COVID–19 SUPPLEMENTAL FUNDING: DID IT PROTECT AND IMPROVE VETERAN CARE?

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

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C O N T E N T S

TUESDAY, MAY 23, 2023

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TUESDAY, MAY 23, 2023

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

The committee met, pursuant to notice, at 10:01 a.m., in room 360, Cannon House Office Building, Hon. Mike Bost (chairman of the committee) presiding.

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

OPENING STATEMENT OF MIKE BOST, CHAIRMAN

The CHAIRMAN. Thank you. That is better. Thank you. Good morning. The Committee will come to order. Now, before we begin this oversight hearing today, I want to welcome back Army Master Sergeant Matt Reel, the majority's full committee staff director, from a lengthy deployment overseas. Thank you, Matt, for your continued service this to Nation and welcome back.

I also want to announce that Mr. Parker Chapman, the Staff Director of the Subcommittee on Oversight and Investigations, is leaving the committee. I wish him well. I wish he was not leaving, but he is. He is moving on. Parker has been a valued member of this committee for nearly 6 years. He has worked for at least three different subcommittees, and I will miss his thoughtful and wise counsel. I wish him well in all of his endeavors as he moves on, as people do around here, and I wish him the best. Thank you for your service. Appreciate it.

I also want to welcome our witnesses at today's hearing. I will have to leave the hearing at some point to mark up one of my bills in another committee, and I apologize for having to step away like that. I would like to start by again thanking the VA staff for the incredible work that they did during the pandemic. Today, we are here to review how the Department of Veterans Affairs used the nearly $37 billion that Congress provided in supplemental funding during the pandemic.

Now that we are at the end of the pandemic emergency, it is time to look back at how well or poorly the VA handled the money. The funding spanned three bills. The Families First Coronavirus Response Act provided the first $60 million. Then the Coronavirus Aid, Relief, and Economic Security (CARES) Act provided $19.6 billion. Finally, the American Rescue Plan (ARP) Act provided another $17 billion. While Families First was bipartisan and the

CARES Act was nearly unanimous, the ARP was jammed through on party lines.

The rules placed on the VA for spending these funds got looser and looser and looser each time bills passed. By the time we got to the ARP, it looked a lot like a slush fund. From the beginning, I was concerned that VA would struggle to account for the money that they had spent and that they spent it correctly.

I wrote more than a few letters about it. Ranking Member Takano and I also introduced the VA Transparency and Trust Act to require VA to report to Congress on how this money was being spent, which later became law. We were right in our concerns. The Inspector General released an audit of the CARES Act a few weeks ago. We all know that VA's outdated fiscal system barely functions under normal circumstances. The huge influx of COVID money only made things worse. More often than not, VA failed to document why they were transferring the dollars from one account to another. The problems cannot be blamed entirely on the old system.

Despite only looking at a small number of medical centers, Office of Inspector General (OIG) estimates that the VA failed to follow its own internal controls in over 10,000 supply purchases and service contracts. Those transactions were worth $187 million and the Inspector General questioned the transactions for fraud and waste. The problems go well beyond this one report. I requested more information on the categories that the VA spent the COVID money on, and some of them make sense, but it is hard to see how others relate to COVID. Now, what I am talking about are things like garage maintenance, pest management, libraries, and Veterans Integrated Services Network (VISN) directors' offices. VA's regular budget should easily be paying for these things.

We have not seen an audit of the ARP spending yet. Congress put even fewer guardrails on the ARP money than the CARES money, so that audit may be troubling. Even though these funds were specifically for COVID, there was very little rhyme or reason for how the VA spent the money. One office used it a certain way and the next office did it a different way. Most of the money went toward regular operations or projects that would have happened anyway.

Particularly, no one could tell the difference between a COVID supplemental dollar or a regular dollar. VA saw them like these two dollars, identical. Identical dollars that could be spent whatever, however, whenever they wanted. Now, the problem with that is, when somebody ask for a ransom they ask for dollars and unmarked bills. Now unfortunately, that is kind of what we did. We gave you dollars in unmarked bills. Now we are trying to figure out what you did with those unmarked bills. I am concerned that the VA is getting dependent on these one-time supplementals from Congress. We need to provide veteran's care and benefits in regard to the budget and oversee that money to ensure that veteran services are going to the veterans, and they serve them well.

That is exactly what the Republicans on the Appropriations Committee did last week. They advanced a bill that fully funds VA at exactly the level that President Biden requested. Let me say that again. They advanced a bill that fully funds VA at exactly the level

that President Biden requested. The only difference is they put about $15 billion in VA's regular healthcare accounts rather than putting everything in the Toxic Exposure Fund.

The scare tactics from the other side of the aisle over the last few weeks about a 22 percent cut have not stopped. We kept our word and the numbers do not lie. Now I want you to look at the chart we have behind us here. Here were the requests for each of the last 3 fiscal years. I want you to look where we were at, and where we funded, and tell me, does any of it look like a cut to you? Can anybody look at that and say we cut?

Republicans are counting on fully funding VA in addition to the billions of dollars of COVID money. We have kept our word. Now it is time to put the partisan bickering and the partisan showboating to the side. It is not helping anyone and is not what we were sent here to do. Ranking member Takano, I now recognize you for your opening statement.

OPENING STATEMENT OF MARK TAKANO, RANKING MEMBER

Mr. TAKANO. Thank you, Mr. Chairman. I am glad you recognized me. Thank you.

The CHAIRMAN. You look just like you did yesterday.

Mr. TAKANO. I appreciate that you gave recognition of the fact that my Staff Director Matt Real is back from a long deployment. I am looking forward to one of my staffers, Chris Bennett, who has also been away on leave, who has been on a deployment, and ironically, Chris Bennett was Matt Real's commanding officer.

The CHAIRMAN. They just can not get away.

Mr. TAKANO. It just kind of brings to mind that we have taken the Uniformed Services Employment and Reemployment Rights Act (USERRA) law seriously, that we held open as per law their right to return to their jobs, back from their deployment. Mr. Chairman, I just wish that we could work together to make sure that USERRA works for every service member and every reservist——

The CHAIRMAN. Yes.

Mr. TAKANO [continuing]. and that we do away with the I am trying to think of the term that is used. Anyway, there is no private right of action if employers have forced arbitration if there is a forced arbitration clause in their employment contract, service members have returned and not being able to get those jobs because they have not been able to get their case into court because of these forced arbitration clauses. I would hope on a bipartisan basis that we can work together to make sure that no one who goes on a deployment, who is a reservist cannot come back to their job, as we have said in law, should be the case.

Now, as for my opening statement during the great influenza epidemic more than 100 years ago, it is estimated that 50 million people died worldwide due to the lack of pharmaceutical interventions. A century later, the world was in the grip of another global pandemic that caused significant fear and great uncertainty in the early days. Thankfully, in that time, science and medicine advanced considerably. In fact, within a year of identifying the SARS-CoV–2, scientists had developed several vaccines. The supplemental funds provided to VA during the COVID–19 pandemic sup-

ported the Department's ability to respond heroically to a global public health disaster.

VA not only sustained its own capacity to provide care to veterans and prevent the spread of the virus among its workforce, but it also provided critical care to civilians as it served as the backdrop to the American healthcare system in more than one part of the country. More than 6,000 Veterans Health Administration (VHA) employees volunteered to deploy to assist civilian and Tribal health systems. During the course of the pandemic, these funds allowed VA to care for more than 750,000 veterans, vaccinate, more than 4.5 million veterans, and another 130,000 veteran caregivers, family members, and dependents. Provide well over 1 million pieces of personal protective equipment and conduct over 900 research projects.

While these actions were in response to the very real emergency this country faced, the silver lining in this work can also help us better prepare for the next global pandemic. Last December, I convened a full committee hearing on VA's pandemic response. We received testimony from Dr. Richard Stone, who was chiefly responsible for implementing the supplemental funds Congress provided to the Veterans Health Administration. In his book, Save Every Life You Can, he spoke at length about the importance of working relationships and how critical they were in VA receiving the resources and authorities it needed during the pandemic. I ask unanimous consent to add an excerpt from his book highlighting the importance of the emergency supplemental funding Congress provided.

The CHAIRMAN. Without objection.

Mr. TAKANO. Thank you, Mr. Chairman. With the funding and flexibilities Congress authorized during the pandemic, VA reduced veteran homelessness by 11 percent, the largest drop in the point in time count we have seen in years. VA used these supplemental funds to bring veterans indoors and provide them with basic needs like clothing and food. Funding was used to place veterans in hotels and motels to lessen the risk of COVID–19 transmission that vulnerable veterans would otherwise face in congregate shelters, the streets, or homeless camps, encampments.

VA was also able to innovate and implement new programs that have proven successful in preventing housing insecurity like shallow subsidies. The pandemic served as a test case for what VA can do with more funding and more flexibility to address the homeless crisis. VA showed us that they can use that funding to get veterans the care and housing they need. VA showed us how to end veteran homelessness. I look forward to continuing to work with my colleagues to ensure that VA maintains this funding and tools in pursuit of our shared goal of a place to call home for every veteran who has served our country.

Now, on the Veterans Benefits Administration (VBA) front, VA also seamlessly pivoted using the authorities granted by Congress to allow hundreds of thousands of student veterans to continue their educational pursuits in the face of an unprecedented health crisis. VA had also administered the Veteran Rapid Retraining Assistance Program using $386 million appropriated by Congress in a truly bipartisan effort to train over 13,000 veterans who lost

their job due to COVID–19 for new employment. While the program had a rocky start, I look forward to hearing more from VA on the results.

The appropriation of emergency funds to VA saved countless lives and supported care for veterans. At the same time, we must never forget that the COVID–19 pandemic took more than 1.1 million lives in the United States, including 23,507 veterans and 259 VA employees. This unprecedented crisis called for a major infusion of funds and Congress delivered by providing $36.7 billion in emergency funding for VA.

However, a recent report from the Inspector General revealed a number of administrative flaws in tracking those funds. VA's financial management system is 30 years old and is difficult to maintain and adapt to emergency requirements like those presented during the pandemic. The Inspector General found that because of the current system's inability to directly obligate supplemental funds, manual expenditure transfers were used to move funds across VA. The Inspector General found that the use of manual transfers limited transparency and accountability of employee payroll and other contractual services and medical supply purchases. Further, VA's Office of Finance did not follow established policy and develop guidance for documentation to create an audit trail.

I realize that during the Pandemic, things were stressful for all employees at VA and that everyone was doing the best they could to procure supplies and contract for support. This does not, however, absolve VHA management from providing basic guidance to account for those funds. I am appalled to see the extent of the issue discovered by the Inspector General. The lack of accountability and transparency that can be provided to auditors and to Congress as a result of this failure damages VA's credibility and invites questions about the extent of potential waste, fraud, and abuse. I wish we could have used this hearing to focus on the good that VA has done for employees and veterans during the pandemic, but this does cast a shadow over those efforts.

This once again highlights the desperate need for the modernization of IT systems at VA. The Financial Management Business Transformation (FMBT) Program is intended to provide that solution. The pace of the rollout and the issues with integration and adoption within VHA has not given our committee confidence. As a result, this Congress, I introduced H.R. 1659, the IT Modernization Improvement Act. My legislation will require independent verification and validation of large IT programs, including the Financial Management and Business Transformation Program. Because of how important this program is and the impact that delays are having on the ability to manage and audit finances at VA, this bill has been included in the recent Electronic Health Record (EHR) Reset Act that I have co-sponsored with Chairman Bost. He mentioned that in his opening comments. I appreciate that this is something that we can work on together in a bipartisan manner and help get this and other large IT projects on track.

I look forward to the hearing. I look forward to hearing from the witnesses today to talk about both the good and the bad. We provide necessary funding and entrust VA to serve our veterans and ensure they are provided with care and benefits that they have

earned. The administrative and financial management of this department must evolve and rise to this challenge, and it is time for VA to step up, admit mistakes, and make changes. With that, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Ranking Member Takano. We will now turn to our witnesses. Testifying before us today we have Mr. John Rychalski, the Assistant Secretary of Management and Chief Financial Officer of the Department of Veterans Affairs. He is accompanied by Ms. Laura Duke, Chief Financial Officer of the Veterans Health Administration, and Mr. Robert McDivitt, Director of VISN 23 of the Veterans Health Administration. We also have Hon. Mike Missal, Inspector General for the Department of Veterans Affairs, and Ms. Whitney Bell, President of the National Association of State Veterans Homes.

If you would not mind, would the witnesses please stand and raise their right hand.

[Witnesses sworn.]

Thank you. Let the record reflect that the witnesses answered in the affirmative. Mr. Rychalski, I now recognize you for 5 minutes for your opening statement.

STATEMENT OF JON RYCHALSKI

Mr. RYCHALSKI. Good morning, Chairman, Bost, Ranking Member Takano, and members of the committee. Thank you for this opportunity to discuss how the Department of Veterans Affairs use of supplemental funds enabled us to meet the challenges of the COVID–19 pandemic by providing essential care and benefits to our Nation's veterans during this unprecedented public health crisis. I am John Rychalski, Assistant Secretary for Management and Chief Financial Officer of the VA. Joining me today are my colleagues Laura Duke, who is been introduced, and also Robert McDivitt from VISN 23.

I want to thank Congress for their support of the VA and more importantly, for their support of the veterans we serve. An excellent example of this is the $36.7 billion Congress provided in supplemental funding outside of our annual appropriation. With the resources from three COVID–19 relief laws provided at a time when the pandemic's path, duration, and impact were unclear, VA responded with tremendous effort to maintain healthcare and benefit services while protecting the lives of veterans, their families, and VA personnel. Our staff worked heroically and at great personal risk throughout the pandemic to provide services and benefits to those whom we owe so much. We are grateful for the courageous dedication of VA personnel in providing care and benefits to veterans throughout this difficult time.

The critical role played by the supplemental funds provided by Congress cannot be overstated. Between March 2020 and the end of the public health emergency, VA provided more than 332 million healthcare appointments to all veterans via in person visits, community care visits, telehealth visits, and more. The most appointments for such a timeframe in VA history. This included caring for more than 870,000 veterans with COVID–19 and admitting nearly 700 U.S. non-veteran citizens for care at VA medical centers. In addition, VHA accepted 196 mission assignments from the Federal

Emergency Management Agency. VA vaccinated more than 4.5 million veterans, 320,000 employees, and 130,000 veteran caregivers, family members, and dependents. VA also gave booster shots to more than 2.3 million veterans.

COVID–19 supplemental funds enabled VA to hire over 136,000 new clinical and administrative staff between 2020 and 2022. This occurred during one of the most challenging labor markets in history, especially in the medical community. As a result of our financial flexibility during the pandemic, today the VA enjoys one of its strongest staffing levels in many years. With the supplemental funds, we provided emergency housing and supportive services for veterans who needed to be isolated for their safety or the safety of others. Supportive services for veteran families placed over 23,000 vulnerable veterans in hotels or motels to reduce their risk of exposure. There were also over 18,000 emergency housing placements. More than 77,000 technology devices were made available for distribution to homeless or at-risk veterans to help them stay engaged with healthcare providers and support systems when face to face visits were not an option.

The supplemental funds allowed the VA's geriatrics and extended care services to distribute 350 million in one-time payments to State extended care facilities for COVID–19 related expenditures and operational costs. Some used these funds for nurse retention grant requests from states, which increased 1,250 percent during the pandemic. Five hundred million of supplemental funding was designated to provide grants through the current Capital Grant program for construction of state veteran homes. With that extra 500 million, we were able to fund a total of 34 additional projects. One hundred fifty million was designated for grants for capital needs to modify State veteran home buildings to respond to COVID–19. We also waived the required 35 percent of matching funds by the state.

These funds enabled us to meet the pandemic's many challenges, and we have worked to manage the resources entrusted to us responsibly. The IG and GAO have each conducted extensive oversight of VA's execution of the COVID–19 relief funding. We appreciate their work, and VA has accepted all findings and has closed some recommendations and is working through action plans to address the remainder. The IG's findings identified longstanding issues that we have been aware of and have been well documented in our financial statement audit. We have been working for several years to address them by implementing a modern financial and acquisition system, consolidating accounting and payroll functions at our financial services center, and greatly improving training of our financial workforce.

We are seeing positive results from these efforts. The VA has maintained 24 clean financial statement audit opinions that cover all funding sources, including these supplemental funds. As recognized by the Government Accountability Office in March 2023, VA has reduced overall improper payments by 76 percent and reported its lowest rate of improper payments in 8 years. Let me say that again, there will be a report coming out this week in which we are reporting our lowest rate of improper payments in 8 years. The fi-

nancial statement audit and the improper payment testing are both overseen by the IG.

VA is proud of the role we played in the Federal response to the Pandemic, which touched every part of VA's operations. In particular, our response to COVID–19 demonstrated the strength and agility of an integrated healthcare system that was provided the resources needed to accomplish its mission. Again, I thank you for the opportunity to testify today and would be happy to answer any questions that you have. Thank you.

[THE PREPARED STATEMENT OF JON RYCHALSKI APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Rychalski. I now recognize Mr. Missal for 5 minutes.

STATEMENT OF MICHAEL MISSAL

Mr. MISSAL. Thank you. Chairman Bost, Ranking Member Takano, and members of the Committee, I appreciate the opportunity to discuss the OIG's oversight of VA's use of COVID–19 supplemental funds. The COVID–19 pandemic significantly altered the way VA provided services and benefits to veterans and their families. The OIG recognizes that VA staff worked tirelessly throughout the pandemic, often at significant risk and sacrifice. I would also like to thank the OIG staff who seamlessly continued our oversight work during these last three years. The additional funding that Congress provided us ensured that we could quickly adapt to these unprecedented times. We pivoted to not only pursue our customary oversight work, but also published over 40 pandemic related reports and investigated dozens of COVID related criminal matters.

In response to the pandemic, Congress provided VA with more than $36 billion in supplemental funding. The OIG has published five reports in the last 2 years related to this funding. We found that VA generally complied with the Transparency and Trust Act of 2021, which requires VA to provide to Congress a detailed plan outlining its intent for obligating and expending funds covered by the act. However, we made two recommendations for VA to improve the quality and sufficiency of information reported to Congress.

In our report published this month, we found that VHA lacked general controls over its medical facilities' use of CARES Act Funds. We also estimated that over 10,000 COVID–19 related transactions that were directly obligated from the CARES Act fund were noncompliant with key fiscal controls, resulting in the OIG questioning costs totaling an estimated $187 million.

These deficiencies were due in part to VA's outdated financial management system. VA is currently implementing a new financial management system, Integrated Family Application Management System (iFAMS), which may be able to resolve some of these issues. However, VA does not expect a fully automated solution in this decade.

Another challenge VA faces is its decentralized financial management structure. The Chief Financial Officers (CFOs) of VHA, VBA, and National Cemetery Administration (NCA) do not report to Mr. Rychalski, the VA CFO. Also, the CFOs at VISNs and medical centers do not report to Miss Duke, the VHA CFO. This structure has

been a material weakness or significant deficiency for many years in our audits of VA's consolidated financial statements.

In addition to our oversight of pandemic related funding, we performed audits and inspections of numerous other programs and issues related to COVID–19. These include VHA's efforts to expand telehealth, the failure to adequately track and reschedule millions of canceled appointments, and inspections of medical facilities' pandemic readiness. Moreover, our criminal investigators brought numerous COVID-related criminal cases, including one in which an individual attempted to obtain orders from VA for over $800 million of nonexistent personal protective equipment.

When I testified before this committee in February, I noted that a recurring theme about the deficiencies we identified in VA programs centered on accountability. Our COVID–19 related reports had similar deficiencies in several critical areas of accountability, such as the need for strong governance, adequate staffing, updated IT systems, quality assurance, and stable and effective leadership.

COVID–19 posed considerable challenges to the operations of VA and its staff. We recognize that VA is working to address the issues we identified in all our pandemic related reports. The OIG is steadfastly committed to our mission of conducting meaningful, independent oversight that will help VA improve the services and benefits that it provides.

Finally, as we approach the Memorial Day observances, on behalf of the OIG, I would like to express our deep gratitude to all who gave their lives in defense of our country. Chairman Bost, and members of the Committee, 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. Ms. Bell, you are now recognized for 5 minutes.

STATEMENT OF WHITNEY BELL

Ms. BELL. Thank you, Chairman Bost, Ranking Member Takano, and members of the Committee. As President of the National Association of State Veterans Homes (NASVH), I am pleased to offer testimony on how COVID–19 impacted State homes and how VA supported us and the veterans we care for throughout the Pandemic.

My full-time job as administrator of the State veterans home in Fayetteville, North Carolina. However, today I am pleased to share the combined experiences, observations, and recommendations of my NASVH colleagues. As you know, the State's Veterans Home Program is a partnership between the Federal Government and states that provide long term residential care to aging and disabled veterans through 163 state homes located in all 50 states and Puerto Rico. With over 30,000 authorized beds, the State homes provide half of all federally supported nursing home care to veterans, and we do so with less than 20 percent of VA's nursing home budget.

Although states own and operate the homes, VA has wide ranging oversight authority, performing at least one comprehensive inspection annually to assure the quality of care. In addition, various

state homes are also inspected and audited by VA's Inspector General, the Justice Department, Centers for Medicare and Medicaid Services (CMS), as well as State and local authorities.

Mr. Chairman, when the pandemic began in 2020, State homes were among the first to implement significant precautions. However, the asymptomatic nature of COVID combined with the lack of testing, treatments, and vaccines, made it virtually impossible to prevent COVID from entering any facility or location in the country. It is important to note the veterans in state homes are significantly older than those in VA, Community Living Centers (CLCs), or community nursing homes, and they are more likely to be receiving end of life care in our homes.

In addition to the devastating physical toll on veteran residents and staff, the pandemic also put tremendous financial strain on our homes. With new admissions suspended and veterans passing away from COVID and non-COVID causes, daily census levels declined and thus VA per diem support declined significantly, even though our fixed cost stayed the same. Fortunately, soon after the pandemic began, VA responded as part of its fourth mission. For example, in North Carolina, VA provided testing and training on infection control. In Illinois and Michigan, VA provided thousands of face masks and protective gowns. In California, VA provided testing of up to 200 residents and employees weekly. In Iowa and Idaho, VA provided direct staffing support, particularly nurses. These are just a few of the ways the VA medical centers supported state homes during the pandemic.

Congress also responded quickly, and NASVH was grateful to work with this committee and its Senate counterpart to enact legislation to help mitigate some of the pandemic's impacts. The CARES Act included waivers from occupancy rates and veteran percentage requirements, and VA was also able to waive bed hold requirements. NASVH would especially like to thank this committee for helping to secure emergency supplemental funding in the American Rescue Plan and CARES Acts, which allowed the VA to provide $1 billion in supplemental funding to state veterans homes, including $650 million for construction grants to rehabilitate and retrofit homes to increase safety for our veterans. $350 million in direct assistance to help State homes prevent and respond to the spread of COVID.

Mr. Chairman, although the public health emergency has ended, state homes continue to face significant financial challenges. In response, bipartisan legislation was recently introduced in the Senate to continue the bed hold waiver, and we would welcome companion of similar legislation in the House. NASVH is also seeking congressional support to set the basic per diem rate at 50 percent of the daily cost of care, fully fund the construction grant program, at least 600 million in FY 2024, and enact new legislation to help State homes fill critical staffing shortages, particularly nursing.

Mr. Chairman, in conclusion, NASVH greatly values our Federal and state partnership, and we look forward to working with this committee to find new and innovative ways to strengthen state veterans homes for the men and women we serve. That concludes my testimony, and I will be pleased to answer any questions you or the members of the committee may have.

[THE PREPARED STATEMENT OF WHITNEY BELL APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Ms. Bell, and thank you to all the witnesses for their testimony. We are now going to questions, and I will recognize myself for 5 minutes.

Mr. Missal, and I know you expanded on this in your testimony, but why did the VA struggle to account for CARES Act funds? Have any of the underlying problems been cured as of yet?

Mr. MISSAL. There are a number of different reasons why they struggled. First, they have an antiquated Financial Management System, FMS, that has created challenges over the years. Second, the governance structure of the financial management organization makes it really difficult because of the gaps in terms of who reports to whom, which I talked about in my opening statement. Third, policies and procedures and guidance, it is really critical that they are clear; they are complete; and they are accurate. Fourth, they have to make sure that people know their roles and responsibilities. We identified a number of situations where people did not know who was responsible for certain things.

Training is also critical. They have to be properly trained to be able to do their job. Finally, with all of that, you have to make sure you have internal controls to identify and to correct any deficiencies that you may find.

The CHAIRMAN. Thank you. Mr. Rychalski, just how much of the American Rescue Plan money remains unobligated?

Mr. RYCHALSKI. Thank you for the question. You can call me John if you want, sir.

The CHAIRMAN. Okay.

Mr. RYCHALSKI. Yes, I know that last name. I think as of yesterday, I think we are right around 500 million of ARP.

The CHAIRMAN. Five hundred million?

Mr. RYCHALSKI. Yes.

The CHAIRMAN. Okay. Have you changed your spending plan for the ARP funds since the end of the COVID emergency?

Mr. RYCHALSKI. Have not, no. You know, consistent with our 2023 budget submission, I think we had communicated to Congress how we intended to use those funds. We execute every day, including with cost transfers and journal vouchers. I know it is just been business as usual. Keep in mind, we are heading to the end of the third fiscal quarter, you know, so it is waning, as we expected it would.

The CHAIRMAN. Well, maybe now that the pandemic is over, the justification for supplemental funds is gone. Are you struggling to manage it all? Were you struggling to manage it all along?

Mr. RYCHALSKI. I want to ask Laura and Robert to answer that question because they really manage the funding.

The CHAIRMAN. Okay.

Mr. RYCHALSKI. Thank you for the question.

Ms. DUKE. Good morning, sir. Speaking in terms of our management of the ARP, I will note that as you mentioned in your statement, the purpose of the ARP was a little bit broader than that provided by the CARES Act. To the extent that we were transparent in our congressional budget, justification of how we would use ARP and base funds collectively to deliver healthcare to veterans throughout the year and we have delivered healthcare

throughout the year. As we noted, it was a higher level of care because we are still making up for the deferred care and the long-term consequences of the pandemic. We do expect that our costs will be higher in the short run and then will come back down as we have proceed in the post pandemic period.

The CHAIRMAN. Okay. We have a president that said the pandemic is over. We gave you money to use for the pandemic. In the last 2 weeks, you have spent $1.5 billion of the ARP money. It is over. When does the plan change so that you go back to operating on your regular funds and we actually see what we can possibly save from those funds? I mean, that is what the American citizen is going to ask me, what my people in my district are going to ask me.

Ms. DUKE. Our 2024 president's budget indicates that we fully expected to expend the ARP. As we go forward, we are clear regarding our outstanding needs for the future. When we have funds that we do not expect to utilize in our budget, we identify that they are available for the purposes of Congress to determine.

The CHAIRMAN. Okay. If we are done, and that is a real problem that the people will see, is if we are done with this, as I said, $1.5 billion in the last 2 weeks alone. That is concerning to the taxpayers of this United States.

Let me also ask this. The Biden administration asked for $325 billion for VA and our Appropriations Committee gave them $325 billion. Now, the only difference is whether or not it would put the money in the regular account or in the Toxic Exposer Fund. Is there anything that a dollar in the regular budget can accomplish that a dollar in the Toxic Exposer Fund can not?

Mr. RYCHALSKI. Sir, I can answer that question. The short answer to your—the short answer is no, there is not. There is one consideration, and that is if we go back to the Choice Act. We have had situations where benefits have been expanded, funding was provided, but it turned out to be inadequate based upon the demand of the new benefit. We had to go back to Congress a couple of times mid cycle, which was problematic. Then, with the Mission Act, there was much more, I think, scrutiny or concern over adequacy of funding. There was not a separate fund for Mission Act. We worked with staff to sort of carve out the Mission Act costs to make sure they could track it.

Come along to the The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) act and the Toxic Exposure Fund (TEF) fund, It was my understanding that was supposed to be a solution for those previous situations where there was not enough visibility or maybe enough funding for those benefit enhancements. The short answer is no, there is not a difference. There is, I think, some rationale for how we have evolved to where we are. You know better than I do why Congress passed the TEF and all of that. but it made a lot of sense based upon my history at the VA and some of the challenges we have had in the past.

When I first started, there was a lot of frustration with Choice and VA coming back time and time again for additional funding in the middle of the budget year.

The CHAIRMAN. Thank you. My time has expired. I right now recognize Ranking Member Takano.

Mr. TAKANO. Mr. Rychalski, I just want to verify with you that ARP funds were not connected to the pandemic. When they lifted the public health emergency, there was nothing in the ARP bill language that linked the two.

Mr. RYCHALSKI. That is correct. AFP funds came as sort of like general purpose funds, and we made it very clear that we were using those for healthcare, like we would use our baseline funds. It was one part of the funding equation for this year, correct.

Mr. TAKANO. In fact, the pandemic changed significantly the spending patterns of VA and ARP money was very helpful in getting you through some difficult moments.

Mr. RYCHALSKI. More than helpful. It was critical. Absolutely critical.

Mr. TAKANO. It was critical.

Mr. RYCHALSKI. Yes, it was.

Mr. TAKANO. I want to turn my attention to Ms. Bell. Ms. Bell, based on your testimony, it is clear how critical the supplemental funds and authority flexibility were to operate state veterans homes across the country during the pandemic. Of course, the state veterans homes, as opposed to the CLCs, the community living centers that are run by the VA, were the locus of some really terrible tragedies. The lack of understanding of how to deal with infection control, the antiquated facilities that you had that made for congregate living situations where the virus was spread very easily among very vulnerable patients. With the end of the public health emergency, what challenges remain for state veterans homes?

Ms. BELL. Thank you for that question. Challenges right now we are facing are not only staffing because you have to have people to go into these nursing programs to want to be in healthcare. We have to have people to take care of people. Without those people, we do not have a census of veterans to take care of. At the forefront is our staffing at this time.

As you talk about congregate living, a lot of facilities who are semi-private rooms in facilities help to continue the spread of COVID, that being part of the Construction Grant program to allow us, the funds to be able to restructure and retrofit to prevent that spread in the future would help.

Mr. TAKANO. Well, thank you. VA currently provides a per diem payment for each veteran that covers about 30 percent of the cost of care, and states make up the difference. As supplemental funds from the Federal Government disappear and state veterans homes return to reliance significantly on State budgets what if any concerns do you or your colleagues have?

Ms. BELL. In concerns to the per diem?

Mr. TAKANO. Yes.

Ms. BELL. The cost of care?

Mr. TAKANO. As it disappears, yes.

Ms. BELL. We would definitely recommend the per diem to go up to 50 percent of the cost of care.

Mr. TAKANO. You actually would like to see an ongoing

Ms. BELL. Yes, please.

Mr. TAKANO [continuing]. 50 percent of care be covered by the Federal Government? You do not want to see that 30 percent disappear?

Ms. BELL. We cannot.

Mr. TAKANO. As we start to look back at the lessons learned during the last few years, what kind of changes or reforms should Congress focus on to enable VA and the states to better focus resources on preventing and responding to future outbreaks in state veterans homes and other long term care settings that serve our most vulnerable populations?

Ms. BELL. NASVH and my colleagues are requesting to fully fund the State veterans Home Construction Grant program, increasing the basic per diem rate, enacting the legislation to strengthen the State veterans home programs, and faithfully implement standardized sharing agreements under each site.

Mr. TAKANO. Well, Ms. Bell, I am sympathetic to the notion that the veterans homes need more funding. We need to upgrade the facilities, but I am concerned about what the role of VA should be in terms of oversight. Would you be open to VA having more oversight authority to help ensure that homes are properly staffed, appropriately staffed, and adhering to infection control standards, among other things?

Ms. BELL. We would embrace that partnership. Just as they done boots on the ground when COVID began, we did have that support from our VA Medical Center onsite in our facilities educating us. We would embrace that.

Mr. TAKANO. That is very important for me to hear. I thank you for that, and I thank you for that concession because I am really scared that we are going to lose our memory over what happened during the pandemic. The numbers of people in homes across the country, not just state veterans homes, but the whole industry. That is where we saw a huge chunk of our loss of human life.

Supplemental funding allowed state veterans homes to retrofit facilities to handle pandemic conditions like infection control better. What conversations have your organizations engaged in regarding the need to upgrade and review construction requirements for future homes and avoid unnecessary deaths?

Ms. BELL. There has been much investigation, research done in explaining and showing how facilities can prevent the spread within the home. It could be making those semi-private rooms private rooms, as well as incorporating the smart air systems to help filter the air to help prevent the spread through the ventilation systems. There has been numerous conversations concerning the retrofit of facilities construction with engineers, with architects to talk about safety. Private room versus semi-private room is safe.

Mr. TAKANO. My time is running out. I wish we could spend more. Mr. Chairman, I hope we can work together on this oversight piece. I really feel that we can not forget just the numbers of deaths we had in these state veterans homes. I am open to the idea that we fund you better, but we have got to have more oversight. I yield back.

Mr. BERGMAN.

[Presiding] Thank you. Dr. Miller-Meeks, you are recognized for 5 minutes.

Ms. MILLER-MEEKS. Thank you, Mr. Chair. Mr. Missal, one example in your report on page 10 is a medical of $35. The supporting documents they gave you were actually submitted for a different transfer that was previously approved. Basically, they tried to submit the same receipts twice. Your office could not conclude what was purchased, why it was purchased, or whether anyone approved the purchase. First of all, Mr. Missal, did anyone ever determine what was purchased?

Mr. MISSAL. We were never able to determine what was purchased.

Ms. MILLER-MEEKS. How widespread do you think this is, and have you seen anything like this during your tenure?

Mr. MISSAL. We found numerous examples where transactions were not properly documented. Unfortunately, we have seen that in a number of other projects that we have worked on. As I said before, there is a lot of different issues and challenges that VA has with respect to its financial management system, and this situation really highlighted those challenges.

Ms. MILLER-MEEKS. Thank you. Mr. Rychalski, the IG estimated that 10,064 CARES Act purchases, these are purchases, not dollars, 10,064 purchases worth 187.2 million had problems. That was based on examining just eight medical centers purchases. Have you also audited both the CARES Act purchases and the ARP purchases? If not, do you intend to do so after reading the OIG's report?

Mr. RYCHALSKI. Thank you. Yes, so, the IG does great work. We are a close partner with them. The things they have identified are things that we have known for some time. I want to be clear that it is not the Wild West. This is somewhat alarmist. Let me give you some context. Things were exacerbated there is no question by the pandemic. I mean, I would rather be here explaining to you why we do not have a receipt than why we harmed a veteran. This is one way to look at it.

The crux of the issue is, you know, the accounting system is old and it requires a lot of manual processes. I mean, it is very heavily, manually intensive. We have people of different skills, motivation levels that may or may not follow the policy. We do audit these funds in our annual financial statement audit with a public accounting firm. These funds have been audited. They also go through our improper payments testing.

The difference here is, in the financial statement audit that lasts a year, you know, they will take the samples of transactions. They will find the same thing. In fact, if you look at our Financial Statement Audit Report, we have a material witness with the exact same findings. They frequently will go a little bit deeper to see if the core of the foundational accounting transaction is solid and——

Ms. MILLER-MEEKS. Well, it does not sound like that is a new issue or a new problem. You have known about your financial system. As the chairman said, our duty is to make sure dollars when we are spending, appropriating record amount of dollars, so, not just in COVID money, not just in ARP money, in record increases in the VA's budget the past 2 years in a row. We need to be able to account for those and do proper oversight. Mr. Rychalski, when did the President end the COVID–19 national emergency?

Mr. RYCHALSKI. Recently, May 11. Is that correct?

Ms. MILLER-MEEKS. May 11. From the time I have been in Congress, to me, COVID expenditures should be timely, targeted, and temporary, i.e., they are related to the COVID–19 pandemic, not other expenditures that may need to be done or nice to be done. Do you know how much unspent money allocated for COVID–19 related, nonrecurring maintenance you have leftover, according to documents you sent this committee?

Mr. RYCHALSKI. Are you talking about a CARES act funds or ARP funds?

Ms. MILLER-MEEKS. COVID related.

Mr. RYCHALSKI. I would have to get that for you. I think we have obligated CARES Act like 99.6 percent, and I think we have about 500 million of the ARP. Then I think for the Families First, it was 99.8 percent. I first, I——

Ms. MILLER-MEEKS. 1.17 billion.

Mr. RYCHALSKI. Is left?

Ms. MILLER-MEEKS. It is a lot of money. The VA issued 41,000 iPads to veterans for virtual healthcare appointments seemed to be an appropriate expenditure. Unfortunately, only half of those were ever used for a healthcare appointment. The IG has also noted that the VA has not attempted to retrieve many of those unused iPads valued at $6.3 million. Does the VA plan on getting these back if they are not being used for a virtual appointment?

Mr. RYCHALSKI. I would have to take that—that is a little bit out of my lane. I have to take that for the record. I do not know if our other witnesses, Robert, if you have?

Mr. MCDIVITT. Yes, Congressman. I am Rob McDivitt. I am the VISN director from VISN 23. I have the great State of Iowa in my network. We are endeavoring right now. We issued over 3,000 cell phones to homeless veterans early in the pandemic so they could stay connected with healthcare and with the VA. We issued over 8,500 iPads to veterans in our very rural network and are tracking them. Not all of them have been used, and we have put a process in place to contact the veteran, make sure that they use their device or we retrieve it. We are endeavoring to do that. We did put them out as quickly as possible to make sure the veterans remain connected to VA.

Ms. MILLER-MEEKS. Yes, I think retrieving the unused devices would be an appropriate utilization of your time. Thank you, and I yield back.

Mr. BERGMAN. Thank you. Mr. Levin, you are recognized for 5 minutes.

Mr. LEVIN. Thank you, General. Thank you to our witnesses. I want to thank you for all your work during the pandemic.

Eliminating veteran homelessness is a key objective of mine. I know it is not going to be easy, but I commend you for the work that was done. I saw the 11 percent decrease in veteran homelessness between 2020 and 2022. I know that is in part because of the increased funding and the flexibilities that Congress provided to you during the pandemic.

I was glad to see in particular that Supportive Services for Veterans Families (SSVF) used some of the funds for the Shallow Subsidy. Representing San Diego in the Congress, I know that our re-

gion benefited greatly from the Shallow Subsidy Initiative to provide rental coverage for up to 2 years for very low income, extremely low-income veterans. Direct payments to landlords on behalf of the veteran to prevent homelessness in the first place.

I was proud to host Chairman Van Orden of our subcommittee a few weeks ago in my district in Oceanside, California. We talked to a lot of the local nonprofits who used the Shallow Subsidy and talked about the positive impact it had. I am concerned that we are not going to continue the robust funding for the Shallow Subsidy or for SSVF generally, and that we are going to fail to build on the progress that we have made.

Assistant Secretary, I will ask if you could discuss how the Shallow Subsidy program has helped to prevent veteran homelessness in the last few years.

Mr. RYCHALSKI. It might be a question best for Laura, but I know that they were able to help over 3,700. I know that those grants or those payments are critical. For those that are not familiar with the Shallow Subsidy, it is for a, you know, a person or a family that has housing, but that is at risk of losing their housing. You can just imagine that it is much more efficient to keep them in their house than it is to have them go homeless and have to start again. Laura, maybe you want to talk a little bit about that.

Mr. LEVIN. Please do.

Ms. DUKE. Yes. As you correctly noted, the Shallow Subsidy program has been a success and has enabled us to reach veterans who are kind of in a cusp situation. The issue with the shallow subsidies is not so much a funding issue as it is an authorities issue, because with the expiration of the medical emergency, we now need additional authority from Congress to be able to continue to meet veterans in this unique situation. We have been in contact with you regarding that need and some of the other needs where we have learned from our pandemic experience ways that we can provide a higher quality of service to veterans even outside of a pandemic.

Mr. LEVIN. How about some of the other initiatives that were funded during the pandemic? Some of the landlord incentives, the housing navigation, to the extent those are not going to be sustained, how do you see that impacting our ability to end veteran homelessness?

Ms. DUKE. Well, I think we have requested authority to continue some of those that are more promising. We continue our commitment to ending veteran homelessness in our 2024 and 2025 budgets. We are continuing to grow the program, recognizing that particularly economic situations continue to put more veterans at risk. I think our commitment is sustained even beyond the end of the public health emergency.

Mr. LEVIN. That is good to hear, and we will definitely keep our eyes on that. One of the things I was very proud of during the beginning of the pandemic with my friend Gus Bilirakis of Florida, we provided flexibilities to allow the funding to cover different things food, shelter, clothing, transportation, other essential personal needs.

VA has used nearly $9 million to support over 39,000 homeless or at-risk veterans with foundational needs in the last few years.

It was very disappointing to see that Congress failed to act to extend the flexibilities on May 11. I am very proud to support my colleague Rep. Cherfilus-McCormick's bill to make those flexibilities permanent. Assistant Secretary, for you or for the panel, can you share how those funding flexibilities were used during the public health emergency and what effect they had on veteran homelessness?

Mr. RYCHALSKI. Sure, I can take that, Congressman. In our VISN, we use the flexibilities to do the things you talked about, to prepay rent for veterans who are moving from homelessness into permanent housing, but also for food subsidies. We found many veterans are food challenged and certainly were during the pandemic and used the temporary authority to support that. Also, for transportation, we set up rideshare programs across the country that were able to connect many veterans to VA health services or community resources that they needed during the pandemic, and that was tied to the temporary authorities.

Mr. LEVIN. Well, I would just close by saying in 2020, there were 37,252 veterans experiencing homelessness. By 2022, 33,136. I think that reduction is a direct result of some of what we did in Congress and a lot of what you all did and what folks on the ground level did. Let us continue that progress. Let us continue that momentum as we try to achieve functional zero veteran homelessness. With that, I will yield back.

Mr. BERGMAN. Thank you. Dr. Murphy, you are recognized for 5 minutes.

Mr. MURPHY. Thank you, Mr. Chairman. Thank you guys for putting this committee together. I think the overall theme really of this session in the Republican majority has been accountability. There is nothing wrong with accountability, nothing wrong whatsoever. In some of the other committees I have been on, we bring folks forward who have not appeared before the committee for many, many years—before Congress, rather, for many, many years. All of a sudden, there is accountability. Billions of dollars were spent, and billions of dollars were spent well.

It was a tragedy. We were building a plane while we were flying it. Everybody knew that. There are also guardrails as to when you are given money, this is what you are supposed to use it for. I have had to apply for medical grants, for scientific grants. You put down there exactly what you are going to spend it on. If you do not spend it on that, it is a problem. I think that is what we are seeing here.

Some of these issues, some of these things were not spent on, and there was no paper trail. There was no accountability. I think that is what the issue is here. If this were to occur in the private sector, I can guarantee you some people would be out of a job and they are protected in the Federal Government. This is why this committee, its work is so important.

Mr. Rychalski, let me just ask you a few questions. You actually mentioned something a few moments ago that this was alarmist. I want to follow up. What did you mean by that?

Mr. RYCHALSKI. I said it sounds alarmist. What I meant was that all of these transactions go through our annual financial statement audit. We maintain a clean audit opinion. They all go through our improper payments testing. We have reduced improper payments

by 76 percent. When we dig into these transactions, we find that they are, from an accounting standpoint, fundamentally sound. We have more time during the improper payments testing and the financial statement audit.

Mr. MURPHY. All right, well, let me follow up that I understand you do your own audits and you believe that OIG——

Mr. RYCHALSKI. The IG does our audit. The IG does the audit with a public accounting firm.

Mr. MURPHY. Okay. I believe you stated that——

Mr. RYCHALSKI. Same as a private company does.

Mr. MURPHY. I believe you have stated the OIG is mistaken in many of the errors that they have found.

Mr. RYCHALSKI. No, I never—no, I 100 percent agree with everything they found, 100 percent.

Mr. MURPHY. Okay, all right.

Mr. RYCHALSKI. Yes.

Mr. MURPHY. That is excellent. I am glad that we are on the same page with that, so. Let me go to Mr. Missal, back to Mr. Missal. Your written testimony cites your successful efforts in pretending into—trying to prevent attempts of fraud of the supplemental funds. Can you expand upon that a little bit? Tell us what was attempted to be fraud, what was going on?

Mr. MISSAL. Yes. We obviously were very concerned, given all the money that was coming in, about potential fraud. We have a really great group of criminal investigators that follow up on all the leads that we get. We also put out fraud alerts to give people notices of where they could be subject to fraud.

Mr. MURPHY. Were these fraud from veterans or were they fraud from VA funds being spent fraudulently?

Mr. MISSAL. It could be from all sorts of ways. The one I mentioned in my opening statement about the potential $800 million fraud, that was caught because a senior VA official contacted me to say, "Something does not sound right with this transaction." The Secretary had required all VA employees to take training on working with the OIG. I had just met with the senior official a few days before she contacted me and said, "I probably would not have known to contact you without getting this information." And it is——

Mr. MURPHY. Excellent.

Mr. MISSAL. It is endeavors like that that really help us to identify fraud, but we really want to see a culture of accountability at VA. If people see something that does not seem right, contact us. That is where we are able to identify a lot of the issues.

Mr. MURPHY. I think that is a healthy environment. It should not be a watchdog state. It should be a healthy environment. It is not your money. It is not my money. It is the taxpayers' money. That is what it is. We are trying. What is the number one thing? I have cared for patients for years is what is best for the patient?

I will just follow up with one other question. When I was young and if I had a date, which was not too often, but you never know. I asked my dad for $20 to go out for pizza and a movie, and it cost me 15, he expected the $5 back, right? Mr. Rychalski, what are we doing to do with the unspent funds?

Mr. RYCHALSKI. Well, consistent with our 2023 budget, we are going to spend them. We had planned for these resources. We communicated that to Congress. The appropriation took them into consideration.

Mr. MURPHY. For what things are now COVID? The emergency is over.

Mr. RYCHALSKI. No, we were very clear ARP was going to be used with baseline funding for all healthcare for this year. Some of it is COVID-related. You know, it is an extension of people being sick or are waiting. All of it was going to be used for healthcare for this year. That is consistent with what we told Congress and how they appropriated the funding.

Mr. MURPHY. See, this is where I think the last expenditure bill was way too lax in allowing too much freewheeling with what was sent. Anyway, with that, I will yield back. Thank you, Mr. Chairman.

Mr. BERGMAN. Mr. Deluzio, you are recognized for 5 minutes.

Mr. DELUZIO. Thank you, Mr. Chairman. You know, I have heard plenty of concerns from my Republican colleagues say about growth in the VA's budget. I will be pretty frank, if you did not want to care for veterans and deal with the rising cost of that care, you should not have sent us off to 20 years of war. We are going to have more costs to care for veterans because we sent people to fight at war.

I also want to respond to the chairman's claims about partisan showboating around budgets. I do not think it is partisan showboating to point out that House Republicans voted to pull back $2 billion from the VA. That their own appropriations bill underfunds the Toxic Exposure Fund by nearly $15 billion. Again, if you did not want to guarantee veterans care from burn pits and tox exposures, you should not have sent folks off to 20 years of war. I think it is a betrayal of the purpose of the PACT Act, the obligation this country has to all those who have served, many of whom are on this committee.

To the topic of today and the OIG reports and Mr. Missal's testimony in particular, I agree the need for robust oversight. What I am not seeing is substantive reporting on the oversight of money used in the fee for service or community care side of the ledger. VA has received nearly 37 billion in emergency relief funding for COVID, approximately 30 billion or so spent on medical services, 1/5 of which was spent on fee for service or community care.

Mr. Missal, my question for you, sir. Costs for this program, community care, are ballooning faster than VA medical care costs. Does OIG have any insight into how these fee for service providers used COVID–19 relief funds?

Mr. MISSAL. We have not done any projects on that specific topic. We have looked at community care in a number of different projects. We have some ongoing work right now. Given the future—or given the increases going forward, we will continue to watch community care very closely.

Mr. DELUZIO. Is there some legislative need to provide additional authority to have more insight into that what spending is happening in community care?

Mr. MISSAL. I do not think we need any legislative authority to do the kind of oversight that I think is appropriate.

Mr. DELUZIO. Okay. On April 18, the subcommittee here, Dr. Julie Kroviak from your office, voiced, "our office has published reports related to community care detailing delays in diagnosis and treatment, lack of information sharing or miscommunication between providers, and significant quality of care concerns." Is there anything stopping your office from providing that same level of detail on how community care funds are spent, just as you are doing with the VA here?

Mr. MISSAL. No. We have the ability to look at that to the extent we can get information from community care providers or other sources.

Mr. DELUZIO. I would urge you to do that, certainly, as this is a much faster growing part of medical care costs we are seeing across the VA.

Switching topics briefly to VA Video Connect and the program. Mr. Missal, would you agree that VA adapted quickly in the pandemic and that telehealth increased use of mental health services, closing gaps in veterans care?

Mr. MISSAL. We saw a significant increase in VA telehealth appointments, and I would agree that VA pivoted very quickly to meet the needs of veterans at the beginning of the pandemic.

Mr. DELUZIO. Okay. I think, and it sounds like you agree, that VA's demonstrated having access to VHA telehealth is a benefit to veterans and healthcare, helped reduce suicidal behavior, emergency department visits. Do you think it would make sense for telehealth to count as an access standard under the Mission Act?

Mr. MISSAL. I have not looked into that specifically, but it is certainly something to consider.

Mr. DELUZIO. Very well. Ms. Bell, anything you wanted to add to that? I saw you nodding along.

Ms. BELL. I just would like to echo the sentiment that the telehealth for our veterans in the facility and in the community on a personal level, is very beneficial to their care.

Mr. DELUZIO. Very well. Thank you, Mr. Chairman. I yield back.

Mr. BERGMAN. Thank you. Just before I yield to Mr. Van Orden. You know, toxic funding is in the regular budget. Congress is funding the care needed. It is now up to the VA to appropriately use that money for all the veterans. Community care is veterans care, period. Over the time of the Choice Act, the Mission Act, we had to fight in this committee to make sure that the veterans received their care wherever they could get it and have it be quality first, accessible second.

The VA is working with challenges, as it always has to take, if you will, some might call an urban model that applies to a suburban model to be transitioned to a rural model, and then some cases a remote Zoom model. That is the future. I would applaud the VA and the veterans for accepting new ways to get their healthcare, you know, over the course of the last few years.

Having said that, Mr. Van Orden, you are recognized for 5 minutes.

Mr. VAN ORDEN. Thank you, Mr. Chairman. Mr. Rychalski, how many veterans died of COVID?

Mr. RYCHALSKI. I would have to take that for the record, sir. I do not know.

Mr. VAN ORDEN. Okay. How many died with COVID?

Mr. RYCHALSKI. I do not know.

Mr. VAN ORDEN. Okay. How many vets got COVID in a VA facility?

Mr. RYCHALSKI. I would have to take that for the record.

Mr. VAN ORDEN. How many employees got COVID in a VA facility?

Mr. RYCHALSKI. Same.

Mr. VAN ORDEN. How many family members of veterans or employees got COVID in a VA facility?

Mr. RYCHALSKI. I would have to take that for the record.

Mr. VAN ORDEN. Okay, sir. These are the most basic metrics you should have showed up to this committee with. This is about whether or not your department has spent billions of dollars protecting our veterans. If you can not answer those off the top of your head, that means you are very ill prepared for this committee meeting, and that is bad. Your preparation is as shoddy as some of your accounting practices here.

I read your testimony, and quite frankly, I was not impressed with it. I am going to read something to you. A painful emotion caused by the awareness of having done something wrong or foolish. Do you know what that is? That is the definition of the word shame. That is where you guys should be hanging your head right now. A lot of people in your leadership. You should be hanging your head in shame because you have politicized your department.

On April 21, your department published a blatantly, political, misleading, and disingenuous release on your website saying the Republicans are going to gut veterans' health and slash the VA budget. I would like to enter this for the record. It says we are going to cut 81,000 jobs. We are going to have 30 million fewer appointments. We are going to undermine telehealth, worsen the wait times for benefits, prevent construction of healthcare facilities, fail to honor all of our veterans, cut housing for veterans, increase food insecurity for veterans, deprive veterans of mental health, substance use, and other services, eliminate job training and other support to veterans.

The Secretary graciously came to our office, my office. Mr. Luttrell and Ms. Kiggans, and Mr. Crane were all there. He was explicitly clear, the Secretary of Veterans Affairs, that the Veterans Affairs is not a political organization. Do you agree with this statement?

Mr. RYCHALSKI. I absolutely agree with that.

Mr. VAN ORDEN. Okay. Well, then on May 16, the Military MilCon-VA Appropriations bill was released. It proved, proved unequivocally that everything that your department has said politically is a lie. I ask you this. Have you issued a public statement retracting the blatant political lies that you have posted on your website as of this morning?

Mr. RYCHALSKI. Have I personally? No.

Mr. VAN ORDEN. Has your department?

Mr. RYCHALSKI. I am not aware of that.

Mr. VAN ORDEN. Okay. You are not aware of it, because you did not. Why would you not do that?

Mr. RYCHALSKI. Well, Mr. Van Orden, I prepare the analysis supporting that I do not control the message.

Mr. VAN ORDEN. I know, listen——

Mr. RYCHALSKI. but the analysis that I provided——

Mr. VAN ORDEN.—we can all stand around point fingers at each other.

Mr. RYCHALSKI. Mr. Van Orden, the analysis that I have done every year for a continuing resolution——

Mr. VAN ORDEN. Listen, unfortunately——

Mr. RYCHALSKI [continuing]. government shut down, lapse in appropriations——

Mr. VAN ORDEN. I got you. I got you. Unfortunately, your actions and the actions of your leadership have clearly demonstrated that you have blatantly politicized your department. You and your leadership have done a tremendous disservice to our veterans and should be ashamed of your conduct. Your department must remove this inflammatory and inaccurate statement from your website and start a public relations campaign explaining to our vets that the VA is fully funded, including the PACT Act. You must do that.

If you do not do this, you are going to be proving to the American people that you are intentionally fear mongering with our veterans for political purposes. That is shameful. Let me tell you why. This weekend I was in Sparta, Wisconsin. I met Don. He is a 93-year-old World War—excuse me, Korean and Vietnam veteran, and he was scared. He was terrified because he thought he is losing all of his care because you guys decided to politicize this. You are terrifying Don on purpose, and that is inexcusable. Don does not know how to get on a computer and look this up and find the appropriations bill proving that what you said is a lie. He does not know how to do that. Do your job, sir.

Mr. RYCHALSKI. Mr. Van Orden, most of the requests I got for the 22 percent analysis came from veterans who are concerned about the cut.

Mr. VAN ORDEN. Yes? Well, it is a lie. Now you know it is wrong. You 100 percent know it is wrong. I know you can read, sir. Read the appropriations bill that counteracts everything in this. I am asking you to do that. With that, I yield back.

Mr. BERGMAN. Mrs. Cherfilus-McCormick, you are recognized for 5 minutes.

Ms. CHERFILUS-MCCORMICK. Thank you, Mr. Chair. My question is for Mr. Rychalski. The VA's Office of Information Technology was awarded 2.2 billion in CARES Act funding. Can you tell me if and how any of this funding was used to support and bolster the VA's electronic health record modernization program?

Mr. RYCHALSKI. Could I refer that to Laura? Do you know specifically for Electronic Health Record Modernization (EHRM)?

Ms. DUKE. I cannot speak to the IT portion of it. I can tell you that under the CARES Act that we did not support EHRM. Under the ARP, there was investment in the modifications of our infrastructure to accommodate the EHRM and details of that are in our budget.

Mr. RYCHALSKI. I would like to take that for the record. I do not believe any CARES Act funds were used for EHRM, but I would like to confirm that.

Ms. CHERFILUS-MCCORMICK. The investments that were made, was there any positive results from those investments?

Ms. DUKE. Well, certainly the investments in our facilities, to the extent that a lot of our facilities are very, very old and never anticipated the need for server rooms and the type of infrastructure that is necessary to support a modern electronic health record, those modifications are an essential prerequisite for us to continue the electronic health modernization. Those modifications are necessary and needed to be funded. Certainly it makes a big difference. Beyond the electronic health record, I think just in general, the other investments that have been mentioned, and I would welcome my colleague, Mr. McDivitt, to speak for a veteran centric lens.

Mr. MCDIVITT. From a field perspective, early in the pandemic, Congresswoman, the IT infrastructure money was essential. As you heard from Mr. Missal and others, we had to move to telehealth at a rate that ended up being 2,000 times faster than we thought we would. We needed laptops, we needed IT infrastructure to support that, and it came very quickly. Same with the move. When we had to move many of our employees to telework almost overnight, we were very unsure that would work and we were provided the resources to do that.

In terms of ARP money that is allowed us to upgrade our IT infrastructure and to do many long overdue projects will benefit veterans for decades to come, we feel.

Ms. CHERFILUS-MCCORMICK. Thank you. My next question is for Inspector General Missal. I serve as the ranking member of the Technology Modernization Subcommittee here on the Veteran Affairs Committee. Your testimony initially focused on deficiencies in IT systems and business processes. The VA's current financial management system is about 30 years old and represents a significant risk to the department's operations. What would it mean for the VA to have a modern financial management system and would modernization help the VA comply with audits and oversight?

Mr. MISSAL. Absolutely. We have noted this in our audits of the financial statements, the deficiencies in the current financial management system, FMS. That is something that is desperately needed to improve. That is not the only thing. As I noted in my testimony, there is other issues that they have to comply with as well. Certainly, getting a new financial management system is a big step in the right direction.

Ms. CHERFILUS-MCCORMICK. Thank you. My next question is for Ms. Bell. Your testimony mentioned staffing ratio flexibility offered to state veteran homes during public health emergencies. Since the public health emergency ended on May 11, how are state veteran homes working to increase workforce recruitment and retention to ensure patient safety standards for our veterans?

Ms. BELL. Well, we are continuing to advertise. We are continuing to recruit. We have seen, as one of my colleagues stated earlier in New York, an increase in Certified Nursing Assistants (CNAs) applying for their CNA school. We are starting to see people applying to these programs. Now, you can not hire if you do not

have people going through the education system to get trained. We are working with our local community colleges, universities that have those nursing programs and CNA programs, as well. As well as reaching out to the VA for the—and utilizing the nurse retention grant program.

Ms. CHERFILUS-MCCORMICK. Thank you. My next question is also for you, Miss Bell. Your testimony mentioned that 72 percent of state veteran homes receive funding from both the VA and the Medicare program and are subject to similar week-long inspections from either agency. Can you tell me how these inspections differ from each other or if they feel redundant?

Ms. BELL. I would say that the VA survey has always been the top-notch survey for state veterans homes. I have been in the state veterans home program for 23 years. It has always held the bar higher than CMS traditionally. It is also been an educational survey. To have that VA survey onsite leading into a CMS survey, we felt more prepared for the CMS survey. That cannot seem as an education tool for us like VA survey. We also, to add to that oversight, some of our facilities are Joint Commission accredited as well. We also have life safety coming in. The VA standards have always been more stringent than CMS, and we always embrace those surveys to teach us to do better for our veterans.

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

Mr. BERGMAN. Thank you. Mr. Luttrell, you are recognized for 5 minutes.

Mr. LUTTRELL. Thank you, Mr. Chairman. Good morning. Mr. Rychalski, how long have you been in your current position?

Mr. RYCHALSKI. Going on 6 years.

Mr. LUTTRELL. Six years?

Mr. RYCHALSKI. Yes.

Mr. LUTTRELL. Ms. Duke?

Ms. DUKE. Four years.

Mr. LUTTRELL. Do not sharpen your pencil. Sir, how long have you been the IG?

Mr. MISSAL. I have been the IG 7 years and 19 days I believe.

Mr. LUTTRELL. I am assuming this is not the first report that you have received from the IG.

Mr. RYCHALSKI. No, it is not, no.

Mr. LUTTRELL. Okay. Mr. Missal said, reoccurring issues, accountability, breakdown in leadership, poor communication. I am assuming that these issues have been in multiple reports that you have issued to the VA, correct, sir?

Mr. MISSAL. That is correct.

Mr. LUTTRELL. Mr. Rychalski and Ms. Duke, and unfortunately, since you have been there long enough, this falls on your shoulders.

Mr. RYCHALSKI. It does.

Mr. LUTTRELL. Okay. I know the VA is a very cumbersome department and it is an ugly machine, if you will. The IG said that——

Mr. RYCHALSKI. We do not call it that around the office.

Mr. LUTTRELL. Yes. The IG stated that the financial management system is not due to be integrated or updated correctly in this decade. My first question to the panel is, are we to assume, given

the amount of money we have lost over the past few years for that to continue, because the blame has been put on the management system itself. sir.

Mr. RYCHALSKI. The blame is not just on the management system. I mean, it is on the people, the processes as well. We are not losing money and we have sound accounting, but we do not have all of that.

Mr. LUTTRELL. It does not say sound accounting. It says weak accounting practices from the IG's report.

Mr. RYCHALSKI. Right, it does, but I counter that with our clean audit opinion——

Mr. LUTTRELL. That is a large statement——

Mr. RYCHALSKI [continuing]. and are improper payments.

Mr. LUTTRELL [continuing]. from your sound accounting to weak accounting. That is 180 out, sir.

Mr. RYCHALSKI. Our financial statement auditor says we have sound accounting and they are run by the IG.

Mr. LUTTRELL. You guys are not talking to each other?

Mr. MISSAL. No, I think we are talking to each other. We both agree, even with our financial statement audits, we have continually found material deficiencies and significant weaknesses, and a big part of that is the internal controls.

Mr. LUTTRELL. What are we going to do for the next 6 years, 7 years to course correct this ship so we do not continue to lose this money, because we up here on this panel have a very difficult job of moving money in proper places. If we can limit the amount of fraud, waste, and abuse, it makes our jobs easier and it is even better for the veterans, yes?

Mr. RYCHALSKI. We are going to continue to roll out our state-of-the-art accounting system. We are going to continue to consolidate accounting in our financial services center, and we are going to continue to train people. We will see improvement. For example, you may have read about Journal Vouchers. Journal Vouchers last year to this year are down 55 percent because of the work that we are doing.

Mr. LUTTRELL. Let us do this. The IG also said, and Miss Duke, I think you said this too, that it is challenging in who we will report to, who has a certain role and responsibility, those breakdown in communications and silos, right? VA is very siloed department to department. Who is responsible for creating roles and responsibilities, and then who is responsible for communicating that down and into the organization so you are well-informed and that problem goes away? There has got to be a name.

Mr. RYCHALSKI. You are looking at them right here. I am ultimately responsible.

Mr. LUTTRELL. Okay, sir. How long, again, have you been in this position?

Mr. RYCHALSKI. Six years.

Mr. LUTTRELL. That seems to be a problem, sir.

Mr. RYCHALSKI. I am not sure I would be a problem.

Mr. LUTTRELL. Well, we just had Ms. Duke and the IG say that there is a reoccurring issue on accountability, communication, and roles, and responsibilities. You say that lives on your shoulders and you have been in that position for six years.

Mr. RYCHALSKI. Correct. That is correct. He also mentioned that not—the organizational structure is they do not report to me. I mean, it is my job to work within the organizational structure that we have. They do not work directly for me, but, yes, I am ultimately responsible.

Ms. DUKE. If I may say, although I organizationally report to the Undersecretary of Health, I do not feel like there is a lot of daylight between myself and Mr. Rychalski regarding the expectations of financial controls, regarding our cooperation on the audit, regarding our coordination to roll FMBT out to my organization. I work very closely with my counterparts in the VISNs and in the medical centers so that we maintain frequent communication.

Mr. LUTTRELL. Okay, well, at a leadership level, if you are saying that that is copacetic, it seems down and inside the organization is where we are misallocating $187 million is a breakdown.

Ms. DUKE. What I would say is that the IG correctly identified that in certain incidences during the evolving concerns of the pandemic which did demand a greater use and reliance on journal vouchers we were not as ready as we could have been at the outset to provide clarifying guidance to our field, in part because we were still learning what the expectations were on the medical centers during the pandemic. Now that we have learned from that, we are clearer in the guidance that we issue to convert the guidance that we get from CFO into something that is useful and material to our financial folks out in the medical centers to adopt those practices.

Mr. LUTTRELL. I am out of time, sir. I yield back.

Mr. BERGMAN. Thank you. Ms. Brownley, you are recognized for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. Mr. Missal, I wanted to ask you in your testimony this morning, you talked about the issue of oversight and transparency and the fact that medical centers are sort of independent, and that is somewhat problematic in terms of full implementation. I am curious for your opinion. Is the autonomous nature of medical centers sort of an ongoing issue when you look at oversight issues in relationship to a lot of different policies and regulations, is that something that sort of crops up frequently?

Mr. MISSAL. Yes, that is a theme in a number of our reports, the decentralized nature of the governance structure. They do benefit because a lot of health care is local. There needs to be proper oversight of that, and that is where the decentralized nature sometimes fails in the oversight.

Ms. BROWNLEY. Yes, it is a frustrating point for me because I find that I understand the benefits of working independently and so forth, but when they are not complying to policies that we have passed and become law and following the regulations, it becomes a little bit frustrating. Not a little bit, a lot frustrating.

Mr. Rychalski, in terms of the IT systems and certainly the issue about the FMS system. Is Mr. DelBene involved in the execution of completing that process at all?

Mr. RYCHALSKI. He is. Or his team is, yes. In fact, we have an IT component embedded with our iFAMS program office, mm-hmm.

Ms. BROWNLEY. Do you have a timeframe for when we, I mean, we have spent God knows how much money, billions of dollars

when it comes to all of the IT systems. In terms of this one, do you have a sense of when you will be online?

Mr. RYCHALSKI. Well, we are online. This has been, in my estimation, a read success story. We have had five successful implementations. We have 3,000 users. We have 99.97 percent availability. We have processed 3.1 million transactions. We have dispersed 9.3 billion through Treasury. There is a 96.9 percent iFAMS satisfaction. We are going to go live with our next major implementation, which includes the IG in 3 weeks, which is why I have my resume up to date. If you are hiring, I would be interested in, yes.

Ms. BROWNLEY. I guess if it is——

Mr. RYCHALSKI. So, it is——

Ms. BROWNLEY [continuing]. great, and that——

Mr. RYCHALSKI. It is on time. It is on budget. We are proceeding. The reason it is going to take so long is we have 130 different instances of VHA we are going to have to go through. We may be able to speed it up, but it is been a real success. I mentioned that our journal vouchers are down by 55 percent attributable to the iFAMS' implementation.

Ms. BROWNLEY. I see. It just was not working to get through the supplemental issues that we had with——

Mr. RYCHALSKI. VHA received the preponderance of the supplemental funding and they do not have iFAMS yet. That is correct.

Ms. BROWNLEY. Yes, Okay. I just want to make for the record——

Mr. RYCHALSKI. Thank you for the question. we are very proud of iFAMS. It is been a real success——

Ms. BROWNLEY. I understand and I, you know, I commend you for the success you have had so far. I am just asking, you know, when the entire system is going to be up to speed.

Mr. RYCHALSKI. That is——

Ms. BROWNLEY. I had to kind of dig for that answer a little bit.

Mr. RYCHALSKI. I am sorry. So about 6 years——

Ms. BROWNLEY. Okay, thanks.

Mr. RYCHALSKI [continuing]. it will be done.

Ms. BROWNLEY. Are you familiar at all with a bill that I have introduced, the Elizabeth Dole Community Based Services bill for veterans?

Mr. RYCHALSKI. I have heard of it, but I am not familiar on it.

Ms. BROWNLEY. Well, it is, I mean, simply enough, it is a bill to move away from institutionalized care into, you know, care for veterans who are aging, who have disabilities, et cetera, to be able to stay in their homes. I guess, you know, just understanding that and what its purpose is, do you believe that A, that is sound policy from a fiscal perspective, and B, do you think it is sound policy in anticipation of another pandemic or another disaster, weather related disaster, which we can only assume will happen?

Mr. RYCHALSKI. Based on what you described, it sounds like very sound policy, yes.

Ms. BROWNLEY. Okay, thank you. Ms. Bell, through the ARP funding, VA anticipates 12 new state veteran homes that will open in 2023 and 2024. It appears once again we may soon find ourselves with a backlog of State veteran home construction projects. VA's only requested 164 million for Fiscal Year 2024. As you noted

in your testimony, once VA releases its new priority list, the actual need may be closer to 900 million. What does that mean for veterans across the country and the timelines?

Ms. BELL. Even though you spoke about the Elizabeth Dole and taking care of them at home, what we see is not every veteran has family that is local. They do not have the capacity to do that. These homes are going to allow them to come into a State veterans home to be with, as they call it, their comrades. What we have learned is some veterans in the communities plan 10 years out to go into the nearest State veterans home by them when the time comes. They anticipate.

I am in talks right now with a veteran and his daughter has me talking to him on a weekly basis that this is the anticipation. We are talking about his care, his life. What happens next in that next year chapter.

Ms. BROWNLEY. No, no, no, I understand. Are you developing waiting lists for these potentially 12 new state veteran homes?

Ms. BELL. They are called applicant lists in each section, and we have one in North Carolina as well, yes.

Ms. BROWNLEY. Very good. Mr. Chairman, I yield back.

Mr. BERGMAN. Thank you. Mr. Self, you are recognized for 5 minutes.

Mr. SELF. Thank you, Mr. Chairman. I will start this out by Chairman Bost started this out with that chart, if you remember right. I just want to emphasize the fact that your secretary has damaged the relationship with Congress by the 22 percent. Let us just make no mistake about it. Of the 10K purchases or contracts that were reviewed, resulting in 187 million in mistakes, what percentage of the total purchases or contracts was that 10K? Just an order of magnitude.

Mr. RYCHALSKI. I have to take that for the record. I do not know how much of that funding was spent on payroll versus contracts. I do not have those numbers before me, so I would have to look at that.

Mr. SELF. I would assume it is many times more than 10K purchases and contracts. Many times more. The 187 million that we have thrown around here is probably a very small subset of what it actually is. Is that a fair statement?

Mr. RYCHALSKI. It is, yes.

Mr. SELF. Okay, so the 187 million is a small subset of what actually transpired. What accountability has been held because there are people behind every system. I have also heard a lot about a system that is being rolled out that will help. It does not matter whether you are using the old system or the new system. There are people behind every system. There is a person that is responsible. I am also concerned about the CFOs that do not have a formal chain of command relationship with other CFOs. Being a military guy, that seems to make sense to me, because money is one of the things that will get you in trouble every time.

Who has been held accountable for these errors? Again, I want to point out the 187 million is probably a very small percentage of the dollars we are talking about that were mistakenly contracted. Who has been held accountable?

Mr. RYCHALSKI. I would say that we all have. We take the IG report, in addition to our financial statement, auditing our improper payments, and we use that to provide additional training. You know, obviously, if somebody has committed a crime, there is, you know, there is culpability for that. Most of this has to do with, you know, the individual's motivation, training, how they followed processes.

We work with them to provide remedial training. In some cases, you know, there may be some disciplinary action if, you know, it is blatant, but, you know, I think we are all accountable for it. I am sorry, Rob.

Mr. MCDIVITT. Just Congressman, early in the pandemic, we set up a process to track every dollar. It was largely a manual process, as Mr. Rychalski indicated. We put audits in place. We used our usual financial management processes. We had our compliance officer audit the process to make sure that we were doing what we needed to do.

Mr. SELF. Okay, that is process oriented. I am talking about accountability. Now, to me and let me go back and just make sure I understood, your $800 million in nonexistent Personal Protective Equipment (PPE). Did I hear that right?

Mr. MISSAL. Yes, a gentleman tried to sell VA $800 million of PPE that did not exist. Fortunately, we were able to get to that person before VA contracted for that $800 million.

Mr. SELF. Very good. When I talk about accountability, I mean demoted, reassigned, disciplined, formally disciplined, and ultimately fired. When I talk about accountability, that is what I mean. Who has been held accountable for anything?

Mr. RYCHALSKI. Well, if there are any actions that warranted that, you know, that level of intervention, we would do so. I can not speak through the entire organization, I mean, but, I mean, we take actions as appropriate as we find things. If it is a matter of they were not trained properly, that is probably on us and we train them. They did not follow policies or procedures. There could be a letter of recommendation, things like that.

Mr. SELF. You prepared, obviously you prepared hard for a hearing before Congress about a very small percentage of transactions that were wrong at $187 million. You prepared. I know you did. Yet that is one of the things that I think you would have been prepared to tell this committee and Congress what you have done about it. Training and processes is all good, but eventually people are behind everything, and accountability means what have you taken in the personnel action area to correct it? Chairman, I yield back.

Mr. BERGMAN. Thank you. Ms. Budzinski, you are recognized for 5 minutes.

Ms. BUDZINSKI. Thank you, Mr. Chairman. Thank you to the panelists for being here today. As we are all very well aware, the COVID–19 pandemic has devastated, has had devastating impacts across the country, and affected all Americans in some way. Unfortunately, our veterans, who tend to have higher chances of experiencing a disability or have mobilities, excuse me, due to their unique military experiences, were one of the communities most disproportionately impacted. As has been made clear by my colleagues

in the OIG report, mistakes were made on how the VA handled supplemental funds and spending related to the pandemic. I do have a few questions on that, but I also want to take a moment to highlight the noteworthy and rapid response the VA took in the face of an unprecedented pandemic.

The VA helped care for over 750,000 veterans with COVID, helped over 200,000 veteran families experiencing financial difficulties retain their homes during the pandemic. Vaccinated almost 5 million veterans, and reduced veterans homelessness by 11 percent between 2020 and 2022. As made clear by Miss Bell's testimony, VA's efforts and supplemental funding was instrumental in helping State veterans home sustain operations, hire new staff, and build new infection control systems.

That being said, I do want to touch on a few issues, a few of the issues identified by the IG report. Mr. Rychalski, as I mentioned before, there were several issues in how funds, specifically those from the CARES Act, were used. There was a lack of accountability and transparency in how the VA directed and used funds, mainly due to the VA's outdated financial management system, which I know we have been talking about. I will highlight, as does the IG report, that the controls developed to track these expenses were developed during the pandemic when decisions had to be made rapidly in order to prioritize and utilize funds for the most pressing needs. My question, Mr. Rychalski, given that there are still at least, I think, 500 million unspent supplemental funds, what specific steps has the VA taken to improve their financial control systems going forward and have more transparency in how these funds and other funds are used?

Mr. RYCHALSKI. I would say the number one thing is we will and have provided more explicit guidance for the use of supplemental funding.

Ms. BUDZINSKI. Okay. Okay, and then what lessons, Mr. Rychalski, has the VA taken from this experience to better prepare in case there is another public health emergency?

Mr. RYCHALSKI. I want to ask Robert to answer that. He is kind of at the tip of the spear and I think his experiences are probably the most relevant.

Mr. MCDIVITT. Sure. Thank you, Congressman. The lessons from COVID are many. I think the main one is that we are able to respond as a system. I have eight states in my network, eight medical centers, 62 community-based outpatient clinics. All of them remained open and operating every day during the pandemic. We made sure that veterans were safe and well cared for. We made sure that employees were safe. We were able to support caregivers. We were able to reach out to community partners, including state veterans homes, as Ms. Bell noted, in the state of Iowa and in Minnesota where I live.

We really focused on the system nature of the VA, that I operate a large integrated regional healthcare system. We moved resources where they needed to be, whether it be within my network or around the country. We functioned for the first time in my long VA career as a fully integrated national system. That is a lesson that we will take into the next challenge, whether it be a pandemic or something else.

Ms. BUDZINSKI. Okay, thank you. My next question to the panel, the Limit, Save, Grow Act, if passed in the Senate, would rescind critical supplemental funding. This is funding we have right now which is urgently needed by our veterans across the country, specifically veterans in my rural district that I represent in central and southern Illinois, where we can build upon our community care partnerships as well as on telehealth, two of my top priorities. Could you share some of your insights on what negative impacts do you anticipate in rural health care services if this 500 million were to be rescinded? On the other side, what are some ways that funding could be utilized to promote rural veteran care?

Ms. DUKE. Thank you for the question. I think that, as is clear in our budget, we are always focusing resources on the unique needs of our rural health population. Because we anticipated having the ARP funding in conjunction with our base funding, any interruption in that would interfere with our plans in terms of our investment for rural health care. As you know, we are continuing to make our significant investments in telehealth. We are continuing to expand our community partnerships for those to receive community care, and we are just continuing to utilize the best ways that we found to reach our rural veterans and respond to their unique needs.

Ms. BELL. Might I add that from the State veterans home perspective, to take the time to get a veteran up out of bed and put him on a van and transport him, he or she for two and a half hours one way to an appointment and back to the facility, making it an 8-hour day, telehealth would be so much more convenient for their quality of life and the care that they receive.

Ms. BUDZINSKI. Thank you. I agree. I yield back, Mr. Chairman. Thank you.

Mr. BERGMAN. Mr. Rosendale, you are recognized for 5 minutes.

Mr. ROSENDALE. Thank you very much, Mr. Chair. I really appreciate that. Mr. Rychalski, I had a whole line of questioning here regarding the blatant lies that you put out in your press release on the Veterans Affairs website. My colleague, Representative Van Orden, did such an excellent job at exposing it and his condemnation of the same. You are not going to need the button for a couple of minutes, so just relax.

Mr. RYCHALSKI. Okay.

Mr. ROSENDALE. This is my turn.

Mr. RYCHALSKI. Okay.

Mr. ROSENDALE. This is my turn. His condemnation of the way that you put that information out and the way that you have left it out there scaring veterans is an embarrassment, quite frankly. What I would like to make sure everybody is aware of, I have been doing a little bit of digging around while we had this additional time. The 2022 enacted funds for the Veterans Administration was $273.9 billion. The increase, not including ARP, to 2023 was $34.6 billion. A 12.6 percent increase is what the veterans were able to have utilized to provide them benefits.

You, sir, did a poor job of making sure that that money was utilized to deliver benefits. Those are the realities. You had another $4.3 billion that was allocated through ARP, and you squandered $3.8 billion of that. Now you have got $500 million that is still not

spent. We are still talking about a total of $38.4 billion that the Veterans Administration has spent more from 2022 during the fiscal 2023 year. There is $500 million that has not been used that you do not feel we should be redirecting and utilizing for other purposes, whether it is to deliver real benefits to the veterans or to help the Treasury pay the bills. That is what this room finds unacceptable. I will tell you that.

As you sit there and you brag with your snide remarks about the improper payment rates that you have improved so dramatically by 76 percent, which is, oh, by the way, since 2017, not since 2022, since 2017. That sounds like a big number, but percentages you can not put in the bank. What you can put in the bank is dollars. That was based upon, as Representative Self was talking about, you started with $12.74 billion. We still have improper payments on $509 million.

Most people in this room find that to be an extremely large number still. Please do not sit there and take credit for dramatic improvements. As we have already demonstrated, you have been there for 6–1/2 years, and you are cleaning up your resume. I would as well. I would as well. I would hope that there were not many people out in television land listening to your prior performance, because I do not think a line will be forming to pick up that resume.

Let me ask you about an example from the OIG report on page eight. A medical facility did an expenditure transfer totaling $714,000 for nurses' salaries. That is a perfectly valid way to spend COVID supplemental funds. The problem is, when the OIG asked for the documentation showing how much money was actually paid out and who approved it, the VA had nothing. Their response was the person who processed it retired. They do not have any of the documents. This is no way to run a business or an agency. Polish up the resume, Mr. Rychalski. Were you able to establish whether $714,235, or a different amount, was paid out?

Mr. RYCHALSKI. I have not looked in that specific case yet, no.

Mr. ROSENDALE. The COVID–19 pandemic has long been over. President Biden even recognized this reality by signing H.J. Res. 7, which terminates the national emergency declaration. Despite this, Montana VA is still enforcing an unscientific mask mandate. The Montana VA is still denying veterans care over their unwillingness to wear a mask. How many veterans have had their care delayed or denied as a result of this arbitrary mandate?

Mr. RYCHALSKI. I do not know, sir.

Mr. ROSENDALE. How much has the VA spent implementing and enforcing this mask mandate?

Mr. RYCHALSKI. I take that for the record.

Mr. ROSENDALE. The mandate is the exact opposite of what the supplemental funds were intended to support. Do you think it is better to use the funds to enforce a senseless mask mandate than it is to actually use those delivering healthcare to our Nation's heroes?

Mr. RYCHALSKI. That is out of my lane. That is a healthcare question, sir.

Mr. ROSENDALE. Mr. Chair, thank you so much. I yield back.

Mr. BERGMAN. Thank you. Congresswoman Ramirez, you are recognized for 5 minutes.

Ms. RAMIREZ. Thank you, Chairman and Ranking Member Takano. I really appreciate that we are holding today's hearing. I additionally want to express many thanks to every one of the witnesses for joining us today and engaging in a very critical and lively discussion today.

We have been talking about COVID–19 and the pandemic. During the public health emergency, the Department of Veteran Affairs homeless programs acted quickly to bring veterans indoors and to decongregate shelters to reduce the spread of COVID–19. The VA utilized funding to pay for hotel and motel stays for veterans experiencing homelessness, to enhance housing, navigation, resources. This question is for the gentleman of the hour here, Mr. Rychalski?

Mr. RYCHALSKI. Correct, yes.

Ms. RAMIREZ. I got it correct? Okay.

Mr. RYCHALSKI. Call me Jon, yes.

Ms. RAMIREZ. Oh, I am big on honoring people's names? Delia Ramirez and you are Mr. Rychalski. How did the use of COVID funding in this way streamline VA's ability to move veterans into permanent, stable housing during the Pandemic?

Mr. RYCHALSKI. I think, I wonder Robert, do you want to? You probably have more on the ground experience than I do?

Mr. MCDIVITT. Yes. Thank you for your question, Congresswoman. In answer, it was very helpful. As I indicated across our VISN, we were able to quickly move veterans out of congregate housing into hotels, motels, other more secure places. We were able to utilize the funding for transportation of veterans to get them to appointments or to other things they needed. We were able to address food insecurity issues with some of that funding with homeless veterans. Clearly there was a benefit to veterans and to homeless veterans in particular from that.

Ms. RAMIREZ. Thank you, Robert. I know Ms. Duke, in the conversation with Congressman Levin, we talked a lot about homelessness and the impact of some of these resources and helping drop that number. He mentioned we were at about 37,200 and something people experiencing homelessness, and that number has dropped to 33,000, and I could not catch the last number of it. You had also indicated, as we talked about some of the funding that you have for this upcoming budget, a real commitment to continue to reduce that number in the 2024–2025 budget. Tell me a little bit of the projected goals you have around the reduction of homelessness for our veterans.

Ms. DUKE. Thank you. I would say the core of our homeless is our coordination with Housing and Urban Development. We continue to provide support services for their Department of Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) vouchers to ensure that those vouchers are utilized and that veterans are connected with them.

We are continuing to make investments in providing telehealth to homeless veterans, whether through devices, but to make sure that they are able to meet their appointments. We are, as we have mentioned, working with you all on which of the authorities that

were extended under the public health emergency that makes sense outside of a public health emergency, to continue to reach those veterans and enable us to utilize those dollars for investments that are what veterans really need.

Ms. RAMIREZ. Great. Thank you, Ms. Duke. I know that throughout the hearing today, we have heard a lot about how the pandemic has ended and how we are no longer impacted in a real way around COVID–19. We also know, however, that long term effects of COVID, otherwise known as long-COVID, are still being studied. This question could be for Mr. Rychalski or any of you. Will you tell me how the VA would use COVID–19 supplemental funding for research efforts on long-COVID? Before you answer, specifically, I am interested in knowing how it is affecting the underserved veteran populations and what mechanisms the VA has created to stay on top of changing variants.

Ms. DUKE. I would like to take for the record specific investment in underserved populations. I can say that we did utilize ARP resources to add on to our already robust base, medical and prosthetic research investment with a specific focus on what we could learn about the COVID pandemic. We are continuing to track veterans who were experienced COVID to learn better about long-COVID. We are utilizing the lessons that were learned in terms of preventing any contagion, not just COVID, from spreading throughout our facilities.

Ms. RAMIREZ. Thank you. This is a final question to Mr. Rychalski. We have talked a lot about the budget and any cuts to the budget. Quick question, yes or no, any cuts to the VA budget, would it result cuts to veterans?

Mr. RYCHALSKI. Absolutely, yes.

Ms. RAMIREZ. Any cuts to the budget, would it impact housing services, food insecurity for veterans?

Mr. RYCHALSKI. All that.

Ms. RAMIREZ. That is what I figured. Thank you, and I yield back.

Mr. BERGMAN. Thank you. Mr. Crane, you are recognized for 5 minutes.

Mr. CRANE. Thank you, Mr. Chairman. I appreciate you guys being here today. I will start with Mr. Rychalski. Sir, do you know what percentage of the VA budget is spent on mental health care for our veterans?

Mr. RYCHALSKI. Percent wise, I have to do the math, I am sorry.

Mr. CRANE. Could you give me even a ballpark? Anybody up here? I mean, that is a pretty broad question.

Ms. DUKE. On the delivery of care, it is upwards of $10 billion.

Mr. CRANE. Ten billion dollars?

Ms. DUKE. Yes.

Mr. CRANE. I asked for a percentage, do you have any idea?

Ms. DUKE. Of the overall VA budget?

Mr. CRANE. Yes.

Mr. RYCHALSKI. It depends on what the denominator is. I take it for the record to get you an exact percent.

Mr. CRANE. You what?

Mr. RYCHALSKI. I would take it for the record to get you an exact percent.

Mr. CRANE. Okay. Next question. Is anybody on the panel, does anyone believe that betrayal, humiliation can lead to depression and poor healthcare for our Nation's veterans? Anybody at all? I see you shaking your head, Mr. McDivitt. Betrayal, humiliation, can that lead to depression, poor healthcare for our Nation's veterans?

Mr. MCDIVITT. I am not a clinician Congressman, so I can not comment on that definitive——

Mr. CRANE. Do you have common sense, Mr. McDivitt?

Mr. MCDIVITT. I can say that a significant amount of our care is provided for mental health, and that is certainly the case in our VISN where between, depending on the facility, 15 and 25 percent of veterans are receiving mental health services.

Mr. CRANE. Yes. Do you think that betrayal, humiliation might be a part of that mental health?

Mr. MCDIVITT. Again, I can not comment on that.

Mr. CRANE. Anybody at all? What about you, Ms. Bell? Does that sound like something that might cause mental health issues in our veterans?

Ms. BELL. Our veterans are very outspoken, and they have to be able to trust their caregivers, so we have to develop and cultivate that. When we do not, there are bad outcomes, yes.

Mr. CRANE. All right. That is not what I asked. Are any of you guys aware that 73 percent of our Afghanistan veterans feel betrayed right now? About 67 percent feel humiliated because of our withdrawal from Afghanistan. I mean, you guys are Veterans Affairs, right? Any of you guys aware of the Brookings Institute survey that came out November 2021 stating that 73 percent of our Nation's veterans feel betrayed, 67 percent feel humiliated. No one is aware of that? It is kind of problematic.

Well, I can guarantee you because of the findings of that survey and just common sense, that is costing the American taxpayer a lot of money knowing that because and since none of you guys even knew it, I am going to ask the follow up question anyway so I can look at more blank stares. Do you think this President, Commander in Chief should own any of the impact and cost on our veterans healthcare and the tax dollars that are going to have to be spent because of their decreasing healthcare, because they feel depressed, humiliated, and betrayed? Does anyone think that the Commander in Chief should take any ownership of that whatsoever? Great. More crickets.

Mr. Rychalski, I am going to double tap on something that my colleague Mr. Van Orden and Mr. Self were pushing on. The Secretary of the VA has done tremendous amount of damage with the relationship with not only Congress, but also to our Nation's veterans by lying to them about our spending cuts and our spending package. I want to go through some stuff with you because I was in many of the conversations that were going over that, sir. The Republicans were actually trying to target our cuts toward, and go ahead, feel free to take notes since I do not think that you are aware of this based on some of your previous testimony. We are going after the Regulations From the Executive In Need of Scrutiny (REINS) Act. Are you familiar with what that is, sir?

Mr. RYCHALSKI. I am not.

Mr. CRANE. Okay. Internal Revenue Service (IRS) agents, the funding for the 87,000 IRS agents doubling that. Yes, we were going after that. We also went after student loan bailouts. We do not think that the American taxpayers should have to pay for everybody that, you know, applies for a student loan. Also, the Inflation Reduction Act, also known as the Green New deal light. We are going after that as well. We do not think that American taxpayers should have to be funding the disruption of our energy dependence in this country.

The reason I say that is because our cuts are actually very targeted. Not once, not once did anybody in this conference, any Republican, in any phone call that I was on, in any meeting that I was ever at, say anything about cutting veteran healthcare. You all took it upon yourself to play political games, and you might have thought it was effective initially because you stirred veterans up. Congratulations. Congratulations, you did. I will tell you what you really did. You destroyed your integrity. You are going to see that come appropriations time where we do not cut anything, you guys will be proved once again to be dishonest and misleading. Thank you. I yield back my time.

Mr. BERGMAN. Mr. Mrvan, you are recognized for 5 minutes.

Mr. MRVAN. Mr. Missal, one of the recommendations your office made to the Undersecretary for Health is to establish guidance to support the amounts identified in the manual journal vouchers. Is the issue with the guidance and the standards for these manual journal vouchers limited to expenditure of the supplemental funds?

Mr. MISSAL. They would be with respect to this report, but we have seen the lack of guidance in many other situations.

Mr. MRVAN. Okay. Is there any reason to consider the age of the financial management system and why the VHA would not already have guidance and standards in place before the pandemic for these vouchers?

Mr. MISSAL. Given the limitations of the financial management system, you would hope that there would be guidance, clear policies and procedures, and clear understandings of roles and responsibilities because of the limitations that the financial management system has.

Mr. MRVAN. Okay. If you could, for my own knowledge, redefine limitations for me.

Mr. MISSAL. Some of the transactions were not able to be put through the system. They had to be done manually. Anytime you have manual transactions, you have a greater risk that they are not going to be done correctly and that you open it up to potential fraud.

Mr. MRVAN. Okay. Who is the accountable official responsible for issuing this guidance at the VA and the VHA specifically?

Ms. DUKE. It is my responsibility to communicate the guidance from Jon's office to the VHA.

Mr. MRVAN. Okay. Is this issue enhanced by the fact that Veterans Administration Medical Centers (VAMCs) are well known to operate as unique entities?

Ms. DUKE. I would say that that is definitely part of the challenge. In this particular case, I think it was that the VAMCs were responding to the pandemic. Since our primary focus was keeping

veterans and our staff members safe, we were sometimes operating under less than ideal staffing circumstances.

Mr. MRVAN. Okay. Has your office provided any recommendations for addressing lack of guidance in the standardization being decimated from VA headquarters to the medical centers?

Ms. DUKE. We are in the process of improving our processes consistent with the recommendations that the IG made in the report. For my office, that is the responsibility of standardizing the guidance. Then we are working collectively with the Office of Integrity and Compliance within VHA that is responsible for going out into the field and ensuring that roles and responsibilities are followed appropriately. I do not know if Mr. McDivitt wants to add.

Mr. MCDIVITT. That was certainly one of the lessons learned from the pandemic for us, Congressman. Working with Ms. Duke's office. My CFO is working with medical center CFOs to standardize processes. We endeavored to do that. I can say the things that we did as an integrated system throughout the pandemic were much easier to track and account for than the things where we did journal vouchers and things of that nature, although we endeavored to manually keep track of that as well. So, we have changed processes.

Mr. MRVAN. Okay. Mr. Missal, your report recommends that the VHA staff segregate duties, make certain that a purchase card holder is not the requester and approver, and ensure that contracting officers, representatives, or cores know and understand their duties and responsibilities for these certifications and payments of invoices. These recommendations seem to me to be something that VA should have already been doing. This is pretty basic stuff. Are you surprised that your office is having to make these recommendations to VA?

Mr. MISSAL. We agree that these are basic responsibilities or sort of fundamental to good internal controls, and those recommendations remain open.

Mr. MRVAN. Okay. I am assuming that supplemental funds and the pandemic are not just highlighted issues that have been at VA for years. Why is there not a process in place to train and educate contracting and purchasing staff on these basic roles?

Mr. RYCHALSKI. There is. You are right, those are basic functions. We have to test it and provide remedial training, sometimes disciplinary action. You are 100 percent correct. Yes, it is variability across the system that we continually try to, you know, to fix.

Ms. DUKE. I would say during the Pandemic, the increased reliance on journal vouchers, because when we receive supplemental funding, what is automated is no longer able to be taken advantage of. It was highlighting a challenge that we were already aware of and making it more urgent.

Mr. RYCHALSKI. Keep in mind, during the pandemic, we had acquisition people working, you know, 24 hours a day trying to acquire supplies and equipment. We had financial management staff that were repurposed to take temperature at the front door of AMCEE. It was a very different situation with that.

Mr. MRVAN. Yes. With that I yield back chairman.

The CHAIRMAN. The gentlemen, yields back. Representative Mace, you are recognized for 5 minutes.

Ms. MACE. Thank you, Mr. Chairman. I want to thank Ranking Member as well, and I want to thank General Bergman for letting me slide in here to ask a few questions before I have to leave today. I wanted to take a moment also and thank the VA Appropriations Committee for writing their bill which fully funds the Department of Veterans Affairs. Despite the continued comments from the administration and from the left that Republicans do not want to want to fund or want to cut funding from veterans. Nothing could be further from the truth.

Some of you up here today have participated in a bed of lies, bullshit, and lies regarding the debt ceiling. Quite frankly, it is extremely disrespectful to our veterans to posit or even to accuse us of wanting to cut VA benefits. None of us up here on the left or the right, Democrats or Republicans want to do that.

We are concerned about the lack of accountability, waste, fraud, and abuse within the VA. I am also concerned with that enormously and looking at the COVID supplemental funding, as we have been discussing today, the fraud and abuse, and that is appalling. The VA received roughly 40 billion in extra funding between 2020 and 2021 when the OIG audited 14.5 billion of the money. The OIG found the record keeping was usually incomplete. It was not signed. There were a lack of descriptions of purpose, no documentation. In some cases, none at all existed.

I have a few questions this morning. Mr. Missal, my first one is for you. Did your report say the VA struggled to account for CARES funds, failing to maintain audit trails for majority of internal transfers, failed to adhere to internal controls, and 10,000-plus supply purchases or service contracts worth over 187 million, yes or no?

Mr. MISSAL. Yes.

Ms. MACE. Thank you. Mr. Rychalski, would you consider not being able to account for $187 million fraud, waste, and abuse?

Mr. RYCHALSKI. I would not.

Ms. MACE. I am sorry. If I gave you $187 million and you did not know what to do with it, you would not call that waste?

Mr. RYCHALSKI. No. Unless it is proven as fraud, waste, and abuse. It could just be the fact you did not have a receipt. When you look farther, which we have, and we find the receipt.

Ms. MACE. Okay. In Mr. Missal's report that they could not find, you know, they did not have information on $187 million. If you just spend that money and you do not have the receipts, you would not call it waste. I do not know how you have your job, quite frankly, if that is your position. Based on that example, do you think that the VA has any issues with waste, fraud, and abuse?

Mr. RYCHALSKI. We absolutely do. Yes, we do.

Ms. MACE. Where would that be?

Mr. RYCHALSKI. It is across the system, and we work very diligently to root it out.

Ms. MACE. But just——

Mr. RYCHALSKI. There is a difference between fraud, waste, and abuse and not having a receipt or an accounting anomaly or a journal voucher. There is a big difference between those.

Ms. MACE. Yes, I would say if you spent $187 million and you do not know where it went, that was definitely waste, fraud, and

abuse, and so would the American taxpayer and so would our veterans. Do you think $187 million could have helped veterans if you knew what it was actually spent on?

Mr. RYCHALSKI. I know it was spent on veterans, so I think it did help them.

Ms. MACE. Yes, I would disagree with your position on that. This hearing's findings reveal a troubling lack of oversight. I have heard my colleagues on our side of the aisle talk about that lack of internal controls within the VA and inability to adequately document transfers of funds. You say you have the receipts. Mr. Missal's report says otherwise.

A lack of adherence to fiscal controls are clear indicators of a system that is in disarray. These shortcomings can not be ignored as they have been a result of the inability for the VA to account for significant sums of money. We have many veterans on our committee today, and I concur and agree with the frustration that they have. Almost every one of my family members has either been through the VA or will be in their future because almost all of them have served, and they deserve so much better than what they are getting today, particularly with the chip that you have on your shoulder and your testimony before this committee. Maybe leave it at the door next time. Thank you, Mr. Chairman. Any extra time I have, I will yield to General Bergman. Thank you and I yield back.

The CHAIRMAN. General Bergman, you recognize for 5 minutes.

Mr. BERGMAN. Thank you for the lady for yielding, because then I will consume as much time as the chairman will allow. You know, bad news does not get better with time. That is a fact. Let us start with a little trivia question here. Anybody here in this room know who the Army Corps of Engineers reports to? No one? When you think about why would I start at a Veterans Affairs Committee hearing with that statement? When you are an entity that may be good folks working hard in that entity who is not accountable to any entity or person above you, you have a natural tendency to make life about you and your priorities. I chose to speak last here today, if you will. Chairman accepted here for closing remarks.

Having had the gavel on the Oversight Subcommittee during the 115th Congress, I have heard a different level of BS today that was more convincing than I have heard in a long time from some of you. Now, do not you think, according to one of the questions where who responded, Mr. Rychalski, as far as the veterans reaching out about, you know, they were reaching out to you all about the cuts. Do not you think maybe we would have cut down or maybe eliminated that outreach if we had not lied to them on the front end about the 22 percent cuts in the Limit, Save, Grow Act, which we know is not true. Never has been, never will be.

You have got a lot of members of this committee, both sides of the aisle, who have put their country first before anything else. That is not a core competency of any bureaucracy, any bureaucracy. We need not only accountability, we need you to just flat out be truthful with us, okay? That is all we are asking for. While you may not report to us, in the end, we all report to the veterans, us as elected Members of Congress. You as people work within a system that has the arguably second largest bureaucracy in the Fed-

eral Government, second only to Department of Defense (DoD). Guess what? Where do those veterans come from? They come from being fed a line of bologna, sometimes within the DoD during their service.

They get a little tired of being, I am not going to say lied to, but just being pushed sideways for the wrong reasons. You know, let me ask you a question, Mr. Missal, I would rather ask questions than talk, but I felt compelled to speak after hearing this. Going back to who reports to who, could you repeat your statement regarding who does not report to who within the VA? Did I get right that you made a couple of comments about lack of reporting?

Mr. MISSAL. Yes, I did. Within the VA financial management structure, Mr. Rychalski is the CFO of VA. However, the line CFOs from VHA, which is Ms. Duke, VBA, and NCA do not report to Mr. Rychalski. Similarly, under Ms. Duke within VHA, while she is the CFO of VHA, the CFOs of the VISNs, the CFOs of the medical centers do not report up to her.

Mr. BERGMAN. You know, when I first started looking at, and this was before being elected to Congress, the VISN system, I wondered how it would, you know, work being VISNs, having a lot of independent ability to do their business. At first I was a little concerned that that may be a bad thing. I would suggest to you that what I have seen over the last 6-plus years is that a healthy VISN competition to see which VISN can do things better so that the other VISNs can advance the end product for the veteran. I am not proposing at all changing the VISN system, but I also believe that under the leadership of the VA, and I do not know if any Secretary of the VA can do that, whether it was Secretary Wilkie, now Secretary McDonough, their biggest concern in knowing both of them is the veterans. They are also concerned is they understand the lack of responsive nature of the bureaucracy.

I will just close by saying stop, stop trying to feed us a lineup here. We are eventually going to find out and it is not going to be pretty for you, but it is going to be good for the veterans. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Bergman. Representative Ciscomani, you are recognized for 5 minutes.

Mr. CISCOMANI. Thank you, Mr. Chair. Mr. Rychalski, the Department of Veteran Affairs has continually received record high annual appropriations. I sit on the Appropriations Committee and in fact, House Republicans just published their MilCon-VA Appropriations bill, which not only meets the administration's request, but it provided an $18 billion increase from the previous year. Let me repeat that it includes an $18 billion increase from Fiscal Year 2023 numbers which shows Republicans commitment to veterans in spite of the misleading and irresponsible statements from Secretary McDonough which impacted our veterans more than anyone. I think we can all agree that our veterans deserve access to all the resources and benefits that they have earned.

Now, in my community of Tucson, we are home to the Tucson VA Medical center. I consistently hear from my constituents about the high-quality care they received. I am all for maintaining our medical centers well-funded. Now, in light of the continual high levels of regular appropriations, could you please explain to me why the

VA needs to spend the remaining supplemental funding set aside for COVID–19 related purposes when the COVID–19 public health emergency is now over, especially nonrecurring maintenance projects that you are not able to execute by the end of the year?

Mr. RYCHALSKI. I can, because it was never set aside for COVID. ARP was general purpose funds. We explained that with the budget for 2023. It was part of the total funding package to provide care to veterans. You might as well just take the base funding. I mean, there is no difference. It is the same funding for this year.

Mr. CISCOMANI. What amount are you looking at——

Mr. RYCHALSKI. It is on budget for this year.

Mr. CISCOMANI [continuing]. right now?

Mr. RYCHALSKI. Pardon me?

Mr. CISCOMANI. What is the amount that we are talking about?

Mr. RYCHALSKI. Five hundred million left in ARP. It is the same as base funding. That is what we had. We communicated to Congress, they appropriated the funds knowing that we had that money, that we were going to use that money for veterans this year. There is no difference between the two. It is not set aside for COVID.

Mr. CISCOMANI. You are telling me that that money was not set aside for COVID.

Mr. RYCHALSKI. I said it was not appropriated specifically for COVID. It was not set aside for COVID, and we made it very clear, and Congress knew that and they appropriated the funds this year.

Mr. CISCOMANI. Then can you tell me where the misunderstanding comes from? Why is this the common notion and knowledge about these funds?

Mr. RYCHALSKI. Well, it is in the appropriation law, sir.

Mr. CISCOMANI. Expand on that.

Mr. RYCHALSKI. I will send you the appropriation law. You can read that it does not say it is specifically for COVID. It is based on statute for healthcare.

Mr. CISCOMANI. Now, in the OIG report stated by Veterans Health Administration, "needed to establish a method of tracking and accounting for COVID–19 related costs." It is a quote.

Mr. RYCHALSKI. Correct.

Mr. CISCOMANI. The agency developed multiple memos, alerts, and questions and answer documents, but none of these documents addressed oversight of transaction processing. Also in the report, it states that, "the OIG estimated that in 93 percent of the transactions, documentation of medical facility staff's authority to make COVID–19 related purchases was missing." I understand you have your own audits, and I see that Under Secretary of Health concurred with one of the recommendations in the OIG report to require medical facility staff have documented authority through proper delegation to make purchases. Can you explain how you will implement this and make sure all transactions are documented? Can we expect these recommendations to be implemented with the remaining American Rescue Plan funds?

Mr. RYCHALSKI. Yes, I think I am going to refer to Ms. Duke. I think eight of those recommendations were for VHA and for their implementation at the field.

Ms. DUKE. Yes. What I would say is we are in the process of creating clarified guidance, not just for the ARP, but for all of our journal voucher transactions, to ensure that the field is well aware of the expectations of clarifying the purpose. Then we are, in conjunction with our Office of Integrity and Compliance, working on the oversight procedures that they will utilize to go out and ensure that those procedures are being followed throughout our enterprise.

Mr. CISCOMANI. Thank you for that chair. Mr. Chair, I yield back.

The CHAIRMAN. Thank you. Mr. Takano, you will be recognized for closing remarks.

Mr. TAKANO. Thank you, Mr. Chairman. I am glad that Representative Bergman raised the issue of how different leaders within the VA report to the CFO. You know, I just want to point out that our bill, I think, proposes a solution to the reporting issue by creating an undersecretary level position on management. I certainly am frustrated by the elements within the IG's report related to the transparency or the lack of transparency due to the continued intensive use on the manual nature of our transactions. I hope that VA and I want to send a message that VA does need to implement the new financial management system faster than they have announced. It is very important.

Mr. Chairman, I also want to respond, I think, to the charge that the VA has been politicized by so called falsehoods and lies surrounding the Limit, Save, and Grow Act of 2023, which every Republican on this committee voted for, which is in reality, the Default on America Act. During its passage, the majority created a nexus between raising the debt limit, which is about paying America's already incurred bills, and the appropriations process. They should be completely separate things. The debt limit should be the debt limit. We should not question our ability or question whether or not we are going to pay those bills. It should not be used as leverage in order to determine the spending priorities or policies of this Congress. That has always been negotiated. There should be a compromise. Each side should be able to weigh into that process, but it should not be an all or nothing proposal or proposition that we get everything we want because we are going to threaten not to pay America's bills. That is just simply wrong. It is unreasonable, and it is extreme.

At the time of the passage, the majority laid out the principle of 22 percent cuts across the discretionary spending in our country. That amounts to about $142 billion, $142 billion is one estimate. What that means. The majority is saying we are going to cut $142 billion. At the time that the bill was moving through the House, nowhere in that bill, nowhere in the Default on America Act was there any protection for VA spending. That, at the time we provided the analysis, VA helped us with the analysis. They had analysis. We had analysis coming out of our appropriators, the Democratic appropriators, that would mean a $30 billion cut. That is where we get the 30 million outpatient appointments that would disappear and be cut at a time when we are trying to meet 3.5 million newly eligible veterans for health care and the PACT Act, 3.5 newly eligible. The president said, we are not going to phase in these eligibilities. We Are going to do it all at once.

What was mentioned is that well, let me just finish my train of thought here. Also, at the time of the majority, they laid out at the time of passage of the bill, the majority laid out the principle of a 22 percent cut to discretionary spending, which amounts to about $142 billion making no protections for VA spending.

Even as in order to get the votes to pass the bill, there was language written into the bill to protect ethanol subsidies. Ethanol subsidies were important enough to protect in language, but no language in this bill was written in to protect the VA budget, which is the second largest Federal department. Only after attention was called to the logic of the 22 percent cuts to the discretionary budget and the impact on VA's budget did Republican appropriators produce a MilCon-VA mark to fund the TEF at 5.5 billion. As was said, the overall VA budget was about $80 million more. Let us remember that the 3.5 million veterans, the VA says in order to be able to actually take care of the spending necessary to take care of toxic exposed veterans, that they need $15 billion. 5.5 billion versus 15. That seems like a big hole in terms of underfunding the VA.

The majority now believes that the MilCon-VA mark is a successful jujitsu move that proves that they have protected veterans from, you know, from their share of the $142 billion cut. What has not been laid out is how much is going to be cut from defense or is defense going to be held harmless? There is, I think, a very difficult situation, as evidenced today by the fact that four subcommittees on appropriations have canceled their markups today because they can not figure out, well, if you are going to give VA this much money, how much is going to be allocated to labor, Health and Human Services (HHS), and transportation, and also defense.

If you are going to hold defense and VA harmless, let us think about what those cuts are going to mean to these other categories of spending. Mark my word, veterans are going to be harmed if we cut Medicaid to the tune that the logic of their cuts would mean. Veterans are going to be hurt when HUD-VASH vouchers are not available so we can house homeless veterans.

By the way, all this talk about unspent Inflation Reduction Act money or unspent American Rescue Plan money, the 500 million of unspent American rescue plan money. I want to just remind the committee again that there was never a link to the public health emergency and the American Rescue Plan, funding. Indeed, this notion that these two things be tied together is being reinforced by an extreme logic. That extreme logic is being played out in the fact that this committee could not find the will in the majority to renew or extend authorities that reduced veteran homelessness by 11 percent. Why? Because it has got to fit into this ideology that all this unspent money is going to be clawed back and is part of this Limit, Save, Grow logic.

Meanwhile, who is paying the price for that? Who is paying the price for that are the homeless veterans that we can still take off the streets. Who is paying the price for that is our Americans all across the country who do not want to see veterans homeless. We are talking about $6 million, $6 million that we could have together worked on to find a solution for.

Look, the MilCon-VA mark, is not a settled matter. It is not as if that is the truth because we have no visibility into what the other 11 subcommittees and appropriations have got to do in order to meet this $142 billion cut. With that, Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Let me go through a few things and correct a few things. One, the situation as far as when the floor debated the Limit, Save, Grow Act. We already had in record a letter from the appropriators, the chairwoman of the Appropriations Committee, that VA would not be cut. To say that you did not know at that time, apparently either staff or someone did not pay attention because then also I spoke on the floor, as the chairman of this committee, saying it would not be cut.

Now, to say that VA has not been used as a political tool, you need to talk to all the veterans who were scared to death by the piece of paper they put out saying what a 22 percent cut would do, even though we knew that there was not going to be a 22 percent cut. You have been used as a political tool whether you want to admit that or not. We are in support of trying to take care of our homeless veterans. We are in support of the PACT Act. We are in support of those things. The budget that came out yesterday proves that.

Now, in response to why there are not budget meetings going on now, it is because there is negotiation between the President of this United States and the Speaker of the House of this United States. When we come together to work on a budget, we need a bottom line. We do not have a bottom line. That is the normal process. When the three get together, the Senate, the House and the President, this is the process. Acting like that process is not part of it is why they are not meeting right now. Until we get that bottom line, we do not know where we are negotiating from.

You are right in the fact that the debt limit is a separate thing. The thing is, I think it explains it best whenever we say that a debt limit is similar to whenever you have sent your child off to college and they have maxed out the credit card. When they max out the credit card, you got two choices. One, you got to pay it. That is not an option. You got to pay it. Or you just look at your child and go, hey, just keep spending like that, it will be fine. Or you can finally get somebody to the table with your child and go, hey, you are going to stop the spending. That is what we are in the middle of negotiating and doing.

I have got another concern with the VA, and I am not even going to ask for an answer, but I am going to tell you how this sounds when you explain that you do not think that the COVID money was specifically directed toward COVID and that you could spend it anywhere you want. Well, let me tell you the problem that exists with that. If you can remember, the first COVID bill was $60 million that was the quick response. Then we came back with the CARES Act, and that was $19.6 billion. Now, let us put this in perspective and discuss what exactly happened before this Committee in November 2020. In November 2020, we had lost the majority on the Republican side, and the presidency was switching over to President Biden. We asked in November or early December for the VA to come before this committee. They did. We said, how much

of the CARES Act money is still available? Are you okay? The answer was, $10 billion. Yes, we are fine. We do not need any more. We do not need any more. That is exactly what was said before this Committee. We did not need the extra $17 billion, but by golly, we pumped $17 billion more into a program that did not have the controls that were necessary and should have had controls that were necessary. Now you tell us, no, we can really spend that money any way we want.

Well, let me tell you, this bothered me when you said that, because the Secretary came before us a few months ago, and both myself and the ranking member asked, why in the world would you use the TEF money for construction? The answer was, "because you gave us the authority to." People, you need to understand, we have got to be responsible, both sides of the aisle. This is why people are so frustrated with bureaucracy, because you can not see the common sense of saving and being sensible. A lot of those things that you are talking about providing for do not provide squat for the veterans. They provide a lot for the agency, but they do not provide squat for the veteran. To have you come before us and then all of a sudden say, oh, we are doing exactly what we are supposed to be doing. No, you have got to be accountable. Our job is to make you accountable.

Now, I appreciate you guys coming in here today, but I am going to tell you this. This is all demonstrated that we should continue to closely examine everything you do. We need to make sure that the money is being spent wisely. You can say that it is a paperwork error. You can say whatever, but that is why we have oversight, and the taxpayers require us to do that. No offense to the sailors, but the last 3 years during COVID we have spent money like drunken sailors. The oversight has not occurred. It is going to occur. We need to make sure that that oversight is there, and we are going to continue to do that.

With that, I want to thank everyone for being here. We will continue with these hearings, and we will watch closely on how the money is spent. Also put down very, very clearly, we will not cut benefits to our veterans, but we will make sure that you are very, very wise in how you are spending that money. The Committee is adjourned.

[Whereupon, at 12:32 p.m., the committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF WITNESS

Prepared Statement of Jon Rychalski

Good morning, Chairman Bost, Ranking Member Takano and members of the Committee. Joining me today are my colleagues, Laura Duke, Chief Financial Officer, Veterans Health Administration (VHA); and Robert McDivitt, Network Director, Veterans Integrated Service Network (VISN) 23.

VA, alongside our Federal partners, is proud of our role in the Federal response to the Coronavirus Disease 2019 (COVID–19) pandemic beginning in 2020. The COVID–19 pandemic touched every part of VA's operations, as it has other Federal agency operations, State, local and Tribal governments, and private industry. The pandemic's path, duration, and impact were unclear when COVID–19 first emerged in the United States. VHA's response to COVID–19 demonstrated the strength and agility of an integrated health care system geographically distributed across the U.S. and operating as a single enterprise. The Veterans Benefits Administration (VBA) ensured the health and safety of Veterans by pausing all Compensation and Pension (C&P) examinations for Veterans and working with VHA on local risk assessments prior to resuming examinations. Because of VBA's swift and effective response to the COVID–19 pandemic, VBA's Medical Disability Examination Office was able to increase the number of examinations for every year of the pandemic, even with the 2-month pause in 2020.

VA appreciates Congress' supplemental appropriations, which provided approximately $36.7 billion in supplemental funding outside our annual appropriation from three COVID–19 relief laws between 2020 and 2021. The Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116–136) provided $19.6 billion to VA in 2020. The CARES Act resources provided for Veterans' COVID–19 related health care in VA facilities and in the community. The funding supported all levels of our COVID–19 response, from procurement of test kits and specialized equipment to the overtime and travel costs for staff rotating into hot zones. It allowed VA to grow telehealth capabilities, provide financial support to State Veteran Homes (SVHs) and support the unique economic and health care needs of Veterans who were experiencing homelessness or at risk of becoming homeless. VA obligated 99.6 percent of the CARES Act funding within the period of availability. VA also received $60 million in the Families First Coronavirus Response Act (FFCRA) (P.L. 116–127), which prohibited VA from charging any copayment or other cost-sharing payments under Chapter 17 of title 38 for COVID–19 testing or medical visits that resulted in COVID–19 testing.

In 2021, approximately a year into the pandemic, Congress passed the American Rescue Plan Act of 2021 (ARP, P.L. 117–2) to continue providing comprehensive support to the American people. The ARP included $17.1 billion to ensure that Veterans had continued access to quality health care and protections against COVID–19, as well as needed economic relief. It provided funding for health care, debt relief and additional support for SVHs. As of April 25, 2023, VA has $2.1 billion remaining in ARP funding, targeted for obligation by their expiration at the end of FY 2023.

The VA Office of Inspector General (OIG) and the Government Accountability Office have each conducted extensive oversight of VA's execution of the COVID–19 relief funding provided in the CARES Act and ARP. OIG produced three reports as required by the VA Transparency & Trust Act of 2021 (Transparency Act; P.L. 117–63).[1] In the inaugural report, OIG focused on whether VA's spend plans provided to Congress on December 22, 2021, satisfied the requirements of the Transparency Act. OIG made two recommendations to me as the Assistant Secretary for Manage-

[1] VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: March 2023, VAOIG–22–00878–79, March 21, 2023; VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: Sept 2022, VAOIG–22–00879–236, September 22, 2022; VA's Compliance with the VA Trust & Transparency Act of 2021; VAOIG–22–00879–118, March 22, 2022

ment/Chief Financial Officer, and both of these recommendations are now closed. In the two subsequent reports, OIG found VA generally complied with the Transparency Act and made no recommendations. VA also acknowledges the OIG report VHA Can Improve Controls Over Its Use of Supplemental Funds (OIG Report #21–03101–73), published earlier this month. We have concurred with the nine recommendations and are working through the action plan to address them.

The dedication and commitment of VA employees at all levels of the organization are evident in our response to this pandemic. Again, I want to thank Congress for the $36.7 billion in supplemental funding to fight this battle and keep Veterans and their communities safer. Without this support, we would not have successfully put into action all the necessary work to assist Veterans, their families, and their caregivers.

Utilization of CARES Act and ARP

The CARES Act and ARP funding, combined with resources in the base budget, supported Veterans' health care needs in VA facilities and the community. VA estimates that Veterans' care needs in FY 2023 will face increased costs attributable to COVID–19-related delays in care, more complex care, and greater reliance on VA due to economic impacts from the pandemic.

Staffing

The resources and hiring flexibility Congress provided enabled VHA to hire over 136,000 new clinical and administrative staff across the health care system in FY 2020 to 2022 to optimize continued delivery of care. This included a record 5,000 hiring increase over the average 43,000 from FY 2018-FY 2021 to 48,665 new external hires for VHA in FY 2022. Many hiring flexibilities were utilized to support emergency hiring during the COVID–19 pandemic. The Office of Personnel Management (OPM) granted VA Direct-Hire Authority (DHA) for several critical occupations. DHA enabled VHA to hire, after public notice, any qualified applicant without regard to competitive rating and ranking, or application of Veterans' preference. VHA also utilized the COVID–19 Schedule A Hiring Authority for Temporary Appointments authorized by OPM. Under this authority, VHA could temporarily appoint qualified individuals nationwide, at all grade levels, to any positions needed in direct response to the effects of COVID–19.

With additional support for our emergency management response, VA added over 2,500 medical/surgical and Intensive Care Unit beds. VHA supported 76 additional travel nurse positions to support COVID–19 deployments. The Office of Nursing Services' (ONS) Registered Nurse Transition to Practice (RNTTP) Program was awarded CARES Act funding to support various nurse staffing initiatives as well as the salaries for RNTTP and Veterans Affairs Learning Opportunities Residency (VALOR) Residents. This funding enabled ONS to support the recruitment of nearly 1,700 Graduate and Student Nurse Technicians as well as VALOR Residents. This effort greatly assisted in bridging the clinical practice gap for Registered Nurses and ensured a seamless transition from the academic to a clinical practice setting. Likewise, ONS sponsored an RNTTP Recruitment and Marketing Campaign as well as the national Nurse Manager Institute in collaboration with the American Organization of Nursing Leaders. As a result, roughly 600 new Nurse Managers developed critical management skills necessary to be an effective nurse leader, and to build a culture of engagement, problem-solving and conflict management.

VBA utilized available funding during the pandemic to focus on the disability compensation and pension (C&P) claims and appeals backlog. We were able to utilize ARP funds to hire and train 2,000 employees and for overtime to ensure timely claims processing. The COVID–19 pandemic temporarily halted the supply of critical medical evidence and Federal records necessary to render decisions on Veterans' disability claims. The backlog peaked in October 2021 at 264,000 claims due to these supply chain issues, but we were able to recover and achieve a backlog of fewer than 165,000 claims in August 2022, immediately prior to the passage of the Honoring our Promise to Address Comprehensive Toxics (PACT).

Homelessness

The CARES Act and ARP funding also proved essential to addressing the unique economic and health care needs of Veterans who are homeless or at risk of becoming homeless. This funding provided emergency housing, including placing Veterans in hotels and providing homelessness prevention assistance to mitigate the expected wave of evictions and potential homelessness resulting from extensive unemployment. Between January 2022 and March 2023, there were 18,447 emergency housing placements. From March 2020 through January 2021, VA's Supportive Services for Veteran Families (SSVF) program placed over 23,000 vulnerable Veterans in ho-

tels or motels. Prior to the pandemic, placement rates annually were less than 10,000. The placements helped to reduce the vulnerable Veterans' risk of exposure to COVID–19 in congregant and unsheltered settings while permanent housing placements were explored.

Additionally, CARES Act and ARP provided authority and funding that enabled VA to waive per diem rate limits in the Grant and Per-Diem (GPD) program during the public health emergency. This allowed grantees to provide needed emergency housing and supportive services for Veterans who needed to be isolated for their safety or the safety of others. Between April 2020 and May 11, 2023, GPD grantees requested nearly 1,200 per diem rate modifications, and many submitted multiple requests as their needs fluctuated during the pandemic (for example, utilization of motels). The additional funding and flexibility with our authority allowed existing grantees to develop individualized housing settings to serve homeless Veterans more safely in transitional housing. The Health Care for Homeless Veterans (HCHV) Program used ARP funds for temporary rate increases aimed at establishing safety protocols in residential contracted services. The rate increases were used to purchase essential personal protective equipment (PPE), and establish additional sanitation, testing, and isolation protocols.

In addition, the Homeless Programs Smartphone Initiative was implemented at the onset of the COVID–19 public health emergency to help homeless or at-risk of homeless Veterans remain engaged with their health care providers and support systems when face to face visits were not an option. These devices allowed Veterans to attend virtual groups and recovery programs, assist with virtual housing and job searches and help VA staff monitor their well-being during this unprecedented time. From March 2020 through April 2023, VA disseminated more than 77,000 technology devices to VA Medical Centers (VAMC) and SSVF grantees for distribution to Veterans at-risk of or experiencing homelessness.

ARP funding was also utilized to support the statutory authority, under section 4201 of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116 –315), which authorized VA, during a covered public health emergency, to use amounts appropriated to provide certain supportive services and goods to eligible Veterans that would otherwise be prohibited. Through March 2023, over 62,740 Veterans experiencing homelessness benefited from such support services and goods as rental deposits, utility payments, move-in kits, furniture, bus passes, groceries, hygiene items, hotel/motel vouchers, and landlord incentives. In addition, VA was able to support Veterans with transportation to medical appointments, job interviews, housing searches, and other mental health and homeless services through its Rideshare program. From August 2021 through March 2023, the VA Rideshare program served over 42,000 individual Veterans and provided over 451,000 combined rides.

These resources have been essential to the 11 percent decrease in the number of Veterans experiencing homelessness from 2020 to 2022 (i.e., 37,252 Veterans as reported in the 2020 Point-in-Time Count to 33,129 Veterans in 2022). This decline follows several years in which the number of Veterans experiencing homelessness remained virtually unchanged, despite having decreased significantly from 2010 to 2016. Overall, Veteran homelessness has decreased by 55.3 percent since 2010. Additionally, these resources were instrumental in over 40,000 Veterans becoming permanently housed in calendar year 2022, exceeding VA's goal to house at least 38,000 Veterans experiencing homelessness by more than 6 percent.

Regional Readiness Centers (RRCs)

The COVID–19 pandemic prompted a sudden surge in demand for PPE and other COVID–19 related supplies as unparalleled PPE requirements stressed the supply chain. VHA was charged with building resiliency into the supply chain while distributing urgently needed PPE to VAMCs nationwide. VA's existing warehouse and distribution capabilities at the beginning of the COVID–19 response complicated this challenge because there was no centralized infrastructure to store, manage, and distribute PPE to VAMCs. RRCs enabled VA to maintain Veteran care by ensuring that PPE and other critical medical supplies remained available to VAMCs even during supply chain disruptions. As COVID–19 incidences varied by jurisdiction, and despite global shortages of PPE, critical equipment, and consumable items, VHA was able to sustain operations in locations experiencing high demand by cross-leveling staff, PPE, and equipment such as ventilators from areas with low levels of disease. The RRC network distributed over 212 million items to VAMCs and Fourth Mission entities from March 2020 through May 2023.

IT Infrastructure and Equipment

In response to the COVID–19 pandemic, VA's Office of Information Technology (OIT) received two sources of COVID supplemental funding through the CARES Act for FY 2020 and 2021 and ARP for FY 2022 and 2023. With the conclusion of the pandemic emergency response, OIT remains focused on continuing to meet legal, fiscal, and performance requirements for covered funds. OIT was allocated $2.2 billion in CARES Act funds, and obligated 100 percent of the amount, with 99 percent paid expenditures as of May 11, 2023. ARP provided OIT with a $1.4 billion allocation with 73 percent obligated and 49 percent paid expenditures as of May 11, 2023.

The demand from the pandemic further stressed the IT tools and needs to support care. OIT supported the growth or development of over 20 programs to include activations, telehealth, and VA Health Connect. Activations allowed VA to quickly provide clinicians, frontline health workers, and medical staff the necessary equipment to move remotely and safely provide care to Veterans during the pandemic. CARES Act funding paid for new IT equipment, increased temporary staffing, significantly enhanced telehealth and clinical contact center services, and expanded telework/bandwidth remote work capabilities. ARP funding supported the continuation of pandemic medical care activities and enterprise-level IT investments initiated under CARES Act and provided funding for supply chain modernization.

This supplemental funding was crucial in advancing and modernizing VA's IT infrastructure and capabilities so that Veterans received uninterrupted care and services during the pandemic. The reliance on telehealth in VA continues to grow, consistent with changes in the health care industry in general, as the care delivery system transitions from a mostly in-person model to one providing options for digital care. VA has been and continues to be a leader in this transformation, as demonstrated through the evolution of the COVID–19 pandemic. Throughout the pandemic, OIT doubled the remote end-user connectivity capacity at VA's communications gateways and increased the Department's Telehealth VA Video Connect capacity by a factor of five. In fact, from March 2020 to April 29, 2023, OIT supported over 27.8 million telehealth visits during the pandemic. The number of video visits to offsite locations in FY 2022 represents a more than 3,000 percent increase compared to FY 2019.

Additionally, OIT created several significant Veteran-facing applications that improved direct Veteran communication for vaccination and appointment support. These investments supported a surge in usage of VA's digital health tools during the pandemic, an increase that shows no sign of abating. For example, from January – March 2023, Veterans and their VA health care providers exchanged over 8.9 million secure messages, a 10 percent increase over the same period in 2022 and a 61 percent increase compared to the 5.5 million messages exchanged in the period of January – March 2020, immediately before the pandemic.

OIT also supported behind-the-scenes upgrades and improvements that ultimately led to improving Veteran care, including:

- New clinical applications and data management reporting systems managing pandemic support and national tracking and reporting;
- Acquiring nearly 200,000 laptop end points in support of additional staff, multiple vaccination centers, test centers, and facilitating new workflows for infection control;
- Cybersecurity enhancements protecting VA's data and networks against evolving threats in an increasingly remote connectivity environment;
- Increased bandwidth across the entire VA enterprise that supported and facilitated remote telemedicine applications such as TeleCritical Care; and
- Instrumentation of nearly 100 critical clinical applications and infrastructure to build the telemetry and visibility necessary to support and sustain resiliency properly.

CARES Act and ARP funds remain crucial in providing much-needed IT services and infrastructure, ultimately protecting and improving Veteran care. OIT is working to obligate the remaining ARP funds, currently committing $237 million to project-level funding execution in data integration and management, cybersecurity, hardware maintenance, and Veteran-facing services on VA.gov.

Research

VHA remained invested in ongoing research and innovation, and was also a significant contributor to the national research response to COVID–19. VHA rapidly established its clinical trials enterprise to contribute to several treatment studies and vaccine trials sponsored by the National Institutes of Health and private industry. Through its Office of Research and Development (ORD), VHA funded a number of clinical studies including ones looking at convalescent plasma and Degarelix, an

FDA-approved medication for prostate cancer (these were not pivotal trials); VA also leveraged its infrastructure to partner with the National Institutes of Health and industry in trials they sponsored on various COVID treatments (e.g., ACTIV trials) and vaccines; leveraged its electronic medical records to conduct in-depth analyses on COVID–19 and Long-COVID, and the creation of a national biorepository, the VA Science and Health Initiative to Combat Infectious and Emerging Life-Threatening Diseases (VA SHIELD). In a partnership with the Department of Defense, ORD co-funded a longitudinal research cohort in which VA enrolled over 2,800 Veterans to learn more about the natural history and outcomes among those affected by COVID–19.

VA also established a Veteran research volunteer registry in which over 58,000 Veterans stepped up to participate in COVID–19 research studies when needed. While specific to COVID-related research, this effort helped lay some groundwork for what VA can do for other studies in the future. During a 7-month period in 2021, VHA started more than 50 COVID–19 studies and published 316 COVID–19 related articles. The research includes studies on health effects such as Long COVID, clinical trials, treatments and genomic sequencing for variant identification. Additionally, VHA Advanced Manufacturing (part of the VHA Innovation Ecosystem) continued to provide COVID–19 support through its 3D Printing Network by producing face shields, face masks, ear savers and nasal swabs that were utilized across VHA. A key activity related to this effort, the Nasal Swab Objective and Statistical Evaluation Study, was done in partnership with the Food and Drug Administration (FDA). As part of this effort, three VAMCs registered with the FDA as medical device manufacturers. VHA is exploring how point-of-care manufacturing can be used in operating rooms and hospitals, as well as for immediate supply chain resilience.

Non-Recurring Maintenance

ARP resources supported VA facility enhancements to better prepare VHA to deliver care in a pandemic or post-pandemic environment. More than 170 individual contracts were issued for infrastructure and delivery improvements to VAMCs across the country, amounting to more than $193 million in emergent investments, many of which were issued at the height of the pandemic and continuing throughout the emergency. Funds were directed to such functions as increased air-flow in patient areas, creating negative pressure spaces where recommended, conversions of space to inpatient care areas, improving laboratory testing facilities, providing safe and secure entryways and alternate patient triage, intake and testing areas, sterilization equipment and utilities, placement of related medical equipment, improved patient communication systems, pandemic equipment storage facilities, and improvement of isolation facilities. In addition, utility systems such as electrical and steam generation and distribution were upgraded at some facilities to better manage increased energy consumption and heating, ventilation and air conditioning upgrades, boiler upgrades and other projects to prevent pandemic contagion were executed.

ARP resources also supported the modernization of VHA facility infrastructure to support new systems such as the electronic health record, financial management, and biomedical technologies. In FY 2022, $818 million was obligated to fund design and construction projects to modernize data centers, telecommunication rooms, and upgrade fiber and cabling backbones to improve data connectivity and resiliency. An additional $183 million was invested in FY 2023 with plans to spend the remaining $253 million on projects that are currently in solicitation.

Education Service

VA used CARES Act funding to start the modernization of the GI Bill information technology (IT) platform to deliver benefits faster, provide better customer service, and strengthen our compliance and oversight activities. By streamlining and automating the Post–9/11 GI Bill application experience, VA is now able to provide some Veterans and Service members eligibility decisions within seconds, pre-filled service history, quick access to digital copies of eligibility letters and a better user experience with intuitive designs.

Another program, the Veteran Rapid Retraining Assistance Program (VRRAP), was enacted as part of the ARP. It offers eligible Veterans up to 12 months of tuition and fees, and a monthly housing allowance. VA stopped accepting applications from Veterans on December 10, 2022. As of May 1, 2023, VA has received 31,593 applications from Veterans and issued 22,817 Certificates of Eligibility. To date, there have been 13,626 total VRRAP participants. As of this same date, VA has verified 1,294 Veterans' employment statuses with an average starting salary of $54,049. Of the $386 million authorized for VRRAP in ARP, VA currently anticipates obligating $366 million in benefit payments through the end of the program.

File Conversion Services

VBA was able to increase scanning records efforts at the National Personnel Records Center (NPRC) in St. Louis, Missouri and College Park, Maryland as a result of National Archives and Records Administration facilities closings. VBA utilized CARES Act funding to execute Option Year 1 of its File Conversion Services contract, which provides contractor support to retrieve and digitize historical paper and alternative media records stored at NPRC, making those materials available for immediate use to adjudicate Veteran disability compensation claims. CARES Act funds paid for digitizing nearly 700,000 Veteran Claims Files, and nearly 1.1 million Official Military Personnel Files. We established an onsite scanning facility at the NPRC, which enables VBA to scan up to 1,500 records per day within 24 hours of receipt.

State Home Per Diem Program

VA's Office of Geriatrics and Extended Care (GEC) received $100 million in CARES Act and $250 million in ARP funding to distribute one-time payments to State Extended Care Facilities for COVID–19-related expenditures and operational costs. The funds also assisted in providing additional staffing, tuition forgiveness and recruitment and retention incentives for personnel at SVHs. SVHs also used funds for COVID–19 testing (which allowed several States to maintain compliance using aggressive COVID–19 testing practices), PPE supplies, purchases of freezer systems for COVID–19 vaccinations, mobile air purification systems and purchases of entry point systems at each SVH that screen for COVID–19 and takes individual temperatures. SVH facilities also strengthened their telehealth and video conferencing capabilities through equipment purchases and modification to existing facilities to create isolation capabilities.

VA waived the 90 percent occupancy rate for bed holds for Veterans in the hospital up to the first 10 consecutive days, allowing 129 of 153 State Veteran Homes not meeting the 90 percent Veteran occupancy threshold to continue to receive payments for bed holds. Additionally, VA waived the 75 percent Veteran and 25 percent non-Veteran occupancy requirements, consistent with authority granted by Congress. VA GEC provided additional supplemental per diem increases of 2.9 percent in March 2020, 2.6 percent in April 2022, and 2.2 percent in April 2023. Per diem was not supplementally increased in FY 2021.

State Veterans Homes (SVH) Construction Grant Program

$500 million from ARP was designated to provide grants through the current grant program for SVH construction in addition to the regular FY 2021 appropriation for SVH construction grants of $90 million. There was a total of 34 projects for $500 million. All funds were obligated.

Funding of $150 million from the CARES Act was designated for SVH construction grants, but specifically for projects preventing, preparing for, and responding to COVID–19, and which modify or alter existing SVHs, or for previously awarded projects, to cover construction cost increases due to COVID 19. The CARES Act, as amended by section 513 of the Consolidated Appropriations Act, 2021 (P.L.116–260), removed the general requirement of 35 percent matching funds by the State for SVH construction grant projects, as well as other requirements, to include the requirement to establish a priority list, but the Secretary was required to establish a new competition to award grants to States. The Secretary signed a memo establishing a competition to award grants for these COVID–19 related projects funded under the CARES Act, accepting applications on a rolling basis, and awarding grants on a first come, first serve basis. States that had previously submitted approved CARES Act COVID–19 Project applications were sent funding offers on March 18, 2021, for 35 projects totaling $124 million.

Conclusion

Chairman Bost, Ranking Member Takano, thank you for the opportunity to speak on VA's record fighting COVID–19 today. I look forward to your questions.

Prepared Statement of Michael Missal

Chairman Bost, Ranking Member Takano, and Committee Members, thank you for the opportunity to discuss the Office of Inspector General's (OIG) oversight of VA's expenditure of supplemental funds to respond to the COVID–19 pandemic. The OIG expresses our deep gratitude to the VA employees who–often at significant risk and great personal sacrifice–worked tirelessly throughout the pandemic and navigated the intense healthcare demands of not only veterans and their families, but

also those of community members whose hospitals were stressed or under-resourced. VA's employees showed their commitment during a time in history when commitment was needed most, and the OIG recognizes and lauds them for that dedication.

I would also like to thank and recognize the OIG staff who seamlessly continued our oversight work throughout these challenging times. COVID–19 required adaptability and perseverance on the part of OIG personnel, who had to find alternatives to onsite inspections and other oversight measures to effectively address VA's response to the pandemic. The additional funding Congress provided the OIG was integral to these efforts. To minimize the time our work typically requires of VA leaders and clinical personnel, OIG teams found other ways to inform their ongoing oversight activities, such as expanded internal capabilities for data collection and monitoring, advanced analytics, and data modeling. These capabilities were used to assess, for example, mortality and patient flow at VA community living centers and medical facilities, and monitor COVID–19 outbreaks, appointment cancellations and rescheduling, and emergency and urgent care activity.

When I testified before this Committee earlier this year, I discussed several recurring themes and deficiencies in VA programs that centered around accountability, which is critical to continuous improvement.[1] Since April 2020, the OIG has published over 40 pandemic-related reports. These reports identify deficiencies in several areas of accountability, such as strong governance, adequate staffing, and quality assurance. I will initially focus my statement on deficiencies in information technology (IT) systems and business processes, and then discuss criminal prosecutions and healthcare access and delivery. In short, the OIG pandemic-related reports referenced below illustrate how system and process limitations can negatively affect veterans, their families, and their caregivers and can lead to waste or misuse of taxpayer dollars.[2]

OIG OVERSIGHT OF COVID–19 SUPPLEMENTAL FUNDS

The COVID–19 pandemic was declared a national emergency on March 13, 2020. Within two weeks, Congress provided $60 million in supplemental funding for VA to respond to the pandemic through the Families First Coronavirus Response Act (FFCRA) and then another $19.6 billion through the Coronavirus Aid, Relief, and Economic Security (CARES) Act.[3] About $17.2 billion of these funds was appropriated to the Veterans Health Administration (VHA) to support VA's efforts to prevent, prepare for, and respond to the COVID–19 pandemic, including $14.4 billion allocated to the VHA medical services fund, which is the fund for direct patient care. Later, in March 2021, VA received another $17.1 billion in supplemental funding from the America Rescue Plan Act of 2021 (ARP).[4]

The OIG found that VA has had significant challenges in assuring accountability and transparency in how it obligates and expends funds due to VA's outdated financial management systems. While this problem existed long before the pandemic, it ultimately led to a lack of assurance that funds allocated specifically for COVID–19-related purposes were being spent as intended.

VA Lacks Adequate Controls on Expending COVID–19 Supplemental Funds

Following the Office of Management and Budget's guidance, the OIG initiated a June 2021 review to report on efforts by VHA to establish financial oversight mechanisms for tracking and reporting supplemental funding.[5] VA did, in fact, meet the FFCRA and CARES Act requirements to submit monthly reports to OMB and Congress on COVID–19 supplemental fund obligations and expenditures, and it supplemented established policies related to accounting structures for use during declared emergencies. However, the OIG identified concerns that impacted the completeness and accuracy of VA's reporting, which are indications of weaknesses in VA and VHA internal controls for meeting reporting requirements. Additionally, the OIG found that VHA's reliance on several accounting subsystems for payroll and purchase card transactions meant that VHA staff had to perform a significant amount of manual work to identify and perform adjustments so that the COVID–19 obligations and expenditures were captured in VA's reporting. The complexity of VHA's reporting proc-

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[1] VA OIG, *Statement of Inspector General Michael J. Missal, Hearing on "Building and Accountable VA: Applying Lessons Learned to Drive Future Success*," February 28, 2023.

[2] See the appendix for a list of OIG reports related to the COVID–19 pandemic.

[3] Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116–127, 134. Stat. 178 (March 2020); Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. 116–136, 134 Stat. 281 (March 2020).

[4] American Rescue Plan Act of 2021, Pub. L. No. 117–2, tit. VIII, 135 Stat. 4, 112–17 (March 2021).

[5] VA OIG, *Review of VHA's Financial Oversight of COVID–19 Supplemental Funds*, June 10, 2021.

ess indicates that controls around VA's data reporting and validation efforts can be improved. Accordingly, the OIG recommended VHA and VA's Office of Management develop procedures to review and validate data to ensure that information in reports accurately represents the underlying source transactions.

To provide for greater oversight of VA's spending of these supplemental funds, the VA Transparency & Trust Act of 2021 (Transparency Act), which was enacted in November 2021, requires the OIG to report semiannually on VA's actual obligation and expenditure of the supplemental funds compared to its plans.[6] To date, the OIG has published three reports, and the inaugural report concluded that VA only partially complied with the Transparency Act. In the inaugural report, the OIG found it unclear whether all of the planned uses of ARP Act funds were captured in the plan VA submitted to Congress, as the plan did not include a projected cost to support maintaining IT projects originally started with CARES Act funds.[7] The OIG made two recommendations to the assistant secretary for management/chief financial officer and both are closed.

In the second Transparency Act report, the OIG found VA generally complied with the Transparency Act because VA provided justification for its spend plan programs and activities and generally aligned actual spending to the plan.[8] However, VA was using expenditure transfers, a manual adjustment process to transfer funds from one account to another, for nearly half of its ARP Act obligations and expenditures. The OIG found that VA's manual expenditure transfer process resulted in at least 53 potential reporting errors. VA corrected these errors by manually adjusting funding balances to avoid misstating VA's reported obligations and expenditures to Congress.

VA was again found to have generally complied with the Transparency Act in the OIG's third and most recent review, but VA did not provide sufficient supporting documentation requested by the review team to assess line-level details needed to make a full assessment.[9] Additionally, VA's Office of Management acknowledged that "manual processes for expenditure transfers can lead to potential reporting errors and data reliability issues" and that replacing its "antiquated legacy financial management system by implementing a modern solution" will reduce these potential errors.

This issue of using manual expenditure transfers due to system limitations contributed to the lack of transparency and accountability into VHA purchases that used CARES Act funds. Earlier this month, the OIG published a proactive audit on the effectiveness of VA's controls over VHA's use of supplemental funds, which found issues involving both methods used by VHA medical facility staff to process COVID–19-related transactions: (1) manual expenditure transfers and (2) the direct obligation of funds from the CARES Act medical services funds.[10] First, manual expenditure transfers require staff to make several manual entries using journal vouchers to document the transfers in VA's financial management software system, so that an audit trail is maintained. However, medical facility staff were not always properly preparing the journal vouchers, supporting the vouchers with documentation showing amounts or reasons for transfers, or having the vouchers signed by an authorizing official. This failure limits transparency and accountability. This happened, in part, because VHA's Office of Finance was not following established VA financial policies. In other words, the systems' limitations and lack of guidance meant that VHA medical facility staff were left to determine what documentation would be sufficient to ensure the vouchers were supported without the benefit of proper internal controls.

Second, medical facility staff did not comply with key controls when they made pandemic-related purchases directly from CARES Act supplemental funds. In an estimated more than 10,000 transactions, medical facility staff did not always

- have documented purchase authority;
- segregate duties so the same employee was not approving the purchase or acting as the purchase card holder and requestor;
- certify and pay invoices properly; and/or
- track the receipt of goods to ensure the quantities ordered were received.

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[6] VA Transparency & Trust Act of 2021, Pub. L. No. 117–63, § 2(c), 135 Stat. 1484, 1485 (November 2021).

[7] VA OIG, *VA's Compliance with the VA Transparency & Trust Act of 2021*, March 22, 2022.

[8] VA OIG, *VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: September 2022*, September 22, 2022.

[9] VA OIG, *VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: March 2023*, March 21, 2023.

[10] VA OIG, *VHA Can Improve Controls Over Its Use of Supplemental Funds*, May 9, 2023.

These issues occurred because VHA did not develop guidance that included protocols for accounting processes and procedures that outlined clear roles and expectations related to the oversight of its supplemental fund's purchases. As a result, the OIG reported an estimated $187 million in questioned costs in CARES Act funds, and the OIG made nine recommendations to the Office of Management and VHA to resolve these problems. Notably, the OIG recommended that VA assess the financial system it is currently implementing, the Integrated Financial and Acquisition Management System (iFAMS), to determine whether integration with payroll subsystems can be accomplished to resolve some of the payroll-related expenditure transfers. VA concurred, noting that it would develop interfaces for an end-to-end automated solution by September 2030.[11]

These reports echo the problems of the decentralized nature of governance seen in VA's financial management structure. Under the Chief Financial Officers (CFO) Act of 1990, 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.[12] 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.

VHA Can Improve Its Equipment Acquisition and Distribution Processes

Like healthcare systems across the globe, VA faced challenges in securing and distributing personal protective equipment (PPE) during the first weeks and months of the pandemic. The OIG determined that while VHA swiftly developed tools to gather supply and demand data at its medical facilities, it had issues with recording expired supplies, the double-counting of inventory, a limited inventory management system, and inconsistent data reporting.[13]

In addition to surges in the need for PPE, medical facilities were concerned about securing enough ventilators, which are used in the treatment of patients with severely impaired lung functions. In a report published last month, the OIG examined the acquisition and accountability process for ventilators procured for the Audie L. Murphy Memorial Veteran's Hospital in Texas from March 1, 2020, through November 30, 2021, and found the hospital acquired more ventilators than were needed for veteran care.[14] Facility and VHA officials duplicated purchases, resulting in the facility obtaining 112 ventilators, while it usually had about 40. The 56 ventilators from the VHA purchase, worth about $2.5 million, were left unused for more than 19 months, while other facilities reported insufficient ventilator stocks.[15] The hoarding of ventilators occurred because leaders were concerned about a congested ventilator supply chain, and they also lacked a method to determine how many ventilators they needed. Contributing to these unnecessary purchases was VHA's lack of an inventory system that can identify excess inventory nationally. Later, the excess ventilators were redistributed to other VHA sites. The OIG recommended the facility determine the number of ventilators it needs and turn in excess equipment.

VHA facilities also had existing options to secure ready supplies. The four prime vendors of VHA's Medical/Surgical Prime Vendor-Next Generation (MSPV-NG) program offered medical facilities a no–cost option to develop advance-order supply lists tailored to catastrophic events and contingency plans.[16] Three of the four vendors also offered options to purchase and store medical supplies in advance. The OIG found none of the 16 medical facilities assessed took advantage of those emergency strategies, and most leaders did not know those plans existed. Most medical facili-

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[11] VA has also been attempting 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. Central to the FMBT program's modernization efforts is the multiyear deployment of the iFAMS.

[12] VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2022 and 2021*, December 7, 2022.

[13] VA OIG, *Reporting and Monitoring Personal Protective Equipment Inventory during the Pandemic*, February 24, 2021.

[14] VA OIG, *Audie L. Murphy Memorial Veterans' Hospital Missed Opportunities to Distribute Excess Ventilators during the COVID–19 Pandemic*, April 11, 2023.

[15] For example, leaders in Veterans Integrated Service Networks 2 and 5 described having an inadequate number of ventilators during the pandemic. VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID–19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, April 7, 2022.

[16] VA OIG, *Medical/Surgical Prime Vendor Contract Emergency Supply Strategies Available before the COVID–19 Pandemic*, June 14, 2021.

ties reported maintaining their own contingency stocks, which were at risk of quickly depleting. That risk increased when prime vendors were unable to fulfill orders, leading staff to purchase medical supplies on the open market where VHA's data showed they paid higher prices. VA can apply lessons learned during the pandemic, and the OIG shaped its recommendations to address those lessons. VA can continue to refine its contract requirements for prime vendors to address catastrophes and ensure that chief logistics officers learn about existing contingency plans and ensure they understand how these can help mitigate supply shortages. The OIG also recommended clarifying for local facilities the intent of the emergency and continuous supply contract provisions.

The problems that have plagued the VA supply chain, however, are not new. Prior to the pandemic, OIG reports and congressional testimonies identified long-standing IT, contracting, and staffing problems that contributed to some VA medical centers not consistently having supplies when and where they needed them for patient care.[17] Facilities have long experienced barriers to real-time tracking of inventory, purchasing, distribution, storage, and other supply management functions, leading to operational breakdowns and the need for work-arounds that sometimes lack compliance with VA policies and procedures. These work-arounds are often the result of dedicated VA clinical staff on the front lines doing whatever is necessary to meet the needs of patients under difficult circumstances.

THE OIG IDENTIFIED AND TERMINATED ATTEMPTS TO DEFRAUD VA OF SUPPLEMENTAL FUNDS

From the beginning of the pandemic, the OIG's Office of Investigations redirected resources to detect and prevent attempts to defraud VA of supplemental funds, particularly cases involving the safety and care of veterans and medical staff. These efforts were first marked by stopping those attempting to profit from scarce PPE supplies at start of the pandemic. Kenneth Ritchey was charged with conspiracy to commit wire fraud and mail fraud, conspiracy to defraud the United States, conspiracy to commit hoarding of designated scarce materials, and hoarding of designated scarce materials.[18] After the first US-confirmed case of COVID–19, Ritchey participated in a scheme to defraud healthcare providers, including VA, of more than $1.8 million by acquiring PPE and other designated materials from all possible sources, including home improvement stores and online retailers, and ultimately hoarding the same. Due to nationwide PPE shortages and COVID–19-related fears, Ritchey directed sales representatives to solicit healthcare providers, including VA, to purchase PPE and other designated materials at excessively inflated prices through high-pressure sales tactics and misrepresenting sourcing and actual costs. Ritchey sold PPE to healthcare providers desperate to acquire it at incredible markups. For instance, he sold N–95 masks to VA and other companies for as much as $25 a mask, despite acquiring such masks at much lower prices. Ritchey pleaded guilty in March 2023.

In addition to these challenges, VA was also forced to deal immediately with individuals intent on fraudulently obtaining government contracts for PPE. For example, Robert Stewart Jr. was the owner and president of Federal Government Experts LLC.[19] In this capacity, between April 1, 2020 and May 14, 2020, he made false statements to the Federal Emergency Management Agency (FEMA) and VA to obtain lucrative contracts to provide PPE. In addition to the false statements to FEMA and VA, he fraudulently obtained loans under the federal Paycheck Protection Program and the Economic Injury Disaster Loan Program. Stewart also defrauded VA by falsely claiming to be entitled to veteran's benefits for serving in the US Marine Corps despite never having served. He was sentenced to 21 months in prison with three years of supervised release for making false statements to multiple federal agencies to fraudulently obtain multimillion-dollar government contracts, COVID–19 emergency relief loans, and undeserved military service benefits.

In a particularly egregious case, Christopher Parris was sentenced to 244 months in prison and restitution of approximately $106 million after pleading guilty to wire fraud in connection with a COVID–19 scam and an unrelated Ponzi scheme.[20] Importantly, this investigation came about after a VA senior official from VA's Office

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[17] VA OIG, *Statement of Leigh Ann Searight, Hearing on "Examining the U.S. Department of Veterans Affairs Supply Chain"*, November 18, 2021.

[18] U.S. Department of Justice, *Businessman Charged in Scheme to Hoard Personal Protective Equipment and Price Gouge Health Care Providers*, January 27, 2021.

[19] US Department of Justice, *Former CEO Sentenced for Defrauding Multiple Federal Agencies*, June 16, 2021.

[20] US Department of Justice, *Former Rochester Man Going To Prison For More Than 20 Years For His Role In Ponzi And COVID–19 Fraud Schemes*, December 20, 2022.

of Acquisition, Logistics, and Construction referred their concerns to the OIG. Parris also agreed to forfeit approximately $3.2 million that was seized by the VA OIG and Homeland Security Investigations. In March 2020, Parris made fraudulent misrepresentations in an attempt to secure orders from VA for PPE that would have totaled more than $806 million. Parris promised that he could obtain millions of genuine 3M masks from domestic factories but knew this would not be possible. He attempted to acquire an upfront payment from VA of over $3 million and received approximately $7.4 million from State governments and private entities by making similar false representations regarding his ability to get PPE.

Unfortunately, some VHA employees also took the early days of the pandemic as an opportunity to steal from VA. From 2019 to 2020, the assistant chief of supply chain management for the Gulf Coast Veterans Healthcare System in Biloxi, Mississippi, stole N–95 masks, electronics, and medical devices. He received 12 months of incarceration, 36 months of probation, restitution of more than $23,000, and a fine of $40,000.[21] A respiratory therapist at the VA medical center in Seattle who stole a ventilator and other respiratory medical equipment during the pandemic was later sentenced to three months in prison, nine months of home confinement, and restitution of more than $132,000.[22]

OIG OVERSIGHT OF VHA'S HEALTHCARE RESPONSE TO THE COVID–19 PANDEMIC

VA's COVID–19 response plan issued March 23, 2020, included providing most outpatient care using telehealth when appropriate. The OIG recognizes VHA has been a pioneer in the development of telehealth delivery, particularly in using clinical video telehealth, which allowed VA providers to diagnose and often treat veterans in real time via interactive, live video.[23] In 2016, VA established the Office of Connected Care (OCC) to administer telehealth programs throughout VA. In 2017, VA launched its VA Video Connect (VVC) mobile app to provide a secure environment for patients and providers to carry out video telehealth visits, regardless of where the veteran and provider were located. VHA clinicians also provide telehealth care via telephone. Starting in March 2020, VHA took actions to expand telehealth delivery to patients. They expedited the credentialing and privileging of healthcare providers in anticipation of staffing shortages and authorized VHA clinicians to use any third-party audio or video communication technology with privacy features for telehealth appointments. In the first year of the pandemic, VHA doubled the number of patients with a telehealth encounter.

Opportunities and Challenges with Increased Utilization of Telehealth

The OIG recently assessed the implementation and use of VVC prior to and during the pandemic.[24] Specifically, the review team explored factors affecting why primary and specialty care providers used telephone communication more frequently than VVC at the onset of the pandemic and in lieu of in-person encounters, and how VHA resolved technology issues. The OIG also examined VHA provider experience with VVC prior to and during the pandemic to identify benefits of and barriers to VVC use. When the pandemic started, VHA was not readily able to support the increased demand of VVC use, leading providers to perform patient care through telephone encounters. This occurred despite VHA having developed telehealth strategic plans, which focused on improving technology to support VVC, increasing provider capability, and identifying emergency preparations for disaster scenarios.

Notably, OCC's chief officer said video visits increased from 2,000 to 40,000 per day and emphasized that, "the technical infrastructure was not scaled to that kind of . . . unexpected and unplannable [*sic*] for growth." As the pandemic continued, providers continued to use VVC, recognizing its value in increasing access to care, and enabling more comprehensive evaluations than telephone encounters could offer. There were identifiable barriers, however, including patient difficulties with technology, lack of clinical and administrative support during the encounters, and challenges with scheduling VVC appointments. VHA concurred with the OIG's three recommendations to address those barriers.

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[21] US Department of Justice, *Former Biloxi VA Employee Sentences to Prison for Stealing VA Property* , January 7, 2022.

[22] US Department of Justice, *Veterans Affairs respiratory therapist pleads guilty to stealing and selling COVID–19 respiratory supplies*, October 5, 2020.

[23] Pandemic Response Accountability Committee, *Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic*, December 2022.

[24] VA OIG, *Review of Access to Telehealth and Provider Experience in VHA Prior to and During the COVID–19 Pandemic*, April 26, 2023.

Veterans also received more telehealth through community care.[25] In the 12 months before the pandemic (March 2019 through February 2020), less than one percent of veterans who received care in the community did so at least once via telehealth. From March 2020 through February 2021, however, about 19 percent of the 871,000 veterans who received care in the community did so at least sometimes via telehealth. Fewer veterans received at least some telehealth care in the community from March 2021 through December 2021–only 8 percent of about 1.1 million veterans.

Overcoming the Digital Divide

During the summer of 2020, VA introduced a new consult process called the digital divide consult, where patients are issued a video-capable device after obtaining a referral from their care team, licensed independent practitioner, or designee, and the approval of a social worker who has conducted a socioeconomic assessment. The process also allowed veterans experiencing homelessness who were enrolled in the Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program to receive devices. The CARES Act gave VA the authority to expand mental health services to isolated veterans through telehealth and required VA to ensure that telehealth capabilities were available to HUD-VASH participants.[26]

The OIG found that the VA's digital divide program was successful in distributing devices to veterans but identified several gaps in oversight and guidance preventing the program from fully meeting its intended purpose for patients to receive virtual care via VVC.[27] After introducing the digital divide consult, VA issued devices (iPads) to about 41,000 patients during the first three quarters of fiscal year 2021. These devices were not always used to connect to video telehealth, as only an estimated 20,300 of those patients (about 49 percent) with issued devices completed a VVC appointment. The remaining patients (about 51 percent) had not used the devices for VVC appointments. An estimated 10,700 patients never had a VVC appointment scheduled, as there was no requirement to schedule, and neither the patient nor the staff initiated scheduling a VVC appointment. The OIG also estimated that more than 10,000 patients had a VVC appointment scheduled but not completed for various reasons, such as technical issues or a cancellation, and a subsequent VVC appointment was not completed.

There were also lapses in device issuance and management during the review of VA's tablet dashboard data. VA staff did not retrieve about 8,300 unused devices (valued at $6.3 million) for other patients' use when they did not have VVC activity, as required by the standard operating procedures. As of January 2022, there was a backlog of about 14,800 returned devices pending refurbishment before they could be redistributed. The returned devices accumulated primarily because of technical issues with the refurbishment system VA used. Despite the backlog, VA did not suspend purchases of new devices from its contractor and placed a purchase order for additional new devices in August 2021. As of December 2, 2021, VA bought 9,720 devices under this purchase order, totaling about $8.1 million.

The program does have positive value, with VHA noting an April 2022 study that found veterans with a history of mental healthcare use and in receipt of a video-enabled tablet were associated with increased use of telemental health services, increased psychotherapy visits, and reduced suicidal behavior and emergency department visits.[28] VA-loaned devices represent a sizable investment, and their use should be monitored closely. The OIG's recommendations included revising the program's standard operating procedures, implementing an alert system that notifies the requesting clinic that a patient has received a device and can now be scheduled a VVC appointment, and updating and enabling systems to check for and initiate retrieval activities for duplicate devices and augment tracking mechanisms.

Assuring Access to Care

Taking advantage of telehealth's opportunity requires VA to schedule appointments timely. At the onset of the pandemic, VHA was challenged to track and fol-

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[25] Pandemic Response Accountability Committee, *Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic*, December 2022.

[26] VA OIG, *Purchases of Smartphones and Tablets for Veterans' Use during the COVID–19 Pandemic*, May 4, 2022.

[27] VA OIG, *Digital Divide Consults and Devices for VA Video Connect Appointments*, August 4, 2022.

[28] Kritee Gujral, James Van Campen, Josephine Jacbos, etc., "Mental Health Service Use, Suicide Behavior, and Emergency Department Visits Among Rural US Veterans Who Received Video-Enabled Tablets During the COVID–19 Pandemic," *JAMA Network Open* (April 6, 2022), *https://doi.org/10.1001/jamanetworkopen.2022.6250*.

low-up on millions of canceled appointments.[29] While VHA had made progress in tracking canceled appointments, it had opportunities to strengthen monitoring of follow-up of care, particularly in specialty care.[30] In another inspection, the OIG found that inadequate staffing within the Martinsburg, West Virginia, VA medical center's Care in the Community Service led to delays in scheduling community consults.[31] 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 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.

CONCLUSION

The OIG appreciates the supplemental funds Congress provided to increase oversight and will continue to make recommendations that assist VA in achieving the most from its resources. The COVID–19 pandemic stressed all aspects of every healthcare system in the country, and the existing problems and limitations within each healthcare system were further exposed and tested. This includes the limitations of systems and processes that are critical to VA operations, and whose deficiencies continue to impact patient care, supply management, as well as stewardship of taxpayer dollars. Congress provided VA with significant regular and supplemental funds to respond to the COVID–19 pandemic, while requesting clarity into their use. The OIG has repeatedly found that VA's failure to effectively modernize its systems leads to significant challenges in assuring accountability and transparency in how it obligates and expends any funds; makes it difficult for VA staff to plan, order, and track the expenditure of supplies; and hampers transparency and oversight into VA's use of these funds. The OIG recognizes 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. However, their efforts are undermined by aging systems that create additional hurdles.

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[29] VA OIG, *Appointment Management During the COVID–19 Pandemic*, September 1, 2020.

[30] VA OIG, *VHA Progressed in the Follow-Up of Canceled Appointments during the Pandemic but Could Use Additional Oversight Metrics*, November 3, 2022.

[31] 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.

APPENDIX: COVID 19-RELATED OIG PUBLICATIONS FROM 2023 TO 2020

1. *VHA Can Improve Controls Over Its Use of Supplemental Funds*, May, 9, 2023.

2. *Review of Access to Telehealth and Provider Experience in VHA Prior to and During the COVID–19 Pandemic*, April 26, 2023.

3. *Audie L. Murphy Memorial Veterans' Hospital Missed Opportunities to Distribute Excess Ventilators during the COVID–19 Pandemic*, April 11, 2023.

4. *VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: March 2023*, March 21, 2023.

5. *Physician's Falsification of VA Video Connect Blood Pressures at the North Las Vegas VA Medical Center in Nevada*, January 25, 2023.

6. *Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic*, December 1, 2022. Published in conjunction with the Pandemic Response Accountability Committee.

7. *VHA Progressed in the Follow-Up of Canceled Appointments during the Pandemic but Could Use Additional Oversight Metrics*, November 3, 2022.

8. *VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: September 2022*, September 22, 2022.

9. *The Veterans Health Administration Needs to Do More to Promote Emotional Well-Being Supports Amid the COVID–19 Pandemic*, May 10, 2022.

10. *Purchases of Smartphones and Tablets for Veterans' Use during the COVID–19 Pandemic*, May 4, 2022.

11. *Comprehensive Healthcare Inspection of Facilities' COVID–19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6*, April 7, 2022.

12. *VA's Compliance with the VA Transparency & Trust Act of 2021*, March 22, 2022.

13. *Audit of Community Care Consults during COVID–19*, January 19, 2022.

14. *Systems and Tools Implemented to Track COVID–19 Vaccine Data*, December 7, 2021.

15. *Comprehensive Healthcare Inspection of Facilities' COVID–19 Pandemic Readiness and Response in Veterans Integrated Service Networks 1 and 8*, November 18, 2021.

16. *Deficiencies in Select Community Care Consult (Stat) Processes During the COVID–19 Pandemic*, November 10, 2021.

17. *Vet Center Inspection of Southeast District 2 Zone 2 and Selected Vet Centers*, September 30, 2021.

18. *Vet Center Inspection of Continental District 4 Zone 2 and Selected Vet Centers*, September 30, 2021.

19. *Vet Center Inspection of Pacific District 5 Zone 1 and Selected Vet Centers*, September 30, 2021.

20. *Failure to Mitigate Risk of and Manage a COVID–19 Outbreak at a Community Living Center at VA Illiana Health Care System in Danville, Illinois*, September 28, 2021.

21. *Care Concerns and the Impact of COVID–19 on a Patient at the Fayetteville VA Coastal Health Care System in North Carolina*, September 27, 2021.

22. *Comprehensive Healthcare Inspection of Facilities' COVID–19 Pandemic Readiness and Response in Veterans Integrated Service Network 19*, July 7, 2021.

23. *Medical/Surgical Prime Vendor Contract Emergency Supply Strategies Available before the COVID–19 Pandemic*, June 14, 2021.

24. *Review of VHA's Financial Oversight of COVID–19 Supplemental Funds*, June 10, 2021.

25. *Use and Oversight of the Emergency Caches Were Limited during the First Wave of the COVID–19 Pandemic*, June 9, 2021.

26. *Inconsistent Documentation and Management of COVID–19 Vaccinations for Community Living Center Residents*, April 14, 2021.

27. *Review of Community-Based Outpatient Clinics Closed Due to the COVID–19 Pandemic*, April 6, 2021.

28. *Comprehensive Healthcare Inspection of Facilities' COVID–19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20*, March 16, 2021.

29. *Potential Risks Associated with Expedited Hiring in Response to COVID–19*, March 11, 2021.

30. *Review of Veterans Health Administration's Virtual Primary Care Response to the COVID–19 Pandemic*, March 11, 2021.

31. *Reporting and Monitoring Personal Protective Equipment Inventory during the Pandemic*, February 24, 2021.

32. *Medication Delivery Delays Prior to and During the COVID–19 Pandemic at the Manila Outpatient Clinic in Pasay City, Philippines*, January 28, 2021.

33. *Added Measures Could Reduce Veterans' Risk of COVID–19 Exposure in Transitional Housing*, December 18, 2020.

34. *Review of Veterans Health Administration's Emergency Department and Urgent Care Center Operations During the COVID–19 Pandemic*, December 17, 2020.

35. *Enhanced Strategy Needed to Reduce Disability Exam Inventory Due to the Pandemic and Errors Related to Canceled Exams*, November 19, 2020.

36. *Veterans Crisis Line Challenges, Contingency Plans, and Successes During the COVID–19 Pandemic*, October 28, 2020.

37. *Date of Receipt of Claims and Mail Processing during the COVID–19 National State of Emergency*, September 17, 2020.

38. *Appointment Management During the COVID–19 Pandemic*, September 1, 2020.

39. *Alleged Deficiencies in the Management of Staff Exposure to a Patient with COVID–19 at the VA Portland Health Care System in Oregon*, August 27, 2020.

40. *Review of Veterans Health Administration's COVID–19 Response and Continued Pandemic Readiness*, July 16, 2020.

41. *Review of Highly Rural Community-Based Outpatient Clinics' Limited Access to Select Specialty Care*, July 7, 2020.

42. *OIG Inspection of Veterans Health Administration's COVID–19 Screening Processes and Pandemic Readiness*, March 26, 2020.

Prepared Statement of Whitney Bell

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

Thank you for inviting the National Association of State Veterans Homes (NASVH) to testify about the impact of the COVID–19 pandemic on State Veterans Homes (SVHs), and how the Department of Veterans' Affairs (VA) supported SVHs and the veterans we care for. As you may know, NASVH is an all-volunteer organization dedicated to promoting and enhancing the quality of care and life for the veterans and families in our SVHs through education, networking, and advocacy.

My full-time job is Administrator of the State Veterans Home in Fayetteville, North Carolina, where I oversee a 150 bed facility providing skilled nursing care to aging and disabled veterans. Today I am pleased to share with the Committee my direct experiences and observations, together with those of my NASVH colleagues, about how the pandemic has and continues to challenge State Veterans Homes, and the many ways that VA has been able to support us over the past three years.

Background

The State Veterans Homes program is a partnership between the federal government and state governments that dates back to the post-Civil War period. Today, there are 163 State Veteran Homes located in all 50 states and the Commonwealth of Puerto Rico, with over 30,000 authorized beds providing a mix of skilled nursing care, domiciliary care, and adult day health care. SVHs provide half of all federally supported institutional long-term care for our nation's veterans, however as VA's FY 2023 budget submission makes clear, State Veterans Homes will consume less than 20 percent of VA's FY 2023 total obligations for veterans' long term nursing home care. Furthermore, VA's calculation of the institutional per diem for SVH skilled nursing care is 40 percent lower than for private sector community nursing homes and less than one-eighth that of VA's Community Living Centers (CLCs). It's clear that this federal-state partnership provides tremendous value for VA and for veterans.

To help cover the cost of America's veterans residing in SVHs, VA provides per diem payments at different rates for skilled nursing care, domiciliary care, and adult day health care (ADHC). VA also provides State Home Construction Grants to cover up to 65 percent of the cost to build, renovate and maintain SVHs, with States required to provide at least 35 percent in matching funds for those projects.

As a responsibility of providing Federal funding, VA certifies and closely monitors the care and treatment of veterans in State Veterans Homes. Although VA does not have direct statutory "*...authority over the management or control of any State home*."[38 USC 1742(b)], federal law provides VA the authority to "*...inspect any State home at such times as the Secretary deems necessary*." and to withhold per diem payments if VA determines that the Home fails, "*to meet such standards as the Secretary shall prescribe...*"[38 USC 1742(a)]

Oversight of State Veterans Homes

As required by law, VA performs a comprehensive inspection survey of each State Veterans Home annually to assure resident safety, high-quality clinical care, and sound financial operations. This inspection survey is typically an unannounced week-long comprehensive review of the Home's facilities, services, clinical care, safety protocols and financial operations.

VA has extensive regulations covering every aspect of SVH operations. 38 C.F.R. Part 51, Subpart D, sections 51.60 through 51.210, provide a description of the standards for skilled nursing facilities that every State Veteran Home must comply with to ensure resident rights, quality of life, quality of care, nursing services, dietary services, physician services, specialized rehabilitative services, dental services, pharmacy services, infection control, and the physical environment of the Homes. In total, there are more than 200 clinical standards reviewed during VA's annual inspection survey, in addition to dozens of fire and life safety standards, which are outlined in the National Fire Protection Association (NPFA) Life Safety Codes and Standards. Finally, VA surveys and inspections conduct a financial audit concerning the Homes financial operations and to ensure proper stewardship of residents' personal funds. There are also similarly detailed regulations for domiciliary and adult day health care programs run by State Veterans Homes.

About 72 percent of State Veterans Homes are also certified to receive Medicare support for their residents and must undergo annual inspections by the Centers for Medicare and Medicaid Services (CMS) to assure safety and quality care. The CMS inspection survey process also covers more than 90 percent of the same clinical life and safety sections of the VA inspection survey in a week-long inspection that is

not announced in advance. All deficiencies identified by the CMS inspection must be corrected as a condition of continuing to receive CMS financial support.

In addition to the VA and CMS inspections, State Veterans Homes are also subject to both regular and periodic inspections and audits from the Inspector General of the Department of Veterans Affairs, and the Civil Rights Division of the Department of Justice. SVHs generally function within a state's department or division of veterans' affairs, public health, or other accountable agency, and typically operate under the governance and oversight of a board of trustees, a board of visitors, or other similar accountable public body. State Veterans Homes also have regular inspections from State and local authorities examining their fire safety preparedness, pharmaceutical practices, health and sanitary protocols, food safety practices and other public health and sanitization protocols.

How the COVID–19 Pandemic Has Impacted State Veterans Homes

Chairman Bost, when COVID–19 first emerged in 2020, State Veterans Homes were among the first institutions to take significant precautions to protect our residents. Battling communicable viruses has always been a regular part of our operations and we have strong infection control regimens which have long been utilized to help prevent and mitigate the spread of influenza and other viruses in our facilities. However, the outbreak and spread of COVID–19, particularly in its early asymptomatic form, made it virtually impossible to prevent it from entering any facility or location in the country. Despite myriad precautions taken – including enhanced use of personal protective equipment (PPE), suspension of visitation and new admissions, screening of staff and residents for symptoms, and strict social distancing – the lack of vaccines, treatments and testing capacity nationally made all nursing homes a prime target of COVID–19.

It is important to note that veterans in State Veterans Homes are primarily older men who have significant disabilities and comorbidities, and that studies have shown that COVID–19 disproportionately affected older men with underlying health conditions. In fact, the percentage of veterans residing in SVHs aged 85 or older (38 percent) is double the percentage of both VA's CLCs (18 percent) and community nursing homes (19 percent).

From the onset of the pandemic, State Veterans Homes proactively sought to procure sufficient PPE to protect veterans and staff. However, inadequate national inventory and stockpiles of PPE – particularly N95 masks, isolation gowns and face shields – posed a tremendous problem. Another critical challenge was the inability to quickly and accurately test for COVID–19 and receive timely, valid results for both residents and staff. As a result, when one resident or staff member tested positive, Homes would often quarantine other staff or residents who might have come in contact with the person who tested positive. This resulted in large numbers of staff in some State Veterans Homes being required to remain at home until they passed a 14-day quarantine period or had one or more negative test results to indicate they did not carry the virus. Consequently, SVHs were forced to dramatically increase overtime for remaining staff or to bring in additional temporary staff, significantly increasing costs.

As the pandemic stretched from months to years, the impact on the finances of SVHs has been devastating. Every State Veteran Home has had to significantly increase expenditures for PPE, cleaning and sanitizing supplies, and laundry services. Depending on the level of COVID–19 spread in a facility, Homes have had enormous increases for personnel costs to cover wages, overtime, hazard pay, sick leave and temporary staffing. In addition, many Homes have made modifications to buildings and rooms for isolation and sanitization, including the purchase of new equipment.

At the same time, occupancy levels in most SVHs declined as veteran residents passed away due to COVID and non-COVID causes, and because new admissions were suspended. Today, even with effective vaccines, treatments, and testing now available to mitigate many of the dangers from COVID–19, SVHs still face significant challenges in bringing their occupancy rates back up to normal levels, primarily due to national staffing shortages impacting all health care facilities. As a result, the level of VA per diem support provided each year to State Veterans Homes has declined significantly over the past three years, creating serious financial challenges for Homes to remain solvent at a time when their State budgets are also in crisis.

How VA Supported State Veterans Homes During the COVID–19 Pandemic

Early in the COVID–19 pandemic, VA began to provide a range of support to SVHs under its "Fourth Mission" to support the Nation's health care system in national emergencies. In North Carolina, VA provided testing, PPE, training for properly using respirators, and additional training in infection control to our Homes.

Our relationship with VA throughout the pandemic has been very strong and made a key difference for our Homes and our veterans.

Other SVHs also received a variety of support, depending on their local needs and VA's local capabilities. For example, VA provided thousands of face masks and protective gowns to Homes in Illinois and Michigan. In California, VA provided testing for up to 200 State Home residents and employees weekly. In Iowa and in Idaho, VA provided direct staffing support for Homes facing critical vacancies, specifically nurses. In Idaho, the VA also supplied testing collection kits and rendered COVID–19 testing services through their lab for the State Homes' residents and staff. South Carolina received over 100,000 gowns, gloves, masks, face shields, and 2,000 test kits. In New York, VA supported a Long Island State Veteran Home program that delivered meals and checked regularly via telehealth on veterans unable to access the Adult Day Health Care program due to COVID–19 restriction. These are just some examples of the many ways that VA worked to support SVHs during the pandemic.

Waivers During the Public Health Emergency

As the pandemic quickly took hold in March 2020, NASVH worked with this Committee and its counterpart in the Senate to look for ways to mitigate the impact of COVID–19 on State Veterans Homes. One of the key challenges was meeting staffing requirements as employees either contracted COVID–19 or had to be quarantined due to exposure. To help limit the loss of financial support during the pandemic, Congress included provisions in the CARES Act (P.L.116–136) to provide temporary waivers from occupancy rates and veteran percentage requirements, as well as a provision authorizing VA to provide PPE to SVHs during this public health emergency. VA was also able to waive the bed hold requirement during the public health emergency so that SVHs would not lose per diem for veterans who were receiving temporary in-patient treatment in an acute care setting.

However, with the formal end of the public health emergency on May 11, 2023, SVHs are now at risk of losing significant financial support from VA, which is particularly challenging at a time when staffing shortages continue to limit their ability to bring up their occupancy rates. To address this financial burden, bipartisan legislation was introduced in the Senate (S. 1436) which, among other provisions, would allow SVHs to receive per diem payments for bed-holds even when the SVH does not meet the required 90 percent occupancy rate. The bill would also continue to allow VA to provide PPE and supplies to SVHs at its discretion to help keep residents and staff safe during other health emergencies. Mr. Chairman, we would welcome the opportunity to talk with you or other members of the Committee who might be interested in sponsoring companion or similar legislation to support veterans residing in SVHs.

Financial Support for Per Diem and Construction Grants

NASVH would like to thank this Committee for all its outreach and support during the pandemic, particularly for helping to secure emergency supplemental funding for SVHs. As a result of provisions included in the American Rescue Plan (ARP) Act of 2021 and the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act as amended by the Consolidated Appropriations Act, 2021, VA was able to provide $1 billion in supplemental support to SVHs:

- $500 million from the ARP designated to provide additional State Home Construction Grants
- $250 million from the ARP for one-time grants related to operating needs based on each SVH's share of total veteran residents receiving skilled nursing home and domiciliary care;
- $150 million from the CARES Act designated State Home Construction Grants to modify buildings to prepare, prevent, respond to, or mitigate the risk of COVID–19; and
- $100 million designated by the Consolidated Appropriations Act, 2021, for grants for emergency payments to existing State Veterans Homes to prevent, prepare and respond to COVID–19.

SVHs have been able to use these supplemental resources to sustain operations, hire new staff, expand, and build new infection control systems, and modify facilities to help prevent the spread of COVID, influenza, other viruses, and infectious diseases.

In addition, VA has begun accelerating basic per diem rate increases to support veterans in SVHs with two increases a year, rather than just a single annual cost-of-living adjustment. NASVH is grateful for all the emergency support provided by

Congress and VA over the past three years, and we are proud of the continued partnership between states and the federal government to support the men and women who served.

Additional Support Requested from Congress

Mr. Chairman, although the public health emergency has ended, State Veterans Homes continue to face significant challenges to continue caring for aging and disabled veterans, and we respectfully ask this Committee to continue working with us to address these needs.

As mentioned above, the bipartisan CHARGE Act (S. 1436) is pending in the Senate, and we would be grateful if a companion or similar bill were introduced and considered in the House. NASVH is also seeking congressional support for legislation to address several other needs SVHs have been facing in recent years.

Although VA is authorized to pay a basic per diem that covers up to 50 percent of the cost of a veteran's care, the basic per diem rates in recent years have been less than 30 percent, even lower during the height of the pandemic. We would ask for legislation to set the basic per diem rate at 50 percent of the daily cost of care.

NASVH is also seeking support from Congress to fully fund the State Home Construction Grant program. Over the past decade, annual appropriations for this program have been extremely volatile: typically providing funding for only a small portion of the qualified state matching grants, but fortunately with a couple of years that met the full demand for federal matching funds. For FY 2024, NASVH is asking Congress to provide at least $600 million to the State Home Construction Grant program, although once the VA releases its new priority list the actual need may be closer to $900 million.

Finally, NASVH is asking Congress to enact legislation to help SVHs recruit and retain sufficient staffing to allow full occupancy of our nursing homes and other programs. As this Committee is fully aware, there is a staffing crisis affecting every health care system in the Nation, particularly for nurses and other critical clinical positions. State Homes have been grateful for the Nurse Recruitment and Retention Scholarship program which has had a positive impact on a number of SVHs. We are asking Congress to expand that program so that more Homes can benefit from it. At the same time, we believe that a similar program for other critical staffing vacancies could help boost the ability of SVHs to compete with private sector employers who are able to offer higher salaries and benefit packages.

In conclusion, NASVH greatly values the federal-state partnership underlying the State Veterans Home program. During the COVID pandemic, we experienced firsthand the tremendous value of VA supporting SVHs, and that dynamic must continue. The veterans we serve have greatly benefited from that partnership, and in particular, from the supplemental funding Congress provided to VA. As we look to the future, NASVH hopes to continue working with this Committee and Congress to find new and innovative ways to further strengthen the State Veterans Homes system for the men and women who served.

Mr. Chairman, that concludes my testimony. Thank you for the opportunity to appear before the Committee today. I would be pleased to answer any questions that you or members of the Committee may have.

STATEMENT FOR THE RECORD

Prepared Statement of National Coalition for Homeless Veterans

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

In the United States there is broad bipartisan agreement that no man or woman who has sacrificed for and served our country should struggle to meet their basic needs. Despite this, over 33,000 veterans experience homelessness on any given night. The Department of Veterans' Affairs' (VA) continuing ability to provide services to these vulnerable veterans expired on May 11th with the end of the Public Health Emergency (PHE).

Since 2009, the United States has cut the number of veterans experiencing homelessness on any given night by over half; we know what works and what more is needed to cross the finish line. Congress in its wisdom enacted provisions into law to enable VA to better serve veterans, albeit during a time of national emergency. The initial feedback from this response shows certain measures were incredibly effective. Last year alone, VA worked with communities to help more than 40,000 veterans out of homelessness and into the safe, stable homes that they deserve," said VA Secretary McDonough. "We know that it's possible to end homelessness because we are making real progress every day . . ." We know that while the community at large was unable to keep up with the pace of homelessness over the course of the PHE, VA and the homeless veteran community of providers were able to reduce veteran homelessness by 11 percent from 2020–2022.

The bipartisan *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020* (P.L. 116–315) strengthened programs that emphasize permanent solutions to housing instability and homelessness among veterans. Section 4201 of P.L. 116–315, also known as Isakson/Roe, is an effective authority that must be maintained since as a VA official recently testified, "we will not eliminate veteran homelessness without these additional authorities." As knowledge of VA's new authorities spread and implementation improved, the number of veterans VA has been able to assist has skyrocketed. Whereas VA was able to help 32,000 veterans with just Section 4201 authorities alone in 2022, these authorities supported over 7,000 veterans in 1 month this year.

A quick real-life example that utilizes multiple authorities such as access to hotels, rideshares, and phones. A female veteran was able to be placed in a hotel in the rural town where she was seeking permanent housing and had no access to shelters there. With the stability in the hotel, she was able to engage in substance abuse treatment and mental health care at the VA super Community Based Outpatient Center or CBOC. Rideshare transported her to these appointments until she was housed in HUD/VASH supportive housing. Without 4201 she would not have had the opportunity to attain stability and the likelihood of her following through with substance and mental health care was slim. In addition, the very rural area of Southeast Missouri has zero public transportation. The rideshare provided a lifeline to their homeless population. The veteran was provided with a cell phone, which made all this possible through the ability to contact her.

There are thousands of stories just like this veterans', and NCHV takes this opportunity to lift up the legislation introduced in the 118th Congress that is attempting to rectify the loss of these commonsense authorities:

H.R. 645 the *Healthy Foundations for Homeless Veterans Act* Veterans are better able to get to appointments, access their supportive services, have access to necessities as well as be contacted facilitating access to telehealth services in remote locations. Using section 4201 authority under Isakson/Roe, VAMCs provided additional services ranging from items like tents and food, to communications, and transportation in the form of bikes and ride shares for tens of thousands of veterans during the public health emergency. The bill was also referred with bipartisan support by voice vote in the House Veterans Affairs Committee's Subcommittee on Economic Opportunity.

We also highlight the *Return Home to Housing Act* or **H.R. 491**, a bill that would adjust the maximum reimbursement rate for VA grantees for shelter, clinical services, and essential sustenance for veterans, as the daily amount available for reimbursement has dropped over 60 percent to $64.52 a day. The increased financial burden of prioritizing COVID safety measures paired with ongoing operating and maintenance costs makes these programs unsustainable at this level and may leave grantees with no option but to discontinue providing these essential services altogether.

Service providers are being forced to make tough financial decision others have related to prioritizing health safety measures at a financial loss. Limits are being put on essential services for veterans such as meals, wrap around services, beds, facility security and some are having to make the decision to maintain staff. NCHV has seen providers pleading with their representatives explaining how letting these authorities' sunset was essentially cutting their access to funds to assist veterans by over $60,000 a month. Every veteran deserves access to safe shelter and housing, whether they are currently experiencing homelessness or are facing housing-associated costs that put them at risk of homelessness.

The proposals in these two bills are included in the recently introduced **S. 1436** – the *Critical Health Access Resource and Grant Extensions (CHARGE) Act of 2023*.

This legislation would extend successful, essential veterans' programs and authorities from the last few years that expired May 11th. The bill includes extensions of critical provisions related not only to homelessness but health care access, caregivers, and State Veterans Homes as well:

- Increases the maximum reimbursement amount for grantees receiving funds from VA to provide temporary housing for homeless veterans. Without this provision, most of these programs, especially in rural and isolated areas with minimal financial support alternatives, are being forced to reduce services, beds, and even cease their programs due to the limitation on reimbursement amounts.
- Allows VA to continue providing gap services and support to homeless veterans in circumstances where other support is not available, including providing necessary personal and hygiene items, transportation services, food, landlord incentives for housing homeless veterans, and more.
- Extends authority to allow veterans and caregivers to elect for virtual home visits through September 30, 2023, or until VA finalizes their new regulations for the Caregivers program.
- Extends the State Veterans Homes' occupancy rate requirement waiver until September 30, 2023, so that State homes are not financially penalized for staffing shortages.
- Makes permanent an authority that allows VA to share PPE, vaccines, medical supplies, and other resources with State Veterans Homes.

As you consider further oversight in the 118th Congress, the National Coalition for Homeless Veterans (NCHV) asks you to look at how VA is forced to compensate in lieu of passing the Critical Health Access Resource and Grant Extensions (CHARGE) Act of 2023 (S. 1436), the Healthy Foundations for Homeless Veterans Act (H.R. 645) which has already been reported favorably out of the Subcommittee on Economic Opportunity, and the Return Home to Housing Act (H.R. 491).

All three pieces of legislation are a testament to the dedication and challenging work of communities nationwide, and the responsiveness and bipartisanship of the House and Senate Committees on Veterans' Affairs, its Members, and their dedicated staff. We are committed to working with Congress and our partners across the country to end homelessness among veterans, and passage of H.R 645, H.R. 491, and S. 1436 will be crucial in this endeavor. Thank you in advance for your consideration and support.

Very respectfully,

The National Coalition for Homeless Veterans

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