BUILDING AN ACCOUNTABLE VA: APPLYING LESSONS TO DRIVE FUTURE SUCCESS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

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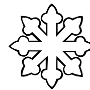

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BUILDING AN ACCOUNTABLE VA: APPLYING LESSONS TO DRIVE FUTURE SUCCESS

TUESDAY, FEBRUARY 28, 2023

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
Washington, D.C.

The committee met, pursuant to notice, at 2:24 p.m., in room 360, Cannon House Office Building, Hon. Mike Bost (chairman of the committee) presiding.

Present: Representatives Bost, Radewagen, Bergman, Rosendale, Miller-Meeks, Murphy, Franklin, Van Orden, Ciscomani, Self, Kiggans, Takano, Brownley, Levin, Pappas, Mrvan, Cherfilus-McCormick, Deluzio, McGarvey, Landsman, and Budzinski.

OPENING STATEMENT OF MIKE BOST, CHAIRMAN

The CHAIRMAN. If we can get our witnesses to come forward. If we can have our witnesses come to the witness table, that would be fine.

Good afternoon and thank you all for being here. Welcome to the House Committee on Veterans Affairs' first Oversight Hearing of the 118th Congress. I am honored to be the chairman of this important committee and leading a group of great members. Every one of these members, Republican and Democrat, is here because they believe in President Lincoln's promise. We all have the responsibility, every man and woman who has served in our armed forces, to craft laws that deliver veterans the care and benefits they have earned.

This starts by overseeing VA to make sure that those laws are carried out as intended. Unfortunately, VA at times has fallen short of that promise to the veterans. And last year Inspector General Michael Missal, who is here with us today, put it plainly. While discussing the tragic incidents of the VA medical centers in Arkansas and West Virginia, Mr. Missal stated these failures were the consequences of "disengaged leadership and dangerous culture that is fostered when leaders are not attentive to or invested in their staff and the veterans they serve." Mr. Missal, those were powerful words. They ring in my ears. They echo in this room. I hope they keep those failed leaders up at night.

Sadly, they are not the only instances of failed leadership. Recently, we have seen veterans denied access to community care in direct defiance of the Mission Act guidelines, poor care coordination, and delayed diagnoses, resulting in low quality care for veterans. VA improperly rejecting 31,000 disability claims submitted through its own website, senior leaders ignoring disciplinary rec-

ommendations, and failing to hold management accountable. The Electronic Health Record (EHR) Modernization Program is on its fourth director in 5 years and continues to burn money and distribute care and disrupt care. The VA prioritizing employee productivity at the expense of veterans receiving compensation and pension benefits.

Strong, engaged, and thoughtful leadership is the single most important factor needed to successfully run an organization of any size, be it a family owned trucking company like the one I used to run, or one of the largest departments of the Federal Government. I am confident that every member of this committee agrees with me. All of the examples I just listed are areas where leadership failed.

However, they are not the end of the story. We can and we must learn from these failures to deliver a VA that is worthy of veterans' service to our great country. This is how we will drive VA toward success. Like medical facilities' empowered employees to identify and address issues without fear of punishment. Helping over 2 million veterans secure housing with a VA home loan over the last 2 years, saving over 200,000 veterans from having their houses foreclosed on during record high inflation caused by the Biden administration, and ensuring that veterans receive a dignified burial.

There are all these successes that we can be proud of, but unfortunately, they are not yet the norm. VA is simply not where it should be. Bringing VA into the 21st Century for veterans is my No. 1 priority. With engaged and accountable leadership on every level, VA can get to where our veterans need it to be. That starts today. We can get there with tough but fair oversight, common sense legislation, a commitment from VA leadership to always put veterans at the forefront of their decisionmaking process. With that, I thank our witnesses for being here today. I now recognize ranking member Takano for his opening comments.

OPENING STATEMENT OF MARK TAKANO, RANKING MEMBER

Mr. TAKANO. Well, thank you, Mr. Chairman. You and I have served together on this committee for more than 8 years now. While we may have our differences from time to time, and while there are certain issues on which we will never see eye to eye, one thing I have appreciated about working with you is that whenever possible, we have done our best to find common ground. I think one of the most fundamental things we agree on is our obligation to hold VA accountable for achieving its sacred mission of caring for and honoring our Nation's veterans and their families, caregivers, and survivors.

The last 4 years were busy and productive ones for this committee. We saw 36 bills enacted into law, including legislation that will address the effects of toxic exposure, improve veterans mental health, and reduce suicide, strengthen delivery of health care and benefits to women veterans, support veterans experiencing housing insecurity, and strengthening VA's IT modernization efforts and cybersecurity.

Dr. Elnahal, Mr. Frueh, and Ms. Quinn, you hold a tremendous amount of responsibility. We know you and Secretary McDonough are facing many challenges as VA strives to meet its mission. One

such challenge, a substantial one to be sure, will be implementing the Honoring our PACT Act, the landmark legislation I championed that finally recognizes the effects of toxic exposure as a cost of war. Because of the PACT Act, more than 3.5 million veterans are newly eligible for VA health care and disability benefits, the most significant VA eligibility expansion in decades.

Like the witnesses, this committee also holds a tremendous amount of responsibility. We must conduct rigorous oversight to ensure the Department faithfully implements new legislation like the PACT Act, while also holding VA accountable for efficiently and effectively delivering all other health care and benefits veterans have earned.

Fortunately, we have with us today two of our Nation's foremost experts in accountability. VA's Inspector General, Mr. Michael Missal and Comptroller General Gene Dodaro of the Government Accountability Office. Together, they bring to the witness table at least 80 years of collective experience in conducting independent, nonpartisan oversight, and investigations. As such, they will be able to speak extremely knowledgeably about what it takes to ensure accountability at VA, the extent to which the Department is successfully meeting its mission, and what, if anything, Congress can do to support improved accountability across VA.

It is clear from their testimony that both Inspector General Missal and Controller General Dodaro believe strong, stable leadership is the foundation upon which accountability is built. Having served on this committee since my first year in Congress, I could not agree more. Mr. Missal and Mr. Dodaro, Chairman Bost, and I have all been in our current roles since the Obama administration and have witnessed numerous transition in VA leadership during our tenure.

I am sure today's hearing will provide many opportunities for us to examine the negative effects of leadership instability on VA's programs. In addition, I anticipate today's hearing will also provide an opportunity to examine other major management challenges at VA, including persistent staffing shortages, antiquated information technology, an aging infrastructure, and the extent to which VA is equipped to address them.

I look forward to engaging with our witnesses this afternoon and to beginning the work ahead of our committee, this Congress. Thank you, Chairman Bost, and I yield back.

The CHAIRMAN. Thank you, Ranking Member Takano. We will now turn to our witnesses' testimony. Testifying before us today, we have Hon. Michael Missal, Inspector General of the Department of Veterans Affairs, Hon. Gene Dodaro, Comptroller General of the United States, and Hon. Shereef Elnahal, Undersecretary for Health and VA. Now, he is joined by Mr. Michael Frueh, Principal Deputy Undersecretary for Benefits at the VA, and Hon. Matthew Quinn, Undersecretary for the Memorial Affairs at VA. Mr. Missal, you are recognized for 5 minutes.

STATEMENT OF MICHAEL MISSAL

Mr. MISSAL. Thank you, Chairman Bost, Ranking Member Takano, members of the committee, I appreciate the opportunity to discuss how the Office of Inspector General's (OIG) work enhances VA's accountability. The OIG shares this Committee's goal to con-

duct effective oversight of VA so that it can better serve our veterans, their families, and caregivers. Our dedicated staff is passionate about their work and committed to our mission of meaningful independent oversight.

In Fiscal Year 2022, our office released more than 250 oversight publications with 894 recommendations to VA. We made over 230 arrests and more than 180 convictions. We had a monetary impact of more than $4.5 billion, in addition to the invaluable work of our healthcare inspectors that enhance patient care and safety. These efforts to improve benefits and services for veterans and their families would not be possible without the funding and support we receive from Congress.

Our office appreciates the work VA does every day on behalf of veterans. We have regular interactions that we have—we value the regular interactions that we have with Secretary McDonough and other senior leaders to discuss their concerns and priorities. We generally get very good cooperation from the Department.

In addition, we have a strong and collaborative relationship with Comptroller General Dodaro and his staff. We coordinate efforts with the Government Accountability Office (GAO), which promotes more consequential oversight. Our oversight work has identified at least five principles that are foundational to accountability, and there are examples of each in my written testimony.

They are, first, strong governance and clarity of roles and responsibilities. We have found tension between VA offices that have policy and oversight functions and leaders in the field who are not accountable to those offices. In other cases, staff do not understand their roles and responsibilities, or there is outdated or conflicting guidance.

Second, adequate and qualified staffing to carry out those duties. VA faces high staff vacancy rates across its programs and operations, especially within Veterans Health Administration (VHA). These long-standing shortages make it challenging for VA to carry out its many programs and functions.

Third, updated IT systems and effective business processes. VA is in the process of modernizing a number of significant systems that are critical to its operations. We have been proactively overseeing VA's implementation of these systems. This includes publishing 14 reports on the transformation of VA's electronic health record system alone.

Fourth, effective quality assurance and monitoring to detect and resolve issues. VA often lacks controls that effectively and consistently ensure that quality standards are met. Breakdowns in routine monitoring and workarounds undermine efforts to ensure eligible veterans and their families receive timely services and benefits.

Fifth, stable and effective leadership. Frequent turnover, vacancies, and long-term use of leaders in acting positions have significant negative consequences. Stable and dedicated leadership fosters open communication, collaboration, psychological safety, and responsibility among all staff.

I would like to emphasize that OIG report findings and recommendations directed to a singular facility, system, or program are typically a roadmap to help prevent or correct similar problems. These problems are often undetected or unaddressed in other facili-

ties or offices across VA. I hope that this committee will join me in encouraging leaders at every level of VA to review our work proactively to determine if findings and recommendations are applicable to their areas of responsibility.

We recognize that VA is working to develop these foundations of accountability. We routinely observe personnel committed to providing the highest quality care, benefits, and services to veterans and their families, despite obstacles. The OIG will continue to provide practical and meaningful recommendations to help VA remove these obstacles and to improve its programs and operations.

Chairman Bost, and members of the committee, this concludes my statement. I look forward to answering any questions that you may have.

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

The CHAIRMAN. Thank you, Mr. Missal. Mr. Dodaro, you are now recognized for 5 minutes.

STATEMENT OF GENE DODARO

Mr. DODARO. Good afternoon, Mr. Chairman, Representative Takano, ranking member, and members of the committee. I am very pleased to be here today to talk about GAO's work regarding the Veterans Administration. The VA is filled with talented people dedicated to their noble mission of serving our veterans. However, they work in an unwieldy, highly decentralized organization where efforts to bring about positive change are extremely difficult to happen. In fact, many initiatives to make improvements result in little, if any, meaningful change within the Department.

As a result of observing this over a number of years, I added a number of VA areas to a list we keep for the Congress of what we consider to be high risk programs and activities. These are programs where there is waste, mismanagement, or in need of broad-based transformation. We have added veterans' healthcare, the acquisition management area, and disability exams to this area.

Now, in the healthcare area, there are a number of things we pointed out. First, there is a need for better standards and measures to ensure timely access of veterans to the care that they need. Also, in the mental health and behavioral health area, more analysis to provide services targeted to veterans in need of intensive medical health services could be improved, particularly for rural veterans. Also, efforts to integrate behavioral healthcare into primary health services, which is one of VA's strategies, has been hampered by a lack of staff shortages, and more attention needs to be put in that area. Also, oversight of long-term care facilities needs to be improved, both in the oversight of State nursing homes that VA provides funds to, as well as VA's own community living centers.

There also needs to be greater attention to ensure there are enough providers in the networks to provide care, and also that ineligible providers are rooted out, and not allowed to provide care in the system, and that employees really pass the background screening investigations that they must pass in order to ensure the care of veterans and protect our veterans. Also, as Mr. Mitchell mentioned, there is a need for much more disciplined management

practices to ensure the effective implementation of the electronic healthcare record system.

Now, in the acquisition management area, this area, there needs to be better strategies to purchase medical and surgical supplies in a much more efficient manner than there has been. There needs to be attention to supply chain management, so not only what is purchased, but how it is managed to get to the right places at the right time. Also, to make sure you have an adequate workforce in the acquisition area that is trained and competent to carry out their responsibilities, to provide the support necessary to give medical care to our veterans.

In the disability exams area, this is one of long-standing concerns. You know, we are still using the Veterans Department, you know, medical criteria and earnings loss information based on a 1940's model. This needs to be improved. VA has been working on it. They are 8 years behind schedule. While there have been studies, there have not been improvements to this system. Also, there is a big backlog. There is about 80,000 cases from their legacy appeals process, which on average is taking 7 years to render an appeal. There is a 380,000 backlog in appeals under the new five option appeals process that they have.

As a result of these legacy issues, they are not as well positioned as I believe they need to be and could be in order to implement the PACT Act. Now that is going to be a heavy lift for them and they need to learn from some of these past areas where they are not applying best management practices to effectuate a good, efficient disability system that ensures timely processing of original claims, as well as the appeals process going forward.

We are dedicated at GAO to working with the Inspector General with the Veterans Department. I have noticed some improvement lately in our efforts to get agreement of what needs to be done with the Department. I see some glimmers of progress, but that is only the beginning, and there is a long way necessary to really bring about the type of change that our veterans deserve. I would be happy to answer questions at the appropriate point.

[THE PREPARED STATEMENT OF GENE DODARO APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Dodaro. Dr. Elnahal, you are recognized for 5 minutes.

STATEMENT OF SHEREEF ELNAHAL

Mr. ELNAHAL. Thank you, Mr. Chairman, Ranking Member Takano, members of the committee for this opportunity to appear before you today to discuss the Department of Veterans Affairs and our accountability efforts. I am joined today by my colleagues from the National Cemetery Administration, Mr. Matthew Quinn, Undersecretary for Memorial Affairs, and Mr. Michael Frueh, Principal Deputy Undersecretary for Benefits.

The three of us have had the pleasure to lead a workforce that goes above and beyond to serve our Nation's veterans. Linda Nair, a licensed practical nurse in Lewistown, Montana, demonstrated that dedication when she traveled through two feet of snow to ensure veterans receive care during inclement weather recently. She does not believe she did anything special, but I believe that she

demonstrates our employees' dedication at every level of the organization. I am sure Mr. Quinn and Mr. Frueh can provide similar examples of staff who go the extra mile for veterans.

I want to express gratitude for the PACT Act, the largest expansion of benefits and care to veterans in a generation, and the Consolidated Appropriations Act of 2023, which provided additional authorities and funding to advance our mission. VA is also grateful for the partnership with independent investigators that improve the way that we serve veterans. Our transparency and accountability efforts are significantly enhanced by the Government Accountability Office, Office of the Inspector General, Office of the Special Counsel, and accreditation organizations.

Thus, I have made it a practice to meet regularly with OIG, and I have met directly with GAO officials like Mr. Dodaro and his healthcare team multiple times to proactively identify opportunities for improvement. As a high reliability organization, or HRO, our goal is to enhance the overall culture of safety and decrease patient harm events across the organization. The HRO accountability framework involves instituting a just culture which balances individual accountability with systems thinking.

Patient safety literature has shown that system vulnerabilities account for the vast majority of patient safety events and lapses in care, and it is incumbent upon staff and leadership alike to report and respond to systems issues. However, the framework also allows for individual culpability in cases of malfeasance, neglect, or instances where leaders fail to learn from or respond to patterns of problems when they arise.

Accountability is also a culture and not a specific instance of wrongdoing. At VHA, our healthcare operations center has established a system to track implementation of our priorities. Review of key performance indicators in every facility and Veterans Integrated Service Network (VISN) allow us to understand which regions are exceeding expectations, which have made significant improvements, and which could benefit from additional support to ensure every veteran receives the care they deserve, regardless of where they live.

Recently, the Office of Accountability and Whistleblower Protection, or OAWP, has undertaken a significant outreach in education strategy that involves onsite visits by OAWP senior leaders, and more widespread, tailored training. All three VA administrations have embraced these efforts and are working with OAWP to extend their reach.

My colleague, Mr. Quinn, is ensuring that our national cemeteries are held to a standard befitting of a national shrine. Each year, cemetery directors conduct self-assessments of their cemeteries to ensure compliance with established standards. National Cemetery Administration (NCA) teams also conduct meticulous onsite reviews of selected cemeteries, and sites are required to develop plans to address any areas noted for improvement.

Recently, NCA achieved an index score of 97 on the American Customer Satisfaction Index, the highest score ever achieved by any organization, public or private. My colleagues, Mr. Frueh and Mr. Josh Jacobs, are ensuring that veterans receive appropriate and timely benefits. I am proud to say, as their colleague, due to

the efforts of dedicated Veterans Benefits Administration (VBA) employees, VBA processed a record number of claims in fiscal years 2021 and 2022. We have already processed more claims so far in Fiscal Year 2023 than we have at the same point last year.

In addition to increasing total production, VBA employees also increased productivity in fiscal years 2021 and 2022, completing more rating claims per Full Time Equivalent (FTE) than ever before. Further, of the more than 320,000 PACT Act related claims received since the PACT Act was signed into law, nearly 140,000 claims have been processed, and 1,500 terminally ill veterans have been granted presumptive service connection.

VA continues to conduct compliance and quality reviews to ensure leaders are accountable for quickly and accurately providing veterans the benefits they have earned. The Legacy Appeals Inventory has been reduced to just over 25,000 cases, representing a 92 percent reduction. Caring for our country's veterans and their families is a mission that unites us all. I am honored to work with this committee, Congress as a whole, and our many other partners to embrace our collective responsibility to serve veterans.

Chairman Bost and Ranking Member Takano, thank you for the opportunity to appear before you today, and we look forward to your questions.

[The Prepared Statement Of Shereef Elnahal Appears In The Appendix]

The CHAIRMAN. Thank you, Dr. Elnahal. We are going to now go to questions, and I would like to recognize myself first for 5 minutes.

Dr. Elnahal, on January 31 of this year, Dr. Miller-Meeks and I sent a joint letter to you asking regarding data regarding abortion provided by the VA. We requested that you would provide us that data by February 10, 2023. However, my office is still waiting for your response. Can we get a commitment from you that we can get that response by March 3?

Mr. ELNAHAL. Chairman, we will certainly respond to the letter. We have to make sure that our response respects the safety and privacy of the veterans we serve.

The CHAIRMAN. Right. Believe me, in the letter, we were not asking for names. We are asking for numbers. That is what we are asking for. Also, with that, we are asking the procedures and at what point these were done.

No private information. We are not wanting any private information. We are looking at this as a whole. Also, we are needed to ask also if you could respond to the quarterly request for data starting on March 31, because we know there is pending suits over this. We are just wanting to know where we are at as far as your mission and the procedures that you are doing without names.

Mr. ELNAHAL. I understand, Mr. Chairman. We are committed to getting you a response to that letter.

The CHAIRMAN. All right, thank you. Also, I need to applaud VHA for their efforts to create an environment where any employee can raise their hand and report a problem. We appreciate that. However, too often I hear from employees who have reported harassment and hostile work environments, but nothing happens. We

are losing good employees because we are not removing bad ones. How do we turn that around? That is for you, doctor.

Mr. ELNAHAL. Mr. Chairman, I think the initiative that we are undertaking around high reliability speaks exactly to what you are asking about. We want every single employee in our healthcare system and beyond to understand that they have the right to raise a voice and in fact, that they should be encouraged to raise issues when they see them without fear of retaliation and in a manner that protects whistleblowers so that we can respond effectively to improve the system on behalf of veterans. That is the core of the high reliability effort, which started years ago and is now in place at every single facility as of September of last year.

The CHAIRMAN. I really do believe that you as an administration and the Secretary are trying to do that. I do believe that there are certain administrators at different facilities that maybe do not encourage that as much. We want to work with you to make sure that when we get those reports, that we make sure that the employees understand we want them to come forward, because it is about the veterans. It is not about the management of any one facility.

Mr. Missal, you have been the Inspector General since 2016. Your statement about disengaged leadership is very powerful. Do you believe VA leadership is up to the task of running the one of the largest departments in the Federal Government?

Mr. MISSAL. We have found that the very senior leadership at VA is very engaged, and they understand the importance of oversight. They work with us very closely. However, all levels of leadership need to be engaged to have the highest functioning operation. What we have found in our reports is that a root cause toward many of the problems is due to some failure of leadership at some level.

Getting back to your last question about what can be done. If VA does not hold people accountable for issues that they have, it is really hard to improve the culture, and it is really hard to improve leadership.

The CHAIRMAN. I understand. Mr. Frueh, VBA is faced with a growing backlog of disability claims. How are you working to build trust with veterans that VA will decide their claim correctly the first time?

Mr. FRUEH. Excuse me?

The CHAIRMAN. Yes.

Mr. FRUEH. We take our mission very seriously to provide benefits to veterans, to all veterans, and we do not want any veteran to wait to access the benefits they have earned. We have positioned ourselves in the last several years with a series of people, process, technology changes throughout our organization. In terms of people, hiring more people in the last several years. In terms of technology, providing more enabling technology so we can quickly gather information and reach a decision, whether it is for a compensation claim, or an education claim, or a certificate of eligibility for a loan guarantee. Through processes trying to find a way to get feedback from our people to the people that design the processes to say that is not working as well as we can.

We have been changing dramatically over the last several years, and the results have shown that we have been able to increase our production and deliver more quickly, more benefits to more veterans, more equitably than we ever have in the past before. I hope veterans judge us by what they see through the service we deliver.

The CHAIRMAN. Thank you for those answers. With that, I will yield back and now recognize the ranking member, Ranking Member Takano.

Mr. TAKANO. Thank you, Mr. Chairman. Dr. Elnahal, House Republican leaders recently announced their intent to cap Fiscal Year 2024 discretionary spending at the Fiscal Year 2022 enacted level. For VA, this would mean a cut of at least $31 billion in funding for veterans health care because Congress approves funding levels for VA medical programs one Fiscal Year in advance.

I expect this committee will have a much more robust discussion about this at our annual budget hearing later this spring. Since the topic of today's hearing is applying lessons learned to drive future success, please tell us what a $31 billion cut would mean for VA's future success.

Mr. ELNAHAL. Well, if that were to happen, Mr. Ranking Member, I would be deeply concerned about resourcing the health care needed, not only for our existing base of veterans, but for veterans who are expected to increase their reliance on healthcare within the VA, including the aging veterans already enrolled in VA Healthcare, but also the veterans who are standing to benefit from the PACT Act, both new enrollees and veterans currently enrolled who stand to increase our priority group after they apply for additional benefits from VBA.

On top of that, we have a situation where we expect demand to grow significantly year to year. We need more funding and more support, not less. I would be very concerned about resourcing the care needed for veterans.

Mr. TAKANO. Well, thank you. Beyond the fact—thank you for that response—beyond the fact that this would destroy your ability to prepare for the up to 3.5 million PACT Act eligible veterans to enter the VA health care system, and I mention that because Inspector General Missal just cited in one of his five concerns about the success of VA is the understaffing, the chronic understaffing. VA is already chronically understaffed. Can you comment about what this $31 billion cut would mean for VA's ability to staff up just in the professional arena? The professional providers or medical providers what this would mean to be able to staff up for the 3.5 million veterans we anticipate entering into the system?

Mr. ELNAHAL. I think it is a very good question, Mr. Ranking Member. Certainty to at least to the greatest extent possible on funding in the out years is really important when it comes to the hiring mission. Of course, we need the funding to start paying for new employees now as we bring them on. We brought on a record of 18,500 additional employees within the healthcare system in the first quarter of this fiscal year. If you ask our operational leaders in the field, as I do every time we meet in our governing board about concerns they have for funding into the future, this is an FTE base that we hope continues into the out years. The need to be able to pay these employees to meet the veteran mission will

continue into the out years. We do hope that we continue to see the generous funding that Congress has been able to provide VA.

Mr. TAKANO. Well, you know, what programs or operations could withstand a cut of this magnitude? Are there any at VHA?

Mr. ELNAHAL. I can not think of one, Mr. Ranking Member.

Mr. TAKANO. Thank you. Dr. Elnahal, I am sure you are aware the Drug Enforcement Administration (DEA) proposed two rules relating to prescribing controlled substances via telemedicine. These rules are urgently needed because we are rapidly nearing the end of the COVID–19 public health emergency, which for almost 3 years now, has waived requirements for patients to have in person evaluations with their prescribers prior to receiving controlled substance prescriptions. Very quickly, I do not have much time, will VA commit to providing a bipartisan briefing for committee staff no later than this Friday so we can better understand the potential effect of this rule for our veterans?

Mr. ELNAHAL. We will definitely brief you, Mr. Chairman, when it comes to the implication for veterans. I am very pleased to see that DEA put this rule out. We were very concerned about the ability to initiate new prescriptions for controlled substances, which not only include pain medications like opioids, but also immunosuppressants, for example, critical medications for conditions that veterans commonly face. We do hope this rule comes into effect, of course, before the public health emergency ends, so that we do not see any lapses in care for veterans getting care through telehealth.

Mr. TAKANO. Yes, well, thank you for that. We only have 30 days to comment on the rule, as you know. We are already hearing from some stakeholders that DEA's rules are still too strict and could present unnecessary barriers for patients who need these medications to treat pain, substance use disorder, and other mental health conditions. You just mentioned immunosuppressants. It is not just about controlling opioids. We got to make sure that our patients in rural areas remain capable of being able to get these medications without undue burdens. I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Ranking Member. I now recognize General Bergman for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman. We will get right to it, folks. Mr. Frueh, I would like to ask you about the current flaws in the VA accreditation system for agents who are assisting veterans in obtaining disability benefits. Under the current model, accredited agents cannot charge fees for assisting in an initial claim, but instead collect on the back pay after the process is complete. Do you agree that this creates a financial incentive for those accredited agents to drag out the process as long as possible instead of getting things right initially?

Mr. FRUEH. As I said before, I do not want any veteran to wait to receive their benefit. In terms of accredited agents, agents are not allowed to charge a veteran for submission of a claim before VA. They are able to charge for an appeal, but not for an initial claim.

Mr. BERGMAN. The agent benefits if there is an appeal.

Mr. FRUEH. We always recommend to veterans to look for——

Mr. BERGMAN. Let me cut to the point here. I guess the goal is, when do the veterans benefit, because we can talk about things like efficiency and effectiveness. You can be very efficient. You can answer 1,000 emails today. What was the effectiveness to the, if you will, the end game in this case, benefiting the veteran if none of those emails resulted in a positive outcome for them?

Remember, last time I checked, we are all on this earth on a timeline. It is God's timeline. It is not anybody else's. The point is, a moment lost is lost forever. I would suggest to you that when you think about the requirement in the mission statement and the culture at the VA, and I applaud all of you, I applaud all of you for doing what is right for the veterans because they did what is right for our country through their service.

We need to understand that to delay outcomes for the wrong reason is then hurting the veterans in the long term. I will just, you know, I could probably talk about that for a long time and give examples, but time is of the essence for any veteran.

Dr. Elnahal, we continue to receive reports from veterans and providers alike that VHA referrals for community care are still taking excessive time to be approved and processed. Why is this? What is the Agency doing to alleviate this, and better adhere to Mission Act guidelines for providing veterans care as timely as possible? Remember, time is of the essence. Sir.

Mr. ELNAHAL. Thank you, General, for the question. It speaks to my priority around ensuring veterans the soonest and best care possible, including in the community. Frankly, the time it takes on average for our system to schedule appointments in the community, as you mentioned, is much too long. It is an average of about 28 days. From the time that a veteran knows they need an appointment to the time that they receive a confirmed appointment in the community, we have to reduce that timeframe.

That is why it is one of our True-North metrics that we are monitoring across the system, facility by facility, VISN by VISN, and tracking over time to reward the high performers and top improvers in improving their processes, but also to recognize the folks that need help and have the system come to their assistance.

We are also making sure that we look at new scheduling systems to assist our offices of community care across the system. In fact, we have a request for information for a commercial off the shelf solution that should help with scheduling.

Finally, we are also introducing an initiative to have veterans schedule their own appointments as an option should they choose to do so, as we have seen in pilots across the country, that it dramatically improves the time it takes for a veteran to receive a confirmed appointment, after which the veteran circles back to us so that we can ensure that care is coordinated. I want to make sure this is an option available across the country, General.

Mr. BERGMAN. Thank you. I know my time is about to run out, but that is an example of giving the veterans control of their future outcomes, just like giving them control of who they can work with for disability claims, for getting care in the community, for anything. Enable the veterans, and they are going to get into it, and the VA will be better. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you, Mr. Bergman. Ms. Brownley, you are recognized for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. First, Dr. Elnahal, I just wanted to express my strong support for the interim final rule around reproductive healthcare and your department's efforts to ensure access to a full complement of healthcare. I really want to compliment the team that you have put on. We have had several meetings with them to follow up, and I just appreciate your diligence on that, your team's diligence. I just want to say, for the record, abortion is healthcare. Thank you. Thank you very much.

You know, this is a broad hearing. I am going to ask a broad question. Dr. Elnahal, what do you think VA is doing well with regards to serving women veterans? This is a broad question, but I want to know what the answer is with regard throughout the entire enterprise. I am not really interested in that, you know, perfect pilot program that is out there that is doing really well or a certain area that is just providing outstanding healthcare to our women. You know, what is VA doing well with regards to serving women? What do you think VA has the most opportunity for improvement?

Mr. ELNAHAL. Well, I share your prioritization, Congresswoman, of better serving women veterans every day in this organization. The fastest growing demographic of veterans by far, accounting for 30 percent of new enrollees in our healthcare system every year. We are seeing some positive signs, certainly with the capacity building we have been doing.

We have women's health program coordinators now at every major medical center within the system. We have women's health mini residency programs to be able to train every primary care provider that we can in comprehensive women's health. Some of these providers have been seeing mostly men for many years. We want to make sure they have that updated education about how to treat women veterans with the full scope of care. Of course, we are working as hard as we can to hire more gynecologists and specialists on women's health.

I think where we have some room to grow is the trust among women veterans. That has everything to do with making sure our space is accommodating. We provide more and more dedicated entrances to women veterans in facilities. That is an infrastructure challenge. Making sure our programming across the board is meeting women veterans' needs.

Ms. BROWNLEY. Thank you for that. Just to follow up, I think with the Inspector General here, I know that one issue that he has pointed out are Military Sexual Trauma (MST) coordinators across the enterprise. I guess, you know, I should ask you or ask the Inspector General, you know, what is it going to take to get—the intention of an MST coordinator is to have a full-time MST coordinator in all of those areas where the demand is. I know that there can be some exceptions to that out in a rural area somewhere where they are just not servicing women veterans. I get that. What is it going to take to get to a, you know, full FTE MST coordinator throughout the VA? Is it going to require the fact that we mandate that so the local medical centers do not have control over their resources with regards to deciding if it is going to be 1/10 of an FTE or 50 percent of an FTE, et cetera?

Mr. MISSAL. Well, certainly our reports on MST, we have got multiple reports on MST certainly show that more can be done in this area. I know we have had discussions with Dr. Elnahal and his staff about this. I think they recognize a need. As you pointed out, it could very well just be a resource issue. We agree that more attention needs to be given to this area. Hearings like this and the previous hearing that we had, I think, really shine the proper spotlight on it.

Ms. BROWNLEY. Dr. Elnahal, in the last women's veterans task force that we had, we had a roundtable to look at the implementation of Deborah Sampson. It was really pointed out to us by women veterans representing lots of different agencies, and Veterans Service Organizations (VSOs), and, you know, across the country as well, really stating that this issue around sexual harassment and assault within the VA is still problematic, that it is implemented in some places, and not in others, and it is slow moving. That they cited examples of women being really retraumatized for reporting these incidences and coming to the VA to report them.

I will just say I do not have any time left, but, you know, we have got to be vigilant across the entire enterprise to make sure that if any woman walks into the VA that they will be free from any kind of harassment or sexual assault. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you, Ms. Brownley. Mr. Franklin, you are recognized for 5 minutes.

Mr. FRANKLIN. Thank you, Mr. Chairman. Mr. Frueh, my first question would be for you. In the last Congress, I served on the Oversight and Reform Committee. Part of that oversight involved the National Personnel Records Center. One of the big concerns we had at that time was with those employees working remotely and so many of the medical records not being digitized, we had a huge backlog of veterans unable to verify eligibility for VA benefits and that sort of thing. Wondering what the impact is currently on you, what is the backlog, and what do you see coming down the pike? How can we fix that problem faster?

Mr. FRUEH. The backlog today is just over 200,000, 201,000 out of 750,000 claims. It is about 26 percent, which is a fairly standard amount. In terms of National Personnel Record Center (NPRC), that is actually a very good story where National Archives and Records Administration (NARA) personnel came to us for vaccination through VHA several years ago. We placed three different shifts of VBA personnel in the Personnel Record Center so that we could pull files.

After the first few months of the pandemic, that led to a backlog in their records retrieval, which hurt us in terms of operations.

Within a few months, we returned to two-to-three-day responsiveness in retrieving records from the NPRC. I would say that is no longer an impact in our operations. What we see now is the impact in the number of claims that are ready for decision, where they were in gather evidence mode before, now we see a lot more claims in the ready for decision, which is the last stage before we complete a claim.

The production of records from NPRC is no longer an issue. We are actually scanning every PACT veteran's records into NPRC and

eventually every veteran's records, living and dead. When someone files a claim, they will not have to wait a second for us to get access to their information. We provide those files to NPRC or NARA so they can access them as well to deliver to their customers.

Mr. FRANKLIN. I have a company in my district, a private company, that is been contracted to digitize those. What I do not know, I am not sure the timeline. When do you anticipate all those records being fully digitized?

Mr. FRUEH. We are talking about 46 million or so records. That will be many, many years. The PACT records, the veterans that we believe fall in the PACT cohort I think it is about a year and a half is when we expect to have all of them digitized.

Mr. FRANKLIN. All right, thank you. Dr. Elnahal, as the greater veteran population continues to age, the importance of noninstitutional or home and community-based services becomes more important. What are you all doing to ensure that veterans get the care and support that they need, whether it is through the VA or the community, especially for veterans living in rural areas?

Mr. ELNAHAL. It is a big priority for us, Congressman, especially as we see the veteran population aging and more in need of homebased care where we can. We in fact have an initiative called the Aging In Place Initiative to see the full scope of options available to vets and to extend all of them where we can. We, of course, have our community care-based home services. We also have our Caregiver Support program, which we are investing in more and more, and we are reevaluating our eligibility criteria for that, while we have a 3-year moratorium on legacy participants in the caregiver support program, particularly the Parent Child Assistance Program (PCAP) program.

Then finally, we are expanding the Veteran Directed Care initiative to every single facility within 2 years, which is an acceleration of the original 5-year timeframe. Because we know that so many veterans have been able to benefit from this by basically asking a loved one or close, someone close to them to be their caregiver and allow them to have that financial support. We are pushing hard on expanding that capacity, and we share your prioritization of this important issue.

Mr. FRANKLIN. Very good. Thank you, Mr. Chairman. I go back.

The CHAIRMAN. Thank you, Mr. Franklin. Mr. Levin, you are recognized for 5 minutes.

Mr. LEVIN. Thank you, Mr. Chairman. Mr. Frueh, I appreciate that VA's testimony addressed the Veterans Rapid Retraining Assistance Program, or VRRAP program, which was established to help retrain veterans who were unemployed due to the pandemic. You may remember I was pretty vocal last year about using as much of the $386 million appropriated for the program to benefit veterans before the program expired.

In early September 2022, which was 16 months into the program, VA had only allocated around 56 percent of the funds. I was surprised, pleasantly surprised, that VA was ultimately able to obligate 98 percent of these funds by mid-December. My question for you, Mr. Frueh, is how was VA able to drastically accelerate veteran participation in the span of 3 months?

Mr. FRUEH. I think a lot of that went to consummate awareness. Not to use the word advertising in the traditional sense but getting the word out to veterans and getting the word out to schools, because two of the issues we had with VRRAP were supply and demand. The number of programs that were willing to say, I want to operate under this payment structure of VRRAP was hard to get off the—to get off the ground at the beginning, but by the end, we had 1,300 programs enrolled in the VRRAP program.

Then awareness to veterans because the restriction on who is eligible to be certified for enrollment where you had to be unemployed due to a COVID related circumstance and have not received any Federal or State aid, and not have any remaining Vocational Rehabilitation and Employment (VRE) or education entitlement, it made it difficult at first to get the wheels rolling. As we got the word out, as people started to go through the programs, we got a lot more. I think eventually we had 30,000 applicants almost for the program, of which 4,300 graduated through the program, and we are very happy that we got more through.

Mr. LEVIN. That is a good segue to my next question, which is about the data. I understand that the data on all the outcomes is not available, as lots of veterans are still enrolled in programs or within the 180-day mark for certifying employment.

We do have some data. To the best of my knowledge, as of January 3, VA had verified that 818 veterans who participated in VRRAP had secured employment. By comparison, 2,744 veterans had not secured employment. Mr. Frueh, to what factors does VBA attribute this relatively low success rate? What is VA doing to improve outcomes for veterans who are still participating in VRRAP?

Mr. FRUEH. Well, one, we have a lot of experience in VRE in terms of working with employers and future employers, and the Vet Tech program is a good analog to this in a different sector, in Science, Technology, Engineering and Mathematics (STEM) related or cyber related things. We have an employer consortium in that area which we work with to find suitable employment as quickly as we can afterwards.

One of the tenets of VRRAP that I like, that I think we are starting to see some benefit from is the payment to the program upon employment. Programs are getting better at recruiting for their students. As of now, we are at, I think, 1,000 employees. We have gone up a few hundred in the last several weeks. We will see as we get through the next four to 6 months after more of the people in the program complete the program. I think a lot of it is relying upon the programs themselves to push for a positive outcome at the end.

Mr. LEVIN. What are any other important lessons that you might have learned as a result of this program, and specifically, how will you incorporate the lessons that you have learned in similar programs in coming months and years?

Mr. FRUEH. I think the pay for performance is a nice feature of it from the terms of make sure people do not just go through the program. Our programs just do not apply to get Federal aid without any positive outcomes at the end. I think that feature is something that was a deterrent at the beginning, but as we worked our way through it, we got a lot more programs involved.

I think starting earlier, getting the word out a whole lot earlier would have enabled us to get more programs involved earlier, which would, of course, then enable more enrollment by veterans in those different programs.

Mr. LEVIN. Mr. Missal and Mr. Dodaro, do you have anything you would like to add to anything that has been said?

Mr. MISSAL. No, I mean, we looked just very broadly at that program, but not in any detail. Obviously, you know, we looked very closely at all the VBA programs to see whether or not we should be doing projects in them, and we are always open to looking even more.

Mr. DODARO. I do not have anything to add.

Mr. LEVIN. Well, I am out of time. I would just hope that the next time we stand up a program, that it does not take so long to really get things rolling, and that you have hopefully learned some lessons from that initial year where very little was happening. I am sure it will be talking about it, although I hope it is nothing like a pandemic or anything like that. I know we will be having new programs in the years to come, so I appreciate the work you are doing, and I will yield back.

The CHAIRMAN. Thank you, Mr. Levin. Mr. Rosendale, you are recognized for 5 minutes.

Mr. ROSENDALE. Thanks so much, Mr. Chair. General Quinn, it is so good to see you.

Mr. QUINN. Congressman, good seeing you.

Mr. ROSENDALE. Dr. Elnahal, I have got a couple of questions for you. On September the 9th 2022, the VA published an interim final rule titled Reproductive Health Services to immediately amend its regulations to remove the exclusions on abortion and abortion counseling. As you well know, I was deeply disturbed by that. I was proud to co-sponsor a resolution of disapproval being led by Congressman Cloud and Chairman Bost.

This rule is in clear violation of Section 106 of the Veterans Healthcare Act of 1992, which restricts abortions. The administration's explicit decision to violate the law is a slap in the face to Congress and the separation of powers. Specifically, the rule would direct the VA to provide abortions when health of the mother would be endangered. This rule also directs the VA to provide abortion counseling. While you and I may disagree on this issue, the taxpayers deserve to know how their dollars are being spent. With that being said, how many abortions has the VA provided since September 2022?

Mr. ELNAHAL. Congressman, I appreciate the question. It is actually a number that is small enough to possibly allow for triangulation and identification of veterans and clinicians involved. I think in this public forum, it would be quite risky to communicate that information. We are happy to work with you. Of course, the Chairman's letter response will be important in getting feedback back to this committee.

Mr. ROSENDALE. We certainly want to make sure that we do get that information. How many dollars has the VA spent providing abortions since 2022?

Mr. ELNAHAL. What I can say, Congressman, is that we projected in the impact analysis of the interim final rule that we are talking

about less than 1,000 veterans per year based on how we restricted the ultimate abortion service latitude in cases of the life of the veteran, the health of the veteran, rape, and incest. It was really the impetus was around veteran safety in the wake of the Supreme Court decision that no longer made abortion a constitutional right.

Mr. ROSENDALE. Dr. Elnahal, I understand our differences of opinion and what may or may not happen and the definition which provides for this to be allowable. What is the dollar amount spent providing these abortions?

Mr. ELNAHAL. All of that is to say that the number of veterans is quite small. The dollar amount is compared to, of course, our total appropriation a very small number.

Mr. ROSENDALE. I see you will not answer the first two questions. How many veterans have received abortion counseling since September 2022? Can we answer that one?

Mr. ELNAHAL. For the same reasons I mentioned before, Congressman, with all due respect, I think we would have to look at the implications of veteran safety before communicating that in the public forum.

Mr. ROSENDALE. Okay, well, we will look forward to getting that information in a more private setting. Even more egregious, there are no conscious protections for VA medical staff. A VA nurse practitioner, army veteran Stephanie Carter, asked the VA for religious accommodations, but allegedly was told by the Department that there is no process that exists to review such requests. The Department says that it does allow employees to opt out of providing certain services based on their religious beliefs. Yes or no? Can the VA medical employee opt out of providing abortions or abortion care?

Mr. ELNAHAL. Yes, Congressman. In fact, we have made that policy clear very shortly after the release of the interim final rule through an all-employee message. As of earlier this year, we put out specific, clear guidance on how staff and physicians alike can opt out of doing these types of services. We want to respect points of view on this and personal values and religious beliefs. That is a core principle that we are following.

Mr. ROSENDALE. Thank you. I would like to see that actually placed into the rule to avoid any confusion. If we could make sure that that happens as we go forward. I want to jump to another subject real quick.

I am glad to see literally everyone here in the room today with no facial coverings. We can actually see what you look like. I wrote the VA a letter last week regarding a veteran who contacted my office in regards to being denied service at a Montana VA clinic for refusing to wear a mask. It is outrageous to deny anyone, particularly a veteran, medical care over a personal decision. The Biden administration announced that the public health and national emergencies would terminate on May the 11th 2023. While the date is very arbitrary, even the President recognizes he can no longer hold the public hostage with these executive powers. Do you support denying veterans care over their unwillingness to wear a mask?

Mr. ELNAHAL. Well, Congressman, I will say that we have looked at this recently as the pandemic has evolved into a much better place. Just as of this week, we have taken the opportunity to maxi-

mally relax the masking restrictions in our facilities according to Centers for Disease Control and Prevention (CDC) guidelines based on transmission levels locally. We are bound to follow CDC guidelines. We think it is important to be consistent with those guidelines, but we are trying to be as open as possible to veteran, and clinician, and staff preferences alike on this.

Mr. ROSENDALE. When do you anticipate lifting these masking requirements, period?

Mr. ELNAHAL. Well, again, Congressman, we work with the CDC on this. We not only follow their guidelines, we partner with them regularly. As the pandemic evolves, we will see what comes next.

Mr. ROSENDALE. Thank you, Mr. Chair. I yield back.

The CHAIRMAN. Thank you, Mr. Rosendale. Mr. Pappas, you are recognized for 5 minutes.

Mr. PAPPAS. Thanks very much, Mr. Chairman. I want to direct my first question to Mr. Frueh. There has been a little bit of a conversation here about claims backlogs, and I just want to draw your attention to one specific issue. The committee has received several inquiries regarding delays in processing aid and attendance pension claims, and I am wondering if you can shed any light on those backlogs and what steps are being taken to address it.

Mr. FRUEH. It is almost like I am on my computer. Aid and attendance backlog, there is a slight backlog in aid and attendance. There are several thousand claims, and I now actually have numbers here, which probably easier if I get to you there. Our average days to complete aid and attendance is hovering around 110 days, I think, now. The reasons for backlogs are varied, you know, in the claims portfolio. It is because of the large volume of claims and the lack of ability to produce documents back in time in aid and attendance. It is a smaller volume of work, but in a commensurately smaller organization. I do not know how large the backlog is. I would be happy to dig into that with you further, but anything we can do. As I said before, I do not want any veteran to wait for a benefit.

Mr. PAPPAS. That is helpful. Maybe we can dig into the specific issues that we have been hearing about and see if there is anything that is materially changed around that and just see what attention can be drawn to it.

I am wondering if you could answer an additional question. Last Congress, the Disability Assistance and Memorial Affairs Subcommittee, of which I am now the ranking member, had a hearing regarding VA's outreach to survivors and dependents. I think everyone was surprised at the lack of personnel and resources that has been dedicated to important tasks, including the proactive communication with new survivors. I am wondering if you can talk about what action has been taken since that hearing to bolster outreach and any steps that have been taken to address this issue for survivors' independence and make them aware of benefits that are available through VA.

Mr. FRUEH. Awareness is one of the most key elements of enabling veterans to access their benefits. For survivors, we have an Office of Survivor Assistance that is, you know, within VBA, but it is for the entire department. We also have an Office of Outreach and the Office of Outreach and Office of Survivor Assistants work

together with Public and Intergovernmental Affairs and others to get word out. For example, with the new PACT Act, we reached out to every former Dependency and Indemnity Compensation (DIC) applicant who was denied to say, please apply again. There is new rules. There is a new legislation you might be able to apply for.

We work with the branches of the military casualty assistance officers, and we work through county VSOs, State VSOs, and big national VSOs to amplify our message to eventually get to the people who need the information. I can say as a son of a deceased veteran whose mother, my mother did not know about benefits were eligible she was eligible for. I hated not knowing what was eligible for her and I worked at VA. I am more educated now in the benefits. And I want to make sure that there is no survivors like my mother that are unaware of the benefits that can help them with their lives.

Mr. PAPPAS. Well, thank you for that commitment. One final question for you. Last year, the Department announced that it is closing a gap in survivor benefits for certain LGBTQ-plus veterans, specifically those who are unable to get married before the 2015 Obergefell decision. I am wondering if you can provide a status update on VA's benefits for these same sex surviving spouses and how many survivors have applied for benefits through VA so far.

Mr. FRUEH. That is something I will definitely have to talk to you offline. I do not have the numbers on veterans who have applied for those benefits, but our goal for that was to act as if those survivors were in the same if they were in a State that did not allow a marriage between a same sex couple, we wanted them to have access to the same benefits as if they were. The opening of that was geared around equity to veterans in different groups. The numbers I will have to work with you offline for.

Mr. PAPPAS. Okay, thank you. We will follow up on that. I yield back, Mr. Chair.

The CHAIRMAN. Thank you. I now recognize Representative Van Orden for 5 minutes.

Mr. VAN ORDEN. Thank you, Mr. Chairman. Thank you all for coming here today. I appreciate it greatly. I am a 100 percent service-connected disabled veteran, and I get all of my healthcare through the VA. I want to share with you and preface these comments, my comments that the vast majority of my experiences at the VA have been overwhelmingly positive. I am very grateful for the staff throughout Western Wisconsin, including La Crosse and the medical center in Tomah. I am very proud of them.

However, we can all do better. That is what we do as Americans. We continuously seek improvement. In that spirit, Dr. Elnahal, I want to share with you how I spent my first day in Congress. I got sworn in and I received an email, and I am going to read it to you. Right now. My wife and I tonight attended my brother's visitation, and I will be attending tomorrow his funeral. He passed away on Wednesday before Thanksgiving. He is a Wisconsin born, recently retired from the army after 22 years, currently residing in North Carolina. He leaves behind a beautiful wife and three beautiful young children. He went to the VA for help for mental health issues and was turned away. He took his life the Wednesday before Thanksgiving. Two days later, a letter from the VA came in the

mail accepting him. It was too late. His name is Retired Major. I will not read that publicly.

It should be illegal for the VA to refuse a soldier who is retired or active duty trying to get help from getting admitted. I am requesting for you to work with your counterparts in North Carolina on some kind of legislation to prevent this from happening to another soldier or veteran again.

I spent my first day as a United States Congressman calling the brother of this dead soldier, calling the father of this dead soldier, calling the widow of this dead soldier, and apologizing profusely for the Federal Government's inability to schedule a medical appointment. It sits on my desk with this sticky pad and it said, this is why I am here.

I know you have got a tough job. I know that sometimes we can be distracted by the events, especially when you are leading a huge bureaucracy like the VA. I prepared this for you. Will you bring that to him, please? Will you bring that to the doctor? This is a copy of this letter, sir. You can put that on your desk or you can hang that on your wall. There is a blank sticky pad there. I think it would do us all well if you wrote on there why you are here, and to never forget that.

Things are going to be dark some days. People are going to get on you. I understand that. Every day when you wake up in the morning, me and my fellow millions of veterans throughout the United States of America would be deeply grateful for you if you remember why you are here. With that, I yield back.

The CHAIRMAN. Cherfilus-McCormick, Congresswoman Cherfilus-McCormick, you are recognized. I am sorry.

Ms. CHERFILUS-MCCORMICK. Thank you, Mr. Chair. My first question is for Mr. Dodaro. In 2008, the National Defense Authorization Act directed VA and the Department of Defense (DoD) to develop and implement systems that would allow for interoperable electronic patient healthcare information exchange between the Department. After numerous starts, stops, and failure attempts, that requirement has not been achieved. Now, both departments are working in deploying Cerner Corporation's EHR platform across the respective healthcare systems.

Mr. Dodaro, does GAO have an estimate of the VA's expenditures on failed EHR modernization efforts before the current Cerner EHR project? We are very concerned that the total cost for the Electronic Health Record Modernization (EHRM) project remains to be seen. It would be helpful for the committee to know the running total for taxpayer spending on past EHR modernization efforts.

Mr. DODARO. The cost that we estimate is over $1.7 billion for failed predecessor electronic healthcare record systems that either failed or did not come to fruition.

Ms. CHERFILUS-MCCORMICK. Thank you so much. My next question is for Dr. Elnahal. Dr. Elnahal, the EHRM program is in the midst of another pause, presumably to address some of the system's long standing technical and design issues. What has your office's participation been in this evaluation, and do you think this pause is going to positively impact the direction of the program? If so, how?

Mr. ELNAHAL. Well, Congresswoman, that was the exact intent of doing the pause. We called it the assess and address period, because that is exactly what we have been engaged in diligently since we announced it. We are looking specifically at the system configuration issues, but also people and process matters that led to our need to disclose to tens of thousands of veterans that their care may have been delayed or affected by the implementation of this system. We took that responsibility very seriously.

In the coming weeks, we are going to be releasing the results of that work to include not only Oracle Cerner's responsibility to fix the configuration of the system, but also our own and making sure our people and process matters continue to improve. We are very dedicated to that.

Ms. CHERFILUS-MCCORMICK. Thank you. My last question for you. The total number of veterans enrolled in the VA's health system increased from 7.9 million in 2006 to about 9.2 million in 2022. This increase in beneficiaries needs to be matched with an increase in providers to meet the need of every veteran. What steps has the VA taken to ensure that there are enough healthcare providers to care for our veterans and ensure that the veterans of Color receive cultural competence and trusted care from providers that look like them and understand their healthcare needs?

Mr. ELNAHAL. I absolutely agree, Congresswoman. It is why the first and most important priority that I have set for the healthcare system is hiring faster and more competitively. We absolutely need to be staffing our hospitals and clinics, but also our support personnel to the greatest extent possible, not only to serve our existing base of veterans, but to, for example, meet the need of all the new enrollees we expect to see from the PACT Act. That includes the staff that you are talking about, and we have already hired more than 18,500 staff in the first quarter of this year. We have also seen a higher retention rate compared to January of last year when we had a 4 percent loss rate. We only had a 2 percent loss rate just last month. The combination of greater retention and greater hiring has led to 388,000 employees on board. That is an end strength that we think will continue to get better throughout the year because of our attempts to improve hiring.

Ms. CHERFILUS-MCCORMICK. Thank you so much. My next question is for Inspector General Missal. One of the final hearings the committee held while Democrats were still in the majority in December 2022, was an oversight hearing on the VA's progress in implementing the PACT Act. This hearing provides a significant opportunity to get updates on the VA's progress, meeting major milestones outlined in the law.

VA has processed PACT Act claims on January 1, 2023, according to the data committee received from the VA this week, since the law's enactment in August 2022. More than 309,000 veterans and survivors have submitted PACT Act related claims. In your role as the Inspector General, what oversight do you have in processing the PACT Act claims? How can we ensure veterans are having a streamlined process while awaiting confirmation of benefits?

Mr. MISSAL. Well, as previously noted, the PACT Act was one of the most significant increases in VA benefits in its history. We recognize the importance of it. They are just starting to process those

claims at this point. We have already put together a team of people to address it from a number of different areas, including the people, the staff that they are needing to hire, the processes, how they are processing the claims, and the technology, what they are doing along technology lines as well. We expect to have a vibrant oversight, just given the importance and the amount of money at issue.

Ms. CHERFILUS-MCCORMICK. Thank you so much for your responses, Mr. Chairman. I will yield back.

The CHAIRMAN. Thank you. The gentlelady yields back. Representative Ciscomani, you are recognized for 5 minutes.

Mr. CISCOMANI. Thank you, Mr. Chair. I serve a community in Southern Arizona in the Tucson area where the VA hospital there serves two military bases, Davis-Monthan (DM) Air Force Base and Fort Huachuca Army Base in Sierra Vista. Therefore, I serve a large veteran community. I do hear constant good feedback and a lot of improvement, and specifically the VA hospital. I, like my good friend Congressman Van Orden, also believe that there is room for improvement, like, in anything.

My question is also in the same vein as my colleague. Dr. Elnahal, Chairman Bost sent a letter to the Secretary weeks ago asking the Agency to expand on its methodology for counting veteran suicide deaths. An issue that concerns me is that a large number of these deaths are ruled accidental or undetermined by our coroners, and as opposed to suicide or homicide. Many of these undetermined veteran deaths are drug overdose deaths as well.

Does the VA have any intention of examining these deaths due to overdose or risky behavior within the context of suicide prevention? Could the VA include this type of data in its suicide report? This is a real issue that we see on the rise more and more, unfortunately, among our veteran population, and one that I hear from my community constant, and specifically after this example from the Congressman, I think it deserves weighted attention on this.

Mr. ELNAHAL. I agree, Congressman, and we are always open to feedback and input about how we calculate veteran suicide information. Every year, we work with the CDC closely on this, medical examiners across the country, our methodology is published online. I want to say that we are not only focused on veteran suicide, which is my top clinical priority and has been for the Agency for years, but also the various different inputs into deaths that some folks may be trying to categorize, or are giving us feedback, saying that we should categorize or consider doing so for suicide.

For example, substance use disorder. We have extensive programming to include residential treatment, medication assisted treatment, and various programming for veterans suffering from that. Also, the broad scope of our mental healthcare services continue to expand. We are doing more telemental health care than we have ever done before. We have more than 17,000 providers across the system providing these services.

We are, of course, dedicated to expanding that capacity as much as possible. To Congressman Van Orden's request of me, I will keep this on my desk, and I will always remember that story. I will make sure that we continue to try and do better and better to prevent this scourge and to deal with this pressing, pressing public health issue.

Mr. CISCOMANI. Thank you. I yield back.

The CHAIRMAN. Mr. McGarvey, you are recognized for 5 minutes.

Mr. MCGARVEY. Thank you, Mr. Chairman. I appreciate it. Thank you, gentlemen, for being here today. I echo the comments of some of my colleagues, Mr. Ciscomani, Mr. Van Orden. I also suggest that cutting $31 billion in the VA budget is not the way to best address some of those problems in the next year.

I want to switch to something going on in my district, specifically. In August 2022, the VA OIG issued a report about issues with Camp Lejeune processing, the claims processing, a topic of which I hear about a lot from my veterans at home. Mr. Missal, this one is going to be for you. It was in a report that the VA OIG recommended that the VBA consider centralizing all Camp Lejeune related processing claims in the VBA's Louisville Regional Office.

As you are likely aware, compared to other regional offices, the Louisville Regional Office actually had a much lower error rate. They processed a lot of claims. They only had an 8 percent error rate. That is compared to a 40 percent error rate of all the other offices combined. 40 percent for all the others, 8 percent for Louisville. In response to those recommendations, the VBA said it would assess all of the regional office's accuracy of processing Camp Lejeune related claims over time. If the accuracy has not shown consistent improvement, that VBA would consider further centralization. My question is, what progress has the VBA made on determining the need for centralizing the processing of Camp Lejeune claims since the report was published?

Mr. MISSAL. As you correctly pointed out, there were significant problems with the processing of the Camp Lejeune claims. We projected out of the 37,000 during a 4-year period, 21,000 were not processed properly, 17,000 of those, 21,000 were prematurely denied because they did not have enough information. One of our recommendations involved the centralization of the claims. My understanding is that VBA is going to centralize it, but before we close out that recommendation, we want to see that it is actually done and how it is working. Then there is a second recommendation from that report that remains open as well.

Mr. MCGARVEY. I appreciate that because it does seem like there is some hesitancy in moving forward with that recommendation on centralization. I guess for maybe Mr. Frueh, what I would say is we do have spaces in the VA that deal with this already. We have teams at VBA that currently specialize in processing certain types of claims such as military, sexual assault, trauma. Why is there a hesitancy in going ahead and centralizing those claims in the Louisville office?

Mr. FRUEH. I would say that the issue with specialization versus generalization is there is a lot of different disabilities and there is a finite capacity to centralize into different areas. It is not a lack of desire to get better. It is not a lack of desire to find that the answer of centralization will answer this because if we did that with all of the disabilities, we would run out of offices to do the centralization.

Our goal and what I consider a quality organization is a veteran that applies from any State through any modality, through any external help, whether it is a VSO accredited representative or us

has access to the same outcome. Centralizing makes that more likely because you are looking at one place to enforce outcomes. We do have a distributed workforce and we do do a lot of work around the Nation, and our goal is to make that as high quality as we possibly can across the Nation.

Mr. MCGARVEY. Well, you know, I am not saying centralization is necessarily the answer. I think the numbers that Mr. Missal gave illustrate the real problem that potentially tens of thousands of Camp Lejeune related disability claims have been subject to processing errors. The most important thing here are the men and women who served who are not potentially getting the care, the treatment, the resources they need. Mr. Frueh, what is the VBA doing to proactively identify those claims that were processed incorrectly, to notify the veterans of the error, and to allow them to update their claims accordingly?

Mr. FRUEH. I would have to go back to the report. The last time I looked at it was a few months ago. When we got the identification of claims that the IG said were processing error, we did reach out to everyone. We did relook at every single claim. When we found a claim that we did find an erroneous answer. Some that were process and error that were prematurely decided, when we looked at them again, they came to the same conclusion. The answer was still the same answer that we got before. When we get to a claim that we readjudicate and we get a different answer, then we reach out to that veteran and reopen the claim and work with them to the ultimate conclusion.

Mr. MCGARVEY. I am out of time, so I yield back.

The CHAIRMAN. Thank you. Representative Self, you are recognized for 5 minutes.

Mr. SELF. Thank you, Mr. Chairman. My issue is the director of the Dallas VA Center. You are free to select your senior leadership any way you will. I believe that you have damaged your relationship with your stakeholders. The Dallas VA Center is not in my district, but the Metroplex is a large place, and that VA Center is the second largest in the country I understand. You are free to select your director, but the deputy was not considered for the job. Highly qualified. He had been the deputy for the second largest center in the Nation for a number of years. The man that was selected to be the director came from a very small center, and the deputy was not considered at all.

If I go through the other, central Texas conducted a full and open interview process. Amarillo was full and open. El Paso was full and open. You did not even post the position in the second largest center in the Nation. Again, I believe that you have damaged your relationship with the stakeholders, with the veterans in the area. Believe you me, there are a lot of veterans in the Dallas Metroplex and in North Texas. My questions are, did Mr. Jones, is it Dr. Jones, the H.R. director? Mr. Jones, Dr. Jones, your H.R. director, did he follow proper protocol when considering the new executive director of the North Texas Dallas VA? Then the real question I have is, does it make sense that he would select a candidate from a clinic of 17,000, move him to the second largest in the country, with a budget of roughly 20 billion?

Mr. ELNAHAL. Congressman, I had a chance to visit the Dallas VA Medical Center. I met the individuals that you are talking about. Wendell Jones is the network director across VISN 17 for Texas. I think it is an extraordinary asset for the veterans and the community.

Personnel decisions are always very difficult. Before I signed off on this action, I checked with our Office of General Counsel, and they determined that the process was within the scope of the law. What I can tell you is we have a commitment to ensuring that the entire team there is supported to meet the mission on behalf of veterans in the Dallas area.

Mr. SELF. In your mind, you signed off of it. You just gave me a legal process. How about the personnel process? Did you hire the best man for the job or woman for the job? We are not discussing names here. Did you hire the best person for the job——

Mr. ELNAHAL. In my discussion——

Mr. SELF [continuing]. realizing that the deputy had been there for a number of years in this second largest VA center in the Nation?

Mr. ELNAHAL. Well, candidly, Congressman, there are a lot of inputs that go into these very difficult decisions about picking our leaders in the organization. After I consulted with Mr. Jones on this, we came to the determination that we did. That is not a disparagement at all of anybody else who wanted that job. What I am committed to doing is making sure that we are meeting the mission on behalf of veterans in every performance indicator we can in the Dallas VA.

Mr. SELF. Understand, the deputy was not considered, as far as anyone knows. I think that you have some work to do to regain the trust of the stakeholders and the veterans in the Metroplex area, in the North Texas area.

With that, I would like to move to a different issue. Mr. Quinn. In 2021, the VA IG reported that NCA could better ensure that VA grant funded State veterans cemeteries were maintained according to national shrine standards. How has the NCA improved the oversight over those State veterans cemeteries?

Mr. QUINN. Congressman, thanks for the question. I will make sure I have a voice through this hearing. We have looked very closely at that State in particular that was mentioned in the IG report. We have gone back for additional assistance visits with that State, and we have done an additional inspection of that State, and we do that with all states. We want to make sure that this partnership between the Federal Government and the State, Tribal, territorial, grant funded cemeteries are out there, that we maintain national shrine standards. The veterans deserve that. The family members deserve that. We will take every step necessary to make sure that those are national shrines.

Mr. SELF. You are assuring me that it is meeting the traditional national shrine standards today?

Mr. QUINN. Congressman, we are still working with that State to ensure that they meet national shrine standards. Yes, sir.

Mr. SELF. Thank you, sir. I yield back, Chairman.

The CHAIRMAN. Thank you, Mr. Mrvan.

Mr. MRVAN. Thank you, Chairman Bost. This week, I am introducing the VHA Leadership Transformation Act, a bill I believe will help address some of the leadership and governance challenges that are described in the Inspector General Missal's and Comptroller General's Dodaro's testimony. First, my bill will establish a 5-year term for the Undersecretary for Health in order to provide greater leadership, stability, continuity within the Veterans Health Administration. Second, my bill will remove existing statutory limitations on the number of Assistant Undersecretaries for Health that VHA can have, as well as the requirement that nearly all of them be doctors.

This will give VA greater flexibility to determine its organizational structure and expand the pool of healthcare executives who can be considered for these senior leadership positions. Mr. Missal and Mr. Dodaro, what are your thoughts on the idea of depoliticizing the appointment of the Undersecretary for Health? What would be the potential benefits of greater leadership, stability, and continuity at VHA? Third, and could VHA benefit from having greater flexibility to design its organizational structure?

Mr. DODARO. First, I think there are tremendous benefits to be gained of sustained leadership and stability over a period of time, provided it is the right person in the leadership job. In fact, the criteria that we have for getting off GAO's high risk list, the very first criteria is sustained leadership. That is pivotal. Without that, you are not going to make progress.

There are a number of other positions across government with 5-year terms. The Internal Revenue Service (IRS) Commissioner within the Treasury Department. The FAA Administer in the Department of Transportation, Small Business, or excuse me, Social Security Administration has a 5-year term. Unfortunately, two of those, all three are vacant right now, so they are trying to be filled.

I believe that with the right person, sustained leadership is important, particularly at VA, where if you want to have change of the magnitude that is needed there, you need to have stability over time to guide it to a successful conclusion. I also think it is important to consider people who have management skills, as well as medical skills in order to effectuate the type of change that is needed over at the VHA. I would submit to you, although you did not ask me, that the same thing should be true for VBA and the Benefits Administration to have that stable leadership over a period of time when you have such important functions that we have and these are functions that need to be performed. To be successful, you need to have continuity over time.

Mr. MISSAL. I would just add second what Mr. Dodaro said about leadership. Effective leadership and stable leadership is so critical, particularly for an organization as large, complex, and decentralized at VHA. I have been the IG for a little more than six and a half years. In my time at VA, there have been six people who have sat in the undersecretary's chair at VHA, either an acting basis or as a Senate confirmed position. I know that the Commission on Care in 2016 recommended 5-year terms for the VHA. I think they called it the executive director, with the possibility of being renominated for it. I agree with Mr. Dodaro that anything that gets stability within these very important positions would be very helpful.

Mr. MRVAN. Then, Dr. Elnahal, do you have any views to add? Do you think by making the statue less restrictive, VHA could recruit the kind of senior healthcare executives it needs?

Mr. DODARO. Yes. I think you—oh, I am sorry. Was it to me or to the doctor?

Mr. MRVAN. To the doctor.

Mr. DODARO. Okay, I am sorry.

Mr. MRVAN. No, problem, sir.

Mr. ELNAHAL. Thank you. I am glad we agree.

Mr. MRVAN. I am just going to direct all my questions to you.

Mr. DODARO. No, I am sorry. I am sorry.

Mr. MRVAN. Thank you, sir, very much.

Mr. ELNAHAL. Thank you, Congressman. Of course, as we do with proposed legislation analyzing the implications of such a bill, we have not had a chance to come to a position yet as an agency or administration. I would just concur in principle with my colleagues that continuous leadership is really important. I am very focused, for example, on filling our medical center directors and VISN directors with permanent folks and making sure we utilize every single PACT Act authority, and hiring authority, and retention authority that we have to sustain that leadership.

I am very sensitive to the oversight of my colleagues, the colleagues to my right in various reports about the risks of, you know, continuously transitioning leadership. It is hard to sustain initiatives. It is hard to hold folks accountable. It really sets a path for continuous improvement that is consistent with our high reliability effort to have continuous leadership.

Mr. MRVAN. With that, I yield back my time. I thank you very much.

The CHAIRMAN. Dr. Murphy, you are recognized for 5 minutes.

Mr. MURPHY. Thank you, Mr. Chairman, gentlemen, thank you for coming today. I represent North Carolina's 3rd congressional District. One-seventh of my constituents are veterans or active-duty military. It is a heavily populated military district. Our veterans issues are, very, very important to me. I have also been a physician for 30 years plus now. The trials and tribulations that go on in the VA are not lost on me. To your point of stability, trying to fill doctors in, I get it, because we in the civilian world are facing a cataclysmic fall in physicians, even more so with surgeons. I know sometimes recruiting is very difficult in rural areas and especially in VA areas. Any help that we can do in that regard, you have to let us know because that is a big deal for our veterans. They signed on the dotted line to serve and sacrifice for us. As far as I am concerned, the day they come home is the time for us to turn our attention on the second part of that contract.

Veteran suicide is a big problem. Dr. Elnahal, I wish you could speak to that and what improvements, where you see this going, because we are at now, what, 22, 24 a day? Absolutely unacceptable. What are we doing? What are we doing in the VA to change that? How can we help or what fires do we need to light to make a difference?

Mr. ELNAHAL. Well, Congressman, I share your priority around preventing veteran suicide. It is my top clinical priority for the

healthcare system and it has been so for the Agency for years. We will simply not be satisfied until we bring that number to zero.

Every veteran suicide is a tragedy. We are focused with a comprehensive public health approach, everything from ensuring access to crisis care, both through our veteran crisis line and urgent care through our emergency settings, to lethal means safety, to ensuring same day access to care and continuous mental healthcare. Very importantly, community-based organizations need to be our partners in this to include, of course, our veteran service organizations. We have put in more than $50 million in this Sergeant Parker Gordon Fox grant program to fund community-based organizations in partnership with us.

We just announced $20 million in funding to innovative organizations, startups, community-based organizations alike through our Mission Daybreak program. We are simply not going to stop until we get to zero.

Mr. MURPHY. Thank you. I appreciate that. That said, we are not bending the needle. We are not changing things. I appreciate the work. It is a hard-to crack. I am not belaying that whatsoever, especially in today's society when you wake up and you do not know who you are, which whatever you pick these days, and there is so much pressure by society to be something different. I get it. No wonder suicide rate is up, actually across all age groups, primarily with young girls. That is a different issue.

I will tell you this, and I need your help with this, and I need your opinion on this I have, as a surgeon, I have worked with wound care for over 30 years, wounds that will not heal. I have found absolute and repeatable excess with hyperbaric oxygen. I will tell you, I have studied the literature. It is somewhat controversial. I will readily admit, being an objective scientist. I will tell you, I have known many well, several veterans who I know, who have undergone hyperbaric oxygen at their last thread, and it has saved their life. I want your opinion, and I really want a commitment that the VA is going to really put some effort into this for a last thread. If we are going to really do everything, if we are not going to leave anything on the table, we have to explore this option.

Mr. ELNAHAL. The first thing I will say is I fully respect your perspective, Congressman, as a surgeon and a physician yourself, and appreciate that you have seen the benefits of this yourself. We do allow for referrals for hyperbaric oxygen therapy in the community. That is a patient by patient, physician by physician, or provider determination at the point of care.

Mr. MURPHY. Does the VA pay for this?

Mr. ELNAHAL. Yes, the VA does pay for that therapy in the community. If the referral is made at the front line and the clinical determination is made.

Mr. MURPHY. Okay, that is news to me, because that is not the word that I am getting back. I will take you for what you said, and that is in the record, and we will go from there. Mr. Chairman, I am done. Thank you all for what you do for our veterans. It is critical. I just say this, we do not go to bed without something worrying about what the next thing is. I expect you guys to not go to bed every night not worrying about that next veteran. Thank you, sir. I will yield back.

The CHAIRMAN. Ms. Ramirez, you are recognized for 5 minutes.

Ms. RAMIREZ. Thank you, Chairman. Before I went into the State legislature, for a very long time, I was the executive director of a social service agency. We worked primarily with people experiencing homelessness. Many of them were men experiencing homelessness, and about 20 percent of them were veterans. Being on this committee is first an honor and a privilege, and certainly, there is a lot of work to be done as we talk about housing insecurity and the connections between mental health and housing insecurity.

Mr. Frueh, as we have thought about access to permanent stable housing and particularly even as we think about homeownership, I know that recently the VA, in coordination with a broader White House initiative, announced it was enhancing its oversight procedures to better identify and act against discriminatory bias in VA home loan appraisals. VA is also recommending that all VA fee panel appraisals and all lenders staff appraisal reviewers take training on appraisal bias, fair housing, and fair lending. Can you tell me how VA—can you tell me if the VA has already removed any appraisers under its newly enhanced oversight process for detecting bias and discrimination?

Mr. FRUEH. First, I would say thank you so much for focusing on housing and housing America's most vulnerable population. From our perspective, every benefit, every veteran deserves access to their benefits, not some veterans. We want to make sure we root out discrimination wherever it is from the loan guarantee program and the new focus on finding bias in appraisals, I do not think that it is yet identified bias. I think it is a new program that is still being implemented. I would be happy to talk with your staff and you about this as we go forward with it. I do not yet have any results from that work.

Ms. RAMIREZ. You are still in the process of putting together the program and the training itself, is that correct?

Mr. FRUEH. I believe so. I know it is in its infancy.

Ms. RAMIREZ. Okay. For the record, I would like to be able to work with you and closely learn how the training program is being designed and then how we are going to be enforcing it. I think the last thing I would say is I started as a case worker, actually as a mail lady, when I worked at the Social Service Agency. I started at the age of 17. I remember I was a senior in high school, and I would run right after school to the shelter to help distribute mail to people that did not have a permanent mailing address. As young, as naive as I was, I sat in a room and I heard people who have dedicated their life, who died in service, who nearly died in service, talk to me about the traumas they had experienced, trauma that I could not connect with. I kept asking myself, how could you have fought for our country and now be in a church basement with no access to supports?

I would say to you that I have been honored to work on some of the affordable housing initiatives on veteran housing in the State of Illinois. I really want to put on record how incredibly important it is, as you have said, that we continue to prioritize housing as we see the housing crisis across this country, veterans, both women and men, are struggling between paying for their rent and

paying, in some cases, for either utility bills or rising costs of other things.

I am grateful that the healthcare system within the VA continues to improve, but we still have a long way to go. I just want to make sure that as we talk about mental health, as we talk about trauma, that we understand that there is an intersection between housing, employment, supports for family, and that we continue to work to make housing a top priority for veterans. I look forward to working with all of you to make that happen. Thank you. I yield back, chairman.

The CHAIRMAN. Thank you. Ms. Budzinski, you are recognized for 5 minutes.

Ms. BUDZINSKI. Thank you, Mr. Chairman. Good afternoon. My name is Nikki Budzinski. I have the honor and privilege of representing Illinois 13th congressional District, which is in central and southern Illinois, a little further south of Congresswoman Ramirez. I have two VA clinics, one in Decatur, one in Springfield, that I have the honor of getting to work with and represent. I also have a lot of constituents that are serviced by a VA hospital in St. Louis, as the district is quite long and reaches over there.

I am really excited. I am the granddaughter of two World War II veterans to get to serve on the Veterans Affairs Committee and help my constituents, including many of those that are servicemen and women. As a new member and as a part of the Veterans Affairs Health Subcommittee, I look forward to helping to ensure our veterans have access to the highest quality and affordable healthcare. This includes, for me, really prioritizing issues around expanding access to telehealth, supporting, and helping to recruit the workforce of the VA. I know a number of members have spoken to shortages and looking at how I can be helpful in that area and ensuring that Americans have—our veterans—excuse me, have access to behavioral health services, something that I know a number of other members on the committee have also spoken to. Because my district is predominantly rural, as you know, there are a lot of specific challenges that rural communities face when trying to tackle some of these priorities.

I believe our veterans have sacrificed so much for our country, and it is our duty as a member, as Members of Congress, to work together to find the best solutions. Another point I would make is I am honored to serve on this committee, which has a long history of bipartisan working together to service our men and women that are veterans. I am committed to working with my colleagues to do just that.

I just want to say a thank you to all of your honor being a part of this panel. This was very informative, and I am sorry, with our schedules, that we have to kind of come back and forth, in and out of our committee hearing. I did want to ask specifically to Dr. Elnahal, you know, with the ongoing work of the PACT Act, which is, I think, very exciting for our veterans in this country, I am very specifically interested in how specialized care can be expanded through the work of the implementation of the PACT Act. Then as a second part of that same kind of question around the PACT Act is how you are looking at the unique challenges that implementation in rural communities, how you are going to be tackling those.

Mr. ELNAHAL. Well, thank you, Congresswoman. We share your dedication, of course, to providing the highest quality, best care we can, including to rural veterans. I think the most enabling thing we have to do to fully implement the PACT Act to its fullest extent is to hire enough talented, quality providers to be able to do so. The PACT Act actually affords us the requirement, frankly, to do a study on making sure we maximize all of the tools we have to be able to recruit specific staff to be able to meet the needs of rural veterans. We have already commenced with that important work. We are, of course, also trying to maximize, as you mentioned, the use of telehealth, because that just makes care more accessible, especially to rural veterans.

We have a partnership with the Federal Communications Commission, the FCC, to be able to extend wireless and broadband access. We are handing out tablets as well, and devices for folks in rural areas to be able to receive that care. We are making sure they are trained to be able to do so, including training and supporting caregivers. Across the spectrum, hiring the number of providers we need to hire, making sure we are as productive as we can be with our clinics, with various initiatives to be able to improve productivity, but also extending connectivity and telehealth to meet rural veterans' needs.

Ms. BUDZINSKI. Thank you, Mr. Chairman. I will yield back my time. Thank you.

The CHAIRMAN. Thank you. That concludes all of the people who are having questions. Ranking Member Takano, do you have closing remarks?

Mr. TAKANO. Yes, just briefly, Mr. Chairman, thank you for putting this hearing together and calling all the witnesses. I want to extend my deep sympathy and condolences to Representative Van Orden for the tragic loss of it was your brother. Unfortunately, this event occurred at a time when VA had not implemented the recent COMPACT Act. I want to use this opportunity because I think we might want to get this message out to folks that the COMPACT Act was implemented on December 17—January 17, January 17 of this year. It was a bill that I introduced and carried and very proud of it. What that bill does is it says that a veteran can call 988, the crisis hotline, and be evaluated and be immediately referred, immediately referred to a mental health practitioner. It could be inpatient or outpatient, and it could be in VA or out of VA, wherever it is, whatever is the pathway. This eligibility extends to anyone who wore the uniform. Even if you are not eligible for VA and you are going through an emergency health mental health crisis, you can call 988 and press 1 and be connected.

I wish it had been implemented earlier, but I am very grateful Dr. Elnahal, that we have it implemented now. I just want to take this moment to make sure that people know about it and all our offices can be involved, making sure our veterans know about it. Since I took over the chairmanship in 2017, suicide prevention has been my No. 1 priority.

I want to thank you. Many of the new Members of Congress coming in, new people coming onto the committee have made it their top priority. I agree with Dr. Elnahal, we will not rest until that number is zero. Thank you.

The CHAIRMAN. I want to thank the ranking member for bringing that up, because it is vitally important that all of our members know and understand what that is. The outreach can be quick and that no one would be denied.

I do want to thank all of our witnesses for being here today. I think it is clear that VA has a lot of work to do. We can get VA to where it needs to be by going back to the basics and conducting thorough oversight of VA and the Biden administration and where fixes are needed to be made. We will work hard to enact thoughtful, necessary legislation that puts veterans first and fiscally responsible. We will propel VA into the future, force it to keep pace with the modern healthcare systems for this generation of veterans and the next. Our veterans deserve no less than that but the best in exchange for their service. The VA, they use day in and day out should reflect that. I look forward to working with the honorable members of this committee and our stakeholders to accomplish these objectives.

Again, I want to thank you for being here today. Now, I ask unanimous consent that all members shall have 5 legislative days in which to revise and extend their remarks and include extending their material. Hearing no objections, so ordered. With that we are adjourned.

[Whereupon, at 4:16 p.m., the committee was adjourned.]

APPENDIX

Prepared Statements of Witnesses

Prepared Statement of Michael Missal

Chairman Bost, Ranking Member Takano, and Committee Members, thank you for the opportunity to discuss how the Office of Inspector General's (OIG) work enhances VA's accountability and continuous improvement efforts for its services, programs, and operations. The OIG's mission is to serve veterans and the public by conducting meaningful independent oversight of VA. Our more than 1,100 staff conduct and support accurate, fair, and impactful audits, reviews, healthcare inspections, and investigations across the Nation. In just this past fiscal year, the OIG produced 250 oversight publications with 894 recommendations for corrective action. Our personnel have made over 200 arrests, fielded more than 36,000 contacts to our hotline, and testified before congressional committees on 14 occasions, including 10 before this committee or its subcommittees. Our work has resulted in a monetary impact of more than $4.5 billion for VA. This would not be possible without the funding and other support we receive from Congress.

The OIG appreciates the work VA does every day on behalf of veterans. Secretary McDonough, other VA leaders, and the vast majority of personnel with whom the OIG staff engages recognize the benefits of meaningful, independent oversight and have been very responsive to our requests for information. We also value the regular interactions we have with senior leaders to understand their concerns and priorities. In addition, we have a strong and collaborative relationship with Comptroller General Dodaro and his staff and our work often complements and builds on their oversight.

FOUNDATIONS OF ACCOUNTABILITY

The OIG's oversight reports reveal recurring themes and deficiencies that often center around key elements of accountability. They are routinely shared with VA leaders across the enterprise to encourage positive change and efficiencies within their respective programs and operations. OIG recommendations that focus on even a single medical facility or benefits process are often a road map for other facilities and offices across VA to help prevent or correct similar problems that have gone undetected or unaddressed.

The OIG's work often focuses on five components of accountability:

1. Strong governance and clarity of roles and responsibilities
2. Adequate and qualified staffing to carry out those duties
3. Updated information technology (IT) systems and effectual business processes to support quality healthcare delivery, accurate and timely benefits, and efficient operations
4. Effective quality assurance and monitoring to detect and resolve issues
5. Stable leadership that fosters responsibility for actions and continuous improvement

The OIG reports referenced below help illustrate how weaknesses in any of these areas of accountability can negatively affect veterans, their families, and caregivers and can waste or misuse taxpayer dollars.

Strong Governance and Clarity of Roles and Responsibilities

Misconduct, failures to take appropriate action, and persistent problems are often the result of VA personnel or contractors not understanding their roles and responsibilities. In other cases, they understand their duties, but simply do not or cannot fulfill them. This may be due to outdated policies and procedures, conflicting guidance, or a lack of clear decisionmaking—often with those best positioned to act lacking the authority to do so.

Some oversight reports reveal the tension between program offices that may have the policy and oversight functions but lack the authority to direct staff in the field.

OIG reports have noted this, for example, in the governance structure for VA police.[1] An OIG audit conducted in response to concerns about accountability found VA did not have adequate and coordinated governance over its police program, due in part to confusion about police program roles and authority and lack of centralized management. Governance of the police program has been divided between the Veterans Health Administration (VHA), whose medical facility directors directly supervise police assigned to their facilities, and the Office of Security and Law Enforcement (OSLE) that oversees police policy and inspections. In this structure, OSLE had the authority to inspect medical facility police programs but no authority to ensure the problems they detected were promptly fixed.

An OIG healthcare inspection described concerns with the oversight and supervision structure for military sexual trauma (MST) coordinators.[2] The VHA Office of Mental Health and Suicide Prevention oversaw and provided funding for the national MST Support Team that was tasked with facilitating communications among regional staff, MST coordinators, and other VA staff. Yet funding for MST programs at the facility level was allocated by facility leaders, resulting in MST coordinators having to compete against other medical facility needs for support. The OIG found that inadequately protected administrative time, insufficient support staff, and deficient funding were among the problems that challenged MST coordinators' ability to fulfill their responsibilities to patients. The OIG made one recommendation to the under secretary for health to evaluate the guidance and operational status and take necessary actions.

A review of the Intimate Partner Violence Assistance Program (IPVAP) revealed personnel at both the Veterans Integrated Service Network (VISN) and facility levels were confused about their roles and responsibilities, impeding the progress of this program.[3] In interviews, VISN champions expressed the need to clarify their responsibilities and those of VISN lead coordinators. Almost half of the IPVAP facility coordinators described inadequate resources to fulfill their responsibilities. Fourteen percent of IPVAP facility coordinators reported that their facilities did not implement routine screening to help detect and offer services and supports to patients who might be subjected to intimate partner violence. Although IPVAP facility coordinators are identified as responsible for program evaluation, the OIG found that VHA had not established standardized program evaluation methods or measures.

Confusion over roles and decisionmaking that is not fully informed can affect patient care and business operations on even the most routine operations. The OIG review on the cause of a backlog of mail at the Atlanta VA Health Care System (HCS) in Decatur, Georgia, revealed that the HCS and VHA's Payment Operations and Management (POM) office mismanaged incoming mail from November 2020 to September 2021, causing a backlog of more than 17,000 mailed items.[4] The mail included veterans' medical records, claims for payment from veterans and community care providers, and checks totaling nearly $207,000. The cause was traced to a verbal agreement that transferred POM's responsibility for mail management to HCS personnel, without engaging HCS staff expected to take on this work. HCS leaders lacked a clear understanding of the additional workload they assumed and did not ensure enough staff were adequately prepared for managing the influx of mail. POM officials were later reluctant to help, citing the transfer of their responsibilities in a verbal agreement. VA concurred with the OIG's five recommendations, including one recommendation focused on addressing all negative consequences, but that recommendation remains open.

Similarly, OIG reports on Veteran Benefits Administration (VBA) claims-processing deficiencies identified the tension and disconnect between VBA's Office of Field Operations (OFO) and Compensation Service office. OFO manages the employees who process veterans' claims, sets production goals, and oversees personnel management. Compensation Service provides the "how to" guidance, training, and quality assurance checks. The disconnect between the two offices is illustrated through the deficiencies involving MST-related claims processing. The OIG issued two reports on the processing of MST claims, one in 2018 and a follow-up in 2021, which actually showed an increase in incorrect claims processing following the inef-

[1] VA OIG, Inadequate Governance of the VA Police Program at Medical Facilities, December 13, 2018; VA OIG, VA Police Information Management System Needs Improvement, June 17, 2020.

[2] VA OIG, Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations, August 5, 2021.

[3] VA OIG, Intimate Partner Violence Assistance Program Implementation Status and Barriers to Compliance, September 28, 2022. VA has divided the country into 18 regional systems of care referred to as Veterans Integrated Services Networks. See www.va.gov/HEALTH/visns.asp.

[4] VA OIG, Atlanta VA Health Care System's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims, April 27, 2022.

fective implementation of OIG recommendations.[5] In the follow-up report, the OIG found that the Compensation Service and OFO did not communicate effectively to resolve claims-processing problems identified in 2018 and managers and claims processors were not being held accountable for adhering to updated VBA policies and procedures. Communication and cooperation between these offices is crucial to successfully overseeing the processing of claims, and the OIG recommended that VBA develop, implement, and monitor a written plan that requires these two offices to strengthen communication, oversight, and accountability.

The OIG report, *Improvements Needed to Ensure Final Disposition of Unclaimed Veterans' Remains*, demonstrates the repercussions of having 27 program offices with responsibilities related to unclaimed remains.[6] This led to inadequate and ineffective administration and oversight of benefits and services by VHA, VBA, and the National Cemetery Administration. The OIG team obtained more than 9,000 records from a Department of Justice database and found more than 400 matches of individuals whose remains were unclaimed that appeared to be veterans based on a search of full names and dates of birth and death.[7] Additionally, the team identified multiple instances of individuals who may be veterans interred in mass graves as well as those with final interments delayed as long as 44 years. There were three key areas in which VA governance of benefits and services for deceased veterans whose remains are unclaimed was not effective: (1) insufficient outreach to funeral homes and other custodians of unclaimed remains and collaboration with external entities to locate deceased veterans and facilitate their burials; (2) a financial oversight structure that did not support cross-administration or VA-wide reconciliation of payments made for these deceased veterans; and (3) inadequate oversight across and within VA's three administrations.

The problematic decentralized nature of governance is also seen in VA's financial management structure. Under the Chief Financial Officer (CFO) Act, the VA CFO has the responsibility for establishing financial policy, systems, and operating procedures for all VA financial entities. VA administrations and other offices are responsible for implementing those policies and producing financial information, but they are not under the supervision of the VA CFO. This fragmented structure has been a consistent concern and finding in the audit of VA's consolidated financial statements.[8] Without active involvement from VA's senior leaders to overcome organizational silos and ensure collaboration, problems at the administration level may not be elevated for resolution.

Adequate and Qualified Staff

VA faces high vacancy rates across its programs and operations, especially within VHA. These long-standing shortages of qualified personnel make it difficult for VA to carry out its many goals and functions, impeding its ability to serve the Nation's veterans. Having the right people in the right positions committed to doing the right thing is essential to building a culture of accountability.

To address these staffing shortages, VA has engaged in surge hiring and other recruitment strategies under their expanded authority. While expedient hiring is critical, VA cannot lower its standards for suitability and expertise. A report released last week focuses on suitability (background) checks. It was prompted in part by the recognition that nursing assistant Reta Mays, convicted for murdering seven patients in a West Virginia VA medical center, had not undergone a timely background check that might have prevented her from attaining her position.[9] In the course of auditing the personnel suitability process across all VA medical facilities, the OIG detected problems with how this process was being conducted at the VA medical center in Beckley, West Virginia. In addition to finding that suitability personnel support was significantly understaffed at Beckley, the review of the facility revealed a need to tighten controls for ensuring individuals are suited for their positions. Thankfully, no patient harm was detected and all affected personnel had ei-

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[5] VA OIG, Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma, August 21, 2018; VA OIG,Improvements Still Needed in Processing Military Sexual Trauma Claims, August 5, 2021.

[6] VA OIG, Improvements Needed to Ensure Final Disposition of Unclaimed Veterans' Remains, December 15, 2021.

[7] The National Missing and Unidentified Persons System (NamUs) is the Department of Justice data base used. The review team referred all NamUs-matched records to VA for follow-up to conclusively identify veterans and eligible dependents, which may require coordination with the medical examiner, coroner, or law enforcement agency that has custody of the remains.

[8] VA OIG, Audit of VA's Financial Statement for Fiscal Years 2022 and 2021, December 7, 2022.

[9] VA OIG, Personnel Suitability Process Concerns at the Beckley VA Medical Center in West Virginia, February 23, 2023.

ther left VA or were successfully cleared. Making certain that staff are and remain competent to do their jobs is central to the quality assurance issues discussed below as well.

As for persistent shortages, VA is not alone. Medical systems across the country are facing challenges in finding and retaining qualified personnel. The OIG is required by law to conduct an annual review to identify clinical and nonclinical VHA occupations with the largest staffing shortages within each VHA medical center.[10] In the Fiscal Year 2022 review, the OIG found that all 139 VHA facilities that were surveyed reported at least one severe occupational staffing shortage.[11] The total number of their reported severe shortages was 2,622. Twenty-two occupations were identified as a severe occupational staffing shortage by at least one in five facilities, including the medical officer and nurse occupations, which have been reported as severe shortages every year since 2014. Practical nurse positions were the most frequently identified "clinical severe occupational staffing shortage" in Fiscal Year 2022 (62 percent of facilities), with custodial worker and medical support assistance positions being the most frequently reported nonclinical and "Hybrid Title 38" shortages, respectively.[12] The total number of severe occupational staffing shortages increased by 22 percent from the prior year. This was also the first Fiscal Year that facilities identified more than 90 occupations as severe shortages.

In a recent inspection, the OIG found that inadequate staffing within the Martinsburg, West Virginia, VA medical center's Care in the Community (CITC) Service led to delays in scheduling community consults (referrals).[13] Sixty-two percent of the COVID Priority 1 cardiology consults during a one-year period were scheduled more than 30 days beyond the clinically indicated date, which is the date the patient needs to be seen based on their clinical status. To meet workload demands, the CITC Service at the facility needed a minimum of 23 schedulers and 11 clinical employees. At the time of the inspection, they had only 10 scheduling and four clinical staff, with facility leaders reporting significant staff turnover and a lack of training as contributing factors.

In another recent report, the OIG team focused on VA's accountability for the physical security of its medical facilities.[14] The report identified multiple security vulnerabilities and deficiencies at the time of the review, most notably staffing shortages that contributed to the lack of a visible and active police presence.[15] To meet VA's established security requirements, facilities need to fill police officer vacancies to correct security weaknesses. Other measures facilities can take to improve campus security include increasing security personnel resources, such as suitable police operations rooms; operable surveillance cameras with consistent monitoring; and adequate equipment. Moreover, the report found that facilities need to do a better job securing doors and restricting public access to high-risk areas. VA concurred with the OIG's six recommendations, which included delegating a responsible official to monitor and report monthly on facilities' security-related vacancies; authorizing sufficient staff to inspect VA police forces; and ensuring medical facility directors appropriately assess VA police staffing needs, authorize associated positions, and leverage available mechanisms to fill vacancies.

In addition to addressing staffing shortages, VA should also make sure that its existing personnel are equipped and prepared to do their jobs. The OIG recently reviewed whether staff at VBA were correctly following procedures when requesting medical opinions, a process that is vital to ensuring veterans receive the benefits to which they are entitled.[16] The review found that claims processors did not consistently identify relevant medical evidence for the examiner's review, did not always use clear and accurate language, did not regularly request all warranted med-

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[10] VA Choice and Quality Employment Act, Pub. L. No. 115–46, 131 Stat. 958 (2017).

[11] VA OIG, OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2022, July 7, 2022.

[12] In 2003, Public Law 108–170 provided for 21 Title 5 occupations to be converted to "Hybrid" 38 positions, including psychologists, respiratory and physical therapists, and medical technologists. This conversion provided greater benefits related to appointment, advancement, and some pay matters, while retaining some traditional Title 5 employment provisions, including performance appraisals, leave, work schedule, and retirement benefits. See 38 U.S.C. §§ 7403 and 7405.

[13] VA OIG, Care in the Community Consult Management During the COVID–19 Pandemic at the Martinsburg VA Medical Center in West Virginia, February 16, 2022.

[14] VA OIG, Security and Incident Preparedness at VA Medical Facilities, February 22, 2023.

[15] Police staffing shortages have remained in the top 10 most frequently reported positions with severe shortages annually in the OIG's annual survey of occupational shortages. VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2022*.

[16] VA OIG, VBA Could Improve the Accuracy and Completeness of Medical Opinion Requests for Veterans' Disability Benefits Claims, September 7, 2022.

ical opinions, and sometimes requested unnecessary medical opinions. One contributing factor to these issues was inadequate training. The mandatory training for claims processers on making medical opinion requests did not explain how to correctly complete the requests using VBA's electronic systems, including what information to input in particular fields. The training also did not describe what constitutes relevant evidence for a medical examiner's review or provide examples of what language should be used to ensure requests are adequate and well written. These failings can lead to inaccurate medical opinions, incorrect decisions on veterans' claims, delayed decisions for veterans, as well as an inefficient use of resources (such as when the medical opinion requires rework).

Modernizing IT Systems and Business Processes

VA is in the process of modernizing a number of significant systems that are critical to its operations. The OIG has been proactively overseeing VA's implementation of these crucial systems. However, as the OIG has detailed in multiple reports, VA has had significant troubles with upgrading or replacing key systems that support patient care, supply management, benefits to veterans and their families, and the stewardship of taxpayer dollars. These issues must be resolved for VA to remain accountable for the care, services, and benefits it provides. VA's process for replacing crucial IT systems, however, faces significant ongoing challenges. Major plans to modernize electronic health records, supply chain management, claims processing, and financial management systems have been marked by critical missteps. These have typically included weaknesses in planning, lack of stability in leadership positions, insufficient stakeholder engagement, failures to promptly fix known issues, and program management or coordination deficiencies. The OIG recognizes the tremendous complexity and cost of these efforts and continues to provide recommendations that are as practical and actionable as possible to support VA personnel working tirelessly to ensure patient safety and to deliver benefits and services to eligible veterans.

Perhaps the largest contract in VA history, and one that affects patient care, is VA's Electronic Health Record Modernization (EHRM) program. Key objectives of the new system include achieving interoperability of VA and DoD systems to provide complete health records for veterans and enhancing the ability to exchange records with external healthcare providers.[17] Essential to implementing and budgeting this multibillion-dollar effort, VA needs a high-quality, reliable, integrated master schedule to ensure all tasks are properly and fully completed and accounted. An OIG audit found, however, that this foundational master schedule had significant reliability weaknesses, including missing tasks, no baseline schedule, and no risk analyses.[18] Without remediation, VA cannot offer reliable assurances on timelines and costs. Further, the OIG has estimated that any delay in the program's completion would cost about $1.95 billion a year.

Overall, the OIG has released 14 reports on VA's rollout of the new electronic health record system that identify critical missteps and lack of remediation. Of the 68 recommendations issued to date, 24 have not yet been implemented—with 12 open for more than a year and two open nearly three years. The open recommendations include VA minimizing the number of required mitigation strategies healthcare providers must use when the system goes live, determining if veterans' appointments are being scheduled correctly, and addressing unresolved issues related to medication management and care coordination. These reports have also been highlighted in seven congressional hearings in which the OIG testified.[19] Unless VA more effectively engages and coordinates all affected offices and contractors, IT solutions will continue to be delayed, more cost overruns will occur, and the risk to patients and VA operations will increase.

Although VA paused its EHRM rollout in June 2022, users of the new system continue to raise troubling complaints that the system hinders the delivery of prompt, high-quality patient care. The effects on staff, workload, and the risks for errors are also concerning. The OIG is continuing its oversight, including an examination of system degradations and outages.

Similarly, there are other key systems essential to maintaining effective and efficient VA operations in other areas that are also in critical need of updates or re-

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[17] VA OIG and DoD OIG, Joint Audit of the Department of Defense and the Department of Veterans Affairs Efforts to Achieve Electronic Health Record System Interoperability, May 5, 2022.

[18] VA OIG, The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule, April 25, 2022.

[19] Prior EHRM congressional statements can be found at www.va.gov/oig/publications/statements.asp.

placement. In March 2019, VA decided to modernize and standardize its supply chain management, replacing up to 12 legacy systems with a system already in use at DoD—the Defense Medical Logistics Standard Support (DMLSS) system. The OIG reviewed VA's oversight and coordination of the system's implementation at the pilot site to identify challenges that could affect supplies getting to where and when they are needed and to inform future deployments.[20] The OIG found that the system did not meet more than 40 percent of the high-priority essential business requirements identified by VA medical facility staff at the pilot site. This occurred because the VA Logistics Redesign (VALOR) program manager did not follow VA's acquisition framework as required. After months of trying to determine the way ahead, VA announced in December 2022 that it will not deploy the DMLSS multibillion-dollar supply chain management system across the department's health and medical services.[21] In considering next steps, supply chain modernization is not just about the system; it is about the people, processes, and technology limitations. Without clear roles and responsibilities, business requirements, and effective tools, VA will struggle to achieve accountability for its multibillion-dollar logistics portfolio.

Making sure veterans are promptly and accurately provided benefits is one of VA's most important responsibilities, yet it is often hindered by outdated IT systems and unclear or complex business processes. For example, VA improperly created debts in veterans' accounts when reducing disability levels. In a national review of the issue, the OIG found instances in which VA employees retroactively reduced disability levels and erroneously created debts without always informing veterans—in part due to system limitations. Based on the review of a statistical sample, the OIG estimated errors resulting in incorrectly created veteran debts totaling about $13.4 million.[22]

The OIG has also released a series of reports on GI bill benefits in response to concerns that eligible beneficiaries were not getting payments owed to them or were being underpaid.[23] Starting with an issue statement in 2019, the OIG identified delays in system modifications needed to satisfy the statutory requirements, in part due to the lack of an accountable official to oversee the project.[24] The OIG team found that approximately 10 months passed from the time Congress enacted the Forever GI Bill until VA received the initial software development release and began testing the system modifications. VA's testing of the software development release identified defects, prompting the development of additional versions. Based on interviews, when user testing occurred, there were failures related to scenarios that VBA did not account for when personnel developed the business requirements. In a recent report on the Post–9/11 GI Bill, the OIG found errors in VBA's processing of school vacation breaks due to the process being entirely manual, resulting in about $624,000 in underpayments to beneficiaries for monthly housing allowances and college funds.[25]

Another report indicated improper payments were being made to veterans who were deceased because VA needed to better monitor its death match records automated process, and VBA missed opportunities to discontinue payments by not coordinating with and obtaining data from VHA.[26] In one case, payments continued to be improperly paid to a veteran who was deceased for a total of about $99,000.[27]

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[20] VA OIG, DMLSS Supply Chain Management System Deployed with Operations Gaps That Risk National Delays, November 10, 2021.

[21] Edward Graham, "VA Cancels Future Deployments of New Supply Chain Management System," Nextgov, December, 13, 2022, https://www.nextgov.com/technology-news/2022/12/va-cancels-future-deployments-new-supply chain-management-system/380841/. The article states that the decision to abandon DMLSS deployment followed the OIG report findings.

[22] VA OIG, VBA Improperly Created Debts When Reducing Veterans' Disability Levels, July 28, 2022.

[23] VA OIG, Forever GI Bill: Early Implementation Challenges, March 20, 2019; VA OIG, Controls Appear to Have Addressed Prior Overpayments of Post–9/11 GI Bill Monthly Housing Allowance, June 23, 2020; VA OIG Management Advisory Memorandum, Post–9/11 GI Bill Non-College Degree Entitlement Calculations Lead to Differences in Housing Allowance Payments, January 19, 2021; VA OIG, Processing of Post–9/11 GI Bill School Vacation Breaks Affects Beneficiary Payments and Entitlement, May 3, 2022.

[24] VA OIG, *Forever GI Bill: Early Implementation Challenges*.

[25] VA OIG, *Processing of Post–9/11 GI Bill School Vacation Breaks Affects Beneficiary Payments and Entitlement*.

[26] VA OIG, *Additional Actions Can Help Prevent Benefits Payments from Being Sent to Deceased Veterans*, April 21, 2022.

[27] In a recent OIG criminal investigation, the daughter of a deceased widow who had been receiving VA survivors benefits continued to receive those benefits even after her mother passed by forging her mother's signature and fraudulently filing VA paperwork to make it appear as if her mother was still alive. The daughter was ordered to pay restitution of almost $462,000. VA OIG, *Monthly Highlights*, January 2023.

An automated system also was to blame for improper processing of pension reductions as detailed in a 2021 report, leading to veterans not being notified that their benefits were being reduced or given the information necessary to appeal those reductions. All of the estimated 13,100 cases contained notification errors that made it difficult for beneficiaries to determine what action they should take, such as submitting evidence that the benefit should not be reduced or requesting a hearing. Errors identified were the result of inadequate planning and implementation of the automated pension reduction process.[28]

VA has also been struggling since the early 2000's to replace its financial management system. After several failed attempts in 2004 and 2010, VA used the lessons learned and established the Financial Management Business Transformation (FMBT) program. The program's mission is to increase the transparency, accuracy, timeliness, and reliability of financial information across VA, ultimately resulting in improved care and services for veterans and accountability to taxpayers. Central to the FMBT program's modernization efforts is the multiyear, phased deployment of the Integrated Financial and Acquisition Management System (iFAMS) beginning with NCA. In September 2021, the OIG issued a management advisory memorandum on inadequate business intelligence reporting capabilities in iFAMS that hindered NCA's ability to easily monitor its budget and operations.[29] In June 2022, the OIG issued another memorandum on the results of a consulting engagement related to financial reporting controls for iFAMS at NCA.[30] This memorandum identified risks that could lead to inaccurate financial reporting, including interface errors, more manual data entry, and the lack of automated controls. VA is currently reviewing a draft report related to the deployment of iFAMS at NCA that discusses issues that should be addressed as VA moves forward with further deployment of iFAMS.

Quality Assurance, Monitoring, and Reviews

VA often lacks controls that effectively and consistently ensure quality standards are met. Routine monitoring breakdowns and workarounds undermine efforts to ensure eligible veterans and their families receive timely quality services and benefits. Failures in quality assurance and monitoring relate not just to systems and processes, but to personnel as well—particularly in areas such as credentialing, privileging, and monitoring of healthcare personnel entrusted with veterans' care.

VBA and VHA programs have various types of quality assurance programs; however, they are not consistently and effectively implemented and the results are not always clearly communicated or resolved. Among the many reports the OIG has published, a series of four focused reports and a roll-up report have been released on VBA's multifaceted quality assurance program.[31] The program is managed by VBA's Compensation Service but VBA's OFO is responsible for ensuring regional office employees adequately address claims-processing deficiencies routinely identified by the quality assurance program. The individual reports on elements of the quality assurance program identified weaknesses in the program, and the summary report identified systemic weaknesses in OFO's oversight and accountability. Two aspects of the quality assurance program are the STAR Program and the Quality Review Team Program. However, OIG staff have observed those programs focus on an *overall* statistical sample of completed disability compensation claims. That means that complex claims, such as claims for military sexual trauma and ALS (Lou Gehrig's disease), are not the focus of the sample. Processing deficiencies related specifically to these complex claims may go undetected if they are simply grouped with claims at lower risk for error. Without more focused sampling, quality assurance results provide incomplete information to VBA on how well staff are processing claims more vulnerable to error.

One of the OIG's reports on VBA's quality assurance program examined VBA's site visit program of regional benefits offices, which is designed to not only correct

[28] VA OIG, *Improper Processing of Automated Pension Reductions Based on Social Security Cost of Living Adjustments*, October 28, 2021.

[29] VA OIG, *Inadequate Business Intelligence Reporting Capabilities in the Integrated Financial and Acquisition Management System*, September 8, 2021.

[30] VA OIG, *Results of Consulting Engagement Related to Selected Financial Reporting Controls for the Integrated Financial and Acquisition Management System at the National Cemetery Administration*, June 15, 2022.

[31] VA OIG, *The STAR Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies*, July 22, 2020; VA OIG, *Deficiencies in the Quality Review Team Program*, July 22, 2020; VA OIG, *Site Visit Program Can Do More to Improve nationwide Claims Processing*, August 18, 2020; VA OIG, *Greater Consistency Study Participation and Use of Results Could Improve Claims Processing nationwide*, September 29, 2020; VA OIG, *The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings*, May 18, 2021.

deficiencies at individual regional offices, but also to identify error trends across multiple regions that could be used to drive nationwide improvements in claims processing. The OIG reviewed the site visit reports for 47 regional offices and found that almost 50 percent had deficient workload management plans, 36 percent had no plans at all to clear the backlog of errors pending correction identified by quality review teams, and 23 percent were deficient in MST claims processing.[32] While the site visit program identified these and other frequently recurring deficiencies, OFO did not require all offices across the country to apply the information to ensure widespread improvements. As a result, VBA missed opportunities to provide impactful oversight and drive positive change, which could ultimately improve the accuracy and consistency of veterans' disability benefit decisions. Until VBA leaders ensure improvements are made, veterans may not get the benefits to which they are entitled.

VA has identified patient safety as a top priority.[33] Healthcare facilities committed to patient safety routinely follow protocols that prioritize high-quality care and have a structured and proactive quality and safety management oversight team. OIG reports, however, routinely identify instances in which staff fail to adhere to policy or to take actions that ensure a culture of patient safety. For example, a recent OIG report found that the Tuscaloosa VA Medical Center and VISN 7 had insufficient oversight of the facility's Patient Safety Program.[34] The OIG received a VHA Issue Brief identifying concerns with the program's management not completing the required patient safety root cause analyses and risk assessments, and the former Patient Safety Manager (PSM) not attending meetings with facility and VISN committees. These concerns followed the extended leave and abrupt retirement of the former PSM. The OIG substantiated the concerns and identified other issues with program oversight and the facility's culture of safety. According to the report, the facility and VISN leaders did not take appropriate action. Facility leaders failed to fully engage with Patient Safety Program staff and did not sufficiently use available tools to assess and evaluate reported concerns related to patient safety, putting patients at unnecessary risk.

Ensuring high-quality patient care was also identified in a report on the Columbia VA Health Care System in South Carolina.[35] That report focused on adverse clinical outcomes for three patients. While reviewing the allegations related to those patients, the OIG found weaknesses in the peer review and quality management processes. The peer reviews and the peer review committee practices were inefficient and there was a delay in the initiation of an institutional disclosure to the patient's family and completion of a root cause analysis of the problem. All seven of the report's recommendations remain open, including three focused on the facility's quality management program.

Proper documentation practices are an important aspect of accountability in both benefits and healthcare settings. Those practices help VA and oversight entities ensure that policies and requirements are being met. In healthcare settings, proper documentation is especially critical as it communicates to members of an integrated healthcare team critical data that are necessary to ensure coordination and collaboration. For example, in an inspection of the VA Pittsburgh Healthcare System, the OIG found that failures in completing a thorough assessment and documentation may have contributed to a lack of appropriate intervention and ultimately an adverse clinical outcome for a patient.[36] A behavioral health nurse practitioner did not document a comprehensive suicide risk assessment for eight patients, even though this was required based on their positive screen for suicidal ideation. The nurse practitioner also failed to consistently document intent, risk and protective factors, and a mitigation plan for the patients. The OIG also found that a nurse manager who was responsible for conducting ongoing professional practice evaluations (OPPE) had given this nurse practitioner a "satisfactory" rating for the "safety plan completion for high risk for suicide patients" and "copy and paste use" elements—even though the nurse manager admitted to not reviewing these elements of documentation. In fact, the inspection team found that the nurse practitioner not only

[32] VA OIG, *Site Visit Program Can Do More to Improve nationwide Claims Processing*.
[33] See, e.g., VA, "Patient safety a primary concern at VA," March 15, 2021, https://news.va.gov/85809/patient-safety-primary-concern-va/, and "VHA National Center for Patient Safety" (web page), VA, *https://www.patientsafety.va.gov/about/approach.asp*.
[34] VA OIG, *Deficiencies in the Patient Safety Program and Oversight Provided by Facility and VISN Leaders at the Tuscaloosa VA Medical Center in Alabama*, February 27, 2023.
[35] VA OIG, *Surgical Adverse Clinical Outcomes and Leaders' Responses at the Columbia VA Health Care System in South Carolina*, September 27, 2022.
[36] VA OIG, *Deficiencies in a Behavioral Health Provider's Documentation and Assessments, and Oversight of Nurse Practitioners at the VA Pittsburgh Healthcare System in Pennsylvania*, May 3, 2022.

failed to complete a safety plan for eight patients, but also inappropriately copied and pasted significant sections of notes from prior documented clinical encounters. The OIG's recommendations centered on the improvement of assessment and documentation practices, verification of the review of performance elements in OPPEs, and manager oversight of those OPPEs.

Quality controls and process monitoring must be coupled with ensuring the competency of personnel to meet the requirements of their position and their commitment to serving veterans. Delayed responses to concerns related to the competency of healthcare providers cannot only put patients at risk and compromise the trust of staff, but can negatively affect the skills and practices of the providers in question. A report on the Richard L. Roudebush medical center in Indiana highlights this issue.[37] The cardiology nursing staff had expressed multiple concerns to facility leaders regarding the skills of a newly trained interventional cardiologist. As a result, the cardiologist's cardiac catheterization laboratory privileges were suspended and a factfinding investigation was initiated. However, these actions were not completed in a timely manner. The factfinding investigation was finalized more than 3 months after the cardiologist's suspension, and it took almost another three months for the cardiologist's privileges to be reinstated so that leaders could initiate a second observed evaluation of the cardiologist's performance in the catheterization laboratory. After 6 months out of practice, the cardiologist refused to participate in a practice review and resigned. Ultimately, the OIG did not substantiate that the interventional cardiologist provided poor quality of care to patients at the facility.

Stable Leadership That Fosters Responsibility and Continuous Improvement

VA leaders at every level often do not get the information they need to make effective decisions; some fail to take necessary and prompt action, while others struggle to create a culture where every employee feels empowered to report problems. The frequent turnover in key positions or the long-term use of acting positions exacerbates these challenges.

The OIG's recent report on the mistreatment of a patient admitted to the Miles City Community Living Center (CLC), part of the VA Montana Healthcare System in Fort Harrison, describes failures in leadership that led to several incidents of patient abuse.[38] The OIG learned that nurses and a physical therapist forced a critically ill patient to walk after the patient verbally refused and lowered to the floor to further refuse participation. Staff reported the physical therapist, and a nurse forcefully lifted the patient by the arm to stand and then pulled the patient's walker forward and out of reach, compelling the patient to walk. A VA police report documented bruises to the patient's arms, and staff told the OIG that the patient sustained skin tears during this session. The OIG concluded that the physical therapist and nurses violated VHA policy by failing to respect the patient's right to refuse treatment and subjecting the patient to mistreatment during two physical therapy sessions. The OIG also determined that there were three previous investigations with confirmed findings of mistreatment or abuse in the CLC. Two nurses involved in the mistreatment of this patient were also involved in two of the other incidents, one in a 2018 incident and both in an August 2020 incident. The OIG determined that facility leaders did not complete oversight processes for the CLC, including intervening in prior findings of CLC patient mistreatment in 2018 and 2020. Facility leaders also failed to oversee the sole physician responsible for the CLC patients. The lack of oversight repeatedly placed patients at risk. With a distance of over 350 miles to the Fort Harrison facility, staff easily escaped accountability.

The Montana case is an example of a culture the OIG has found in other facilities that did not foster the prompt and candid reporting of concerns. Leaders' failures to create a culture in which personnel feel safe in reporting clinical personnel's incompetency or errors can lead to tragic outcomes. For example, in a 2021 report, the OIG detailed how Dr. Robert M. Levy, the former pathologist at the VA Health Care System of the Ozarks in Fayetteville, Arkansas, was found to have been working while impaired by substance use and misdiagnosed thousands of patients' pathological specimens. His errors resulted in some veterans not being diagnosed with cancers for which they needed prompt and tailored treatments and others undergoing interventions they did not need—some with significant side effects. In addition, in his position as chief of pathology, he was able to alter quality management

[37] VA OIG, Deficiencies in Credentialing, Privileging, and Evaluating a Cardiologist at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana, January 17, 2023.

[38] VA OIG, Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison, January 26, 2023.

documents to conceal his errors.[39] Dr. Levy was sentenced to 20 years in federal prison (including one count of involuntary manslaughter), followed by three years of supervised release, and ordered to pay $497,745 in restitution.[40] Like the Reta Mays serial murder case mentioned earlier, personnel had concerns regarding the circumstances surrounding the hypoglycemic events, but not all personnel promptly reported concerns and there were insufficient follow-up actions taken.

In a number of OIG reports, leaders' stated commitment to improvement is not reflected in closing, sustaining, or fully implementing recommendations for corrective action.[41] As stated earlier, the OIG has reviewed VBA's processing of posttraumatic stress disorder (PTSD) claims related to MST several times due to delays in implementing recommendations for improvement or sustaining those corrective actions. In August 2018, the OIG found that claims processors did not follow the proper procedures for about half of denied claims to veterans, resulting in premature denials. The OIG made six recommendations including calling for VBA to have MST claims handled by a specialized group of claims processors. In response, VBA identified a list of designated claims processors and in January 2019 established a procedure requiring that only designated employees process MST claims.[42]

However, in August 2021, the OIG concluded in a followup to the 2018 report that VBA leaders had not sustained the corrective actions.[43] About 80 percent of claims denied from October 1 through December 31, 2019, were processed by one or more VBA employees who were not designated MST claims processors. Based on a sample of claims processed after VBA acted on the prior OIG recommendations, the review team estimated about 620 of 1,100 denied claims (57 percent) were incorrectly processed, which was not an improvement from the previous error rate.

VA has a special obligation to provide veterans who are claiming benefits every opportunity to support their claims. Leadership duties do not end when the OIG closes a recommendation based on VA-provided documentation that demonstrates sufficient plans and steps have been taken to address identified issues. Leaders must instill in all VA personnel a commitment to continuous improvement, including fully addressing and sustaining corrective actions taken in response to OIG recommendations.

A lack of commitment to full transparency in reporting operational problems can also hinder OIG and other oversight. In reviewing VA's new EHR system at the Mann-Grandstaff VA Medical Center in Spokane, Washington, the OIG found that leaders in what was then the VA Office of Electronic Health Record Modernization (OEHRM) showed a careless disregard for the accuracy and completeness of the information they provided, and that those leaders' lack of due care and diligence resulted in misinformation being submitted to OIG staff.[44] The OIG recommended that the program's leaders clarify to their personnel that all staff have a right to speak directly and openly with OIG staff and ensure that direct communication with OIG staff is not impeded when needed to clarify requests or responses.[45]

Conclusion

There is no question that the overwhelming number of VA leaders and personnel are committed to serving veterans, their families, and caregivers, as well as answering the call for assistance from their local communities in times of crisis. They often have to navigate obstacles and overcome challenges to make certain that patients receive prompt high-quality care and that veterans and other eligible beneficiaries receive the compensation and services they are owed. Unfortunately, the OIG has found that VA has struggled with the foundations of accountability, including strong governance and clarity of roles and responsibilities; adequate and qualified staffing; updated IT systems and effectual business processes; effective quality assurance and monitoring; and stable leadership that fosters responsibility for actions and contin-

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[39] VA OIG, Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas, June 2, 2021.

[40] US Department of Justice, "Fayetteville Doctor Sentenced to 20 Years in Federal Prison for Mail Fraud and Involuntary Manslaughter," January 22, 2021, www.justice.gov/usao-wdar/pr/fayetteville-doctor-sentenced–20-years-Federal-prison-mail-fraud-and-involuntary.

[41] See, e.g., VA OIG, *Follow-Up Review of the Accuracy of Special Monthly Compensation Housebound Benefits*, December 15, 2021.

[42] VA OIG, *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma*.

[43] VAOIG, *Improvements Still Needed in Processing Military Sexual Trauma Claims*.

[44] VA OIG, *Training Deficiencies with VA's New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, July 8, 2021. In December 2021, OEHRM was restructured to form the Electronic Health Record Modernization Integration Office (EHRM IO).

[45] VA OIG, *Senior Staff Gave Inaccurate Information to OIG Reviewers of Electronic Health Record Training*, July 14, 2022.

uous improvement. Without a greater emphasis on these areas of accountability, VA will not always provide the highest-quality care, benefits, and services to veterans and their families.

Prepared Statement of Gene Dodaro

United States Government Accountability Office

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VETERANS AFFAIRS

Addressing Longstanding Management Challenges Requires Sustained Leadership

Statement of Gene L. Dodaro,
Comptroller General of the United States

GAO-23-106636

February 28, 2023

GAO Highlights

Highlights of GAO-23-106636, a testimony before the Committee on Veterans' Affairs, House of Representatives

VETERANS AFFAIRS

Addressing Longstanding Management Challenges Requires Sustained Leadership

Why GAO Did This Study

VA is responsible for providing benefits to veterans and their families. This includes disability compensation and health care. VA operates one of the largest health care delivery systems in the nation.

Over the last decade, GAO has identified significant challenges in VA's leadership and operations, including health care, acquisitions, disability programs, and cybersecurity. These longstanding challenges can affect VA's current efforts to provide timely access to high quality care and benefits. They can also impede its capacity to take on new responsibilities for the recent expansion of benefits for those exposed to toxins.

This testimony summarizes the longstanding management challenges at VA that GAO has identified, including those about (1) health care, (2) acquisition management, (3) disability benefits, and (4) privacy and cybersecurity. This testimony also highlights the recommendations GAO has made to VA to improve these issues. It is based on findings from prior reports from 2012 to 2023.

Since 2000, GAO has made 1,519 recommendations to VA. VA has implemented many of those. As of February 2023, 220 remain to be addressed; 19 of these GAO considers high priority.

View GAO-23-106636. For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov for VA health care issues; Shelby S. Oakley at (202) 512-4841 or oakleys@gao.gov for VA acquisition management issues; Elizabeth A. Curda at (202) 512-7215 or curdae@gao.gov for disability benefit issues; Jennifer Franks at (404) 679-1831 or franksj@gao.gov for privacy and cybersecurity issues; and Thomas Costa at (202) 512-7215 or costat@gao.gov for VA sexual harassment and racial discrimination issues.

What GAO Found

The Department of Veterans Affairs (VA) has faced growing demand for its health care services. In fiscal year 2023, VA received a total budget of $303.2 billion. This includes the largest discretionary budget in its history, $134.7 billion, about $22.5 billion higher than in fiscal year 2022.

Over the past several years, GAO added VA health care; VA acquisition management; federal disability programs, including VA disability compensation; and government-wide cybersecurity to GAO's High Risk List. This list identifies areas that are most vulnerable to fraud, waste, abuse, or mismanagement, or are in need of transformation. VA has made marked progress recently in addressing these high-risk issues, such as by identifying root causes of the deficiencies and establishing action plans to address them. However, these are only the initial steps of the long-term commitment required to achieve transformational change.

VA health care. The total number of veterans enrolled in VA's health care system increased from 7.9 million to about 9.2 million from fiscal year 2006 through fiscal year 2022. GAO has identified challenges related to VA's management and oversight of its health care system, including

- Ensuring veterans' health care appointments are scheduled in a timely manner.
- Having complete information to determine if it has an adequate number of health care providers to meet veterans' needs.
- Effectively identifying and meeting the demand for mental health and other behavioral health services among veterans.
- Ensuring timely implementation while addressing data quality issues as it works to modernize its electronic health record system.

VA acquisition management. VA obligated about $56 billion for goods and services in fiscal year 2022. GAO has identified challenges in VA's acquisition programs such as VA's development of adequate strategies and policies, as well as its management of its supply chain and its acquisition workforce.

VA disability programs. As one of the largest disability compensation programs in the nation, VA provided over $112 billion in compensation to approximately 5.6 million veterans and their families in fiscal year 2021. GAO has identified challenges within these compensation programs, including overseeing the medical exams needed to make decisions about disability claims.

VA cybersecurity and privacy. Vulnerabilities arising from VA's increased dependence on information technology can result in the compromise of sensitive personal information, such as inappropriate use or disclosure. The VA Office of Inspector General identified significant deficiencies in VA's efforts to implement an agency-wide information security program that met the requirements of the Federal Information Security Modernization Act of 2014.

Addressing each of these longstanding challenges requires sustained leadership and would help ensure veterans receive the care and benefits they deserve.

Chairman Bost, Ranking Member Takano, and Members of the Committee:

I appreciate the opportunity to be here today to discuss the Department of Veterans Affairs' (VA) management challenges. VA is responsible for providing benefits to veterans, including health care and disability compensation. In fiscal year 2023, VA received a total budget of $303.2 billion. This includes the largest discretionary budget in VA's history—$134.7 billion, about $22.5 billion higher than in 2022.[1]

We, along with VA's Inspector General, continue to identify significant deficiencies in VA's leadership oversight and operations—all of which can affect health care and benefit programs for the nation's veterans.[2] Since 2000, we have made 1,519 recommendations to VA. These include recommendations to improve VA's management and oversight of the health care services, disability programs, acquisition programs, and privacy and cybersecurity. VA has implemented many of these recommendations; however, 220 recommendations have not been implemented as of February 2023, including 19 recommendations that we deem the highest priority for implementation.[3] Fully addressing these open recommendations could significantly improve VA operations.

Given the scope of VA's responsibility to serve veterans, effectively addressing its management challenges will require sustained commitment from VA leadership. The agency also needs to improve its ability to ensure that it has the appropriate capacity and structures in place to take

[1]The majority of VA's discretionary budget goes toward medical care. VA's fiscal year 2023 budget also included $168.5 billion in mandatory funding, mostly for disability compensation and pensions.

[2]See GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, GAO-21-119SP (Washington, D.C.: Mar. 2, 2021). See also Department of Veterans Affairs Office of Inspector General, *Fiscal Year 2022 VA Inspector General's Report on VA's Management and Performance Challenges.* The VA Inspector General identified its top management and performance challenges as health care services, benefits, stewardship of federal dollars, information systems and innovation, and leadership and governance.

[3]GAO, *Priority Open Recommendations: Department of Veterans Affairs,* GAO-22-105630 (June 30, 2022). Priority recommendations are those that GAO believes warrant priority attention from heads of key departments or agencies. They are highlighted because, upon implementation, they may significantly improve government operation, for example, by realizing large dollar savings; eliminating mismanagement, fraud, and abuse; or making progress toward addressing a high-risk or duplication issue.

on new responsibilities in a timely manner. For example, VA has faced management challenges in estimating resources needed to provide community care, which is intended to ensure veterans have timely access to health care services delivered by non-VA providers. In fiscal years 2017 and 2018, the obligations for VA's community care programs were $1.2 billion and $2.2 billion higher than VA originally estimated, respectively, forcing VA to seek additional funding to make up the shortfall.[4]

VA also faces well-known challenges with its disability compensation program, its information technology modernization initiatives, and privacy and cybersecurity. These challenges raise questions about VA's ability to effectively meet the needs of a significant number of veterans seeking health care and disability benefits, an increase driven in part by the Honoring our PACT Act of 2022 (PACT Act).[5] According to VA, the PACT Act is the most significant expansion of veteran benefits and care in more than three decades. Since VA has not adequately addressed well-known challenges in processing disability claims and updating information in its eligibility criteria that we have reported on since 2003, the department is not as well-positioned as possible to respond to an increase in veterans seeking health care services and other benefits. Additionally, VA has undertaken a number of major modernization initiatives—such as acquisition and implementation of its new electronic health record and key financial management systems—but faces delays in the implementation of these efforts. VA also faces challenges safeguarding its information systems and information obtained from veterans receiving VA health care and benefits.

To draw sustained attention to these challenges, we have added VA health care; VA acquisition management; federal disability programs, including VA disability compensation; and government-wide cybersecurity to our High-Risk List. This list focuses attention on government operations

[4]An obligation is "a definite commitment that creates a legal liability of the government for the payment of goods and services ordered or received, or a legal duty on the part of the United States that could mature into a legal liability by virtue of actions on the part of the other party beyond the control of the United States." See GAO, *A Glossary of Terms Used in the Federal Budget Process*, GAO-05-734SP (Washington, D.C.: Sept. 1, 2005).

[5]Pub. L. No. 117-168, 136 Stat. 1759 (2022). The PACT Act changes certain disability compensation examination requirements and expands presumptive conditions associated with exposure to burn pits and other toxins, among other things, resulting in a potential increase in eligibility for certain health care and benefits.

that are most vulnerable to fraud, waste, abuse, or mismanagement, or are in need of transformation.

VA has made marked progress recently in addressing these high-risk issues, such as by identifying root causes of the deficiencies and establishing action plans to address them. However, these are only the initial steps of the long-term commitment required to achieve transformational change.

In March 2022, we reported on key practices needed to successfully address high-risk programs based, in part, on the experiences of the 27 high-risk areas that have been removed from the list since its inception in 1990.[6] Office of Management and Budget engagement and federal agencies' sustained leadership, planning, and execution were keys to success. In addition, Congressional action, oversight, and attention were not only critical factors in the success of areas that were removed but also in the progress we have observed in other high-risk areas that remain on the list. These factors will be critical in addressing the longstanding management challenges we have identified as high risk at VA. We will issue our High-Risk List update in spring 2023.

My statement today focuses on VA's longstanding management challenges we have identified and recommendations made in the following major areas:

1. health care,
2. acquisition management,
3. disability benefits, and
4. privacy and cybersecurity.

We also discuss other challenges VA faces.

This statement is based on our body of work that spans more than a decade. More detailed information on the scope and methodology of our prior work can be found within the specific reports on which this statement

[6]See *High-Risk Series: Key Practices to Successfully Address High-Risk Areas and Remove Them from the List*, GAO-22-105184 (Washington, D.C.: Mar. 3, 2022).

See GAO's High-Risk List for more information.

is based. Some of these reports are listed in the related products page at the end of this statement.

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

VA Health Care

VA operates one of the largest health care delivery systems in the nation through its Veterans Health Administration (VHA). It entails 172 medical centers and more than 1,000 outpatient facilities organized into regional networks. VA also provides care through community providers when veterans face challenges accessing care at VA medical centers. VA has faced growing demand by veterans for its health care services, with the total number of veterans enrolled in VA's health care system rising from 7.9 million to about 9.2 million from fiscal year 2006 through fiscal year 2022. In fiscal year 2023, VHA received $119.6 billion of VA's $134.7 billion discretionary budget, about $21.7 billion higher than in fiscal year 2022.

Our work has continued to identify challenges related to VA's management and oversight of its health care system. We added VA health care to our High-Risk List in 2015 due to the challenges we identified with VA's ability to provide timely, cost-effective, and quality care. To address these challenges, VA developed and continues to refine an action plan that identified root causes of the issues, corrective actions, and metrics intended to track progress. Installing a Senate-confirmed Under Secretary for Health for the first time in 5 years, as of July 2022, helps to ensure improvements in VA's oversight and accountability for health care provided to veterans. VA has also benefitted from relative leadership stability in the Chief Information Officer, a Senate-confirmed position, for the last 4 years.

Access to care. VA has faced challenges ensuring that veterans have consistent and timely access to health care services and providers. In 2018, Congress took steps to expand the ability for eligible veterans to receive care from community providers, such as when they cannot access care in a timely manner from a VHA facility. However, we and the VA Office of Inspector General have identified ongoing challenges related

to veterans' access to care.[7] This includes VA's (1) inability to effectively monitor wait times for appointments; (2) inadequate networks of providers; and (3) challenges ensuring providers are qualified to provide veterans care. Examples follow.

Appointment scheduling and wait times. VA considers a key component of access to be the time it takes veterans to receive care at VHA facilities or in the community. Over the last decade, we have made a number of recommendations for VA to improve its appointment scheduling process for both VHA facility and community care, including to establish timeliness standards (time frame within which a veteran's appointment should occur) and metrics to measure whether VA is meeting these standards.

In June 2018 we recommended (and VA concurred) that VA establish a community care scheduling process with time frames within which veterans' (1) referrals must be processed, (2) appointments must be scheduled, and (3) appointments must occur.[8] Although VA implemented the first two components of our recommendation, the agency has not established a timeliness standard within which veterans' appointments must occur. As a result, our recommendation related to community care appointments has not yet been fully implemented. In January 2023, we similarly recommended (and VA concurred) that VA develop a timeliness standard for appointments to occur at VHA facilities to help ensure that veterans receive timely access to care, regardless of the source of care. This recommendation has not been implemented.[9]

Also, in 2012 we recommended (and VA concurred) that VA take actions to improve the reliability of wait time measures for appointments at VHA

[7]For example, see GAO, *Veterans Health Care: VA Needs to Address Challenges as It Implements the Veterans Community Care Program*, GAO-19-507T (Washington, D.C.: Apr. 10, 2019) and VA Office of the Inspector General, *Veterans Health Administration, Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities*, Report No. 18-05121-36 (Washington, D.C.: Jan. 16, 2020).

[8]GAO, *Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of Its Community Care Programs*, GAO-18-281 (Washington, D.C.: June 4, 2018).

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

facilities.[10] This recommendation, which we consider a priority, remains open as of February 2023. In 2020, we recommended VA align its monitoring metrics with its time frames established for scheduling community care appointments to effectively monitor the extent to which veterans receive care within such specified time frames.[11] VA did not agree with our recommendation at the time of our report and has not implemented it, as of February 2023.

The Consolidated Appropriations Act, 2023, requires VA to establish a specific wait time measure (the number of days from the date of request for the appointment to the first next available appointment) for veterans' eligibility to obtain care under its community care program and requires its community care contractors to furnish care within this standard.[12] This requirement should allow VHA to monitor timeliness in its community care program and may close our recommendation related to community care. It does not, however, establish a similar metric for furnishing care in VHA facilities.

In February 2023, VA officials stated that they are currently evaluating the technical, logistical, and financial implications of operationalizing the community care requirement. We will review the actions VA takes to implement the new requirement to determine if it fully implements our recommendation. We continue to believe that establishing reliable wait time measures for both VHA facility and community care appointments will permit VA to more effectively monitor the timeliness of veterans receiving care regardless of whether the care is received at a VHA facility or from a community care provider.

Aligning resources with veteran needs. We have identified issues with the information VA uses to make decisions about allocating its resources to meet veterans' needs and to determine if it has an adequate number of health care providers. In February 2022, we found gaps in the data VA used to assess the capacity of 96 health care markets nationwide as part

[10]GAO, *VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, GAO-13-130 (Washington, D.C.: Dec. 21, 2012).

[11]See GAO, *Veterans Community Care Program: Improvements Needed to Help Ensure Timely Access to Care,* GAO-20-643 (Washington, D.C.: Sept. 28, 2020).

[12]Pub. L. No. 117-328, div. U, §§ 121, 125, 136 Stat. 4459, 5415, 5416-18 (2022).

of its efforts to realign VA health care delivery.[13] We found that VA lacked complete data relevant to determining both the supply of and demand for community care. For example, VA lacked complete data on the extent to which its contractors maintain an adequate number of non-VA providers to ensure veterans have timely access to community care.

We recommended VA review the data to identify any gaps and take steps to address data completeness. While VA agreed with this recommendation, the agency had not yet taken action to implement this recommendation as of February 2023.

In November 2022, we found VA does not have complete data on the providers operating and available in its regional networks of community providers, limiting its ability to know if they have an adequate number of providers to meet appointment scheduling needs.[14] Further, we found that VA's assessment of the network's adequacy was based on incomplete data, as contractors did not include all claims and that VA was unaware of this issue. We recommended (and VA concurred) that VA ensure these data are complete and accurate to help VA identify the extent to which its networks are adequate to meet veterans' needs. The agency has not yet taken action to implement the recommendations, as of February 2023.

Provider qualifications. VA has faced challenges in ensuring that its health care providers deliver safe and effective care to veterans. We have previously identified situations where providers who were removed from employment by VA medical facilities for quality of care concerns went on to provide care outside VA and to enroll in VA's community care networks, allowing them to continue to care for veterans.[15]

[13]GAO, *VA Health Care: Incomplete Information Hinders Usefulness of Market Assessments for VA Facility Realignment*, GAO-22-104604 (Washington, D.C.: Feb. 2, 2022).

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

[15]See GAO, *Veterans Health Administration: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*, GAO-19-6 (Washington, D.C.: Feb. 28, 2019) and *VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety* Concerns, GAO-18-63 (Washington, D.C.: Nov. 15, 2017).

In February 2021, for example, we identified 227 providers that had been removed from VA employment and were potentially providing care in a community care network.[16] We recommended (and VA concurred) that VA take actions to assess and address this issue. VA implemented our recommendation in October 2021 by reviewing and excluding 155 providers from participating in VA's community care networks.

In December 2021, we found vulnerabilities in the controls VA and its contractors use to identify health care providers who are not eligible to participate in VA's community care program, resulting in the inclusion of potentially ineligible providers.[17] Of over 800,000 community care providers assessed, we identified over 1,000 providers who were ineligible to work with the federal government or had revoked or suspended medical licenses.[18] These vulnerabilities potentially put veterans at risk of receiving care from unqualified providers. We made 10 recommendations to VA (and VA generally concurred), including that it enhance its existing controls. VA has taken steps to partially address two of the recommendations, but all 10 have not been fully implemented, as of February 2023.

Behavioral health services. VA has faced some challenges in ensuring it can effectively identify and meet the demand for behavioral health services—both mental health and substance abuse related services—among veterans, particularly for rural veterans. For example, in February 2023 we found that while VA monitors patient access to and use of intensive mental health care programs, it does not analyze its data by rurality.[19] This limits its ability to understand the extent to which programs

[16]See GAO, *Veterans Community Care Program: Immediate Actions Needed to Ensure Health Providers Associated with Poor Quality Care Are Excluded*, GAO-21-71 (Washington, D.C.: Feb. 1, 2021).

[17]See GAO, *Veterans Community Care Program: VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers,* GAO-22-103850 (Washington, D.C.: Dec. 17, 2021).

[18]The Department of Health and Human Services Office of Inspector General maintains the List of Excluded Individuals/Entities (LEIE), a database of individuals and entities prohibited from participating in all federally funded health care programs, including Medicare, Medicaid, and VA. Individuals can be excluded from federal health care programs for a number of reasons, including revocation or surrender of a license to provide health care; crimes related to patient abuse; and felony convictions relating to health care fraud or controlled substances.

[19]GAO, *VA Mental Health: Additional Action Needed to Assess Rural Veterans' Access to Intensive Care*, GAO-23-105544 (Washington, D.C.: Feb. 9, 2023).

effectively reach rural veterans. We analyzed VA's fiscal year 2021 data and found that rural veterans used intensive mental health care programs at lower rates than their urban counterparts.

We recommended that VHA analyze intensive mental health care utilization and performance data by rurality and assess and update, as appropriate, guidelines for establishing outpatient intensive mental health programs. VA agreed with the recommendations and, in January 2023, identified steps it would take to implement them.

Some servicemembers face particular challenges—such as mental health and substance use—when transitioning from military service to civilian life that increase their risk of suicide. Vet Centers provide readjustment counseling to help address these challenges. However, in our May 2022 report we found that VHA was not measuring the extent to which Vet Centers meet veteran needs collectively. We also found that Vet Centers lack data on veterans needed to better target outreach, among other issues.[20] We made five recommendations for VHA to improve its oversight of the effectiveness of Vet Centers. VHA agreed with our recommendations but these were not yet implemented, as of February 2023.

One way VA has tried to meet increased demand for mental health services is by integrating certain mental health services within primary care settings. Specifically, facilities are required to have mental health providers, such as psychologists, psychiatrists, and social workers, available within primary care settings to work collaboratively and share responsibility with primary care providers. In December 2022, we found that persistent staffing challenges across VHA facilities have negatively affected these efforts.[21] We also found VA did not monitor whether or not facilities took appropriate actions to correct issues identified in their integration efforts.

We recommended that VHA monitor the development and implementation of corrective action plans and evaluate strategies to help mitigate staffing challenges. Doing so would help ensure that veterans

[20]GAO, *VA Vet Centers: Opportunities Exist to Help Better Ensure Veterans' and Servicemembers' Readjustment Counseling Needs Are Met*, GAO-22-105039 (Washington, D.C.: May 17, 2022).

[21]GAO, *Veterans Health Care: Staffing Challenges Persist for Fully Integrating Mental Health and Primary Care Services*, GAO-23-105372 (Washington, D.C.: Dec. 15, 2022).

receive the most appropriate and timely mental health care services available. VHA agreed with our recommendations and identified several actions it has completed to mitigate staffing challenges. To fully implement our recommendation, VA needs to comprehensively evaluate the actions and strategies it has employed to date.

VA has made progress in its efforts around suicide prevention, which is VA's highest clinical priority. In September 2020, we reported that VA lacks accurate information on the number of suicides and comprehensive analyses of the underlying causes.[22] We recommended that VA improve its process to accurately identify all on-campus veteran suicides and conduct more comprehensive analyses of these occurrences. VA took steps to address these recommendations in 2022, including publishing VA-wide reporting procedures for suicide deaths on VA property. Further, in September 2022, we reported that a VA program that uses a predictive model to analyze veterans' health record information helped identify veterans who might be at increased risk of suicide that were not flagged by other screening programs.[23]

However, we have continued to identify challenges with VA's suicide prevention efforts. In January 2022 we found that VA cannot readily search for and identify the full universe of its agreements with nongovernmental groups that aim to make veterans aware of available suicide prevention programs and mental health services.[24] Without better tracking and oversight, VA cannot easily identify gaps in its partnerships or the extent to which existing partnerships could be better leveraged to reach veterans not using VA services. We recommended—and VA agreed—that it should require the use of its Strategic Relationships Application to track these agreements and provide training and comprehensive guidance. VA has not yet implemented these recommendations, as of February 2023.

Long-term care facilities. Thousands of veterans rely on nursing home care provided or paid for by VA to help them meet their skilled nursing

[22]GAO, *Veteran Suicide: VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides*, GAO-20-664 (Washington, D.C.: Sept. 9, 2020).

[23]GAO, *Veteran Suicide: VA Efforts to Identify Veterans at Risk through Analysis of Health Record Information*, GAO-22-105165 (Washington, D.C.: Sept. 14, 2022).

[24]GAO, *VA Mental Health Care: Improvements Needed in Tracking and Overseeing Partnerships with Nongovernmental Entities*, GAO-22-104674 (Washington, D.C.: Jan. 13, 2022).

and personal care needs. Many veterans receive this care in community living centers, which are owned and operated by VA, or state veterans homes, which are owned and operated by states and receive payment and some oversight from VA. VA has opportunities to enhance its oversight of the quality of care provided to veterans in community living centers and state veterans homes.

In November 2022, we found increases in both the number and the severity of deficiencies cited during annual inspections of state veterans homes.[25] For example, the total number of deficiencies cited increased from 424 in 2019 to 766 in 2021. A majority of the increase was in the quality of care and infection control categories, which cover accidents and staff hand hygiene. We recommended (and VA generally concurred) that VA (1) identify additional enforcement tools to bring these homes into compliance with quality standards, (2) implement a process to ensure homes with quality issues carry out corrective active plans within a timely manner, and (3) ensure it has the capabilities needed to analyze inspection data to improve its oversight. VA identified plans to implement our recommendations, but has not implemented them as of February 2023.

In November 2021, we found that VA had insufficient policies, limited monitoring, and unclear guidance for addressing complaints about care in its community living centers.[26] Complaints can range from reports of abuse or other serious resident safety concerns to feedback on resident preferences for their living environment, such as the food available at the community living center. Complaints are a valuable source of information about the quality of care in nursing homes because investigations of these complaints can identify and resolve issues quickly for this vulnerable population. We recommended that VA require documentation of these complaints for tracking and resolution, establish a complaint monitoring process, and develop a centralized source of complaints data to inform its oversight. VA agreed and, as of February 2023, implemented the recommendations to require documentation of complaints and establish a monitoring process. VA reported plans to modify an existing

[25]GAO, *VA Nursing Home Care: Opportunities Exist to Enhance Oversight of State Veterans Homes*, GAO-23-105167 (Washington, D.C.: Nov. 14, 2022). To receive VA payments, state veterans homes must meet VA quality standards related to quality of care, quality of life, infection control, and resident rights, among other areas. Homes that fail to meet the standards can be cited for deficiencies by VA.

[26]GAO, *Community Living Centers: VA Needs to Strengthen Its Approach for Addressing Resident Complaints*, GAO-22-105142 (Washington, D.C.: Nov. 30, 2021).

complaints database to consistently capture community living center complaints data for use in its oversight.

In November 2021, we also recommended that VA update its policy and training documentation to make it clear which quality standards community living centers are expected to follow and to collect and analyze important data—including veteran experience data and data on safety events—to improve its oversight.[27] VA agreed with our recommendations and provided plans to implement them. They have not been implemented as of February 2023.

Information technology modernization. VA has faced implementation and data quality challenges as it works to modernize its electronic health record system, which can pose risks to patient safety and timely access to care. VA relies on electronic health records for patient care, operations, and health research.

In June 2020, we reported on the process for configuring the department's new electronic health record system.[28] We noted that VA's decision-making procedures were generally effective, but the department did not always ensure key stakeholder involvement. We recommended (and VA concurred) that VA ensure the involvement of all relevant deployment site stakeholders in the electronic health record system configuration decision process. VA has begun to improve subject matter expert identification and involvement, but this type of involvement needs to continue until different stages of modernization unfold. As such, our recommendation remains not fully implemented as of February 2023.

In February 2021, we reported that VA had made progress toward deploying the new electronic health record system by making configuration decisions, developing capabilities and interfaces, completing testing events, and deploying the system at the first site in October 2020.[29] However, we noted that the department was at risk of

[27]GAO, *VA Community Living Centers: Opportunities Exist to Strengthen Oversight of Quality of Care*, GAO-22-104027 (Washington, D.C.: Nov. 30, 2021).

[28]GAO, *Electronic Health Records: Ongoing Stakeholder Involvement Needed in the Department of Veterans Affairs' Modernization Effort*, GAO-20-473 (Washington, D.C.: June 5, 2020).

[29]GAO, *Electronic Health Records: VA Has Made Progress in Preparing for New System, but Subsequent Test Findings Will Need to Be Addressed*, GAO-21-224 (Washington, D.C.: Feb. 11, 2021).

developing a system that may not perform as intended or could negatively impact the likelihood of successful adoption by users if critical and high severity test findings (that could result in system failure) were not resolved prior to future deployments.[30]

We made two recommendations (and VA concurred) in February 2021, including that VA postpone deployment of the new electronic health record system at planned sites until any resulting critical and high severity test findings are appropriately addressed. VA stated that it planned to continue to test and appropriately adjudicate all critical and high severity test findings prior to future deployments. We will continue to monitor VA's actions to implement our recommendation as the department makes additional system deployments.

In February 2022, we reported that our work and VA's analyses indicated challenges with the quality of transferred data and with how the new electronic health record system worked for some users.[31] For example, VA identified errors in allergy, medication, and immunization data, which raise patient safety concerns. We recommended (and VA concurred) that VA establish and use performance measures and goals to ensure the quality of transferred data. VA has not begun taking steps to implement our recommendation as of February 2023.

VA decided in July 2022 to delay the rollout of its new electronic health record system at additional medical centers while the department works to address issues including system and data quality concerns. We have an ongoing review of VA's system that is focused on evaluation of users' satisfaction, resolution of system issues, and implementation of change management practices.

VA Acquisition Management

VA relies upon its acquisition programs to provide many capabilities and services that are essential to provide health care to veterans and their families, such as the purchase of medical supplies for VA medical centers. While acquisition management may seem like a purely

[30]A critical test finding results in the failure of the complete software system. A high severity test finding results in the failure of the complete software system; however, there are acceptable workarounds.

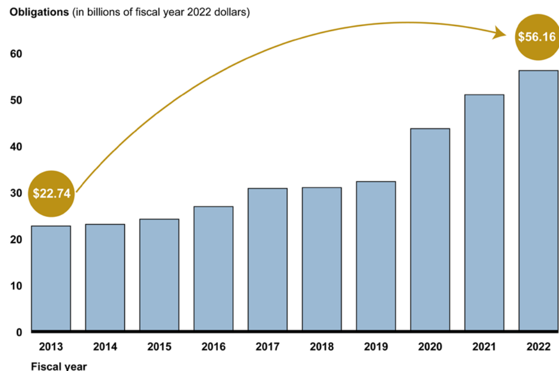
[31]GAO, *Electronic Health Records: VA Needs to Address Data Management Challenges for New System*, GAO-22-103718 (Washington, D.C.: Feb. 1, 2022).

administrative process, it has a direct effect on the quality of health care veterans receive.

Over the past 10 years, VA's total contract obligations increased substantially, rising 147 percent, as shown in figure 1. In fiscal year 2022, VA obligated about $56 billion for goods and services. We added VA acquisition management to our High-Risk List in 2019 due to numerous challenges to efficiently purchasing goods and services, including medical supplies.

To address these challenges, VA issued a corrective action plan in March 2021, which identified root causes of the issues. VA continued to update that plan, most recently in September 2022, to include corrective actions and some metrics. VA has implemented 38 of our 60 recommendations related to acquisition management. For example, in response to our recommendations VA implemented training and developed comprehensive guidance for contracting staff in its Federal Supply Schedules program used to purchase billions of dollars in medical supplies each year.

Figure 1: Department of Veterans Affairs (VA) Contract Obligations Growth, Fiscal Years 2013 through 2022



Source: VA obligation data from the Federal Procurement Data System. | GAO-23-106636

While VA has made progress on some aspects of its acquisition management, our work continues to identify challenges including (1) developing adequate strategies and policies, (2) managing its supply chain, and (3) managing its acquisition workforce.

Developing adequate strategies and policies. We reported in August 2022 that VA was not consistently using its 2017 acquisition framework for managing how it purchases goods and services in major acquisitions.[32] This framework includes features—such as identified decision authorities—that are in line with leading acquisition practices and could provide for more standardized management and oversight of VA's major acquisitions. Almost none of the VA's most costly and mission-critical acquisition programs were following VA's 2017 acquisition framework, but rather used program-specific approaches that varied widely in robustness.

VA's challenges in managing acquisitions have impacts on its ability to meet its mission. For instance, at the outset of the COVID-19 pandemic, VA's antiquated inventory system exacerbated medical supply challenges. That system had been in place for decades, and VA had only recently begun work on a replacement, which it has since abandoned due to challenges with the program.

Without a framework to guide its acquisitions, it is challenging for VA to provide uniform oversight for acquisitions and consistently identify opportunities to improve acquisition outcomes. We have made seven recommendations to VA (and VA concurred) to address these challenges, all of which have not been implemented as of February 2023.

Two key examples illustrate some of the specific challenges we identified.

First, as described above, VA has experienced significant delays and challenges implementing its Medical Surgical Prime Vendor program, which is intended to provide an efficient and cost-effective way to get critical supplies to medical centers. In 2017, we reported that VA's initial implementation of its Medical Surgical Prime Vendor program was flawed, as it lacked an overarching strategy, stable leadership, and medical

[32]GAO, *VA Acquisition Management: Action Needed to Ensure Success of New Oversight Framework*, GAO-22-105195 (Washington, D.C.: Aug. 11, 2022).

center buy-in, among other issues.[33] Without such a strategy, VA could not ensure that all stakeholders worked together in a coordinated manner to achieve program goals. Since 2017, VA has pursued four different versions of this program, but none have fully achieved VA's goals. As of February 2023, VA is again developing another iteration of this program. According to VA acquisition officials, this new iteration is intended to address some of the issues we have previously identified.

Second, VA has also faced challenges replacing its aging financial and acquisition systems, which are difficult to maintain and adapt to new requirements. VA established the Financial Management Business Transformation program to roll out one integrated system—the Integrated Financial and Acquisition Management System. This is VA's third attempt to replace its aging systems; the first two attempts failed after years of development and hundreds of millions of dollars in cost. In March 2022 we reported among other concerns that, although VA had developed metrics, established baselines, and begun to measure operational benefits for its new financial management system, the department's reporting of results was incomplete because it had not identified targets for achievement.[34]

Until the program identifies specific targets for performance (such as goals), it will be limited to comparing metric results to the baseline. As such, the program may not be positioned to report that measurable progress has been made over time to fully meet the needs of the department and maximize the return on its multibillion-dollar investment. We recommended (and VA concurred) that VA identify targets for achievement. As of February 2023, VA has not implemented this recommendation.

VA is working to implement a new framework to better manage its major acquisitions and faces challenges that will require leadership engagement. This includes ensuring framework compliance and identifying which programs will be subject to the new oversight framework.

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[33]See GAO, *Veterans Affairs Contracting: Improvements in Buying Medical and Surgical Supplies Could Yield Cost Savings and Efficiency*, GAO-18-34 (Washington, D.C.: Nov. 9, 2017).

[34]GAO, *VA Financial Management System: Additional Actions Needed to Help Ensure Success of Future Deployments*, GAO-22-105059 (Washington, D.C.: Mar. 24, 2022).

Managing its supply chain. VA also needs to develop additional capacity to manage its supply chain. Like most medical institutions nationwide, VA faced difficulties obtaining medical supplies in the early stages of the COVID-19 pandemic, such as personal protective equipment for its medical workforce. Longstanding problems with its antiquated inventory management system exacerbated VA's challenges.

In March 2021, we reported that VA was pursuing multiple major initiatives to modernize its supply chain.[35] VA has developed plans of varying maturity and completeness for all of these initiatives. However, these initiatives are highly interrelated and being developed and implemented concurrently. We recommended that VA develop a comprehensive supply chain management strategy that, among other things, outlines how its various supply chain initiatives relate to each other. Although VA is in the process of developing a comprehensive supply chain strategy intended to guide these initiatives, it has yet to fully implement our recommendation as of February 2023. Continuing challenges in supply chain management hinder VA's efficient acquisition management and its mission to meet veterans' needs.

Managing its acquisition workforce. In September 2022, we reported that VA lacks comprehensive data to track the totality and characteristics of its acquisition workforce—that is, contracting officers, contracting officer representatives, and program or project managers—that plays a central role in buying the goods and services that VA needs to accomplish its mission.[36] However, VA does not have accurate counts of the acquisition workforce, what office they are located in and support, or what certifications they hold. Addressing these issues would help enable VA to implement its planned acquisition framework, and make data-driven human capital decisions. We recommended (and VA concurred) that VA (1) take steps to ensure VA keeps accurate and up-to-date acquisition workforce records and (2) document roles and responsibilities for managing the acquisition workforce. As of February 2023, VA had not implemented them.

[35]GAO, *VA Acquisition Management: Comprehensive Supply Chain Management Strategy Key to Address Existing Challenges*, GAO-21-445T (Washington, D.C.: Mar. 24, 2021).

[36]GAO, *VA Acquisition Management: Actions Needed to Better Manage the Acquisition Workforce*, GAO-22-105031 (Washington, D.C.: Sept. 29, 2022).

To obtain insights on VA's acquisition workforce's perspectives on performing its responsibilities for our September 2022 report, we conducted a generalizable survey, which found that

- Staff were considerably less satisfied with senior leaders than they were with their immediate supervisors.
- More than one third of our survey respondents said they were likely to leave their job within the next 3 years, nearly half of whom said they expected to leave VA.

Providing consistent leadership and execution of management priorities is key to addressing VA's acquisition management challenges. VA has made progress on prior challenges with acquisition leadership instability—the Office of Acquisition, Logistics and Construction reports no current leadership vacancies, and the Chief Acquisition Officer and Senior Procurement Executive have been in their roles for about 2 and 4 years, respectively.

VA's acquisition leaders, including the Chief Acquisition Officer, have taken steps to address the challenges they face. As part of its high-risk action plan, VA created the Acquisition Leadership Team in February 2022 to collaborate on an overall strategy to address its acquisition management challenges. VA will need sustained leadership commitment to ensure it has clearly-established authorities, roles, and responsibilities for implementing the action plan. The plan requires ongoing efforts by a number of different individuals and organizations across the agency, such as the Office of Information and Technology and Veterans Health Administration, and clear accountability mechanisms will be needed to ensure consistent execution.

VA Disability Benefits

VA administers one of the largest federal disability compensation programs in the nation. It provided over $112 billion in compensation to approximately 5.6 million veterans and their families in fiscal year 2021. Veterans with service-connected disabilities (i.e., injuries or illnesses incurred or aggravated during military service) may receive monthly VA disability compensation payments according to the severity of their disability.[37]

[37]See generally 38 U.S.C. Ch. 11.

VA's disability compensation program has been on our High-Risk List since 2003 for continuing challenges with managing its claims workloads and modernizing eligibility criteria. For example:

- VA overcame an approximately 610,000 initial claims backlog in 2013 to about 195,000 in February 2023. However, VA faces a workload surge not only for initial claims but also for appeals. For appeals, VA must contend with workloads under the old process (legacy) while veterans file appeals in a new process. Under the legacy process, the subset of appeals resolved by VA's Board of Veterans' Appeals has taken, on average, 7 years to resolve. Overall, VA reported that appeals awaiting decisions in the legacy process have declined from about 285,000 in January 2020 to about 80,000 in January 2023. Those in the new process continue to climb from 112,000 in January 2020 to about 380,000 in January 2023.
- VA continues to rely on outdated medical and earnings loss information to determine eligibility for benefits. VA's August 2022 corrective action plan indicates that medical information for 5 of the 15 body systems remain out of date. VA continues to experience delays and has extended the timeline to complete all body systems updates by the end of fiscal year 2024, more than 8 years beyond VA's initial goal. VA's efforts to update earnings loss information is also a work in progress and has not been updated since the 1940s to reflect changes in the labor market.[38]

To address these challenges, VA issued a corrective action plan in 2020, which identified root causes of the issues, corrective actions, and metrics intended to track progress. VA continued to update that plan, most recently in 2022. However, VA has experienced instability in top leadership for the benefits program; over the past three administrations, there have been several years-long periods without a Senate-confirmed Under Secretary for Benefits.

While VA now plans to address this high-risk area, our work has continued to identify challenges related to VA's management of programs and projects intended to improve overseeing medical exams, training for claims processing staff, and processing disability claims. Underpinning many of these challenges are VA leaders and managers not fully using sound planning and other leading management practices. Using such

[38]Benefits for veterans with service-connected disabilities are based upon an average reduction in earning capacity across a group of individuals with a similar physical or mental condition. VA is obtaining updated information on the average earning loss associated with service-connected disabilities.

practices would help VA improve benefit decisions and alleviate delays in providing benefits to eligible veterans and their families. Another key to addressing these challenges is fully implementing our recommendations and identifying the lessons learned from VA's past efforts. Doing so would position the Department to achieve its goal of addressing surges in claims workloads, such as those expected to result from exposure from toxic exposures, including burn pit toxins.

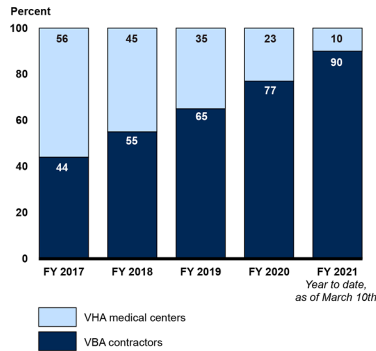
Oversight of disability medical exams. VA faces backlogs in conducting medical exams needed to make disability claims decisions. This work has increasingly shifted from VA medical centers to contractors, who performed about 1.1 million of the 1.4 million exams completed in fiscal year 2020, based on data that was available at the time of our March 2021 report.[39] (See fig. 2.) However, in that report we found that VA has not applied sound planning practices in transferring this work to contractors that could help ensure veterans receive timely and accurate exams. For example, we found VA had not assessed potential risks, such as the loss of VHA capacity to help reduce the exam backlog and meet the anticipated surge in claims from veterans who may be newly eligible.[40] We recommended (and VA concurred) that VA develop plans for its allocation of disability medical exam workloads that incorporate sound planning practices. As of February 2023, VA has not yet implemented our recommendation.[41]

[39]GAO, *VA Disability Exams: Better Planning Needed as Use of Contracted Providers Continues to Grow,* GAO-21-444T (Washington, D.C.: Mar. 23, 2021).

[40]At the time of our review, VA faced a surge in workloads related to changes in the eligibility determination process for certain claims, such as Blue Water Navy claims. Since then, Congress made further changes under the PACT Act.

[41]VA has developed a plan that includes information on strategic goals, coordination and communication, and general information on risks. However, it lacks information related to other sound planning practices, such as documenting a strategy for achieving its goals and developing clear timelines. Though the plan includes general information related to potential risks, it does not include detailed assessments of these risks and other potential risks associated with VA's increased reliance on contractors. It does not assess the degree to which VHA medical centers may lose existing expertise for performing disability exams or include plans for managing that risk.

Figure 2: Percent of Disability Exam Workload Completed by VBA Contractors and VHA Medical Centers, Fiscal Years 2017-2021



Source: GAO analysis of Veterans Benefits Administration (VBA) and Veterans Health Administration (VHA) data. | GAO-23-106636

Note: Contractors completed a small number of VHA exams in fiscal year 2017 under VHA-managed contracts, according to VHA data.

Training for claims processing. Investing training dollars effectively is key to ensuring disability claims processors have the skills to successfully handle disability claims—especially as VA hires more staff, implements new initiatives, and updates information in the eligibility criteria for assigning a degree of disability and compensation level. In a June 2021 report, we examined VA's training program for claims processors against a wide range of leading practices for training related to planning, design, implementation, and evaluation.[42] For example, we identified challenges VA faces with balancing the hiring of claims processors to address increased workloads and training new hires, such as ensuring appropriate instructor-to-student ratio. We made 10 recommendations (and VA concurred), including that VA establish an integrated and comprehensive plan and performance goals for its training program, develop policies to monitor compliance with required training, and evaluate training on a

[42]GAO, *VA Disability Benefits: Veterans Benefits Administration Could Enhance Management of Claims Processor Training*, GAO-21-348 (Washington, D.C.: June 7, 2021).

recurring basis. While VA implemented four of our recommendations, it has not yet fully implemented the remaining six as of February 2023.

Improvements to disability claims processing. Veterans and VA spend substantial time, money, and effort applying for and processing disability compensation claims. In July 2022, we reported that VA undertook 23 initiatives in recent years to improve its disability compensation program. However, we found that VA did not consistently follow leading management practices, such as establishing goals for the reforms and involving key stakeholders, to achieve intended results, including providing valuable services to veterans.[43]

For example, VA has undertaken wide-ranging reforms to improve how it processes military sexual trauma claims, including changes to trainings, policies, and office consolidations. However, in planning these changes, VA did not fully incorporate input from external stakeholders, including veterans with disabilities related to military sexual trauma or their representatives, to account for how the reform affects these stakeholders. Further, VA had no way to track and prioritize these initiatives.

In our July 2022 report, we made eight recommendations (and VA generally concurred), including that VA take additional actions to follow leading practices where needed for the selected reforms; designate a centralized leadership team to oversee VA's many reforms; and develop and implement a policy describing the leading practices that VA officials should follow when undertaking reforms. VA has not yet implemented them as of February 2023.

VA Privacy and Cybersecurity Challenges

To provide health care and other benefits to veterans and their dependents, VA relies on IT systems and networks to receive, process, and maintain sensitive data, including veterans' medical records and associated personally-identifiable information. Consequently, vulnerabilities arising from VA's increased dependence on IT can result in the compromise of sensitive personal information, such as inappropriate use, modification, or disclosure.

We have previously reported that while VA had implemented key federal privacy practices, it had some gaps. Further, we have highlighted key

[43]GAO, *VA Disability Benefits: Compensation Program Could Be Strengthened by Consistently Following Leading Reform Practices*, GAO-22-104488 (Washington, D.C.: July 18, 2022).

security challenges that VA has faced in safeguarding its information and information systems.

Privacy challenges. In September 2022, we highlighted the extent to which VA addressed 10 key practices for implementing its privacy programs.[44] At that time, VA had implemented six of 10 practices, but had not fully addressed four of the selected practices.[45] For example, VA only partially defined and documented a process for involving privacy officials in reviewing IT budget requests; did not provide documentation describing the role of privacy officials in privacy workforce management; only partially documented the role of privacy officials in carrying out risk management steps for authorizing systems containing personally-identifiable information; and had not fully developed a continuous privacy monitoring strategy.

We made recommendations to VA associated with each of these four practices (and VA concurred).VA implemented one recommendation related to its privacy continuous monitoring strategy. However, as of February 2023, the remaining three recommendations had not yet been implemented.

Challenges in securing information systems. Federal systems and networks, including those of VA, are often interconnected with other internal and external systems and networks, thereby increasing risk and the means used to initiate cyberattacks. Without proper safeguards, computer systems are vulnerable to individuals and groups with malicious intent who can intrude and use their access to obtain sensitive information, commit fraud and identity theft, disrupt operations, or launch attacks against other computer systems and networks. Since 1997, GAO

[44]GAO, *Privacy: Dedicated Leadership Can Improve Programs and Address Challenges*, GAO-22-105065 (Washington, D.C.: Sept. 22, 2022).

[45]VA had (1) established policies and procedures for developing system of records notices to identify personal data collected and how they are used; (2) established policies and procedures for conducting privacy impact assessments; (3) documented a privacy program plan; (4) ensured that privacy personnel coordinate with the department's staff responsible for information security activities; (5) defined roles and responsibilities for privacy officials with respect to responding to privacy incidents including breaches of personally-identifiable information; and (6) developed a privacy risk management strategic plan, which discussed the department's privacy risk tolerance.

has designated information security as a government-wide high-risk area—a designation that it retains today.[46]

In July 2019, we reported that VA had fully met one of the five foundational practices for establishing a cybersecurity risk management program by establishing a Cybersecurity Risk Executive.[47] However, VA did not meet four other key cybersecurity practices. For example, VA did not (1) include key elements in its cybersecurity risk management strategy, such as risk tolerance and risk mitigation strategies or (2) have a policy for an agency-wide risk assessment. We made four recommendations related to these and other findings and the department has since taken steps to implement all of them.

Further, in 2022, the VA Office of Inspector General noted that VA faced challenges in implementing components of its agency-wide information security program to meet requirements of the Federal Information Security Modernization Act of 2014 (FISMA).[48] The report identified continuing significant deficiencies related to access controls, configuration management controls, change management controls, and service continuity practices designed to protect mission-critical systems from unauthorized access, alteration, or destruction. In addition, an OMB report to Congress summarizing fiscal year 2021 agency cybersecurity

[46]See GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, GAO-21-119SP (Washington, D.C.: Mar. 2, 2021); *High-Risk Series: An Overview*, GAO-HR-97-1 (Washington, D.C.: February 1997); and *High-Risk Series: Information Management and Technology*, GAO-HR-97-9 (Washington, D.C.: February 1997). In 2003, we expanded this area to include computerized systems supporting the nation's critical infrastructure and, in 2015, we further expanded this area to include protecting the privacy of personally identifiable information.

[47]GAO, *Cybersecurity: Agencies Need to Fully Establish Risk Management Programs and Address Challenges*, GAO-19-384 (Washington, D.C.: July 25, 2019).

[48]The Federal Information Security Modernization Act of 2014 (FISMA 2014) Pub. L. No.113-283, 128 Stat. 3073 (Dec. 18, 2014) largely superseded the Federal Information Security Management Act of 2002 (FISMA 2002), enacted as Title III, E-Government Act of 2002, Pub. L. No. 107-347, 116 Stat. 2899, 2946 (Dec. 17, 2002). As used in this report, FISMA refers both to FISMA 2014 and to those provisions of FISMA 2002 that were either incorporated into FISMA 2014 or were unchanged and continue in full force and effect. The act requires each agency to develop, document, and implement an agency-wide information security program. FISMA also requires agency Inspectors General to annually assess the effectiveness of the information security policies, procedures, and practices at their parent agency.

performance noted that an independent assessment had concluded that VA's program was not effective.[49]

Continued attention to security challenges is important. The provision of timely and quality health care and benefits for veterans and other eligible individuals depends, in large part, on the security functionality, effectiveness, and ease of use of VA's information systems. As VA continues to pursue electronic health record modernization, it is critical that the department consider and take steps to address privacy and security challenges.

Other Challenges

In June 2020, we reported on VA's efforts to prevent and address sexual harassment at the agency and made seven recommendations, including that VA ensure that its Equal Employment Opportunity (EEO) Director position is not responsible for personnel functions; require managers to report sexual harassment centrally; and require additional employee training. VA concurred with all but the EEO Director position recommendation, which GAO maintains is warranted.

VA has taken some steps to start addressing these recommendations. Specifically, in 2022, VA formalized its Harassment Prevention Program (HPP) and now has a finalized HPP Handbook that outlines key processes the agency should follow in addressing sexual harassment allegations. VA also developed three new trainings that include more information on the reporting processes available to employees, including the HPP, and provide more in-depth information on sexual harassment.

While these are positive steps, VA has yet to fully implement our other recommendations. Most notably, VA has not taken sufficient actions to realign its EEO organizational structure to avoid potential conflicts of interest. VA's EEO Director position remains unchanged since our recommendation. Further many EEO Program Managers, in particular at VHA, continue to report directly to facility management. Legislation was

[49]Office of Management and Budget, *Federal Information Security Modernization Act of 2014 Annual Report to Congress, Fiscal Year 2021* (Washington, D.C.: Sept. 14, 2022).

passed that would require VA to take action that generally aligns with six of seven of our recommendations.[50]

We also have ongoing work examining potential racial discrimination at the VA, which will be completed later this summer. Improving these programs and policies will help to ensure that the VA employees serving our nation's veterans are better protected from the potentially harmful effects of harassment and discrimination.

In conclusion, VA serves those who have served our nation, so its responsibilities are both vital and sacred. The scope of these responsibilities–ensuring access to care for millions of veterans through one of our country's largest health systems–is one inherent with challenges, but we have identified many that are within VA's power to overcome. VA has undertaken many initiatives, some of which have been intended to address those areas we have identified that are of the highest concern. But the department continues to face challenges in delivering health care, managing acquisitions, providing disability benefits, and managing privacy and cyber security in its networks and systems. Sustained leadership with a commitment to oversight and accountability is the key to driving the sort of transformational change that can help ensure the access to timely, high quality care and benefits that our veterans deserve.

Chairman Bost, Ranking Member Takano, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions you may have.

GAO Contacts and Acknowledgments

If you or your staff have any questions about this testimony, please contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov for VA health care issues; Shelby S. Oakley at (202) 512-4841 or oakleys@gao.gov for VA acquisition management issues; Elizabeth A. Curda at (202) 512-7215 or curdae@gao.gov for disability benefit issues; Jennifer Franks at (404) 679-1831 or franksj@gao.gov for privacy and cybersecurity issues; and Thomas Costa at (202) 512-7215 or costat@gao.gov for VA sexual harassment and racial discrimination issues. Contact points for our Offices of Congressional Relations and

[50]Following GAO's 2020 report, legislation was proposed that would require VA to take action that generally aligned with six of seven of our recommendations. See, H.R. 2704. 117th Cong. (2021). These provisions were later included in the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022, enacted as part of the Consolidated Appropriations Act, 2023.

Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Ann Tynan (Assistant Director), Summar C. Corley (Analyst-in-Charge), and Cathy Hamann Whitmore. Other contributors include Mark Bird, Matthew Crosby, Gina Flacco, Krister Friday, Alexander Galuten, Jacquelyn Hamilton, Franklin Jackson, Tammi Kalugdan, Teague Lyons, Monica Perez-Nelson, Lisa Rogers, Nyree Ryder Tee, Kevin Smith, Julie Stewart, Umesh Thakkar, James Whitcomb, and Merry Woo.

Related GAO Products

VA Mental Health: Additional Action Needed to Assess Rural Veterans' Access to Intensive Care. GAO-23-105544. Washington, D.C.: February 9, 2023.

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

Veterans Health Care: Staffing Challenges Persist for Fully Integrating Mental Health and Primary Care Services. GAO-23-105372. Washington, D.C.: December 15, 2022.

VA Nursing Home Care: Opportunities Exist to Enhance Oversight of State Veterans Homes. GAO-23-105167. Washington, D.C.: November 14, 2022.

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

VA Disability Benefits: Compensation Program Could Be Strengthened by Consistently Following Leading Reform Practices. GAO-22-104488. Washington, D.C.: July 18, 2022.

VA Vet Centers: Opportunities Exist to Help Better Ensure Veterans' and Servicemembers' Readjustment Counseling Needs Are Met. GAO-22-105039. Washington, D.C.: May 17, 2022.

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Prepared Statement of Shereef Elnahal

Our Nation's most sacred obligation is to prepare and equip the troops we send into harm's way, and to care for them and their families when they return home. VA is honored to fulfill the promise made to care for our brave Service members and we will stop at nothing to serve Veterans, their families, caregivers, and survivors every bit as well as they have served us.

VA has provided more care, more benefits, and more services to more Veterans than ever before. Across the enterprise, VA has achieved record-breaking numbers in providing benefits and care. In 2022 alone, the Veterans Benefits Administration (VBA) completed more than 1.7 million disability compensation and pension claims for Veterans, an all-time VA record that broke the previous year's record by 12 percent. Continued focus on claims processing fundamentals, such as expanded C&P examination capacity, digitization of federal records, and ensuring a robust hiring and onboarding process, contributed to the agency's ability to meet these goals. This resulted in Veterans and survivors receiving over $128 billion in disability compensation and pension benefits in 2022, including nearly $10 billion in retroactive awards.

During this same period, the Veterans Health Administration (VHA) also provided more than 115 million clinical encounters, with VA serving over 6.4 million patients. This included roughly 40 million in-person appointments and more than 31 million tele-health and telephone appointments and approximately 38 million community care appointments in 2022 alone.

In addition, the National Cemetery Administration (NCA) interred nearly 150,000 Veterans and eligible family members in our national cemeteries during Fiscal Year 2022—the highest number of annual interments VA has recorded. NCA also provided more than 350,000 headstones, markers and columbarium niche covers around the world. We also provided nearly 12,000 medallions in 2022 to mark the privately purchased headstones of Veterans. In 2023, VA will continue to deliver more care and more benefits to more Veterans than ever before, and continue to fight for all Veterans, their families, caregivers, and survivors.

To continue this momentum, VA has a threefold approach. First, VA is focused on **increasing access** to world class health care and earned benefits by improving customer service and ensuring that Veterans and their families trust VA by expanding outreach to underserved Veterans and implementing new authorities (such as the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act to expand services, programs, and benefits.

Second, VA is **investing in its people**. This means VA is hiring more staff across the Department to ensure that care and benefits are delivered in a timely manner. VA is also focused on improving employee experience to help improve outcomes for Veterans, their families, caregivers, and survivors which makes sure that we keep the Veteran at the center of everything we do. Additionally, VA is implementing new hiring authorities and new retention authorities to grow and maintain a diverse, talented workforce with a shared mission to provide more care and more benefits to more Veterans. For example, using the recently approved Direct Hire Authority for mission critical occupations, VBA was able to increase its total workforce by more than 5 percent (more than 1,300 employees) in the first four months of Fiscal Year 23, compared to less than 1 percent growth in the workforce over the same time period in Fiscal Year 22.

Third, VA is **transforming systems, processes, and infrastructure** in order to achieve operational excellence, increase productivity, and ensure that systems and processes are easy to use by both the staff and the Veterans we serve. Outcomes for Veterans drive everything we do – because Veterans, not us, are the ultimate judges of our success. The proof of VA's ability to deliver on this promise is evident in NCA's recent top score in the prestigious American Customer Satisfaction Index (ACSI)[1] ratings. For the second time, NCA has scored 97 (out of 100) on the index, which is the highest score ever achieved by any organization rated by the ACSI, public or private, including the best-known companies in our country. The ACSI survey describes itself as "the only national cross-industry measure of customer satisfaction available in the United States."

This is the seventh time NCA has been ranked first in customer satisfaction by ACSI. This remarkable achievement is testament to the extraordinary hard work

[1] In 1999, the federal government selected the ACSI to be a standard metric for measuring citizen satisfaction. The ACSI measures citizen satisfaction with over 100 services, programs, and websites of federal government agencies. The objective of the survey is to measure customer satisfaction with a score of 0–100.

that every member of the NCA team puts in every day. They are motivated every day to ensure that Veterans receive the final honor they have earned from our grateful Nation – a place of eternal rest in a National shrine. NCA's impressive customer satisfaction scores are an inspiration for all of us in VA. Every employee in VA shares that dedication and motivation to serve our Nation's Veterans every day.

Increasing Access

Across VA, VHA, VBA, and NCA have focused on increasing access to world class health care and earned benefits to all Veterans, their families, caregivers, and survivors. We will continue to do so by facilitating timely access, focusing on women's health care, and expanding mental health care and suicide prevention.

Access to the Soonest and Best Care

Providing Veterans access to the best care in a timely way is at the core of our mission. Over the last 2 years, VA has delivered more care to more Veterans through both VA and community care providers than during any time in our Nation's history. Veterans completed more than 73 million outpatient appointments in VA and another 38 million community care outpatient appointments in calendar year 2022. While enrolled Veterans continue to receive the majority of their outpatient care in VA, more than 3.5 million Veterans have completed at least one outpatient appointment with a community care provider since we implemented the VA MISSION Act of 2018. As such, more than 1/3 of all Veterans enrolled in VA health care have been eligible for and chosen to elect to receive at least one community care appointment at some point in the last five years.

Veterans today have more options for care than ever. VA has more than 1,100 medical centers and community-based outpatient clinics for Veterans to receive their care. VA offers care in-person, over the phone or through video appointments as clinically appropriate. VA's community care network has more than 1.3 million community care providers across all 50 States and U.S. Territories. Enrolled Veterans also have access to community urgent care, and all Veterans have access to emergent suicide care.

Veterans' trust levels for VA health care exceed 90 percent nationally, whether care is received in VA or through a community provider. Veterans believe VA health care is getting better, according to studies by the Veterans of Foreign Wars, more than 90 percent of Veterans surveyed say they would recommend VA care to other Veterans. VA is seeing more patients than ever before and studies show VA compares favorably to the private sector for access[2] as well as quality of care[3] – and in many cases exceeds the private sector.

Women's Health Care

VA remains committed to providing high-quality, equitable care to women Veterans at all sites of care. More women are choosing VA for their health care than ever before, with women accounting for over 30 percent of the increase in Veterans served over the past 5 years. The number of women Veterans using VHA services has more than tripled since 2001, growing from 159,810 to more than 600,000 today.

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. VA tracks sites with fewer than two WH-PCPs to enhance national training and local hiring initiatives in rural areas and in additional areas where we have gaps in capacity to treat women.

While maternity care is not provided in VA facilities, a significant number of Veterans use maternity services provided through VA-authorized care in the community. Pregnant and postpartum Veterans continue to receive care in VA for other conditions and may also need primary care, emergency care and require coordination of Community Care services. To support pregnant and postpartum Veterans, VA has developed a Maternity Care Coordination (MCC) program in all VA health care systems to ensure coordination of care both in VA and in the community. To

[2] Comparison of Wait Times for New Patients Between the Private Sector and United States Department of Veterans Affairs Medical Centers : Health Care Quality : JAMA Network Open : JAMA Network

[3] VA Health System Generally Delivers Higher-Quality Care Than Other Health Providers : RAND

further support our Veteran population and in response to Public Law (P.L.)116–79, Protecting Moms Who Served Act of 2021, VA is expanding the maternity care coordination program to follow pregnant Veterans for one year postpartum, a particularly vulnerable time for families. VA MCCs support pregnant Veterans through every stage of pregnancy and postpartum. MCCs help pregnant Veterans navigate health care services both inside and outside of VA, connect to community resources, cope with pregnancy loss, connect to needed care after delivery and answer questions about billing. MCCs screen Veterans for intimate partner violence, perinatal mental health conditions, substance use disorders, homelessness and food insecurity and ensure Veterans are connected to appropriate resources and needed services.

VA is focusing on enhancing care coordination for preventive care, such as breast and cervical cancer screening. VA is actively implementing the Dr. Kate Hendricks Thomas Supported Expanded Review for Veterans In Combat Environments (SERVICE) Act. Beginning in March 2023, VA will be providing breast cancer risk assessments, including toxic exposure risk assessments, to Veterans eligible under the SERVICE Act with referral for mammography as clinically indicated. Breast and cervical cancer screening programs require meticulous tracking to ensure that all eligible Veterans receive appropriate screening and receive results of screening tests, and that followup care is arranged as needed. To ensure accuracy, timeliness and reliability, VA tracks the provision of breast and cervical cancer screening and the availability of breast and cervical cancer care coordinators across the system.

Preventing Suicide

Preventing Veteran suicide is a top priority, and VA has implemented a comprehensive public health approach to reach all Veterans. This approach is in full alignment with the President's national strategy, Reducing Military and Veteran Suicide[4], advancing a comprehensive, cross-sector, evidence-informed public health approach with focal areas in lethal means safety, crisis care, and care transition enhancements, increased access to effective care, addressing upstream risk and protective factors, and enhanced research coordination, data sharing, and program evaluation efforts.

With the goal to reach Veterans both inside and outside VA care, VA launched *Suicide Prevention* 2.0 (SP 2.0). SP 2.0 is a population-based, public health model of intervention. SP 2.0 includes community-based prevention strategies and evidence-based clinical strategies that empower action at National, regional, and local levels. To accomplish the goal of working toward ending suicide among all 20 million U.S. Veterans, a comprehensive approach to suicide prevention that blends community-based prevention and clinically based interventions is needed. The model works to reach Veterans in the community and those we currently serve in VA with evidence-informed community-based prevention strategies combined with strategies with known outcomes for reducing suicide and suicide attempts based upon the VA-Department of Defense (DoD) Clinical Practice Guidelines.

Another tool VA actively uses to combat suicide is the Veterans Crisis Line (VCL), which offers support to Veterans who reach out for help. Since July 16, 2022, the VCL has been easily accessible via 988, and pressing 1. The new, shorter number, implemented thanks to the National Suicide Hotline Designation Act of 2020, directly addressed the need for ease of access and clarity in times of crisis, both for Veterans and non-Veterans alike. Between 2007 and October 2022, VCL has taken more than 6.4 million calls, 269,000 texts, 772,000 chats and provided more than 1.2 million referrals. Since the official launch of 988 through February 5, 2023, VCL has seen a 12.35 percent increase in call volume and 25.46 percent increase in text volume compared with last year. Average calls per day exceeded 2000 between July 15, 2022, and February 5, 2023. Additionally, VCL campaigns are designed to raise awareness of call, chat, and text supports for Veterans in crisis. The campaign also provides social media, web, print and video resources that can be broadly shared through the Spread the Word Initiative .

In partnership with the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, VA is facilitating State-level efforts to prevent Veteran suicide with the Governor's Challenge to all States and territories. The Governor's Challenge advances a public health approach to suicide prevention by bringing together key State leaders to develop strategic action plans focused on Veteran suicide prevention. As the President announced in the State of the Union address, VA is working with the Departments of Health and Human Services and Defense to work with the States and territories through the Governor's Challenge. VA is launching a new $10 million program to further bolster these efforts.

[4] Military-and-Veteran-Suicide-Prevention-Strategy.pdf (whitehouse.gov)

We appreciate Congress' support in this regard. Additionally, with the launch of Mission Daybreak, VA invited innovators across the country to participate in a $20 million challenge to help VA develop suicide prevention strategies for Veterans. VA received over 1,300 submissions and recently announced 2 Grand Prize Winners as well as second and third place prize winners. The prize winners have at least one element in common: they each reflect various innovative approaches to clinical and community-level suicide prevention and intervention and they each are well-positioned to be deployed across a variety of settings and communities as part of our collective suicide prevention efforts.

VA is expanding outreach to Veterans like never before. To reach Veterans wherever they are, VA has emphasized paid media campaigns to facilitate suicide prevention awareness. These include: 1) Don't wait. Reach out; 2) Keep it Secure; and 3) the Veterans Crisis Line. To develop the "Don't Wait. Reach Out" campaign, VA entered into an agreement with the Ad Council, a national non-profit organization that uses donated communication industry resources to elevate messaging. The campaign strategy was informed by extensive research with Veterans and portrays real Veterans in all videos. For the Don't Wait, Reach Out Campaign, from October 2021-July 2022, we have had over 1 billion impressions with over $10 million in donated media value.

The Keep it Secure campaign is a national public health campaign, launched in September 2021, focused on safe storage for firearms during times of distress. From launch through January 2023, the campaign has garnered over 1.8 billion impressions, and over 20 million website visits to access resources and support for safe storage. As part of the White House Strategy to Reduce Military and Veteran Suicide, VA will continue expansion of this lethal means safety campaign this year with new communication endeavors also focused on providers, caregivers, and family members of Veterans, encouraging secure storage of firearms and medication.

Finally, the VCL campaign works to reach Veterans and those who love them to support them 24/7 during times of crisis. Since the launch of the VCL campaign in February 2020 until July 2022, there have been nearly 2 billion impressions. When developing these and other campaigns, VA strives to represent the demographic and cultural diversity of Veterans. Together with ongoing campaigns like AboutFace and Make the Connection, VA hopes every Veteran will see themselves represented and know VA is here to serve them. VA is also making it easier for customers to connect with us with VA.gov and VA's Health and Benefits mobile app as our digital front door and 1–800-MyVA411 as our telephonic front door.

With the enactment of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act , P.L. 116–171) , VA is using new authorities that improve Veterans' mental health and substance use disorder care and services through the expansion of mental health care options. This includes the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP), which awards grants to eligible entities to provide or coordinate suicide prevention services to eligible individuals and their families. This grant program is the first-of-its-kind effort by VA to provide funding for local suicide prevention programs through outreach, suicide prevention services, and connection to VA and community resources.

Through this new program, VA awarded $52.5 million to 80 grantees in 43 States, the District of Columbia and American Samoa. Twenty-one grantees serve Tribal lands including Navajo Nation, Cherokee Nation, Choctaw Nation, Alaskan Native Tribes and others. Funding decisions reflect VA's authority to prioritize the distribution of grants to rural communities, Tribal lands, Territories of the United States, medically underserved areas, areas with a high number or percentage of minority Veterans or women Veterans, and areas with a high number or percentage of calls to the Veterans Crisis Line.

In addition to implementation of the authorities in the Hannon Act, VA continues to implement several other statutory requirements related to mental health care. As of January 17, 2023, as part of the COMPACT Act, eligible individuals (including Veterans) in suicidal crisis are eligible to receive covered emergency care – including transportation costs, inpatient or crisis residential care—from any health care facility, whether at VA or in the community. Inpatient care is available for up to 30 days, and outpatient care is available for up to 90 days.

Access to Burial Benefits

VA is focused on increasing access to burial benefits as well by developing new National cemeteries, developing additional gravesites at existing National cemeteries, and establishing and expanding Veterans cemeteries through grants to States, territories, counties and Tribal organizations. VA has been steadily managing the largest expansion of the cemetery system since the Civil War. VA has

opened 13 new cemeteries in the last decade with one more planned this year. We also plan to open one new cemetery in each of the next two years. These National cemeteries will provide new or enhanced burial access to over 3.8 million Veterans and their families.

VA is also working with States and Tribal authorities to encourage the development and placement of VA grant-funded cemeteries in locations where Veterans do not have reasonable access to a burial option, either in a VA National or VA grant—funded Veterans' cemetery. Tribal access is a particular focus for VA. Within the last year, VA has engaged directly with the Crow Tribe in Montana, the Pascua Yaqui tribe in Arizona and the Sisseton Wahpeton Oyate tribe in South Dakota to address challenges and identify potential solutions regarding utilization of their grant-funded cemeteries. Similar sessions with leaders from the remaining eleven tribes with grant-funded Veterans cemeteries are planned.

In Fiscal Year 2022, VA interred nearly 150,000 Veterans and eligible family members in our National cemeteries—the highest number of annual interments VA has recorded. Also in Fiscal Year 2022, VA also provided more than 350,000 headstones, markers and columbarium niche covers around the world, as well as nearly 12,000 medallions to mark the privately purchased headstones of Veterans. But these statistics reveal a key challenge for VA: ensuring Veterans know about and take advantage of interment in a VA national cemetery, or a VA-funded State, territorial or tribal cemetery.

Approximately half of all Veterans are eligible for benefits and services, about one third of all Veterans actively use VA health care, and 85 percent of eligible Veterans use their GI Bill benefits (either themselves or by transferring those benefits to a family member). However, only 15 percent of all Veterans who die each year are interred in a VA National cemetery, with another 5 percent interred in a VA-funded State, territorial or Tribal cemetery. That's why we are embarking on a campaign to ensure that Veterans know they have the option to Choose VA for their final resting places. To ensure they know that VA stands ready to fulfill our solemn obligation to them: to care for them and their loved ones in a manner that mirrors their own dedicated service and devotion to our Nation – in perpetuity.

Serving Veterans with Environmental Exposures

Passage and enactment of the PACT Act marked the largest and most significant expansion of Veterans' care and benefits in decades, empowering VA to deliver additional care and benefits to millions of Veterans and their survivors. VA issued sub-regulatory guidance and provided training before going live with nationwide claims processing on January 1, 2023. Prior to implementation of the law, the VA used its authority under sections 403, 404, and 406 of the PACT Act to treat all presumptive conditions newly added as part of the PACT Act as applicable as of August 10, 2022, instead of future phased-in dates as prescribed by the law, to allow VA to deliver much-needed benefits and access to care to Veterans, family members, caregivers, and survivors as soon as the law was signed. As of February 4, 2023, VA has received nearly 300,000 PACT Act-related claims and completed over 110,000 claims. Using the new PACT Act authorities, VA has granted presumptive service connection for over 1,200 terminally ill Veterans.

VA immediately began executing a comprehensive, targeted outreach effort to encourage Veterans and survivors to apply now for PACT Act-related care and benefits. VA hosted 127 PACT Act "Week of Action" events between December 10th and 17th in all 50 States, the District of Columbia, and Puerto Rico. Each event was open to Veterans, their families, caregivers, survivors, and advocates as well as the press. Invitations were also extended to Members of Congress, State Directors of Veterans Services, and local officials and stakeholders. More than 50,000 attendees participated in person or online, VA completed 5,600 exposure screenings, and received 2,600 claims for benefits, and more than 800 applications to enroll for health care. Over the coming weeks and months, VA will continue targeted outreach efforts to include public service announcements (PSA), advertisements such as the video billboard in Times Square, social media posts, and radio, TV, and audio streaming.

One of the biggest challenges VA faces is identifying and contacting survivors, even more so now that many more may now be eligible for benefits under the PACT Act. We have mailed nearly 300,000 letters to potentially eligible survivors and are working with Veterans Service Organizations and survivor organizations such as the Tragedy Assistance Program for Survivors (TAPS) and Gold Star Wives to amplify and streamline messaging. VA is also leveraging social media and posting YouTube videos to provide easy to read information on PACT Act. VA's goal is to provide information on the PACT Act not just to survivors themselves, but to anyone who may know a survivor so that VA's message can reach as many impacted individuals as possible.

Toxic Exposure Screenings

As of February 8, 2023, VA has screened more than 1.78 million Veterans for toxic exposure. Of the 1.78 million Veterans screened, 43 percent required follow-up. This includes both Veterans who reported possible exposure, and Veterans who were unsure of potential exposure concerns and had additional questions. When the screening is initiated by physicians (MD), osteopathic doctors (DO), advanced practice registered nurses (APRN), and physician assistants (PA) with privileges, 90 percent of followup screenings occur on the same day as the initial screening. If a screening is initiated by a staff member without clinical privileges (such as the facility Toxic Exposure Screening, or TES Navigator), the followup screening is then referred to and completed by a clinical provider. This ensures all Veterans with health concerns receive appropriate clinical assessment in a timely manner.

Toxic Exposure Research and Registry

VA has completed a review of the Airborne Hazards and Open Burn Pit Registry in light of the 2022 National Academy of Sciences Engineering and Medicine (NASEM) 5-year review of the Registry, VA's internal Office of Inspector General review and our partnership with DoD to better address a Service member's (soon to be a Veteran's) health through the separation health assessment done at separation or retirement from military service.

Title V of the PACT Act elevates the timely progress of exposure science through a whole-of-government approach. VA, in collaboration with the heads of other Federal entities, will establish an interagency, mission-aligned toxic exposure research working group with the goal of collaboratively developing and executing a 5-year strategic research plan on the health consequences of toxic exposures experienced during active military, naval, air, or space service, as required by section 501 of the PACT Act. VHA's Office of Research and Development met with other Federal agencies on February 2, 2023, to address section 501 of the PACT Act, and establish an interagency Toxic Exposure Research Working Group, which will, in part, identify collaborative research activities and resources available among entities represented by members of the Working Group to conduct collaborative research activities and develop a 5-year strategic plan for such entities to carry out collaborative research activities.

Ending Veteran Homelessness

VA has made significant progress in preventing and ending Veteran homelessness and VA remains focused on ending homelessness for all Veterans. Since 2010, the number of Veterans experiencing homelessness in the United States has declined by more than 55 percent. More than 1,000,000 Veterans and their family members have been permanently housed, rapidly rehoused, or prevented from falling into homelessness through VA's homeless assistance programs. VA housed over 40,000 homeless Veterans in 2022. This accomplishment along with VA's ongoing collaborative efforts with the Departments of Housing and Urban Development and Labor and the U.S. Interagency Council on Homelessness, are anticipated to further reduce the overall number of Veterans experiencing homelessness.

Supporting Transitioning Service Members

VA is charged with ensuring that every Veteran is aware of and understands the benefits they have earned as they transition from military service. In Fiscal Year 2022, VA conducted 6,467 Transition Assistance Program (TAP) briefings to over 164,000 Service members and provided 58,356 one-on-one counseling sessions.

The VA Solid Start program which launched in December 2019 has successfully connected with 315,604 (66.4 percent) eligible Veterans and provided information about, and access to, the benefits and services they have earned. Additionally, to reduce the Veteran suicide risk and to ensure continuity of care, VA Solid Start provided priority contact to those Veterans who met certain risk criteria. Since the program launched, VA Solid Start has successfully connected with 53,220 (78.9 percent) priority Veterans supporting a successful transition to VA mental health care treatment.

VA has begun work with DoD on a TAP Military Life Cycle (MLC) module with Other than Honorable (OTH) discharge as the topic focus. Further, VA will look to update OTH information in the VA TAP Benefits and Service Participant Guide beginning in March 2023. VA has found Veterans with an OTH character of discharge did not receive adequate information or support to connect with the VA benefits and services for which they are eligible, which may have detrimental downstream effects on a population already prone to crisis situations (mental health emergencies, joblessness, suicidality, homelessness, etc.).

VA has a special commitment to understanding and supporting the unique needs of women Veterans. The Women's Health Transition Training Program is a critical resource tool that provides a comprehensive holistic approach to help transitioning Service women and recently separated women Veterans understand their VA health care benefits and services. In concert with our TAP interagency partners, VA has worked diligently to promote the Women's Health Transition Training Program through TAP and other means to make sure every Service woman is aware of this specialized course and is able to participate in this effective learning opportunity through five modules.

Improving Economic Opportunity

VA is dedicated to improving the economic opportunity of Servicemember, Veterans and their families. VA has undertaken a number of improvements with the Veteran Readiness and Employment (VR&E) Program, Education Program, Home Loan Guaranty Program and Insurance Service to ensure that Veterans have an opportunity to achieve suitable employment, attain an education, obtain affordable housing, and maintain life insurance for themselves and their families.

In Fiscal Year 2022, VA implemented a six-point plan to improve outcomes for Veterans participating in the Veteran Readiness & Employment (VR&E) Program. This plan includes implementing a new comprehensive data management system (RES), formerly known as the Case Management System (CMS); implementation of e-VA, electronic document signing, and other system enhancements; enhancements to the Veteran Success on Campus (VSOC) program; Employment Services; Quality Review Teams; and increased Vocational Rehabilitation Counselor (VRC) recruitment and retention.

VA continues its efforts in realigning the services provided by the VSOC program. VSOC counselors have taken on increased workload allowing for more Veterans to be served in a counseling capacity at the school to which they are assigned. Therefore, an updated position description has been classified, removing the positive education requirement, which ultimately expands the population of individuals who can qualify to work as a VSOC counselor.

Through the Digital GI Bill (DGIB), the VA is also transforming how GI Education Benefit Claims are submitted, reviewed, and processed using a multi-prong strategy – with the intent of enhancing the Veteran and beneficiary education experience. In August 2022, for the first time, Veterans were able to submit original Post–9/11 GI Bill applications could through an automated system. Applicants receive a head start by having pre-filled service history information which leads to quicker eligibility decisions, including as soon as the same day instead of more than 10 days on average.

In support of the DGIB, the Office of Information and Technology (OIT) has worked with its VBA partners to successfully deploy "My Education Benefits" through va.gov, allowing the automated processing of original claims for the first time ever. The DGIB team has also moved the DGIB Application to production, saving the government millions in infrastructure costs for cloud computing and storage. DGIB is ready to deploy the "Enrollment Manager" and Chatbot to over 45,000 school certifying officials around the world, which will improve the user experience for schools and increase automation of claims. This allows for the decommissioning of the VA-Once legacy application. In addition, VA has refined the rules so that Supplemental Automation has consistently been above 50 percent and as high as 62 percent. Last, the DGIB team deployed text messaging (with opt-in rates above 90 percent) and email services, enabling faster communication with VA that allows Veterans and beneficiaries to easily verify their enrollment in college courses.

The Veterans Rapid Retraining Assistance Program (VRRAP) was enacted on March 11, 2021, under the American Rescue Plan to support Veterans seeking retraining and economic opportunities in response to the effects of the COVID–19 pandemic. VA worked on a highly effective PSA campaign with over 29 million impressions on television and radio, as well as a robust social media campaign to increase Veteran and eligible schools' awareness and participation in VRRAP. VA processed over 5,600 enrollments in less than 90 days. These actions were vital in allowing VA to obligate 98 percent of the $386 million available for Veterans to train and find suitable employment.

The Veteran Employment Through Technology Education Courses (VET TEC) is a 5-year pilot program for eligible Veterans to help them secure meaningful employment in the technology sector. VET TEC pairs eligible Veterans with market-leading training providers offering sought after high-tech training and skills development. Since the program started, over 93,000 Veterans have applied for VET TEC with 64,463 receiving Certificates of Eligibility. 9,075 Veterans have graduated from a VET TEC training program and 4,089 have found meaningful employment with an

average salary of $65,118. The VET TEC Employer Consortium helps Veterans bridge the gap between program completion and meaningful employment, it also fosters a network of employers and training providers for graduates to leverage at the beginning of, and throughout, their careers.

VA is dedicated to protecting Veterans as they pursue higher education. The Department of Education (ED) recently announced final rules that will better protect Veterans and Service members from predatory recruitment practices. These regulations implement an important change made by the American Rescue Plan, closing a longstanding loophole in the Higher Education Act of 1965 that allowed for-profit colleges to aggressively recruit Veterans and Service members because they could count money from Veteran and Service member benefits toward their 10 percent revenue requirement (other than Federal assistance). VA worked with ED on this effort and is assisting schools in maintaining compliance with ED's 90/10 rule, by providing training on how to obtain reports from VA detailing GI Bill payments.

Since 1944, VA's home loan program has helped almost 28 million Veterans achieve the dream of home ownership. This program continues to maximize opportunities for Veterans, Service members, and surviving spouses to obtain, retain and adapt their homes. Veteran households have higher homeownership rates than the general population and, for many Veterans, VA's home loan program is the most advantageous mortgage option. Veterans make up approximately 6 percent of the U.S. population, but VA home loans account for 13 percent of the current mortgage market. VA's home loan program is popular because Veterans receive competitive interest rates, pay limited closing costs, and avoid private mortgage insurance requirements—usually without having to make a down-payment. Due to efforts of the Loan Guaranty Service to improve the program, even in today's higher interest rate environment, rates for 30-year, fixed-rate VA home loans currently average nearly one-half of 1 percent (or 50 basis points) lower than rates on conventional loans. Another specialized feature of the home loan program is the individualized service VA loan technicians provide to Veteran borrowers facing financial difficulty.

VA continues to look for opportunities to improve the homebuying process for Veterans and their families. Through people, process, and technology enhancements, 76 percent of home loan certificates of eligibility (COE) are issued instantaneously. Appraisal timeliness has shown steady improvement, with average business days to completion decreasing from 10.4 business days in October 2021 to 6.7 business days in January 2023. As a member of the Property Appraisal and Valuation Equity (PAVE) Task Force, supporting Veterans' ability to utilize their home loan benefit without bias or racial impacts is of utmost importance. VA's commitment is further augmented by the fact that VA is the only agency that maintains and oversees an independent appraisal panel. VA recently announced advanced oversight procedures to improve methods of screening for potential appraisal bias and discrimination.

VA remains committed to expanding opportunities for homeownership to Native American Veterans residing on trust land. VA is providing expansion through increased outreach to and collaboration with the 574 federally Recognized Tribes. VA has signed 111 memoranda of understanding allowing the signatory Tribes to participate in the Native American Direct Loan (NADL) program. We continue to work with stakeholders in the State of Alaska to expand this vital direct loan program for Native American Veterans residing in Alaska.

At the start of the COVID–19 pandemic, VA proactively announced numerous flexibilities in servicing guidelines to help Veterans with VA home loans. Since the start of the pandemic, VA's loss mitigation options have helped more than 200,000 Veterans remain in their homes, with more than 30,000 Veterans assisted through VA's temporary home retention options, the COVID–19 Veterans Assistance Partial Claim Payment, and the COVID–19 Refund Modification programs. As the COVID–19 national emergency nears an end, VA continues to explore changes in servicing policies and home retention options to assist Veteran borrowers.

As VA celebrates the 75th anniversary of the Specially Adapted Housing (SAH) grant program this year, it is worth reflecting on the nearly 50,000 grants that have been awarded under this program since inception. Each SAH grant represents VA's enduring commitment to assisting the Nation's most severely disabled Veterans live independently in their homes. The enactment of the Ryan Kules and Paul Benne Specially Adaptive Housing Improvement Act of 2019 led to expanded SAH assistance, with nearly $250 million in grant approvals in fiscal years 2021 and 2022.

VA Insurance Service provides 5.7 million Veterans, Service members, military families and survivors insurance coverage totaling over $1.45 trillion with Servicemembers Group Life Insurance (SGLI) coverage increasing to $500,000, the highest level ever. This makes VA the Nation's 12th largest American life insurer. Additionally, on January 1, 2023, VA launched VALife, a whole life policy which eliminates time barriers and medical underwriting for all service-connected Vet-

erans with any rating (0–100 percent) aged 80 and under. VALife offers automated online applications and instant approvals even through a smart phone and at the most competitive rates which will never increase.

Supporting Family Caregivers

VA expanded its Program of Comprehensive Assistance for Family Caregivers (PCAFC) to eligible family members and Veterans of all eras on October 1, 2022, and has received over 44,300 applications as of February 8, 2023. Previously, PCAFC was only available to eligible Veterans who served on or after September 11, 2001. On October 1, 2020, VA expanded the program to eligible Veterans who served on or before May 7, 1975, or on or after September 11, 2001. Currently, there are over 44,800 Veterans participating in the PCAFC across the country, including territories. As of February 8, 2023, 98 percent of PCAFC applications are dispositioned in under 90 days.

VA is not only adding to the services and supports that we offer our caregivers but focusing on how VA offers it. Additionally, VA is enhancing and expanding the types of resources provided to caregivers, including enhanced respite, mental health services, and the caregiver and Veteran experience. The Caregiver Support Program has partnered with the Office of Mental Health and Suicide Prevention to fund 54 mental health clinicians who will be dedicated to providing mental health services for our Family Caregivers through clinical resource hubs. In addition, VA is funding 14 respite liaisons to assist caregivers in experiencing a smooth and seamless respite experience.

VA has trained over 120 staff at 54 sites to be health and well-being coaches for Caregivers. These coaches focus on providing individualized personal care plans on areas that matter most to caregivers. By the end of this fiscal year. VA will have staff trained at every VA medical center in this model. VA has also trained over 7,271 staff through the Campaign for Inclusive Care, which seeks to move from caregiver support to caregiver integration, making the caregiver an integral part of the Veteran's treatment team.

In addition, caregivers participating in PCAFC will have access to services such as household budget planning, debt management, retirement planning review and education, and assistance with advanced directives, power of attorney, simple wills, and guardianship.

Investing in Our People

Providing Veterans, their families, caregivers, and survivors access to world class health care, timely access to earned benefits, and when the time comes, a final resting place is only possible with an enterprise-wide team of the best and brightest in their respective fields. VA is investing in our people by dramatically increasing hiring, holding onboarding surge events to onboard staff more quickly, increasing the use of incentives for recruitment and retention, maximizing pay authorities and scheduling flexibilities, expanding scholarship opportunities, and providing more education loan repayment awards than ever before.

Veterans' Health Administration

In Fiscal Year 2022, VHA nearly doubled the number of scholarships for clinical education offered to employees and increased the number of Education Debt Reduction Program (EDRP) awards to over 3,000. Additionally, the percentage of staff receiving recruitment, retention, and relocation incentives (3Rs) more than doubled from 5.9 percent to 12.2 percent. At rural facilities, the use of 3Rs increased from 4.3 percent to 18.9 percent. And for some critical shortage occupations, such as housekeeping aides (10.5 percent to 35 percent) and food service workers (2.1 percent to 18.7 percent), the use of 3Rs increased even more dramatically. These incentives assisted with the reduction of loss rates for critical shortage occupations in those areas to address increased competition for health care and entry level staff.

The nationwide onboarding surge event that occurred in November 2022 resulted in onboarding more new staff in VHA in the first quarter of Fiscal Year 2023 (12,900 staff) than first quarter onboarding in any previous year, this was 86 percent higher than the typical number onboarded in the first quarter. Onboarding continued to be high in January 2023 (5,603 new staff onboard, approximately 600 more than last January). VHA's emphasis on hiring has also resulted in a net increase in onboard staff of 2.1 percent as of January 31, 2023. This is already two-thirds of our end strength goal of 3 percent growth just 4 months into the fiscal year.

Veterans Benefit Administration

Through the implementation of the PACT Act, VA has actively engaged the workforce through a variety of avenues and solicited feedback. Since the enactment of the PACT Act, VA has hosted open townhalls with VA leaders, hosted local townhalls led by the Regional Office Directors and engaged with both labor partners and claim processors to ensure the workforce is equipped with the necessary information to process PACT claims and to resolve concerns. VA created a PACT Act inquiry tool to allow regional offices direct access to policy experts for questions about process and policy. In response to feedback on training, VA hosted additional live training sessions and created additional tools to aid processors in understanding how to implement the law.

These investments in employee engagement are critical as we look to hire more employees than ever before. Under the initial Toxic Exposure Funding (TEF) spend plan approved on October 6, 2022, VA allocated 1,871 positions toward claims processors and supporting staff. As of February 21, 2023, VA has hired 1,257 of the 1,871 positions (67.2 percent).

Currently, VA is hosting in Salt Lake City the 7th in-person PACT Act Career and Hiring Fair of the month. These events have been a resounding success with thousands of candidates coming in-person to learn about available jobs, participate in onsite interviews, conduct suitability assessments, and complete fingerprinting, resulting in hundreds of candidates receiving tentative job offers the same day. VA is leveraging all available hiring options to ensure we meet our PACT Act hiring goals – including the use of expanded hiring authorities provided in Title IX of the PACT Act.

VA continues to partner with military installations to recruit military spouses and transitioning Service members. The Secretary visited the VA Intake Center at Fort Hood and discussed the total rewards of a VA career directly with Service members. Additionally, during the Waco hiring fair, the Secretary spoke directly to candidates interested in career opportunities with VA. Fiscal Year 2022 was a record year for VA hiring and by the second quarter of Fiscal Year 2023, we are pleased to report that we have already surpassed 60 percent of Fiscal Year 2022 total hires.

National Cemetery Administration

Developing our staff is a critical investment for all of VA. The Cemetery Director Development Program trains the next generation of leaders at NCA by teaching them how to lead, manage burials, conduct maintenance, and manage administrative operations at a national cemetery. The Cemetery Caretaker/Representative is the face of VA to grieving families at our National cemeteries and VA has recently upgraded the position to increase recruitment and retention of these important staff and to provide them with advancement opportunities.

Transforming Systems, Processes, and Infrastructure

VA has strengthened its capital construction project change management processes for Major Construction, Major Lease, and CHIP In Act (Community Helping Invest through Property and Improvements Needed for Veterans Act of 2016) projects. This has been accomplished through regular engagement on projects at both the local and national levels, collaborative review of decision event documents, and synchronization of the VA change management processes for these programs. Over time, this will improve VA's ability to deliver large projects within budget and on schedule, and to be good stewards of taxpayer investments while bringing modernized health care infrastructure to support care for the Nation's Veterans.

Authorities in Title VII of the PACT Act have already helped further our infrastructure further improvement in our infrastructure All 31 leases authorized by the PACT Act are in development, with some already in the solicitation phase. The revised approval and budget authorities for leases allow VA much greater flexibility than in the past, particularly accelerating timelines for leases that fall below the new Major Lease threshold but above the previous threshold. VA is in active discussion with multiple academic affiliates and multiple DoD entities on opportunities enabled by new authorities in the PACT Act, and both are already informing our Fiscal Year 2025 Strategic Capital Investment Process currently underway.

VA is making progress in upgrading its facility infrastructure to correct deficient building systems, such as horizontal cabling and electrical upgrades, that will support modernized technologies such as the electronic health record, financial management, and supply chain management systems. This needed investment in facility infrastructure will allow timely and efficient future deployments of these modernized systems. The increase in non-recurring maintenance funding in recent fiscal years has allowed VA to make bigger investments per project and allowed many more projects to be funded. These improvements will help VHA address more of the Facility Condition Assessment backlog than has been possible previously.

The modernization of VA's electronic health record (EHR) system is a highly complex clinical and business transformation endeavor, with the opportunity to standardize and optimize clinical operations for VA health care personnel, support delivery of consistent, high-quality care for Veterans, and ensure interoperability with the DoD and the broader health care community. In October 2022, VA delayed upcoming deployments until June 2023 to address challenges with the system. VA has been focusing on assessing and remediating identified issues at the five current sites where the system has been implemented and has been planning for future sites. VA is committed to continuous improvement of the electronic health record and associated health information technologies, even while executing ongoing deployments across the health care system in the years to come. VA continues to develop and finalize a new deployment schedule and remains fully committed to implementing a modernized electronic health records system, in service of providing the best possible care for our Veterans.

Our national cemeteries are also transforming and evolving with the rest of the agency to meet Veterans' expectations in the modern, cyber-driven world. Beyond merely establishing the physical burial locations, NCA has embraced technology and made significant improvements to its digital landscape to better serve Veterans and their families. The Veterans Legacy Memorial (VLM) continues to expand its reach among Veterans, their families, and friends. Loved ones and others can upload tributes, photos, and other items to a Veteran's VLM page, hosted on NCA's public-facing webpage. The number of VLM pages, for those individuals buried in National and VA grant-funded cemeteries, increased to 4.4 million pages in 2022. This year VA is planning to add VLM pages for those interred in 28 DoD-managed cemeteries, including Arlington National Cemetery, 18 Army post cemeteries, 5 Navy cemeteries, and 4 Air Force cemeteries. VLM was awarded three industry awards last year, further highlighting its unique position in honoring the lives and legacies of Veterans.

NCA is also preparing to meet the changing needs and preferences of Veterans and their families in the 21st century. With the enactment of the National Cemeteries Preservation and Protection Act of 2022 (P.L. 117–355), NCA will soon begin piloting green burials at the Pikes Peak National Cemetery with potential expansion to other locations. Green burial sections will include a natural appearance of the grounds, with a design and grounds maintenance plan based on the cemetery's geographic location, which may include use of natural prairie and meadow grasses and wildflower mixes.

The Path Forward

As described throughout this statement, there are many joint concerted efforts to address every domain of Veterans, their families, caregivers, and survivors' lives. While many of these efforts are still in early stages, we commit to a continued partnership of transparency and accountability to ensure VA is doing right by those we serve. VA is a Veteran-centric, collaborative and transparent organization dedicated to serving more Veterans than ever before.

STATEMENTS FOR THE RECORD

Prepared Statement of Concerned Veterans for America

Statement of Russ Duerstine

Executive Director, Concerned Veterans for America

on

"Building an Accountable VA: Applying Lessons Learned to Drive Future Success"

House Veterans Affairs Committee

February 28, 2023

Thank you to Chairman Bost, Ranking Member Takano, and Members of the Committee for the opportunity to submit this statement on behalf of Concerned Veterans for America (CVA). CVA is a grassroots network of thousands of veterans, family members, and patriotic citizens across the country who advocates and defends policies to preserve freedom and prosperity for all Americans. Our organization is driven to organize and amplify the American veteran's unique perspective to both the American people and our leaders in Washington.

CVA's History in Veterans' Health Care Reform

As a leading advocate for reform and accountability at the Department of Veterans Affairs and for increased health care choices for our veterans since 2012, CVA is well-positioned to discuss the importance of robust congressional oversight of the VA and the policies that so many of our nation's bravest rely on. As systemic failures came to light in 2014 after the Phoenix VA scandal, CVA activists were on the front lines from the beginning demanding change, contributing to bringing three major pieces of veterans' health care legislation across the finish line.

In the immediate aftermath of the Phoenix VA scandal, CVA fought for the Veterans Access, Choice, and Accountability Act of 2014, which established the first iteration of a choice program for veterans to seek care outside the VA. CVA also backed the VA Accountability and Whistleblower Protection Act of 2017, which gave the VA the freedom to fire poorly performing employees while shielding whistleblowers from retaliation. While these efforts laid an early foundation to change incentives at the VA and improve outcomes for veterans, more work was needed to improve veterans' care experiences.

CVA was a key supporter of the passage of the VA MISSION Act in 2018, which passed with overwhelming bipartisan support. This legislation incorporated many of the recommendations of the 2015 Fixing Veterans' Health Care Task Force convened by CVA, namely by creating the Veterans Community Care Program (VCCP). By consolidating existing choice programs and simplifying access standards, the VA MISSION Act offered greater health care choice to millions of veterans, enabling far more to access care where and when they needed it.

Ensuring the full implementation of the VA MISSION Act and holding the VA accountable for failures to do so have been consistent priorities of CVA's since the legislation passed. The VA's reluctance to honor its

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regulatory and statutory obligations since the VA MISSION Act's passage has limited millions of veterans' health care choices, too often resulting in delayed and denied care. Ensuring successful implementation of the VA MISSION Act is an essential oversight priority for the 118th Congress. This legislation was passed to proscribe the conditions that caused the Phoenix VA scandal, and neglecting its execution risks these failures recurring. After the passage of the PACT Act last year, the VA has new treatment obligations to millions of veterans, and ensuring the VA MISSION Act is fully implemented as intended will be essential to helping the VA keep its promises to these and existing beneficiaries.

VA MISSION Act Implementation Failures: Community Care At Risk

Since the VA MISSION Act's passage, the VA has chosen to effectively pick and choose what regulations and sections of the law to follow.

Rather than support the success of the VCCP as a treatment option that will enable veterans to get care faster and improve the VA's capacity to provide care at its own facilities, the agency has taken several actions to minimize the VCCP's use among veterans. Reports have emerged of VA administrative staff overruling doctors' assessments of patients' best medical interests and overruling community care referrals, even though these clinical referrals are listed as a source of community care eligibility in the VA MISSION Act text.[1] The VA engages in little-to-no outreach to veterans about the access standards for community care eligibility, and VA internal guidance discourages employees from offering to review veterans' eligibility for community care during appointment requests.[2] CVA's experiences with thousands of veterans across the country corroborates this guidance and reports from Congressional offices that constituents are simply not being told by the VA that community care is an option available to them.[3] In 2021, the VA announced plans to shut down the Office of Community Care itself and the VA MISSION Act website.[4]

If this weren't evidence enough of the agency's hostility to community care, documents obtained through an ongoing Freedom of Information Act lawsuit filed by Americans for Prosperity Foundation (AFPF) reveal that VA internal phone scripts actually direct schedulers to attempt to dissuade veterans who ask for community care from using it.[5]

This pattern of unelected bureaucrats subverting the stated will of Congress in the VA MISSION Act demands robust oversight and accountability from lawmakers.

The House Veterans Affairs Committee should continue to hold hearings on the implementation and status of the VCCP, and legislators should freeze performance bonuses for senior VA leaders and subject the Office of the Secretary to funding penalties in the FY 2024 appropriations cycle if they continue to put administrative roadblocks in place for veterans' access to community care.

Wait Time Calculations

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[1] Jill Castellano, "The Mission Act is supposed to help US veterans get health care outside the VA. For some, it's not working." *USA Today*, November 1, 2021. https://www.usatoday.com/in-depth/news/investigations/2021/11/01/mission-act-aid-veterans-healthcare-va-isnt-letting-it/8561618002/

[2] "Standard Mission Act Guidance: Patient Eligibility and Scheduling Sheet." *Department of Veterans Affairs*, October 28, 2020. https://americansforprosperity.org/wp-content/uploads/2021/09/03-Mission-Act-Guidance-Oct.-2020.pdf

[3] Letter to Secretary Denis McDonough. *Office of Senator Steve Daines*. July 14, 2022. https://www.daines.senate.gov/wp-content/uploads/imo/media/doc/VA-%20Community%20Care-%20FINAL%207.14.2022.pdf

[4] Leo Shane III, "Changes to VA's community care program raise concerns about vets' health care access." *Military Times*, October 13, 2021. https://www.militarytimes.com/veterans/2021/10/13/changes-to-vas-community-care-program-raise-concerns-about-vets-health-care-access/

[5] Referral Coordination Guidebook. *Veterans Health Administration*, March 10, 2021. Pg. 62. https://americansforprosperity.org/wp-content/uploads/2021/09/Referral-Coordination-Initiative-Guidebook.pdf#page=62

Despite clear VCCP regulations the VA put in place after the VA MISSION Act took effect in 2019, the VA has ignored its own guidance, adopting legally incorrect, misleading, and often obsolete measurements that artificially make veterans' wait times appear shorter than they truly are.[6] For years, the VA's failures to follow the standards of the VA MISSION Act in wait time calculations have come under criticism from the Government Accountability Office, the VA Inspector General, and veterans' organizations such as CVA.[7]

In May 2021, the Government Accountability Office wrote Secretary McDonough, outlining why the VA's current scheduling practices leave wait time calculations, central to determining community care eligibility, "subject to interpretation and prone to scheduler error."[8]

Documents obtained through the Americans for Prosperity Foundation's ongoing FOIA lawsuit with the VA corroborate the GAO's concerns.[9] These records reveal that the VA is refusing to refer eligible veterans for community care, manipulating wait time data by continuing to use outdated scheduling guidance to calculate wait times based on the "patient-indicated date" (PID) metric rather than a veteran's actual date of request for an appointment as directed in the VA's own guidance for the VCCP issued after the MISSION Act.[10] Through a variety of means, such as beginning wait time clocks after VA schedulers input requests into their scheduling system or restarting wait time measurements after existing appointments are canceled or rescheduled, faulty VA measurements make wait times appear artificially shorter than they truly are.

Wait time manipulation has concrete effects on how many veterans can access community care. For example, AFPF's FOIA revealed that the Southern Arizona VA's outdated PID wait time calculations left only 4.2 percent of veterans' primary care appointments eligible for community care providers, compared to the over 21 percent that would qualify if they used the veterans' "date of request" as the MISSION Act requires.[11] It's a similar story for specialty care, where the Southern Arizona VA's PID wait time calculations left only 9.3 percent of veterans' appointments eligible for community care, compared to the 26.7 percent that should qualify.[12]

Fortunately, in the end-of-year December 2022 omnibus, an included provision now statutorily obligates the VA to calculate and publicly display wait times from a veterans' date of request to their actual date of appointment.[13] Congress must ensure that the VA adheres to these obligations immediately. Should the VA fail to update its wait-time calculations for public display and community care eligibility to the required date of request to date of appointment measurement, Congress should freeze performances bonuses for senior VA leaders and subject the Office of the Secretary to funding penalties in the FY 2024 Appropriations cycle.

Disengaged Leadership: Stonewalling Transparency

Unfortunately, VA leadership has displayed a pattern of resisting transparency efforts from both Congress

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[6] For a detailed explanation of the VA's wait-time calculation errors, see: "Delayed and Denied Care: Transparency and Oversight Needed for VA Wait Times." *Concerned Veterans for America*. February 22, 2022. https://cv4a.org/wp-content/uploads/2022/02/22_298900_VAPolicyBriefingHandout.pdf

[7] "Veterans Health Administration: Concerns with Consistency and Transparency in the Calculation and Disclosure of Patient Wait Time Data," *Department of Veterans Affairs Office of Inspector General*, April 7, 2022. https://www.va.gov/oig/pubs/VAOIG-21-02761-125.pdf

[8] "Priority Open Recommendations: Department of Veterans Affairs." *Government Accountability Office* to Secretary Denis McDonough. May 10, 2021. https://www.gao.gov/assets/720/714332.pdf

[9] Records confirm VA's use of inaccurate wait time numbers." *Americans for Prosperity Foundation*, October 1, 2021. https://americansforprosperity.org/records-confirm-va-inaccurate-wait-time-numbers/

[10] "Veterans Community Care Program" Department of Veterans Affairs, *Code of Federal Regulations*, title 38 (2019): 26278. https://www.federalregister.gov/documents/2019/06/05/2019-11575/veterans-community-care-program

[11] "Records confirm VA's use of inaccurate wait time numbers." *AFPF*.

[12] Ibid.

[13] Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, §2, Div. U. https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf

and the public. The VA's dismissive approach to AFPF's ongoing FOIA lawsuit regarding the VCCP and VA wait-time calculations provides a trenchant example.

As AFPF explained in a December 2022 motion to modify the court-ordered production schedule:

> Of the 1,767 pages of responsive records produced so far, only 269 pages have been non-duplicative after accounting for identical records released across multiple interim productions… Roughly 85% of all pages disclosed to AFPF, in other words, have been duplicate copies. In September 2022, for example, the VA produced a two-page email 44 times, and over the course of three months (September-November) it produced a twenty one-page PowerPoint file 42 times.[14]

Veterans and taxpayers deserve better than this woeful approach to transparency on a program that is a cornerstone of access to care for millions of veterans. The VA displays an ongoing resistance to embracing the Veterans Community Care Program as a partner, choosing instead to view it as a threat to its narrow bureaucratic interests. In the interests of ensuring the tenets of the VA MISSION Act are upheld, the House Veterans Affairs Committee should formally subpoena the records at issue in the AFPF FOIA litigation. Court filings reveal that the VA has already uploaded all potentially responsive records to its ediscovery software program, so the agency should be able to immediately turn them over to the Committee.

Conclusion

VA's failures to follow the implementing regulations and statutory requirements of the VA MISSION Act place access to care for millions of veterans in danger. Given the VA's substantial new PACT Act obligations, the agency's hostility to community care could not come at a worse time. Popular veterans' programs such as the GI Bill's educational benefits center on veterans by maximizing their individual control and choice. We do not require veterans to use their GI Bill benefits at public universities—it is the commitment to funding veterans' education that matters, not the delivery system.

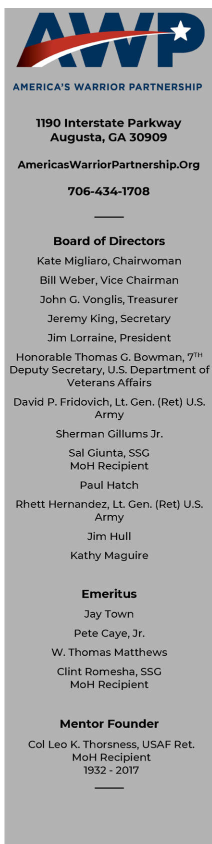
VA should adopt the same approach toward veterans' health care, and Congress should continue to demand reporting from the VA on local, regional, and national average wait times, as well as community care outreach efforts. Putting veterans at the center of their health care by maximizing the choices they have available best keeps our promise to those who have borne the battle.

Sincerely,

Russ Duerstine
Executive Director
Concerned Veterans for America

[14] "Plaintiff's Motion for Modification of the Court's Production Order." *Americans for Prosperity Foundation v. U.S. Department of Veterans Affairs*. Civil Action No. 21-1954 (RC). https://americansforprosperity.org/wp-content/uploads/2023/01/ECF-No.-28-Pl.s-Mot.-for-Modification-No.-21-1954.pdf

Prepared Statement of America's Warrior Partnership



Statement for the Record
House Veterans Affairs Committee
"Building an Accountable VA: Applying Lessons Learned to Drive Future Success"
February 28, 2023

By Jim Lorraine, America's Warrior Partnership

Chairman Bost, Ranking Member Takano, Honorable Members of the Committees:

It is an honor to present this statement for the record. The topic of accountability at the VA is necessary and long-overdue. Thank you for raising this issue, and dedicating time and attention to ensure the VA is providing the best possible service to our nation's veterans.

Over the past several decades, Congress has passed numerous laws providing widespread authority for the VA to expand programs, run efficiently, and increase the workforce. At the same time, Congress was also very clear that outcomes would be tracked, and improvements would need to be proven. If those were not met or issues arose, laws were created to enable the VA to demonstrate accountability.

However, in those decades, the changes have not materialized. The same issues that plagued the VA 30 years ago remain, and in some cases, have compounded. This has led to a loss in trust in the VA among veterans.

More accountability is needed at the VA for both programs and people. And senior leaders need to take responsibility for the programs and people they are charged with overseeing.

Problems such as access to care, long wait times, claims backlogs, and others, persist across the system. In fact, at America's Warrior Partnership, one of the biggest issues that veterans regularly communicate to us is confusion and delays in accessing health care. Whether it is the VA purposefully trying to keep services in the VA system, or veterans not being told of the ability to request a community referral, accessing care remains a top issue. And in response, veterans have requested more community referrals than ever, and continue to vote with their feet to show that the preference for many is not to get care in the VA.

The delays in accessing care have compounded re-occurring health issues, especially mental health. Waiting months to see a different mental health counselor every visit is taxing on the veteran and poor healthcare practice given an antiquated documentation system. It is amplified by the overwhelming urge of many mental health professionals to over-prescribe as a reflex to the challenges presented, rather than taking the time to build the necessary relationships with veterans.

This leads to an ongoing issue over over-prescribing and overdose. As AWP found in our Operation Deep Dive Study, drug overdose continues to plague the veterans community in the same manner it has infiltrated communities across the nation. This undercurrent is something that VA has not appropriately resourced or acknowledged. Fentanyl and opioids are dangerous. And they are more dangerous when individuals have access regular to them. This includes many of those veterans who seek help, only to end up with countless bottles of dangerous pills. The solution is not matching Narcan distribution to every opioid prescription. The solution is combining continuity of care with proximal and timely services.

Much of this is likely tracked by the VA. However, it is hard to tell because there is very little transparency by VA researchers who put together the Annual Veteran Suicide Study or overdose reports. In fact, both the House and Senate VA Committees have written letters laying out multiple questions regarding the methodology of the study. The VA needs to be much more open about what the data behind the study includes, how the numbers are gathered and determined, and what is left out the study.

By contrast, Operation Deep Dive has clear data: including names, manner of death, and full-service records of all those included in the suicide study. However, as we have mentioned to this Committee on numerous occasions, the one piece of data missing from the study is VA data. Congress has been very clear in law and intent; the VA must share data with research organizations. In fact, nearly all the organizations are attempting to help the VA tackle major issues. The VA must recognize that there is a common goal to be accomplished, and be a more productive partner – and it starts by sharing data.

Finally, the VA has spent great time and effort to create a professional atmosphere amongst employees and facilities. There are countless hard-working and dedicated VA professionals at well-run facilities throughout the United States. However, a small number of individuals continue to cause problems that damage the professional culture. This leads to a loss of trust amongst veterans and employees and has caused retention issues of top talent.

The VA must liberally and judiciously use authorities granted by Congress to remove bad employees within the VA, regardless of occupation, tenure, or demand. It is the only way top talent will stay at the VA and foster the professional culture required to fix systemic issues.
the necessary relationships with veterans.

Again, thank you to all the Members of the House Veterans Affairs Committees for your thoughtful and diligent work on behalf of our nation's veterans. Your service in Congress to those who served in uniform is mirrored by the high regard our citizens have for their veterans. The respect is borne of great sacrifice, and it is an honor to work on their behalf.

With sincere thanks and respect,

Jim Lorraine
President and CEO
America's Warrior Partnership

Prepared Statement of American Federation of Government Employees

Chairman Bost, Ranking Member Takano, and Members of the Committee:

The American Federation of Government Employees, AFL–CIO (AFGE) and its National Veterans Affairs Council (NVAC) appreciate the opportunity to submit a statement for the record on today's hearing titled "Building an Accountable VA: Applying Lessons Learned to Drive Future Success." AFGE represents more than 750,000 Federal and District of Columbia government employees, 291,000 of whom are proud, dedicated Department of Veterans Affairs (VA) employees. These include front-line providers at the Veterans Health Administration (VHA) who provide exemplary specialized medical and mental health care to veterans, including those newly eligible for treatment under the Sergeant First Class (SFC) Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act. Furthermore, we represent the Veterans Benefits Administration (VBA) workforce responsible for the processing veterans' claims, the Board of Veterans' Appeals (Board) employees who shepherd veterans' appeals, and the National Cemetery Administration Employees (NCA) who honor the memory of the Nation's fallen veterans every day.

With this firsthand and frontline perspective, we offer our observations on the problems the VA Employees are facing, many of which were created or exacerbated by VA leadership. AFGE provides these examples with goal of both urging the VA to address these issues administratively and highlight to the House Veterans Affairs Committee to use its oversight and legislative authority to better enable VA employees, over a third of whom are veterans themselves, to continue serving veterans. Specifically, AFGE will identify current issues and needed solutions related to:

- Veterans Benefits Administration:

  o Performance Standards, including:

- Counterproductive Frequency of Changes to Processes
- Failure to Award Credit for Each Issue Claimed
- "Talk Time" at VBA National Call Centers

  o Addressing the critical need for staffing with the rapid influx of new PACT Act claims.

  o Ensuring the training for VBA employees is adequate, nationally consistent, and beneficial.

- Board of Veterans Appeals

  o Performance Standards

  o Recruitment and Retention

- Veterans Health Administration

  o Monitoring that VHA has the staff it needs to meet the increased demand created by the PACT Act.

  o Ensuring that VHA is using the compensation tools it gained in the PACT Act to benefit lower-grade front line clinicians.

  o Ensuring that VHA compensates its employees what they are owed.

  o Restoring full HR functioning at the facility level through additional hiring, training, and decentralization.

- VA Police

We hope you find these suggestions constructive, and we stand ready to work with the Members of the Committee to make necessary and positive improvements to the VA.

Performance Standards for VBA Employees

For many years prior to the passage of the PACT Act, AFGE has highlighted the many problems with the VBA performance standards faced by its employees. Standards are often introduced and implemented for VBA staff in a haphazard manner and are overly focused on metrics that prioritize quantity over quality, providing a disservice to the veterans they are intended to benefit. Unfortunately, these problems have not been solved by the PACT Act, but instead further highlighted with increased demand from the PACT Act. When asking bargaining unit employees in the VA's Regional Offices (VARO) to identify the single biggest obstacle they face

to successfully performing their duties and serving veterans, the universal answer is constantly changing performance standards.

Counterproductive Frequency of Changes to Processes

A classic example of VBA's constant change to performance standards was the implementation of new performance standards for Veteran Service Representatives (VSR) and Rating Veteran Service Representatives (RVSRs) on October 1, 2020, with a three-month acclimation period. Since the implementation of these standards, VBA made changes to these standards in November 2020 and December 2020, and then announced at the end of the end of December 2020 that it would make more changes leading to another three-month acclimation period. These standards were changed again in January 2021, again in March 2021, and were finalized on April 1, 2021. For context, these standards are incredibly complex and take time to learn, requiring acclimation periods to allow the employees to fully understand them. Having six changes made in six months was severely disruptive and made it difficult for staff to perform their duties and effectively serve veterans. Had VBA worked collaboratively with AFGE representatives from the beginning when changing these standards to gain employee perspectives and input, many of these problems could have been avoided and VBA would have been able to process claims in a more efficient and timely manner.

The implementation of the PACT Act is leading to changes in performance standards for numerous positions throughout VBA, while the manual that states correct procedures and provides technical advice is updated weekly. Through AFGE's midterm bargaining, AFGE proposed a Memorandum of Understanding to allow for a 180-day adjustment period for claims processors to learn these new complex procedures and adjust accordingly. The VA refused, and instead stated that the 90-day adjustment period was non-negotiable. This unnecessary and self-imposed obstacle will only continue to stress and pressure VBA employees, lead to additional errors, and inadvertently cause errors to veterans' claims.

Furthermore, since the start of 2023, VBA has imposed new standards for Authorization Quality Review Specialists, Rating Quality Review Specialists, Fiduciary Program Specialists, and Quality Review Specialists in the National Call Center. AFGE attempted to reach a memorandum of understanding with VBA on these changes prior to their implementation on January 1, 2023, rather than VBA unilaterally imposing new standards on the workforce. While AFGE was able to bargain issues related to appropriate arrangements and procedures with the VBA, the VBA refused to negotiate the metrics themselves. These standards will lead to additional employee errors, burnout, higher turnover, and decreased service to the veterans they serve. As these standards are implemented and other performance standards are updated, AFGE urges VBA to work in good faith with AFGE to design fair and attainable standards that prioritize quality over quantity, and best serve veterans. Specifically, AFGE recommends that the VBA offer a more generous grace period to learn the evolving complexities in both PACT Act and older claims and give employees additional time between manual updates which will allow employees to absorb information prior to adjusting to changes. AFGE also urges the committee to perform oversight on the developments of new VBA production and quality standards in response to both older claims and new PACT Act claims to ensure that these standards enable employees to serve the best interests of veterans.

Failure to Award Credit for Each Issue Claimed

Clearly, every veteran is supposed to be treated equally by the VA, but VBA performance standards can cause disparate treatment depending on the claim filed. When evaluating claims, VBA does not easily distinguish the number of issues or contentions each veteran makes in their claim, instead using a complex tier system that unnecessarily hurts the ability of VSRs and RVSRs to meet their standards. This is arbitrary and punishes employees who get assigned claims with a significant number of contentions, but not enough to earn additional credit. This can unfairly punish veterans who, through no fault of their own for the number of contentions they submit in a given claim, realize negative decisions affecting their claims.

The PACT Act will lead to the filing of many claims with significantly more contentions and distinctions. While we have advocated repeatedly for a change in employee production standards that adequately account for complicated claims, the implementation of the PACT Act necessitates a fair and accurate recalibration of standards, and new training programs and procedures to factor in the additional work and time that will be required to process these new claims and urge the committee to monitor the implementation of these performance standards.

We also urge the Committee to monitor the VBA's changes to these standards and ensure that they enable employees to best serve veterans, instead of meeting arbitrary and self-imposed internal metrics.

"Talk Time" at VBA National Call Centers

For years, AFGE has raised concerns to this committee about the VBA's measure of the timeliness or "talk time" component for Legal Administrative Specialists (LAS) who answer veterans' questions at VBA's eight national call centers. Each LAS is allotted a certain amount of time they can be on the phone with a veteran based upon the employee's GS level. This can be as little as eight minutes and thirty seconds. This is a one size fits all standard that does not consider common issues veterans often call in about including a "first notice of death call" where a veteran's spouse is calling to inform the VA that the veteran has passed away. Such a call may take 20–30 minutes. The standard also does not take into account the numerous older veterans who have difficulty communicating or veterans who have more than one question or issue to resolve. It also does not account for a veteran not having their VA "Pin Number" available and leaving the LAS on the phone while they attempt to locate the information. Additionally, the standard effectively disincentivizes an employee from suggesting to a veteran about a benefit or program he or she may be eligible for but does not know to ask about, because it would take more time on the phone.

With passage of the PACT Act, there has been a predictable surge in calls to the national call centers with numerous questions for VBA employees. Despite the fact this problem that was easily anticipated by VBA leadership, employees, including those in the National Call Centers, have not been given any additional time to meet their talk time standards, and were only provided with a short generic script to respond to a veteran's complex questions.

An employee whose primary responsibility is to answer a veteran's questions should not have their performance measured by how quickly they can get a veteran off the phone, and the VA should not prioritize a contrived metric over providing valuable customer service to veterans, especially in the wake of a massive and complex expansion of benefits to millions of veterans. VBA should remove Talk Time as a critical component of employee performance.

Furthermore, it has come to AFGE's attention that on October 20, 2022, VBA instituted new performance standards for the call centers that further restricted the use of "wrap up time" at the end of the day for LASs to input data, prepare mail to veterans and complete other tasks that they could not handle during calls. This change was also accompanied by a new availability standard that substituted percentages for raw minutes, further increasing stress on workers, and unnecessarily increasing the difficulty of the job. These rules, which result in unnecessarily limiting bathroom breaks, are pennywise and pound foolish, and decrease the quality of service that veterans receive.

VBA Staffing and Backlog

The enactment of the PACT Act has resulted in a need to increase the size of the VBA workforce to process the expected surge in claims from newly eligible veterans. In a Senate Veterans Affairs Committee Hearing on February 16, 2023, Josh Jacobs, the nominee for Undersecretary of the VBA stated that VBA expects 700,000 new PACT Act claims to be filed in 2023. This in part explains why in a presentation made to AFGE representatives, VBA estimated that the current backlog of 150,000 claims is expected to increase to 450,000 claims in 2023. Additionally, according to the data on staff vacancies required by Section 505 of the VA MISSION Act, VBA has 2,806 vacancies as of the end of the third quarter of Fiscal Year 2022. Despite this, while the VA has hired many new claims processors, AFGE has heard reports of slow hiring for employees, one example being the Cleveland, Ohio, VARO, which is having a delay in hiring candidates who are disabled veterans. These delays have taken months, causing some applicants to accept other jobs. Additionally, given the months it takes to effectively learn to process claims, this delay is worsening the backlog to the detriment of veterans. AFGE urges the VBA to continue to quickly ramp up its staffing and training of claims processors and allow it to better manage the backlog of claims, instead of relying upon mandatory overtime, which exacerbates employee burnout.

Training

The PACT Act mandates several new VA workforce training initiatives. However, the information shared with employees since enactment has been greatly inadequate. So far, VBA employee have five Talent Management System courses, the vast majority of which last 30 minutes each, courses and given a new Standard Op-

erating Procedure to read. To date, no hands-on training or opportunities to ask questions of a live instructor have been offered.

This will foreseeably create inconsistency in the future with different VAROs creating different determinations. AFGE urges the VBA to increase training, including ample opportunity to ask questions. Specifically, for all training to be effective, including PACT Act training, it is essential that management solicit input from the labor representatives' rank and file members who are actually working claims as to what training would enable them to better serve veterans. Furthermore, AFGE recommends that VBA create a team of specialized instructors to travel to different to regional offices and provide this training to employees while using real claims as examples, giving employees the opportunity to ask questions in real time. By using this model and not having each Regional Office assemble their own team, this will ensure consistency in training across the agency, and create less variability between Regional Offices.

Board of Veterans Appeals

AFGE is proud to represent the employees who work at the Board of Veteran Appeals (Board). This dedicated workforce plays a critical role in the final stage of the claims process for claims that require additional review. However, there have been recent decisions made at the Board that have created negative consequences for Board attorneys and the veterans they serve.

Performance Standards

Board attorneys, like VBA claims processors, face difficult to meet performance standards that cause burnout and harm recruitment and retention. Prior to the implementation of the Appeals Modernization Act (AMA), Board attorneys were expected to complete 125 cases a year, a pace that averaged 2.4 cases per week. Each case, regardless of the number of issues decided, carried the same weight toward an attorney's production quota. In Fiscal Year 2018, the Board increased its production standards from 125 to 169 cases per annum, (or 3.25 cases per week), a 35 percent increase in production requirements which was overwhelming for Board attorneys. In Fiscal Year 2019, the Board created an alternative measure of production for Board attorneys which evaluated the total number of issues decided by an attorney, regardless of the number of cases completed, setting that number at 510 issues decided. AFGE supports the creation of this alternative metric as it better accounts for the work required to complete each case. However, we caution that measuring the number of issues can also be manipulated to create unfair metrics. Unfortunately, this manipulation appeared in Fiscal Year 2020, the first full year the AMA was fully implemented, because while the case quota remained at 169, the issue quota was raised to 566. Finally in Fiscal Year 2021, the quota was changed to a more manageable but still difficult 156 cases or 491 issues. Unfortunately, AFGE has heard reports that the Board intends to increase its production quota for the next Fiscal Year in an attempt meet expected appeals as a result of the PACT Act. Simply increasing the quota will not increase production and may result in reduced quality for veterans who have often waited years to have their appeals heard.

These standards are also harmed by the rule that a Board attorney may only receive credit for a case once a judge signs off on the work. While this requirement may appear reasonable, delays caused by overburdened judges can cause attorneys to miss their quotas through no fault of their own. When attorneys are adjudged to be performing poorly based on such missed quotas, it violates Article 27, Section 8, Subsection E of AFGE's collective bargaining agreement with the VA, which states "When evaluating performance, the Department shall not hold employees accountable for factors which affect performance that are beyond the control of the employee." The VA should adhere to the terms of the collective bargaining agreement and not penalize workers for no fault of their own. This is especially true since the Board recently began the practice of hiring Veteran Law Judges, or Board Members, who have no experience in Veterans law, and are simultaneously harming employees' performance and slowing down the appeals process for veterans who have waited long enough for their claims to be finalized. The leadership of the VA and the Board should revert to hiring Board Members with significant veteran law expertise and look to current Board Attorneys to fill those positions.

Recruitment and Retention

To further assist with recruitment and retention, the Board of Veterans' Appeals is a place where attorneys should have a path to work for their entire careers. To accomplish this goal, the Board needs to re-establish a standard career ladder for GS–14 Board Attorney positions which had until recently existed for new hires. Eliminating this level of growth and compensation for attorneys is a direct way of

dissuading qualified applicants from joining the Board of Veterans Appeals or choosing to stay long term. The VA should reverse this shortsighted policy and attract the best candidates to the Board's ranks.

Additionally, AFGE strongly supports the creation of a journeyman non-supervisory GS– 15 Board Attorney position. Currently, Board attorney grades range from GS–11 to GS–14. Of the 871 attorneys currently at the Board, 439 attorneys are at the GS–14 level. While not all attorneys would qualify or choose to advance to a GS–15 position, creating the possibility for 100 to 200 GS–15 attorneys would help with long-term recruitment and retention. It is also important to note that there are non-supervisory journeyman GS–15 attorneys within the VA Office of General Counsel, thus setting a precedent. As Board attorneys are in the Excepted Service, it is within the Secretary's discretion to create and fill these new positions. AFGE has and continues to encourage the Secretary to create this advancement opportunity and has asked Congress to voice its support for this change or pass legislation establishing its creation.

VHA Staffing, Compensation, and Other Workforce Issues

As a result of the PACT Act, VHA is facing an unprecedented increase in demand for medical care. The hiring and training of additional health care personnel will be essential to meet the screening and treatment needs of newly eligible veterans in virtually every medical center service line, in particular primary care clinics, emergency rooms (ER), cardiology, pulmonology, urology, gastroenterology and dermatology. Unfortunately, an informal survey of our members reveals very limited efforts to hire, train or carry out other activities for an effective rollout of new PACT Act health care initiatives and increased demand for services.

Staffing

There is an urgent need for VHA to address the chronic short staffing that significantly worsened during the COVID–19 pandemic. According to the data on staff vacancies required by Section 505 of the VA MISSION Act, VHA had 76,531 vacancies as of the end of the third quarter of Fiscal Year 2022. Outpatient clinics are forced to shut their doors due to lack of staff.

Many facilities cannot reopen their hospital beds due to a critical nurse staffing shortage, leaving veterans in the ER for up to 48 hours waiting to be admitted. AFGE received an encouraging member report from a VISN 6 facility that is actively carrying out onboarding events to expedite the hiring of more clinical staff, an effort that should be replicated across the country. Another VISN 6 provider provided a less encouraging report that his facility's management has failed to step up recruitment and retention efforts, and in some cases, is actively pushing employees to resign.

AFGE has received very troubling reports from our locals at numerous facilities that medical center directors who received retention incentive funds provided by the PACT Act have not distributed them to front line clinicians even in the face of high vacancy rates. Also, the job listings posted by medical centers in many locations failed to align with the much higher vacancy rates used to justify these retention incentive dollars. More generally, congressional oversight of the deeply flawed and unreliable vacancy data that is currently collected and published by the VA is badly needed.

A failed HR modernization effort launched under the Trump Administration and continued under the Biden Administration is exacerbating staffing shortages. Under this modernization, Human Resources (HR) functions traditionally performed by personnel at medical centers were centralized at the VISN level. AFGE members across VISNs report that lack of coordination between the facilities and the VISN are extending the time it takes to hire employees and often leads to "bait and switch" offers where new employees take jobs based on compensation, benefits and duties that change when they begin the job. Many qualified candidates lose interest in VA positions or accept a job only to quit shortly thereafter when it was not what was agreed upon. This situation deteriorates even further for many employees who choose to stay, as VA employees also report that HR mistakes create "debt" for employees whose pay is clawed back retroactively. Employees receive inadequate information about how they can have this debt waived.

For an agency that has claimed it wants to recruit the best providers possible and that recruitment and retention of employees is a top priority, the counterproductive centralization of HR functions away from the medical centers must be reversed. Front line personnel and their labor representatives need access to knowledgeable HR specialists *at the facility level* to resolve routine personnel matters.

Compensation

Compensation that is not competitive with private pay remains a major barrier to both recruitment and retention. The pay grades of a number of lower-wage VHA positions, including the nursing assistants and licensed practical nurses who make up the core of VA community living center workforces, are still too low to recruit and retain sufficient staff. Similarly, medical support assistants who handle patient scheduling and other critical support functions are already working at a low grade that causes a lot of attrition and in some cases are facing downgrades to even lower positions.

According to the VA master agreement, the VA should review wages offered by non-VA hospitals in a region to determine if VA pay is competitive but often fail to fulfill this obligation. As a result, VA employees are often paid based on out-of-date information about local wages.

While it is encouraging that the PACT Act may make it easier to hire more housekeepers to keep medical facilities clean and safe, this position has had a high attrition rate for many years. VA needs to raise their pay grades to make them more competitive with the private sector.

The lack of mobility between grades further worsens shortages as employees stymied by lack of opportunity for promotion—even after years of experience and/or receiving additional training—leave for jobs where their advanced skills are rewarded.

Collective Bargaining

In 1991, Congress amended Title 38 to provide medical professionals who work at VA facilities with limited collective bargaining rights (which include the rights to use the negotiated grievance procedure and arbitration) (P.L. 102–40 § 202). Under 38 USC § 7422, covered employees can negotiate, file grievances and arbitrate disputes over working conditions except "any matter or question concerning or arising out of":

- professional conduct or competence (defined as direct patient care or clinical competence);
- peer review; or
- the establishment, determination, or adjustment of employee compensation.

This has resulted in VA management interpreting these exceptions very broadly and refusing to bargain over virtually every significant workplace issue affecting Title 38 medical professionals. It is also very problematic that VA managers are increasingly asserting "7422" themselves, rather than requesting a 7422 ruling from the VA Under Secretary for Health (USH) as required by statute. (The statute authorizes the VA Secretary to make 7422 rulings. In a 1992 memorandum, the VA Secretary delegated this authority to the USH (formerly called the Chief Medical Director.).

When managers refuse to seek a USH 7422 ruling, the union's efforts to enforce the rights of Title 38 professionals are hamstrung because nothing prevents the VA medical center from belatedly and retroactively obtaining a USH 7422 ruling when the Federal Labor Relations Authority (FLRA) threatens the VA with ordering remedial relief for the professionals. When local management asserts Section 7422 but does not seek an USH ruling, the union is forced to file an Unfair Labor Practice (ULP). The FLRA Regions generally decline to take any action. However, if the FLRA region starts to pursue an action over the ULP charge, the management will then seek an USH ruling even though it is late in the FLRA litigation process.

VA Title 38 medical professionals have extremely limited collective bargaining rights in comparison to their counterparts in other federal agencies, State and local government systems, and the private sector. As a result, Registered Nurses (RNs), doctors and other impacted employees at the VA are experiencing increased job stress, low morale, and burnout. This in turn, exacerbates the VA's recruitment and retention problems. AFGE seeks a legislative fix that would restore full collective bargaining rights to title 38 employees. But in the absence of this reform, VA should be held accountable for its overuse of 7422 exceptions to block workers' right to grieve agency wrongdoing.

Contract Care Access Standards

The MISSION Act required the Department to implement access standards to determine when veterans should be referred outside the VA health care system for care in the private sector through the Veterans Community Care Program (VCCP). These standards consider how long veterans wait to access VA in-house care and how long it takes for the veteran to drive to the closest VA medical facility in order to determine if the veteran should be referred to a VCCP provider. If a veteran must wait more than 28 days for VA in-house care or drive more than 30 minutes for

VA in-house primary care or 60 minutes for VA in-house specialty care, than he or she can choose to go outside the VA to a VCCP provider instead.

The access standards have caused unprecedented number of VCCP referrals. But the double standard on wait times for VA vs. VCCP care has resulted in many veterans waiting longer and driving further for non-VA care than they would have if they continued receiving VA in-house care. A Government Accountability Office analysis of VHA data from the third quarter of Fiscal Year 2022 found that VA medical scheduled timely referrals for VHA facility appointments more frequently than community care.

The current double standard must be eliminated; a revised access standard must be applied equally to the VA and VCCP providers. Currently, the access standards do not consider the wait times and driving times that veterans will face to access care outside the VA.

In addition, the driving time component of the access standard is not restrictive enough and results in the overuse of contract care even when a veteran would be better served by in-house care. VCCP providers should be supplementing, not supplanting the VA. Multiple studies have shown VA's own care to be of higher quality with better health outcomes, and less costly than private sector care.

The access standards also apply a double standard to care provided by telehealth and tele-mental health ("telehealth"). The VA has long been recognized as a leading telehealth model by other health care systems. Yet, the access standards do not count VA in-house telehealth services in determining if the VA has met the standard. As a result, veterans who would have not had any wait for VA-provided telehealth care are sent to VCCP providers who treat them through telehealth programs of unknown quality and at greater cost to taxpayers.

Last Congress, Secretary McDonough testified before the Senate Veterans' Affairs Committee that he was considering revising the access standards in order to address the skyrocketing costs of VCCP care. He also committed in his testimony to propose changing the way that VA telehealth availability is factored in determining eligibility for community care. The department has not yet proposed these changes.

Oversight is needed to ensure that the VA Secretary revises the current access standards to increase the drive time limit and count VA in-house telehealth when determining whether the VA has met the standards. Additionally staffing levels at facilities must be adjusted so that veterans' needs for in-house care are not compromised by workloads associated with VCCP referrals.

Privatization

The VA MISSION Act of 2018 established a nine-member Asset and Infrastructure Review (AIR) Commission to make recommendations regarding "closure, modernization and realignment" of VHA facilities. AFGE took a cautious approach at first to the Commission, hoping that the process might result in more attention to the VA significant need for infrastructure investment and modernization. However, in March 2022, the VA announced its recommendations to the AIR Commission, calling for a vast privatization of VA services through the closure or downsizing of nearly 60 VA medical centers, around a third of the total across the country. The VA's plan called for transferring these functions to new, mostly smaller facilities that had yet to be funded or built, or to the private sector, with almost no analysis of the quality, cost, or availability of those private services. The VA used outdated, pre-pandemic analyses to support its recommendations, an approach that was lambasted by its own OIG, the Government Accountability Office, and a panel of private experts the VA convened through MITRE Corporation. Despite the obvious frailty of the VA's process, the MISSION Act established a fast-track process for approving the recommendations, with little opportunity for Congress or other stakeholders to exert any influence.

AFGE and the NVAC mobilized across the country in opposition to the AIR Commission, holding rallies, contacting Members of Congress, publishing articles, and partnering with affected veteran organizations. As the result of these efforts, in June 2022 a bipartisan group of senators including many from the Senate VA Committee announced their opposition to confirming any AIR Commission members. In July 2022, a bipartisan House majority voted to strip funding from the AIR Commission and to deauthorize the commission in the annual NDAA. In December, Congress approved the 2023 omnibus spending bill which defunded the AIR Commission and imposed new restrictions on the VA ability to close or downsize rural healthcare facilities.

Nonetheless, the threat of privatization persists. A separate section of the MISSION Act, unaffected by Congress's recent actions, directs the department to conduct strategic infrastructure reviews every four years, with the first review expected in 2023. In the late summer of 2022, following the collapse of the AIR process, sev-

eral VISN's contacted AFGE locals with plans to continue pursuing the hospital closures recommended to the defunct AIR Commission, with no apparent attempt to update the discredited market assessments behind those recommendations.

Other VHA Workforce Matters

Veterans in need of screening and treatment for toxic exposure need and deserve the thorough, specialized, comprehensive care that only the VA provides. We received a concerning report from VISN 23 that veterans may be shortchanged by a new "bookable hours" policy that cuts the time that a provider can spend to assess a new patient from sixty to thirty minutes. Doctors unable to meet this standard must choose between working extra hours off the books to compensate for time they spend assessing new patients or depriving veterans of the care they deserve.

Our members report that the online training on new screening tools that has been provided is a good first start but that more comprehensive training is needed to ensure that all clinicians and support personnel have a full understanding of the specialized screening processes and treatment needs of veterans with toxic exposure.

VA Police

AFGE is proud to represent the VA Police Officers in facilities across the country. As is evidenced by a VA Office of the Inspector General (OIG) Report issued February 22, 2023, titled "Security and Incident Preparedness at VA Medical Facilities," there are significant challenges facing the VA Police Department. As the summary of the report states that "[t]he OIG identified multiple security vulnerabilities and deficiencies, most notably staffing shortages that contributed to the lack of a visible and active police presence. To meet VA's established security requirements, facilities will need to fill police officer vacancies, as employing sufficient security personnel and correcting security weaknesses are inextricably linked."

AFGE agrees with the need to recruit and retain more police officers to keep veterans and employees safe at VA facilities. Approximately 90 percent of VA police officers are veterans. Its officers are highly trained in crisis intervention to de-escalate situations at VA facilities, and these officers have unique knowledge of the facilities within their jurisdiction and how to interact with veterans. However, regardless of the number of officers recruited, if the VA cannot retain them, it does not help the agency. As AFGE advocated for years, the single biggest change that VA leadership can do to help with the recruitment and retention to the VA Police Force is to grant the VA Police Officers Law Enforcement Officer (LEO) Retirement either through administrative action or by supporting this bipartisan legislation.

AFGE has raised this issue before, including in submitting a Statement for the Record on a hearing before the House Veterans Affairs Committee Subcommittee on Oversight and Investigations titled "Modernizing the VA Police Force: Ensuring Accountability" in the 117th Congress on July 13, 2021. As was stated previously, under 5 U.S.C 8336(c), any LEO who either serves 25 years or is age 50 or older and serves 20 years is entitled to immediate retirement with a full pension and has mandatory retirement at age 57 (with few exceptions). These are commonly referred to as "6(c) special retirement benefits" (6(c) benefits). However, the definition of LEO relied upon in the code (5 U.S.C. 8401(17)) to grant 6(c) benefits does not include VA Police Officers, and in turn they do not receive special retirement benefits on par with federal law enforcement officers at other federal agencies. AFGE has endorsed the "Law Enforcement Officers (LEO) Equity Act," introduced by Representatives Bill Pascrell, Jr. (D-NJ), Andrew Garbarino (R-NY), Gerry Connolly (D-VA), and Brian Fitzpatrick (R-PA) (this bill was H.R. 962 in the 117th congress, and is pending re-introduction in the 118th Congress). If enacted, this bill would grant 6(c) benefits to VA Police Officers as well as law enforcement officers of other federal agencies who do not have 6(c) benefits, including the Department of Defense (DoD), Federal Emergency Management Agency (FEMA), and the Federal Protective Service (FPS). In the 117th Congress, this legislation earned 105 bipartisan co-sponsors, including Chairman Mike Bost (R-IL), Ranking Member Mark Takano (D-CA), and seven members of the House Veterans Affairs Committee in the 118th Congress.

Granting 6(c) benefits to VA Police Officers would significantly help the VA Police Force with recruitment and retention. Currently, the VA hires many new recruits, sends them to the Law Enforcement Training Center (LETC) for training, and sees these officers depart the force for other opportunities within the federal government that have 6(c) benefits, or to other State and local police departments. If VA Police Officers were granted 6(c) benefits it is expected many more would stay with the department and feel less financial incentive to leave.

The continuous turnover of VA Police Officers represents a significant cost for the VA. Not only does the VA have to pay for new officers to attend LETC to backfill

positions, at a cost of thousands of dollars per officer, but the VA is spending resources on specialized training for its officers who leave the VA. A key example of this is the suicide prevention training that was enacted as part of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020. Because of this law, VA Police Officers who serve at VA Medical Centers, Community Based Outpatient Clinics (CBOC), or VA Regional Offices are now trained to prevent a veteran in a crisis situation from harming himself or herself or others. This is incredibly critical and specialized training that the VA invests in to save lives. The high attrition rates of VA Police Officers who undergo this training puts an added strain on VA resources. Granting 6(c) benefits to VA Police Officers will diminish this turnover, and help the VA maintain a stronger and better trained police department with higher morale. While the "Law Enforcement Officer (LEO) Equity Act," is not in the jurisdiction of the House Veterans' Affairs Committee, AFGE urges that members of this subcommittee, and consequently the full committee, to join their colleagues to become co-sponsors of H.R. 962 and urge its passage in the House. Additionally, while not a permanent solution, AFGE urges Secretary of Veterans Affairs Denis McDonough to use his administrative powers to grant 6(c) benefits to the VA Police Officers until these benefits can be codified.

Conclusion

AFGE thanks the House Veterans' Affairs Committee for the opportunity to submit a Statement for the Record for today's hearing. AFGE stands ready to work with the committee and the VA to address the workforce issues currently facing the department and find solutions that will enable VA employees to better serve our Nation's veterans.

Prepared Statement of Student Veterans of America

Chairman Bost, Ranking Member Takano, and Members of the Committee: Thank you for inviting Student Veterans of America (SVA) to submit a statement on the topic of Building an Accountable Department of Veterans Affairs (VA).

Through a dedicated network of campus-based chapters worldwide, SVA aims to inspire yesterday's warriors by connecting today's military-connected students, student veterans, family members, and survivors with a community of dedicated SVA chapter leaders. Every day these passionate leaders advocate for the necessary resources anywhere. This population is pursuing their education while working to provide support through networking and fostering a sense of comradery post-military service to ensure student veterans can effectively connect, expand their skills, and ultimately achieve their greatest potential.

Transparency and Accountability

SVA firmly believes that transparency and accountability go hand in hand. We encourage the Committee to focus on the following topics when considering how to build a more transparent and accountable VA so it can better serve student veterans and other military connected students.

1. Increase oversight of VA communications with institutions and training providers.

SVA heard growing concerns from School Certifying Officials (SCOs), institutions, and training providers recently concerning a lack of timely and accurate communications on policy changes and guidance.

Over the last 3 years, many important and necessary changes have been made to laws governing VA education benefits. For instance, the landmark Johnny Isakson and David P. Roe, M.D. *Veterans Health Care and Benefits Improvement Act of 2020*—appropriately dubbed by VA as "transformative"—required the Department to implement more than 30 new provisions.[1] SVA supported this bill and will be forever grateful for this Committee's work. However, based on our conversations with SCOs and other institutional representatives, VA has had challenges implementing certain aspects of the legislation. This has been particularly true when it comes to the Department disseminating clear, consistent, and timely guidance to institutions.

Communications issues at VA have also impacted certain aspects of its Digital G.I. Bill modernization project. This long-overdue project is making significant

[1] Isakson and Roe Veterans Health Care and Benefits Improvement Act of 2020, U.S. DEP'T OF VETERANS AFFAIRS, https://benefits.va.gov/gibill/isaksonroe.asp (last updated July 18, 2022).

changes to GI Bill IT systems.[2] Of course, these changes have implications for institutions as well. For instance, the Department is about to release its new Enrollment Manager—an updated system for SCOs to use when certifying enrollment for students using VA education benefits.[3] SVA believes this is an important update and supports the overall effort. Yet, we have been perplexed by some of the decisions made by VA and the seeming lack of consideration the Department has shown for input from insitutions.

Last year, for instance, VA announced plans to transition from the current VA-ONCE system to the new Enrollment Manager during arguably the busiest enrollment period of the spring semester. This decision came despite feedback from SCOs that doing so would have potentially disastrous consequences for student veterans and military-connected students due to delayed certifications resulting in late benefit payments, among other issues. We commend VA for ultimately heeding these concerns and delaying the rollout, but we still have reservations as to why the original decision was made in the first place and why input from SCOs was seemingly not considered earlier in the process.[4] At the time of this hearing, VA-ONCE sunset a few days ago, and VA's new Enrollment Manager will kick in March 6. SVA stands by to hear those using the new system.

SVA often hears from SCOs that they are not receiving the guidance they need from their VA Education Liaison Representatives (ELRs). The problem has sometimes been attributed to a shortage of ELRs. Though based on comments we have heard from VA representatives, it appears the Department simply views their ELR structure as in transition. Whatever the true nature of the issue, SVA believes ELRs are critical for VA to disseminate timely and accurate guidance to institutions. Considering what we have heard from SCOs about the current state of VA communications and guidance, SVA urges the Committee to explore whether ELRs are truly fulfilling their essential duties. If necessary, we ask that the Committee intervene to correct deficiencies.

As a general matter, SVA encourages the Committee to ramp up its oversight of VA's communications at all levels with institutions and training providers. We ask that the Committee more closely monitor VA's communications for timeliness and consult with institutions and training providers regularly regarding the clarity, consistency, and workability of VA communications, including on policy guidance.

2. Address concerns with VR&E processes and personnel.

SVA believes the Committee should focus a brighter oversight spotlight on the Veteran Readiness and Employment (VR&E) program.

In 2021, VA announced a self-identified change in how it assesses eligibility for VR&E as it relates to other veterans' education benefits. In short, a veteran may use their VR&E eligibility up to a 36-month cap and then, separately, use another education benefit, such as the Post–9/11 GI Bill, up to its own 36-month cap, with a total cap of 48 months. SVA would like to commend VA for identifying and changing its interpretation. This change provides a greater benefit to eligible veterans and complies with the underlying statute.

To continue this positive trend, SVA encourages the Committee to place a focus on ongoing areas of concern with the program that we hear about from student veterans, such as the lack of counselors, difficulty in contacting VA to determine eligibility, long timelines in the assessment process, inconsistent counselor guidance and determinations, among many other issues.

VR&E is one of the most flexible and important programs in VA's portfolio. Indeed, in certain scenarios, it provides a vastly greater benefit than even the generous Post–9/11 GI Bill. Particularly considering the recent change to entitlement charges by VA. It is more important than ever to thoroughly review this program for obstacles, barriers, and shortfalls that prevent it from fulfilling its true potential as a benefit. We look forward to working with the Committees on the best path forward for the program.

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[2] Transforming the GI Bill Experience, U.S. DEP'T OF VETEARNS AFFAIRS, https://digital.va.gov/delightful-end-user-experience/transforming-the-gi-bill-experience/ (last updated Feb. 22, 2023).

[3] Bulletin from Veterans Benefits Administration to School Certifying Officials (Dec. 13, 2022), available at https://content.govdelivery.com/accounts/USVAVBA/bulletins/33ced9d.

[4] See generally Letter from American Council on Education et. al to the Hon. Denis R. McDonough, Secretary, U.S. Department of Veterans Affairs (Dec. 8, 2022), available at https://www.acenet.edu/Documents/Letter-VA-Enrollment-Manager–120822.pdf (explaining institutional concerns); see Bulletin, supra note 3 (explaining VA chose to delay the rollout to "optimize functionality.").

3. Support and monitor ongoing improvements to the GI Bill Comparison and Feedback Tools.

The GI Bill Comparison and Feedback Tools are important transparency mechanisms that give students critical information to make informed choices about where to use their VA education benefits. Students can get cost estimates, see if a school has key veteran support programs and services, and view complaints against institutions, among other things. Yet, the tools also remain a source of great untapped potential. We urge the Committee, as we have in the past, to consider the following options to improve the GI Bill Comparison and Feedback Tools.

As it stands, the lack of coordination between the Department of Education (ED) and VA on College Navigator, College Scorecard, and GI Comparison Tool reduces the overall delivery of powerful data to veterans.[5] The Comparison Tool has unique data, justifying itself as a separate tool from ED's options, but the underlying data is not being shared effectively between these tools, leaving prospective students an incomplete view of their options. We encourage members to explore ways to better share and integrate the data across ED and VA resources.

SVA also believes student outcome measures should be displayed in the GI Bill Comparison Tool. Establishing the appropriate data feeds and displaying the information in the tool would require IT upgrades that fit neatly alongside those currently happening at VA. In one of our most common-sense recommendations, each institution should be required to disclose how effective it is at delivering on its promise to students. By informing military-connected students, student veterans, family members, and survivors about the effectiveness of GI Bill-eligible programs, we allow them to make informed decisions about how to spend their education benefits.

Additionally, we ask that the Committee encourage VA to note whether an institution participates in the VA VITAL Program. VITAL can provide critical mental health support for student veterans, assistance with academic accommodations, and foster a more veteran-inclusive campus culture. The GI Bill Comparision Tool currently includes a section on "Veteran Programs and Support" where VA could easily note whether the institution participates in VITAL and link to more information about the program's benefits.

The GI Bill Comparison Tool also suffers from a lack of detailed information about student complaints. For any given school, the tool simply shows a tally of complaints across broad categories. The tool also only publishes complaints from the prior 24 months. SVA provided specific recommendations to address these issues in a public comment on VA's continued collection of information through the GI Bill Feedback Tool:

> VA should publish and maintain a comprehensive data base of all school-specific complaints submitted through the Feedback Tool. Students should be given the option to disclose their narrative comments publicly, and those comments should be included in the data base. The feedback data base should be presented in a familiar interface, preferably one that mirrors other popular review websites. This means it should include helpful user features like search, filters, and sorting. We further recommend the Department include a link on each school's profile page in the GI Bill Comparison Tool that directs students to a full, detailed list of complaints submitted about that institution. This will help students identify and better understand the true nature of complaints submitted about each school. It will also improve the ability of advocates and researchers to monitor and analyze past and present institutional compliance with the Principles of Excellence and other laws.[6]

To address concerns about fake or inaccurate reports, we believe VA should verify that reports come from current or former students of the institution for which feedback is being provided and that schools be given the opportunity to issue public responses to complaints.

VA should also place caution flags on schools in the GI Bill Comparison Tool that receives an inordinate number of student complaints. VA currently only places cau-

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[5] See generally College Navigator, NATIONAL CENTER FOR EDUCATION STATISTICS, US DEPARTMENT OF EDUCATION, https://nces.ed.gov/collegenavigator (last visited March 1, 2020); College Scorecard, US DEPARTMENT OF EDUCATION, https://collegescorecard.ed.gov (last visited March 1, 2020); GI Bill Comparison Tool, US DEPARTMENT OF VETERANS AFFAIRS, https://www.va.gov/gi-bill-comparison-tool/ (last visited Feb. 24, 2021).

[6] SVA Comment on OMB Control No. 2900–0797 Agency Information Collection Activity: Principles of Excellence Complaint System Intake, STUDENT VETERANS OF AMERICA 3 (2020), available at https://www.regulations.gov/comment/VA–2020-VACO–0001–0084.

tion flags on schools with a program of education subject to “increased regulatory or legal scrutiny” by VA or other Federal agencies.[7] SVA supports this use of caution flags, but student veterans also deserve to be alerted when a school has received a troubling number of student complaints.

SVA also asks that VA develop a mechanism to maintain closed schools within the GI Bill Comparison Tool versus having them simply disappear. This removal of schools from the tool means associated data also disappears, leaving significant gaps in the overall picture of how those schools served students. We look forward to working with Congress and VA to update this valuable resource so it can better serve student veterans, service members, and their families.

SVA applauds Senators Schatz, Rounds, Portman, and Coon's leadership on this issue with their championing of the *Student Veterans Transparency and Protection Act* last Congress. The bill would make numerous improvements to the GI Bill Comparison and Feedback tools, while also providing entitlement restoration for beneficiaries that are the victims of misconduct perpetrated by bad-actor institutions. We look forward to that bill being reintroduced this Congress and encourage the Committees' members to support it as well as the other improvements we have outlined here.

Finally, SVA acknowledges and applauds VA's ongoing efforts to improve the GI Bill Comparison Tool. The Department has made great strides in recent years, by adding new information like context about accreditation and details on institutional ownership as well as important new features like side-by-side comparison and map functionality. We look forward to collaborating closely with Congress and VA to further refine these important tools.

4. Establish a Veteran Economic Opportunity and Transition Administration with Undersecretary representation for all economic opportunity and transition programs.

For years, SVA and others have called for the creation of a fourth administration at VA—a Veteran Economic Opportunity and Transition Administration. This new administration would provide VA's economic opportunity programs with the dedicated, senior-level leadership they deserve. As DAV, PVA, and VFW pointed out in the 2016 Independent Budget, a “new undersecretary for EO would refocus resources, provide a champion for these programs, and create a central point of contact for veterans service organizations and Congress.”[8] If we want to “build a more accountable VA”—especially with regards to economic opportunity programs—a fourth administration would do just that.

As SVA has noted, we believe the greater focus must be placed on economic opportunity for veterans, including through higher education. This would be best achieved by building on the early success of the new office at VA dedicated to transition and economic opportunity and elevating it, and Education Service, to its own administration at VA. Presently, economic opportunity programs such as the GI Bill, home loan guaranty, and many other empowering programs for veterans are buried within the bureaucracy of Veterans Benefits Administration and functionally in competition against disability compensation policy for internal resources.

Over the past century, VA has focused on compensating veterans for loss, but the reality of the 21st century and beyond demands the additional goal of empowering veterans to excel post-service and improving a veteran's social determinant of health. Critically, this will further advance our nation's goals of enhancing economic competitiveness and increasing protective factors against suicide. A focus on veteran contributions to business and industry, to governments, to non-profit organizations, and to communities through the best education programs in our country will result in impressive returns on the taxpayers' investments and save lives.

The continued success of veterans in higher education in the Post–9/11 era is no mistake or coincidence. In our Nation's history, educated veterans have always been the best of a generation and the key to solving our most complex challenges. This is the legacy we know today's student veterans carry.

We thank the Chairman, Ranking Member, and Members of the Committee for your time, attention, and devotion to the cause of veterans in higher education.

[7] GI Bill Comparison Tool: About This Tool, U.S. DEPARTMENT OF VETERANS AFFAIRS (June 11, 2020), https://www.benefits.va.gov/gibill/comparison—tool/about—this—tool.asp#sourcedata.

[8] Id. at 121.