increase, what is the Department's projected backlog numbers by the end of FY 2022, taking into account the 3**

additional Agent Orange presumptions added in the FY 2021 NDAA, the Nehmer case, and the backlog that resulted from the COVID-19 pandemic?

Response: VA has requested and was granted overtime funding in two instances:

- VA received authority to transfer up to $140 million in Coronavirus Aid, Relief, and Economic Security (CARES) Act funding to support claims processing overtime. To date, $75 million has been transferred.
- VA requested and was authorized $262 million by the American Rescue Plan (ARP) Act of 2021 to support improvements in VBA claims processing, to include $100 million to fund overtime.

These two overtime requests, coupled with VBA's request for 429 additional employees in the FY 2022 budget will directly support claims processing and backlog reduction, to include the Nehmer court ordered readjudication and new Agent Orange claims, and reflects the growth in VBA's programs that require additional employees. While these employees are needed to sustain long-term claims processing requirements, they require up to 2 years of training and experience to achieve an acceptable level of proficiency. Overtime hours worked by experienced staff will remain critical to the FY 2022 performance.

By the end of FY 2022, with the resources listed above and with sustained improvement to the claims evidence supply chain, VBA aims to meet the Secretary's goal of reducing claims pending over 125 days to approximately 100,000. This reduction assumes continued increases in C&P examination output from the contract examination providers and VHA, resulting in a reduction of examination inventories to normal levels by the end of the fourth quarter of FY 2021, as well as continued improvement to Federal records availability.

VA is continuing to evaluate the impact of adding the Gulf War presumptive conditions (asthma, sinusitis, and rhinitis) on backlog. While VA does anticipate that there will be a workload impact, a full determination of the impact is not finalized.

Question 19. **Due to COVID, there was an impact on C&P exams both at the department and through contract exams, which led to the current backlog of exams and disability claims decisions. How does the FY 2022 budget request reflect VA's plan to bring down the over 300,000 claims backlog, as well as the pending exams (65% of the pending claims, according to VA) that have not yet been conducted due to the pandemic?**

Response: The Veterans Benefits Administration (VBA) fiscal year (FY) 2022 budget request included contract examination costs to address the excess inventory of examinations needed to reduce the claims backlog.

Question 19a. **In the FY 2022 budget request, the Department articulated that payments for the contract exams program in 2020 increased by $442.1 million from the original estimate due to an increase in the volume of work completed by contract examiners as a result of VHA transitioning C&P exams to VBA. Please expound on how many C&P exams will be shifted completely out of VHA and to VBA contract examiners?**
Response: VHA's budget projects approximately $461 million obligations in 2021 and $694 million obligations in 2022 for continued VHA support for C&P examinations.

Question 19b. **How does the budget request account for the expanded telehealth and acceptable clinical evidence exams (ACE) that were conducted last year during the suspension of in-person exams last year?**

Response: VBA's budget requests incorporated costs associated with the completion of ACE and Tele-Health exams. The cost savings associated with these examination types were countered by the increased volume of completions of in-person examinations conducted once the suspension of in-person examinations was lifted.

Question 20. **The American Rescue Plan provided an additional $272 million for VBA and BVA to fund FTE overtime and expanded telework for medical disability exams (MDEs) and claims examiners, despite the fact that VA told this Committee that overtime money was not needed. Will the Department continue overtime hours for these FTE as VA tackles the backlog and, if so, how does the budget request reflect these additional FTE and man hours?**

Response: VBA currently plans to fund $100 million for overtime in FY 2022, which will be used to reduce the projected backlog of claims related to the impact of COVID-19 delays in completing medical disability exams.

Question 21. **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.**

The Department is now asking for another increase to $125 million a year. This Committee is extremely supportive of this program and wants to ensure that it is successful and that as many veterans benefit from this program, as possible. If we are going to increase the authorization cap

again, we need to understand the outcome measures of this program and why an additional increase from $45 million to $125 million is needed. Could the Department provide a formal interim report 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.

Response: As of June 1, 1,956 Veterans have completed a VET TEC program, and 1,135 Veterans have secured employment in the technology field that he or she studied in. 371 graduates are within their 6-month window to secure employment post-graduation, and there are over 700 Veterans currently training in a VET TEC program. For those who have found employment, the average salary is $58,000, and the average days to hire is 68 days. Many Veterans find employment in fields that are in high demand including cyber security, computer/software programming, and system administration and support. With over 27,000 Certificates of Eligibility issued for VET TEC and the continued need for individuals with high tech skills to support the country's economy and future, VA expects the VET TEC pilot program's popularity with Veterans and the technology industry to grow.

Participating VET TEC training providers and their locations are available here: VET TEC Training Providers - Education and Training (va.gov).

Question 22. **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 FY 2022 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?**

Response: VA seeks to ease the transition from military service to civilian life and we have several interagency and community partnerships that assist Veterans and their families as they leave the military.

The Transition Assistance Program (TAP) supports over 250,000 Service members who transition from the military to civilian life annually, serving as the gateway to VA. VA collaborates with interagency partners including the Department of Defense (DOD), Department of Labor (DOL), Department of Homeland Security (DHS), Department of Education (DOE), the Small Business Administration (SBA) and the Office of Personnel Management (OPM) to carry out the requirements of the Veterans Opportunity to Work (VOW) to Hire Heroes Act, P.L. 112-56. VA and DOL coordinated the TAP employment curriculum

course content to ensure that their respective courses are complementary to each other and not redundant.

Additionally, the VA Solid Start Program is a collaborative effort among VA, DOD and DHS to contact 250,000 newly separated Service members during their first year of transition from the military to civilian life.

VA also provides two key programs to enhance the Veteran's experience beyond separation: Economic Development Initiatives (EDI) and Personalized Career Planning and Guidance (PCPG). VA plans and executes bi-annual EDI events in economically distressed locations with high Veteran populations defined as Internal Revenue Service (IRS) Qualified Opportunity Zones. EDI events include benefit fairs, town halls, claims clinics, job fairs and workshops. These events connect Service members, Veterans, and their families with networking opportunities and VA benefits and services to improve their economic wellbeing. They offer in-person support to sign up for disability compensation benefits, education benefits, offer opportunities to learn about local business and employment prospects. VA hosts EDI events in coordination with VA regional offices, state Departments of Veterans Affairs, DOL, regional organizations, non-governmental organizations, and industry leaders.

Lastly, FY 2022 includes $3.6 million to develop a VA Disability Employment Pilot Project and $5 million to support the DOL in developing a clean energy job t raining program for eligible Veterans, transitioning Service members, and military spouses.

Question 23. **The Administration has requested $2.7 billion for the Veterans Electronic Health Record account. What justification is there after successive delays in the Mann-Grandstaff medical center's "go-live" date, a reshuffling of the sequence of facilities for future "go-lives," and the commencement of a strategic review of the program?**

Response: VA's fiscal year (FY) 2022 budget request of $2.7 billion for the Veterans Electronic Health Record account is based on the deployment schedule submitted to Congress in August 2020. VA followed this schedule and deployed capability set 1.1 to Mann-Grandstaff VA medical center (VAMC) in Spokane, Washington, in October 2020. In March 2021, VA Secretary Denis McDonough announced the Department will conduct a strategic review of the Electronic Health Record Modernization (EHRM) program. While Columbus is currently scheduled to remain the next "go-live" site, the date of its go live is under consideration, along with the order of subsequent deployments.

Stability of funding allows necessary work to be performed prior to deployment and minimize duplication of work when OEHRM re-engages with sites post-strategic review. With this funding, VA will be able to fulfill the mission to provide our Veterans the best quality care possible. The Office of Electronic Health

Record Modernization (OEHRM) is focusing on an enterprise-wide approach to prepare VAMCs for the new electronic health record solution. This approach involves having more sites conduct pre-deployment activities earlier in the timeline of the program, such as completing necessary infrastructure upgrades six to eighteen months prior to deployment. After recommendations from the strategic review are completed, VA will provide Congress with the revised schedule that aligns with EHRM's overall strategy, 10-year timeline and funding implications for FY 2022. We look forward to brief the committee on the strategic review by our assessment team.

Question 24. **The Administration has requested $4.8 billion "in total resources" for the Office of Information and Technology (OIT). This represents an approximately $100 million cut from the FY 2021 appropriation. Why is there a cut to aggregate information technology funding given the fact that nearly all other VA accounts continue to increase rapidly, and additional employees, programs, and systems inevitably create costs for OIT?**

Response: OIT will only use the $670M request from the Transformational Fund to support Operations and Maintenance (OM) for Infrastructure Readiness Program (IRP), Financial Management Business Transformation (FMBT), and Human Resources (HR). Please see the allocation below ($ in millions):

- Infrastructure Readiness Program (IRP): $477.543
- Financial Management Business Transformation (FMBT): $122.886
- Human Resources (HR): $69.571

Total: $670.000

Question 25. **The Office of Accountability and Whistleblower Protection's FY 2022 budget request is $26.5 million and 135 FTEs, an increase of around $4 million over the FY 2021 enacted level. The Office of Special Counsel's FY 2022 budget request is less than a million more than OAWP at $27.4 million and 126 FTEs despite its statutory requirement to address complaints related to whistleblower and prohibited personnel practices from every federal agency. The budget indicates that OAWP resolved 570 cases dating back to 2017 and made a total of 83 recommendations in since September 2019. In FY 2019, OSC received 1,843 cases from the VA alone and managed to resolve 6,193 cases. Given the disparity in caseload between the agencies, please justify OAWP's budget request. OSC's budget request breaks down the office's funding request and FTEs assigned to each component, including resources budgeted for diversity, outreach, and training of federal employees. Please break down OAWP's budget request by component.**

Response: It is important to note that OAWP, OSC, and the VA OIG each have unique statutory authorities. For example, OAWP investigates VA senior leader misconduct and poor performance whereas OSC would not investigate senior leader poor performance and only investigate senior leader misconduct if it involves prohibited personnel practices. OAWP also promotes organizational accountability within VA by tracking and confirming recommendations made by internal and external oversight entities, by referring certain whistleblower disclosures within VA for investigation, and by analyzing trends and making recommendations to the Secretary.

In terms of numbers, from June 1, 2020 to May 31, 2021, OAWP directly investigated 419 cases; referred 473 cases for investigation to VA administrations and staff offices and maintained oversight on those cases; performed three confirmation compliance audits; trained over 354,000 VA employees on whistleblower rights and protections training; and issued 101 recommendations, including 71 recommendations for disciplinary action. In comparison, OSC's FY 2021 budget request states states that they "achieved 27 disciplinary actions" across the entire government.

With regard to a breakdown of the FY22 budget request by OAWP component (component descriptions are on p. 415 et seq. of the budget submission), please see the chart below:

Labor		
Row Labels	**FY22**	**Total Labor (in 1000s)**
Immediate Office of the Assistant Secretary	**1**	**$173.8**
Assistant Secretary	1	$173.8
Compliance & Oversight Directorate	**21**	**$3,650.2**
Executive Director and Directorate Support	2	$347.6
Compliance Division	8	$1,390.6
Information Systems Management Division	11	$1,912
Investigations Directorate	**90**	**$15,644**
Executive Director	1	$173.8
Intake & Referral Division	17	$2,955
Operations & Training Division	7	$1,216.8
Quality Division	6	$1042.9
Investigations Division	59	$10,255.5
Management & Operations Directorate	**23**	**$3997.9**
Deputy Assistant Secretary	1	$173.8
Resource Management & Operations Division	10	$1,738.2
Stakeholder Engagement Division	12	$2,085.9
Grand Total	**135**	**$23,465.9**

Non-Labor	
TRAVEL	$444
SHIPPING	$5
RENTS, COMM. & UTILITIES	$170
PRINTING	$5
CONTRACTS	$2,284.1
SUPPLIES	$71
EQUIPMENT	$57
Non-Labor Total	**$ 3,036.1**
FY22 Request	**$ 26,502.0**

Post-Hearing Questions for the Record
Secretary Denis McDonough, SVAC Hearing on VA's FY22 Budget Request
From Senator Jerry Moran

Question 1. **On June 19th, the Secretary announced the Department's intentions to expand VA care to gender confirmation surgery. Can you please provide additional information on the estimate timeline and necessary steps the Department would need to take to include such services?**

VA Response: The Department of Veterans Affairs (VA) will initiate steps to modify its regulations to expand VA's care to transgender Veterans and include gender-affirming surgery. The draft proposed rule will be developed along with a Regulatory Impact Analysis which will be reviewed by the Office of Management and Budget prior to publishing any proposed rule in the Federal Register for public comment. Comments will be reviewed and addressed before publishing a final rule, which will finalize any change in the Medical Benefits Package.

Revising the medical benefits package in this manner will enable a safe, coordinated continuum of care that is Veteran-centric and consistent with VA values of equity and respect for all Veterans. VA is in the process of establishing a Transgender Care Coordination (TCC) Integrated Project Team with a plan to establish rigorous standards for health care services, including assessment of quality for surgeries.

Gender-affirming procedures have been proven effective at mitigating serious health conditions, including suicidality, substance use disorders and dysphoria. Updating this policy will allow VA to provide transgender and gender diverse Veterans with coordinated, medically necessary, transition-related surgical procedures.

The process to make the necessary regulatory changes may take up to 2 years, including a period for public comment. During this time, VA will continue to work to develop the framework to provide the full continuum of care in a way that is consistent with VA's rigorous standards for quality health care.

Question 1a. **How many veterans does the Department project may utilize gender confirmation surgery?**

VA Response: It is not known how many Veterans may seek gender confirmation surgeries. Based on diagnostic codes, it is estimated that Veterans Health Administration (VHA) currently offers transition-related care to about 10,000 transgender Veterans. Based on current VA utilization patterns (e.g., accessing hormone therapy), it is estimated that fewer than 4,000 of these VHA-enrolled Veterans may be interested in this surgical care.

Question 1b. **Please explain what budgetary impacts (for FY21, FY22, and FY23) the Department anticipates as a result of expanding care to include gender confirmation surgery?**

VA Response: VA is currently in the process of identifying the number of interested Veterans and the associated cost of these procedures. VA anticipates including more details in the 2023 President's Budget.

The estimated annual costs to VA will be developed as a part of the initial steps to modify the rules to include development of a formal Regulatory Impact Analysis (RIA). Costs per surgery also will depend on whether care is delivered within VA or outside VA through community partners.

Question 2. **I am a big proponent of the MISSION Act because it places veterans at the center of the health care decision-making process. You noted MISSION Act requires a review within three years of implementing the access standards. We just passed the two year mark, giving VA less than a year to complete a thorough review.. Has the Department started the review process?**

VA Response: As the Secretary has testified, the review process has started. The Secretary affirmed that the review process will be thorough, Veteran-focused and a transparent process. One part of that process is to use contract support to conduct a review of the utilization of the existing access standards. The contractor support began work this summer on an environmental scan of existing access standards. The environmental scan consisted of a review of other government agencies and private health care providers to determine access standards used by them and any changes since 2018.

Question 2a. **What feedback are you receiving on the access standards from the veteran community?**

VA Response: Although VA captures Veteran feedback on community care through both VSignals (used in VA medical centers at point of care) and the Survey of Healthcare Experiences of Patients (SHEP), there is not a question for specific feedback on the access standards. The community care portion of SHEP has been in use since February 2016 and has indicated an increase in overall community care satisfaction in FY 2021. The original baseline measure of 73% was captured by the survey in February 2016. The current measure as of March 2021 is 83.3%.

Question 2b. **Given that the MISSION Act was intended, in part, to consolidate and simplify the myriad community care programs that existed prior to its enactment to make it easier for veterans and VA employees to understand, wouldn't altering the access standards so soon after their adoption, without cause, run contrary to that intent?**

VA Response: There is a requirement in the MISSION Act to conduct a review of the access standards and submit a report to Congress in June 2022 regarding the findings and any recommendations to change the standards. To ensure compliance with the requirements of the MISSION Act, VA will conduct the required review in a transparent way and ensure stakeholders are informed throughout the process. Since the access standards were established in

regulation, if VA were to alter them, then we would need to go through notice and comment rulemaking and provide a clear expression of our reasons and justifications for such a change.

Question 3. **Any changes to the access standards that restrict eligibility would unfairly take away the veterans' choice to stay in VA or go to the community. The current access standards also serve as important goal posts for the VA in a post-Phoenix environment. These standards reasonably define timely care as objective measures that all medical facilities should strive to meet while creating accountability to veterans when these facilities fall short. According to the MISSION-mandated report on access standards, 81% of new patient appointments for mental health and 65% of new patient appointments for primary care were completed within 20 days. Average wait times for new patients was under 28 days for seven specialties. We have also heard from VA officials that veterans are increasingly choosing internal VA care. Don't these data suggest that the access standards are working as intended?**

VA Response: The MISSION Act included six eligibility criteria for community care, one of which was based on the designated access standards. As a highly reliable organization, and in compliance with the MISSION Act, VA want to ensure that we are reviewing the access standards based on the current environment. We intend to do that with input from our stakeholders in a way similar to the effort that was conducted in 2018.

Question 3a. **When a veteran receives care in the community how frequently is it the result of a choice exercised due to eligibility conferred by the existing access standards?**

VA Response: The designated access standards under the MISSION Act, which include wait time and drive time, are just one of six eligibility criteria for community care. VA currently does not have a verifiable, accurate way of determining the eligibility of Veterans based on the access standards for drive time and wait time. We do, however, have estimations based on Decision Support Tool usage reports, which provide drive time eligibility and Veteran's decision either to opt in or out of community care. In FY 2021 to date (October – July), approximately 72% of all eligible Veterans who opted into community care met the drive time eligibility criteria. For wait time, we look at the number of Veterans who have internal consults that are forwarded to community care, which means they are eligible for various reasons and have opted in to community care. We have determined that of the eligibilities documented, approximately 25% of those consults met the wait time eligibility criteria. These data are approximate and do not reflect when a Veteran may be eligible under multiple eligibility criteria and, a significant number of forwarded consults do not have an eligibility reason formally documented. The new Consult Toolbox 2.0, which should be fully implemented in October of 2021, will require eligibility determination documentation so we will be able to provide more accurate data by the second quarter of FY 2022.

Question 4. **While your budget submission notes the Department's desire to place veterans at the center of their own care, it also prioritizes a rebalance of direct care and community care. However, the Department fails to detail what a rebalance would entail in the budget submission. At the Committee's June 16 hearing, you told me that a rebalance would be governed by 1) asking veterans what they want in terms of care delivery and 2) a desire to hire and retain specialists to provide direct care so that the department is less reliant on the community for that need. Please elaborate on your answer. Isn't having access standards and giving veterans a choice to go to a community provider the very essence of "asking veterans what they want"?**

VA Response: The community care eligibility criteria, including access standards, allow Veterans who are eligible for community care to choose where they will receive their care—either in VA or in the community. VA want to ensure Veterans understand their options for care so they can make informed choices. VA prides itself on providing outstanding, Veteran-centric, integrated care within our health care system and being the provider that Veterans choose to meet their health care needs. To do this, it is critical to ensure our staffing and infrastructure are optimized to provide outstanding access to care within our internal care delivery system while also ensuring we have a robust community care network.

Question 4a. **Which specialists are you seeking to hire and retain so that the department is less reliant on the community?**

VA Response: VHA consistently has a need for nurses and physicians, and each year those occupations rank highest on a list of shortage occupations. The shortage occupation list is compiled through a yearly review process that is conducted in conjunction with the facilities and is rolled up to the national level. VHA's FY 2020 top eight clinical and nonclinical shortage occupations are listed in the table below. VHA is working to support the recruitment of several physician specialties including Psychiatry, Primary Care, Gastroenterology, Emergency Medicine and Urology. Nurse specialties that are in focus include Geriatrics (community living center), Critical Care, Mental Health, Emergency Department/Urgent Care and Primary Care Nurse Practitioners. These occupations and specialties represent what facilities have indicated are needed most within their areas, medical centers, clinics, etc. to provide for the needs of the Veterans they serve. VHA currently is working on several hiring initiatives including a Mental Health Hiring Sustainment Initiative and developing a strategic nurse workforce plan to guide hiring over the next several years to target critical areas of practice and specialties needed. Several other initiatives have been ongoing including Hire Right Hire Fast (a program designed to streamline recruitment and onboarding) for MSAs (schedulers) and Custodial Workers (housekeeping aids). In addition, facilities and Veterans Integrated Services Networks (VISNs) are encouraged to target their shortage occupations with recruitment and retention incentives.

Rank	Clinical Occupations
1	0602 Medical Officer
2	0610 Nurse
3	0644 Medical Technologist
4	0620 Practical Nurse
5	0180 Psychology
6	0647 Diagnostic Radiologic Technologist
7	0185 Social Work
8	0649 Medical Instrument Technician

Rank	Nonclinical Occupations
1	0083 Police
2	3566 Custodial Worker
3	0679 Medical Support Assistant
4	0801 General Engineering
5	7408 Food Service Worker
6	0675 Medical Records Technician
7	0201 Human Resources Management
8	0622 Medical Supply Aide and Technician

Question 4b. **I note that the FY 2022 budget (if fully funded) when combined with American Rescue Plan spending would result in a near 54,000 FTE increase in staff since 2018 alone, a 17% increase. Is the hiring and planned hiring occurring in the specialties that are a part of the rebalance you spoke of? Please elaborate.**

VA Response: Between the end of FY 2018 and through May of FY 2021, VHA has grown by 9.3% or by nearly 31,500 employees. Historically, VHA has grown by approximately 2-4% per year. In FY 2020, the growth rate was at the high end of that range at 4.0%. It is expected that VHA will see typical to high levels of growth through FY 2022 resulting in a total increase across the 4 years that will be on the high end of historical trends. This increase may result in approximately 14-16% growth between the end of FY 2018 and the end of FY 2022.

The largest portion of VHA's historical growth is due to growth in the targeted shortage occupations (see Question 10 for a list). Since the end FY 2018, the combined growth of the clinical and non-clinical shortage occupations resulted in a net increase of nearly 21,000 employees or 67% of VHA's total growth (31,500) over this time. The clinical shortage occupations alone account for 57% of VHA's overall growth over this timeframe. This growth is the result of multiprong approach to our recruitment and hiring efforts that targets these occupations and specialties. As VHA rebalances to pre- pandemic service levels, additional hiring will need to continue to support increased enrollment and expansion of covered services.

Question 5. **VA proposed to define ambulance to "mean advanced life support, level 1 (ALS1); advanced life support, level 2 (ALS2); basic life support (BLS); fixed wing air ambulance (FW); rotary wing air ambulance (RW); and specialty care transport (SCT), as those services are defined in 42 CFR 414.605. Consistent with 42 CFR 414.605, the definitions of these terms would apply to ground (both land and water) ambulance services and to air ambulance services unless otherwise specified.**

VA further proposed to revise 38 CFR 70.30(a)(4) to "establish in regulation a new payment methodology for travel by ambulance. VA would adopt the Medicare Part B AFS [Ambulance Fee Schedule] for transport by ambulance, and we would pay for ambulance services based on the lesser of either the AFS payment amount or the actual charge, unless (as would be stated in 38 CFR 70.30(a)(4)) VA has executed a contract for ambulance services from the vendor in which case the terms of the contract would govern VA payments. For ALS1 and BLS, the AFS includes rates for emergency and nonemergency transportation. For purposes of proposed section 70.30(a)(4)(i), VA would apply the applicable CMS Medicare rate based on the vendor's coded invoice for all Benefits Travel. New 38 CFR 70.30(a)(4)(i) would read as follows: 'Travel by ambulance: VA will pay the lesser of the actual charge for ambulance transportation or the amount determined by the fee schedule established under section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)).'"

Has VA examined other means for cost-control that accounts for the fact that government reimbursement payments under Medicare may be inadequate to support air ambulance services without cost shifting to commercial insurance payers, and could harm veterans that VA is charged to serve by reducing the national coverage map for air ambulance transportation and further closing of air ambulance bases?

VA Response: VA's October 28, 2020, Economic Regulatory Impact Analysis for RIN 2900-AP89(P), Change in Rates that VA Pays for Special Mode Transportation, did provide review on alternative policy approaches. However, this review did not determine or comment on the adequacy of Medicare's existing air ambulance payment rate structure, as that is a matter under the purview of the Centers for Medicare & Medicaid Services (CMS). Through its proposed rule, VA proposed to reimburse non-contracted air ambulance vendors 100% of Medicare's established rate or the actual charge, whichever is less.

Question 6. **In 1997, Congress passed the Balanced Budget Act of 1997, which required the Secretary of HHS to develop a national fee schedule for Medicare air and ground ambulance reimbursement. This fee schedule was not based on actual costs per service because "[this] data [did] not exist."[1] Through a negotiated rulemaking process involving air and ground ambulance stakeholders, the fee schedule was negotiated based upon a fixed amount of funding limited to historical**

[1] 67 Fed. Reg. 9104, 9117

amounts paid by Medicare for all ambulance services, minus 1%. The fee schedule has seen nominal increases, but the benefit of any increases has been blunted since 2010 with the implementation of sequestration of federal funding at an annual rate of 2%, resulting in years where the adjustment was a *net negative*. Reliance on the Medicare fee schedule for Benefits Travel creates a greater amount of uncompensated care that adds more pressure to rely on commercial insurers to cover the offset. In response, commercial insurers not only act to reduce their level of coverage, but also threaten higher premiums and larger deductibles, further exacerbating the ongoing problem. Has VA gathered data to understand the actual cost of air ambulance services, and if not, why is the VA seeking to rely on Medicare as the index? If it has gathered such data, are the actual costs higher than the Medicare fee schedule?

VA Response: In the Economic Regulatory Impact Analysis cited in response to question 12, VA used aggregated data for ground and air ambulance transportation due to VA's data challenge isolating specific air transports. VA does not have the ability to determine payments made by individual facilities by applicable reimbursement code but determined that Centers for Medicare & Medicaid Services (CMS) reimbursement rates are on average 13.68% lower than costs being reimbursed under the current regulations (i.e., billed charges).

Although VA has not evaluated what commercial insurers may or may not do, VA has historically relied on Medicare's fee schedule for both reimbursement under the Veterans Community Care Program and emergency transportation coverage under 38 U.S.C. § 1725 and its implementing regulations. VA proposed to amend 38 C.F.R. Part 70, Subpart A, on November 5, 2020 (RIN 2900-AP89, 85 Fed. Reg. 70551), to implement the discretionary authority provided by 38 U.S.C. § 111(b)(3)(C). Section 111(b)(3)(C) authorizes VA to pay the lesser of the actual charge for ambulance transportation or the amount determined by the Medicare Part B Ambulance Fee Schedule (AFS) established under section 1834(l) of the Social Security Act (42 U.S.C. § 1395m(l)), unless VA has entered into a contract for that transportation. Currently, VA is reviewing comments received in response to this proposed rule.

Question 7. **The VA requires veterans to maintain their health through regular contact with the VA, and disqualifies veterans from care if they go more than two years between visits to a VA facility for health care services. Without this care, chronic conditions can go untreated. However, an otherwise perfectly healthy veteran can sustain an accidental injury, and be left without veterans Benefits Travel coverage because there was no reason for her or him to visit a VA facility prior to the accident. Can the VA explain why a veteran should not be covered for air ambulance Benefits Travel services?**

VA Response: Veterans who are eligible for beneficiary travel under 38 C.F.R. § 70.10, may be eligible for reimbursement of special mode transportation, including air ambulance. Reimbursement for special mode transportation, including air ambulance, does not require prior approval in a medical emergency; however, the travel must be medically required.

The requirement that a Veteran must have received care from VA within 24 months relates to non-departmental emergency care provided under 38 U.S.C. § 1725 (see 38 U.S.C. § 1725 (b)(2)(B)), and urgent care provided under 38 U.S.C. § 1725A (see 38 U.S.C. § 1725A(b)(2)).

Question 8. **Veterans are diabetic at a higher rate than the general population, with one fourth of VA patients managing the disease. The pandemic has had an adverse effect upon this disease management for many. Clinic closures and other challenges of quarantine have resulted in more diabetic foot ulcers, known as DFUs, which often quickly lead to lower extremity amputation. A diabetic amputation can cost up to $100,000, and those who receive even minor ones have lesser prospects for survival than many cancer sufferers – sadly, 44 percent at 5 years. In 2020, VA treated 115,000 diabetic foot wounds and spent more than $3.6 billion on DFUs – making them responsible for 80 percent of non-traumatic amputations in the VA.**

VA has leaned into remote temperature monitoring technology as an effective early warning preventative intervention. Recent data from VA patients utilizing this capability point to a 71% reduction in all lower-extremity amputations, as well as significant drops in inpatient hospitalizations (50%) and emergency visits (40%). This data is especially significant for African American and Native American veterans, as racial and ethnic disparities exist in the risk of DFUs. Thanks to the VA innovation Center having led in adoption of this technology, VA has increased access and improved outcomes for minority veterans, which the Committee lauds as one of your priority goals.

- **Given the doubling of the Department's budget over the past 10 years and your requested 10% increase based upon what the Department anticipates is pandemic-related deferred care such as that of diabetes management, and given the proven outcomes and cost-savings associated with adoption of this care management technology, what is VA's strategy for scaling its use, to improve quality of life for minority veterans and all diabetes sufferers at risk of DFUs, to radically reduce the need for costly amputations and save lives?**

VA Response: Today, 1,300 Veterans are engaged in Remote Monitoring, and VA plans to enroll an additional 2,300 Veterans using $7 million in funding through the end of 2022. VHA's Office of Health Equity is supporting an evaluation of the remote temperature monitoring mats being deployed to screen and detect diabetic foot ulcers across VA. Because certain Veteran groups are more likely to have diabetes and lower extremity complications, these mats may have important equity implications. The evaluation examines the extent to which use or uptake of these mats varies by race and geography, and differences in ulcers and lower extremity amputation related outcomes. The findings of this evaluation will inform targeted approaches to ensure Veterans at greatest need have access going forward.

Question 9. **The FY 2022 budget submission notes that this budget fully funds P.L. 116-171, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act.**

Please provide a detailed summary of FY 2022 budget request for P.L.116-171 provisions outside of the SSG Parker Gordon Fox Suicide Prevention Grant Program (§201) and the Readjustment Center Scholarship (RCS) Scholarship Program (§502).

VA Response: The 2022 Budget matched the Congressional Budget Office estimate of $61 million in 2022; however, costs by section were distributed differently: SSG Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) (§ 201) $55.694 and the Readjustment Center Scholarship (RCS) Scholarship Program (§ 502) $301,000. There are three cost components in the FY 2022 budget submission that are outside of sections 201 and 502 that utilize the remaining $5.005 million: the Precision Medicine Initiative to identify and validate brain and mental health biomarkers (§ 305) is projected to cost $134,000, which affords a Senior Project Manager for this initiative.

The plan to implement this section includes: The mental health precision medicine initiative Million Veteran Program-Measures Investigating Neuropsychological Disorders (MVP-MIND) will establish a cohort of 50,000 Veterans with severe mental health illness and substance use disorders, expanding on and leveraging the MVP infrastructure and enrollment process, adding a mental health survey developed in consultation with other global cohorts. Participants will include Veterans with depression, anxiety, posttraumatic stress disorder (PTSD), schizophrenia, bipolar disorder, traumatic brain injury (TBI) and substance use disorders. Joint Mental Health Programs by VA and Department of Defense (DoD) (§ 405) are projected to cost $335,000 which affords 3.5 full time employees (FTEs). These FTEs will request and compile program input for a new Annual Congressional Report to summarize all DoD, VA, and Joint Mental Health Programs. This is a reoccurring annual requirement for administrative support to:

- Request and collect responses from VA and DoD program offices.
- Compile responses into a report.
- Provide technical writing and desktop publishing support for the report.
- Support coordination of review and feedback from VA and DoD program offices.
- Implementation of remaining $4.535 million is a reserve to implement all other sections as their implementation plans are developed and determined that funds are required.

> *Question 9a.* **Additionally, please provide detailed information regarding requests for funding of the MVP-MIND research program and the Precision Medicine for Veterans Initiative (§305)**.

VA Response: Million Veteran Program - Measures Investigating Neuropsychiatric Disorders (MVP-MIND) FY 2022 Budget request: $1,429,566.

The MVP-MIND FY 2022 budget funds the centralized recruitment infrastructure, including project management; site management and oversight; biospecimen collection and processing; and data and informatics activities at the MVP Core as well as funding for recruitment and enrollment staff at sites. The 12 MVP-MIND sites across the country will be responsible for conducting the study recruitment and enrollment activities and will be staffed with 1 FTE per site. Mailing and public relations activities include recruitment materials,

printing/distribution/scanning of the MVP-MIND Survey and public relations (PR) materials including but not limited to fact sheets and brochures.

In addition, the Precision Medicine for Veterans Initiative (P.L. 116-171, § 305) will demonstrate the ability of VA to process large scale multi-modal assessments. VA will tap into the Long-term Impact of Military-relevant Brain Injury Consortium (LIMBIC). LIMBIC is a coordinated, multicenter collaboration linking brain researchers from VA, the military and academia to effectively address the long-term effects of mild TBI and its frequent co-morbidities (e.g., substance use, depression and PTSD) to develop better diagnostics and treatments. The participants in this study have had MRI imaging, EEG, and their blood biospecimens are being analyzed for biomarkers. The de-identified data from LIMBIC is being shared through the Federal Interagency Brain Injury Research (FITBIR) Database (housed at the National Institutes of Health (NIH)) and can be accessed by qualified researchers. Currently, VA is funding this initiative with $5 million per year.

MVP-MIND and LIMBIC are funded through the Medical and Prosthetics Research appropriation and will form the foundation of the mental health precision medicine initiative. Planning for further development of VA's precision medicine efforts in mental health are underway and any additional research costs (i.e., for FY23 and beyond) needed to fully meet the intent of § 305 will be requested as part of the budgeting process in future years.

Question 10. **Can the Department provide more detail regarding the request for $25 million for Coronavirus related research?**

VA Response: The $25 million in additional funding requested is comprised of $18 million for COVID-19 pandemic-related research. The estimated FY 2022 need shown in the table below totals $18.2 million and represents a portion of the $57 million estimated in the Designated Research Area (DRA) tables (for all infectious disease studies) on page 584 of the Office of Research and Development (ORD) Budget Chapter

Title	Estimated FY22 need
ORD COVID-19 Biorepository/VA SHIELD	$2,462,366
Variant Sequencing	$2,856,250
Epidemiology, Immunology and Clinical Characteristics of COVID-19 (EPIC3) within VHA	$5,500,000
COVID-19 Pandemic-Related Disrupted and Deferred Care	$1,400,000
COVID Observational Research Collaboratory	$1,000,000
Study of Vaccine Hesitancy	$500,000

Title	Estimated FY22 need
Mobile Phlebotomy Contract	$500,000
New investigator initiated COVID-19 Projects	$4,008,959
Total	$18,227,575

There is $12 million to fund projects delayed due to the COVID-19 pandemic: The estimate is based on extensions for projects where funding was distributed related to the impact of the COVID-19 pandemic in 2020 and 2021.

Note: The request is for $25 million although the total estimated costs related to the COVID-19 pandemic are $30 million. The additional $5 million will be funded out of current base resources (within the Infectious Disease Designated Research Area (DRA), which is estimated at $57 million for FY 2022).

Question 10a. **Additionally, please provide the detailed research plan from the Office of Research and Development.**

VA Response: As noted above, the $25 million in additional funding requested is comprised of $18 million for COVID-19 pandemic-related research. The estimated FY 2022 need shown in the table below totals $18.2 million and represents a portion of the $57 million estimated in the DRA tables (for all infectious disease studies) on page 584 of the ORD Budget Chapter.

Title	Estimated FY22 need
ORD COVID-19 Biorepository/VA SHIELD	$2,462,366
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Mobile Phlebotomy Contract	$500,000
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Total	$18,227,575

There was a total of $12 million to fund projects delayed due to the COVID-19 pandemic. The estimate is based on extensions for projects where funding was distributed related to the impact of the COVID-19 pandemic in 2020 and 2021.

Note: The request is for $25 million although the total estimated costs related to the COVID-19 pandemic are $30 million. The additional $5 million will be funded out of current base resources (within the Infectious Disease DRA, which is estimated at $57 million for FY 2022).

Question 10b. **Can the Department include a summary quantifying and illustrating how VA research funding is necessary when considering the abundance of national and global research already being conducted on COVID-19?**

VA Response: VA Research is uniquely positioned to provide its expertise in COVID-19 research as the largest integrated health care system in the country. COVID-19 research funding would support efforts begun during the pandemic and done in coordination with other Federal agencies. For example, one of the included studies is establishing a cohort of Veterans and active duty military personnel to determine the longer-term outcomes of individuals infected with COVID-19.

VA has capabilities for conducting multi-site activities embedded within the VA health care system and several national academic and scientific leaders in infectious diseases. Several of the national research studies already being conducted include VA contributions. These studies take advantage of VA's ability to connect research and patient care data to understand the disease and its long-term outcomes more fully. Expanded research activities within VA's Veteran population will track real world evidence of vaccine implementation and failure.

Currently, study teams are working with the Centers for Disease Control and Prevention, NIH and other groups to determine how to best share information on the VA population, which has a richer dataset in regard to vaccinations compared to others. This information can aid in determination of need for vaccine booster, new vaccine design, etc. VA is positioned to conduct these analyses because of access to electronic health record data of all patients who are vaccinated within the VA system.

In addition to on-going activities, newer efforts would focus on:

- Vaccine failure: Vaccine and time post-vaccination (enhanced with large Veteran population with many comorbidities who are high risk for COVID-19 complications).
- Variant surveillance and correlation with clinical outcome based on medical counter measures (MCM) implemented (vaccine, therapeutic, etc.). Real world evidence of efficacy of products.
- Clinical outcome /severity: Course of disease, longer term sequelae (long haulers) in a population with higher rates of comorbidities.

Question 11. **How does the Department plan to utilize FY 2022 funding to maximize high-quality virtual care options for veterans who reside in rural and highly rural areas, besides distributing iPads and tablets?**

VA Response: VA plans to use FY 2022 funding to maximize high-quality virtual care options for Veterans through VA's continuing efforts to improve access to broadband-delivered services on three fronts. First, VA will continue to improve the telehealth capacity of our highly rural community-based outpatient clinics (CBOC) to facilitate equitable, clinic-based access to primary and specialty care services in hard-to-reach rural and highly rural communities. Next, VA will (through our participation in the administration's multi-agency Rural Health Interagency Policy Committee (IPC) and Rural Prosperity IPC) continue to advocate vigorously for the expansion of broadband service into rural and highly rural communities. Finally, VA will also continue to expand services in our 18 Clinical Resource Hubs (CRH), which already provide primary and mental health care to thousands of rural Veterans every day, to capture specialty care services that are increasingly difficult to find in rural and highly rural communities. VA's commitment to specialty care in our CRHs is reflected in its expansion from access to 9 different specialty care services in FY 2021 to more than 20 specialties in FY 2022 in all 18 of the CRHs. These specialties services include Immunology, Cardiology, Endocrinology, Oncology, Geriatrics, Infectious Disease Care, and 15 more specialty services, all focused on ensuring rural Veterans have equitable access to the highest quality virtual care.

Question 12. **Can the Department provide more detail on the addition of the VA's new Chief Scientific Officer and Scientific Integrity Officer roles within the Office of Research & Development?**

VA Response: In accordance with the January 27, 2021, Presidential Memorandum on Restoring Trust in Government Through Scientific Integrity and Evidence-Based Policymaking, VA designated a new Chief Science Officer (CSO) and a new Scientific Integrity Official (SIO). The roles of CSO and SIO are not ORD roles per se as evidenced with Dr. Carolyn Clancy being named the CSO. The responsibilities of the CSO and SIO, as outlined in the Presidential Memorandum, have impact on all VA administrations (Veterans Benefits Administration (VBA), National Cemetery Administration (NCA) and VHA) within the Agency and each administration will be called upon to provide representatives to help implement the details of the Presidential Memorandum. As the SIO, Dr. Rachel Ramoni will chair a sub-council on Integrity as part of VA-level Evidenced Based Policy Council and manage the deliverable identified in the Presidential Memorandum through coordination with additional identified Scientific Integrity points of contacts across VA.

Question 12a. **Specifically, how much funding in the FY2022 budget is allocated for these new roles?**

VA Response: As both individuals in these positions will be performing these duties as an additional responsibility to their normal positions, the new responsibilities will incur minimal additional cost and be funded out of base FY 2022 resources.

Question 12b. **Additionally, please provide the job descriptions, expected goals and benchmarks for each position to achieve each year, and how these new roles will be a value-add to veteran-centric research.**

VA Response: Pursuant to the January 27, 2021, Presidential Memorandum on Restoring Trust in Government Through Scientific Integrity and Evidence-Based Policymaking, the roles of the CSO are to:

- Serve as the principal advisor to the head of the agency on scientific issues and ensure that the agency's research programs are scientifically and technologically well-founded and conducted with integrity.
- Oversee the implementation and iterative improvement of policies and processes affecting the integrity of research funded, conducted or overseen by the agency, as well as policies affecting the Federal and non-Federal scientists who support the research activities of the agency, including scientific-integrity policies.
- Oversee the work of the SIO.
- Attend regularly convened interagency meetings of CSOs to encourage the discussion and expansion of effective scientific-integrity policies and practices among agencies.

The primary focus of the role of the CSO is to ensure the conduct of research (grant decision, selection of reviewers, performance of study and analyses of data) is done with integrity. ORD has longstanding policies to ensure the integrity of these processes. A thorough review of all existing policies is undertaken regularly, and corrective actions taken when needed. As the role of the Chief Research and Development Officer is to oversee the research operation within the VHA, the CSO becomes a secondary oversight role to functions that are not covered under the work of the Office of Research Oversight which focuses on the research that is conducted, not on the processes within ORD. Having this secondary oversight strengthens the integrity of all processes, which ultimately helps research that support that health and health care of Veterans.

The role of the SIO is to:

- Oversee implementation and iterative improvement of scientific-integrity policies and processes, including implementation of the administrative and dispute resolution processes.
- Coordinate the efforts of additional identified Scientific Integrity points of contact across VA.

The SIO's role is broader in ensuring that there are mechanisms in place to promote the use of science in evidence-based policy making and ensure that VA has appropriate mechanisms in establishing and publishing an administrative process for either central or Administration specific reporting, investigating and appealing allegations of deviations from policy, disputes or disagreements. The SIO also is responsible for ensuring an adequate educational program for all VA employees is in place. The SIO's role is less focused on the conduct of the research and more focused on the overall role of the application of science, which supports the overall mission of VA and not specifically the research mission.

Question 13. **In its FY22 budget request NCA is requesting $7.6M for continued activation of 7 new veterans cemeteries. Additionally, NCA is requesting $7.7M for workload increases and project expansions at existing cemeteries. Combined, this accounts for nearly 40% of the requested increase for NCA's Operations and Maintenance budget. With another 6 cemeteries slated to come online in the next 5 years, and continued arising expansion project needs, does the Department project similar requested increases for the next 5 fiscal years?**

VA Response: VA is committed to investing in NCA's infrastructure, particularly to keep existing national cemeteries open and to construct new cemeteries consistent with existing burial policies.

NCA is amid the largest expansion of the cemetery system since the Civil War. Between 2011 and 2026, NCA will have established 18 new national cemeteries across the country, including rural and urban locations. The 2022 Budget includes operations and maintenance funding to continue activation of new cemeteries and provide for workload increases at cemeteries open for burials.

NCA included a request for $7.6 million and 11 FTEs for the continued activation of Fargo National Cemetery in North Dakota, the Cheyenne National Cemetery in Wyoming and the Northwoods National Cemetery in Oneida County, Wisconsin (rural initiatives) and the replacement cemetery in Morovis, Puerto Rico. Continued activation funding ensures newly opened cemeteries receive the resources required as interment activity and maintenance workload increase after the initial opening. The 2022 Budget request also includes funding for the initial activation of the St. Albans and Indianapolis columbaria-only urban cemeteries and the Cedar City rural cemetery. Staffing new sites ensures local procedures, equipment and training to support cemetery operations are in place on day one. NCA anticipates that the remaining three cemeteries (Alameda Point, California, Chicago, Illinois, and Elko, Nevada) will be open by 2026. NCA will request activation funds for these cemeteries to prepare for the initial opening and continued funding as burial operations commence.

NCA is nearing its goal to provide 95% of Veterans with access to a burial option in a national, state or Tribal Veterans cemetery within 75 miles of their homes. In addition to developing new national cemeteries, VA expects to develop additional gravesites and columbaria at existing national cemeteries to maintain gravesite availability. Included in the 2022 budget request is an additional $7.7 million and 35 FTEs to maintain burial services at existing cemeteries. NCA workload is not static. Although the number of interments is expected to peak and then slowly decline, NCA will maintain an increasing number of gravesites in perpetuity. In 2022, NCA will maintain almost 4.1 million gravesites, an increase of 12% from the 3.65 million gravesites maintained in 2017. With the gravesite expansion projects underway, the number of developed acres will reach 9,483 in 2022, an increase of 4% over the 9,117 developed acres in 2017. 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. The additional funds are required to maintain the frequency of cemetery ground and gravesite maintenance activities including mowing and

trimming grass and maintaining trees, as well as cleaning headstones and markers at existing cemeteries.

The following chart displays the increase in workload since 2017.

	2017	2018	2019	2020	2021	2022	Percent Change 2017 - 2022
Planned Workload							
Interments	133,798	135,306	134,833	126,884	136,533	135,770	1.5%
Graves maintained	3,650,056	3,738,869	3,820,937	3,911,500	4,000,516	4,089,282	12.0%
Developed acres	9,117	9,210	9,245	9,324	9,421	9,483	4.0%

Note: The 2021 and 2022 interment workload are the start of year estimate and does not include the impact of delayed interments due to the pandemic. The number of actual interments is expected to be over 142,000 in 2021. FY 2020 interments were lower due to the pandemic.

> *Question 14.* **With 2021 anticipated as the peak year for interments before a gradual decline, and with more cemeteries coming online in short order, do you anticipate the resources for the Veteran Cemetery Grant Program remaining flat or growing as the focus for veterans without burial access options shifts?**

VA Response: NCA's strategic goal is for 95% of the Veteran population to have access to a burial option in a national or state cemetery within 75 miles of their homes. The Veterans Cemetery Grants Program (VCGP) complements VA's system of national cemeteries by establishing Veterans cemeteries in locations where VA is unlikely to establish a new national cemetery.

The VA Office of Inspector General (OIG), Veterans Cemetery Grants Program Did Not Always Award Grants to Cemeteries Correctly and Hold States to Standards (Report No. 20-00176-125), was issued on June 24, 2021. In its report, OIG stated, "Increased funding would support projects not only to improve cemetery appearance, but also to expand and create new cemeteries. These grants help NCA meet its strategic goal of providing 95 percent of veterans a burial option within 75 miles of their residence" and recommended that NCA continue to seek an increase in cemetery grant funding in excess of $45 million. NCA concurred in principle with this recommendation and will continue to seek Federal funds to adequately address VCGP through the Federal budget process.

> *Question 15.* **What is the anticipated operational impact of the estimated approximately 8,300 delayed memorial services for families of veterans who had direct interments in the early months of the COVID-19 pandemic?**

VA Response: All NCA national cemeteries remained open for interment and public visitation throughout the pandemic. NCA modified its operational posture consistent with local, state and Federal guidance to protect the health and safety of our employees and visitors. From March through June 2020, NCA conducted "direct" interments only—suspending the provision of military honors and committal services at all cemeteries. In June 2020, NCA restored the provision of military honors and committal services with limits on gathering sizes based on local and state guidelines and various other factors.
On May 26, 2021, NCA lifted all restrictions on gathering sizes at committal and memorial services in VA national cemeteries.

In 2020, NCA conducted 126,884 interments, a decrease of 6% from the previous year. An estimated 12,382 interments were either postponed or delayed and NCA expects that most of these are cremated remains that can be held by the family and will be (re)scheduled for interment in the coming months. In addition, NCA conducted 20,780 direct interments without committal services (13,774 caskets and 7,006 cremains). NCA has contacted all families who received a direct interment to offer a memorial service. About 40% of families (or 8,312) indicated they were interested in a memorial service. However, many of those interested families indicated they were not ready to schedule a memorial service and would likely hold off for several months. Through May 2021, NCA has conducted 2,389 memorial services for families that had a direct interment.

Public Law (P.L.) 116-260, the Consolidated Appropriations Act, 2021, allowed (per section 514) for the transfer of up to $26 million in unobligated balances from funds provided under P.L. 116-136, Coronavirus Aid, Relief, and Economic Security Act (CARES Act) supplemental. In 2021, $12 million was transferred to NCA to assist with costs associated with the COVID-19 pandemic. NCA gathered resource requirements from its cemeteries and distributed the CARES Act funding for operational needs, including overtime funds to provide additional interments and memorial services.
P.L. 116-260 stipulated (per section 514) that the transferred funds may not be used to increase the number of full-time equivalent positions.

Question 15a. **Has NCA planned for appropriate distribution of resources to the cemeteries where these services are to take place in the coming months?**

VA Response: NCA continues to closely monitor workload impacts of the COVID-19 pandemic to ensure resources are properly allocated. Sufficient resources are available to address all burial and memorial requirements.

Question 15b. **Does NCA anticipate any overtime or additional FTE to carry out these delayed services?**

VA Response: NCA anticipates that some overtime will be needed to carry out additional COVID-19 pandemic-related workload. P.L. 116-260, the Consolidated Appropriations Act, 2021, allowed (per section 514) for the transfer of up to $26 million in unobligated balances from funds provided under P.L. 116-136, CARES Act supplemental. In 2021, $12 million was transferred to NCA to assist with costs associated with the COVID-19 pandemic. NCA gathered

resource requirements from its cemeteries and distributed the CARES Act funding for operational needs, including overtime funds to provide additional interments and memorial services. PL 116-260 stipulated (per section 514) the transferred funds may not be used to increase the number of full-time equivalent positions. In addition to overtime, CARES Act funds also will be used for personal protective equipment (PPE) for employees, deep cleaning janitorial contracts, delayed maintenance, additional equipment necessary to maintain social distancing and supplies.

Question 16. **Within the budget request, VA requests $2M to support initiatives to remain a burial provider of choice, please elaborate on these initiatives and what all they entail for NCA.**

VA Response: The 2022 Budget request includes $2.0 million and 26 FTEs to support NCA's initiatives to remain a burial benefit provider of choice. Of this amount, NCA requests $1.2 million and 14 FTEs to manage workload increases within its National Cemetery Scheduling Office (NCSO) for the Pre-Need Program and the State Cemetery Headstone and Marker application processing. The Pre-Need Program started in 2016 and since the initial program kick-off, the program has been an overwhelming success. Pre-need eligibility determinations allow Veterans and their family members to find out in advance if they can be buried in a VA national cemetery and can help make the burial planning process easier for family members in their time of need. The program is specifically aimed at helping Veterans make sure their wishes are known, assisting in using the benefits they have earned, eliminating unnecessary delays and reducing stress on families at a difficult time. In 2020, NCSO received 51,866 Pre-Need applications, an increase of 18% from the 43,937 Pre-Need applications received in 2019. The NCSO received over 31,500 applications in the first seven months of 2021, putting them on track to receive over 54,000 this fiscal year. Pre-Need application requests are expected to continue to increase due to outreach activities.

The state and tribal cemetery headstone/marker eligibility determination process is a new initiative. Formerly, NCA provided headstones and markers to state and tribal cemeteries automatically after state and tribal cemeteries used the NCA Burial Operations System to record an interment where the state and tribe had determined the decedent eligible. NCA has learned that a Federal employee must make the determination that the decedent buried by the state/tribe is entitled to receive a VA headstone or marker before issuing the headstone or marker and therefore must shift away from the automatic process. In 2020, there were 37,268 interments in grant-funded state cemeteries.

The 2022 Budget request includes $860 thousand and 12 FTE for expansion of NCA's Cemetery Apprentice Program (CAP) and reintroduction of the Cemetery Director Development Program (CDDP). The CAP program offers entry-level technical training and permanent employment in national cemeteries to Veterans who are homeless, at risk of homelessness or who recently exited homelessness. Apprentices complete foundational technical coursework in their career field, which is then reinforced through daily on-the-job training at the cemetery. Those who complete all training requirements graduate from the apprenticeship and may remain in their entry-level position or seek promotion to a permanent position in NCA or elsewhere in VA. Program

graduates who move into higher-graded positions create opportunities for other homeless Veterans to receive employment, thus establishing a continuous training pipeline. In addition, CAP supports succession planning for the Cemetery Caretaker position, a mission critical occupation. There are 21 positions available for CAP in 2021. This initiative will increase the program to 27 positions in 2022, with a goal of establishing a future sustainable CAP with full operating capacity of 35 permanent positions.

The CDDP is year-long developmental program that seeks to recruit high potential team members to become the next generation of NCA leaders. During training, the Cemetery Director Trainees will gain a foundational education in all aspects of cemetery administration. In 2019, the previous iteration of this program was put on a strategic pause to conduct a thorough analysis and make recommendations to strengthen the program. The program was evaluated through feedback of its effectiveness and then modified to improve candidate recruitment, program format and course content. The CDDP was reinstituted in Spring 2021. CDDP participants trainees are hired as full-time NCA team members and this initiative will ensure that the positions are included in NCA's future FTE baseline.

Question 17. **NCA is requesting $4.3M for initiatives to improve internal controls, $1.5M of which is for GPS/GIS to enhance accounting of remains, marking of graves, and mapping of national cemeteries. Please provide more detail on the benefits these actions will provide to the NCA, beneficiaries, and the public.**

VA Response: NCA requests $4.3 million to support outcome-based initiatives. Of this amount, $1.5 million is requested for Geographical Information System/Global Positioning System (GIS/GPS) remediation. NCA is implementing and using GIS to enhance the accounting for remains and the accuracy of marking gravesites to further increase the level of trust with Veterans and their family members. Through the GIS program, NCA is leveraging GPS technology to establish a permanent and verified geospatial record of interments while improving internal control systems to facilitate the accurate and timely marking of gravesites.

Through several efforts, the GIS program is collecting geospatial data and grave marker photos for operational use internally and for public-facing products externally. The GIS information improves quality control oversight of burial and marker activities and identifies potential discrepancies, such as grave marker inscription errors, mis-numbered grave markers or illegible grave markers. While these occurrences are rare, the GIS information will allow for the quick identification of issues and their resolution. A product of the GPS data collection effort is the Discrepancy Resolution Report, which compares inscribed headstone and marker names at each cemetery to permanent interment records in NCA's operations support system to identify potential discrepancies for further evaluation and reconciliation. These reports are complex and require significant time and manpower to analyze and resolve.

The GIS program positively impacts customers by improving NCA's ability to more accurately account for remains, to include the identification and correction of historical and/or current burial discrepancies. The GPS equipment and collection workflows integrated into NCA's daily interment operations, at all active national cemeteries, are improving quality control methods

NCA uses to permanently document and account for daily burial and marker placement activities. Other NCA products also are supported and being developed through the GIS program, such as the NCA Cemetery Viewer and the Gravesite Burial and Marker Accounting Tool (GBMART). When fully implemented these tools will provide near real-time incorporation and quality control verification of cemetery-collected interment data and photos.

Question 18. **Secretary McDonough testified that VA is now seeing increased demand due to care deferred during the pandemic. Please provide the number of outpatient visits, the number of inpatients treated, and average daily census for March, April, and May of 2021.**

VA Response: The following tables provide the requested breakouts for outpatients, the number of inpatients treated and average daily census for the requested time periods from Questions 31 and 32. Please note that the inpatient data is focused on hospital inpatients and does not include domiciliary, nursing home, community care, etc.

	VHA Outpatient Visits (Mar-May FY18 & FY19)					
	Mar-FY18	Apr-FY18	May-FY18	Mar-FY19	Apr-FY19	May-FY19
Face to Face	4,771,943	4,687,511	4,914,350	4,728,475	5,014,650	4,927,811
All CVT	93,740	95,248	98,631	114,406	125,066	124,376
Telephone	1,494,298	1,436,864	1,497,864	1,449,441	1,515,435	1,500,227
Total	6,359,981	6,219,623	6,510,845	6,292,322	6,655,151	6,552,414

	VHA Outpatient Visits (Mar-May FY20 & FY21)					
	Mar-FY20	Apr-FY20	May-FY20	Mar-FY21	Apr-FY21	May-FY21
Face to Face	3,084,995	630,855	754,354	4,420,232	3,786,323	3,037,815
All CVT	199,467	402,242	488,434	1,000,024	917,792	825,960
Telephone	2,577,202	4,096,908	3,630,143	3,002,518	2,672,628	2,352,677
Total	5,861,664	5,130,005	4,872,931	8,422,774	7,376,743	6,216,452

	Total Inpatients Treated			
	FY18	FY19	FY20	FY21
March	52,413	50,871	40,952	44,853
April	49,999	50,454	29,790	44,429
May	51,405	50,878	33,798	44,149

	Average Daily Census			
	FY18	FY19	FY20	FY21
March	9,768	9,651	8,486	9,137
April	9,642	9,465	6,664	9,145
May	9,365	9,323	7,217	9,252

Question 18a. **Please provide the same data for March, April, and May of 2018, 2019, and 2020.**

VA Response: The following tables provide the requested breakouts for outpatients, the number of inpatients treated and average daily census for the requested time periods from Questions 31 and 32. Please note that the inpatient data is focused on hospital inpatients and does not include domiciliary, nursing home, community care, etc.

	VHA Outpatient Visits (Mar-May FY18 & FY19)					
	Mar-FY18	Apr-FY18	May-FY18	Mar-FY19	Apr-FY19	May-FY19
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Telephone	1,494,298	1,436,864	1,497,864	1,449,441	1,515,435	1,500,227
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March	9,768	9,651	8,486	9,137
April	9,642	9,465	6,664	9,145
May	9,365	9,323	7,217	9,252

Question 19. **For outpatient visits, inpatient facilities, and average daily census measures: What did VA's Enrollee Health Care Projection Model (EHCPM) predict for these three categories during March-May of 2021 when VA submitted its FY21 budget request prior to the pandemic?**

VA Response: VA's EHCPM uses Global Relative Value Units (GRVUs) to aggregate data across health care services, representing the total resource requirements to provide VA health care. For FY 2021, the pre-pandemic EHCPM-projected GRVUs were 626 million for ambulatory services and 281 million for inpatient services (excluding long-term services and supports, dental, prosthetics and pharmacy services). Note: the EHCPM does not project workload by month nor does it project average daily census.

Question 19a. **For these three categories, what did EHCPM predict demand would be for March-May of 2021 when VA submitted its FY22 budget request?**

VA Response: VA's EHCPM uses Global Relative Value Units (GRVUs) to aggregate data across health care services, representing the total resource requirements to provide VA health care. For FY 2021, the post pandemic EHCPM-projected GRVUs were 587 million for ambulatory services and 309 million for inpatient services (excluding long-term services and supports, dental, prosthetics and pharmacy services). Note: the EHCPM does not project workload by month nor does it project average daily census.

Question 19b. **How did the change in expected demand forecast by EHCPM impact VA's request for medical care funding for FY22?**

VA Response: Many demographic and environmental drivers impact the cost of VA health care, which are incorporated into the EHCPM projections. The most impactful key drivers for the FY 2022 expenditure projections are COVID-19 drivers with increases expected due to the increased reliance from the economic recession and the return of care deferred in FY 2020 and FY 2021 and health care trends of inflation, intensity and utilization (in a non-COVID-19 environment, health care trends are the largest driver of expenditure increases for all health care providers—Medicare, Medicaid, commercial and VA). In addition, the FY 2022 expenditure projections include increases due to net enrollment growth and demographic mix changes as well as an increase from MISSION Act impacts.

Question 19c. **What does VA expect to need for medical care funding in FY24 and FY25 based on the EHCPM modeling for the FY22 budget request?**

VA Response: The EHCPM cost projection typically accounts for about 90% of the overall obligation projection in the budget year. The upcoming 2023 President's Budget will include the model-informed 2024 funding need with the advance appropriation request. The 2024 President's Budget request will update the 2024 projection based on the newest modeling and will also include the projected 2025 funding in the advance appropriation.

Question 20. **VHA is increasing its funding for FTEs by 17,403 from FY21 to FY22, and keeping the FTE level steady for FY23. Is the FTE level of 352,444 for FY21 adequate to meet expected demand for care?**

VA Response: The projected obligation amount of $104.1 billion in 2021 is adequate to meet expected demand in 2021, which will enable Medical Care FTE to grow to a projected 352,444. The final 2021 FTE total and obligations by account and function will vary as workload and budget execution patterns are updated.

Question 20a. **Is the FTE level of 369,847 adequate to meet expected demand for FY22 and FY23?**

VA Response: The projected obligation amount of $119.8 billion in 2022 is adequate to meet expected demand in 2022, which will enable Medical Care FTE to grow to a projected 369,847. The final 2022 FTE total and obligations by account and function will vary as workload and budget execution patterns are updated. The 2023 President's Budget request will revise the 2023 projections to incorporate VHA program office budget evaluations and a new actuarial projection that accounts for 2021 spending patterns.

Question 20b. **If the advanced funding request for medical accounts in FY23 is 3.7% less than for FY22, why are FTE levels remaining flat instead of reflecting a similar 3.7 % decrease?**

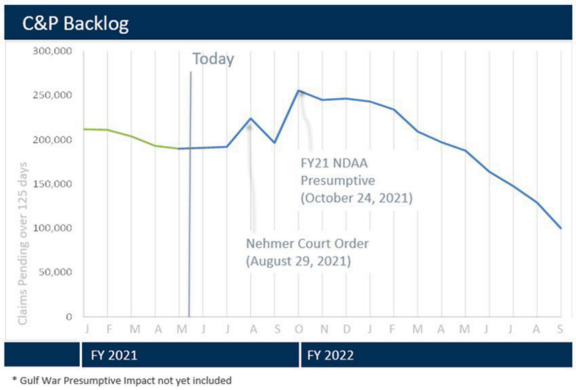
VA Response: The projected 2023 Medical Care "1st bite" obligation amount is $115.327 billion, a decrease of $4.425 billion or 3.7% from the 2022 $119.752 billion obligation level afforded by this President's Budget Submission. The 2023 funding and projected obligation level will be re-evaluated? as part of the 2023 President's Budget Submission second bite formulation. The decrease in the 2023 advance appropriation obligations are reflected in decreases to equipment, non-recurring maintenance, leases and Community Care. Personal services costs sustain the FY 2022 FTE level into 2023.

Question 21. **You noted in your written testimony that VA is implementing changes related to Blue Water Navy and additional Agent Orange presumptive diseases. What impact will those changes have over the next five years in terms of mandatory spending, VBA's workforce, and the current claims backlog other veterans are already experiencing?**

VA Response: Over the next 15 months, VA expects the claims backlog to increase due to ongoing processing of two large claim groups (See graph below). The Blue Water Navy (BWN)-Nehmer readjudication will increase the backlog beginning in late August and additional Agent Orange presumptive conditions will increase the backlog beginning in late October.

The FY 2022 Budget includes the resources requested to support Agent Orange presumptive processing (334 FTEs), as well as 95 FTEs for general Compensation and Pension (C&P) claims processing. In addition, VA is leveraging CARES Act transfers and American Rescue Plan (ARP) funding to administer overtime to ensure timely claims processing. Assuming continued improvement of VBA's evidence supply chain C&P examinations and Federal records, VA's goal is to reduce the current claims backlog to 100,000 claims by the end of FY 2022. Prior to the pandemic, VBA's working backlog was between 70,000 and 80,000 claims in inventory. The goal to reduce the backlog to 100,000 represents the working goal towards pre-pandemic backlog levels.

Figure 1



The 2022 President's Budget incorporates the following:

- VBA's mandatory spending:
  - $3.0 billion in obligations in 2022 related to implementation of three new Agent Orange presumptive conditions (hypothyroidism, bladder cancer and Parkinsonism).
  - $2.3 billion in obligations in 2022 related to Blue Water Navy Veterans.
- VBA's discretionary spending and workforce: $40.3 million in obligations in 2022 to fund an additional 334 FTE in 2022 for the three new Agent Orange presumptive conditions.

Question 22. **Your testimony briefly touched on the new process you created for VA to review scientific evidence relating to exposures, and your recent decision to initiate rulemaking to presume service connection for three diseases. Please describe this new process, who initiates it, which internal and external subject matter experts are involved in it, and how does it differ from VA's past practice on deciding presumptives?**

VA Response: VA has established processes to review reports and reviews from the National Academy of Science, Engineering and Medicine (NASEM) regarding military environmental exposures. These processes are outlined in VA Directive 0215. This directive can be found online by searching for VA Directive 0215, Management of Institute of Medicine Reports to obtain the PDF file of the directive.

Secretary McDonough has reconstituted the VA Executive Board (VAEB) as a forum for senior leaders to advise him on issues important to Veterans, Veteran service organizations (VSOs),

Congress and the media. The first among the issues addressed was that of toxic exposures. Beyond established processes using the NASEM to evaluate scientific and other information in deciding presumptions, the Secretary has initiated new processes that build on VA's expertise in military environmental exposures. Any system deciding on presumptive conditions related to exposures must be evidence based and science driven. The collection of evidence will broaden beyond using solely NASEM consensus reports of the literature.

VHA's Post Deployment Health Services/Health Outcomes of Military Exposures (PDHS/HOME) regularly reviews research concerning military environmental exposures. When there is new scientific evidence for conditions related to military environmental exposures PDHS/HOME will conduct a review. In addition, PDHS/HOME will use VBA data to look for trends that need further review. If PDHS/HOME identifies evidence that suggests a presumption is warranted, this recommendation is passed through the Deputy Under Secretary for Health to the VAEB for consideration. VAEB then deliberates with relevant leadership and Subject-Matter-Experts. Ultimately, the Secretary decides whether to pursue rulemaking to establish a presumption.

Question 23. **The Moran-Blumenthal Toxic Exposure Research Act was signed into law in 2016. It mandated an agreement between VA and the National Academies to study generational impacts of toxic exposure, with a follow-on VA advisory board to analyze the findings. The VA Budget Submission lists completion of this task as a recent accomplishment. VA has still not provided the required report to Congress on the advisory board's findings even though it was due in January. Why has this report not been provided?**

VA Response: The report was transmitted to Congress on July 21, 2021.

Question 23a. **Please provide the requested report as soon as possible.**

Question 23b. **What is VA's determination on the feasibility of further studies?**

VA Response: Section 632(d) of P.L. 114-315 required the Secretary of Veterans Affairs to certify his understanding regarding the feasibility of conducting further research into the health conditions of descendants of Veterans subject to in-service toxic exposures. This certification was to occur after the previous Secretary reviewed a November 2018 report by the National Academies of Sciences, Engineering and Medicine (NASEM), "Gulf War and Health, Volume 11: Generational Health Effects of Serving in the Gulf War." Given the scope of the report and NASEM's recommendation of forming a Health Monitoring Research Program (HMRP), the previous Secretary advised in a March 22, 2019, letter to your Committee that VA needed additional time to properly evaluate the issue.

After considerable investigation and discussion, the Secretary certified further research as outlined in the NASEM report is not feasible. The Department relied on the work undertaken by a 15-member working group that provided perspective from several Federal agencies as well as

subject matter expertise on exposures, birth defects and men's and women's health. At the conclusion of its work, the group determined that the type of HMRP discussed in the NASEM report would ultimately fail. This projected outcome is due to several structural and scientific barriers that would preclude the HMRP from producing meaningful results upon which our Veterans and their families can rely. These barriers include limitations due to the lack of a national health record and a national birth defects database from which to draw data, the inability to meet administration and infrastructure requirements and scientific evidence that does not support a link between in-service toxic exposures and adverse intergenerational health outcomes.

Despite the conclusion, the Secretary remains committed to improving our knowledge on the impact of deployment exposures to Veterans' descendants.

Question 24. **How does standardization of VHA's credentialing and privileging specialist position descriptions, updated staffing models, and enhanced training for these specialists impact VHA's budget request for FY22?**

VA Response: In December 2020, VHA released the standardized credentialing and privileging specialist position descriptions which mandated implementation by March 31, 2021. The Executive Decision Memorandum which approved this Workforce Modernization Project (dated June 12, 2020) indicated that the budget would remain neutral initially and that VHA may require additional resources to further strengthen the program. The modernization effort for VHA Credentialing and Privileging includes two critical components: staffing and training. The VISN Credentialing and Privileging Officer (GS-12) positions for each VISN (new positions) will cost $2,000,000 and the development of the training courses is cost neutral.

Question 25. **VBA recently began implementing the Claim Accuracy Request (CAR) pilot, in lieu of the 48-hour pre-decisional review period for attorneys and VSOs that VBA halted last year. Understanding that this pilot uses the high-level review framework from the Appeals Modernization Act, how does this pilot impact claims processing timelines and how does the budget reflect this new review process and the FTE needed to conduct this additional review?**

VA Response: The Claims Accuracy Request (CAR) pilot workload represents a subset of higher-level reviews (HLRs) which neither impacts the budget nor requires additional FTEs. A CAR is an expedited HLR. As of June 30, 2021, the average days to complete a CAR is 9.5 days, which is substantially below the overall HLR goal of 125 days. To be eligible for the CAR program, a clear error in fact or law must be identified; therefore, VBA does not anticipate a high inventory of these claims. Since CAR implementation, CAR claims have made up less than 0.2% of HLR production.

Question 25a. **If VA decides to halt the pilot after the pilot window, what are alternate processes the Department is considering and how does the budget support these possibly other options, if at all?**

VA Response: Claimants have three review options if they are dissatisfied with a decision made by VBA : (1) submit an HLR if they do not have additional evidence to add, (2) submit a supplemental claim and provide additional evidence for consideration and (3) submit an appeal to the Board of Veterans' Appeals. All three of those review options are currently in place and do not impact the budget. Further, even after all appeal periods have expired and a VA adjudication is final, claimants may still request revision based on clear and unmistakable error in accordance with 38 C.F.R. §§ 3.105(a)(1) and 20.1403 (implementing 38 U.S.C. §§ 5109A and 7111).

Question 26. **VBA recently put out an RFI for market research surrounding the medical disability exams program and the contract vendors involved in conducting these exams, and closed the RFI in May and is currently analyzing the data. While VBA has not committed to any action that could be taken after the research is analyzed and has said that the Department is not necessarily on a path of recompeting these contracts, there is concern that the Department is going to bring more exams back in house and is not appropriately comparing the quality and performance metrics of providers under the MDE vendor contract to the same exams being provided by VHA examiners.**
Can you please comment on any plans to halt or lessen the footprint of the contract vendors in conducting MDEs and require VHA providers to bring on more of the MDE workload?

VA Response: In March 2020, VHA issued guidance to VHA Facilities to eliminate all but urgent face-to-face visits across all VHA clinical services to reduce the risk of COVID-19 infection and exposure for Veterans, which aligned with Centers for Disease Control and Prevention recommendations. VHA resumed in-person C&P examinations at VHA Facilities based on each individual facility's local risk factors and pandemic emergency response plan to provide critical services in a safe environment for Veterans and VA employees. VHA continues to work with VBA and VAMCs nationwide to increase C&P examination completion capacity to best serve Veterans and Service members. VA continues to work through abnormal pandemic-related examination issues. All VBA contract exam vendors are completing exams at the rate of 130% or more of their pre-pandemic completion rates. VHA also is assisting to complete C&P examinations as they have the capacity to do so. Currently, there are 115 VHA facilities completing C&P examinations. VHA and VBA continue to expand their capacity to complete more C&P examinations.

Medical disability examination (MDE) vendors are evaluated on timeliness, customer satisfaction, and quality. Their quality standard is based on contractual compliance and proper completion of the disability benefits questionnaire. VBA and VHA are working collaboratively to establish uniform metrics to assess quality for MDE vendors and VHA staff.

Question 26a. **VBA is instituting additional quality metrics and analyzing outcomes of contract exams based on these new metrics as the Department did not believe contract examiners' performance levels were aligned with the agency needs. However, VBA has said they cannot require the same of VHA examiners since they are not a part of the VBA contract and VHA examiners**

have other responsibilities outside of the MDE program. This is concerning, as these exams should all be under the same quality metrics, and we should be able to measure outcomes across the board whether a veteran is seen by a provider through one of the contracted vendors or through VBA or VHA. Can you speak to how the Department will address these concerns?

VA Response: VHA and VBA leadership tasked their respective C&P exam quality staff with establishing a chartered quality work group assigned with identifying quality metrics that could be uniformly applied to both C&P disability exams completed by VHA and VBA Medical Disability Examination contractors. Creation and implementation will be extensive as this work group will address differing VHA and VBA information technology (IT) systems; needed adjustments to audit language; and audit training development and delivery to ensure consistency. VA leadership will be briefed monthly on progress and upon request.

Questions for the Record
Senate Veterans Affairs Committee
"Review of FY 22 Budget and 23 Advance Appropriations Requests for the VA"
Wednesday June 16, 2021
Senator Blumenthal

VA Infrastructure

Question 1. **Secretary McDonough, with your acknowledgement of the negative operational impacts of aging infrastructure, do you anticipate this $2.2 billion amount will truly make a dent in addressing VA's pressing VA infrastructure issues?**

Question 1a. **What amount is needed for the VA to expedite the completion of its priority list?**

VA Response: This $2.2 billion in FY 2022 construction funding will address our most pressing needs as prioritized through the Strategic Capital Investment Planning (SCIP) process. This process reflects a significant supplement to our recuring levels of projects executed at the VAMC level.

The median age of private sector hospitals in the United States is 11 years. Conversely, the median age of VA's portfolio is 58 years, with 69% of VA hospitals being older than 50 years. The age and condition of VA facilities demand that we do better by Veterans. Historic capital investments levels

have resulted in facility correction costs doubling from $11.6 billion in 2010 to $22.3 billion in 2020. It is expected that going forward funding levels consistent with the FY 2022 funding increase will slow this increasing condition degradation rate but not impactfully reduce the outstanding backlog represented by this total correction cost. Recapitalization or replacement of VAMCs also would be required to significantly reduce the outstanding backlog.

Question 2. **Secretary McDonough, do you have a point of view on the need for more comprehensive planning by the VA over a longer horizon?**

VA Response: VA believes the current capital program planning efforts are comprehensive and will identify and prioritize investments needed to best care for our Veteran community. Long-term facility recapitalization planning with analyses is completed at 5, 10, and 20-year horizons. VA is performing a comprehensive, data-driven process to identify and prioritize potential sites. The data leveraged will include physical attributes, such as age and condition of the facilities, as well as capacity attributes related to the functional fit of our facilities to meet health care demands.

VA is developing and prioritizing enterprise-wide critical infrastructure system improvements needed at existing VHA medical facilities that will be executed via the Recurring Expenses Transformational Fund. Costs to modernize infrastructure systems (such as central utility plants) have increased significantly. These mid-term core infrastructure improvements will address needed improvements that have historically been deferred.

In addition, immediate needs, including those addressing green energy, Veteran health care equity and aging Veteran requirements, will continue to be identified, vetted and prioritized annually via the existing SCIP process to ensure best and most impactful application of limited capital funding.

All prioritized investments will be assessed regularly to ensure alignment with knowledge gained from the quadrennial Market Assessment and the Asset and Infrastructure Review Commission process as well as Veteran access requirements. These programs will be reviewed in whole to ensure continued internal alignment of investment priorities.

In summary, VA does have a comprehensive planning system in place, and it is being improved

every year. In addition, the 10-year planning horizon provided though SCIP, along with the long-term 20-year planning horizon for the recapitalization, provide the ability to develop a detailed plan while also offering the flexibility to implement the plan based on available funding.

Claims backlog

Question 3. **Secretary McDonough: how will the level of funding for new staff, including 334 new employees for Agent Orange claims and 95 new employees for general claims processing, seriously address the backlog of claims?**

VA Response: Prior to the pandemic, VBA's working backlog was between 70,000 and 80,000 pending claims in inventory. The current claims backlog is largely a result of disruption to VA's evidence supply chain (C&P examinations and Federal records) during the COVID-19 pandemic. The CARES Act and ARP overtime funding, as well as the additional 429 claims processing employees in the FY 2022 budget request, will allow VA to process claims received under the expansion of Agent Orange benefits in the FY 2021 NDAA and will further reduce the backlog by the end of FY 2022.

Question 4. **Secretary McDonough: How has this budget accounted for new claims stemming from new toxic exposure rules around your recent decision VA plans to enter the rulemaking process for burn pit-related presumptions of service connection?**

VA Response: The FY 2022 President's Budget was issued prior to any toxic exposure action and therefore does not include funding for the rulemaking related to toxic exposures among Gulf War Veterans. VA will notify Congress when the rulemaking and cost estimates are finalized.

Question 5. **Secretary McDonough: what budget is needed for the VA to expedite the completion of its claims backlog?**

VA Response: VA claims backlog will never be zero, as there will always be some claims that take more than 125 days due to claims complexity and/or timeliness of evidence received from third parties. VA aims to complete most claims (over 70%) in 125 days or less and the claims backlog reduction to pre-COVID-19 levels will be a multi-year process. VA requests continued congressional

support on all funding requests to expand Federal record digitization, IT funding requests aimed at improving claims processing, and FTE requests.

Questions for the Record
Senate Veterans Affairs Committee
"Review of FY 22 Budget and 23 Advance Appropriations Requests for the VA"
Wednesday June 16, 2021
Senator Kyrsten Sinema

Questions for Secretary McDonough

Question 1. **As we talk to our Arizona VA Medical Center Homeless Program offices and the organizations that support veterans experiencing homelessness, we encounter two reoccurring issues. VA Medical Center HUD-VASH case managers are managing growing caseloads and their time is divided with other responsibilities. And there is a lack of housing that accept vouchers, so while there are vouchers available for veterans, there is a lack of housing to place them in. As the VA considers staffing levels for FY 22, what analysis has been done to consider additional staffing needs for homelessness prevention efforts?**

VA Response: As outlined in the recently submitted report to Congress, Report on Staffing of Department of Housing and Urban Development-Department of Veterans Affairs Supportive Housing Program (HUD-VASH) as Required by P.L. 116-315 § 4208, VA's analysis suggests that approximately 4,200 case managers are required to support the 105,435 HUD-VASH vouchers currently allocated by HUD. The Homeless Program Office (HPO) evaluates HUD-VASH case management staffing on a continual and recurring basis as a part of routine administration, and factors anticipated growth in staffing needs (including new HUD voucher allocations and other factors) into budgetary requests for future fiscal years. HUD-VASH case managers play a critical role not only in housing homeless Veterans but also in preventing a return to homelessness. In this way maintaining adequate case management staffing in the HUD-VASH programs serves to support broader homelessness prevention efforts among the Veteran population.

Question 2. **The Arizona VA Medical Centers are trying to address challenges with the lack of housing for veterans experiencing homelessness locally. For example, the Southern Arizona VA Medical Center just held a wonderful landlord appreciation event to recognize and thank those individuals who participate in the program. The FY 22 budget includes funding for up to 10,000 additional HUD-VASH vouchers. As you look to increase the number of vouchers, what steps are you taking enterprise-wide to address the growing challenge of lack of housing availability for veterans experiencing homelessness and what lessons have you learned from the pandemic that can help inform the VA's efforts to provide housing for veterans experiencing homelessness**

moving forward?

VA Response: While staffing levels can have a strong influence over voucher utilization, there are several other internal and external factors which impact voucher use at the local level. These factors include geographic proximity of VHA facilities to voucher allocations, access to affordable housing stock, public housing authority (PHA) collaborations and available community resources. The COVID-19 pandemic afforded opportunities for increased collaboration with VA and community partners to meet the emergent needs of homeless Veterans, and the VHA HPO is working with the field to identify and support the continuation of these partnerships. Examples of successful collaborations with VA, PHA, and community partners (both prior to and during the pandemic) include a variety of housing solutions, including community-based project-based developments, Enhanced Use Leases for project development on VHA property, special housing types for elderly and medically vulnerable populations (group homes, medical foster homes, etc.) and landlord events such as the one held in southern Arizona.

Question 3. **In October 2020, the VA implemented phase one of the expansion of the Program of Comprehensive Assistance for Family Caregivers as mandated by the VA MISSION Act. Since this implementation, the VA has received more than 81,000 applications for the program and approved only 7,000. This is a large and concerning discrepancy. What steps has the VA taken to better understand what is driving such a large number of denials and what processes are in place so the VA can check its own work as these applications are processed across the VA enterprise?**

VA Response: Between October 1, 2020, and July 7, 2021, VA has received over 91,000 joint applications to the Program of Comprehensive Assistance for Family Caregivers (PCAFC). Each joint application includes one Veteran and up to three Family Caregiver applicants. Of the joint applications received between October 1, 2020, and July 7, 2021, approximately 71,000 eligibility determinations have been made. Approximately 62,500 applications have been denied due to a variety of reasons, including the applicant not meeting statutory eligibility criteria, application withdrawal, eligibility determinations resulting from initial screening at the facilities, failure of the applicant to complete the application process, death of a Veteran and eligibility determinations made by the inter-professional licensed practitioners on the Centralized Eligibility and Appeals Teams (CEAT). Approximately 9,500 applications have been approved and approximately 21,500 applications remain under evaluation.

VA has provided facility Caregiver Support Program (CSP) staff with extensive standardized training on the types of eligibility determinations that can be made at the facility level during the initial stages of the joint application evaluation process. Some examples of this include, if the Veteran is not 70% Service Connected or if the Caregiver is less than 17 years old, the facility can make an eligibility determination. If facility CSP staff confirm these eligibility requirements are met, the application process continues and a consult is completed referring the application to the CEAT. If facility CSP staff are unable to assess or determine any of these eligibility requirements in the joint application during these initial stages, the application is referred to the CEAT for review and determination of those eligibility requirements.

VA takes a multifaceted approach to support standardization of eligibility determinations, inclusive of determinations made by CEATs, by using standardized Electronic Health Record

(EHR) note templates, standard operating procedures (SOPs) and intensive standardized staff training to ensure consistency and standardization of eligibility determinations. In addition, determinations made by CEATs are informed by reviewing standardized evaluations and assessments completed at the local VAMC.
The Caregiver Support Program Office routinely analyzes data and has regular contact with the field regarding process improvement. Through an environment of continuous improvement, the CSP Office identifies the field's needs for enhanced education, improved procedures and consultation with subject matter experts. These efforts are ongoing. VA currently is working to establish a quality assurance process to ensure all eligibility requirements are accurately and consistently applied when rendering any determinations.

To note, compilations of data may not result in mathematically exact totals as each application can include up to three Family Caregiver applicants (up to one Primary Family Caregiver and up to two Secondary Family Caregivers) and each applicant is dispositioned (approved or denied) individually; therefore, one application could be counted as denied, approved and in process at one point in time.

Question 4. **Processing such a large number of caregiver applications is time and resource intensive for both the veteran/caregiver team, and the VA. In October 2020, I sent then Secretary Wilkie a letter asking him to create a process where the VA uses existing data to proactively identify and notify veterans with caregivers who are eligible for this program and assist them in program enrollment. After investing so heavily in an IT system to support the Family caregiver expansion, there must be a way to configure this system to more proactively support eligible veterans. Has the VA considered how to do this? What steps would the VA need to take to adopt such a system and how can congress help?**

VA Response: Since October 1, 2020, VA has received approximately 91,000 applications for PCAFC. While this number far exceeds the number of individuals VA anticipated would apply, it demonstrates the success of VA's outreach to VSOs, Military Service Organizations, Veterans and caregivers about the availability of this valuable program. We agree that processing applications for the PCAFC is time and resource intensive. Eligibility determinations for PCAFC are complex, requiring a multistep process based on clinical evaluation and decision-making. The Caregiver Record Management Application (CARMA) is not a clinical decision-making tool, but rather a workflow management tool designed to support the administration and oversight of PCAFC, the Program of General Caregiver Support Services (PGCSS) and the Caregiver Support Line (CSL). CARMA supports documentation of the PCAFC application workflow, tracking of initial and ongoing eligibility for PCAFC and PGCSS, ongoing assessment and monitoring, automation of the PCAFC stipend payment process and supports tracking of calls to the VHA's CSL.

The Caregiver Support Program (CSP) and the Office of Information and Technology (OIT) continue to work to improve and enhance CARMA to support efficiencies in workflow for staff, with the goal of improving customer service and application processing timeliness for Veterans and their caregivers. CARMA is deployed with iterative releases, designed to offer continuous

improvements in workflow, data integrity and reporting needs. We also successfully deployed the online PCAFC application on the VA.gov portal. Since October 1, 2020, VA has received approximately two-thirds of all PCAFC applications online. We believe the rapid utilization of this platform speaks to improved efficiency in application submission and a better overall experience for Veterans and caregivers applying to PCAFC.

Question 5. **The VA's Medical Foster Home program allows veterans with serious conditions who need a nursing home level of care, but prefer a non-institutional setting, to live in the private homes of VA-approved caregivers. The VA program allows no more than three veterans to reside in the same home to ensure a high level of personalized care and promote a family-like setting. The typical rate in a traditional nursing home can be more than seven thousand dollars a month, while the cost of a medical foster home is two thousand to three thousand dollars a month. Unfortunately, the VA does not cover the care of this program and veterans must pay out-of-pocket for this option. Would investing in programs like the VA's Medical Foster Home program ultimately lead to cost savings for the VA and veterans? Does the VA have plans to further expand programs like Medical Foster Homes to increase veterans' access to home and community based services?**

VA Response: Medical Foster Homes (MFH) provide an alternative to long-stay nursing home (NH) care at a much lower cost. The program, in existence for 20 years, has already proven to be safe, preferable to Veterans, highly Veteran-centric and half the cost to VA compared to NH care. Veterans who elect to receive their care in a MFH maintain their independence by living in a private care home of no more than three care recipients, thus allowing for more individualized care. Veterans are served by an interdisciplinary care team, either Home Based Primary Care or Spinal Cord Injury Home Care, which includes a medical and mental health care provider, nurses, social worker, therapist, dietitian and pharmacist.

MFH has shown significant success in 43 states. According to current data, there are over 550 VA-approved caregivers providing MFH care in their homes to approximately 800 Veterans daily nationwide, which is paid for by the Veterans themselves. For all Veterans served in MFHs, their care needs are fundamentally no different whether they reside in a MFH or in a NH. These needs can be met at substantially lower costs in a MFH rather than NH. VA believes many more service-connected Veterans referred to or residing in NHs would choose MFHs if VA paid the costs for MFHs, but VA only has authority to cover costs at a NH, which can cost more than twice as much as a MFH. MFHs have demonstrated that costs were $71.28 less per day when compared to matched Community NH care. In addition, mortality rates were 12% higher for a matched comparison group of Veterans in traditional NHs.

The Office of Geriatrics and Extended Care has plans to expand the MFH program by 58 additional sites over 4 years, which would allow for MFH at every VAMC. The estimated cost savings from this expansion would be $54 million for 464 Priority 1a Veterans who would elect placement in MFH rather than NH.

Question 6. **In May 2021, the VA Office of the Inspector General issued a report concluding that the VA Electronic Health Record Modernization (EHRM) program underrepresented the cost of the physical infrastructure upgrades needed to support the modernization effort by anywhere from $1-2.7 billion and that the original $2.7 billion estimate for these costs were not included in the original cost estimate for the program. The FY 22 budget requests an additional $2.6 billion for the EHRM program. As part of the VA's 12-week assessment of the EHRM deployment, is the VA assessing the cost estimate to confirm its accuracy and ensure that it is comprehensive, including physical infrastructure needs?**

VA Response: VA recently completed a top-to-bottom, 12-week strategic review of the Electronic Health Record Modernization (EHRM) program on June 15, 2021. VA understands that a successful EHR deployment is essential in the delivery of lifetime, world-class health care for Veterans and is committed to getting this right, including reporting accurate, enterprise-wide life-cycle costs moving forward.

VA recognizes the need to have a full and complete perspective of program costs. Based on the recommendations by the OIG to improve cost identification, estimating, updating and reporting, VA will take a more synchronized, enterprise level approach that will provide greater clarity on the VA EHRM program's life cycle costs, including IT infrastructure requirements, VHA infrastructure modernization requirements and management of any identified and emerging project needs.

VA has contracted with the Institute of Defense Analyses (IDA) to complete an independent cost estimate (ICE) of all EHRM holistic program costs. The ICE will be completed within approximately 12 months of the kick-of meeting, which will be held in October 2021. VA's Office of Management is also coordinating with OEHRM, VHA and OIT to conduct a historical review of EHRM related costs. Both efforts will provide greater fidelity into the full EHRM spend plan and life cycle costs. Once completed, VA will provide the findings to Congress during the next quarterly update.

Since the inception of the EHRM program, VA has provided Congress with program cost estimates specifically for the Veterans Electronic Health Record (EHR) account. IT infrastructure (VHA and OIT) costs do not fall under OEHRM's appropriation and were not included as a life cycle cost estimate category in the Veterans Benefits Transition Act of 2018, which requires the Secretary of VA to report the annual and life cycle cost estimates of the EHRM program to Congress on a quarterly basis. As previously reported in an OIG report on physical infrastructure cost estimates, OEHRM included only those costs that were funded by the EHR account in its cost estimates. Until now, this has been the guidance VA has followed in its reporting to Congress.

Question 7. **In the June 9th SVAC Infrastructure hearing, Mr. Murray testified on behalf of the VA that these physical infrastructure needs would be included in the VA's SCIF process, rather than as part of the EHRM program budget. Do**

you believe this is an appropriate way to plan for the needed physical infrastructure updates associated with the EHRM program, or should this be accounted for separately and as part of the EHRM program budget?

VA Response: VA's Strategic Capital Investment Planning (SCIP) process is the basis for the Department's capital budget for physical infrastructure (e.g., major construction, minor construction, non-recurring maintenance) across the enterprise. EHRM prioritization to ensure maximum impact and effectiveness of limited program funding will be performed via the established SCIP process. Prioritization via SCIP will ensure appropriate prioritization of EHRM projects within the Medical Facilities appropriation.

Furthermore, VA lacks legal authority to fund physical infrastructure improvements with the Veterans EHR account, as the Veterans EHR account lacks construction-type wording such as "constructing, improving, altering, extending or renovating buildings or facilities."

Question 8. **The use of Peer Support Specialists has over the past few decades has greatly enhanced how mental health services have been provided throughout the United States. The VA has used/employed Peer Supports in extremely low numbers compared with the public behavioral health services around the country. What is the VA's plan to build on the success of peer support specialists to enhance mental health services offered to veterans at the VA?**

VA Response: VHA appreciates the Committee's interest in ensuring Veterans have access to peer support services in the VA mental health care programs where they receive their health care services. VHA continues to be the single largest employer of peer support specialists in the United States. Currently, there are 1,205 peer specialists (80.6% male and 19.4% female) working in the VA health care system. They work in a variety of different health care programs, including outpatient, inpatient and residential mental health programs, homelessness programs, primary care patient-aligned care teams (PACT, and the national Veterans Crisis Line's new Peer Support Outreach Call Center. In the Peer Support Outreach Call Center peer specialists on staff provide outreach calls to offer short-term telephone-based peer support services to Veterans who recently called the Veterans Crisis Line. In all these programs, peer specialists work alongside other health care professionals and bring a unique perspective to the interdisciplinary treatment teams. The expertise of peer specialists is founded in their personal experiences of overcoming challenges with their mental health and wellness, resulting in them successfully living in recovery in their daily lives. Peer specialists meet with Veterans individually and/or in groups, and they have been trained to use their personally lived experiences with recovery to promote hope and assist Veterans to identify and achieve self-determined goals for recovery and personal wellness.

VHA makes several efforts to support the successful implementation of peer specialists in mental health care services across the VA health care system. The VHA Office of Mental Health and Suicide Prevention (OMHSP) collaborates with the VHA Office of Workforce Management and Consulting to provide guidance to VAMCs' Human Resources leaders and facility management teams regarding policies on peer specialist certification requirements, hiring and

promotions for peer support staff. To support hiring Veterans as new peer support staff members, OMHSP provides funding for the required peer specialist certification which GS-5 Peer Support Apprentices access during a 1-year term appointment that also allows them to obtain supervised on-the-job experience, thus making them eligible for open peer specialist staff positions at VA facilities.

The Peer Support Services Section of OMHSP serves as an operational partner for several VA research investigators who are studying the implementation of peer specialists in a variety of different mental health care settings and the benefits of peer support services for Veterans' health care outcomes. When the studies' results are available, the Peer Support Services Section assists with dissemination of the outcomes through the Section's well-established communication systems (webinars, mail groups and a quarterly national newsletter). The study results encourage leadership at VA facilities to work with peer specialists because they are beneficial for Veterans' health care outcomes and our system and to keep peer specialists in mind as they determine funding allocations for new staff positions.

VHA OMHSP continues to support the expansion of hiring peer specialists in VHA. Recent efforts have included:

1. In the FY 2022 President's Budget, VA included funding to specifically address the needs of Veterans with substance use disorders (SUDs). This request will enable VHA to hire over 300 additional peer specialists to work in VHA SUD treatment programs where they would provide individual and group-based peer support services for Veterans with SUDs.

2. Section 5206 of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116-315) requires VHA to conduct a peer specialist staffing capacity assessment to determine whether the VA health care system currently has sufficient staffing of female peer specialists to be able to provide peer support services to women Veterans. This Act also requires VHA to use the results of the subsequent assessment report to write and submit a female peer specialist staffing improvement plan to Congress by October 2022. The female peer specialist staffing capacity assessment is well underway, and the assessment report and female peer specialist staffing improvement plan will be submitted to Congress in 2022 by their required deadlines. The results from this Act will likely lead to additional hiring of female peer specialists across the VA health care system within the next few years.

Questions for the Record
Senate Veterans Affairs Committee
"Review of FY 22 Budget and 23 Advance Appropriations Requests for the VA"
Wednesday June 16, 2021
Senator Thom Tillis

Question 1. **Section 152 of the VA MISSION Act created the Center for Innovation for Care and Payment to explore different models of paying for care that would tie reimbursement for care to the quality of that care. Have you considered setting up a value-based care model for dialysis through the Center? A pilot program under the Center would be an ideal opportunity to assess whether VA could achieve costs savings and improve quality for this patient population that often has many co-morbidities.**

VA Response: The VHA Center for Care and Payment Innovation (CCPI) is exploring several chronic conditions in which CCPI's pilot capabilities could have an impact. Chronic Kidney Disease (CKD) and End-Stage Renal Disease (ESRD) have been identified as priorities due to prevalence in the Veteran and the greater population, impact on quality of life and outcomes and significant resource requirements for treatment and management. Value-based modeling is a key strategy to advance CCPI's mission and approaches such as risk sharing, bundling and shared savings are all options to improve cost savings and clinical care delivery and outcomes for Veterans with chronic conditions. CCPI is investigating models that have been successful in the commercial market, as well as developing new concepts, to pilot and scale across the enterprise. CCPI also is exploring opportunities to deliver care in other settings, such as at home, as well as address other aspects of a Veteran's whole health.

Question 2. **The Fayetteville region has the highest ratio of VHA enrolled dental eligible veterans per dental treatment room and, while there is construction of new dental facilities in progress and planned for the near future, I am concerned that these additions may not keep pace with the rapidly growing veteran population in the region. How do you plan to address the future dental needs of veterans in regions like Fayetteville, and what more can Congress do to support you in this endeavor?**

VA Response: The Fayetteville Ramsey Street location is in active construction phase for expansion of its dental clinic from 13 chairs to 26 chairs. In addition, DoD partner memorandums of understanding with Womack Army Medical Center/Seymour Johnson Air Force Base to use eight chairs in the Goldsboro, North Carolina area. A proposed Health Care Center in Jacksonville, North Carolina, is slated for nine chairs (three hygiene rooms/six multifunction rooms). Sites maintain dental care in the community (CITC) teams and will continue work with our community partners to ensure Veterans receive the care they need.

Question 2a. **Do you assess the expansion of available dental exam rooms at the Fayetteville campus from 13 to 26 as adequate to meet the dental needs of Fayetteville area veterans?**

VA Response: Yes. In North Carolina, VISN 6 has recently awarded a minor construction project to increase the number of exam rooms at the Fayetteville campus from 13 to 26. The

Fayetteville VAMC also is working with Seymour Johnson AFB to allow VA to use eight chairs for VA care.

Question 3. **VHA review has identified significant gaps in analysis between the SCIP / OCAM projections and National Dental Office projections for dental care needs. Can you provide any further updates on how you plan to address this gap?**

VA Response: The Office of Dentistry is collaborating with the VA Facilities Standards Service to review the gaps between the two models. The goal of this working group will be to harmonize the two models and reduce or eliminate significant gaps.

Questions for the Record
Senate Veterans Affairs Committee
"Review of FY 22 Budget and 23 Advance Appropriations Requests for the VA"
Wednesday June 16, 2021
Senator Blackburn

To the Honorable Denis McDonough, Secretary, Department of Veterans Affairs:

Question 1. **On June 19, 2021, the Department of Veterans Affairs' (VA) announced plans to offer gender confirmation surgery to transgender veterans. Where in the statute does the VA have the authority to make this change?**

VA Response: VA has statutory authority to provide hospital care, medical services and extended care services pursuant to 38 U.S.C. § 1710. This authority includes the authority to provide gender confirmation surgery. However, VA's regulations at 38 U.S.C. § 17.38(c)(4) exclude provision of "gender alterations" from VA's medical benefits package. VA has the authority to make changes to its own regulations in accordance with the requirements of the Administrative Procedure Act. VA will initiate steps to modify its regulations to expand VA's care to transgender Veterans and include gender-affirming surgery. Gender-affirming procedures have been proven effective at mitigating serious health conditions, including suicidality, substance abuse and dysphoria.

By making this change, VA would be able to provide transgender and gender diverse Veterans with coordinated, medically necessary, transition-related surgical procedures. This situation would enable VA to create a safe, coordinated continuum of care that is Veteran-centric and consistent with VA values of equity and respect for all. The process to make the necessary regulatory changes may take approximately 2 years, including a period for public comment. During this time, VA would continue to work to develop the framework to provide the full

continuum of care in a way that is consistent with VA's rigorous standards for quality health care for Veterans.

Question 2. **What impact will expanding care to include gender confirmation surgery have on the budget?**

VA Response: VA is currently in the process of identifying the number of interested Veterans and the associated cost of these procedures. VA anticipates including more details in the FY 2023 President's Budget.

The estimated annual costs to VA will be developed as a part of the initial steps to modify the rules. Costs per surgery would depend on whether care is delivered within VA or outside VA through community partners. A formal Regulatory Impact Analysis will offer increased insight, but the preliminary figures of adding these procedures suggest that the added costs would be negligible.

Question 3. **Why did the department not include the plans to expand VA care to gender confirmation surgery in the budget?**

VA Response: VA is currently in the process of identifying the number of interested Veterans and the associated cost of these procedures. VA anticipates including more details in the FY 2023 President's Budget. The Secretary recently initiated a rulemaking process and that process can take approximately 2 years to complete. Estimated annual costs to VA will be developed as part of the rulemaking process through a Regulatory Impact Analysis. The Regulatory Impact Analysis has not been completed yet, but the preliminary figures of adding these procedures suggest that the added costs would be negligible. Once costs for gender confirming surgeries are known, they can be included in the VA budget as appropriate.

In the last decade, the VA budget has nearly doubled. The VA's Government Purchase Card Program is just one of the VA's charge card programs. A recent VA-OIG report found that up to 20 percent of charge card transactions reviewed were potentially illegal, improper, or wrong. Agency purchase spending increased by over $400 million from FY18 to FY19 and the risk for waste fraud and abuse has not been addressed.

Question 4. ***In light of multiple VA-OIG reports flagging potential risk of abuse, is the VA working decrease the use of GPA's?***

- ***If yes, how?***
- ***If no, why?***

VA Response: VA is not working to decrease spending on purchase cards. The overall cost of

using a purchase card versus Treasury check or EFT is much lower and saves VA millions of dollars annually. VA continues to put more controls in place each year to mitigate the risks of illegal, improper or wrong payments. In November 2020, VA began transitioning to a new Integrated Financial and Acquisition Management System (iFAMS), which will support the government purchase card program. The current Financial Management System requires a unique purchase card transaction per Veteran giving the appearance of duplicate payments. This process will change under iFAMS. VA also continues to increase the use of data analytics via multiple platforms for completing more in-depth reviews of all purchase card transactions to assist with identifying and mitigating risks.

Question 5. ***What is the VA doing to identify and cut back on potentially duplicative payments, and improper or illegal transactions?***

VA Response: VA continues to increase the use of data analytics, in multiple platforms, completing a more in-depth review of all transactions. In addition, VA's Financial Services Center (FSC) continues to flag potential duplicate payments and provide information to VA customers for resolution.

Question 6. **In FY19, data showed a surge of year-end purchase card spending. In the last 2 months average spending increased by nearly $40 million.** ***Why do you think there was such a surge in spending at the end of the fiscal year?***

VA Response: VA receives 4th quarter rebates from the contracted purchase card bank in mid-September. VA must use the rebates in the current fiscal year creating additional spend of approximately $30M. VA plans for this additional budget spend in advance knowing the money will be put back in the appropriate appropriation.

Question 7. **The DoD Electronic Catalogue program provides VHA a non-GPC method for procuring medical devices bought direct from manufacturers. What efforts are in place to ensure VA Medical Centers are using those sources instead of the GPC, specifically for micro-purchases which are not competed by contracting?**

VA Response: Except as required by Federal Acquisition Regulation (FAR) 8.003, or as otherwise provided by law, including but not limited to 38 U.S.C. § 8127, VA is required to satisfy requirements for supplies and services from or through the mandatory Government sources and publications. VA personnel must follow the mandatory ordering hierarchy to procure medical supply commodities (VA Acquisition Regulation (VAAR) 808.002). VA ordering officers are trained and designated as "authorized" and are required to use the ordering hierarchy

when determining the source of supplies. DoD Electronic Catalog is prioritized above use of GPC/Open Market in the ordering hierarchy. VHA Directive 1761, Supply Chain Management Operations, also details the mandatory procurement instruments.

Questions for the Record
Senate Veterans Affairs Committee
"Review of FY 22 Budget and 23 Advance Appropriations Requests for the VA"
Wednesday June 16, 2021
Senator Tuberville

Question 1. **Secretary McDonough, the President's budget includes $598M for veteran suicide prevention outreach programs, a 92% increase from last year's funding level.**
Can you briefly describe your plan for how this money will be spent and, outside of funding to increase the capacity of the Veterans crisis line, which outreach programs will be utilized?

VA Response: There are four primary programmatic areas that account for the suicide prevention budget increase: (1) the Veterans Crisis Line's (VCL) implementation of 9 8 8, (2) Suicide Prevention 2.0, (3) PREVENTS and(4) (SSG Fox SPGP).

The VCL accounts for 50% of the total increase, which is to support operational readiness in fulfillment of the National Suicide Hotline Designation Act of 2020 (P.L. 116-172), which requires the Federal Communications Commission to designate 9-8-8 as the universal telephone number for the National Suicide Prevention Lifeline and the VCL. A volume increase of 122% to 154% is anticipated for VCL and the transition to 988 must be complete by July 16, 2022. Once activated, the 988 expansion will directly address the need for ease of access and clarity in times of crisis for Veterans and non-Veterans alike. By providing a universal, unique 3-digit dialing code, it also will give VA an opportunity to work in greater collaboration with the suicide prevention community across the United States and open the door to engage new individuals in life-saving care.

The increase for Suicide Prevention (SP) 2.0, which accounts for 12% of the total increase, is to further the implementation of our public health approach to suicide prevention. To accomplish its goal of reducing suicide among all 18 million Veterans, and 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 prevention strategies and evidence-based clinical strategies that will empower action at the national, regional and local levels. This initiative is

informed by the evidence supporting suicide prevention interventions and public health approaches. The Center for Disease Control and Prevention, the Substance Abuse and Mental Health Services 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 innovative community-based prevention strategies combined with strategies with known outcomes for reducing suicide and suicide attempts based upon the 2019 updated VA-DoD Clinical Practice Guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide.

The increase for PREVENTS, which accounts for 18% of the total increase, is to support Roadmap implementation and completion to include an aggressive plan integrating Roadmap recommendation 1 with Roadmap recommendation 8 across FY 2022.

The SSG Fox SPGP accounts for 19% of the total increase. SSG Fox SPGP supports Section 201 of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (P.L. 116-171) and 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 (2018), 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.

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Suicide Prevention Outreach Program:							
Veterans Crisis Line	$111,770	$115,163	$113,891	$255,968	$260,803	$142,077	$4,835
National Suicide Prevention Strategy Implementation	$35,807	$35,950	$41,258	$42,131	$43,897	$873	$1,766
Demonstration Projects	$6,109	$3,022	$5,793	$4,744	$4,821	($1,019)	$77
Suicide Prevention 2.0 Initiative	$4,216	$41,481	$31,361	$66,606	$67,535	$35,245	$929
PREVENTS	$21,251	$33,400	$33,400	$104,482	$97,482	$31,082	($7,000)
Centers of Excellence (includes MIRECC and SMITREC)	$3,899	$5,525	$5,596	$5,311	$5,365	($285)	$54
Local Facility and Community Outreach Activities	$710	$750	$750	$750	$750	$0	$0
Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program	$0	$0	$1,847	$55,694	$56,507	$54,047	$813
Specific Purpose [Subtotal]	$183,762	$235,291	$252,019	**$536,686**	**$537,160**	$283,667	$1,474
Suicide Prevention Coordinators and Teams	$57,012	$59,344	$59,344	$60,311	$65,427	$2,967	$5,116
Total Suicide Prevention Outreach Program	**$240,774**	**$312,636**	**$311,363**	**$597,997**	**$602,587**	**$286,634**	**$4,590**

Question 1a. **Does this funding level include any funding necessary to carry out the suicide prevention community grant program enacted as part of the Hannon Act?**

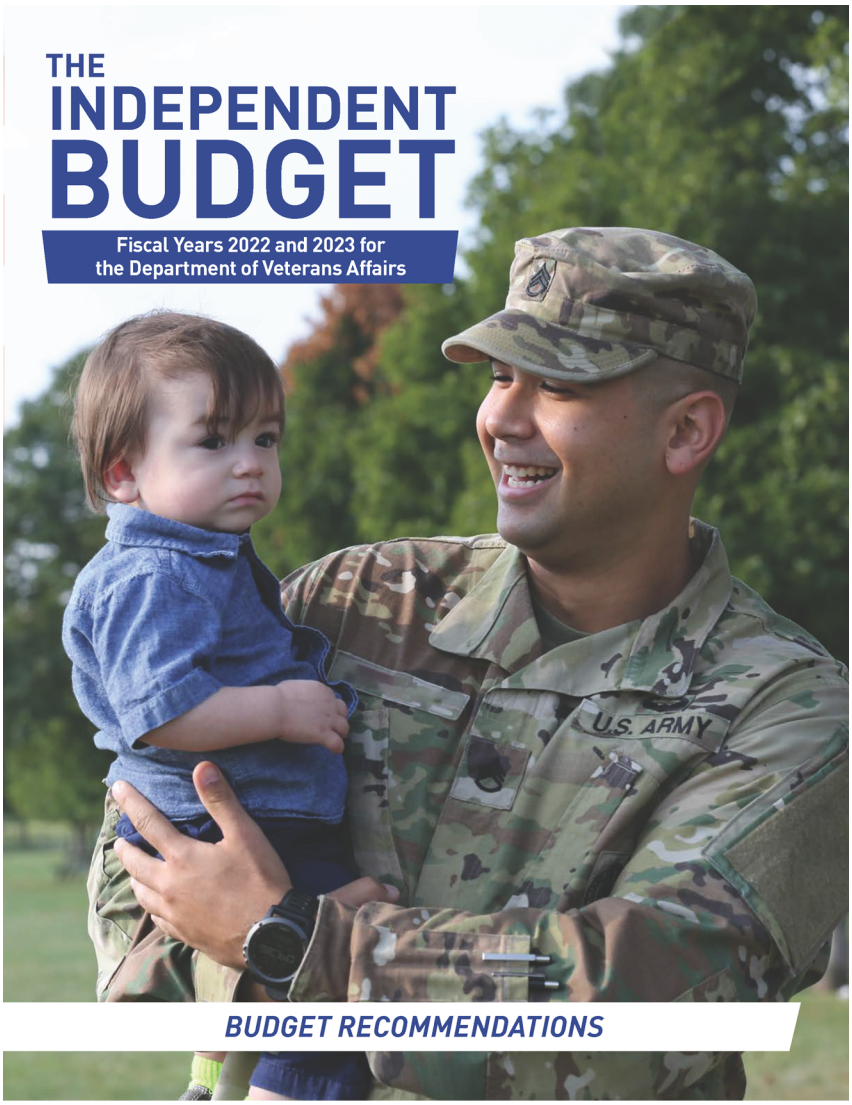
VA Response: VA's budget request included $55.7 million for FY 2022 to support the implementation of the SSG Fox SPGP enacted by Section 201 of the Hannon Act. The Hannon Act included an authorization of appropriations for a total of $174 million for fiscal years 2021 through 2025 to carry out the SSG Fox SPGP.

Question 2. **Last week's hearing about VA infrastructure included a discussion on the $18 billion the American Jobs Plan allocates for VA facility maintenance and construction. I asked Mr. Simms, from VA Office of Asset and Enterprise Management, about the role telehealth will now play in how veterans access and receive health care.**

Mr. Simms was unable to answer my question because it is too early to tell whether veteran preferences for receiving care will be permanently affected by the pivot toward telehealth services caused by the COVID-19 pandemic.

The VA budget includes a 30% increase in construction funding. Along with the $18 billion from the American Jobs Plan, this allocates more than $20 billion for facility upgrades and construction. If the VA is still awaiting data on what the future looks like, such as how veterans will prefer to receive care, how do you expect to spend this money and what questions are you going to work on answering first to get to a concrete plan on how to allocate this funding?

VA Response: The age and condition of existing infrastructure warrants a recapitalization and modernization strategy to efficiently and effectively support Veteran health care needs that cannot be addressed solely by telehealth. Site prioritization of these long-term investments is in progress and will incorporate any lessons learned on Veterans' preference for telehealth vice on-site care and resulting on-site care demand decreases. In addition, this construction funding addresses known, near-term needs targeting green energy, women Veteran health care equity and aging Veteran requirements, as well as accelerating existing major construction projects. These near-term, mature requirements are being pulled from the existing SCIP process and will still be required to support patient needs that cannot be addressed via telehealth.


THE
INDEPENDENT
BUDGET
Fiscal Years 2022 and 2023 for
the Department of Veterans Affairs
U.S. ARMY
BUDGET RECOMMENDATIONS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THE INDEPENDENT BUDGET

Fiscal Years 2022 and 2023 for the Department of Veterans Affairs

A Comprehensive Budget Created by Veterans for Veterans

DAV Paralyzed Veterans of America VFW

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Acknowledgments

For more than 30 years, The Independent Budget veterans service organizations (IBVSOs)—DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW)—have worked to develop and present concrete recommendations to ensure that the Department of Veterans Affairs remains fully funded and capable of carrying out its mission to serve veterans and their families, both now and in the future. Throughout the year, the IBVSOs work together to promote their shared recommendations, while each organization also works independently to identify and address legislative and policy issues that affect the organizations' members and the broader veterans' community.

Disabled American Veterans (DAV)

DAV (Disabled American Veterans) empowers veterans to lead high-quality lives with respect and dignity. It is dedicated to a single purpose: keeping our promises to America's veterans. DAV does this by ensuring that veterans and their families can access the full range of benefits available to them; fighting for the interests of America's injured heroes on Capitol Hill; linking veterans and their families to employment resources; and educating the public about the great sacrifices and needs of veterans transitioning back to civilian life. DAV, a non-profit organization with more than one million members, was founded in 1920 and chartered by the U. S. Congress in 1932. Learn more at **www.dav.org**.

Paralyzed Veterans of America (PVA)

Paralyzed Veterans of America (PVA), founded in 1946, is the only congressionally chartered veterans service organization dedicated solely for the benefit and representation of veterans with spinal cord injury or disease. For 75 years, the organization has ensured that veterans receive the benefits earned through their service to our nation; monitored their care in VA spinal cord injury centers; and funded research and education in the search for a cure and improved care for individuals with paralysis.

As a life-long partner and advocate for veterans and all people with disabilities, PVA also develops training and career services, works to ensure accessibility in public buildings and spaces, and provides health and rehabilitation opportunities through sports and recreation. With more than 70 offices and 33 chapters, PVA serves veterans, their families, and their caregivers in all 50 states, the District of Columbia, and Puerto Rico. Learn more at **www.pva.org**.

Veterans of Foreign Wars of The United States (VFW)

The Veterans of Foreign Wars of the U.S. (VFW) is the nation's largest and oldest major war veterans' organization. Founded in 1899, the congressionally-chartered VFW is comprised entirely of eligible veterans and military service members from the active, Guard and Reserve forces. With more than 1.6 million VFW and Auxiliary members located in 6,200 Posts worldwide, the nonprofit veterans' service organization is proud to proclaim "*NO ONE DOES MORE FOR VETERANS*" than the VFW, which is dedicated to veterans' service, legislative advocacy, and military and community service programs. For more information or to join, visit our website at **www.vfw.org**.

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Introduction

For more than three decades, the Independent Budget veterans service organizations (IBVSOs) – DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW) – have produced annual budget and appropriations recommendations for the Department of Veterans Affairs (VA) and its many programs, services, and benefits. In this budget report, the IBVSOs present our recommendations for fiscal year 2022 (FY 2022), as well as for advance appropriations for VA medical care programs for FY 2023.

The past year has been one of the most challenging ever for VA and veterans as the COVID-19 pandemic disrupted VA's operations across the country, significantly impacting veterans' ability to access, benefits, and transition services. With the pandemic far from over, these disruptions are expected to continue for most, if not all, of FY 2021. As a result of this unprecedented and unpredictable national public health emergency, there is significant uncertainty about many of the normal assumptions underlying VA's budget projections, including enrollment, utilization, reliance, inflation, and unemployment. The IBVSOs recommendations reflect a cautious approach based on historical trends.

> **"Our budget recommendations reflect a number of critical new veteran policy initiatives that cannot be ignored**

VA continues to implement three major transformations that are critical to the future of the veterans' health care system and care for our nation's ill and injured veterans: 1) increasing VA staffing levels and building internal capacity as required by the VA MISSION Act of 2018; 2) the upcoming Asset and Infrastructure Review (AIR); and 3) the Electronic Health Record Modernization (EHRM). Each of these systemic changes has significant budgetary consequences for the Veterans Health Administration (VHA) in both the near and long term, and each has been and will continue to be affected by the COVID-19 pandemic and its economic consequences, adding further uncertainty.

The IBVSOs job is to present honest and accurate budget estimates without any regard to the political or economic environment of the moment. The IBVSOs budget recommendations reflect our best estimate of the funding VA will require to meet future demand for services and benefits by veterans. Our budget recommendations reflect several critical new policy initiatives that cannot be deferred or ignored and are presented as recommended plus-ups to VA's FY 2022 budget.

Given the amount of uncertainty in the years ahead, the new Administration and VA leadership must continue to work closely with Congress, the IBVSOs, and other VSO stakeholders to ensure that there is full transparency about VA expenditures throughout FY 2021. VA must be prepared to request, and Congress must be prepared to approve, supplemental appropriations should any of the assumptions underlying the enacted FY 2021 VA appropriations fall short of what veterans need and deserve. Similarly, VA and Congress must be ready to adjust FY 2022 budget requests and appropriations if warranted. ◆

VA Accounts for FY2022 & FY2023 Advance Appropriations (in thousands)

Veterans Health Administration (VHA)	FY 2021 Appropriation FINAL Enacted	FY 2022 Adv Approp FINAL Enacted	FY 2022 Appropriation IB Recomnd	FY 2023 Adv. Approp IB Recomnd
Medical Services	56,655,483	58,897,219	66,242,951	71,809,902
Medical Support and Compliance	8,214,191	8,403,117	8,431,503	8,642,010
Medical Facilities	6,583,265	6,734,680	6,791,578	6,963,225
Medical Care Collections (VA Medical Care)	3,632,600	3,790,816	--	--
Subtotal, VA Medical Care	**75,085,539**	**77,825,832**	**81,466,032**	**87,415,137**
Medical Community Care	18,511,179	20,148,244	20,718,159	21,788,820
Medical Care Collections (Community Care)	797,400	895,302	--	--
Subtotal, Medical Community Care	**19,308,579**	**21,043,546**	**20,718,159**	**21,788,820**
Total, Medical Care Budget Authority	**94,394,118**	**98,869,378**	**102,184,191**	**109,203,957**
Medical and Prosthetic Research	815,000		902,000	
Total, Veterans Health Administration	**95,209,118**		**103,086,191**	
General Operating Expenses				
Veterans Benefits Administration	3,180,000		3,563,728	
General Administration	365,911		393,618	
Board of Veterans Appeals	190,000		216,352	
Total, General Operating Expenses	**3,735,911**		**4,173,698**	
Department Admin and Misc. Programs				
Information Technology	4,912,000		5,201,878	
EHRM (Center)	2,627,000		3,011,430	
National Cemetery Administration	352,000		365,414	
Office of Inspector General	228,000		232,802	
Total, Dept. Admin and Misc. Programs	**8,119,000**		**8,811,524**	
Construction Programs				
Construction, Major	1,316,000		2,822,767	
Construction, Minor	390,000		810,000	
Grants for State Extended Care Facilities	90,000		275,000	
Grants for State Vets Cemeteries	45,000		69,000	
Total, Construction Programs	**1,841,000**		**3,976,767**	
Other Discretionary Programs	206,044		210,384	
Total, Budget Authority	**109,111,073**		**120,258,564**	

Veterans Health Administration

Total Medical Care

FY 2022 IB Recommendation	**$102.2 Billion**
FY 2022 Enacted Advance Appropriation	$94.2 Billion
FY 2022 Estimated Medical Care Collections	$4.7 Billion
Total, FY 2022 Advance Appropriation	**$98.9 Billion**
FY 2021 Enacted Appropriation	$90.0 Billion
FY 2021 Estimated Medical Care Collections	$4.4 Billion
Total, FY 2021 Appropriation	**$94.4 Billion**
FY 2023 IB Advance Appropriation Recommendation	**$109.2 Billion**

The COVID-19 pandemic had a significant impact on veterans' ability to access VA health care services during the second half of FY 2020, continuing through the first half of FY 2021, and will likely continue through the remainder of the year. As a result, we anticipate that a significant volume of care that would have otherwise been provided or paid for by VA will have been deferred, creating both pent-up demand and increased sickness and morbidity resulting in additional VA health care usage during FY 2022. Furthermore, the new Veteran Care Networks (VCNs) created by the VA MISSION Act of 2018 were still being implemented into FY 2021, having been further delayed by the pandemic. Further increases in veterans' health care utilization are also expected as these networks become more convenient and efficient. The economic downturn and increased unemployment in 2020 are likely to lead to an increase in veterans applying for VA benefits and health care, further increasing future costs.

For FY 2022, the IBVSOs recommend approximately $102.2 billion in total medical care funding and approximately $109.2 billion for FY 2023. The FY 2022 recommendation reflects adjustments to the baseline for all Medical Care program funding in the preceding fiscal year based on inflationary factors and increased workload, as well as plus ups for new enrollment and other programmatic initiatives. The FY 2023 advance appropriation recommendation builds on the IBVSOs FY 2022 recommendation to sustain the FY 2022 expansions and continue the new policy initiatives.

Note the IB does not include estimated receipts from the Medical Care Collections Fund (MCCF) as part of our recommendations since MCCF funds are part of the total need for Medical Care appropriations. If the total MCCF funds received by VA are less than had been estimated, Congress must be prepared to provide supplemental appropriations to ensure full Medical Care funding.

Medical Services

FY 2022 IB Recommendation	**$66.2 Billion**

FY 2022 Enacted Advance Appropriation	$58.9 Billion
FY 2022 Estimated Medical Care Collections	$3.8 Billion
Total, FY 2022 Advance Appropriation	**$62.7 Billion**

FY 2021 Enacted Appropriation	$56.7 Billion
FY 2021 Estimated Medical Care Collections	$3.6 Billion
Total, FY 2021 Appropriation	**$60.3 Billion**

FY 2023 IB Advance Appropriation Recommendation	**$71.8 Billion**

Appropriations for FY 2022

For FY 2022, the IBVSOs recommend approximately $66.2 billion for Medical Services. This recommendation is a reflection of multiple components, including the following recommendations:

Current Services Estimate	$62.0 billion
Increase in Patient Workload	$1.9 billion
Additional Medical Care Cost	$2.3 billion
Total FY 2022 Medical Services	**$66.2 billion**

The current services estimate reflects the impact of projected uncontrollable inflation on the cost to provide services to veterans currently using the system. This estimate assumes a 2.2 percent increase in pay and benefits across the board for all VA employees in FY 2022.

While the IBVSOs anticipate a decrease in medical services provided to veterans compared to budget estimates for FY 2020 and FY 2021 due to pandemic restrictions, this will not significantly lower the VHA's overall spending because most of its budget covers personnel, facilities, IT, and other fixed costs. With the pandemic currently expected to be significantly diminished by the start of FY 2022, there is an expectation that deferred care and other pent-up demand by veterans will increase utilization and/or reliance on VA health care. The IBVSOs have assumed a modest 1 percent increase in VA health care utilization and reliance. We also anticipate that the economic slowdown and increased unemployment will lead to a modest increase in the number of veterans seeking health care and benefits at VA in FY 2022.

New Enrollees and Users ($1.9 billion)

Our estimate of growth in patient workload is based on a projected increase of approximately 80,000 new unique patients, partially driven by pandemic-related job and economic losses. These patients include priority group 1– 8 veterans and covered non-veterans. We estimate the cost of these new unique users to be approximately $1.9 billion.

Filling Vacancies (10,750 FTE / $1.4 billion)

In recent years, the VA health care system has experienced a rising number of health care vacancies, including critical

clinical personnel, which averaged about 43,000 in 2021. The large number of vacancies that have persisted for more than a decade has been a major factor leading to longer waiting times for veterans seeking VA care, and ultimately has the effect of suppressing the true level of veterans' demand for care. During the pandemic, VHA was able to find ways to more expeditiously hire and onboard medical personnel and we hope that they continue these practices in FY 2021 and beyond. For FY 2022, we recommend that VHA continue this aggressive hiring trend and seek to fill at least 25 percent of pending vacancies, which would be 10,750 full-time employees (FTE) and cost approximately $1.4 billion.

Long Term Care ($335 million)

VA's Long-Term Services and Supports (LTSS) program provides both institutional care and non-institutional home and community-based services. Despite VA's increased spending in recent years, the overall number of veterans served remains a small percentage of the total need. As the aging veterans' population continues to rise, VA must continue expanding the number and variety of its home and community-based programs and capacity, while maintaining institutional long-term care for those veterans without other alternatives. The enacted FY 2022 advance appropriation assumes approximately $11.2 billion for LTSS programs, and the IBVSOs recommend increasing VA's LTSS programs by an additional $335 million to expand capacity to meet the unmet demand of aging veterans.

Caregiver Program Expansion (700 FTE / $73 million, $361 million for benefits)

In October 2020, VA began the first phase of its caregiver assistance program expansion to veterans who were severely injured or became ill on May 7, 1975, or earlier, finally providing this long-overdue benefit to thousands of World War II, Korean, and Vietnam War veterans, and their family caregivers. However, this one-year delay means that the second phase of the expansion mandated by the VA MISSION Act would begin a year later than the law required on October 1, 2022. As discussed in the IB's Veterans Agenda report, we believe that Congress must amend the statute to begin the second phase of the caregiver program expansion no later than October 1, 2021, as intended, and therefore recommend an additional $73 million to hire approximately 700 FTE and $361 million to cover the costs of stipends and other benefits for these newly eligible caregivers.

Prosthetics and Sensory Aids

In FY 2020, VA requested approximately $3.9 billion for the office of Prosthetic and Sensory Aid Service (PSAS) to provide prosthetic and orthotic services, sensory aids, medical equipment, and support services for veterans. However, due to the impact of the COVID pandemic, many veterans deferred needed services and actual obligations in FY 2020 may have been closer to $3.5 billion. In FY 2021, VA requested $4.1 billion for PSAS, which together with carryover from FY 2020 should be sufficient considering the continued impact of the pandemic, notwithstanding the increased needs of the disabled veteran population served by VA. For FY 2022, the enacted advance appropriation for PSAS was $4.4 billion. We believe there will be significant deferred care and pent-up demand that manifests in FY 2022; however, we also anticipate significant carryover from FY 2021 and do not call for additional funding in FY 2022. We do urge VA and Congress to carefully monitor this account to determine if supplemental appropriations may be required to meet demand.

Women Veterans ($120 million)

The Medical Services advanced appropriation for FY 2021 included $540 million designated for gender-specific health care for women veterans. Following up on last year's recommendation to increase funding for women veterans' health care, the IBVSOs again recommend investing an additional $200 million, of which $120 million would go to Medical Services as follows.

The IBVSOs recommend $100 million to hire the staff necessary to develop additional women's comprehensive care centers (doctors, nurses, care coordinators, peer support specialists, and administrative support); ensure care coordinators are available at every VA Medi-

cal Center that lacks in-house mammography or cervical care; and hire sufficient Women Veterans Program Managers to ensure adequate coverage at each network and medical center. This funding should also be used to support training to ensure that designated women's health providers who meet VHA practice standards are available at each VA medical facility.

The IBVSOs recommend $20 million to develop strategic plans for women veterans throughout VA, which must include appropriate training, as well as consultation and awareness of these plans by key staff within each service line, such as mental health, pain management/ anesthesiology, and cardiology.

Overall, this funding will help support increases in growth and demand for women's health services likely due to the pandemic. Women are disproportionately affected by pandemic-related unemployment since they are more likely to leave work voluntarily to manage the needs of children and elderly relatives and work in sectors such as service and retail that have been adversely impacted.

In addition to the above, the IBVSOs have specific FY 2022 recommendations in other VA accounts related to VA medical facilities, research, and organizational culture to improve access for women and minority veterans.

Minority Veterans ($10 million)

The IBVSOs recommend $10 million to hire additional peer support specialists and navigators to support the unique needs of women and minority veterans in VA's nonmental health programs.

Emergency Care

The IBVSOs continue to note that there will be additional funding required to meet the costs for previously provided emergency care as dictated by the Richard W. Staab v. Robert A. McDonald court ruling. VA has yet to fully account for these claims and associated costs; however, we continue to call on VA to fulfill its responsibility to fully implement this decision, and for Congress to be prepared to appropriate additional funding as required.

Advance Appropriations for FY 2023

For FY 2023, the IBVSOs recommend approximately $71.8 billion for Medical Services, which include the following recommendations:

Current Services Estimate	$67.6 billion
Increase in Patient Workload	$1.8 billion
Additional Medical Care Cost	$2.4 billion
Total FY 2022 Medical Services	**$71.8 billion**

Our estimate of growth in patient workload is based on a projected increase of approximately 81,000 new patients. These new unique patients include Priority Group 1–8 veterans and covered nonveterans. We estimate the cost of these new patients to be approximately $1.8 billion. The IBVSOs recommendation includes continuations of several important medical program initiatives, including the accelerated caregiver expansion, eliminating VHA vacancies, strengthening long-term care options, and women veterans' health care programs.

Medical Support and Compliance

FY 2022 IB Recommendation	$8.4 billion
FY 2022 Enacted Advance Appropriation	$8.4 billion
FY 2021 Enacted Appropriation	$8.2 billion
FY 2023 IB Advance Appropriation Recommendation	**$8.6 billion**

For Medical Support and Compliance, the IBVSOs recommend $8.4 billion for FY 2022. Our projected increase primarily reflects growth in current services based on the impact of inflation on the FY 2021 appropriated level. Additionally, for FY 2023, The IVBSOs recommends $8.6 billion for Medical Support and Compliance, which also primarily reflects an increase in current services from the FY 2022 advance level.

Medical Facilities

FY 2022 IB Recommendation	$6.8 billion
FY 2022 Enacted Advance Appropriation	$6.8 billion
FY 2021 Enacted Appropriation	$6.6 billion
FY 2023 IB Advance Appropriation Recommendation	**$7.0 billion**

For Medical Facilities, the IBVSOs recommend $6.8 billion for FY 2022 and $7.0 billion for FY 2023, which includes funding for Non-Recurring Maintenance (NRM) and leases. VA uses major and minor leases instead of facility construction to address access needs and space gaps to quickly respond to health care advances and adopt changing technology to provide state-of-the-art health care to veterans when a lease is better aligned with the Department's overall capital strategy.

The NRM program is VA's primary means of addressing its most pressing infrastructure needs as identified by Facility Condition Assessments (FCA), which is an alternative method to address construction needs. These assessments are performed at each facility every three years and highlight a building's most pressing and mission-critical repair and maintenance needs.

VA needs to prioritize NRM representing critical deficiencies that directly affect patient safety daily, such as the need for heating and cooling systems repairs, or generator upgrades, which may not immediately stand out as critical, but failures of these systems could lead to safety issues. Additionally, deferring regular maintenance issues and upgrades are typically not prudent as this often exacerbates problems that necessitate more costly future remedies.

Women Veterans Health Care Modifications ($20 million)

The IBVSOs recommend that $20 million be earmarked within the Medical Facilities account to address the environment of care deficiencies and corrections for women veterans care in VA facilities, such as adding doors, curtains, or soundproofing in treatment areas, as well as check-in areas.

Medical Community Care

FY 2022 IB Recommendation	**$20.7 Billion**
FY 2022 Enacted Advance Appropriation	$20.1 Billion
FY 2022 Estimated Medical Care Collections	*$0.9 Billion*
Total, FY 2022 Advance Appropriation	**$21.0 Billion**
FY 2021 Enacted Appropriation	$18.5 Billion
FY 2021 Estimated Medical Care Collections	*$0.8 Billion*
Total, FY 2021 Appropriation	**$19.3 Billion**
FY 2023 IB Advance Appropriation Recommendation	**$21.8 Billion**

VA Medical Community Care was also significantly impacted by the pandemic. We anticipate the deferral of care by veterans in FY 2020 and FY 2021 could lead to an increase in community care in FY 2022, due to pent-up demand and additional medical need from complications of untreated conditions or COVID-related care.

There may be additional changes in veterans' usage of community care because the VCNs were only fully implemented last year while the COVID-19 pandemic restrictions were in place. Since FY 2022 will be the first year that the MISSION Act's new VCNs will be fully functional, we anticipate modest growth in veteran utilization of community care. VA and Congress must carefully monitor community care usage to ensure sufficient resources are available while ensuring that VA health care facilities remain fully funded.

For Medical Community Care, the IBVSOs recommend $20.7 billion for FY 2022, which reflects the growth in current services as impacted by uncontrollable medical inflation and utilization increases discussed above. For FY 2023, we recommend $21.8 billion for Medical Community Care, again primarily based on the increased cost for current services.

Medical and Prosthetic Research

FY 2022 IB Recommendation	$902 million
FY 2022 Administration Request	$-- million
FY 2021 Enacted Appropriation	$815 million

The VA Medical and Prosthetic Research program has made significant contributions to improved care for veterans, as well as the nation's entire health care system. The research program continues to support VA's recruitment and retention of health care professionals and clinician-scientists to serve our nation's veterans.

For FY 2022, the IBVSOs recommend a total of $902 million for VA research which would cover inflation and provide new investments to address COVID-19, veterans' health disparities, clinical trials access, and data storage while renewing support for groundbreaking programs like the Million Veteran Program (MVP) and research on chronic and emerging needs of our nation's veterans.

Women's Health Care ($10 million)

As women continue to become a larger share of VA's patient population, VA must research disparities in the efficacy and safety of medical treatments for women veterans and tailor protocols to better meet their needs. The IBVSOs recommend $10 million of the FY 2022 research budget be dedicated to additional research on women's specific treatment needs. ◆

General Operating Expenses

Veterans Benefits Administration

FY 2022 IB Recommendation	$3.6 million
FY 2022 Administration Request	$-- million
FY 2021 Enacted Appropriation	$3.2 million

The Veterans Benefits Administration (VBA) account is comprised of seven primary service lines. These include Compensation; Pension and Fiduciary; Insurance; Education; Home Loan Guaranty; Veteran Readiness and Employment; and Transition and Economic Development. For FY 2022, the IBVSOs recommend approximately $3.6 billion for all the VBA's operations, an increase of approximately $380 million over the estimated FY 2021 appropriations level, which primarily reflects increases for inflation and federal pay raises, as well as increases in workload.

Like most of the country, VBA was significantly affected by the pandemic's social distancing requirements, preventing public contact and necessitating the move towards working from home and other virtual working environments. One of the key consequences of the pandemic has been an alarming increase in the backlog of disability compensation claims, which has risen over the past year to more than 200,000 claims pending over 125 days. While the CARES Act provided some limited funding ($13 million) to help the VBA mitigate the impact on its operations, there are additional funding requirements across the VBA for personal protective equipment (PPE) and other mitigation needs. For these reasons, the IBVSOs make specific recommendations for additional personnel and funding to address several critical priorities in FY 2022.

Claims Backlog (1,000 FTE / $112 million)

The IBVSOs recommend an additional 1,000 FTE for VBA to primarily address the rising VA claims backlog and prepare for the influx of claims from the recent addition of three new diseases to the Agent Orange presumptive list. These new personnel should also be used to expand the capabilities of VA Call Centers and address the backlog of pending Freedom of Information Act (FOIA) requests. We recommend that each VA Regional Office add at least two FTE to address pending FOIA requests; that each Call Center receive additional FTE; and that the remainder is apportioned among VA Regional Offices based on the need to address claims processing and adjudication workload.

Virtual Work Environments ($95 million)

While much of its workforce was already working remotely before the pandemic, VBA was forced to accelerate the transition to virtual work for its employees. Even if the pandemic comes to a close in FY 2021, the shift to virtual work environments will continue. The IBVSOs recommend $95 million to provide additional resources to VBA to support its expansion and improvement of virtual work environments.

Continuing Impact of COVID ($75 million)

As COVID-19 caused delays in claims processing and VA examinations, the IBVSOs recommend $50 million for overtime costs in FY 2022 for work that will not be completed in FY 2021 due to the pandemic. We also recommend an additional $25 million to ensure adequate PPE for all the VBA employees at all VA Regional Offices and other locations around the country.

VA Call Centers ($30 million)

In addition to the extra FTE referenced above, the IBVSOs recommend $30 million be provided to VA Call Centers to cover the increased volume of calls resulting from the lack of public contact and social distancing, as well as overtime pay and additional PPE to cover all employees.

Reinstating Pre-Decisional Review ($5 million)

In 2020, VBA ended the seven-decade policy of allowing accredited VSOs to review VA decisions before final adjudication and removed this function from within the Veterans Benefits Management System (VBMS). The IBVSOs call for VA to reinstate the pre-decisional review policy and recommend an additional $5 million for VBA to make the necessary changes. A separate funding recommendation is included below to accomplish the IT changes required.

VBA IT Needs

In addition to the above needs, the IBVSOs recommend specific IT initiatives that would be funded as part of VA's IT budget, as presented below. Importantly, the IBVSOs recommend that Congress provide VBA with project management ownership and full funding upfront to better manage the development of new IT systems.

General Administration

FY 2022 IB Recommendation	$394 million
FY 2022 Administration Request	$-- million
FY 2021 Enacted Appropriation	$366 million

The VA General Administration account is comprised of 10 primary divisions. These include the Office of the Secretary; the Office of the General Counsel; the Office of Management; the Office of Human Resources and Administration; the Office of Enterprise Integration; the Office of Operations, Security, and Preparedness; the Office of Public Affairs; the Office of Congressional and Legislative Affairs; the Office of Acquisition, Logistics, and Construction; and the Veterans Experience Office. For FY 2022, the IBVSOs recommend approximately $394 million, an increase of approximately $28 million over the FY 2021 estimated level. This increase primarily reflects an increase in current services based on the impact of uncontrollable inflation across all of the General Administration accounts, as well as two specific initiatives discussed below.

Minority and Underserved Veterans ($10 million)

The IBVSOs recommend $10 million for the Veterans Experience Office to explore the experiences of racial and ethnic minorities, and LGBTQ veteran populations to help with diversity training and improve VA's workplace culture.

Ending Sexual Harassment and Violence Against Women ($10 million)

The IBVSOs recommend $10 million to ensure adequate staff and resources are available for enterprise-wide awareness and training (both staff and veterans) to promote cultural transformation and support the goals of the Stand Up to Stop Harassment and White Ribbon Campaigns.

Board of Veterans Appeals

FY 2022 IB Recommendation	$216 million
FY 2022 Administration Request	$ -- million
FY 2021 Enacted Appropriation	$190 million

For FY 2022, the IBVSOs recommend approximately $216 million for the Board of Veterans Appeals (BVA), an increase of approximately $26 million over the estimated FY 2021 appropriations level, which primarily reflects current services with increases for inflation and federal pay raises, as well as staffing increases to address the growing hearing backlog.

To properly implement the Appeals Modernization Act (AMA), as well as address other critical Board improvements, the IBVSOs recommend additional IT funding for both BVA and VBA, which is included in the FY 2022 IT budget recommendation below.

Hearing Backlog (200 FTE / $22 million)

Since the AMA took effect in February 2019, there have been significant changes in how veterans can appeal claims decisions at the Board. There are currently 33,000 pending AMA hearings with the Board and 54,000 pending legacy hearings, for a total of 87,000 pending hearings. This is an increase of 11,000 pending hearings from the previous year. Roughly 50 percent of all legacy appeals request a hearing versus 60 percent of AMA appeals. Based on the increased hearing backlog compared to just a year ago and the increased rate of hearing requests, the IBVSOs recommend an increase of 200 FTE for the Board to address the 87,000 pending hearings. ◆

Department Administration & Miscellaneous Programs

Information Technology (IT)

FY 2022 IB Recommendation	$5.2 billion
FY 2022 Administration Request	$ -- billion
FY 2021 Enacted Appropriation	$4.9 billion

The VA Office of Information Technology (IT) provides day-to-day support and development for all of VA's IT needs, including those of VHA, VBA, and the National Cemetery Administration (NCA). For the past several years, VA has had a separate appropriation account for Electronic Health Record Modernization (EHRM), which primarily covers the costs for VA and Cerner to make this massive generational transformation. [See below.] However, VA must continue to support its current electronic health record (EHR) system—VistA – until the conversion is complete. Currently, parts of VistA require either modernization or replacement during the 10-year replacement cycle of VA's EHR system, and funding for both development and sustainment must continue to be robust to support VHA's delivery of health care.

For FY 2022, the IBVSOs recommend approximately $5.2 billion for the administration of the VA's IT program to meet the need to sustain VistA as well as other critical IT programs for VHA, VBA, and NCA, and to fund specific new IT initiatives described below.

VBA IT Needs ($175 million)

Updated and modern IT is critical to the smooth operation and success of VA's claims and appeals processing systems, and particularly to complete implementation of the Appeals Modernization Act, P.L. 115-55. In FY 2020, VBA had over $700 million in shortfalls for funding necessary IT projects, including many that would address the needs of accredited VSOs working in VA Regional Offices. For FY 2022, the IBVSOs recommend $175 million be provided to funding critical pending VBA IT projects, including top VSO priorities.

BVA IT Needs ($25 million)

BVA uses several IT platforms such as VBMS, Veterans Appeals Control and Locator System (VACOLS), and Case Flow. However, VACOLS is the legacy program for tracking and maintaining appeals within the Board. Case Flow is currently used to manage all Board requested hearings, as well as the pilot program for virtual hearings, and thus is an integral part of their daily functioning. Case Flow was created to replace VACOLS; however, as Case Flow has many functionalities yet to be implemented, both systems must be used by the Board, which greatly reduces their efficiency. VACOLS allows the Board to store data, specifically their decisions on each case. Case Flow was not designed for data storage; however, if it retains the functionality of VACOLS, it will be a better IT platform to phase out VACOLS. The IB recommends $15 million in IT funding to accelerate and complete BVA's Case Flow system.

Currently, the Board must manually enter and upload all mail received from appellants from either faxes or U.S.P.S. mail. While VBA has artificial intelegence (AI) to scan, read, and upload mail, the Board does not. The IBVSOs recommend $10 million of additional IT funding for the Board to develop a modern AI system to address its ever-increasing paper mail volume.

Medical Research IT Needs ($42 million)

To more effectively support VA research programs, the IBVSOs recommend $42 million be earmarked to accomplish nine projects for the Office of Research and Development.

Electronic Health Record Modernization (EHRM)

FY 2022 IB Recommendation	$3.0 billion
FY 2022 Administration Request	$-- billion
FY 2021 Enacted Appropriation	$2.6 billion

The EHRM account is comprised of three major sub-accounts: Cerner Contract, Infrastructure Readiness, and Project Management Office (PMO). For FY 2021, Congress appropriated approximately $2.6 billion for EHRM, which included $1.2 billion for the Cerner contract, $1.2 billion for infrastructure readiness, and $255 million for the PMO.

The IBVSOs applaud VA for the launch of its new electronic health record rollout in the Pacific Northwest and Las Vegas; however, VA has a long way to go to reach its goal of full deployment at the department's 170 other medical centers and more than 1,260 outpatient sites nationwide by 2028. The IBVSOs understand VA plans to deploy its electronic health record across twenty-three sites of care over the next two years, which will require increased funding and oversight.

For FY 2022, the IBVSOs recommend a total of approximately $3.0 billion, of which approximately $1.5 billion would go to the Cerner Contract, an increase of $300 million due to the expanded scope of work. The IBVSOs recommend approximately $1.2 billion for VHA infrastructure upgrades, network equipment and other IT infrastructure upgrades at locations making the conversion to Cerner's EHR. The IBVSOs also recommend $260 million for PMO.

Centralized Scheduling Solution ($60 million)

As Cerner continues implementing the new EHR systems, it is also moving forward with developing and implementing a new Centralized Scheduling Solution (CSS) to improve access for veterans and streamline medical appointment scheduling operations across VHA. The IBVSOs recommend an additional $60 million to accelerate the deployment of the CSS in FY 2022.

Federal Electronic Health Record Modernization

The IBVSOs would also note the importance of providing sufficient funding to support the Federal Electronic Health Record Modernization (FEHRM) office, which is a joint office of VA and the Department of Defense to ensure smooth implementation of interoperability between the two departments' medical record systems.

National Cemetery Administration

FY 2022 IB Recommendation	$365 million
FY 2022 Administration Request	$-- million
FY 2021 Enacted Appropriation	$352 million

NCA which receives funding from eight appropriations accounts, administers numerous activities to meet the burial needs of our nation's veterans. For FY 2022, the IBVSOs recommend approximately $365 million for NCA, an increase of approximately $13 million over the estimated FY 2021 appropriations level, which primarily reflects current services with increases for inflation and federal pay raises.

Due to a continued increase in demand for burial space which is not expected to peak until 2022, NCA must continue to expand national cemeteries and provide more burial options for veterans. The IBVSOs strongly believe that VA national cemeteries must honor the service of veterans and fully support NCA's National Shrine initiative, which ensures our nation's veterans have a final resting place deserving of their sacrifice to our nation. The IBVSOs also support NCA's Veterans Legacy Program, which helps educate America's youth about the history of national cemeteries and the veterans they honor.

COVID Impact ($6 million)

Due to COVID-19 related delays and requirements related to internments and burials, NCA was required to find an additional $3 million in FY 2020 to cover those costs. As the pandemic continues to surge and disrupt NCA's operations throughout FY 2021, the IBVSOs recommend an additional $6 million for COVID-related delays as well as to provide PPE for employees and veterans, and families attending burials and internments.

Office of the Inspector General

FY 2022 IB Recommendation	$233 million
FY 2022 Administration Request	$-- million
FY 2021 Enacted Appropriation	$228 million

The Office of Inspector General (OIG) performs audits, inspections, investigations, and reviews to improve the efficiency, effectiveness, and integrity of VA programs and services. The IBVSOs recommend approximately $233 million for OIG, an increase of approximately $5 million over the estimated FY 2021 appropriations level, which primarily reflects current services with increases for inflation and federal pay raises. ◆

Construction Programs

Major Construction

FY 2022 IB Recommendation	$2.8 billion
FY 2022 Administration Request	$-- billion
FY 2021 Enacted Appropriation	$1.3 billion

Last year, VA requested, and Congress appropriated a significant increase in funding for major construction projects— an approximate $700 million increase. While these funds will allow VA to begin construction on key projects, many other previously funded sites still lack the funding for completion. Some of these projects have been on hold or in the design and development phase for years.

It is time for the projects that have been in limbo for years or that present a safety risk to veterans and employees to be put on a course to completion within the next five years. To accomplish this, the IBVSOs estimate VA will require $1.7 billion in FY 2022 to fund either the next phase or fund through completion all existing projects and begin planning and design development on all major construction projects that are the highest ranked on VA's priority list.

Seismic Corrections ($1 billion)

Additionally, there are almost $7 billion in outstanding seismic corrections on VA's priority lists. These are potential life safety issues that cannot be overlooked. VA needs to ensure all seismic and life safety issues are placed at the top of the Strategic Capital Investment Plan (SCIP) list and remain at the top until they are rectified. Having seismic deficiencies on the SCIP list year after year is unacceptable and could lead to catastrophic events if left unresolved. VA must begin making these corrections as quickly as possible to mitigate the potential life safety risks. The IBVSOs recommend Congress appropriate $1 billion in FY 2022 and each year thereafter until this backlog is eliminated.

Research Infrastructure ($100 million)

For decades, VA construction and maintenance appropriations have failed to provide the resources VA needs to replace, maintain, or upgrade its aging research facilities, which threatens VA's highly successful research program. Based on a 2012 congressionally mandated report, over $200 million is required to correct all research infrastructure deficiencies, including approximately $100 million for life and safety corrections. The IBVSOs believe that designating funds for specific VA research facilities is the only way to bring VA research up to standard. For capital infrastructure, renovations, and maintenance, the IBVSOs recommend $100 million for VA research facilities to address the most pressing repairs.

Managing Infrastructure (175 FTE, $23 million)

VA Capital Infrastructure's backlog of projects is growing faster than VA can keep up with it. To begin to draw down the backlog in a ten-year plan, VA would need to perform approximately seven to eight billion dollars in projects every year. Neither VA's Office of Construction and Facilities Management nor the individual VA facilities have the manpower to oversee the amount of work necessary to decrease the backlog. If project management staff is not added to oversee VA's infrastructure needs, then the backlog will continue to grow, and many necessary projects will face years of delays. Investing in the oversight and completion of these critical projects will at a minimum save VA money in the long term, and potentially save lives if done correctly. VA needs to hire additional FTE to oversee infrastructure projects. Adding personnel to an office of strategic planning and increasing the personnel at individual major facilities to oversee local projects is critical to decreasing the backlog. VA Capital Infrastructure's workload cannot increase to the necessary annual levels until there is an increase in personnel to handle the workload.

The IBVSOs recommend an increase of 175 FTE ($23 million) to plan and oversee construction projects, with new personnel assigned to each of VA's major medical centers or other appropriate regional locations.

Asset and Infrastructure Review

As discussed in the IB's Veterans Policy Agenda for the 117th Congress, the MISSION Act's mandated Asset and Infrastructure Review (AIR) has begun and will continue on a multi-year effort to review, realign, modernize, and expand VA health care infrastructure required in the

coming decades. The IBVSOs call on Congress to ensure that funding to maintain and improve VA's health care infrastructure is not reduced or delayed while the AIR process takes place, as was intended by Section 208(b) of the VA MISSION Act.

Minor Construction

FY 2022 IB Recommendation	$810 million
FY 2022 Administration Request	$ -- million
FY 2021 Enacted Appropriation	$390 million

To ensure VA funding keeps pace with all current and future minor construction needs, the IBVSOs recommend Congress appropriate $810 million for minor construction projects. It is important to invest heavily in minor construction because these are the types of projects that can be completed faster and have a more immediate impact on services for veterans.

Women Veterans Health Care ($40 million)

To support the expanding women veterans health care programs within VA facilities, the IBVSOs recommend $40 million to be earmarked to address the environment of care deficiencies and additional needs such as separate entryways, creation of safe spaces within facilities for women to use for socializing, and to develop safe, sanitary, and private lactation areas.

Grants for State Extended Care Facilities

FY 2022 IB Recommendation	$275 million
FY 2022 Administration Request	$ -- million
FY 2021 Enacted Appropriation	$90 million

Grants for state extended care facilities, commonly known as state home construction grants, provide up to 65 percent of the cost of construction, rehabilitation, and repair of state veterans' homes, with the state providing at least 35 percent.

There is once again a growing backlog of State Veteran Homes Construction grant requests pending in VA, expected to top $1.3 billion when the new priority list is released. For FY 2022, the IBVSOs recommend $275 million for grants for state extended care facilities to fund approximately 50 percent of the anticipated $550 million Priority List for Group 1 grant requests that have already secured their required state matching funds.

Grants for State Veterans' Cemeteries

FY 2022 IB Recommendation	$69 million
FY 2022 Administration Request	$ -- million
FY 2021 Enacted Appropriation	$45 million

The State Cemetery Grant Program allows states to expand veteran burial options by raising half the funds needed to build and begin the operation of state veterans' cemeteries. NCA provides the remaining funding for construction and operational funds, as well as cemetery design assistance. Funding additional projects in FY 2022 in tribal, rural, and urban areas will provide burial options for more veterans and complement VA's system of national cemeteries. To fund these projects, the IBVSOs recommend Congress appropriate $69 million.

Other Discretionary Programs

FY 2022 IB Recommendation	$210 million
FY 2022 Administration Request	$ -- million
FY 2021 Enacted Appropriation	$206 million

Other VA discretionary programs include the Veterans Housing Benefit Program Fund, Vocational Rehabilitation Loans Program, and Native American Veterans Housing Loan Program. The IBVSOs recommend approximately $210 million for these discretionary programs, an increase of approximately $4 million over the estimated FY 2021 appropriations level, which primarily reflects current services with increases for inflation and federal pay raises. ◆

For more than 30 years, The Independent Budget veterans service organizations (IBVSOs)—DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW)—have worked to develop and present concrete recommendations to ensure that the Department of Veterans Affairs remains fully funded and capable of carrying out its mission to serve veterans and their families, both now and in the future. Throughout the year, the IBVSOs work together to promote their shared recommendations, while each organization also works independently to identify and address legislative and policy issues that affect the organizations' members and the broader veterans' community.

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